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Intergenerational Effects in Families of World War II Survivors from the Dutch East Indies

Aftermath of Another Dutch War

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INTRODUCTION

It is generally know that The Netherlands, along with many other European countries, was occupied by Nazi Germany during World War II. It is less known that many Dutch, civilians and military alike, also suffered as a consequence of the war in the Far East. For three centuries, The Netherlands dominated a beautiful and exotic archipelago, presently known as the Republic of Indonesia. In 1942, the Japanese occupied the Dutch East Indies and terrorized those of European descent until the end of the war. In the years following World War II, most war victims who had special ties with the Dutch moved to The Netherlands. However, upon arrival, little or no attention was paid to the survivors from this former Dutch colony. Approximately halfway into the 1980s, it became clear that some children of East Indian war victims displayed symptoms and problems similar to those of, for instance, children of Holocaust survivors.

In the 1970s, along with their American and Israeli colleagues, Dutch mental health professionals were among the first to publish on intergenerational traumatization. In those early days, studies were mainly focused on children of the few surviving Dutch Jews (de Graaf, 1975; Musaph, 1978). In The Netherlands, a distinction is made between various groups of children of World War II survivors. First of all, but by no means the most numerable, are the offspring of Jewish survivors of Nazi persecution. Second are children of participants of the resistance against the German oppressor (Op den Velde, Chapter 9, this volume). The third and most ignored group are children of so-called Dutch quislings (Lindt, Chapter 10, this volume). The last, but likely the most sizeable group, are the sons and daughters of survivors of World War II from the former Dutch Indies. Very little has been published on the latter.

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The effects of the occupation of the former Dutch Indies by the Japanese and the Indonesian War of Independence have only recently become open to public reflection and debate in The Netherlands. For more than four decades, the warfare in the former Dutch Indies seemed forgotten. This chapter will elaborate upon

1. The reasons for this forgetfulness within Dutch society. Society as a whole plays a significant role in the individual's mastery of traumatic experiences, particularly when the traumas are of man-made origin.
2. Mechanisms and expressions of intergenerational traumatization in children of survivors from the Dutch Indies, with an emphasis on projective identification.
3. Presentation and discussion of some brief vignettes and a case presentation to exemplify the concepts used to illuminate different expressions of intergenerational traumatization.
4. The results of studies on the second generation of survivors from the Dutch Indies.

The chapter begins, however, with a brief overview of relevant historical processes and events of this "other" Dutch war.

THE DUTCH INDIES DURING WORLD WAR II

The prosperity of the Dutch Republic in the seventeenth century, commonly called its Golden Age, was to an important extent obtained from the trade with the islands that are now known as Indonesia. The small seafaring nation benefited from the rich variety of exotic spices, which yielded high profits in the West. Soon this trade developed into straightforward colonization by the Dutch. Over the centuries, large agricultural estates and trade centers developed and generated considerable revenue and status not only for the Netherlands but also for the individuals that ruled them on site. The bulk of the hard work required for the returns was provided by the indigenous population. The upper class consisted of the Dutch rulers and their families. In reality, of course, the social structure developed into a much more complex system. The native population of the Dutch Indies was culturally and ethnically highly diverse, with its own standards for prerogatives. Furthermore, ever since the first European sailors had set foot ashore, children were born that showed conclusive signs of mixed origin. Once the Dutch began to settle, their numbers increased. In particular, families that had lived in the Dutch Indies for several generations were often partly of inland blood. As a rule, however, ethnic descent and wealth determined ones authority and status: the whiter and richer, the better.

Late in December 1941, some 3 weeks after the attack on Pearl Harbor, the Japanese army invaded the Dutch Indies. Resistance from the military proved futile, and in March 1942, the Dutch Indian army surrendered. By then, the Indian islands were practically occupied. It was estimated that on the eve of the Japanese invasion nearly 250,000 Europeans lived in the Dutch Indies. Some 210,000 were of Dutch origin. Approximately 134,000 were Indo-European families that had lived in the Dutch Indies for several generations (Stevens, 1991). As part of the policy to free Eastern Asia from Western domination and influence, the Japanese isolated the European inhabitants and began to stir the resistance of the native population against the "white oppressors" by means of intensive, anti-imperialistic propaganda.

