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Self-Development and Civic Virtue:
Mental Health and Citizenship in the Netherlands (1945–2005)

By Harry Oosterhuis[*]

ABSTRACT

This article is about the development of mental hygiene and mental health care in the Netherlands from the Second World War to the present, aiming to explore its relation to social and political modernization in general and the changing meanings of citizenship and civic virtue in particular. On the basis of three different ideals of individual self-development, my account is divided into three periods: 1945–1965 (guided self-development), 1965–1985 (spontaneous self-development), and 1985–2005 (autonomous self-development). In the conclusion, I will elaborate some more general characteristics of Dutch mental health care in its sociopolitical context.

INTRODUCTION

In the nineteenth and early twentieth centuries, the relationship between institutional psychiatry and citizenship was "negative" or "exclusive" in the sense that hospitalization in a mental asylum generally implied legal certification and therefore the loss of, and potential serious infringement on, basic civil rights. In the course of the twentieth century, however, in two ways a more "positive" or "inclusive" connection between psychiatry and liberal-democratic citizenship was established. First, the last three decades of the century saw increased attention to and recognition of the civil rights of the mentally ill. In many Western countries, the legislation on insanity was amended, reflecting a shift from values associated with maintaining law and order to values associated with mental patients' autonomy, responsibility, and consent, as well as their right to adequate care and treatment. Second, from the early twentieth century on, in psychiatry as well as in the broader field of mental hygiene and mental health care, psychological definitions of citizenship were advanced. Expressing views about the position of individuals in modern society and their possibilities for self-development, psychiatrists, psychohygienists, and other mental health workers connected mental health to ideals of democratic citizenship and civic virtue. Thus they were clearly involved in the modern liberal-democratic project of promoting not only virtuous, productive, responsible, and adaptive citizens but also autonomous, self-conscious, assertive, and emancipated individuals as members of an open society.

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This article is about the development of mental hygiene and mental health care in the Netherlands after the Second World War and explores its relation to social and political modernization, in general, and the changing meanings of citizenship and civic virtue, in particular.[1] In the course of the previous century, citizenship in the Netherlands took on a broad meaning, not just in terms of political rights and duties but also in the context of material, social, psychological, and moral conditions that individuals should meet to develop themselves and be able to act according to those rights and duties in a responsible way. Notions such as fairness, social justice, social responsibility, tolerance, emancipation, and personal development became elements of the definition of good citizenship. On the basis of the three different ideals of individual self-development that I identify, my account is divided into three periods: 1945–1965 (guided self-development), 1965–1985 (spontaneous self-development), and 1985–2005 (autonomous self-development).[2] Before turning to the postwar period, I will briefly sketch the rise of the mental movement in the Netherlands and its sociopolitical background during the first half of the twentieth century. In the conclusion, I will elaborate some more general characteristics of Dutch mental health care in its sociopolitical context.

MENTAL HEALTH AND CITIZENSHIP BEFORE THE SECOND WORLD WAR

From the late nineteenth century, Dutch psychiatrists had aligned themselves with social hygiene, in which the effort to prevent people from falling ill through a reform of their living conditions and way of life held center stage. The assumed danger of degeneration and the increase in the number of new clinical phenomena, such as neurasthenia, moral insanity, and criminal psychopathy—whereby less the rational powers than the emotional life and moral awareness were affected—provided psychiatrists with arguments for expanding their intervention domain from mental asylums to society at large. To counter the harmful influences of modern society that were supposedly undermining people's minds and nerves, psychiatrists pointed to the relevance of proper hygiene and also self-control, willpower, a sense of duty and responsibility, moral awareness, and moderation as ways of thwarting mental disorders.

Between the mid-1920s and the early 1940s, the groundwork was laid for the Dutch psychohygienic movement and a national network of social-psychiatric and public outpatient mental health care provisions, which developed mainly independently and at a distance from mental asylums. Most of these facilities were established by secu-

[1] The Dutch terms *burgerlijk* and *burger(schap),* just like their German equivalents *bürgerlich* and *Bürger(tum),* are not easily translatable. The Dutch and German terms combine at least two meanings for which in English, as well as in French, there are separate words. In this paper, I will use "bourgeois" or "middle class" to refer to a social group with specific socioeconomic and cultural features and "civil, "civic," and "citizen" in the sense of public domain, political rights and duties, and the political status of individuals.

[2] These models of self-development are borrowed from J. W. Duyvendak, *De planning van ontplooiing: Wetenschap, politiek en de maakbare samenleving* (The Hague, 1999); and E. Tonkens, *Het zelfontplooiingsregime: De actualiteit van Dennendal en de jaren zestig* (Amsterdam, 1999). These two studies focus on the development of the Dutch welfare state and on social work and mental health care, in particular. Their periodization is in line with more general political and cultural histories of the Netherlands in the twentieth century: the reconstruction after the war (1945–1965), the "sixties," which as a cultural period lasted from the mid-1960s to the early 1980s, and the last two decades, which have been characterized in terms of "no-nonsense" and witnessed a rejection of the heritage of the sixties.

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lar as well as religious voluntary organizations, and they received support from local or provincial governments. The individuals involved—psychiatrists as well as other physicians, teachers, educational experts, psychologists, criminologists, lawyers, social workers, and clergymen—were concerned about the perceived increase in mental and nervous disorders in modern society. This growth could be contained, they argued, by taking preventive measures, such as treatment of the early stages of mental and behavioral problems to prevent them from becoming worse—an approach that had proven effective in the fight against epidemics and contagious diseases.

The professional domain claimed by psychohygienists was wide: it stretched from marriage, sexuality, procreation, and family life to education, work, leisure activities, alcoholism, crime, and the care for mentally ill, feebleminded, and psychopathic individuals. The psychohygienic ideal materialized in the establishment of pre- and aftercare services for the mentally ill and retarded, Child Guidance Clinics and other mental health facilities for problem children, centers for marriage and family problems, a public institute for psychotherapy, and a growing number of counseling centers for alcoholics. The regime of these facilities basically consisted of providing consultations, mobilizing social support, conducting surveillance, offering a form of moral re-education aimed at building self-discipline, and promoting social reintegration and rehabilitation.[3]

The underlying reasoning of psychohygienists was rooted in a more broadly shared cultural pessimism about the assumed harmful effects of the rapid changes in society as well as in the optimistic belief in the sheer potential of scientific knowledge to help solve those problems. Psychohygienists viewed modern society's pace of change and mounting complexity as major causes of the increase of mental and nervous problems. A rising number of people would have trouble keeping up with the rapid technological advances and the high-paced lifestyle of industrialized and urbanized society. During the period between the two world wars, such cultural pessimism was, in fact, widespread among Dutch intellectuals; it was intensified in the 1930s by anxieties about Americanization as well as the rise of totalitarianism in other European countries. Fearing cultural decay and social disintegration, intellectuals repeatedly stressed the significance of spiritual values and a sense of community.[4]

Mental health care developed against the backdrop of social and political modernization. The emergence of mass society and ongoing democratization—universal suffrage was introduced in 1919—caused mounting concerns in society's upper echelons regarding the dominance of irrational emotions and drives, which would only lead to more unruliness, mental slackening, and social disintegration. The question was whether all people had the necessary rational and moral qualities to meet the social

[3] T. E. D. van der Grinten, *De vorming van de ambulante geestelijke gezondheidszorg: Een historisch beleidsonderzoek* (Baarn, Netherlands, 1987); J. C. van der Stel, *Drinken, drank en dronkenschap: Vijf eeuwen drankbestrijding en alcoholhulpverlening in Nederland. Een historisch-sociologische studie* (Hilversum, Netherlands, 1995); L. de Goei, *De psychohygiënisten: Psychiatrie, cultuurkritiek en de beweging voor geestelijke volksgezondheid in Nederland, 1924–1970* (Nijmegen, Netherlands, 2001); H. Oosterhuis, "Insanity and Other Discomforts. A Century of Outpatient Psychiatry and Mental Health Care in the Netherlands, 1900–2000," in *Psychiatric Cultures Compared: Psychiatry and Mental Health Care in the Twentieth Century: Comparisons and Approaches,* ed. M. Gijswijt-Hofstra et al. (Amsterdam, 2005).

[4] R. van Ginkel, *Op zoek naar eigenheid: Denkbeelden en discussies over cultuur en identiteit in Nederland* (The Hague, 1999), 86–98; R. Schuursma, *Jaren van opgang: Nederland 1900–1930* (Amsterdam, 2000), 76–100.

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responsibilities of an increasingly complex society and would be able to act as accountable political citizens. However, modernization had given rise not only to deeply felt worries but also to a social and moral activism aimed at tackling material and moral deprivation. Various behaviors, ranging from drinking, dancing, gambling, fair going, and other forms of "low entertainment" to idleness and money squandering, and from impulsive satisfaction of needs and sexual licentiousness to child abandonment and crime, became the targets of interference and intervention by both voluntary organizations and the state.[5] Resolving social wrongs and misfortunes, such as poverty, illness, backwardness, and exploitation, was not all that mattered; it was considered equally important to achieve a virtuous life and a sense of social responsibility for everybody.

The psychohygienic doctrine basically fit in with efforts to "civilize" the people, particularly the lower classes. In the nineteenth century, these activities had been promoted by the liberal bourgeoisie, but since the turn of the century they had become entangled with orthodox Protestant and Catholic as well as socialist politicians to further the social emancipation and national integration of their constituencies. These efforts indeed suggested an optimistic belief in the perfectibility of mankind, even though such a vision was frequently couched in a more or less conceited moral-didactic paternalism. In pleas for a national-level education of the common people, "character formation" was central. While classic liberalism had emphasized rational and autonomous thinking as the engine of social progress, the focus at this point was on teaching a sense of norms and duties, raising community spirit, and instilling willpower and self-discipline.[6] Although Dutch society and politics was divided and hierarchically organized along class as well as religious lines—the so-called pillarization[7]—the various social elites generally propagated an ideal of citizenship that stressed middle-class values. An industrious and productive existence, self-reliance, a sense of order and duty, thrift, and the family acted as cornerstones of the democratized bourgeois ideal of citizenship. Central notions were self-control and having a sense of responsibility: the curbing of erratic impulses and the postponement of instant gratification of needs aimed at a proper balance between individual independence and community spirit, as well as at long-term personal and collective well-being.[8]

In the interest of a well-ordered, democratic society, it was considered essential to elevate the people morally and to inculcate a civil sense of responsibility and decency

[5] A. de Regt, *Arbeidersgezinnen en beschavingsarbeid: Ontwikkelingen in Nederland, 1870–1940; een historisch-sociologische studie* (Amsterdam, 1984); P. Koenders, *Tussen christelijk réveil en seksuele revolutie: Bestrijding van zedeloosheid in Nederland, met nadruk op de repressie van homoseksualiteit* (Leiden, Netherlands, 1996); D. J. Noordam, "Getuigen, redden en bestrijden: De ontwikkeling van een ideologie op het terrein van de zedelijkheid, 1811–1911," *Theoretische Geschiedenis* 23 (1996): 494–518.

