



'Nothing New to Medical Science'

**The construction of war neurosis and the life
course outcomes of WW2 veterans**

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ABBREVIATIONS

AAMC	Australian Army Medical Corps
ADFA	Australian Defence Force Academy
AIF	Australian Imperial Force
AGH	Army General Hospital
ANZAC	Australian and New Zealand Army Corps
ARC	Australian Red Cross
AWM	Australian War Memorial
CCS	Central Clearing Station
CO	Commanding Officer
DAH	Disordered Action of the Heart
DVA	Department of Veterans' Affairs
DSM	Diagnostic and Statistical Manual
EEG	Electro-encephalograph
ECT	Electro-convulsive Therapy
GHQ	General Headquarters
ICT	Insulin Coma Therapy
LMO	Local Medical Officer
RAMC	Royal Army Medical Corps
RGH	Repatriation General Hospital
RMO	Regimental Medical Officer
RSA	Returned Services Association
RSL	Returned Services League (later Returned and Services League)
RSSAILA	Returned Soldiers, Sailors and Airmen Imperial League of Australia
SCI	Sub Coma Insulin

ABSTRACT

Australia became a nation in the twentieth century and part of the price was participating in two very costly and destructive wars. These wars gave rise to the application of psychiatric ideas for military purposes, in response to the 'epidemic' of psychiatric casualties in the British forces. Australia adopted the British ideas and practices, but responses to 'mental illness' among soldiers were always driven primarily by manpower concerns not humanitarian concern for individuals. Disorders of war were considered to be functional in origin, and neurosis was the dominant diagnosis. In both WW1 and WW2 the majority medical opinion was that there was nothing new in the neuroses of war, and after the rejection of shell-shock as a diagnostic category, no diagnosis with any semantic reference to war was adopted.

The thesis documents and evaluates the experience and life outcomes of a sample of WW2 veterans against the landscape of ideas about the neuroses of war. Thus the thesis is made up of two histories – the history of medical ideas about the psychological casualties of war and the history of lives of participants. Life histories revealed four distinct patterns of outcomes over time. The first was of those who exhibited no disturbance over time. A second included men who experienced disturbance that was not life disruptive, but were offered no encouragement to explore this experience. The other two patterns were of serious disturbance. The third was of men who were seriously disturbed but whose suffering was not acknowledged as being of traumatic origin. In the fourth, men were diagnosed and treated as psychiatric casualties, and were directly affected by ideas and practices on the neuroses of war.

The medical framework and social context that underpin the construction of war experience is critically examined in this thesis. One consequence of the medical individualising of dysfunctional soldiers is a restrictive view of the need for discursive resources. At a broader level, medicalising individual experience has seriously limited any examination of the nature of war as a threat to public health.

DECLARATION

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university, and to the best of my knowledge and belief, the thesis contains no material previously published or written by another person, except where due reference is made in the thesis.

I give consent to this thesis being made available for photocopying and loan if accepted for the award of the degree.

Gabriel John Raftery:

Date: 25/08/00

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I began this research over a decade ago so this thesis is only one outcome of a long association with a remarkable band of men and women: the veterans, their partners and families, who are the focus of the study. I have refused to call them subjects because they have names and lives and have had a great influence on me. They, rather than the academic community, have been the mainstay of my commitment to this work. I am deeply indebted to my participants who allowed me to enter their world in my fumbling attempts to understand their experience. My particular thanks go to Ray Baldwin, John Burns, Clive Edwards and Harry Katekar, veterans of the 2/27 Battalion. Many of my participants died during the course of this research and I acknowledge them below.

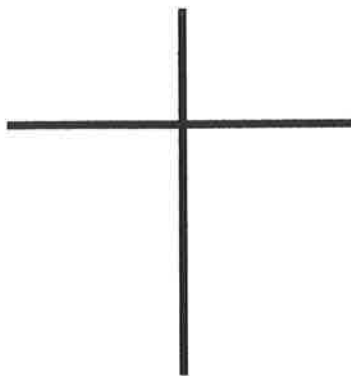
Apart from my informants, a number of people have supported me in what has been a long and sometimes tortuous pursuit. My brothers and sisters have wondered why I keep studying but have always encouraged me. My biggest regret is that I am unable to share my harvest of words with my father, Bill, whose story of WW1 was mostly lost, and my mother, Zita.

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LEST WE FORGET
Participants who died during
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John McKinna

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CHAPTER 1

INTRODUCTION: Australia, War and Traumatic Stress

On 2 September 1945, at 0940 hours, on board the *USS Missouri* in Tokyo Bay, General Sir Thomas Blamey co-signed the Instrument of Surrender, and accepted, on behalf of the Australian government, the surrender of the Japanese government. This marked the end of the 1 364 days, 5 hours and 14 minutes of the Second World War (WW2) in the Pacific.¹

On that day, Australian troops were deployed or imprisoned throughout the South West Pacific area, in places like Borneo, Papua, New Guinea, Bougainville, Solomon Islands and the various prison camps in South East Asia and Japan. Many troops had already been repatriated for various reasons: illness, wounds, mental breakdown or because they had completed five years of service. A few remained after the surrender in peacekeeping roles in occupied territories where Japanese troops were being repatriated. How did they settle into civilian life? Were these men to re-experience their war after discharge? How would they be treated if their war memories became too intrusive? These questions, which have received little attention in previous Australian research, are central to this thesis.

On 24 February 1944, a headline 'Is this Rehabilitation?' appeared in *Smith's Weekly*. It told a story of a young Queensland soldier who had joined the Australian Imperial Force (AIF) on 5 November 1941, and had served for 605 days, 445 of those in active service. In New Guinea he had injured his leg in an accident. After a period of hospitalisation he was sent to training camp where his leg again broke down, and he was sent back to hospital. The reporter said that while he was in hospital he 'went adrift, and as far as I have been able to ascertain from him, he had no idea where he went or what he did for the fourteen days'. The soldier returned of his own accord, but to the army authorities in Queensland. This was an act of desertion and he was arrested by the provosts and charged with things of which he had no recollection, and sent to jail. In prison he turned aggressive towards his mother and attempted suicide twice. Consequently he was declared insane, a prerequisite for confinement to a mental hospital, and sent to Goodna Mental Hospital for nine months. The strain of this was too much for his mother who died while he was there. The young man was

¹ *Instrument of Surrender*, The Awani Press, Fredericksburg, Texas, 1945.

eventually let out on parole and started work, but his military discharge form recorded his conviction, which ‘branded him as a criminal for the rest of his life’, and he was sacked.

The story highlights the core issue in this thesis – the medicalising of war-related dysfunction for military purposes. A central feature of this medicalising was the appropriation of personal narratives and symptoms to elicit a diagnosis for political and organisational purposes. Such appropriation of experience into a medical discourse is not new, as Hacking (1998) has shown in his detailed examination of the diagnosis of fugue states (*aliens voyageurs*) in the nineteenth century, a diagnosis that might have been appropriate for the young soldier. In the ecological niche (a term used by Hacking) of the latter part of the nineteenth century medical specialists constructed a diagnosis of ‘fugue’ to account for such wanderings. Thus wandering became acceptable and could be tolerated once it was construed as a mental disorder.

There was no such tolerance in the later ecological niche of World War One (WW1) where soldiers often left their post in a dazed and confused state (see Babington 1997). A British soldier who wandered could be accused of desertion, court martialled and sentenced to death. Cases are now being retrieved from British Army Archives, such as that of a 21 year old private who was executed after he went missing in 1915, even though he had claimed that he had lost his memory from nerves shattered in the battlefield, and had not been medically examined.² The only thing that might have saved him was a lesser ‘diagnosis’ of mental disorder, such as shell-shock or neurasthenia. The young Queensland soldier of WW2, who had just returned from the stressful jungles of New Guinea, displayed similar behaviour to nineteenth century ‘travellers’ and dazed WW1 soldiers, and was labelled insane. This label bore no relationship to what he had seen or done in New Guinea.

The history of how this medical labelling came about will be explored in detail in the ensuing chapters but I will briefly address some features here. The peculiar feature of the Australian military labels, inherited from the British Army, was the absence of any reference to war. The labels of war were the same as those assigned to the mentally disordered of peacetime – anxiety state, depression, hysteria, neurasthenia, traumatic

² Babington, A. (1997) *Shell-Shock: A History of the Changing Attitudes to War Neurosis*. London: Leo Cooper, p. 56.

neurosis and psychosis.³ This contrasts to some degree with American usage where terms such as combat neurosis and combat fatigue had been in use since WW1. These civil terms have deep social and cultural roots. The primary basis of classification was neurosis, which was an invention of the eighteenth century, made popular in the nineteenth century, to account for symptoms where there was no observable neuro-physiological lesion.

Another feature of the constructions of the mental disorders of war was the tension between psychological and neuro-physiological explanations of dysfunction. Did the traumatic experience actually cause a neurological lesion and produce a kind of psychic wound? This question highlights the tension between mechanistic and psychological interpretations in the construction of illness. Different generations have proposed answers to these questions and the two major wars of this century became testing grounds for these answers. During WW1 functional disorder and neurosis assumed dominance.⁴ The 'disorder' was construed to be fundamentally psychological in origin and this explanation continued to hold sway throughout WW2. Such a construction left open the possibility that the inadequate constitution of the soldier could account for any breakdowns.

This thesis situates veterans with significant combat exposure within the context of the history of ideas about mental health and war. The detailed account of the incorporation of civil labels into war usage will be set down in subsequent chapters. At this point it is important to note that any historical appraisal of psychiatry in war-time can only be understood against the background of broader historical developments in the framing of psychiatric disorder. To explore the construction of mental illness in war I chose the Second World War because it was an event that crossed the lives of a large segment of the Australian population, many of whom were still available as informants. Thus there are two interconnecting threads drawing this thesis together; the history of ideas about the construction of mental illness and war, and the life story narratives of WW2 veterans.

³ In his summary of WW1 pension disabilities, Butler, A. (1943) did use 'war neurosis' as a general category, but the actual diagnoses were neurosis, shell-shock, hysteria, neurasthenia, psychasthenia, psycho-neuroses and various neuroses (e.g. cardiac).

⁴ For an extended treatise of the nature of neurosis and traumatic neurosis see Fenichel, O. (1945) *The Psychoanalytic Theory of Neurosis*. New York: WW Norton & Co.

Well before the beginning of WW2, shell-shock and traumatic neurosis (neurosis attributed to trauma-induced neurobiological lesion) were no longer considered useful concepts to explain the psychological casualty, but this rejection opened up a much more complex philosophical and medical discourse. If the condition could no longer be attributed to a simple pathogen such as explosive shock, a coherent explanation had to be found in the way the individual responded to an event. This is why psychodynamic explanations had such appeal. These explanations, broadly grouped under the rubric of neuroses, eventually became acceptable to military authorities for a number of reasons, not the least of which was economic.

Shell-shock was the only term with a reference to war, but it was rejected during WW1 in favour of standard psychiatric labels of disease. The significance of this shift was two-fold. In the first place, it left the way open for dynamic explanation of how a psychic shock could produce disturbance. Secondly, the new labelling suggested that emotional and mental distress was not related to dreadful things soldiers may have seen, done or had done to them in conflict. This shifted attention not only away from the possibility of automatic compensation, but also deflected it from the destructiveness of war, as a source of ill health.

This thesis was partly prompted by the observation that there are significant gaps in the discourse on traumatic stress and war. This discourse, especially in Australia, has lacked a critique of the ideas informing its foundations. To lead into the description of the thesis I will briefly outline some of the features of recent studies in the field of trauma studies, which has now become known as traumatology.⁵ While debates have arisen about particular issues in etiology and treatment, few participants in the discourse have adopted a critical stance on the foundations of the dominant psycho-medical paradigm framing the understanding of human distress following trauma. Within this model trauma (derived from the Greek verb for breaking the skin) has been adopted as a type of psychic shock or wound, which causes the victim to lose equilibrium (see Wilson 1993, Garland 1999). Freud (1920) is understood to have also adopted the meaning of wounding the mind and proposed that healing was entirely an inner individual activity.

⁵ Traumatology is a relatively new term. Valent (1998) who defined it as 'the study of serious threats to survival and fulfilment of life' (p. ix), traces the first formal use of the term to Donovan (1991).

A small but significant emerging discourse does engage in a critique of a linear, medical model (e.g. Young 1995; Hacking 1995, 1998; Kleinman 1995), but these writers have remained on the margins of the central traumatic stress discourse. A further gap in the field is a lack of a public health perspective. With the exception of a few researchers such as Staube (1996), Summerfield (1997), and Bracken & Petty (1998), who engage in broader social analysis, the problem of the traumatised person has been largely construed as an issue of individual pathology. Summerfield is one of the few to propose an alternative framing of post-traumatic reactions. Summerfield (1997) has depicted the dominant model of medicalising trauma experience as one of 'an individual-centered event bound to soma or psyche [which] is in line with the tradition in this century in both Western biomedicine and Western psychoanalysis of regarding the single human being as the basic unit of study'.⁶ Erikson (1994) proposed that trauma should not be construed just as an individual experience which has a linear relationship with a single event, but as a consequence of a broader social condition.⁷

Another dimension of trauma literature is a focus on the long term effects of exposure. There has been, at least in the English speaking and European versions of this knowledge, an explosion of research and a resurgence of inquiry into the effects of traumatic experience in the last quarter of this century. This body of knowledge 'claims' received a significant boost from America's involvement in the Vietnam War, which provided another rich site of inquiry on traumatic experience. Even though there has been significant work on populations such as Holocaust survivors, survivors of significant WW2 battles, ex-prisoners of war, and civilian participants such as merchant seamen, Vietnam Veterans have attracted the most research attention, especially in the United States.

This US research has been mainly located within the US Department of Veterans Affairs National Center for PTSD, a national network of research and treatment facilities across the United States. The Center has played a significant role in the expansion of trauma research in the United States. Aimed initially at meeting the needs of Vietnam Veterans, this centre provided well funded opportunities for training and research, out of which emerged a pool

⁶ Summerfield, D. (1997) Addressing human response to war and atrocity: major challenges in research and practices and the limitations of western psychiatric models, p. 18. In Kleber, R. et al (eds) *Beyond Trauma*. New York: Plenum Press.

⁷ Erikson, K. (1994) *A New Species of Trouble*. New York: W. Norton.

of highly trained researchers and clinicians throughout the country. Personnel linked with the Center formed the nucleus of the International Society for Traumatic Stress Studies, which has now expanded outside of the United States, with affiliates in Europe and Australia. Annual meetings and world congresses every four years and many other smaller workshops and seminars provide venues for disseminating ideas and perpetuating the culture of the organisation.⁸

The dominant views in this new wave of development is conveyed primarily but not exclusively, through the quarterly *Journal of Traumatic Stress*, which is now in its tenth year of publication. It has provided a specialised forum for academic publications that were previously scattered throughout other psycho-medical journals. In the past decade there has been a significant increase in published monographs, such as Raphael and Wilson (1993), Peterson, Prout & Schwarz (1992), van der Kolk, McFarlane & Weisaeth (1996) and Yehuda & McFarlane (1999) and several series such as the Plenum Series on Stress and Coping.⁹ Since this review was undertaken, more edited books have appeared. Numerous trauma-focussed web sites have been established, such as the David Baldwin Trauma Pages and the PILOTS Database at the US National Center for PTSD. These sites provide opportunities for the neophytes and high priests to explore and perpetuate a particular culture in traumatology. In some cases former 'high priests' such as Janet (1859-1947), Freud (1856-1939), and Rivers (1864-1922) are being revived and reintroduced into the discourse, for example, van der Kolk (1989) on Janet and Young (1995) on Rivers.

Interest in the effects of traumatic experience over time did not just start with the inclusion of Post-traumatic Stress Disorder in the Third Edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM-III). Since WW2 there has been some degree of interest in long term effects. For example over 20 years after WW2, in the latter half of the 1960s, a series of workshops sponsored by the National Public Health Service and supported by the McGregor Health Foundation in Detroit, were held at Wayne State

⁸ There are a number of other organisations focussing on trauma; for example the Critical Incident Stress Foundation, which has an Australian equivalent, the Australasian Critical Incident Stress Association. Many other organisations have centred on specific conditions or treatments such as Eye Movement Desensitisation (EMDR) and Dissociation.

⁹ The edited books in particular actually recycle articles that appeared earlier in journal form, or the editions recycle authors. As an example, see Horowitz, M. (1999) *Essential Papers on*

University. Krystal (1968) published a summary of the significant papers and outcomes of these workshops. The workshops focussed on the psychological effects of 'massive psychic trauma' – Nazi persecution, concentration and extermination camps, and Hiroshima. These were the more spectacular events of the war and ones from which serious ongoing effects would be expected. Survivors exhibited anxiety, sleep disturbance, psychosomatic disease, memory and cognition disturbance, chronic depression and some serious psychotic breakdowns. The participants in the workshops relied on existing theoretical frameworks to make sense of these horrors. Explanations were dominated by psychoanalytic ideas – projection, death wishes, defence mechanisms, reaction formation, unconscious identification and so on. Krystal argued that the existing nosology could not adequately incorporate these survivor behaviours and experiences. Furthermore, 'Kraepelinian psychiatry has led to many erroneous notions and fallacious testimony in forensic psychiatry'. (p. 340)¹⁰

Krystal's critical review appears to be one of the first serious attempts to refine a comprehensive theory of post-traumatic symptomatology as well as provide a voice for a previously unacknowledged trauma population. It was also the beginning of the formulation of the concept of trans-generational traumatisation. The forum held at Wayne State University (Texas) focused on an aspect of mental health that has been lost in more recent forums – the implication of trauma for public health. Krystal hoped that the insights from the study of the effects of very serious violent acts would help in the understanding of the effects of civil events such as natural disasters and even the effects of incarceration and hospitalisation. His final thought was 'in the end we hope that the knowledge gathered will be useful in the treatment *and prevention* [emphasis added] of massive traumatisation'. (p. 348)

The recent historical interpretations of the development of traumatology place more emphasis on a nightclub fire after a football game than the Wayne State Deliberations. In the context of the examination of the effects of WW2 it is ironic that this fire occurred in 1942, the most dramatic year of the Pacific War. In some recent reviews this one incident is highlighted as a significant progenitor in conceptualisation of traumatic stress (cf. Peterson

Posttraumatic Stress Disorder. New York, New York University Press, where at least 12 authors were common with Wilson & Raphael (1993).

1992, Lifton 1993, Wilson & Raphael 1993, van der Kolk & McFarlane 1996). In August 1942, 168 revelling college football fans died in the Cocoanut (sic) Grove Nightclub Fire. The relatives of the victims of this fire became some of the subjects in a study undertaken by Lindemann (1944) on grief experience at Massachusetts General Hospital.¹¹ Some of the 101 psychiatric admissions were relatives of victims of the night club fire. Some patients had also lost relatives in WW2 but this aspect has not featured in references to the study. Some commentators (e.g. van der Kolk, Weisaeth & van der Hart 1996) draw a conceptual line between Lindemann and other significant contributors in the development of the intensive study of traumatic events, such as Horowitz (1978).¹²

In fact, Lindemann's primary focus was not so much on traumatic stress as the course of grief reactions after such events. His model has been cited as a significant authority in recent works on dealing with grief. (see Raphael 1985, and Wordon 1991) War death did not feature in the paper and reference to war veterans was a secondary aspect of his argument. Nevertheless, the work of Lindemann published in 1944, with all its limitations, is construed as a breakthrough in modern understanding of trauma reactions over time.

This example highlights the process of the theory development and illustrates the construction of psychiatric knowledge. In trauma theory, a relatively minor study of the effects of a tragic event in 1942 has been accorded much greater status in the construction of one version of knowledge in traumatic stress reactions, than the devastating war of 1942. The impact of imprisonment and maiming on millions of allied and enemy troops, and civilians in the South West Pacific and in Europe, has virtually been ignored in traumatology research.

¹⁰ Krystal, H. (1968) (ed.) *Massive Psychic Trauma*. New York: International Universities Press.

¹¹ The original article was Lindemann, H. (1944) Symptomatology and management of acute grief. *American Journal of Psychiatry*, 101; 141-148.

¹² Although the event has assumed significant historical status in traumatology, some confusion surrounds the actual event. The commonly cited 1944 paper does not state where the fire was but since Lindemann worked at Massachusetts General Hospital it is assumed to be Boston. Williams, in Wilson et al (1988), thought it was in New York, while van der Kolk, Weisaeth and van der Hart (1996) thought it was in Boston. McFarlane and van der Kolk cite Lindemann as a significant influence on Horowitz' comprehensive stress model, but in fact Horowitz (1986) only focussed on the grief aspect of Lindemann's study and was critical of the methodology. Gersons & Carlier (1992) thought that there were 500 casualties (p. 745). Whatever the facts about Lindemann, the discourse surrounding this event is an interesting example of the creation of received knowledge.

The study of the long-term effects of war in this thesis addresses some of these identified deficiencies. The most glaring is the lack of a careful reconstruction of the personal histories of those involved in war and an examination of the constructions of mental illness and their impact on individuals. This justifies to an examination of the concept of life course in the context of the history of ideas on mental health.

The recent traumatic stress research and literature have revived the debates of the latter part of the nineteenth century about the psychological consequences of a traumatic experience. Underlying any discussion on the effects of traumatic experience is the concept of toxic shock, or as a recent review stated, the problem of post-event distress (see Bowman 1997).¹³ The formulations, particularly since 1980, have endorsed a logic to explore the effects of events over time. This logic is that a person experiencing a highly stressful event will be prone to develop symptoms that can become a psychologically debilitating disorder.¹⁴ This type of event threatens not only physical well being, but the core of the inner psyche itself, and has reverberating effects over time (Wilson 1989, Horowitz 1986).¹⁵

War is the most damaging event of the century and thus has obvious potential for generating traumatic experience, as shown in studies of populations such as the victims of the Holocaust (Danielli 1988), and WW2 resistance workers (Op den Velde et al 1990). Although not nearly so extensive as the Vietnam literature, WW2 sparked a number of studies on the long term effects of war. Negative consequences of WW2 have been clearly established in a number of independent studies. An identifiable suite of English language studies has come to be accepted as a significant repository of the body of knowledge about long term effects. During and after WW2 a number of studies focused on the more

¹³ Bowman advances the argument that the effects of traumatic experience, particularly as it is formulated in the PTSD literature, has been under-examined. She argues that the shift in the PTSD diagnosis to focus on the traumatic event resulted in a distortion in thinking.. In effect she shifts the emphasis back to the contribution of the individual – ‘toxic life events have different power depending on the way in which they are construed’ (p. 144).

¹⁴ At this point I am only presenting the dominant paradigm. I am aware of the critique on at least two fronts. The first is the challenge to PTSD as a medical construction of experience. Bracken (1998), for example, challenges the western construction of PTSD as context bound. The other front is the assumed linear relationship between event and consequence as a form of dose-response modelling (see Bowman 1997).

¹⁵ Diagnostic criteria for Posttraumatic Stress Disorder in the American Psychiatric Society Diagnostic and Statistical Manual Version IV: 1994. The specific requirements to meet a diagnosis are listed in Appendix A.

immediate effects of combat experience such as Hastings Wright and Gluk (1943); Gillespie (1945); Kelley (1945); Grinker (1943); Grinker & Spiegel (1945); Muliner (1945); Swank & Marchant (1946); Appel (1946); Guttman (1946); Teicher (1946); Kardiner & Spiegel (1947). These early studies varied in quality, and consisted almost entirely of clinical observation and measurement of dysfunction. There were two notable exceptions. The first was a sociological study of the social adjustment of a small sample of Mid-West veterans (Eaton 1946), and a much larger study (Stouffer et al 1949 in the *Studies in Social Psychology in World War II* series), of the post-war adaptation of American soldiers.

Longer-term studies emerged two to three decades later, evaluating the longer term effects of exposure (e.g. Archibald & Tuddenham 1965; Nefzger 1970; Beebe 1975; Askevold 1976), and after 1980 (Zeiss & Dickman 1989; Speed et al 1989; Goldstein 1987; Wilson 1989; Miller et al 1989; Op den Velde et al 1990; Hovens, et al 1992, 1994 & 1993; and Crocq et al 1993). In these post-1980 studies, PTSD became the diagnostic focus, but in earlier studies there was no post-event terminology available in diagnostic categories. Recently, a number of British researchers and practitioners (Davies 1997; Hunt 1997; Orner et al 1997) also revisited the British WW2 population in smaller studies. These studies vary in quality and orientation, and are all one-off examinations of cohorts of veterans to determine their current level of morbidity and functioning.

Spiro, Schnurr & Aldwin (1994) found from a study of 1 210 WW2 veterans on the Normative Aging Study that there was a significant link between military service and psychological aging and that combat exposure was 'particularly toxic'.¹⁶ Scaturro & Hayman (1992) assessed how an aging veteran sample managed post-war life tasks using Haley's six stages of the life cycle as a framework. Although it was not a systematic study and is based on a review of literature (mostly of Vietnam veterans) and the researchers' own clinical experience, the use of life stages provides a useful framework.¹⁷ They claimed that the effects of combat trauma can be mitigated over time with appropriate interventions, but they do not cite adequate evidence of this in relation to WW2 veterans. They do make the

¹⁶ Spiro, A, Schnurr, P. & Aldwin, C. (1994) Combat-related post-traumatic stress disorder symptoms in older men. *Psychology and Aging*, 9,1; 17-26.

¹⁷ A. G. Butler (1940) *Official History of the Australian Army Medical Services*, p. 860. For the period 1916-18 on Western Front total killed or died of wounds and other causes was 46 166; wounded, sickness, shell-shock, gassed, etc 370 125. Listed as shell-shock – 1 624

point that to fully understand the effects of the exposure to trauma it needs to be placed within a broad social and historical context.¹⁸

A close examination of a sample of these studies reveals a consistency in findings. Archibald & Tuddenham's (1965) twenty year follow-up of over 100 WW2 American veterans, confirmed that veterans did continue to experience distress many years after discharge and that this could not be explained by the desire for compensation or the need to protect a pension. They concluded that a

clear cut picture emerged of the combat veteran's chronic stress syndrome, a severely disabling but non-schizophrenic condition involving startle reactions, sleep difficulties, dizziness, blackout, avoidance of activities similar to combat experience, and internalization of feelings. (p 476)

...[It is] clear that tension and anxiety reactions still characterize these combat patients two decades after the events that traumatized them. ...These particular veterans cannot blot out their painful memories. Indeed there is a distinct possibility that changes incident on their age are exacerbating their problems and reducing their power to cope with the stresses of civilian life.¹⁹

In their view this study confirmed the findings of a number of similar studies that there existed a specific post-stress syndrome and that this condition was 'highly persistent over long intervals and resistant to modification.

Zeiss & Dickman (1989) used a PTSD model in a study of 442 ex-POWs. After a gap of 40 years they found enduring symptoms of PTSD in 55 percent of their sample. They concluded that:

the findings ... suggest a complex interaction between the person and the situation producing and maintaining the symptoms of PTSD. Residual difficulties are likely as long as 40 years after the event.²⁰

Goldstein, et al (1987), observed similar outcomes in a study of survivors of the battles of Bataan and Corregidor and their subsequent experience of survivors. They highlighted the resilience of survivors despite the extreme hardship and trauma.²¹

¹⁸ Scaturo, D. & Hayman, P. (1992) The impact of combat trauma across the life cycle: clinical considerations. *Journal of Traumatic Stress Studies*, 5, 2: 273-288.

¹⁹ Archibald, H. C. & Tuddenham, R. D. (1965) Persistent stress reaction after combat. *Archives of General Psychiatry*, 12: 475-481.

²⁰ Ziess, R. A. & Dickman, H. R. (1989) PTSD forty years later: Incidence and person-situation correlates in former POWs. *Journal of Clinical Psychology*, 45, 1: 80-87.

²¹ Some of this information was gleaned from Andrew Miller, a survivor and a member of the Survivors of Bataan and Corregidor Association, in an interview in Albuquerque on 25 April 1996. Miller personally experienced the battles and was then imprisoned. As a prisoner he experienced

Harel, Kahana & Wilson (1993) began a systematic survey of 240 survivors of Pearl Harbor in 1986. Their 16 page Pearl Harbor Research Questionnaire obtained detailed information on recollections of the attack as well as comprehensive assessments of post-war effects. Their study confirmed the existence of enduring memories of the traumatic experience 'which become stored and embedded in one's memory and are likely to be recalled and/or will intrude periodically in very vivid imagery' (p. 273). The authors cautiously attribute pathological labels such as PTSD to the experiences reported by veterans, but acknowledge this attribution is not always appropriate.²²

Deahl (1995) concluded from a review of the impact of combat on participants in the major wars of this century, that it is surprising that not more service men and women have suffered long term psychological and psychiatric sequelae. He highlighted the fact that PTSD has become the primary framework for establishing these effects. Symptoms and behaviour that have been observed in the diagnosis of post-traumatic stress disorder continue to affect the individual and anyone who came into contact, such as families. Deahl raised an issue rarely considered in the trauma literature – the role of medical authorities. He maintains that the main thrust of the studies of combat stress in this field reinforces a view that the 'duty of psychiatrists as citizens [is to] to serve them [the victims], by promoting awareness, diagnosing and effectively treating this disorder'. In the received knowledge on traumatic stress there is rarely any questioning of the social and administrative practices or conditions surrounding the 'disorder'. In more recent studies (Kluznik, Speed & van Valkenburg 1986; Speed, Engdahl & Schwartz 1989; Beal 1995) claims have been made that PTSD has been a long-standing disorder in WW2 populations, up to fifty years after discharge. These studies confirm that specific populations have

severe deprivation, was in a ship that was torpedoed and sunk, starved, severely punished and was on burial detail for dead colleagues. Miller presents a face of resilience. He did not report any of the classic signs of ongoing disturbance – nightmares, anxiety, of flashbacks – and had achieved at a high level in civil life as an engineer. He identified his discharge as a time when he needed 'some kind of group therapy', but felt no need for help at the time of interview. Even though during war they were 'flirting with death every day', he would not like to go through it again, and 'wouldn't have missed it'.

²² Harel, Z., Kahana, B. & Wilson (1993) War and remembrance: The legacy of Pearl Harbor. In Wilson, J. P. & Raphael, B. (1993) (eds) *International Handbook of Traumatic Stress Syndromes*. New York: Plenum Press.

demonstrable and compensable psychological and physical disorders, which are independent of the particular diagnostic category employed.

Further light has been shed on the long-term effects of events by a series of studies that tapped into longitudinal studies that had been initiated well before WW2. This small but significant body of research, utilising existing rich longitudinal data sets, re-examined links between WW2 experience and life outcomes. These data sets, initiated in the 1920s and 1930s, all contained substantial psychological and social information on participants gathered at regular intervals. In the later data gathering, questions about war service were added.

The Grant Study of 269 Harvard undergraduates begun in 1938 is one such study. George Vaillant, one of the researchers in that study, wrote the most comprehensive original monograph on the study in 1976 and later returned to the sample in 1995 to examine the effects of war service. Of the original Grant cohort, nineteen died in WW2, and 152 served overseas. These men were studied 'intensively' and interviewed before and after WW2 and between the ages of 47 and 57. Interviews had contained information on war service. Surviving members of the cohort had been physically examined every five years and surveyed by mailed questionnaire every two years. Lee, Vaillant, Torrey & Elder (1995) examined this data. Within the acknowledged limitations, for example that Harvard graduates excluded men of lower socioeconomic status, the authors claim the data confirms that traumatic experience can have enduring effects, whether these are defined in terms of PTSD, or other morbidity measures such as neuroticism and major depressive disorder. Another finding confirmed in the study was the existence of persistent 'intrusively imprinted' memories.²³ These findings have been replicated in varying degrees in different studies.²⁴

Another significant body of research originated with cohorts of Californian children (Oakland Growth Study, the Berkeley Guidance Study and the Terman Study of gifted children at Stanford) in the 1920s. Systematic observations, testing and interviews at regular

²³ Vaillant, G. (1977) *Adaptation to Life*. Boston, Little Brown. There seems to be some confusion about the sample in the study. In an earlier revisiting of the study, Vaillant & Vaillant (1990) described the sample as 204 sophomores selected between 1940 and 1942.

Another significant body of research originated with cohorts of Californian children (Oakland Growth Study, the Berkeley Guidance Study and the Terman Study of gifted children at Stanford) in the 1920s. Systematic observations, testing and interviews at regular intervals documented a generation with rich longitudinal information that could be used in assessing the effect of WW2 over their life span. Glen Elder, of the Center for Population Studies in UNC, and a number of collaborators, including Bessel van der Kolk, re-assessed the survivors in these cohorts in the late 1980s. They obtained further data on war experiences and trauma exposure. Utilising sophisticated modelling of life trajectories, Elder established that military service and combat exposure could have developmental as well as detrimental effects on individuals. Symptom reports, chart audits and clinical interviews clearly show the existence of PTSD as long as four decades after the precipitating event (p. 30 Elder & Clipp 1992).

As the WW2 population moves into the later stages of life there has been some renewed interest in the enduring effect of earlier stressful events. In a review of studies of aging veterans and Holocaust survivors, Kahana (1992) reinforced the findings of Elder et al and concluded that:

Memories of trauma continue to intrude into the lives of these older adults, thereby testifying to the long-term duration of PTSD symptoms subsequent to war stress. At the same time these data underscore the remarkable resiliency among long term survivors of extreme stress. (p. 168)

Apart from these landmark studies, in the traumatic stress literature there has been relatively exploration of traumatised WW2 populations using a life span perspective. The consistent finding in this research is that experience of a traumatic event can precede, or result in, persistent disturbance over time. Just how traumatic memory features in this has not been clearly established.

Australia is no exception in the limited focus on the impact of WW2, but the war story in Australia is part of a much larger history and traumatic past that has not been well examined or documented. This Australian story is the focus of the next section.

AUSTRALIA, WAR AND A TRAUMATIC PAST

Australia has a significant traumatic war memory, but this has not featured strongly in expanding the body of knowledge on the long-term impact of traumatic events. In fact Australia has a long collective history of traumatic experience but only recent events have attracted significant research. Since the arrival of the first European explorers and the beginning of the dislocation of the culture and health of the original inhabitants there has been a great range of tragic events, some of which could be classified as disasters. The more recent events such as Cyclone Tracey (1974), the Granville Train Crash (1977), the Newcastle earthquake (1995), Ash Wednesday (1983) bushfires and the Pt Arthur killings in 1996 have attracted significant attention, but a long list of other tragic events have occurred since 1770. In 1899, 239 crew members of a lugger fleet were lost in the Bathurst Bay Cyclone, and 400 immigrants were drowned in Bass Strait in 1845 when the *Cataraqui* went down. In January 1939 wildfires claimed 81 lives in Victoria, mostly in the Gippsland area. Now there is daily loss of life in industrial accidents, road crashes (more than 2 000 killed and 24 000 seriously injured annually) and through suicide (approximately 2 500 per year).²⁵ However, two single events have placed Australian researchers on the world stage. The first was the work by McFarlane (1988, 1988c) in a series of studies on the effect of a major wildfire on victims and firefighters in 1983 – since known as the Ash Wednesday Bushfires.²⁶ The second was the Granville train crash, studied by Beverley Raphael.²⁷ Other dramatic events such as the Hoddle Street shooting in Melbourne have resulted in event-impact research (see Creamer et al 1993) These events have attracted more research funding and interest in Australia than either of the two major wars.

Australia since European settlement has been spared the scourge of a major industrialised war on its soil, unlike all other inhabited continents and the majority of

²⁵ Bell, Peter. (1996) *If Anything Too Safe: The Mt Mulligan Coalmining Disaster*. Brisbane: James Cook University.

²⁶ McFarlane continued his research on a number of other populations, including victims of car crashes and war veterans. He is a leader in the International Society for Traumatic Stress Studies, having been elected as the first president outside of the USA, and has published extensively, including editing several books on traumatic stress.

²⁷ Apart from a large number of academic papers Raphael's two major contributions are *Anatomy of Bereavement* and *When Disaster Strikes*.



Fig 1.1 2/27 Battalion marches down King William St. Adelaide April 1944



Fig 1.2 2/27 Battalion AIF Ex-Servicemen's Ass. King William St March ANZAC Day, April 1994

countries, including the United States.²⁸ Nonetheless, war has formed a central part of the history and the emergence of Australia's national identity, but all these wars (Crimea, Boer War, WW1, WW2, Malaysia, Korea, Vietnam) have been fought on foreign soil.²⁹ The two world wars have been the most dominant influences because of the extent of involvement.

In these wars over one million men and women have served overseas from a country that has never had more than 19 million people. The scope of the involvement and the casualty rates in these lesser conflicts, such as Korea and Vietnam, are very small compared with the major wars.³⁰ Veterans of WW2, where more than 696 000 Australians served overseas, represent the biggest single potentially traumatised section of the Australian population and warrant detailed examination. Despite this, there has been no major follow-up study of their life outcomes after the 1914-18 or the 1939-45 wars. The Vietnam War, even though it involved relatively few Australians, has been construed as a more damaging event than the major wars, and has attracted far more research attention. There have been at least two major outcome studies conducted within the past ten years. The first was by O'Toole et al (1996) who carried out an intensive psychological review of a large sample of Australian Vietnam veterans. The second was the Dept of Veterans' Affairs Morbidity Study completed in 1997, and repeated in 1999.³¹ As part of the Young Veterans' Program the Repatriation Commission has funded the establishment of the National Centre for War Related PTSD, and the Vietnam Veterans' Counselling Service.

Even though it is difficult to arrive at precise casualty rates, a reasonable estimation can be made of the physical cost of these wars. In the First World War, 60 284 (18.2%) of the approximately 331 781 personnel serving overseas lost their lives. On the Western Front

²⁸ This may be disputed by some in relation to Aboriginal history. The recent Human Rights Commission Inquiry into the Australian government policy on the removal of Aboriginal children concluded that the policy and practice amounted to genocide.

²⁹ This avoids the question of whether the invading colonial forces waged a war against the Australian Aborigines. Reynolds (1995) argues that there was a war in a real sense that has never been acknowledged by the white majority government. Inglis (1999) acknowledged Aboriginal losses in his study of Australia and war memorials.

³⁰ This carnage of war in itself is potentially a major contributor to psychological distress in innocent primary (refugees) and secondary victims (families of veterans) as well as combatants. Other effects such as the grief of relatives and the secondary trauma have been poorly documented. Damousi (1999) has rectified this to some extent.

³¹ Commonwealth Department of Veterans' Affairs (1997) *Mortality of Vietnam Veterans*, and Australian Institute of Health and Welfare (1999) *Morbidity of Vietnam Veterans: Validation Study*.

alone, between April 1916 and August 1918, 46 000 Australians died and over 320 000 non-fatal casualties were recorded.³² Overall, wounds and sickness accounted for 156 000 individual non-fatal casualties.

In WW2 more than 10 percent of the population enlisted and an estimated 696 660 men and women served outside of Australia, of which 28 565 were imprisoned, most in long term imprisonment under the Japanese. The total killed or dying from other causes was 39 429. Over 7 000 died or were killed while prisoners of the Japanese. Total casualties from wounds and illness is estimated at 534 596 non-fatal admissions. The psychological cost of the Japanese POW experience has never been adequately evaluated.³³,

The stark reality of these physical casualties can be seen in the average daily rates of death, particularly in WW1, where 41 Australian soldiers died for each day of the war. This translates into a 1 in 5 chance of surviving if you were a member of the Australian Imperial Forces. In WW2 the actual battle deaths amounted to 13 per day, and 18 men and women died from all causes. This contrasts with the Vietnam conflict (1965-1972) where of the approximately 46 000 Australian Army personnel were deployed in South Vietnam, 501 personnel died in eight years.³⁴

While Vietnam has been the focus of a number of major studies (O'Toole et al 1996a, 1996b, 1996c, 1998a and 1998b), and some smaller clinical studies (Tennant, Streimer &

³² Butler, A. G. (1940) *The Official History of the Australian Army Medical Services in the War of 1914-18, Vol 2 The Western Front*. Australian War Memorial, Canberra, pp. 864-875.

³³ Long (1976) points out, that it is very difficult to give accurate estimates of participation and casualties in both wars. My estimates were compiled from a number of sources: Butler, A. G. (1943) *Official History of the Australian Army Medical Services 1914-18, Vol III; Problems and Services*; Morrison, A. (1989) Repatriation, in Heseltine, H. *The Shock of Battle*; Walker (1952); and O'Keefe, B. & Smith, F. (1994) *Clinical Problems of War*. The Australian War Memorial Archives claims 300 000 enlisted in WW1 and over 60 000 died. In WW2 the estimate is 30 000 prisoners, 39 000 deaths. The *Australia Remembers* Campaign of 1995 rounded out the deaths in WW2 to 50 000. One person could have been wounded and/or injured more than once. The higher survival rate of WW2 reflects the improvement in evacuation and treatment, especially the availability of antibiotics. See Nelson (1985) p. 4. Long (1976) seems to be at variance with other authors on the numbers of Japanese Prisoners of war.

³⁴ See O'Keefe, B. & Smith, F. B. (1994) *Medicine at War: Medical aspects of Australia's involvement in Southeast Asia 1950-72*, St Leonards, New South Wales, Allen & Unwin. The low participation rates and improved retrieval and treatment no doubt influenced these casualty rates, but it is also significant that a large number of personnel were not in combat situations. In fact recreation was a far greater contributor to disease than combat. Between 1965-1972 there were 1 952 battle injuries, but at the same time, 11 384 cases of venereal disease were treated, while only 499 cases of psychiatric illness were recorded for the same period.

Temperly 1985, 1990) the two world wars generated no major psychological research on stress syndromes in Australia. A limited number of studies of Australian WW2 veterans have established mental health as a worthy issue, but have produced no major advances in thinking about traumatic stress. The evidence for post-war psychological damage is also found in a variety of historical works. Three significant clinical investigations have been reported in Australia and New Zealand. Dent, Tennant & Goulston (1987) compared 170 surviving prisoners of the Japanese with 172 veterans who served in South East Asia in WW2. They found some evidence of depression in the sample but did not establish a diagnosis of PTSD. Kidson, Douglas & Holwill (1993) found a relatively high incidence of PTSD among WW2 veterans receiving psychiatric treatment in a DVA hospital. In New Zealand, Macleod (1991) reported a clinical study of 18 WW2 veterans where a pattern of persistent psychological scarring was evident 45 years after discharge. Macleod observed that this population seemed to be reluctant to reveal their 'weakness'.³⁵

THE THESIS

Against this background, my thesis can now be stated. The thesis consists of two main parts. The first is an examination of the ideas put forward during the twentieth century to explain and respond to the psychological casualty in WW2. The historical account traces the development of ideas prior to, and including WW1, and extends to WW2 and the period after the war, when veterans might have experienced ongoing difficulties. This extended history has not been undertaken previously. The second component is the excavation of the lives of a sample of men who experienced a traumatic period of WW2. The life stories of these veterans provide a window on psychological outcomes of the WW2 veteran population, which is the empirical focus of this thesis.

Thus the thesis is thus made up of both histories – the history of ideas on the psychological casualties of war and the history of lives. These two histories began to merge in the 1939-45 War when men encountered situations far more threatening and debilitating than in civil life. The chosen site of WW2 experience is the period 1942-43 in New Guinea,

³⁵ Macleod, A. D. (1994) The reactivation of post-traumatic stress in later life. *Australian & New Zealand Journal of Psychiatry*. 28; 625-634.

which included the Kokoda campaign and the subsequent battles for Gona, Sananander, and Buna on the northern coast.³⁶

Primarily British ideas underpinned Australian practice. Psychiatric ideas this century have been incorporated into the psychiatric services in all branches of the armed services and rehabilitation. Services, in limited form, were initially established in WW1 in response to the 'epidemic' of psychiatric casualties in the British Army, and were utilised for Australian casualties and expanded in WW2. These psychiatric services were driven primarily by concerns for manpower and the war effort and not concern for the suffering of individuals. The outcome was to establish mechanisms for categorising and treating individual pathology to reduce casualties and minimise wastage. Most conditions were considered to be functional in origin, and were captured under the general term of war neurosis. In both WW1 and WW2 the majority of medical authorities insisted that there was nothing new in the neuroses of war. These practices continued into post-war rehabilitation services. No diagnosis with any semantic reference to war appeared in British and Australian nosologies.

This medical individualising of dysfunctional soldiers did achieve some humane outcomes for combatants but also served to distract from a broader questioning of the environment to which combatants did not adapt, and the pursuits in which they were engaged. I argue that a whole generation of veterans has not been served well by medical ideas. This medicalising has also severely constrained how two generations of veterans and families constructed their personal narratives.

This thesis does not sit neatly within any single body of knowledge. Although the main focus is on the effect of traumatic events over time, the inquiry spans a number of fields, including psychology, history, anthropology, sociology and public health. Most of the recent discourse on traumatic stress is situated within a psychiatric medical discourse. I will expand this discourse and critically reflect on the received knowledge on post-traumatic stress disorder.

³⁶ I decided to include any combat soldier who was in the Papua and Owen Stanleys regions during the period 1942-43. This meant that some men were involved in the Milne Bay battle (May), which involved members of the 2/10 Battalion, who also fought at Sananander, a similar battle those at Buna and Gona.

AUTOBIOGRAPHY AND RESEARCH

At this point I want to state that this study is bound up in my personal history and I would argue that any form of scientific enquiry and production of formal knowledge is a personal journey. Personal experience and rational inquiry inform each other in the development of understanding of any complex inquiry. While distance and objectivity need to be maintained in any observations, the researcher needs to be aware of his or her personal stance. My writing of this thesis then is not an abstract exercise but a part of my personal narrative and the construction of my own identity. The written product forms part of the life narrative, and is an example of what McAdams (1988) described as the process of people making sense of their lives through their narrative.

I will briefly illustrate this with a sample of my family story, which is developed further in Appendix F. A number of my life strands merge in this final product. My father died October 1982, during the time I was stationed in Papua New Guinea, the eventual site of my thesis inquiry. On my flight back to Australia to be with my father before he died, I fortuitously found a copy of Bert Facey's *A Fortunate Life* in an airport bookshop. Some of Facey's experiences paralleled those of my father. They were both born in 1894, they both served in the Great War (1914-18) and both returned back into rural life after discharge. There are two aspects of Facey's writing which are common to my father's experience. He made little of the extreme stress of his war experience and quietly submerged any after effects. Most of Facey's text describes his life of hardship and survival before the war. He recounted his time at Gallipoli in detail, but did not dwell on the grief he felt at loss of his brother there, or seeing so many dead in Shrapnel Gully, nor the strain of battle which resulted in 'a lot of nerve cases'.³⁷ Of his own experience Facey only recounted his recovery from wounds, getting married, finding work and getting resettled in civilian life. In his own quiet way, my father dealt with his war in a similar way. My father never constructed a coherent narrative of his own, he talked little about the war and made light of any effects. In fact I found out after his death that he had a very interesting, but unreported, life at war which has never become part of the family narrative. These experiences sowed

³⁷ See Facey, A. (1981) *A Fortunate Life*. Sydney: Penguin.

the seed of this thesis. The work of Facey inspired an interest, not just in the narrative of war service, but also in the life story as a genre.

STRUCTURE OF THESIS

The thesis consists of five sections. The first is a chapter outlining the nature of remembering in a veteran community and how this is constrained by social context. The second section is an extended review of the origins of ideas about the psychological casualty. In this there are five chapters on the British ideas from which Australian practice emerged and the Australian ideas that informed military and rehabilitation practice. The third section comprises an account of a tour of duty and describes the site of exposure to combat. The fourth section is the empirical section that comprises a description and justification of the methods used and a summary of the outcomes. A third chapter in this section scrutinises these outcomes in relation to the history of ideas in the form of extensive case studies. Finally I review the whole thesis and theorise about its implications and contribution.

The four chapters on the history of ideas, and the account of the Rehabilitation system in Australia, are lengthy but necessary. Even though the original material did not form a unified body of knowledge, I have attempted to create a narrative from the nineteenth century through to the post-WW2 period, including Australian literature. It essentially traces the influence of ideas inherited from Britain and Europe into Australian practice. In this I have avoided a strict cut-off date because I refer to the adoption into the DSM of the diagnostic category Post-traumatic Stress Disorder in 1980. I have also spent considerable space describing the chosen site of traumatic exposure in New Guinea. This is justified because it is not only an essential part of the total narrative, but it is crucial to an understanding of the post-war lives of veterans. The thesis needs to be read as a collective life narrative of a population of men whose lives span most of the twentieth century.

CHAPTER 2

THE SOCIAL CONTEXT OF REMEMBERING WAR

This chapter describes the context of the veteran world that I needed to enter to conduct this study. Such an inquiry was only possible because of the existence of memory. All memory is a process as well as a store or repository of experience, skills and knowledge, and exists within individual and social contexts. As a process it is the individual and collective reconstruction of past experiences, which is governed by individual and social strategies of containment. War has produced a strong tradition of remembering and memorialising on a national scale in Australia, but in this there are boundaries that delineate what can be remembered. The extensive practice of commemorating the sacrifice of war dead, through national and international memorials, illustrates the significance of war in Australian history (see Inglis 1999). Monuments of commemoration have assumed a religious as well as social significance, and are the focus of regular public ceremonies.¹ Death and sacrifice are part of this public remembering, but mental health problems arising out of traumatic experiences in war generally are not. Within this broad context of remembering, there is a very limited and deliberately constrained discourse about the traumatic component of this memory. I illustrate this through an examination of the constructions of memory among veterans, and of other forms of social remembering. I will describe mechanisms developed to monitor the memory of WW2, with particular reference to the battalion that was the main source of informants in this thesis. It is important to understand this context before exploring personal memory and history in detail.

Around WW2 there are a number of collective memories, some of them institutionalised and ritualised, that are subject to clear regulatory processes. There is a constructed collective memory that informs national representations of the past, such as the *Australia Remembers* campaign of 1995, and various annual commemorations such as ANZAC Day (25 April) and Remembrance Day (11 November). As well, there are static public monuments in the national and state War Memorials. For members of unit associations there is a more idiosyncratic and focussed collective unit memory, which is captured in a number of forms such as a published battalion history, stories shared at reunions, and a range of other transactions that occur among veterans. There are also

community memories of how a trauma affected a more defined social group which has experienced serious natural disasters like the Cyclone Tracy in Darwin in 1974.² Some of these collective memories are perpetuated and supported in public rituals (e.g. the Port Arthur murders) and within institutions and representative groups. As well as collective memories there are individual memories, many of which are not made public in any way. Serious fictional writing about war emerged in both WW1 and WW2 and the former is probably the most interesting. There is however very limited reference to war strain and its effects.³

As a preface to an extended discussion on the social context of memory, I present an excerpt from a poem by an Australian veteran of the New Guinea campaigns, which portrays the state of his troubled mind as he was recovering in a field hospital in the Markham Valley in 1943.

The wounds they cop in war time, are not always blood and bone
Others cannot see them - you are on your own
It starts above your shoulders, and only you know it isn't right
'Cause these weird and wondrous happenings are only for your sight.⁴

S. H. Ashenden 2/27 Battalion, 1943.

The type of experience he describes is rarely found in veteran discourse.⁵ Older veterans do write about their lives but reference to mentally damaging effects of war or

¹ Inglis, K. B. (1999) *Sacred Places: War memorials in the Australian landscape*. Carlton: Melbourne University Press.

² For an enlightened discussion, see Chapter 7, Read, P. (1996) *Returning to nothing*. Cambridge, Cambridge University Press.

³ The popular discourse on the major wars has not included a focus on enduring psychological effects. See Bert Bishop (1991) *The Hell, the Humour and the Heartbreak. A private's view of World War 1*, and Downing (1998) *To the Last Ridge* as examples of extended reminiscing. Two significant pieces of fiction were Leonard Mann, *Flesh in Armour*, and Martin Boyd, *When Blackbirds Sing*. A review of some relevant literature is found in *The Shock of Battle*, published by the English Department of the Defence Force Academy in 1989. Only a few novels have focussed on the WW2 experience, such as Hungerford's *The Ridge and the River*, which is based on action in Bougainville where a central character broke down under the strain.

⁴ Stirling Ashenden, from an unpublished poem *Cerebral Malaria*. Ashenden was one of five brothers who survived WW2. In fact there was a hidden story within the family. One of his brothers had a serious mental collapse after the war, but this was not common knowledge among members of his unit or even among the family. The youngest of the brothers had only a vague knowledge of the older brother having a struggle after the war.

⁵ I define discourse as a set of transactions surrounding a particular topic or body of knowledge. It incorporates the talk, narratives, stories, writings and other representations that surround a particular theme. Discourse can be found in any medium of presentation. In this sense it is closer to the Foucauldian concept than to the narrow use in text or discourse analysis. (See McHoul & Grace 1997.)

psychological difficulties is rare.⁶ Ashenden is therefore unusual among his colleagues in his battalion. Only one other 2/27 Battalion veteran wrote about the effects of war stress, but this was in his extensive autobiographical work of unpublished novels and short stories under a pseudonym. He described a number of stressful events that happened either to him or to other members of his unit.⁷

This individual reticence about the effects of trauma is perpetuated in ex-servicemen's associations. Most units that fought in WW2 have their own associations that are still very active. Some associations have formed out of a particular experience such as being a prisoner of war, or a Rat of Tobruk, but most are based on the original regiment.⁸ Unit and Division associations function independently from the general veterans' associations such as the Returned and Services League (RSL).⁹ The 2/27 Ex-servicemen's Association is typical of many unit associations which provide a forum to exchange information, maintain networks, and offer moral and material support, as well as perpetuate the culture of the unit. The strongest link for this unit is their service in New Guinea, particularly in the Owen Stanleys and Gona campaigns. The 2/27 Association has a regular monthly meeting, an annual general meeting, and on commemorative occasions, such as ANZAC Day, its members participate in the march and meet for reunion luncheons. Meetings of the association maintain rituals, create a collective military narrative, and perform a gate-keeping function in maintaining memory. This gate-keeping ensures that the transactions within the association are restricted to relatively safe topics and focus little on the stressful side of war.

⁶ Among the sample of veterans for this thesis, who will be described in more detail later, at least a quarter had prepared some form of autobiographical account of their lives, which was primarily for their immediate family.

⁷ Lieutenant Robert Johns described the main character in one novel returning home after action in New Guinea as having 'years of living with his nerves screwed up and his body pressed at times to the end of his endurance'. From his unpublished novel *The Old Lieutenant*, p. 203. He has written two novels and a number of short stories, all based on his and others' experiences.

⁸ These associations are a world-wide phenomenon. The large numbers of Australian Prisoners of the Japanese and Germans associate under the auspice of the Ex-Prisoners of War Association of Australia. Their official newsletter is *Barbed Wire and Bamboo*.

⁹ This is the current name. The previous titles were the Returned Servicemen's League (RSL) and the Returned Sailors, Soldiers & Airmen's Imperial League of Australia (RSSAILA).

**2/27th BATTALION A.I.F.
EX-SERVICEMEN'S ASSOCIATION**



***50th Anniversary
Celebration
of the formation of the Battalion
1940***

SOUVENIR PROGRAMME

ANZAC WEEK

21st to 25th APRIL, 1990

AND

**HISTORICAL RECORD OF THE
2/27th BATTALION A.I.F.**

1940 - 1945

Fig. 2.1 Example of veteran association reunion event.

Special occasions preserve the spirit of the unit and its memory. On these occasions, especially the monthly luncheons, grief and loss are acknowledged in ritual remembering of deceased veterans, both in the past and recent times, and formalised in the Ode of Remembrance, which is recited after the reading of the names of the recently deceased.¹⁰

The spirit of the association is illustrated in a statement made at the end of 1992, fifty years after the first New Guinea campaign by the commanding officer of the 2/27 at the time, Geoffrey Cooper. He was the officer who gave the order to retreat from Kokoda, and to make the disastrous attack at Gona.

The year 1992 has passed. For Australian servicemen it was a year of memories. For ex-members of the 7th Australian Division it was a year for the remaining few to gather together, and revive each other's memories of fifty years gone, back to a year of disaster, tragedy and success, that was not all evident.

Strain, stress, or mental breakdown are not topics covered in any battalion association literature, nor in the official battalion history of this unit (Burns 1960). This reticence began in the original 2/27 official war diary (a record kept during the war) which played down the strain of service in New Guinea, and contained no mention of atrocities or the effect of extreme situations.¹¹ In a private conversation, John Burns, author of the unit history, a corporal in the 2/27 and Military Medal recipient, described how two of his mates had been bayoneted while tied to a tree in 1942, but he chose not to include this in his history. He also knew of a member of his unit who had killed his mate when the correct password was not given while on sentry duty in Syria. The soldier who was on duty was known to have been in 'a mess' since the war but none of this was part of the public memory. Another 2/27 member had been badly wounded in an action that earned him a Military Medal. He returned to South Australia and spent many years in and out of the public mental hospital during his recovery. Other 2/27 members who were interviewed discussed these types of events and experiences only after they felt comfortable, but the more common response was reticence. Stories of war-time atrocity and breakdown are not part of the discourse within the Association.¹²

More evidence of the careful containment of memory can be found in the newsletter of the 2/27 Association, *The Brown and Blue Diamond*, which is a repository of association culture.¹³ Publications like the newsletter preserve a collective memory of a unit's history, and place boundaries on what that memory may contain. A review of several issues of this newsletter revealed no evidence of concern for the mental health of veterans. There is regular reporting on members such as their latest physical illness or frailty, and in every issue there is a commemoration of those who have died in the

¹⁰ The Ode: 'They shall grow not old, as we that are left grow old: Age shall not weary them, nor the years condemn. At the going down of the sun and in the morning, we will remember them.'

¹¹ Archives, Australian War Memorial, Canberra.

¹² This was reported in an interview with Burns on 2 December 1998. He recounted another unrecorded story about RK who had led the party that rescued a group of wounded men left in the jungle with Burns in August 1942. RK was shot through the lungs at Gona and left under a bush. Burns returned later to retrieve a radio battery and found RK but it was too late.

previous month under the heading of 'Last Post'. The newsletter provides opportunities for networking between members in each State and even overseas. There is the occasional comment on society, reflection on the unit history, philosophical statements, sometimes poetry, written by members or quoted from somewhere else, and there are occasional attempts at humour.¹⁴ But there is no evidence of a veteran discourse, either in the newsletter or other settings, on mental health and illness. All other illnesses sustained by these veterans and their partners are publicised and described in detail, but there is never any mention of mental health, even though there is common knowledge of difficulties experienced by the members. For example, one of the most distinguished officers of the 2/27 experienced a psychotic episode in final six months of his life and was admitted to a mental hospital. Only his physical illness and death were reported at the monthly luncheon, even though some of his fellow officers had visited him in the psychiatric hospital ward. Another former officer was admitted to a private psychiatric hospital in 1997 with major depression, and this was not reported. This is a reflection of general societal attitudes but even though these experiences are fairly common knowledge in the veteran community, the unit association is not used as a means of educating veterans about them or assisting veterans. Consequently their public narrative has significant gaps and the full story of life after war is not recorded. Any adjustment difficulties late in life continue to reside in the private domain and are managed privately as a medical problem.¹⁵

By and large, the memory of the battalion is focussed on patriotism and commitment. In September 1987 Major Harry Katekar, the former adjutant of the unit, published 'The Adjutant Reminisces' in the newsletter. At this stage in history he was free of the obligation of silence imposed after discharge, especially on senior officers, and could then speak his mind. Katekar had buried his personal memories of the war in

¹³ Brown and blue is the colour patch of the 2/27. A reproduction is displayed in all association material and some members have it displayed on their car number plate and even on their houses.

¹⁴ *The Brown and Blue Diamond* is a more sophisticated production than some others, but each unit has its own version.

¹⁵ Another dramatic example of this is a former officer who did not attend reunion luncheons for several months. He was in fact confined to a private mental hospital for a period of time after his 'lady friend' had suicided. Another longstanding, normally placid member of the Association had been getting increasingly aggressive with his partner and had to seek help. A private who was boarded out on psychiatric grounds after the Middle East campaign, and had struggled mentally for most of his life, 'returned to the battalion' late in life. Few knew of his problems.

hard work, and community involvement, on his rural Riverland property. He had established himself there as a very successful businessman, having turned his back on a career as a lawyer in 1946. In his first public statement on his version of the New Guinea campaigns he briefly touched on the potential distress of war.

I prefer to keep fresh the memories of those with whom I served. I do not like to see them growing old and enfeebled. Nevertheless I always remain interested and ever keen to help. Even though we have served in war, we do not want anyone else to be involved in another war. In hindsight, those of us who had the unexpected, perhaps unwarranted, and certainly hazardous, experience of serving in a unit like the 2/27th Battalion AIF, especially those with responsible positions in the section, platoon or company, in circumstances where our lives were in peril, must rate that experience as unforgettable and enduring.¹⁶

In 1990 President Peter Sherwin, who had his leg amputated after the battle at Gona hinted at the negative impact of war in an article to create interest in preparation for the 50 Anniversary celebrations of the formation of the battalion. He referred made a special tribute to 'our long-suffering wives who put up with so much and still come up smiling'. He reminded his members that 'those few war-time years which followed [May 1940] which impacted so drastically on every one of our lives are now long past'. This kind of reference is the exception, and another veteran's statement is more apt.

