Re-Minding the Dutch

Hans Pols

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Verward van Geest is commended because of its careful, balanced, detailed, meticulously researched, and comprehensive approach of the development of the psychiatric profession in the Netherlands. The authors relate Dutch developments to initiatives abroad, some of which were taken up by Dutch psychiatrists and developed further. The development of the extensive network of out-patient mental health facilities in particular, which makes the Dutch system stand apart from that of most others, receives a lot of attention. Unfortunately, the history of psychiatry in the former Dutch colonial empire is not covered. The study is applauded for providing a wealth of material that could give a new impulse to discussions about the nature of mental health in the Netherlands, such as the following: How are supply and demand in mental health care related to each other? Do individuals with a lower socio-economic status have adequate access to care? How did the relationship between biological, social, and psychological approaches to mental illness and individual distress change over time?

Once upon a time, the history of psychiatry was terribly exciting. First, a narrative of universal liberation held sway. It related how, for centuries, a number of religious denominations with their rigid, oppressive, and authoritarian organizational structures held society tightly in its grip. Only after psychiatrists (and psychologists, social workers, and other professionals of the psy-complex) provided us with the ability to express our emotions and make our own decisions were we freed from the shackles of religion. The second narrative struck a very different tone by describing the psy-complex as a tool of social control in modern, (late-)capitalist societies. It forced everybody to conform to ideologically determined norms of behavior and ideals of normality. Even today, it entices us to conform by presenting ideals of normality, by providing psychotherapeutic treatment, or, when these measures fail, resorts to institutionalization and medicalizing deviance.[1] In these evocative narratives, the power of psychiatry, whether it is repressive or liberating, is immense.

These grand narratives have motivated historians to investigate the development of psychiatry more closely. As a result, a great number of highly detailed investigations based on extensive analyses of patient records, archival sources, administrative records, and the published literature has been undertaken. The volume and quality of research on the history of psychiatry in the

[1] I could cite a great number of studies, amongst others the work of Christopher Lasch, Michel Foucault, Ronald Laing, Thomas S. Szasz, Philip Rieff, Thomas J. Scheff, and many others. For a recent example see Frank Furedi, *Therapy Culture. Cultivating Vulnerability in an Uncertain Age* (London 2004).

Netherlands is truly impressive. These studies have focused on the medical ideas and social ideals of psychiatrists, the everyday reality of mental hospitals, the activities of attendants, nurses, social workers and others involved in mental health care, the development of extramural mental health care, changes in government policies, and the ways in which mental illness and life problems have been conceptualized. These studies have greatly enriched our understanding of the history of psychiatry by offering insights which transcended the earlier more ideological narratives. However, because of the detailed nature and the local focus of many of these studies, they did not result in a comprehensive view on the development of psychiatry and mental health care services in the Netherlands.

Zaal voor bedverpleging van onrustige patiënten in Meerenberg, getekend door H.M. Krabbé, 1897 (Bron: Het Dolhuys, Haarlem)

Compared to the earlier and ideology-driven narratives, the three-volume study under review here is refreshingly modest. The authors are not inspired by grand social theories which opportunistically use examples from psychiatry and mental health care as vehicles to criticize (or valorize) modern (Western) society or to drive home ideological or philosophical points. Instead, they provide a comprehensive, detailed, and exhaustive description of the development of the profession of psychiatry and of mental health care facilities in the Netherlands. They rely on the extensive work on the history of psychiatry in the Netherlands that has been conducted over the last forty years as well as on research undertaken for the project itself. The real achievement of this study lies in incorporating the results of a great number of detailed studies to provide a comprehensive vision on the development of psychiatry in the Netherlands. It thereby overcomes the local and thereby sometimes fragmented nature of the great number of historical studies conducted thus far.

The current study is cautious, precise, concerned with interpreting a variety of source materials, and descriptive. The study is 'lightly' (as opposed to obstructively) theorized by employing (amongst others) the civilization theories of Norbert Elias and the work of the sociologist Abram de Swaan. Because of the descriptive nature of the book, the interpretive framework of the authors often escapes notice. In the description of the radical initiatives of the 1970s, the authors quote several sources which express the opinion that the initiatives of that decade had been overblown and had led to the neglect of the most vulnerable patients. These opinions are hardly controversial today, and it might have sounded overly didactic if the authors had stated that they shared these opinions. However, in the way this material is presented, it almost appears that both historical developments as well as their interpretation and evaluation are based on historical materials. Naturally, it is commendable that the opinions of participants in the field are provided, although I kept wondering whether the authors might have been a bit too modest in presenting their own views (which, after all, have been informed by the most extensive study of the development of mental health care practices in the Netherlands to date).