[6] H. te Velde, *Gemeenschapszin en Plichtsbesef: Liberalisme en Nationalisme in Nederland, 1870–1918* (The Hague, 1992).

[7] The three main pillars—networks of organizations in the fields of politics, economy, health, education, and culture—were those of orthodox Protestants, Catholics, and Social Democrats. The liberal bourgeoisie, which had dominated Dutch politics until the First World War, never organized itself into a pillar.

[8] H. te Velde, "How High Did the Dutch Fly? Remarks on Stereotypes of Burger Mentality," in *Images of the Nation: Different Meanings of Dutchness, 1870–1940,* ed. A. Galema, B. Henkes, and H. te Velde (Amsterdam, 1993), 59–79; R. Aerts and H. te Velde, eds., *De stijl van de burger: Over Nederlandse burgerlijke cultuur vanaf de middeleeuwen* (Kampen, Netherlands, 1998); J. Kloek and K. Tilmans, eds., *Burger: Een geschiedenis van het begrip "burger" in de Nederlanden van de Middeleeuwen tot de 21^{e} eeuw* (Amsterdam, 2002).

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in them. Apart from politicians, inspired social reformers, and moral entrepreneurs, the proponents of this social-moral activism were found especially among the professional groups that were gaining influence and self-awareness, such as physicians, teachers, educational specialists, youth leaders, civil servants, engineers, social workers, and from the 1920s on, psychohygienists and mental health workers.[9] With their particular understanding of public mental health, psychohygienists closely aligned themselves with the paradigm of an orderly mass society based on the unconditional adaptation of the individual to a collectively shared system of norms and values.

GUIDED SELF-DEVELOPMENT (1945–1965)

In the 1940s and 1950s, the Dutch outpatient mental health care facilities—the Child Guidance Clinics and Centers for Family and Marriage Problems, in particular—expanded rapidly. Worries about social disruption and moral decay in the wake of the German occupation and subsequent liberation by allied forces strongly promoted the growth of these facilities. Because the war and the atrocities of Nazism epitomized the cultural pessimism of the psychohygienists in quite concrete and dramatic ways, in the postwar years the psychohygienic doctrine won more support among politicians and social elites. Various forms of misconduct and shortcomings in ethical standards—including idleness, malingering, juvenile mischief, lack of respect for authority and ownership, along with family disruptions, growing divorce rates, greater autonomy of women, and sexual license—were considered serious threats to both the moral fiber and the mental health of the nation. The leitmotiv of this widespread anxiety was the observation that uncontrollable drives and urges had gained the upper hand, which seriously threatened the overall sense of community. It was widely felt that to rebuild the devastated country, create unity, and hold off the new threat of communism, people's moral resilience needed to be strengthened and broken-up families and individuals who had gone astray should be put back on track. Again, the insistence on self-discipline and a sense of duty served to underline the importance of responsible citizenship in a democratic mass society as well as in the emerging welfare state.[10] Government officials and psychiatrists emphasized that a social security system would only be effective if its potential beneficiaries had a well-meaning attitude. Close monitoring and moral education were needed to cut off profiteers and those with malicious intentions.[11]

In their striving for a mental recovery of the Dutch people, psychohygienists displayed a great sense of mission while also claiming a broad professional domain.

[9] H. Nijenhuis, *Volksopvoeding tussen elite en massa: Een geschiedenis van de volwasseneneducatie in Nederland* (Amsterdam, 1981); De Regt, *Arbeidersgezinnen en beschavingsarbeid* (cit. n. 5); W. A. W. de Graaf, *De zaaitijd bij uitnemendheid: Jeugd en puberteit in Nederland, 1900–1940* (Leiden, Netherlands, 1989); S. Karsten, *Op het breukvlak van opvoeding en politiek: Een studie naar socialistische volksonderwijzers rond de eeuwwisseling* (Amsterdam, 1986); W. Krul, "Volksopvoeding, nationalisme en cultuur: Nederlandse denkbeelden over massa-educatie in het Interbellum," *Comenius* 36(9) (1989): 386–94.

[10] J. C. H. Blom, "Jaren van tucht en ascese: Enige beschouwingen over de stelling in Herrijzend Nederland 1945–1950," *Bijdragen en Mededelingen betreffende de Geschiedenis der Nederlanden* 96 (1981): 300–33; H. Galesloot and M. Schrevel, eds., *In fatsoen hersteld: Zedelijkheid en wederopbouw na de oorlog* (Amsterdam, 1986); Van Ginkel, *Op zoek naar eigenheid* (cit. n. 4), 177–205.

[11] I. de Haan, *Zelfbestuur en staatsbeheer: Het politieke debat over burgerschap en rechtsstaat in de twintigste eeuw* (Amsterdam, 1993), 92; F. S. Meijers, *Inleiding tot de sociale psychiatrie* (Rotterdam, 1947), 68–9.

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Through the use of medical-biological metaphors—society viewed as body, the family as vital organ, the individual as cell, social wrongs as pathologies, and specific problem groups as nidi—social and moral problems were framed as issues of public mental health. Initially mental health workers, focusing on trouble children, uprooted juveniles, and "asocial families," continued to look for solutions in moral-pedagogical measures.[12] However, what in the late 1940s was still seen as lack of moral strength and willpower, in the 1950s was increasingly explained in psychological and relational terms. Personality defects, developmental disorders, and unconscious conflicts, brought about by a defective education and poorly functioning families, it was believed, constituted the underlying causes of deprivation and misbehavior. This meant that moral preaching and coercion needed to be replaced by treatment and cure. For instance, the psychiatrist S. P. J. Dercksen, who in Amsterdam headed a Dutch Reformed mental health institution, argued that a sense of responsibility could not be imposed through "authoritarian coercive advice" because people felt an inner aversion to such an approach. Instead, "subtle psychological work" was called for to make them accept mental health care.[13]

The results of preventive psychiatric treatment of allied soldiers during the war, the psychodynamic model, and new (American) psychosocial methods, such as social casework and counseling, raised expectations about the potential of psychiatry and the behavioral sciences to change and influence people's mental makeup. Even more than before the war, the psychohygienists linked a sustained cultural pessimism with an optimistic belief in the potential of scientific knowledge and professional expertise to avert doom. Inspired by the World Federation for Mental Health, they emphasized that it was not only important to prevent, treat, and cure mental disorders but also crucial to improve mental health in general, thereby ensuring maximal opportunities for all citizens to develop themselves in a wholesome way. Thus the distinction between normal and abnormal, or illness and health, was put into perspective. The notion of public mental health was turned into a comprehensive concept that was tied to the prevention of totalitarianism and the realization of a better world.

The development of mental health care was strongly influenced by the specific ways in which the experts in this field interpreted social transformations. When around 1950 the moral panic about the disruptive effects of the war had faded, the experts began to focus, in particular, on the potentially harmful influences of ongoing social and economic modernization. The Netherlands came out of the Second World War as a destroyed and impoverished nation, but the 1950s brought a new and vigorous economic dynamic, based on great confidence in science and technology. Large-scale urbanization, industrialization, and infrastructural innovation had far-reaching effects on people's social relationships and everyday life. The makeup of the working population changed drastically: as the agrarian sector declined, the industrial and services sectors saw great expansion. Spatial and social mobility rose sharply, allowing more individuals to evade the paternalism and social control of small communities, the church, and their families. In addition, the extension of the motorized traffic system, the growth of higher education, the increasingly international cultural orientation—

[12] A. Dercksen and L. Verplanke, *Geschiedenis van de onmaatschappelijkheidsbestrijding in Nederland, 1914–1970* (Meppel, Netherlands, 1987); F. W. van Wel, *Gezinnen onder toezicht: De stichting volkswoningen te Utrecht, 1924–1975* (Amsterdam, 1988).
[13] S. J. P. Dercksen, "Sociaal-psychiatrische ervaringen," *Folia psychiatrica, neurologica et neurochirurgica neerlandica* 59 (1956): 195–205, on 197.

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geared toward America in particular—and the rise of new media such as television widened the horizons of many Dutch. A steadily increasing prosperity provided more material security, and class differences and other hierarchical relationships gradually lost their edge. Increasingly, the new dynamic of the everyday life of the Dutch was at odds with the still prevailing traditional middle class and Christian norms and values with their clearly defined dos and don'ts.[14]

In the views that Dutch psychohygienists articulated about these developments, a cultural pessimism reminiscent of the prewar years reverberated. Its essence seemed basically unchanged: the mental and moral development of man, if it had not been severely harmed by the ongoing economic and technological progress, had at least fallen out of step with it.[15] Like other intellectuals, they argued that the socioeconomic modernization caused society to be dominated by a one-sided, instrumental rationality that jeopardized moral and spiritual principles as sources of meaning. Their critique focused on modern man who was absorbed by mass culture (*de massamens*). This man, the embodiment of all evils that accompanied modernity, was lonely and uprooted, had no fixed norms and values, and no longer felt any ties with religion, tradition, and community. His mind was nihilistic, and he was swayed by the issues of the day; he let his life be dictated by his unconscious drives and emotions and showed no regard whatsoever for moral authority. His inner emptiness was shown by his flight into material consumption, popular entertainment, and sexual gratification. This rudderless man, critics argued, undermined social solidarity and democratic citizenship. They looked for a remedy in an activist cultural politics, as advanced by German sociologist Karl Mannheim before the war. Mannheim argued in favor of social planning and a normative education of the people directed by elites to prevent democratic mass society from degenerating into either anarchy or dictatorship. Although rationalization was regarded as one of the main causes of the cultural crisis, there was great confidence in the possibility of steering and controlling society with the help of the social and human sciences, which is why sociologists as well as psychohygienists believed they had a major task to fulfill.[16]

Initially, mental health workers stressed the significance of a fixed collective morality and the social adaptation of the individual to safeguard overall social stability, but in the 1950s the workers' defensive stance toward modernization gave way to an accommodating approach. More and more they acknowledged that moral restrictions and external coercion only affected the outer behavior of people while leaving their inner self untouched. The belief that socioeconomic progress was inevitable brought along a new perspective on their task: a striving for normalization and social integration, not only by offering support to people who did not manage to keep pace with the rapid developments but also by enhancing the mental attitude and psychological

[14] P. Luykx and P. Slot, eds., *Een stille revolutie? Cultuur en mentaliteit in de lange jaren vijftig* (Hilversum, Netherlands, 1997); K. Schuyt and E. Taverne, *1950: Welvaart in zwart-wit* (The Hague, 2000).

