Madness, Mental Health and Citizenship:
From Possessive Individualism to Neoliberalism

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Abstract:
Since its emergence as a branch of medicine in the wake of the Enlightenment and French Revolution, psychiatry has experienced significant transformations against the background of different socio-economic and political changes in Western societies. In this wider context we see a recurring tension between the interest of the individual and that of the social body as a whole. This friction is closely related to opposing dynamics in psychiatry and mental health care: humanisation versus disciplining, emancipation versus coercion, inclusion versus exclusion, and democratic citizenship versus political subjection. This article provides a conceptual analysis and an historical overview on the ambivalent relations between on the one hand psychiatry and mental health care and on the other politics, and, more particularly, the development of the modern understanding of citizenship.

Key words: madness, mental health, citizenship, politics, individualism, liberalism.

Introduction
In the past two centuries the care arrangements for the mentally ill and others suffering from major or minor mental and nervous troubles have gone through four innovative and expansive phases: (1) the emergence of mental asylums and psychiatry as a medical specialty since around 1800; (2) the extension of psychiatry, from the late nineteenth century on, in other institutions (hospitals, sanatoria, university clinics, and private practices) and in social-hygienic as well as eugenic settings; (3) the emergence and diffusion of outpatient social-psychiatric services and mental health facilities since the early twentieth century; and (4), deinstitutionalisation, the shift from hospitalisation of psychiatric patients to community care since the 1960s and 1970s.

A fundamental dynamic behind the steady expansion of the psychiatric and mental health field was the recurrent alternation of therapeutic pessimism and optimism. Time and again, psychiatrists and other mental health professionals argued that the existing provisions fell short in providing adequate care and treatment to patients. Organizing alternative ones would lead to successes where prior efforts had failed. Repeatedly, new facilities enlarged the psychiatric and mental health domain and catered for new groups of patients, whereby again and again distinctions were made between those who were considered to be treatable and curable, and those who were less likely so or not.

There is no clear correlation between the frequency of mental suffering among the general population and the degree to which individuals make use of professional care. Socio-political and cultural factors have probably had greater influence on the supply and consumption of care than the actual occurrence of mental troubles. Apart from a core group of severely mentally ill individuals, whose relative size in the population has remained fairly stable over time, the definition, experience, and approach of mental difficulties is variable. Misery is of all times, but its specific construal as psychiatric or mental health complaints has been strongly determined by the availability of specialised care arrangements and their specific treatment options, and of the medical and psychological discourse used by the helping professions. In this way a host of tacit mental troubles became identifiable and they could be expressed as problems which needed care and treatment.

The growing supply of medical and psychological expertise advanced demand for care and treatment. However, next to this push factor, some external pull factors should be taken into account to explain the expansion of psychiatry and mental health care, although its scale and shape differed substantially between countries. In modern society people became more and more dependent on scientific knowledge and professional expertise as constitutive elements in the organisation of personal and social life. Rising levels of education, heightened communication and the belief in control over life and death play an important role in this process. Modernity implies that misery and shortcomings are not experienced any more as inevitable fate, God's will or simply bad luck. Rising expectations about the ability to tackle imperfections, to improve life and to fashion one's self by free choice have furthered the demand for professional services. Modern political regimes, liberal-democratic as well as fascist and communist ones, have accorded professional expertise an important role in the organisation of social life and the management of (ab)normality.

The transformations of psychiatry and mental health care occurred against the background of sweeping socio-economic and political transformations in Western societies. In this wider context we see a recurring tension between the interest of the individual and that of the social body as a whole. This friction is closely related to opposing dynamics in psychiatry and mental health care: humanisation versus disciplining, emancipation versus coercion, inclusion versus exclusion, and democratic citizenship versus political subjection. This article is about the ambivalent relations between on the one hand psychiatry and mental health care and on the other politics, in particular the development of citizenship[1]. Psychiatrists and other mental health professional were involved in delineating norms, requirements and ideals with regard to citizenship. Expressing views about the capacities and possibilities of individuals, they articulated mental criteria for either or not qualifying for the

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[1] This article draws on my chapters in three co-authored and co-edited books: Marijke Gijswijt-Hofstra, Harry Oosterhuis, Joost Vijselaar & Hugh Freeman (Eds.), *Psychiatric Cultures Compared. Psychiatry and Mental Health Care in the Twentieth Century: Comparisons and Approaches* (Amsterdam: Amsterdam University Press, 2005), introduction and chapter 10; Harry Oosterhuis & Marijke Gijswijt-Hofstra, *Verward van geest en ander ongerief: Psychiatrie en geestelijke gezondheidszorg in Nederland (1870-2005)*, 3 Volumes (Houten: Nederlands Tijdschrift voor Geneeskunde/Bohn Stafleu Van Lochum, 2008); Frank Huisman & Harry Oosterhuis (Eds.), *Health and Citizenship: Political Cultures of Health in Modern Europe* (London and Brookfield: Pickering & Chatto, 2014; London and New York: Routledge, 2016), introduction and chapter 7.

status of citizenship.

The relevance of mental health for citizenship
Citizenship is, like health, a complex, historically layered and contested concept with a wide variety of meanings and dimensions, used in a descriptive as well as in a normative sense. Citizenship is generally about what draws individuals together into a political community, in the modern world in particular the nation, and what keeps that sense of belonging, on the basis of a shared past and future, enduring and meaningful to its participants. In contrast to traditional socio-political relations of subordination and dependence, citizenship presupposes some sort of balance between public commitment and individual self-determination. Democratic citizenship as a rights-bearing status includes universal human rights, but is at the same time particularistic because it depends on membership of a (national) community. Defined and secured in the legal and political framework of the state, citizenship, involving both domination and empowerment, is also inevitably entangled in a dynamics of inclusion and exclusion.

Citizenship has a formal political-legal and an informal sociocultural dimension. The first is about reciprocal legal, political and social rights and entitlements, granted and guaranteed by the state, as well as responsibilities and duties towards the state and civil society. Roughly, legal, political and social citizenship have been realized between the late eighteenth and mid-twentieth century in three stages together with the formation of the liberal-constitutional state, parliamentary democracy based on universal suffrage, and the welfare state. At least, this is the North-West European pattern, but the timing, sequence and particular realization of the stages was different elsewhere. In the United States, for example, social citizenship has hardly been attained (which explains the continuing controversy about public health insurance), whereas in Germany and later, in Eastern Europe under communism, the emergence of social citizenship preceded rather than followed the full implementation of political citizenship. In most Mediterranean countries democratic citizenship was attained only from the 1970s onwards.