All Europeans and Indo-Europeans were forced to demonstrate openly their subservience to the Japanese. For instance, they had to bow deeply while passing by the Japanese. Brutal punishment would follow any sign of insolence or disobedience. Men were separated from their wives, mothers, and children, and young and old were forced to work under deplorable circumstances on the many projects the Japanese initiated. Probably due to the popular film

The Bridge over the River Kwai, the construction of the railroad through Burma and Siam is the most notorious. Exhaustion, famine, and infectious diseases in the work camps were life threatening. Some 41,000 Dutch men, military and civilian alike, were imprisoned in work camps. Nearly one-fourth did not survive the war.

Women and children, too, were confined, first in restricted urban areas and later, when the interned population grew more and more dense, also in specially built camps. By the end of the war, there was a large number of concentration camps scattered throughout the Indian islands. Approximately 100,000 Dutch women and children were interned in civilian camps. Some 16,000–18,000 American men, women, and children were also trapped in Japanese internment camps in the Pacific war theater (Potts, 1994). Although conditions varied among camps, by and large the situation and regime worsened over time. Famine was one of the greatest predicaments, but also the numerous, lengthy, sometimes unscheduled roll calls caused immense suffering. The internees had to wait for hours, heads up, shoulders straight, unprotected from the burning sun. Most camps were overpopulated, and deportations from one camp to another occurred frequently. The hygienic circumstances in the concentration camps were abominable and, when combined with famine and exhaustion, were a short cut to death.

Life in the camps was hard for other reasons as well: Families had been torn apart. The uncertainty of the whereabouts and fate of loved ones was agonizing. Children, however, usually stayed with their mothers. For most children and women, the Japanese guards were the only men they were to see for years. The relation with fathers, sons, and husbands could only survive in often idealized fantasies. Fervent competition between groups of prisoners was frequent, although bravery and altruistic behavior also evolved. Education of children was strictly forbidden and had to be organized by the women in secrecy. Each individual was repeatedly confronted with severe illness and death. Medical care in the camps was primitive. Depending on the policy of each particular camp, boys at the age of 10, 11 or 12, far too young to be separated from their mothers and siblings, were sent to prison camps for men, where the conditions were even worse.

Contrary to the Nazi concentration camps in Europe, the Japanese internment camps were not designed to annihilate the captives. Their main purposes were the isolation, exploitation, and humiliation of Europeans: Western influence in Eastern Asia had to be eliminated and replaced by Japanese hegemony. The mortality rate in Japanese civilian concentration camps was 12.8%, contagious infectious diseases and starvation being the main causes of death. In the European concentration camps, close to 70% did not survive the war (Van Waterford, 1994). Not all the Dutch were interned in the Japanese concentration camps. Analogous to the Nazis' Nuremberg Law, the number of Indian grandparents determined to some extent whether one became interned. Those who had enough Indian grandparents escaped internment. Again, the color of the skin proved crucial for one's position. The situation outside the camps was rather different but by no means less complicated. The anti-Western propaganda of the Japanese in the Dutch Indies proved successful. Some of the Indonesians turned fiercely against those who were related to the former Dutch rulers. Therefore, the Indo-Europeans had to fear not only the Japanese but also the adherents of Indonesian independence. Many of those who were not in the camps were forced to live in strict isolation or hiding and feared for their lives. Food in the internment camps was, however limited, at least provided regularly by the Japanese. The Indo-Europeans outside the camps had to obtain their own food by trading whatever they possessed. During their daily ventures for nourishment, they had to be extremely careful, since trading with the inlanders was strictly forbidden. Their situation during World War II could best be characterized as completely outlawed. Furthermore, with regard to their identity, they had to perform a complicated psychological twist: Having always been proud of the status derived from their relation with the Dutch, they now had to deny any such association.

Apart from the Soviet army in 1945, there is only indirect evidence of sexual torture in Europe during World War II. There are only a few testimonies of women who were forced into prostitution or fell victim to sexual torment in German concentration camps (Krystal, 1968, see also Brownmiller, 1975). It is unlikely that the incidence of sexual assaults in Nazi Germany and concentration camps will ever be known. However, there is ample evidence of sexual exploitation by the Japanese during World War II. So-called "comfort women" were forced to satisfy the sexual urges of Japanese soldiers on a large and well-organized scale, an average of 1 woman to 50 soldiers. These women were not "volunteering" Japanese prostitutes, but were young women from occupied territories, abducted in raids especially designed for this purpose (Hicks, 1995). Some years ago, a now middle-aged Dutch woman publicly told of having been sexually abused by the Japanese in the former Dutch Indies. A few more Dutch women have recently dared to tell of their distressing sexual harassment by the Japanese. However, in the former Dutch Indies, the victims were more often East Asian than European women and girls, and there is no indication that a high proportion of European women became sex slaves of the Japanese army. The Japanese, apparently, did not prefer blondes.

