Discussing historical trends in psychiatry and mental health care

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About twenty years ago (1981) the well-known Dutch sociologist Paul Schnabel, at that time supervising the research department of the Dutch Centre for Mental Health (now Trimbos-Institute), wrote a short piece in the *Maandblad Geestelijke Volksgezondheid*, the monthly *Journal of Mental Health*. Its headline was: "Here everything is better, but apparently we don't know". Although in the same journal Dutch mental health care was and is often criticised, Schnabel plainly claimed that there was no country in the world having such an extensive and differentiated supply of very accessible mental health care facilities and spending so much money per capita on mental health care as the Netherlands. As far as the quantity and quality of mental health care was concerned, according to Schnabel, Holland was a big power. If you had to go insane, you'd better be in or go to the Netherlands, thus ran Schnabel's message, adding that the Dutch did not appear to be aware of, let alone proud of their achievement, because for them it was so self-evident.

I would not dare to confirm or deny Schnabel's self-congratulatory statements. Instead I would like to compare the Netherlands with other Western countries from a somewhat more detached and analytical viewpoint. To what extent was the development of mental health care in the Netherlands similar to developments elsewhere in the Western world and to what extent was it different or perhaps even unique from an international perspective? It is one of the questions Marijke Gijswijt and I would like to answer in our book on the 20th-century social history of Dutch psychiatry and mental health care that we are writing - a question we can, however, hardly answer without your help. In fact throwing some light on the similarities or differences between Dutch mental health care system and that in other Western countries is the main purpose for having organised this workshop. Therefore, I would like to discuss some general international trends in 20th century psychiatry and mental health care and, as a way of prompting the discussion, point to some Dutch peculiarities and speculate on to what extent we would be able to speak of a special Dutch case. Next to the papers which have been discussed today, I will also briefly refer to papers that are programmed for the next days. The issues that I will raise might be relevant for the whole conference and I hope that they will be discussed not only today but also on Friday and Saturday.

Let me first have a look at the history of **intramural, institutional psychiatry**.

Some main trends that Marijke Gijswijt, Hugh Freeman and Volker Roelcke refer to in their papers can probably be found in all Western countries.

1 The gradual transformation of **closed asylums** where patients were admitted only or mainly with **legal certification** and more often than not for social rather than medical reasons into more **open hospitals** that more and more admitted patients on a **voluntary basis** and according to **medical criteria**. However, this does not mean that the old asylums were by definition institutions of social control and that there was something like a great confinement. Marijke Gijswijt and Hugh Freeman as well as Akihito Suzuki, Gerald Grob, Patrizia Guarnieri and Joost Vijselaar have convincingly refuted such a revisionist view. Reading and comparing their papers, some on them focusing on patients, alerted me to how complicated and divergent patterns of care and of institutional admission and discharge actually were. Above all, it appears that social, political, administrative, financial considerations as well as family-interests and gender and class relations were crucial rather than medical criteria in themselves. In this way these papers at the same time underline one of tenets of revisionism, namely that the history of (institutional) psychiatry should and can only be a form of social history, including politics and also economics.

2 Closely connected to the transformation I just mentioned, is that the emphasis shifted from **shelter and care** to **treatment and cure,** although we should be aware of the fact that the shelter-function of mental institutions might have been dominant much longer than is often assumed, as becomes clear from Joost Vijselaar's paper. In many countries the early 1950s appear to mark a turning point: more and more patients were actually treated instead of just being cared for and from then on we also see, especially in the second half of the 20th century, a reduction of the average time-periods in which individuals were hospitalised. As far as psychiatric treatment is concerned, several papers suggest that the current idea of a strong antagonism of and alternation between a medical-biological approach and psychological as well as social methods has to be put in perspective. More often than not, it seems, psychiatric practice - contrary to theory - was eclectic. Different interventions co-existed. Thus Toine Pieters and Stefan Snelders make clear that the vast increase of the consumption of psychiatric drugs and a psychological approach were mutually reinforcing rather than excluding or opposing each other.