The second, more practical, everyday dimension of citizenship, implying certain attitudes and behaviours acquired through socialization, is about how people are supposed to act as involved and competent members of a community. It is about how they adopt and give concrete meaning to rights, duties and contributions, and meet requirements for adequate functioning in society, for example with regard to obeying the law, voting and paying taxes; self-reliance, work and productivity; raising children, education and vocational training; appropriate public conduct and social participation; and health and hygiene. The lived reality of citizenship took shape, not just in terms of formal legal and political rights and duties, but also in relation to the material, social, psychological, and moral resources that individuals have at their disposal in order to develop themselves and to be able to act according to those rights and duties. In the context of advanced (social) democracy, values such as fairness, social and distributive justice, tolerance of difference, self-determination and emancipation became elements of the definition of good citizenship.

In liberal democracies, in which coercion by the state was disputed on the basis of civil liberties, norms and requirements for citizenship were not only defined by the state, but also by professionals acting as intermediaries between

governmental authority and individual citizens. By delegating the execution of social policies to the more or less independent helping professions, such interventions were removed from political disputes and ideological controversy. Operating at some distance from the state and politics, professionals supposedly applied objective scientific knowledge about what was normal, healthy and efficient. They used neutral technocratic expertise to tackle social problems, from poverty, social unrest and disorder to criminality, depravity and ill health. The human sciences made the bodies and minds of individuals observable, measurable, knowable, controllable and transformable. Behaviour could be regulated through systematic methods: classifying, counting, sampling, social surveying, testing, interviewing, assessing procedures, education, therapy, counselling, monitoring, surveillance, and disciplining. The lack of democracy inherent in such expertise was compensated for by the professional ethos, which presupposed scientific competence, technocratic rationality, and disinterested dedication to the public good, all of which would serve the just and efficient management of modern mass society.

This is what Michel Foucault has characterized as 'governmentality': a range of practices and rationalities which interfere with individual behaviour while avoiding crude coercion and domination. Under traditional regimes the exercise of power was 'negative': rulers affirmed their sovereignty by taking the lives and possessions of rebellious subjects. The modern employment of power, on the other hand, was 'positive', that is aiming at the advancement of the health and fitness of individuals and the quality of the population in order to increase the strength and productivity of the nation. Individual citizens were expected to take responsibility for their lives on the basis of standards of normality and abnormality. Against this background, the helping professions have played a substantial role in the advancement of a form of citizenship through which personal choices are aligned with the ends of government.

The articulation of the psychological dimension of democratic citizenship by the helping professions was part of a more general historical shift from top-down and external social control to a more inner, self-motivated regulation of behaviour. In traditional systems of political domination, which subjected people by coercion and force, whether they accepted it or not, their mentality was of minor importance. Until the late nineteenth century citizenship depended on exclusive and formal attributes, which were largely given: male sex, social position, education, substantial property and tax liability. In the twentieth century, universal suffrage and the welfare state made citizenship accessible to just about every adult. Now the central issue was not so much: who is the citizen (on the basis of self-evident external qualities) but rather: what makes the citizen? The last question referred in particular to inner motivation and the proper mentality: the individual capacity to use one's liberties in a thoughtful and responsible way. The urge to internalise certain values and patterns of behaviour became greater the more a society was democratised. Democratic citizenship presupposes public commitment on the basis of individual consent and self-guidance. The social dynamic of democratic societies requires a considerable degree of self-awareness and psychological insight in the attitudes of others. Such inwardness went hand in hand with increasing pressure on people to open their inner selves for scrutiny by others and to account for their urges and motivations. The psychological interpretation of the self and of other people's motives and behaviour can be traced back to the late eighteenth

century, but until far into the twentieth it was largely restricted to intellectual and bourgeois circles, urban and well-educated groups, and mental health professionals. It was not until the 1960s and 1970s, when economic, social and political developments enabled the definitive breakthrough of individualisation on a massive scale that the psychological habitus, with a focus on personal self-expression, gradually spread among the populations of Western societies. Emotional 'psycho-babble' is fairly common nowadays and it has infused (and, I would add, messed up) democratic politics. Psychologisation also implies that social interactions and tensions between people have ramifications for their inner life and thus result in mental pressures and troubles.

Possessive individualism and the liberal bourgeois-capitalist ethos
The political relevance of *mens sana in corpore sano* can be traced back to classical antiquity. The founding moment of the modern interlinking of health and citizenship, however, can be found in the liberal-capitalist notion of possessive individualism, introduced by Thomas Hobbes in his *Leviathan* (1651) and elaborated by John Locke in his *Two Treatises of Government* (1690). Hobbes' materialist and Locke's empirical conceptualization of man as a being that is fundamentally driven by 'natural' feelings of pleasure and pain, grounded morality and the justification of socio-political order in concrete physical and mental sensations instead of supernatural, religious values. Their axiom that life in itself is good and the taking of life is bad, implies that physical security is the most basic need. The foundational claim of their theory of the social contract is that individuals, as prime owners of their bodies, possess an inherent natural right to oppose pain and death and preserve their lives.

Locke's argument about the centrality of individual self-determination and the constitutional state protecting vital rights, depended on his understanding of possessive individualism. In his view not only the possession of one's body, but also of cultivated soil and material goods is such a right, because what the body develops and produces by means of labour is the rightful property of the person who owns that body. Likewise, according to Locke, individuals are the rightful owners of their thoughts, memories, feelings, acts, experiences, talents and capacities. This leads him to the assumption of the continuity of personal consciousness enabling the individual to experience himself as the same being in different places, social settings and times – in other words, to have a personal identity apart from one's social position and the moral destiny of one's soul. And identity, which is essential for recognizing all one's thoughts and actions over time as one's own, and for reflecting and judging on them, enables taking personal responsibility for them. In this way Locke articulated the modern secularized notion of the person as a self-reflective, accountable and self-reliant agent. Such self-owning individuals should be free to decide for themselves what they do with what is naturally theirs, without owing society anything – at least as far as they do not impede others from exercising the same freedom. The state should uphold the natural law norm that 'no one ought to harm another in his life, health, liberty or possessions', but for the rest it should refrain from interference with citizens' undertakings and self-development. In classical protective liberalism, as articulated by Locke, the legal framework of the constitutional state is fundamental for enabling property-owning male citizens to lead ordered and secure lives and pursue their interests on the free market.

For us today, as far as we believe in liberal-democratic values, Locke's

possessive individualism, implying the right of self-determination over our bodies and minds, may be self-evident, but in traditional, authoritarian and totalitarian settings this fundamental principle was (and is) largely lacking. In Christianity the body and mind ultimately belong to God (and therefore his earthy representatives, the clergy, have a say about it). Under traditional hierarchical social relations superiors (fathers, spouses, landlords, princes) dispose of the bodies of inferiors (children, women, servants, serfs, slaves, other ethnic groups). And under totalitarian (fascist or Communist) regimes the body can be claimed by the state, often in the name of 'the people' or 'the proletariat' and people's minds are often manipulated. Even in democracies the state, in specific situations, may take control over the fate of their citizens' bodies – for example, those of conscripts at the time of war or of convicts undergoing the death penalty. And the bodies and minds of hospitalized somatic and mental patients are subjected to a medical regime.