The surrender of the Japanese in August 1945, however, did not bring and end to the misery of the survivors in the Dutch Indies. Instead of being able to return to their homes and families and resume their previous occupations and positions, they were confronted with a serious threat from the Indonesian nationalists. World War II marked the finale of centuries of imperialism. Strong movements for national independence had evolved and reached a climax at precisely the time the oppressing nations were preoccupied with conflicts among themselves and with the recovery from World War II. The English soon lost most of their empire and ceased to "rule the waves." France, Germany, and Belgium gradually lost control over their African colonies. In the Dutch Indies, a war of independence immediately broke out after the proclamation of the Republic of Indonesia, only 2 days after the capitulation of Japan. In a way, this was more painful for the Dutch survivors than the oppression by the Japanese, for many had survived, hoping to restore their "normal" prewar lives. Instead of the usual compliance of the inlanders, they met overt animosity. Many survivors experienced this as yet another injury to their pride: Humiliation was their turn again. Many had to remain in, or return to, the internment camps, only this time, paradoxically, to be defended by the Japanese against the aggression of the Indonesians.

In order to preserve the Indies, the Dutch government immediately sent the military overseas to fight the Indonesian revolt. So soon after the liberation from Nazi Germany, many Dutch people feared that the economy could not recover without the revenues derived from their former colony. Without the necessary economic growth, many feared social disintegration as a consequence of a communist revolution. Until the end of 1949, several military efforts to preserve Dutch rule were undertaken. However, they failed, and Indonesian independence was firmly established. From the beginning, all critical voices concerning the goal of the military actions in Indonesia, and atrocities committed by the Dutch military, were stifled. Only recently has the policy of the Dutch in Indonesia been somewhat open for public debate. Simultaneously, a growing awareness developed that many Dutch civilians and military suffered the sequelae of this distant war.

MIGRATION TO THE NETHERLANDS

Shortly after World War II, the majority of Dutch survivors from the Indies, who still had ties with The Netherlands, returned. Later, many Indo-Europeans also moved to the small country, which most of them knew only from stories. For them, leaving the Indies was mainly

motivated by Indonesian violence. Over the years, some 300,000 men, women, and children, migrated to The Netherlands (Van der Velde, Eland, & Kleber, 1994). The loss of their homeland and the necessity of adapting to a new country, however, caused severe strain. Migration, in general, is known to be a significant stressor (Grinberg & Grinberg, 1989). Indeed, for the survivors from the Dutch Indies, there were three distinctive stages that were potentially traumatizing.

- World War II, including the eventual internment in Japanese camps.
- The war for Indonesian independence.
- The return or migration to The Netherlands.

At some point after the war, families were reunited. Surviving husbands and wives, sons, and daughters needed to reestablish their bonds, which was particularly difficult after having been separated for so long. Like many trauma survivors, they often scarcely spoke about their predicaments during the war. Of course, not all spouses, parents, and children were able to bridge the gaps easily. Especially younger children hardly remembered or even knew their fathers. The atrocities each individual had survived had changed many beyond recognition, and fantasies concerning each other, cherished throughout the war, often proved false. The initial estrangement between family members sometimes persisted.

The migration to The Netherlands presented additional challenges to their ability to adapt to new circumstances. As it is in psychic trauma, loss is crucial in migration too, especially when the migration is coerced by adverse circumstances. Also, the contrast between the small, Northern European country and the exotic islands in the Pacific was enormous. The climate, colors, language, smells, even daily life itself, could not have been more dissimilar, and many survivors yearned for their lost homeland. Furthermore, many men had to accept jobs that were far below their former occupations in both wages and status. Women had to get used to keeping house themselves, or adapt to living with relatives or in lodgings during the first years after their migration. There was yet an additional problem for the Indo-European migrants. Their fine features and dark complexions revealed their (partially) foreign descent. Children especially, but also adults, sometimes faced discrimination by the Dutch. Most survivors did not articulate their difficulties or openly mourn their losses, but concentrated as much as they could on the present and future.

There were also external reasons to remain silent over the decades following their traumatic experiences. What made migration particularly difficult was the Dutch indifference to their situation. The survivors were given some material support. Not unlike the reactions to Jewish survivors, almost no one was interested in what they had gone through in a war that was fought and suffered so far away. Underlying this indifference was a new but strong ambivalence on the part of the Dutch population about the military involvement in the young Indonesian Republic, particularly intensified by harsh criticism from the United Nations. Not many Dutch were prepared to question the policy and warfare against the Indonesians. This reciprocal silence reduced the survivors' opportunities for recovery from their traumatic experiences.

