The Changing Professional Identity of the Dutch Psychiatrist 1960 - 1997

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From the second half of the nineteenth century on, the professional identity of psychiatrists in the Netherlands has been determined first and foremost by their status as physician. Because of their shared medical training, physicians and psychiatrists have always belonged to the same professional group. Today, however, Dutch psychiatrists tend to consider themselves no longer primarily as medical doctors. Last year the Dutch Association for Psychiatry issued a new professional profile in which the psychiatrist is described as a "bio-psycho-social generalist" in the area of mental health care. This new conception of professional identity - which is not undisputed - did not emerge out of the blue but is a result of substantial changes in the field of mental health care since the 1960s, including the growing input of other professional groups (such as psychologists, social workers, psychiatric nurses), the increased involvement of patients, and the broadening of the psychiatric domain outside of the confines of the hospital or institution.

Between the 1960s and the 1990s, psychiatry in the Netherlands suffered from an identity crisis. Major concerns about the relationship between neurology and psychiatry, the psychiatrist's professional training, and, more generally, the scientific character of psychiatry were raised continually. In this article, we will try to determine how since 1960 the cognitive orientation and the professional interests of Dutch psychiatry began to change and what role was played by the relevant professional organizations and by developments in Dutch mental health care at large. We will focus our discussion on the professional organization of psychiatrists, the relationship between neurology and psychiatry, and the growing significance of ambulatory mental health care, psychotherapy in particular.

The Professional Organization of Psychiatry

In contrast with the United States and England, where neurologists and psychiatrists parted ways early on, in the Netherlands these two medical specialists were represented by one professional organization, the Dutch Association for Psychiatry and Neurology (NVPN), for a long time, from 1895 to 1974.[2] In its early days, the NVPN focused much of its energy on scientific explanations for mental disorders. Although psychological approaches gained ground in Dutch psychiatry before the Second World War, mainly under the influence of psychoanalysis and phenomenology, it was in the brain and the central nervous system that the causes for mental illness were primarily sought. The handful of psychiatrists that were active in the Netherlands at the beginning of this century were also practicing neurologists and by and large they embraced a medical-scientific approach. In 1930, the umbrella organization of the Dutch medical world, the Royal Dutch Society for the Improvement of Medicine (KNMG) began listing medical specialists. Until 1972, it listed the combined field of neurological and mental illness as one specialty. Whether prospective specialists chose either neurology or psychiatry as their main field, in both cases they would be registered as "nerve specialist" and they were qualified to be active on each other's field of expertise. Up until 1984 neurology was a substantial and mandatory part of the Dutch psychiatrist's basic training.

The early 1960s marks the beginning of the official division between neurologists and psychiatrists in terms of their professional organization. In 1962 the NVPN created separate

sections for neurology and psychiatry[3], but this could not prevent the Association's ultimate demise: in 1974 it was split into the Dutch Association for Psychiatry (NVvP) and the Dutch Association for Neurology (NVvN).[4] Over the years, members of both sections had witnessed the two disciplines drift apart and it was widely considered desirable that psychiatrists and neurologists follow their own independent course with regard to professional training, scientific future, and the internal differentiation of their respective fields. In the years to follow, psychiatry evolved into a much more diversified, multidisciplinary field, partly as a result of the growth of a public, non-institutional mental health care system, whereas neurologists became more closely associated with a strictly scientific orientation. Their exclusively medical specialization had little to expect from the multicausal approach that was gaining ground in psychiatry.[5]

Although the division was regretted by some, especially when in the 1970s significant progress was made in the biological and neurological research of mental disorders, most psychiatrists considered the separation a step forward; having their own organization gave them something they seriously needed - more of a sense of professional identity. They felt they hardly benefitted from neuropathology and some believed that psychiatry would be unable to develop into a separate discipline if a proportionally small group of neurologists continued to have a say in, for instance, basic psychiatric training requirements. The professional identity of the psychiatrist was changing as a result of the widening of his role in mental health care, which itself was a burgeoning field with a host of non-medical professionals playing an increasingly larger part. The new NVvP sought to extend its reach and lift psychiatry out of its strictly medical constellation by opening the Association to members of other professional communities who qualified as associate member because of their training or involvement in the area of mental health. Other medical specialists, physicians without one particular specialism, or those still in training but somehow connected to the field could now become a member of the Association as well. It was clear that the NVvP presented itself no longer exclusively as a medical organization of specialists, but as a broad interest group of people involved in mental health care. However, psychiatrists held the upper hand as far as their training and their interests as physicians were concerned.