3 **Internal and external differentiation** of the asylum population, increasingly according to medical criteria, such as chronic cases and emergency cases, and also the separation of care and therapeutic treatment, and the **"transinstitutionalisation"** - as Gerald Grob has aptly characterised it - of mentally handicapped and psycho-geriatric patients to specialised institutions in the second half of the 20th century, thus leaving behind in the mental hospitals, so to speak, patients with "pure" psychiatric disorders. Such differentiation has not always served the well-being of all patients, as Volker Roelcke has made clear in the case of the Nazi-Germany.

4 Very crucial, I think, are changes in the way mental institutions were **financed** and **administered**. Until far into the 20th century they were largely dependent on poor relief and their social and medical status was low. Sooner or later (countries like Sweden and Britain were in the vanguard) in the context of the welfare state, collective medical insurance and social security schemes have replaced poor relief. More money and the growing involvement of national governments, but the question still is whether the quality of care and living conditions of the mentally ill improved. In this respect Marijke Gijswijt has treated the quality of care as one of her themes and she and also Peter Nolan have raised the question whether there was progress from a humanitarian viewpoint. Closely connected to this change in administration and financing is that after the second World War **central governments in western welfare states** have subsumed the former role of local or provincial governments, although in many countries responsibilities have been decentralised again during the two last decades of the 20th century.
5 In the last decades of the century, we see **deinstitutionalisation** almost everywhere, although in some countries it was introduced earlier and more radically than in others. Compared to the Anglo-Saxon countries and Italy, where there was a demise of the public system of mental institutions, or at least a considerable reduction of its size, in Germany, France, Belgium and the Netherlands as well as the Nordic countries as far as I understand from the papers of Einar Kringlen en Gunnel Svedberg, deinstitutionalization started later and it was carried through more gradually and by no means radically. After reading the papers of Akihito Suzuki and Patrizia Guarnieri one also realises that the policy of de-institutionalisation from the 1960s and 1970s on has historical and non-western equivalents. It appears that officially sanctioned family-care already existed on a fairly large scale in early 20th-century Japan and Italy. Perhaps late 20th-century de-institutionalisation was far from unique and it should be put in perspective.

In what sense might Dutch intramural psychiatry have been different from that in other countries? Three features might be relevant here.

1 In the field of asylum psychiatry The Netherlands lagged behind most other Western countries. Until the last decades of the 19th century most mental institutions were old - sometimes centuries old - and small and they were situated in towns. The "great building" of modern asylums in the countryside took only place in the last decades of the 19th century and the first decades of the 20th century. The Netherlands was among the first countries to introduce an insanity law emphasising the insane were patients to be treated and cured and imposing state supervision on asylums to guard good standards of care and treatment, but the Dutch government showed not hardly any zeal to incite the provincial governments to build public asylums, as the insanity law required.
2 The second characteristic more or less follows from the first. In the context of the so-called **pillarization** of Dutch society, private, religiously inspired initiatives played a prominent role in the building and administration of mental

institutions. But here I should add that in Belgium and probably also in Germany the churches and religious organisations have also played a significant part in the organisation of mental institutions. As in other social sectors there has always been a delicate balance in Dutch mental health care between **private organisation and administration** on the one hand and **public financing and government supervision** on the other. The role of the Dutch government was rather passive in the field of mental health care, at least until the mid-1970s, when it began to formulate and implement its own policies. The overall impact of pillarization as an outstanding feature of Dutch intramural mental health care is still question-begging. To what extent did **religion**, orthodox protestant as well as catholic, make a difference as far as actual care and treatment of patients in mental hospitals are concerned? I suspect that the influence of religion was more meaningful in extramural mental health care than in psychiatric institutions.

