Mental Health and Civic Virtue:
Psychiatry, self-development, and Citizenship in The Netherlands, 1870-2005

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As a product of nineteenth-century bourgeois society, psychiatry developed in a dynamic between social-political integration and exclusion. Into the twentieth century, institutional psychiatry fulfilled two functions: a medical one (care and cure), which gave priority to the interests of patients, and a social-political one (segregation), which was geared toward freeing society of the nuisance and danger associated with the insane. Which function was most prominent varied with a country's political constellation. From around 1840 various West-European countries adopted legal regulations for the institutionalisation of the insane. Within the margins of the constitutional state, they served to protect citizens against random deprivation of freedom and to allow for effective admission procedures to ensure public order as well as medical treatment for mental patients. The hospitalised insane fell under special jurisdiction and state supervision, which implied a suspension of their civic rights. The liberal contract society assumed autonomous individuals who were capable of serving their own rights and interests while respecting those of others. Liberalism linked citizenship to rationality, autonomy, and responsibility, which were precisely the qualities mental patients had to do without. Mental incapacity counted in fact as the opposite of citizenship as it had been articulated on the basis of the ideals of freedom and equality since the American and French Revolutions.

The relationship between institutional psychiatry and liberal-democratic citizenship was 'negative' or 'exclusive' in the sense that hospitalisation in an asylum generally required legal certification and therefore the loss of basic civil rights. In the course of the twentieth century, however, a more 'positive' or 'inclusive' connection between psychiatry and citizenship was established in two ways. Firstly, the last three decades of the last century saw a growing recognition of the civil rights of the mentally ill, reflecting a shift from values associated with maintaining law and order to values associated with mental patients' autonomy and consent. Secondly, from the early twentieth century on, in psychiatry as well as in the broader field of 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 and other mental health workers connected mental health to ideals of democratic citizenship. Thus, they were clearly involved in the liberal-democratic project of promoting not only productive, responsible and adaptive citizens, but also autonomous, self-conscious, and emancipated individuals.

In this article I focus on the development of mental health care in the Netherlands from the late nineteenth to the early twenty-first century in order to explore its relation to socio-political modernisation in general and changing meanings of citizenship in particular. Citizenship 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 in order to develop themselves and be able to act according to those rights and duties in a responsible way. On the basis of the four different ideals of self-development that I identify, my account is divided into four periods: 1870-1945

(self-development through social adaptation), 1945-1965 (guided self-development), 1965-1985 (spontaneous self-development), and 1985-2005 (autonomous self-development).[1] In the last section I will elaborate some more general characteristics of Dutch mental health care in its socio-political context.

Self-development through social adaptation (1870-1945)

In 1848 the liberal constitutional state was established in the Netherlands. With the granting of fundamental liberty rights all Dutch became equal citizens before the law. Voting rights, however, were limited to the upper classes whose members met the liberal criteria for active citizenship: economic independence, paying taxes on property, and education. The masses were excluded from political participation. In the last decades of the nineteenth century, however, the exclusive political citizenship of the liberal bourgeoisie increasingly came under pressure. In part as a consequence of industrialisation, growing geographical and social mobility, and the emergence of mass politics and a civil society, disadvantaged groups like the working class and women as well as religious groups that had been excluded, began to make themselves heard. Reform-minded liberals became convinced of the need to integrate these groups into the political nation and to solve the 'social issue' by extending the role of the state in society. If classic liberalism started from the self-reliance and diligence of individuals while seeking to minimise state intervention, social-liberals acknowledged that the individual opportunities for self-development depended not only on talents and will power, but also on changing economic and social circumstances and the general risks of life. Collective social insurance was considered necessary to protect the socially weak from disaster and to create such conditions that those lagging behind might also improve their social position, which in turn would render them eligible for full citizenship.[2] The process of political democratisation, which in 1919 led to universal suffrage, was gradual. The striving for emancipation of disadvantaged groups was mainly geared toward social integration on the basis of middle-class values, which now were less tied to social position and took on a more general significance as civic virtues that applied to all members of society. Self-control, a sense of order and duty, social responsibility, a proper balance between individual independence and community spirit, an industrious and productive existence, and family values acted as cornerstones of the democratised middle class ideal of citizenship.[3]

The emergence of mass society caused mounting concerns among the upper and middle classes regarding the dominance of irrational emotions and drives, which would lead to unruliness and social disintegration. Divergent behaviours, ranging from drinking, gambling, and other forms of 'low entertainment' to sexual licentiousness, child abandonment and crime, became the target of interference and intervention by both voluntary organisations and the state. The question behind this was whether all individuals had the necessary rational and moral qualities to meet the demands of modern society and to act as responsible citizens. What mattered was not just the resolution of social wrongs and misfortunes like poverty, illness, backwardness, and exploitation; it was equally important to achieve a productive and virtuous life for everybody. As society's democratisation progressed, it was deemed all the more essential to elevate the lower orders morally and to inculcate in them a civil sense of responsibility and decency.

