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Ootes, S.; Pols, A.J.; Tonkens, E.; Willems, D.

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Bridging boundaries

The concept of ‘citizenship’ as a boundary object in mental healthcare

Sabine Ootes, Jeannette Pols, Evelien Tonkens & Dick Willems

For some time now, Dutch mental healthcare has framed its ideals regarding the societal position of its clients in terms of ‘citizenship’. Different definitions of citizenship exist, which would entail different practical goals for one and the same context. In mental healthcare, however, a concept of citizenship is used without discussing its definition. So what function does the concept of citizenship perform in mental healthcare? This article investigates this question by studying a leading Dutch journal, which functions as a forum for professionals, researchers and policy makers to debate the practice and ideals of mental healthcare. By analysing the function of the concept of citizenship in the articles in this journal, we show that one of the advantages of ‘citizenship’ over other concepts is that ‘citizenship’ can function as a boundary object. ‘Citizenship’ is sufficiently heterogeneous and malleable to encompass a large variety of functions, which can be used to strive for manifold, sometimes even conflicting goals in mental healthcare.

[citizenship, social inclusion, mental healthcare, boundary object, Netherlands]

Introduction

In the 1960s and ’70s, Goffman’s seminal work on institutional life (Goffman 1961) and other writings of the anti-psychiatric movement introduced the idea of deinstitutionalisation into public debate. This gave rise to ‘deinstitutionalisation’ as a policy objective in mental healthcare in many Western countries in the 1980s. But putting the policy into practice has exposed the drawbacks of deinstitutionalisation: at present, mental healthcare clients may live in the community, but cannot be said to be members of it (Ware et al. 2007). Social inclusion has therefore become an important objective in mental healthcare internationally (Leff & Warner 2006).

The Netherlands has followed international developments. The 1980s and ’90s heralded the introduction of policy changes and new laws aiming to transform the institutionalised patient into an autonomous client living in the community and receiving ambulant care (Van de Bovenkamp 2010; Van Lieshout 1985). In the Netherlands,

the problem of social inclusion has become prominent too: research warns us that mental healthcare clients suffer from loneliness and self-neglect, or cause trouble in the community (Wolf 2002; Wolf et al. 2002). As in other countries, the ideal of social inclusion in the Netherlands has been constructed around a new buzzword: citizenship (Tonkens & Newman 2010). 'Clients-as-citizens' rhetoric is frequently used in Dutch mental healthcare journals (e.g. Boevink 1997; Kwekkeboom 2004; Van Loenen 1997; Van Weeghel 2005) and in 2008 alone, two large, national conferences on the practice of mental healthcare had the word 'citizenship' in their title (GGZ Nederland 2008; Kenniscentrum Rehabilitatie 2008).¹

Ideals that are now assembled under the heading of citizenship have long been propagated in one form or another in the context of mental healthcare. After the Second World War, mental healthcare began spreading norms of responsibility and self-development (Oosterhuis 2007). Subsequently, the focus became trained on patient rights, as a strong social movement campaigned to make mental healthcare more 'democratic' during the 1960s and '70s (Van de Bovenkamp 2010; Donker 1992; Van Houten & Jacobs 2005; Tonkens 1999; Tonkens & Weijers 1999). In the decades that followed, opportunities for patients to voice their opinions were implemented both on the individual and collective levels. Patient rights were articulated and from then on, taken into account. Thus, virtues pertaining to citizenship have for some time now been part and parcel of mental healthcare discourses. Having said that, the explicit focus in the Netherlands on citizenship for mental healthcare clients appears to be a more recent phenomenon in the Netherlands (Oudenampsen 1999). It seems that the concept of citizenship serves as a useful new tool for Dutch mental healthcare to define its goals.

While the concept of citizenship came into swing in mental healthcare, it became a focal point for discussing a range of problems facing society as a whole, too: globalisation, ethnic and religious diversity, the gap between the political arena and individual voters, etc. (Beiner 1995; Van Gunsteren 1998; Heater 2004). These challenges have instigated debates about the meaning of citizenship itself. Alongside the introduction of the concept of citizenship in mental healthcare, citizenship literature experienced a revival in the 1980s and academics recognized citizenship as a concept that can mediate between liberal and communitarian philosophies (Kymlicka 2002). A broad range of definitions of citizenship has been articulated over the years, reflecting the various political perspectives available (Lister 2007; Turner 1993).