[15] T. de Vries, *Complexe consensus: Amerikaanse en Nederlandse intellectuelen in debat over politiek en cultuur, 1945–1960* (Hilversum, Netherlands, 1996); Van Ginkel, *Op zoek naar eigenheid* (cit. n. 4), 207–44.

[16] M. Gastelaars, *Een geregeld leven: Sociologie en sociale politiek in Nederland, 1925–1968* (Amsterdam, 1985); E. Jonker, *De sociologische verleiding: Sociologie, sociaal-democratie en de welvaartsstaat* (Groningen, Netherlands, 1988); De Goei, *De psychohygiënisten* (cit. n. 3); I. de Haan and J. W. Duyvendak, *In het hart van de verzorgingsstaat: Het ministerie van Maatschappelijk Werk en zijn opvolgers (CRM, WVC, VWS), 1952–2002* (Zutphen, Netherlands, 2002), 27, 76–83.

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abilities individuals needed to function properly in a changing society. Thus the pursuit of more dynamic and flexible adaptation took the place of frantic attempts at restoring morality and community spirit. It was now believed that new social conditions required a redirection of norms and values and that individuals should be granted more responsibility for self-development.

Steering a middle course between tradition and renewal, paternalism and liberation, and spiritual values and psychological insight, leading psychohygienists began to present themselves as guides who prepared people for the particular dynamism of modern life. In their view, the main precondition for cultural improvement was a change in people's mentality. Inspired by phenomenological psychology and personalism—which stressed personality formation, spiritual reflection, and giving meaning to one's life in a self-conscious way—they now identified "maturity," "inner freedom," and "self-responsible self-determination" as the basis of mental health. Such mental qualities were the opposite of impulsive behavior; they entailed inner regulation, which would guarantee that people could do without external regulations to lead a responsible life. It became the individual's task to develop into a "personality" and to achieve a certain measure of inner autonomy regarding the outside world. What was crucial in this individualizing and psychologizing perspective was, in particular, the internalization of social norms and values in an autonomous self. The mentally healthy were not those who uncritically subjected themselves to rules and regulations but rather those who were independent, conscientious, and responsible—those who knew how to make decisions on their own, pursued optimal self-development, and thoughtfully adapted to social modernization.[17]

The psychohygienists backed up their argument for a mental reorientation not only with their psychological insights but also with a moral appeal—a form that gave their message a familiar ring to many in what was still largely a very Christian country. Invoking conscience and a sense of responsibility, they called upon people to identify with high moral values. Yet there was still concern about the harmful effects of social changes on people's mental balance. If individuals were to be able to decide on their own how to shape their lives, scrupulous self-examination was needed to assure that their intentions were conscientious and based on good grounds. Individuals were assumed to follow their own conviction, but they were also considered to do so in line with social expectations involving a morally responsible mode of life, as articulated by mental health workers and other expert leaders. Surely, this project of self-development was at odds with hedonism, extravagance, egoism, and egocentrism. People could only develop their personality in a meaningful way if they, of their own accords, were able to live up to high moral standards. For those who failed to realize their selves adequately, mental health supervision or treatment was the best solution. Constant reflection on individual conduct and motivation was called for in order to find the right balance between guidance and self-determination. By fostering such an

[17] F. J. J. Buytendijk, *De zin van de vrijheid in het menselijk bestaan* (Utrecht, 1958), 10; Buytendijk, *Gezondheid en vrijheid* (Utrecht, 1950); H. M. M. Fortman, *Een nieuwe opdracht: Poging tot historische plaatsbepaling en tot taakomschrijving van de geestelijke gezondheidszorg in het bijzonder voor het katholieke volksdeel in ons land* (Utrecht, 1955), 20; cf. De Goei, *De psychohygiënisten* (cit. n. 3), 154, 194–7; I. Weijers, *Terug naar het behouden huis: Romanschrijvers en wetenschappers in de jaren vijftig* (Amsterdam, 1991); H. Oosterhuis, *Homoseksualiteit in katholiek Nederland: Een sociale geschiedenis, 1900–1970* (Amsterdam, 1992).

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attitude, mental health care would contribute to creating the conditions for participation in civil society and political involvement (which was a civic duty, after all) and thus for maintaining and deepening democracy.[18]

The ideal of citizenship promoted in the 1950s and early 1960s can be characterized as guided self-development. This model was geared toward socioeconomic modernization, a process that called for a functional individualization, meaning flexibility and mobility. Self-identity used to be a product of given and more or less stable social categories, such as class, religion, and family background, but it increasingly turned into a product of personal qualities and preferences. This individualization was understood as an inescapable effect of modernity, but in an effort to avoid social disintegration, psychohygienists considered it essential to offer moral guidance and add normative standards, as a counterbalance to the individual's growing freedom. Those who managed to internalize such standards successfully would be able to adapt to the constantly changing circumstances of modern society in flexible ways, while at the same time they would succeed in resisting its disintegrative forces on their own.

SPONTANEOUS SELF-DEVELOPMENT (1965–1985)

Dutch psychohygienists believed in controlled modernization and guided personal development through social and cultural planning under the supervision of a morally inspired and professionally trained elite. This patronizing approach was characteristic of the postwar period of reconstruction, but beginning in the mid-1960s it came under attack. In the ensuing decade, the Netherlands changed from a rather conservative and law-abiding nation into one of the most liberal and permissive countries of the Western world.[19] Secularization and depillarization, as well as growing prosperity and the expanding welfare state, caused more and more people to break away from established traditions and hierarchical relationships to enhance their independence and individuality. Since the 1950s, there had been a leveling of differences in income, a democratization of consumption, and widely available access to (higher) education, which increased the political awareness of many.[20] Various protest movements loudly voiced participants' concern for more openness, democratization, liberation, and self-determination. The control of emotions and the individual's adaptation to society were no longer considered signs of responsibility but rather examples of the repression of personal freedom and the authentic self. The ideal of spontaneous self-realization, extolling self-exploration and self-expression, superseded that of guided self-development. It paved the way for an assertive individualism that, together with

[18] G. Brillenburg Wurth et al., eds., *Geestelijke Volksgezondheid: Nederlands Gesprekcentrum Publicatie No. 17* (Kampen, Netherlands, 1959).

[19] J. Kennedy, *Nieuw Babylon in aanbouw: Nederland in de jaren zestig* (Amsterdam, 1995); H. Righart, *De eindeloze jaren zestig: Geschiedenis van een generatieconflict* (Amsterdam, 1995); S. Stuurman, "Terugblik op een *Ancien Régime:* Nederland in de twintigste eeuw," in *Sociaal Nederland: Contouren van de twintigste eeuw,* ed. C. van Eijl, L. Heerma van Voss, and P. de Rooy (Amsterdam, 2001), 201–16.

[20] G. van den Brink, C. Brinkgreve, and L. Heerma van Voss, "Verworven gelijkheid en gevoelde verschillen: Contouren van de sociale eeuw," in Van Eijl, van Voss, and De Rooy, *Sociaal Nederland* (cit. n. 19), 1–12; C. J. M. Schuyt, "Sociaal-culturele golfbewegingen in de twintigste eeuw," in ibid., 25–34, on 26; J. Luiten van Zanden, "De egalitaire revolutie van de twintigste eeuw: Nederland 1914–1993," in ibid., 187–200.

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the democratization movement, rocked the foundations of Dutch society and its mental health care system. If beforehand individuals had been expected to comply with the social order, now society itself had to change to facilitate their optimal self-development and the ultimate fulfillment of democratic citizenship. After the liberal constitution (1848) had provided the Dutch people with basic civil rights, the introduction of universal suffrage (1919) had made them into citizens in the political sense, and the postwar welfare state had guaranteed their material security, now, as some psychohygienists argued, the time was ripe for taking the next step in this continuing process of emancipation: the settling of immaterial needs in order to advance personal well-being for everybody.[21] In the 1960s and 1970s, the welfare state, in general, and welfare work, in particular, received an aureole of moral dignity: they came to be seen as the touchstones of civilization and human solidarity.

Embracing some of the basic tenets of the protest movements and antipsychiatry, mental health workers increasingly voiced self-criticism and responded to clients who began to protest against what they saw as undemocratic relationships and a structural neglect of their own influence in the social services system. A growing number of professionals were trained in the behavioral sciences, sociology, and social work, and they demanded attention to the social causes of mental distress. Therapeutic treatment of individuals with the aim of adapting them to society became subject to debate. Instead, people needed to be liberated from the "social structures" that caused unlivable or intolerable situations and that restricted their spontaneous self-development. The realization of this objective seemed more dependent on welfare work and political activism than on psychiatry and mental health care.[22] However, whereas institutional and medical psychiatry were put on the defensive, in the 1970s the psychosocial and, especially, psychotherapeutic services more than ever increased in size and prestige. The critique of the 1960s protest movement and antipsychiatry was absorbed in a way that legitimized this expansion. The very dissatisfaction with medical psychiatry prompted new pleas for better and more alternative forms of mental health care, such as therapeutic communities in hospitals and outpatient facilities in society at large.[23] Their growth was facilitated by embedding mental health care in the welfare state: more and more collective social security and health care funds financed the costs. From an international perspective, welfare and mental health arrangements were generous and guaranteed their broad accessibility. Since about 1960, the growth of the expenditures for social services and government subsidies, in relation to the GNP, was nowhere more substantial than in the Netherlands.[24] The prevailing trend between 1965 and 1985 was, then, one of a substantial increase and scaling up of pub-

[21] J. A. Weijel, *De mensen hebben geen leven: Een psychosociale studie* (Haarlem, 1970); J. van den Bergh et al., *Verbeter de mensen, verander de wereld: Een verkenning van het welzijnsvraagstuk vanuit de geestelijke gezondheidszorg* (Deventer, Netherlands, 1970); G. van Beusekom-Fretz, *De demokratisering van het geluk* (Deventer, Netherlands, 1973).