In pleas for a national-level education of the people, ‘character formation’ was central. Apart from politicians, 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, youth leaders, social workers, and, later mental health workers.[4]

It was against the backdrop of social-political modernisation that from the late nineteenth century asylum-doctors began to break the isolation of their professional domain and seek to expand it. The leading members of the Dutch Society of Psychiatry, founded in 1871, were liberal and positivist-minded physicians who considered science and social conscience as crucial for progress. Despite their focus on scientific medicine, they not only pointed to the biological causes of insanity and nervous disorders. They also blamed the spread of mental disorders on certain harmful behaviours and social-cultural influences, such as pauperism, poor hygiene, immorality, alcoholism, bad upbringing, and the hectic pace of urban life. New clinical entities such as neurasthenia, moral insanity and criminal psychopathy, and the assumed danger of degeneration provided psychiatrists with arguments to expand their intervention domain from asylums to society at large. They thus aligned themselves with social hygiene, in which the effort to prevent people from falling ill through reform of their living conditions and way of life was centre-stage. To counter the debasing influences of modern society that were considered to undermine people’s nerves and mental well-being, psychiatrists pointed to the relevance of self-control, will power, and a sense of discipline.[5]

Between the First World War and the early 1940s, the groundwork was laid for the psycho-hygienic movement and a national network of outpatient mental health care provisions, which developed independently of the mental institutions and which were staffed by psychiatrists as well as other physicians, teachers, psychologists, lawyers, social workers, and clergymen. The professional domain claimed by these psycho-hygienists was wide: it stretched from family-life, sexuality and education to work and leisure, alcoholism, crime, and the social rehabilitation of mentally ill, mentally disabled, and psychopathic individuals. The psycho-hygienic ideal materialised in a growing number of counselling centres for alcoholics, pre- and aftercare services for the mentally ill and retarded, child guidance clinics, centres for marriage and family problems, and institutes for psychotherapy. In these facilities psycho-hygienists mainly adopted social, moral-didactic, pastoral, and psycho-dynamic approaches rather than biomedical or eugenic ones.[6]

The psycho-hygienic movement was rooted in a more broadly shared cultural pessimism about the harmful effects of the rapid changes in society, as well as in the optimistic belief in the potential of scientific knowledge to solve those problems. They viewed modernisation, marked by fragmentation and disorientation, as the major cause of the increase in mental and nervous problems. A rising number of people would have trouble keeping up with the complexity and fast-paced lifestyle of industrialised and urbanised society. This trend could be contained, psycho-hygienists argued, by taking preventive measures, such as treatment of the early stages of mental and behavioural problems so as to prevent them from becoming worse. Fearing cultural decay and social disintegration, they repeatedly stressed the significance of spiritual values and a sense of community.[7] The psycho-hygienic doctrine basically fitted in with efforts to ‘civilise’ the people. In the nineteenth century, these activities had been promoted by the liberal

bourgeoisie, but from the turn of the century they became entangled with confessional as well as socialist politics aimed at furthering the emancipation and national integration of their constituencies. This effort indeed suggested an optimistic belief in the perfectibility of mankind, even though such vision was frequently couched in a more or less conceited moral-didactic paternalism. With their particular understanding of public mental health, psycho-hygienists closely aligned themselves with the paradigm of an orderly mass society that was based on the unconditional adaptation of the individual to middle-class norms and values. In their view, responsible citizenship required the development of 'character': self-control, will-power, social adaptation and community spirit.[8]

Guided self-development (1945-1965)