Each definition of citizenship can be translated into a distinct set of concrete goals in mental healthcare. Thus one might presume that in mental healthcare, choices are made between these definitions: choosing whichever conception of citizenship best fits the concrete goals that mental healthcare has formulated for itself. The choices made are important, since they entail very real consequences for the citizens affected. They affect the demands placed on citizens, the rights they can lay claim to and the identities they have (Kymlicka & Norman 1994). Winance, for instance, describes how citizens' rights vary between different positions on citizenship (2010). From a feminist perspective it makes sense to economically valorise certain care responsibilities by means of governmental benefits for carers, while from a disabilities perspective

funds are better paid out to those in care: using the benefits they can hire staff to care for them, thus eliminating the emotional dimension in the care provided. Winance's example illustrates a crucial point: how the ideal of citizenship is defined determines which concrete goals are pursued in practice.

Citizenship in mental healthcare

In this article we investigate how mental healthcare deals with this conceptual multiplicity. Does mental healthcare make clear choices between the different definitions of citizenship? Or is the concept left undefined and poly-interpretable? If so, how is it used? In order to answer these questions we trace the use of the concept of citizenship in this field by asking: what function(s) does the concept of citizenship perform in mental healthcare? By concentrating on the functions the concept of citizenship performs, it becomes possible to reflect on and question them. Do they tally with the concrete goals of mental healthcare? If so, how? And with which goals exactly? Is the actual goal of helping mental healthcare clients find work, for instance, fostered by a striving for citizenship? Awareness of the constraints of the language with which mental healthcare workers and others verbalize goals may stimulate them to rethink these goals and the language in which they are pursued. Perhaps goals should be framed differently, using different words and catchphrases. The aim of this article is to help mental healthcare professionals, policy makers, and other parties concerned reflect on such questions.

In order to explore the functions of the concept of citizenship in mental healthcare, an analysis has been conducted of discourses in the Dutch Monthly Journal for Public Mental Health (*Maandblad Geestelijke Volksgezondheid*, MGV), the leading Dutch journal in the field. The journal serves as a forum for workers, researchers, policy makers, lay experts and others concerned, in which the practice and ideals of mental healthcare are debated. We took samples of the journal once every five years from the 1970s onwards, looking for when and how the concept 'citizenship' was used. We read all titles and scanned abstracts and articles published in that one volume of the journal. We looked at original articles, editorials, open letters, book reviews, conference reviews and film reviews relating to client care.

We wanted to investigate the use of the *concept* of citizenship, not just the word 'citizenship' itself. We therefore searched texts in the MGV for the word 'citizen' and all its derivatives (search term: 'burger*'). We found words such as 'citizens' and 'citizenship', but also 'citizenry', 'civil/bourgeois', etc. (in Dutch: 'burgers', 'burger-schap', 'burgerij', and 'burgerlijk' respectively). We scanned all articles a second time for relevance; articles not relating – in the broadest sense – to the societal position of clients were excluded from our study.

Table 1 Articles found and articles included

<i>year / volume</i>	<i>articles found</i>	<i>articles included</i>
1970-1985 / 25-40	0	0
1990 / 45	3	3
1995 / 50	4	3
2000 / 55	18	9
2005 / 60	25	11
totals	50	26

Functions of the concept of citizenship

In this article we explore the function the concept of citizenship performs in the MGV. Table 1 shows the amount of articles in which the concept occurs in our sample of the MGV and states the number of articles included in this study. Our analysis reveals that the concept of citizenship was introduced in this context in the early 1990s. We have established that the concept of citizenship was first mentioned in 1990, after which there was an increase in its use. Our analysis allows us to make two general observations.

Firstly, the popularity of the concept of citizenship, which was described in the introduction, does not resonate too strongly in the MGV. Although there has been an increase since the early 1990s, in 2005 the concept occurred in just 11 articles. As its incidence is so low, it is difficult to draw definitive conclusions on historical trends in the use of the concept. In addition, the concept generally occurs only once or twice in each sample article. There are five exceptions where the concept of citizenship is mentioned 4, 4, 9, 25, and 3 times. The concept, therefore, generally plays a rather marginal role in the journal's authors' argumentations.

Secondly, after having analysed the material, it is clear that the authors of the MGV do not discuss the concept of citizenship explicitly. Where one would perhaps have expected authors to reflect on their new vocabulary, they do not do so in our sample, nor do they make explicit choices in definition. How, then, does the language used relate to the goals the sector has set itself? We answer this question by drawing out five functions that the word 'citizenship' may perform in texts in the MGV. These five functions will be discussed in turn below. For each function, we shall point to the goals these functions may give rise to in mental healthcare. The remaining part of this article scrutinizes the relationship between the goals to be achieved and the language in which they are discussed.