Only a few veterans raise the subject of war, so these distressing memories are rarely discussed. Items covered [at reunions] are sport, family matters, general ailments, news of other veterans, etc. If war memories are raised they are almost always amusing stories - probably embellished with faulty recall.¹⁷

On this occasion Katekar wanted to redress the shabby treatment 21 Brigade had received from Field Marshall Blamey after their withdrawal from the Owen Stanley Ranges in 1942.¹⁸ For Katekar, the 'self-aggrandisement and bloody mindedness' of people like Blamey had been responsible for sending so many young men to their death, when it really wasn't necessary. In the newsletter of March 1995 the editor stated:

The bonds that were forged between members of the 2/27 back in those wartime years have remained with us ever since. They can best be illustrated from the following extract from H.D. Steward's book, *Recollections of a Regimental Medical Officer*. 'The spirit with grows up in a battalion when it has been welded together into a true fighting unit, is a comradeship almost supernatural in its

¹⁶ *Brown and Blue Diamond*, 79: September 1987.

¹⁷ A. N. Ward, questionnaire response, 13/6/95. A survey of 28 veterans in this study supported the view that they only talk about amusing incidents.

¹⁸ As noted in Chapter One Blamey publicly criticised 21 Brigade and accused them of cowardice after their withdrawal from Kokoda.

strength and intensity. It springs from the hardships shared equally, risks run by all in common, and its power exceeds most of the emotions that an ordinary man will ever know. The care of the soldiers for one another, their sure and calm dependence on each other are hard to understand by anyone who has not known it'.¹⁹

Burns (1961) expressed the same sentiment in his record of the 2/27 campaigns, *The Brown and Blue Diamond at War* when he concluded,

Yes, almost every man who wore the brown and blue diamond to war has taken back into civilian life the spirit of comradeship and torch of service kindled during his service days, and has spread the ideals, the standards and traditions of the 2nd 27th Battalion into the community. And now, instead of fighting a physical enemy, they are serving freely, generously and vigorously in a very wide field of public duties so that Australia may be a better country so many gave their all for. (p. 231)

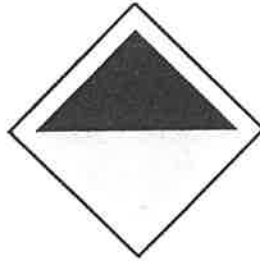
This sense of pride and noble service is perpetuated in the association, where only physical weakness is acknowledged. Illness and admissions to hospital for physical treatment can be reported, but not bouts of depression, or admissions to the Repatriation Hospital psychiatric ward. Mental health crises are not part of the illness discourse – only physical crises such as strokes, heart attacks, and cancer. This avoidance of any reference to mental health in association transactions is repeated in other unit associations. In *The Good Guts*, the newsletter of the 39 Battalion Association, the same level of discourse and remembering is sustained. There is no permission to explore the darker side of war.²⁰

In the broader context of writing about WW2, there is at least some reference to mental health issues. However, considering the size of the population of Australian veterans, and the great loss of life and disruption, the story of the Australian mental casualty for both wars is very sketchy. Some evidence of an underlying story can be gleaned from the literature found in a few novels, biographies and historical texts. Gammage (1980) gave a detailed account of the experiences of WW1 soldiers at Gallipoli and on the Western Front and documents the appallingly stressful conditions

¹⁹ *Brown and Diamond*, 85: 1995.

²⁰ The 39 Battalion Association, for example, based in Victoria, produces *The Good Guts*, which is similar to the 2/27 publication, and contains news of members, including obituaries. A review of the issues of *Guts* for the past three years indicated no reference to mental health problems among veterans even though this was clearly evident in the interviews conducted with 39th veterans.

THE BROWN AND BLUE DIAMOND



THE OFFICIAL JOURNAL OF THE 2/27TH BATTALION A.I.F. EX-SERVICEMEN'S ASSOCIATION

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*At the going down of the sun
and in the morning
We will remember them.*

Figure 2.2 Newsletter of 2/27 Battalion Association with monthly death notices.

Deaths of study participants highlighted

and mentions some instances of the mental effects of such strain.²¹ Thomson (1994) explored the interface between the historical construction of WW1 by WC Bean and the personal narratives of a sample of veterans. His informants testified to nervous problems both during war-time and after the war. One informant developed a 'nervous disorder' in France and broke down again later. Breakdown had to be managed against the expectation of being a noble ANZAC warrior. The same informant experienced a 'nervous breakdown' after discharge.²² Adam-Smith (1992) unearthed fleeting reference to psychological strain during captivity and in the homecoming of prisoners of war.

Historians have also mentioned highlighted mental health issues and post-war adjustment problems among WW2 veterans. In his extensive survey of 3 200 Australian WW2 veterans Barrett (1986) found evidence of hidden psychological problems. His respondents volunteered numerous accounts from their own and other veterans' experience describing stress in post-war life. Their stress was often masked by drunkenness, suicide, difficulties in relationships and anti-social behaviour, some of which resulted in imprisonment. The most commonly reported aberrant behaviour, excessive use of alcohol, began in military service and continued in a dysfunctional way after discharge. Of his whole sample, 11 percent of Barrett's informants reported some kind of psychological problem for themselves and 30 percent spoke of others having such problems.²³

Other historical works, including battalion histories, point to evidence of ongoing effects of war strain, but references are tangential to their main story. Two recent battle and battalion histories (Brune 1991, Barter 1994) make passing mention of the reality of the effects of strain on individuals. Johnston (1996) examined war-time strain and devoted three chapters to breakdown in the front line, but did not pursue this into post-war life. Another biographical study of middle class Melbourne people by McCalman (1993) found that some veterans returning to civilian life did not all find post-war life

²¹ One of Gammage's (1980) informants noted several old hands cracking up as the occupation at Gallipoli set in. Another said 'one's nerves get very nervy ... having been on a continuous strain of looking, watching and listening'

²² In New Zealand the long silence has been broken by the publication of *Silent Casualties* (1995) in which Alison Parr makes public the lives of seven men who had experienced war neurosis. The personal impact of war is also explored in the dramatic portrayal of the lives of women affected by war in the film by Gayle Preston and later in book form by Fyfe, J. (1995) *War Stories Our Mother Never Told Us*.

²³ See Barrett, J. (1987) *We Were There*. Sydney: Penguin.

easy to manage and had limited access to counselling. She also referred to some veterans who managed to survive the war 'only to break down once there was time and space for it'.²⁴ The official accounts of medical history of WW2 (Walker 1952, 1957), which will be discussed at greater length later in this thesis, lack a thorough treatment of mental health issues. The original officially sanctioned histories of the 2/27 (Burns) and 39 (Austin) battalions provide detailed lists of those killed and wounded but record no information on mental strain or psychiatric casualties.²⁵

A recent oral history of soldier settlers in the River Murray district in South Australia by George (1999) revealed evidence of families affected by psychological problems of veterans. Even though she only cited a few specific cases, George formed the impression from those and other sources that 'large numbers carried the psychological effects of war experiences'. Ex-prisoners of war were particularly affected and were 'psychologically run down and traumatised'. Others battled with 'war-induced anxiety'. These problems were largely managed within the family with little outside help of any kind. George described veterans who were short tempered, 'shattered', having nightmares, were highly strung and anxious. Much of her evidence was found in government records which had never been used in a case for better services.²⁶

Historical studies of Prisoner of War populations, highlight a degree of post-war stress. Beaumont (1989) followed up 48 survivors of captivity on Ambon, one of the most severe Japanese POW camps in WW2, and found evidence that the stress of captivity continued to interfere with their efforts to get on with life. Their ongoing problems were manifest in depression, moodiness and poor concentration, which were particularly evident in the first few years after release. She concluded that:

They believed it [POW experience] made them more tolerant and understanding of others, while strengthening their own characters. They treasured the mateship that their shared suffering had nurtured. For the historian, as an outsider, however, the impression remains that the legacy of captivity was predominantly negative; a continuing struggle with ill-health, reduced career opportunities and, in some cases, undue strains in personal relationships.²⁷

²⁴ McCalman, J. (1993) *Journeyings: The biography of a middle class generation 1920-1990*. Melbourne: Melbourne University Press, p. 202.

²⁵ See for example, Burns, J. (1961) *The Brown and Blue Diamond at War (2/27 Battalion)*; Austin, V. (1988) *To Kokoda and Beyond (39 Battalion)*.

²⁶ George, K. (1999) *A Place of Their Own*. Adelaide: Wakefield Press, pp. 124-5, 145, 203.

²⁷ Beaumont, Joan. (1988) *Gull Force: Survival and Leadership in Captivity 1941-1945*. Sydney: Allen & Unwin, p. 51.

A detailed historical analysis of post-war service and medical records by Garton (1996) established that Australian veterans from both major wars had significant mental health problems following discharge. These problems, which Garton incorporated under the rubric of shell-shock, were extended into post-war life in a number of ways and often expressed in a quest for compensation. These pension cases which were mostly from WW2 veterans, provided a testing ground for ideas on the etiology of war neurosis. Garton produces sufficient evidence to suggest that there was a significant problem that was carefully hidden from public scrutiny and contained within official confidential records. In an earlier work (1988) on the social history of insanity in New South Wales, 1880-1940, he described the post-war psychological problems of 'shell-shocked' WW1 veterans.

The Murdoch Sound Archive, another important site of WW2 war memory, was begun in is worthy of mention. The archive is a repository of audio recordings and transcripts of 365 interviews with veterans of all ranks and roles and service arms, including a number of female personnel. The intention was to record personal accounts of military involvement and many interviews cover the post-war settlement period. As an unintended consequence there are references to strain, stress, and neurosis in some transcripts. Personal accounts of breakdown and the resettlement experiences were particularly informative, and some of these have been incorporated into this thesis. The archive initiative provided a significant publicly available forum for veterans to create a narrative of experience which had previously had no other space.²⁸

Other references to war strain and subsequent problems can be found in less well known recent private and other publications. Ambrose (1987, 1989) privately published rich stories of former POWs that contained a few detailed descriptions of traumatic events and the effect these had in later life. A similar study by Shaw (1989) described the experiences of five brothers who had all served in WW2, but the study did not

²⁸ Copies of the original Murdoch recordings and transcripts are kept in the Australian War Memorial archives. The Murdoch Archive is indexed on the Australian War Memorial site www.awm.gov.au.

emphasise any mental health effects, even though in the latter publication the author acted as a sounding board to encourage participants to tell their stories.

The 'Australia Remembers' campaign of 1995, commemorating the fiftieth anniversary of the end of WW2, was an occasion for remembrance on a grand scale, but there was little space for discourse on mental health. One example of a project in that year is a publication by Ilton (1995), who compiled a comprehensive set of stories from men and women in the Shire of Campaspe in Victoria. Most of the 23 narratives consisted of descriptions of war-time experiences, many of which highlighted the wastefulness and futility of war. Only a few mentioned post-war difficulties, and this mostly in relation to others. V. L. Mitchell, a New Guinea veteran and POW, for example, stated that 'many failed to adjust'.²⁹

Examination of some print and other media of the early post-war years indicates that there was an undercurrent of discourse about the 'disturbed man' that was never fully acknowledged. An interesting example was the popular radio serial 'Blue Hills' (1949-1976), which was a mirror of Australian post-1950s life. It portrayed post-war families, centred on the Gordons, headed by Dr Neil Gordon. Twenty-two year-old Bruce, one of the four children, had returned from the war with war neurosis and was studying medicine. Bruce was a 'medical student back from the war, and suffering still from its effect on his nerves. Bruce is trying to do a job for which he is unfitted.'³⁰ Just why war neurosis was a chosen is not clear from the existing records, but the choice indicates that it was a significant issue and part of the social fabric of the period. There is also the suggestion that it could affect those of stable professional background. The inclusion of such a character suggests that the script writer had first hand knowledge of, or at least an interest in, war neurosis.

The print media in the early post-war years took up the issue of the mental health of veterans. Soon after the war ended there were warnings of the psychological consequences of war, both in the popular and more serious press. For example in the *Sun* newspaper, December 1945:

When Private Bill Smith came back from the jungle and just couldn't fit into the old life again, his mates shook their heads a little, and said, "Bomb happy" or "Troppo".

²⁹ Ilton, Ian H. (1995) *Australia Remembers: The Shire of Campaspe recalls*. Victoria: The Shire of Campese, p. 65.

³⁰ Australian Broadcasting Commission Archives Document *Blue Hills*, and *ABC Weekly*, 29 January 1949.

Perhaps he can't settle down at home, is irritable, impatient, restless. He's a difficult man to get along with, and lacks the confidence and patience to master his old job again.

He might run through a lot of jobs, and it's possible he will become estranged from his wife, family and friends. In the extreme he might end up in the padded cell or under restraint.

There are now a lot of Bill Smiths about, and there will be many more when the harvest of this savage jungle war and the Jap prison camps is gathered in.

Major H. R. Love MB, BS AAMC, in the Australian Medical Journal (1942) states that: "Neurotic illness in soldiers is a potential source both of serious wastage of manpower in the field and of prolonged and refractory post-war disability".

According to the journalist this disability was widespread - the 'nervous wrecks' might come home, be afraid of large crowds and confined spaces, be irritable, rebellious, irresponsible or even dishonest.

The influential *Smith's Weekly* gave significant attention to mental health problems among veterans from WW1 through WW2.³¹ The *Weekly* (1919–1951) had a history of being highly critical of the government's treatment of returned soldiers from WW1. Even though much of the reporting was polemical and somewhat sensational, the paper did reveal a significant amount of concern for the mental health of veterans. This stance was openly supported by the main financier of the paper, Sir James Joynton Smith, who had set up a convalescent home in his own Coogee mansion for 40 shell-shocked WW1 men before 1939. During and after WW2, the editor's strategy was to focus on specific cases of apparent injustice in order to expose and highlight government inadequacy. One example of the type of case *Smith's* would take up was for JES, aged 24, who had served in Syria, Palestine and New Guinea. He was passed A1 on enlistment, but after the war was a 'nervous case' having been diagnosed as schizophrenic. The man's discharge papers stated that his mental condition was not attributable to war service even though a psychiatrist argued it was at least aggravated by it. Such cases of injustice were 'legion', and the Repatriation Department was described as 'slow, unsympathetic and stingy' in dealing with such cases.³²

³¹ These articles also showed a general lack of sophistication in understanding psychological problems, which was reflected in the way 'nerves' was portrayed in the press. It was implied that these problems could be addressed with simple prophylactics such as analgesics. In the same publications that contained the references to war neurosis there were advertisements for Aspros which would 'speedily relieve these depression effects'. Another in May 1943 advocated a new hormone treatment for nerves that would relieve fatigue, restlessness, irritability and disinclination to work. It would 'soothe nerves that had not lost their tension'. In the same issue Dr William's Pink Pills were promoted as a cure for the 'anaemic and nervy'.

³² *Smith's Weekly*, 10 June 1944, p. 3.

A sample of issues from 1944 onwards clearly illustrate that there was a great deal of public concern about mentally damaged men returning from WW2. One major topic was acceptance of neuroses as compensable injuries. On 20 May 1944, Minister for Repatriation CW ('Hoar') Frost was reported as saying: 'It would not be equitable to automatically accept mental disorders suffered by all ex-members of the services as due to war service when such a principle does not apply in respect of other disabilities'. Other reports from then on covered the 'callous, horrible treatment of mentally-sick and bomb-happy soldiers', and on 29 July it was argued that 'humane US methods contrasted where the "maladies of the mind" were entitled to treatment the same as men wounded in action'.³³

In August 1946 *Smith's Weekly* ran a feature on the Repatriation Commission's Annual Report, where it was stated that those accepted for a pension for neurosis, psychoneurosis, mental disorders and other similar disorders (5 890) exceeded those accepted for physical wounds (3 640). The Air Force Association claimed that 67 000 (sic) applications for pension on grounds of war neurosis had been rejected. This had prompted the Commission to establish a special committee of inquiry. The Air Force Association established a special fund to assist these men.

The most serious manifestation of disturbance highlighted in *Smith's* was suicide, which also received media attention. One horrifying suicide occurred in Adelaide.

This case was so shocking as to provoke comment from the South Australian coroner, Mr. Cleland. The victim was H, aged 47, of Adelaide. He was decapitated by a railcar at Mile End on March 5. H had been arrested for drunkenness on February 16. He tried to take his life in his cell by slashing his wrists. After two weeks at Enfield mental home he was released on March 2, and arrested the same day for drunkenness. The Coroner said His condition was due to war captivity. He had been a POW for three and a half years. His body was lacerated with torture marks. (*Smith's Weekly*, 17 April 1948, name published at the time).³⁴

³³ Other headlines included: 'Repat falls down on its job' (10 June 1944); 'How they treat war neurosis' (5 August 1944); 'Repat and Civil asylums' (26 August 1944); 'No repatriation for neurosis' (26 February 1945); 'Army mishandles sad case' - 'Soldier was arrested and put in mental ward of army hospital; wife cleared out to America; he is on verge of nervous collapse; discharged from army suffering from hysteria in New Guinea' (21 April 1945); 'War neurosis and returning POWs' (15 September 1945); 'How Army treats its mental patients' (3 November 1945); 'Treatment of Army Mental patients' (2 November 1945); 'And they said this man was mad' (26 January 1946); 'Slam for Hollywood's psychiatric cycle' (22 June 1946); 'Treatment of War Neurosis - One of the biggest problems confronting ex-service personnel' (9 March 1946); 'War neurosis campaign' (14 September 1946).

³⁴ The *Weekly* was a somewhat sensationalist paper and had a strong overtone of humour on all issues. The tone for the treatment of war neuroses is set by the portrayal of women. Cartoons were often risqué with scantily clad women making jokes about men and relationships. One

Media publicity brought a response from veteran organisations and raised the issue of ownership of mental health problems. One veteran mounted a personal campaign and argued that the healing community needed to be expanded beyond medical clinics. In Adelaide he complained to a local paper about the lack of support in the community. He said he that the attitude of some people 'made me feel unwanted. I seemed to be running into unsympathetic brick walls'.

The public attitude toward war neurosis frightens them away from treatment. The people who can help these men are ordinary people, their workmates, the people in their street. Medical clinics and psychiatrists are all very well; but it is the understanding of our fellow men the war neurosis victim needs most.³⁵

The editorial in the same issue used his story and the suicide incident cited above to call for more community support for 'war neurosis victims'. The prime need of the victim was 'the stepping in of ordinary men and women to help and cheer him up after the specialists have done their job'.

Calls had also come from other quarters to improve the services for returned soldiers. Early in September the South Australian Wheat and Wool Growers' Association asking him to take up with Repatriation authorities the plight of 'returned soldiers suffering from psychiatric ailments caused by war service'. In particular they complained about ex-soldiers being placed in mental hospitals 'where they had no hope of recovery'. The Association argued that the needs of ex-soldiers could best be met in a special clinic for 'returned soldiers suffering from psychiatric ailments caused by war service'.³⁶

In South Australia, this type of publicity about war neurosis brought a reaction from the Returned Sailors, Soldiers & Airmen's Imperial League of Australia (RSSAILA, later known as the RSL). In response to these criticisms and other publicity the RSSAILA called a meeting on 6 September 1949, to address the 'many irresponsible and unfounded statements regarding the treatment of war neurosis cases'. The meeting, convened by the President of the League (a Victoria Cross winner), included service organisations, Legacy and Red Cross, and representatives from the SA Hospitals

cartoon raised the issue of psychological disturbance, depicting two women having a conversation. The first said, 'How do Beryl's nerve attacks end?' The second replied, 'With the husband putting on his hat and slamming the door behind him'.

³⁵ *Sunday Mail*, 17 April 1948. I interviewed this man in the early stages of my research. He had a lifetime of periodic admission for treatment to the psychiatric ward at the repatriation hospital.

³⁶ Copy of letter forwarded to the Minister for Repatriation, 29 September 1949. Australian Archives SA: D2048/0 G1220.

Visitation Committee as well as the National Council of Women. At the outset the chairman made it clear that 'irrational statements on War Neurosis did not help anyone, least of all the patients and their relatives'. Two 'medical men' gave their interpretation of the term war neurosis. The meeting made a number of statements and recommendations. One conclusion was there were relatively few cases of war neurosis 'directly due to actual battle experience', and problems could be more accurately be attributed to instability before enlistment. Many cases should have been screened out at enlistment. Post-war problems of veterans were construed as responses to the challenges of readjustment to civilian life rather than the trauma of war experience. While the meeting recommended some changes to services, the final resolution was:

That this meeting representing all servicemen organisations, Australian Red Cross and other bodies interested in the Ex-servicemen and women expresses its confidence in the government and its medical officers and Staffs [sic] in the approach they are making to this very vital matter and pledge themselves to cooperate and assist authorities in all matters appertaining to the welfare of Mentally Ill ex-service personnel.

This large representative body very clearly pushed the discourse into a medical framework. In effect there was no case to answer and any problems with neuroses were to be kept within medical confines. From that time no representative body made an issue of mentally damaged WW2 veterans and there was no public education or information program. It was to be left to the medical experts in the Repatriation Commission to deal with the problem as a clinical problem on an individual basis.

In the overall assessment of the post-war period, narratives of impaired functioning, or mental ill health, were rare in any of the WW2 discourses, or were short-lived and focussed on justice for individuals. Mental health problems of WW2 veterans have not been the subject of public discourse since the early post-war years, when the media took up the cause and elicited action and public interest. Memorialising has been directly focussed on loss and bereavement not on the on-going mental health effects of such loss. The mental health outcomes of war only became politically acceptable as a public issue when Vietnam Veterans adopted a political stance in order to have their needs met. This coincided with the emergence of a more acceptable diagnosis of PTSD, and the emergence of the American Vietnam veteran movement.

The way in which information about the mentally damaging effects of war was managed was a significant part of the process of containing memory about mental damage. The largest and richest repository of information is contained in medical and

hospital records that accompany every investigation of war disability and request for treatment. These are private records and can only be accessed under strict guidelines and have consequently been excluded from any public discourse. Education and dissemination of information is a recent phenomenon in the Department of Veterans' Affairs. A document disseminated by the department of Veterans' Affairs there has been no public discussion or education about the effects of war stress. A document on post-traumatic stress disorder and other diagnoses relating to war veterans was disseminated to veterans and families was only produced in 1999, after a validation study on the morbidity of Vietnam veterans was released. It is essentially a description of post-traumatic stress disorder and co-morbid conditions as defined by the American Psychiatric Association. A range of treatments and interventions were advocated but these could only be delivered by experts within the Department of Veterans' Affairs.³⁷

I propose that the discourse about the mental health of the largest population of war veterans in Australia has been carefully contained and suppressed for most of this century. It has not been part of the culture of veterans themselves. Any manifestations of dysfunction have been managed within the medical framework of the government agencies and kept out of the public view. The early post-war public concern, as reflected, for example, in *Smith's Weekly*, soon dissipated. Since the end of the early post-war display of concern for the psychologically damaged WW2 veteran, there has been no significant interest in his plight. In the established sites for maintaining the culture of the WW2 veteran there is no forum for discussion of this experience other than when it becomes a medical condition. Already a picture is emerging of a context where there has been a constrained discourse. This constraint extends to the way in which more serious problems have been framed and dealt with, and also to the broader context of how any form of stress is brought into a personal or collective narrative. Within this context I set out to explore the experience of the Australian veteran and how the history of the way in which war stress has been construed and the organisational responses to it in the two major wars.

³⁷ National Centre for War-related Post-traumatic Stress Disorder (1999) *Post-traumatic Stress Disorder (PTSD) and War-related Stress: Information for veterans and their families*. West Heidelberg: National Centre for PTSD.

CHAPTER 3

CREATING WAR NEUROSIS IN WW1: Railways and Hysterical Women

This is the first of five chapters reviewing the history of war neurosis that will end with an account of how ideas on psychiatric casualties were translated into Australian military and rehabilitation policy. An understanding of this history is essential for an appreciation of the impact of these ideas on men participating in WW2. This chapter focuses on the origins of the response of the British army to the psychiatric casualty in WW1, which emerged from civil practices of the nineteenth century. At the beginning of the twentieth century there was no recognised and unified body of knowledge in psychiatry, but there was increasing interest in scientific inquiry in medical practice. Neurology, psychology and psychiatry, were very broadly defined areas of expertise with no clear-cut boundaries.

There was no ready-made military precedent for dealing with psychiatric casualties prior to WW1. In the nineteenth century, a time when psychiatry and neurology were struggling for recognition as professions, little interest was taken in the psychiatric casualty of the major wars (see Ellis 1984, Shorter 1997). In the American Civil War (1863-1865), in which over 600 000 Americans died on American soil, there were no provisions for such casualties. If those who were disturbed did survive, they were hidden away in primitive civil institutions for the insane.¹ Binneveld (1997) acknowledged that the Surgeon General Hammond took an interest in psychological casualties, but 'for psychiatry the conflict proved to be of no significance. The psychologically wounded soldier passed into oblivion'.² It is claimed that Silas Weir Mitchell, who actually served in the Civil War as a Union surgeon, treated Civil War soldiers who were diagnosed with neurasthenia and hyperaesthesia using his Rest Cure, but it is more likely that his interest in the diagnosis and treatment developed later.³ The

¹ See Dean, E. (1997) *Shook Over Hell: Post-traumatic stress, Vietnam and the Civil War*, Cambridge: Harvard University Press.

² Binneveld, H. (1997) *From Shell Shock to Combat Stress A comparative history of Military Psychiatry*. Amsterdam: Amsterdam University Press, p. 4.

³ Ellis, P. S. (1984) The origins of war neurosis: Part 1. *Journal of the Royal Naval and Medical Service*. 70; 168-177. Ellis argues that at the time of the Civil War (1861-65), Mitchell's patients were either diagnosed with 'irritable heart' or nostalgia. Mitchell did not use the term neurasthenia until Beard and Page influenced his own theory on a form of post-traumatic

only identified form of organised military psychiatric service in war appears to have been in place during the Russo-Japanese (1904-05). In that conflict psychiatric casualties were extensive, and the Russian army medical department and the Red Cross Society of Russia established the 'first forward psychiatric clearing hospital equipped with its own specialists' (see Ellis p. 174). At that time, however, there was no specific term for this type of casualty. Ellis (1984) argued that Honigman used *Kriegsneurosen*, (war neurosis) in 1907 as the first specific war related term, but this term did not emerge in British literature.⁴

PRECURSORS OF SHELL-SHOCK: RAILWAYS AND HYSTERICAL WOMEN

I will briefly address some of the precursors to thinking about psychiatric issues in WW1. The foundations of the twentieth century ideas on psychiatric casualties were laid in the nineteenth century. In that era, asylums were little more than unhealthy jails, where even enlightened doctors would helplessly watch patients wallow in their own misery and violence.⁵ Nonetheless, it was an age when very serious attempts were made to harness advances in neuroscience in the cause of treatments for the disturbed. Most of the experimental treatments were in the spas and private clinics, but public hospitals also provided patients as experimental subjects, such as at La Salpetriere, where Charcot tried to unravel the mystery of hysterical complaints. Essentially there were two broad approaches to psychiatric disturbance in the civil field, the alienist and eugenicist.⁶ The alienist was concerned with identifying and treating pathology in individuals. The eugenicist, emerging out of Darwinian notions of creating a more resilient race, was more concerned with promoting mental health. As well as these broad conceptual

neurosis brought on by gun shot wounds. His treatment of neurasthenia using the Rest Cure appears to be a later development. This is supported by Shorter (1997).

⁴ Ellis (1984), *The Origins of War Neurosis; Part One, Journal of the Royal Navy Medical Service*, 70: 168-177. The 1922 Shell Shock Inquiry cited Laurent's term *commotion cerebrospinale* - nervous injuries produced by projectiles - as another example of a pre-WW1 diagnosis

⁵ There were some minor exceptions such as the reforms of Tuke in the York Retreat. The parlous state of institutions even extended into the twentieth century as late as the 1950s. See autobiographical accounts of mental health systems by Sargant (1957) in England, and Cawte (1998) in Australia.

⁶ Healy (1993) argues that the war served to bring the alienists out of the asylums and establish themselves in broader community territory. He also portrayed, rather thinly in my opinion, the psychologist staking a claim for some medical territory. Merskey's (1996) extensive review of shell shock outlines the rise of psychiatry through WW1, and the entrenchment of a medical role in maintaining military order.

divisions there was a tension between neurological and psychological explanations of dysfunction.

What were the breeding grounds for the neuroses of war? As scientific knowledge raised hopes of a cure for most ailments in the nineteenth century, problematic mental conditions came into clearer focus, and gave rise to a cluster of new diagnoses. Among these new diagnoses were hysteria and neurasthenia, which were primarily women's ailments. Neurasthenia had been one of the most commonly diagnosed disorders at the end of the nineteenth century, but its popularity in the civil arena declined after WW1.⁷ Problems of the mind also emerged in the debate about conditions such as Railway Spine. The end of the nineteenth century saw the introduction of compensation insurance, with conditions arising from traumatic events attracting considerable attention and debate about the organic basis for pain and the potential for malingering.

The notion that a life event could 'cause' neurotic disturbance began to appear in medical usage early in the eighteenth century, before the scientific inquiry of the nineteenth and twentieth centuries. Robert Whytt (1714-1766), Professor of Medicine at Edinburgh, observed that nervous conditions could be triggered by life events or disturbing stories, even 'horrible and unexpected sights'. Cullen (1710-1790), Whytt's successor at Edinburgh, who is attributed with being the first to use the term neurosis (see Kaplan 1995), described insanity as a type of dynamic nervous disorder, which had symptoms such as memory impairment, false perceptions and strong emotional outbursts. This idea that social experiences could result in disturbance was also proposed by the French social reformer, Phillippe Pinel (1745-1826), who advocated careful listening to the patient's story to look beyond symptoms for some form of precipitating circumstance.⁸

In the nineteenth century, physicians and neurologists grappled with problematic patients, mostly women, who presented with pains and various symptoms, but had no identifiable lesion. These patients emerged from two levels of social strata. The first were the poor and disturbed who were admitted to the asylums. The second were those

⁷ See Dembe, A. (1996) *Occupation and Disease*. New Haven; Yale University Press. p. 44.

⁸ For an extensive treatment of the origins of hysteria and neurosis see Brown, T. M. *Mental Diseases*, in Bynum, W. F. & Porter, R. (1993) *Companion Encyclopedia of the History of Medicine*, London, Routledge. Phillippe Pinel, the French social reformer during the Revolution (Bicetre 1793 and Salpetriere 1795) is attributed with having initiated the liberation of the insane from chains, as well as using the asylum as a place of healing. In the same vein, William Tuke, a Quaker, founded the Retreat at York in 1796, where madness could be controlled in a religious and moral atmosphere.

who were well bred and/or more affluent, like members of the James family, who could afford to travel the world seeking the most modern cures in clinics and sanatoria. Women who developed symptoms of pain, paralysis, or fatigue, for which there was no organic explanation, attracted diagnoses of hysteria and neurasthenia, which were in one sense opposing attributions. The first was thought to originate in the psyche and the second in the soma.⁹

One of those affluent women seeking help in the clinics was the American Alice James, sister of the psychologist William James and the novelist Henry James, whose case provides an informative example of a nineteenth century encounter with medical ideas. Vague symptoms had plagued her most of her life and she was described by her brother William as having a 'nervous weakness'. Alice had her first experience of 'nerves', in her late teens, when she was described as easily excited, highly strung and 'nervous'. One of her many medical specialists, Dr Charles Taylor, believed that nervous activity drew energy from the body depleted her physical 'bank accounts', leaving her exhausted. In 1866 Taylor offered her motopathic treatments, which included massage, stretching and exercise.¹⁰

Around this time on the East Coast of America, neurologists like George Beard and Silas Weir Mitchell were refining the diagnosis of neurasthenia, which they believed was not a mental illness and did not require treatment in a mental hospital. James was diagnosed with neurasthenia and hyperaesthesia, to explain her morbid fears, headaches, exhaustion, constipation, loss of appetite, impotence, or fainting spells and spasms. She was treated with the Rest Cure by Silas Weir Mitchell, which required bed rest, feeding with milk, massage, listening to reading, and isolation. This isolation she found intolerable.¹¹ None of these interventions worked and Alice's suffering continued for many years until she was finally diagnosed with breast cancer by Andrew Clark and William Baldwin, which lifted her 'out of the formless vague'. The suffering and

⁹ Elaine Showalter expounds her feminist critique of shell shock in three works - *The Female Malady* (1985) London, Virago Press; Rivers and Sassoon: *Inscriptions of Male Gender Anxieties*, in Higonnet, M; Jenson, J., Michel, S. & Weitz, M. (eds) (1987) *Behind the Lines*, New Haven, Yale University Press; and *Hystories: Hysterical epidemics and modern media*. (1996) New York: Columbia University Press.

¹⁰ Strouse, J. (1980) *Alice James: A biography*. Boston: Houghton Mifflin. Physical activity was considered an antidote to the effects of inactivity in pastimes like reading novels that made women of able personality too excitable. Men could think calmly and sensibly without depleting the body, whereas women became too stimulated and excited by intellectual activity, which drained their nervous energy.

¹¹ See Strouse, op. cit.

nebulous symptoms of women like Alice James were defined as medical conditions, divorced from the environment from which they emerged.

The original diagnosis of neurasthenia is attributed to the American neurologist George Beard, who described it as early as 1868 as 'exhaustion of the brain (cerebrasthesia) and spinal cord (myellasthenia)'. In his view the nervous system was like a bank account that could be overdrawn, which easily occurred in the hustle and bustle of modern industrial society. Such patients could have itchy feet, sweaty palms, dyspepsia, and myclonic twitches while dozing off, and 'fatigue that was subjectively felt'. They had innumerable discomforts and pains, a dull feeling in the head, with intense feelings of fatigue and weakness. It superseded the earlier Victorian disease 'Brain fever'.¹² These conditions could be attributed to moral and behavioural causes, with some physicians and neurologists (including Freud) ascribing neurasthenia to deviant sexual practices like masturbation.

The significance of this discussion is that neurasthenia became one of the diagnoses used in WW1 and to into WW2. Discussion of neurasthenia is found in the WW1 literature, where Forsyth (1915) for example, observed that it was well known that the neurasthenia of civil practice, exhibited in lassitude, emotional depression, spinal irritation, pressure on the head, and dyspepsia, was caused by 'excessive onanism'.¹³

Hysteria, another diagnosis used in WW1, preceded neurosis as a formal diagnosis, has a complicated history and is linked, at least conceptually, with the notion of neurosis.¹⁴ As well as being a medical construction of a problematic condition, hysteria had the added element of mimesis, in that the symptomatology reflected the origin of the condition. Mutism, or the inability to speak for example, could be explained by an experience where the patient had been unable to shout when being attacked. Formal diagnosis of hysteria preceded the nineteenth century large-scale investigation of hysterical conditions. For example, both Mesmer (1734-1815) in Austria, and Braid (1795-1860) in Britain, are attributed with successful treatment of hysteria (see Kaplan 1995). The diagnosis of hysteria was mostly applied to women, whose pains were considered to move from one part of the body to the other, which led male physicians

¹² Beard, G. (1880). *A Practical Treatise on Nervous Exhaustion*, New York, William Wood. See Shorter, E. (1992) *From Paralysis to Fatigue*, New York, The Free Press.

¹³ Forsyth, D. (1915) Functional Nerve Disease and the Shock of Battle, *Lancet*, 25 December: 1399-1403.

¹⁴ An extensive treatment of hysteria can be found in Roy, A. (1982) *Hysteria*.

describing it as 'a disease of spinsters, whose dry wombs wandered around their bodies in search of moisture'.¹⁵

Many prominent physicians and neurologists studied hysteria, one of the most famous being Jean-Martin Charcot (1825-1893) at Salpêtrière, where some patients were victims of railway accidents. Charcot's hypothesis was that if a person experienced a sudden shock in an accident, he or she went into a temporary hypnoidal state and became suggestible to symptoms of physical injury.¹⁶ Charcot initially observed that a number of patients exhibited all the signs of epilepsy but he could find no organic basis for the condition, which he called hystero-epilepsy. Shorter (1992) argued that even though Charcot did diagnose and treat men, his main fascination was with women, and being primarily a clinician he would even examine ovaries in autopsies. Charcot claimed he could differentiate hystero-epilepsy from the 'true' epilepsy with his clinical 'magic', such as pressing on hystero-genic points 'which when touched would elicit marked physical and emotional reactions in patients where there was no organic dysfunction as in epilepsy'. In his Tuesday lectures a room full of male physicians would observe as a young woman when touched on the ovarian part of her body or under her left breast by an intern, would display:

the epileptoid phase, arched back, and then vocalizations - 'now let us see if she is ovarian' - [the intern then touches her ovarian region] - 'see how the attack is momentarily suspended by abdominal compression - a real epileptic would not do this'.¹⁷

Most of Charcot's subjects were working class women forced into poor and traumatic circumstances, but neither these circumstances, nor their personal history, were considered a factor in the etiology. One famous patient, Blanche, had previously been raped at knifepoint, but this was not considered relevant to her dysfunction. She was treated with drugs, controlled with the straightjacket, and subjected to solitary confinement. Charcot believed that a common mechanism, hysterical anaesthesia, accounted for all types of disorder, and this could be traced to heredity factors. Despite being recognised as a contributor to the understanding of psychiatric illness, Showalter

¹⁵ Richmond, Caroline (1989) Myalgic encephalomyelitis, Princess Aurora, and the wandering womb. *British Medical Journal*. 298; 1296.

¹⁶ See Hacking I. (1995) *Rewriting the Soul: Multiple personality and the sciences of memory*. Princeton, Princeton University Press, who pointed out that there was 'far more happening beyond the precincts of Charcot's wards and his famous lectures', such as the disastrous Franco-Prussian War and political upheavals in Paris.

¹⁷ Porter, Roy (1991) *The Faber Book of Madness*. London: Faber and Faber, p. 389.

claims that 'he [Charcot] took away their dignity and their hope'.¹⁸ The practice of Charcot at Salpêtrière, which was eventually described as a circus, declined after a number of serious challenges were made against his methods and conclusions.¹⁹

Railway Spine was another important precursor to WW1 and shell-shock, as it was the first traumatic injury 'epidemic' to cross the boundary of physical trauma into psychic trauma, and opened up debate on the psychogenic origin of physical symptoms. The iron rails of nineteenth century Europe provided fertile ground for ideas about traumatic neurosis.²⁰ This new form of transport, much faster and fiercer than any previous form of conveyance, was carrying 507 million passengers by 1875, and accounted for 1200 deaths and 13 000 serious injuries between 1830 and 1865.²¹ Trains introduced a new element into the nineteenth century psyche, in that people could either become frightened by them, or be involved in accidents that would leave psychic scars.²² Herbert Page, Charcot and Oppenheim separately explored the mysterious conditions that emerged, and added to the body of knowledge on conditions arising from traumatic events. Oppenheim, who preferred preferred to call it 'railway brain' introduced the term traumatic neurosis, where neuro-physiological was the explanation of disturbed behaviour. The diagnosis was assigned to the passive train passenger who was physically shocked in a sudden movement or a collision, and subsequently experienced mental reminders of the event and was often unable to resume normal functioning.²³

Maty first diagnosed 'Railway Spine' in a litigation case of palsy after an accident in a coach in 1761. He argued that severe concussion could impact on the spinal cord and

¹⁸ Since I do not have access to original Charcot material I have relied primarily on the sources quoted in Showalter (1997) and Porter (1991).

¹⁹ Shorter (1992) provides a vivid description of this 'circus' in Chapter 7 of *From Paralysis to Fatigue: A history of psychosomatic illness in the modern era*.

²⁰ For extended description of neurosis see Oppenheim, J. (1991) 'Shattered Nerves'; *Doctors, patients, and Depression in Victorian England*. Oxford, Oxford University Press; and Haller, John S. & Haller, Robin M. (1974) *The Physician and Sexuality in Victorian America*, London, University of Urbana Press.

²¹ See Dembe (1996), op cit. pp. 107-109.

²² For example Freud, could explain his phobia for travelling on trains after he discovered under analysis that he had seen his mother naked during a train trip when he was aged 2 years. Charcot and Oppenheim recorded other cases of patients seeing naked mothers on trains. See Drinka, F. (1984) *The Birth of Neurosis: Myth, malady and the Victorian*, New York: Simon and Schuster; and Laughlin, H. (1967) *The Neuroses*, Washington: Butterworths.

²³ This was also the age of increased medicalisation of the human condition. For a recent discussion of this see Hacking (1998) *Mad Travellers: Reflections on the reality of transient mental illness*, London, University Press of Virginia.

produce behavioural symptoms. John Erichsen referred to an 'obscure injury of the nervous system' in the early 1880s, but suggested that the abnormalities were of the sympathetic, not the central nervous system. Herbert Page published *Injuries of the Spine and Spinal Cord Without Apparent Mechanical Lesion* in 1883 in which he reviewed Erichsen's 230 cases and produced an analysis of 234 of his own cases. He discarded the notion of railway spine and said there was no evidence for sub-acute meningitis and found other attributions for these symptoms such as a history of syphilitic infection.²⁴

In Britain, the *Campbell Act* of 1864 excluded psychological damage from compensation claims, but the search for explanations of traumatic injury continued. In the discourse that arose, malingering and functional impairment were central points of contention. Some new technologies, such as post-mortem and mutilation of animals, allowed more minute observation of the body to find organic explanations, and provided tools for separating the malingerer from the genuine sufferer. Railway Spine, a diagnosis for maladies arising out of traumatic accidents, was later acknowledged as a conceptual precursor to shell-shock, such as Ross (1941).

A discussion of precursors is not complete without some reference to Freud (1856-1939) who had a profound but largely indirect influence on ideas on the neurotic war casualty, but had no experience in the military field. Freud's contribution was to provide a coherent if not scientifically valid set of principles governing the mental processes to explain abnormal behaviour that had no organic foundation. He originally studied under Charcot in 1885 and is commonly attributed with the development of the most comprehensive theory of neurotic illness, and has been referred to as the father of neurosis. His ideas changed over time, but his notion of conversion disorder is relevant to an understanding of war neuroses. He argued that the fatigue neurasthenic conditions were conversion disorders, and that a neurosis was a 'flight into illness' as a way of coping with the conflict between fear and duty. By 1906 Freud had described functional disorders as 'somatic compromises between a forbidden impulse and the defence against it'.

Towards the end of WW1 he accepted that patients 'exhibited severe disturbances in their mental life' after 'frightening and dangerous experiences such as railway

²⁴ See Shorter, *op cit.*, p. 114, and Trimble, M. (1981) *Post-traumatic Neurosis: From railway spine to whiplash*. New York: John Wiley & Sons, Ch. 1.

accidents'. However, the neuroses of war differed not in the nature of the frightening experience, but in the nature of the conflict in the ego. The 'conflict was between the soldier's old peace-time ego and his new war-like one'. He attributed ongoing effects of traumatic experience to repression, which 'lies at the basis of every neurosis'.²⁵

Freud acknowledged the importance of memory, as well as the mimesis exhibited in hysteria. Traumatic memories that were dissociated from normal consciousness at the time of the trauma, could manifest themselves in 'somatic enervation' at a later time. Psychoanalytic techniques provided a key to release unconscious wishes and drives that led to the symbolic somatic representations (hysteria). Such explanations were considered extremely valuable in explaining military casualties.

W. H. Rivers, for example, was heavily influenced by Freud and modelled much of his own thinking on his ideas. Rivers is quoted as saying that during the war neurologists were presented with 'an unexampled opportunity to test the truth of Freud's theory of the unconscious'. Rivers' interpretation of dreams for example substantially followed a Freudian line. Dreams were expressions of earlier repressed wishes or resolution of conflicts. War and battle dreams, according to Rivers, differed 'from the general run of dreams', but 'falls in line with the rest in regard to the infantile form where it finds expression'.²⁶ At least such a theory would give credence to the experience of soldiers and an alternative to some form of moral degeneracy as the explanation of dysfunction.²⁷

WORLD WAR ONE AND THE BRITISH EXPERIENCE

Against this historical background, the scientific and medical community began to turn its attention to the problem of the mentally damaged soldier during the Great War of 1914-18. The war presented psychiatry with an opportunity to expand and establish itself as a discipline, because it presented medical and military authorities with a psychiatric epidemic never encountered before. This was partly a function of a new type of army in the post-industrial age that required trained and healthy manpower. It was also an age when medical intervention could ensure a relatively physically healthy

²⁵ Freud, S. (1955) *The Complete Psychological Works of Sigmund Freud*, Vol XVII (1917-1919) Translated and edited by Strachey, J., pp. 207-215.

²⁶ See Butler, A. (1943) *The Official History of the Australian Army Medical Services in the War of 1914-18: Vol III: Problems and Services*. Canberra: Australian War Memorial, p. 75, and Rivers (1918) The repression of war experience. *Lancet*. February, 173-177.

²⁷ See Gay, Peter (1988) *Freud: A life for our time*, London: W. W. Norton, p. 376.

workforce, through public health practices such as inoculation. The discourse about shell-shock was far from unified, and took place in enemy ranks as well. On both sides, the purpose of the discourse was to improve military efficiency, and reduce losses. Like the British and French, the German doctors were also engaged in trying to understand and address the problem of heavy losses through psychiatric casualties on each side of the Western Front. Lerner (1996) explored these same issues among German soldiers 1914-21.²⁸,

In the British, French, Canadian, and German armies, shell-shock became the psychological plague of the early part of the twentieth century. The war was the first event of the century to test the ideas available on the unwounded casualty. In the first few months of the Somme campaign alone, the British Expeditionary Force had nearly 35 000 neurotic casualties, and Canada approximately 4 500. It was reported that 80 000 men passed through mental hospitals, which along with the horrendous physical casualties, represented huge manpower losses and posed a serious threat to morale (Stone 1985). These losses, coupled with heavy physical losses (e.g. by Christmas 1914, 85 000 of the British Expeditionary Forces had been killed or wounded), required a dramatic response. This 'epidemic' was costly both financially and militarily. The need to maintain a cohesive fighting force with high morale and minimum losses, meant that army medical authorities could not ignore or incarcerate these casualties as they could in civilian practice. Military solutions, such as execution for desertion or cowardice, were ineffective and counterproductive (see Brook 1999, and Babington 1997).

There was no pre-existing body of knowledge available to address the problem, at any level. In the years leading up to WW1 there was no single coherent body of knowledge on war related stress. There were a number of largely separate streams of knowledge and practice developing in Britain, France (cf. Roussy and Lhermitte), the United States and in Germany, to explain the non-organic injuries and maladies, and

²⁸ Lerner (1995) asserts that the framing of the symptoms of the German soldier by German doctors was shaped by the pathologies of industrialisation. Psychiatric intervention had the dual role of restoring men to military duty and productive work. Patients were thus subordinated to the 'logic of industrial rationalisation'. For an extensive critique of German medicine and war, see Berg, M. & Cocks G. (1997) *Medicine and Modernity: Public health and medical care in nineteenth and twentieth century Germany*, Cambridge: Cambridge University Press; and Cocks, G. (1998) *Treating Mind and Body: Essays in the history of science, professions, and society under extreme conditions*, London: Transaction Publishers.

when war broke out these were enlisted by military authorities.²⁹ However the mind specialists were unready for the war. W. H. R. Rivers stated in his introduction to *Instinct and the Unconscious* in 1920, that:

the medical administration of our own and other armies was wholly unprepared for the vast extent and varied forms in which modern warfare is able to upset the higher functions of the nervous system,

and

the outbreak of war found the medical profession with no common body of principles and measures as those which enabled Medicine and Surgery to deal so successfully with the more material effects of warfare.³⁰

The theories and practices adopted in WW1 were adaptations of those already available in civil practice, not developments arising out of war experience with the casualties of war. These ideas informed the early diagnosis of shell-shock, as well as the later diagnoses of functional and neurotic disorders. The effect of the war was 'to bring neuroses into the mainstream of mental medicine and economic life, and set psychiatry within the social fabric of industrial society'. (Stone, 1985, p. 266).

The beginning of the war proved fertile ground for psychodynamic ideas, which had replaced traumatic shock as explanations of the effects of trauma. These ideas were canvassed in a lecture to the Royal College of Physicians of Edinburgh in 1915 Dr W H Stoddart. He outlined the state of civil psychiatric medicine at the beginning of the war, and focussed on fundamental psycho-dynamic principles such as instinct, psychical determinism, the unconscious, complexes, and conflict, most of which could be understood as conflicts between herd and individual instincts, particularly sexual. He paid homage to Freud, as well as Hughlings Jackson, for their contribution to the current knowledge. The diagnostic terms anxiety neurosis, psychoneurosis, hysteria, and neurasthenia, described by Stoddart, were to become commonplace in military usage by

²⁹ The most significant publication conveying these 'foreign' ideas was a translation by Christopherson of *The Psychoneuroses of War* by Roussy, G & Lhermitte, J. (1918). In the editorial introduction, Auldren Turner, pointed out that the authors had set out in a logical way the causes of the functional disorders that had become known as shell shock. He reinforced the view that emotion was the fundamental causation of psychoneuroses. This emotional element manifested itself in hysterical paralysis, contracture, tremor etc, which Lhermitte and Roussy observed in soldiers of the French Army. War experience was only significant as a contributing factor in the development of psycho-neurosis if there was a clear evidence of true physical concussion, but only when there was no emotive content. The French Army had established Neurological Centres to provide early intervention and prevent the entrenchment of symptoms. Cure was dependent on the correct atmosphere and 'the strong will' of the physician who employed psycho-analytical and re-educative methods.

³⁰ Quoted in Butler (1943), op cit., p. 73.

the end of the war. Freud's concept of neurosis, and his techniques for uncovering the unconscious elements of a soldier's experience would contribute to unravelling paralysis, spasms, mutism, blindness, and the like, which predominated among both officers and ranks.³¹

At the outbreak of WWI there was no established army psychiatric service, nor were there any experts trained in military medicine. Military authorities had to rely on recruiting or co-opting experts from the civil field, who virtually had to learn on the job. Some of these neurologists and physicians, like Henry Head who treated Virginia Woolf between 1913 and 1915, had been involved in treatment of disorders in civil practice. Others were drawn from more remote academic areas such as the medical anthropologist W. H. R. Rivers from Cambridge, who volunteered on his return from an anthropological expedition in 1915. At the age of 51 Rivers was able to fulfil the earlier desire expressed in 1892 to 'go in for psychiatry'. He initially treated shell-shocked men at Maghull Military Hospital and later at Craiglockart War Hospital. C. S. Myers, a student of Rivers at Cambridge who had accompanied Rivers on the original Torres Straits Expedition of 1898, went to France as a civilian doctor and was later commissioned as Lieutenant Colonel with the Royal Army Medical Corps.³² Head, Myers, Seligman, Pear, Elliot Smith who became prominent 'neurologists' in WW1, all had close academic associations with Rivers prior to the war.

Medical ideas were implemented at two levels – in the field for immediate casualties, and at home in dealing with repatriated casualties.³³ In Britain, a system of hospitals was established to cater for casualties away from the front. One of these was Craiglockhart Hospital in Edinburgh, where W. H. Rivers encountered hundreds of damaged officers including Siegfried Sassoon and Wilfred Owen. The physicians and neurologists who took on these positions expanded their existing frameworks in the light of experience. They acknowledged they were dealing with new behaviour but applied existing labels and treatment frameworks.

³¹ Stoddart, W. H. B. (1915) *The New Psychiatry*. *Lancet*, 1: 583-590. Neurasthenia and sexual proclivities seemed to have a special fascination for Stoddart, who reminded his audience that in Fatigue State 'without exception, there is always to be found one essential etiological factor – viz. sexual excess'. In the majority this took the form of masturbation.

³² See Stone (1985), and Slobodin (1978).

³³ I am not dealing directly with the mentally damaged soldier who was treated as a deserter or a coward. As stated elsewhere, Brook (1999) and Babington (1995) deal with this in detail. It is clear from recent analysis that many soldiers court martialled and/or shot were traumatised.

For example, Forsyth (1915), who was a physician at Charing Cross Hospital in London, observed that psychiatric casualties of war had 'become unprecedentedly numerous', and could not be explained in terms of compensatory gain or grievance against the army. For him, WW1 presented a unique opportunity to re-examine neuroses and add to the body of knowledge about etiology and treatment and revisit diagnoses such as railway spine. He discounted the notion of traumatic neurosis of Oppenheim because it 'lacks clinical foundation', but he disagreed with many of his peers in saying that 'these traumatic cases are certainly not the neurasthenia of civil practice'.³⁴

Forsyth concluded that, although diagnosed with neurasthenia and hysteria, these men had different characteristics from the excessively fatigued. They were 'shaken in nerves, jumpy, physically exhausted, tense, worried, starting up at night, emotional, irritable, having fearful dreams of the horrors they had witnessed or undergone, and were unable to concentrate or remember'. These symptoms were 'directly referable to the strain of active service' (p. 1399). He could identify the types of stressors – the strain of shellfire, the heat of explosion, and suffocating fumes, all of which violently assaulted the senses. This assault was exacerbated by 'the shrieks and groans and the sight of the dead and injured'. The effect of such experiences was very diverse even though men were 'exposed to the same strain'. The psychic importance of such an event is that it 'involves the risk of death.' How could similar experiences affect men differently? The explanation could be found, through the application of psychodynamic theory, in some form of inherent individual weakness. According to this theory, the individual could protect himself against this fear with the instinct of self-preservation and an act of will, but those of previously 'nervous disposition' find this control more difficult. The strain becomes more intense and in the final act even a small event can push him over the edge.

For Forsyth, this etiological understanding provided a basis for intervention. The affected soldiers needed first to be sorted into acute and less acute cases. The less serious cases could be 'cured' with physical rest, mental quiet and good food, but there should be no other intervention at that stage, not even talking about the experience, and men should be left to themselves without being worried by medical histories. They

³⁴ Forsyth, D. (1915) Functional nerve disease and the shock of battle. *Lancet*, 15 December, 1399-1402.

could even go away to the country. These less acute cases would generally return to normal functioning. They could be helped with an 'opportunity to talk freely' and be re-educated at a later time. Those who did not respond to this mild intervention, needed further treatment and extended psychotherapy. Their fundamental reason for breakdown, could only be uncovered with psychoanalysis. 'The medical problem is now the psychical development of the patient since childhood; and further treatment must follow psycho-analytic lines – the patient who has not been able to regain his self-control after three to four months, is in need of extraneous help.' In the final analysis the key to recovery was overcoming the anxiety about returning 'to the dreadful scenes at the front'.³⁵

Various treatments emerged. Ernest White, Inspector of shell-shock and neurasthenic patients in hospitals under the Western Command for the Royal Army Medical Corps (1916-1918), used shell-shock to classify young men, aged 15 to 18 years, who presented with:

Intense suffusion of face, free perspiration, widely dilated pupils, rapid heart's action with weak pulse and cold clammy extremities, terminating in a hysterio-epileptic seizure with marked clonic spasms of comparatively short duration. [This was] Shell shock - the outcome of the terrible explosives now used in the war and the continued mental and physical strain of trench warfare. Tremors may affect all body parts. The coarse tremors are often simulated by the malingerer or skrimshanker; the fine they cannot affect.³⁶

He recommended that these men not be pampered, and enumerated ten principles to observe in treatment. This may have been a warning against treatments such as the Weir Mitchell Rest Cure, which required complete bed rest, regular feeding, isolation and massage (Olfson 1984). The White treatment principles included: open air, exercise, avoiding crowds, going to bed before 10 pm, avoiding all alcohol, maintaining a regular simple diet, avoiding cold baths, having no electricity treatment nor massage, learning self-control and developing self-confidence through re-education. Above all, while on leave, they should 'stay in the country in high altitude, and avoid noise, worry, explosives and gunfire; never travel by train, car, nor tram' (p. 422).

Another specialist, William Aldren Turner, Physician to King's College Hospital and the National Hospital for the Paralysed and Epileptic, became a temporary Lieutenant-Colonel in the Royal Army Medical Corps. He adopted a more straightforward approach

³⁵ Forsyth, *op cit*.

and in 1915 described men in the Base Hospitals in France to be of ‘general neurasthenic character’, whose condition was attributable to ‘exhaustion of the nervous system’, and some cases were comparable to the ‘hypnoidal state of civil practice’.³⁷

As the war progressed, explanations of dysfunction centred on individual vulnerability and constitution. For Mott (1918), who worked at the Maudsley extension of the 4th London Hospital, the two most important war psych-neuroses were hysteria and neurasthenia. Adapting Dejerine’s definition of neurasthenia, Mott maintained that three symptoms were required for true neurasthenia – continued emotivity, persistent neural exhaustion and preoccupation. The challenge was to explain how fear could explain the continued emotivity. To do this Mott called on Walter Cannon, not Freud. According to Cannon activation of the adrenal and thyroid glands produced ‘muscular energy’ and resulted in either flight or fight. This adrenal excitation continued some individuals when subconscious fears and images emerged in dreams. He concluded that ‘there is sufficient evidence to prove that contemplative fear or terror has left a deep impress on the minds of these men and produced a continual state of fear emotivity’. Why then did not all soldiers exhibit the same levels of emotivity and fear? Mott believed that ‘by far the most important factor in the genesis of neurasthenia is an inborn or acquired tendency to emotivity’ (p. 127). The fears of war should not be unique, since ‘war psycho-neuroses neurasthenia and hysteria do not differ in any essential way from those met within civil life, except they are coloured and determined by war experience’. The only distinguishing feature of war psycho-neuroses was they were not, as they were in civil life, associated with ‘sexual disorders, sexual abuse and fears regarding impotence’. Men who broke down ‘owe their condition to an inborn temperamental neurotic condition’, which was more likely to occur in conscripts. The acquired tendency to emotivity was a result of the ‘shock and strains war’ lowering the resistance of individuals. The crucial mechanism was fear that acted on a ‘pre-war emotive brain’. Exhaustion was a result of the conflict ‘which has been going on

³⁶ White, Ernest (1918) Observations on shell shock and neurasthenia in the hospitals in the Western Command. *British Medical Journal*, April 13; 421.

³⁷ Turner, W. A. (1915) Remarks on cases of nervous and mental shock observed in base hospitals in France. *British Medical Journal*, May 15; p. 833

continually in his mind between the self-conservative instinct and the moral obligation of duty and patriotism'.³⁸

Underlying this psychological conflict was a biophysiological struggle being played out in the 'lower cerebro-spinal and sympathetic secreto-motor, bulbo-spinal, and autonomic centres'. This underlying action explained hysterical phenomena such as tics and paralysis more effectively than Freudian psychological mechanisms. These entrenched mechanisms manifest themselves during sleep, when 'vivid imaginings of their previous experiences are arousing defensive and offensive reactions in the face of the imaginary enemy'. Mott concluded that psychotherapy aimed at unraveling the relationship between dreams and disorders of the mind and body, had limited chances of success.

In his second paper, (*The Psychology of Soldiers' Dreams*) delivered to the psychiatric section of the Royal Society of Medicine on 18 January 1918, Mott proposed that an 'incident of war associated with an emotional shock is graven on the mind', and recurs continually 'in a vivid and terrifying manner in their dreams, half-waking state, and in some cases even in the waking state, in the form of hallucinations' (p 169).

A more eclectic theory emerged in the work of Elliott G Smith, Dean of the Faculty of Medicine and Professor of Anatomy at the University of Manchester, and T. H. Pear. Their monograph of 1918 provided an important summary of the kinds of ideas that were around towards the end of the First War. The second edition was partly a response to critics of the first edition who claimed that they neglected to mention a number of important treatments in technology, such as massage, electricity baths etc. Smith and Pear advocated a counselling model in which incorporated intimate, personal, confidential discussion between the patient and doctor during treatment. Sisters and nurses could provide firm care, but none of the specific responsibilities of doctors should be delegated to a nurse. Therapy should consist of psychological analysis and treatment by persuasion. They claimed that 'history of the trouble must unravel in conversation', and without this emotion emerging in the treatment, there is no psycho-neurosis. The characteristics of shell-shock, which required exposure to severe

³⁸ Mott F. W. (1918) War psycho-neurosis. (1) Neurasthenia: the disorders and disabilities of fear, *Lancet*, I, 25 January: 127-129. Mott, F. W. (1918) War Psycho-neurosis. War Psycho-neurosis (II) The Psychology of Soldiers' Dreams, *Lancet*, I, 2 February: 169-172

emotional disturbance involving anxiety and suppressed fear, was instability and exaggeration of emotion, not the intellect.

Smith and Pear argued that the 'discovery' of shell-shock in WW1 stimulated later reforms in the mental health system that had been stalled by professional inertia. These had been recommended in a damning report on the status of psychiatry in 1914 by the Medico-psychological Association. When the war broke out, many of the first attacks of insanity were attributed to syphilis or alcohol, just as they had been in the lunatic asylums of the nineteenth century. However, 'the stress of war has compelled us to see matters in another light' and opened up the idea that mental disorders were recoverable.³⁹

Before pursuing the British experience further, I will briefly address the situation on the enemy side. I will not discuss American ideas at this point, since they played little part in the British practice.⁴⁰ The other stream of ideas was on the other side of the Western Front in the German experience of dealing with the equivalent of shell-shock in WW1.⁴¹ Like some British experts (cf. Maudsley 1895) the majority of the German medical profession, looked to the WW1 as an opportunity for a great therapeutic cleansing of the mental malaise and neuroses that had descended on Europe since the Industrial Revolution.⁴² The war to them was to be a great laboratory for all kinds of medical learning, including psychiatry. The euphoria that the war was going to produce a much stronger, fitter, mentally healthier race and nation soon waned as large numbers of casualties began appearing in German medical centres.