Social and political circumstances can also partly explain why various groups of World War II survivors and their offspring were mainly studied separately. In order to get society in general, and politicians in particular to address individual and collective needs of war victims, the barriers of silence needed to be removed. Thus, the various Dutch indemnification laws for war victims were passed only at those points in time when society as a whole was willing to face the historic events that shaped the life of each particular group of war victims. The first compensation law for veterans of the Dutch resistance was passed in 1947; the second, for survivors of persecution, was passed in 1973. During its first decade, this law was mainly used

on behalf of Jewish survivors. Lately, the majority of applicants are survivors from the Dutch Indies. Children of Dutch quislings had to wait until 1994 for some governmental financial support. Indeed, it took a social movement to interest not only policy makers, but also most mental health professionals (Herman, 1992). This may also explain the tendency of some clinicians, themselves often belonging to the particular victim group, to generalize clinical findings to the victim population, thereby exaggerating the incidence of severe pathology, and, as a result, neglecting evidence of resilience and health in trauma survivors and their children.

FAMILIES OF SURVIVORS FROM THE DUTCH INDIES

There are no grounds to assume that the majority of Dutch Indian war survivors developed serious and lasting complaints. However, it is clinically well established that unresolved posttraumatic conflicts may interfere with parental functioning. Over the years, it has become apparent that some children of Indian war survivors developed symptoms and complaints similar to those of children of Holocaust survivors. Problems related to affect regulation, diffuse ego boundaries, extreme loyalty and overattachment to the parents, self-deprecation, repetition, compulsion, guilt feelings, acting-out behavior, and depression, for example, have been reported by various clinicians (Dorelijers & Donovan, 1990; Filet, 1987). In themselves, such phenomena are by no means typical of offspring of trauma survivors. They often can be observed in any group of patients in Western society. What makes the problems and symptoms of children of World War II survivors distinctive is not so much the group of diagnostic characteristics but the underlying pathogenesis. Family dynamics, in combination with personal susceptibility, appear to be crucial to the process of intergenerational traumatization.

A conspiracy of silence is generally understood to be at the core of the dynamics that may lead to more or less serious symptomatology in the second generation. Silence about the parents' experiences was often motivated by a sincere wish to spare the children such devastating knowledge. But, at the same time, it served to protect the parents themselves from confronting their memories and helped to stifle their emotions. However, the conspiracy of silence is truly mutual, as all parties involved are well aware of the themes that are governed by silence and share in the efforts to maintain their suppression. As mentioned earlier, the conspiracy of silence was not limited to the families. Repression was encouraged by the society, and silent adjustment was, therefore, typical of the postwar adaptation of Indian war victims in The Netherlands. One general survival strategy was the avoidance of any display of conspicuous behavior. War experiences, or problems related to their immigration, were hardly ever mentioned. Children soon learned to share in this conspiracy. Even in families where parents did speak about the war, children refrained from asking particular details. As a consequence, children tended to fantasize, not always consciously, about their parents' experiences. Furthermore, the secrecy of one's deepest thoughts, images, and emotions sometimes transcended the realm of traumatic war experiences to cover other aspects of the personality as well. Emotions such as pain, loneliness, anger, and fear became associated with a sense of imminent danger. Loyalty toward parents often hindered children from rebelling against this restriction on their vitality and needs. Overadaptation to "normality," which is generally regarded as characteristic of families of survivors of the Dutch Indies, could lead to a pathogenic breach of inner world and outer reality.

> Donna was referred to a psychotherapist at the age of 38. She appeared to suffer from dysthymia and had trouble falling asleep. Her mother, who had survived Japanese internment camps, had previously been married. Her infant son had not survived the war. After returning to The Netherlands, she divorced her first husband and, some years later, married Donna's father. Her mother always claimed that it was not a marriage of love but of reason: He was a good and quiet man who took

good care of her and Donna. She neither spoke about the war nor about Donna's deceased half-brother. She was very depressed and isolated. The essence of her identity was of being a powerless victim in an evil world. As an only child, Donna never managed to separate from her symbiotic relationship with her mother. Her father was emotionally unavailable to her. Donna recalls suffering from nightmares and panic attacks from a very young age, and frequently fantasizing about the cruelties she imagined her mother to have gone through. In treatment, she was not only secretive about these fantasies but also about the life she led as a fairly gifted and mature woman. Secrecy had become second nature to her, while splitting enabled her to escape partially from her mother's symbiotic demands.