3 The third characteristic concerns **the therapeutic regime** in Dutch mental institutions. In general, Dutch institutional psychiatrists followed international medical developments, but the very prominent role of **active therapy** in the Netherlands from the 1920s on until the 1950s or 1960s is striking. Although active therapy, a **social and didactic** rather than medical approach to mental illness, originated in Germany, this 20th-century version of 19th-century moral therapy seems to have been popular and lasting especially in the Netherlands. I don't know if there are any countries in which it played a similar prominent role. How can it be explained? Perhaps it has something to do with the rather small scale of Dutch mental institutions, certainly compared to the ones in the US, Britain, France and Germany. The Santpoort institution near Amsterdam that in the early 1930s hospitalized almost 1500 patients was by far the largest institution in the Netherlands ever. Most of the mental hospitals, which were often built according to the pavilion or cottage system, were much smaller. Another explanation would be that active therapy fits in with a more general preference for moral didactic and social approaches that can also be found in extramural mental health care and social work. Compared to their colleagues in other European countries, Germany in particular, Dutch psychiatrists were more reserved towards somatic treatments; in general, their approach was rather eclectic and many of them, especially had an open mind for psychoanalysis as well as social, phenomenological and anthropological psychiatry. Again pillarization - several psychiatrists created an orthodox protestant or catholic profile of their profession - seems to have played an important role here. In this respect I also would like to point to some specific features of **psychiatric nursing** in the Netherlands, the subject of Cecile aan de Stegge's paper. The Netherlands is one of the few countries where psychiatric nursing developed apart from general nursing in somatic medicine and where there has been a separate training system for psychiatric nurses from the late 19th century on. In the Netherlands this separate training existed until 1997 and in the course of the 20th century, partly under the influence of orthodox protestant ideas on psychiatric care, more and more psychological, didactic, and social

approaches were brought to the fore. I have the impression that in many other countries, Sweden for example, as Gunnel Svedberg suggests, nursing was much more medically oriented.

Let me now turn to the **development of psychiatry outside of the mental institutions**. The international position of the Netherlands is, I think more, more exceptional in the field of extramural than in that intramural mental health care.

One of the distinctive general features of the 20th-century history of psychiatry is **the expansion of its domain** - although one should not forget that psychiatry also more or less lost some fields such as the care and treatment of the mentally handicapped and what developed as psycho-geriatrics. Whereas in the 19th century psychiatry was predominantly confined to asylums, in the course of the 20th century it gained ground in other institutions like general hospitals and clinics, in private practice, and in new outpatient mental health treatment and care facilities. Ido Weijers has illustrated this development by presenting some quantitative data on the changing workplaces of Dutch psychiatrists in the course of the 20th century and I assume that similar developments can be seen in other Western countries. Psychiatry became part of the more-embracing field of mental health care and its growing size, in both absolute and relative terms, was accompanied by **professional expansion** and also by an **increasing professional diversity**. As David Healey quite cynically remarks, if there is any progress in the history of psychiatry, it is certainly to be found in the increasing numbers of mental health professionals. Until the 1950s, psychiatrists and nurses or attendants still dominated the field. Since the 1960s they began to be confronted with growing numbers of psychologists, social workers, pedagogues, specialized psycho- and other therapists and several other, often new, professions. This professional expansion and diversity, of course, reflected an increasingly wider spectrum of patients and clients. Not only serious mental illnesses, but also an increasing variety of relatively mild psychic disorders and complaints and a wide diversity of more or less common problems in modern life have become part of the mental health system's sphere of action. In the last two decades of the 20th century this apparently unbridled extension was questioned, primarily motivated by financial reasons, but also, because it has become clear that the boom of what Einar Kringlen characterizes as "cosmetic psychiatry" often was at the cost of people suffering from serious and chronic mental illnesses, as Gerald Grob has also emphasised.