1 Designating a living space

The first function we observed the concept of citizenship to perform occurs in two texts in our sample of the MGV. In these two texts, the concept of citizenship seems to designate a certain public space or domain. One of the texts is a report by Visser and colleagues on a conference discussing how to guarantee continuity of care in a

community care situation. One of the conference's workshops focussed on the successes and difficulties of projects to create community residences for mental health-care clients and other marginalised groups. The discussion that followed the workshop yielded a plan:

[...] to create special residences for people that have no intention of adapting to the civil habitat (Visser & Van Busschbach 2000: 585).²

The merits of this plan can be disputed, as indeed they were at the conference. What the quote does establish though, is that invoking the concept of citizenship can create distinctions between spaces. By mentioning 'civil habitat', a physical or social space is marked out as separate from other spaces. To be more specific, a distinction is made between institutional life (which is thereby deemed 'un-civic') and life in the 'outside world' (the civil habitat).

Ever since the anti-psychiatric movement criticized institutional life for depriving its inhabitants of their civic roles (Goffman 1961), deinstitutionalisation has been a primary goal in mental healthcare. This goal is consistent with the ideal of citizenship: building community houses for mental healthcare clients can be seen as fostering clients' citizenship. Changing discourses on deinstitutionalisation into discourses on citizenship is an interesting strategic move on the level of rhetoric. It replaces negative language (No to the institutions!) with positive language (Yes to citizenship!); it specifies the mental healthcare ideal in a positive way. Interestingly, the quote shows that in this change of discourses, the objective of the old discourse has lost value. It shows that it has become possible again to debate whether or not clients are served by providing separated living environments. In the new language of striving for citizenship, it is possible to make separated living spaces for mental healthcare clients a goal, while at the same time promoting the dominant ideal in mental healthcare, namely citizenship.

2 Assigning a bearer of rights and duties

A marginal function that only comes up once in our sample mentions citizenship in the context of describing social roles. This text reports on a study into the social functioning of people diagnosed with schizophrenia. Social functioning was measured by indicating how clients function in eight different social roles, one of them being the 'citizen role'. The exact meaning of 'citizen role' remains unspecified in the text. By its juxtaposition to other roles, it appears to allude to the fulfilment of civic duties (e.g. voting, paying taxes, being active in the community) and watching the news is mentioned explicitly as important for fulfilling the citizen role. The author describes the citizen role as one high up in a hierarchy of social roles:

Where norms and values are most prominent, failing in social roles will be most visible. This goes for the 'higher' roles especially: de occupational role, the social role, the citizen role and the parent role [...] (Asselbergs 1990: 4).

According to Asselbergs, it is important to support clients in fulfilling their social roles, since failing to do so can lead to sanctions: people can be expelled from them, especially the higher ones. What is implied is that in the long run, failing to fulfil civic duties will raise controversy on the allocation of civil rights to mental healthcare clients. Indeed, in certain restricted cases, not being a well-behaved citizen still leads to hospitalization against the consent of the client. The right to freedom is then overruled by the duty to be a well-behaved, responsible citizen. The quote above thus warns us that a claim to civil rights entails certain duties.

In discussing the importance of the citizen role in terms of benefits and responsibilities, the concept of citizenship sees the mental healthcare client emerge as a new kind of entity: He is not just a patient, employee, friend and/or parent, he is also a citizen. Invoking the concept of citizenship in this function makes the mental healthcare client a bearer of rights and duties and people who attach importance to these rights underscore the importance of the citizen role in general. Therefore, this function of the concept of citizenship translates striving for citizenship into training and supporting clients in their citizen role – not just in claiming rights, but also in fulfilling duties.

3 *Characterizing an ideal type*

Invoking the concept of citizenship had the effect of characterizing ideal type citizens five times in the texts in our sample. Personal traits that members of civil society are expected to have, or that should be cultivated, are described, but the interpretation given to these traits varies. For instance, we found an article on the challenges posed by the new Dutch market-oriented healthcare system to mental healthcare and its clients. This new system allocates funds to which care clients are entitled in three different ‘compartments’: cure, care, and ‘well-being’ oriented services. Clients applying for finance of the care they receive ought therefore to be able to understand and take stock of their own situation. The author of this article questions these abilities in mental healthcare clients by remarking:

[T]he client, as an *independent, assertive*³ citizen, is expected to be able to decide for him- or herself which care he or she wants to apply for at the counter. But everybody knows that clients need a lot of help in clarifying their wishes and needs, and in subsequently obtaining and using the desired assistance (Droës 2005: 1010, our emphasis).

