Mental health, citizenship, and the memory of the Second World War in the Netherlands (1945-1980)

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My paper is about the connection between mental health, citizenship and the public memory of the Second World War in the Netherlands. First, just a brief clarification of what I mean when referring to mental health and citizenship. I'm not talking about the connection between institutional psychiatry and citizenship in the sense that hospitalisation generally implied legal certification, meaning that the civil rights of patients were suspended. In this context mental illness counted in fact as the opposite of citizenship as it had been articulated on the basis of the ideals of freedom and equality since the French Revolution. Neither do I refer to the growing attention for and recognition of the civil rights of the mentally ill from the 1960s on, reflecting a shift from values associated with maintaining law and order to values associated with mental patients' autonomy and consent. What I will discuss are more general psychological notions of citizenship that were articulated and advanced in the broader field of mental hygiene and outpatient mental health care, and that were aimed at the entire Dutch nation.

Expressing views about the position of individuals in modern society and their possibilities for self-development, mental health experts connected mental health to ideals of democratic citizenship and civic virtue. Thus, they were involved in the liberal-democratic project of promoting not only productive, responsible and adaptive citizens, but also autonomous, self-conscious, and emancipated individuals as members of an open society. Entwined with definitions of self-development, ideals of citizenship took on a broad meaning, not just in terms of political rights and duties, but also in the context of social, psychological and moral conditions that individuals should meet in order to realise those rights and duties. Notions such as fairness, social justice and responsibility, tolerance, and emancipation became central elements of the notion of good citizenship. In the late 1940s and 50s as well as in the 1960s and 70s, the link between mental health and citizenship was coloured by the memory of the Second World War and the German occupation, albeit in completely different, and even opposite ways. My argument is that the memory of the war, and especially the public consideration of its victims, changed drastically in the mid-1960s, and that the mental health sector played a crucial role in bringing this change about.

Before turning to the post-war period, let me briefly sketch the rise of the mental movement in the Netherlands and its socio-political background during the first

half of the twentieth century. Between the mid-1920s and the early 1940s, the psycho-hygienic movement and a network of social-psychiatric and other outpatient facilities were established. Its domain was wide: it stretched from the non-institutional care for mentally ill and feebleminded individuals to marriage, sexuality, and family-life, education, work, alcoholism, and crime. Although Dutch psychiatry to a large extent was modelled on German examples, this new mental health sector contrasted with developments in Germany and some other countries, where eugenics gained ground. Eugenics was discussed in Dutch mental health circles, but in fact it hardly played a role. Confidence in the possibility of reforming human beings, which in the Netherlands was strongly rooted in the tradition of moral education and social work, won out over biological determinism. Furthermore, Catholics and Protestants, whose views could not be ignored given the prominent socio-political role of the religious denominations believed eugenics to be at odds with Christian principles.

The mental health sector developed against the backdrop of social and political modernization. The emergence of mass society and ongoing democratisation – universal suffrage was introduced in 1919 – caused mounting concerns among the bourgeois elite regarding the presumed prevalence of irrationality among the lower orders. The crucial question was whether all people had the necessary rational and moral qualities to meet the challenges of an increasingly complex society and to act as responsible political citizens. It was considered essential to elevate the people morally and to inculcate a civil sense of responsibility and decency in them. The pursuit of public mental health basically fitted in with older bourgeois efforts to 'civilise' the lower classes. Psycho-hygienists closely aligned themselves with the paradigm of an orderly mass society that was based on the adaptation of the individual to collectively shared middle-class values. Their democratised bourgeois ideal of citizenship was all about self-control and responsibility, and a proper balance between individual independence and community spirit.

In the 1940s and 1950s, the rapid expansion of mental health facilities was strongly advanced by worries about social disruption and the presumed moral decay in the wake of the German occupation and the liberation by the allied forces. Because the war and Nazism epitomised the anxieties of mental health experts about modern mass society in dramatic ways, in the post-war years their stock of ideas won more public support. Right after the liberation, political and religious authorities as well as intellectuals and professionals characterised various forms of misconduct as serious threats to the moral fibre and the mental health of the Dutch nation. There was a strong concern about malingering, juvenile mischief, trading on the black market, lack of respect for authority and ownership, but also family disruptions, growing divorce rates, greater autonomy of women, and especially sexual license. The leitmotiv of such anxiety was the supposition that uncontrollable drives and urges had gained the upper hand, which seriously threatened the overall sense of community. There was a general trend, articulated in particular by mental health experts, to interpret the Nazi crimes as

the product of a derailed collective mind. This can be illustrated by the worries about the presumed wide-spread sexual debauchery. Thus Nazism was associated not only with violence and cruelty, but also with sexual excesses. The Catholic Medical Journal, for example, put divorce, abortion and sexual licence in one box with racism and the persecution of Jews.