One reason for the depth in the pre-war German discourse is that psychiatry was a much more established profession and there was serious research in psychiatry and neurology. When mental casualties appeared there were a large number of doctors involved in the business of trying to understand hysterical wounds and many of the

³⁹ Smith, G. & Pear, T. (1918) *Shell Shock and its Lessons*. Second edition. London; Longmans.

⁴⁰ I will be referring to Kardiner's contribution on Traumatic neurosis in the next chapter.

⁴¹ For this review of German ideas I rely heavily on Lerner, P. (1998), *Hysterical Men: War, neurosis and German mental medicine 1914-1921*, University of Ann Arbor: USA.

⁴² Maudsley provided the initial funding for the establishment of Maudsley Hospital in Inner London, which later became a specialist centre for shell shock cases in WW1 and war neurosis in WW2. He believed at the end of the nineteenth century that 'idleness, luxury and self-indulgence' contributed to insanity and also believed that war could regenerate a society and further human progress. See Maudsley (1895) *Pathology of the Mind*. London: MacMillan.

26 300 doctors supporting the war effort tended nearly six million cases of wounded soldiers and 21.5 million cases of illness.⁴³

There are a number of common threads in the German and British experiences in WW1. The first was the notion of an epidemic of mental disease, which could infect an army and destroy it as efficiently as a physical disease such as malaria or typhoid. Another commonality was the adoption of the term hysteria, which was the most common diagnosis for cases of 'shell-shock'. The central issue in all the debate was causality. Was the origin in the nature of the traumatic event or the constitution of the person?

In Germany there was an established tradition of recognition of traumatic neurosis. Between 1899-1926 for example, the German Imperial Insurance Company acknowledged traumatic neurosis as a compensable disease. At this time there was increasing acceptance of a nosology of mental disease. For example from 1883, Kraepelin published the first edition of *The Textbook of Psychiatric Diseases*, the culmination of years of meticulous observation, in which he classified mental disease on the basis of outcome. This provided a basis not only for diagnosis but also for prognosis, a tool not previously available to specialists. Shorter (1997) claims that developments like these were a greater contribution to the understanding of disorder than Freud.⁴⁴

Oppenheim (1811-1917) was a significant contributor to the understanding of psychic wounds and trauma, although he was marginalised in much of the discourse. His early (1881) proposal of traumatic neurosis as an organic lesion was criticised on the grounds of the methods he used and the objectivity of his diagnoses and he eventually lost his academic post in 1892. Two years later he published his monograph on traumatic neuroses, in which he acknowledged a psychic element in reactions to emotional shock. He is quoted as saying, 'a sickly mind can create a lasting illness by reacting abnormally' (see Lerner p. 62). Nevertheless, he was the forerunner in establishing traumatic neurosis as a category distinct from other mental illnesses.⁴⁵ Oppenheim and traumatic neurosis remained virtually dormant until 1914 when he was appointed in charge of a military hospital established in the former Berlin Museum of

⁴³ Lerner, op cit. p. 36.

⁴⁴ See Shorter, E. (1997) *A History of Psychiatry*. New York: John Wiley & Son. It is argued that the 1899 edition provided the basis for the American Psychiatric Association Diagnostic and Statistical Manual.

⁴⁵ Oppenheim believed that being a Jew was a disadvantage and had brought the wrath of many of his colleagues against him (Lerner, 1995).

Applied Arts. His observation of traumatised soldiers confirmed his belief that organic or neural damage was the critical factor in the development of neuroses. Oppenheim's ideas were again rejected by his colleagues, particularly in a meeting of the Berlin Society for the Psychiatry and Nervous Illness on 14 December 1914.

A whole range of people became involved in this debate, including Bonhoeffer, who argued that hysteria was a consequence of the mental disposition of a person and the development of abnormal reaction was subject to the will of the person. The problem was that there was no objective way of making diagnostic decisions in this condition. The exploding shell was only a problem if the soldier's ideas and desires converted the shock and fear into illness. The inability to walk and sensory irregularities could all be explained through this internal interpretation. As in Britain the German specialist medical personnel achieved control over the problem of nervous soldiers. They argued that the mild hysteric 'was no longer deemed worthy of compensation and that there should be no reinforcement for bad nerves and hysterical affects'.

In this context Freud can be revisited, even though he had little direct influence on German ideas. His single work on war neuroses, originally published in 1919, was only nine pages long, including an appendix of five pages. For some of his material he relied on secondary sources such as Eitington.⁴⁶ While he saw neurosis as a 'genuine' condition, he considered it was primarily a disease of the conscript who was escaping into illness for secondary gain. He was disappointed that in 1919 'the greater number of neurotic disturbances brought about by war simultaneously vanished'. This deprived him and others of the opportunity to study these 'affections'. Despite his seemingly cursory treatment of war neuroses his ideas about psychic structure and mechanisms helped military medical experts make sense of a chaotic world of war. The Great War became a 'vast laboratory in which to verify psychoanalytic propositions'. There were far more experienced practitioners, for example Stern, Sauer and Mohr who either worked in field hospitals or general hospitals treating shell-shocked German soldiers.

On the whole, Lerner argued that Freud was not a great influence on German psychiatry in WW1. The 'insistence of Freud and his followers that a sexual aetiology underlay post-traumatic neuroses was almost universally rejected in German mental medicine' (p. 412). Rather, the German doctors relied on their previous experience with

⁴⁶ For example in Vol VI of *The Psychopathology of Everyday Life* (Strachey edition, 1968) Freud referred to the case of Lieutenant X from Eitington (1915), to illustrate the psychogenic nature of traumatic war neurosis (p. 114).

accident hysterics to explain the behaviour of men on the Western front. There is a very close parallel between the German and British views, in the practice of attributing dysfunction to psychogenic characteristics of the individual rather than the pathological nature of war.

Freud had an opportunity to clearly state his position on war neurosis at a German Commission of Inquiry into the practice of a Doctor Wagner-Jauregg, after complaints about his treatment of a soldier called Kauder, whom Wagner regarded as a malingerer. The Inquiry provided a forum for examining ideas on the etiology of neurosis, the difference between civil and military conditions and the efficacy of treatments. The extreme form of treatment was the use of electricity, which had a number of prominent advocates, such as Yealland in Britain and Kaufmann in Germany. These faradic treatments provided an antidote or aversive stimuli to the intolerable experience of war. The electric shock, when applied in sufficient force, would 'drive the patient out of his illness' and back to face the terrors of war. Electricity was a more efficient method than lengthy psychotherapy with encouraging results at Posen. The German, Austrian and Hungarian Army commands had been planning to set up more centres along psychoanalytic lines. Wagner argued that 'psychoanalysis often takes God knows how long, and that is why this method is not useable in war'.⁴⁷

As an expert witness to the inquiry, Freud outlined the state of knowledge about war neuroses, and referred to civilian patients, who after experiencing 'traumas (frightening experiences such as railway accidents)' suffered 'severe disturbances in their mental life and activity'. The war had produced an 'immense number of these traumatic cases'. For Freud, the key to understanding the condition was in the personality of the traumatised rather than the severity of the trauma. Civil neuroses could explain war neuroses – they could be traced to disturbances of emotional, historical origin, which were unknown to the patient, and could not be attributed to conscious malingering.

Freud did agree with Wagner on the etiology of war neuroses and only disagreed with the manner of treatment. Of major interest here is Freud's critique at the Commission on the use of medical knowledge to serve military purposes. He pointed out that electrical treatment was only serving a military purpose and that in fact had no lasting effect and soldiers, who soon relapsed. This high rate of recidivism only caused some German doctors to increase the charge to unbearable levels, even to the point of

death in some cases, which was the reason for the Inquiry. In his interrogation at the Commission, Freud reiterated his position that 'all neuroses are a flight from the conditions of war into illness. This term originated with me, and medical science has accepted it' (pp. 58-59). He went further, describing medical personnel as 'machine guns' behind the front line, driving back those conscripted men who had fled.⁴⁸

The effect of the attention on psychogenic origins was to shift the therapeutic focus away from the business of war to individual personality and ego dynamics. Freud argued that the real problem was that war triggered childhood fears and experiences, which after the event could be released by catharsis. A Freudian approach offered a safer and more attractive alternative to the harsh physical treatments such as those of Kaufmann and Wagner-Jauregg. Dream interpretation, association and cathartic hypnosis (a kind of psychoanalytic x-ray) provided therapists with tools. Cathartic hypnosis, for example could reveal the traumatic events ('mine the unconscious') and make the association that lay beneath the neurosis.

Freudian explanations are found in British practice in various forms. Dillon (1919) for example, described his treatment of what he termed 'composite neurosis', citing the case of a 23 year old stretcher bearer who had been in France for about a year and was one of a stretcher squad that was blown up. The three others in the squad died. The soldier was shaky and nervy for some time and after a short rest away from the line he returned where he again 'lost his nerve', and was referred for psychiatric treatment. Dillon reported that he had no obvious sign of a pathological background and apart from a sleep-walking sister, had a stable family background. The real clue to his breakdown was revealed by analysis of a single dream. The source of vulnerability to war trauma was the conflict between his strong love for his mother and his attachment to his fiancée, who was of lower status and not approved of by his mother. Dillon concluded from his analysis that 'as the nature of the condition was rendered clear it became evident that the symptoms expressive of war strain – the shakiness, loss of nerve under fire, etc – were of minor importance in comparison with the mental conflict seen to be dependent on causes wholly antecedent to the war conditions'.⁴⁹

⁴⁷ Eissler, K. R. (1986) *Freud as an Expert Witness: The discussion of war neuroses between Freud and Wagner-Jauregg*. Connecticut: International Universities Press, p. 67.

⁴⁸ Eissler, op cit. The exchange between the chairman, Freud and Wagner-Jauregg is reported over pages 20-74.

⁴⁹ Dillon, F. (1919) The Analysis of a Composite Neurosis, *Lancet*, 1: 57-60.

The main British forum to examine the functional and nervous diseases of WW1 was the British War Office inquiry of 1920, chaired by Lord Southborough. The fourteen member committee included Frederick Mott and Aldren Turner, who had both contributed to the literature on shell-shock. The Inquiry opened 7 September, 1920, at which time there were 65 000 ex-servicemen drawing disability pensions for 'neurasthenia' in Britain, and 9 000 of those were still in hospital. The committee met 41 times and 59 witnesses were examined. The terms of reference were:

To consider the different types of hysteria and traumatic neurosis, commonly called shell-shock; to collate expert knowledge from service medical authorities and medical profession with experience in the war, with a view to recording for future use the ascertained facts as to the origin, nature, and remedial treatment, and to advise whether by military training or education, some scientific method of guarding against the occurrence can be devised.⁵⁰

The resulting report in 1922 was a significant document in consolidating the ideas about war and neurosis. It was an opportunity to integrate the knowledge developed during WW1. The document was an important marker in the establishment of psycho-medical dominance in the description and treatment of psychological consequences of war service. It effectively put an end to the organic attribution of traumatic neuroses in shell-shock and enshrined the nosology of the time for mental disorders. It had the effect of discounting any possibility of attributing current symptoms to a neurological lesion and established the psychiatric view of mental disorder.

The Inquiry assembled most of the significant experts in medicine, neurology and psychiatry, with experience in dealing with mental casualties in WW1. Many of the 59 witnesses had been initially recruited or coopted into the war effort from civil practice to address the problem of the major loss of manpower from mental breakdown at the front. Witnesses to the Inquiry included experienced specialists such as Henry Head, former neurologist in the Royal Air Force Hospital, and William Rivers, consultant at Craiglockart Mental Hospital, who had both been significant contributors in the literature. Others to appear were Hurst and Roussy (the latter a consultant to the French Army). Four former patients also contributed. Some notable absentees were T. A. Ross, J. R. Rees, C. S. Myers, consultant psychologist to the Army in France and Ernest White, Inspector of Shell Shock and Neurasthenic patients, RAMC 1916-18.

⁵⁰ Southborough, Lord (1922) Report on the Committee of Inquiry into "Shell-shock". London: Wyman & Sons, p. 3.

Myers explained in his biographical work (1918) that he was very disappointed with the lack of recognition given to the members of the neurological service who were engaged in a duty 'far more trying and exhausting than that of ordinary operating, fracture setting'. From his post-war Cambridge laboratory, he declined the invitation of the Shell-Shock Committee because 'the recall of my past five years of work proved too painful for me to accept the subsequent invitations'.⁵¹ Myers used the term shell-shock but considered that it was 'the result of functional dissociation arising from loss of the highest controlling functions', and was optimistic about a cure in most cases. He also maintained that there was a category of disorder that was explained by organic damage, but in the main he believed that the 'war neuroses are to be regarded as the result of functional dissociation arising from the loss of the highest controlling mental functions' (p. 51). He believed that there was no agreement on just how this condition arose, nor was there any foolproof way of restoring function. 'Those of us who have had most experience in war neuroses, are generally agreed that different physicians achieve different degrees of success, according to their particular mode of use of the same treatment, and that there is hardly any form of treatment recommended that has not its value in appropriate cases.'⁵²

To return to the Southborough Inquiry, members of the committee came to a consensus that shell-shock was a broad term to cover any form of 'functional nervous incapacity', and recognised 'from the outset that the term "shell-shock" was wholly misleading'. They 'disliked the word intensely', and declared that it should only be used in 'concussion cases', and for a 'nervous breakdown in the line'. Army neurologist W Johnson expressed a common view that 'war produced nothing new in psycho-neurosis' (p. 81). Mental disorder was a state of persistent or recurring fear, 'which overrides the self-control of the individual', was a blight on troop morale, and 'shell-shock or war neurosis was a very contagious source of trouble when it gets into a battalion' (Professor T Elliott).

Few witnesses argued a case for taking traumatic memory seriously. One exception was William Rivers, who objected to the term shell-shock 'root and branch', and never used the word 'neurasthenia' because in his view it was 'useless'. He preferred the

⁵¹ Myers, C. S. (1940) *Shell Shock in France 1914-18*, Cambridge, Cambridge University Press, p. 141.

⁵² Myers, C. S. (1919) A Final Contribution to the Study of Shell Shock; being a consideration of unsettled points needing investigation, *Lancet*, 11 January; 53.

diagnosis anxiety neurosis (sometimes combined with hysteria), and argued that the only valid case of neurosis was a breakdown after 'long and continued strain'. He believed that officers were well trained from private school days to repress emotions and do their duty. Consequently they developed anxiety disorders. Those from the ranks who were not trained to cope with stress, easily developed hysterical reactive illness. A commotional event was not significant in aetiology, but the ongoing stress of war, such as that experienced by Siegfried Sassoon, was a valid contributor. Graves (1929) claimed that Rivers had explained to him the neurasthenia, and consequently a decline in military usefulness developed because the thyroid failed to pump its sedative chemical into the blood.

Rivers believed that a 'mental wound' could develop as a result of continued strain, but a small event could precipitate the actual breakdown. A number of circumstances such as fatigue, as well as fearful events could contribute, but the soldier might focus on a particular event as having explanatory power. Within a Freudian framework he argued that there were two mechanisms operating in neuroses. The first was that the soldier repressed the terrible memory, which emerged either in dreams and nightmares, or in hysterical (mimetic) symptoms. The second was that he could 'brood over them constantly until their experience assumes vastly exaggerated and often distorted importance and significance'.⁵³

In the Inquiry and other places, Rivers (1918) strongly criticised the medical advice to put the harmful thoughts out of mind and keep busy, or even 'imagine you are in your garden at home'. Instead he proposed that the real problem was repression of experiences. This was a healthy means of survival in the trenches, but after discharge active repression was unhealthy. The therapist's task was to reverse this process of repression, but after a judgement had been made about suitability.

I advocate the facing of painful memories, and deprecate the ostrich-like policy of attempting to banish them from the mind. It must not be thought that I recommend the concentration of the thoughts on such memories. On the contrary, in my opinion it is just as harmful to dwell persistently on painful memories or anticipate and brood upon feelings of regret and shame, as it is to attempt to banish them wholly from the mind.⁵⁴

⁵³ The most scholarly account of Rivers' views is found in Young, 1995, op. cit. Ch. 2.

⁵⁴ Rivers, W. H. R. (1918), *The Repression of War Experiences*, *Lancet*, 2 February p. 177. The section above incorporates Rivers' submission to the War Office Inquiry into shell-shock.

The extension of this in Sassoon's case was for Rivers to persuade him to return to the front. Rivers allowed him to 'air his anti-war complex' but did not support his views that the war was a waste of lives. Sassoon was assisted through a medical board by Rivers and eventually declared fit for service. His auto-gnosis had allowed Sassoon to discover the seat of his conflict and while he did not abandon his pacifist views chose to continue to fight until he was wounded (see Slobodin pp. 65-67).

Much of River's thinking was lost in the final conclusions of the Southborough Report, which deflected attention well away from the conduct of the war. The majority view of the committee was that 'the stress of war rarely produced insanity in the stable man', and war stress was only a factor affecting those who 'by predisposition were liable to break down'. In conclusion, it was recommended 'that the term shell-shock should be eliminated from the official nomenclature, [and] the disorders hitherto included under this heading be designated by the recognised medical terms for such conditions' (p. 190). The accepted terms were to be fatigue, exhaustion and confusional states, conversion hysteria, anxiety states and obsessional states. Ill-defined diagnoses such as Not Yet Diagnosed, Nervous or Mental (NYDN), and Disordered Action of the Heart (DAH), were to be avoided.⁵⁵ The most prominent recommendation was that, even though it was acknowledged that psychological disturbance was alarmingly high, neuroses were not *to be regarded as a war wound*. [emphasis added]

No cases of psycho-neurosis or of mental breakdown, even when attributed to a shell explosion or the effects thereof, should be classified as a battle casualty any more than sickness or disease is so regarded.⁵⁶

The Committee confirmed the view that any nervous disorders occurring in war were no different from what had already been observed in civil medical practice. More importantly, only concussion or commotion with evidence of organic lesion, should be accepted as a battle casualty.⁵⁷

⁵⁵ For an extended description of DAH see Lewis, T. (1918) *The Soldier's Heart and the Effort Syndrome*, London, Shaw and Sons. DAH, also linked with Effort Syndrome, was a category often linked with malingering and hysterical symptoms in soldiers. It was proposed as an explanation of why men who presented with symptoms resembling an impending heart attack – fatigue, pain, palpitation, fainting, giddiness, headache, sweating, raised heart rate and changes in blood pressure – but had no serious organic problem.

⁵⁶ Southborough (1922), op cit. p. 190.

⁵⁷ Brook (1999) pointed out that even at the end of WW1, a pension was a relatively new benefit. Veterans of previous wars had to depend on charitable organisations, and organisations like the 'Not Forgotten' Association, were formed to meet the needs of damaged soldiers.

This medicalisation of the reactions to war stress did represent an advance in the sense that it allowed a legitimate exit from war, however difficult this might have been made. Men wandering in a confused state might have had a better chance of attracting a medical diagnosis than a court martial and the firing squad (see Babington 1997). However it did not allow any questioning of the war. The 'wilful defiance' against an unacceptable war by Siegfried Sassoon, was less acceptable than the neurasthenia with which he was labelled by the medical board.⁵⁸

An equally important outcome of the Inquiry was the confirmation of medicine as an integral part of military organisation. In the event of another war, this was to require a number of levels of involvement. At the entry level, medical Boards would be involved in recruitment and selection. In training, a number of operational measures were recommended. Mental breakdown could be minimised by bolstering the individual through physical fitness, improving morale and discipline, and weeding out weaker members. Tours of duty should be limited, especially in highly strenuous areas, and medical officers should be involved in detecting and preventing fatigue and nervous breakdown. Medical officers were to promote the provisions of good hygiene, rest, adequate food and recreation. Treatment of casualties should be systematic and efficient in forward areas, with neurological centres established as near to the front as possible, and in psychiatric wards established in base hospitals for evacuated cases. Special instruction should be given to medical officers of the RAMC, on psychology, neurology, psychiatry, psychopathology and clinical instruction. There were no recommendations to question bad military strategy.⁵⁹

In terms of treatment, the Committee adopted a conservative line, and argued that 'an atmosphere of cure is the basis of all successful treatment', with the personality of the physician of the central importance. Rest for the mind and body was essential, and only simple forms of treatment such as explanation, persuasion and suggestion would be implemented. These could be supplemented with mild interventions such as baths, electricity, massage, and suitable occupation. More intensive methods such as hypnosis should only be used in selected cases. Long term Freudian psycho-analysis was not

⁵⁸ See Graves, R. (1929) *Goodbye To All That*, pp. 234-242, and Showalter (1995) Ch .7.

⁵⁹ One witness, Colonel J. Fuller reported to the Inquiry that poor strategy and manpower allocation had led to huge losses of good men. The early recruits were of a 'very high category' but 'we got them killed off'. And 'It was wicked in war to see the number of highly skilled mechanics shoved in trenches and shot down, in thousands'. He argued that recruiting should be

recommended under any circumstances. The advice for treatment, against any counsel from experts like Rivers, was to be practical and down to earth.

Generally, the evidence we have heard has convinced us that enough attention is not yet paid to the mental and psychological aspects of military service. The establishment and maintenance of discipline and morale as well as the cultivation of the fighting spirit and esprit de corps depend essentially upon an intelligent, accurate, and continuous appreciation of the mental calibre and outlook of the soldier, and the continuous application of his training to his psychology.⁶⁰

By the end of WW1, medical and army authorities had no knowledge of the long term effect of the war and only some anticipation that those already being treated might experience continuing problems. Apart from recommending that mental disorders were not to be regarded as war wounds and, and not be rewarded with a pension, there was little recognition of long term effects of war damage. More importantly, the war had established medical supremacy in the business of observing symptoms and categorising illness based on these observations. This was to be a lasting legacy and would prove to be a significant factor in the continuing conservative view of the mental casualty.

Other evidence suggests that there was a central role of memory in understanding the effects of traumatic events. A minority view, represented by Rivers, provided a framework for unravelling the complexity of traumatic experience. This new medical knowledge could be applied in more effective manpower management techniques. This view construed man as an organism with a mind as well as feelings, who could now be managed effectively and rehabilitated back into fighting fitness or discharged as unsuitable. The role of the 'mind' in the etiology of illnesses of war was now clearly on the agenda.⁶¹

The neurotic explanation had shifted the emphasis from the 'real' effects of the traumatic event, to memory of the event, and how it was construed. Hysteria hinged on the mimetic power of the mind and the psychic significance of the event being mimicked in behaviour. Uncovering this traumatic memory and the accompanying affect either through psycho-therapeutic or chemical means, was considered essential

on a scientific basis, and not on the 'footing invented by somebody who measured Grenadiers by the yard' (p. 189, South borough, op cit. 1922).

⁶⁰ South borough (1922) op cit. p. 168

⁶¹ The role of traumatic memory was not entirely clarified by the war experience. On the one hand traumatic memory was essential to the logic of pathological response to awful circumstances. In *Harmony of Illusions*, Young (1995) argued that by the end of the WW1, despite the observation of millions of traumatised men, knowledge of the influence of memory

for a cure of the pathologic condition. Not everybody agreed on etiology, but even the faradists acknowledged that the inner dynamic, or 'mental' mechanisms, had to be taken seriously.⁶² The danger in the logic, which will be developed throughout this thesis, is that this intervention diverted attention from the original circumstance of the traumatic experience. Pacifism had not only been silenced, but it had been relegated to irrelevance, a practice supported by the medical experts. In the classic example of Siegfried Sassoon, Rivers did not support his questioning of the war and essentially persuaded him to return to his duty at the Front.

POST-WW1

After war was over most medical experts engaged in the same kind of repression and forgetting as combatants. Some of the information gained from the war from war flowed into the civil scene. While there were developments and continuation of work with damaged veterans, there were still few major advances in mental health provision and there was no flourishing literature on, or practice in, traumatic war neuroses. The war did bring some serious study, and after the war special clinics such as at the Maudsley Hospital, the West End Hospital for Nervous Diseases, and the psychoanalytic practice at Tavistock Clinic, continued to unravel the mysteries of neurosis. Two training centres were established for the treatment of neuroses. Seal Hayne was oriented towards the use of suggestion, explanation and persuasion as the basis of cure. Here the practitioner might learn more rapid methods to 'persuade, cajole, or bluff the patient out of his symptoms'. The second centre at Maghull, was more psychoanalytically oriented and offered the painstaking and prolonged methods of analysis.

There was no flourishing literature on traumatic war neuroses, but there were some contributors. Culpin (1931) a lecturer in Psycho-neuroses at the London Hospital Medical College, and in Medico-Industrial psychology at the London School of Hygiene and Tropical Medicine, attempted to translate some of the ideas from war into the civil arena. In *Recent Advances in the Study of the Psychoneuroses*, he applied his views on psycho-neuroses problems in industry. He acknowledged that the advances in knowledge of the physiology of the nervous system of the nineteenth century had failed to reveal the secrets of mental processes in neuroses. This was dramatically shown in

had not advanced. The heroes of the field, even Rivers, looked backwards for their explanations, by 'conjuring up the ghosts of Spencer, Hughlings Jackson and Ribot'.

WW1 where 'the outbreak of the Great War proved medicine to be in a state of unpreparedness to deal with the mass of psychoneurotic material that soon made its appearance' (p. 12). But 'fundamentally there was no distinction between the war cases, even those of apparently sudden and severe onset were described as shell-shock and psychoneuroses occurring in civil life' (p. 15). Shell-shock as a diagnosis was considered a danger to morale, and was soon discarded, but Culpin pointed out that since psycho-neuroses had no place in the medical curriculum, no-one was capable of understanding this new 'material'.⁶³

Culpin took traumatic memory very seriously. He argued for a thorough exploration of the underlying events that were locked in the unconscious. 'There is nothing new in the observation that a terrifying experience could be the starting point of hysteria' (p. 5). For Culpin, the advice to 'forget the war' was entirely unnecessary in most cases, it was extremely difficult to get any shell-shocked man to talk about his experiences.⁶⁴ Amnesia was a function of the mental process, not physical commotion and the real work of liberation was to release the emotion associated with his past experiences. As a key process, Culpin encouraged men while in a relaxed state, to visualise and describe their first experience of fighting - their actions, feelings and sayings. This revival of the past and subsequent abreaction was often a piecemeal process, but the actual episode had to be brought into full consciousness to effect a cure.

Culpin countered the popular idea that suggestion was the cause of the neuroses. If this were the case the neurotic could just be distracted by being told 'forget all about the War my man, and get out in the fresh air'. Work and recreation helped prevent men from running away from life, but it were 'secondary to the psychological treatment'. Effecting a cure was not an intellectual exercise directed at convincing the patient of his wellness and freedom, but rather an individual, often painful experience of reconnecting events with powerful feelings. Nevertheless, Culpin maintained that there was nothing new in the neuroses of war. By this he meant that the symptoms bore the 'mark of war', but there were no new phenomena. Ideas such as Freud's had been tested by war and

⁶² Faradism, the use of electric current in treatment, is a term is derived from William Faraday who discovered electricity.

⁶³ Culpin, M. (1931) *Recent Advances in the Study of Neuroses*. London: JA Churchill.

⁶⁴ Resistance to talking could be achieved in a number of ways. A favoured analogy used by Culpin was to describe terrible memories as 'a little box of devils who were constantly trying to force the lid which he was as persistently holding down, that whenever they forced the lid and popped out he suffered terrifying dreams, fits, tremors and what not; the reasonable way of dealing with them was to open the lid and let them out into daylight' (p. 27).

confirmed. He agreed with Farquar Buzzard that war had stimulated intellectual interest for the medical and public mind and shown that the problem was capable of solution. The ideas of war could be applied to curing the ills of society. Neuroses could be cured, not by tonics but by psychotherapy.

Apart from this major paper from Culpin, interest in war neuroses waned after WWI. A small piece of applied knowledge appeared in a text written to reform the British medical curriculum in the 1930s. In the textbook on Psychological medicine, Gordon, Harris and Rees (1936) offered a rationale for anxiety and functional disorders. The authors give an account of a shell-shock victim, seventeen years after WWI, which they labelled the 'Jack in the box' syndrome. In this model, when the combatant

first experienced the horror of the trenches and the sense of the imminence of death, he felt annoyed with himself and perhaps a little annoyed, that he that he should experience fear. He 'pulled himself together', repressed his fear, and went about his job. This type of experience, varying in intensity, were repeated many times during his service, and the conflict between his sense of what he ought to be and his awareness that he was experiencing fear was dealt with by repression in each case, so long as he could keep it up. The 'Jack-in-the box' fear was pushed down straight into its box out of sight until some experience in civilian life caused the lid to be lifted.⁶⁵

In this model, repression was a useful mechanism, but if repeated and intensified he could not keep material indefinitely repressed and it would surface later. The key mechanism was the dissociation of the mental record of the original incident from the intense emotion of the time. In post-war life a soldier would experience unattached fear and anxiety, which would emerge in dreams and nightmares. The symptoms of fear 'incapacitated them, but the fear was a revival of that experienced in the trenches'. This fear has such a strong emotional charge that there was a 'leakage and anxiety back into consciousness'.

The inability of these patients to control and maintain the repression of their fear was illustrated also by the fact that they practically all suffered from war nightmares, anxiety dreams, due to the emergence of unconscious anxiety in sleep.⁶⁶

This was what the authors called the 'Jack-in-a-box' syndrome. There is a certain elegance and economy in this model, since it explains current symptoms by associating

⁶⁵ Gordon, R., Harris, N. & Rees, J. (1936), pp. 155-157. Rees became a prominent specialist in the RAMC in WW2. The book must have had some influence. It was produced for a British officer who had broken down after the invasion on Normandy. The officer gave me the same book in 1996.

the detached emotion to a logical cause. It also provides a rationale, rather than an explanation, for why some have more difficulty than others. There was no mention of a sexual dimension and no discussion of a neurophysiological dimension of traumatic neurosis.

At this point in historical development two things are evident. The first is that military medical specialists insisted almost to a man that the ideas of civilian practice could be applied to psychiatric problems of war-time, which were essentially neurotic functional disorders. While there were some sophisticated explanations of the dynamics of these conditions, such as those proposed by Rivers and Myers, the diagnoses and etiological explanations were adapted from civilian practice and theory. By the end of the war these diagnoses were accepted in preference to shell-shock.

The second feature is what I choose to call the emergence of the *restricted therapeutic loop*. In this loop a combatant is exposed to a toxic event, which physically and psychologically assaults him. He consequently presents his symptoms of dysfunction to a medical specialist, who for ethical and administrative reasons, is compelled to diagnose and treat him. The specialist appropriates the patient's description and applies a medical label. In doing this, the emphasis is on finding a diagnosis for the individual. The source of the 'pathology', the traumatic experience and the violent environment is not examined in this process. It is here that the therapeutic loop is restricted in a way that does not occur in some other individual manifestations of illness of epidemic proportions. There, in seeking a 'cure' for physical illness, specialists examine the environment to determine the source of the 'infection'.

Freudian psycho-dynamic ideas provided an ideal set of tools for this focus, by concentrating on the psychogenic explanation, or internal dynamics of the individual. Without the sexual dimension, Freudian ideas dominated, and any focus beyond the individual only went as far as improving military practice. Freud, like many others did acknowledge the need for developing corporate morale, but there was no questioning of the fundamental source of 'infection': the pursuit of violence. Like many epidemics, the problem of the 'nervous soldier' attracted many explanations, some of them fanciful, such as his personal habits and sexual preference. The most stark parallel is the cholera epidemic of the eighteenth century, where quackish explanations were proposed,

⁶⁶ Gordon et al (1936) op cit. p., 157.

including poor personal habits and divine retribution for sin, until the more fundamental socially based cause of water borne infection was discovered. Unfortunately psychiatrists did not have the vision of John Snow.⁶⁷

This entrenched role of psychiatry in military affairs and the predominantly psychological explanation of psychiatric casualties in the British Army continued into WW2, and this will be explored in the following chapter. At this point in the development of ideas at the end of WW1, traumatic memory was considered important even though extensive psychotherapy was not always advocated.

⁶⁷ Snow's famous action of having the handle of the Broad Street pump removed and thus altering the course of the 1854 cholera epidemic focussed attention on the fundamental cause of the disease, the contaminated water supply. This eventually led to legislation and regulation to deal with the problem at its source. See Richardson, B. (1936) *Snow on Cholera: being a reprint of two papers by John Snow MD together with a biographical memoir*. New York: The Commonwealth Fund.

CHAPTER 4

WORLD WAR TWO AND BRITISH MILITARY PSYCHIATRY

The outbreak of the second major war of the century in 1939 required the RAMC to re-invent its psychiatric services. To do this they revisited the experts of WW1, and incorporated some of the developments from civilian psychiatry since WW1. Work with veterans of WW1 had continued in a number of places. Rees (1945) claimed that 'some hundred thousand' men were drawing pensions or receiving treatment after 1919. Ministry of Pensions hospitals and specialist clinics like Tavistock Clinic and Maudsley Hospital provided specialised psychiatric care. Rees described a general improvement in education and treatment. WW2 was another opportunity to learn. Despite these advances when WW2 broke out in 1939 the Ministry of Pensions and military authorities had no blueprint for action and turned to the experience of WW1 for ideas. At the end of that conflict neurosis had been accepted as a primary diagnosis and internal psychological mechanisms could explain any breakdowns, rather than the shock of battle.

In December 1939 the British Ministry of Pensions, keen to avoid an epidemic of psychiatric diagnosis as occurred in WW1, issued a memorandum to all members of the medical profession. This memorandum emanated from a conference convened in July of the same year to advise the government on the general principles for dealing with cases of nervous breakdown in war, in both civilian and military populations. The memorandum advised that 'shell-shock' should no longer be used as a diagnosis and must be 'rigidly avoided'. Furthermore, the anticipated civilian and military casualties would be no different from those encountered in peacetime. Breakdowns were to be considered neuroses of psychological origin and should be more correctly labelled anxiety states and hysteria. Anyone arriving at an aid post should be convinced that their symptoms would soon disappear, and no encouragement was to be given to suggestions that there was real lasting damage. According to the instruction, patients should be sent home as soon as possible, under escort if necessary, and not be given any encouragement to allow their symptoms to become entrenched. More serious cases should be referred to specialised clinics.

This requires a firm and authoritative but sympathetic attitude on the part of the medical officers and their assistants. In-patients who are simply frightened, and in

emotional cases, reassurance combined with an appeal to personal and patriotic pride and a large dose of bromide will usually be sufficient.¹

This advice, which reflected the spirit and some of the letter of the 1922 Southborough Committee report on Shell-Shock, set the tone for psychiatric intervention in WW2. The editorial comment in the *British Medical Journal* in March 1942 reminded the profession that the 1914-18 war had confirmed the importance of psychological factors in casualties and settled the tension between physical and psychic causes. It stated that 'the last war may have begun with the neurologists, who believed in cerebral commotion as a cause of war neuroses', but 'ended with psychiatrists, who saw that personal factors, especially fear, anxiety and conflict, lay behind the symptoms in most cases'.

As WW2 progressed, an increasing number of publications appeared as medical specialists with experience in the First War added their views to medical experts who tested their ideas on WW2 soldiers. A considerable amount of British literature emerged during WW2 (e.g. Sargant 1940, 1942; Hurst 1940; Sutherland, 1941; Ross 1941; Rees 1943; Fairbairn 1943; Gillespie 1945; Mulinder 1945; Rees 1945; Strecker 1945; Jones 1946). These publications were partly motivated by the desire to avoid the mistakes of WW1, especially a repeat of the shell-shock epidemic. Many of these writers had worked at the front line or in major treatment hospitals during and after WW1 and some of their views had previously been recorded in the 1922 Shell-Shock report.

Sir Arthur Hurst (1940), summarised his experience as a specialist in WW1 in *Medical Diseases of War* published at the beginning of WW2 and claimed that by 1918, six percent of the 341 025 men discharged as unfit were neurotic. Their 'diseases of war' included hysterical conditions, functional disorders, stupor and amnesia, hyper-adrenalism, soldier's heart, trench fever, anxiety neurosis, exhaustion, neurasthenia and cerebral and spinal concussion. These conditions presented a major problem for compensation and Hurst argued against pensions, because 'the chief predisposing causes of war neurotics are a neuropathic and psychopathic inheritance and a previous nervous and mental breakdown' (p. 1). The problem was located within the individual not the environment. Hurst believed that most conditions could be cured by simple psychotherapy in the form of 'explanation, persuasion, and re-education'. The basis of

¹ British Ministry of Pensions (1939) Neuroses in War Time: Memorandum for the medical profession. *British Medical Journal*, 16 December; 1200.

good treatment was taking a thorough history, through which the physician would discover the root of the anxiety, and reassure the patient he was not insane. The patient should talk so 'he can discharge some of the perilous stuff that weighs upon his heart'. Even conditions like Disordered Action of the Heart (DAH) only needed explanation.²

From their experience early in WW2 at Maudsley Hospital, Sargant and Slater (1940) tried to alert authorities to the possibility of another epidemic of neurotic casualties early in the war, with their description of acute cases of neurosis returning after the Dunkirk evacuation. Among these men the stresses and strains of the invasion, along with exhaustion and physical strain, were sufficient to break men 'of normal intelligence, personality and work history'.

The belief that the cause of breakdown was attributable to the inadequacy in the individual soldier was written into official policy. A British War Office pamphlet *The Psychiatric Disorders of Battle*, was published in 1941 to help NCOs and officers to understand enough to 'forestall breakdown in themselves and others'. It defined a psychiatric casualty as a 'man who becomes ineffective in battle as a direct result of his personality being unable to stand up to the stresses of combat' (p. 63). The Ministry document endorsed the view that the neuroses of war were no different from those occurring in civilian life. A neurosis provided an honourable escape from intolerable fear, but pensions should not be given on psychiatric grounds. The document also promoted the view that persuasion and suggestion were the most effective means of cure.

One of the most comprehensive summaries of ideas available in WW2 is found in *The Neuroses in War*, edited by Emanuel Miller. Miller and his contributors presented a comprehensive account of the ideas on etiology and treatment available at the beginning of the war. They argued for doctors to be aware of the complexity of diagnoses and to avoid imprecise diagnoses such as 'shell-shock' or NYD. Instead they proposed an array of diagnostic categories which enabled the physician to separate the psychogenic casualty from the rare cases of traumatic shock. They essentially followed the line of the 1922 Shell-Shock Inquiry.³

No new war-related diagnoses were proposed and the main change was in the relative incidence of particular diagnoses with a shift from hysteria and neurasthenia to anxiety

² Hurst, J. (1940) *Medical Diseases of War*. London: Edward Arnold.

³ Miller, E. (1940) *The Neuroses of War*. London: MacMillan & Co.

neurosis. Psychoneurosis was the dominant condition, and was broadly subdivided into anxiety states, conversion hysteria and obsessive states. More sophisticated classification allowed sorting into more discrete categories such as exhaustion and confusional states, massive dissociated states, fugues and wandering with some amnesia, or states of partial dissociation. In fact there was a host of conditions to choose from, including

- Anxiety States: Generalised, Phobic, and Anxiety-hysteria.
- Hysterical paralysis and fixations, and hysterical sensory disturbances, somatic & visceral, including syndromes like 'left infra-mammary pain'.
- Somatic neuroses: Effort Syndrome; Emotional hypertension; Stress dyspepsia; Peptic Ulcer; Emotional diarrhoea; Obsessional & Compulsive states.
- Character Deviations: Obsessional character disorders; Paranoid trends with depression, anxiety; Paranoid trends with irascibility; Schizoid trends with isolation, sensitivity; Epileptoid character reactions – periodic rages, insubordination, egoistic attitude & dramatic religiosity; Psychopathic personality; Delinquency.
- Simulation of neuroses & malingering.

Miller conceded that 'military neuroses are preceded by terrifying experiences' and did not subscribe to a general view that previous pathology or inadequate personality alone explained all breakdowns. Nor did he believe that all individuals had their breaking point, since certain types of psychopathic personality 'often did well as soldiers'. The explanations for casualties followed the line that war did bring extraordinary strain, and required 'a man' to become uncivilised and aggressive, and suspend many of his values. In service he would learn to tolerate the 'grossly abnormal conditions', and when his tolerance of these conditions broke down he developed neurosis. Some of the abnormal conditions came from army life and some from battle. Long periods of strain, deprivation, over use of tobacco and alcohol, witnessing the loss of comrades, and separation from family provided a softening up of the soldier. When confronted with fearful situations, his resistance was weakened and could crack. His pre-disposition was the primary predictor of breakdown. An inadequate predisposition could be due to innate biological or psychological inferiority, anatomical lesions of the nervous system (rare), or prior sensitisation from an earlier experience.⁴

⁴ Miller, *Ibid*, Ch. 1.

The authors summarised the available treatment options in the field, including pharmacology. The main development was the application of a range of physical therapies. In general, medical personnel were urged not to be too sympathetic and should develop 'hopeful yet military attitudes' in clinics. All treatments were aimed at restoring the soldier to a fighting unit, not healing, and fears were expressed about contamination of other troops from neurotic cases. After a breakdown, troops could be initially calmed with hypnotics. Rest, reassurance and even forgetting were prescribed in this early period. Approaches to treatment prevailed. The first was the harsh approach, which gave no encouragement to malingering and in some cases, simulated punishment, advocated by physicians like Kaufmann and Yealland. Kaufmann for example, had three stages of treatment. First the patient was prepared with strong suggestion, then given electric shocks for up to 2 hours. To 'set the cure' he was made to undergo active physical exercises. Yealland imposed a strongly authoritarian and bizarre regime which often would not allow patients to leave the locked room until they changed their behaviour. A more benevolent approach was to provide good food and rest and in some cases sedation, such as bromide. Patients would be reassured with firm words and given encouraging talks, and as they improved they would be given occupational therapy. Counselling consisted of simple explanation of their condition and an appeal to their sense of patriotism and duty. Mild faradism might be applied and even hypnosis. The third option was long-term psychotherapy to release repressed emotion.

These were not mutually exclusive and the second two could sometimes be combined. The major advance since WW1 occurred in drug therapy and a range of physical therapies. In an appendix to *Neuroses*, the Miller detailed the protocols for drug treatment, including the type of drug, dosage level, method of administration and conditions. Instructions were provided for the relatively new narco-analytic treatments. Narco-analysis facilitated the discovery of the 'central emotional problems', especially 'where symptoms seem to have arisen from recent stress'. Narcotics such as Pentothal, Evipan or Coramine were injected to induce a deep sleep for up to 15 minutes. When awake the patient could be expected to freely respond to questions and discuss his problems. Such treatments were short cuts to accessing traumatic material, but they could have serious side effects. Evipan, for example, could produce dissociative states paralleling the traumatic events themselves, but they had toxic side effects. These approaches acknowledged the intrusive nature of traumatic memories, and were

designed to provide efficient release from the effects these memories. This was thought to be more efficient than long term psychotherapy aimed at reversing the splitting off from emotions that occurred in battle.

The predisposition theory and need for firm explanation was supported strongly by T. A. Ross (1942), who was described posthumously as having 'probably a higher reputation as a psychotherapist than any other doctor in the country'. Ross belonged to the humane school where the patient should have the opportunity to tell his story freely and describe his fears and grievances. Once given free reign he could then be told why he had been experiencing the violent emotions that underlay all his symptoms.

The views of Miller, Hurst and their contributors were informed by their experience in WW1. Some challenge to their prevailing notion of constitutional inadequacy came from those caught up in treating early casualties in WW2, who observed that even 'good soldiers' of sound background could also break down. The German invasion of Flanders and the subsequent evacuation at Dunkirk exposed this new type of casualty. From his experience of treating these men at Maudsley Hospital, Sargant (1940, 1967) argued that constitutional insufficiency alone could not explain the breakdown of a significant number of men. These men had adapted well to army life, previously had a good work history, and showed no evidence of low intelligence or poor personality. The only explanation was that war stress was 'altogether different from any to which they could expect to be subjected to in ordinary life'.⁵ The accumulation of strain from bombardment, danger, food deprivation, loss of sleep, sight of comrades killed or maimed, sense of helplessness and seeing civilian refugees being killed, produced their breakdown. A feature of these acute casualties was hysterical amnesia, in which patients forgot the incidents they experienced but they converted them into symptoms.

Sargant advocated the use of hypnosis and intravenous barbiturate administration to access these memories and exorcise the accompanying powerful emotions, but was more partial to physical therapies. He was a staunch advocate of the physical treatments to reduce anxiety, such as ECT and insulin therapy, and considered them more efficient than standard psychotherapy.⁶

In these WW2 ideas traumatic memory seemed to be pushed further into the background and there was little discussion on commotional shock. The focus was on the

⁵ Sargant, W. & Slater, E. (1940) Acute War Neuroses. *Lancet*, 6 July; 1.

internal mental machinations that could transform a frightening experience into a personal pathology. Some dynamic explanations of breakdown incorporated dissociation or splitting of emotions from ideational content. Traumatic experience could also revive deeply buried archaic conflicts and lead to infantile regression. Whatever the internal dynamics, there arose a great variety differential diagnoses, which reflected the degree of medicalisation as well as a greater variety of symptoms. The organic injury explanation of psychiatric casualties had been effectively sidelined by WW2 and nothing happened during the course of the war to change this. The concept of Railway Spine was only revived by those who had presided over the neurotic injury of WW1 to ensure that the lessons from WW1 had not been forgotten. Some argued that too much emphasis on the non-organic injury would strengthen it and make the person even more disabled and helpless.

T. A. Ross argued that pensions should not be allocated for psycho-neuroses. This was 'a corollary from the "railway spine" in that in no circumstances should a neurosis, nor any of the hysterical conditions (postures, gaits, tremors etc), functional disorders, soldier's heart, neurasthenia, or trench fever, be pensionable'. Medical men should persuade the neurotic man to get better, and ignore the view that people may develop curious symptoms after the trauma. Ross saved his sternest criticism for lawyers, who 'must be taught that the more you pet and coddle neurotic patients, the more you will have'.⁷

Ross believed that 'war neuroses do not differ essentially from the neuroses of peace' (p. 1), that neurosis only applied to a 'mentally determined' condition, and that prolonged reactions to fear could turn into illness. He enshrined the 'scientific' notion that heredity and education were critical factors in the development of neurosis ('some people are made better than others') and a person of neurotic parents was 'quite certain to have had a bad education' (pp. 10-11). Neurosis was basically a state of mind – it all depended on how one reacted to symptoms and emotional disturbance, and even puts value on being ill. A physical trauma did not cause a neurosis – 'it is not followed by neurosis unless there is some advantage to be gained'. The argument that trauma causes 'emotion' and not 'commotion', was illustrated by Ross with a dramatic example. An enterprising ship's doctor treated the survivors of the sinking of the torpedoed ship *La*

⁶ Sargant described his approach to treatment more fully in Sargant, W. (1942) Physical treatment of acute war neuroses. *British Medical Journal*, 14 November; 574-576.

Provence with a good slapping by vigorous sailors. They soon lost their hysterical symptoms, and he was able to contain the epidemic among the rest of the crew. (pp. 32-34)

Rees (1943, 1945) was also emphatic about eliminating any talk of a shell-shock or a neurosis of traumatic origin. If individual weakness were the primary cause of breakdown, then careful scrutiny by Medical Selection Boards would eliminate the potential neurotic and save the 'psychopathic tenth' from a court martial or prolonged invalidism. In the field potential casualties could be diagnosed and cured even hysterical paralysis, mutism, or amnesia. These were just symptoms a disconnection from the traumatic experience, and techniques like hypnosis could reconnect a man with his traumatic memory. Apart from the need for early rest, lying in bed did not cure the neurotic. Neurosis only occurred when the patient believed he would not be cured.

Fairbairn (1943), former Visiting Psychiatrist in the Emergency Medical Service in Britain, argued that war neuroses were primarily the function of a poorly predisposed personality. He believed that there was general agreement among psychiatrists that war neuroses 'possess no distinctive features differentiating them sharply from the various psychoneurotic and psychotic states which prevail in time of peace'. Fairbairn distinguished between 'psychopathological states which appear to be precipitated by active warfare' and those that 'occur during the course of military service which might equally have occurred in civilian life'.⁸

Fairbairn admitted that traumatic events could precipitate a neurosis but his fundamental position was clear in that the fault lay within the individual. A traumatic experience was 'one which serves to precipitate a psychopathological reaction through the activation of pre-existing but hitherto latent psychopathological factors' (p. 183). Examples of precipitating events were being blown up; trapped in a cabin of torpedoed ship; witnessing massacre of civilian refugees; and having to throttle a German sentry. Neurotic reactions could also develop in response to less threatening events like being let down by an officer in a tight corner; being accused of homosexuality by fellow soldiers; being refused compassionate leave for a wife's confinement and being shouted at by a Sergeant Major. Fairbairn found a unifying explanation, in that breakdown was by and large the product of poor development. In his experience, 'infantile dependence'

⁷ Ross, T (1941) *Lectures on War Neuroses*. London: Edward Arnold, Ch. 1.

was the 'predisposing factor for all psychopathological developments'. Symptoms were either effect of, or a defence against, conflicts engendered by this dependence. He argued that separation anxiety and emotional identification were present in all war neurotics and were often manifest in the compulsion to return home. Infantile dependence and separation anxiety were two critical factors in both breakdown and loss of morale in a unit. 'It is to the symptom of separation anxiety that we must look for the real significance of war neurosis' (p. 186). To illustrate his thesis about unsatisfactory early attachment, Fairbairn cited the example of a soldier who could eat anything his wife cooked at home but would not return to the army where 'every word of command has become the shout of an angry father'. His nightmares were simply the work of these evil powerful figures, not traumatic memories.

Arthur Hurst, a formidable and well-known expert, took Fairbairn to task for these remarks (*British Medical Journal*, 6 March 1943; 299), describing Fairbairn's views on infantile regression and resistance to psychotherapy as 'fantastic'. On the basis of his experience at Seale Hayne Military Hospital for Functional Nervous Disorders, Hurst argued that a 'cure' could be achieved much more simply with firm and sensible persuasion. War neuroses responded to 'simple psychotherapy in the form of explanation, persuasion and re-education'. He reinforced his views with reference to Cooper's and Sinclair's study of psychiatric casualties at Tobruk. The argument with Hurst continued for several issues.

The idea that toxic exposure was not the primary cause of the onset of neurosis became more strongly entrenched as the war proceeded. In March 1943 the Ex-Service Welfare Society convened an annual conference to address the 'Influence of War Stress on Neurosis and Psychosis in the Armed Forces, in Industry, and in the General Population'. This society had extensive experience in helping men suffering from neurasthenia and mental breakdown, and employed some recovering men in an industrial centre. Most of the conference was concerned with the industrial and civil effects of war stress, but the ideas developed by the military psychiatrists such as J. R. Rees, Lt Col T. Tennent, R. D. Gillespie and Aubrey Lewis, dominated. The consensus

⁸ Fairbairn, R. (1943) The War Neuroses: Their nature and significance. *British Medical Journal*, 13 February; 183.

was that pre-existing neuroses and psychoses were activated, not caused by, war experience. The representative from the Ministry of Pensions supported this view.⁹

Medical experts of the 1940s appeared confident that their experience from WW1 would equip them to address any psychiatric problems in WW2. This early confidence proved unfounded. Psychological medicine was firmly in the trenches with the men, but the ideas were still unformed. In response to the needs of discharged servicemen and to address mental health issues in society, a number of prestigious institutions flourished in England, (e.g. Tavistock Clinic and Maudsley Hospital), and psychiatric training improved. The experience of war neuroses also increased the awareness of civilian neuroses and caused authorities to take them more seriously, but Rees (1945) pointed out that on the whole the British Army did not translate the lessons from WW1 into WW2.

A number of field studies on the effects of war stress were conducted in the European theatre (Grinker & Spiegel 1943, 1945; Kardiner 1941; Strecker & Appel 1945; Grinker 1944, 1945; and Hastings, Wright & Glucich 1943), but these appeared to have little influence on the British policy. The US Army adopted more systematic practices of stress reduction in combat situations. The United States Medical Department, for example, included a special volume on combat stress in the medical documentation for the United States Expeditionary Forces (1929). This combat stress control booklet detailed the administrative and professional procedures for combating war neurosis.¹⁰

Brief mention is made here of one American author, because the recent interest in the work of Abram Kardiner, who is now being considered to have had a major influence on thinking about traumatic stress. In fact his views do not markedly differ from his British counterparts. Kardiner, who undertook analysis under Freud, adopted an essentially Freudian position to explain how traumatic experience could form into a neurotic condition. He described the literature of the post-WW2 period as vast but 'anarchic', and argued that there was no common frame of reference, with each author adopting a different stance. He tried to impose a unity in description of war neurosis.

Kardiner (1959) explained that pathology was a problem of imbalance between the organism and its adaptive resources. The development of pathology was not so much a

⁹ Reported in *British Medical Journal*, 3 April; 423-424.

¹⁰ Salmon, T. and Fenton, N. (1929) *Combat Stress Control Historical Experience Booklet 1*. Washington, DC: The Medical Department of the United States Army.

problem of regression to earlier adaptive mechanisms as a problem of disorganisation. What is disorganised? Not the ego but the 'whole series of action systems that carry out the intentions of the ego' (p. 251). Pathology occurred when the soldier tried to live with an executive apparatus that is either completely impounded or operates with spastic 'inelasticity'.¹¹

Kardiner shifted slightly in the use of the term 'functional', which was a failure to adapt to a new environment, rather than an internal conflict between the id and ego. For him, a post-traumatic neurosis was the record of the lasting consequences of an abrupt change in the external environment to which resources of the individual are unequal - the ego fails in adaptation. So there was a significant shift from the psychogenic, or the internal mechanism, to an influence from the external event, pressure and stress. Kardiner has no illusions about the role of the psychiatrist, which was to maintain military morale; 'the therapeutic job is to prevent the soldier from capitulating and taking refuge in his escape from duty'. In rehabilitation, the 'prime social consideration is the conservation of manpower, with particular emphasis on the return of the intact soldier to his original environment'. He agreed with British medical men that compensation in the form of a pension, would only entrench the neurosis - 'Once the traumatic becomes entrenched in a parasitic existence, the idea of rehabilitation excites the most violent opposition'. The most effective way to ensure he does not retreat is to keep the soldier's symptoms connected with the traumatic event, which can be achieved through hypnosis. A key element in therapy was the integration of the traumatic event.

In WW2 British psychiatrists took on the role of classifying discordant servicemen and most psychiatrists could have been described as alienists, as it was their business was to diagnose and treat the mentally ill (see Shorter 1997, Rees 1945). Rees, consultant to the British Army Medical Service and medical director of the Tavistock Clinic, claimed that the psychiatrist of 1914-18, by differentiating the neurotic from the organically damaged, provided the insight and understanding needed in these conditions. This insight increased the awareness of the psycho-dynamics of neurotic reactions and provided the army with more efficient ideas on selection, diagnosis, treatment and disposal.

¹¹ Kardiner A. (1959) Traumatic neuroses of War. Ch 12 in Arietti, S. (ed.) *American Handbook of Psychiatry*. New York; Basic, pp 253-257.

The dominant explanation of dysfunction centred on the inadequate mental structure of the individual, not their traumatic experience. Gillespie (1945), for example, defined a traumatic neurosis as 'a mental and functional-physical disturbance of some kind following a psychological disturbance from without'.¹² The neuroses were a 'rupture of the barrier against stimuli'. In the final analysis, the war provided an opportunity to entrench medical ideas about illness and cure, even though there was still argument about etiology and disposal. This placed the medical community on a military footing and there is little evidence of any of them being able to think outside this role.

Military psychiatry was firmly settled within the military establishment by the end of WW2. The role of the medical corps, both psychiatrists and physicians, was as Crichton-Miller stated in *The Neuroses of War*,

War is not only very irrational, it is very cruel. To those who have little imagination, few susceptibilities and fewer ideals it may constitute a wonderful adventure. Some turn their backs on the fear, and consciously escape into distractions, indulgence and excitements. But more are trying to escape into some sort of face-saving invalidism. It is our business, as medical men, to open their eyes to this situation; but let us at the same time help them to save their faces.¹³

The medical view of psychiatric casualties in WW2 is summarised in a monograph by F. M. Richardson in 1978, intended to help officers understand breakdown in themselves and others. A Major General, but not a trained psychiatrist in the RAMC during WW2, he argued that the biggest mistake was to give traumatic events some credence and perpetuate a diagnosis like shell-shock, which had been 'the doctor's first mistake'. Diagnoses of shell-shock and traumatic neurosis only created the impression that the 'violent stress of war' was entirely responsible for various nervous and mental disorders in servicemen, and it was 'not the war alone, but their personalities, which is at the root of their trouble' (p. 68). It was not the traumatic event but the weakness in the man that precipitated neuroses. 'The so-called psychiatric casualty' was 'the last stage in the failure of a man's morale'. Signs of this loss of morale were restlessness, poor sleep, loss of appetite, irritability and jumpiness, loss of efficiency, and change of temperament. He cited a War Office pamphlet *The Psychiatric Disorders of Battle*, where a psychiatric casualty was defined as 'the man who becomes ineffective in battle as a direct result of his personality being unable to stand up to the stresses of combat'.

¹² Gillespie, R. (1945) War neuroses after psychological trauma. *British Medical Journal*, 12 May; 4401.

¹³ Miller (1940) *The Neuroses of War*. MacMillan, p. 210.

Casualties were more rightly to be labelled with anxiety or hysteria, conditions that were much more amenable to change.

Richardson recognised the role of the unconscious in any fear or anxiety state, but argued that a cure did not require extensive psychotherapy. Such problems could be managed with rest, discipline and good man management, with a view to improving morale and efficiency. He also maintained that the lessons from war could apply to the building of a healthy nation, where psychological stability could be modelled on the 'great military traditions – Napoleon, Montgomery, Slim and Lord Moran' - which could be 'woven into the fabric of the nation'.¹⁴

The British military medical establishment had shifted little from the 1922 Inquiry conclusions. They confirmed that the 'cause' of neurosis was primarily in the individual pre-disposition and inability to stand the stresses of front line service. A more impressive arsenal of diagnoses and treatment were developed. Which were aimed primarily at improving medical efficiency and reducing manpower wastage.

How would these ideas serve a British combatant? To explore this I present a case of particular British officer who was caught up in the ideas about war neurosis. This particular story also introduces the other strand of this dissertation - the life long effects of traumatic encounters.¹⁵

At the time of writing an 84 year old ex-Major of British Army, is lying in hospital with a chronic back condition and contemplating suicide. He was doing the same thing in 1944, except that his back is now far worse. The surgeons have now handed him over to the psychiatrist because he has been displaying some strange behaviour. His last encounter with psychiatrist had been in 1945 when he was discharged from the army as a nerve case.

Ron had fought in five major battles, including the invasion of Normandy, in 1944 when he was in the field for 16 days and nights. He noticed that he was behaving the way he had observed his men at Alamein, where they went 'mad with the intensity of battle'. He was wounded and admitted to Military Hospital in England in an exhausted state in July 1944. He described himself at the time as 'bomb happy'. His psychiatrists noted that he was irritable, impatient, restless, impulsive, depressed, and in battle 'reckless and ill-controlled'. He also had bouts of aggressive anxiety and fits of

¹⁴ Richardson, F. (1978) *Fighting Spirit: A study of psychological factors in war*. London; Leo Cooper, Chapter Seven. Moran was Lord Moran who wrote *Anatomy of Courage*.

weeping. By August his condition had been diagnosed as 'anxiety state, recent, severe and unspecified'. After discharge from hospital he was posted as an instructor to an Infantry School, where after a serious altercation with a senior officer, he had to be restrained from shooting him.

He was admitted to Dumphries Hospital in November 1944, 'tired, anxious, voluble and depressed', and described by the psychiatrist as 'undisciplined, histrionic, with unanchored personality and rebel traits of an immature neurotic variety.' His early history revealed that his family had no history of nervous disorder, but he did exhibit 'mild neurotic straits in childhood'. His diagnosis was 'recent and severe anxiety state of unspecified type aggravated to a material extent by his present war service'.

Ron was discharged from Army Service on psychiatric grounds (anxiety state), with the rank of Captain (reverted from major) in April 1945 and had to find a new life. He took up teaching again in a Cambridge College, but this proved to be a strain. He was observed on at least one occasion crying in his room, and 'the stress of working with boys in their teens seems to have stirred memories' of the young men of his unit who had been killed in the previous year.

He was admitted to a small psychiatric hospital for treatment including 27 days of prolonged narcosis. While in hospital his psychiatrist gave him a copy of *An Introduction to Psychological Medicine* by Gordon, Harris & Rees (1936). He was told that this standard textbook would 'explain his problems'. There he read that psycho-neuroses and anxiety states were 'mental' disorders, because they originated from the mind, not from an injury to the nervous system cause. They may involve a partial change in personality, but were not a true psychosis. They originated in the main 'from mental conflict, followed by repression'.

An essential element was ignored in the psychiatric treatment. Ron was a Quaker and committed to pacifism and seeing young men die needlessly, had conflicted with his beliefs as well as his strong sense of duty and loyalty to his fighting unit. According to the Rees text the events of Sicily, Alamein and Flanders had been repressed by his strong military-induced Super-ego. In classic Freudian mode Ron had become dissociated from his strong emotion and vivid memories.

Ron was discharged with an agreement to consult the Command's psychiatrist and his family doctor, but his problems were only beginning – he had to start again and

¹⁵ This material is derived from several interviews and copies of Ron's pension submission.

support his wife and two young children. He was receiving an interim 30 percent pension for 'psycho-neurosis aggravated by war service', which was expected to last only six months, and this was inadequate. On discharge the psychiatrist was not confident of the likelihood of improvement, saying.