There is much to commend about this study. First of all, it does not merely focus on the development of psychiatry as a profession, but on all professions involved in mental health care. In particular in the Dutch context, it is necessary to take the activities of psychologists, social workers, and many others into account. In addition, this study does not focus extensively on psychiatric *theory*, but mostly on *practices* in mental health care facilities. This enables the authors to relate theoretical developments to changes in the organization of mental health care facilities and the nature of the care they provide. Third, unlike most histories of psychiatry and mental health care, this study includes developments up to the very recent past. Fourth, the experiences of patients are highlighted (although not systematically), which, in the end, bolsters one of the more important messages of the books: who benefited from changes in the mental health care services as they have developed in the Netherlands, and who, in the end, was left out? The authors conclude that individuals with severe and chronic forms of mental illness have often not received the care they needed, while individuals suffering from lesser complaints received ample attention.

The attempt of the authors to relate developments in Dutch psychiatry to developments abroad is successful and informative. In the last part of each chapter, Dutch ideas and initiatives are connected to similar ones from abroad. The authors relate which ideas and practices inspired Dutch ones (out-patient care in Germany, for example), and which ones were not taken up (German eugenics, to name one). In many respects, the development of psychiatry (and mental health care) is a trans-national phenomenon; physicians are part of both national and international networks. Professionals in a small country like the Netherlands actively engaged with international developments, which are selectively taken up and transformed to suit conditions at home. It is interesting to see how, initially, ideas and approaches from Germany and France were influential, while the influence of the United Kingdom and the United States of America increased during the twentieth century. There was

one issue about which I wished to find out more: Did Dutch initiatives influence developments abroad? Is it Dutch modesty to assume that Dutch psychiatrists received ideas from abroad but did not influence international developments? There are several other questions about the interconnection of Dutch and international developments one could ask. For example, can something general be said about why certain international ideas are received and others ignored? Were German phenomenological ideas actively discussed in the Netherlands because they were compatible with theological perspectives which were, at some point, held by psychiatrists? Were American ideas on the organization of out-patient mental health care services followed with great interest because Dutch psychiatrists were actively developing such services themselves? I suspect that both general public opinion as well as specific professional preoccupations played a central role here.

Despite the international focus of this extensive investigation of psychiatry and mental health care in the Netherlands, the former colonies are completely left out. Over the past two decades, historians of medicine and psychiatry have displayed an keen interest in colonial history.[2] Often, medical innovations and social reforms were first tested in the colonies before they were applied at home. In 1881, the first large mental hospital opened in the Dutch East Indies (near Buitenzorg), to be followed by at least three large institutions and a number of smaller ones. It would have been most interesting if the authors had analyzed the similarities and differences between colonial and mainland practices as well as the extent to which psychiatrists held positions both in the colonies and at home, and the consequences of this for Dutch psychiatry. In particular, it would have been very interesting to see whether the racial and ethnic preoccupations of colonial psychiatrists affected Dutch psychiatry at all.[3]

Because of the great wealth of material covered, the extensive study of Oosterhuis and Gijswijt-Hofsta[4] is an excellent source for future discussions both about the history as well as the future of mental health care in the Netherlands as well as in other Western countries. The authors present copious food for thought for historians, policy makers, physicians, and others who are

[2] The work of Megan Vaughan and David Arnold has been both path-breaking and influential. See Megan Vaughan, *Curing Their Ills. Colonial Power and African Illness* (Stanford 1991); David Arnold, *Colonizing the Body. State Medicine and Epidemic Disease in Nineteenth-Century India* (Berkeley 1993). See also, for example, Jonathan Sadowsky, *Imperial Bedlam. Institutions of Madness in Colonial Southwest Nigeria* (Berkeley, CA 1999); Richard C. Keller, *Colonial Madness. Psychiatry in French North Africa* (Chicago 2007); Sloan Mahone and Megan Vaughan, *Psychiatry and Empire* (London 2007). For a by now already somewhat outdated overview see Richard C. Keller, 'Madness and Colonization. Psychiatry in the British and French Empires, 1800-1962', *Journal of Social History* 35:2 (2001) 295-326.