The Training of Psychiatrists and the Relationship between Psychiatry and Neurology

From the 1950s on, the growing gap between neurology and psychiatry became noticeable in particular in the discussions about substantial changes in both content and length of the basic training period for psychiatrists. Although psychiatry as a medical specialty was already taught by 1896, only in 1930 the KNMG established a Specialists Registration Commission which decided that a "nerve specialist" should go through a training period of three years.[6] This period was extended with one year in 1950: two and a half years psychiatry and one year and a half of neurology for those who chose psychiatry as their main field, and the reverse for those with neurology as main field. By 1956 it also became mandatory that those who wanted to be psychiatrists work six months in an institution as part of their training.

To advise the NVPN on educating psychiatrists and neurologists, the KNMG established the "Consilium Neuro-psychiatricum" in 1958. Four years later, when the NVPN took the initiative to set up separate sections for psychiatrists and neurologists, this committee proposed to have separate training curricula as well, so as to provide more space for specialized education. It was suggested that the two and a half years of specialized training for Dutch neurologists and psychiatrists was far less than that of such specialists elsewhere. In 1964, therefore, the training period was again extended with one year, so that now psychiatrists and neurologists received a

total of five years of education, of which three and a half years in their respective main fields. To educate psychiatrists, a broad basic approach was adopted. In addition to two years of clinical and outpatient psychiatry, during which the candidate was familiarized with fields and techniques like clinical psychology, electroencephalography[7], psychotherapy, and psychiatric research, it was also required to do six months of institutional psychiatry, six months social psychiatry, and six months child psychiatry.[8]

This new training curriculum, however, elicited various objections from both neurologists and psychiatrists. Although the two fields had increasingly grown apart during the 1950s and 1960s and although most "nerve specialists" tended to be heavily specialized in either psychiatry or neurology (so that it made more sense to be certified as one or the other), the idea of the combined specialty was formally held up after all.[9] Neurologists continued to focus their attention on curing somatic disorders of the nervous system, whereas psychiatrists increasingly devoted their attention to neurotically and socially disabled patients for whom psychotherapeutic treatment seemed more appropriate than any strictly medical treatment. In this light, it is relevant that at the 1967 Spring Meeting of the NVPN, the Amsterdam professor and psychoanalist P.C. Kuiper argued in favor of a multicausal approach in psychiatry as opposed to the one-sided neurological focus on somatic medicine. Psychiatry should be concerned with somatic, psychological, and social aspects of mental disorders. "In daily practice the double specialty has become a nuisance," he argued, saying that it was no longer possible for anyone to have an overall view of the two specialties, let alone cover them. "Neurology and psychiatry will only have a bright future as independent specialties."[10] Kuiper felt that neurology obstructed the evolution of psychiatry toward an integral "bio-psycho-social" discipline and that the required one year and a half of neurological training was hardly useful to a psychiatrist. A future social psychiatrist or psychotherapist would hardly ever benefit from having solid neurological knowledge.

Other objections against the new training curriculum for psychiatry involved its proposed length of five years and its far-reaching differentiation: the various mandatory internships would result in dissipation of energy.[11] Furthermore, a practical issue was that the required portion of neurology caused long delays and waiting periods because there were few internships (or residencies) available. Finally, it was seen as a problem that the new proposal left no space for choice or individual emphasis.

The ensuing debate ultimately caused the introduction of the registration of neurology and psychiatry as separate specialties in 1972. This meant the end of the double specialty, as neurologists and psychiatrists were now no longer licensed to practice each other's field of expertise.[12] Based on EEC guidelines, psychiatric training was again limited to four years, one year of which was to be devoted to neurology. During the two-year basic training program a wide variety of aspects of psychiatry were addressed: the biological, neurological, psychological, and social dimension of psychiatric syndromes; social and non-institutional psychiatry; child psychiatry; clinical psychology; geriatric psychiatry; psychopharmacology; and various forms of psychotherapy. Mandatory internships were abolished and opportunities for individual choice were enlarged; the prospective psychiatrist would complete his training by doing one year of internships as desired.

During the second half of the 1970s, however, the precise content of psychiatric training was questioned once again, especially the relevance of the one year of neurology training. After it was proposed repeatedly that the mandatory year of neurology be replaced with a year of a more general somatic internship, Professors M. Romme and M. Richartz of the University of Maastricht proposed to devote more attention to issues of biological psychiatry instead of neurology.[13] They argued that "biological psychiatry encompasses much more than just the diagnosis and treatment

of organic (neurological) disorders in psychiatric patients." They even worried that holding on to the mandatory neurology internship, rather than be an incentive, would pose an obstacle to Dutch clinical psychiatry in its attempt to garner more awareness of biological and somatic aspects in psychiatric patients.[14]

There were other Dutch psychiatrists who shared the views of Romme and Richartz. During the mid-seventies a number of them criticized the existing psychiatric training program in the leading Dutch journal for psychiatry, the *Tijdschrift voor Psychiatrie*.[15] Although there were differences of opinion on the exact content of psychiatric training, there was agreement on the impossibility of designing one all-embracing program. Psychiatry was seen as a specialty that is at once broad and general as well as narrow and specific. It should be desirable, therefore, to complement a more general basic training period with a period of specialization in one specific area of psychiatry.