He is not in my opinion suitable for re-employment. Conflicts are still present relating chiefly to his mental attitudes to war. His marriage relationship is a difficult one. He expresses the wish to be upgraded to 'A' [for military purposes], but this appears to spring from a desire to escape from his problems. There is a suggestion of a suicide wish behind this impulse, which in any case is without roots. He would quickly break down in action.

The prediction proved to be incorrect. Ron gradually moved on to a career in the British Dept of Employment and eventually worked in the International Labour Office with postings in Lybia (1 year) and Bangladesh (5 years). While in Lybia he slept with a revolver under his pillow, and could wake instantly. In fact, he had a very successful career as a civil servant and was able to retire comfortably with the satisfaction of seeing his family grow up and establish their own lives. He and his wife migrated to Australia after he retired but he regretted this move and in his 'exile' he revisited parts of his past. Disturbing relics of the past emerged through events like a letter from the daughter of his former Batman, informing him that he had died. Other memories emerged spontaneously, such the image of his wounded Sergeant Major begging Ron to shoot him.

Ron is a prime example of an individual encounter with medical ideas. His distress at seeing so many killed and his personal conflict about the use of violence was construed as a form of mental illness. His intense personal experiences were seen as contributing to his illness but this was a matter of personal, not collective, responsibility. He got on with his life and used knowledge about psychology gleaned from training courses to make some sense of his experience. The 'crack' of his breakdown had been successfully 'cemented over', at least until his retirement.

Ron's story is not a diversion but is at the centre of this dissertation. His life is a site for the application of ideas developed in WW1 and applied again in WW2. The ideas he encountered provided one possible rationale for his breakdown, but did not offer him a framework of life long understanding. This was repeated in later encounters which were aimed at determining his eligibility for compensation not facilitating his self-understanding or enabling him to come to terms with his war.

The debates of the previous war about commotional shock and the inner dynamic of neurosis, and the relative contribution of factors like sexual instinct were largely settled by 1945, and Army psychiatry was much more straightforward and systematic business. Diagnoses still focussed on individual pathology of neurotic origin and had become set into administrative procedures. Explanations of disturbance, although seductive in their depth, centred on individuals rather than the toxicity of the environment. Treatment options were thought to be more efficient with the introduction adoption of an increased range of physical treatments. How these ideas and practices were transferred into the Australian military structure and policy, which will be described in subsequent chapters.

CHAPTER 5

THE AUSTRALIAN NEUROTIC SOLDIER IN WW1

The British ideas and practices outlined in Chapters 3 were adopted in the WW1 Australian army and repatriation services.¹ In this chapter I outline how this was worked out, using the states of New South Wales and South Australia as examples to illustrate repatriation issues. The States' facilities were authentic microcosms of the national scene, and therefore provide an insight into the more general landscape. In this period the key medical stakeholders repeated the view that war presented nothing new to medical science; that the nervously wounded soldier presented a potential threat to manpower and morale, both in military and civilian life; and any form of neurosis was not to be encouraged as a pensionable war injury.

The First World War (WW1) has an important place in the history of war neurosis for two reasons. It marked the introduction of psychic wounds into Australian war history, and it was the first war in which post-war problems were acknowledged in legislative and administrative provisions to cater for the ongoing problems of soldiers. The Gallipoli campaign, where 'there was already evidence of abnormal behaviour caused by war strain, although the aetiology of shell-shock was largely undeveloped' was the first place to test the unfit.² As in Britain at the outbreak of the 1914-18 war, there was no commonly agreed body of knowledge on the effects of battle experience.

The discourse around psychiatric casualties that did emerge was almost entirely medical, and there was no professional challenge to the medical construction of war-related dysfunction. Other professionals such as psychologists and social workers were primarily there to support medical and administrative effort, not to diagnose, advise on policy, treat patients, or develop programs. Little debate emerged in this Australian context, but there were three contentious issues. One point was the use of the term shell-

¹ For the sake of simplicity the term war neurosis will be used as a general term for a psychiatric casualty. The label is used in the literature but was never an official diagnosis. It was a convenient term psychiatric casualties, rather than a new neurosis attributable to war events. Psycho-neurosis was commonly used to distinguish from psychoses.

² Butler, A. (1943) *The Official History of the Australian Army Medical Services in the War of 1914-18: Vol III*. Canberra: Australian War Memorial. Chapter 6, Lloyd, C. & Rees J. (1994) *The Last Shilling: A history of repatriation in Australia*. Melbourne: Melbourne University Press.

shock. A second was the Freudian notion about the sexual origin of neuroses. The third issue was the question of granting pensions on psychiatric grounds.

In Australia, the public discourse about the needs of mentally damaged soldiers of WWI was very restrained. With the exception of the newspaper *Smith's Weekly*, there was little outcry from outside authorities and groups on the treatment of psychiatric cases. Organisations such as the Red Cross provided facilities for 'nerve cases', and maintained this role until WW2. After a flurry of activity at the end of the war, any concern for the returned man gradually dissipated as post-war reconstruction got under way.

What was it about WW1 that might give rise to mental disturbance? For Australians in WW1, Gallipoli, and the battles on the Western Front, were the two most traumatic sites. The terrible experience of men who participated in campaigns where almost 60 000 Australians were killed, is brought to life in two letters sent home from the front.³ The first is from a young man writing to his mother about ANZAC Cove in June 1915.

My Dear Mother. I am taking this opportunity of writing home to you, as one of our AMC men is catching a boat to leave for Australia tomorrow morning ...

Well mother, we could not say too much in letters about what goes on here as they would be torn up. We went to Egypt under sealed orders and went to a island called Timnos, and stopped there for ten day. We steamed away to the war, and were told we might have to land under fire. In the morning before daylight we heard the big guns firing, and a little while after we could hear and see them.

Everyone was ordered on deck, and we saw boats being lowered off the other boats in the harbour, then we got orders to disembark and land. We could see and hear rifle, machine gun and shrapnel fire; it was splashing all around us, and when we got a little closer, it simply rained bullets and shrapnel. We were fairly lucky, only a few in our boat-load got hit landing, but one boat load was towed in together (about 150 men and only 29 landed safely out of them). When we landed, we could see our boys, bayonets out and after the Turks, and we had to follow. Our mates were dropping down all around us, but we could not do anything for them. We had to push forward and we did it. We had to stop there for a week, with very little water and tucker, as when we landed we threw our packs away...

We camped in a rest camp a couple of miles from the point for a few days, and then we got orders to move. Marched a couple of miles, then had to dig trenches. Just as we finished we had orders to go forward – no-one knew how far. We had five minutes to leave the place, and advanced under shrapnel, very heavy, for 300 yards. It was nothing to see a section get wiped right out with one shell, but we had to go straight on, as to stop meant death; there was no cover at all. So we went

³ See Butler (1943) op cit. On the basis of a check of all personal records of WW1 soldiers in the AIF Butler estimated that 325 562 soldiers and nurses embarked overseas, and 258 011 returned to Australia. 58 856 were officially killed or died, which is approximately 1 in 5.

forward. About 700 left the camp (with our reinforcements) and when we arrived at the firing line, half of them were wounded.

Went straight on for about 400 yards under fire just like rain, and had to lie on level ground and dig trenches. Hundreds got shot trying to dig in, but we held on till dark when we were reinforced. The moans and groans of the wounded were awful to listen to, but we could do nothing until stretcher bearers came and got them away; those that could walk had to chance getting shot again, getting back to the trenches where the doctors were. The field we had advanced over was strewn with dead Turks, and hundreds of our own men. You could not describe it on paper – it was an awful sight ... Our Battalion mustered only 140, with 1st, 2nd, 3rd reinforcements. It was awful, you could not really imagine it.

The first few days we were very nervous and the AMC [medical corps] was kept very busy. The beach was crowded with wounded and dead soldiers; even after a week on the beach there was a lot of casualties...

You can be sure now dear mother, that I will return home safe and sound to you, and all that love at home... Your loving son, Jack'.⁴

The second is from a young doctor who was in the trenches in Belgium in September 1916.

Dear Father,

Perhaps you would like to hear a description of the Regimental Aid Post. I will describe the one we occupied in our second Pozieres stunt. It was situated beyond the demolished town and as about 400 yards behind the front line. It was on a main communication trench, in fact then the only way in and out of the line. The communication trench had been blown up in several places and in other places it had been filled in over a body, of which you see a leg or an arm projecting, or perhaps recognize its presence underneath by a characteristic squelch on treading. You see, those places could not be repaired or a man dug out while those continuous barrage stunts were kept up. You can imagine how embarrassing it was to meet a company going out the first time I went up, and to be held up while they went by.

On arrival at the dugout you see a dark hole (as per photo of mine at Anzac) and we are told to go down backwards and hold on to the rope on the left hand side, and to avoid bumping your head. At the bottom it opens up right 10' and left 30' and off each one of these are small bunks about 8x8x6. At times the wounded come in so rapidly that one only treats the moderately severe cases, allowing the slight or walkers to go on, placing the very severe cases on one side. Well, one day five of the last named died at my doorstep, and as there was a block at the time, I told the men to temporarily place the dead in a shell crater over the parapet close by. This they did but unknowingly placed them in the head of the subsidiary entrance.

This was not discovered until three days later, when some signalers, who slept at the bottom of the shaft, had reason to investigate the cause of a very bad smell, and

⁴ Letter from Sgt A. G. Carey, 2nd Infantry Brigade, AIF. The complete letter contains more detail of the landing and the battle experience. 7 818 Australians were killed at Gallipoli and 45 044 men were killed on the Western Front 1916-1919 (Butler 1943, p. 900).

found the missing cadavera [sic]. You can believe the smell was indescribably horrible – that of stale blood together with that after rabbit poisoning.

The only place I could treat the wounded was that part of the trench directly opposite the dugout. Imagine the difficulty when at one time I had eight stretcher cases blocked up and a fatigue party going up with rations...

The fatigue parties are a revelation. They take rations etc up to the front liners, and as I say the whole communication trench was being shelled very systematically. Those chaps on arrival would look absolutely done ... They are being shelled so much that they have to double most of the day and they know that probably several will be laid out before they get back to the dump.

Some ignorant critic has said that the Australians are so successful as soldiers because they are used to the bush and are duller of instinct than most city men. But if you saw one of these parties going up you would see how incorrect this was. You see in each one of these men a very highly sensitized, and at the time very over-strung organism. You can see it in their faces that they are men of imagination, you can see that they realise the possibility of each shell or of each salvo, and that they are more or less terrorized--yes, but not panicked. Not a man would turn back and every man will crack a joke.⁵

These are just two of the young men who experienced or witnessed events they were in no way prepared for. They describe some of the very stressful conditions as well as the resilience of those who survived. The conditions that might have led to such an 'injury' were described in graphic detail by historian Bean (5 volumes 1927-1936), and to some extent by the medical historian Butler (1940). Anyone at Gallipoli or on the Western Front, would have experienced raw fear, and been confronted with incidents like those described above that might crawl under the skin of the mind. They saw close friends blown up alongside them or mown down; they lived in appalling conditions; they were bombarded with shells or were caught in enfilading fire; and they made fatal charges. Others, like my father in the Fourth Division Artillery, rained shells on the enemy, or supported those in the front line. On the Western Front Australian troops were exposed to more prolonged strain and hardship as well as fierce fighting conditions, than in any other modern war. When a man could not take the strain and broke down he either became a mental casualty or, in some cases, deserted. Justifiable mental breakdown was often confused with cowardice.

There is no evidence that Australian psychiatric casualties reached the epidemic proportions of the British. Unless it was a well hidden 'disease', the incidence of psychiatric disorder was far less than that exhibited in shell-shock casualties in the British and Canadian Expeditionary Forces. Butler (1940, 1943) argued that the low

⁵ Extracts from a letter from Fred, a medical officer, to his parents. AWM, IORL/592.

incidence of mental breakdown was attributable to the high moral and physical standards of Australian troops. Psychiatric casualties did not form a neatly defined group. Because of the limited screening at enlistment, many men of limited mental capacity and a previous record of instability or dubious habits were only detected after they had enlisted and were under pressure. Thus the early days of service became a sorting out period at both a psychological and moral level. As in the British army neurosis and hysteria were the most commonly attributed psychiatric illnesses. A minority were labelled with Disordered action of the Heart (DAH), but this was modified to Effort Syndrome. This accounted for 'war weary' soldiers who showed no clinical evidence of organic disease. Butler noted that there was a resistance to the 'new psychology' and that there was a fine line between neurosis and malingering or cowardice.⁶

The most comprehensive academic account of the Australian WW1 psychiatric casualty and services is found in the three volume (1930, 1940 and 1943) official medical history by Butler.⁷ He described psychiatric casualties as 'moral and mental disorders'. Butler's synthesis of the WW1 experience was compiled in hindsight and no such body of knowledge was available to WW1 practitioners at the outbreak of war. Butler (1943) argued that the medical profession had been unprepared for the mental casualties of WW1. According to Butler, there was no common body of opinion, there was little scientific basis for the measures that were taken, and the field was torn by a 'deep divide in opinions'. He decried the inadequacies of the medical knowledge available at the beginning of the war, particularly the classifications available for 'mental disease'. These classifications broadly covered delinquent conduct, psychoneuroses, and the psychoses. Only in the latter disorder was the person not fully aware of his state, and considered insane. For Butler, breakdown under strain was as much a moral failure as it was a mental breakdown. Consequently, he argued that most of the mental disorders could be prevented through the 'promotion of moral health' (p. 60). This is central to his thesis that proper mental attitudes to withstand strain can be

⁶ Butler, A. G. (1940) *The Army Medical Services in the War of 1914-18, Vol II, The Western Front*. Canberra, Australian War Memorial.

⁷ Arthur Graham Butler (1872-1949) served as a regimental medical officer with the AIF and had a distinguished career in Egypt, at Gallipoli and in France. He was awarded the Distinguished Service Order at Anzac, and commanded the 3rd AGH until 1918. After a period in medical records he returned to Australia to private practice. When he agreed to write the official history he moved to Canberra, where he died in 1949 (ADB, 1891-1939).

developed through 'training, discipline and habituation'. In establishing this argument Butler reviewed the state of knowledge about insanity prior to WW1, by which time a framework of understanding had been established based on introspective, experiential and biological knowledge.

Some independent thought in Australia came from neurologists such as A. W. Campbell, George Rennie, and Eric Sinclair in the Lunacy Dept in NSW, and Henry Maudsley and Richard Stawell in Victoria.⁸ The only psychologist to make a significant contribution was Elton Mayo in Brisbane but he was outside mainstream psychiatric medicine. A few reports on the Australian experience appeared in the literature around the time of WW1, one of them from the field from A. W. Campbell. Another is found in the proceedings of a meeting of a section of an Australasian Medical Congress held in Brisbane in August 1920. Under the chairmanship of Henry Maudsley, a number of experts gave their views on the war neurotic and his treatment. Some of these reports were based on experience in British (Maudsley & Ashurst) hospitals, as well as Australian hospitals (No. 5 Australian General Hospital & No 2 Military District).⁹

W. Ernest Jones, Inspector General of the Insane in Victoria at the outbreak of war, warned the Australian medical community as early as 1916 about the likely return of neurotic soldiers.¹⁰ These would have been 'little understood nervous and mental affections', and present 'unusual cases of hysteria, neurasthenia, phobias, and obsessions of various kinds'. They might display loss of memory, loss of speech, blindness, mutism or stammering. He illustrated this with the case of a 20 year old soldier who had been buried alive by a shell at Gallipoli in July 1915, and repatriated to Australia. He had been admitted to hospital, was unable to speak and had occasional impulsive outbreaks and moody periods, but no organic lesion was evident. The soldier had been confined to a padded cell for a period after he had become violent and attacked other patients, and during the journey home he had attempted to throw himself

⁸ Henry (Harry) Maudsley should not be confused with the British psychiatrist Henry Maudsley (1835-1918), whose inspiration and gift of 30 000 pounds in 1908 to the London County Council resulted in the foundation of Maudsley Hospital (Obituary in the *Lancet*, 1, 1918, 193-194).

⁹ See note on Maudsley above.

¹⁰ Jones, W. E. (1916) A case of shell shock. *Medical Journal of Australia*, 1: 203-204. He is not Professor Ernest Jones of London who later became the President of both the International Psychoanalytic Society and the British Psychoanalytic Association and was editor of the *International Journal of Psychoanalysis*. For reference to W. Ernest Jones, see Brothers, C. (1957) *Early Victorian Psychiatry, 1835-1905*. Melbourne: AC Brooks.

overboard. Jones cited this as an example of the 'little understood nervous and mental affection, not only where a definite wound has been received, but in many cases where nothing of the sort appears' (p. 203).

Back home in Australia the mute man settled into convalescence. Jones saw him a number of times, but the key to his recovery was not the wiles of a psychotherapist, but a snake that he encountered on a picnic from the convalescent home. The excitement of killing the snake caused him to shout and triggered a recovery of full speech. Jones cited Mott (*British Medical Journal*, December 1915), and Sarbo (*British Medical Journal*, July 1915), to support his view that many such cases were functional disorders, since there was no organic damage to the nervous system. At the time of writing however, he maintained that 'the pathology of these disorders has yet to be written'.

The theory of individual vulnerability to stress began to emerge at this time. An editorial of the 1916 issue of the *Medical Journal of Australia*, in which the Jones' article appeared, warned that there would be functional disorders from war and that they should be treated seriously. However 'a soldier with an unstable nervous system is indeed likely to exhibit some strange manifestations of an hysterical and neurasthenic nature'. The author also stated that 'the affection is not new: it has only become more frequent under the conditions of modern warfare' (p. 205).

Butler summarised most of the views of the time. In these the dominant view was that neurotic reactions were a result of poor training and low morale, was similar to Freud's view that a strong ego could be developed through discipline and training. This discipline and training could prevent the 'flight into illness', and the development of a neurosis.

The old ego protects itself from the danger to life by flight into traumatic neurosis in defending itself against the new ego, which it recognises as threatening to life. The National Army was the condition, and fruitful soil, for the appearance of war neuroses; they could not appear in professional soldiers or mercenaries.¹¹

Butler pointed out that the search for understanding was also a struggle for dominance among the specialists, predominantly waged in Britain not Australia. He cited the case of C. S. Myers as an example of a battle between the neurologist's view of shell-shock and that of the 'psychologist'. Myers had been appointed as a specialist in nerve shock originally, but this was changed to consultant psychologist, reflecting the

¹¹ From *Introduction to Psycho-Analysis and the War Neuroses*, by Ferenczi, Simmel & Jones, quoted in Butler (1943) op cit., p. 92.

shift in emphasis from the body to the 'mind'. The basis for the distinction was the explanation of symptoms - were they a result of a physical shock to the brain or were they a manifestation of disordered mental processes and 'flights from fear'? This was never satisfactorily resolved. When the AIF reached the Front, medical officers were given instruction on how to classify shell-shock as a wound, but Butler claimed that the instructions were inadequate and most could not access detailed information.¹²

As the battles proceeded, 'shell-shock' as a 'wound' lost credibility as the number of cases of breakdown with no 'commotional shock' grew. New and innovative labels and treatments had to be found and men did respond to enforced rest, good food and reassurance. It was thought that breakdown was a temporary condition rather than an exacerbation of pre-existing pathology. Butler, thus concluded:

It is equally certain that a great many men who sought refuge under the Geneva Cross from the intolerable strains and shocks of warfare, were suffering from exhaustion, a breakdown of the power of resistance, physical and "moral", and not, as in Colonel Campbell's Gallipoli cases, from the culmination of some grave, longstanding disorder of personality, inherited or otherwise.¹³

This led Butler to argue that shell-shock should have been more appropriately called 'battle shock', and the 'ultimate psychopathic picture' contained a large proportion of men who were not chronic long term pathological cases. Consequently casualties were labelled with:

- mental conflict
- anxiety state
- moral and mental and perhaps physical shock
- stupor
- confusion and amnesia
- psycho-neuroses

Major A. W. Campbell (1916) observed psychiatric casualties evacuated from battlefields like the Dardanelles to No. 2 AGH in Cairo in 1916.¹⁴ These cases of 'neuroses and psychoses contributed to modern war casualty lists more heavily than we had previously supposed' and were presenting a problem hitherto unrecognised by authorities. He classified these casualties broadly as:

¹² The official manual for the AIF was *Injuries and Diseases of War*. Shell shock 'W' was the early diagnosis offered to MOs.

¹³ Butler, (1943) op cit., p. 106.

¹⁴ Campbell A. W. (1916) Remarks on some neuroses and psychoses in war. *Medical Journal of Australia*. 1; 319-323.

- Neuroses, including hysterical type reactions;
- Neurasthenia (including trench spine);
- Psychoses (which Butler interpreted as a type of anxiety neurosis)

The term psychosis applied to men who had experienced prolonged periods of strain and eventually broke down, as well as to the men who were clearly 'insane'. However, these cases, 'taken as a whole did not differ from those seen in civil practice' (p. 87). Another category of men was suffering from some battle induced condition, for whom there was 'no end to these so-called functional affections of the motor apparatus and common sensibility'. For Campbell, admission to hospital was the end of the line and these men were virtually 'useless for further fighting service'. In most cases patients reported some type of harrowing incident or extreme battle condition preceding their problems, and exhibited restlessness, nervous demeanour, easy excitation and disturbing dreams. However, extreme battle conditions were not considered a primary causative factor in the etiology of the 'disease'. Rather, the reason for their breakdown could be found in their prior disposition and experience, which in some had shown up in training. Men had often experienced commotional shock, fatigue, and mental strain, but Campbell insisted on 'the importance of disposition'. He reported that 'time after time, on going into the family and personal histories of such cases, we found evidence of neuropathic and psychopathic tendency, and this was the fundamental cause of their downfall' (p. 323). These men 'were not malingerers', but nevertheless were sources of 'psychic contagion' and a danger in the ward. Treatment in a hospital with limited facilities was difficult because they needed to be isolated and kept active, not confined in bed.

Butler did not entirely agree with Campbell, and acknowledged that at Gallipoli, the 'cause' of the injury was the physical conditions as much as a 'neurotic disposition'. According to Butler, Gallipoli had been a testing ground for ideas but the development of systematic diagnosis, which evolved out of experience rather than from empirically based medical knowledge. The shock of exploding shells was initially accepted as a major condition for development of mental problems but the most significant discovery was that the incidence of breakdown was greatly influenced by the morale of the unit. Thus mental health became construed as a moral problem as much as a medical problem.



Figure 5.1 Scenes from the Western Front, Passchendaele and Ypres 1917-18. Aust. War Museum No. E691, E941

Springthorpe (1919), had been in charge of the Australian war neuroses cases in the Australian Auxiliary Hospital in England between 1916 and 1918, and had diagnosed and treated functional nervous disorders in the civil arena since 1880. In treating the 'neurasthenic or functionally diseased patient', he had rubbed shoulders with some of the key British identities such as Hurst, Myers, Rivers, Collie and Fearnside. Like Butler, he considered that in WW1 the medical profession was almost entirely unprepared for the high casualty rates among the British (15% of 170 000 pensions),

French (14 000 in one hospital alone), and Canadian troops (12% of casualties in Quebec alone).

Springthorpe argued that in WWI many soldiers were found to be mentally and organically unfit to cope with mental strain. War had shown the overpowering part that emotion and suggestion, rather than commotion or concussion in battle played in the development of disorder. Treatment had to be preceded by a process for detecting the malingerers and those with organic brain concussion, so that treatment of the 'true neurasthenics, psychasthenics, neuromimetics and hysterics' could proceed.

In Springthorpe's view, suggestion and persuasion were key elements in treatment. His rationale was that since the condition was induced by suggestion in the first place, men should be cured through suggestion and firm counselling, supplemented by finding employment. Suggestion, persuasion and manipulation, applied after careful ground work with the patient, could cure a condition where other more elaborate treatments such as electricity, massage, fixation, diathermy, radiant heat, baths and orthopaedic devices had failed. These physical treatments only encouraged the patient to focus on their symptoms. Another plank in Springthorpe's approach was re-education, which was more laborious and not as efficient as suggestion. Re-education, where 'you attempt to rebuild the person mentally', needed to be carried out in an atmosphere of cheerfulness, optimism and understanding. A modified form of psychoanalysis, rather than the more intensive Freudian analysis, was required in the initial stage to uncover the dynamics of the internal strife a soldier was experiencing. This was the only concession to Freud, as war neuroses had completely shattered the original perverted notion of the sexual basis of neuroses and the war had projected Freud 'into oblivion'.

Springthorpe believed that lessons from WWI could be translated into civil practice, not just in psychotherapy or psychiatry, but in every field of medicine, such as surgery, when dealing with paralysis, oedema, joint stiffening, partial paralysis, or any other medical condition even where there is an organic cause. Like most of his contemporaries, Springthorpe was particularly scathing of the practice of compensating a person for traumatic injury arising from accidents. He said, 'In civil practice, compensation takes the place of a return to the front'.¹⁵

¹⁵ Springthorpe (1919) War neuroses and civil practice. *MJA*, 2, 14; 282. Springthorpe's notion of the doctor-patient relationship was 'centred on a theme of social and moral order', in which the physician has the power to cure. This seemed to be what Foucault referred to. See Foucault, M. (1961) *Madness and Society*, London, Tavistock.

Other contributions are worthy of mention. Two reviews of overseas publications on shell-shock appeared in the *Medical Journal of Australia* in March 1919. The first was *Commotion and Shock of War* (Andre Leri), in which the reviewer pointed out the need to distinguish between two similar conditions, one of which was clearly neurotic in origin, the other caused by organic lesion. A second text was *War Neuroses*, by John McCurdy, which highlighted the similarity between civil and military disorders. The neuroses of war essentially arose out of conflict between duty and the instinct for self-preservation, rather than the sexual instinct, which explained civil neuroses. A neurosis appeared when mental mechanisms could no longer contain the effects of fatigue, explosions and other distressing occurrences which 'are the spring releasing the accumulated morbid mental forces' (p. 173).¹⁶

In April 1919, W. R. Regnell presented a paper to the South Australian meeting of the British Medical Association summarising the ideas in Australia at the end of WW1.¹⁷ Regnell had worked at Seale Hayne, one of the main British military hospitals for the treatment of neurotic conditions, as well as sitting on review boards in the United Kingdom. In his paper he warned of the possibility of 'large numbers of neurotic casualties', and wanted authorities to avoid the mistake of awarding pensions for this disability. He believed that disorders neurasthenia, psychasthenia,¹⁸ and hysteria were largely functional and would worsen if compensated, but they could also successfully be treated if addressed at the right time with the right approach. Psychasthenics for example, were unable to adapt themselves to reality and could best be cured through persuasion and psychotherapy. Regnell claimed that this form of psychotherapy was similar to that prescribed by Dejerine, Janet, and Dubois, not Freud, Jones or Jung. It broadly consisted of an assessment of the underlying sub-conscious mental conflict producing the symptoms (which could include dream analysis and word association), to provide a basis for treatment. The underlying complexes, the best example of which was love, were a 'direct stream of consciousness', which 'colored a young man's thinking'. A number of other dynamic mechanisms such as repression were part of the internal

¹⁶ Review section *Medical Journal of Australia*, 1, 1919; 173, Shell Shock and Concussion, and War Neuroses.

¹⁷ Regnell, W. R. (1919) The psycho-neuroses of war. *Medical Journal of Australia*, 1, 23; 455-460.

¹⁸ There seems to be some confusion about the spelling and use of the terms psychasthenia and psychothesia. I have assumed they mean the same thing but have used them in the same way as authors.

dynamic, but the primary focus in therapy was on rooting out the underlying deep inner complexes, rather than dealing with any remnants of the war. Unless there was a definite injury, hysterical conditions were always functional, and since they were produced by suggestion they could be removed by 'pure persuasion'. 'The seat of the disorder is not in the arm or in the leg, but in the mind' (p. 456). Other forms of treatment such as electricity, drugs, massage and hypnotism tended to focus on symptoms and were generally not recommended. Echoing his British and Australian counterparts, Regnell advocated firmness and authority in dealing with war neurotics.

At the same conference a Dr Hayward, who had also worked in London during the war, reminded his audience that the 'neuroses described had been in evidence from time immemorial'. In these functional cases the severity of the condition bore no relationship to the original causality, such as mine explosions. Improvement of patients was strongly influenced by the personality of the medical officer in charge of the ward. Hayward thought that if the functional nature of these neuroses had been acknowledged earlier, society might have been spared the sight of the 'many mental wrecks in their midst'. Recovery could not be expected if these men were 'coddled' with support like pensions. He did not blame the soldier but argued that he should not be discharged until given proper treatment and retraining.¹⁹

Elton Mayo, an academic and clinical psychologist in Brisbane, was one innovative therapist in the field who received little recognition. Towards the end of WW1 his lectures on psychology at the University of Queensland sparked the interest of Dr Thomas Matthewson, who specialised in functional and nervous diseases at the Sick Children's Hospital. They developed a professional relationship and Mayo was asked by Matthewson to assess some of his problematic patients. One case was a young officer who had returned from WW1 distressed by a series of intensely disturbing experiences and been diagnosed with shell-shock. He had been treated by a number of doctors without success but one session with Mayo won his confidence and he continued treatment with significant improvement. Mayo used a number of techniques, such as Jung's association test and hypnosis, to tease out a soldier's experiences and repressed memories. He treated a number of psychoneurotics and continued to advise Matthewson, even arranging for him to be appointed resident medical officer at the Russell Lea hospital for shell-shocked veterans in New South Wales. Mayo developed a

¹⁹ Reported in *Medical Journal of Australia*, 7 June 1919; 472-473.

dynamic psychological theory on war neuroses, and argued that effective 'cure' required abreaction and purposive re-education. His work with veterans effectively ceased when he left for the United States in 1922 and embarked on a distinguished career in industrial psychology.²⁰

THE REPATRIATED PSYCHIATRIC CASUALTY

Expectations that all conditions could be cured prior to discharge proved to be unfounded, and in the repatriation of these cases, Australian authorities had to develop new systems. Lloyd and Rees (1994), point out that many hundreds of Australians had to be repatriated early in the war, because they were unable to stand the strain, but may have not been diagnosed as psychiatric casualties. In his official account, Butler was unable to furnish accurate and complete records of 'moral and mental disease', but it was certainly not regarded as great a problem in the AIF as it was in the British Expeditionary Forces. Despite the fierceness of the action and conditions at Gallipoli, there were only 1 640 cases of neurosis, psychosis, and delinquent conduct treated in hospital. These represented only 2.1 percent of all disease admissions in 1915. This is very likely a gross underestimate of the problem, as there were other ways of masking mental strain or illness such as desertion or wounds, whether self-inflicted or honourably sustained.²¹ Butler conceded that there was a psychic element in many illnesses and wounds that never appeared as psychiatric casualties (pp. 462-463). There were also neurotic components in soldiers recovering from wounds, gassing or other conditions.

The other measure of incidence is the number of pensions granted to Australian soldiers on grounds of mental illness after WW1. By 1930 there were 12 844 veterans receiving pensions on psychiatric grounds. Given that these would have been granted only after close scrutiny, and many would have been rejected as not related to war service, this is a large number of casualties. Eighteen different categories of illness were recorded, and the largest diagnostic categories were neurasthenia (5 138), and Effort Syndrome (4 567).²² This is a significant part of the veteran population and highlights a substantial piece of history that has been confined to medical files and archives. The

²⁰ Mayo's work is described in the biography by C. S. Trahair, *The Humanist Temper*.

²¹ Many men yearned for a 'Blighty', which was a wound that warranted repatriation away from the front – if serious enough they would be sent to England (Blighty).

highest level was in 1939, when five percent of all pensions paid were for war neurosis (3 345). These included 519 mental patients under restraint. By 1939, 4 891 cases of war neurosis had been treated in repatriation facilities. In this case, war neurosis included shell-shock, epilepsy, neurasthenia, alcoholism, and the inebriates. There is evidence of a slightly elevated prevalence of suicide among veterans.²³

There were minimal support, through pensions and psychiatric rehabilitation facilities, for early evacuees from the war. The main recourse for rehabilitation assistance for WW1 soldiers outside the Army Medical system in the early war years was through the charitable agencies or private providers. Although most medical experts argued against pension on psychiatric grounds this argument was lost. Even though the country was impoverished after a long war, the government could not ignore the needs of almost 300 000 men, who might have posed a threat at the ballot to the government of the day. Bodies like the RSSAILA, a powerful veteran lobby group, which had been established in 1916, persuaded the government to change its mind on entitlement for psychological injury not the medical community.²⁴

Pensions were previously allocated through the Pensions Board and funded from Patriotic Funds, which were in turn funded by public subscription. Pensions were taken over as a government responsibility in amendments to the Pensions Act and Australian Soldier's Repatriation Act of 18 January 1917, introduced by Senator Edward Miller. The Australian War Pensions Scheme was implemented in August 1918, and the government, having accepted responsibility for repatriation and compensation,

²² Other categories included shell shock, neurosis, various nervous conditions including nervous dyspepsia, and insanity (see Butler 1943, op cit.).

²³ From 1917 to 1939, an average of 32 ex-soldiers committed suicide in New South Wales per year. The number peaked in 1930, a time of high unemployment and poverty, and suicide rates among WW1 ex-soldiers exceeded those in the general population in all years. In 1930 there were 4.005 veteran deaths per 10 000, compared with 3.5 per 10 000 in the civilian population. Social isolation and alcoholism were identified as veteran problems. In 1933 there were 226 438 surviving veterans in Australia. If the NSW rates are extrapolated nationally this represented a major health problem. (see Minogue, *Medical Journal of Australia*, 1945)

²⁴ The first organisation was the Returned Soldiers' Association (RSA), which was changed in 1940 to the Returned Soldiers, Sailors & Airmens' Imperial League of Australia. This became the Returned Services League (RSL) in 1965, which was renamed the Returned and Services league in 1990. All have been national organisations with state branches. The longest serving president, Sir Arthur Lee MM, an ex-member of 2/27 Battalion, participated in this study.

established the Repatriation Department in 1918 to provide separate rehabilitation facilities for ex-servicemen.²⁵

Before admission to rehabilitation and treatment facilities troops needed to be assessed and sorted into diagnostic categories. The initial assessment had been undertaken in the field when Australian casualties were either treated in British Army neurological hospitals or repatriated to Australia, where more accurate diagnoses than NYD could be made. Psychoneuroses were classified as:

- Simple exhaustion
- Neurasthenia
- Hysteria
- Confusional States
- Medical conditions - miscellaneous.

More serious psychotic conditions encompassed idiocy, imbecility, feeble-mindedness, moral imbecility, mania, melancholia, maniacal-depressive, insanity, mental stupor, delusional insanity, psychasthenia, acute delerium, infective disease insanity, general paralysis of the insane, confusional insanity, insanity due to alcohol, dementia praecox and dementia primary or secondary. Many of these conditions existed because the fact that there was no psychological screening on entry to the forces, and underlying problems emerged under pressure, and more rigorous scrutiny.

There was a strong imperative to retain men in service until they were 'cured', for two main reasons for this. The first was to ensure that soldiers would not contaminate society after demobilisation. The second was to reduce the likelihood of a pension being granted on psychiatric grounds. Butler stringently opposed granting pensions on psychiatric grounds, arguing that the 'nervous soldier' should not be released to contaminate the community and unless a soldier was adequately treated before discharge he would be a 'drain on the life blood of the nation'.

It was argued that releasing untreated men could even exacerbate the original condition, and facilitate the development of an actual neurosis from a potential neurosis. The best prophylaxis for these men was the same as that recommended for the development of a strong fighting force – *esprit de corps*, discipline and organisation. On Butler's estimation, 'the proportion of pensions for this type of disorder greatly exceeds

²⁵ This is a brief outline of a very complex story. For much more detail, see Lloyd & Rees (1994) *The Last Shilling*. A brief, yet detailed account is found in Galbraith (1946) *Medical Journal of Australia*, 2: 1-8.

the total sum of the disorder actually seen in the war', which could only be explained either through some form of latent neurosis or malingering. According to Butler, malingering was fostered in the economic depression of the 1930s.²⁶

It must be noted that at the end of WW1 there was no adequate provision of public health care and mental health facilities were little more than crowded understaffed asylums. As an example, at the beginning of the century, Springthorpe, the Official Visitor to Victorian Metropolitan Asylums, undertook a careful comparison between Victorian institutions and those in New York and Britain. He concluded that 'our Metropolitan asylums are disgracefully behind those of America of ten years ago, and that in aims and ideals they are not in the same class as their modern English and Scottish fellows'.²⁷ Rehabilitation facilities included convalescent homes, hostels for the permanently incapacitated and separate facilities for those suffering from severe shell-shock and other psychological conditions. Reliable information on the extent of the disability is not available the Dept of Veterans' Affairs mounted a public display in 1999 on the history of veterans' health care. In this it was claimed that medical repatriation was a response to the 'massive numbers of service men and women suffering from shell-shock' (p. 1).²⁸

Apart from military guidelines for dealing with war neuroses, repatriation authorities had no policy on the 'neurasthenic soldier'. A conference was convened in June 1918 to work out how the Commonwealth would deal with this problem. This prestigious gathering, presided over by the Surgeon-General G. Cusaden, included Eric Sinclair, the principal Medical Officer of the 2nd Military District, A. H. Sturdee, Principal Medical Officer of the 3rd Military District, and several other experts. The meeting decided that the term neurasthenia would cover most conditions, including ordinary neurasthenia and hysteria, as well as toxic 'shell-shock', Disordered Action of the Heart, and virtually any disturbance, including certifiable insanity.

The final resolutions effectively were:

²⁶ See Brook, R. (1999) *The Stress of Combat: The combat of stress*. Brighton: Alpha Press, p. 26. Brook noted that in 1939 there were 120 000 British WW1 veterans receiving a pension on psychiatric grounds.

²⁷ See Springthorpe (1903) Our Metropolitan Asylums, *Intercolonial Medical Journal of Australasia*, 8,3: 109-124.

²⁸ Department of Veterans' Affairs internal document, 1999. See Lloyd & Rees (1994) for an extensive history of the Repatriation Department. The mental health aspect of this receives cursory treatment. Garton (1994) provides a more elaborate coverage of the provisions for WW1 soldiers.

- There would be no 'boat leave' for psychiatric patients when they arrived.
- Men suffering from shell-shock and true neurasthenia, the borderline insane, and curable inebriates, should be retained either until they were cured, or were ready for referral for repatriation.
- Members from the 3rd Military district would be sent straight to MacLeod Hospital where they would be segregated.

Who would know how to deal with these casualties? The committee was keen for local expertise to be utilised such as the knowledge of the asylum trained female nurses at Broughton Hall Military Hospital for Neurasthenics in New South Wales. There was also a strong recommendation to provide employment and vocational training as an integral part of treatment.²⁹ To cater for returned soldiers, the largest state, New South Wales, developed the most comprehensive treatment facilities, modelled on British institutions such as Seale Hayne and Maudsley Hospitals.

In the treatments in place, psychodynamic ideas had some influence. An Australasian Medical Congress in Brisbane in 1920, on neurology and psychological medicine, devoted a small amount of time to war related conditions. Godfrey (1920) reported on 400 men admitted to the No. 5 Australian General Hospital in Melbourne, with conditions of nervousness, hyperaesthesia to light and noises, insomnia, night terrors, a feeling of falling through space when asleep, and impaired memory. Men also displayed tachycardia, tremors, stammering, aphonia, paraesthesia and anaesthesia, blindness, functional paralysis, deafness or visceral disorders. They were not 'shell-shocked', but were 'suffering from emotional traumata, and the term anxiety hysteria appeared to be appropriate'.³⁰ Godfrey's explanation was that their symptoms arose out of the repression of the unpleasant or agitating experience.

At the same meeting, White described the practices at Ashhurst Hospital in Oxford, where he had treated cases of hysteria. The root of their problem was amnesia, where the 'subconscious mind was worrying over the shock which originally produced the trouble'. The work of uncovering these memories through psycho-analysis and hypno-analysis, could only be achieved by experts, not charlatans. In another paper, Withington, reported that 95 percent of soldiers could be hypnotised, but agreed that

²⁹ *Medical Journal of Australia*, 2, 1918: 480-481.

³⁰ Godfrey and a number of others including W Ernest Jones were at a Medical Congress Meeting in 1920. This was reported in the *Medical Journal of Australia* in September 1920.

such practice needed to be kept out of the hands of charlatans. Hypnosis, which increased suggestibility, and therefore facilitated persuasion, was highly recommended. Noble pointed out that in the various Red Cross institutions, and at No 23 Auxiliary Hospital in New South Wales, those suffering from mental diseases and alcoholism, were segregated from those affected with war neuroses. He advocated a very regimented treatment in which a well-trained team did not want their efforts 'thwarted by outside interference from family members'. Nursing staff who even 'unconsciously suggested contra-therapy' would be weeded out. This treatment team would use psycho-analysis, suggestion, hypnotism, and physical treatments.³¹

Until April 1918 all care for veterans other than those still being treated in military hospitals was the responsibility of the state mental institutions in each state. Initially shell-shocked patients were isolated during their voyage home and on embarkation housed in specially designated sections of the hospitals in Sydney and Melbourne. If they were not cured within twelve months they were sent back to their respective State Lunacy Depts. At this time all mentally disturbed citizens were subject to states statutes which determined how they were treated and housed.³²

Most states provided facilities for specific conditions such TB, Alcoholism (the latter under the Inebriates Act and the Convicted Inebriates Act), and lunacy, and soldiers discharged from the army were absorbed into these state facilities. In South Australia, for example, specialised institutions were established, such as the Karinya Home for Inebriates that provided a place in the open air with picturesque surroundings, where 'the drunks' would be dried out and reformed. Facilities included billiards, reading and smoking rooms and 53 acres for sport and leisure.

Patients were admitted to the South Australian Parkside Asylum diagnosed with mania, melancholia, alternating insanity, stupor, dementia, dementia praecox, delusional insanity, general paralysis, idiocy and imbecility, moral insanity, confusional insanity and volitional insanity. Almost all of the 235 inmates in 1918 were from lower social classes, the majority being labourers (21%) and domestics (29%). A small number (16%) were veterans but of these, war experience was considered the principal

³¹ See *Medical Journal of Australia*, 2, 1920: 324-325.

³² Lloyd, C., & Rees J. (1994) op cit p. 142.

contributor to the first onset of illness in only two cases. There was no war-related diagnosis.³³

Prior to discharge disturbed ('shell-shock') soldiers were held in the No 17 Auxiliary Hospital at Torrens Park. Here they had quiet surroundings, where they 'gradually improved' until they could be discharged. Because there were provisions for payment of pensions after discharge, the Principal Medical highlighted the need to effect 'cures' prior to discharge to reduce the burden and expense.³⁴

The only attempt to cater specifically for the veteran psychiatric casualty was the provision of care outside the military hospital system. In 1917 the Mental Treatment (War) Act, allowed for approved private and public institutions to accept mental patients for 'curative treatment'. Some of the beds were to be allocated to those returning from war service suffering from 'nerves' or those who had suffered a 'nervous breakdown'. Proprietors would be paid 35 shillings for each patient. Two homes, the King George Hospital in Unley Park and the 'Erindale' home, are on record as applicants for providing treatment. The application from the latter stated that they would only be able to cater for 'easily managed and harmless cases'.³⁵ In September 1917 the Inspector General of Hospitals had requested the Commissioner of Public Works to provide 200 additional hospital beds for mentally defective soldiers, which was questioned by General Featherstone of the Australian Army.³⁶ The more serious cases of breakdown were still housed in the state mental institutions, where the quality of care was inferior to that in private homes.

In the larger states of New South Wales and Victoria, separate institutions were established. The facilities of the army and the Repatriation Department were obviously inadequate for the damaged soldier, not just because of scarce resources, but also because of a lack of finance and low status of the issue. This resulted in some philanthropic initiatives. In New South Wales, for example, Sir James Joynton Smith, who financed the journal *Smith's Weekly*, converted his mansion in Coogee to a 40 bed hospital for 'those suffering from war strain'. As mentioned elsewhere, the *Weekly* was a constant thorn in the side of government on veteran issues.

³³ *Annual Report of the Inspector General of Hospitals on the Mental Hospital, Parkside*, p. 15, and *The Certified Mental Defectives*, 1918. Adelaide, Government Printer.

³⁴ Letter from Principal Medical Officer Lt Col N. Russell of the 4th Military District, Australian Military Forces at Keswick, 12 February 1918.

³⁵ South Australian Archives, 11/18; No 53.

The Australian Red Cross (ARC) Home Hospitals and Convalescent department established a network of post-hospital convalescence and rehabilitation facilities in New South Wales for 'mental and nerve cases'. The generous conditions in the ARC facilities contrasted starkly with the poor conditions in state asylums. Numbers in these homes increased dramatically after 1917 as more damaged men returned from the front. Numbers increased again after Armistice was declared in 1918, partly because of the release of many cases who had been retained in hospital, to make them fit for return to service or be 'cured' them before entry to society. In 1917 the first Nerve and Shell Shock Home was established to cater for those cases too severe for the convalescent home and not bad enough for acute facilities. Nerve cases constituted the second most prevalent 'disease' category requiring long term rehabilitation - second only to TB. These men were the 'shell-shock and neurasthenic cases in which severe relapses frequently take place'.³⁷

Demand appeared to peak at the end of 1919, and this demand was expressed in the annual report in 1920 by the Chairman of the New South Wales ARC, when he lamented 'Will this work ever end?' By the end of 1919 the ARC had established five homes devoted to 'nerve cases'. The Russell Lea became the reception and sorting facility and the specialist functional nervous disorder treatment centre where a patient might spend 4-12 weeks, and the other homes, the Exeter, Novar, Scarborough and Waley Homes provided treatment and rehabilitation.

The services at Russell Lea included psychological assessment, treatment with psychoanalysis, hypnotism, relaxation, re-education, reassurance, suggestion, persuasion, electric massage, and medications. When sufficient progress had been made the patient would be transferred to one of the country homes, where they would be in the open air with 'physical occupation and mental rest in the healthy highlands'. These farms were well organised and provided outdoor activities such as dairying, poultry farming, vegetable growing and woodcutting. This idyllic existence could not last forever and sooner or later the patient had to re-enter the real world.

³⁶ South Australian State Records No 653 Reports of the Inspector General of Hospitals.

³⁷ The information on the work of the Red Cross is from the Annual Reports of the New South Wales Red Cross Society Archives from 1914. In the period June 1917-June 1918, the numbers treated in the NSW homes doubled on the previous year. In 1918, 10 168 passed through the No. 4 Convalescent Room, and in 1919, 17 194.

The Australian Red Cross report of 1922 poignantly described difficulties faced by a 'nerve case', who were:

so cruelly handicapped in not being able to obtain light employment when they leave our nerve hospitals. A patient is discharged after many months of careful treatment and supervision, ready and eager to become a useful citizen once more. What confronts him? Days and weeks of fruitless search for suitable work - then he gives up in despair. In several cases he has been known to take his life, in others he becomes really mental from worry and the prospect of a hopeless future for his wife and children. Another may be compelled to take on heavy manual labour for which he is physically and mentally unable. This means relapse and he is soon back in the nerve hospital depressed and discouraged having lost hope and self-confidence'. Above all, they needed a helping hand that they might regain step by step their old confidence. Occupation of mind and body is their only salvation'.³⁸

After 1920 the numbers of nerve cases in the homes gradually declined, but the numbers of chronic functional and nervous cases and chronic alcoholics remained steady. By 1923 only the Exeter, Waley and Russell Lea Homes remained. The latter closed in 1923, and patients, who still suffered paralysis, loss of voice, shakiness, heart pounding, headaches, weakness, sleeplessness and a host of other functional nervous disorders, were transferred to the Prince of Wales Hospital. Only a few were unfit for 'responsible employment', and a few 'almost hopeless cases' who were readmitted, did not require treatment for as long a period as in their first admission. The residual nerve cases were absorbed into the existing system, especially Callan Park Mental Hospital.³⁹ As the homes declined, the ARC transferred their effort towards hospital visitation and support.⁴⁰

For public civilian institutions each state had its own legislation governing the 'insane' and mentally defective. Under these statutes the disturbed could be labelled insane, mentally defective, or just lunatics, or if they had a drinking problem, inebriates. For example in South Australia, the Mental Defectives Act of 1913 and the Inebriates Act of 1908, applied to veterans as well as civilians. Prior to 1913 all mentally disturbed people were covered by the Lunacy Act of South Australia, according to which they were classified as insane or lunatics. The public mental health facilities were provided in South Australia at Parkside Mental Hospital, where no special consideration was

³⁸ 1921-22 Chairman's Report, p. 12.

³⁹ Callan Park later became the training hospital for army psychiatrists in WW2.

⁴⁰ One example was a 'nerve case' who was out of work and very depressed (1938 report) and unable to pay his rent. He was given food and rent relief, 'We probably staved off another nervous breakdown by this prompt assistance'.

given for returned soldiers at this time. This situation persisted with no major reforms until WW2.

Within this context it is not surprising that right up until 1939 the medical construction of the psychically damaged soldier was different from the response to physical damage. The rehabilitation provisions outlined above were still overshadowed by a view that the ongoing psychological problems of the veteran were of his own doing and should not be attributed to war. Butler still considered the 'so-called war neurosis' to be a 'disability of conduct that comes more properly within the field of *morale*'. Following his review of more serious cases of disturbed men repatriated to Australia, which revealed 'no excess of major psychoses', he concluded that,

The consensus of opinion in medical officers of the Repatriation Department strongly favours the view generally held, that the war *per se* cannot be regarded as a 'cause' of those various morbid states - diseases - that make up the content of major psychiatry.⁴¹

In retrospect, the shell-shock story of the Australian soldier was essentially no different from that of his British counterpart. He did not present anything new to medical science and was classified according to the nosology of the day, with no new diagnoses emerging. Shell-shock, although persisting as a popular term, was eliminated from the official nomenclature, and replaced with those representing functional or neurotic conditions. The locus of the problem was thus shifted from the pathogen of war to the pathological pre-trauma history and susceptibility of the soldier. Memory of traumatic experience was taken seriously by a small number of specialists, but lengthy psychotherapy was discouraged. All the soldier really needed was some firm but kindly authority, thorough assessment of the problem, a healthy environment and short term psychotherapy consisting of explanation and persuasion.

Fundamentally, as with most of the medical ideas translated into military practice, both in the British and Australian literature, the focus was on individual pathology. The disorders of war were primarily psychogenic in origin, not physical. The men who could not cope with the heat of battle were examined and classified according to the existing medically defined pathologies. Soldiers with no physical wound to justify their withdrawal were a danger to morale and efficiency and, although this was not openly stated, could even run the risk of being called 'scrimshankers', as they were in the British Army.

WW1 and the response to the mentally damaged reflected some of the activity in the civil arena in the post-war era. Movements like the Mental Hygiene Movement, in which causes for mental illness were found in hereditary and constitutional factors, fitted well with the interpretations on war-related breakdown. Many of the war experts, such as Springthorpe, Ellery, Dawson, Noble, Bostock, and Maudsley were also leaders in the eugenics movement. Many were influenced by European ideas on 'neurotic illness', and treatments like hypnosis and psychotherapy. The 'shell-shocked' soldiers of WW1, who had no organic injury fitted neatly within this framework. At the same time these cases of breakdown could be accommodated within the existing pathological nosology. Both the alienist and eugenicist had an influence on the construction of the symptoms of war stress, as they did in Britain.⁴²

One of the most interesting features of this early medical story was the absence of any questioning of the circumstances of war that contributed to traumatic memory. The treatment required men and medical authorities to accept that they were part of a war machine, and not question the actions of the politicians and generals who may have contributed to or have created the original traumatic situation. The decisions to order an insane landing at Gallipoli, or to persist with the fruitless charges on the Western Front, were never questioned as a hazard to public mental health. Given the status of psychiatry in medical matters at the time, this may not be considered surprising, but in other fields of medicine, doctors did play a part in maintaining a healthy army. Through practices like inoculation against disease and advising on sanitation and hygiene, medical experts like William Osler in the British army, did intervene to facilitate a healthier environment.⁴³ Psychological preventive measures were very limited and psychiatric services, such as they were, only focussed on early detection of potential casualties and intervening as soon as possible, but the principles of immediacy and proximity in treatment were not systematised until WW2. The purpose of this intervention was to maintain manpower. Broader intervention to achieve psychological

⁴¹ Butler A. (1943) op Cit. pp 831-835.

⁴² For an extended discussion of eugenics in Australia, see Garton, S. (1994) Sound Minds and Healthy Bodies: Reconsidering eugenics in Australia, 1914-1940, *Australian Historical Studies*, 26, 103: 163-181.

⁴³ See Cushing, H. (1925) *The Life of Sir William Osler*. Oxford: Clarendon Press. Butler (1940) outlines the preventive health measures taken on the Western Front by the AIF in Chapters 18 & 19.

health was limited to encouraging efficient training and development of the morale of the fighting unit.

In this part of the Australian story, shell-shock, or war neurosis, was not seen to be a major problem, as there was no evident epidemic of casualties. Any diagnosis that implied some organic lesion, such as shell-shock, was rejected. A policy to 'cure before discharge' was advocated, but was difficult to implement, and in fact proved to be an unrealistic expectation. Generally the army medical authorities expected that most men, by 'getting on with life' and getting a good job, such problems would go away they would not present a drain on civilian resources. This proposition has never been tested with post-war research on Australian WW1 veterans, but the fact that facilities such as ARC homes had to be established, and pensions continued to be sought and granted, suggests that many hundreds of soldiers remained damaged after discharge.

There is little evidence that the experience of dealing with the psychologically damaged soldier and veteran of WW1 brought any new developments that translated into improvements in the civilian treatment of the mentally ill in Australia.

CHAPTER 6

THE AUSTRALIAN PSYCHIATRIC CASUALTY IN WORLD WAR TWO

This British experience was again the source of policy for Australian military authorities at the beginning of WW2. In this chapter I address the ideas and practices applied in the field. The purpose of psychiatry and medicine was to facilitate the development of an efficient fighting unit and at the same time minimise losses through efficient treatment of casualties. Again, there was a role for both the eugenicist and the alienist. The former could set about filtering out the unfit and ensuring that morale and spirit were high in the armed forces. The alienist could confidently classify and sort the neurotic and psychotic casualties and apply the treatments of the day. As Rees (1945) had stated in relation to the British forces, the doctor was to 'concern himself with health and with prophylaxis', and 'sustain morale'. He might sometimes find it difficult to adapt to this new task of 'maintaining efficiency, keeping the maximum number of fit men on duty', and it was possible to go the extreme of being a 'malingerer hunter'.¹

Interpretations of neurotic breakdown in Australia followed the conventional view of how men break down under severe strain centred on fear and conflict. In battle conditions there was an obvious fear of being killed or maimed, which often produced a conflict between the duty to fight and the desire for self-preservation. Combatants had to find ways of managing this fear or else they would 'retreat into illness' and develop a neurosis. To maintain an efficient force these retreats into illness needed to be kept to a minimum, to reduce manpower losses. This was a primary role of medical specialists. In this chapter I briefly explore the frameworks underpinning the practice of dealing with the psychiatric problems of Australian troops in the field during WW2. I use the term war neurosis as a convenient term to cover the broad area of psychological problems of combatants, even though it was not a recognised diagnosis.

In Australia at the beginning of WW2 there was no articulated body of knowledge and no official policy to deal with the mental casualty. The Australian Army Medical Corps (AAMC) again looked to the British to find a suitable way of dealing with the problem. At no stage was there a great outcry about an 'epidemic' of war neurosis. The planning to cater for the mental casualty seemed to be in anticipation of problems rather

¹ Rees, J. R. (1945) *The Shaping of Psychiatry by War*, pp. 17-19.

than a response to an identified need in WW2. A strategic response to dealing with psychological problems, as with any medically defined problem, required the following:²

- A theory about the etiology of the problem
- A system of diagnosis and classification of dysfunction
- An organisational structure to systematise intervention
- Methods and facilities for treatment
- Trained personnel
- A set of protocols for disposal, including the administrative requirements, such as Medical Boards for determining fitness for duty

The most prevalent diagnosis was neurosis as distinct from psychoses. According to the rubric of neurosis, the psychological casualties were explained in terms of the inner dynamics of how a person responded to extreme experiences, not the severity of the experience. Their medical experts contributed a number of tools for unravelling the individual experience:

- The clinical interview to map the dynamics of breakdown
- Guidelines for screening out those unsuitable for military service
- Specialised treatment techniques - hypnosis, electricity, persuasion

Among the relics of WW1, the most significant was the inheritance of Sigmund Freud, who provided a way of mapping the mental structure and the dynamic influence of the past and techniques for integrating memory and emotion, for example, abreaction. WW1 had canonised a shortened version of Freud's talking cure, but rejected the sexual dimension in etiology. In the more complex versions of psychotherapy careful listening and talking could exorcise cankerous emotions and could relieve the sufferer from the effects of traumatic experience. But the talking and listening also revealed the past history of the patient, particularly childhood experiences, which would explain his failure to adapt to the stresses of war. In military practice in front line situations the talking cure was modified to a form of authoritative persuasion, which followed on from attentive listening to a man's story.

² Note that at this point in the thesis I am describing a received body of knowledge rather than offering a critique of a medical construction of illness.

This was the starting point of medical theory and application at the beginning of WW2. The beginning of the war coincided with the emergence of a number of new physical treatments, still in experimental form, which were being tried in civil institutions in Australia. These pharmacological treatments and technological devices (e.g. narco-analysis and ECT) were incorporated into military strategies to deal with neuroses.

As an introduction I will consider a case history of one person where personal experience collided with ideas of medical diagnosis in the Australian Armed Services. This is the case of a young flying officer of 75 Squadron operating in Papua in the years 1942-43. Arthur had just turned 22 when he was posted there with an RAAF fighter squadron, only three months after the fall of Rabaul with the bloody Tol Plantation massacre, and a month after the fall of Singapore, when thousands of allies were taken prisoner. Only a week before, on their flight to New Guinea, two pilots in Arthur's squadron had died when their planes crashed in low cloud north of Sydney. Like hundreds of other young men he had been hastily recruited, minimally trained and sent north to repel the Japanese invasion. In Papua he slept in a tent without adequate protection against malarial mosquitos, rose at 3 am 9 days out of ten and stood by at the airstrip ready to scramble until dark. As food and sanitation were poor Arthur was seriously ill many times (malaria, dysentery and sub-clinical beri beri). He described it as living on death row: after eight weeks, six out of twenty more experienced pilots had been killed in action and only two from his own school of ten recruits were alive. He had helped retrieve bodies and came to dread fire in the cockpit. His senior officer publicly berated any pilot showing signs of weakness, such as reporting sick with dysentery. One fellow pilot suicided after being accused of 'lack of moral fibre'.

During his second tour of duty in Dutch New Guinea in December 1943 Arthur reported to the squadron doctor with 'an intractable itch' but no sign of rash. He 'couldn't bear to wash himself'. During the medical investigation of his condition there was some discussion of his fear of fire in the cockpit, particularly when the tropical heat prevented pilots from wearing full flying gear, and so the focus quickly shifted from a skin irritation to the possibility of underlying psychiatric disorder or malingering.³

Arthur's recollection of this time:

I went to see our doctor in Merauke. And I remember he really dressed me down on this business of neurasthenia.

Now, you see, our doctors didn't know anything. But what was more at the end of 1943, the doctor was saying that I was 'troppo' ... I've shown you the medical book that said that nebulous symptoms were to be treated as neurasthenia. They were intent on always putting it back on neurasthenia, without thinking or listening; and therefore no one had learned anything and people went on being made sick and it not being recognized.⁴

The 'medical book' Arthur referred to was Alan Walker's official history of *Medical Services of the RAN and RAAF*. After the first air raids on Port Moresby in 1942, Walker reported that a number of airmen complained of 'nebulous symptoms which they hoped would cause them to be boarded out of the danger area', but he considered:

It was unwise to be too sympathetic, as this would have encouraged imitators. On the other hand discretion had to be used, as their condition was infectious. Eventually the worst cases were evacuated south with the diagnosis of neurasthenia, and thereafter evacuations from this cause were few.⁵

Later, while he was on leave, Arthur discovered from a nurse with prewar experience in Java that 'aquapuritis' was a known side effect of continuous use of quinine. The itch disappeared when he corrected the dosage, but officially his diagnosis was of nervous origin, and more problematic.

Obviously Arthur was under stress at the time, but the interesting question here, is not whether he had a 'real' complaint or not, but that he was diagnosed with one of the 'nervous affections' of the nineteenth century, which was defined by American neurologist George Beard in 1868 as 'exhaustion of the brain and spinal cord'⁶ In civil life neurasthenia had been a diagnosis for excitable women who were drained of energy by reading too many novels, and for men who were given to excessive onanism.⁷

Neurasthenia was in fact one of the range of diagnoses drafted into British and Australian military service in WW1 to frame the experience of men who were unable to adapt to the mayhem and destruction on the Fields of Flanders and Gallipoli. It was

³ Arthur's story was derived from a number of sources, including an interview conducted in February 1999, several subsequent telephone contacts, letters and a questionnaire, as well as the text of the original Murdoch Sound Archives interview conducted in June 1989 by E Stokes.

⁴ MSA interview transcript, p. 95.

⁵ Walker, A. (1952) *Medical Services of RAN and RAAF*, Canberra: AWM, p. 272.

⁶ Beard, G. (1880). *A Practical Treatise on Nervous Exhaustion*, New York: William Wood. See Shorter E. (1992) *From Paralysis to Fatigue*, New York, the Free Press.