[3] For a recent and interesting overview of psychiatry in the Dutch East Indies see Nathan Porath, 'The Naturalization of Psychiatry in Indonesia and Its Interaction with Indigenous Therapeutics', *Bijdragen tot de Taal-, Land- en Volkenkunde (BKI)* 164:4 (2008) 500-528.

[4] H. Oosterhuis and M. Gijswijt-Hofstra, *Verward van geest en ander ongerief. Psychiatrische en geestelijke gezondheidszorg in Nederland (1870-2005)* (Houten 2008).

involved in mental health care today. In the remainder of this review, I will therefore highlight three themes that are either present in *Confused in Mind and Other Discomforts* or have been present in analyses of the development of mental health care in the Netherlands. The enormous amount of material provided by the authors promises to provide new and interesting insights on these issues. The three issues I wish to highlight are: the relationship between care targeting life problems and that addressing chronic and persistent forms of mental illness, the psychologization of society as a whole, and the relationship between psychotherapeutic and somatic approaches in psychiatry.

First, to me, this study appears to consist of an elaborate contemplation of the paradoxes of mental health care services already noted by August B. Hollingshead and Frederick C. Redlich in their groundbreaking 1958 study *Social Class and Mental Illness*.[5] After extensive research in psychiatric epidemiology and the utilization of mental health care facilities, these authors concluded that (a) severe and chronic forms of mental illness are concentrated in the lowest socio-economic strata; and (b) within mental health care, most funds are expended on the treatment of individuals from the higher socio-economic classes whose condition is generally far less severe than those of individuals in the lower strata. In other words, mental health care facilities mostly serve those individuals who need them least. Another basic problem they identify is that individuals who need psychiatric care the most hardly ever request it. These conclusions are echoed by Oosterhuis and Gijswijt-Hofstra in their analysis of the relationship between supply and demand of mental health care services. Ruefully, they conclude that the immense expansion in the provision of care mostly benefited individuals suffering from 'other discomforts' rather that those suffering from severe and chronic forms of mental illness.

In general, health care facilities follow different economic principles than the market for goods and services. Under normal market conditions (according to economic theories which provide an idealized image of how markets function), an oversupply of certain goods leads to a decrease in price, which then leads to a reduction in supply. An expansion in the supply of health care, on the contrary, is always able to meet demands, even if that means that new demands are created in the process. The expansion of mental health care after World War II met many demands which were new, both in the sense of not having been recognized previously as well as dealing with life issues with previously would not have been considered mental health problems. This is, in itself, not too troubling. What is troubling is that the individuals who needed care the most received less of it – even to the point that mental health care professionals excluded them because they would not be responsive to the psychotherapeutic treatment methods they had on offer. A second problem arises from the nature of chronic forms of mental illness. Psychiatry is

[5] August B. Hollingshead and Frederick C. Redlich, *Social Class and Mental Illness. A Community Study* (New York 1958). For a short synopsis see Hans Pols, 'August Hollingshead and Frederick Redlich. Poverty, Socioeconomic Class, and Mental Illness', *American Journal of Public Health* 96:10 (2007) 1755-1757.

probably unique within medicine in that the demand for its services is partly driven by individuals seeking assistance and partly driven by broader social demands, which can be administered to individuals, if necessary, without them asking for it in the first place (or even against their will). This becomes particularly pertinent when mental health care workers have to deal with aggressive and unpleasant patients who are increasingly less tolerated in society.

A second topic worth elaborating upon is the unique nature of the extensive development of out-patient (or ambulant) mental health care services in the Netherlands, in particular its expansion after World War II. The authors relate this, first of all, to the pillarization of Dutch society. The different denominations which controlled most of social and cultural life in the Netherlands before the 1960s felt compelled to alleviate the suffering of its members in a way that conformed to their theological leanings. Initially, pastoral care was mostly provided by priests, ministers, and lay members of the church, who were later supplemented (and then replaced) by psychologists, social workers, and others. This denominational domain, aimed at aiding individuals within a framework of moral and theological ideas, was gradually transformed into the domain of mental health care, addressing problems of living in the seemingly neutral and scientific language of personality development and self-realization. Two factors were central in this transformation; first, a number of enlightened intellectuals within the pillars (Catholic intellectuals figured most prominently here) convinced clerical authorities that their expertise could bolster the hold of the church over its members. Second, the government placed conditions on subsidies for mental health care facilities set up by the denominations, as a consequence of which trained professionals rather than the clergy became dominant there. Ironically, the acquiescence of the pillars eventually led to their dismantling (in particular through the process of 'reverse pillarization': because the Catholic pillar was so well organized, new ideas that eventually undermined the authority of the church spread very quickly).