In 1981, the discussion caused the NVvP to adopt new basic training standards. The new four-year program consisted of a two-year basic training period in clinical and outpatient psychiatry, one year of residency (with a choice of either social psychiatry, child psychiatry, psychotherapy, or institutional psychiatry), and one year of neurology. If a candidate were to fail to succeed in finding an opening for his residency in neurology (these were scarce and there were long waiting periods), he was allowed to seek out another training option, preferably in internal medicine or child psychiatry, if, at least, he satisfied all requirements and asked for advance permission from the Specialists Registration Commission.[16]

This new curriculum included many of the suggestions of Romme, Richartz, and others, and it was clearly an attempt to bring a more integral approach to psychiatric training. In addition to a general clinical-psychiatric education, the candidate had to devote at least two hundred hours to psychotherapy, eighty hours to biological psychiatry, and forty hours to social psychiatry. There was also more freedom of choice. But one of the major complaints of previous decennia, the neurology requirement, was still not yet fully met. Although the amount of neurology as part of psychiatric training had gradually been reduced over the years, only in 1983 it was finally decided to abolish it as a mandatory part of the curriculum. Reasons for this, though, turned out to be practical rather than ideological: there was a great shortage of training opportunities in the neurology departments of the various Dutch general hospitals. When speculating on the reasons why a majority of the membership of the NVvP has hold on to neurology as part of psychiatric training for so long, it is probably associated with the concern for the medical status of their field. Despite the growing attention for psycho-social approaches, they held on to their professional identity as medical specialist. The board of the NVvP emphasized in 1982 that the medical character of the overall psychiatric training program had to be guarded. After the mandatory neurology segment was abolished, required training in somatic pathology was added to the basic standards[17]. Moreover, starting in 1984, the psychiatric training program was extended with six months, to include a mandatory segment of social psychiatry. The program now consisted of three years of clinical and outpatient psychiatry (the so-called basic training period), six months of social psychiatry, and one year of various internships.[18]

In addition to the role of neurology in psychiatric training, one of the major issues that kept returning over the years was the question of a general versus a diversified training approach. During the 1960s most psychiatrists favored a generalist approach, as became clear in the training requirements of 1964 and 1972. By the end of the 1970s, however, there was a greater demand for specialized psychiatrists and there was a plea for more differentiation and individual choice within the psychiatric training program. However, this was not expressed in the 1981 training requirements. Even when the neurology segment was done away with, there was still little space

for diversity. To this day, Dutch psychiatric training is basically generalist, with for the advanced candidate some opportunities to focus on developing sub-specialties while still in training.

Ambulatory Mental Health Care and Psychotherapy

The debates on the relationship between psychiatry and neurology and on the proper training of psychiatrists are best understood against the backdrop of developments in mental health care in the Netherlands, notably the growth of non-institutional, ambulatory care after 1945 and that of psychotherapy after 1960.

In the years following the Second World War, psychiatrists increasingly found themselves employed outside of the mental institution. Psychiatry not only became more integrated into general hospitals but psychiatrists also more and more focused on providing ambulatory mental health care. The Dutch mental health care system, which is basically government subsidized, developed an extensive psychiatric network that existed independently from mental institutions and hospitals. The ambulatory mental health care system (AGGZ), characterized by a mixture of preventive and curative medicine and by a multidisciplinary approach, evolved out of various, largely private and religious organizations which over time merged into one care system. In 1982, this process toward the integration and regionalization of the existing clinical and ambulatory facilities was completed with the establishment of so-called RIAGG centers, local or regional facilities for out-patient mental health care. In addition to these RIAGG centers, independent psychiatric practitioners and psychiatric polyclinics continued to provide similar services.[19]

The Dutch ambulatory mental health care system consists of a heterogeneous group of practitioners and facilities that offer a variety of approaches and methods of treatment. The roots of this situation go back to the 1920s and 1930s when many preventive and post-care services were set up, for example, the Social Psychiatric Services (SPD), aimed at the medical and social support of psychiatric patients who for various reasons were no longer or not yet eligible for admittance into hospital. The Medical Counselling Bureau (MOB), founded in 1928, was geared toward behavioral disorders and psychiatric problems of children. During the 1930s and 1940s, a number of facilities for adults were established, such as the Centers for Life and Family Issues (LGV) and the Catholic Bureaus for Marriage Counselling. The Institute for Medical Psychotherapy (IMP), founded in 1940, was initially aimed at providing short-term psychotherapeutic help to adults who suffered from war traumas. After the Second World War, psychotherapy gradually became available to the population at large, culminating in the 1970s in what has been called "the marketplace of well-being and happiness," where an army of psychotherapists is always ready to offer a wide variety of customized care.