⁷ Forsyth, D. (1915) Functional Nerve Disease and the Shock of Battle *Lancet*, 25 December; 1399-1403

primarily a disorder of fear and anxiety, and accepted by most WW1 medical specialists such as Frederick Mott & Aldren Turner. As pointed out previously it was rejected by Rivers.

Neurasthenia was used in Australian military practice and persisted into WW2. It was listed in *The Nervous Soldier: [Handbook for the Prevention, Detection and Treatment of Nervous Invalidity]* by Bostock and Jones (1943), where the neurasthenic was one of the personality types likely to develop a neurotic reaction to stress in battle. It was also in the *Hints to Medical Officers* issued by General Headquarters in 1942 in the Middle East.⁸

The behaviour of the army doctor is not surprising in the context of the ideas available to the medical men of the time. The medical officer had been assigned a clearly defined place in the manpower management and the maintenance of military morale. In addition, functional nervous disorders or neuroses were shown to be at the centre of the theory and practice of managing reactions to the stress of war. This particular medical officer had carried out his role of sorting out the scrimshanker and malingerer, as advocated by Bostock & Jones (1943).⁹ Their *Handbook for the Prevention, Detection and Treatment of Nervous Invalidity* listed the neurasthenic as one of the personality types likely to develop a neurotic reaction to stress in battle. Neurasthenia was also included as a diagnostic category in the *Hints to Medical Officers* for handling psychiatric casualties issued by General Headquarters in 1942 in the Middle East in 1942.

Neurasthenia had in fact a much longer history, but served a useful purpose for the British and Australian armies. It was included as a minor classification of illness in the classic British text, *The Neuroses in War* by Emanuel Miller, where it was described as exhaustion, mental apathy, with vague aches and pains, and dizziness, mostly following periods of intense strain. The legitimate skin complaint of the pilot was interpreted as an unconscious or conscious attempt to escape his duty, just as Ernest White had suggested over twenty years previously (White 1918). If there was sufficient information available on this man the 'diagnosis' might be retrospectively tested out, but it is unlikely the

⁸ There was probably little information available to the medical officer on the effect of flying in such conditions, such as Ironside & Batchelor (1945), *Aviation Neuro-psychiatry*. Edinburgh: Livingstone

⁹ On p. 27 of *The Nervous Soldier* Bostock & Jones stated, 'Army efficiency is a matter of life and death for the community. Whenever in doubt it is wiser to consider that a man is a malingerer rather than that he may be a neurotic'.

diagnosis would have met the criteria of Beard or Silas Weir Mitchell for neurasthenia. If he did have symptoms of extreme fatigue, myclonic twitches, disturbed sleep, it was more likely the result of recurring malaria, living in a tent subject to bombing raids, and spending long hours either on stand-by or in the air, always in danger. Death had been a daily spectre ever since he started training in Australia and its likelihood increased in New Guinea. Had the medical officer listened he would have heard how stressful it was flying 'by the seat of your pants' through low cloud to make a forced landing on Goodenough Island.

There was little information available to the medical officer on the effect of flying in such conditions. Ironside and Batchelor (1945) could have even provided the doctor with a greater range of diagnostic categories than 'neurasthenia'. The study on the 8th Air Force flying personnel by Hastings, Wright and Gluck (1943) would have provided Operation Fatigue as a legitimate complaint, but for them the majority of 'psychiatric failures' were fear reactions and functional disorders.¹⁰ In the absence of this background, the medical officer had to make do with the frameworks available.

The reality was that at the beginning of the war medical specialists did not know how to effectively deal with war stress. The official medical historian of the Australian armed forces, Allan Walker (1952), pointed out that at the beginning of the war medical authorities were not prepared for psychiatric casualties, and quoted Brigadier G. W. B. James, the consulting psychiatrist to the British troops in the Middle East, who stated:

The doctors of the empire, no matter where they were trained, were, with few exceptions, bewildered by the psychiatric casualty; they looked on him with distaste, and were quite unable to deal with him effectively.¹¹

This view was reinforced in a later report by Hurt and Nettle (1962) who concluded that 'medicine was quite unprepared for the magnitude of the psychiatric problem. Pre-selection of service personnel was inadequate and the number of trained psychiatrists very small and quite unable to cope with the number of psychiatric cases that swamped the wards.'¹²

¹⁰ Hastings, D., Wright, D. & Gluck, B. (1943) *Psychiatric Experiences of the 8th Air Force*, but even these would have emphasised the importance of the predisposition and the fear of the combatant rather than the environment as the significant factor in explaining breakdown.

¹¹ Walker, A. S. *Clinical Problems of War*, (1952) Canberra: Australian War Memorial. p. 465.

¹² Hurt & Nettle (1962) *A Survey of Psychiatric Services to Veterans in Australia and Overseas*, p. 2.

What was available to medical officers? How were these ideas applied in the field? Essentially, the ideas informing military medical practice were little different from those outlined in the *Shell Shock Inquiry Report* of 1922. Medical officers were not to use shell shock as a diagnosis and were only to use the psychiatric labels of the day for diagnosis and treatment. Walker (1952) described the standard nomenclature that was used to label the various forms of breakdown. These were psychoneuroses, anxiety states, and conversion hysteria. The official medical guidelines for General Headquarters, Middle East forces (1942), emphasised the place of individual inadequacy in a breakdown and enumerated the causes of breakdown as the three Ps:

- Parental – ‘the whole family history, the patient’s nurture and upbringing and what is vaguely described as his constitution, in fact his whole life story’
- Psychological - the interpretation of events, attitudes, distress
- Physical. - physical weakness, illness, fatigue, high blood pressure etc.

In 1943 John Bostock & Evan Jones published the only textbook produced specifically for doctors and officers to enable them fulfil the dual role of preserving and promoting military morale and discipline, as well as healing casualties.

The medical officer may say that the foregoing pages unfold a counsel of perfection. It may be said that we have forgotten the time factor. On busy days there will be no spare hours in which to boost the community spirit or explore an individual consciousness. Upon occasion this may be true, but medicine is subject to variation. Even an epidemic wanes. There will be quiet days when it will profit the Medical Officer to dally with his patients, extracting the story of their lives so that they appear not as men in uniform, but as human souls striving from infancy through the trials of youth and the perils of adolescence to a near stability endangered by the cataclysm of war. It is your privilege to be able to disentangle the threads and to restore stability.¹³

Bostock & Jones believed that soldiers, ‘though bludgeoned by the blows of fate, must be prepared to rise above their difficulties’, but if they did become mental casualties they were basically considered to be a nuisance. Men with these disorders ‘are a source of constant anxiety in the field, undermining morale’, and occupy ‘beds often urgently needed for casualties’. They would also be a ‘recurring expense’ to the state after discharge. Responsibility for prevention required that the medical officer adopt the role of ‘statesmen’ who have to ‘temper feelings of kindness with the steel of discipline’. In a later paper Bostock (1943) argued that over-diagnosis of nervous

conditions had led people to expect a pension as a right, not a privilege. Specialists too often elevated normal symptoms into unwarranted disease categories, and two decades of military and civil pensioning after WW1 had made mere prostration or nervous breakdown into a pensionable disease.¹⁴

The theory of breakdown expounded by Bostock & Jones appears to be a mixture of psychodynamic theory and neuro-biological theory. They begin with an explanation of the stress response to fearful situations, in that fear activates adrenalin, which in turn stimulates the sympathetic nervous system, thus increasing heart rate, blood flow, etc. These are normal responses, but they can be converted into pathological states, either by conscious or unconscious mental activity. This process of conversion could even be facilitated by suggestion from a medical officer offering inappropriate advice. The stress of war produces emotional conflict centred on fear, the suppression of which produces an anxiety state. This suppression dissociates the painful thoughts and feelings from the original stressor.

According to Bostock & Jones, the nervous disorders (excluding psychotic conditions) seen under war conditions consisted basically of two types – anxiety (conscious conflict with suppression) and hysterical states (dissociation and conversion). Some men would seek a short circuit out of the fearful situation through suicide, malingering (malingerers were described as the ‘scabs’ of the community), or self-inflicted wounds. Bostock & Jones argued that army efficiency required that at first contact it should be assumed that man was a malingerer rather than neurotic. Those who did not choose these escape routes, but still broke down under strain, could be classified as neurotic, which was more than likely a consequence of a certain personality type.

The majority of men would not break down because they were so well balanced and ‘great stress will be needed to create a morbid state’. According to Bostock & Jones, inherent personality weaknesses could be observed in anxious folk, neurasthenics, hysteroids, paranoids, mental defectives, schizoids, psychopaths, over-conscientious types and morbid and moody types. In looking for the likely weak types, the medical officer needed to watch for fatigue, moodiness, hypersensitivity, unsociability, sullenness and a long list of other unpleasant behaviours.

¹³ Bostock, J. & Jones, E. (1943) *The Nervous Soldier*, Brisbane, University of Queensland Press,

¹⁴ Bostock (1943) The Problem of Returned Soldier Organisations, *Medical Journal of Australia*, 12 June; 534-536.

This view enabled men to be sorted into three broad categories or 'pigeon holes' by the medical officer at the front line. :

- Normal nervousness - the jitters, shakiness and other normal reactions
- Psychoneuroses - organically based disorder, anxiety state, hysteria, malingering and delusional state.
- Acute psychosis - grave anxiety, acute mania, acute melancholia, schizophrenia, paraphrenia, confusional state, alcoholic state, head injuries, epilepsy and commotional shock.

Shell shock was never to be used as a diagnosis. The primary role of the medical officer was to maintain the morale of the unit, as well as provide treatment. In the front line, Freudian psychoanalysis and insulin therapy were 'quite impracticable under service conditions'. Away from the front line, there was a full range of possible interventions: persuasion, suggestion, hypnotic suggestion, simple analysis and hypno-analysis, narco-analysis, and shock therapy (with cardiozol or phrenazol), narco therapy, faradism, physiotherapy including relaxation methods, Weir Mitchell type isolation, and re-education and occupation. Memories could also recovered through narco-analysis. Convulsion and shock therapy were sometimes appropriate for anxiety and hysterical states. Above all the medical officer was to adopt a firm supportive role, paying great attention to taking a careful life history to achieve and understanding of the nature of the man's condition. A key therapeutic activity was to draw out the suppressed 'terrifying emotional experiences'. Bostock and Jones also warned of the benefits and dangers of the use of alcohol to evade reality and recalled the use of alcohol in WW1 (War Office Report of 1922), when a ration of rum was issued every day. When overuse turned into alcoholism they advocated the use of vitamin B as a prophylaxis and treatment.

In effect Bostock & Jones offered a smorgasbord of possibilities for medical officers in WW2. The main problem with the book was availability. Few medical officers would have been trained in the range of treatments proposed. It is unlikely that any but a few specialist psychiatrists would have had access to their book. Training for army psychiatrists did not start until the beginning of 1941 and even then it was limited to a short crash course of 12 weeks. There was no systematic training for regimental medical officers on dealing with the psychiatric casualty.

Love (1942), of the Australian Army Medical Corps, offered his ideas on neurosis but placed more emphasis on the psychobiological basis of the condition. He used the

term neurosis, but did not adhere to the quasi-Freudian theories of conflict and complexes. He drew on a number of prominent theorists (Pavlov, Walter Cannon, and Paul Wood) to explain the dynamics of fear and anxiety states, which comprised the majority of casualties at the front. The symptoms of men who were admitted to casualty stations with insomnia, exhaustion, tremulousness, dizziness, anorexia, headaches, abdominal discomfort, nausea, blurred vision, weeping, enuresis, or inability to concentrate, could be explained in neuro-physiological terms. Under the stress of battle soldiers have two competing emotions - fear (producing fatigability, muscular exhaustion and depression) and anger (sense of muscular power). Their state of sympathetic excitement that continued long after the danger had passed was complicated by the secondary effects of prolonged adrenal activity.

Training and the accoutrements of battle could bolster the soldier, but when exposed in helpless situations like the Tobruk bombardment, fear reactions became conditioned reflexes (Pavlov, Herbert Spencer, James and Lange), and 'abnormal fear and anxiety developed when there was poor adaptation and faulty cognitive management of fearful stimuli. Overtaxing of adaptability could result in a break down and lead to 'intractable neuroses'. Furthermore, some injury, either physical or trauma induced could interfere with the functioning of the hypothalamic mechanisms.¹⁵

To sum up, the genesis of fear states and anxiety neuroses in dysfunction or perversion of the sympathetic-adrenal fear reflex would seem to rest upon the firm basis of both theoretical probability and confirming fact. The contributing factors are therefore 'congenital hypersensitivity of the mechanism, organic interference, and various conditionings, either biologically logical or associated with overtaxing and breakdown of the cortical analyzer'. (p. 142)

This mechanistic explanation, based entirely on an intra-individual psychobiological dynamic, had implications for prevention and treatment. First the potentially weak individuals needed to be detected and sorted at recruitment. Further 'weeding out' could be achieved during initial training, where troops were put under pressure to expose their vulnerability. Those who were left needed to be well-equipped and instilled with esprit de corps and a fighting spirit. Nervous conditions in the field (nervousness, restlessness, and moodiness) needed to be recognised and treated early. Treatment for 'fully developed neuroses' initially consisted of rest and sleep, which could be induced by doses of hot drinks and the sedative Luminal. The medical officer would learn to

‘strengthen such as do stand; and to comfort and help the weak-hearted; and raise up them that fall’. Evacuation was only to be a last resort and every medical officer should aim at a ‘nil return’.

The official medical historian of Australian medical services in WW2, Allan Walker (1952, 1957), provided the most comprehensive retrospective account of psychiatric services and ideas in WW2.¹⁶ In *Clinical Problems* Walker outlined the psychiatric provisions in the army against a background of the history of medicine in Australia. Medicine had become much more specialised on the one hand, but the public also had more access to medical information and products. This was a threat to the dominance and authority of the doctor. In terms of mental health this trend was decried by Walker who argued that ‘positive harm could be done by publicising certain aspects of some subjects, such as neurotic types of illness.’ This had led to such evils as the ‘universal aspirin in the handbag’ and in ‘numerous proofs of self-drugging in the sanctuary of the bathroom cupboard’ (p. xxiii). Walker outlined how prior to the war, medical services in civil life were provided largely on an individual, private, level and this style was to some extent transferred to the war services. The scientific revolution in other medical fields had not filtered into psychiatry.

Psychiatric ideas were first applied in the Middle East, which proved to be a fruitful learning site. The medical establishment there allowed the few psychiatrists to test out their methods of classification and treatment. One of the features of the WW2 services was a more systematic system of managing the psychiatric casualty, which occurred at five levels:

- Regimental Medical Officer
- Field Ambulance Station
- Central Clearing Station
- Psychiatric clinic
- Australian General Hospital

In the ideal field situation, the Army Medical Corps established psychiatric centres. The term ‘psychiatric centre’ rather than ‘war neurosis centre’ was deliberately chosen

¹⁵ Love, H. (1942) Neurotic Casualties in the Field, *Medical Journal of Australia*, 22 August; 137-143.

¹⁶ A. G. Butler’s medical history, was not published until 1943, and although Butler did publish a few articles in the *Medical Journal of Australia*, he appeared to have minimal influence on WW2 thinking.

to deflect attention from an 'inaccurate name for conditions not necessarily associated with the war'. These centres provided more specialist treatment after casualties had been sorted at the field ambulance station and Central Clearing Station level. Medical officers were instructed (e.g. No 17 Middle East Series) on how to provide initial treatment in the field and make decisions about further referral. The primary purpose of such efforts was to involve the medical profession in more systematic measures 'to control mental illness' and to create a more efficient fighting force.

One of the results of the Middle East experience was to make a clear distinction between 'battle casualties' and the inherently deficient conditions such as mental defectiveness and psychotic states. Battle casualties, the 'neurotic casualties in the field', were classified as anxiety states, fear states, neurasthenia, reactive depression, compulsive states and various types of hysteria. Walker restated the view that war produced no new conditions that were not evident in civil life. He did make an exception for prisoners of war from Greece and Crete where 'life as a war prisoner with all its trials and horrors does not characteristically produce neuroses of the usual civilian life'.

A few systematic studies were undertaken in Australian Army General Hospitals, one of the more notable being that of Cooper & Sinclair at 104 AGH at Tobruk in 1941. Alec Sinclair was significant figure in the Australian Army mental health system and his study of casualties during the siege of Tobruk provided a particularly interesting site for exploring the application of psychiatric ideas.¹⁷ A number of Australian battalions, including the 2/10 and 2/43, were part of a garrison assigned to hold the coastal town of Tobruk on the Mediterranean Sea, from early April 1941 until October the same year. The German siege was maintained from the land, but supplies could be brought in under enemy aerial bombardment by sea. Casualties were housed in the General Hospital established in the town. Cooper and Sinclair surveyed 210 psychiatric patients in this AGH where they could observe men under extreme stress, (bombardment, strafing, machine gun attacks, monotony, helplessness) and severe hardship, (fleas, poor food, privation, flies, limited water) and document their reactions.

These Tobruk patients had been subjected to desert exposure, fear of bombing attack, machine gunning from air, exhaustion, intense bombing or shelling and extended

¹⁷ Cooper, E. L. & Sinclair, J (1942) War Neurosis at Tobruk. Internal report, Australian Infantry Forces. AWM54 48/12/120.

exposure. Casualties presented with over-alertness, loss of concentration, fearful half-waking imaginings bordering on hallucinations, frequent need to micturate, and profuse sweating and tremor. They diagnosed hysteria, fugue states and mimicry, depression, psychomotor retardation, sense of unworthiness, hypochondriasis, exhaustion states, psychopathy, mental instability, congenital mental defect, malingering and psychoses. The most common explanation for these conditions was constitutional inferiority.

The conditions and length of the siege allowed little more than careful history taking and talk therapy. The primary purpose of interviewing was to articulate the immediate circumstances of the breakdown and carefully examine prior experiences to establish the 'root causes' of the soldier's weakness under pressure. Fear states for example, were said to occur in men with 'less well integrated personalities', and with 'long-standing fear reactions dating from childhood' (p. 505). The primary focus in diagnosis and treatment was on the individual patient not the traumatic events.

Sinclair (1943) also provided a first hand account of the psychiatric aspects of the New Guinea campaigns. These campaigns were quite different in terms of terrain, (steamy jungle and rugged mountain ranges compared with open relatively flat country) and type of warfare, (jungle, patrol oriented jungle warfare with no armoured support such as line formation attacks with tank and artillery support) which evoked different responses from troops. In New Guinea the enemy was often hidden in dense jungle. Troops had to be constantly alert, and operated in small groups or as individuals, rather than in concerted large-scale formations. In Sinclair's opinion type of fighting this heightened personal aggressiveness and courage. The psychiatric casualty rate was, as in the Middle East, relatively low. For example, only 2-3 percent of the 500 casualties admitted to the base hospital near Port Moresby, including those from the Kokoda, Gona and Buna battles, were psychiatric casualties.

The classification and incidence of disorders was similar to those in the Middle East, with a slight increase in psychopathic states - anxiety states (35%), psychopathic states (20%), fear states (15%), hysteria (15%), psychotic disorders (10%) and depressives, hypochondriacs, mental defects (5%). The etiology was not made clear but, for these casualties, the stress of the environment appeared to play a role as well as individual weakness. Careful examination of prior experience led Sinclair to conclude that weakness in character was at the basis of these breakdowns. Some of these breakdowns had actually shown up during training - 'psychological breakdown often goes hand in

hand with an unsatisfactory service record'. Less than half of these casualties could be linked with battle experience, but those with no battle experience were more likely to have had features of psychological breakdown in their past history.¹⁸

The treatment of soldiers in New Guinea was no different from that offered in the Middle East, although there were restrictions on what could be done. It will become clear from my later Chapter Eight that medical facilities in the field were very primitive and medical officers were overtaxed with more pressing demands to treat wounds and epidemics of sickness such as dysentery. According to Sinclair, the most common condition of anxiety could generally be alleviated with physical exercise, mild sedation, psychotherapy and occupation. Modified hypoglycemic treatment was given to acute cases of anxiety and 'functional' dyspepsia cases. A major component of the treatment was education about the nature of their anxiety. Evacuation by air of psychotic patients presented a particular problem for medical authorities. They required more invasive treatments such as cardiozol-induced shock therapy and restraint to be safely transported. These could only be administered in the large base hospitals in Port Moresby and Lae and were more available in the latter stages of the war.

In a major essay in 1944 Sinclair synthesised his experience in four major theatres of war, which included the Middle East and New Guinea. He based his views on observations of over 1 000 men, and summarised ideas and practice in the field and in rehabilitation. His 1944 paper was a statement about what psychiatry had achieved in five years of war. He has no illusions about the role of the psychiatrist in the armed forces was to 'keep men fighting, as well as care for those who are mentally incapacitated'. Every patient 'represents a potential unit of fighting power', and in wartime the psychiatrist 'returns his patient into a rude world peopled by men whose business is warfare'. Sinclair was adamant that pensions should not be granted for neuroses. On the basis of his experience he was clear that the 'folly' begun during WW1 of pensioning a soldier with psychiatric problems, should not be repeated. He did not deny that men developed post-war neuroses but 'there seems no doubt that to shackle the neurotic to his symptoms and disabilities by a monetary dole is a poor solution to his problems'. He maintained that the interests of the veteran would be better served by an 'army of psychiatric social workers' giving the veteran 'constructive, creative and

¹⁸ Sinclair, A. (1943) Psychiatric casualties in an operational zone in New Guinea, *Medical Journal of Australia*, II, 4 December: 453-460.

sympathetic service than by paying him a fortnightly pension in an endeavour to forget him' (p. 514).¹⁹

A final statement on appeared in a paper delivered by Sinclair at the Beattie-Smith lectures at the University of Melbourne 22 and 29 November 1944.²⁰ He viewed becoming a soldier as a process of socialisation, in which he entered a world where he would lose his individuality and become a member of a fighting machine. The majority of men successfully integrated themselves into 'this new social pattern of war' but those who failed to adjust were 'psychologically damaged individuals'. Sinclair's explanation of how this failure came about was relatively simple. To adapt, a man had to accept authority, become part of the fighting unit. Consequently, 'the psychoneuroses are in the ultimate analysis, social disorders of the individual'. He dismissed nerve concussion, physical exhaustion and illness as significant causes of neurosis. Rather, the neurotic state was a result of 'conflict between the instinctual urges towards survival and the pursuit of the community goal'. (The community goal of course, was killing enemy soldiers and winning battles.) Those who had the right background and breeding (neurological make-up and psychological constitution) could withstand the fear of annihilation in battle. He ended with speculation that the fundamental explanation of breakdown might be found in Grinker & Spiegel's theory of defective regulation of stimuli in the hypothalamic area.²¹ In Sinclair's view there was little room for an examination of traumatic memory. Sinclair's accounts suggest that there was nothing new in diagnoses and ideas in WW2. The only major difference was the increased range of treatment options. These options were a shift away from according the traumatic experience a significant place in the etiology of conditions.

Walker (1952) considered that 1939-45 saw a shift in the role and status of psychiatry. This was a shift from 'detect the malingerer and bash back the neurotic' role, to a more organic role in the maintenance of an efficient fighting unit. The psychiatrist had come down from his scientific perch and circulated among the ordinary men in the ranks. Psychiatric influence filtered into every level of medical service from

¹⁹ Sinclair, A. (1944) Psychiatric Aspects of the Present War, *Medical Journal of Australia*, 1, 28; 501-514.

²⁰ Sinclair, A. (1945) The Psychological Reactions of Soldiers, *Medical Journal of Australia*, 2; 229-234.

²¹ Sinclair does not reference Grinker & Spiegel but he is probably referring to Grinker, R. & Spiegel, J. (1945) *Men Under Stress*. Philadelphia, Blakiston.

front line treatment to the general hospital and rehabilitation services. However, the neurotic casualty was the only organising framework and there was little shift from WW1. The thrust of this was to take the emphasis right away from the traumatic event.

Walker confirmed the predominant idea that the fundamental 'cause' of the breakdown was individual weakness. 'Speaking in the most general terms, influences stretching back into childhood are probably of more significance than recent or present domestic or social maladjustments: the former may supply the key to the latter.' These 'maladjustments' determine how a person will react to the strain of events such as war. Like many of his contemporaries and predecessors, (e.g. Butler, Springthorpe), Walker believed that the experience gained in recognition, prevention and treatment of mental illness in the army could be fruitfully applied in the civil field. Walker thus provides a setting for the further exploration of the discourse surrounding mental health of combatants and veterans.

The problem of how to dispose of the neurotic soldier after discharge was a separate but related problem and will be described in a subsequent chapter. Walker and others did not support the repatriation system that had developed during the inter-war period, in which, they argued, the policy of granting a pension to the psycho-neurotic casualty only exacerbated his problems. It was a policy 'based on a non-medical point of view'. The erroneous, non-medical view was that 'damage through the violence of war is alone responsible for the mental disorders of service men and women'.

In fact Grinker & Spiegel (1943), in their analysis of the experience of US pilots and troops in WW2, provide a classic example of the integration of psychiatric ideas into the business of war. They described war an 'unnatural experiment' which enabled them to study the ego in various stages of dissolution and repair. War neuroses had offered them the 'best opportunity for the study of ego functions and their interrelation with biological and psychological drives'. Their experiments had made it possible for them to make practical recommendations in the field of psychiatry (p. 299).

They clearly did add serious thought to the problem of neurotic reactions to war but framed their ideas only within the confines of existing psychiatric paradigms. In 1973 Grinker stated that one of the major outcomes of WW2 was the 'rapid acceptance of psychosomatic concepts' to describe the effects of stress, and this view was adopted by Australian experts. According to this view, the combatant functions in a state of free anxiety. He fluctuates between attacking the stimulus aggressively to over come the

disturbance, and flying into avoidance, conversion or manipulation of the anxiety into a psychoneurotic defence system, or withdrawing from the scene into a catatonic stupor. For the 'psychoneurotic [now a derogatory term] never retreats quite far enough or successfully enough' (p. 172).

The end of the war brought no new labelling, only a shift in emphasis from the pathologies identified in WW1. The psychiatric diagnoses are shown in Table 6.1.

The final status of diagnosis is shown in the classification of soldiers admitted for treatment at 114 AGH in new South Wales in 1945. These are shown in Table 6.2.

Problems of adjustment in war-time were confirmed as individual medical medical problems. Any casualties were to be 'treated' in the same way as civilian casualties. This effectively diverted any attention from any other consideration of the broad context of war and its contribution to health.

Table 6.1: Psychiatric labelling 1914-1960

WW1 1916	WW2 1943	Post-War 1962
<ul style="list-style-type: none"> • Simple exhaustion • Neurasthenia • Hysteria • Confusional States • Miscellaneous. • (Butler 1943) 	<ol style="list-style-type: none"> 1. Anxiety states 2. Psychopathic states 3. Fear states 4. Hysteria 5. Psychotic disorders 6. Depressives, hypochondriacs, etc (Sinclair 1943) 	<p>Psychoneuroses</p> <ul style="list-style-type: none"> • Anxiety neuroses • Hysteria • Ob. Com. Neuroses • Reactive depressions • Somatic psychoneuroses • Mixed psychoneuroses <p>Psychoses</p> <p>Character disorders</p> <p>(Hurt & Nettle 1962)</p>

**Table 6.2 Classification of Psychiatric admissions of 3050 Psycho-neurotics
114 AGH 1945**

Diagnosis	Number	%
Anxiety state	1 851	60.00
Personality defect	755	25.00
Organic disease	18	0.04
Hysteria	172	6.00
Depressive state	156	5.00
Mental deficiency	90	2.95
Epilepsy	8	0.01
Total	3 050	100

Little had changed in thinking about neuroses from the experience in WW2. No new diagnoses emerged and the major development was more efficient organisation in the military structure. Breakdowns were still primarily explained in terms of constitutional weakness. The next chapter describes how these ideas were translated into policy and practice in the post-war rehabilitation of 'neurotic' veterans.

Spanning the wars: The contribution of Paul Dane

In the veteran treatment milieu of WW2 in Australia, long-term psychotherapy was the least preferred option and certainly not encouraged in the 1950 Appropriation Bill. Very few psychiatrists either advocated or practiced analytical psychotherapy with war neurosis cases. One exception was an 'irritable' Irishman called Paul Greig Dane. He was a symbol of rebellion in dealing with the casualties of war. His life spanned the two major wars and he honed his psychoanalytic skills on both WW1 and WW2 soldiers.

Dane was born in 1880 and kept working as a psychiatrist until his death in 1950. He stood out in that he was one of the few to develop and articulate a comprehensive theory to underpin his practice. He was probably the first in Australia to employ hypnosis and abreaction. Dane completed his M.D. at the University of Melbourne in 1909 and started his practice in Ballarat where he also became an officer in the Sixth Field Ambulance. An exposure to the 'magic hand of the genius' of Freud came in the form of a lecture by Havelock Ellis in Sydney in 1911. When WW1 was declared in 1914 he volunteered at the age of 34 and served as a medical officer in Egypt and at Gallipoli. He continued his work with veterans after discharge both in private practice and in the repatriation system. An interest in neurology and the problems of 'shell-shocked' soldiers led to disenchantment with electrical stimulation, and he was converted to psychotherapy under the influence of J. W. Springthorpe and C. Godfrey.²²

Dane published his views in a number of articles. While he was a neurologist in the Caulfield (Victoria) Repatriation Hospital in the 1920s, he observed a 'steady stream' of neurotic soldiers. He argued strongly that wrong treatment was worse than no treatment at all, and that time 'does not work a cure'. He strongly rejected the advice offered by medical practitioners that 'time will heal'. Some of the treatments of the day such as drugs, gland tabloids, massage, baths, and trips to the country, only served to encourage the soldier to fixate on his condition, and to enrich the 'quack'.²³ Dane classified patients in his early work as having:

- Anxiety state
- Compulsion neurosis
- Conversion hysteria
- Neurasthenoid condition
- Organic conditions associated with psycho-neurotic disturbance.

²² Details of his life were gathered from an obituary written by R. C. Winn in the *Medical Journal of Australia*, 23 December 1950 and from an interview with a psychiatrist Dr Howard Whitaker who trained under Dane in the late 1940s.

²³ Dane, P. (1925) The Psychoneuroses of Soldiers and Their Treatment, *Medical Journal of Australia*, 25 April: 427-431.

He considered that most of these conditions had no 'material base', and the true aetiology was to be found in mental conflict and disharmony in the unconscious mind. Dane derived this idea from Charcot, Freud, Janet, and Putnam, but of these, Freud had a far greater influence, rather than the likes of Adler and Jung. In Dane's view, even an intimate knowledge of the brain and the 'layers of ganglia and associated fibres' could not bring this understanding. In this inner conflict, sooner or later it would be revealed, according to Dane, that there was a sexual origin. His analysis of cases revealed 'narcissistic and homosexual trends' as the basis of psychic trauma, and supported the common belief that 'there is no difference in the psychic mechanisms involved in the neuroses of peace and war'. Evaluation of 145 of these war neurosis cases led him to believe that hypnosis and suggestion were the most effective methods of treatment.

Spurred on by his experience with WW1 soldiers, Dane immersed himself more deeply in the analytic field. In 1928 he travelled to Europe for analysis under Joan Riviere, and returned to Melbourne to continue his practice and help form the Melbourne Institute of Psychoanalysis. He did not spend all his time in psychiatric practice. He was a lover of animals and held a number of influential posts including President of the Victorian Zoological Society and a member of the Victorian Racing Club and the Animal Welfare League.

By the 1940s, when WW2 soldiers began to appear as neurotic casualties, Dane again became closely involved in their treatment, and in the training of repatriation psychiatrists. He still rued the fact that at the beginning of WW2, the medical profession had neither understood nor accepted the ideas of Freud, and 'medical personnel of the army, and psychiatrists in general, were unprepared for the proper evaluation of the possible psychiatric casualties of the war'. In WW2 he was shocked to find that that the advances in psychotherapy of the previous 28 years were being ignored, psychotherapy was little practiced, and that electro-shock treatment was being used to treat the psychiatric casualty - 'These patients had of course in many cases lapsed, and their second state was worse than their first'. Dane again advocated that 'the only rational treatment for such disorders is to restore to consciousness the lost memory, and allow an appropriate motor reaction for the affect [abreaction]'. He considered that the best results were achieved if this was done as soon after the traumatic impact as possible.²⁴

Attention to traumatic war memories was a key plank in Dane's theory, but unconscious conflict rather than the traumatic event, was still the most cogent explanation. Towards the end of his life he shifted slightly in diagnostic orientation

²⁴ Dane, P. (1949) Traumatic Psychoneuroses, *Medical Journal of Australia*, 25 February; 266-267.

when he made a distinction between traumatic neuroses, and ordinary psychoneurosis. He described men who had experienced a single 'severe traumatic experience' presenting as irritable, sensitive to light, having headaches, insomnia and battle dreams, who were easily fatigued, and had bouts of amnesia'. In these cases he considered a diagnosis of shell shock appropriate, but still maintained that a long term disabling condition could only be explained by a repressed unconscious and distorted sex drive. 'Those who are to experience intense psychic trauma without developing neurotic symptoms are those who have been able to surmount successfully all infantile traumatic experiences, thereby allowing a smooth and harmonious development of their Ego'. All phenomena could be explained in Freudian terms. Battle dreams for example, were a result of a partial return of the repressed event, at a time when the Ego's defences were weak. For Dane the only effective treatment was to address the amnesia by recalling the event through hypnosis and abreaction. Even unsuccessful treatment could be accommodated on the grounds that the man had a Freudian death wish.²⁵

Paul Dane was never fully acknowledged by the establishment and he made no direct contribution to policy formation. This may have been fortunate, in that Freudian ideas did not become enshrined in policy, with even more attention being focused on constitutional pre-disposition, and not on the nature of the stressor. On the other hand, had he been accorded more credibility, there may have been more serious consideration of the importance of traumatic memory as a factor in treatment.

²⁵ Dane, P. (1949) Shell Shock or Traumatic Neuroses, *Psychoanalytic Review*, 36; 3. Reproduced in Australian Archives D2048/0, G1220. Page numbers not given

CHAPTER 7

REHABILITATING THE AUSTRALIAN 'NEUROTIC' CASUALTY

PSYCHIATRIC REHABILITATION: Introduction

The final piece of the landscape of mental health provisions for veterans is rehabilitation. I begin this with a short narrative.

Tom grew up in an orphanage and as a member of the AIF 2/10 Battalion was 22 when he was separated from his section and became lost for several days while on patrol in New Guinea in 1942. This seemed to unseat him. He was assigned to non-combat duties, and eventually evacuated to Australia suffering from chronic dermatitis and what he described as 'nerves'. When he arrived in Australia he was subjected to a range of treatments.

When I first came back for me nerves they used to give you shock treatment; and they used to tie you down without putting you to sleep; and you know you would scream. Absolutely scream with murder. I was not the only one. And you used to sleep on the floor. There were no beds. For bad cases you had a mattress on the floor. I wasn't getting any better so they turned around and they automatically gave me insulin.

They would give us a good meal the night before - eggs and all - and the next morning they would come around about 4 or 5 o'clock and get us out of bed, and march us down to the toilet. And orderlies would be with us to see we did not have a drink. Then back to bed, and they would come along with a great bloody needle and they would shove this needle into you, and away you would go; make sure you had plenty of blankets on you and you started to sweat; oh, sweat, sweat, sweat and then go into a coma; go out completely. Afterwards they would come around with this big pannikin of glucose and make you drink it. And you would feel yourself coming out of it.

They would keep us in bed and an orderly would take our temperature. We used to get up and have breakfast and then we would have a session - what would they call it, group therapy. They'd have all these patients and they would start talking about your life, married life, and all - you'd say something and then someone across the room would say something. I used say to things went wrong with me and then 'why did you get like this?' and they would go round and round. All the doctors would be taking notes. I was in hospital for a long time. One of the doctors came up and lined us up in the hall instead of having a session and he said, "I want a volunteer for the truth drug". Nobody volunteered. I knew I had nothing to hide - what I'd done and what I'd seen. So I said I would do it.

They put me to sleep and they said I talked like a rat. I went on and on. And they got everything out. The next day the doctor called me up and said I want to read the statement. He read it out and said is that true? I said I didn't say that. Yes it is true I

said. They said they would not put it on the file but I found out afterwards it was on my file. I think I helped them [doctors] a lot - I never refused treatment.¹

Tom did not return to duty and spent many months in this hospital, with many subsequent admissions. The army hospital became a repatriation facility and the psychiatric ward continued as a rehabilitation centre, providing treatment and work preparation. Did the initial treatment help him? 'No it didn't do me any good. I was eventually discharged and went back to work'. He was granted a TPI pension and had periodic re-admissions to hospital throughout his life. In 1995 he was still anxious and depressed and receiving outpatient psychiatric treatment through the Repatriation Commission. Other conditions like heart disease had complicated his health story. One recent treatment in 1995 was a trial on Prozac. In the interview he became very distressed whenever he recalled aspects of his New Guinea experience.

This chapter outlines the developments in rehabilitation services for this type of psychiatric casualty in the post-WW2 period. The history of the ideas on military psychiatry in the Australian Army has been described in the previous chapters. A particular feature of this part of the story is that there were no new diagnoses for post-war conditions. The labels used in wartime also applied in peacetime. An outline of the context in which rehabilitation was developed precedes a detailed description.

CONTEXT OF MENTAL HEALTH

The development of rehabilitation services occurred in a context of limited ideas and frameworks. There was some professional interest in the needs of the veteran with psychological problems, but they were not a high priority. A meeting of the New South Wales Branch of the British Medical Association in April 1946 considered rehabilitation of war neurotics. While speakers supported the need for specialised rehabilitation services for the neurotic soldier, many argued against any practice that would encourage the condition. They argued that the 'illness is essentially no different from that occurring in civilians who were not subjected to the emotional stress of service conditions' and 'it is generally

¹ Personal interview. His brother, who was in the same AIF unit, was also interviewed, and he could not really understand why T had the 'nerves', because everyone was under the same kind of strain. He admitted being lost in the jungle might have made a difference.

medically agreed that the war neurotic does not differ essentially from the civilian neurotic' (McCarthy). McCarthy also argued that the war neuroses should be referred to as the 'neuroses of war' because they were 'essentially no different from that occurring in civilians who were not subjected to the emotional stresses of service conditions' (p. 910). And 'In few cases does neurosis arise directly from battle stress or conditions peculiar to warfare. Most neuroses in the services could equally well have arisen in the same way in civilian life' (Hastings Willis). The general notion that 'pensions or compensation should only be granted in exceptional cases', because they are 'serious obstacles to the recovery of the neurotic' was supported by speakers (p. 913). McCarthy and Hastings Willis argued strongly against 'propagandists' in the community who lobbied for better compensation and pensions for war neurosis, and against neuroses 'made' by bad medical diagnoses. They did support the need for a comprehensive approach incorporating treatment and vocational adjustment. Hastings Willis outlined a team approach where a 'socially minded' psychiatrist worked with a 'lay' psychologist, an employment officer and a social worker to ensure successful transition. Employers also played a key role. Galbraith supported this approach in 1949.² Some of these ideas found their way into policy and administrative provisions, but within the broader community there was little appreciation of the need for enlightened policy. In fact, the ideas on neuroses and their treatment in the civil arena were archaic.

The general status of mental health provision in the 1940s and early fifties had little to offer in the treatment of ex-soldiers. Mental health facilities provided by the states were inadequate, research was virtually non-existent and there were virtually no academic base for research and training. At the national level there was no policy or legislative provision on how to provide for the mental health needs of all Australians, let alone returning servicemen and women.³ At the outbreak of WW2 and beyond, mental health facilities were extremely limited by current standards. Allan Stoller highlighted the shortcomings in civil facilities in a report on psychiatric facilities and services in Australia in 1955,

² The Willis and McCarthy papers are published in the *MJA*, 29 June 1945; 910-915. See also Galbraith (1949) Rehabilitation of the disabled in Australia, *MJA*, 27 August: 306-309. Galbraith was a Lieutenant Colonel in the AAMC.

³ Stoller A. and Arscott, K. (1955), *Report on Mental Health Agency Facilities and Needs of Australia*, Department of Health of the Commonwealth of Australia. Garton, S. (1987) Changing minds, in Curthoys A., & Martin A.(eds) *Australians from 1939*. Broadway NSW: Fairfax, Syme and Weldon Associates.

commissioned by the then Minister for Health in Australia, Sir Earl Page.⁴ Stoller reported that there were major inadequacies throughout Australia in the services available to mental patients, and a general neglect and inertia in establishing professional world standard resources and facilities. Overcrowding was a major shortcoming with an estimated shortfall of 10 000 beds throughout Australia. There was a long list of other deficiencies: the low medical standards in institutions, a lack of adequately-trained psychiatric, medical and nursing staff, and little community focus in any of the mental health facilities. Overcrowding and inadequate facilities were also noted by Garton (1987), who estimated that by 1949 there were nearly 3000 more patients than proper beds in Australian mental hospitals, much of this accommodation was ramshackle and antiquated, and there were too few doctors and nurses (p. 343). Mental institutions existed to contain 'madness' and treat illnesses, not provide normalisation back into society. Effective civil psychiatric rehabilitation only emerged with the Commonwealth Rehabilitation Service after 1945.⁵

Some sense of the quality of state institutions can be gained in a brief look at the South Australian mental health system around WW2. The psychiatric institutions in the states were administered under the various state acts of parliament, and in essence they were seen as asylums for the insane. In South Australia institutions were administered under the *Mental Health Act* (1935-63) from 1935, but the *Mental Defectives Act* (1913-1941) remained in force as the basis for admitting patients until after WW2, despite some criticism of it being anachronistic. For example, in the 1957 Annual Report of the mental health services Superintendent Birch remarked that the *Act*, which referred to 'our patients as "mental defectives"' is certainly not less harsh or medieval than the concept of 100 years ago'. He argued that the treatment was in accordance with recent advances in modern psychiatric practice but in fact the legislation was 'an anachronism in name, scientifically inaccurate and socially unacceptable'.⁶ Despite this plea, patients continued to be certified

⁴ Stoller's earlier role in the development of repatriation facilities and policy is outlined in this chapter.

⁵ Those veterans not accepted for war pension and medical benefits were to be accepted under Part IV of the *Reestablishment and Employment Act, 1945*. The Rehabilitation Plan was authorised to be implemented by the Dept of Social Services in June 1946.

⁶ 43rd Report of the Superintendent Mental Institutions, Dr H. Birch, 1957. In a recent publication, Cawte (1998) explained Birch's parsimony and lack of reform in the mental health system in terms

under the *Mental Defectives Act* on admission as mentally defective until at least 1963. The proportion of voluntary patients increased slightly over the years but as of June 30, 1962 over eighty percent were certified as mentally defective.

From 1950 the annual reports on the South Australian mental health system consistently describe a rise in the number of admissions of patients with alcohol-related problems, and an increase in aging patients. The latter was partly explained by the reduction in the number of private hospitals able to cater for senile patients (Annual Report 1945). The rise in alcohol-related conditions, also reported to be a problem in the Repatriation hospitals, could have been war-related. The overall admission rates suggest that the war had not affected society from 1939 onwards.

The fact that for the previous ten years the average annual increase was 58 reveals that there is definitely no material increase in the incidence of mental disorder in this state consequent on the stress of war. (p. 4 Annual Report 1943)

Birch supported his argument with British evidence that even when the war was much more intrusive, as it was in Britain, where 'by and large the British people have a most remarkable capacity in withstanding extreme stress and privation, and even for the period after the war I do not consider that there will be any great increase in mental illness' (p. 4).

The Birch legacy in the mental health system kept the hospitals back in the dark ages of mental health, and ensured that it was ill-prepared for the returned soldier who was seriously disturbed. In fact Birch's views were consistent with the idea that constitutional factors were the main explanation of mental illness. Birch was greatly influenced by Henry Maudsley (1835-1918), who argued in 1885 that diseases 'of the mind' were primarily genetic and constitutional, and that the insane were difficult to redeem because of their inheritance, which could not be modified. They could be housed and fed and have their madness contained to some extent but prevention could only be achieved by controlling propagation and suppressing the germ of insanity. Like Maudsley, Birch believed that people went insane because they could not develop the will power to withstand the pressures of life.⁷

of his alienist views. Birch's view was that inmates were constitutionally inferior and were in essence not worth spending money on (p. 53).

⁷ See Cawte (1998), *The Last of the Lunatics*, and Maudsley (1885) *The Pathology of Mind: A study of its distempers, deformities, and disorders*.

Little special attention was given to ex-soldiers admitted to the system. If they were admitted to institutions, no separate facilities were provided and no specialised treatment was prescribed. Dr Harry Southwood, the Deputy Superintendent of Enfield Receiving Home during the war years and until 1949, did not see any need for special consideration of veterans; who 'went mad just the same as civilians'.⁸

In South Australian mental health services no effective general reforms were implemented until the Scottish trained psychiatrist, William Cramond, was appointed Superintendent of mental institutions in 1961. Some of the reforms were made possible with the availability of the major tranquillisers. Although he remained in the position for a short time, he had a major influence on the reform of mental institutions. As a young man Cramond had served as a British officer in the Indian army, but illness had forced him to retire and return to Scotland where his father, through connections, had arranged for him to enter medical school. When completing a Diploma in Psychiatric Medicine, he was influenced by former army psychiatrists such as Fairbairn (see chapter on origins of British psychiatry). In Scotland he had observed the application of principles of manpower management, and the value of fostering morale, during the reform of the mental health system. When he arrived in South Australia in 1961 as Director of Mental Health, he found a very run down system, which had been allowed to decay and meander for over thirty-six years. Cawte (1998) who worked in Parkside in 1951 in the Birch era, admitted that patients lived in squalor and poverty. Cramond set about sorting patients according to disability and age and establishing systematic treatment and education. Mentally retarded patients, who had never been segregated from the other patients, nor even been toilet trained, were provided with separate facilities and developmental activities.⁹

It is not surprising that in such a run down system war veterans were given no special treatment. The only concession for war service was support from members of the RSL visitation committee. Treatments were the same for veterans as for civil patients including

⁸ Interview 20 September 1999; Southwood was more interested in psychoanalysis and undertook training during the war years, and was one of the founders of the Australian Association of Psychiatry after 1945.

⁹ Cramond recalled that the human waste from nappies (diapers) from Adult patients had to be removed and cleaned each morning and were sluiced into a public drain. His selling point to convince the Minister for Health, Sir Lyall McEwen, of the need for more funds was to take him to the nearby creek where the sewage washed down. Interview W. Cramond.

ECT, coma therapy, early forms of behaviour therapy, and after 1957 the use of major tranquillisers.¹⁰ It would have still been very easy for a veteran to be lost in these institutions or have his difficulties masked by alcohol abuse and attempted suicide. Part of this camouflaging would have been reinforced by the lack of specific war related diagnosis. At this time there was no political will to make a special issue of veterans in these institutions. Trauma or war experience did not feature in any diagnostic nomenclature. There was no official term for war neurosis, and war related traumatic neuroses were not mentioned in psychiatric literature (with the exception of Paul Dane), or in official documentation (Repatriation records or pension applications) until after 1980. The only other reference was in Attestation Form completed on entry into service, when applicants were required to state if they had previously been diagnosed with shell-shock or neurasthenia.¹¹

For veterans, as for any member of the community, there were four main categories of diagnosis.

- the congenital/organic disorders – mental deficiency, epilepsy
- those developing a neurosis presumed not trauma related
- conditions causally connected with trauma exposure – traumatic or anxiety neuroses
- more serious psychotic conditions.

Just how these diagnoses were related to service experience and eligibility for treatment is not clear, but any psychic war wounds had to be proven beyond doubt. The only suggestion of clearly war-related trauma was traumatic neurosis, a rare classification reserved for those who had experienced some form of commotional shock similar to the shell shock condition of traumatic origin (they comprised .017 percent of accepted claims in 1944). This system of mental accounting reinforced the view that most 'genuine' casualties would be of short-term duration. Those conditions that did persist could be attributed to the personal inadequacy of the patient, not their war experience.

¹⁰ The main antipsychotic drugs introduced at this time were Melleril and Largactil, which controlled psychotic symptoms, especially those of the delusional. It meant that in institutions effective control could be achieved without keys and restraint.

¹¹ This was the AA Form D1, Revised May 1939. The questions were Qu. 2. Have you ever suffered from Neurasthenia or nervous breakdown? Qu 10. Have you been wounded, suffered from Shell Shock, or Gas Poisoning?

The treatment and methods of disposal of those with accepted disabilities followed 'standard psychiatric lines'. Most of these treatments were invasive. A review of the use of the psychiatric service at RGH (South Australia) in 1948 stated that thirteen of the 421 admission to the RGH facilities had been transferred to the Enfield Receiving Home for destructiveness, aggressiveness, suicidal tendencies, and treatment of alcoholism.¹² The latter was a modern alternative to classic psychotherapy as a means of purging the patient of repressed traumatic memory. In this procedure either Sodium Amytal or Pentothal was injected intravenously to produce a cathartic abreaction. Former senior psychiatrist W. A. Dibden recalled that he had heard 'glowing accounts of the beneficial results' of this from the front line. His own experience of applying the treatment was actually disappointing and he assumed that the disturbances had become more deeply embedded in the time between front line service and admission for treatment on the mainland, thus making the 'traumatic memory less accessible'.¹³

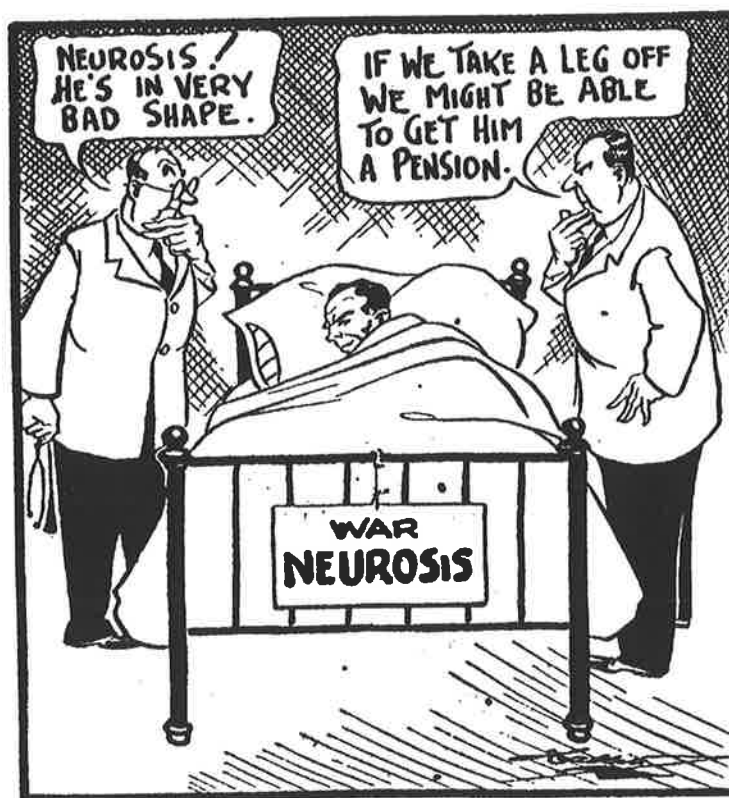


Figure 7.1 'Repatriation: Pensions not granted in war neurosis cases'.
Smith's Weekly; March 1945

¹² Australian Archives SA: D2048/0, Item G1220. File No. G 1869/1/8.

¹³ Interview 19 March 1998.

Dibden describes his early experience with the use of cardiozol at Parkside Hospital¹⁴:

The induction of a convulsion by intravenous Cardiazol caused me anxiety. Only the satisfaction of seeing depressed patients get better kept me going. This was an attempt to produce a cathartic abreaction under a hypnotic drug, usually by the slow intravenous injection of Pentothal sodium or sodium amytal. Cardiazol was given as a large injection, usually 6-8ccs depending on the weight of the patient. A large bore needle was used because it had to be injected fast. The speed of the injection often determined whether the patient had a convulsion or not. If the patient convulsed, well and good. If not, then you had to give a second, larger injection as fast as possible to prevent the terrible effects of a mis-convulsion. It was alleged to produce a sense of utter dissolution. The only way to avoid this was to induce a second convulsion. The consequent retrograde amnesia would mask the unpleasant sensations. A mis-convulsion made the patient apprehensive and restless. It was no fun trying to get into a jumping, bobbing vein using a large syringe with a cc more than the first injection, and to push it in as fast as one could. In the end I became as apprehensive giving Cardiazol injections as some of the patients became of taking them. It was a vast improvement and a relief to me when the drug was replaced by electroconvulsive therapy (ECT).

I must confess that I was rather disappointed with this technique. The reports coming from the combat area gave encouraging accounts of beneficial results obtained. I could only conclude that the disturbances had become more deeply embedded over the intervening months since the onset of symptoms, and evacuation across the seas to Australia, and that the repressed traumatic material became less accessible. I used a little hypnosis but never had much confidence with this method. I consoled myself with the recollection that Freud himself had started off with hypnosis and given it up.

Dibden's career at as an army doctor at Daws Road was short lived and in March 1943 he became ill so he was discharged from the army and decided to train further in psychiatry and obtained a position at Parkside Mental Hospital.¹⁵ Dibden's described a hospital system where general training was inadequate particularly in nursing, under-staffed wards made the use of physical methods of restraint both necessary and acceptable. Restraint was achieved

¹⁴ The principle of coma-inducing treatments was to speed up the production of glucose, but not in the blood stream. With the correct dosage the effect was to induce a short-term coma or state of shock. The recovery from shock was facilitated by ingestion of glucose to re-establish the levels of supply to the brain. Two substances used to induce this shock were insulin and cardiozol, the latter (experimented with originally by a Dr Meduna in Budapest) having similar effects without the risks of complications with camphor. Electro shock treatment was another development that was first experimented with in Italy by Drs Cerletti and Bini. Details supplied by W. Salter.

¹⁵ The Parkside Lunatic Asylum, as it was then known, was the third asylum in South Australia, still somewhat antiquated in the style of the Public Colonial Lunatic Asylum (from 1846) and the Adelaide Lunatic Asylum (from 1852). The latter was closed in 1902 and the remaining patients were transferred to Parkside Lunatic Asylum that had opened in 1870.

with the straight jacket and ankle and wrist straps, as well as the camisole, which encased the whole body and laced up at the back. It was useful for patients who stripped themselves or had a tendency to self-mutilation, or for melancholic patients who were suicidal or stubbornly refused to eat or drink. He reflected that

In retrospect these methods of control appeared barbaric and in a sense they were. We now know that the behaviour arose not from the mental disease from which the patient suffered, but also from the effects of deprivation of liberty, over-crowding and the loss of identity that admission to a mental hospital entailed. It must be remembered that apart from sedation, there was then no chemical way of modifying violent behaviour. The care was largely custodial until the physical methods of treatment were introduced, and in those days the hospital was a closed institution. Windows were barred, doors giving access or egress from a ward which were locked, and all staff carried a bunch of keys.

CONTEXT OF PSYCHIATRIC PRACTICE

In the period of psychiatric rehabilitation development psychiatry itself was in a very early stage of development. Psychiatric training was still limited to eight one-hour lectures per year including a lecture on psychoanalysis and a visit to the Enfield Receiving Home. The only other training that might have occurred was while psychiatrists were members of the forces. To equip them for front line psychiatry the army provided a basic twelve week training course at Kenmore in New South Wales, run by Alec Sinclair ('a pleasant chap, a good teacher', according to one participant, William Salter). This was a rudimentary training course with basic topics about therapy and management of psychiatric cases. The therapies included training in the use of insulin and coma therapy, ECT and rudimentary psychotherapy. Trainees were introduced to the ideas of Freud and how the subconscious expressed itself in symptoms.

For his army psychiatric training Dibden completed a twelve-week course at the School of Neurology and Psychiatry in Melbourne. This enabled him to qualify as an adult psychiatrist in South Australia. The school was run by Dr H. F. Wadsley and Dr J. Williams and practically all the senior Victorian psychiatrists from the State mental hospitals were involved. He described that experience:

We had lectures every day, sometimes in the evening. We read a lot and there were visits to hospitals. We had an opportunity to see patients under supervision. Convulsion therapy and full coma insulin therapy were demonstrated and the malaria treatment for syphilitic nervous disorder, GPI, or general paralysis of the insane. The lectures

provided us with a grounding in psychopathology. In twelve weeks it was impossible to acquire any but the simplest psychotherapy skills. The course was comprehensive, intensive and very stimulating. After the war about half of those who took part remained in psychiatry.¹⁶

William Salter, who succeeded Dibden at RGH and later became the Superintendent of Hillcrest Hospital in South Australia, served as a regimental Officer Northern territory. He had attended a 12-week course in 1944 at Goulbourn, New South Wales, and was then appointed to Hollywood Psychiatric Hospital in Western Australia until August 1945.

There was no university based training in psychiatry, and the neuroses of war were not significant topics in professional development of psychiatrists and general practitioners. Ideas about war neurosis were discussed periodically at meetings of the British Medical Association in some Australian states but no professional medical body took them up as a major issue. There was minimal involvement and interest from other professional bodies such as psychologists.¹⁷ There was no college of psychiatry in Australia until 1963, and there were no Australian psychiatric journals. The only site of discourse on war-related issues was the *British Medical Journal*, the *Medical Journal of Australia*, and the *Lancet*, where a number of articles appeared, most of which have been reviewed in the two preceding chapters. None of the early literature on war trauma formed part of the clinical material available to the experts in psychic rehabilitation.¹⁸ There was no text for psychiatric training in psychological rehabilitation, and Henderson and Gillespie's *Textbook of Psychiatry* was the basic Psychiatric text available.¹⁹ This was the standard British text for psychiatric training (Henderson was professor of Psychiatry at Edinburgh University). The authors down-played the effect of traumatic events, and gave little credence to the on-

¹⁶ Interview conducted in 1991. Dibden's biographical details are recorded his unpublished autobiography held at the University of Adelaide Barr Smith Library.

¹⁷ The Australasian Society of Psychiatrists founded in 1946, the forerunner to the College of Psychiatry in Australia did not take this up as an issue. Psychological societies such as the British Psychological Society, which had Australian members, were not concerned with the mental health of veterans or problems of war but more with issues of measurement and disposal for vocational purposes. Psychologists and social workers, although beginning to play a role by the late 1940s, were not involved in the policy development in the armed services and the Repatriation Commission.

¹⁸ The Psychoanalytic Institute, still in early stages of development, paid little attention to war veterans.

¹⁹ *Textbook* was originally published in 1927 and revised in 1962 & 1965.

going effects of war trauma after 1945. In the 1962 revision it was even suggested that 'traumatic neurosis and traumatic psychoneurosis should be abandoned' as diagnostic categories. They admitted that a terrifying experience would produce a short-term reaction of anxiety and panic and often terrifying dreams, but these symptoms 'usually diminish and ultimately disappear'. It was as though the war was only a minor interruption to the stream of received knowledge in psychiatry.²⁰ That is the extent of their portrayal of trauma as a source of mental illness.

Medical specialists could have had access to the first edition of the American Psychiatric Association Diagnostic and Statistical Manual in 1961, in which there was a diagnosis of 'gross stress reaction'. This diagnosis, nor any rationale underpinning it, did not appear in any Australian literature or clinical discussion.²¹

The only other major text in analytical psychiatry was Otto Fenichel's *The Psychoanalytic Theory of Neurosis*, which was first published in 1945. It was available to psychiatrists and trainees in the post-WW2 period, but was mainly of interest to those doing psychoanalytic work.²² Fenichel adopted a classic Freudian analytic stance but at least acknowledged the reality of the effects of traumatic experience. He described trauma as 'a relative concept, in which factors such as mental economy, dependent on constitution as well as on previous experiences, and on the actual conditions before and during the trauma, determine what degree of excitation overtaxes the individual's capacity' (p. 117). How one coped also depended on the capacity to take action at the time – 'foxhole waiting is more dangerous than active warfare'. He listed the symptoms of traumatic neurosis as a) blocking, or decrease of ego functions; b) spells of uncontrollable emotions; c) sleep disturbance with dreams in which trauma is re-experienced, as well as mental repetitions

²⁰ The amnesia in psychiatric literature is quite astounding. The war presented nothing new to medical science and little new emerged out of the war experience in WW2. Even in 1962 a standard text in the Repatriation system, listed the 3 types of psychiatric disorder. These were: Psychoneuroses (anxiety, hysteria, obsessive compulsive behaviour, reactive depression, somatic disorders, mixed); Psychoses (Organic and non-organic – including schizophrenia and manic depression); Character disorder (basically psychopathic or constitutional insufficiency).

²¹ American Psychiatric Association (1952) *Diagnostic and Statistical Manual*. For discussion see Young (1995) p. 107.

²² Fenichel, O. (1945) New York, W. W Norton & Co. This was a standard text used by trainee psychiatrists, particularly those training in psychotherapy. Testimony of Howard Whitaker, a psychiatrist who trained in Melbourne and worked at Rockingham Centre 1949-54.

during the day; d) secondary psychoneurotic complications. Fenichel maintained that if the event was sufficiently severe it could precipitate a neurosis. If the person were already predisposed with a neurotic disposition, he would react to a minor event 'with a reactivation of his infantile conflicts'. In essence 'traumatic neuroses represent an insufficiency of the basic function of the ego', which is to overcome past traumata and avoid future traumata.

The psychoanalytic ideas presented by Fenichel had some influence on the work of psychiatrists in the 1940s and 1950s at the Rockingham treatment centre in Victoria. Another influence was the work of Maxwell Jones and his concept of therapeutic community.²³ There is no evidence of such a clearly articulated approach in either therapeutic orientation in the South Australian repatriation system.

