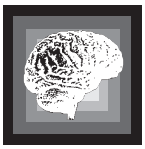

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Mental health, citizenship, and the memory of World War II in the Netherlands (1945–85)

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Abstract

After World War II, Dutch psychiatrists and other mental health care professionals articulated ideals of democratic citizenship. Framed in terms of self-development, citizenship took on a broad meaning, not just in terms of political rights and obligations, but also in the context of material, social, psychological and moral conditions that individuals should meet in order to develop themselves and be able to act according to those rights and obligations in a responsible way. In the post-war period of reconstruction (1945–65), as well as between 1965 and 1985, the link between mental health and ideals of citizenship was coloured by the public memory of World War II and the German occupation, albeit in completely different, even opposite ways. The memory of the war, and especially the public consideration of its victims, changed drastically in the mid-1960s, and the mental health sector played a crucial role in bringing this change about. The widespread attention to the mental effects of the war that surfaced in the late 1960s after a period of 20 years of public silence should be seen against the backdrop of the combination of democratization and the emancipation of emotions.

Keywords

Citizenship, democracy, memory, mental health, Netherlands, psychiatry, self-development, World War II, 20th century

Introduction

In the nineteenth and early twentieth centuries, the relationship between institutional psychiatry and citizenship was ‘negative’ or ‘exclusive’ in the sense that hospitalization in a mental asylum generally implied legal certification and therefore the suspension and potential serious infringement of basic civil rights. In fact, in this context mental illness counted as the opposite of citizenship as it had been articulated since the French Revolution on the basis of the ideals of freedom and equality. The most extreme example of the violation of civil rights of psychiatric and mentally

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handicapped patients is the eugenic programme of large-scale, mandatory sterilization and so-called 'euthanasia' in Nazi Germany.

In the course of the twentieth century, however, in two ways a more 'positive' or 'inclusive' connection between psychiatry and liberal-democratic citizenship was established in many Western countries. Firstly, the 1970s and 1980s saw a growing attention to and recognition of the civil rights of the mentally ill, reflecting a shift from values associated with maintaining law and order to values associated with their autonomy and consent. Secondly – and this is the focus of my article – from the early twentieth century on, in psychiatry as well as in the broader field of mental health care, psychological definitions of citizenship were advanced. The more a society was democratized, the greater was the need to shape individuals and make them internalize certain values and behaviour-patterns. In democratic societies, which rejected blatant force and coercion and which presupposed that the social and political order was basically founded on the autonomous consent of individual citizens, the inner motivation of the citizens was considered of crucial importance for the quality of the public domain. Expressing views about the position of individuals in modern society and their possibilities for self-development, psychiatrists and other professionals connected mental health to ideals of citizenship, including civil rights as well as civic obligations. Thus, they were clearly involved in the modern 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.

In Great Britain for example, from the 1920s on, mental health provided a paradigm to articulate in psychological terms a secular ideal for self-development as the groundwork for responsible democratic citizenship. In the USA the mental hygiene movement displayed a strong impulse to formulate a diagnosis of modern American society from the perspective of psychiatry and psychoanalysis. The ills of modern society and the malaise in individuals were linked together, and mental health experts employed theories of personality development to underline that they could contribute to the formation of robust and self-reliant democratic subjects. In Germany it was especially when striving for fundamental reforms in psychiatry in the 1960s and 1970s, whereby the Nazi past was explicitly used as a spectre, that mental health care acquired a strong political dimension. Against the complicity of psychiatry in the atrocities of the Third Reich, a democratic countervision of mental health care emerged, based on a conception of citizenship that stressed political awareness, emancipation and the social rights of the infirm and indigent (Kersting, 2003, 2005; Pols, 1997; Thomson, 1998, 2000).

Psychological notions of citizenship were articulated even more strongly in the Netherlands. What was often missing in countries like Britain, the USA and Germany was an extensive network of public outpatient mental health facilities to underpin the rhetoric about mental health and citizenship with concrete care-providing practices. The psycho-hygienic movement and facilities were more lasting and more broadly spread in the Netherlands than in most other Western countries (see Oosterhuis and Gijswijt-Hofstra, 2008). Therefore, in the Netherlands, psychological models of citizenship materialized in the practice of mental health care. Framed in terms of self-development, ideals of citizenship took on a broad meaning, not just in terms of political rights and obligations, but also in the context of material, social, psychological and moral conditions that individuals should meet in order to develop themselves and be able to act according to those rights and obligations in a responsible way.