A different article investigates how to determine the competency of clients. Hondius and colleagues write a case report on a man suffering from both somatic and mental health problems, whose somatic problems go untreated because he refuses treatment. Only after the client has been judged to be incompetent can his will be overruled so that his somatic problems can be treated. Hondius and colleagues note that as a general principle:

Resistance against treatment by someone that is *competent* should [...] be respected; those are the basic rights of each and every *autonomous* citizen (Hondius et al. 2005: 602, our emphasis).

Citizenship takes shape as an ideal type in the two quotes above. ‘Independence’, ‘assertiveness’, ‘competency’ and ‘autonomy’ are presented as *civic* personal traits. Even though clients may not yet possess them, they are presented as desirable or even natural traits citizens have. If the ideal is that clients be recognized as citizens, the goal should be to instil these properties in them.

4 Creating common ground between individuals

The concept of citizenship has the effect of creating common ground between individuals sixteen times in our sample of the MGv, most frequently in a text by Van Weeghel. This author discusses ways of alleviating stigma: the differences between anti-stigma projects, important messages to get across, and best practices in which stigma is successfully combated. One of the effective ways to alleviate stigma against people with psychiatric disabilities is by bringing them into contact with other citizens. This is done in anti-stigma projects that welcome people with mental health problems into society.

These [anti-stigma projects] offer people with psychiatric disabilities and other citizens the opportunity to meet each other in a positive context [...] (Van Weeghel 2005: 387).

By writing about ‘other citizens’, the common ground between people with and without psychiatric disabilities is made clear: all are fellow citizens. People in the anti-stigma projects voluntarily meet their psychiatrically disabled opposites because – as the text implies – they are all citizens. Yet communication between these groups may also lead to tensions. Van Weeghel again:

Other citizens may find some of the conduct of people with psychiatric disabilities that much obscure, that they are embarrassed by it (Van Weeghel 2005: 385).

This quote highlights once again that however hard it is to understand each other and however much the way people walk, talk and act differs, those with and without psychiatric disabilities belong to one and the same group: the citizenry. This common denominator presupposes contact and implies a sense of community and identification between members of the group. It is a function of the concept of citizenship that ushers mental healthcare to set goals to alleviate stigma and create places of contact between clients and non-clients in order to promote a group spirit.

5 Making distinctions between citizens

Throughout quite a few texts, words such as ‘deviant’ and ‘non-standard’ vs. ‘average’, ‘plain’ and ‘ordinary’ appear in relation to the concept of citizenship. These words mark out distinctions between citizens or groups of citizens. In sum total this function occurs ten times in the sample, of which we shall give two examples. Firstly, in the light of increased care consumption in mental healthcare, Hutschemaekers tries to answer the question whether the Dutch suffer from increasingly ill health. He brings together a large body of data on care consumption in 1980, 1988, and 1997 and comes to the conclusion that it cannot be stated with any degree of certainty that the Dutch actually are more ill. This conclusion indicates that there is no direct relationship between the extent of mental health problems among the Dutch population and the extent to which the public experiences mental healthcare clients as causing public disturbance. The attitude against people with mental health problems seems to be toughening. People are less tolerant of the problems mental healthcare clients cause, irrespective of whether or not they cause problems more frequently. Hutschemaekers quotes a source whose statement illustrates his conclusion:

[This author] alludes to the potential threat [clients] pose to the quality of life of *ordinary* citizens (Hutschemaekers 2000: 329, our emphasis).

Emphasis on the infringement on the quality of life of the general population is the general tenet in public discourse, according to Hutschemaekers.

The second example is a text by Broekaar in response to an earlier contribution in the MGJV. That previous MGJV article provides an enthusiastic perspective on the new market-oriented care system introduced in the Netherlands. Broekaar criticizes the way in which vulnerable groups of people such as mental healthcare clients may suffer serious consequences from the introduction of the new system. One of her doubts about the new system addresses the way in which it portrays clients as critical consumers:

For a lot of mental healthcare clients [living up to this image] is too hard: even for the ‘*average* citizen’ making choices [between health insurance policies] is very difficult and time-consuming (Broekaar 2005: 1076, our emphasis).