The interference of unmetabolized traumata or posttraumatic changes of the personality of the parent(s) with the development of their children is very complex and unique in each case. However, typical patterns of divergent family dynamics have been described by Danieli (1981). Although she referred to families of Jewish Holocaust survivors, many of the (ideal–typical) characteristics she described can be recognized in families of other groups of war victims. Overvaluation and overprotection on the one hand, and neglect or overt aggression toward children on the other, are parental inadequacies that may well harm the child's development. Sometimes parents envy their children's "unburdened" youth. Jealousy of parents toward a child may manifest itself in a restrictive and humiliating control over his or her life, while at the same time demanding unconditional loyalty and love.

During the war, Peter was incarcerated by the Japanese and worked on the Burma railroad. After the war, he repeatedly claimed to be totally unaffected by it. On the contrary, it had taught him how to survive. He was always strong and healthy, and would never give in to any emotion. Once, upon breaking his leg, he could hardly be persuaded to go to a hospital. But because his professional career was not what he had expected, he became a very embittered man. He saw it as his responsibility to teach his two children the lessons that he found so valuable in Burma: They should never complain; they should never be ill; they should never be demanding or wish for anything; they had better not be heard or seen too often. Shortly after his fiftieth birthday, he broke down.

His youngest child, a daughter, sought psychotherapy not long before her expected graduation from the university. She was unable to concentrate on her studies, and she suffered from anxiety attacks. She progressively isolated herself. Only after several sessions was she willing to discuss her father's lessons and the little she knew about his war experiences. She was unable to feel any resentment toward him, and she refused to criticize the regime that dominated her childhood. She did not complete her education. Her older brother also failed to pass his final exams. The children's breakdown during late adolescence was perhaps due to their effort at bringing to the surface some of the never-articulated pain of their father. They may also have been afraid that their own potential educational achievements would confront their father with his own unsuccessful career. Their failure proved their loyalty.

THEORIES ON THE TRANSMISSION OF TRAUMA TO SUCCEEDING GENERATIONS

Various psychological schools have contributed significantly to our understanding of intergenerational transmission of trauma. Indeed, most of the earlier studies on the second generation were reported by psychoanalysts. *Drive theory,* for instance, helped us understand how the traumatized parents' confrontation with the wide range of emotions in a young dependent child can reactivate the struggle between conflicting affects and self-images. Combined with the suppression of affects, regression is crucial to surviving life-threatening persecution. However, once the threat is over, and such survival strategies and defenses have outlived their usefulness, they may nevertheless persist. The normal developmental stage related to preoccupation of

children with food, excrement, birth, death, and omnipotent monsters confronts the parent(s) with traumatic images out of their past and makes it hard for them to respond in a comforting, understanding, and playful manner. The result may well be a subsequent lack of basic trust and feelings of shame, guilt and anger in the children.

Many clinicians recognized that fantasies concerning the parents' past experiences play an important role in the symptom formation of second-generation patients. These fantasies are not only determined by the parents' actual communication, but also by the particular developmental stage of the child (Bergman & Jucovy, 1982; Grubrich-Simitis, 1979; Kestenberg, 1972). The relationship between parental trauma and the nature of sexual(ized) problems and conflicts in World War II survivors' offspring has been a mostly neglected theme in the literature. The children's sexuality could be expected to be affected, especially when the parent has been sexually molested during the war. The sexual violence and abuse of victims themselves has been commonly neglected as well.

Psychoanalytic *object relation theory,* especially Mahler's work on the separation–individuation process in children (Mahler, 1975), also amplified the understanding of family dynamics underlying pathology in the second generation. The special meaning of having children for survivors of massive traumatization could lead to excessive overprotection and symbiotic demands, or to rage and powerlessness, thereby burdening the separation and individuation of their children. The quest of the individual to maintain continuity of relationships with the self and others in the presence of contradictory pleasurable and distressing, loving and hateful feelings, is central in object relations theory. This theory's concept of *projective identification* proved fruitful in deepening the insight into the transmission of parental trauma and the pathogeneses in the second generation. Unbearably conflicting and, therefore, split off parts of the parents' posttraumatic imagery can induce behaviors or feelings in their children. These could be the acting out of parental conflicts, or the projection onto the child of feelings of shame, despair, rage, or worthlessness. Some children became tormented by aggressive fantasies, mostly, but not always, emotionally associated with hurting the parents like the oppressor did. Others engaged in unacceptable aggressive and even delinquent behavior.