In the 1940s and 1950s, the Dutch outpatient mental health care facilities expanded rapidly. Their growth was strongly advanced by worries about social disruption in the wake of the German occupation and liberation by the allied forces. Because the war and Nazism epitomised the cultural pessimism of the psycho-hygienists, in the post-war years their doctrine won more support among politicians and other influential groups. Various forms of misconduct and presumed lack of ethical standards – idleness, juvenile mischief, lack of respect for authority, but also family disruption, growing divorce rates, and sexual license – were considered as serious threats both to the moral fibre of the nation and public mental health. The leitmotiv of this widespread anxiety was the observation that uncontrollable urges had gained the upper hand. It was widely felt that in order to rebuild the devastated country in unity and to ward off the new threat of communism, the people's moral resilience should be strengthened. Again, the insistence on self-discipline served to underline the importance of responsible citizenship in a democratic mass society as well as in the emerging welfare state.[9] In their striving for a mental recovery of the Dutch people, psycho-hygienists displayed a great sense of mission. 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 problem groups as nuclei – social and moral problems were framed as public mental health issues. The notion of mental health was turned into a comprehensive concept that was tied to the prevention of war and totalitarianism, and the realisation 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 the moral panic about the disruptive effects of the war faded around 1950, they began to focus in particular on the potentially harmful influences of ongoing modernisation. The 1950s brought a new and vigorous economic dynamic, based on great confidence in science and technology. Large-scale urbanisation, industrialisation, and infrastructural innovation had far-reaching effects on people's social relationships and everyday life. Spatial and social mobility rose sharply, allowing more individuals to evade the paternalism and social control of small communities, the church, and their families. A steadily increasing prosperity provided more material security, and class differences and other hierarchical relationships gradually lost their edge. Increasingly, the new dynamic of everyday life was at odds with the still prevailing bourgeois and Christian norms and values with their clearly defined dos and don'ts.[10]

In the views that psycho-hygienists articulated about these developments, cultural pessimism reverberated. Its essence seemed basically unchanged: the mental and moral development of man was out of step with the ongoing economic and technological progress.[11] Like other intellectuals, they argued that modernisation caused society to be dominated by instrumental rationality and materialism, which jeopardised moral and spiritual values. Their critique focused on the so-called mass-man, the embodiment of all evils that accompanied modernity. He was lonely and uprooted, had no fixed norms and values, and no longer felt any ties to religion, tradition, and community. 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 argued in favour of social planning and a normative education of the people, so as to prevent democratic mass society from degenerating into either anarchy or dictatorship. Although rationalisation was regarded as one of the main causes of the cultural crisis, at the same time there was great confidence in the possibility of reforming society with the help of the social and human sciences. That is why sociologists as well as psycho-hygienists believed they had a major task to fulfil.[12]

Initially, mental health workers stressed the need for a fixed collective morality and the social adaptation of the individual and they looked for solutions in moral-pedagogical measures.[13] In the 1950s, however, their defensive stance toward modernisation made way for a more accommodating approach. More and more they acknowledged that restrictions and coercion only affected the outer behaviour of people while leaving their inner self untouched. What in the late 1940s was still seen as lack of moral strength, in the 1950s was increasingly explained in psychological and relational terms. Personality flaws, developmental disorders, and unconscious conflicts, caused by defective education and poorly functioning families, it was now believed, constituted the underlying causes of deprivation and misbehaviour. The older moral-didactic discourse about the need to develop 'character' was beginning to give way to a psychological argument around the development of 'personality'.

The belief that social-economic progress was inevitable, brought about a new perspective on the task of mental health professionals. The results of preventive psychiatric treatment of allied soldiers during the war, the psycho-dynamic model, and new (American) psychosocial methods such as social case-work and counselling, raised expectations about the potential of psychiatry and the behavioural sciences to shape people's mental make-up. Inspired by the World Federation of Mental Health, psychiatrists underlined not only that prevention and treatment of mental disorders mattered, but also that it was crucial to improve mental health in general and thus ensure maximal opportunities for all citizens to develop themselves in a wholesome way. Apart from offering support to people who did not manage to keep pace with modernisation, mental health workers also should enhance the mental attitude and abilities that individuals needed to function properly in a changing society. Thus the pursuit of a 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 scope for self-development.

Leading psycho-hygienists began to present themselves as guides who prepared people for the dynamism of modern life by spear-heading the effort to change people's mentality. Inspired by phenomenological psychology and personalism, which stressed personality formation, they now identified 'maturity,' 'inner freedom,' and 'self-responsible self-determination' as basic elements of mental health. Such mental qualities were the opposite of impulsive behaviour; they entailed inner regulation, which would guarantee that people did not need external pressures to lead a responsible life. It became the individual's task to pursue optimal self-development and grow into a 'personality'. The mentally healthy were not those who uncritically subjected themselves to rules, but those who achieved a certain measure of inner autonomy in relation to the outside world and at the same time thoughtfully adapted to social modernisation.[14] If individuals were to be able to decide on their own how to shape their lives, scrupulous self-examination was needed to ensure that their intentions were conscientious and based on good grounds. People 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. Individuals could only develop their personality in a meaningful way if they were able to internalise social norms and values in an autonomous self. By fostering constant reflection on individual conduct and motivation, mental health care would reinforce the conditions for civil and political involvement, and thus for maintaining and deepening democracy.[15]

The ideal of citizenship promoted in the 1950s and early 1960s can be characterised as 'guided self-development.' It was geared towards social-economic modernisation, which required more individuality 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 became a product of personal qualities and preferences. This individualisation was understood as an inescapable effect of modernity, but in an effort to avoid social disintegration, psycho-hygienists considered it essential to offer guidance and add normative standards, as a counterbalance to the individual's growing freedom.