The innovative and radical character of Locke's possessive individualism should not be underrated, but this is not to imply that he favoured democratic egalitarianism. In the classical liberal perception not all individuals can constitute themselves as self-owning and rights-bearing persons and therefore as full citizens. Self-conscious autonomy and self-reliance essentially require freedom from dependence on the wills of others. Such independence is understood as a function of ownership and appropriation. It is striking that the precondition for citizenship was defined in these terms and that these assets are related to the requirement of an intact body and sound mind. Full citizenship on the basis of a capable body and mind was associated with the capacity to supersede irrationality, to exercise will and control over one's own potentially disruptive drives and passions as well as over dependent others. Until into the twentieth century full citizenship was only granted to independent adult male property-owners and denied to other groups, apart from the economic category of social class, largely on the basis of naturalist criteria: sex, ethnicity or 'race', age, and mental coherence. Women, non-natives, wage labourers, the poor, minors, convicted delinquents, and those diagnosed as disabled, insane and feeble-minded were excluded because their bodies, in particular their nervous systems and brains, were supposedly inadequate. Their incapacity of a self-reliant and rationally organized life, and therefore of acquiring and managing property, was situated in an inevitable natural inequality which overrode the formal liberal ideal of equality of opportunity. Classical liberalism took for granted the uneven distribution of property in capitalism as well as the subordination of women and others on the basis of the belief in the existence of unequal biomedical categories of people.

The possession and management of a sound body and mind was an essential ingredient of the self-definition of the rising bourgeoisie, its secularized and naturalized moral order, and its progress-oriented attitude. Health and hygiene embodied its self-affirmation against both the frivolous and squandering aristocracy and the imprudent lower classes, lacking any drive to improve their existence. They were supposed to be neither capable nor willing to invest in a healthy body and mind. The broad meaning of health, as it took shape in enlightened thinking, was entwined with core middle-class merits: independence and self-reliance, self-control and responsibility, soberness and moderation, cleanliness and moral purity, regularity and order, willpower and foresight, utility and achievement, and thrift and investment. Since the

eighteenth century more and more aspects of life have been evaluated in terms of health, such as reproduction and sexuality, family life and educational issues, housing conditions, mental and behavioural disorders, addictions, crime, economic productivity and labour relations, lifestyle, habits and diet. As such, health and illness would gradually and increasingly become an object of modern politics.

Under the influence of enlightened optimism about the progress of science and technology and the vision of a rational and efficient organisation of society, health and illness, including insanity, were explicitly conceptualized as a public and political issue. The political revolutions between the 1770s and 1848, more and more transforming passive subjects under authoritarian rulers into citizens with rights and duties, stirred the democratic vision of health and illness in the sense that an inclusionary and equalizing promise was added to the exclusionary leanings of classical liberalism. In fact, Locke had already raised that hope when he mentioned health among the basic natural rights and thus suggested its incorporation in citizenship. Now it was also articulated by French and American revolutionaries and influential socio-political thinkers such as the French Ideologues (including Philippe Pinel, one of the founding fathers of psychiatry) and English utilitarian thinkers. The public programs for health care and disease prevention, including a new therapeutic approach of madness, that were debated during the French Revolution mentioned rights and obligations for citizens. The basic idea was that the nation's health ultimately depended on the state's ability to protect citizens against infections and unhealthy situations as well as their responsible and motivated attitudes: participation in physical examinations; fulfilling doctor's orders; the practice of temperance and hygiene; undergoing preventive measures such as vaccination; and frugal use of public resources.

Not only in France, but also in America and England some liberal thinkers believed that the realisation of civil liberties required good health, which should be advanced not only through charity and philanthropy, but rather through constitutional and democratic government. This view was also expressed by the utilitarian philosopher Jeremy Bentham. He compared the purpose of curative and preventive medicine with that of legislation and the administration of justice, healing the harmony of the social body and countering crime. Both had essentially the same purpose: fighting grief and promoting the greatest happiness of the greatest number. For Bentham a politics of health was not only indispensable for socio-economic efficiency and progress, but it was also a democratic achievement in the sense of advancing the equality of opportunity. Such thinking marked a significant reference point for the link between physical and mental health and democratic citizenship, which would eventually be realized in the course of the nineteenth and twentieth centuries.

However, this historical development was not without complications and contradictions. From the start of liberal thinking and the gradual realization, in the course of the nineteenth and twentieth century, of more or less democratic political regimes, health and citizenship have become entangled in a twofold, mirroring way. On the one hand, intact health, an able body and a sound mind, was framed as a requirement for full citizenship. On the other hand, citizenship became the precondition for the right (and perhaps also the duty) to health, for access to the means for maintaining and restoring it. Both connections involved a continuously shifting balance between rights and duties as well as inclusion

and exclusion of either good and full citizens or (im)possible, failed, marginal and sub- or non-citizens. All of this entailed a tension between on the one hand agency, self-determination, consent, liberation, empowerment and social integration, and on the other hand regulation, control, coercion, and social exclusion.

Psychiatry under classical liberalism: the insane as non-citizens
In the wake of the Enlightenment and French Revolution, psychiatry as a branch of medicine emerged in close relation to the care of the insane in asylums. The underlying idea was that madness should not any longer be understood in moral and religious terms – as God's punishment for sin or as a demonic influence – but as illness that could and should be treated. Locke's empiricist view of man inspired to a large extent the new attempted methods for bringing back the insane to reason: controlling their living environment by isolating them from society and institutionalizing them; placing them under a medical-educational regimen ('moral therapy'); and substituting the use of restraints and force for a compassionate and patient approach. Although asylum-doctors or 'alienists', as they were also known, claimed that asylums were hospitals, these institutions mainly functioned as large-scale shelters and were often overcrowded with chronic and incurable patients. They suffered not only from mentally illness, but also from physical and mental disabilities, dementia and neurological afflictions such as epileptics and paralysis. Apart from their ailments, their complete dependence on care and disturbing or dangerous behaviour was the main reason of their institutionalisation, which was closely intertwined with poor relief and juridical admission procedures implying that patients were deprived of their freedom and legal competence. Asylums were isolated from the rest of society and stood in bad repute among the general public, the more so because of widely publicised outrages about maltreatment and enforced hospitalisation against the will of patients.

Until far into the twentieth century, institutional psychiatry fulfilled two basic functions: care, which might be in the interest of patients and their relatives, and the maintenance of public order: freeing society of the nuisance and danger of insanity. Medical criteria were often overruled by socio-political and financial considerations. It was only in the course of the twentieth century that the main function of mental institutions shifted from shelter and care to treatment and cure. Until the mid-twentieth century or later, the legal-administrative framework of the asylum system varied according to different national political regimes. From around 1840 several European countries and American states adopted laws and administrative procedures which regulated the institutionalisation of the insane on the basis of a medical diagnosis or the consideration of public security. Supervision by the state should protect patients against abuse and citizens who were not insane against compulsory admission.