In the post-war period of reconstruction (1945–65), as well as between 1965 and 1985, the link between mental health and ideals of citizenship was coloured by the public memory of World War II and the German occupation, albeit in completely different, 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, I will briefly sketch the rise of the Dutch mental health movement and its socio-political background in the 1920s and 1930s.

Mental health and citizenship before World War II

From the late nineteenth century, Dutch psychiatrists had aligned themselves with social hygiene, which focused on efforts to prevent people from falling ill through a reform of their living conditions. The assumed danger of degeneration and the increase of some new clinical pictures, such as neurasthenia and other nervous disorders, moral insanity and criminal psychopathy, provided psychiatrists with arguments to expand their intervention domain from mental asylums to society at large. To counter the harmful influences of modern society that were supposed to undermine people's minds and nerves, they pointed to the relevance of self-control, willpower, and a sense of duty and responsibility. Their concern about the increase of mental and nervous disorders was shared by educational experts, psychologists, criminologists, lawyers, social workers and clergymen. The psycho-hygienic movement, founded in the mid-1920s, advocated preventive measures, such as treatment of the early stages of mental problems. The professional domain claimed was wide: it stretched from the non-institutionalized care for mentally ill, feebleminded and psychopathic individuals to marriage, sexuality, procreation, family-life, education, work and leisure, alcoholism and crime.

Between the mid-1920s and the early 1940s, the psycho-hygienic ideal materialized in the establishment of a growing number of social-psychiatric Pre- and Aftercare Services, Child Guidance Clinics, Centres for Marriage and Family Problems, Counselling Centres for Alcoholics and public Institutes for Medical Psychotherapy. Most of these outpatient provisions were established by secular as well as religious voluntary organizations. Their regime basically consisted of providing consultations, mobilizing social support, offering a form of moral re-education aimed at building self-discipline, and promoting social rehabilitation (De Goei, 2001; Oosterhuis, 2005; Oosterhuis and Gijswijt-Hofstra, 2008: 375–412; Van der Grinten, 1987). Eugenics hardly played a role in these facilities, although it was discussed in mental health circles. As far as the implementation of concrete measures was concerned, most mental health experts proved rather sceptical of eugenics. In the psycho-hygienic movement, confidence in the possibility of reforming human beings, which was strongly rooted in the tradition of moral education and social work, won out over biological determinism. Furthermore, Catholics and orthodox Protestants, whose views could not be ignored given the prominent social and political role of religious denominations in the Netherlands, also believed eugenics to be at odds with Christian principles (see Noordman, 1989).

Mental health care developed against the backdrop of socio-political modernization. The underlying reasoning of psycho-hygienists was rooted in a broadly shared cultural pessimism about the assumed harmful effects of the rapid social changes, as well as in an optimistic belief in the potential of science to solve these problems. They viewed the high-paced lifestyle and mounting complexity of industrialized and urbanized society as major causes of the increase in mental and nervous problems. Between the World Wars such cultural pessimism was in fact widespread among intellectuals and it was intensified in the 1930s by anxieties about 'Americanization' as well as the rise of totalitarianism in Europe (Schuursma, 2000: 76–100; Van Ginkel, 1999: 86–98). The emergence of mass society and political democratization – universal suffrage was introduced in 1919 – caused mounting concerns in society's upper echelons regarding the prevalence of irrational emotions and drives among the working class and the poor. They wondered whether the masses had the necessary rational and moral qualities to meet the challenges of an increasingly complex society and to act as responsible citizens. Such worries gave rise to a social and moral activism of both voluntary organizations and the state. It targeted divergent, supposedly immoral

and irresponsible behaviours, ranging from drinking, dancing, gambling and other forms of 'low entertainment' to idleness and money squandering, and from impulsive satisfaction of needs and sexual licentiousness to child abandonment and crime (De Regt, 1984; Koenders, 1996; Noordam, 1996). In the interests of a well-ordered democratic society, it was considered essential to elevate the people morally and to inculcate a civil sense of responsibility and decency in them. Apart from politicians, inspired social reformers and moral entrepreneurs, the proponents of this activism were found especially among the professional groups such as physicians, teachers, educational specialists, social workers and, from the 1920s on, also mental health experts (De Graaf, 1989; De Regt, 1984; Karsten, 1986; Krul, 1989; Nijenhuis, 1981).