Feelings of shame, despair, rage, or worthlessness can be split off and subsequently projected onto the child. For example, the parent can induce the feeling in the child that his or her anger is evil, sometimes even by verbally comparing the child with the Japanese oppressor. The child is at risk of internalizing this image of badness, and the interaction between the parent and the child can become a repetition of an aggressor–victim dyad from the traumatic past, that first became an intrapsychic conflict, and subsequently, through projective identification, sought outlet in object relations. The concept of projective identification may also clarify phenomena such as anniversary reactions, observed in some children of survivors when a child becomes hard to handle, ill, or even psychotic at precisely the same developmental stage in which the parent was traumatized.

Yet another significant issue emanating from the latter is the so-called core identity as (potential) victim or aggressor. Thus, the ambiguity between good and bad self-representations is mainly an intrapsychic force; it may also bear on external relations. Gratification may be found in the acting out of a victim role, thereby evading confrontation with inner conflicts and avoiding self-responsibility. Moreover, a supreme victim identity compensates for the narcissistic blow of originating from a group of victims but may just as well derive from jealousy of the "special" victim parent(s). However, such a pseudoidentity, gratifying as it may be, places the individual outside the community until this conflict is faced and resolved (Aarts & De Graaf, 1990).

Jonathan, a 20-year-old man, was referred to a psychiatrist in a state of manic excitement and displaying ideas of grandiosity. In the first session, although denying the need for professional care,

he shared that he was very afraid of his father, who, according to him, was aggressive. The following sessions were with Jonathan and his father.

Previously a conscientious and timid student, at age 15, Jonathan had suddenly begun to cause serious problems at school. He disturbed his classes and refused to do his homework. He claimed to be a genius, capable of effortless and complete comprehension. After he was dismissed by one school, his father sent him to another. His misconduct, however, persisted. Jonathan's parents responded with utter helplessness. His father explained in one session that he gave in to Jonathan's demands for money because he might otherwise steal it, which, eventually, he did.

Both Jonathan's parents had been interned in Japanese concentration camps as young children. At the age of 5, Jonathan's father, here named Paul, was caught stealing some sugar cane by a female inmate of the camp. The woman severely battered and nearly suffocated Paul by forcing a wooden stick into his throat. He remembers his mother watching the scene from nearby without trying to interfere.

After the Japanese capitulation, Paul's father, whom he could hardly remember, joined the family but was soon recruited by the Dutch army to fight the Indonesian independence movement. The family emigrated to The Netherlands when Paul was 15 years old. Paul's father, like many migrants from the Dutch Indies, had to accept a job much below his former standards. Feeling humiliated, he loudly and frequently complained about his fate. For reasons Paul never quite understood, his father also felt disappointed with, and betrayed by, the Dutch military command. He left the care of Paul and his siblings entirely to his wife, completely yielding to her wishes. He showed no recognition of Paul's achievements at school. Instead, he sometimes seemed jealous of Paul's progress at school.

As a husband and father himself, Paul has always done his best to hide his feelings from both his wife and Jonathan, for fear of burdening them with his problems, as his own father did to him. However, unlike his own father, Paul was strongly involved with Jonathan's education. He could neither eat nor sleep when Jonathan had to take a test at school. Although Paul clearly overvalued Jonathan, he could not help feeling that his son took advantage of his dedication and made a fool out of him.

In therapy, quite unexpectedly, Jonathan's condition improved impressively. The advancement was apparently caused by Paul's sudden and furious reaction to his son's grandiloquence. His outburst happened upon coming home from therapy, finding the living room a complete mess, and feeling an overwhelming resentment for having to see a psychiatrist for his son's benefit, while Jonathan continued his misconduct with utter indifference to his parents' worries and sacrifices. For the first time, thereafter, Jonathan showed some understanding for his father's concerns.

A careful scrutiny of the psychodynamics and particular symptom formation of offspring of World War II survivors from the former Dutch Indies and their antipodes of the European war theater do not reveal that mechanisms of intergenerational traumatization are unique to any group of offspring of World War II survivors. Some features that can be directly understood from the unique historical and geographic circumstances are nevertheless typical for the progeny of survivors of the war in the Far East. Just like the Jewish second generation, they, somehow, need to come to terms with their particular sociocultural identity, their historical inheritance, and their relation toward the Dutch.