[22] Weijel, *De mensen hebben geen leven;* Van den Bergh et al., *Verbeter de mensen, verander de wereld;* Van Beusekom-Fretz, *De demokratisering van het geluk.* (All cit. n. 21.)

[23] D. Ingleby, "The View from the North Sea," in *Cultures of Psychiatry and Mental Health Care in Postwar Britain and the Netherlands,* ed. M. Gijswijt-Hofstra and R. Porter (Amsterdam, 1998), 295–314; G. Blok, *Baas in eigen brein: "Antipsychiatrie" in Nederland, 1965–1985* (Amsterdam, 2004).

[24] G. Therborn, *European Modernity and Beyond: The Trajectory of European Societies, 1945–2000* (London, 1995), 93, 156; cf. P. Schnabel, *De weerbarstige geestesziekte: Naar een nieuwe sociologie van de geestelijke gezondheidszorg* (Nijmegen, Netherlands, 1995), 102; Schnabel, "Psychiatry after World War II: An Overview," in Gijswijt-Hofstra and Porter, *Cultures of Psychiatry and Mental Health Care* (cit. n. 23), 29–42; Oosterhuis, "Insanity and Other Discomforts" (cit. n. 3).

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lic services, with steadily growing numbers of clients.[25] In the early 1980s, the various outpatient mental health facilities merged into Regional Institutes for Ambulatory Mental Health Care, the Dutch version of community mental health centers, which were aimed at a broad spectrum of psychosocial problems and psychiatric disorders.

It was striking how swiftly mental health workers, among them new professionals such as continuing education experts (*andragogen*) and (nonmedical) psychotherapists, restored their self-confidence and the belief in their own therapeutic effectiveness. While engaging in heated debates on the political implications of their work, they widened their professional domain to include welfare work, a sector that, in the 1970s, stimulated by a government dominated by Social Democrats and other leftists, experienced enormous growth. Together with social workers, psychotherapists undertook the task of supporting people to enable them to liberate themselves from the coercive social structures. While avoiding a patronizing stance at all costs, the practitioners were expected to encourage clients to become aware of their true needs and to "grow" as a way to develop their true selves and their assertiveness. As psychiatrist J. A. Weijel explained in his "psychosocial study" *De mensen hebben geen leven* (*People Have No Life*), personal unhappiness should not be viewed as an individual fate but as a social evil that can be remedied.[26] Mental health workers revealed themselves as inspired advocates of personal liberation in the areas of religion, morality, relationships, sexuality, education, work, and drugs, as well as advocates for the emancipation of women, youngsters, the lower classes, and other disadvantaged groups, such as the gay community and ethnic minorities. As some of these advocates emphasized, countering prejudice and advancing tolerance was part of the broader effort to improve the quality of social relations and "democratize happiness."[27]

There was much talk about "social action" among mental health workers, but it proved rather difficult to change society in the day-to-day practice of mental health care. Yet these years were the heyday of psychotherapy, which, apart from psychiatrists, was practiced more and more by nonmedical professionals, such as psychologists and social workers and which, in the popular view, was the *pars pro toto* of mental health care. By the late 1970s, the Netherlands had become one of the countries with the highest number of therapists in proportion to the size of the population, in part as a result of the rapid growth of the number and size of public psychotherapeutic institutes.[28] A growing number of people began to consider it more or less self-evident to seek psychotherapeutic help for all sorts of discomforts and personality flaws that bothered them, ones not previously regarded as mental problems. Both therapists and clients viewed themselves more or less as a cultural avant-garde: psychotherapy would liberate individuals from unnecessary inhibitions and limitations and provide

[25] Nationale Federatie voor de Geestelijke Volksgezondheid, *Gids voor de Geestelijke Gezondheidszorg in Nederland* (Amsterdam, 1965–1969), 11, 159, 223–4; Nationaal Centrum voor Geestelijke Volksgezondheid, *Gids Geestelijke Gezondheidszorg 1982* (Utrecht, 1981), 21, 43–241; C. T. Bakker and H. van der Velden, *Geld en gekte: Verkenningen in de financiering van de GGZ in de twintigste eeuw* (Amsterdam, 2004), 65.

[26] Weijel, *De mensen hebben geen leven* (cit. n. 21), 10.

[27] Van Beusekom-Fretz, *De demokratisering van het geluk* (cit. n. 21).

[28] F. M. J. Lemmens and P. Schnabel, "Vestiging en ontwikkeling van de psychotherapie," in *Oriëntatie in de psychotherapie,* ed. C. P. F. van der Staak, A. P. Cassee, and P. E. Boeke (Houten, Netherlands, 1994), 9–26, 15; W. J. de Waal, *De geschiedenis van de psychotherapie in Nederland* ('s-Hertogenbosch, Netherlands, 1992), 126; G. J. M. Hutschemaekers and H. Oosterhuis, "Psychotherapy in the Netherlands after the Second World War," *Medical History* 47 (2004): 429–48.

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them with opportunities for self-discovery, personal growth, and improving the quality of their lives. The psychotherapeutic ethos was not without contradictions. Although critical mental health care workers blamed social evils for psychological problems, psychotherapy focused exclusively on the individual inner self. The ethos also tied in with optimistic expectations about the possibility of changing personal characteristics in a purposive and rational way, while at the same time, it focused on authenticity: spontaneous self-development implied that people had to discover and realize their hidden, preexisting natural cores and true selves.

Notwithstanding this turn back from social criticism to the inner self in mental health practice, psychiatrists and other psychohygienic experts played a crucial role in public debates, and some of them put controversial and sensitive issues on the social agenda. Already in the 1950s and early 1960s, psychohygienists such as the Catholic psychiatrist C. J. B. J. Trimbos were strongly contributing to changing the moral climate in the areas of family, marriage, and sexuality. They replaced the strained and suspicious attitude toward sexual matters and the predominant focus on reproduction with a more positive evaluation of satisfactory sexual relationships as the basis for affective bonds and individual well-being. By breaking down taboos about birth control and homosexuality, these practitioners laid the foundation for the sexual revolution.[29] From the late 1960s on, psychiatrists called attention to the suffering of war victims and other traumatized individuals. As a result of psychiatrists' concern about phenomena such as war traumas and concentration camp syndrome, politicians and the general public became aware of the mental suffering of war victims, which resulted in measures aimed at providing both material and psychological support. Touching on current controversies surrounding the war—the younger generations accusing the majority of the older ones of having failed to resist Nazism as well as of having ignored the suffering of its victims—the psychiatric logic proved especially effective in the effort to render the rights of war victims, and later those of sufferers from other "psychological traumas" as well, socially acceptable.[30] Obviously, it was neither the first nor the last time that disadvantaged groups and their spokespersons called attention to mental suffering in order to get public opinion on their side and see their interests and rights protected. Whoever in the Netherlands convincingly argued the case of an individual or group that suffered mentally on account of specific social wrongs could generally count on public attention and support from the government.

Psychiatrists also stood up for the self-determination of patients and the decriminalization of euthanasia, abortion, and drugs.[31] In this way, they contributed to a new

[29] D. A. M. van Berkel, *Moederschap tussen zielzorg en psychohygiëne: Katholieke deskundigen over voortplanting en opvoeding 1945–1970* (Assen, Netherlands, 1990); Oosterhuis, *Homoseksualiteit in katholiek Nederland* (cit. n. 17); Oosterhuis, "The Netherlands: Neither Prudish nor Hedonistic," in *Sexual Cultures in Europe: National Histories,* ed. F. X. Eder, L. A. Hall, and G. Hekma (Manchester, UK, 1999), 71–90.

[30] I. de Haan, *Na de ondergang: De herinnering aan de Jodenvervolging in Nederland, 1945–1995* (The Hague, 1997); J. Withuis, *Erkenning: Van oorlogstrauma naar traumacultuur* (Amsterdam, 2002).

[31] J. Kennedy, *Een weloverwogen dood: Euthanasie in Nederland* (Amsterdam, 2002); E. Ketting, *Van misdrijf tot hulpverlening: Een analyse van de maatschappelijke betekenis van abortus provocatus in Nederland* (Alphen aan den Rijn, Netherlands, 1978), 82–3; J. V. Outshoorn, *De politieke strijd rondom de abortuswetgeving in Nederland, 1964–1984* (Amsterdam, 1986), 123, 139, 179–80; M. de Kort, *Tussen patiënt en delinquent: Geschiedenis van het Nederlandse drugsbeleid* (Rotterdam, 1995).

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public morality and the implementation of practices that were quite liberal, certainly when considered from an international perspective. In so doing, they drew on the 1960s culture of liberation and democratization; but they also followed in the footsteps of the reform-minded psychohygienists from the 1950s.[32] By raising issues that earlier were largely silenced, they sought to break taboos and put an end to hypocrisy, thus paving the way for more openness, understanding, tolerance, and liberation. To achieve all this, so they explained, a sense of responsibility, conscientious positioning, a sincere exchange of arguments, and the willingness of people to listen to each other was required. As psychiatrist R. H. van den Hoofdakker wrote in his book on medical power and medical ethics, "[I]n a world of emancipated and independent human beings" there was only one way to overcome outmoded ideas and habits, and that was "talking, talking, talking."[33] Rules and laws should not be rigidly applied but discussed and sensibly interpreted. Emphasizing an issue's "debatability" (*bespreekbaarheid*)—which in the Netherlands became a major norm that served as the basis for policies of controlled toleration (*gedogen*)—was essentially the opposite of being noncommittal or outright permissive.[34] What mattered was countering the invisible abuse of specific liberties and channeling and controlling them carefully, in good faith and in open-minded deliberations with all parties. Making sensitive issues debatable was inextricably bound up with the belief in an open, egalitarian, and fully democratized society. Only mature, self-reflective, socially involved citizens empathized with others, did not shy away from unpleasant truths, regulated their emotions, and were capable of making rational considerations and—through negotiation and mutual understanding—arriving at balanced decisions. This psychohygienic ideal of citizenship made great demands on people's psychological competence.