The development of a broad network of ambulatory mental care facilities in the Netherlands went hand in hand with the rise of social, out-patient psychiatry, but it was also greatly stimulated by the ‘pillarized’ political structure of Dutch society and by the influence of the Mental Health Movement that originated in the United States. Although the Dutch Association for Mental Health Care was established (in 1930) on a general, non-ideological basis, it was mainly the various confessional organizations (e.g. Catholic, Protestant, Reformed) that were responsible for providing the actual care. These organizations were also the first to combine their forces in the area of mental health care. The serious concern for the social devastation that resulted from the occupation and the liberation greatly enhanced the growth of out-patient mental health care in the post-war period. New areas of attention included the care for derailed youngsters, the recuperation of disrupted families, and the treatment of war victims. Influenced by the Mental

Health Movement, the ambulatory mental health care organizations not only counted the prevention and curing of mental disorders and deviant behavior among their tasks, but they also considered it their role to improve the mental health of the population at large.

The organizations for mental health care not only directed their efforts at curing psychological disorders such as neuroses but also at various psycho-social problems in the realms of marriage, family, raising children, education, sexuality, labor, crime, and drug or alcohol addiction. The conviction that in many of these areas the medical, clinical-nosological model fell short caused a number of psychiatrists to argue in favor of a multidisciplinary and multicausal approach in psychiatry.[20] Influenced by phenomenology, the social sciences, and the growing importance of social work, they arrived at the view that humans are more than isolated subjects and that a patient's profile was not only determined by organic or psychological factors but also by aspects of his or her social context. In addition to the dominant institutional psychiatric model, the medical-somatic one, a more psychological and sociological approach of mental disorders gained ground. In a psycho-social approach, for example, mental problems were linked to drives and motives or the patient's social environment, whereas remedies were sought in psychological or behavioral therapies.

The rise of social-psychiatric approaches during the 1960s was accompanied by a growing attention for the psychotherapeutic aspects of psychiatry. Because there was an increasing demand for psychotherapy, the various forms of therapy shifted from the periphery to the center of mental health care in the Netherlands.[21] Personal growth and the unfolding of individual talents became more highly valued in Dutch society - which had become more affluent - and this new ideology contributed to the trend that relatively healthy people with some deficiency in their personality structure or development became an object of psychotherapeutic care. New institutes for psychotherapy were established in several Dutch cities during the 1960s and the number of clients could rise quickly because psychotherapy was covered for those on social security (from 1965 to 1976) or those receiving disablement benefits (from 1976 to 1980).[22]

The issue of psychotherapeutic competence was an important subject at meetings of the NVvP during the seventies. Psychiatrists had always been qualified to practice psychotherapy, even though it was never a specific area of attention in their training, nor was their therapeutic competence ever specifically tested.[23] During the mid-sixties, however, their monopoly came under attack. In 1966, the Dutch Society for Psychotherapy (NVP) decided to admit not only psychiatrists but also physicians and psychologists[24] as members. This meant that they could be trained as psychotherapists at an Institute for Multidisciplinary (formerly: Medical) Psychotherapy (IMP). As a consequence, it was no longer the sole right of psychiatrists, based on their medical training, to perform psychotherapy.

In the 1970s there was a confrontation between two groups that practiced psychotherapy: those who were employed by the IMP (mainly psychiatrists and psychologists) and a group of independently established psychiatrists. The discussion converged around the issue whether psychotherapy was exclusively a medical-psychiatric discipline or a separate field of expertise, entirely independent from psychiatry. Psychiatrists who had their own practice tried to challenge the competition of other professional groups by arguing that only a medical specialist is capable of deciding what therapy is appropriate and then apply it. But the IMP therapists suggested that psychiatrists who had not been specifically trained as psychotherapists had no advantage whatsoever over therapists without medical training and that psychotherapy was most likely to be successful if an interdisciplinary teamwork approach was adopted. They argued that clinical psychologists were in fact better qualified than psychiatrists. The non-medical psychotherapists won their first victory in 1973 when a Government Commission on the Medical Profession (the

De Vreeze-Commission), whose assignment it was to prepare new legislation for medical practice, asserted the right to apply therapy to psychiatrists as well as to therapists with no medical training. [25] Psychotherapeutic expertise was not necessarily identical with medical-psychiatric expertise.