All of this implied that the civil rights of the hospitalized insane were suspended for either a shorter or longer period of time. The medical diagnosis of insanity, implying the fundamental lack of reason and self-control, legitimized the removal of civil rights and legal competence – in fact bringing them down to the position of non-citizens – in liberal society. Their loss of citizenship was supposed to be compensated through humanitarian care and adequate medical treatment – recovery would imply a return to citizenship. However, this medical promise was hardly backed up with legal guarantees and it was not uncommon

– in particular under authoritarian and totalitarian political regimes, but also in liberal democracies – that the humanitarian and therapeutic objectives lost out against the priority of social order and cost control, in particular with regard to the majority of the lower-class asylum-population.

The institutionalisation of the insane confirmed the implicit liberal norm that full citizenship required self-possessive, reasonable individuals who were capable of tending their rights and interests. In practice only a minority of well-educated, property-owning and tax-paying upper and middle class males completely fulfilled these criteria. This elite was qualified to vote and or to be elected for political office, whereas the masses were excluded from political participation and the liberal constitutional state only granted formal legal equality for all (male) adults. In the last decades of the nineteenth century, however, this restriction of democratic citizenship 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, the working class, women and other unprivileged groups began to make themselves heard. These new claimants to citizenship undermined its established status as a bastion of masculinity and property.

Defensive and accommodating responses to mass-democracy
The period between 1870 and 1920 saw the extension of the right to vote, resulting in universal suffrage. For liberal-bourgeois elites a crucial concern was whether all individuals had the necessary rational and moral qualities to meet the practical requirements of full citizenship. Overall their response was twofold: a pessimistic and defensive one as well as a more optimistic and accommodating one - which reflected the ambivalence of the Enlightened view of man. Naturalist explanations of man's physical and mental make-up tended to the assumption that many, if not the majority of human-beings were determined by irrational forces beyond self-control: by heredity, deep-rooted reflexes and instincts, and the physical and social environment. The definition of human subjectivity in terms of autonomy, freedom and responsible self-development, on the other hand, assumed reason as the essence of a common human nature and stressed philosophical voluntarism and the possibility of improvement through social reform and education.

Defensive reactions among bourgeois elites were stirred by mounting anxiety about the disintegrating and disorienting effects of social modernisation and mass-society. Many in the upper echelons of society feared the consequences of the inevitable advent of universal suffrage and emancipation of unprivileged groups. The irrationality and primitiveness which they saw embodied in the lower orders and a growing number of mental misfits (habitual criminals, alcoholics, vagrants, a-socials, sexual perverts, neuropathic, feeble-minded and insane persons) undermined social order and stability as well as their leading position. Persistent pauperism and an avalanche of deviance was associated with inborn and acquired defects of the brain and the nervous system caused by developmental anomalies and the strains of modernisation and indicating either a regression towards primitivism (atavism) or a digression from regular evolutionary and sociocultural progress. By the late nineteenth century, the concern over degeneration and a massive nervous breakdown affecting the strength and 'efficiency' of the nation, became something of an obsession in many countries. National rivalries were framed in Darwinian terms

of demographic battles for the survival of the fittest. In some countries, such as France and Italy, there were also concerns about national unification and integration being hampered by backward population groups which did not keep up with modern times.

Many liberals felt that in democratising mass society there were other priorities than individual freedom and equality of opportunity; especially when they faced deviance and deprivation, they stressed the need to protect the vitality and cohesion of national society. Society was compared to a living organism, in which the parts, individuals, like body-organs, were supposed to subordinate themselves to the healthy well-functioning of the whole. Social problems and deviant behaviours could be framed as pathologies. The expanding body politic was in need of effective guidance (by state-supported voluntary groups as well as scientific experts), just as the health of the individual body and mind required continuous vigilance. Such biomedical rhetoric underlined the belief that differences between classes, 'races', the sexes and between the normal and the abnormal were ingrained in nature, and it thus justified the social and political inequalities in the established liberal-bourgeois order. Biomedical knowledge about abnormality was used as a non-political and positivist means to set selective standards for citizenship. Those who were thought to be dominated by crude physical impulses and instincts, were the very opposite of rational political subjects because they lacked the guidance of the will by rational insight and self-control. They tended to be seen as impossible or inferior citizens who had to be either isolated from society or elevated to normality through sanctions, control and discipline.

The accommodating approach, on the other hand, was rather reformist and geared to social integration. Reform-minded liberals as well as social-democratic and Christian-democratic leaders became convinced of the urgency to tackle the 'social issue' by extending the supportive role of the state in society. If classic liberalism prioritized private enterprise and self-reliance over state-intervention on behalf of the collective good, social-liberals acknowledged that the individual opportunities for self-development depended not only on talents and willpower, but also on economic and social circumstances and the general risks of life. Collective social arrangements were considered necessary to protect the unprivileged from adversity and to offer them some structural support. What mattered was not just the resolution of social wrongs and misfortunes like poverty, illness, backwardness, and exploitation; it was equally important that those lagging behind might also improve their social position and achieve a productive and virtuous life. When rulers and social elites faced the broadening of the electorate, it became difficult to ignore the needs of broad layers of the population. As a consequence of the extension of suffrage, the political emancipation of the working class, and the sacrifices of millions of soldiers in the First World War, in most Western countries the state, either through direct intervention and funding or indirectly through corporatist arrangements, would increasingly assume responsibility for social security. Older practices of charitable poor relief were transformed into social insurance schemes covering sickness, disability, old-age, and unemployment. Collective health care benefits, which would be realised by governments of different political colours, were an essential ingredient of such entitlements. Equal access to basic health care came to be seen in terms of civil rights.

The melioristic approach did not only target socio-economic deprivation,

but also aimed at the integration of the working class into the political nation. As society's democratisation progressed, it was deemed all the more crucial to elevate the lower orders morally and to inculcate in them a civil sense of responsibility and decency on the basis of middle-class values, which would render them eligible for democratic citizenship. A sense of order and duty, social responsibility, an industrious and productive existence, and family values should work as cornerstones of the democratised middle class ideal of citizenship. Apart from politicians, social reformers and moral entrepreneurs, the proponents of this social-moral activism were found especially among the professional groups gaining influence and self-awareness, such as physicians, teachers, youth leaders, social workers, and later, also mental health workers.