STUDIES ON CHILDREN OF WORLD WAR II SURVIVORS IN THE DUTCH EAST INDIES

As stated earlier, only very little has been published specifically on the offspring of survivors from the Dutch East Indies. Dorelijers and Donovan (1990) reported that their search of international databases yielded only one publication concerning Dutch Indian camp survivors. They concluded that "these individuals and their families are clearly the forgotten souls of the

1940's" (p. 435). Furthermore, the few existing reports are all clinical and, as such, reflect a selected fraction of the population only. In most cases, the war in the former Dutch Indies was part of the clinicians' own family history. Two recent Dutch studies, however, are worth mentioning. The first is a small study based on semistructured interviews with experienced clinicians concerning problems and treatment of children of Dutch Indian survivors (Aarts, 1994). The second is an extensive, controlled, empirical study involving the same group (Van der Velden *et al.,* 1994). The latter was initiated and financed by the Dutch Ministry of Welfare, Health, and Culture, and focused specifically on the prevalence and nature of problems in a representative sample of Indian survivors' offspring born after 1945.

In the first study, Aarts (1994) interviewed 6 psychotherapists concerning their experiences with children of survivors from the Dutch Indies. They were selected from a list of expert psychotherapists, compiled by the Dutch National Institute for Victims of War (ICODO). Although their actual work experience with children of survivors from the Dutch Indies proved highly variable (ranging from 1 to nearly 50 patients), all 6 had considerable expertise with second-generation patients in particular, and with treating average Dutch patients in general. The interviews, therefore, included questions concerning possible differences between the second-generation and non-war-affected Dutch patients.

There was a consensus among all 6 therapists that children of parents who were not able to master their (war-related) traumas run a higher risk of developing complaints and pathology. To the interviewed clinicians, it was obvious that themes that are bound to become pivotal in each child's development, such as aggression, shame, guilt, attachment, and loss, intensify the parents' posttraumatic struggles. As a response, according to the therapists, the parents were often either too permissive or too strict, or even sadistic with their child. Parents sought to avoid confronting these complex emotions or actively engaging in them. In various, subtle ways, the parent also may have lured the child into acting out ambivalent behavior or emotions in an effort to externalize their own inner conflicts. It was, in fact, "the return of the repressed" within the family, whose impact depended on the severity of the parents conflicts and the individual susceptibility of the child.

The interviewed therapists described the underlying family dynamics of their second-generation patients as shrouded in a potentially pathogenetic "conspiracy of silence," which, in turn, caused disregulation of strong affects such as aggression and attachment. Most second-generation patients entered treatment with unspecific complaints such as dysthymia and a low self-esteem, which was often manifested in self-destructive behavior. Many expressed problems concerning separation, individuation, and autonomy. Loyalty conflicts, insufficient basic trust, identity diffusion, and difficulties in expressing and/or regulating strong emotions were mentioned as the core complaints of second-generation patients. Interestingly, one therapist mentioned a marked discrepancy between these complaints on the one hand, and the high level of occupational functioning on the other.

Most of the therapists' conclusions and opinions in the study were in concert with the ones cited in the mainstream literature on the second generation. Moreover, all 6 therapists stated that, in general, their second-generation patients were more difficult to treat than their average patients. This relative difficulty concerned both the intensity and duration of the therapy. In their view, this was not so much caused by the severity of pathology as by the rigidity of defense mechanisms and intense loyalty toward the traumatized parent(s). It is important to note that the opinions of these expert psychotherapists do not principally contradict the results of the empirical study reported below. The two analyses are based on populations that are not comparable. The results of neither study can be, or should be, generalized from one group to the other.

Comparing characteristics of children of survivors from the Dutch Indies with those of other second-generation groups, the clinicians mentioned shame and lack of assertiveness. Shame, especially in children of Indo-Europeans, may be related to the "typical" Asian shame-culture, whereas their subaggressive attitude or "inconspicuousness" can be viewed as a survival strategy during the war, and as a postwar adaptation. Transference was especially burdened. Time and again, the therapists felt subtly tested for their loyalty toward these patients. Sudden aggressive outbursts from these otherwise timid and compliant patients seemed typical. It was particularly difficult when sadomasochistic patterns were reenacted in transference, while aggression within the relationship with the parents was passionately denied. Some patients indirectly endeavored to humiliate the therapist, as they themselves had felt humiliated, while demanding unconditional loyalty at the same time. Therapists often had to struggle not to become overwhelmed by the complexity of such transference. Establishing a balance between the fear of pushing the patient away while interpreting his or her attitude, and of getting caught in a protective narcissistic collusion, proved crucial for the success of the therapy (see also Op den Velde, Koerselman, & Aarts, 1994).