Initially, the NVvP remained silent on the issue. It counted both IMP therapists and independent psychiatrists among its members, so it was difficult to express a univocal point of view. Moreover, the psychiatrists themselves were divided on the issue. Displeased with the entire situation, some of the independently established psychiatrists founded the Association of Dutch Psychiatrists (VNP) in 1977. The VNP considered psychotherapy to be an exclusively medical form of treatment.[26] One year later the NVvP made its view public in a discussion paper entitled *Psychotherapy and Psychotherapist*. Although it claimed that psychotherapy was a medical treatment and that psychiatrists were qualified to practice it because of their medical training, it was also put forward that psychiatrists needed more psychotherapeutic training and that cooperation in multidisciplinary teams was an important step forward. The Consilium Psychiatricum subsequently suggested that five per cent of psychiatric training should be specifically reserved for training in psychotherapy, a proposal which became effective in 1981.[27]

Meanwhile, the government had become a player in the discussion - which, by then, was a heated one - about the fees, funding, and training standards of psychotherapy and about its demarcation from other forms of psycho-social services. In 1977, the General Director of Public Health set up a special study group for psychotherapy (the Verhagen Commission I). Like the De Vreeze-Commission, this commission viewed psychotherapy as a specialty that could also be practiced by those without medical training, if at least they satisfied certain prescribed training requirements. Therapeutic expertise could be acquired by following a specifically designed training for which a background in various disciplines was allowed to serve as basis.[28] In addition to medicine (preferably psychiatry), two other preparatory studies were singled out as appropriate basic training: a degree in one of the behavioral sciences (preferably clinical psychology) or specific advanced training in the theory and practice of social work.[29] The training of psychotherapists had to consist of a general part, a specialization, and an internship at one of the psychotherapeutic institutes. The outcome of the government's involvement is that psychotherapeutic expertise was not seen as restricted to one professional group or one discipline. Although psychiatrists were forced to give up their monopoly and accept psychologists and social workers as their equals, the NVvP could still agree with the final report of the Verhagen Commission I. It made it possible for psychiatrists to reformulate the conditions of their training in such a way that they became officially qualified to perform psychotherapy.[30]

The Identity Crisis of the Dutch Psychiatrist

The discussions about the content of psychiatric training, the scientific character of psychiatry, and the proper qualifications for psychotherapy are signs of the sketchy professional profile of psychiatry. It is part of a more general dilemma that psychiatrists have had to face for a long time. There are several reasons why the professional identity of the psychiatrist has never been self-evident. First, from the nineteenth century various sciences and practices have contributed to the development of modern psychiatry; the delineation from other disciplines, such as medicine/neurology and (clinical) psychology but also philosophical anthropology, law, and criminology, has therefore been subject to debate and susceptible to fluctuation. Second, psychiatry is difficult to define as a science because its object and the objectives of the psychiatrist are not fixed. Contents, meanings, and names of psychiatric disorders have changed regularly. What counts as

mental illness is largely a matter of definition and interpretation. While psychiatrists of the nineteenth century were preoccupied primarily with what was called "madness" (meaning unpredictable and dangerous behavior) and neurological disorders like epilepsy, dementia, and serious mental disorders like psychosis, the object of psychiatry in this century was extended to include various forms of maladjusted or non-conformist behavior, various psychological and neurotic symptoms, developmental disorders, disturbed relations and emotions, identity problems, existential problems, questions of life's meaningfulness, and the (dys)functioning of groups of people (within families, in the army, at school, at work). From the 1950s on, in the context of ambulatory mental health care, psychiatrists have been engaged not only in curing symptoms but also in the prevention of psychiatric disorders and the improvement of the general population's mental health.

This extension of the professional psychiatric domain caused an increase in the number of professional roles. Whereas at the beginning of the century the psychiatrist's professional horizon was limited to the confines of the mental institution, the university, and the independent practice, during this century psychiatrists found work in psychiatric clinics of general hospitals, in social and forensic psychiatry, in various non-institutional mental health care facilities, the army, the rehabilitation of prisoners, education, the care for drug and alcohol addicts, and in various managerial positions. The extension and differentiation of their professional roles contributed to changes in psychiatry's treatment practices and scientific concerns. If before 1900 psychiatry was largely geared toward the locking up and safeguarding of people (the asylum function), after the turn of the century psychiatrists were increasingly involved in evaluation (diagnosis and classification), treatment (including medical and pharmacological interventions and therapeutic manipulation), and the general support of patients.[31]