It was against the backdrop of defensive as well as accommodating responses to socio-political modernisation that psychiatrists began to expand their professional domain beyond the walls of the asylum. Sharing liberal values and a positivist orientation, many of them believed that psychiatry should tackle social problems and contribute to the progress of society. This aspiration followed the example of preventive medicine and sanitary reform that from the mid-nineteenth century on addressed the disruptive effects of industrialization and urbanization on the health of the population. Urban cleansing and infrastructural and sanitary provisions should push back endemic and contagious diseases, thus improving the environmental conditions of health and the prevention of illness. This was more than a medical project targeting unhealthy living conditions. Wavering between the voluntary and the coercive, the sanitary reform movement – a broad coalition of physicians, philanthropists and social reformers – also articulated what was normal and virtuous, and referred to social order and the public good. Public health included the broader moral-didactic zeal to supervise and civilise the lower orders, and thus, at the same time, to make life for the middle classes less risky. From the late nineteenth century, the 'social issue' broadened the effort to improve the living conditions of the lower classes. Increasing social activism, either organised in civil society or by (local) governments, addressed a wide array of problems, such as chronic poverty and unemployment, poor housing, neglected children, alcoholism and prostitution.

In the last decades of the nineteenth century, doubts if not despair about the therapeutic effects of hospitalisation in closed asylums triggered psychiatrists' effort to prevent serious mental disorders by treating milder nervous and psychosomatic complaints, and by detecting mental misfits in society and taking appropriate measures. Thus psychiatrists focused on new categories of patients and targeted the mental health of society at large. Under the banners of public health, social and mental hygiene, criminal anthropology and eugenics, they claimed expertise on various disturbing conditions and behaviours: feeble-mindedness, habitual and juvenile crime, alcoholism and other addictions, sexual lapses, prostitution, vagrancy, chronic pauperism, suicide, educational deprivations, anti-social and recalcitrant attitudes, war trauma's, and more in general the difficulties to cope with the complexity and fast-paced lifestyle of industrialised and urbanised society. Older and newer diagnostic labels referring to a whole range of pathologies in the grey area between normality and full-blown insanity, such as moral insanity, psychopathy, various forms of monomania and perversion, degenerative deficiencies, neurasthenia, hysteria and neurological disorders, stretched the definition of

mental illness. Next to biological, hereditary causes of mental and nervous disorders, psychiatrists attributed their spread to harmful social-cultural influences, in particular the strains of modern society that supposedly exhausted people's nervous energy and mental vigour.

Both the defensive and the accommodating responses to the rise of mass-democracy can also be found in the expansion of psychiatry into society. The exclusionary effect that characterized asylum psychiatry's negative relation to liberal-democratic citizenship was continued to a large extent in psychiatry's social-hygienic and eugenic approaches during the late-nineteenth and early-twentieth century psychiatry. They targeted a wide variety of mental and social misfits as inferior or failed citizens.

The hygienic expansion of the psychiatric domain was underpinned by degeneration theory, Social Darwinism, eugenics and racial doctrines. Medical and evolutionary dichotomies and hierarchies – healthy versus diseased, normal versus abnormal, and developed versus un(der)developed – set a scientific standard for identifying threats against the liberal-bourgeois order and for either inclusion in or exclusion from modern society. The physical and mental capacity for citizenship of various mental and social misfits was questioned, now more explicitly than before: many of them came to be viewed as inadequate sub-citizens. Like other physicians, psychiatrists were involved in top-down, coercive health policies which focused on the quality of the population *en masse* for the sake of national vitality and survival. In such settings medical professionalism, based on exclusive expert authority, was at odds with democratic citizenship, it tended to violate the formal liberal threshold of individual rights and liberties. Such a trend, supplanting liberal possessive individualism by exclusionary possessive *étatisme*, occurred in several countries, albeit in different degrees and in particular in countries under totalitarian rule. The active role of physicians, including many psychiatrists, in large-scale eugenic and euthanasia programs as well as medical experiments in Nazi Germany is the most extreme example of the affinity of biomedical expertise with the 'biocratic' aim to purge society of all those considered as defective, unfit, dangerous or a public burden, including psychiatric and handicapped patients.

In the same period a more positive, inclusionary connection between on the one hand psychiatry and the new and broader field of mental health care and on the other citizenship emerged. Mentally and socially disadvantaged individuals were increasingly approached as possible citizens, who were entitled to support in order to develop the mental and behavioural capacities that would qualify them for full citizenship.

Mental health care: potential and emancipated citizens
Next to mental asylums, new psychiatric institutions emerged in the late nineteenth and early twentieth century: sanatoria and hospitals for nervous and psychosomatic sufferers; psychiatric and neurological wards and outpatient clinics of general hospitals for acute patients; and private practices of psychiatrists and neurologists. Catering to middle and upper-class sufferers to a large extent, these facilities admitted and treated patients on medical grounds, without certification and the associated loss of citizenship status – thus also uplifting psychiatrists' professional standing as doctors instead of guardians in closed and isolated institutions. The feeling that the turbulences of modern life strained the nervous system of all layers of the population, including

respectable citizens, advanced an understanding approach of nervous patients as well as distinctions between grave and threatening misfits and pitiful and improvable ones. The affiliation of psychiatry with neurology, psychoanalysis and psychotherapeutic treatments (including hypnosis and suggestion) reflected a general preoccupation with 'nerves' as the vital, but vulnerable link between mind and body, and with 'nervous' in the sense of restless, irritable, stressed and exhausted. Innovative psychodynamic and psychosocial treatments were also advanced in military psychiatry dealing with shellshock and other war-trauma's during the First and Second World War.

In the first half of the twentieth century institutional psychiatry underwent a gradual transformation of more or less closed asylums, in which patients were admitted only or mainly with legal certification and often for social rather than medical reasons, into more open mental hospitals, with increasing numbers admitted and discharged according to medical criteria. Amendments in the legislation on insanity attuned the shifting emphasis from legal procedures associated with maintaining law and order to voluntary admission and patients' right to receive adequate care and treatment. Also, the population in mental institutions was increasingly differentiated and segregated according to medical criteria: mentally handicapped and psycho-geriatric patients, for example, moved to specialized care facilities, thus leaving behind those with 'pure' psychiatric disorders, who were separated in wards for chronic and acute cases. The way psychiatric hospitals were financed and administered also changed. Until into the twentieth century, they largely depended on poor relief, but sooner or later collective medical insurance and social security schemes guaranteed more adequate funding and better quality of care. From the mid-twentieth century on more and more patients were actually being treated instead of just sheltered. The prescription of new anti-psychotic drugs in particular enlarged the opportunities for psychotherapeutic and social-psychiatric treatment of patients and shortened the average duration of their hospitalisation.