In both these quotes, the authors use the distinctions they make between mental healthcare clients and other citizens to expose problems. In the first quote the problem is framed as a problem for society in general. Making distinctions between citizens sets the goal for mental healthcare in terms of ‘damage control’, giving rise to early intervention programs, more coercive measures, etc.

By contrast, in the second quote, the problem focuses mainly on the mental healthcare client. Making a distinction between ‘average citizens’ and mental healthcare clients enables the authors to make a claim for special needs and rights of clients as ‘disabled persons’. For some time, psychiatric rehabilitation has spent much effort

on decreasing the ‘skill deficits’ clients experience in relation to their environment (Anthony et al. 1982); it has revolved around the principle of reducing the differences between clients and non-clients, where being different was translated as falling short. These quotes show that making distinctions between citizens can also, contrary to the subtext of psychiatric rehabilitation, be in the interest of clients. They show us that clients and other citizens should not always be treated in the same way. Making distinctions between citizens allows mental healthcare workers to set the goal of campaigning for special rights for citizens who happen to be mental healthcare clients.

The concept of citizenship as a boundary object

This article began by observing that citizenship has become a popular ideal in mental healthcare. However, there are different definitions of citizenship, each entailing different practical goals for one and the same context. We wondered how mental healthcare professionals deal with this ambiguity and asked what function the concept performs in the leading Dutch journal on mental health: the *MGV*. Although we found that authors in the *MGV* do not make it explicitly clear what they mean when using the concept of citizenship, we were able to make some interesting observations about the functions the concept performs in the *MGV*. We have described five functions: ‘designating a living space’, ‘assigning a bearer of rights and duties’, ‘characterizing an ideal-type’, ‘creating common ground between individuals’, and ‘making distinctions between citizens’. These functions can all be translated into goals that set the agenda for mental healthcare and we have given examples of the concrete goals they may give rise to in practice.

Boundary objects

By enumerating the functions the concept of citizenship performs in the *MGV*, it becomes clear that the ambiguity that the concept of citizenship has in theory is mirrored by its use in the practice-oriented context of the *MGV*. The ideal of citizenship does indeed lead to multiple concrete goals to be strived for in mental healthcare practice. All involved should choose for themselves how to put the concept to best use. Nevertheless, we suggest that citizenship is an enticing concept for mental healthcare, because it enables bridges to be built: the concept of citizenship acts as a boundary object in the way that Star and Griesemer have described (1989). They state that some ‘objects’ – be they abstract or concrete – can create bridges between intersecting social worlds by being internally heterogeneous. The boundary nature of these objects is “reflected by the fact that they are simultaneously concrete and abstract, specific and general, conventionalized and customized” (p. 408). More specifically, we suggest that citizenship functions as an ‘ideal-type’ boundary object. According to Star and Griesemer:

[an ideal-type boundary object] is abstracted from all domains, and may be fairly vague. However, it is adaptable to a local site precisely because it is fairly vague; it serves as a

means of communicating and cooperating symbolically – a ‘good enough’ road map for all parties (Star & Griesemer 1989: 410).

Being an ideal-type boundary object, the concept of citizenship is indeed quite vague, yet it is able to set the agenda: it can be simultaneously abstract and concrete and is internally heterogeneous. We shall now flesh out some of the ways in which the concept of citizenship acts as a boundary object by indicating how it builds bridges between the different goals in mental healthcare and pointing to its internal heterogeneities.

Bridges

Firstly, the concept of citizenship creates bridges between *a large diversity* of goals that can be strived for in mental healthcare. It can build bridges between different goals precisely because it is such a broad concept. Other catchphrase concepts in mental healthcare, such as ‘deinstitutionalisation’ and ‘socialization’,⁴ do not share its broad scope. Deinstitutionalisation only sets goals for clients’ physical living space. Socialization paints larger vistas: it makes claims for more changes than just in physical surroundings. The social environment of clients has to change, too, and clients themselves need to be socialized. Citizenship, with its functions of ‘designating a living space’, ‘assigning a bearer of rights and duties’, and ‘characterizing an ideal-type’ connects the goals of deinstitutionalisation and socialization. It also leads to new goals, like the claim for (special) rights yielded by the function ‘making distinctions between citizens’. In addition, the concept of citizenship allows one to talk of duties: responsibilities that clients have as part of civil society and responsibilities that citizens have with respect to fellow citizens who happen to be clients. Thus the concept of citizenship connects a large set of previously distinct, concrete goals of the mental healthcare sector; it is an ideological language that brings together all these goals.

