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### Baas in eigen brein. 'Antipsychiatrie' in Nederland, 1965-1985

Blok, G.

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## Summary

### *Master of one's own mind. 'Antipsychiatry' in the Netherlands, 1965-1985*

During the 1960s and 1970s, from the United States to Italy, a wave of criticism flooded western clinical psychiatry. This international attack on clinical psychiatry is commonly referred to as 'antipsychiatry'. The most famous critic was the British psychiatrist Ronald D. Laing, whose books have sold millions of copies worldwide. According to Laing, his Dutch follower Jan Foudraïne and other critics, the dominant 'medical model' of mental illness, which presented madness as an individual disease with hereditary properties, was a sham. They claimed that there was nothing wrong with the brain, the body or the genes of the 'mentally ill', but that the 'mentally ill' suffered from understandable problems in living. Their claims suggested that so-called psychiatric patients were the victims of western society, which valued outward appearance, conformity, competition and money at the cost of emotional expression and individual freedom. Those individuals who were too sensitive or wayward to adjust, were rejected by both their families and society, put away in psychiatric hospitals, unjustly labelled as ill and given medication and electroshock therapy, allegedly to cure their illness but in reality to smother their maladjusted behaviour.

Nowadays, antipsychiatry is remembered by many laymen, historians and psychiatrists alike as an attack on the very legitimacy of psychiatric care and a plea for its abolishment. Moreover, it is often viewed as part of the anti-authoritarian spirit of the sixties. The charge against clinical psychiatry was alleged to have been largely adopted by Marxist intellectuals, psychedelic revolutionaries, journalists and movie directors, who projected their cultural criticism on clinical psychiatry without having any real knowledge of mental illness.

This thesis, which focuses on Dutch criticism of clinical psychiatry between approximately 1965 and 1985, argues that this historical image of 'antipsychiatry' is only partially correct, at least as far as the Netherlands is concerned. Certainly, some radical critics expected no good from any kind of institutionalised psychiatry. In Holland as well as America and England, around 1970 the ideas of Laing and like-minded thinkers were all the rage in the media and amongst artists, users

of mind-expanding drugs and critical academics. However, for a large part, the charge against the medical model in clinical psychiatry came from within. It was voiced by people who worked in the lion's den, the psychiatric hospitals. The negative umbrella term 'antipsychiatry' does not fit the optimistic content of this reform movement within clinical psychiatry, which was characterised by a strong psychotherapeutic and humanitarian optimism and an urge to cure psychiatric problems. Therefore, in this thesis the alternative term 'critical psychiatry' is used.

To illustrate the character and backgrounds of this reform movement in Dutch clinical psychiatry, this book offers an in-depth analysis of one case study; the events during the 1970s at 'Conolly', a ward for acute admissions of male patients of psychiatric hospital Brinkgreven in Deventer. This case study is based on interviews with former employees of Conolly, their publications, hospital archives and a qualitative analysis of fifty patient-files. At Conolly, a newly installed head nurse, psychologist and psychiatrist cooperated from 1970 onwards to transform Conolly into a therapeutic community, in order to replace the 'medical model' of madness by a 'social model'. All nurses, including the students, were actively involved in this process and were introduced to a bulk of new literature. Next to well-known critical psychiatrists such as Laing and Foudraire, the humanistic psychologist Carl Rogers was widely read at Conolly, as well as the Marxist psychoanalyst Erich Fromm and the American 'system therapists' Paul Watzlawick and Jay Haley. All these authors put forward ideas that bared many similarities to those of Laing and Foudraire, but they presented them in a less polarised manner. Most nurses were enthusiastic about the social model because they had grown critical of the traditional dominance of medication and work therapy in the treatment of patients. The psychological approach of the social model offered them the possibility to have more personal interaction with the patients and actually assist in their treatment.