AUTONOMOUS SELF-DEVELOPMENT (1985–2005)

Until the late 1970s, there was great faith in the Netherlands in social planning as a way to change society in directions that would allow for individual self-development.[35] However, the practice of rational planning, which was self-evident during the reconstruction era's directed economy and guided democracy, as well as in the context of the Social Democratic reform policies of the 1970s, conflicted with society's increasing individualization. As there was progressively more emphasis on personal emotional life and individual self-realization, the socially critical dimension of the self-development ideal eroded: the pursuit of social reform was replaced with the values of the "me-generation," stressing an inner-directed, independent self. At the same time, the welfare state was under attack, mainly because its costs had gone up tremendously but also because critics argued that collective services nullified people's sense of responsibility and self-reliance. Around 1980, welfare work, in particular, was singled out as a target. Rather than enlarging people's self-autonomy, it was seen

[32] I. Weijers, "De slag om Dennendal: Een terugblik op de jaren vijftig vanuit de jaren zeventig," in Luykx and Slot, *Een stille revolutie?* (cit. n. 14), 45–65; Weijers, "The Dennendal Experiment, 1969–1974: The Legacy of a Tolerant Educative Culture," in Gijswijt-Hofstra and Porter, *Cultures of Psychiatry and Mental Health Care* (cit. n. 23), 169–84.

[33] R. H. van den Hoofdakker, *Het bolwerk van de beterweters: Over de medische ethiek en de status quo* (Amsterdam, 1971), 50.

[34] Kennedy, *Een weloverwogen dood* (cit. n. 31); cf. Kennedy, *Nieuw Babylon in aanbouw* (cit. n. 19).

[35] Duyvendak, *De planning van ontplooiing* (cit. n. 2).

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as making them dependent.[36] In addition, the generous public funding of psychotherapy drew criticism: psychotherapists, who appeared as the elite among mental health workers, made good money by serving a privileged YAVIS-clientele (young attractive verbal intelligent successful), while neglecting psychiatric patients with serious mental and behavioral disorders.[37] With their politics of deregulation and privatization, conservative liberals and Christian Democratic politicians began to shift the emphasis from the state-organized collective care facilities to the self-reliance of citizens in the community and on the market. Autonomous self-development of responsible and independent individuals on the basis of their talents and efforts, with a minimum of interference from government and social bureaucracy, came to be the new standard of good citizenship. Self-development was considered merely a personal matter and no longer a social issue, let alone a political one (as leftist activists, welfare workers, and many mental health experts had argued).

However, the crisis of the welfare state, which led to a downsizing of welfare work, hardly affected mental health care; on the contrary, the latter underwent more expansion in subsequent years, although its focus changed. Further growth of the outpatient sector, in particular, was stimulated by the effort to push back institutional psychiatry and to develop community care for psychiatric patients, which became a governmental priority. Mental health care also adapted better than welfare work to the changing social climate, notably the depoliticization of social issues coupled with ongoing individualization. Professionalism, efficiency, rationalization, standardization, and a partial remedicalization of psychiatry as well as the issue of costs and benefits took the place of the lofty ideals of the sixties movement. Increased attention to elements of the free market and people's own sense of responsibility went hand in hand with the development of a more formal, legally based relationship between clients and care providers: rights and responsibilities were fixed into laws, rules, and procedures.[38]

The government and some psychiatrists repeatedly argued that the main outpatient facilities, the Regional Institutes for Ambulatory Mental Health Care, were geared one-sidedly to deal with clients with minor psychological afflictions, causing an endless increase in the demand for mental health care. The treatment and care of acute and chronic psychiatric patients was now to become a priority, along with keeping the number of admissions to mental hospitals as low as possible. Only those patients unable to get by in society without hurting themselves or others were considered to be eligible for hospitalization. Others were to be cared for in halfway and outpatient facilities to allow them to be, as much as possible, regular members of society. In the late 1990s, in order to improve cooperation between psychiatric hospitals and outpatient services, the government pressured both to merge into comprehensive mental

[36] H. Achterhuis, *De markt van welzijn en geluk: Een kritiek van de andragogie* (Baarn, Netherlands, 1980): De Haan and Duyvendak, *In het hart van de verzorgingsstaat* (cit. n. 16), 121–2, 182, 352–3.

[37] Among the clientele of psychotherapy, certain social groups were indeed over-represented. Workers with little or no education, for one, were hardly found; most clients had a middle-class background and were familiar with the notions and thinking of psychotherapists. More specifically, clients tended to be young, well educated, nonchurchgoing, and still studying or professionally active in sectors such as health care, social work, and education. C. Brinkgreve, J. H. Onland, and A. de Swaan, *Sociologie van de psychotherapie 1: De opkomst van het psychotherapeutisch bedrijf* (Utrecht, 1979), 97, 104, 124; A. de Swaan, R. van Gelderen, and V. Kense, *Sociologie van de psychotherapie 2: Het spreekuur als opgave* (Utrecht, 1979), 37, 50, 84–6.

[38] J. Legemaate, "De juridisering van de psychiatrie," in *De Januskop van de psychiatrie: Waarden en wetenschap,* ed. C. F. A. Milders et al. (Assen, Netherlands, 1996), 131–40; P. Schnabel, "Het jonge en het oude gezicht van de psychiatrie," in Milders et al., *De Januskop van de psychiatrie,* 151–9.

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health facilities that offered intramural as well as extramural care. The psychotherapeutic treatment of minor psychosocial problems was increasingly relegated to private practices. All of this marked a break with the historically developed constellation of Dutch public mental health care, which since the 1930s had been divided between clinical psychiatry for serious mental disorders and an outpatient sector with a strong psychosocial orientation for a wide spectrum of milder problems.

The "socialization" of psychiatry, as this policy was termed, echoed some of the democratic ideals of the 1960s and the 1970s, such as the need to counter the social isolation of psychiatric patients, improve their self-autonomy, and respect their civil rights. In 1970, the paternalistic, for-your-own-good criterion in the Insanity Act of 1884, which until then had justified involuntary institutionalization, was now replaced by the criterion of danger.[39] A new mental health law enacted in 1994 set down strict criteria for forced hospitalization against the will of patients, insisting on commitment only if someone posed a threat to himself or others. The law—which brought an end to the possibility of certification and the loss of full citizenship simply because it was considered in the best interest of patients—was a judicial stamp of approval for the increased recognition of the individual autonomy, freedom, integrity, and responsibility of the mentally ill. The mentally ill regained, so to speak, their status as citizens, an aim that since the 1970s had been championed by the critical patient's movement.[40]

One of the basic motivations for the policy of socialization was to assure that, although psychiatric patients—just like other groups in need of care—were limited in their autonomy, judgment, and decision-power, they should not be excluded in advance from exercising both their rights and duties as citizens. The degree to which they would be able to realize themselves as more or less independent members of society relied, in part, on social conditions that could be shaped: a mental health care that was organized in a way that made sure such individuals were not isolated from the rest of society and would receive sufficient social support to bring about their integration into society. This reasoning, which was largely rooted in the ideas of the 1960s and the 1970s, was quite similar to the way in which, one century before, social intervention was promoted to develop members of disadvantaged groups into full citizens. The underlying idea was that achieving citizenship largely depended on the degree to which the social structure actually enabled people's self-development, including the support and the encouragement they needed.

In practice, however, the citizenship of psychiatric patients met with obstacles time and again and was directly challenged in the 1990s. Critics pointed out that the principle of autonomous self-determination, on which the modern ideal of citizenship was grounded, entirely ignored what, in effect, constituted the essence of mental illness: the limited power for self-determination and self-reliance and the loss of the basic and taken-for-granted patterns of social interaction. Furthermore, critics argued that the emancipation of psychiatric patients as citizens was quite paradoxical as their representatives, more than they themselves, were the ones insisting that they should be able to take care of themselves, allowed to or even compelled to make decisions on their

[39] F. A. M. Kortmann, "Bemoeizorg en de WGBO," in Milders et al., *De Januskop van de psychiatrie* (cit. n. 38), 141–50, on 145.

[40] A. J. Heerma van Voss, "De geschiedenis van de gekkenbeweging: Belangenbehartiging en beeldvorming voor en door psychiatrische patiënten (1965–1978)," *Maanblad Geestelijke volksgezondheid* 33 (1978): 398–428; R. van der Kroef, *25 jaar en nog steeds geen normaal mens ontmoet: Pandora, psychiatrie en beeldvorming* (Baarn, Netherlands, 1990).

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own, and participate in society. With the emphasis on autonomy and self-reliance as meaningful modes of existence, other needs of psychiatric patients moved to the background: safety, security, protection, rest, the longing for an orderly and quiet life shielded from society, and recognition of their own experiences and fragility.[41] As long as the defining qualities of citizenship were autonomy, agency, and active social participation (especially by having regular work), the mentally ill and disabled were in fact consigned, at best, to the category of marginal citizens.

Care providers and the government inspectors of public mental health, as well as patient organizations and their families, also questioned the positive evaluation of self-determination because it allowed the mentally ill with serious behavioral problems to refuse psychiatric treatment, even if they were unable to take care of themselves, caused social trouble, or were potentially aggressive. From this perspective, the socialization of psychiatry soon ran up against its limits. The striving for the social integration and employment rehabilitation of psychiatric patients was complicated by increasing pressure on the social cohesion in (sub)urban neighborhoods and the ever higher demands of the labor market (proper training, social skills, performance, assertiveness, competition, flexibility, and being immune to stress), which many psychiatric patients were certainly unable to meet. It also became clear that since the late 1980s, the tolerance of the Dutch population toward those with psychiatric disorders, particularly when accompanied by disturbing conduct, had begun to wane the more they were directly confronted with the mentally ill in everyday life.[42]

The policy of socialization had its downsides: isolation, abandonment, and impoverishment of some patients, a lack of daytime activities for many others, an overburdening of social care facilities and the general environment, and the rise of a variety of social problems caused by, among other things, homelessness, alcohol abuse, and drug addiction. "They keep coming back in and leave again (*draaideuren*), roam around, do drugs and move elsewhere," as one psychiatrist summarized the fate of many afflicted.[43] Neither society nor those "depraved and impoverished" individuals were seen as benefiting from the legally sanctioned reticence of care providers; hence the for-your-own-good criterion, it was believed, needed to be reconsidered.[44] Pleas for more pressure and coercion in socio-psychiatric care and for a vigorous public mental health policy under the government's authority, as well as new experiments in outreach care for mental patients who were unwilling to cooperate or hard to reach, put earlier ideals of emancipation and self-determination into perspective. Basically,

[41] A. K. Oderwald and J. Rolies, "De psychiatrie als morele onderneming," *Tijdschrift voor Psychiatrie* 32 (1990): 601–15; P. Schnabel, *Het recht om niet gestoord te worden: Naar een nieuwe sociologie van de psychiatrie* (Utrecht, 1992); G. van Loenen, "Van chronisch psychiatrische patiënt naar brave burger: Over de moraal van psychiatrische rehabilitatie," *Maandblad Geestelijke volksgezondheid* 52 (1997): 751–61; G. A. M. Widdershoven, R. I. P. Berghmans, and A. C. Molewijk, "Autonomie in de Psychiatrie," *Tijdschrift voor Psychiatrie* 6 (2000): 389–98; J. Rasmussen, "Bij zinnen: De betekenis van het lijden in de psychiatrie," *Maandblad Geestelijke volksgezondheid* 56 (2001): 833–41.