Secondly, the concept of citizenship bridges (*potentially*) *conflicting* goals. It is able to do so because – to a certain degree – it is ambiguous about the explicit goals that ought to be pursued. In other words, the concept of citizenship binds because it can remain abstract. When it becomes concrete, it becomes manifold, heterogeneous. For instance, a certain friction occurs between the functions ‘creating common ground between individuals’ and ‘making distinctions between citizens’. In the same context, the same word – citizenship – can be used to make completely opposing claims: we are all the same vs. we are in some respects crucially different. Both can be used to foster the interests of mental healthcare clients, yet the claims themselves conflict one another.

Within the function of ‘making distinctions between citizens’ a second example of friction occurs. We can point to differences between clients and other citizens in order to fight for client rights, or to restrict client movement in society to protect the general population. Campaigning for the citizenship of clients can therefore have the effect of increasing or restricting clients’ freedom to act. The concept of citizenship bridges by transcending, or ‘covering up’ these frictions. It can retain heterogeneity; it does not at once reveal its true colours. Thus, one of the main strengths of the concept

of citizenship is that it is *not* univocal. This heterogeneity allows bridges to be built between potentially conflicting ideas and parties. As a boundary object, the concept of citizenship acts as a bridge between the goals that mental healthcare sets itself, bringing together the people and disciplines that articulate them in a common discourse.

Discussion

In the previous we have concluded that citizenship's conceptual ambiguity is productive: its heterogeneity allows it to function as a linguistic bridge that connects different goals in mental healthcare. As an abstract ideal, it unites mental healthcare to strive for a common good, referred to as citizenship. We have also seen that outside of a concrete context, the concept of citizenship remains ambiguous about what exactly these good things are or for whom they are good. In some instances the call for citizenship may be empowering, while in other cases a plea for citizenship will call on people to answer to a set of duties. By bringing together different goals, the concept of citizenship has a depolarizing effect: the concept's unifying nature obscures possible tensions between specific goals.

One may wonder though, whether it is always a good thing to have concepts make tensions invisible. Would mental health care not be better served with concepts that bring tensions between ideals into focus, so that parties concerned can continue to reflect on these? It may be useful to discriminate between, for instance, the ideal of all being equal ('creating common ground between individuals') and that of creating special positions for people with disabilities ('making distinctions between citizens'). When these tensions remain hidden, the ideals behind them may get quietly lost along the way. With this article, we hope to create awareness of both the unifying and the problematic effects of citizenship's nature as a boundary object.

Notes

Sabine Ootes studied biology and philosophy and is currently a PhD-candidate at the Medical Ethics section of the Department of General Practice at Amsterdam Medical Centre. In her project she studies the citizenship of people with long-term mental health problems. E-mail: s.t.ootes@amc.uva.nl.

Jeannette Pols is assistant professor at the Medical Ethics section of the Department of General Practice at Amsterdam Medical Centre. E-mail: a.j.pols@amc.uva.nl.

Evelien Tonkens is professor of active citizenship at Amsterdam Institute for Social Sciences Research (AISSR) at the university of Amsterdam. Her research focuses on the interaction between ideals of citizenship and social change. E-mail: e.h.tonkens@uva.nl.

Dick Willems studied medicine and philosophy and worked as a general practitioner in a Dutch village for about 15 years. In 2003, he became professor of medical ethics at the University of Amsterdam/Academic Medical Center. His research focuses on home care technology and care for the dying. E-mail: d.l.willems@amc.uva.nl.

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- 1 In addition, in October 2009 a national project called ‘Recovery and Citizenship (‘Herstel en burgerschap’) has taken lift-off (GGZ Nederland 2010). In this project, mental health care, civil, and client-organisations, local governments, and health insurance companies work together to make citizenship one of their main goals in improving the social position of people with severe mental health problems in the Netherlands.
- 2 This translation and all subsequent translations were made by SO.
- 3 The Dutch quote read ‘mondig’, which literally translates as ‘mouthy’, but this word does not reflect its meaning. The Dutch ‘mondig’ means being apt to articulate one’s rights and needs, especially vis-à-vis public institutions: being independent, responsible and articulate. We have chosen to stay with ‘assertive’, since this word also communicates looking after interests, especially – as does the word ‘mondig’ – self-interest.
- 4 In Dutch: ‘vermaatschappelijking’.

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