Let me suggest some possible explanations of the expanding domain of mental health care:

First, I think this development is part of the **internal dynamic of modern psychiatry** that goes back to its birth around 1800. If there is a law in the history of psychiatry, I would suggest that to a very large extent supply increasingly created demand. The **recurrent alternation and juxtaposition of therapeutic optimism and pessimism** again and again advanced the creation of new

psychiatric facilities and the expansion of its clientele. Time and again, experts argued that the existing facilities fell short in providing adequate treatment to patients, let alone cure them. Yet this observation almost never led to the conclusion that psychiatry itself, as discipline, was fundamentally flawed; instead the belief prevailed that new ways of organizing care, establishing new facilities and introducing new therapies would lead to successes where older efforts had failed. It is striking that newly established facilities often did not so much improve the treatment of existing patients, but rather caused the emergence of new groups of patients, whereby the distinction made between those who were treatable and those who were not, was underlined. This frequently implied that more attention for the former led to the neglect of the latter.

In the 20th century, the mental hygiene movement, the prescription and consumption of psychiatric drugs and even anti-psychiatry, despite it's radical criticism of psychiatry, perfectly fit into this picture, which is illustrated in the papers of Hans Pols, Gerald Grob, Toine Pieter and Stefan Snelders and Gemma Blok, and also in my own paper. The psycho-hygienic effort that was geared toward the prevention of mental disorders gradually caused a substantial expansion of psychiatry's patient group, because people who were basically still healthy, but who were considered to be at risk of becoming mentally ill, were included. More treatment facilities for more people was the psycho-hygienic message. Pieters and Snelders draw attention to a dynamic, apparently inherent in drug prescription and consumption. Various drugs that were basically developed or discovered as curatives for serious mental illnesses, sooner or later were consumed by people suffering from rather mild psychological disorders or just emotional problems. More and more the boundary between therapeutic and cosmetic treatment seems to be fading. Ironically anti-psychiatry strengthened rather than weakened the expansion of mental health care in Western societies. Aiming its shots at medical and institutional psychiatry, it still argued for better and even more intensive treatments along social-psychological lines, either in clinics or even better, in outpatient facilities. So, the expanding mental health care system had few problems absorbing elements of the anti-psychiatric critique. From the 1960s on, mental health expanded to comprise welfare and individual well being as well: many psychotherapists catered to individuals who were basically healthy but who nevertheless were troubled by personality flaws, their potential for self-development, or questions associated with finding meaning in one's life.

Next to this internal dynamic of psychiatry, **the push factor**, there were, of course, some external, social developments in modern society have to be taken into account. There were also strong **pull-factors** that might explain the expansion of mental health care. Let me briefly mention three of them:

1 The growing dependence of lay-people on scientific, expert knowledge, that sociologist Anthony Giddens has characterized as the reflexivity of modernity: the regularized use of scientific knowledge, often in popularized forms, about personal and social life as a constitutive element in its organization and

transformation. In this connection also the phenomenon of "protoprofessionalization" is relevant, a term created by the Dutch sociologist Abraham de Swaan to indicate the growing tendency of lay-people to adopt professional language and modes of interpretation. Of course, rising levels of education among the general population play an important role here.

2 Raising expectations of people concerning the ability to treat and solve personal problems, to fashion their individual lives by free choice, and to create or recreate their self. To a much lesser extent than in past times, people in Western societies are willing to accept all sorts of individual shortcomings or unhappiness as a inevitable, natural part of life, as God's will, or simply as matter of bad luck.

3 The strong growth of mental health care in the second half of the 20th century reflected a more general process of psychologization, a change of mentality that can be described as a combination of growing individualization, internalization and self-guidance, and that was related to changing social manners and relationships. The psychological interpretation of the self and of other people's motives and behavior can be traced back to the human sciences as well as the arts of the late 19th century, as Mark Micale has pointed out, but I think that until far into the 20th century it was largely restricted to intellectual and bourgeois circles and mental health professionals themselves. In general it was not until the second half of the 20th century, when economic, social and political developments enabled the definitive breakthrough of individualization on a massive scale, that the psychological way of thinking gradually spread among the populations of Western societies. Gemma Blok points to the emergence of a new psychological morality in the Netherlands around 1970s, focussing on authenticity, self-determination, and self-expression.