Partly for strategic reasons, that is in order to legitimise the expansion and growing funding of mental health care, psycho-hygienists painted the moral and mental health condition of the Dutch people in dark colours. They pointed to a large number of risk groups that needed special attention because their lives had become so disorganised that they risked falling prey to demoralization and mental and nervous disorders. Strikingly, the victims of the war, such as concentration camp survivors, received little attention from mental health professionals. Only a few of them were concerned about the mental harm that might result from persecution, imprisonment, witnessing mass murder and other atrocities, and participating in the underground resistance. And only in the consulting rooms of some psychiatrists war victims might find a listening ear. As a result, their mental problems were associated mainly with their individual life history or personality. Other psychiatrists, however, argued that psychiatric aid might also have a contrary effect: too much attention would potentially strengthen the feeling of being ill or make them 'spoilt'. References were made to possible 'disease profit' and 'interest neurosis', concepts that earlier were used abroad with respect to claims from victims of accidents as well as from shell shock victims of the First World War. As far as support was offered to war victims in the late 1940s, the emphasis was on short-term physical recovery and social adjustment, and mental problems received little attention. One of the leading psycho-hygienists reported in 1955 that most of the war victims had managed to resume their life and that permanent mental harm only occurred in those who as individuals were less resilient to begin with, independently of the war. Such a view was echoed by some psychiatrists who treated and studied war victims. In general their work hardly captured the attention of a wider audience.

So, in the post-war years, interest in the experiences of war victims was overshadowed by concerns about the moral decline of the Dutch population and the need to restore social order. In their striving for a mental recovery of the Dutch people, psycho-hygienists discussed all sorts of social problems and moral issues in terms of a lack of mental health. Again, their insistence on self-discipline and a sense of duty served to underline the importance of responsible citizenship in democratic mass society as well as the emerging welfare state. In order to rebuild the devastated country, prevent the resurgence of fascism, and thwart the new threat of communism, people's moral resilience should be strengthened. Initially mental health workers looked for solutions in moral-pedagogical measures. However, what in the late 1940s was still seen as lack of moral strength and willpower, in the 1950s was increasingly explained in psychological and relational terms. Under the influence of various British and American psychosocial methods, partly developed in military psychiatry, more

and more personality defects, developmental disorders and unconscious conflicts were considered as the underlying causes of deprivation and misbehaviour. This meant that moral preaching and coercion should be replaced by counselling and some sort of therapy.

Against the background of rapid socio-economic modernisation in the 1950s, in mental health care psychosocial approaches began to set the tone. Despite their cultural pessimism, professionals were optimistic about their potential, not only to prevent and treat mental problems, but also to improve mental health in general and thus ensure maximal opportunities for all citizens to develop themselves in a wholesome way. Leading psycho-hygienists began to present themselves as guides who prepared people for the dynamism of modern life by enhancing the required mental attitude and psychological abilities. They argued that moral restrictions and external coercion only affected the outer behaviour of people while leaving their inner self and motivation untouched. It became the individual's task to develop into a 'personality' and to achieve a certain measure of inner autonomy and flexibility in relation to the outside world. This psychological ideal of citizenship can be characterised as 'guided self-development.' The need for self-development was understood as an inescapable effect of modernity, but psychological guidance was considered as an essential counterbalance to the individual's growing freedom and the danger of social disintegration. Good citizenship was associated with the internalisation of certain normative mental health standards.

This psychological approach, differing from the didactic moralising of the 1940s, but still rather patronising, came under attack from the mid-1960s. In the ensuing decade the Netherlands changed from a rather conservative and Christian nation into a much more liberal and permissive country, in which a democratised and assertive individualism set the tone. The control of emotions and the individual's adaptation to society were no longer considered as signs of responsibility, but as the repression of personal freedom and the authentic self. The ideal of spontaneous self-realization, which extolled self-exploration and self-expression, superseded that of guided self-development. If beforehand individuals had been expected to develop themselves in compliance with the social order, now society itself would have to be adapted in order to facilitate their optimal self-development and well-being. That would be the ultimate fulfilment of democratic citizenship.

Whereas the anti-psychiatric movement forced institutional and medical psychiatry on the defensive, in the 1970s the psychosocial and especially psychotherapeutic services more than ever increased in size and prestige. Collective social security and health care funds guaranteed their broad accessibility. Together with social workers, mental health professionals undertook the task of enabling people, especially marginal groups, to liberate themselves from what was seen as coercive social structures. As some of them emphasized, countering prejudice and advancing tolerance was part of the

broader effort to improve the quality of social relations and, as one of them aptly phrased it, 'democratise happiness.'