The psycho-hygienic approach basically fitted in with efforts to 'civilize' the lower orders. In the nineteenth century, these activities had been promoted by the liberal bourgeoisie, but since the turn of the century it had become entangled with the efforts of orthodox Protestant, Catholic and socialist leaders to further the social emancipation and national integration of their constituencies. While classic liberalism had emphasized rational thinking as the foundation of responsible citizenship and social progress, at this point the focus was on 'character formation', that is, teaching a sense of norms and duties, raising community spirit, and instilling willpower and self-discipline (Te Velde, 1992). Although Dutch society and politics were divided and hierarchically organized along class as well as religious lines – the so-called Pillarization[1] – the various social elites propagated a general ideal of citizenship that stressed middle-class virtues. An industrious and productive existence, self-reliance, a sense of order and duty, and family-values acted as cornerstones of the democratized bourgeois model of citizenship. Central notions were self-control and responsibility: the curbing of erratic impulses and instant satisfaction of needs was aimed at a proper balance between individual independence and community spirit (Aerts and Te Velde, 1998; Kloek and Tilmans, 2002; Te Velde, 1993). With their particular understanding of public mental health, psycho-hygienists closely aligned themselves with the paradigm of an orderly mass society that was based on the unconditional adaptation of the individual to a collectively shared system of norms and values.

Guided self-development in the post-war period of reconstruction (1945–65)

In 1940, just after the beginning of the German occupation, the first public facility for psychotherapy was established in Amsterdam. It was geared towards those who were suffering mentally from exposure to the violence of the war. Also, the first Centres for Marriage and Family Problems were organized in the early 1940s in order to support families suffering from distress as a consequence of the war. In the 1940s and 1950s, these and other mental health provisions, the Child Guidance Clinics in particular, expanded rapidly and received more government funding. Their growth was strongly advanced by worries about social disruption and moral decay in the wake of the German occupation and the liberation by the Allied Forces. Because the war and the atrocities of Nazism epitomized the cultural pessimism of the psycho-hygienists in concrete and dramatic ways, in the post-war years their view won more support among politicians and the general public. Secular and religious authorities, professionals and other influential intellectuals characterized various forms of misconduct – including idleness, malingering, juvenile mischief, trading on the black market, lack of respect for authority, family disruptions, growing divorce rates, greater autonomy of women, and sexual licence – as serious threats to both the moral fibre and the mental health of the Dutch nation. When in 1945 a prominent Catholic lawyer characterized 'the moral degradation and unruliness' as the 'evilest' elements of the dilapidated country, he articulated a

view that circulated among Confessional, Liberal and Social-Democratic leaders (Westhoff, 1996: 93; cf. Galesloot and Schrevel, 1987). The leitmotiv of such widespread anxiety was the observation that uncontrollable drives and urges had gained the upper hand, which seriously threatened the overall sense of community.

The psycho-hygienists seized upon the pervasively felt need to fight spiritual desperation to legitimize their objective. In their view a large number of risk groups needed special attention: neglected youngsters who tended towards asocial conduct; Jewish children who had lost their parents; returning prisoners of war, concentration camp prisoners, forced labourers and individuals who had been in hiding during the war; former members of the Dutch Nazi party and collaborators and their families; spouses who because of the war had lived apart and had grown estranged from each other; and students who had been forced to discontinue their education. The lives of many people had become so disorganized that they risked falling prey to demoralization and mental disorders (De Goei, 2001: 156–7). To curb this risk, as one of the leading psycho-hygienists argued, mental health care would have to cover a 'sheer endless' territory. Apart from the 'urgent problems of the times' connected with the war, this included family life, child-raising, education, labour, 'life problems', asocial conduct, and the wide array of mental complaints heaped together under the label of 'neurosis' (De Goei, 2001: 156–9; Hutschemaekers, 1990: 106–14; Lekkerkerker, 1947: 12; Mol and Van Lieshout, 1989: 97–106). All sorts of issues that touched on public order, personal life, ethics and religion were framed in terms of (a lack of) mental health. Social problems were largely regarded as having their origin in individual shortcomings and malfunctioning families (Buytendijk, 1958: 49, 51; KCVGV, 1949: 4, 6, 80; Fortmann, Van der Does de Willebois and Kiewied, 1953). Psycho-hygienists played a leading role in the launching of a moral revival. Partly for strategic reasons, they painted the mental health condition of the Dutch people in dark colours. The extent to which morality and mental health were put in the same category was clearly revealed in considerations about sexual licentiousness. As the leading protestant psycho-hygienist A. Bouman (1946: 98) wrote in the first volume of the psycho-hygienic movement's *Maandblad voor de Geestelijke Volksgezondheid* (Monthly Journal of Public Mental Health): 'Violently, the war has awoken slumbering sexual instincts and caused them to break adrift. Like a reckless icebreaker, the war has cut through the ice sheet of our sexual morality and now the dykes are groaning because of all the drift ice piling up'. In their renunciation of National Socialism, Catholic leaders highlighted the immorality and the 'worldly pleasures' which, in their view, it promoted, while marriage and family life were undermined (Westhoff, 1996: 93–4). By linking divorce, abortion and sexual licentiousness with Nazism, racism and the persecution of Jews, the *Catholic Medical Journal* (*R.K. Artsenblad*) espoused a similar view (Anon., 1947; Huddleston Slater, 1946: 18, 101). 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.