Spontaneous self-development (1965-1985)

Psycho-hygienists believed in controlled modernisation and guided self-development under the supervision of a morally inspired and professionally trained elite. Their patronising approach was characteristic of the post-war period of reconstruction, but from the mid-1960s it came under attack. In the ensuing decade the Netherlands changed from a rather conservative and Christian nation into one of the most liberal and permissive countries in the Western world.[16] Secularisation as well as growing prosperity and the expanding welfare state caused more and more people to break away from established traditions and hierarchical relationships so as to enhance their independence and individuality. Various protest movements loudly voiced their concern for democratisation, liberation, and self-determination. The control of emotions and the individual's adaptation to society were no longer considered signs of social responsibility, but as the repression of the authentic self.

The ideal of spontaneous self-realisation paved the way for emotional self-expression and assertive individualism, which together with the democratisation

movement rocked the foundations of Dutch society and its mental health care system as well. If individuals had previously been expected to comply with the social order, now society itself had to change to facilitate optimal self-actualisation and fulfilment of democratic citizenship. The 1848 constitution had provided the Dutch people with basic civil rights, the introduction of universal suffrage in 1919 had made them into citizens in the political sense, and the post-war welfare state had guaranteed their material security. Now, some psycho-hygienists 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.[17]

Embracing some of the basic tenets of the protest movements and anti-psychiatry, mental health workers increasingly voiced self-criticism. A growing number of them were trained in the behavioural and social sciences, and they demanded attention to the social causes of mental distress. The therapeutic treatment of individuals with the aim of adapting them to society became subject to debate. Instead, people needed to be liberated from the coercive 'social structures' that restricted their spontaneous self-development. Welfare work and political activism seemed more helpful to realize this objective than psychiatry and mental health care. However, whereas institutional and medical psychiatry were forced on to the defensive, in the 1970s the psychosocial and especially psychotherapeutic services increased more than ever in size and prestige. The very dissatisfaction with medical psychiatry prompted new pleas for alternative and better mental health care, like therapeutic communities and more psychosocial outpatient facilities.[18] Their growth was facilitated by the welfare state: more and more collective social funds guaranteed broad access to mental health care. The prevailing trend between 1965 and 1985 was a substantial increase in and scaling-up of services with steadily growing numbers of clients. In the early 1980s, the various outpatient facilities merged into Regional Institutes for Ambulatory Mental Health Care, which were aimed at a broad spectrum of psychosocial problems and psychiatric disorders.

The 1970s were the heyday of psychotherapy, which, psychiatrists apart, was practised increasingly by psychologists and social workers in a growing number of public psychotherapeutic institutes. Although critical mental health care workers blamed social evils for psychological problems, psychotherapy focused on the inner self. A growing number of people began to seek psychotherapeutic help for all sorts of discomforts or personality flaws that bothered them and that previously were not regarded as mental problems. Both therapists and clients strongly believed that psychotherapy would liberate individuals from inhibitions and limitations, advance their 'personal growth', and improve the quality of their lives.[19]

While engaging in heated debates on the political implications of their practice, mental health experts widened their professional domain to include welfare work, a sector that experienced enormous growth in the 1970s. Together with social workers, they undertook the task of encouraging clients to become aware of their true needs and selves. As a psychiatrist explained, personal unhappiness should not be viewed as an individual fate, but as a social evil that could be remedied.[20] As some of them emphasised, countering prejudice and advancing tolerance was part of the broader effort to improve the quality of social relations and to 'democratise happiness.'[21] Some psychiatrists and other psycho-hygienic experts put controversial issues on the social agenda and played a crucial role in public debates. Already in the 1950s and early 1960s,