In terms of the explanation and treatment of psychiatric disorders, there was - and is - hardly any dominant paradigm or fixed cognitive basis in psychiatry. The world of psychiatry has been characterized by pluralism: diverging models, theories, and therapies replace each other or exist side by side. They are either philosophical-anthropological [32] , medical-scientific, psychological, social, or some combination of the last three mentioned. Since the second half of the nineteenth century, psychiatrists have relied on a scientific-medical basis, yet at the same time the scientific status of psychiatry - just like its medical basis - has never been undisputed. The early history of psychiatry shows that this medical emphasis is partly derived from a distinction between the psychological and the somatic. During the first part of the nineteenth century, the pioneers of institutional psychiatry applied therapies having a moral and psychological basis (the "traitement morale") rather than adopting a strictly medical treatment. From the beginning, psychiatry has been stuck with this duality, this pendulum of somatogenic and psychogenic approaches. On the one hand, psychiatry leans heavily on the model of scientific medicine in which (subjective) complaints are transformed into objective symptoms of an underlying somatic pathological process, thus excluding the psychological experience of the patient. On the other hand, psychiatric practice is geared toward actual psychological phenomena and realities, relying on an individual, hermeneutical, and normative approach.[33] Furthermore, the medical dimension of a psychiatrist's profession loses validity as soon as psychiatrists involve themselves with problems that have a social, ethical, or political basis. In recent years, psychiatrists have become more deeply involved in social-political or ethical issues, such as abortion, labor conditions and the medical examination of employees, drug addiction, sexual abuse, and euthanasia and assisted suicide.

Especially during the 1960s and 1970s, there was great confusion about the professional profile of the psychiatrist. At least three reasons for this uncertainty can be identified. First, the

legitimacy of psychiatry as a medical science was questioned by the outside world as well as by some critical psychiatrists. People involved in social sciences, the antipsychiatry movement, and the client movement were extremely critical of institutional psychiatry in particular, because of its dominant medical regime involving forced institutionalization, stigmatizing, hospitalization, and "inhuman" methods of treatment like electroshock and psychopharmaceuticals.[34]

Secondly, the social and behavioral sciences began to play an increasingly larger part in mental health care which broke down the psychiatrist's monopoly in this area as well as his sense of professional autonomy and expertise. Treatment of patients was increasingly coordinated by multidisciplinary teams that were horizontally and democratically structured and in which the psychiatrist was just one expert among others.[35] Psychiatrists responded to this new situation by exchanging their medical image with a more psycho-social one and by broadening their own field of expertise, making it more an integral - that is, a biological and psycho-social - specialty.[36] But in their cooperation with the other professional groups they reserved a central, leading, or managerial role for themselves, which in turn provoked the others to argue that the role of the psychiatrist as physician should only be limited.[37] A potential leadership role of the psychiatrist in the new democratically organized and multidisciplinary structure was not at all self-evident to the other parties involved.

Third, the rapid development of ambulatory mental health care obfuscated the borders of the psychiatric domain. The increase in the number of approaches and methods of treatment made psychiatry quite a versatile field, less medical and more psycho-social and psychotherapeutic. The internal contradictions of psychiatry as a profession came to light right after the split between neurology and psychiatry. During the seventies, for instance, there was clearly a polarization between the medical-biological and the psycho-social approach in psychiatry, while a conflict of interest between psychiatrists who performed psychotherapy in private practices and those psychiatrists who worked in IMP's in multidisciplinary teams became visible as well.

Revisionist historians and sociologists have often depicted psychiatrists as powerful agents of social control who successfully expanded their professional domain. However, we observe that especially from the 1960s psychiatrists have had difficulties in convincing other professional groups and the public that as physicians, they had an exclusive and scientific insight in the nature of mental disorders. To this day, the absence of a sharply delineated professional profile constitutes a dilemma for psychiatrists. Their medical status was always largely derived from the close ties with neurology but these were severed in the early 1970s.[38]

Psychiatrists continue to struggle with two uncertainties: How is their specialty related to, on the one hand, medical science, and the social and behavioral sciences on the other? And what is their relationship to members of the various other professional groups in mental health care? In the early 1980s, the NVvP held a survey among the over twelve hundred psychiatrists that were then active in the Netherlands about their professional role; the results showed that substantial competition was felt from other professional groups and that psychiatrists thought they were quite dependent on government policies.[39] Many psychiatrists believe that their influence has diminished over the years. Their professional association, the NVvP, is often trailing new professional and political trends, rather then setting the agenda, and tends to be quite cautious and conservative in an attempt to reconcile the sometimes conflicting views within its membership. The major innovations in psychiatry of the last twenty-five years - the growing significance of empirical research, the application of psychopharmaceuticals, and the increased awareness and rights of patients - were not the result of initiatives from within psychiatry but they were pushed by outside forces, including other professional groups (psychiatric nurses, empirical psychologists, pharmacologists, and biomedics), the client movement, and the government.[40]