Strikingly, the victims of the war, such as the survivors of concentration camps in Europe and the Dutch East Indies, as well as members of the underground resistance, received fairly 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. Only a few psychiatrists were willing to listen to these war victims. Insofar as they found a listening ear, the mental problems of war victims were associated mainly with their individual life history or personality. Some psychiatrists published articles, partly based on their own experiences, about the possible mental after-effects of imprisonment in concentration camps, advocating psychiatric and psychotherapeutic aid to the victims (De Windt, 1949; Withuis, 2002: 21–2). Other psychiatrists argued, however, that such support might also have a contrary effect: too much attention would potentially strengthen the feeling of being ill. Moreover, as the prominent Professor of Psychiatry H.C. Rümke asserted, not all members of the resistance had started from noble

intentions: the underground had also attracted potentially psychopathic individuals (Mooij, 2001: 263). In *Stichting 1940–1945* ('Foundation' or 'Counsel 1940–1945'), an organization that advised on the granting of special pensions for former resistance fighters, there were also worries that too much attention for their problems would make them 'spoilt'. References were made to possible 'disease profit' and 'interest neurosis', concepts that had earlier been used abroad with respect to claims from victims of accidents in the workplace as well as from World War I veterans suffering from shell-shock. In the recovery centres of *Stichting 1940–1945*, which in 1949 were closed down, mental problems received little attention: the emphasis was on physical recovery and social adjustment (Hermans and Schmidt, 1996; Mooij, 2001: 265–6; Withuis, 2002: 26–30).

One of the leading psycho-hygienists, psychiatric-social worker E.C. Lekkerkerker, asserted in 1955 that most of the war victims had meanwhile managed to resume their life and that permanent mental harm only occurred in those who were less resilient to begin with, independently of the war (Lekkerkerker, 1955: 175–6). The psychiatrist J. Bastiaans, who in the 1950s studied the psychosomatic complaints of former members of the resistance and who in 1960s and 1970s, as a professor in Leiden, became a leading authority in the field of war traumas, used a similar reasoning in his dissertation on psychosomatic consequences of oppression and resistance (Bastiaans, 1957). Adopting a psychoanalytic angle, he observed that among members of the resistance mental disorders occurred, but he thereby focused on their personality structure and childhood development. Earlier, in 1952, the physician E.H. Cohen, an Auschwitz survivor, had devoted his dissertation to the physical and mental health condition of Jews in the concentration camps, but like other 1950s publications on war victims, this study hardly captured the attention of a wider audience (Withuis, 2002: 31–5).

In the post-war years, interest in the mental problems of war victims and their need for support and treatment was overshadowed by concerns about the assumed moral decline of the Dutch people and the need to restore social order and rebuild the nation. The morality offensive tended strongly towards translating political and social problems into spiritual and moral terms, and it was put at the service of establishing consensus and labour stability. In this climate of 'discipline and austerity', individuals who demanded attention to their personal problems and gave in to their particular leanings had no reason to count on sympathy. Again, the 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. It was widely felt that in order to rebuild the devastated country in a unified manner, prevent the resurgence of Fascism, and thwart the new threat of Communism, people's mental resilience should be strengthened (Blom, 1981; Galesloot and Schrevel, 1987; Van Ginkel, 1999). Although individuals had a right to self-development, the boundaries of their liberty should be clearly delineated by collective values. This would also be of importance to the building of the welfare state. The government official A.A. van Rhijn, who during the war years in London had developed a plan for organizing social security, emphasized that such a system would only be effective if its potential beneficiaries had a well-intentioned attitude. Close monitoring was needed in order to exclude profiteers and those with malicious intentions (De Haan, 1993: 92). One of the founding fathers of social psychiatry in the Netherlands, F.S. Meijers, concurred with Van Rhijn. Meijers warned of the likely 'degenerating impact' of the welfare state, because social security benefits were conducive to 'parasitism and selfishness'. Therefore, social psychiatry had an important task to fulfil: by promoting a sense of social responsibility and community spirit, Meijers argued, it would help to clarify 'the often turbid boundaries between human rights and duties' (Meijers, 1947: 68–9).