The process in which the clergy has been replaced by mental health care workers has received ample attention in the historical and sociological literature on the psychologization of society (and in this study, a great amount of detail is added). Interestingly, the many ways in which mental health care workers acquired or retained the characteristics of the clergy has been investigated to a much lesser extent. To me, it is interesting how a number of mental health care professionals (C.J.B.J. Trimbos and H.M.M. Fortmann come to mind immediately) were able to counsel the nation about controversial issues such as abortion, drug addition, homosexuality, contraception, the effects of war trauma (in particular in relation to the responsibilities of the government), and the reasons why individuals could be declared unfit to work. In the process, they steadfastly undermined the authority of the church even further. They could, however, only do so by taking the social space previously occupied by its representatives. The almost religious zeal of social scientists, anti-psychiatrists, and non-medical mental health care professionals in the 1970s and 1980s clearly reflects the prophetic role they sought in the modernization and liberalization of the Netherlands. For most Netherlanders, it was

clear that the topics mentioned above could no longer be discussed fruitfully within moral and theological perspective. Nevertheless, the religious fervor of the reformers now appears as overblown, counterproductive, and mostly self-serving (in particular in the case of the critical psychiatrists of the 1970s).

As a consequence of the psychologization of Dutch society, the clergy has been replaced by psychotherapists (to present a simplified view). Recently, however, a number of social commentators have expressed reservations about the increasing psychologization of broader social discussions of topics that have clear moral ramifications, such as crime and culpability, trauma and compensation, and the demands that should be placed on individuals with respect to their ability to earn a living. Psychologists and psychiatrists employ an allegedly scientific and morally neutral vocabulary to discuss these issues. This, however, could make their contributions less suitable to address highly moral issues. What type of compensation is justified when individuals suffered trauma in acts of warfare sanctioned by the government? Is providing a diagnosis of Posttraumatic Stress Disorder the most appropriate and desirable way to recognize the sacrifices made by soldiers and other citizens? Is providing free access to psychotherapy the best way of recognizing suffering, trauma, and sacrifice?[6] Even though these arguments have an immediate appeal, it is not yet clear what could take the place of the psy-professionals in adjudicating the compensation for distress and other discomforts.

A third theme that recurs is the relationship between biological and social-psychological approaches in mental health care services. Often, protagonists of both approaches have presented them as mutually incompatible, although, in practice, medication, psycho-social support, and psychotherapy have reinforced each other. Only because of the introduction of psychopharmacological treatments in the 1950s was it possible to realize the ideals of progressive mental health care workers. Medicated patients were much better able to participate in occupational therapy, for example. The reverse also holds true: the effects of the neuroleptic medications were much more pronounced in institutions where occupational therapy and other forms of treatment were practiced. Interestingly, treatment in which both medication and psycho-social support had a place turned out to be the most successful. A second, more troublesome example of the way in which psychopharmacological treatment and psychological approaches have reinforced each other is the current expansion in the use of anti-depressants (SSRIs) and medications for Attention Deficit and Hyperactivity Disorder. The authors rightly conclude that the efforts of the mental hygienists and non-medical mental health care workers greatly expanded the domain of mental health care in the Netherlands, which

[6] Allan Young, 'The Self-Traumatized Perpetrator as 'Transient Mental Illness', *Evolution Psychiatrique* 67:4 (2002) 630-650; Derek Summerfield, 'A Critique of Seven Assumptions Behind Psychological Trauma Programmes in War-Affected Areas', *Social Science and Medicine* 48 (1999) 1449-1462; Derek Summerfield, 'The Invention of Post-Traumatic Stress Disorder and the Social Usefulness of a Psychiatric Category', *British Medical Journal* 322 (2001) 95-98; Jolande Withuis, *Erkenning. Van oorlogstrauma naar klaagcultuur* (Amsterdam 2002).

now includes a variety of 'discomforts' not previously considered worthy of the attention of psychiatrists. The pharmaceutical industry has been able to capitalize on this development by developing and marketing medications which treat conditions that would never have been conceived to be medical problems by psychiatrists before World War II. In an ironic dialectical development, these problems now fall squarely within the domain of psychiatry rather than that of non-medical mental health care workers, who first brought them to the attention of the public. In general, it appears that the 'psy'-complex is slowly being replaced by a 'brain (and gene)'-complex. It would be interesting to contemplate the ramifications this has both for the organization of mental health care, social representations of relatively minor psychiatric problems, and the experience of individuals who have them.