VETERAN PSYCHIATRIC REHABILITATION

As outlined in Chapter Five a form of psychiatric rehabilitation had been established for the damaged WW1 veteran but there had been little further development in the period before WW2. The Red Cross had taken on the responsibility of providing the bulk of rehabilitation facilities, but by 1939 these had virtually closed down. A new system had to be established based on new legislation.

Rehabilitation is an integral component of the broader activity of repatriation. As the term implies, repatriation is a process of returning men and women to their home country and normal life after war service. As well as pension entitlement, repatriation provisions included a raft of benefits, including low interest housing loans, land grants, education for the children of deceased soldiers, and benefits for widows. For repatriation to be effective, it had to be underpinned by administrative policy and an organisation that would implement this policy. This was only realised fully on a national level after WW2. Rehabilitation consisted of more specialised assistance within the repatriation provisions to return those who were sick or disabled to former levels of functioning, or at least enable them to resume a place in civilian life. Rehabilitation required treatment programs, social and material support, as well as vocational training and re-training schemes. Tipping (1992) pointed out that during WW2, 'rehabilitation was sometimes used to describe the process of assisting all

²³ See Whitaker, H. (1954) Group therapy: a review and report on its use in a therapeutic community. *Medical Journal of Australia*. 2; 899-904.

the returning men and women to gain employment, regardless of disability'.²⁴ Galbraith (1946), citing Andrew, defined rehabilitation as

That method by which function²⁵, both physiological and psychological, is restored following illness or injury. It thus connotes the restoration of free movement of stiffened limbs, vigour to tired minds, of courage and confidence to quailing spirits; in short, the physical, mental and ethical toning up of the whole individual being.

For the soldier who either returned in a damaged state, or developed problems after discharge, there was no specific diagnostic category for an illness occurring long after the initial 'injury'. To be eligible for any form of rehabilitation, the 'injury' had to be deemed to be caused by war experience. With the 'unseen wounds' of war this was not a straightforward matter. The determination of repatriation entitlement could only be made on the basis of the prevailing ideas about war neurosis. In effect there was no diagnostic protocol that incorporated the experience of a prior trauma, nor post-trauma reactions.

To qualify for rehabilitation damaged men had to be assessed, classified as either psychotic or neurotic, and then treated. There were two additional considerations. The first was to decide if the condition was war related, which meant the Repatriation Commission would pay for treatment. A non-war related condition would preclude the veteran from treatment in the Commission facilities, and he/she would have to seek help privately or in the state or commonwealth facilities. With the establishment of the rehabilitation service within the Commonwealth Department of Social Services, the latter option was somewhat improved, but for the chronic cases of psychiatric disability the state mental health systems had little appeal. The second consideration was eligibility for pension or monetary compensation for the disability. At the end of WW2, there were two basic types of pension. The first was a full or part allocation of a general rate of pension for disability – a range from 10 percent to 100 percent. A greater rate was granted for those who were classified totally and permanently incapacitated (TPI). For very damaged men who could not 'support their families' the granting of TPI was a considerable relief for their anxiety. As outlined in

²⁴ Tipping, J. (1992) *Back on Their Feet: A history of the Commonwealth Rehabilitation Service 1941-1991*. Australian Government Publishing Service.

²⁵ Galbraith, D. (1946) The responsibility of the doctor in regard to rehabilitation and hospital practice. *Medical Journal of Australia*, 6 July; 1-8, p. 1.

previous chapters the medical profession had argued against granting pensions on psychiatric grounds.

Even though the argument against pensions had been lost in 1918, some psychiatrists, such as W. A. Dibden in South Australia, still argued in WW2 that a pension did not encourage a person to 'shrug off his mental demons', and should not be automatically granted even when the soldier was clearly disturbed. For Dibden, a pension 'served no useful purpose' and only confirmed in the patient's mind that he was suffering from 'organic lesion resulting from war service'.²⁶ In the context of readjustment to work, which was regarded as an essential part of mental and emotional readjustment to normal life, it was argued that a pension would act as a disincentive, because the recipient might not struggle to overcome his problems.²⁷ In their analysis of the work of the Repatriation Commission in the WW1 era, Lloyd & Rees (1994) concluded that 'with genuine psychic cases, those who obtained regular work soon after returning usually recovered quickly because they had no time for psychic ailments'.

The foundations for the WW2 psychiatric programs had been partly laid in the aftermath of WW1. The Red Cross institutions, established in the 1920s in the larger states to heal the shell-shocked, men supplemented the army hospitals, but were not based on an agreed central policy incorporating a defined etiology, pension eligibility, treatment facilities, training, and funding for specialised staff. Although there were some facilities for physical rehabilitation at the beginning of WW2 the government of the day still had no clearly articulated policy for dealing with the neuroses of war. Moreover, having dismantled the WW1 treatment facilities in the period before WW2, the infrastructure had to be rebuilt.

Repatriation and rehabilitation were massive undertakings for the 600 000 men and women returning after WW2. A systematic psychiatric rehabilitation service for WW2 ex-service personnel emerged initially in a piecemeal fashion. Just as they had in the battlefield, Australian authorities relied heavily on the British Army policy on war neurosis in soldiers. This is evident in memorandum to the Deputy Commissioner of the Department of Repatriation in Adelaide on 19 April 1940, circulated to all senior medical personnel in

²⁶ Dibden (1945) Psychiatric Casualties as a Repatriation Problem, *Medical Journal of Australia*, 1, 3: 49-57.

²⁷ See the views of Fry below.

the Repatriation Commission. It was accompanied by a report from the British Minister of Pensions in London, that had emerged out of a conference July 1939, to advise the British government on 'the general principles for dealing with cases of nervous breakdown which may become manifest in wartime'.

The members of the British conference were Lord Hawder, Sir Hubert Bond, Sir Farquar Buzzard, Dr Bernard Hart, Dr Gordon Holmes, Professor Mapother, Dr J. McDonald, Dr Crichton Miller, Dr Aldren Turner, the Directors General of Medical Services of the Navy, Army and Air Forces, and representatives of the Ministry of Pensions. Many of these men had been prominent in dealing with the neuroses of war in WW1. Crichton Miller for example, was a contributor to *The Neuroses in War*, edited by Emanuel Miller in 1940, and Mapother was former clinical director of the Maudsley shell-shock program.

The British conference concluded:

The conference endorses the findings of the War Office Committee of Enquiry into Shell Shock appointed in 1920, and draws attention to the following factors which tend to increase the incidence and severity of mental and nervous disorders in time of war.

- a) All those factors by which an individual is encouraged to believe that weakening or loss of mental control provide an honourable avenue of escape from duty.
- b) The ignorance of the general community regarding the origin, nature and significance of mental, and especially emotional disorders.
- c) All those preventable conditions which undermine a man's mental and physical health and lower the power of resistance and morale, for example insufficient sleep and rest and recreation and relaxation, bad accommodation, abuse of alcohol, lack of attention to comfort and wellbeing.

The introduction and perpetuation of the term shell shock, a term that has proved to be a costly misnomer in the last year, should be eliminated from our vocabulary.

The conference advises that the policy of the Government during the period of the war should aim at dealing with all cases of nervous breakdown by way of treatment and rehabilitation, rather than the endowment by compensation. It is pointed out that war produces no new nervous disorders; that the incidents and duration of the neuroses are greatly affected by the methods adopted for handling them; that as neuroses differ from other disabilities in being so largely conditioned by psychological factors. It is finally recommended that a different standard, based on an understanding of these factors, should be adopted for dealing with them.

Normally the emotional reactions induced by fear, danger or shock and the effects of exhaustion and war strain are of only temporary duration and quickly disappear if early and suitable treatment is given. In intractable cases there already exists an inborn or acquired predisposition to excessive and therefore pathological reaction, and this constitutional factor is of vast importance. The conference therefore recommends that 'during war, so far as is practicable, no man shall be discharged from any of the fighting services in consequence of developing a neurosis, and similarly, no civilian

should be granted exemption from any liability for national service in consequence of manifesting a neurosis during war.

These views show little development since the Shell-Shock Report of 1922, which had rejected traumatic shock as a causal factor in the majority of neuroses, and recommended the adoption of standard psychiatric nomenclature. The 1939 conference was confident that any adverse reaction to the extremes of war would quickly dissipate and not become a long-term public liability. If it did it would be attributable to the constitutional weakness of the individual.

The report argued that men should not be discharged before they were well, and that most rehabilitation should be achieved during service and convalescence. Granting a pension on psychiatric grounds was not to be a blanket policy, since for this class of case, 'compensation was often particularly harmful to the individual'. The conference therefore recommended that no person should be given a pension on account of a neurosis during wartime, 'except in special circumstances, but at the termination of the war, expert consideration should be available for individual cases with reference to any possible residual incapacitation.' Since the report came out at the beginning of the war there was also a recommendation to eliminate any doubtful cases, especially those with a neurotic background, either at recruitment or during training. The ideas outlined in the report formed the framework of Australian repatriation policy, except for the British hard line on pensions.²⁸

Veterans had been poorly served after WW1, but the Menzies government made a commitment in 1941 to establish a national rehabilitation system for all Australians.²⁹ This meant the development of two separate large commonwealth government departments, the Department of Social Services, and the Repatriation Commission, which both catered for ex-service personnel. The Repatriation Commission only treated those with disabilities accepted as war-related, and since psychiatric disabilities were not automatically accepted

²⁸ Australian Archives D2048/0, G1220. A document that accompanied the original report, *Neuroses in Wartime*, was to be made available to the Deputy Commissioner but was not in the archival material.

²⁹ It is not proposed to describe the history of the general development of Rehabilitation in Australia. The full story of how the DSS and Repatriation Commission worked together can be found in Tipping (1992) op cit.

as war-related, many veterans with psychiatric problems were catered for within the Department of Social Services.³⁰ In his history of the Commonwealth Rehabilitation Service, Tipping (1992) noted that 'among the people with non-war-caused disabilities who became clients under the scheme, there was a high proportion of people who had psychological and psychiatric complaints'. By June 1946 these comprised 25 percent. This high proportion was explained by the high rate of rejection of psychiatric cases. A review of some anxiety neurosis cases (ex-POW in Germany, a man caught in the Sydney submarine raid) suggests that many of these were subjected to traumatic wartime experience. Plans to establish separate 'neurosis' centres never materialised. Tipping also pointed out that up to 25 percent of admissions to centres were 'neurosis' cases, some of whom were ex-servicemen³¹

Psychiatric rehabilitation facilities evolved out of the military establishments, particularly hospitals, which were gradually adapted to civil repatriation requirements. These functions were transferred gradually to the Commission from the army system. For example, in South Australia in 1942 the Daws Rd Military Hospital (105 AGH) provided treatment for men who would either return to the front or be discharged. It only became a Repatriation Commission hospital later and became known as Repatriation General Hospital (RGH). The task of rehabilitating the mentally damaged soldier was not new in the 1940s, as there were still WW1 veterans in the civil and repatriation systems being treated for war neurosis in 1939. Even though there was not a significant shift in fundamental ideas, WW2 did stimulate the development of a more systematic and better-resourced rehabilitation services for both mentally and physically damaged men and women. Federal legislation confirming the provisions for the mental health of pensioners was not passed until 1950, but the facilities were well in place by then. By this time expert opinion had been grafted into the system by many medical experts who had played a significant role in the delivery of services at the front line.

There were few trained specialists in the field. The only significant psychiatric text written specifically for the Australian armed forces (Bostock, & Jones 1944), was intended

³⁰ It is too complex to convey all the history of the work of the Repatriation Commission here, and I will only concentrate on aspects of psychiatric rehabilitation. See Lloyd, C. & Rees, J. (1994) *The Last Shilling: A history of repatriation in Australia*. Melbourne: Melbourne University Press.

for medical personnel in the field, but was not widely known among medical practitioners. The skills and frameworks applied in the system were the same as those applied in the field and British nomenclature and ideas predominated. Terminology was the same as had been used for military purposes. Classic analytic models of war neurosis, such as proposed by Freud and Janet, were only applied by a few individuals such as Paul Dane, and were never mainstream.

The British influence on Australian policy was quite pervasive, partly through a number of expatriate British psychiatrists and physicians, and Australian psychiatrists trained in Britain (mostly at Maudsley). The most significant contributor was Alan Stoller, a British psychiatrist who served with the Australian Army (1940-45), and was later appointed as the specialist in psychological medicine in the Repatriation Commission (1947-53). At the national level until 1960 at least, Alan Stoller stands out as the single most important influence on the development of services in psychiatric rehabilitation, and could rightly be regarded as the architect of the system. Stoller graduated in medicine in 1935 and in psychiatry in 1938 in London. His grounding in army psychiatry occurred with the Australian Imperial Forces in Palestine, and for a short time in New Guinea with the AAMC. In Palestine he was involved in treating the growing numbers of psychiatric casualties. As well as treatment, his main role was to provide an assessment of suitability for service by a medical board. At the 2/6 Australian General Hospital in Gaza he observed the effects of the ten days of intense battle at El Alamein, where he treated men with acute stress reactions. To Stoller, this was 'uninteresting work', and he found army life rather stifling.

It was a boring place. There was no real challenge. I was just assessing, giving opinions and first aid. There was very little psychiatric treatment, all of which I regarded as a bit unnerving as an outsider.³²

After demobilisation in 1945, Stoller returned to the University of London to engage in research. He returned to Australia in 1947 with an appointment to the position of the headquarters consultant in psychiatry, or as it was later termed, psychological medicine, with the Repatriation Commission. In a very short period between 1947 and 1953 he

³¹ Tipping (1992) op cit.. p. 18, 35.

³² Interview November 1991.

achieved major reforms within the repatriation system. An overseas study tour of the United Kingdom and the United States in 1948, to observe psychiatric services and the provisions for British and United States ex-servicemen, had a major influence on his thinking. He visited psychiatric facilities in Washington and New York, the Langley Porter Clinic in San Francisco and various other veteran facilities. He could see at first hand the various treatment options in psychoanalysis and psychodynamics, group methods, electro-cerebral therapy, various forms of clinical psychology, psychiatric social work, psychiatric nursing and other ancillary therapies such as electro-cerebral therapy, insulin shock therapy, psychosurgery, including pre-frontal leucotomy and thalamotomy).³³ His attendance at the International Congress on Mental Health in London, 'Mental Health and World Citizenship', opened his horizons even further. (There was no major focus on the problems of war neurosis of war in the conference).

Stoller's breadth of vision and depth of knowledge, which were enhanced by his overseas visit, sometimes stretched the boundaries of Repatriation Commission administrators. He became an advocate for a revision of Australian standards in staffing, and the shift of psychiatric therapy to outpatient clinics, with an eclectic approach to therapy. He advocated the introduction of modern psychiatric concepts into the curriculum of medical schools, establishment of chairs of psychiatry in medical schools, which would ensure that training and research programs would be accelerated for psychiatrists, psychiatric social work, and clinical psychologists.

The thrust of these new ideas was obvious in his recommendations for reform within the Repatriation Commission. These included establishing advisory consultants at headquarters to take responsibility for maintenance of standards in clinical psychology and psychiatric social work and the establishment of federal neuropsychiatric hospitals for ex-servicemen. A third recommendation was to establish a comprehensive university based training scheme for all specialists and psychiatric personnel, including special research fellowship grants from the Repatriation Commission.

³³ Spelling of leucotomy could also be with a 'k'. Leucotomy is the surgical removal of a section of the frontal lobe; Thalamotomy, the destruction of a portion of the thalamus for the relief of pain, involuntary movement and emotional disturbance. (See Stedman's *Concise Medical and Allied Health Dictionary*, Third edition, 1997, Williams & Williams).

Stoller publicised his forthright views in a number of arenas, and was keen to ensure that repatriation policy did not repeat the mistakes made with WW1 soldiers. They had been allowed to return home in a damaged state, collect their pension, but not receive effective psychiatric intervention. He expressed his ideas in a presentation to a meeting of the Section of Neurology and Psychiatry, at the Victorian branch of the British Medical Association on 28 August 1947.³⁴ There he outlined the state of psychiatric knowledge that Australia inherited from the British in the post war period, and the policies and practices he hoped would develop in Australia. He reminded his audience of the changes that had taken place in hospital treatment in the ten years since 1937. These included the psychoanalytic work at Tavistock Clinic in London; the development of the role of psychiatric social workers; the introduction of Cardiazol shock therapy; the use of insulin coma and electro-convulsive therapy (which had replaced Cardiazol which had its beginnings in 1937); and the advances in physical therapies. These physical therapies included what he regarded as 'the greatest single advance - the application of pre-frontal leucotomy'. These physical treatment continued as part of treatment for some years. Frontal lobe leucotomy on the 'seriously anxious' had been performed on two patients at RGH in 1948. Coma insulin treatment was used as a 'tonic', with fifteen cases of full coma insulin therapy, and twenty-seven treatments with sub-coma insulin therapy. All these patients had gained at least two pounds in weight, the average being eight and a half pounds. Electroconvulsive therapy had been used in thirty cases of schizophrenia, endogenous and involuntional depression, mixed neuroses and hysteria. In the case of hysteria this had no effect. Ether was also used to produce abreaction but this had been almost entirely replaced by the end of 1948 with sodium amytal.³⁵

Stoller was keen to shift the thinking of the Repatriation Commission from what he regarded as the outmoded practice of clinical psychiatry. He concluded that, whereas before the war there was heterogeneity and variety,

The war seems to have unified the general outlook, and brought psychiatrists to a common mode of expression and understanding. However, there is still a strong psychoanalytical influence. The old concept of the psychiatrist as an asylum doctor has

³⁴ Stoller, Alan (1947) Modern Trends in British Psychiatry. *Medical Journal of Australia*. 2, 26: 765-772.

³⁵ Australian Archives SA: D2048/0, Item G1220. File No. G 1869/1/8.

disappeared. His frontiers and outlook have broadened. His interests are extending from medicine into the field of education, sociology, criminology, industry and even political science (p. 771).

It is clear from his acknowledgments, that Stoller had been personally influenced by a number of significant overseas experts, such as Aubrey Lewis, (University of London and Maudsley Hospital), Professor D. K. Henderson of Edinburgh University, J R Rees, (ex-RAMC & Tavistock Clinic), and Professor F. Goller (research). Stoller emphasised the need for social methods, which focussed on changing the fundamental conditions in society where a 'stratum of insecurity can foster problems of neurosis'. This was an interesting shift away from a focus on memory of a traumatic past that could account for current dysfunction of a returned soldier. Stoller argued that a soldier's neurosis could more be readily explained by things going wrong in his current life, such as work pressure or conflict at home, rather than a traumatic past. He acknowledged that individual methods of treatment had barely affected the vast problem of neurosis in society. In his opinion, group therapy held more hope of dealing with the greater numbers of cases, but it was only by creating a stable society and eliminating insecurity, that the problem of neurosis would ever be addressed adequately.

Stoller revisited his reforming ideas for ongoing treatment of the mental war casualty, in the third biennial Dorothy Poate Memorial Lecture, delivered at the University of Sydney on 24 June 1948 at the invitation of the Board of Social Studies.³⁶ There he advocated a broad approach in the treatment of war neurotics that incorporated the skills of trained psychiatric social workers. Effective rehabilitation was justified on social and economic grounds. He argued that alleviation of mental disorder in ex-servicemen, whether entitled to compensation or not, was a moral responsibility of the community. He predicted that by 1975 when the WW2 veterans would be in the fifty and sixty-year age bracket, there would be a large proportion still requiring help. This was one of the few references to long term psychiatric problems for the discharged veteran. He also acknowledged a trans-generational effect on the veteran's family, and argued that early intervention in the form of veteran treatment would prevent a snowballing effect on the children. If treatment was given, with or without government support, the chances of the veteran becoming 'a productive unit in

³⁶ Stoller, A. (1949) Social Work and the Ex-Servicemen: A Psychiatric Problem, *MJA*, 1; 639-46.

the wealth of the country is increased by that much', by reducing loss of time in industry through neuro-psychiatric disorders. Stoller supported this argument with a reference to a British Medical Research Council of the Privy Council study of the incidence of neurosis among factory workers by the 1947.

Despite his views on social healing, Stoller still argued that wrong or inappropriate treatment could exacerbate and perpetuate any kind of inadequacy in the ex-serviceman. Obviously referring to the WW1 experience he stated

Critics again state that one should not bother to deal with individuals who are happy only with the pension and with the regular bottle of medicine. Anyone who has seen these "happy old chronics" attending the outpatient department, who has followed their life histories, as we are able to do for thirty years or more, and who has received social reports of the family, cannot but deplore such a negative attitude which in the past has produced over the years a miserable inferior male and a family of substandard citizens. Those of us who have the care of the entitled ex-servicemen are endeavouring to stop such developments in the present returnee. We have envisaged a scheme which allows for the very necessary integration of general medicine and psychiatry.

Furthermore,

In future, psychiatric problems will not hide behind the cloak of physical disorder for years until eventually the patient has become completely fixed in all his attitudes and obsessively reaches for the magic symbolism of the medicine bottle.

These more radical ideas on social psychiatry were not taken up within the repatriation system, and Stoller eventually left the Commission somewhat disillusioned. He had grown tired of the bureaucracy continuing to ignore his advice and returned to the civil field as a clinical officer with the Victorian Mental Health Authority, and later became chairman of the Mental Health Authority in Victoria (1969-1976). His only role with veterans in later years was providing expert opinion to tribunals and assessing treating individual as a consultant.

Despite his disillusionment, many of Stoller's ideas were translated into the policy underpinning the comprehensive system of psychiatric rehabilitation established in the Repatriation Commission. His influence is seen in the Appropriation Bill No. 2, 1949/50 (Psychiatric Disorders in Members of the Forces) introduced into the Commonwealth parliament in June 1950.³⁷ In his accompanying speech, the Minister for Repatriation,

³⁷ Parliamentary Debates, 22 June 1950. Australian Archives SA D2048/0, item G1223

Walter Cooper, outlined the ideas, practices and policy in the post-WW2 period.³⁸ Cooper, no doubt reading a speech prepared by Stoller, reflected the views on neurosis that were common to the day. He acknowledged that the beginning of the 1939-45 war found a number of men from WW1, now sixty and seventy years old, still under medical care in a variety of institutions. These mentally disabled men had been certified under State laws, and were housed in separate repatriation blocks [by 1950] in state mental institutions. A significant development for WW2 men and women was the establishment of a comprehensive repatriation system that included inpatient and outpatient treatment facilities.

Cooper was clear that they did not want to repeat the mistakes made in the facilities provided by the Australian Red Cross (ARC) after WW1.³⁹ The nature of these 'mistakes' is not made clear. Despite the major contribution to WW1 rehabilitation, particularly in NSW, ARC was relegated to a secondary role and reverted to its original purpose, which was the alleviation of suffering, the protection of life and health, and ensuring respect for human beings. On the home front this included a variety of fundraising activities, visiting the sick and wounded in hospitals and convalescent homes, the provision of activities such as libraries, crafts and entertainment, and provision of comforts (socks and cigarettes) both at home and overseas. In terms of physical rehabilitation they maintained convalescent homes and TB Sanatoria. They also trained medical aids for the blood transfusion service, and provided personnel through the Voluntary Aid Detachment Scheme for overseas duties. Clearly there was a need for services to the mentally damaged. An original Red Cross

³⁸ Australian Archives SA: D2048/0, Item G1220.

³⁹ ARC never achieved the same status in mental rehabilitation as it had in WW1. By the outbreak of the WW2 the provision of mental health services was completely the province of the states and the Repatriation Dept. Comforts activity continued throughout 1939-45. Broughton Hall Psychiatric clinic was visited once a week and a tobacco issue was distributed to ex-servicemen. There was some rehabilitation at Gilbula Red Cross farm. A social worker was deployed to provide social service. From 1946-47 there were still WW1 vets in the system. Red Cross was a leader in the provision of occupational therapy and diversional therapy. As resources declined and demand persisted in Repatriation Commission, the ARC considered offering services to the commission for rehabilitation and convalescence. (NSW State ARC Archives)

visitor to the Psychiatric Ward 17 at Daws Road Repatriation General Hospital, recalled, 'There were lots of men and many of them were in a very bad way'.⁴⁰

Cooper was quick to dispel any 'loose thinking' on mental illness, and repeated that 'war neurosis, as such, presents nothing new to medical science'.

The same disorders that are found in our ex-servicemen occur in ordinary civilian general medical practice and the methods of treatment follow well-established patterns'. Their mental afflictions ranged from the 'little nervous or over-anxious' to the violently homicidal or suicidal.

In 1949, 14 886 men and women had been officially diagnosed and accepted by the Repatriation Commission, as partly or fully eligible on psychiatric grounds, under the Australian Soldier's Repatriation Act. Three thousand of these were left over from World War I and almost 12 000 were new cases from World War II. However, while there were 1 900 ex-servicemen and women in mental hospitals throughout Australia, only 47 per cent of those were accepted as a responsibility of the Commission.

Cooper argued that war had consolidated the policy on rehabilitation services, which had emerged out of a special advisory committee on repatriation medical services established in 1946. Part of its agenda was to advise on psychiatric services, and on the advice of the committee, Dr Alan Stoller had been appointed as the director of psychological medicine in the Repatriation Commission. The committee recommended specialised personnel for the early treatment of war damaged men and women, and provision of appropriate accommodation for those who were 'a little anxious to the violently homicidal or suicidal.'

Entry into the rehabilitation system was not automatic. A number of stages had to be negotiated to receive the benefits of the system. Eligibility was based on an assessment of whether the condition was war-related or not, and it is clear from the data on admissions to institutions (see table 7.2), that not all men and women who were mentally damaged were accepted as having a war-related condition. The 1950 legislation rejected provision of treatment for all ex-service personnel with a mental disorder, despite a push, both in Parliament and other places, to have all ex-servicemen and women with a psychiatric condition included under the Australian Repatriation Act. Cooper pointed out that, 'the national responsibility to the discharged man or woman so far as war service is concerned,

⁴⁰ ARC policy documents and interview with Ms Peg Evans, Australian Red Cross archivist in

is to treat him or her and provide pensions in respect of any disability which is war related'.⁴¹

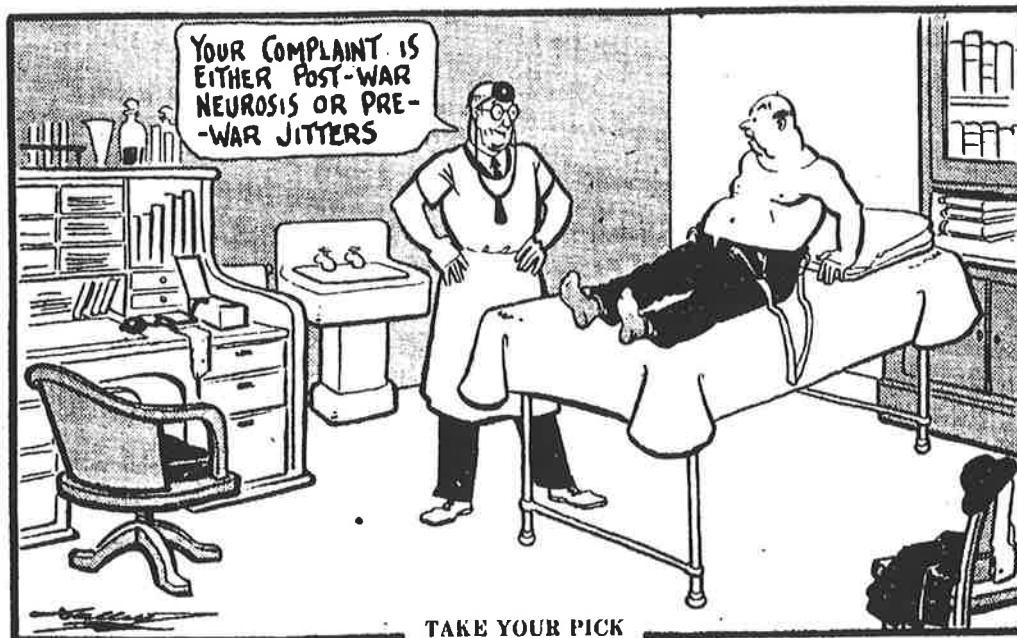


Figure 7.2 *Smith's Weekly*, 17 April 1948

If a veteran patient were considered to have an illness not related to war service, he would be referred to the civil authorities or self-refer for treatment in the civil facilities. If it was war-related, the condition would be classified according to type and severity and a decision made on outpatient or in-patient treatment. Even if the disability was accepted for treatment, there were limits to the treatment offered in the army/repatriation hospital. The chronic and more severe cases, such as psychotic or seriously disruptive patients, would be sent to one of the civil institutions, most of which were still operating under the various state lunacy acts.

Patients eligible for treatment in repatriation hospitals were housed in special segregated in-patient wards, where the general principle was to provide early and brief intervention, with minimal disruption to home and economic life. The aim of such treatment was to engineer some form of social adjustment, and 'cure the condition and to arrange conditions that are to reduce the possibility of further breakdown'. In Cooper's speech, the treatments

Adelaide.

⁴¹ Australian Archives SA D2048/0, Item G1220.

available were lauded as being the most specialised and up-to-date available. They included psychotherapy, pre-frontal leucotomy, abreaction, electric shock treatment and group therapy, all of which were still in experimental stages. A brief form of psychotherapy was to be encouraged, but not the extended form of psychoanalysis.

In July 1951, for example, a ministerial instruction was issued from the Repatriation Commission headquarters advising that psychoanalysis was still experimental in nature and uncertain in its results. Psychoanalysis, for example, was time-consuming and costly and it was therefore decided by the Commission that it should be provided only if there were with special safeguards. These were that it would need to be approved by a three-person committee consisting of the specialist consultant in psychological medicine at headquarters and in the branch and a visiting specialist psychiatrist or psychoanalyst in the State. Abreaction, a kind of psychic purging, was singled out as an advanced form of treatment. It could be brought about with the use of psychoanalytic techniques, or induced chemically. Through abreaction, forgotten distressing memories were brought to the surface and associated with emotions that would be then be released. This was one of the few treatments that specifically dealt with the content of a traumatic past. In some forms of chemical treatment, once the patient had revived, the recorded recollections of these memories would be played back to the patient, and be followed by a relief of symptoms.

Shock therapy induced either by electricity or insulin was considered one of the efficient treatments. As well as facilitating the elimination of traumatic memory it was also thought it would improve the brain function. Cooper pointed out that they had, at least in two States, the latest electroencephalograph equipment with which to diagnose the neurotic condition more expertly. This enabled experts to magnify the brain function and record the vagaries of brain tissue where the function was disturbed. Once a person had reacted favourably to this array of treatment options, they could either be sent to one of the re-establishment centres, which were only available in two States (Victoria and New South Wales), or be discharged into the community and supported through outpatient treatment.

These re-establishment centres, were to be halfway houses in each state where patients could get 'toned up' before re-entry back into the community. (The Rockingham Centre in Melbourne, Victoria was an example of this). They provided a range of social activities, even including ballroom dancing, which would help patients overcome feelings of

inferiority and help them mix again with members of the opposite sex. There were also various kinds of hobbies and training for trades available. These halfway houses were places where there would be a high level of morale, and a 'grand spirit', where men could regain their own spirits.

The proposed legislation reflected the view that effective cure required firm medical authority. Cooper stressed throughout his speech the high degree of expertise and morale among rehabilitation personnel, who had no time for members of the community, or anyone else daring to criticise the work of the Commission. Such criticism could undermine the authority of medical personnel in whom rehabilitees needed to have a high level of faith. He urged the members of the Senate to prevent anyone from undermining this faith, and hindering the prospect of recovery of the men who were being treated. 'I repeat that for the sake of the morale of this service, criticism which is the right of every person in a democracy, should be well-founded and constructive'.

The Cooper speech implemented the British ideas and practices. This was the ideal provision for the mentally damaged. What was the reality?

THE REPATRIATION COMMISSION AT WORK IN SOUTH AUSTRALIA.

Just how the provisions outlined by Cooper worked out in practice can be observed in the workings of part of this national system in South Australia. Those eligible for treatment (and Table 7.1 shows that they had a 40 percent chance of becoming eligible) were treated in the Keswick Outpatients Clinic, or the General Hospital at Springbank (RGH). A physical rehabilitation Centre (Mount Breckan) had been established in Victor Harbor, 52 miles south of Adelaide, but this was considered unsuitable for mental patients. The changes in the repatriation system were being driven from the central office, but the quality of state facilities was to some extent determined by state initiatives and personalities. Many of the reforms that were introduced came through a small band of ex-army doctors, such as W. Salter and W. Dibden.

The distinction between war-related and non war-related neurotic casualties, is illustrated in the repatriation pension in South Australia claims the year ended 30 June 1944 (see Table 7.1). Of the total 2 821 claims lodged in South Australia by ex-members of the armed forces for all disabilities in the period, 26 percent were for mental illness. These applicants would

have mostly returned from the Middle East, Europe and the South West Pacific. The repatriation network was yet to receive claims from those still in Japanese camps (total about 14 000 for the whole of Australia) at the end of 1945. Mental disorders are not defined but are assumed to cover more serious categories like schizophrenia and various psychoses. Two main points emerge from these data. The first is the entrenchment of the standard psychiatric classifications. The second is the difficulty faced by the mentally damaged veteran in gaining a pension, with almost two thirds of applicants rejected. Cases of anxiety neuroses and traumatic neuroses had a greater chance of being accepted as war-related. Neurasthenia and hysteria, common in WW1, were minority diagnoses.

Table 7.1 Pension claims for neurological and mental disorders received in South Australia in the year ended 30.6.44.⁴²

Disability	Cases <i>accepted as due to war service</i>			Claims rejected <i>not due to war service</i>		Total claims
	Pension	Nil incapacity+	Total	Total claims		
				N	%	
Epilepsy	6	1	7	38	84	45
Narcolepsy	1	1	2	-	-	2
Neurasthenia	3	-	3	11	78	14
Hysteria	8	6	14	30	68	44
Anxiety Neurosis	144	57	201	116	37	317
Obsessional Neurosis	5	-	5	13	72	18
Traumatic Neurosis	11	1	12	6	33	18
Mental deficiency	1	-	2	63	97	65
Mental Disorders (All types)	19	10	29	63	68	92
Neuroticism	5	1	6	103	94	109
TOTALS	204	77	281	443	61	724

*'Nil incapacity' is assumed to mean the veteran was granted a pension but was able to work.

For those not accepted for treatment, or if condition was more serious (e.g. attempted suicide or psychosis), life became much more problematic. At this early stage, the

⁴² Australian Archives SA D2048/0, Item G1220.

Commonwealth Rehabilitation Service (CRS) had not been established and even when it did emerge, the psychiatric services were limited. These men and women had to rely on treatment provided in one of the three state institutions, the Enfield Receiving Home, Northfield Mental Hospital, or the Parkside Mental Hospital. In Northfield, there was a special ward (Ward 7) for eligible ex-servicemen where they could be segregated and provided with some special attention. These institutions were only for psychiatric treatment or containment, not rehabilitation. As late as 1949, Stoller reported in his annual inspection of services for ex-service personnel, that minimum accommodation requirements (e.g. floor coverings in the locker rooms, doctors' rooms and linen room) in the state system were not being met in Ward 7.⁴³ In the same report it was noted that of the 191 ex-servicemen and 2 ex-servicewomen in these facilities, only 51 were Repatriation cases.

In a report on RGH in February 1949 Stoller pointed out a number of persistent shortcomings. One deficiency was in personnel. There were still only three part time visiting psychiatrists attending the hospital, Binns, Salter and Dibden, and he recommended the appointment of a full time psychiatrist, as well as a sessional clinical psychologist to provide vocational guidance and personality evaluation of patients.⁴⁴ Alcoholics were a constant problem at RGH. Alcoholic patients were particularly troublesome, and if they suffered from delirium tremens they would thrash around, requiring confinement to a padded cell.⁴⁵ Suicide was not uncommon, and at that time it was officially a criminal act. If suicide was attempted, the patient was certified and sent to Enfield Receiving Home (state institution) in a straight jacket. This was mandatory, whatever the patient or the nature of the problem. Stoller's report makes it clear that there were no rehabilitation interventions beyond psychiatric treatment such as educational therapy.

This focus on rehabilitation distinguished the RGH from the state mental hospital system. Return to suitable employment was a central feature of the program. A recurring problem for the mentally damaged veteran was securing a sympathetic employer who could

⁴³ Australian Archives SA D2048/0, G1220. Report of Specialist in psychological medicine: Visit to Adelaide. February 1949.

⁴⁴ Australian Archives SA D 2048/0, Item G1220.

⁴⁵ Bill Salter took a special interest in alcohol problems. He noted a breakthrough with Antabuse, a chemical that acted as an aversive stimulus when administered with a bottle of beer or stout, became

make allowances for emotional changes and reduced cognitive functioning. There was no industrial policy in place to ensure this and medical authorities continued to argue a pension was counterproductive. One constructive suggestion was to pay an employer allowance to compensate them for inefficiencies in the mentally damaged employee. This came from Dr Fry (who had served in New Guinea), the chief medical officer with the local Board of Health in the City of Adelaide, who raised the problem of servicemen and women suffering from war neuroses receiving treatment. He pointed out in a letter to the Commission in July 1945 that the hospitals were staffed by trained specialists and equipped with facilities for graduated exercise, but:

Cure depends on the successful re-adaption [sic] to employment and social conditions in civilian life. Many will need outpatient oversight during this period of re-adaption. Some will require occasional treatment for the rest of their lives, many will break down, some on repeated occasions, and will require periods of in-patient hospital treatment to rehabilitate them.⁴⁶

Fry acknowledged that the Repatriation Commission did take over these cases as they were discharged from the existing military hospitals, but there was an urgent need for the provision of treatment of discharged sufferers in specially staffed and specially equipped hospitals. Having been personally interested in the treatment of such neuroses for twenty-seven years through the Pensions Appeal Tribunals, he believed that pensions for 'discharged sufferers' was one of the most difficult of all repatriation responsibilities. He was convinced that 'sufferers are weak in self-confidence and their symptoms are those of fear'. Their fear stemmed from financial insecurity that could perpetuate or even increase disabilities. The cure of their neurosis demanded 'long continued uphill efforts to hold their jobs and a normal place in the social life of the community'. Fry argued that granting a pension actually added to their sense of insecurity, undermined their will to maintain themselves in employment, and resulted in the becoming 'lost souls in what they feel to be a hostile and ungrateful world'.

Fry emphasised the important role of the employer who by and large would find that these men were touchy, difficult and inefficient workers. The solution was to provide a

available as a treatment for alcohol abuse in the late 1940s. The patient would subsequently experience severe headaches and hot flushes, thus establishing a conditioned aversion to alcohol.

⁴⁶ Letter, Australian Archives SA: D2048/0, Item G1220.

special subsidy to employers for neurotic workers. Under this arrangement the margin of inefficiency of each sufferer from war neurosis could be determined at appropriate intervals by a special board, which might possibly include lay industrial experts as well as medical. Such a scheme would give full assurance of economic security and any progress towards recovery would not involve any alteration in financial status.⁴⁷

This suggestion was received favourably by the Deputy Commissioner for repatriation in South Australia, who commented, 'I think Dr Fry's suggestion in his last paragraph is a very good one and recommend it be referred to the Commission for favourable consideration'. There is no correspondence or documentation on the outcome of this, but from a review of the general provisions, it is clear that this option was not taken up.

The repatriation facilities were intended to prevent the contagion of war neuroses from spreading into the community. Suicide and the high incidence of alcohol abuse were two indicators that this aim was not being achieved.

Suicide, a sign of serious underlying disturbance, was a major issue in the post-war period and in the repatriation system. The raw face of suicide can be seen in a patient (CWF) who took his own life 7 May 1948.⁴⁸ He had been admitted to the Daws Road hospital on a Friday evening. Earlier that day his wife had contacted the hospital saying that he had been violent and was choking her. CWF left the hospital without permission and was later found dead at home after an overdose probably of sodium amytal. The conclusion of the Medical Superintendent was that

So far as my knowledge of subsequent events is correct, it appears that the ex-member died following the taking of certain substances, the nature of which is unknown to me at present.⁴⁹

Suicide and attempted suicide continued among patients. In 1959 a report and administrative instruction addressed the issue of suicides. In the same administrative instruction there is an appendix recording the individual suicide attempts made between July 1949 and March 1953.⁵⁰ Only eleven of the 140 cases recorded were successful and the

⁴⁷ Australian Archives, SA: D2048/0, Item G1220

⁴⁸ Repatriation General Hospital Memorandum, RGH.91, 25 May 1948.

⁴⁹ Australian Archives SA: D2048/0, Item G1220. 28 May 1948.

⁵⁰ Administrative Instruction No. 60/76; G.8/4/122. Because attempted suicide was a misdemeanour, not a felony, under common law in South Australia suicide among patients raised

most common method of attempted suicide was the use of some kind of poisoning, including an overdose of phenobarbitone, a drug administered by the hospital. The second most popular method was some kind of violent act such as slashing the wrists or slitting the throat. The use of arms, or shooting, was only recorded in four of these cases. This window on the distress of individuals under treatment in one provincial setting can be assumed to be indicative of a wider problem and evidence that the control of the neurosis 'disease' was not entirely effective. One possibility is that a lot of very disturbed men still alive more than five years after demobilisation, were distressed enough to attempt suicide. In the majority of cases they were not very skilled at it, even though they had been trained to kill. It may be that in many cases these men were making a cry for help either in response to some intrusive traumatic experience, such as nightmares, or a response to the frustration and depression at not being able to get their lives back in order.⁵¹

Suicides were a reflection of a troubled group of men, as much as it was an indication of the shortcomings in a system designed to help them. Any criticisms of this system were kept in-house, and not aired in public. One example of criticism is a report to the Deputy Commissioner, Repatriation Commission in Adelaide by the medical superintendent, AB Anderson. In May 1948, Anderson clearly stated that he wished to draw attention to the 'unsatisfactory facilities existing at this hospital [RGH at Springbank] for the treatment of psychiatric patients'. It was unsatisfactory because of the 'mixing of mild cases exhibiting neurotic symptoms with psychotics, the lack of staff trained in the treatment of such disorders, and the lack of proper facilities for restraint and supervision of patients who may be a danger to themselves and others'. This statement was in response to the problem of the Commission wanting to avoid the admission of patients to institutions where certification was necessary. The certification of insanity in order to be sent to somewhere like Parkside

serious legal issues for repatriation staff. The Commission decided that when a patient was admitted to an institution for treatment, and their condition might reasonably suggest that a crime had been committed, such as a Regulation 66, a case treated for a bullet wound, then it was the duty of the officer in charge to report the matter to local police.

⁵¹ Not mentioned in the official reports was the suicide of a senior psychiatrist, and how this might have affected the morale of the unit. This was verified by a number of interviewees, including Sister Henderson who was in charge of the ward, and Dr Keith Le Page who worked as an intern and the partner of the Senior Medical Officer of the time.

Mental Hospital had an obvious stigma. The letter stated that 'neurotic patients are treated in psychiatric wards rather than in general medical wards.' And,

Since I've been Medical Superintendent at this institution, the atmosphere in the psychiatric block has been anything but conducive to the peace of mind and general welfare of patients suffering from minor degrees of neurosis. Treated in the same wards as these patients, are noisy hysterics, noisy schizophrenics and other psychotics.⁵²

He argued that either the psychotics should be treated elsewhere, or the patients with anxiety states, nervous exhaustion etc, should not be treated in the psychiatric wards. And he had stressed the point to the visiting psychiatrists that:

A considerable risk is being run in retaining patients in a psychiatric block at this institution who are actually or potentially suicidal. Many orderlies who have had little, if any training, are of little use in the event of an emergency in the psychiatric wards owing to their lack of familiarity with the proper methods of handling psychiatric cases.⁵³

Psychiatrists wanted to avoid certification of patients, even if 'in the interests of safety of patients and staff, and in the light of the present facilities available, a receiving home is a more satisfactory place for the treatment of such cases'. Difficulties with such patients arose at weekends and to some extent at night, and again reference was made to the case of C. W. F. who had committed suicide and who had not been kept under restraint and supervision when he was admitted to hospital. A more positive spin was put on the facilities by Major General G. F. Wootten, the chairman of the Repatriation Commission on 29 April 1948. In relation to war neurosis and mental illness, he was reported as saying

The psychiatric services of the Commission endeavour to deal with the cases that come into its hands as promptly as possible. In fact it aims at actually preventing cases from developing, and the up-to-date methods of mental hygiene will contribute materially towards bringing this about.⁵⁴

He also stressed that the desire was to give the most modern form of treatment to sufferers of war neurosis and mental illness.

Dr Alan Stoller was appointed last year as the Commission's specialist in medical psychology. The treatment in many cases is a matter of bringing to bear, under the

⁵² Australian Archives SA: D2048/0, Item G1220. Confidential memo 16 April 1948.

⁵³ Ibid.

⁵⁴ *West Wyalong Advocate*, Thursday 29 April 1948. Australian Archives SA: D2048/0. Item G1223.

guidance of the doctor in charge of the cases, the best efforts of the team which includes a clinical psychologist, skilled nursing staff, occupational therapists, psychiatrists, social workers and education and training officers. It is proposed to use the outpatient facilities to the full, keeping the man in his ordinary domestic and industrial surroundings, admitting him to a repatriation general hospital if modern therapy necessitates this, using mental hospitals for the acute episodes, and return to an outpatient treatment as soon as possible⁵⁵

The psychiatric facilities at RGH developed gradually, and by the 1950s the range of services had expanded to include comprehensive vocational rehabilitation.⁵⁶ Rehabilitation was thus a balance between treatment and preparation for the outside world. The rehabilitation team comprised a psychiatrist, a medical officer, nurses, occupational therapists, a vocational guidance officer, an education officer, and a social worker. The normal procedure for entry into the unit was via a referral from a general practitioner or from the Keswick Outpatients' Department and the duty administration doctor in the general section of the Repatriation Hospital. A psychiatrist determined placement, and case management centred on a case conference of all personnel. Diagnoses were three broad categories of anxiety, depression and psychotic disorders. Alcohol abuse was still a major problem, and the DTs was not an uncommon experience.

In the one institution as Tom's story illustrated at the beginning, patients would be treated with ECT, group therapy or even full and sub-coma therapy as well as engaging in skill development in the occupational area and workshops. A practitioner in 1953 described this as "milieu therapy" that provided a supportive environment for containment and resettlement. There was no dynamic exploration of traumatic memory and the idea was to create a close healing community and rather than focus on war trauma. Psychologists were largely confined to the provision of vocational guidance and placement, and clinical assessments (Rorschach was a popular instrument), but had little to do with policy. Treatment was managed by psychiatrists, and social workers, nurses, and psychologists carried out supportive roles under supervision or medical direction.

⁵⁵ Ibid.

⁵⁶ This brief description is mainly based on the testimony of Dr Keith Le Page, who worked as a young doctor in the psychiatric ward at Repatriation Daws Road Hospital from 1953 to 1954. His story provides an important ethnographic account of life in a psychiatric ward and indicates that little advance had been made in training and treatment.

There was little encouragement to explore the psycho-dynamics of the veteran's symptoms. Readmission rates were high and there was a hard core of 'inadequate personalities' with major psychological problems. Treatment was palliative rather than curative. After a period of debilitating anxiety and worry in the world, a readmission and hospital stay provided patients with the opportunity to 'recharge their batteries, and allow them return to the community refreshed'. The discourse in the psychiatric clinic was about their current dysfunction - how they functioned in their current social environment of home life, relationships, their lack of economic opportunity and the conflicts they experienced in their community – rather than their original traumatic experience.⁵⁷

WA Dibden, who was senior psychiatrist at RGH from 1947-49 was a key contributor to the developments in South Australia. Like Stoller he began his career as an army doctor and ended up director of psychiatric services in his state. Dibden enlisted for full time service with the AIF on 1 October 1941 and, because of a childhood illness, was classified B2, 'fit only for indoor duties' and was posted to the Woodside army camp as a relieving medical officer.

When he returned to Adelaide, Dibden was appointed to the 105 Adelaide Military Hospital, known as the Daws Road Hospital, and later as the Repatriation General Hospital (RGH). With his minimal training behind him, he was appointed as a full time psychiatrist. He describes the psychiatric facilities

The psychiatric wards were of a temporary wooden construction but were nevertheless satisfactory for the times. The treatments were those I had learned at the course. Convulsive therapy; Cardiazol and modified (sub-coma) insulin therapy for its calming, tonic effect. I did a good deal of superficial psychotherapy, mainly explanation, reassurance and suggestion. My interest in the need for complete openness and honesty with patients probably derived from this experience. I found that a lot could be done for anxious soldiers returning from traumatic combat experiences, the so-called war neurosis, by a thorough explanation of the nature of their symptoms, and in many cases the physiological basis of the disorder.

I can remember helping some returned soldiers with severe startle reactions in this way and there was one man who suffered from hysterical paraplegia. I was able to demonstrate to him that he developed the spasm of the agonist and antagonist muscles whenever he tried to move his legs. An explanation of the physiological nature of this disturbance, together with the elucidation of its psychological link with a precipitating traumatic experience, helped him to respond satisfactorily and fairly rapidly after many months of incapacity.

⁵⁷ Keith Le Page, who worked as an intern at RGH in 1953/4, is the main informant for this period.

We had bromide, chloral and paraldehyde for sedation. The safest was paraldehyde. The great disadvantage was its powerful smell. It was excreted in the breath and the ward would reek with the pungent distinctive smell if it were used at all extensively for night-time sedation. There were barbiturates such as phenobarbitone, beronal and medenal, and the longer acting drug sulphanol.

While at Daws Rd Dibden maintained an active interest in research and publishing. In one study he reviewed 323 soldiers treated for psychiatric disability between February 1942 and March 1943 at RGH and found clear evidence of the enduring effects of war neurosis. He used phrases like 'large numbers of psychiatric casualties flooding into civil life' and 'psychiatric casualties returning in continuous streams' and argued that the unresolved fears in war did not disappear in civilian life.

The ex-soldier discovers to his cost that the symptoms he sought to escape by severing his association with all things military retain their ability profoundly to affect his peace of mind and his physical health. This projection into civil life of neurotic symptoms that have in many cases become overt during military service forms the basis of repatriation psychiatric practice.⁵⁸

He regarded the existing facilities as inadequate and it was likely that 'a large number of psychiatric casualties will flood out into civil life with their symptoms unrelieved'. Moreover he considered a pension a disadvantage, which 'to the neurotic serves as a prop to his self-esteem and represents partial security. A pension serves no useful purpose'. A cure would bring insecurity, so the solution was not to give a pension in the first instance and make sure that he was 'cured' before discharge.

With the support of the Repatriation commission, he also undertook a research project to elucidate the 'physiopathological' substrata of war neurosis in 1944. Working on the hypothesis that war neurotics displayed continued hypersensitivity to noise, he measured respiratory response to recorded war noises. He observed that those with marked sensitivity to noise evoked vivid mental pictures of war and could be desensitised to noise. Further research observed radial pulse response to the recording using an electrocardiograph and an electric cardio-tachometer. He persisted with this research until at least 1946.

Even though Dibden was energetic and innovative in many areas he remained conservative in his view of neurosis. In a number of places he repeated the view that

⁵⁸ Dibden W. A. (1945) Psychiatric casualties as a repatriation problem. *Medical Journal of Australia*. 1,3; p. 49.

neurosis was a form of individual weakness. In 1945 for example in an address at a meeting organised by the Red Cross Society in Adelaide he stated that ‘psychiatric investigation of war casualties has shown that in the majority of mental breakdowns, major and minor, there was some evidence of maladjustment prior to enlistment’. He enlisted Freud to explain how a man could break down under strain – it was the result of unresolved conflict between instinctual desires and the demands of a war society. He was quite definite that mental derangement is the result of deep inner conflict, for the most part unrelated to current events’. And ‘the man who breaks down was possessed of an unstable nervous system before enlistment’. Under pressure it was the ‘constitutional factor that decides how much stress a man can withstand’.⁵⁹

A report in 1962 by the new consultant in psychological medicine, J Hurt and the Assistant Commissioner for Repatriation, C. A. Nettle, found that the rehabilitation system required an overhaul and recommended implementation of a fully integrated system. There were no new psychiatric diagnoses and the report restated the acceptance of psychoneurotic, psychotic, or character disorder classifications. The most common disorder, psychoneurosis, was defined as an ‘emotionally caused disorder without the presence of an organic disease’, and always occurred where there was some mental conflict. War trauma was not considered relevant other than being an occasion when a conversion of symptoms occurred.⁶⁰

CONCLUSION

The specialised psychiatric rehabilitation programs for veterans that did emerge in the repatriation system after WW2 had the following features:

- Psychiatrists were the architects and managers of programs
- Treatments were primarily aimed at immediate relief of symptoms, not long term psychotherapy
- Interventions were constrained by administrative, economic and political realities
- Resettlement in work was a central plank in programs
- Family members were marginalised and not incorporated into the therapeutic program

⁵⁹ Lecture delivered by Dr W. A. Dibden at Red Cross House 3 March 1945, *Psychiatric Aspects of Relief*.

⁶⁰ Hurt, J. H. & Nettle, C. A., *A Survey of Psychiatric Services to Veterans in Australia*.

These WW2 programs were not informed by any new ideas on war neurosis. There was no new body of knowledge, diagnosis, or diagnostic technology, that would differentiate the mental maladies of war from those of civil life. In fact, it was made clear by all within the system that the war still presented 'nothing new to medical science'.

In view of the very limited facilities at the beginning of WW2, significant gains had been made in the establishment of a comprehensive psychiatric rehabilitation by the end of the war. The problem was the early provisions for WW2 psychiatric casualties had very shaky foundations, not the least of which was a limited theoretical base on the nature of war-related disorders.

At one level the services and provisions developed in the Repatriation system were in advance of their time and the architects did learn from their experience. Legislation was enacted to ensure continuing support and funding for psychiatric facilities. The efforts of dedicated men (women remained the handmaidens as nurses, occupational therapists and social workers) had produced a systematic referral and treatment net for the seriously disturbed that was superior to those in civil facilities. These generally humane provisions of the Commission could be seen as responsible medical care and the advances in Repatriation rehabilitation informed the developments in the Commonwealth Rehabilitation Service.

On the other hand, the Repatriation Commission, with its legislative underpinnings and administrative provisions, could also be seen as an agent of social control over the traumatic past of war. This social/professional gate keeping had a number of implications. The first was that it confined the discourse within an administrative/medical framework. The second was that it gave the illusion of being able to control the 'disease' of mental dysfunction and stop the spread into the community. In this it determined the particular way in which mental effects of war would be constructed. Two examples of social impact (alcohol and suicide) described above illustrate that the attempts at disease control did not work. More recent work on intergenerational trauma has confirmed that. The overwhelming conclusion is that the focus on of the 'disease' of the individual veterans and his/her weakness and the failure to promote any radical discourse on the issue confirmed the suppression of any resolution of the effects of traumatic memory. Just how this was made manifest in the lives of veterans will be explored through the life outcomes of veterans.

This lengthy, yet still cursory account of psychiatric rehabilitation in Australia completes the story of the origins of the neuroses of war. This story is a necessary prelude to understanding the experience of those who were to encounter ideas on mental health in the war beginning in 1939. There are two further tasks to complete before exploring lives of veterans. The first is to describe the world they entered when they enlisted and served in New Guinea (Chapter 8). The second is to outline how their experience was accessed (Chapter 9).

April 17, 1948

STOP THESE SUICIDES!

Nerve Clinics Demanded

The tragedy of men whose war-shredded nerves make life a nightmare for them is being tackled by the RSL. The problem is acute, for the number of war-neurotics is not decreasing.

In recent weeks two of these men have committed suicide.

Demand for a new deal for war neurosis sufferers will be made at an RSL executive conference in Sydney next month.

Federal president of the League (Mr. Eric Millhouse, KC) told Smith's this week that he will press the Commonwealth Government for the immediate creation of "worry clinics" in each State.

Long before the war had ended, ex-Service organisations, and eminent psychiatrists, through Smith's, pleaded the urgency of a more realistic and sympathetic approach to neurosis.

In the last 12 months the outlook of Repatriation has broadened considerably. Pension claims for neurosis are now beginning to get the attention they deserve. But pensions are not enough.

That grim fact is underlined by the two tragic suicides—one in South Australia, and one in Sydney.

The South Australian case was so shocking as to provoke strong comment from the Coroner (Mr. Cleland).

of neurosis among ex-servicemen. Handling of neurosis sufferers requires sympathetic understanding, he said, because the men often do not want to admit their condition to themselves, much less discuss it with others.

A 21-YEARS-OLD Australian soldier, who was convicted and sentenced to nine months' imprisonment by a Queensland Civil Court for an alleged offence against the Army, was subsequently found to be mentally deranged and transferred from gaol to a mental hospital.

While a patient in the mental hospital he received his certificate of discharge from the Army, which gave as the reason for his discharge:

"Having been sentenced during his service to imprisonment by a civil court."

IS THIS REHABILITATION?

Doctor On Treating War Neurotics

If we are to deal rationally with the psychiatric casualty of war, an entirely new approach to the problem is necessary, says a South Australian doctor, Dr. W. A. Dibden, of Glenside, in an article in the current "Medical Journal of Australia."

Dr. Dibden is a retired captain of the Australian Army Medical Services.

Among points he makes are that:

Because of the constant flow of casualties and the ever-present demand for beds, it is often impossible to keep a patient in hospital as long as is really necessary for complete rehabilitation. A general military hospital is not organised to handle psychiatric casualties effectively.

WARNING GIVEN

Page 22 — **Smith's**

August 3, 1946

A "SMITH'S" SURVEY

Neurosis Is Our Biggest Post-War Problem

No grimmer chapter in war's aftermath exists than the official disregard of "war neurosis" cases.

Official figures in the Repatriation Commission's own annual report disclose this appalling fact — that nervous disorders and kindred complaints have taken greater toll of our fighting men than enemy bullets, bombs, and shells.

COMPARE these figures of pensions granted from the annual report:—
Wounds (gunshot), shell, bomb, bayonet, etc. 3640
Neurosis, psychoneurosis, mental disorders and nervous system cases 5890
Only other comparable figure is, for "accidental injuries or wounds," 5816.

That means that of \$5,766 pensions being paid, the terrible proportion of more than one-sixth is for "neurosis cases and mental disorders."

Moreover, according to the Air Force Association, there are no fewer than 67,000 ex-servicemen whose claims to be accepted as suffering from various forms of neurosis have been rejected by the Repatriation Department.

Question of neurosis cases was

taken up with Repatriation by "Smith's." Deputy-Commissioner Carswell said he could not verify the number of claims said to be rejected. But he went on to say that the Government had appointed a Special Committee to report to the Commission "on the whole question of neurosis in relation to war service." The Committee, he said, has presented its report, but it is not available—at least, not yet.

ASKED if the Committee had been appointed as a result of the claim that 67,000 sufferers had sought recognition by Repat, Mr. Carswell said: "As a result of the whole question, generally."

As is generally known, the Commission maintains a special

ward for ex-Service sufferers. It is in the Callan Park Mental Home, Sydney. This houses some 220 patients.

Whether it gets cures is problematic. Mr. Carswell put it this way:

"There have been some discharges. That is when patients are well enough to go home to the care of relatives."

He also said that latest methods of treatment were available for patients there.

Altogether, throughout Australia, there are some 600 patients in Mental Hospitals. It is obvious, therefore, that the Commission's efforts are more concerned with confining serious cases, pensioning others, not accepting the larger numbers who need sympathetic care and specialised treatment to get them on

the right path and into civil life. Some of the pensioned men are treated on an out-patient basis.
For those 67,000 who need treatment now, a Macquarie Street (Sydney) psychiatrist, in an interview with "Smith's," makes a special plea.
"These men need expert treatment, in line with the latest research into the field of mental



CHAPTER 8

NEW GUINEA 1942: War, Tours of Duty and Sites of Memory

This chapter briefly describes the conditions in New Guinea, particularly in 1942, within a context of a typical tour of duty in WW2.¹ An appreciation of the conditions there is essential for understanding this experience of the informants in this thesis. I have chosen the period of 1942 because it encompassed the most strenuous period of the Pacific war for Australian troops.

1942 was a critical period in Australian history. Japan entered the war after Pearl Harbour was attacked on 7 December 1941. Singapore fell on 15 February 1942 and on 18 February Darwin was bombed. By the end of February most of the 22 000 Australian men and women prisoners of war had been captured and were at the beginning of over almost four years of deprivation, hard labour and brutality, which almost 8 000 would not survive. With its most experienced battalions either taken prisoner in Singapore or Java, or still deployed in the Middle East, forces available to withstand a major assault from the north were limited. The 2/22 Battalion had been routed in East New Britain in January 1942 and two inexperienced militia battalions (39 and 55/53) were sent to New Guinea as a main fighting force. Other more experienced battalions, such as the 2/27, 2/14 & 2/26 of 21 Brigade, did not arrive until July. All these units found themselves under-resourced and outnumbered.²

In 1942 New Guinea was a territory administered by Australia. The major New Guinea campaigns, apart from the Milne Bay battle, took place in the Owen Stanley Ranges and the northern coast, which in 1942 had no existing infrastructure such as roads, power, medical facilities and communication. A few mountain airstrips made landing possible for smaller planes. The Kokoda Track, which has assumed a legendary status in the memorialising of Australian military engagements, is the most popularly

¹ New Guinea will be used to refer to the whole of the Papua and New Guinea regions. Port Moresby and Milne Bay, two of the major sites for Australian troops, were on the Southern or Papuan side of the mainland. The main outer islands of Bougainville and East and West New Britain will be referred to as separate regions. Papua New Guinea which includes the mainland and outer islands, including New Ireland, Bougainville and East New Britain as well as the smaller islands were not incorporated as a nation until 1976.