In their pursuit of a mental recovery of the Dutch people, psycho-hygienists initially looked for practical solutions in moral-pedagogical measures. However, around 1950, when the moral panic

about the disruptive effects of the war had faded, they began to adopt a new approach. 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. Personality defects, developmental disorders and unconscious conflicts, caused by a defective education and poorly functioning families, it was believed, constituted the underlying causes of deprivation and misbehaviour. This meant that moral preaching, coercion and punishment should be replaced by therapy and counselling. Various British and American psychosocial methods, partly developed in military psychiatry, began to set the tone. Although eugenics was still discussed by psycho-hygienists, it receded further into the background. Eugenics had become discredited by National Socialism, and Dutch mental health experts were very cautious about it. They rejected all forms of coercion with respect to sterilization, segregation and medical examination before marriage, and refused to provide systematic eugenic information; they merely appealed to individual responsibility (Lekkerkerker, 1958: 203; Noordman, 1989: 141–2; Noordman, 1990: 1276–7; Palies, 1958: 179).

The psycho-dynamic model as well as social case-work and counselling, which followed American and British examples, raised expectations about the potential of psychiatry and the behavioural sciences to change and influence people's mental make-up. Inspired by the World Federation of Mental Health, psycho-hygienists emphasized that not only prevention and treatment of mental disorders mattered. It was also crucial to improve mental health in general and thus ensure maximal opportunities for all citizens to develop themselves in a wholesome way. The notion of public mental health was turned into a comprehensive concept that was tied to the prevention of totalitarianism and the realization of a better, democratic world.

Against the background of rapid socio-economic modernization in the 1950s, 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 feared that modern mass culture and the instrumental rationality of industrial society would degenerate into either anarchy or dictatorship. Their remedy was socio-cultural planning and a normative education of the people directed by professionals (De Goei, 2001; De Haan and Duyvendak, 2002: 27, 76–83; De Vries, 1996; Gastelaars, 1985; Jonker, 1988; Van Ginkel, 1999: 207–44). Previously, mental health experts had stressed the significance of a fixed collective morality and the social adaptation of the individual in order to safeguard overall social stability, but now this restraining approach made way for an accommodating one. In their view, the main precondition for cultural improvement was a change in people's mentality. They argued that moral restrictions and external coercion only affected the outward behaviour of people while leaving the inner self and motivation untouched. New social conditions required a redirection of norms and values, and individuals should be granted more responsibility for self-development. They should be enabled to develop into a 'personality' and to achieve a certain measure of inner autonomy and flexibility in relation to the outside world. 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. Constant reflection on individual conduct and motivation was called for, in order to find the right balance between guidance and self-determination. By fostering such an attitude of 'self-responsible self-determination', as leading psycho-hygienists phrased it, mental health care would contribute to creating the conditions for participation in civil society and thus for maintaining and deepening democracy. Good citizenship was associated with the internalization of normative mental health standards. This psychological ideal of citizenship can be characterized as 'guided self-development' (Buytendijk, 1950, 1958: 10; De Goei, 2001: 154, 194–7; De Lange, 1957: 22; Fortmann, 1955: 20; cf. Brillenburg Wurth, 1959; Duyvendak, 1999; Oosterhuis, 1992; Weijers, 1991).

Spontaneous self-development in the swinging 1960s and 1970s

Psycho-hygienists believed in controlled modernization and personal development under professional supervision. This approach, differing from the didactic moralizing of the 1940s, but still rather patronizing, 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 an 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 (Duyvendak, 1999; Kennedy, 1995; Righart, 1995; Stuurman, 2001). Individuals had previously been expected to comply with the social order, but now society itself had to change to facilitate their optimal self-development and the ultimate fulfilment of democratic citizenship. After the people had been provided with basic civil rights, universal suffrage and material security, some mental health experts argued that now the time was ripe for taking the next step in this continuing process of citizen-emancipation: the satisfaction of spiritual needs in order to advance personal well-being for everybody (Van Beusekom-Fretz, 1973; Van den Bergh, Dekker and Sengers, 1970; Weijel, 1970). As psychiatrist J.A. Weijel explained in his 'psychosocial study' *De mensen hebben geen leven* (Life is Miserable), personal unhappiness should not be viewed as an individual fate, but as a social evil that could be remedied (Weijel, 1970).