[42] M. H. Kwekkeboom, "Sociaal draagvlak voor de vermaatschappelijking in de geestelijke gezondheidszorg: Ontwikkelingen tussen 1976 en 1997," *Tijdschrift voor Gezondheidswetenschappen* 78(3) (2000): 165–71.

[43] J. Droës, "De metamorfose van de GGZ," *Maandblad Geestelijke volksgezondheid* 57 (2002): 143–5, on 143.

[44] Geneeskundige Inspectie voor de Geestelijke Volksgezondheid, *Jaarverslag 1994* (Rijswijk, Netherlands, 1995), 13; Geneeskundige Inspectie voor de Geestelijke Volksgezondheid, *Jaarverslag 1995* (Rijswijk, Netherlands, 1996), 9: E. Borst-Eilers, *Brief Geestelijke Gezondheidszorg aan de Tweede Kamer der Staten-Generaal* (Rijswijk, Netherlands, 1997), 9.

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these were hardly relevant for those who suffered from serious psychiatric disorders, were incapable of living on their own, or could not assert their needs and lacked the ability to reflect on their possibilities and limitations. For them, social reintegration was no real option, and they were living proof that mental illness and full citizenship were hard to reconcile.

With respect to patients who suffered from serious mental disorders, psychiatry still largely proved to be the science of unsolved riddles and despair.[45] The optimism that had since the 1950s prevailed in the psychohygienic movement and large segments of the outpatient mental health community about the possibility of stimulating individuals' self-development and fashioning them into self-aware citizens had, in part, been facilitated precisely because there was a strong tendency to keep patients with serious psychiatric disorders out of the system. The psychotherapeutic institutes, as well as the Centers for Family and Marriage Problems and the Child Guidance Clinics, had distanced themselves from care provision for psychiatric patients in institutions, emphasizing their identity as welfare facilities with a psychotherapeutic orientation. In these facilities, mental health workers catered to a clientele with a variety of psychosocial and existential problems, and they focused on the improvement of people's psychosocial welfare, self-development opportunities, social participation, and assertiveness. A psychological perspective and various talking cures had increasingly set the tone in these facilities. Clients were expected to have some capacity for introspection, verbal talent, initiative, and a willingness to change, and this automatically excluded the mentally ill.

However, when, in the Regional Institutes for Ambulatory Mental Health Care in the 1990s, social psychiatry was prioritized and ever more of these services merged with psychiatric hospitals, the emphasis shifted toward people with more serious and unmanageable mental disorders, those who did not meet the ideal of voluntary perfectibility and malleability. The high expectations regarding people's potential for change and liberation were replaced by the more modest objective of trying to limit or alleviate mental suffering and control its symptoms as much as possible. Notwithstanding the dominance of biological psychiatry and the increasing use of psychopharmaceuticals, the various social, psychological, and behavioral therapies remained in use in public mental health facilities, but they were directed less at self-discovery, self-reflection, and personal growth than at acquiring social and practical skills to cope with life, in good times and bad.

Yet in another way, the ideology of individual liberation and emancipation of the 1960s and 1970s was called into question. Under the influence of the ongoing expansion of mental health care consumption, epidemiological research showing a high frequency of psychological disorders among the population, and prognostic data suggesting a further rise, the social dimension of mental disorders and their possible prevention were highlighted again in the 1990s.[46] The evidence motivated the government

[45] P. Schnabel, "Maakbaar en plooibaar," *Maandblad Geestelijke volksgezondheid* 42 (1987): 490–1; Schnabel, *Het recht om niet gestoord te worden* (cit. n. 41); Schnabel, "Het jonge en het oude gezicht van de psychiatrie" (cit. n. 38), 154–5.

[46] R.V. Bijl, G. van Zessen, and A. Ravelli, "Psychiatrische morbiditeit onder volwassenen in Nederland: het NEMESIS-onderzoek. II. Prevalentie van psychiatrische stoornissen," *Nederlands Tijdschrift voor Geneeskunde* 141 (1997): 2453–60; R. V. Bijl and A. Ravelli, "Psychiatrische morbiditeit, zorggebruik en zorgbehoefte: Resultaten van de Netherlands Mental Health Survey and Incidence Study (NEMESIS)," *Tijdschrift voor Gezondheidswetenschappen* 76 (1998): 446–57.

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to conduct a number of studies on the perceived rise in the number of mental problems and the measures needed to address the problem.[47] The message put forward in subsequent reports and policy recommendations was ambiguous. On the one hand, experts explained that the rising demand for professional care was not necessarily a sign of deteriorating public mental health because the growing care consumption would be, in part, a result of the broadened supply of services, the public's greater familiarity with it, a declining tolerance toward all sorts of inconveniences and misfortunes (often articulated as psychological complaints), and the increased trust in the possibility of treating these groups professionally. On the other hand, the tone of the reports betrayed the resurfacing of a familiar cultural pessimism. They kept pointing to an array of social developments that were likely to trigger psychical problems: the high pace and intensity of social changes; the atomization of society, in part as a consequence of the high degree of social and geographic mobility and the weakening or loss of family ties and other social networks; the loss of normative and meaning-providing frames; mounting job pressures and the (too) high demands placed on people's social skills and mental elasticity; (immanent) unemployment; an information avalanche with which many could barely cope; the social disadvantage and discrimination experienced by ethnic minorities; and the diminishing sense of social security and safety. There was a great deal of emphasis, in particular, on the assumed loss of shared norms and values. For example, one of the reports suggested that in the densely populated and urbanized Netherlands, individual freedom and tolerance could not flourish without social responsibility and cohesion.[48] In another policy suggestion, reference was made to the disappearance of "traditional social bonds," "new risks of dropouts," and the "disintegration of the social-pedagogical infrastructure" that made "the systematic passing on of values" less self-evident.[49]

Inasmuch as policy advisers issued proposals for the improvement of public mental health, they reverted to remedies from the past: the recommendation to not limit care for mental patients and psychological problems to professional care alone but to give the afflicted a place in other social sectors and to involve laypersons as much as possible—an approach that right after the Second World War was recommended as well but hardly realized. In addition, there were pleas for the stimulation of, as it was described, "a *new form of civil society*" and "the articulation and teaching . . . of the values and norms that society wishes to defend."[50] In less shrouded terms, such recommendations were also echoed in the Manifest, in which, on the eve of the 1998 parliamentary elections, the National Fund for Public Mental Health (Nationaal Fonds Geestelijke Volksgezondheid) called on the government to pursue a more active policy to improve public mental health: "In a society like ours—with many disinte-

[47] Scenariocommissie Geestelijke Volksgezondheid en Geestelijke Gezondheidszorg en Onderzoeksteam van het Nederlands centrum Geestelijke volksgezondheid, *Zorgen voor geestelijke volksgezondheid in de toekomst: Toekomstscenario's geestelijke volksgezondheid en geestelijke gezondheidszorg, 1990–2010* (Utrecht, 1990); M. Gastelaars et al., *Vier gevaarlijke kruispunten: Een voorzet voor een geestelijk volksgezondheidsbeleid* (Utrecht, 1991); P. Schnabel, R. Bijl, and G. Hutschemaekers, *Geestelijke volksgezondheid in de jaren '90: Van ideaal tot concrete opgave* (Utrecht, 1992); Landelijke Commissie Geestelijke Volksgezondheid, *Zorg van velen: Eindrapport van de Landelijke Commissie Geestelijke Volksgezondheid* (The Hague, 2002).

[48] Schnabel, Bijl, and Hutschemaekers, *Geestelijke volksgezondheid in de jaren '90* (cit. n. 47).

[49] Landelijke Commissie, *Zorg van velen* (cit. n. 47), 58, 62, 64, 79.

[50] Schnabel, Bijl, and Hutschemaekers, *Geestelijke volksgezondheid in de jaren '90,* 38; Landelijke Commissie, *Zorg van velen,* 62 (emphasis in original). (Both cit. n. 47.)

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grating families, aggression, violence, alcohol abuse, ever growing job pressure, much social fear, much stress, and a collective loss of norms and values—the chance of . . . mental problems or disorders increases." The authors argued that to promote the cohesion of society and mental health, the government had to "make rules, set limits, and articulate norms and values."[51]

Evidently, in mental health care the optimistic view of the 1960s and the 1970s, in which emancipated and motivated people tried to solve problems together in mutual interaction, had been replaced with concern about the loss of community spirit and public morality. In fact, this was in line with a broader criticism of the legacy of the sixties movement since the 1990s. The antiauthoritarian movement and the celebration of individual freedom, politicians and intellectuals argued, had degenerated into egoism, erosion of the personal sense of responsibility, an exaggerated assertiveness that was exclusively based on rights rather than duties, a coarsening of social interactions, and an increase in violent behavior and other forms of crime. The welfare state had resulted in calculating behavior and improper use of benefits. The balance between communal and individual interests was entirely disrupted: spontaneous self-development and assertiveness had led to a colonizing of the public sphere by all sorts of personal claims and preferences. The overall toleration policy and the new taboos of political correctness had led to a lack of self-restraint, a degradation of the public domain, and social disintegration. These developments would have to be countered by the restoration and revitalization of a sense of community and civic virtue.[52]

In the 1980s, the Christian Democrats, in particular, with their ideal of the "caring society," pointed to the significance of community spirit and social participation. But in the 1990s, Social Democrats and liberals also became convinced of the need to regauge collective and individual responsibilities and cultivate a sense of civic virtue with an emphasis on adjustment, integration, and moral regeneration. The policies of the "purple" government coalition (Social Democrats and liberals) foregrounded the reinforcement of social cohesion and the promotion of good citizenship. Exactly at that moment when neoliberalism could develop unchecked and the economy flowered, problem groups that were socially lagging, notably ethnic minorities and the longtime and poorly educated unemployed, became more visible. The taboo on coercion and duties began to recede, particularly in regard to efforts aimed at the reactivation of the unemployed and those previously declared unfit to work as well as at the integration of migrants.[53]

At the start of the twenty-first century, the concern for social disintegration and the degradation of the public domain mingled with fear of the loss of national identity on account of the rising ethnic diversity, continuing European integration, and globaliza-

[51] Nationaal Fonds Geestelijke Volksgezondheid, *Manifest van het Nationaal Fonds Geestelijke Volksgezondheid: Verontrustende ontwikkelingen* (Utrecht, 1998), 3, 8.