The second general feature of 20th-century psychiatry and mental health care is **the shift from institutional to outpatient treatment and care.** The idea that it was better to keep psychiatric patients as much as possible outside mental institutions and establish alternative clinical and ambulatory facilities for them as well as the aim of prevention through early treatment of essentially healthy individuals go back to the first decades of the twentieth century. Social-psychiatric facilities, policlinics, and prevention-oriented counseling centers had been set up in some Western countries before the Second World War, but these small-scale facilities mainly depended on scattered local and private initiatives. Centrally coordinated national networks barely existed in the first half of the twentieth century. The two World Wars, especially the Second World War, brought a number of psychiatric innovations from the Anglo-Saxon World: new principles of outpatient treatment along socio-psychological lines, like brief psychotherapy, group-therapy and the therapeutic community, which were picked up by innovative psychiatrists. However, in most western countries it was **not until the 1960s and 1970s** that the role of extramural mental health care really grew more prominent and that the scope of outpatient facilities was enlarged. They were no longer merely conceived as complementing psychiatric hospitals

but also as replacing them. The shift from intra- to extramural care was advanced by a diversity of factors, practical considerations or necessities as well as ideological and ethical principles: the introduction of psychotropic drugs from the 1950s on; nationally designed plans to integrate psychiatry in the overall health and social care-providing system of the welfare state; the anti-psychiatric criticism of institutional and medical psychiatry; the striving for a humanistic reform of the care and treatment of psychiatric patients and their social integration through de-institutionalization; in Germany also the acknowledgement of the role psychiatry had played in the Third Reich, as Franz-Werner Kersting has shown; and last but not least, financial and political considerations, as Gerald Grob has clearly indicated in his paper on the US. Gerald Grob as well as Hugh Freeman and Jean-Christophe Coffin have also pointed to the recurring gap between intentions and outcomes, lofty ideals and harsh realities. (Perhaps the whole history of psychiatry can be written in terms of good intentions and disappointing results: it's a recurrent theme in many historical studies.) Anyway, the reform of mental health care through de-institutionalization and the promotion of community care was frequently accompanied with high expectations and much enthusiasm, but nearly everywhere this commitment met with financial, political, organizational, or professional obstacles. (David Healy even states that de-institutionalization is a myth.) In most countries the reform plans were developed in the 1960s and early 1970s when the economy was booming and there was a euphoric, change-minded, even revolutionary political climate. When in the ensuing decades plans had to be implemented, the economic and political tide had turned. As a result of the economic crisis that started in 1973 there were fewer funds available and governments cut back on collective services, a policy to which especially the public facilities for mental health care and chronic psychiatric patients fell victim.

The third general trend I want to draw attention to is the link between psychiatry and mental health care on the one hand and **social modernization, state politics and citizenship in particular** on the other. These themes are central in the papers of Volcker Roelcke, Jan Pols, and Greg Eghigian and I have also discussed them in my paper. In the 19th century and the early 20th century the relationship between institutional psychiatry and citizenship was **negative** in the sense that hospitalization in a mental asylum implied legal certification and therefore the loss of some basic civil rights. Also, in particular in Weimar, Nazist and communist Germany as well as in capitalist America and social-democratic Scandinavian countries, psychiatry was involved in social and biomedical policies, eugenics in particular, which subordinated individual rights and individual well-being to state interests and collective values. However, in the course of the twentieth century in two ways a more **positive** connection between mental health care and democratic citizenship was established. In the last decades of the 20th century there was a growing attention for and acknowledgement of the rights of the mentally ill. In many Western countries the legislation on insanity, which often dated back to the nineteenth century, was amended once or twice, and this shifted the emphasis from values associated with maintaining law and order and protecting either society or the insane to

mental patients' autonomy, responsibility and right to receive adequate care and therapeutic treatment. Also, in mental health care and the mental health movement psychological definitions of citizenship were produced from the 1920s and 1930s on. Repeatedly, psycho-hygienists articulated their views about the position of human beings in modern society as well as their ideals of a better society; also, they connected mental health to ideals of democratic citizenship. Thus, psychiatry and mental health care were clearly involved in the modern liberal-democratic project of promoting, not only virtuous, productive, responsible and adaptive citizens, but also autonomous, self-conscious, self-developing, assertive, and emancipated individuals in an open society.