Whereas the anti-psychiatric movement put institutional clinical psychiatry on the defensive, in the 1970s the psychosocial and especially psychotherapeutic services increased more than ever in size and prestige. This was facilitated by the entrenchment of mental health care in the Dutch welfare state: collective social security and health care funds guaranteed its broad accessibility (Bakker and Van der Velden, 2004: 65; NCGV, 1981: 21, 43–241; NFGV, 1965: 11, 159, 223–4; Oosterhuis, 2005; Schnabel, 1998). In the early 1980s, the various outpatient facilities merged into Regional Institutes for Ambulatory Mental Health Care, the Dutch version of community mental health centres, which dealt with a broad spectrum of psychosocial problems and psychiatric disorders. Embracing some of the basic tenets of the 1960s protest movement and anti-psychiatry, mental health workers – a growing number of them were trained in the behavioural sciences, sociology and social work – focused on the social causes of mental distress. Therapeutic treatment of individuals with the aim of adapting them to society became a subject of debate. It was thought that, instead, people needed to be liberated from the coercive 'social structures' which caused unsatisfactory lives or intolerable situations and restricted their spontaneous self-development (Van Beusekom-Fretz, 1973; Van den Bergh et al., 1970; Weijel, 1970; cf. Blok, 2004; Ingleby, 1998). Avoiding a patronizing stance at all costs, the professions involved were expected to encourage clients to become aware of their true needs and to 'grow' as a way to develop their authentic self and their assertiveness. Also, as some mental health workers emphasized, countering prejudice and advancing emancipation was part of the broader effort to improve the quality of social relations and 'democratize happiness' (Van Beusekom-Fretz, 1973; Van den Bergh et al., 1970). They became inspired advocates of personal liberation in the areas of religion, family, marriage, sexuality, birth-control and education, as well as the emancipation of women, young people, the lower classes and other disadvantaged groups such as homosexuals and ethnic minorities.

It was against this background that, in the late 1960s, psychiatrists called attention to the suffering of war victims and other traumatized individuals (Withuis, 2002: 34–5, 46–50). The public silence on the mental effects of World War II ended in 1966 when the psychiatrist E. de Windt claimed that Jewish survivors of concentration camps suffered severe mental distress because they had failed to come to terms with their war experiences. Three years later, in an article in the

authoritative *Nederlands Tijdschrift voor Geneeskunde* (Dutch Journal of Medicine), the physician E.H. Cohen introduced the concept of 'post-concentration camp syndrome' and suggested that it was linked to the repression of war experiences (Cohen, 1969). In newspaper articles he informed the public at large of these insights. Soon afterwards, the psychiatrist P.T. Hugenholtz argued in the *Maandblad voor de Geestelijke Volksgezondheid* that former members of the resistance movement also suffered from mental distress, which was insufficiently recognized in the allowance of war pensions (Hugenholtz, 1970).

In 1972 the Dutch government proposed the early release of three German war criminals, who were serving their life sentences in the prison at Breda. In response to the emotional reactions to and protests against this proposal, a poignant documentary on the psychotherapeutic treatment of war traumas by J. Bastiaans, Professor of Psychiatry in Leiden, was shown on Dutch television, followed by a discussion in which four psychiatrists participated. This broadcast, which for the first time gave viewers an opportunity to call a special phone number if they needed psychological assistance, offered an inside perspective on the mental suffering of war victims to a wide audience. Earlier, in a parliamentary hearing several psychiatrists had argued against granting the 'Breda Three' mercy. Although other mental health representatives favoured their release, it was postponed indefinitely in order to address the heated emotions triggered by the revived memory of World War II. In the public debate and the political decision process, psychiatric and psychological arguments not only sensitized politicians and the general public to the fate of war victims, but these arguments also began to carry more weight than legal ones. This forced proponents of a free pardon for the 'Breda Three' onto to the defensive (Piersma, 2005; Withuis, 2002: 44–5).

Psychiatrists argued that the mental well-being of war victims had been harmed not only by their experiences during the war itself, but also by the public silence and the lack of support for them in the first two decades after the war, which had forced many to repress their traumatic memories. Therefore, in their view, Dutch society and the government were both responsible for the individual suffering of those involved. It was the country's moral duty to ease their burden, not just through material support, but also by creating opportunities for the expression of their feelings and promoting public understanding of their mental complaints. The victims should not be left out in the cold a second time. Touching on current controversies about war – the younger generations accusing the majority of the older ones of having failed to prevent and resist Nazism as well as of having ignored the suffering of its victims – the psychiatric logic proved especially effective in the effort to get social acceptance for the rights of war victims, and later also for the rights of sufferers from other 'psychological traumas'. Feelings of guilt among the Dutch people about the fate of their Jewish compatriots also played a role here; the proportion of the Jewish population deported to extermination camps by the Nazis – 75 per cent – was larger in the Netherlands than in other countries in Western Europe. Furthermore, the psychiatric angle implied that political differences among the various war victims and former resistance members – for example the contrast between orthodox Calvinists and Communists – receded into the background. What they had in common, after all, was that all of them were victims and had sustained mental injury (De Haan, 1997; Withuis, 2002: 57–61, 118–22; Withuis, 2005; cf. Piersma, 2005; Tonkens, 1999: 51).