Between the First and Second World War the groundwork was laid for a further expansion and diversification of psychiatry's field of activity. The development of the psycho-hygienic movement and extramural mental health care broadened attention from insanity to a variety of psychosocial problems. This entailed the involvement of non-medical professions, such as social workers, social-psychiatric nurses, psychologists, psychoanalysts, educational experts and criminologists, and an increasingly wider spectrum of patients and clients. A variety of outpatient mental health provisions emerged: pre- and aftercare services and sheltered workshops for the mentally ill and feeble-minded who were not (yet or any more) hospitalized as well as counselling centres for problem children, such as Child Guidance Clinics, and for adults experiencing minor psychological flaws and behavioural problems or difficulties with regard to work, family-life, marriage, sexuality and alcoholism. Mobilizing social support and moral-didactic, psychosocial and psychotherapeutic approaches rather than medical treatment gained the upper hand in this sector.

The underlying reasoning of psycho-hygienists was rooted in concern about the relation between the hazards of modernity and personal distress. Many people would have trouble keeping up with the rapid technological advances and high-paced lifestyle of urbanised and industrialised society. As social and political democratisation progressed, it seemed all the more essential

to improve their mental resilience. Psycho-hygienists believed in the possibility of reforming and rehabilitating human beings and enhancing their proper functioning in modern society. Their tacit objective was an orderly mass-society that was based on the adaptation of the individual to middle-class norms and values.

Whereas the social-hygienic approach that was closely linked to Social Darwinism, eugenics and racial hygiene, involved drastic infringements on civil rights and exclusion, the psycho-hygienic effort became entwined with the interests and aspirations of disadvantaged groups. Increasingly mental health care relied on the agreement or co-operation of its clientele in order to enhance their living conditions. Although several degrees of coercion and tutelage were applied, more and more mental health workers relied on social support, advice, education and counselling in order to encourage habits and attitudes that were not only conductive to social adaptation and integration, but also to self-responsibility and self-regulation as the basis for robust democratic citizenship.

Supported by the welfare state, mental health care expanded after the Second World War. Psycho-hygienists still pointed out the downsides of modernity, but at the same time they displayed a great confidence in the human sciences and the psychodynamic model as well as a great sense of mission. The 1948 international meeting of the World Federation of Mental Health in London disseminated that not only the prevention and treatment of mental troubles mattered, but also that maximal health and well-being for all citizens should be ensured. This view echoed the World Health Organization's broad definition of health as 'a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.' It was also in line with the *Universal Declaration of Human Rights*, proclaimed by the United Nations in 1948, which reads: 'Everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including […] medical care'.5 The wider purpose of mental health was tied to the prevention of war and totalitarianism, and a careful management of ongoing socio-economic modernisation. Society could be improved, mental health professionals believed, through reforming people's mental make-up with the help of the behavioural sciences and psychosocial and psychodynamic methods. Their practical task was to deal with the troubles of individuals and to remedy their shortcomings, personality flaws, behavioural defects, developmental disorders, unconscious conflicts and relational difficulties. The broader objective was to strengthen people's moral and mental resilience in order to meet the challenges of modernity and the requirements of responsible democratic citizenship. The shaping of self-reflective, adaptive and constructive citizens would contribute to social and political stability.

Whereas in the 1950s the psycho-hygienic ideal of personality formation emphasized adaptive self-regulation on the basis of the internalisation of social norms and a sense of duty, from the 1960s on, ideals of self-liberation and self-actualisation paved the way for a more assertive and emancipatory individualism. Unequal relations of power in various social institutions and also in the private sphere – feminists declared that the personal was political – were questioned and politicised, whereas sensitive issues, such as sexuality, contraception, abortion and also mental suffering and illness were brought up for public debate. Progressive mental health workers sympathised with the 1960s protest-movement and antipsychiatry and they underlined the need to

liberate people from fixed conventions, oppressive 'social structures' and coercive institutional powers, such as those of medical psychiatry. Whereas institutional and medical psychiatry were forced on to the defensive, in many countries with a developed welfare state, psychosocial services increased in size and numbers. A psychological perspective and various talking-cures set the tone in these facilities, and they catered to clients with some capacity for introspection and verbal and communicative skills. The so-called 'me-decade' of the 1970s highlighted the preoccupation with self-discovery, emotional self-expression and personal growth. Mental health care, in particular psychotherapy, played a major part in the psychologisation of personal as well as public life. The mental health and welfare sector articulated new public values as a more open-minded alternative for the traditional bourgeois and religious moral order.

Mental health dovetailed with a pacifying and inclusionary extension of rights that framed social citizenship in the growing welfare state. Liberal constitutions had provided people with basic civil rights, the introduction of universal suffrage around the First World War had realized political rights, and the post-war welfare state had guaranteed their material security. Now the next step was to be taken in this continuing process of democratisation: the settling of immaterial needs in order to advance optimal self-development and personal wellbeing for everybody. All of this was grounded in the optimistic view that emancipated and motivated citizens would guaranty an open, egalitarian and democratic society. This implied the empowering of disadvantaged groups: women, youths, ethnic minorities, homosexuals, the handicapped and the physically and mentally infirm. Against this background psychiatry was brought up for public debate, often with strong political overtones.

The belief that the welfare state in general and outpatient mental health care and social work in particular would advance the egalitarian and integrative potential of social-democratic citizenship, inspired more or less radical reforms of institutional psychiatry. The policy of deinstitutionalisation, implemented in most Western countries from the mid-1960s onwards – although its form, scale, and timing varied substantially – boosted the role of extramural care and community psychiatry. Deinstitutionalisation, aiming at the social integration of psychiatric patients, was pressed forward by grand ideals as well as practical considerations.

Already in the 1950s, the introduction of psychotropic drugs and other more or less successful therapies, which made the behaviour of patients more manageable and compliant, began to advance a shift in psychiatric care from mental institutions to other provisions: psychiatric wards and outpatient clinics of general hospitals, general practitioners, halfway facilities, social-psychiatric services, community mental health centres, mobile psychiatric task forces, sheltered housing, and rehabilitation and work facilities. It was felt that psychiatric care should be fully integrated into national health and welfare systems (and benefit from their increasing budgets), also in order to counter the social isolation of the mentally ill. Plans for more extensive mental health networks were meant to enlarge the accessibility of care-providing facilities for the mentally ill and, in some countries, for clients with minor complaints too.

Deinstitutionalisation echoed democratic and emancipatory ideals as well as the growing criticism of institutional psychiatry, culminating in anti-psychiatry (or in Italy *Psichiatria Democratica*) and protests of patients who organized

themselves in interest-groups. The basic idea was that the mentally ill should be enabled, with the support of public facilities, to participate in society as much as possible. Their social integration would improve their self-worth and self-development, and discourage widely-held prejudices against them. Although limited in their autonomy and judgement, and dependent on more or less support, mental sufferers should not be excluded from civil rights. New mental health laws restricted forced hospitalisation against the will of patients and, if it was inevitable, did not imply any longer the complete loss of citizenship. Particular rights were acknowledged, for example with regard to standards of humane care, self-determination, the integrity of the body and the need for informed consent to medical treatments.