[52] H. Wigbold, *Bezwaren tegen de ondergang van Nederland* (Amsterdam,1995); H. Vuijsje, *Correct: Weldenkend Nederland sinds de jaren zestig* (Amsterdam,1997); H. Beunders, *Publieke tranen: De drijfveren van de emotiecultuur* (Amsterdam, 2002); D. Pessers, *Big Mother: Over de personalisering van de publieke sfeer* (The Hague, 2003); R. Diekstra, M. van den Berg, and J. Rigter, eds., *Waardenvolle of waardenloze samenleving? Over waarden, normen en gedrag in samenleving, opvoeding en onderwijs* (The Hague, 2004); G. van den Brink, *Schets van een beschavingsoffensief: Over normen, normaliteit en normalisatie in Nederland* (Amsterdam, 2004).

[53] H. R. van Gunsteren, *Eigentijds burgerschap* (The Hague, 1992); H. R. van Gunsteren and P. den Hoed, eds., *Burgerschap in praktijken* (The Hague, 1992); S. Koenis, *Het verlangen naar gemeenschap: Politiek en moraal in Nederland na de verzuiling* (Amsterdam, 1997); Duyvendak, *De planning van ontplooiing* (cit. n. 2); De Haan and Duyvendak, *In het hart van de verzorgingsstaat* (cit. n. 16).

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tion. After 2002, the threat of terrorism and two political murders caused a polarization that centered on multicultural values and the role of Muslims in Dutch society. The government has been pushing for a restoration of norms and values—with a prime minister who is inspired by communitarianism—and pursues policies that emphasize a further downsizing of the welfare state, the responsibility of citizens, the activation of the unemployed, the mandatory enculturation (*inburgering*) of migrants, a repressive approach of previously tolerated (mis)behavior, and a toughening of criminal law.

The last decade or so saw a change—a hardening, to be more specific—in the social and political climate, one that has called into question the optimistic view of humankind and the citizenship ideal that since the 1960s had been promoted in mental health care. As to citizenship, the mental health workers seem to have been forced on to the defensive: they mingle in public debates much less than they did in the decades between 1950 and 1980, less inclined to promote a specific public morality than had been the case earlier. The psychiatrist A. van Dantzig, former director of the psychotherapeutic institute in Amsterdam, was one of the few who continued to advocate a socially engaged mental health care. He considered attention to mental suffering and its professional treatment a touchstone of humanitarian and democratic progress and social justice. Mental health care (and psychotherapy, in particular), he claimed, is a valuable product of secularization and growing scientific understanding, and it has, in part, enabled the emancipation of the individual. It must be as comprehensive as somatic health care, so that, in principle, everyone is granted the opportunity to raise their quality of life and achieve maximal happiness with the help of psychotherapy. To avoid mental disorders becoming "privatized," he insisted, mental health care also has the task of exposing the social wrongs that are harmful to individual well-being. If Van Dantzig still embodied the inspiration that had marked many of his colleagues in the 1960s and 1970s, in the 1990s, he could hardly count on support in the world of mental health care, let alone outside of the community.[54]

CONCLUSION

The link between the democratization and psychologization of citizenship—illustrated here by following the development of mental health care in the Netherlands—is, of course, part of a more general historical process in the Western world. In traditional systems of social control and political domination, which subjected people by external coercion, no matter whether they accepted it or not, their inner selves were relatively irrelevant. The need to form individuals and to make them internalize certain values and behavior patterns became greater the more society was democratized. It was in democratic societies, which rejected force and coercion and presupposed that the social and political orders were basically founded on the autonomous consent of individual citizens, where inner motivation was considered of crucial importance for the quality of the public domain. A democratic social order can only be main-

[54] A. van Dantzig, "Persoonlijk lijden als publieke zorg," *Maandblad Geestelijke volksgezondheid* 46 (1991): 635–48; Van Dantzig, *Is alles geoorloofd als God niet bestaat? Over geestelijke gezondheidszorg en maatschappij* (Amsterdam, 1995); Van Dantzig, "Psychologisering en geestelijke gezondheidszorg," in *Het verlangen naar openheid: Over de psychologisering van het alledaagse,* ed. R. Abma et al. (Amsterdam, 1995), 69–74; Van Dantzig, "Geestelijke volksgezondheid," *Maandblad Geestelijke volksgezondheid* 57 (2002): 557–63.

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tained, it has been thought, if individuals use their basic liberties in a responsible way. Ironically, the pursuit of individual autonomy and self-determination went hand in hand with gentle, but persistent, pressure on people to open their inner selves for scrutiny by others and account for their urges and motivations (for example, before mental health experts). Where it could no longer be assumed that the individual's conformity was something natural, in theory each member of society acquired an interest in what went on in the minds of others. If, in the nineteenth century, citizens were largely judged on external aspects (such as property ownership, financial autonomy, sex, tax duty), in the twentieth century—the era of general suffrage and the welfare state's softening of the contradiction between formal political rights and socioeconomic inequality—the formation of a proper mentality gained prominence. This psychologization, which drew attention to the major role of drives and emotions in both individual and collective life, called for an "inner mission."

As said, against this backdrop, the Dutch developments are hardly unique. In Britain for example, from the 1920s on, mental health provided a paradigm to articulate in psychological terms a secular ideal for self-development as the groundwork for responsible democratic citizenship. In the United States, the mental hygiene movement displayed a strong impulse to formulate a diagnosis of modern American society from the perspective of psychiatry and psychoanalysis. The ills of modern society and the malaise in individuals were linked and mental health experts used theories of personality development to show how they could contribute to the formation of robust and self-reliant democratic subjects. In Germany, critical reflection on and the search for fundamental reforms in psychiatry took place in the 1960s and 1970s, whereby the Nazi past was explicitly used as specter, giving mental health care a strong political dimension. Against the complicity of psychiatry in the atrocities of the Third Reich, a democratic and emancipatory countervision of mental health care emerged, based on a concept of citizenship that stressed political awareness, independence of mind, liberalization, and social rights of, and solidarity with, the infirm and indigent.[55]

However, what was often missing in these countries was an extensive network of public outpatient mental health facilities to tie the rhetoric about mental health and citizenship with concrete care-providing practices. In the Netherlands, models of psychological self-development and citizenship were not mere abstract theories: in the practice of outpatient provisions these ideals materialized. From the 1950s on, clients were encouraged to be self-reflective about their conduct and motivations within their private lives as well as in the public sphere.[56] The Dutch psychohygienic movement and the outpatient services were more lasting and broader in the Netherlands

[55] M. Thomson, "Before Anti-Psychiatry: 'Mental Health' in Wartime Britain," in Gijswijt-Hofstra and Porter, *Cultures of Psychiatry and Mental Health Care* (cit. n. 23), 43–59; Thomson, "Constituting Citizenship: Mental Deficiency, Mental Health, and Human Rights in Inter-war Britain," in *Regenerating England: Science, Medicine, and Culture in Inter-war Britain,* ed. Chr. Lawrence and A.-K. Mayer (Amsterdam, 2000), 231–50; J. C. Pols, *Managing the Mind: The Culture of American Hygiene, 1910–1950* (PhD diss., Univ. of Pennsylvania, 1997); F.-W. Kersting, ed., *Psychiatrie als Gesellschaftsreform: Die Hypothek des Nationalsozialismus und der Aufbruch der sechziger Jahre* (Paderborn, Germany, 2004); Kersting, "Between the National Socialist 'Euthanasia Programme' and Reform: Asylum Psychiatry in West Germany, 1940–1970," in Gijswijt-Hofstra et al., *Psychiatric Cultures Compared* (cit. n. 3).

[56] P. van Lieshout and D. de Ridder, eds., *Symptomen van de tijd: De dossiers van het Amsterdamse Instituut voor Medische Psychotherapie (IMP), 1968–1977* (Nijmegen, Netherlands, 1991); Oosterhuis, *Homoseksualiteit in katholiek Nederland* (cit. n. 17).

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than in Britain, Germany, or the United States. Already in the 1940s, these were well-established parts of the mental health sector, and this would continue to be the case until the early 1980s, when they merged into one comprehensive system, the Regional Institutes for Ambulatory Mental Health Care.

The large degree of continuity, a distinctive feature of the Dutch outpatient mental health sector, was perhaps partly caused by the influence of the Dutch (pillarized) social system and the major role played by private initiative, facilitating more or less stable organizational structures even before the government became an active player in this area. That confessional groups had their own mental health facilities lowered the threshold for them to ask for professional care, while it also caused psychohygienic views to be spread more widely than would have been possible in a situation in which only generic services were offered. The pillarized system raised the chances of religious people coming into contact with a more psychological approach toward normative issues.[57] The Dutch government's interference in mental health care only began around 1970, but from then on it greatly contributed to the fact that this sector, compared with such sectors in other countries, prospered. This was an immediate effect of the generous collective funding that since the late 1960s had officially been set aside for mental health care. The Dutch welfare state—one as comprehensive as the Scandinavian welfare states and geared not only toward material security but also toward enhancing immaterial qualities of life—guaranteed that public mental health care facilities were available and accessible to all Dutch citizens and that they functioned properly.

Another striking element of the outpatient sector in the Netherlands was its broad orientation: it not only consisted of social psychiatric for patients but, from the 1930s and the 1940s, also included various counseling centers for problem children, existential problems, marriage and family-related issues, psychotherapy, and alcohol and drug addiction. This broad orientation is, in part, accounted for by the fairly early differentiation between institutional psychiatry and the outpatient sector as well as by the strong psychosocial (rather than biomedical) focus of extramural facilities (at least until the 1990s). In other European countries, the institutional and public mental health sectors were more exclusively geared toward psychiatric patients, while there was also a closer link with the domain of (poly)clinical psychiatry.[58]

In the twentieth century, the mental hygiene movement and the outpatient mental health sector successfully established themselves in the Netherlands. The notion of mental health, which heaped together a host of problems in and between people, caught on precisely because its vagueness served a major strategic function in linking various social domains and appealing to a variety of groups. Mental health applied to both the individual and society, establishing a connection between the private and public spheres. The notion of health care evoked associations with medicine and hygiene, while "mental"—the Dutch *geestelijk* also means "spiritual"—referred to psychical features as well as to religious, moral, cultural, and political values. Thus it was possible to establish an explicit connection with the strong charitable tradition in the

[57] P. J. van Strien, *Nederlandse psychologen en hun publiek: Een contextuele geschiedenis* (Assen, Netherlands, 1993), 88–9.