Let me now once again turn to some **basic characteristics of the Dutch mental health care system** as it developed in the 20th century, which might be relevant from the perspective of international comparison.

The first is **the early establishment and continuity of its public ambulant mental health care facilities**. As far as de-institutionalization is concerned the Netherlands lagged behind the United Kingdom, Italy, and the US and Holland was not very different from other continental countries, but in building an ambulant mental health sector it was clearly in the vanguard. From the outset, the development of extramural mental health care and de-institutionalization (or rather "socialization") were only marginally linked in the Netherlands. After all, an extensive and multifaceted network of outpatient facilities was already in place when, from the 1980s on, de-institutionalization was actively pursued. It was only after ambulant and semi-mural mental health services had been organised, that the capacity of psychiatric hospitals began to be reduced. In part because outpatient facilities had already been founded from the late 1920s, they were well-established since the 1950s and they successfully merged into the Regional Institutes for Ambulatory Mental Health Care, the gap between reform plans and their implementation was smaller in the Netherlands than elsewhere. The great degree of continuity of the Dutch ambulatory sector, was perhaps partly caused by the influence of the Dutch pillarized social system, which facilitated more or less stable organizational structures on the basis of private initiatives, and from the 1960s on by the generous collective funding in the Dutch welfare state. Despite the crisis of the welfare state since the late 1970s, ambulant mental health care saw further expansion in subsequent years.

A second striking element of the ambulant mental health care sector in the Netherlands was its **wide boundaries**. From rather early on, in the Netherlands mental health care was not only social psychiatry in the sense of outpatient pre- and aftercare for psychiatric patients and the mentally handicapped, but it also included various counseling centers for problem children, for marriage- and family related issues, for psychotherapy, and for alcohol- and drug addiction. Also the Regional Institutes for Mental Health Care were aimed at a broad spectrum of problems, from existential problems to mental suffering and serious psychiatric disorders. Mental health care, partly organized on a religious basis,

was not just medical psychiatry or psychotherapy, for a large part it also was (moral) education, pastoral care, and social work. It displayed a clear affinity with the traditions of charitable aid and welfare work, which were strongly developed in the Netherlands. This explains the strong presence of a moral-didactic and psychosocial approaches, which focused on the social environment and the perfectibility of the individual, while the principle of social integration, rather than the principle of isolating or excluding problem groups, gained the upper hand. In contrast with pre-war Germany, the US, and some Nordic countries, eugenics never caught on in the Netherlands; it was discussed but it had basically no influence on the practice of Dutch mental health. While in some other European countries the medical-psychiatric perspective continued to prevail and psychiatrists kept other professional groups at a distance, from the start Dutch psychiatrists – even though until the 1970s many were trained as neurologist as well – collaborated in most ambulant facilities with other, non-medical experts.

The broad orientation of Dutch mental health care can also be explained by **the fairly early and rather strict differentiation between institutional and clinical psychiatry on the one hand and the ambulant sector on the other**. Many psycho-hygienists and ambulant workers distanced themselves from institutional psychiatry, closely associated as it was with certification and poor relief, and they stressed that their client groups had little to do with the insane. There was a strong tendency in ambulant mental health care to keep patients with serious psychiatric disorders that were difficult to treat out of its system. In some other European countries, Great-Britain, France and Germany, the public mental health sectors were more exclusively geared toward psychiatric patients, while there was also a closer link with the domain of (poli)clinical psychiatry. On the other hand, until recently private practices may have covered a smaller segment of the mental health sector in the Netherlands than in Germany, Belgium, France, and the US; in these countries resident psychiatrists and nerve doctors served in large part the clientele with psychosocial problems, a group that in the Netherlands was served by the various publicly funded facilities. Although the number of psychiatrists in private practice went up in the 1980s and 1990s in the Netherlands, most of them, as in Great Britain, continued to be formally tied to public facilities.