The leading treatment team at Conolly boldly stated that 'mentally ill' individuals did not exist. There were only pathological social systems, in other words: families. The seemingly crazy and nonsensical behaviour of an 'identified patient' within a pathological system actually was functional. Bizarre thoughts and actions could, for example, be a cry for help and an effort to expose the pathology of a social system. As Laing put it, 'madness' was simply a smoke-screen behind which a scared, angry or confused person was hiding from a hostile world, which threatened his 'true self'. At Conolly, treatment according to the social model was based on family and relational therapy, group therapy and efforts to confront the patients (or 'residents', as they came to be called) with their own behaviour, which supposedly stunted their personal growth. The goal was to stimulate the residents to face their emotions and relational problems. Whilst critical psychiatry was strongly averse to the implicit moral standards of traditional clinical psychiatry, which supposedly oppressed non-conformist individuals, at Conolly, critical psychiatric ideas thus helped to shape a modern, but likewise moralistic type of psychiatric care. The ward's psychologist, assistant-psychiatrists and nurses

aimed to fundamentally 'change' the residents and their family members according to their own moral standards. They tried to make people accept responsibility for their own mental well-being and the choices they made in the course of their lives. Also, they tried to get the residents to be more honest and open about their feelings. Passive or escapist behaviour was chastised.

At first, the reforms at Conolly were strongly supported by the hospital director, who had been trying from the early 1960s onwards, to transform Brinkgreven from an asylum into a more dynamic treatment centre. Although the Conolly personnel regularly presented their ward as very special and different from the rest of the hospital, other wards of Brinkgreven also introduced group therapy, family therapy and the concept of the therapeutic community during the 1970s. At the same time, these changes were made possible by a growth in finances, nurses and staff. The emancipation of psychiatric nurses and psychologists was another important background of these hospital-wide efforts to reform psychiatric care at both Conolly and other wards. Many psychiatric nurses were tired of being up graded hotel servants, spending most of their time cleaning wards and regulating the strict regime of hospital life. Psychologists wanted to do more than conducting psychological tests.

Conolly was, however, the most radical expression of this broader climate of change at Brinkgreven. Within this ward, the psychotherapeutic optimism and disdain for classical psychiatric diagnoses were stronger than elsewhere and in 1978 a serious conflict evolved. Conolly had antagonised the hospital's director and staff by its hostile attitude towards several psychiatrists who had attempted to work on this ward. Furthermore, the Conolly-team sometimes refused to admit people they did not deem suitable for treatment. This angered family members, general physicians and referring mental health organisations. In addition, an internal conflict had arisen at Conolly. Several nurses had grown uncomfortable with the new approach, which in their view led to a harsh treatment of residents and their family members. In the end, the psychologist and nurse who set the tone at Conolly were forbidden by the hospital directors to continue working on this ward and many of their sympathisers left.

The events at Conolly and in psychiatric hospital Brinkgreven are in many ways characteristic of a much broader reform movement, which existed in Dutch clinical psychiatry during the 1970s. In Holland, several other hospital wards like Conolly aimed at a drastic renewal of psychiatric care. Around some of these similar conflicts evolved. Just as Laing and Foudraine were merely the most polemic among many other psychiatrists and psychotherapists who attacked the medical model of madness at the time, these controversial wards were only the 'tip of an iceberg' of psychotherapeutic optimism, democratisation and efforts to break through the petrification in Dutch hospital psychiatry. Like the Conolly-staff, many other critics likewise called for an *intensification* of psychiatric care. Through methods like group therapy and family therapy, the interpersonal roots of individual emotional suffering should be exposed, instead of being covered up

with medication and reassuring pats on the back. Thus, a mental breakdown could become a breakthrough, as Laing put it: a crucial and instructive phase in a person's process towards self-realization. So-called patients should become masters in their own minds again. Dislodging patients from their supposedly pathological family ties was a leading thread running through this reform movement in Dutch clinical psychiatry, in exactly the same manner as at Conolly.

The critical current within Dutch clinical psychiatry received much support, just as Conolly was initially backed up by the hospital director of Brinkgreven. Many psychiatrists in Holland were strongly oriented towards psychotherapy. The therapeutic community was considered by many to be an ideal setting for effective psychiatric treatment. Symbolic of the low appraisal of neurobiological aspects of mental illness was the split of the Dutch Society for Psychiatry and Neurology in 1974. Furthermore, many directors of psychiatric hospitals supported the attack on the medical model of madness and the authoritarian daily hospital regime, because they were afraid to end up as static asylums for chronic patients. Moreover, biological psychiatry as a scientific branch within clinical psychiatry was still in its infancy whilst criticism was growing with regard to the heavy side effects and low efficacy of the new psycho-pharmaceuticals, which were introduced during the 1950s.