There was (and is) a general trend away from reliance on (long-term) hospitalisation towards a more varied and extramural pattern of care and treatment, although there were considerable variations in the scale, operation and timing of new policies between countries. Deinstitutionalisation and the promotion of community care often raised high expectations, but their implementation met with financial, political, and organisational obstacles. In most countries the reforms started in the 1960s and early 1970s in a climate of economic growth, rising public expenditure and leftist politics. In the ensuing decade of economic depression and a political turn to the right, governments cut down welfare and now tended to promote deinstitutionalisation as a way to save costs for mental health care. Less (welfare) state and more free market was the motto of both the Thatcher government and the Reagan administration, and their neoliberal example was more or less followed on the European continent. In America, Great-Britain and Italy in particular, where deinstitutionalisation was much more drastic than in other countries, the reduction of psychiatric beds was far from fully compensated by alternative professional mental health care and public facilities for social rehabilitation. Instead, the emphasis shifted to voluntary and informal care, whereas privatised care facilities, including private psychiatric and psychotherapeutic practices were only available for acute patients, people of means and clients with minor mental problems.

The result was that psychiatric patients, sometimes including chronic and severely disordered sufferers, were discharged from mental hospitals without there being sufficient alternative care-provisions available. Many of them became dependent upon their relatives or were largely left to their own devices. Thus institutionalisation entailed social abandonment, poverty and nuisance as caused, for instance, by mentally disturbed persons and alcohol or drug addicts who ended up on the streets. In the United States more and more of them joined the growing army of homeless people. Deinstitutionalisation did not always improve the quality of life of the mentally ill, while there was a growing anxiety over those among them who cause public nuisance and who may be violent.

Mental health care under neoliberalism: empowered and failed citizens
The mixed blessings of deinstitutionalisation should be understood against the background of the devaluation of the welfare state from the mid-1980s on. In the post-war period all over the Western world expenditure on health care and welfare benefits has gone up continuously, outstripping economic growth. Rising and eventually unaffordable costs were also propelled by some inherent

dynamics of welfare regimes. They tended to depoliticize potentially controversial social areas and issues (child-raising and education, reproduction and sexuality, a host of mental and behavioural difficulties, work-related disabilities) by redefining them as medical and psychological problems and referring them to the subsidized domain of the helping professions. Although collective solidarity assumes mutual obligations and social responsibility, it rather fostered in citizens a sense of rights and entitlements, and also triggered rising expectations and claims over the range and priorities of provisions. As a result, the endurance of welfare provisions has become disputed, the more so in times of austerity policies.

All of this applies in particular to health, because its substantive meaning has expanded and it has become the crucial benchmark for the quality of life. The pursuit of improved and optimal wellbeing through the shaping of lifestyles or 'life politics', involving a whole array of policies, agencies, services and commodities, seems to be endless, whereas the collective and private means are finite. Moreover, it is difficult to delineate the (civil and human) right to health – as proclaimed by the World Health Organisation and by the United Nations in the *Universal Declaration of Human Rights*. Unlike other civil rights such as freedom of speech or religion, universal suffrage or fair trial, health in itself can hardly be guaranteed by laws or policies. Illness is a large extent a matter of nature and fate, of inevitable biological distinctions between individuals. Equal access to health care may be feasible, but there are no objective criteria for its range and quality, and the fair allocation of scarce resources. Which treatments of which patients should be covered by collective funds and on what conditions? How much of our income and tax-money can and do we want to spend on health care?

Since the upsurge of neoliberalism, the collapse of communism in the East and the retreat of social-democracy in the West, the welfare state is under pressure, not only because of its escalating costs, but also because of the argument that it incited improper use of benefits and inactivity. A concern about citizenship is at stake: the feeling that entitlements have superseded civic virtues and obligations; and that there is a need to boost individual self-reliance and social adjustment – if necessary through coercive measures – of deprived groups (the unemployed, the poorly educated, ethnic and religious minorities and also the physically and mentally disabled), which seem to lack the sociocultural capacities required to get along in a globalizing and dynamic world. Welfare dependency and lack of social integration came to be seen as contrary to good citizenship. Policies of deregulation and privatisation shifted the emphasis from the 'soft' welfare approach to economic incentives, performance and competition on the market. Good citizenship increasingly implies self-reliance and self-activation on the basis of talents and efforts. With respect to health, it is argued that collectively funded care can only be sustained if citizens take more responsibility for their fitness and life style in order to prevent ill health.

Public concern about health has increasingly been articulated in terms of risks, which have to be dealt with on an individual basis and entail obligations. Predictive and preventive approaches focus on the detection and mapping of health risks and the prognosis of possible illnesses among the general population. People are warned for the health risks of tobacco, alcohol, drugs, 'unsafe' sex, stress, unhealthy diets, lack of exercise, and polluted

environments. They are urged to be aware of and monitor their health condition, to know about and manage dangers, to lead healthy lifestyles, to have themselves vaccinated and screened, and to act as conscious 'health consumers'. As far as mental fitness is concerned, all sorts of therapists, trainers, coaches, advisors and consultants offer their services in order to help people meeting the raised requirements with regard to performance, achievement, career-planning, flexibility, social skills and the regulation of emotions. It appears that the personalized and psychologized focus on mental health problems, which emerged against the backdrop of the self-absorptive 'me-decade' and the progressive ideal of a caring welfare state, could also be geared to the neoliberal norm of the autonomous and enterprising individual and the associated model of the self-interested health consumer on the free market.

The implicit suggestion of all of this is that reflective, motivated individuals can, to a considerable extent, have control over health and illness as part of the continuous effort to boost the quality of their lives. These ideals of individual autonomy and self-determination are also central in contemporary medical ethics stressing patient's rights and integrity, free choice and informed consent. Current medical practice indeed shows a more active stance of patients and health consumers, who educate themselves on the basis of the wide availability of scientific and popular information about health and illness, in particular online; who adopt professional language, understand themselves in terms of biomedical knowledge and psychological discourse, and use it for their own purposes; who assess scientific information and may dispute expert authority; who organize themselves in interest and support groups, and shop on the medical market of professional as well as alternative healers.

The requirement of a self-monitoring and self-empowering attitude in contemporary health regimes, dovetails with the neoliberal framing of citizenship in terms of a largely de-socialized and self-interested individualism. It marks a revival and expansion of possessive individualism as the norm, not, as in the past, for an elite of male property-owners, but now for all citizens. The view of individuals as self-sufficient and self-interested agents whose relations with others are mainly contractual, suggests that they have by definition free choice and can optimally shape their lives through an enterprising and calculating manner. Citizens are expected to act according to 'their own best will', exploit their inner resourcefulness and 'get the best out of themselves'. Such an imperative implies particular psychological and social abilities such as proper initiative, decisiveness, continuous self-examination, self-management and self-promotion, but also a flexible, communicative and cooperative attitude. Citizens should act as the owner and vigilant manager of their physical and mental capacities – which insinuates that full citizenship is more than a given entitlement, but has to be earned.