some leading psycho-hygienists contributed significantly to changing the moral climate in the areas of family, marriage, and sexuality. In the 1960s and 1970s, psychiatrists also stood up for the recognition of the mental suffering of war victims and other traumatised people, the self-determination of patients and a de-penalisation of euthanasia, abortion, and drugs.[22] Mental health experts revealed themselves as inspired advocates of personal liberation in many sensitive areas. In this way, they contributed to the implementation of rather liberal practices, certainly from an international perspective. In so doing they drew on the 1960s culture of liberation and democratisation, but they also followed in the footsteps of the reform-minded psycho-hygienists from the 1950s. By raising issues that had earlier been largely avoided, they sought to break taboos and put an end to hypocrisy, thus paving the way for more openness, understanding, and tolerance. To achieve this, so they explained, a sense of responsibility and deliberation, conscientious positioning, a sincere and open-minded exchange of arguments, and a willingness by people to respect each other was required. As psychiatrist R.H. van den Hoofdakker wrote: 'in 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.'[23] Rules and laws should not be rigidly applied, but discussed and sensibly interpreted. Emphasising the 'debatability' of an issue – which in the Netherlands became a major norm serving as the basis for policies of channelled toleration – was essentially the opposite of being noncommittal as well as outright permissive. Making sensitive issues debatable was inextricably bound up with the belief in a fully democratised society. Only self-reflective and socially involved citizens empathised 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. From a psychological and ethical perspective, this psycho-hygie nic ideal of citizenship made great demands on people's competence.

Autonomous self-development (1985-2005)

Until the late 1970s, there was great faith in social engineering as a way to change society in directions that would allow individuals to liberate themselves. However, the practice of social planning, which was self-evident during the post-war era of reconstruction as well as in the social-democratic reform policies of the 1970s, conflicted with society's increasing individualisation. The socially critical dimension of spontaneous self-development eroded when the pursuit of social reform was increasingly replaced by 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 risen 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 would make them dependent.[24] The generous public funding of psychotherapy was also criticised: psychotherapists were accused of making good money by serving a privileged clientele, while neglecting psychiatric patients with serious disorders.

As a consequence of neoliberal politics of deregulation and privatisation, the emphasis shifted from public welfare to the self-reliance of citizens in the community and in the market. Autonomous self-development of independent individuals on the basis of

their talents and efforts, with a minimum of interference from government or welfare agencies, came to be the new standard of good citizenship. However, the crisis of the welfare state, which led to a downsizing of social work, hardly affected mental health care; on the contrary, it saw more expansion in subsequent years, although its focus changed. Further growth of the outpatient sector in particular was stimulated by the effort to develop community care for psychiatric patients, which became a governmental priority. Moreover, efficiency, rationalisation, standardisation, and a partial re-medicalisation of psychiatry as well as market incentives and account of costs and benefits took the place of the ideals of the 1960s and 1970s.

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 clients with minor psychological afflictions, which would cause a boundless increase in the demand for mental health care. Instead, the treatment and care of acute and chronic psychiatric patients should become a priority, also to keep the number of admissions to mental hospitals as low as possible. Only patients who were unable to get by in society without hurting either others or themselves were considered to be eligible for hospitalisation. Others should be cared for in halfway and outpatient facilities so as to allow them to function as much as possible as regular members of society. In the late 1990s, to improve the co-operation between psychiatric hospitals and the outpatient services, the government pressured them to merge in comprehensive mental health facilities that offered intramural as well as extramural care. All of this marked a break with the historical constellation of mental health care, which since the 1930s had been divided between clinical psychiatry for serious mental disorders and a psychosocially oriented outpatient sector for a wide spectrum of milder problems.

The 'socialisation' of mental health care, as this policy was termed, echoed some of the democratic ideals of the 1960s and 1970s, such as the need to counter the isolation of psychiatric patients, improve their self-autonomy, and respect their civil rights. The paternalistic for-your-own-good criterion in the Insanity Act of 1884, which until then had justified involuntary institutionalisation, was replaced by a new mental health law in 1994. It formulated strict criteria for forced hospitalisation against the will of patients, namely when they pose a danger to themselves or to others. This law, which restricted the possibility of certification and loss of civil rights of the mentally ill, as well as some other new laws on patient's rights, sealed the increased recognition of the individual integrity and responsibility of the mentally ill. They regained, so to speak, their status as citizens, an aim that since the 1970s had been championed by the critical patient's movement.