The professional differentiation and bureaucratization of the mental health care system has strongly challenged psychiatrists - as represented in various organizations, commissions, and study groups - to develop a better and less ambiguous sense of their professional identity. In 1993, the NVvP established a special committee aimed at formulating a clear picture of the role of the psychiatrist in mental health care. The committee determined the knowledge and skills a psychiatrist should have and set the terms for cooperation with the other professional groups involved in mental care. Psychiatry was defined as a medical specialty concerned with "mental illness" that uses a "clinical-descriptive" method of diagnosis.[41] However, at the same time the committee distanced itself from this basic view by emphasizing that psychiatry is not only concerned with somatic aspects of mental illness but also with the psychological and social aspects and that psychiatry should embrace a multidimensional approach. As a generalist with medical, pharmacological, and psycho-social expertise, the psychiatrist ought to have a coordinating and leading role when treating patients in a multidisciplinary team.

Against the backdrop of the changes in Dutch mental health care since the 1960s, as discussed in this paper, it is not difficult to understand the professional dilemma of the psychiatrist. On the one hand, the psychiatrist seeks to hold on to his scientific status as medical specialist because that is what sets him apart from the other professionals involved in mental health care. But, on the other hand, the psychiatrist can only have a central and leading role in mental health care by appropriating at least some of the expertise of other professions and by claiming that he is more than just a medical specialist.

Notes

1. The authors are indebted to prof. Mark M.W. Richartz for helpful comments on earlier drafts of this article.

2.The Dutch Association for Psychiatry was established in 1871, but in 1895, after more and more neurologists joined the Association, its name was changed into Dutch Association for Psychiatry and Neurology (NVPN). In addition to the NVPN, a second professional organization of psychiatrists was founded in 1919: the Dutch Association of Institutional Psychiatrists (Its name was slightly altered in 1964). Whereas the NVPN presented itself primarily as a scientific organization, this second association was more geared toward the - material - interests of psychiatrists employed by mental hospitals.

3.There was one central board that served as representative body to the outside world, whereas the control over the decision process continued to be in the hands of the general assembly of the two sections.

4.The new NVvP, which aimed to look after all the interests - but especially the scientific ones - of Dutch psychiatry, consisted of members of the former NVPN and the members of the Dutch Association for Institutional Psychiatrists, which was discontinued on December 31, 1973. Between 1974 and 1982, the NVvP's membership grew from 850 to 1200. (Paul Schnabel, *De psychiater in beeld* (Utrecht: NcGv, 1982), 70-71.)

5.*Mededelingenblad van de Nederlandse Vereniging voor Psychiatrie en Neurologie,* xi (1969), 13-4.

6.This KNMG commission's role was to implement the decisions made by the Central Board involving the licensing and registration of medical specialists and it was also responsible for registering new specialists. Since 1961, the Central Board is a semi-governmental, legislative body regarding all medical specialties. It decides which areas of medicine are acknowledged as medical specialty and it sets the standards for all medical training.

7.Electroencephalography researches electrophysical brain activity and possible cerebral aberrations.

8.Cf. M.S. Vos & H. van Berkenstijn, 'De geschiedenis van de opleiding tot psychiater in Nederland', *Tijdschrift voor psychiatrie*, xxxv (1993), 22; *Mededelingenblad van de Nederlandse Vereniging voor Psychiatrie en Neurologie*, ii (1964), 10.

9.*Mededelingenblad van de Nederlandse Vereniging voor Psychiatrie en Neurologie*, xiii (1970).

10.Kuiper 1968, 17, 21.

11.The plea for a shorter training period was related to an anticipated shortage of psychiatrists. (Sonja van 't Hof, *'Een ambt hoog en subtiel ...' Psychiaters over psychiatrie 1971-1996* (Utrecht: Nederlandse Vereniging voor Psychiatrie, 1996), 68). During the 1960s, the NVPN was not only concerned with the quality of psychiatric training but also with the number of psychiatrists that had to be trained in order to meet the demand. It was estimated that the number of mental disorders that could be treated would go up, yet hard quantitative data about society's need for psychiatrists were unavailable. (*Mededelingenblad van de Nederlandse Vereniging voor Psychiatrie en Neurologie,* vii (1967), 22-8.)

12.Cf. *Medisch Contact*, xxvii (1972), 123. In addition to this new situation, in which one would be registered as either neurologist or psychiatrist, the old option - of being listed as "nerve specialist" - would remain open for ten more years. From 1972 to 1982, therefore, there were in fact three specialties: psychiatry, neurology, and the combined specialty of psychiatry and neurology.

13.Utrecht Professor Van Praag was denounced for his biological approach during the late seventies, but his approach regained some terrain in the 1980s with the comeback of electroshock and the increased use of psychopharmaceuticals (although there were still psychiatrists who warned for reductionism at the cost of psycho-social factors).