Critical psychiatry gained further support from the Dutch government, the media and popular opinion. As early as 1965, Laing came to Holland by invitation of the Dutch Ministry for Social Welfare, to instruct mental health care personnel in the theory and method of family therapy. In the 1970s, this Ministry also helped finance the making of several popular movies, which were strongly inspired by Laingian thought. Next to this, several organisations for 'alternative mental health care' or the emancipation of psychiatric patients came into existence. Critical psychiatric ideas fit in well with the general climate of cultural renewal, which was dominant in the Netherlands at the time. Ideological ties between the call for psychiatric reform and the call for social reform were the ideals of enlarging individual freedom, creating more equality between people, and stimulating emotional openness and honesty. The strong cultural criticism that was present in Holland around 1970 was a fertile breeding ground for the notion that society could create severe emotional and behavioural problems. An important concrete link between psychiatric and social reform was formed by the young psychiatric nurses of the postwar baby boom generation who entered clinical psychiatry at the time.

Around 1980 however, the tide started turning. So-called anti-antipsychiatrists joined issue with critical psychiatric thought and practice. Their case was strong. The professionalisation of biological psychiatry had created new and influential theories about the neurobiological aspects of mental illness. Moreover, in the course of the 1970s the success of the drug Lithium in the treatment of severe mood disorders had become undeniable. Genetics had presented new evidence pointing towards a hereditary basis of schizophrenia. On top of this, anti-antipsy-

chiatrists pointed out that the parents of psychiatric patients often felt badly treated by critical psychiatrists, psychologists and nurses, as if they were to blame for the problems of their children. This anti-antipsychiatric counterattack was supported by many family members – mostly mothers – of psychiatric patients. Slowly, those working along the lines of the supposedly more humane social model turned into the bad guys, the ones who made the victims. Meanwhile, the social movement which aimed at reforming clinical psychiatry and which consisted of (ex-)patients, psychiatric nurses, journalists and academics, slowly turned its attention away from its plea for an intensification of psychiatric treatment using psychotherapeutic methods. They became interested in radical de-institutionalisation: the abolishment of psychiatric hospitals, as was happening in Italy at the time. During the 1980s, critical psychiatry entered a new phase, typified by the slogan: 'Freedom is therapeutic!'

Critical psychiatry had been the extreme tip of an iceberg of psychotherapeutic healing optimism dominant in Dutch clinical psychiatry during the 1970s. As this urge to heal faded and the influence of biological psychiatry grew stronger, the return to the traditional view of madness as a disabling illness proved to blend very well with a social psychiatric approach, aimed at supporting and treating people outside the walls of the psychiatric hospital. At the same time the 'antipsychiatric period', as the 1970s came to be called, was demonised by some influential psychiatrists, journalists and historians alike. This has hindered our understanding of the character and influence of this period. 'Antipsychiatry', as this book has attempted to show, was not merely a cultural fad, initiated by a couple of isolated, radicalised psychiatrists who were mostly popular among 'hippies' and trendy intellectuals. Critical psychiatry was part of a broad and widely supported reform movement within clinical psychiatry, aimed at humanising psychiatric care and healing people. Any period of therapeutic optimism and reform-mindedness in the history of psychiatry has led to both excesses and created new forms of treatment and insight into the dynamics of mental problems. One result of the psychotherapeutic climate of the 1970s is the attention which has grown for the importance of the behaviour of family members for the mental well-being of the clients of clinical psychiatry. Also, the importance of a respectful and individual treatment of clients has since remained an issue. Moreover, for some clients, psychiatrists and nurses, the notion that there is a meaning in madness still has relevance. Likewise, there was a meaning in the apparent madness of the so-called antipsychiatric period.

(Met dank aan Clare Daykin)

# WAAROM 'GEK'

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