In the 1960s and 1970s psychiatrists played an important role in public debates and some of them put sensitive and hitherto suppressed issues on the social agenda. Thus, from the mid-1960s on, they called attention to the suffering of war victims. In 1966 a psychiatrist, who had been imprisoned in a concentration camp himself, claimed that Jewish survivors suffered severe mental distress because they had failed to come to terms with their war experiences. Three years later, in the authoritative *Dutch Medical Journal*, the concept of 'post-concentration camp syndrome' was introduced, suggesting that such mental distress was linked to the repression of war experiences. Shortly thereafter another psychiatrist argued that former members of the underground resistance suffered from psychosomatic complaints, which in the allowance of war pensions were taken into account too little.

In 1972, in response to a heated public debate on the possible early release of three German war criminals, who were serving their lifelong sentence in the prison of Breda, a documentary on the psychotherapeutic treatment of war traumas by a prominent psychiatrist was shown on Dutch television. It was followed by a discussion in which four psychiatrists participated. This broadcast offered an inside perspective on the mental suffering of war victims to a wide audience. In the ensuing public debates psychiatric and psychological arguments not only sensitised politicians and the general public of the fate of war victims, but they also carried more weight than legal ones. The so-called three of Breda were not released. Psychiatrists argued that not only the experiences during the war itself had been harmful to the mental well being of war victims, but also the public silence and lack of support in the twenty years following the war, which forced many to repress their traumatic experiences. In their view Dutch society and the government were co-responsible for the individual suffering and it was the nation’s moral duty to ease their burden, not just through material support, but also by creating room for the expression of their feelings and promoting public understanding. The victims should not be left out in the cold a second time.

Touching on current controversies about war, in which the younger generations tended to accuse the older ones of having failed to prevent and resist Nazism, the psychiatric logic proved especially effective in the effort to render the rights of war victims, and later also of sufferers from other 'psychological traumas,' socially acceptable. Feelings of guilt among the Dutch population about the fate of their Jewish compatriots also played a role here; the proportion of the Jewish population killed by the Nazis - 75 percent - was larger in the Netherlands than in other countries in Western-Europe. Furthermore, the psychiatric angle ensured that political differences among the various war victims and former resistance members receded to the background. Now the focus was on what they all had in common, their psychological trauma's. The psychiatrists' concern for war

traumas resulted in measures and services aimed at providing both material and psychological support. Also, a network of self-help groups, associations and meetings for the various war victims emerged, all searching to find recognition of their suffering. In the course of the 1970s and 1980s psychiatrists, referring to the posttraumatic stress disorder diagnosis, increasingly stretched the concept of ‘war victim’. It might also apply to prisoners of war; civilian victims; detainees in the former Dutch East Indies; those who were forced to go in hiding to prevent arrest by the Nazi's; partners and children of war victims and of former members of the Dutch Nazi party; and the so-called 'liberation children', born of Dutch women and allied soldiers.

The memory of the war as a traumatic experience and the public attention for its victims after a period of twenty years of public silence, was strongly coloured by the liberation and democratisation movement of the 1960s and 1970s in combination with the emancipation of emotions. Talking, exchange of empathy and expression of feelings replaced the toughness and the do-not-complain morality of the 1940s and 1950s. Whoever in the Netherlands during the 1970s and 1980s convincingly argued the case of an individual or group that mentally suffered on account of specific social wrongs could generally count on public attention and sympathy as well as help from the government to have their interests and rights protected.

Mental health experts not only played a key role in the public recognition of war traumas, but also stood up for sexual reform, the self-determination of patients and a de-penalisation of euthanasia, abortion, contraception, and drugs - all those issues that make the Netherlands so famous (or infamous). They drew on the 1960s and 1970s culture of liberation and democratisation, but they also followed in the footsteps of the reform-minded psycho-hygienists from the 1950s. Their notion of citizenship made great demands on people's competence. Advocating openness, understanding, and tolerance, they stressed the need for a sense of responsibility, a sincere exchange of arguments and a willingness of people to listen to each other. As a prominent psychiatrist argued: 'in a world of emancipated and independent human beings' there was only one way to overcome outmoded ideas and habits, and that was 'talking, talking, talking.' Making sensitive issues debatable was inextricably bound up with the belief in an open and fully democratised society, in which self-reflective and socially involved citizens empathized with others, did not shy away from unpleasant truths, and through negotiation and mutual understanding arrived at balanced decisions.

Let me conclude with addressing a question to you concerning the strong influence of the psychological mental health perspective in the reconstruction of the public memory of the war in the Netherlands. I wonder whether the Netherlands held a special position internationally in this respect, as also psychological notions of democratic citizenship were probably articulated more strongly in the Netherlands than in other countries. Can similar developments be found in other countries? In Germany itself for example, it was especially at the

time of critical reflection on and the striving for fundamental reforms in psychiatry in the 1960s and 1970s, that the Nazi past was explicitly used as a spectre and that mental health care acquired a strong political dimension.