² For a more complete historical account of WW2 see Long, G. (1972) *The Six Years War*. For the total period of the war in Papua and New Guinea, 170 000 Japanese and 14 500 Australians died (see King & Rank, 1980).

known battle site.³ The military features of the Kokoda, Gona and Buna battles are important because they frame the responses and experience of participants in this study, but is not necessary to set out all battle detail, which can be found in military and historical accounts.⁴

WAR AND TOURS OF DUTY

For the purpose of this study the personal experience of this period is the central focus, but some further background is necessary for context. This 1942 New Guinea period needs to be placed in a context of a tour of duty for an Australian soldier. To preface this I will provide an insight into the formation of a battalion, and the transformation of civilised men into fighting men. The two main battalions represented in this thesis, the 2/27 and 39 Battalions, differ only in their origins and degree of battle experience.⁵

One further prefatory remark is needed. A tour of duty needs to be viewed within the context of the nature of war. A war or major battle is not a random act of violence as many acts of violence might be. While some military actions have been spontaneous or chaotic, waging war is normally an organised and contemplated act, requiring a great deal of planning and human ingenuity. In addition, war necessarily involves directly or indirectly killing other people, or at least destroying their equipment and support structures. When young men volunteer, or are conscripted, from civilian life to join an army, they have to be transformed into men who are prepared to kill and effect destruction. It goes without saying that war can also be highly dangerous, with a much higher probability of being killed or maimed than in civilian life. As Bourke (1999) points out in her extensive analysis of killing in wartime, soldiers learn to do things that are heavily condemned in civilian life. In civilian life, wilful murder is a crime and will

³ This is illustrated in a number of ceremonies at the site in recent years, especially in the Australia Remembers campaign 50 years after the end of WW2 and at the anniversary of the Kokoda campaign in 1992. In an Australian Army documentary film of the campaign, *The Bloody Track*, Dr David Horner, Australian Defence Force Academy, and the official army historian for the project, described the campaign as the turning point in the war which would 'rank right up there with the Gallipoli Campaign'.

⁴ See Joan Beaumont, *Australia's War 1939-45*, Chapter 2; Lex McAulay, *Blood and Iron*; and *To the Bitter End*; Peter Brune, *Those Ragged Bloody Heroes*, and *Gona Gone*; and Margaret Barter, *Far Above Battle* (especially Part Three); Victor Austin, *To Kokoda and Beyond: The story of the 39th Battalion 194-43*.

⁵ The 39 and 53 Battalions went straight to New Guinea for their first experience of battle, and had no experience in the Middle East.

be severely punished. In wartime, killing is sanctioned and rewarded. The young men in the AIF and militia units in WW2, most of whom came directly from civil life where they were not violent, had to be turned into men prepared to murder under certain conditions. In most armies it is only the front line troops who are required to do this work, with the rest either in command positions removed from the front line, or in support positions such as intelligence, stores, signals, catering, or stretcher bearing.

The informants in this thesis were ordinary civilians with no record of homicidal or criminal behaviour, and like the British soldiers seen by Sargant in 1942 in Britain, had good pre-war work records.⁶ A minority had received some training in pre-war militia units, but most moved directly from civilian occupations into uniform. The transformation into a loyal aggressor was no accident, and training had physical, organisational and psychological dimensions. This training and the formation of a cohesive company were particularly important in the development of psychological containment strategies for men; that is, to contain their anxiety in battle and to manage their mental stress. According to one commissioned officer of the 2/27, a high school teacher and father of two children, training was

something more than fulfilment of duty. We are training to fit every officer and every man to overwhelm and destroy and slay the aggressor who aggressed from us our liberty, our land, our homes and womenfolk and there is no true Australian man who is not prepared to die to prevent this. The whole object of our training is to build up such a spirit that will force our way to victory or death.⁷

A battalion is a highly structured organisation, normally made up of five companies, a headquarters company and four infantry companies. Infantry companies, consisting of at least 100 men at normal full strength, are divided into platoons of a commanding officer and about thirty men, which in turn consist of sections made up of an officer and ten men. Other sections provide logistics support in Intelligence, signals and mortars platoons. Battalions make up brigades, which in turn have their own hierarchical structure. Infantry training centred on the company. The duty of the company commander was to drill his company into an efficient fighting force. The company

⁶ More detail will be given on these men in Chapter 10.

⁷ Diary of F. B. 1969.

structure and the platoon and section structure were particularly important because it was in these that efficient fighting units were developed.⁸

Training was aimed at producing physically and mentally fit men capable of enduring hardship and performing relatively skilled tasks such as operating weapons, map reading, and simple tactics. Training was also a matter of mind as well as body and developing corporate spirit. When marching in formation the companies were encouraged to sing. For example the 2/27 companies would sing *Old King Cole* and *Mademoiselle from Armentieres*, during route marches. 'Esprit de corps' and teamwork were enhanced by rivalry between companies to see who could outdo each other, particularly on outside exercises, where they could sometimes come to blows. Within a company each platoon commander took an intense interest in the thirty men who were under him, not only in their training and development but also in their general welfare. The other component of the training was skill development.

The sense of personal strength achieved through training, and the strong cohesion of sections, platoons and companies, was partly intended to provide a sense of psychological security. The more hastily raised units such as 39 Battalion, initially not intended for overseas service, had much more limited training opportunities before going into battle zones. In his history of the unit Austin (1988) noted that the 39th was raised in October 1941 and 'training had scarcely begun under a nucleus of 1914-18 veteran officers and NCOs when, during the night of 7-8 December 1941, the Japanese struck Pearl Harbour' (p. 1). By 3 January 1942 the 39th had disembarked at Port Moresby. There they were assigned to labouring tasks such as trench digging, airstrip construction and unloading ships, with little opportunity for training. Poor medical facilities, inadequate clothing and hygiene, ensured a high incidence of tropical diseases and dysentery. The 2/27 had a better training period and battle experience in the Middle East, but was still ill prepared for jungle fighting.

There was no fixed term of service in the AIF, so tours of duty were extensive, and could have lasted up to six years, with an option of applying for discharge after five years of service. Militia units, mostly comprised of conscripts, could be sent overseas when it became clear that Australia was under serious threat from the Japanese after the

⁸ This description is mostly based on information from Lt Col O. C. Isaachsen, former company commander, 2/27, and Commanding Officer, 36 Battalion.

fall of Singapore. A tour would normally consist of periods of intense combat interspersed with long periods of training, waiting, recreation, leave, and travelling.

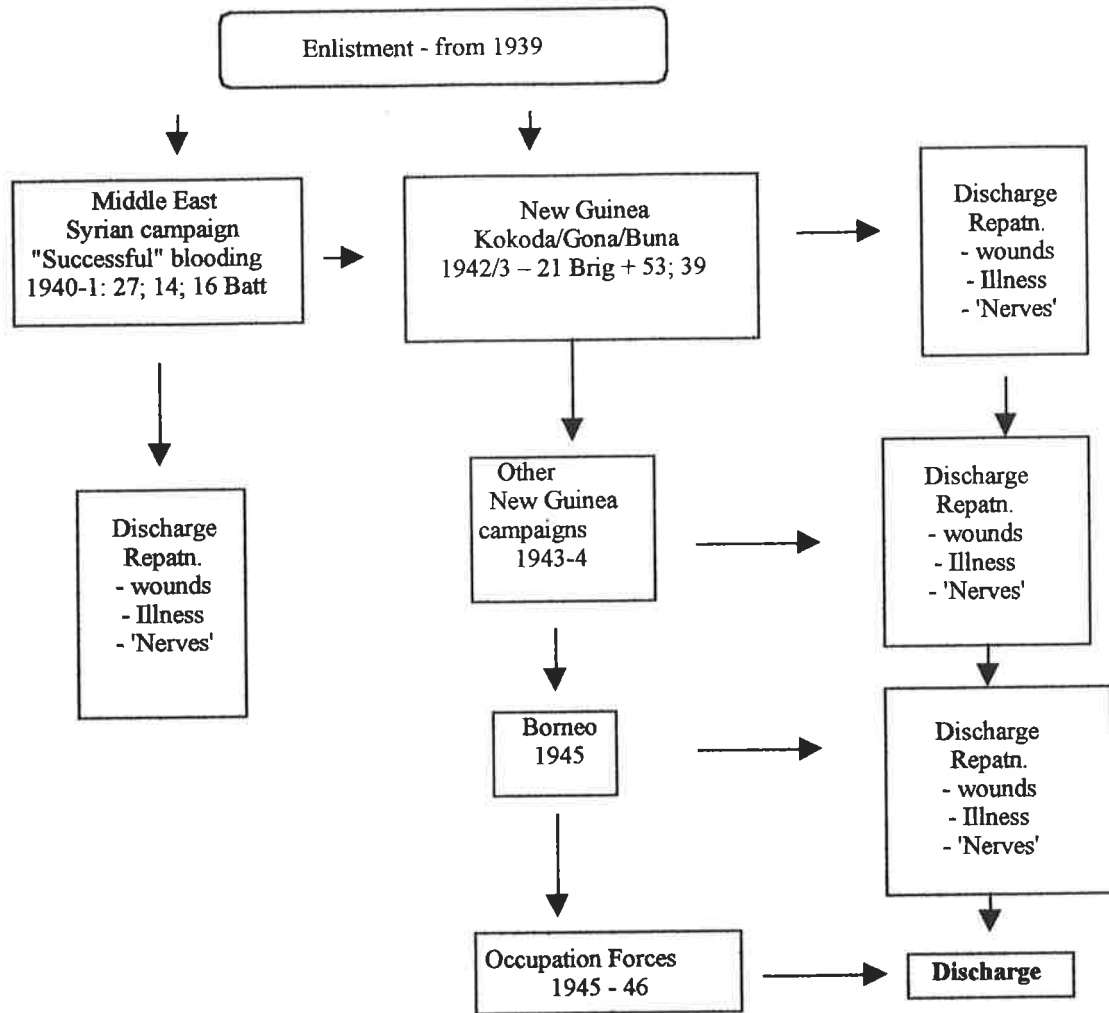
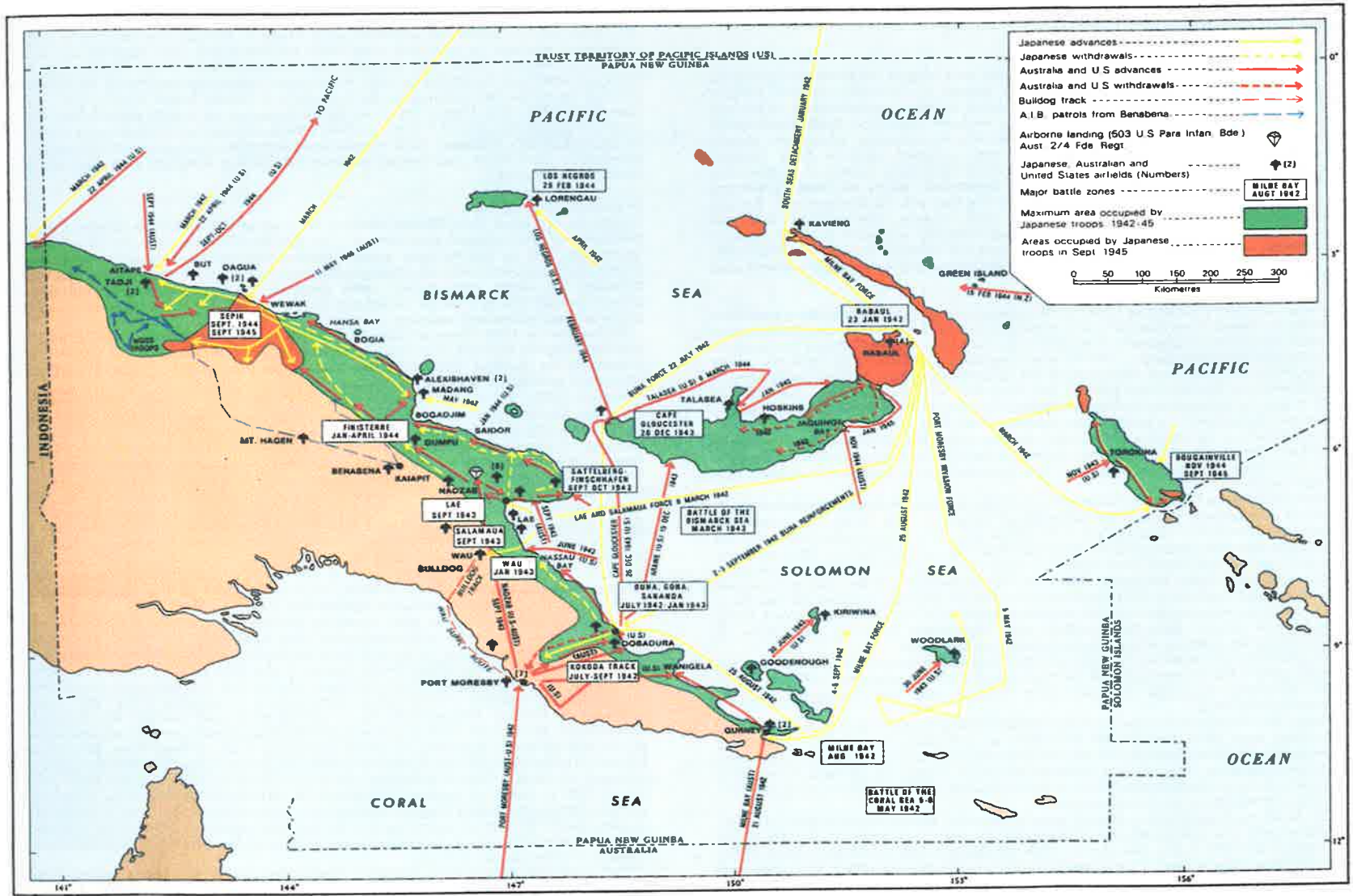


Figure 8.1 Tours of duty in relation to New Guinea campaigns.

Overseas tours exposed troops to new experiences and cultures. For example, the 2/27 Battalion formed in May 1940, sailed for the Middle East in October 1940 to fight against the Vichy French and Germans, returned to Australia in Adelaide 26 March 1942 after the Japanese entered the war, and were sent to New Guinea in July 1942. Those who survived this intense period came back for 14 days recuperation leave in Australia in February, 1943 and returned to New Guinea in the following August. Their

Figure 8.2 Map of Papua and New Guinea showing course of war 1942-45.



last campaign was in Borneo June/July 1945. Active military service has been described as 90 percent boredom and 10 percent fear.⁹

Unless wounded or ill, a WW2 veteran could have spent up to six years in service and have fought in at least two theatres of war. After the New Guinea campaigns many units took part in the invasion of Japanese occupied territories in the South East Asian sites such as Balikpapan and Tarakan. After the surrender of the Japanese there was still a large job to do, with thousands of Japanese to sort out and repatriate, the repatriation of Australian prisoners, and overseeing the transition of occupied territories such as the Dutch East Indies.

NEW GUINEA CAMPAIGNS

The New Guinea campaigns presented great potential for battle strain. Because there was no defined front line in the early campaigns in New Guinea, all men were in danger of being killed, or were required to engage in dangerous patrols and close fighting. They all carried weapons and could be called upon to fire, and would be fired upon. Even medical personnel and some chaplains carried a side arm. All senior officers, many of whom were killed or seriously wounded in New Guinea, were directly exposed.¹⁰ In almost every aspect, the New Guinea campaigns were potentially traumatic for those participating. The general features of the New Guinea conflicts were:

⁹ Even though not as traumatic the times of boredom or inactivity could be as stressful as battle. David Sheppard, of the 2/27th found that waiting around was very boring and stressful, especially when there were no books to occupy the mind. At night in New Guinea when there were no lights for writing and reading, the lack of mental challenge left him only with his thoughts he would get very depressed. Waiting, according to the 2/27 medical officer often brought an increase in psychosomatic complaints.

¹⁰ For example Lt Colonel W. Owen, the Commanding Officer of 39 Battalion was shot through the eye while throwing a grenade; another senior officer Captain S. Templeton died about the same time. See Austin (1998) *To Kokoda and Beyond*. Melbourne University Press, pp. 91 and 97.

- Exposure to serious combat (observable, stereotypical warfare experiences, such as receiving enemy fire, seeing injured or dead colleagues, going on special missions and firing weapons)
- Exposure to atrocities or episodes of extraordinary abusive violence (observable events that might be considered extremely deviant or beyond normal war experiences, including wounding of non-combatants or mutilation of bodies)
- High risk of contracting debilitating diseases such as malaria and scrub typhus
- The general milieu of a harsh or malevolent environment (the extent to which the veterans rated daily war zone living conditions as bothersome, annoying or uncomfortable, including lack of privacy, inadequate food, bad climate, insect infestation, disease and filth).¹¹

The men in this study entered the New Guinea campaign at different points, but all were exposed to these conditions. For individuals this meant all or some of the following:

- Losing and sometimes witnessing a close friend being killed
- Being strafed
- Being ordered to finish off a wounded enemy soldier
- Collecting and burying putrid bodies
- Leaving a dying mate
- Being caught in cross-fire with no escape
- Watching friends die without medical help
- Observing, hearing about or experiencing atrocity
- Sustaining serious wounds
- Retrieving and burying bodies¹²

The Kokoda Track was the most difficult site of engagement for the study participants. The conditions of the track are conveyed dramatically in the following account in the medical report of the Seventh Division recorded in January 1943.

The intense jungle, inducing feelings of claustrophobia, its intolerable quietness rent by eerie sounds, the crashing of enormous rotting trees, the narrow tortuous tracks, the knee deep mud with its vice like grip, and the torrential tropical rains. Into this awe-inspiring scene with its oppressive heat by day and bitter cold by night

¹¹ Morris, P., Raphael, B. & Bordujenko, A. (eds) (1999) *Stress and Challenge: Health and Disease*. Brisbane, Repatriation Medical Authority, p. 10.

¹² The greatest fear of soldiers was to be caught alive by the Japanese and be tortured and mutilated. Many would have seen or heard about this.

place the infantryman clad in jungle greens, the only clothes he possesses, assail him with dysentery, malaria and mite bites which ceaselessly itch.

Every few miles bring the track through a small patch of Kunai grass or a small native garden and every seven or ten miles build a dilapidated group of grass huts as staging shelters, generally set in a foul clearing. Leave beside the track discarded putrefying food and occasional dead bodies, and human foulings. Such is the track a prominent politician described as almost impassable to motor vehicles. On this track day after day followed the walking sick and wounded, stretcher cases being carried by native carriers with improvised stretchers. From each staging post at dawn the walkers, the lame and the halt would be on their way while the native bearers would assemble for their task.¹³

Their most intense engagements in New Guinea for the 2/27, 39 and 53 Battalions were between July and December 1942. It was estimated that by August 1942 Japanese forces outnumbered Australians by about 30:1, and the Australian troops could not withstand their attack. For example on 29 July the 39th was overrun, their commanding officer Colonel Owen was killed in the Japanese attack on Kokoda. As Don Simonson and Len Suckling recalled:

They had their drill - as soon as they struck us they were out and around and we would be cut off from the back. They would strike and then surround you. They would outflank you all the time. So I think that was a lot of the cause for the withdrawing. Early in the piece these Japanese were so good they could find their way in the jungle. If we went off the track we would get lost. Afterwards we learnt all sorts of little ideas about going down ridges and going up rivers. Not that we had maps. They must have had maps. They would infiltrate and come up in all sorts of places where you would least expect them.¹⁴

In a counter attack the 39th ran out of ammunition and food, and had to withdraw. After several weeks of fighting, the headquarters of the Australian Brigade was surrounded and the battalions were forced to withdraw. For the 2/27 Battalion, the withdrawal meant three weeks of deprivation, starvation and exhausting trekking through dense jungle and terrain. During this period they had no aerial support, so supply line, no medical supplies, no mechanical help, and no communications. The majority contracted malaria and dysentery, or even beri-beri, and in some cases, scrub typhus, a normally fatal disease. Being wounded could pose a major problem. The only means of medical evacuation out of the Kokoda area was on a stretcher carried over mountainous terrain, with many river crossings. Often men watched helplessly as their mates died of infection from wounds, disease, starvation or exhaustion. There was a

¹³ Seventh Division Medical diary. AWM Archives.

high probability of injury or wounding and if they were caught by the Japanese they would be tortured and executed. The remnants of the units that did survive were publicly humiliated by their Commander-in-Chief, General Blamey, for withdrawing.¹⁵

CASUALTIES

Heavy losses were sustained in the Owen Stanley Ranges and northern coast battles at Gona, Buna and Sananander. The 2/27 lost 39 killed and 50 wounded (one sixth of the battalion strength) in the first two days of fighting on the Kokoda Track (July 1942), while 200 enemy deaths were recorded.¹⁶ In the Owen Stanleys-Port Moresby period 625 Australians were died, and 1 055 were wounded. Of the original Middle East 2/27 Battalion strength of about 1 000, only 330 were fit for the attack on Gona in November 1942. Of those, only 70 men survived the battle unscathed, and not even the senior officers were exempt. The 2/27 Battalion commanding officer Colonel Cooper was wounded, and the Adjutant Harry Katekar as the only senior officer to survive. On Christmas Day 1942, the battalion strength was reduced to 3 officers and 83 men. In all, seven officers and 59 men were either killed in action or died of wounds in less than a month (see Burns, 1960). Burns described the aftermath of Gona, where at least 500 Japanese were killed.

The whole enemy position was a grim sight. Dead were piled high; in many cases they were in an advanced stage of decay, for the enemy had made little effort to bury his dead, and in some cases they were part of a fire step in his defences (p. 153).

The 21 Brigade itself sustained casualties which reduced it to 41 percent of its original strength (see Brune 1991). The 49 Militia Battalion, which served in the same period, was reduced, through death, wounds and illness from a strength of 646 in August 1942, to 316 in December of the same year. The Australian casualties at Gona-Buna-Sananander, for the period 14 November 1942–22 January 1943, were 1 261 officers and other ranks killed, and 2 209 wounded.¹⁷

¹⁴ Interview 5/6/95.

¹⁵ See Brune, P. (1991) *Those Ragged Bloody Heroes*. Sydney: Allen and Unwin, Chapter 13.

¹⁶ Personal memoirs, of FB 1990.

¹⁷ Walker, A. (1957), *The Island Campaigns*, Canberra, Australian War Memorial, p. 99. See also, Long, G. (1973) *The Six Years War: Australians in the 1939-45 War* (1973) Canberra,



Wounded troops of 21 Brigade, Gona December 1942. Australian War Memorial



Padre Begbie tending graves after Gona (below). Photo: Australian War Memorial.

Figure 8.3 Scenes after the battle for Gona, December 1942

AWM. As a comparison, 46 000 Australian personnel served in Vietnam, 1965-1972. There were 1 952 battle injuries and 396 died in battle or from wounds sustained in battle.

Encounters with the enemy and terrain were not the only life threatening events. During wartime there was always a number of accidental deaths. Some men were actually killed by the 'biscuit bombers', the DC3s which dropped supplies. Bundles, including tins of bully beef and biscuits, had to be dropped without parachutes and at high speed they were lethal missiles. There were also more serious catastrophic events which men found difficult to forget. For example, at Jackson's airfield 'there was this four engine Yank plane taking off fully loaded with bombs and fuel and it just touched some trees and ploughed into a truckload of troops - it was devastating.'¹⁸

NARRATIVES

How was the experience of these conditions translated into personal narratives? Almost every survivor of the Kokoda trail campaign has a personal story of how he got back from Myola to Port Moresby. Some of them made extraordinary journeys through the jungle, with the enemy in the hills, unknown dangers ahead but 'homing with the utmost tenacity of men who wanted to live'.¹⁹ Some sense of this is contained in the following recollections. The period of withdrawal from Efogi and 14 days without food and support stretched this group to the limit. The great majority of men only had one day's rations for fourteen days. Bert Ward recalled:

My most outstanding memory is having to take over as a Bren gunner and for about 30 minutes at Efogi I was the only Australian soldier between the Japs and Port Moresby. I dug a few inches out in the ground. I thought 'they won't be able to bury me here'. This Jap jumped up and I put a burst after him. Eventually they brought in a mountain gun and I was told to move back. As I got back I got hit with a piece of shrapnel on the right shoulder, I put a field dressing on it myself and never reported it to the RAP. I never even reported it. After 14 days it had healed. I have never been able to sleep on my right side. After I retired I sought some treatment.

In recalling the New Guinea period most of the informants tended to understate the intensity and difficulties of their experiences. This may have been influenced by an Australian tendency to modesty and reticence but there have been a need to protect themselves against reviving long buried distressing experiences.²⁰ Exaggerated

¹⁸ Dr Jim Fairley, RMO, 2.27 Battalion.

¹⁹ Uren, M. (1958), *A Thousand Men At War*, Melbourne.

²⁰ This is an example of what Lindy (1985) called the Trauma Membrane. See Lindy, J. (1985) The trauma membrane and other clinical concepts derived from psychotherapeutic work with survivors of disasters. *Psychiatric Annals*, 15,3; 153-160.

description was actually rare, and understatement was the rule. An example of exaggeration appears in a letter written in November 1942 by a man who had reported sick after the Kokoda withdrawal. He described:

the terrific battle against odds by men who refused to be beaten. Often surrounded, we would escape into the jungle and reform and fight at another point. It's not that the enemy defeated us, it was the hunger and awful jungle-clad mountains.

It was ambush or be ambushed, crawling snakelike through the undergrowth to get at the enemy, often being surprised in our turn and firing madly into the undergrowth or tearing insanely on with the bayonet, for Japs do not like cold steel. The ferocity and mercilessness, at first, amazed me, but with such hate, where can there be pity. And we were fighting for our homeland and those who are dearest to us, in three months I saw only one Jap left alive and heard of three more.

Most of which were never recovered from the jungle and so our bodies took on a new thinness. Gaunt, bearded, mud-covered men, clad in rags, we pushed on.

How could we let these savage yellow swine live. We who saw some of their treatment of native women and have learned from eye-witnesses of their treatment of captive white women, of the awful fate suffered by the poor creatures.²¹

A more understated account is found in the letters of Clive Edwards (2/27 Battalion), who maintained that 'were no heroes - just men doing a job'. His laconic style, even allowing for his regard for the censor, is reflected in a letter he wrote to his father on 24 September 1942:

The barest and most essential facts are that I have spent the past three weeks in action once again, this time amongst the wildness of New Guinea and that at present I am in a back area resting and recovering ...

As with the previous state of action, the sound and threat of bullets and bombs didn't perturb me greatly but I did find it a physical effort to keep going because the country is indeed difficult. You would have difficulty recognising me at present because I have lost a great deal of weight and down to around about nine stone.²²

On 9 November 1942 he wrote to his father about the withdrawal from Efogi when the whole battalion was at risk.

It was at the time of the Jap advance and a mob of yellow bellies cut the track behind us and we had literally to go bush to get back again and so for fourteen days we made our painful way back having next to no tucker and taking turns at carrying stretchers containing wounded men and yet still having to carry weapons and armour for fear of a surprise attack by the Japs.²³

²¹ Letter from DC to his fiancée 15 November 1942 from Port Moresby. Subsequent investigation revealed that D. C. was suspected on fabricating much of his war story.

²² Stuart, L. & Arnold, J. (1987) *Letters Home 1939-45*. Sydney: Collins, p. 212.

²³Ibid, p 213.

Edwards was seriously wounded in December 1942, and 'the bullet chewed a chink of flesh out of my leg about nine inches below the knee - about three inches in diameter', but,

It was a couple of miles back to the dressing station and believe me I only just made it. The track was crook leading through jungle and mud in places and open in others where the sun belted down on a poor bloke and the noodle whizzed a couple of times on that ten mile journey.²⁴

Most men preferred to remember amusing things that happened as a way of remaining connected with this part of their lives without allowing the more disturbing aspects to intrude. Some humour was macabre. Towards the end of the war a battle hardened soldier might see the funny side of even the most horrendous situation. For example:

Some days later the Japs had retreated and I found myself looking down over a landscape of bodies. They had only died the day before and were already moving masses of corruption and the air cloying with the stench of rotting flesh. One man had fallen so that he was lying partly across a jeep track, and when a vehicle passed over him he sat up. This made us laugh so heartily.²⁵

Medical officers and chaplains provide another perspective on this period and how men coped with it. Chaplains were exposed to helpless situations particularly in their role in burial services. Unlike the doctors they could not mend the bodies of men, only bury them. Harold Norris was chaplain to the 10 CCS and the 2/10 Battalion between March 1942 and March 1943. He recalled that one of his first duties at Milne Bay was to bury men who had been incinerated when a Bren gun carrier had blown up on a mine. He became known as the chief grave-digger in PNG.²⁶

Witnessing could sometimes be slow and painful, and watching one's mates die was one the most frequently reported distressing experiences. Losing a mate alongside you in one shot was distressing but if you were in a helping role such as a medical officer or stretcher bearer or orderly and were powerless to influence the course of death the impact was even stronger. One stretcher bearer, who was left to care for a group of

²⁴ One of his colleagues recalled that he was amazed that Edwards had been able to walk at all with such a wound. Personal communication, CE.

²⁵ Letter from J. Dowie 2/43 Battalion, 2 September 1992.

²⁶ Interview 31 March 1999.

stretcher cases for ten days with little food and no medical supplies recalled that 'The worst thing was watching your mates die knowing there was nothing you could do'.²⁷

Medical officers interviewed were trained for medical emergencies and on reflection found that the conditions, even though they were far from ideal, were not overly stressful. Their worst experience was not being able to save men they had known personally. For example, Dr Jim Fairley, who was initially assigned as medical officer at Base Hospital at Port Moresby, vividly remembers the day a plane ploughed into three truckloads of men at take off, as one of the most stressful of his service. Most of these men died. As a young medical officer Jim Fairlie treated the men burned in that incident and regarded it as one of the worst experiences of his career. He recalled how he felt helpless, and just had to watch them die. Another medical officer experienced the same reaction:

- It is extremely distressing to have your close friends, some both officers and other ranks, brought to a RAP dead on a stretcher and know there is nothing one can do to help.²⁸

GONA

This battle warrants special mention. It was an unnecessary strategy to send men across an open area of burnt kunai grass to attack the well-entrenched Japanese, when the objective could have been achieved in less costly ways. As well as snipers, there was infiltrating fire from machine guns placed so that they crossed fire on the advancing troops. The order to 'attack and capture' Gona, it is now argued, was a political decision which overrode sound military planning and survivors believe it came from much higher than the divisional headquarters in New Guinea. At the time it was a matter of survival, but added to the extreme stress of battle was the potential for bitterness as men tried to make sense of their experience in later life. Lt Tom Kimber described the first wave attack on Gona:

The manner of the attack at Gona was so unnecessary. After Gona Mission the 39 was detailed to go to Gona West and cut off a force of about 160 Japanese and we had to knock them off - at our own pace. We buried over 150 Japanese with about 20 Casualties - it was murder at Gona Mission. We had to do an attack through Kunai grass and were mown down.

²⁷ John Burns personal communication.

²⁸ Personal communication, Dr Don Duffy, RMO 2/14 Battalion.

I was in the middle of my line of thirty men. I lost 11 killed and nine wounded, and two of those died of wounds. I stood out like country shithouse in the middle and all these blokes falling around me. One man had his face shot away and he was only three feet away.²⁹

After the battle, Australian soldiers had to collect, identify and bury their own dead as well as the Japanese. In the official history of the 2/16 Battalion, Malcolm Uren described the conditions when cleaning up the 640 Japanese who were buried in the area after Gona. One task confronting Australian soldiers was a bunker in which rice was stacked on the enemy dead, with ammunition on top. The rice was green with mould and the bodies were in an advanced state of decomposition.³⁰

A platoon leader in 39 Battalion who participated in a bayonet charge on the day before the 'bloody stupid' final assault on Gona, recalled that only 26 of 90 men survived. A Military Cross winner related his worst experience at Gona:

Having to move forward foot by foot against heavy machine gun fire and well concealed Japanese defences, eliminating one stronghold at a time, in effect hand to hand fighting; then being carried out wounded on a stretcher for two or three days.
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In fact he had captured a machine post single handed, led his platoon to take out another post and was wounded while dressing the wound of a fellow officer.

Another life-threatening situation was being wounded, but this was not always perceived as traumatic. One survivor described his wounding at Gona Beach:

I was in a very shallow hole with one of the officer's batman and this bloody sniper was after us, and after a couple of shots I said 'this is no bloody good, we'd better get over to this tree over here'. I only got about two or three crawls and I got it. It was a feeling I will never forget (at 87 years of age). It was just a feeling as if I was hit with a stone wall, and gradually and slowly going backwards on my back. The two of us struggled up to the tree and I was going every few yards and falling over. My left hand and arm were broken and I kept pulling it over but next time I fell over it went again.

Strangely enough I did not have any feeling at all. Did not even feel it hit me. I think I slept the night in a field hospital. Bill Badser a bloke from Mt Gambier died alongside me that night. Next day they put me in a jeep and it was just like going over steps. By Hell it was rough. When I got back to Popondetta they sent me back to Port Moresby.³²

²⁹ Interview TK.

³⁰ Uren, M. (1959), *A Thousand Men at War: Story of the 2/20 Battalion*, Melbourne, Allen & Unwin.

³¹ R. Plater November 1994

³² Interview HS April 1992.

Another survivor, Bert Ward, recalled his experience with no distress. As a Bren Gunner during the Owen Stanleys he had to take over while the rest retreated, and he had the distinction at that point, of being the northernmost Australian in the Owen Stanleys. He had a little cover, not enough to bury him, and a Japanese soldier broke cover to see if Australian troops were still there. Ward was hit with shrapnel early in the Efogi but at the time he did not worry about it.

It felt like a sledge hammer. There was this blackness - I thought I was dead - I had no feeling anywhere - complete blackness - what comes next - there is none of this life passing before your eyes - after a while there was a kaleidoscope of colour flashing across my eyes and then it settled down into nice soft greens and blues and I thought 'this heaven's a lovely place'. I was flat on my back looking up to the blue sky and palm trees.³³

He was able to turn over and crawl back through the kunai to the RAP. He had some movement in one leg. He actually walked by himself back to Soputa and arrived there about 12 hours after he was wounded.

Being exposed in helpless positions was extremely stressful, especially during strafing attacks. Robert Johns remembers being caught in the sea with nothing on and being strafed. In these circumstances there was nowhere to hide and you were 'completely exposed, and could not fire back'.

JUSTIFIED KILLING

Justification for killing Japanese was relatively simple. They showed no mercy themselves and were brutal with soldiers and civilians. Knowledge of or witnessing the results of such atrocity is well established from eye-witness accounts and verified in War Crime Trials, but is a much hidden part of the historical discourse on New Guinea. Eyewitness accounts such as this were common:

I think we absolutely hated the Japanese. Because on our walk up to the bivouac area I was telling you about we saw the result of their treatment of some of the militia boys they'd caught and some natives. There were some of the Seventh Brigade members who had been tied to a tree with signal wire - I saw this with my own eyes - and they had obviously been bayoneted, all marked all over their body - dead of course. There was a native woman with her breast cut off. There was a native boy with his hair burned off with a flamethrower. I thought he had just been shaved.³⁴

³³ Interview November 1992, Bert Ward 2/27 Battalion.

³⁴ Paul Hope, Murdoch Sound Archive interview.

'Take no prisoners' was an unwritten policy in the early New Guinea campaigns, mainly because of the lack of any prison and medical facilities and the refusal of the Japanese to surrender. Killing a captured Japanese, wounded or not, was basically a case of necessity, especially in the Owen Stanley Ranges. Reports in the Murdoch Sound Archives and my own interviews established that in some circumstances no prisoners were taken and wounded enemy were disposed of. John Morgan, who was an Anglican army chaplain in New Guinea and later became a bishop, recalled seeing the body of a Japanese that had been brought in earlier as a prisoner. He did not see him killed but did hear the shot. The moral justification was:

How could they have got him out? It - there were times in which you can say no prisoners of war are taken. Because you can't look after them, you can say no - therefore fight till - it's killing, and you - you don't take them prisoners, they're just not. And that has to happen. This was something that was never discussed.³⁵

William Refshauge, Australian Army Medical Corps, objected strongly to orders being given to troops 'not to bring back any prisoners', and threatened to court-martial anyone he found disposing of prisoners. He understood the order was a form of retaliation for the practice of captured Japanese blowing themselves and captors up with grenades. Refshauge believed the Geneva Convention should have been honoured.³⁶

There is evidence that in extreme situations when the only choice was to leave a wounded soldier to the hands of the Japanese, a decision was made to hasten his death. None of this is recorded in any unit histories, but there are sufficient testimonies to support the view that it happened on some occasions. The practice of killing wounded Japanese soldiers is more readily admitted but again it is not recorded in histories.

Justification for ruthless practices was found in atrocity committed by the Japanese. This fuelled the Australians' distrust and hatred of them, making it easier to kill and not treat leniently. Some men knew of the Tol Plantation massacre of 23 January 1942, at Rabaul in East New Britain, an island to the north east of the New Guinea mainland. After the Australian garrison had been overrun, those captured were tied to coconut

³⁵ Murdoch Sound Archive interview S 752, Bishop J. Morgan, 29 January 1990, pp. 144-148.

³⁶ Refshauge, Sir W. Australian Army Medical Corps; Murdoch Sound Archive interview 2 August 1991, p. 30-32.

palms and bayoneted.³⁷ Some of the 39 Battalion heard of this from their company commander Colonel Owen, who had escaped from Rabaul, and was near the Tol Plantation at the time of the massacre. He took command of the 39th just before the Owen Stanley's engagement, and then warned his men that they could 'expect no quarter', and 'if they catch you that would be the end of you'.³⁸ Similar atrocities were committed by the Japanese in their first attack on Gona Mission, when they massacred civilians at the mission, including nuns and children.

There were a number of examples of atrocities occurring in the Owen Stanley period. John Burns (2/27 Battalion historian), remembers his mates Teddy Churchett and Victor Knot getting 'nabbed' on the Kokoda Trail. They were later found tied to a tree and bayoneted. Owen Curtis related to his Murdoch Archive interviewer that he had heard of 2 officers who had been bound with their own dressings and tied hand and foot with signal wire and bayoneted, doused with petrol and left to burn. He had also heard about a native boy who had been bayoneted in the anus, women with a breast removed and a native tied to a tree and killed. He had also heard of men having to shoot their own men rather than leave them for the Japanese. Further examples of this will be cited in later chapters.³⁹

Another incident was the bombing of the main dressing station (MDS.) of the 2/4 Field Ambulance, and the 126 United States Combat Clearing Station at Soputa on 27 November 1942. Twenty two men were killed, including two Australian Majors. Events like that also had their strange twists. Glenn Williss (2/27) had been admitted to the MDS with malaria but went back to his unit before the bombing. Unfortunately his name appeared on the list of patients and when he could not be accounted for in the survivors, his parents were notified that he was killed in action.

Hatred of the Japanese was sometimes tempered by seeing them in a more human light, which had a softening effect. John Manol recalled a Japanese taken prisoner after the 39 Battalion had recaptured Haddy's Village [Gona].

³⁷ A full account of the Rabaul invasion and Tol massacre can be found in Downs, I. (1999) *The New Guinea Volunteer Rifles: 1939-43; A History*, Broadbeach, Queensland, Pacific Press. The prisoner transport *Montevideo Maru* with 1 035 Australian prisoners from Rabaul was torpedoed by the *USS Sturgeon* 1 July 1942. At least 158 were murdered at Tol Plantation. Sir John Nimmo, Red Cross, interviewed survivors of the massacre and obtained first hand accounts of the atrocities. AWM Murdoch Interview 16 January 1990 p. 45.

³⁸ Interview Don Simonson 5 June 1995.

³⁹ Australian War Memorial Murdoch Sound Archive interview 541/74.

He spoke perfect English and showed remorse for what the Japs had done so far in the war. The last thing I remember about Haddy's village was the bodies of Japanese soldiers left in the open clearing between the huts and the sea. There were at least 100 or 150 of them.

Jim Ashton (2/27), who had left his wife and two children at home while he went to war, found a photograph of a wife and two children on the body of a dead Japanese. He could no longer sustain his commitment to the war and after a bout of dermatitis was transferred home where he spent the rest of the war on guard duty in an internment camp.⁴⁰

PSYCHOLOGICAL CASUALTIES

Given the extreme difficulty in this period, what is the evidence for psychological damage? The only means of classifying battlefield breakdowns was the psychiatric nomenclature of the time, but there was no specifically war-related disorder. A helpful modern term for discussing dysfunction is Combat Stress Breakdown (CSR). This is a complete breakdown under battle conditions and has been recently defined by Solomon (1992), a researcher with the Israeli army, as:

A psychiatric breakdown on the battlefield ... during which the soldier ceases to function altogether or/and functions in such a manner so extreme that he becomes a danger to himself and his comrades (p. 290).

This breakdown could be a response to a single factor or a combination of fatigue, intense fear or extreme danger and is a different experience from someone functioning adequately under pressure of battle but experiencing a stress reaction much later. CSR does address the other experience of someone who functions on the surface but on the edge of breakdown. An example of a breakdown in the field occurred early in 1943.

Yeah, very rough. Not so much, see me being a bit of an athlete, not that I was any good, [actually played top grade football] you see they'd want someone to go out and start up a supply depot, which I did, me and Turner. Well you take about fifty boys carrying their forty pounds up there and start up this supply depot for when they attack Salamaua; they've got to have supplies as you know. Well we were up there quite a while and used to dodge the Japs up there. They knew we were there but they couldn't find us. Anyhow that fell through, and then after several other jaunts, the big show was at Davidson Ridge, which was sitting behind Salamaua. They sent about six of us under escort from the infantry chaps, because it was in the Jap territory, and we got through to there and three of us up on the plateau where they were going to drop the supplies, which we planned out. The Japs let us all in and then surrounded us, and it was a hell of a mess. My two mates up there

⁴⁰ Interview JA.

were hit, and I covered them while they got out and then I jumped over the edge. And I thought Jesus ...

I dodged around and dodged the Japs and jumped over the edge, and went bush. I didn't know where I was. That was when I got lost and things weren't too good after that. I was lost for a couple of days, but it seems twelve months when you're out there in the Jap territory. I could see Japs all the time, and I'd hide and then go through. I knew the only way to find my bearings was to get to the top of the hill and look around. I did that, found Mt Tambu in the distance, and headed for it. When I got back there, well I just broke up.

[Was there a build up to the breakdown or was it just that one incident?]

No, no I was pretty right. Well we'd had some very nasty experiences. One show we were going to one of these supply things and I bumped into some officer; he'd been wounded. He was in a pretty bad state and I started to help him get through the creeks and rivers there and of course night fall fell and we were miles behind the other couple of blokes and of course we got tangled with the Japs there.

[It wasn't too good?]

None of it. You've got to be lucky you know. Bullets all around you and you don't get hit.

But you can see the blokes going [mentally]. When we were at, oh I don't know where it was, we were down this slit trench, and they were dive bombing us. I said to Alec, 'I didn't know they had a two engine dive bomber.' He said 'shut up.' Bloody plane up at about ten thousand feet, and he's telling me to shut up. That's how they start to go you see. A lot of them ended up the same way. I remember up at Kokoda we knew the Japs were down in the valley and they were coming up. They positioned us at the top of the trap to catch them as they came over you see. Young what was his name, doesn't matter, he walks up the bloody track and I was just going to put a bloody bullet through him and I realised it was one of ours. Silly buggers they do silly things.

You're not normal and you do silly things. Things were not too good - I just broke up. I was in a terrible state. I couldn't stop crying. That was a good thing the doctor told me. He said you don't want to feel ashamed at that, that's nature's way of getting rid of it. I just got to the point where I could not take any more - I don't know whether it was fatigue or nerves - a bit of both I suppose. I got back to the unit and I cried and cried and cried. I realised then I was in a bad way. That's when I met Dr Fry and he said - 'you are finished son.'⁴¹

Accounts such as this do not exist in any official documentation. The official story is that psychological casualties, based on records of actual admissions and diagnoses, were minimal. Walker, the medical historian of WW2, described the conditions of severe strain and constant threat under which men operated, but concluded that 'nervous disorders were on the whole uncommon' during the Owen Stanleys campaign. His general summation of the South Pacific campaigns:

During the Owen Stanleys campaign few neurotic casualties were seen; Robinson records that he saw only three who needed evacuation. In an action which called for

⁴¹ Interview with K. H. Fry, later became the medical consultant to the Adelaide City Council.

fortitude and unselfish endurance of a high order, this again reflects the spirit of the men and their leaders.⁴²

In general, Walker tended to discount the contribution of actual battle stress to these casualties. He noted that in one hospital, of the 343 psychiatric casualties for May-October 1945, battle stress was non-existent in half the number. In other words, only half had a 'just cause' for their condition. He also pointed out that psychiatric 'casualties' increased in non-combat areas as well during the war, some of them correlating with the increase in troop numbers.

Sinclair (1943) surveyed 310 psychiatric cases in the Australian General Hospital at Port Moresby between September 1942 and January 1943. He noted the extreme conditions, which he considered of psychiatric significance, where men 'were tested to the limit of their endurance', and where 'their primitive aggressive tendencies were exposed'.⁴³ Psychiatric casualties comprised only 2.1 percent of admissions to general hospital. He observed that there was no significant difference between the casualties from the militia and the AIF, and the distribution of officers and other ranks was similar to his sample of patients in Tobruk (Cooper & Sinclair 1941). Admissions were classified as anxiety and fear states, hysteria and personality inferiority. Inferiority encompassed the inadequate soldier, schizoid or paranoid types and frankly psychotic. The majority of cases were classified as anxiety states as distinct from fear states. Of interest is the fact that 54 percent of admissions had not been in combat situations, thus confirming in Sinclair's view that 'combat is only one of the factors causing or initiating breakdown'.⁴⁴

The principle causal factor identified by Sinclair was the makeup of the soldier and estimated that only 14 percent of the anxiety states could be wholly attributable to war service. The least desirable patients were those with the 'medical liability' of personality defect, and 'the neurotic officer' who was a 'bad medical investment'.

Another insight on psychiatric casualties came from Captain David Ross of the Australian Army Medical Corps, who reported on psychotic casualties in New Guinea in *MJA* in June 1946. He noted that the numbers of psychiatric casualties requiring

⁴² Walker, A. (1952) *Clinical Problems of War*, Australian War Memorial Canberra, p. 69.

⁴³ Sinclair & Cooper (1941) had completed a similar survey of patients in the AGH at Tobruk during the siege.

hospital treatment increased towards the end of the campaigns. By then psychiatric casualties accounted for 7 percent of all admissions. A new ward was established in August 1944 in the General Hospital (possibly in Lae, although this was not clearly stated) to cater for seriously disturbed patients, and provide treatment that would have previously only have been available back in Australia. The new working conditions for the medical officer, three sisters and twelve medical orderlies, were 'now pleasant and easy and the patients were comfortable'. This new facility did not reduce the numbers requiring evacuation, and with the limited means of sedation, such as sodium amytal and mild coma induction, restraint during flights to the mainland was still necessary and problematic. This led to the decision to establish convulsive therapy facilities in the unit.

Between September 1944 and May 1945, 142 of the 236 patients admitted were administered shock therapy. Ross claimed this produced 'definite and more often than not, dramatic improvement after three seizures'. The large majority of cases were classified as schizophrenic (65%) with manic-depressive (18%), other psychoses (3%) and psychopathic (14%). Some of these states may have been induced by the administration of Atebrin, which had been introduced as a malarial prophylactic during the New Guinea phase of the war. Ross played down the role of exogenous factors by maintaining that patients improved after treatment, not as a result of being removed from as stressful situation.

A more descriptive account is found in the personal experiences and recollections of medical officers who served in the New Guinea, and accounts in unit medical diaries. Their accounts confirm Walker's view that breakdown in the field was the exception rather than the rule, despite the extremes endured by combatants. Terms used by the United States Army such as combat fatigue and combat stress were never adopted by the Australian Army Medical Corps (see Walker p. 692). In the RAMC stress reactions could also be classified as somatic fixations. Anxiety could be manifest in cardiovascular fixations and skin diseases, aggravated by tropical conditions, which would necessitate evacuation. Classifications of Da Costa or Effort Syndrome were also reported, but Fitts (1942) described this as a 'vanishing phenomenon' in WW2.⁴⁵ The

⁴⁴ Sinclair, A. (1943) Psychiatric casualties in an operational zone in New Guinea. *Medical Journal of Australia*, II, 4 December; 453-460.

⁴⁵ These terms were coined to categorise some of the symptoms of soldiers in the American Civil war. They were adopted in the British army in 1914-19. For an account of the civil War

diagnosis of NYD was used when there a diagnosis was not obvious when there suspicion of malingering. By far the most common diagnosis of a neurosis was anxiety state.⁴⁶ Doctors were often involved in deciding who was malingering.

There were good reasons for not placing too much emphasis on, or even discouraging, stress reactions. With losses from illness, wounds and death already high, units could not afford to lose any casualties from 'moral or mental' disorders'. Such losses were a threat to fighting strength as well as morale. For the most part military doctors were sympathetic and understanding but could not afford to encourage unwounded casualties. Their essential role was:

to keep men fighting, as well as care for those who are mentally incapacitated. Every patient whom he handles represents a potential unit of fighting power.

It is the important duty of the army psychiatrist to attempt to return such men to service, even though he returns his patient into a rude world peopled by men whose business is warfare.⁴⁷,

Sinclair's survey demonstrated how a stressful situation can act as a filter for sorting out capable soldiers and how the medical service becomes the filtering agent. The return to active service was relatively high with the majority being returned to their units. If Sinclair's sample is representative the incidence of psychological breakdown was indeed low.

At a personal level, succumbing to strain was a last resort. A serious breakdown would mean being separated from the battalion, a personal loss as well as a source of shame. It meant you had failed the test and were letting your unit down. For an individual psychological casualty who was evacuated, there was no victory parade; just a quiet return to treatment in an overcrowded hospital where treatment was limited and often invasive. Some of the treatment facilities were only tents outside the main general hospital wards. Although officers and medical authorities were on the whole, understanding of the 'genuine' cases, a breakdown was still a source of shame.

experience see Dean, Eric (1997), *Shook Over Hell: Post-traumatic stress, Vietnam and the Civil War*, Cambridge, Harvard University Press.

⁴⁶ This diagnosis persisted for a short time after the war. Allan Stoller, an Australian Army psychiatrist who later became the head of psychological medicine in the Repatriation Dept, reported that it had little credence in British hospitals, particularly at Maudsley, a leading London hospital in the treatment of war neurosis. Interview 1993.

⁴⁷ Sinclair, A. (1944) Psychiatric Aspects of the Present War, *Medical Journal of Australia*, 1; 28: 501-514.

The medical perspective from other sources did not diverge from Sinclair's view that despite the strain, casualties were low and general morale remained high. In February 1945, Brigadier Kingsley Norris of the Australian Army Medical Corps described the New Guinea campaigns at a meeting of the Victorian Branch of the British Medical Association (*Medical Journal of Australia*, December 1945). Most of his rather florid account deals with the history and topography of the islands, with some battle history thrown in. His graphic descriptions reinforce the stressful nature of the battles, particularly the encounters in Gona, Buna and Sananander. He does not describe any aspect of psychological strain or casualty, and medical perspectives were confined to the disposal of the walking wounded on the Kokoda Trail, where the 'courage and cheerfulness were wonderful - beyond praise - almost incredible'.

Other personnel who served in the Owen Stanleys during 1942 and 1943 present the same view that high morale, discipline and training prevented serious mental casualties. Each unit and Brigade kept a medical diary that set out the history of the health of the unit during combat and training. These medical diaries are very useful sources of information about the effects of stressful conditions because they contain detailed accounts of conditions and effects as well as casualty data. These diaries describe the stressful conditions and made much of how inadequate the material support for the Brigade was. Communication was poor, there was limited intelligence available, promises to send supplies were not kept and some poor tactical decisions were made. Consequently they sustained heavy casualties, but reports of psychological strain or 'fear' reactions such as self-inflicted wounds were unexpectedly low.

The Medical report of the 7th Australian Division (which included the 2/27th) by Dr K. Norris in January 1943, gives a clear account of the trek over the Owen Stanleys and the conditions encountered along the way. He listed eight major diseases of Malaria, Scrub Typhus, Diarrhoea, Skin conditions, Urti, Haemorrhoids, Track trauma (physical) and Wounds. The only mention of mental conditions was a small number of Not Yet Diagnosed (NYD).⁴⁸ Medical personnel were almost wholly taken up with treating the sick and wounded, and physical survival, with high priority on ensuring sanitation, hygiene, clean water and adequate nutrition. The 21 Brigade Diary mentions psychiatric cases, with no explanation. The chief medical complaints apart from wounds were

⁴⁸ See also Norris K. (1945) The New Guinea campaign. *MJA*, 15 December; 425-431.

diarrhoea with blood mucus, foot disabilities, and psychiatric cases. Dr H. D. Steward, the RMO of 21 Brigade does not mention psychiatric casualties.⁴⁹

Other indicators of mental strain like low morale were found in references to units such as 53 Battalion, which withdrew from the mountains with very low morale. When it were relieved by 2/27, the 53 Battalion was 'very low in morale, their boots were rubbing, they had blisters, and their socks were adhering to their feet'. On September 1, 1942 'some companies appeared to lose control' and there was far too much straggling and independent movement of troops'. By the time they reached Port Moresby 10 percent of the men paraded sick each day. After they had time to recuperate they were flown back to the north coast at Sananander where they knew they 'were to kill as many Japanese as possible before they were killed'.⁵⁰

By the third week of December the nervous strain of the two attacks (on a Japanese post) was beginning to tell on the troops and that, together with heavy losses suffered plus the appalling conditions under which troops lived, caused a lowering of morale. The effort of trying to retrieve two mortally wounded men (Coote and Henderson) was particularly stressful.⁵¹

The other militia unit, 39 Battalion recorded similar problems with morale. The battalion diary documents a number of incidents that for men in their first battle was threatening. In their first encounter on 25 July they lost 6 men. On 26 July, McLean reported that the whole force had been surrounded and lost and they were subsequently ordered to withdraw to Oivi.

At 1730 hrs on 26 July Capt Templeton was caught in a burst of gunfire and not heard of again. He disappeared without trace. By 30 July they were very tired and 'morale was low' and there were still 20 men missing. Then on 2 August a personal tragedy also struck when Private Hughes was shot [by his own sentry] and killed when he did not answer a challenge.⁵²

Despite the extreme conditions of the Owen Stanleys, which are described in detail in the Seventh Division Medical report, there is no discussion of psychological aspects of the 'track'. The main emphasis is on treating the sick and wounded and improving the appalling sanitary conditions.

⁴⁹ Steward H. D. (1983) *Recollections of a Regimental Medical Officer*, Melbourne: Melbourne University Press.

⁵⁰ AWM 53; 8/3/91

⁵¹ 53 Battalion Diary AWM.

⁵² *Ibid.*

The incidence of psychiatric conditions was reported to be very low. On 30 November 1942 there were 13 cases of NYD and 207 'other'.⁵³

Medical officers in the Owen Stanleys did not regard psychiatric casualties as a major problem and each had their own theories about how men survived the extreme stress. However, none of these men had received any training in the diagnosis and treatment of mental casualties, and relied on their basic training and common sense. They were also constantly occupied with treating the sick and wounded and confirming the dead. Keith Viner-Smith, Regimental Medical Officer for 2/27 Battalion in 1942, recalled only a low incidence of breakdown or loss of nerve:

There were at least 3-4 soldiers who suffered from combat neurosis but I can remember only one - a sergeant whose normal duties who did not include active fighting. In the rather torrid conditions I certainly had no time to diagnose and treat. I used him with probably three other men to carry a wounded man back down the track for several hundred yards to a place where a white officer was holding some native carriers away from the more dangerous area. Unfortunately this team was the first to meet with the Japs behind our unit and had to return to us with the wounded man.⁵⁴

Viner-Smith recalled:

I would try to assess the man concerned. If there was any hope of him regaining his nerve I would keep him in relatively safe position, keep him busy and hope he would regain control. If there was no hope I would try to evacuate him from the area.⁵⁵

Jim Fairley (later RMO of 2/27) treated casualties after the withdrawal from the Kokoda Trail as medical officer at the 2/9 AGH in Port Moresby in 1942. Of the withdrawal his view was.

I think the main reaction was the relief. They were out of it. No, Alec Sinclair was there - the 2/9 AGH psychiatrist - and he was never very busy - at least I didn't think so. From my memory there was no dramatic casualty rate. There was a psychiatric ward. You were always very reluctant to write someone off as a psychiatric case. Another thing with the 2/27, the originals had been through it and they would support the new blokes. In Balikpapan [Borneo, July 1945], there were

⁵³ Medical report 7th Division January 1943, AWM, Canberra.

⁵⁴ Interview Viner-Smith 15 April 1991. Cameron, Alan, Murdoch Sound Archive tapes, 1990.

⁵⁵ Interview RMO 15 April 1991.

no mental casualties as far as I know. It was nerve wracking when we were on patrol.⁵⁶

Fairley had developed his own views on breakdowns in the field, but acknowledged that many problems could be hidden. 'There were a hell of a lot of blokes who never got to a psychiatrist, but had potential psychiatric problems – more like acute attacks'. 'Unstable' men would have a break down under strain, but there were 'normal' men who under 'abnormal strain' sometimes became dysfunctional. A lot of men, according to Fairley, were kept off the psychiatric casualty lists by comrades, NCOs, the RMO, and other officers. If handled properly these men would get better. The unit morale was the best buffer initially. They also needed understanding and explanation. He 'would need to be convinced that his reactions were in the normal bracket – a normal person reacting in a normal way in an abnormal situation. The affected man might weep, become incoherent, have tremors, vomit and be unable to eat'.⁵⁷ Good officers understood this well, without any formal training and doctors were reluctant to write men off as a psychiatric case. Fairley also acknowledged that many 7 Division men had been battle hardened in the Middle East and those who struggled earlier had been screened out. He believed that officers generally accepted the man who 'could not take it'.

At that stage there was complete understanding. I did not see any of my nursing staff who did not understand what had happened to these 'kids'. We knew from the units they came from and what they had been through how good they were. We all thought 'there but the for the grace of God go I'.

As stated above, 39 Battalion experienced the worst of the Kokoda conditions, as well as the initial attack by the Japanese and more cases of psychological distress might be expected in this unit. However there is little evidence of this. The RMO of that unit, Major J. Shera, who served with 39 Battalion on the Kokoda trail, Gona, Sananander, and with other units at Finschafen and Tarakan (Borneo), has a similar version to other medical officers.

⁵⁶ Fairley was himself exposed to threat in Borneo. At night men slept in hammocks and it was common for Japanese to creep in and spear men with sharpened bamboos while they were asleep.

⁵⁷ Incontinence was excluded because being 'shit frightened' was normal. This was an accepted reaction. It was quite normal for men to 'mess their pants' when going into battle. Fairley explained this as a normal animal stress reaction – when under threat you would 'lighten your load and run away'.

As far as I can recall, there was not a high incidence of combat stress in the 39 Battalion during the Owen Stanley campaigns. Before we started the climb there was a slightly larger attendance at sick parade but no obvious attempt to avoid the climb. There was one youth who presented with sore eyes. His eyes were full of grass stalks. I considered this was self inflicted. The lad later performed with exceptional bravery near Deniki.

At Isurava when Battalion headquarters looked like being overrun, one young man became hysterical. Fortunately at the time the 2/14 marched in and took up defensive positions.⁵⁸

Shera had received no training for assessing and treating psychological casualties. His explanation for the low casualties was the youthfulness of the battalion, and the high quality of their leadership. 'They hated the enemy and they did not want to let their mates down'. However he did acknowledge that in another unit he served with later in New Guinea there was a higher incidence of 'combat fatigue' in men who had also served in the Middle East. At least one man had suicided. He believed that the longer a man served, the more likely he was to have psychological problems, thus supporting Cameron's view that cumulative strain was more damaging than short dramatic exposure to stressful events.

Shera had little sympathy for modern views on stress, and adopted a more practical, organisational development approach to reducing psychological casualties.

The buzz word these days is counselling. It is important to eliminate factors such as inadequate clothing, inadequate diet and to make sure that there has been proper military training. Morale tends to drop a little when a meal would consist of a stew of taro roots and a little bully beef mixed up; not a good preparation for combat under dreadful conditions.

A third medical officer who was able to give a first hand account of battle conditions was Douglas Leslie. At the age of 28, he was assigned to the 2/4 and 2/6 Field Ambulance units to establish staging posts along the Kokoda track during the second advance back over the Owen Stanley Range, after the Japanese had retreated. He was also surgeon with the 2/9 Australian General Hospital near Port Moresby. He treated men in the field and also received casualties from Gona and Buna. Even though his focus at the time was on treating physical injury in very primitive facilities, his recollection of his experience is that psychological casualties were low. In 1993 he wrote:

⁵⁸ Letter from J. A. Mc. Shera.