[58] H. Oosterhuis, "Outpatient Psychiatry and Mental Health Care in the Twentieth Century: International Perspectives," in Gijswijt-Hofstra et al., *Psychiatric Cultures Compared* (cit. n. 3).

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Netherlands and the bourgeois civilization offensive, which, in the form of a moral-didactic ethos, was adopted by both confessionals and socialists. The ideal of mental health tied in with the need to articulate public morals and a certain utopian message, not only among liberals and Christians, but also, especially in the 1960s and 1970s, among socialist and other leftist groups that believed strongly in the perfectibility of society. Once the establishment of the welfare state had guaranteed material security, mental and social well-being became the standard for the good life.

The modernization of Dutch society and the evolving views of democratic citizenship provided a sociopolitical context for the pursuit of mental health, whereby either a cultural pessimism or an optimistic belief in society's progress prevailed. In this light, it is possible to identify a turning point in the mid-1950s. Around this time, the defensive response to the modernization process and the emphasis on Christian and traditional middle-class values were exchanged for a much more accommodating stance. At the same time, in reflections about citizenship, there was a shift from unconditional adaptation to the existing system of values and norms ("character") to individual self-development ("personality"). People's personal lives and experiences and their inner motivations came to be center-stage, and therapeutic treatment and social integration were definitively prioritized over external coercion and social exclusion. In the years between 1950 and 1965, by building on the ideal of guided self-development, mental health care hooked up with socioeconomic modernization: individuals had to shape their personalities, develop their autonomy and flexibility, be open for renewal, and in a responsible way achieve self-realization. In the late 1960s and the 1970s, mental health workers embraced spontaneous self-development as a core value, thus legitimizing the need for assertiveness, democratization, and personal liberation. Subsequently, in the last two decades of the twentieth century, they approached their clients as autonomous, mature, and self-responsible citizens, whose freedom to make choices as members of a pluralist market society was perceived as self-evident. At the close of the twentieth century, however, a cultural pessimism reappeared, and the emphasis on self-determination and autonomy as more or less absolute values was brought up for discussion.

The Dutch national government generally kept a low profile regarding the organization and implementation of mental health care and the articulation of civic virtues. At least until the late 1960s, when it began to play a more active role, the state mainly left these issues to voluntary organizations or lower governments, in part because it did not want to intervene in the activities of the various ideological pillars, but also because, in the Netherlands, there has always been a strong aversion to state compulsion.[59] Models for self-development and citizenship were hardly imposed from above by the state, but they were developed and enunciated by leading groups in pillarized civil society itself. Mental health care played a major part in the articulation of the psychic dimension of personal as well as public life, but the spread of a psychological habitus among the Dutch population also took place as an effect of more general social developments. Psychologization, a change of mentality characterized by a combination of growing individualization and internalization, was connected with the democratization of social relationships, the change in manners and authority struc-

[59] R. Aerts et al., *Land van kleine gebaren: Een politieke geschiedenis van Nederland, 1780–1990* (Nijmegen, Netherlands, 1999).

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tures, the shift from external coercion to self-control, the transition from a command order to an order based on negotiation, and the increasingly subjective way of fashioning personal identity.[60]

From the 1950s on, people's behavioral orientation shifted from a submissiveness to fixed, unambiguous norms and guidelines, dictated by given social positions and hierarchies, religious dos and don'ts, a general sense of decency, and authority figures to a valuation of personal autonomy and individual consideration. Yet at the same time, the increased equality forced one to reckon more and more with others and, paradoxically perhaps, show more restraint in social interactions. As explicit rules and formal conventions lost some of their relevance, and individual social conduct became less predictable, the significance of self-regulation, subtle negotiation, and mutual consent grew accordingly. To find the proper balance between assertiveness and compliance, though, one needed social skills, empathy, self-knowledge, and an inner, self-directed regulation of emotions and actions. What mattered in a democratized social dynamic was a strongly developed sense of self-identity and mental resilience as well as insight into, and understanding of, the drives and motivations of others. Thus the interactions between people and the ways in which they evaluated each other became determined more and more by psychological insight. Tensions and conflicts between them had ramifications for their inner lives, potentially leading to mounting mental pressures and increasing the chance of their suffering from serious doubts, fears, and uncertainties.

In the Netherlands, which in social and cultural terms used to be quite conservative and Christian, the cultural revolution of the 1960s was more sweeping than in other countries because it coincided with rapid secularization and depillarization. After the stable and familiar moral frame began to be discussed publicly, it soon lost its relevance for many. In few other countries were control and coercion from above and others so radically excised as in the Netherlands.[61] The moral and spiritual vacuum was partially filled by a psychological ethos; from the 1960s on, mental health care, psychotherapy in particular, expanded at an unprecedented rate. The strongly developed democratization of public and everyday life replaced hierarchy, (group) coercion, and formal power relations with self-development, emancipation, and informal manners. This subsequently required subtle social regulation and psychological insight from individuals. It was more and more common for people to talk about themselves or others in psychological terms and to refer to their moods or feelings as ways to legitimate their behavior. Promoted in mass media and self-help books and by all sorts of therapists, trainers, advisers, and consultants, psychotherapeutic jargon and knowledge have basically—albeit in a watered-down version—penetrated all social

[60] C. Brinkgreve and M. Korzec, *"Margriet weet raad": Gevoel, gedrag, moraal in Nederland, 1938–1978* (Utrecht, 1978); W. Zeegers, *Andere tijden, andere mensen: De sociale representatie van identiteit* (Amsterdam, 1988); C. Wouters, *Van minnen en sterven: Informalisering van omgangsvormen rond seks en dood* (Amsterdam, 1990); Abma et al., *Het verlangen naar openheid* (cit. n. 54).

[61] That external control and coercion were replaced by a high degree of self-control is demonstrated by, among other things, the fact that the Dutch, despite their aversion to authority, are much less inclined than other nationalities toward civil disobedience and unconventional forms of protest, such as boycotts, spontaneous strikes, demonstrations, and occupations. Instead they show greater confidence in interaction and deliberations as means of solving conflicts. L. Halman et al., *Traditie, secularisatie en individualisering: Een studie naar de waarden van Nederlanders in een Europese context* (Tilburg, Netherlands, 1987).

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and cultural domains, ranging from education and religion to sports, advertising, politics, business, public happenings, and politics.[62]

With their emphasis on self-reflection and raising sensitive issues, mental health experts articulated new values and offered a clear alternative for outdated norms. They not only adapted their views to the continuously changing social circumstances, but, especially in the 1950s, 1960s, and 1970s, also functioned as major agents of sociocultural renewal, which, if anything, won them overall public respect. Talking was their preferred strategy for solving problems, linking them not only with the Dutch culture of negotiation and consensus (holding meetings is, after all, a favorite Dutch pastime) but also with the practices of everyday life of many people.[63] Already in the 1930s, the largest segment of the working population had been active in the services sector, where social interaction and communications have increasingly grown central.[64] The strong inclination toward psychologization is also tied to the specific ways in which social and ethical issues are addressed in the Dutch political culture of consensus. It is a culture in which experts figure prominently. Their expertise is frequently called in because their supposedly objective professional stance neutralizes social conflicts associated with sensitive issues. In the articulation of policies involving euthanasia, sexuality, birth control, abortion and drugs, for example, experts such as physicians, psychiatrists, psychologists, and social workers have had a large say. They generally contributed to formulating practical solutions that are both pragmatic and well considered and that focus on individual conditions and motivations.

However, in the past two decades, confidence in the possibility of motivating individuals through considerate, soft psychosocial support toward self-guidance and socializing them in such way that they automatically integrate into an egalitarian and democratic society as full citizens has lost its taken-for-granted status. This approach has proved unsuitable in a society in which neoliberalism gained a foothold, where cultural diversity and polarization have become stronger, and where a large part of the population have viewed crime and safety as the major social problems. As a result of the emphasis on the market, individualization became increasingly couched as competition and the need to perform, rather than as liberation and well-being.[65] The freedom to develop seemed to benefit self-reliant and thick-skinned individuals in particular. They embodied an ideal of citizenship in which (economic) autonomy was elevated to the highest good. Those who wanted to back out of the hectic dynamic of the stress society, or had no choice but to do so, were quickly seen as problem cases. Those lagging behind, many of whom depended on the shrinking welfare state or belonged to ethnic minorities, were increasingly met with force or coercion so as to activate them toward social participation and self-reliance. For them, the emphasis shifted from rights to duties. Dependence on the welfare state and a lack of social integration—because of unemployment, educational disadvantages, insufficient

[62] Abma et al., *Het verlangen naar openheid* (cit. n. 54); J. C. van der Stel, "Individualisering, zelfbeheersing en sociale integratie," in *Individualisering en sociale integratie,* ed. P. Schnabel (Nijmegen, Netherlands, 1999), 126–58; Beunders, *Publieke tranen* (cit. n. 52).

[63] W. van Vree, *Nederland als vergaderland: Opkomst en verbreiding van een vergaderregime* (Groningen, Netherlands, 1994).

[64] H. Knippenberg and B. de Pater, *De eenwording van Nederland: Schaalvergroting en integratie sinds 1800* (Nijmegen, Netherlands, 1990), 128–30; Schuyt, "Sociaal-culturele golfbewegingen in de twintigste eeuw" (cit. n. 20), 223; Beunders, *Publieke tranen* (cit. n. 52), 61, 125–6.

[65] H. Wansink, *De opmars van de stressmaatschappij* (Amsterdam, 1994).

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language skills, or certain religious (that is, Islamic) values—came to be more or less at odds with full citizenship. The view that citizenship had to be earned began to make headway, but along with this, more was expected from educational, employment, entrepreneurial, and criminal law circles than from the psychological subtleties of mental health care. Apart from being an issue of social participation, citizenship is still a matter of the proper mentality, yet the psychologizing angle has largely been replaced with a resurgent inclination toward moralizing paternalism and didactic instruction, on the one hand, and political polarization and juridical correction and repression, on the other.

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