Recent developments in mental health care in the Netherlands appears to make the distinction between somatic and social-psychological approaches less meaningful. As the authors clearly elaborate, many new facilities such as protected living arrangements do not provide any type of treatment but, instead, necessary supportive services which enable individuals with mental illness to live with a modicum of independence. Yet, at the same time, psychiatrists increasingly define their activities in terms of medical interventions. Clearly, these developments lead to rather different ideas as to the organization of mental health care. It appears that the authors endorse an articulation of the demands for mental health care in terms of support services rather than in terms of medical or psychotherapeutic interventions. How this could be translated into effective practices, which transcend the medical model (which focuses on treatment interventions only), is a fascinating question (which historians might not be best equipped to answer).

With respect to the three themes mentioned (who benefits from mental health care; the psychologization of society; and the relationship between psycho-therapeutic and somatic approaches in psychiatry), the current study has an enormous amount to offer and can provide the material that can inform these debates. Although it will mostly be used as a reference work, this work provides an interesting and captivating read from beginning to end. It is organized well, which makes it easy to follow specific developments over time. In particular the quotes from personal narratives of former patients and mental health care professionals provide interesting insights into past practices, which are much harder to trace than past ideas.

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Ander ongerief

Timo Bolt

Inconvenience

Verward van geest en ander ongerief by Harry Oosterhuis and Marijke Gijswijt-Hofstra is a voluminous and sound reference work about the history of psychiatry in the Netherlands. Striving for completeness, however, the authors failed to deliver a synthesis in the true sense of the word. They compiled and pasted an impressive amount of (mostly) secondary literature, but left little room for critical reflection and discussion. Their account of the 'psychologisation' of Dutch society from the 1960s onwards is exemplary and one of the main themes of the book. Oosterhuis and Gijswijt-Hofstra (only) summarize the relevant sociological studies on this subject, without addressing their problematic nature or the inconsistencies between them. As a result, their 'sociologised' description of the supposed process of psychologisation in the Netherlands is rather superficial and stereotypical.

Verward van geest en ander ongerief. Psychiatrie en geestelijke gezondheidszorg in Nederland (1870-2005) bestaat uit drie banden, die gezamenlijk goed zijn voor ruim 1500 bladzijden en een gewicht van vier kilogram. De auteurs, Harry Oosterhuis en Marijke Gijswijt-Hofstra, zeggen dan ook niets teveel als zij in het voorwoord spreken van een 'omvangrijk overzichts- en naslagwerk'.[1] Het is bovendien een fraaie, goed verzorgde en rijk geïllustreerde uitgave. Oosterhuis en Gijswijt-Hofstra hebben onbedaarlijk veel werk verzet. Het eindproduct van hun noeste arbeid mag dan ook beschouwd worden als een verrijking voor de geschiedschrijving van de psychiatrie.

Het zegt iets over de ontwikkeling van dit deelspecialisme, dat een dergelijke 'grote' publicatie mogelijk was. De laatste decennia is er in weinig landen zoveel historisch onderzoek verricht als in Nederland over, met name, de twintigste-eeuwse geestelijke gezondheidszorg. Dat is mede te danken aan het NWO-onderzoeksprogramma 'De gestoorde psyche. Theorie en praktijk in Nederland in de twintigste eeuw' dat in 1999 van start ging. Oosterhuis en Gijswijt-Hofstra waren als coördinatoren van dit project, zoals ze zelf schrijven, 'verantwoordelijk voor de *synthese* van oud en nieuw historisch onderzoek op het gebied van de psychiatrie en geestelijke gezondheidszorg in Nederland vanaf het einde van de negentiende eeuw' (xiii, mijn cursivering T.B.). Ik vind *Verward van geest* echter geen synthese. Daarvoor is mijns inziens te veel gekozen voor het vergaren en samenvoegen van zoveel mogelijk informatie en te weinig voor kritische reflectie en debat. Dit zal ik toelichten aan de hand van één van de dragende thema's in het boek: 'psychologisering'.

[1] H. Oosterhuis en M. Gijswijt-Hofstra, *Verward van geest en ander ongerief. Psychiatrische en geestelijke gezondheidszorg in Nederland (1870-2005)* (Houten 2008).