14.M. Romme & M. Richartz, 'Argumenten voor voorgestelde wijzigingen', *Tijdschrift voor Psychiatrie*, xx (1978), 463.

15.*Tijdschrift voor Psychiatrie*, xix (1977).

16.*Medisch Contact*, xxxvi (1981), 766.

17.Vos & Van Berkestijn, 'De geschiedenis van de opleiding tot psychiater in Nederland', 26-7.

18.*Medisch Contact*, xxxviii (1983), 1646.

19.T. van der Grinten, *De vorming van de ambulante geestelijke gezondheidszorg. Een historisch beleidsonderzoek* (Baarn: Ambo, 1987).

20. See for example: P.C. Kuiper, 'Geestelijke gezondheidsleer en gezondheidszorg', *Maandblad geestelijke volksgezondheid*, xv (1960); Trimbos 1971, 322?

21. P.J. Jongerius, 'Le phenomene hollandais, een geschiedenis van het psychotherapeutisch veld', in C.P. Breemer ter Stege, *Mental health care in the Netherlands* (Utrecht: NcGv, 1983), 127.

22.Health insurance covers psychotherapy done by independently established psychiatrists since 1959. After 1965, the IMPs saw an annual growth of twenty-five percent in the number of requests for psychotherapeutic treatment. In a period of ten years, there was a ninefold increase in the number or requests.

23.Right after the Second World War, when the somatic approach was dominant, there was an unsuccessful proposal to open up space for psychotherapy in the basic training curriculum.

24. From the 1960s on, the number of psychologists increased rapidly in the Netherlands and surpassed that of psychiatrists.

25.For the De Vreeze-Commission's report, see C. Dijkstra & H. van Donselaar, 'Psychotherapie in Nederland 1. Geschiedenis van de psychotherapie van 1900 tot nu', *De Psycholoog*, xxiii (1988), 1-7.

26.'Functie van de psychiatrie', *Maandblad geestelijke volksgezondheid*, xxxiii (1978), 51; M. Valstar, 'De psychiater als psychotherapeut', *Maandblad geestelijke volksgezondheid*, xxxiv (1979), 573-4.

27.*Medisch Contact*, xxxvi (1981), 771.

28.W.J. de Waal, *De geschiedenis van de psychotherapie in Nederland* ('s-Hertogenbosch: De Nijvere Haas, 1992), 117.

29.H. Reijzer, *Naar een nieuw beroep, psychotherapeut in Nederland* (Houten: Bohn Stafleu Van Loghum, 1993), 222.

30.Van 't Hof, *'Een ambt hoog en subtiel ...'*, 60.

31.Cf. P. Schnabel, *De weerbarstige geestesziekte. Naar een nieuwe sociologie van de geestelijke gezondheidszorg* (Nijmegen: SUN, 1995).

32.Until the 1960s, the theoretical foundation of psychiatry in the Netherlands was not only medically but also strongly philosophically oriented.

33.Cf. A. Mooy, *De psychische realiteit. Over psychiatrie als wetenschap* (Meppel: Boom, 1988), 11, 27.

34.In comparison to countries like Italy, England, and the United States, the antipsychiatry movement was less controversial in the Netherlands, partly because many of its ideas were integrated in the widespread system of ambulatory mental health care. There were surely some psychiatrists in the Netherlands who subscribed to the antipsychiatry movement's ideology (or parts thereof), but not everyone could agree with its alternative, romanticized point of view.

35. F. van den Boom, *De RIAGG en de psychiater* (Utrecht: NcGv, 1987), 111.

36.A. Korzec & M. Korzec, 'Een revolutie in de gedachte van het biologisch denken', *Intermediair*, xxix (1993), 31-5.

37.The government more or less supported this view. A 1984 governmental paper on mental health care suggested that the RIAGGs devoted too much attention to minor psychosocial mental problems while not spending enough time on serious mental disorders. It was proposed to shift attention for minor mental problems to the basic care provided by family doctors, psychologists, and social workers, whereas the more serious cases would be treated by psychiatrists in RIAGGs, or in cooperation with polyclinics or outpatient facilities of general mental hospitals.

38.See F. Rouppe v.d. Voort, 'De psychiater en de ambulante geestelijke gezondheidszorg anno 1980', *Metamedica*, lvii (1978), 202-208.

39.Paul Schnabel, *De psychiater in beeld* (Utrecht: NcGv, 1982).

40. Van 't Hof, *'Een amt hoog en subtiel ...'*, 88.

41. W. van Tilburg, *Profielschets psychiater* (Utrecht: Nederlandse Vereniging voor Psychiatrie, 1996), 10, 13.