As a result of the psychiatrists' concern for war traumas, politicians and the general public became aware of the mental suffering of war victims, which resulted in measures and services aimed at providing both material and psychological support (De Haan, 1997; Haans, 1983; Mooij, 2001; Withuis, 2001). The Sinai-clinic in Amersfoort, the only Jewish psychiatric hospital in Europe, treated many patients with war traumas. From 1973 victims also received specialist psychiatric treatment in Centrum '45 in Leiden. In the same year the Compensation War Victims 1940–1945 Act (Wet Uitkeringen Vervolgingsslachtoffers 1940–1945) came into effect, providing compensation to victims of persecution, notably Jewish people and residents of the former Dutch

East Indies. In 1979 the government set up the Information and Co-ordination Bureau for Services to War Victims (Stichting Informatie- en Coördinatieorgaan Dienstverlening Oorlogsgetroffenen) in order to enhance the expertise in the field of mental effects of war. From 1983, the Jewish facility for ambulatory mental health care (Joodse Ambulante Geestelijke Gezondheidszorg) in Amsterdam also fulfilled a major function in the treatment of war traumas (Fuks-Mansfeld and Sunier, 1997: 136–7, 145–8; Meijering, 1978; Withuis, 2002: 42–57).

On the occasion of the opening of Centrum '45 in 1973, the *Maandblad geestelijke volksgezondheid* (Monthly Journal of Public Mental Health) published a special issue which was sent to all general practitioners and psychiatrists in the Netherlands (Vol. 28, Issue 6). In it psychiatrists discussed war trauma and (post-)concentration camp syndrome as phenomena that affected not just Jewish survivors and former members of the resistance, but also other groups such as prisoners of war, detainees in the former Dutch East Indies and those who went into hiding to prevent persecution. In the course of the 1970s and 1980s the concept of 'war victim' was increasingly extended, based on the post-traumatic stress disorder diagnosis. It might also apply to civilian victims; partners and children of war victims and of former members of the Dutch Nazi party; and the so-called 'liberation children', born to Dutch women and Allied soldiers. At first mainly psychiatrists represented victims, but from the 1970s those involved increasingly began to speak for themselves, while their views and feelings became more prominently visible in debates and in decisions on compensation regulations. The 1980s and 1990s saw the emergence of a widely branched network of self-help groups, associations and meetings for the various war victims, all searching for mutual support and recognition of their suffering.

Obviously, it was neither the first nor the last time that groups of victims and their spokespersons called attention to their mental suffering in order to get public opinion on their side and subsequently see their interests and rights protected. In the Netherlands during the 1970s and 1980s, anyone convincingly arguing the case of an individual or group who had suffered mentally because of specific social wrongs could generally count on public attention and help from the government (Withuis, 2002: 118; Zahn, 1989: 185, 220). The moral and emotional status associated with war traumas became clear from the turmoil that emerged when acquired rights were brought up for discussion. In 1985 the government set up a commission to create more order in the confusion of laws and regulations that had come into being in this field. Two psychiatrists investigated the correlation between war experiences and the later manifestation of traumas. Having concluded that this correlation was often doubtful, they proposed to change the conditions for compensation. While according to the existing rules compensation could only be refused if it could be demonstrated that the illness or handicap was unrelated to the war, those who applied now would have to prove that their complaints were actually caused by it. This proposal caused much worry among war victims and the former resistance movement and evoked fierce protests, including some from several prominent psychiatrists and the Dutch Association for Psychiatry. It turned out there was no social basis for a stricter compensation policy (Engelsman and De Jong, 1989; Werkgroep Oorlogswetten van de NVP, 1987: 656).

Concerning the strong influence of the psychological perspective in the debate on the war's effects, the Netherlands may well hold a special position internationally. It was no coincidence that in the 1960s and 1970s Dutch psychiatrists also played a crucial role in public debates about other sensitive issues. Not only did they put war traumas on the social agenda, but they also stood up for sexual reform, the self-determination of patients and a legalization of euthanasia, abortion, contraception, homosexuality and drugs (De Kort, 1995; Kennedy, 2002; Ketting, 1978: 82–3; Outshoorn, 1986: 123, 139, 179–80). In this way, they contributed to a new public morality and the implementation of quite liberal practices. In so doing they drew on the 1960s culture of liberation and democratization, and they also followed in the footsteps of the reform-minded psycho-hygienists from the