The results of the controlled empirical study concerning the well-being and health of children of World War II survivors from the Dutch Indies were published in 1994. Both the randomly selected sample and the sociodemographically matched comparison group contained 266 respondents. The subjects of the target group were divided into two groups of approximately the same size. The first group included children whose ancestors had lived in the Dutch Indies for several generations, the Indo-Europeans. The second group encompassed the (white) offspring of parents who stayed there for a relatively short period and still felt strongly attached to The Netherlands. (In the Dutch Indies, the latter group were called *Totoks*).

Although the data collection and statistical analyses were comprehensive, hardly any significant or near-significant differences between the two target groups and the comparison group were found. The only differences were that the older children of Totoks, born between 1945 and 1955, had sought professional help for their problems in the past more frequently, while the older Indo-Europeans displayed more psychic complaints. Furthermore, children whose parents had been imprisoned in Japanese internment camps had more often consulted professional help in the past. But this fact had no bearing on their current well-being and health. Yet another, but not very surprising, difference was that the Indo-Europeans, in their tender years, had more often been confronted with discrimination by the Dutch. At present, they were also more involved with questions concerning their sociocultural identity. The former experiences with discrimination and present concentration with identity, however, were not related to their general health and well-being. In conclusion, there appeared to be no differences in the nature and number of complaints. Yet an alarmingly high proportion of 16% in both target and comparison groups gave evidence of serious health problems.

The negative results of this study are in accordance with the outcomes of many other empirical studies on the second generation (Felsen & Erlich, 1990; Last & Klein, 1984; Leon, Butcher, Kleinman, Goldberg & Almagor, 1981; Sigal & Weinfeld, 1989). The failure of most empirical studies to give proof of a high(er) incidence of problems or of distinctive pathology in children of trauma survivors was frequently attributed to the use of inadequate diagnostic measures, concepts, and/or research methods (Aarts, Eland, Kleber, & Weerts, 1991; Felsen & Erlich, 1990). Strikingly, the same arguments were used when affirmative results were presented (Harel, 1983; Solkoff, 1981).

The study under scrutiny, however, was of a sufficiently sophisticated design. It combined various relevant, standardized (diagnostic) instruments, with questionnaires particularly tailored

for the target group, and with semistructured additional clinical interviews with 57 out of a total of 532 respondents, who completed the data collection. Notwithstanding the extensiveness of the study, the results are not beyond debate. It is arguable that selection bias has played a role. The response rate in the target group was rather low (approximately 35%), with only a very limited analysis of the nonresponse. The sampling of the comparison group may also have been biased, since quite a number of the controls reported serious war experiences of their parents during World War II (Aarts, 1995).

SUMMARY

During World War II, a Dutch colony, presently known as Indonesia, was occupied by the Japanese. Most Dutch civilians suffered from persecution, and a large number were interned in concentration camps and work camps. In the first decade after the war, many Dutch victims migrated to The Netherlands. A general lack of interest regarding their ordeal in The Netherlands reinforced the tendency to repress and deny their traumatic experiences. A conspiracy of silence ruled society and the families raised by these survivors. Although pathology is not a necessary outcome of growing up with traumatized parents, some clinical reports on the offspring of survivors from the Dutch East Indies reveal mild to severe complaints, which are understood to be related to not having worked through traumatic experiences of the parent(s).

Studies reveal that problems of the second generation may not be found in special diagnostic classifications, but in the psychodynamics that led to each individual's problems. The parents' traumatic imagery can play a pivotal role in various patterns of family dynamics. Overprotection and overvaluation on the one hand, and jealousy and sadomasochism on the other, may dominate the relationship with the children. The traumatic experiences of the parents become the focus of the children's fantasies and grow attached to a variety of complaints and problems. The complaints and problems are not always severe and disabling. The palette on which pathology and health are the extremes appears to be richly shaded.

Neither clinical reports nor research results give evidence that problems of children of Dutch Indian survivors are different from those of offspring of other war victims. However, it is obvious that children who grow up with parents who suffered massive or prolonged traumatization as a consequence of violence and cruelty may be at risk. A maturing understanding of the vulnerability of parents and children might enable us to provide better support for trauma survivors.

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