What seems to be a unique Dutch phenomenon is that **psychotherapy developed as a separate, interdisciplinary profession** - from the late 1960s not only doctors, but also clinical psychologists and social workers practiced psychotherapy - and that it was practiced not only by resident therapists but also in public psychotherapeutic institutes. This ensured broad accessibility of this treatment. In assume that the major role of psychotherapists – psychologists among them in particular – in Dutch mental health since the 1960s sets the Netherlands apart from other European countries, where psychotherapy largely remained limited to the more or less elitist private practices of psychiatrists. In this respect, and especially as far as the more general psychologization of society is concerned, the developments in the Netherlands were more similar to

those in the US than to those in its neighboring countries. In both the US and the Netherlands the emphasis on a multidisciplinary approach in ambulant mental health care during the second half of the twentieth century ultimately resulted in both the expansion of its domain and a strong psychological orientation. The psychologising approach and the prestige of psychotherapy in both countries contributed to the situation where many professionals in extramural care focused their attention on existential and psychosocial problems rather than on mental illness. In the 1970s and 1980s there was a clear parallel in this respect between the development of the American Community Mental Health Centers and the various Dutch counseling centers, psychotherapeutic institutes, and, later, the Regional Institutes for Ambulatory Mental Health Care.

The last point I'd like to raise concerns **the social explanation** of the advancement of mental health care in the second half of the 20th-century. Earlier in my talk and in my paper on the Dutch case I have referred to a variety of relevant developments:

- Economic developments such as growing affluence in general and the welfare state in particular and also from the 1960s on the growing significance of the services sector requiring specific psychological qualities of workers.
- Growing social and geographical mobility and urbanization, which made it more difficult and less self-evident that individuals suffering from mental problems find care and support in family-networks.
- Massive secularization, higher levels of education, and growing dependence of people on scientific expert knowledge and closely related to these the raising expectations of people concerning the ability to fashion their own life and the reduced tolerance of misery and unhappiness.
- Social and political democratization, which required a change of mentality, social manners and new meanings of citizenship and which was closely linked to the more general process of individualization and psychologization.

These are general developments, probably relevant for most Western countries, but in the Netherlands these changes intensified in a relative short span of time, the period between the mid-1950s and mid-1970s. **The cultural revolution of the 1960s**, I presume, has been more pervasive and lasting in the Netherlands than in other Western countries because it coincided with an economic boom, rapid modernization and secularization and the downfall of the largely religious-based and rather hierarchical and static organization of political and social life. More or less suddenly the familiar bourgeois and Christian moral frame lost its relevance for many people. The ensuing moral or spiritual vacuum was partially filled by a new psychological ethos. It is no coincidence that from the 1960s on mental health care grew explosively and became firmly rooted in Dutch society and that at the same time the personal lives of and the social relations between the Dutch became highly psychologized. In many countries workers in mental health care had more or less affinity with social reform, but almost nowhere, I suppose, they, or at least some of them, played such a leading role as moral guides in the mental modernization of the population. With their emphasis on self-reflection,

communicative skills, and flexible and subtle emotion-regulation and raising sensitive issues, mental health care professionals articulated new values and offered a clear alternative for the traditional black and white morality of dos and don’ts.

I acknowledge that these considerations are very tentative and hypothetical. It is very difficult to verify them on the basis of empirical facts. Yet I would like to raise these broader issues, also in order to invite you to comment and speculate on them. And again, in particular I would like to ask our foreign guests to comment on what I have said about the international position of the Netherlands as far as psychiatry and mental health care is concerned.