One of the basic motivations for the policy of socialisation was that although psychiatric patients were limited in their autonomy and judgement, they should not be excluded in advance from either their rights or their duties as citizens. The measure in which they would be able to realise themselves as a more or less independent citizens, partly relied on a mental health care system that guaranteed that the mentally ill were not isolated from the rest of society. In practice, however, the citizenship of psychiatric patients caused problems all the time and was contested in the 1990s. Critics pointed out that the emphasis on their empowerment entirely ignored what in effect constituted the essence of mental illness: the limited power to self-determination and the loss of the basic and taken-for-granted patterns of social interaction. Fragile psychiatric patients were in need of security, protection, and a simple and quiet life shielded from the dynamic of

society. As long as the defining qualities of citizenship were agency and active social participation (especially by having regular work), the mentally ill and handicapped were at best consigned to the category of marginal citizens.[25]

Also, the positive evaluation of self-determination was questioned because it allowed the mentally ill with serious behavioural problems to refuse psychiatric treatment – even if they were unable to take care of themselves, caused social trouble, or were aggressive. From this perspective socialisation soon ran up against its limits. The striving for social integration and employment rehabilitation of psychiatric patients was complicated under increasing pressure on social cohesion in (sub)urban neighbourhoods and the ever greater demands of the labour market in terms of proper training, social skills, performance, and flexibility, which many patients were unable to meet. It also became clear that from the late 1980s the tolerance of the Dutch population towards disturbing conduct of mental patients decreased as direct confrontation with them in everyday life increased.[26]

The downside of the policy of socialisation was the social isolation of some patients, abandonment, poverty, and nuisance as caused, for instance, by homeless mentally ill and alcohol or drug addicts.[27] Pleas for more coercion in social-psychiatric care as well as new experiments in outreach care for unwilling and unreachable mental patients, put ideals of emancipation and self-determination into perspective. Basically, these lacked any relevance to those suffering from serious disorders, who were incapable of living on their own, who could not assert their needs and who lacked the capacity of self-reflection as to their abilities and limitations. For these patients, social reintegration was no real option: they were living proof that mental illness and full citizenship were hard to reconcile.

The optimism that since the 1950s had prevailed in the psycho-hygienic outpatient services regarding the possibility of stimulating individuals in terms of their self-development, had in part been facilitated precisely because there was a strong tendency to keep patients with serious psychiatric disorders out of these facilities. Emphasising their identity in terms of welfare, the psychotherapeutic institutes, centres for family and marriage problems and child guidance clinics, catered to a clientele with a variety of psychosocial and existential problems and focused on the improvement of their social functioning and assertiveness. A socio-psychological perspective and various talking-cures had set the tone in these facilities. Clients were expected to have some capacity for introspection, verbal ability, initiative and willingness to change, and this automatically excluded the mentally ill.

However, when in the 1990s, in the Regional Institutes for Ambulatory Mental Health Care, social psychiatry was prioritised and ever more of these services merged with psychiatric hospitals, the emphasis shifted to people with serious and incurable mental disorders and the ideal of personal change and emancipation was replaced by the more modest objective of limiting or alleviating mental suffering and control its symptoms as much as possible. Notwithstanding the increasing use of psycho-pharmaceuticals, various social, psycho-, and behavioural therapies remained in use in mental health facilities, but they were less directed at personal growth than at the acquisition of social and practical skills to cope with life, for better or worse.

Yet in another way the 1960s and 1970s ideology of individual liberation and emancipation was called into question. Under the influence of ever-expanding mental

health care consumption, and of epidemiological research showing a high frequency of psychic disorders among the population, the social dimension of mental disorders again attracted attention in the 1990s.[28] Studies were made of the causes of the assumed rise in the number of mental problems and the measures needed.[29] The message of the subsequent reports and policy recommendations was ambiguous. On the one hand, the experts explained that the rising demand for professional care was partly a result of the widened care supply, greater public familiarity with it, a declining tolerance regarding all sorts of inconvenience in life, and an increased trust in the possibility of treating complaints professionally. On the other hand, the tone of these reports betrayed the resurfacing of cultural pessimism. They pointed to an array of social developments likely to trigger psychic problems: the fast pace and intensity of social change; individualisation; the pressure of achievement-oriented society; unemployment; the deprivation among ethnic minorities; and the diminishing sense of social security and safety. There was much emphasis in particular on the assumed loss of shared norms and values. One of the reports suggested that precisely in the densely populated and urbanised Netherlands individual freedom and tolerance could not flourish without a high degree of social cohesion. Inasmuch as policy advisors issued proposals for boosting public mental health, they tended to revert to remedies from the past, such as a strengthening of civil society and collective values and norms and more robust government policies that balanced individual freedom with limits and rules.[30] Evidently, in mental health care the optimistic view of society, in which self-responsible citizens tried to solve problems together in mutual interaction, had been replaced by concern about the loss of community spirit and public morality.