1950s. By raising issues that had earlier been largely ignored and silenced, they sought to break taboos and put an end to hypocrisy, thus paving the way for more openness, understanding, tolerance and liberation. They explained that to achieve all this, the following were required: a strong sense of social responsibility, a conscientious positioning, a sincere exchange of arguments and a willingness of people to listen to each other. As psychiatrist R.H. van den Hoofdakker wrote in his book on medical power and medical ethics: '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' (Van den Hoofdakker, 1971: 50). Rules and laws should not be rigidly applied, but discussed and sensibly interpreted. Stressing an issue's 'debatability' (*bespreekbaarheid*) – which in the Netherlands became a major norm that served as the basis for policies of controlled toleration (*gedogen*) – was essentially the opposite of being noncommittal or outright permissive (Kennedy, 2002; cf. Kennedy, 1995). What mattered was to counter the invisible abuse of specific liberties and to channel and control them carefully, in good faith and in open-minded deliberations with all parties. From a psychological and ethical perspective, this psycho-hygienic ideal of citizenship made great demands on people's competence. Only mature, self-reflective, socially involved citizens who empathized with others, who did not shy away from unpleasant truths, who regulated their emotions, and who were capable of making rational considerations, arrived – through negotiation and mutual understanding – at balanced decisions (Blok, 2004: 39, 47, 165, 204; De Rooy, 2001: 240; Hendin, 1996: 134, 136; Kennedy, 2002, 2005: 17; Van den Bergh et al., 1970: 15, 19, 22, 26; Vandermeersch, 1990: 63, 66; Zahn, 1989: 52).

It is remarkable that the public recognition of war traumas was realized at the same time and in the same context – the advancement of an inspired, emancipatory concept of democratic citizenship – as a public debate was initiated about euthanasia in terms of individual autonomy and self-determination. In contrast with other countries, Germany in particular, in this debate the memory of Nazi practices in the field of eugenics and their (mis)use of the term euthanasia hardly played a role. Although several physicians and psychiatrists may have believed in eugenics at a theoretical level, in the Netherlands eugenic measures were never practically implemented, let alone forced on people. Therefore, euthanasia was not implicated with the medical killings by the Nazis of psychiatric and mentally and physically handicapped patients. This might be part of the explanation why an open debate about euthanasia developed in the Netherlands in the 1970s and 1980s, resulting in a rather liberal legislation compared with other countries. Although there is a continuing public and political debate about the possible 'slippery slope' of the practice of euthanasia, in the Netherlands its ethical implications are not negatively associated with what the Nazis euphemistically labelled 'euthanasia'. Making it possible to debate sensitive issues such as war traumas and euthanasia was inextricably bound up with the belief in an open, egalitarian and fully democratized society.

Conclusion

The modernization of Dutch society, the experience of World War II, and the evolving views of democratic citizenship provided a socio-political context for the pursuit of mental health. In the late 1940s and 1950s there was a general trend to interpret the crimes of Nazism as products of a derailed and degenerate collective mind. This psychological explanation for totalitarianism and war, infused by cultural pessimism and moralizing, found much support among the intellectual elite and was articulated in particular by mental health experts. The conviction prevailed that the disrupting effects of the war were linked up with a moral crisis and a lack of a sense of community and responsibility. The victims' mental suffering was seen to be a secondary matter. A turning point can be identified in the mid-1950s, when the defensive response to socio-economic modernization and the emphasis on a rigid Christian and bourgeois moral order were exchanged for a much more

accommodating stance. In reflections on citizenship there was a shift from unconditional adaptation to the existing system of values and norms ('character') to individual self-development ('personality'). People's inner experience and motivation came to be centre-stage, and therapeutic treatment was definitively prioritized over external coercion. The psychological approach in mental health stressed the importance of mental well-being as well as (guided and, later, spontaneous) self-development. This created opportunities for the emancipation of neglected and hitherto nearly invisible groups, including war victims. The memory of the war, of the defenceless victims of the Nazi regime in particular, was strongly coloured by the 1960s and 1970s protest movement against all forms of authority. The widespread attention for the mental effects of the war that surfaced in the late 1960s after a period of 20 years of public silence should be seen against the backdrop of the combination of democratization and the emancipation of emotions. Talking, mutual understanding, expression of feelings, and exchange of empathy replaced the ethos of toughness and the do-not-complain morality of the 1940s and 1950s.

Note

1. The three main pillars, i.e. networks of organizations in the field of politics, economy, health, education, and culture, were those of orthodox Protestants, Catholics, and Social-Democrats. The liberal bourgeoisie, which had dominated society and politics until World War I, never organized itself in a pillar.

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