In the past the socialization of responsibilities for health and illness through sanitary reform, psycho-hygiene and socialized care arrangements, had resulted in a balance between possessive individualism and a more or less benign, inclusionary possessive *étatism*, or, in other words, between individual self-determination and collective responsibilities. The neoliberal revival of naked possessive individualism has upset this balance. There is nothing wrong with active and well-informed citizenship in itself and to a large extent it has materialized. But there is a problem if individual responsibility is enlarged and

taken as the standard for everyone, whereas the individual means to act accordingly are not equally distributed. Neoliberal freedom often lacks protective shields, thus fuelling uncertainty and fear, in particular among the unprivileged. A basic problem is that the one-sided emphasis on autonomous self-determination is at odds with some fundamental ethical and political aspects of mental incapacitation, especially in the age of deinstitutionalization, genetics, biotechnology and psychopharmaceutic drugs. Under neoliberalism, the mental health and citizenship nexus has become problematical in several ways.

To what extent can autonomy and self-determination be adequate guidelines when people suffer from physical or mental illness? As long as we are in good physical and mental health, we tend to believe that we *have* a body and that we are in control of our thinking and behaviour, but illness is the very experience that makes us painfully aware that we *are* our bloody body and that erratic thoughts and feelings can overwhelm us. Our ability to own and control them is not limitless. Illness, implying suffering, pain, dependency, anxiety and confusion, basically involves a partial or complete lack or loss of the essential capacities of possessive individualism. Therefore, the emancipatory ideals of deinstitutionalisation and community care are not without dilemmas.

The emphasis on social integration and participation of psychiatric patients underrated the essence of mental illness: the devastating effect on self-determination and the loss of the basic and taken-for-granted patterns of behaviour and social interaction. Ideals of emancipation were far-fetched for those suffering from serious psychiatric 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. The striving for social participation, including employment rehabilitation, was complicated by the ever greater demands of the labour market in terms of proper training, intellectual and social skills, performance, and flexibility, which many patients were unable to meet. Fragile psychiatric patients in particular need security, protection and a quiet life shielded from the dynamic of society. They may prefer the overall protection and care of a secure institutional environment in order to lead reasonably untroubled lives.

Also, the neoliberal framing of the patient, or the 'client', as a freely choosing consumer is overoptimistic, even more so for mental sufferers than for somatic patients. Although market mechanisms have been introduced in health care, their situation is not like that of the citizen-consumer on the free market. The provisions of collectively funded mental health care are still largely monopolistic, standardized, budgeted and state-regulated, and they restrict patients' freedom of choice. The control of managers and (public or privatized) insurance-companies over care provisions has in fact increased. Professionalism, efficiency, rationalisation, budgeting, and a partial re-medicalisation of psychiatry – neurobiology and genetics have revived determinist explanations – have taken the place of the emancipatory ideals of the 1960s and 1970s.

There are more structural factors hampering autonomy and self-determination. The consideration of health and illness in terms of individual choice and responsibility not only plays down differences between individual constitutions. It also underrates the extent to which mental disorders may be still being determined by socioeconomic and cultural factors, such as poverty,

educational deprivation, unemployment and ethnicity. Moreover, the preventive and enhancement approach in health policies feed rising standards of physical and mental fitness, which may even widen the gap between the better-off and the underprivileged. If optimal fitness and performance becomes not only desirable, but virtually mandatory, either through social pressure or the insistence of insurance and state-agencies, people who cannot (or don't want) to meet the forced up requirements, may be stigmatised and surveyed as high-risk groups. The chronically ill, mental sufferers and the disabled in particular may be marginalized as failed citizens, the more so because of their insufficiency to fulfil the standards of active social participation and, in particular, economic productivity. The complexities of the digitalized information and service networks on the commercial market and in administrative and governmental agencies, make things even worse.

Whereas social security and welfare services have been trimmed down and budgets for mental health care cut, the state and its (partly privatized) administrative apparatuses have increasingly turned to data-collection, assessment, risk-control and scrutiny of problem groups. Also, the emphasis shifted to safeguarding public safety, and in mental health care to more coercion in social-psychiatric care. Deinstitutionalisation has intensified public concern over the risk posed by the mentally disturbed who are unable to take care of themselves and cope with life in society, who are recalcitrant and refuse treatment, and whose serious behavioural problems are considered as a public nuisance or as dangerous to themselves or other people. Their increased right to self-determination has increasingly conflicted with the limited social tolerance for such behaviour among the general population and the curbed options of frequently understaffed and budget tight mental health care facilities. Their outreach interventions do not provide lasting solace. For the rest, psychiatry's treatment of serious and incurable mental disorders centres on the modest objective of alleviating suffering and controlling the disturbing symptoms as much as possible, in particular through medication, so that patients can cope with life, for better or worse.

The other legacy of the emancipatory mental health policies in the 1960s and 1970s – the expression of mental difficulties and personal life in psychological language – also raises mixed feelings. If in this period the aspiration was to make the personal political, in the following decades this logic was inverted: the political was increasingly reduced to the personal. What are the implications for democratic politics, civil society and citizenship if public issues are overwhelmingly discussed in personalized, psychological and increasingly emotional language? In the 1970s and 1980s such discourse may have been liberating and empowering. However, as we have learned in the past decade or so, under the influence of increasing populism the same kind of talk has been upturned and used to express anger and hate and to stir up division. The personalized articulation of mental suffering and psychological inwardness in the 1970s and 1980s has, to some extent, paved the way for the polarized identity-politics and cultural wars dividing Western societies more than ever before. The dominant political rhetoric draws attention away from crucial sociopolitical concerns such as increasing inequality of opportunities, wealth and income. The self-searching therapeutic culture of the 1970s and the neoliberal celebration of individual self-sufficiency both have increasingly pushed critical sociologically informed analysis out of public debates.

Conclusion
This article has outlined how the development of modern psychiatry and mental health regimes was intertwined with the rise and expansion of citizenship. Their relation is tied to its ambivalent origin, which is the liberal principle of possessive individualism. The mental health-citizenship nexus was one of mutual facilitation as well as of antagonism, involving a dynamics of inclusion versus exclusion, equality versus inequality, liberation versus suppression, and rights versus duties. The expansion and socialization of mental health care and the broadening domain of psychiatry during the past two centuries should not only be viewed as an inevitable and coherent medicalization, or imposition of 'biopower', to use Foucault's well-known term. The socio-political implications of mental health and illness were entangled in various interactions and tensions between the state, medical professionals and either more active or more passive citizens. Biomedical reductionism in psychiatry tended to undermine rather than enhance democratic citizenship, whereas in the psycho-hygienic movement and socio-psychological approaches mental health and democratic citizenship mutually reinforced each other. Serious mental illness and full citizenship, however, are hard to reconcile until today.

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