The citizenship ideal that had been promoted in mental health care since the 1960s was called into question more broadly. In the 1990s, politicians and intellectuals - not only Christian-democrats and conservative liberals, but also social-democrats - took stock of the legacy of the 1960s and 1970s, and concluded that it was largely a negative one. The anti-authoritarian celebration of individual liberation, they argued, had degenerated into egoism, a lack of self-restraint, an erosion of social responsibility, and an exaggerated assertiveness that was exclusively based on rights rather than duties. The welfare state had resulted in calculating behaviour and improper use of benefits. These developments had to be countered by a downsizing of social security arrangements, moral regeneration and the restoration and revitalising of a sense of civic virtue.[31] The taboo on coercion and duties began to recede, for instance regarding efforts aimed at the reactivation of the poorly educated unemployed as well as at the integration of migrants. At the start of the twenty-first century the concern for the weakening of social cohesion and the degradation of the public domain mingled with fear for the loss of national identity through rising ethnic diversity, continuing European integration, and globalisation.

Discussion: democratic citizenship and psychological self-development

The link between the democratisation and psychologisation of citizenship, illustrated here by following the development of mental health care in the Netherlands, is part of a more general historical process in the Western world. In traditional systems of political domination, which subjected people by coercion and force, whether they accepted it or

not, their inner selves were generally irrelevant. The need to shape individuals and make them internalise certain values and behaviour-patterns became greater the more a society was democratised. If in the nineteenth century citizens were largely judged on external factors (such as status, sex, economic independence and tax liability), in the twentieth century, when adult suffrage was established and the welfare state softened the contradiction between formal political rights and social-economic inequality, the formation of a proper mentality gained prominence. Democratic citizenship presupposes a sense of public commitment on the basis of individual autonomy, self-determination and self-direction; citizenship can hardly be reconciled with subordination and dependence. It is in democratic societies, in which the social order is basically founded on the consent of individual citizens rather than external constraint, that the inner motivation of the citizen is considered of crucial importance. A democratic social order can only be maintained if individuals are capable of using their basic liberties in a responsible way. Ironically, the pursuit of individual self-determination goes hand in hand with gentle but persistent pressure on people to open their inner selves for scrutiny by others and to account for their urges and motivations, for example to mental health experts.

Against this backdrop, the Dutch developments are hardly unique. In Britain also, for example, from the 1920s on, mental health provided a paradigm to articulate in psychological terms a secular ideal for self-development as the basis for responsible democratic citizenship. In the United States the mental hygiene movement linked together the ills of modern society and the malaise of individuals, 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 it was especially at the time of the striving for fundamental reforms in psychiatry in the 1960s and 1970s, when the Nazi past was critically used as a spectre, that mental health care acquired a strong political dimension. Against the complicity of psychiatry in the atrocities of the Third Reich, a democratic counter vision of mental health care emerged, based on a conception of citizenship that stressed political awareness, independence of mind, and the social rights of the infirm and indigent.[32]

What was often missing in these countries, however, was an extensive network of public outpatient facilities to underpin the rhetoric about mental health and citizenship with concrete care-providing practices. In the Netherlands, models of psychological self-development were not mere abstract theories: in the practice of outpatient mental health care these ideals materialised. From the 1950s on, in various facilities clients were encouraged so be self-reflective about their conduct and motivations, initially in private life, but also with respect to their attitude in the public domain.[33] The psycho-hygienic movement and the outpatient services were more enduring, more broadly distributed, and more generously funded in the Netherlands than in Britain, Germany or the United States.

Another striking element of the Dutch outpatient sector was its broad orientation. It not only comprised social psychiatry in the sense of outpatient care for the mentally ill, but already from the 1930s and 1940s on it also included various counselling centres for problem children, 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 a strong psychosocial (rather than biomedical) focus of the extramural facilities. 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 (poli)clinical psychiatry.[34]

In the twentieth century, the mental hygiene movement and the outpatient 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, and it linked various social domains and appealed to various groups. The notion of health care evoked associations with medicine and hygiene, while 'mental' – the Dutch *geestelijk* also means 'spiritual' – referred to psychic features as well as religious, moral, and cultural values. Thus it was possible to establish an explicit connection with the strong charitable tradition in the Netherlands and the bourgeois civilisation 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 the belief in the perfectibility of society.

The modernisation of Dutch society and the evolving concepts of democratic citizenship provided a socio-political context for the pursuit of mental health, whereby cultural pessimism and an optimistic belief in society's progress balanced each other. In this light, it is possible to identify a turning point in the mid-1950s. In this decade the defensive response to modernisation was exchanged for a much more accommodating stance. In reflection on citizenship there was a shift from unconditional adaptation to established values and norms ('character') to individual self-development ('personality'). People's personal experience and their inner motivations came to be centre-stage, and therapeutic treatment and social integration were definitively prioritised over coercion and exclusion. In the years between 1950 and 1965, by building on the ideal of guided self-development, mental health care hooked up with social-economic modernisation: individuals had to shape their personality, develop their autonomy, be open for renewal, and, in a responsible way, achieve self-realisation. In the late 1960s and the 1970s, mental health workers embraced spontaneous self-development as a core value, thus legitimising the need for personal emancipation. Subsequently, in the neoliberal 1980s and 1990s, they viewed their clients as autonomous and self-responsible citizens, whose freedom to make choices as members of a pluralist market society was highlighted. At the close of the twentieth century, however, cultural pessimism recurred with regard to the self-determination and autonomy of some groups, such as the mentally ill.

The national government generally kept a low profile regarding the organisation 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 organisations or local government. Models for self-development and citizenship were hardly imposed from above by the state, but they were developed and enunciated by leading groups in 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. Psychologisation, a change of mentality characterised by a combination of growing individualisation and internalisation, was connected with the democratisation of social relationships, changed manners and authority structures, the shift from social coercion to self-control, and the increasingly subjective way of fashioning personal identity. People's conduct was more and more seen

as a reflection of personal wishes, motives, and feelings.[35] It was increasingly common for people to talk about themselves or others in psychological terms and to refer to mood or feeling as a way to legitimate their behaviour.

In the Netherlands, which used to be essentially conservative and Christian, the cultural revolution of the 1960s was more sweeping than in other countries because it coincided with rapid secularisation. In few countries was control and coercion from above banned so comprehensively as in the Netherlands.[36] The ensuing moral or 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 democratisation of public and everyday life replaced hierarchy and social coercion with individual emancipation and informal manners. To find the proper balance between assertiveness and compliance, people needed self-knowledge, subtle social skills, empathy, and an inner, self-directed regulation of emotions and actions. What mattered in a democratised and information-ridden new social dynamic, in which formal rules were replaced by negotiation and self-regulation, was a strongly developed mental resilience 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 people had concrete ramifications for their inner life, on account of which mental pressures could mount and the chances of their suffering from serious doubts, fears, and uncertainties increased.

With their emphasis on self-reflection and raising sensitive issues, mental health experts articulated new values and offered a clear alternative to the outdated morality of dos and don'ts. Talking was their preferred strategy for solving problems, which not only linked them with the Dutch culture of negotiation and consensus, but also with the practice of everyday life of many people. From the 1930s the largest segment of the working population has been active in the services sector. It is a sector in which social interaction and communications have increasingly grown central.[37] In the densely populated and highly urbanised Netherlands, therefore, proper social functioning depended much on personality traits associated with verbal and communicative skills and subtle emotion-regulation. Finally, the strong inclination toward psychologisation is also tied to the specific ways in which, in the Dutch culture of consensus, social and ethical issues are addressed by experts. Their expertise is frequently called in because their supposedly objective professional stance neutralises social conflicts concerning sensitive issues. In the articulation of policies on euthanasia, sexuality, birth-control, abortion, and drugs, for example, experts such as physicians, psychiatrists, psychologists, and social workers 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.

In the last two decades, however, confidence in the possibility of motivating individuals through considerate, 'soft' psychosocial support towards self-guidance and socialising them in such way that as full citizens they automatically integrate in an egalitarian and democratic society, has subsided. As a result of the emphasis on the market and growing rationalisation and commercialisation, individualisation has become increasingly characterised as competition and the need to perform, rather than as liberation and immaterial well-being. The neo-liberal ideal of citizenship elevated (economic) autonomy to the highest good. Those lagging behind, many of whom

depended on the shrinking welfare state and/or belonged to ethnic minorities, were seen as problem cases and increasingly treated by coercion so as activate them towards social participation and self-reliance. For these groups, the emphasis shifted from rights to duties. Dependence on the welfare state and a lack of social integration – on account of unemployment, educational disadvantages, insufficient language skills or certain religious (as in, Islamic) values – came to be more or less at odds with full citizenship. The view that citizenship was not a given entitlement, but had to be earned once again began to make headway, but in this construction more was expected from education, employment, entrepreneurship, didactic instruction and a hardening of criminal law than from the psychological subtleties of mental health care.

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