My impression throughout was that the morale of our soldiers was very high indeed and very few of them showed signs of psychological problems. However at Myola I was so busy surgically that, apart from routine post-operative care, I was not able to make any psychological assessment of the troops. One of the most stressful times must have been during the retreat over the Kokoda Trail. My only experience of this phase was in treating the patients who arrived back at Moresby.⁵⁹

Alan Bentley, who became a physician after the war, served medical orderly with the 2/6 Field Ambulance on the Kokoda Track could recall few instances of psychological breakdown in that period. He was more distressed by the extent of the casualties and was reluctant to recall details of the period.⁶⁰

Don Duffy was medical officer with the 2/14 on the Kokoda Track, at the height of the Japanese assault. Like most of his fellow medical officers, had no training in detecting and treating psychiatric casualties before being assigned to the Middle East and New Guinea. Although this may have influenced his observations, he could recall little evidence of psychological disturbance and certainly no psychotic disturbance either in the field or with the 2nd Australian General Hospital. The only mildly psychotic behaviour was considered to have been a side of the malaria suppressant, Atebrin. His preparation for the extreme conditions of New Guinea was rather brief:

I had no special training in the army directed towards the handling of mental cases and my preparation for NG was limited to my meeting with the Director Australian Medical Service HQ on the wharf at Brisbane on the night of our departure. He said he supposed I knew where I was going. I said, 'not for certain'. He replied 'well it is New Guinea, and as the place is malarious [sic] I have put two large tins of quinine tablets on board which you had better distribute to the troops in cigarette tins before you leave Moresby'. He then faded into the darkness. The army had sent me to malaria schools.

The 2/14 was a well-trained unit and had experienced combat in the Middle East. Duffy's theory was that their discipline, training and strong leadership, minimised the possibility of breakdown under duress and that any potential problems would have been eliminated early in their training. This is borne out in his observations of the 39th:

Perhaps there was some degree of anxiety among troops going into battle for the first time but the certain support of trusted reliable mates carried them through. There was an instance of inadequately trained battalion - which means badly officered and led troops - who did not complete a fighting patrol, did not contact the enemy and gave misleading information on return, some men having left their weapons behind. This unit was rapidly returned to Moresby. The blame lay not with

⁵⁹ Personal communication: letter, 15 September 1993.

⁶⁰ Interview and questionnaire 1995.

the troops but the HQ administration who had them loading ships in Moresby at the expense of this basic training and secondly the poor standard of officer command from the C. O. down.⁶¹

Duffy considered the idea of shock induced traumatic neurosis, but did not think the New Guinea conditions produced this. He proposed that the severity of the stressor was a determining factor in occurrence of stress breakdown, but the New Guinea stressors were not severe as in World War 1, where heavy artillery barrages temporarily interrupted 'coherent thought and action'.

In a battle scenario the tremendous noise and shock wave of exploding artillery and mortar shells has been a stress factor which stuns or temporarily interrupts the coherent thought and action. In the First World War, the circumstances were bad enough to have completely disoriented soldiers walking aimlessly about in no man's land. Such circumstances did not prevail in New Guinea where automatic small arms fire and exploding hand grenades provided most of the noise.

The Japs did haul a couple of mountain guns over the ranges and a section of our troops in an exposed forward position on Iorabawa Ridge were fired on repeatedly for a period of two or three days. Every movement on their part seemed to elicit a punishing round of gunfire to which they could not effectively respond. Apart from becoming particularly 'brownd off', they were in no way frightened or dejected. One might imagine physical fatigue might be an important aggravating factor under circumstances of stress but this did not appear to be the case.

Among officers and ranks as well, few could recall cases of men not being able to cope, but though a different language was used to describe strain and its effects. Young soldiers even saw some of their leaders break down under the strain. One officer recalled having to take over a command when a senior officer broke down just before his unit went into the Owen Stanleys.

At that point I was in charge of Don Company. What caused the original collapse of that officer - he realised that his company was not as well trained as some of the others by reason of the young men who had enlisted. His men had Lewis guns from World War One. They may have been all right then but not in World War Two. The officer concerned completely cracked and had to be shipped back to Australia and discharged...his nerves went and he could not control himself or his men nor anything pertaining to it. A complete mental breakdown. It was the initial shock hit everybody - we are now going into action. It became evident that many of the men who had come on the Aquitania should never have left Australia before another six or eight months' training. They enlisted as boys - as the Kokoda trail unfolded in

⁶¹ Letter and questionnaire 12/10/93. The unit referred to is the 53/55 Militia (AWM 53 8/3/91). Budden (1987, 1973) argues that the 53rd was a scapegoat for mistakes by higher command.

front of us and the magnitude of the mountain became clear. The strain of the Kokoda had got to be experienced to be believed.⁶²

In interviews, participants preferred to talk 'off the record' about any cases. Stress reactions were often fused with references to fear and to an inability to face up to particular situations, or displaying cowardice in the face of the enemy. Terms such as 'messed his pants' were used to describe temporary experiences of fear reaction. A man 'who did not acquit himself well', had either broken down or had temporarily given up. In one case a young man was described as not having 'handled himself well' and was later killed by the Japanese. My informant had the difficult job of visiting his mother after the war and telling her that he was a good soldier.⁶³

Only a few informants could recall examples of breakdown like this. These cannot be quantified but a few examples give an indication of what it meant. For example Mick Scanlon recalled:

There was a fellow up in New Guinea who went troppo. I thought he was alright. We were trying to set up our Vickers one night and he came along with this bit of plant and was convinced that it would make my sights luminous. He seemed to be serious.

Trevor King of the 53/55 Battalion recalls that one officer completely cracked and was repatriated.

His nerves went; he just could not control himself, or his men, or anything appertaining to it. Just a complete mental breakdown.⁶⁴

RW, of the 2/27 battalion witnessed a young 17 years old infantryman in his unit hiding behind a tree during the Kokoda period. The young man could not function. RW asked the CO to exempt him from the next battle, but this was refused. The young man participated in the Gona battle and virtually suicided by running in front of enemy machine guns.

Other breakdowns could be have been temporary and would not have been even recorded at a forward Aid Post. Paul Wright for example, recalls the combination of

⁶² Interview JR, 2/27 Battalion.

⁶³ 'Messed their pants' seems to be a code phrase for men going to pieces as well as what literally happened under extreme duress. One senior officer was reported to have messed his pants in his first action in Syria. He was later repatriated to Australia. Most blokes wet their pants in fear but the term was also used colloquially to describe those who could not take it. Interview J. Burns.

⁶⁴ Murdoch Sound Archive interview 13 June 1989, AWM.

poor preparation and conditions in the Kokoda action. He was 18 years old ('18 going on 12, couldn't even drive a car') in May 1942, when with minimal training and no battle experience he and members of the 53 Battalion were sent in to take on the Japanese, who at that point outnumbered the Australians 10 to 1. His most stressful moments were:

Having to kill a man three feet in front of me and seeing the look on his face when your bullets enter his body; seeing your mates lying dead on the ground; having to bury a mate that has been killed; going into the jungle to bring back the bodies of mates killed in ambush; smelling the stench dead bodies from both sides; having to fight the jungle conditions, sickness and weather.⁶⁵

The strain of these experiences, along with several of the 13 bouts of malaria, did tell and during a night patrol he 'saw things no one else saw and shook uncontrollably'. He recovered after a few days away from the fighting.

Nurses who served in New Guinea and in hospitals in Australia could recall some psychiatric cases. Joyce Cleary recalled that there would be 'boys that would break' and be sent off in a convoy to Australia. What happened to them after that was not usually known. These breakdowns tended to occur later in 1943 at Lae and Madang and Aitape in 1944 and some early in 1943 at Buna. She was more aware of the effects of 'nerves' when she was serving back in Australia where, with no experience nor training she had to monitor psychiatric cases receiving large drug dosages as well as shock treatment.⁶⁶

These reflections of medical personnel support a view that it was not just the individual's internal resources that determined survival. Organisational and contextual factors such as training, support, morale, physical resilience also affected their ability to cope, and the notion of a single traumatic incident dislodging a soldier is not part of their analysis. They believed that cumulative stress, which built up over several tours of duty with the exposure to danger, tropical diseases and wounds, was more likely to take its toll.

It is clear there was no outcry about an epidemic of mental casualties. No one supported a view that there were immediate stress reactions to traumatic events. There was a view that casualties did increase with accumulated experiences, as proposed by the official medical historian, Allen Walker (1953). In 1945 he reported an increase in the number of psychotic cases and acute manic states and that psychiatric assistance had

⁶⁵ Questionnaire response, PW.

⁶⁶ Murdoch Sound Archive, Joyce Cleary 13 March 1989, AWM, Canberra.

to be improved and increased. Because by that stage many of them had married or committed themselves they tended to be more careful and more aware of their need to survive. They became more scared and careful and as some put it 'more jumpy', especially in the jungle.

The idea was also supported by Dr Ralph Cameron, 2/5 AGH. The actions on Tarakan and Balikpapan took place at the end of the war just before the dropping of the atomic bombs on Nagasaki and Hiroshima. They were essentially cleaning out exercises to dislodge the remaining garrisons of Japanese from various islands. By that time the enemy had had years to dig themselves in with heavy fortifications, but with no supply lines, it was probably only a matter of time before they might have surrendered. The invasions of the islands were extremely well organised and executed with land and sea support, but there was a sense of them being unnecessary. Cameron believed:

I felt very strongly about this - I saw men being evacuated out of Tarakana and Balikpapan. Soldiers who had gone right through the Middle East. They knew that they were being wasted - that's right - they were prepared to carry on and be good soldiers as they had been while they could see some point in it. But they didn't. But for some there seemed no longer to be any point in it. One of my jobs at the 5th AGH was to handle psychiatric casualties. Kids came back - they were stressed, which they manifest in various ways and varying degrees of seriousness. Some were quite seriously and acutely mentally disturbed. And I had no psychiatrist handy and available and my job was to get them better enough to be safely transported back.⁶⁷

There are number of possible explanations for the apparent increasing incidence of psychiatric casualties later in the war. One is the suggestion that when there is an 'escape hatch' men are less able to control themselves. In the Owen Stanley Ranges and the Markham and Ramu Valleys, there was no easy way out, so soldiers had to find a way of surviving psychologically. Medical officers, for example, were instructed to not evacuate any soldiers with self-inflicted wounds. There was also the possibility of delayed reactions from earlier more demanding campaigns coming out when the pressure was 'off', or the phenomenon of cumulative stress. Another factor may have been the lack of battle hardiness in the reinforcement troops who had been brought in after earlier heavy losses in 1942 and 1943.

A company commander in the 2/14 Battalion, who had seen action in Syria, three New Guinea campaigns and one in Borneo, bears this out.

⁶⁷ Cameron, Alan, Murdoch Sound Archive tapes, 1990

In the firefight at Balikpapan, when I was a company commander, there was a platoon on the right flank - I did not hear a shot from them during the fight. The team commander had been wounded in the bum and the sergeant was in charge - he looked at me and started to cry - What is the matter - my nerve is gone, he said; I have been in every campaign of the unit and this is the first time it has happened. He could not give the order to fire - if he disclosed their position they could be shot. I did not judge him and sent him straight to the RAP. I later found out that the sergeant was sent back to Australia for specialist treatment - he was definitely a nerve case. I think it was because it was the final campaign and he did not want anything to go wrong.⁶⁸

SURVIVING

If the official psychological casualty rates are accepted how did men cope with the strain? The consensus seems to be among survivors that survival is not an accident. As well as mental and physical preparation through training, individuals can take actions that allow them to rise above their fears. One has to learn very quickly to adapt or be overwhelmed by the experience. When this occurs in the context of war, the experience of these men suggests that this learning and adaptation is more than just individual resilience.

In reporting these strategies the veterans did not always distinguish between mental and physical strain. This is not unusual as the two were often seen as connected - one was more likely to withstand mental strain when physically stronger and not ravaged by illness such as dysentery or malaria. Diseases such as dengue fever, cerebral malaria and scrub typhus could also be accompanied by emotional disturbance. There is a qualitative difference between a temporary inability to cope because of fatigue, and a more permanent breakdown of defences, and succumbing completely to fear and strain. The fear of breakdown in the face of mates was a powerful incentive to hold on. As one participant put it:

I suppose the main thing that enables you to rise above your worst fears is simply that there is an even more fearful alternative - the fear that your mates will see you are afraid. You really would rather die than let this happen. The question arises - what is courage? Well, I would never have had the courage to show fear in front of the other men. So yes, you all help each other and the very best way to handle stressful periods in is to be busy. If you have time to pray or think of home then you are very probably not attending to something that needs to be done. Yes, I guess we all send up silent prayers at times, but personally I'm not a prayerful person.⁶⁹

⁶⁸ Interview HD.

⁶⁹ Questionnaire response: J. Reddin.

Clive Edwards reinforced the view that training and can prepare one for stressful events, and that they need not have an immediate or lasting effect.

I would be a disappointing person to gain information from because of my war experiences. Nothing really occurred which was worse than my training and reading had prepared me to expect. For example, my first sight of a corpse with the entrails gaping received no reaction from me for I'd expected to see such things. I spent several days this week with a mate of mine who spent 3 years with me and we both agreed that we were glad we volunteered and he went through Gona from start to finish.

Contact & thoughts of home were very important - writing & receiving letters. Support of mates & Esprit De Corps. It's hard to believe in religion during war but I attended church parades & always kept a copy of the New Testament with me - it seemed a mark of respect to say a short passage from it over a dead mate's body.⁷⁰

The most common thought or fantasy that kept men going in extreme times was thinking about home or loved ones. Sometimes these loved ones were wife, mother, father, brothers and sisters and for some it was a new and blossoming relationship. For example:

As I was sitting in my tent wondering what to do
I saw in the doorway standing a vision dear of you
You were wearing one of the most beautiful dresses
All covered in gorgeous lace
Your hair hung in wonderful tresses and surrounded your lovely face

Your voice as you sang our favourite song
Was sweeter than a dove
Your smile was like that of an angel and shone like the stars above
This alluring vision was just a passing myth
But made me realise what I truly miss.⁷¹

Survival sometimes meant taking some practical action, however small, that would keep the mind focussed or the body alive. Many veterans reported very simple practical actions as a way to survive critical times. For example during the Efogi withdrawal:

I must admit that I was feeling down. No particular reason, the only thing I'm conscious of is that I had not smoked. I realise this afterwards. I noticed that the heavy smokers were feeling it worst. All could think of was the lack of food. I had

⁷⁰ Questionnaire response: Clive Edwards, 2/27 Battalion.

⁷¹ My Love, My Wife, My Own, poem by member of 2/27, S. K. Ashenden.⁷

tried to eat grass or leaves - I did not consume much. We dug up a few potatoes - got a bellyache. All my thoughts were centred on food.⁷²

Another survivor of the Kokoda Trail (GW) and the walk back over with ChaForce kept himself well by always keeping a change of dry underclothes. (How this was possible in the jungle and rain is not clear.) Among other things, mateship and humour also played its part. Some of these 'funny bits' might not seem funny at all fifty years later. John Burns related one story that graphically illustrates battle humour. He was standing one morning with Colonel Cooper and Harry Katekar preparing for a bayonet attack at Gona. John was the radio operator and had to put his left hand up to adjust the aerial to get better reception. He was hit by a sniper and sustained a minor wound which produced a lot of blood. The RSM, who was known as 'Loopy', became very agitated and as was his habit started to carry on, jumping around and waving his arms. One of the men called out 'get down you silly bastard'. The RSM demanded that the soldier identify himself: 'who said that?' Sixty voices cried out in unison from the kunai and jungle: 'I did!'.⁷³

Incidents like this are claimed to have sustained men through the strain of close combat. Jimmy Moir recalled:

At one stage during the Owen Stanleys campaign my mate on the Bren gun and myself were on guard duty at night and were lying in our groundsheets. After a while my mate said he was going to have a nap. Shortly afterwards a couple of objects landed near us and I realised it would be Japs trying to attract our fire and give our position away. I reached over to put my hand over his mouth to prevent him speaking. Then I put my mouth to his ear to tell him what was going on, to which he replied 'thank God its you, I thought it was a Jap crawling over me so I was pretending to be dead'. (Not very funny at the time but we had a few laughs later on over a beer or two.⁷⁴

The other perspective is that many men actually found the whole business a challenge and enjoyed the experience. Often they were too busy to be frightened, but for many soldiers combat was an exhilarating experience and the idea of being stressed did not occur to them. While there were exceptions of men who did give up for many it was more like:

We were that busy we were not frightened. The adrenalin flows and unless you have been in action you would not know what it is like. You can do superhuman

⁷² Questionnaire; J. Reddin: May 1994.

⁷³ Interview JB.

⁷⁴ Questionnaire and telephone interview.

things. You get so fired up. The worst thing is waiting. Some blokes messed their pants once it was on. In the Owen Stanleys it was different.⁷⁵

CONCLUSION

This is a brief description of the stressors to which participants were exposed. A number of points emerge at this point. The New Guinea campaigns of 1942 and early 1943 were periods of intense physical and psychological strain, and heavy losses were sustained. Medical personnel, officers, and combatants acknowledged the strain of this period, but there was no emerging discourse of psychological damage. There was no evidence of an epidemic of psychological breakdown in medical and historical accounts, and the majority of participants, while admitting it was a period of strain, were more likely to emphasise personal survival and unit morale, than breakdown. Criticisms were directed towards the command and politicians who were responsible for military decisions that resulted losses and damage. The more dominant feature of these accounts is the portrayal of the ANZAC fighting spirit in which there is no room for, and no mention of, psychological weakness.

This account is the starting point for exploring the long-term effects of participation in this period of history, through the life history narratives of survivors. This was the period of military history experienced by all men in this study, and provided many occasions for intense fear and anxiety, as well as opportunities to develop strengths. In the light of the earlier accounts of the psychology of traumatic experience, these experiences could also have been occasions for laying down traumatic memory, dissociating from intense feelings and creating potential for post-war difficulties. A central task is to determine if the portrayal of resilience and survival persists over time. This will be explored in the subsequent chapters.

⁷⁵ Interview, HD.

CHAPTER 9

EXCAVATING THE PAST: Questions of Method

This chapter addresses methodological issues in this thesis, and provides a bridge between the extensive review of the origins of the construction of mental illness in WW2, and the empirical section of the thesis.

This empirical material centres on the life course outcomes of a sample of WW2 veterans who experienced the intense period of combat in New Guinea in 1942. The specific methods used to gather information from participants are described below. The documentation of these lives is set within a social and historical context, which was reconstructed through interviews with secondary witnesses, extensive contact with veterans and their organisations within the WW2 network, including attendance at reunions, small gatherings, funerals and ceremonies. I analysed battalion association newsletters, interviewed regimental medical officers and padres who served in the campaigns, formed close ties with several key informants, and read extensively in military and medical history. The results of this analysis has already been integrated into earlier chapters, particularly Chapters Two and Eight.

My purpose in this section of the study was to:

- Generate and document narratives of veterans' lives, including war and post-war experience
- Integrate these narratives with other biographical material and shape it into life stories
- Incorporate these individual lives into a collective account of lives
- Observe and articulate themes and patterns emerging from these lives
- Set these observations against the landscape of ideas on the history of psychiatry and war neurosis

The fundamental research question is what was the impact of a very stressful period of combat on the life course of veterans?

There is no simple method of accessing such complex material, and these procedures require detailed explanation. Because I set out on a journey in a field where there had been few previous explorers, my strategies evolved over the course of the study, rather than being clearly articulated at the outset. The 'method' then, was informed and modified by experience, rather than utilising a pre-conceived package. All of the activities and transactions in the study are relevant, and no distinction is drawn between

preliminary investigation and formal inquiry. My understanding of the veterans' world was achieved through careful and sometimes painstaking excavation. It was not a clinical examination of their mental status, and my intention was to articulate their experience and observe outcomes, not examine symptoms and arrive at a diagnosis.

PRELIMINARY CONSIDERATIONS

I address a number of points before describing the particular methods. These points are epistemological issues, the problem of memory, ethical issues, and terminology.

The Use of Narrative

The study has a phenomenological, constructivist orientation, but is not situated within any one ideological framework. As Dex (1991) points out, both qualitative and quantitative methods can contribute to an understanding of life course development, and my choice of a narrative approach as the main form of inquiry allows both methods to be informed by the evidence. Since my purpose was to discover the individual construction of the informant rather than impose meaning on his experience this approach is considered most appropriate. Some support for the mode of naturalistic inquiry is emerging within the domain of psychology, where there is a small but growing interest.¹ Crotty (1998) argues that our choice of research paradigm, and therefore method, needs to be informed but not dominated by any one approach: 'as researchers we have to devise a research process that serves our purpose best; one that helps us more than any other to answer our research question'.²

Despite the significant movement towards qualitative approaches to understanding of human experience in other fields, trauma research has largely been undertaken in a reductionist mode. This reductionist approach presumes an already defined set of criteria for a diagnostic category and sets about finding the evidence for that form of pathology using standard instruments. These instruments, such as the Impact of Events Scale, or structured interview schedules, such as CAPS, SCID-R, are closed format clinical instruments rather than exploratory devices primarily designed to diagnose

¹ See John, I. (1998) The scientist-practitioner model. *Australian Psychologist*, 33,1: 24-30; and responses by P. Cotton in same issue.

² Crotty, Michael (1998) *The Foundations of Social Research: Meaning and perspective in the research process*, Melbourne: Allen & Unwin, p. 216.

PTSD.³ Such techniques are useful for forensic and epidemiological purposes, but at the same time serve the political purpose of the agency commissioning the research, and have the effect of limiting outcomes of the inquiry to the pre-determined variables.

In most of the psycho-medically oriented trauma literature little value has been placed on the narratives of the participants, other than to use them as another way of producing data. For example, Foa, (1995) coded the transcripts of narratives of rape experiences and analysed the qualitative and quantitative changes that occurred. Narrating was a therapeutic tool, and the generated text was the data that was subjected to analysis. The text of the narrative elicited variables that might not have otherwise been elicited from standard instruments such as Revised Structured SCID-R.

Intrinsic to my mode of inquiry in this study is a challenge to the medical dominance of the framing of human experience, which is particularly evident in traumatology literature of the past 25 years. There are very few precedents to call on in embarking on such an inquiry. One precedent is the recent work of Young (1995) who conducted an ethnographic inquiry in a PTSD clinic in the United States. This led him to re-examine the construct of PTSD and develop an alternative history of PTSD as a diagnostic category. He established the case for utilising an ethnographic perspective in developing an understanding of the impact of traumatic memory, and how it has been incorporated into an institutional/nosological framework. The strong ethnographic tradition in other disciplines and areas of research, such as anthropology and some strands of sociology, provides support for a more naturalistic inquiry mode.

Josselson (1993, 1995), a prominent advocate on the use of narrative, argued that accessing the lived experience is of more value than just taking measures of mental and physical health. Her position is:

Listening to people talk in their own terms about what had been significant in their lives seemed to us far more valuable than studying preconceived psychometric scales or contrived experiments.⁴

And, 'to study whole persons we cannot rely on logical positivist methods that isolate simple factors and trace their effects through statistical analysis'.⁵ Josselson goes further and argues that the use of a narrative approach is not just confined to qualitative

³ See Stamm & Varra, (1993), and Carlson (1996). CAPS is the Clinically Administered PTSD Scale; SCID-R is the Structured Clinical Interview for DSM-III-R.

⁴ Josselson, R. (1993) *The Narrative Study of Lives, Vol 1*. Newberry Park: Sage, p. ix.

research modes. Narrative is also relevant to quantitative inquiry in that the researcher will 'weave a narrative, in which obtaining a certain set of "significant results" makes sense'. Her stance is more about ways of knowing, in that 'we cannot know the real', and our knowing of another is only a version of another's interpretation of self. Translated into a 'method' this means adopting an empathic stance to elicit a person's narrative of self. Such a stance is situated within what she calls 'empathetically grounded narrative' psychology, which is antithetic to standardised methods of empirical inquiry. The empathic stance allows the researcher to 'explicate the architectonics of self – the ways in which parts are held in dynamic relation to each other'. This stance also allows for discovery, rather than seeking confirmation of a hypothesis, and explanations, rather than an exhaustive quest for the truth. The narrative is thus a form of knowing.

In the same vein Bruner (1986) advocated narrative modes of knowing which help to shape and make sense of someone's world. The interview is thus not an inquisitorial, but rather a participatory process during which the participant can help shape the narrative. Kleinman (1988, 1995) reminds us that when encouraging a participant to create narrative we have the potential to frame that narrative as one of illness. Thus it is imperative to adopt a broad focus in a narrative rather than simply eliciting a record of illness as one might do in taking a clinical history.

The central task in my study was to develop life histories from the narratives of participants. Detailed life histories allow a deeper examination of how people respond to life events, and how their responses are woven into their individual life tapestries. An alternative approach to explore in the trauma field is more evident in anthropological and sociological studies.⁶ Life history and narrative are central to these approaches. Armstrong (1991) provides a strong rationale for a life history approach. Tracing the origin of such an approach to the Chicago School movement of the 1930s, he argues that there is no one life history method and researchers have a range of approaches to choose from.⁷ The impetus for the narrative approach has its own history but the

⁵ Ibid. Josselson, along with others, such as Elder and MacAdams, traces origins of this approach to inquiry to the Chicago School of the 1930s.

⁶ See McAdams (1991) and Armstrong (1987) for in-depth reviews of the use of narrative and life history methods. Dex (1991) also provides a review of life history methods.

⁷ This extensive body of knowledge was revived in a special issue of the *Journal of Personality* in March 1988, which proved to be a watershed in the expansion of interest in narrative research in recent times.

approach was revived by researchers such as Gergen and Sarbin (see Sarbin, 1986), who restated the case for challenging the mechanistic/reductionist or logico-deductive modes of inquiry. McAdams (1988, 1992) has also built on these ideas in a number of places and proposed the use of psychobiography as a means of re-formulating stories⁸.

A life story approach requires the researcher to work outside individual boundaries by documenting the significant external shaping events. In the context of understanding the effects of traumatic experience the exploration is also aimed at discovering the inner, less overt, experience. Care needs to be exercised when talking of the past that might evoke distressing material and have the potential to re-traumatise the interviewee. Questions or leading comments are necessary because a coherent life story is rarely available in some existing carefully articulated form. A balance to be struck between the needs of the interviewer and the comfort and privacy of the interviewee. A narrative can be disjointed and obscure for many reasons, and the skill of the interviewer is to organise these pieces of narrative into a coherent whole.

A number of aspects are particularly relevant to eliciting the narratives of older persons. Coleman (1991) provides a set of fundamental ideas for accessing memories of older people and creating a life narrative. In the first place, he proposes that there are four characteristics or factors, which are influential in the construction of one's sense of life story. These are the personality of the person constructing the story; the culture in which the story is developed, the major turning points in a person's life and the overall sense of a search for meaning. In this study war was a major life event, which my review in Chapter One indicated, has the potential to significantly shape their lives. It also presented them with experiences that could challenge their schemas, their meanings, their sense of values, and test their resilience. Remembering these events has been shaped by their immediate culture. Coleman asserts that most people have never been asked to reflect on or construct their life story, and this is true for most of the men involved in my study. Coleman further states that a biography is the most comprehensive account that one can have of one's life, whether it is written by the self or by someone else. In telling the story there is always an audience and this can cause the narrator to be selective of the material, and provide what they think the listener

⁸ Psychobiography, as Runyan (1988) pointed out, had its origins in Freud's Vienna Psychoanalytic Society, but has developed into a much more liberal framework for documenting and understanding lives.

might want to hear. 'Everyone has a story to tell but not everyone is certain of its interest to others'.⁹

In Coleman's view, reminiscing is a key mechanism in this biographical process. Reminiscing provides a link between interiority and consciousness. Interiority is a significant characteristic of aging where the older person can engage in 'increased introspection, reverie and thinking about the past'. This 'interiorising', (my own adaptation) and bringing into consciousness by reminiscing, are processes that enable one to explore 'the theatre of the mind'. According to Coleman, when people get older, their experiences become less immediate, and the range of life experiences that they have to deal with or manage becomes more limited.

When theatre of the mind becomes the only show in town, archival memories begin to be actively explored for scripts'.¹⁰

Thus an important part of observing the life story, or encouraging the construction of the life story, is the process of eliciting and articulating the thoughts and feelings behind a person's account of their life story.

With war-related lives it is appropriate for the researcher to provide an organising framework, which takes into account interiority, as well as exterior achievements and events. Veterans were encouraged to talk about phases of life, their childhood, their growing up, their pre-war experience, their entry into war, and war experience. They could also describe their homecoming and re-settling, as well as features of their mid-life, their career, marriage, family, and life events. There is also an interior life that can be accessed through encouragement to talk about dreams, feelings, and difficulties they might have experienced.

Excavations of this kind cannot be achieved sensitively using a flood of questions aimed at eliciting responses in a limited time, such as in a clinically oriented questionnaire. Rather the participants in this case require a quiet setting to allow the memories to emerge. Coleman (1991) cites a range of evidence that reinforces the complexity of exploring older lives. He argues that there is a great variety of ability to recall and retell one's story, that the last stage of life is a time of review and there are different purposes of reminiscence. He also warns the listener of the possibility of older

⁹ Coleman, P. (1991) Ageing and life history: the meaning of reminiscence in late life. In Dex, S. (ed.) *Life and Work History Analysis: Qualitative and quantitative developments*. London. Routledge, p. 125.

¹⁰ Coleman, P. (1991) *op cit.*, p. 2.

people glorifying the past, and the intricacy of the teller/listener dynamic. Both Coleman and Bellaby (1991), in the same review, point out that the main task of the life reviewer/researcher is to not only facilitate the telling and shaping the life narrative, but also to help locate that life story within historical time and their particular culture. The purpose of this approach is to 'discover a structure beneath the surface of accounts'.¹¹

The approach adopted in this thesis differs from many other works in that the life story of the participant is compiled from a number of sources¹². Advocates of a life story approach do not always support this. Linde (1993) argues that the oral text derived with what she calls an anthropological interview, is the only basis for a meticulous reconstruction of the story. In Linde's opinion, an integral part of the life story is developing a coherent sequence of life elements. I argue that the narrative in the form of personal story telling is not the only way of accessing life story material. I chose to reconstruct the life story with a variety of sources of text, such as questionnaires and archival records. These various sources help to form a collage of a life rather than one remembered version.

Using narrative to explore the effects of traumatic experience respects the personal and potentially problematic nature of trauma research not adequately addressed in mainstream trauma literature. A narrative approach provides a flexibility that protects the participants against intrusion and re-traumatisation. Trauma related narratives could be problematic with older interviewees, partly because they are far removed in time from the original experience. Within the trauma discourse, which is largely psycho-medically oriented, Wolfe (1995) has described the problematic nature of studies based on retrospective accounts of traumatic experience, and suggests that prospective studies are more methodologically sound. This is not necessarily so, as shortcomings in the use of retrospective narrative can be overcome. It should be borne in mind that Wolfe based her conclusions on a review of clinically oriented studies, which were aimed at eliciting clinical histories and examining the neurological sites of memory, such as in Bremner et al (1995).

Terminology

The field of naturalistic enquiry is littered with different terms such as: texts, storytelling, narrative(s), storied world, themes, lived experience, narrative structure,

¹¹ See Bellaby & Coleman in Dex (1991).

¹² See discussion on triangulation p. 292 of this chapter.

story tellers and social constructs. Before embarking on a description of the strategies adopted in this study it is necessary to broadly define some of these terms. There seems to be no consensus on the meaning of these terms, and for the purpose of this inquiry I offer descriptions of relevant terms based on interpretation of the existing literature. Each of these elements can take on different levels of quality according to the person or author.

Story is a portrayal of a particular sequence or event and might be in written or spoken form and include variety of media such as a song with a story line. Story telling is the act of portraying the story.

A **narrative** is a more formal piece of story telling that could incorporate a number of stories. It is the product of narrating. The act of narrating can take different forms and structure according to the setting and audience.

The **life story** is the product of organising a number of narratives in order to create a coherent sequence of the elements or events in a person's life. The coherence in a story comes from authenticity, justification of actions in the story, and reflection on aspects of the life/experience/ values. Thus it has a chronology, meaning and sequence. An organising framework for the story, such as the life span elements of childhood, early adult experiences, middle and later age, can be imposed by an outside agent such as a biographer.

Life Trajectory: Life trajectory is a metaphor conveying a sense of a time line incorporating a number of strands that can emerge and recede at different points in time. A trajectory is different from the narrative. A trajectory is the path taken by an organism or object, and narrative is part of the story that contributes to the trajectory, and is normally only constructed retrospectively.

Discourse is a broader concept than any single element or process described above, and independent of any individual contributor. It incorporates the talk, narratives, stories, writings and other representations surrounding a particular theme, idea or event. Discourse can be found in any medium of presentation.

Text is a general term for any form of stored representation of a narrative or story, not as some would argue only a piece of written text. Generally it is in written form but could be some other artefact such as a photograph which could be observed and interpreted.

Memory

The notion of memory needs further elaboration. There are a number of other dimensions as well, which are related to memory and history. Memory is a key element in the construction of a history of events or people. The way memory operates is also a metaphor for the way history is 'made'. Writing history is a process of reconstructing the past, not recording it as it happened. In the same way, personal memory is the product of a multitude of constructions of the past.

Exploration of memories that contain traumatic elements presents a challenge to the researcher. In the recent debates about recovered memory, a fundamental premise is that memories are constructed representations of the past, not exact replicas. A traumatic past can result in memory of traumatic material being distorted, suppressed or repressed. This has been aired in a number of places including a special edition of the *Journal of Traumatic Stress*, which focussed on research on traumatic memory. The purpose of the issue was to review the available evidence on aspects of memory, and discuss some of the controversial issues such as recovered memory. On the nature of memory, the consensus from those papers was that 'autobiographical and personal memory is a highly complex phenomenon' (p. 717).¹³

More recently the International Society for Traumatic Stress Studies (1998) published a scientific report on the nature of recovered memory. This report again reinforced the complexity of memory processes and confirmed what had been identified in a number of other places, that 'memory is reconstructive and imperfect' (p. 23), and is not necessarily a replica of something that happened in the past. This view is supported by another recent review (Perry 1998). The recovery of stored recollections is also recognised as a political process, and cannot be divorced from the historical and cultural context of the event (Hacking 1995, 1998, Young 1995).

The representation of past experience and events exists only in the memory store, but the retrieval requires a process that is in effect a metaphorical look at past life. The recovered version of this memory, which can be shaped into a personal history, can therefore be subjective. It can also be mediated by extreme stress at the time of the event (see Bremner et al 1995). If the purpose is to construct a reasonably accurate forensic reconstruction, this is important. For the purpose of this thesis the possibility of subjectivity needs to be acknowledged, but the more central task is to access the

¹³ Green, B. & Wolfe, J. (eds.) *Journal of Traumatic Stress*, October 1995, 8, 4.

narrative surrounding the experience. To achieve this, veteran narratives can be supplemented by other means. In this thesis it was not possible to conduct a longitudinal study even though most subjects could be observed over a period of 5-8 years. In some cases there was some evidence, in the form of original letters, diaries, medical and other records, which might sustain a longitudinal perspective on an individual life.

In a comprehensive discussion of the memory of traumatic experience, Antze & Lambek (1996) extend the concept of constructed memory to include the influence of context. In the minds of participants in events such war, a memory can be constructed within the context of the particular conflict as well as their own individual circumstances.

Our memories are shaped in part by the narrative forms and conventions of our time, place, and position. But as they do not appear to come to us in such a mediated fashion but to be simply what they are, convention is sealed.¹⁴

Antze & Lambek argue that acts of memory are indictments or confessions, as well as being performative acts. For them, the signifying practice is an index of the moral discourse of individuals and groups. The task of unpacking memory involves exploring the ways in which collective assumptions and consensus shape commemorative practice.

Ethical Considerations

Exploring potentially traumatic memory raises a number of ethical considerations. The first is the manner of conducting the inquiry, which needs to be done to ensure there is minimal risk of re-traumatisation of participants. I minimised risk in a number of ways. In the first place, participation in the project was entirely voluntary. The interview was only undertaken if the participant was clear about the intention and structure of the interview, and that appropriate support after the interview was available. The mood and affect of the participant was monitored throughout the interview. If there was any sign of distress the interview was interrupted, and only allowed to continue when the participant was ready. Overall, a naturalistic approach allows the flexibility and sensitivity required.

Confidentiality was assured for all participants. Each interview was audiotaped and transcripts made when necessary. If a person other than the researcher completed the

¹⁴ Antze, P. & Lambek, M. (1996) Introduction to *Tense Past: Cultural essays and memory*, London, Routledge, p. 6.

transcription, they were required to treat the material as confidential. Tapes and questionnaires were stored in a private, secure office. Summaries of transcripts and interviews were given to participants for comment on factual and other aspects. In more detailed interviews with participants the same protocols on confidentiality were also observed. In accordance with requirements of the *Freedom of Information and Archives Act*, surviving relatives provided written permission to view medical files retrieved from the Department of Veterans' Affairs. The research method and protocols were approved by the Ethics Committee of the University of Adelaide.

In eliciting stories, I adopted a conservative, non-intrusive approach. The main grounds for this was a sensitivity to the possibility of reviving disturbing memories in a setting where the veteran and a respect for privacy. Experience confirmed the efficacy of this approach, and I cite two examples of this. One example is the case of a survivor of the first Japanese assault on Kokoda, and the battle for Gona. He completed a questionnaire in which he described in some detail the experience of escaping from Kokoda carrying a wounded mate. He had 'trained himself to forget' but was sure he would 'have a bad night after all this recall'.

A second example is a 2/27 veteran, aged 83, who agreed to an interview after reading the study description and signing a consent form. In the interview he recounted his New Guinea experiences, about which he still felt bitter, and the difficulties of getting himself re-established after discharge. Part of his story was about his wife's fatal illness and the three years he nursed her before she died. At the end of the interview he stated it had been good to talk, and agreed to look at a questionnaire which would allow him more time to reflect on his life events. In a follow-up telephone conversation a few days later, he was more subdued and thought it had not been a good idea to take part. The remembering had 'taken him back too far' and 'some things were best left in the memory'. He was somewhat upset and regretted he had agreed to the interview in the first place. He was not pressured to complete the questionnaire.

METHODS AND STRATEGIES

A semi-structured interview was the primary research instrument in the generation of narratives. A life history questionnaire devised and telephone interviews were used to supplement personal interviews, when direct contact was not possible. This open interview adopted in this study allows is an exploration of experience, and at the outset, outcomes cannot be predicted or constrained. This approach is recognised in the

National Health & Medical Research Council (NHMRC) guidelines for qualitative research where the interview process is described in these terms.

A good interview encourages a reflective process, where participants explore their feelings, thoughts and experiences. While this process of reflection often results in people learning new things about themselves, it may also reopen old wounds. Additionally, people often reveal things about themselves in an interview that they never had intended to talk about. Thus, interviews can become confessionals.¹⁵

A relevant precedent for the approach adopted is a study by Rosenberg (1993), who used life stories as the primary means of accessing the experience of Vietnam veterans in a longitudinal study of Dartmouth College graduates of 1967/68. In his open ended interviews participants were 'invited to engage in a narrative reconstruction of his life which is begun by focussing on the 'sixties' as a historical moment of choice and emergence. (p. 46). Participants also completed questionnaires covering various aspects of their lives. Rosenberg argued that these oral histories formed 'texts of their identity', and could be aggregated to obtain a picture of the life course of the cohort. The method was similar to that in the study of Harvard men, which used reiterative interviews at critical times (Vaillant 1977).

In my thesis, the narratives generated from interviews were supplemented where possible with personal records, such as autobiographical accounts and writings, accounts from relatives, and other written records such as Murdoch Sound Archive interviews. In a limited number of cases, medical records of deceased veterans were obtained from the Department of Veterans' Affairs.

The key elements focused on in the life course for veterans are:

General Biographical

Age; relationships; family of origin; marital status

Pre-1939 life

Employment; Education; Early Trauma experience; Childhood experiences

Family; Depression experience

War 1939-45

Enlistment; Role; Tour of duty; Trauma exposure; psychological outcome/Treatment

Illness; Wounds; Coping mechanisms; discharge

¹⁵ NHMRC Guidelines, p. 22. The NHMRC initially formed in 1936 and was established as a statutory body under the *National Medical Health and Research Council Act 1992*. The Council,

Post-war 1945-50

Adjustment; Recovery period; Sleep patterns; Psychological outcome; Health outcome; Relationship outcome; evidence of disturbance; Work outcome

Mid-life 1951-70

Psych/life outcome; Health; Work development; Marital outcome
 Veteran life assessment/satisfaction; Economic progress; Sleep patterns
 Achievements; Morbidity/mortality

Later life 1970-90

Psychological outcome; Health; Work; Marital; Veteran life satisfaction;
 Economic outcome; Sleep patterns; Morbidity/mortality
 A copy of the questionnaire is attached is in Appendix B.

SAMPLING

There is a complex web of networks of veterans in Australia. To obtain a sample of men who had experienced significant combat conditions I initially approached the main umbrella organisation, the Returned and Services League (RSL), in South Australia. This was a deliberate choice, and an alternative to approaching a hospital or clinic, where veterans might be admitted for treatment. The RSL offered two options – to approach either local suburban branches or to contact veteran associations. I eventually took up the second option and approached a South Australian association. This association is described in Chapter Two.¹⁶

Unit associations are made up of the ‘old scholars’ of a particular unit, usually a battalion. The 2/27th Battalion (following the tradition of the 27 Battalion of WW1) was originally formed in South Australia in 1940 and the 2/27 Battalion (A.I.F.) Ex-servicemen’s Association is still based in Adelaide, with several regional groups. To gain access to this organisation I had to pass a number of gatekeepers. The first was the unit secretary who approved my purpose and bona fides status. The second were the members themselves. My first contact was at their monthly luncheon to which I was invited to explain my project. After explaining my purpose I issued handouts giving them a choice of being interviewed face to face, having a telephone interview, or

the largest and most influential research body in Australia, funds several hundred projects each year and develops guidelines for research and other policies.

¹⁶ Sub-branches of the RSL, and the Totally and Permanently Incapacitated (TPI) organisation, were not cooperative.

completing a questionnaire. From this first encounter I had seven responses and I interviewed them shortly after. From then on I expanded the number through personal referrals, further appeals through the newsletter, and other veterans who had taken time to consider my offer and make a decision.

I also contacted other unit associations such as 39th and 53rd Battalions, which had also served in New Guinea in 1942. As these units were based interstate, these members were more difficult to recruit for an interview. Some direct approaches were made to key ex-members of the battalion; four medical officers, the commanding officer of the 2/27 during the Kokoda period, the authors of the 2/27 and 39 Battalion histories and an officer of the 2/6 Field Ambulance. Because of the constraints of distance and time two group interviews were conducted. One was in Melbourne (39 Battalion) and another in Mount Gambier (2/27). Several other individual interviews were conducted in Melbourne, Sydney and country South Australia. One of the most interesting was conducted in a tent in a remote coastal town in South Australia in 37°C heat.

This type of sampling falls within the category of 'snowballing sampling' (Morse 1989), which acknowledges participants' privacy, as well as their willingness to volunteer, and was the least intrusive method of recruitment. Experience proved that other approaches such targeting particular veterans and approaching was invasive and rarely productive. A number of life stories of deceased members were compiled from interviews with family members, and service and medical records. Some material was incorporated from transcripts of the Murdoch Sound Archives.

From the original pool of 65 participants who were surveyed, 23 men were approached for additional information in the form of two short questionnaires. The first was a Memory Questionnaire, an adaptation of the Impact of Events Scale (Horowitz 1986) which I revised (Appendix C). The second Belief Questionnaire (Appendix D) contained twelve items on memory practices, views about war and ways of managing memories. These two questionnaires were not used as clinical instruments, as the IES was originally intended, and were used to elicit more qualitative information on the way men construed and reacted to memories of war experience.

REALITY OF EXCAVATION

The general response of veterans was characterised by reticence rather than effusive talk about the war component of their story. This was particularly true when there was a suggestion of some form of breakdown or mental problems. In some cases I had to wait

for several years to gain an insight into their experience. For example I originally interviewed one man in 1991, but I did not find out until 1995 that he had 'nerve' problems, and that his brother had experienced a more serious mental breakdown from which he never really recovered. Had his first interview been taken at face value my version of his life story would have been distorted. This is something he would have never talked about at reunions nor discussed within the family.

Even after finding men willing to discuss their experience, getting access to what really happened was also difficult. Some veterans still found it distressing to talk, and good sense and professional judgement dictated that their secrets should be left alone. Others had put their memories so far away even they had difficulty accessing them. One of the early respondents returned a scantily completed questionnaire with 'NO PACK DRILL' scrawled across the top of the page. I learned from his colleagues that he had been a heavy drinker after the war. However, his responses in a questionnaire only stated that he 'never settled down', and had been forcibly retired from teaching on grounds of invalidity eight years after the war. There was no mention of a breakdown in his questionnaire response and only a brief mention of some treatment at the repatriation hospital. In his diary that was publicly available through members of his unit association, there was some information on this breakdown.

In these memoirs he wrote

After returning to my civil occupation I suffered a breakdown in health, was discharged from the Education department on medical grounds in 1953. This was the first of momentous happenings since 1946. My wife left me in 1959 and got a divorce in 1961. As a consequence the two boys left me too. I was made TPI after my breakdown in health but during the last few years have learned to live with my disability.

He hinted at some form of breakdown in his time in Borneo in May 1945, 'I wonder if I was beginning to show signs of cracking up even then'. He was visibly changed on his return home in 1945

and when I staggered along the platform at Adelaide in jungle greens looking like a shivering rat, E [wife] and company hardly knew me. I was sent to Daws Rd for a medical but wouldn't listen to their idea of a pension; all I wanted to do was get back to a civilian job of work.¹⁷

On the basis of this information I contacted the veteran's son after his death and obtained permission to view his medical records where it was revealed that the veteran

¹⁷ Questionnaire response and personal diary FB.

had been treated over an extended period in the repatriation psychiatric ward. All this information yielded a composite life story.

In veterans' narratives there might be other brief references to strain in the form of comments like 'most of the chaps have problems', or there were 'years of nightmares', and 'only another soldier would understand'. In one case a veteran contacted me by letter writing that he had experienced 'stress problems' but would not elaborate. The contact expanded through a series of written exchanges, and culminated in a joint interview with the veteran and his wife.

A 2/27 respondent from the country sent a letter in response to a request in a rural newspaper for WW2 vets to participate in the study. His letter indicated he was stressed in his early years and in retirement he thought much about his lost mates. He admitted that 'I myself suffered some moments of for a period of a few years, but appear to have little effect now'. His current experience was focussed on memory of lost mates, which 'front line troops could never eradicate from our minds'. 'I remember them every day and the terrible circumstances under which many of them died'. In an interview he explored some of his feelings. 'Perhaps sometimes we should say a bit more. I don't mean about actual warfare itself, but where we were, some of the experiences and that. Another ten years and most of us people will be gone. I suppose it's difficult for anybody else to understand'.¹⁸

This case illustrates how stories of serious strain rarely came in neatly prepared packages and in most cases the individual story could only unravelled by painstaking excavation. Some informants had attempted to write some form of life story, which focussed on outer external events and achievements, but these helped to form the package of information on participants. This included men who had in retirement compiled a comprehensive biography, incorporating chronological events, photographs and cuttings. Since their intended audiences were most often their grandchildren or children, references to traumatic experience or strain were carefully censored.

Those who gave extensive accounts of traumatic experience and strain in fact needed to be treated with some caution. One interviewee illustrates this. He responded to a letter in a local newspaper asking for veterans of WW2 to share their story. He initiated the contact and arrived at my home for an interview. His skill as a raconteur was seductive and initial indications were that he was revealing a classic trauma story. In his

¹⁸ Letter and interview ML 1992–1995.

version he was a good soldier serving in a crack commando unit in Syria and New Guinea, and the trauma of New Guinea had pushed him over the edge to become a 'nerve case'. While in New Guinea he claimed he had endured horrific experiences in combat, had witnessed torture and atrocity, and eventually broke down. He was discharged medically unfit, and spent the rest of his life in and out of hospital with various diagnoses, including depression.¹⁹ Examination of his medical file and interviews with members of the family revealed that he had in fact fabricated many of his stories, and had constructed a trauma narrative that justified his distress and monetary compensation. This experienced justified caution in the ready acceptance of a dramatic story and warrants the gathering of broad-based information from which to formulate a version of the life story of a veteran.

ANALYSIS: MAKING SENSE OF COMPLEX LIVES

Making sense of complex information generated in this way is difficult and no simple technology or method adequately was available. The approach I adopted is summarised in Figure 9.2, and consisted of an inductive process of working from individual stories to general life stories, and then observing themes and explanations. There were two initial tasks. The first was to compile individual life stories and the second was to collate them into what I term collective life stories. This collective life story is an integrated summary of the individual lives. From the individual life histories, biographical markers such as early life details, pre-war experience, war service, health, work experiences and level of trauma exposure were coded for collation and descriptive summary. A similar procedure was used by McCalman (1993) to collate the life stories of a sample of Australians living in Melbourne between 1920 and 1990.

Individual life stories need to convey a sense of the life trajectory. A trajectory is a metaphor that conveys a sense of movement through space and time, and can be observed by plotting the life events over time and developmental changes and shifts along a vertical axis. Embedded in each life story is the potential for the traumatic

¹⁹ Medical classifications were: A1. Medically fit for all duties; A2. Medically fit for all duties for which the particular disability is not a bar; B. Medically fit to carry out duties which require only restricted medical fitness; C. Temporarily medically unfit; D. Medically unfit for military service. See Walker A. (1953), *Middle East and Far East*, pp. 435-436.

experience to impact on the course of the life trajectory. Meticulous and accurate plotting is sometimes difficult, but a sense of the trajectory can be obtained by plotting the different elements in the trajectory.

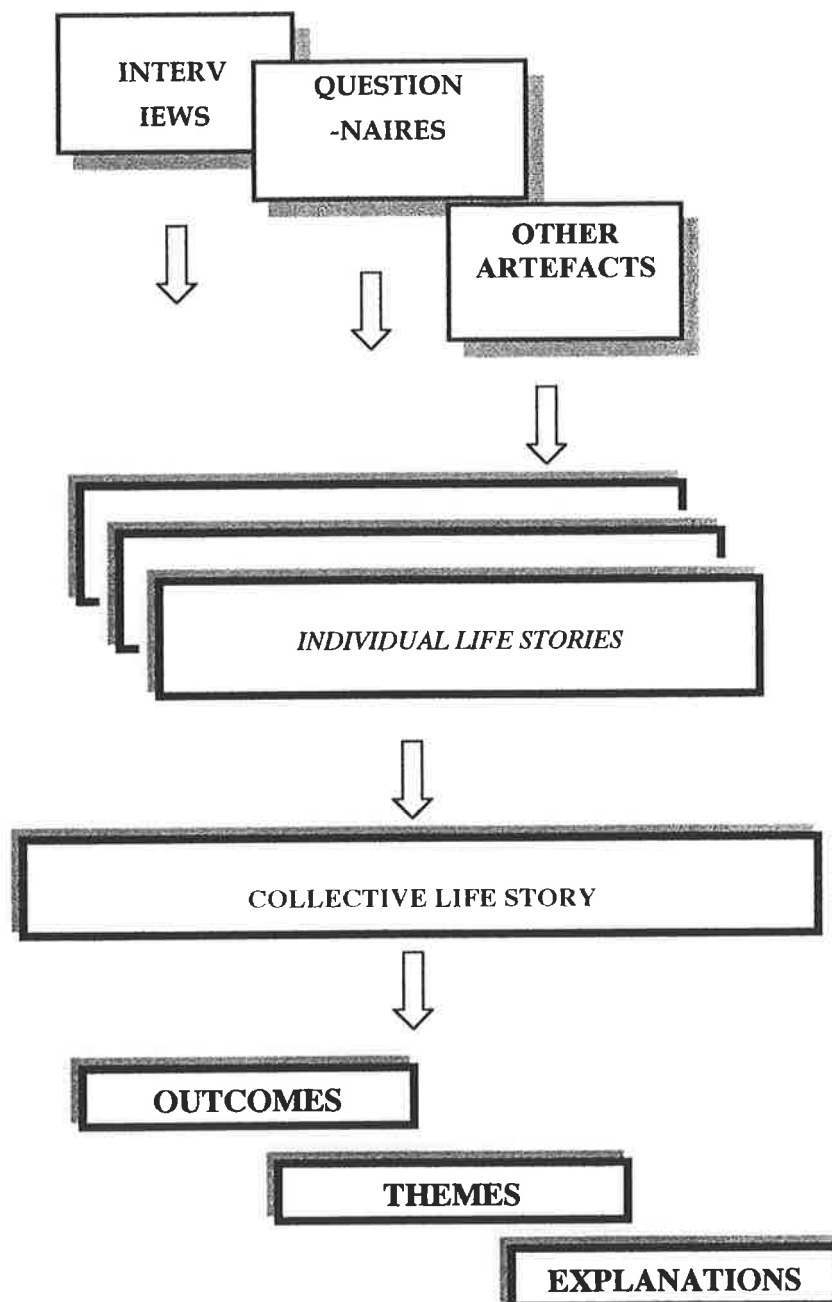


Figure 9.1 Schematic presentation of analysis process

FINAL CHECKS: VALIDITY AND RELIABILITY

What has been described above is only the beginning of the process of making sense of complex material. The production of knowledge is much more than observing a collection of information or data and drawing inferences. Observation of the life

outcomes of veterans and the influence of traumatic experience is an organic, evolving process rather than a clinical examination. This observation cannot be subjected to the exigencies of validity and reliability checks, as applied in a controlled laboratory experiment, but the need for both cannot be ignored.

In this study, validity is addressed in two ways, as advocated by Silverman (1993). The first is through the use of different methods and types of data to build up the picture of individual lives. It is an example of the process of triangulation as described by Silverman (1993). Bellaby (1991), who argues that triangulation provides cross-validation, gives different viewpoints on the same reality, and opens up windows on underlying structure. The term triangulation was originally ascribed to Denzin, who described it as a 'true' state of affairs is arrived at by merging information from different sources and observing where they intersect'. The term derives from the analogy of setting one's position after taking bearings from at least three different positions. This technique provides a composite picture of the veteran life course after war, in which patterns and themes can be observed. The second means of ensuring validity is through respondent validation, which is a process of checking observations and written products with the original informants.

Reliability refers to the degree of consistency in 'data' and applies to the reliability of the recorder as well as the participant. Observer reliability is partly ensured by skill and training, but it can be at least enhanced by a sample of reliability checks on the interpretations made of transcripts and other data. Participant reliability can be monitored through careful analysis of repeated observations particularly with chronological data.

This chapter provides a bridge between the historical review of ideas and the exploration of veteran experience. I will now examine this experience in detail and present the findings in this study.

CHAPTER 10

LIFE AFTER WAR: Life Outcomes of WW2 Veterans

I wish you all on returning to civilian life, every success and happiness and the very best of luck. It is my sincere hope that you will find little difficulty in re-establishing yourselves in the community back home and that you and yours will get just reward for your sacrifices that you have made for Australia.

Speech to troops, August 1945, after the cessation of hostilities.¹
Brigadier Ivan Dougherty, Commander, 21 Brigade.

This statement was made shortly after the second atomic bomb had put an end to the war in the Pacific. Despite its positive and hopeful tone, there is a hint that there may be some difficulties for veterans re-entering civilian life after multiple engagements with the Japanese. This chapter provides an overview of the life outcomes of 65 veterans who had experienced a very stressful period of war in New Guinea in 1942 in particular, where they had been under threat, endured very arduous and dangerous conditions, suffered heavy losses, and observed or participated in brutality. Official accounts of that period highlight the low psychiatric casualty rate and historical accounts minimise any strain and emphasise their high level of morale and resilience.

I will address a number of questions. The primary question is how these men survived physically, emotionally and psychologically over time. Embedded in this are a number of specific questions.

- Is there evidence of unreported strain during service?
- Is there evidence of undetected problems?
- What are the life outcomes for these men?
- Is there evidence of breakdown after service?

As I have stated from the outset, these questions are addressed on the basis of careful recording and synthesising of narratives into life stories of survivors. In this chapter, however, I will not recount these life stories in detail but rather distil their narratives into a collective story. This is actually a difficult task. Lives do not conform to a neat linear trajectory, and each life is infused with many complex interacting elements. However, two extracts from sample narratives provide a broad framework for considering the evidence and give an insight into the range of life long effects.

¹ Burns, J. (1960) *The Brown and Blue Diamond at War*, p. 231.

The first is from a senior officer, a veteran of five campaigns, who sustained minor wounds, had malaria, and was exposed to multiple traumatic experiences.

After living on your nerves for some years, it does take a while - I reckon about a year - to stop over-reacting to a tap on the shoulder or a sudden noise. However, I get disgusted with some of the rubbish they produce on TV and films about disturbed returned men. I do not know anyone like that. No one at all. No doubt there is the exceptional case? Again, any normal person doesn't need special help. The human species is extraordinarily adaptable. Anyone returning to a good family gets whatever help is needed. And really it's no big deal.²

The second is from a militia infantry private who at age 20 experienced his first fighting in New Guinea in 1942. He contracted malaria and was in a fighting zone for most of 1942. He highlights a specific experience.

One Japanese bloke had his arse and legs shot away with machine gun fire. The officer at the time did not have enough guts to kill him and he said to me. Right-oh Smoky finish him off'. I have lived with those eyes looking at me from that day to this. I shot him between the eyes. Bloody terrible.

I dreamed about it for twenty years or so - very bad with me nerves at the end of the war, I'd have nightmares about that chap. I nearly choked my wife. God knows what it does to you and its the first four or five years that's the worst.

In these narratives there is a common theme that being in combat was a strain and that it was followed by a period of adjustment after discharge. From some point a few years after discharge their accounts of life diverge. The officer believed that a stressful experience does have a short-term effect, but those effects will pass without any expert intervention, and adjustment is the norm for most veterans. The second statement is a reflection of a lifetime of struggle of someone who did not settle down after the period of post-war adjustment. His traumatic memory continued to disturb long after discharge and affected his relationships and work. As the following synthesis will demonstrate, there is an element of truth in both statements. For WW2 veterans the second narrative represents a carefully submerged or repressed narrative about the effects of war trauma.

These exemplars flag some elements of agreement as well as divergence. Both informants grew up in poor households during the 1930s Depression. The officer lived in difficult and deprived areas assigned to his evangelical minister father and the family survived on what the parish could provide. The private was also poor as one of 19 children subsisting on a market garden. They have a common experience of extreme

² Questionnaire response from JR.

wartime stress and a period of difficulty adjusting in the post-war period. From that time on their lives diverge markedly.

The officer completed high school in his youth and after he was discharged went on to become a successful stud sheep breeder and businessman. He now lives in a large house with his original partner, and enjoys the material and social benefits of a successful career and a wise choice of partner. His life is one of rich variety with many satisfactions from work and family and more recently from professional hobbies like agricultural history. He is still socially engaged, has published several books and has a strong interest in agriculture and viticulture. His main contact with medical ideas came when he had a heart attack at the age of seventy.

His life narrative is not dominated by his war experiences. He admitted to some distress when reminded of mates he had lost, but this was secondary to his life story. He chose not to emphasise his traumatic experience, and in his questionnaire and first interview highlighted his ability to overcome his fear. When pressed further in his second interview he recalled incidents that could have been turned into a narrative of distress. When the Soputa hospital had been overrun and patients were bayoneted, one of them was a close friend. He had seen two of his mates who had been strung up by their hands and used for bayonet practice. He had watched helplessly as a mate took three hours to die at Gona. When he arrived in the Markham Valley in 1943 he smelt the stench of putrid and bloated Japanese killed and left by the commandos at the landing field at NADZAB. None of these events assumed a central place in his narrative.³

The soldier in the second narrative, whose life is addressed in more detail in the next chapter, never settled and life after war was a continual struggle. He was an angry and aggressive man, his marriage failed, he remained tormented by nightmares and war dreams, and struggled with mental and physical health problems for most of his life. Materially he advanced little and in later life had few possessions, not even a house, of his own. Even though ultimately he was a survivor, his war experience and struggles for health dominated his narrative. As will be shown his later life outcome was eventually more positive but at great cost.

³ In fact a subsequent interview revealed that the officer had taken several years to adjust. His wife testified that he was 'nervy' and the family had to be very careful for several years.

COLLECTIVE LIFE STORY

A collective story was compiled around 33 common elements in each of the 65 life stories. In constructing the collective story some of the rich context of individual stories is lost, but this rich texture will be well illustrated in the following chapter. Two tasks were involved in devising and allocating values in these elements. The first was in the selection of appropriate indicators of the life story. The second is in the assignment of values in each element, for example in the level of intrusion of war memories. A description of the elements used in the analysis is found in Appendix VII. The elements encompassed the following areas:

Biodata:	Pre-war education level Age at end of 1941 Childhood trauma Pre-war occupation Age at death
War Service	Military unit e.g. 39 Battalion Role Rank Years of service
Trauma exposure	Critical Incidents Wounds Illness Combat stress – evidence of breakdown Medical intervention
Post-war	Adjustment Employment Relationships Community work Physical Health Life outcome – external markers of success
Post-war Inner	Psychological outcomes Inner remnants Nightmares/war dreams Intrusive thoughts Rumination Later life intrusions



Photo: Australian War Memorial

Figure 10.1 Life after war.

Top: After John's Knoll Action, October 1943. Lt R. Johns, M. M. second from right.
 Below: ANZAC Parade Adelaide April 1993. R. D. Johns, M. M. front right



Photo: J Raftery

In the individual and collective stories two main life strands were identified. The first is the **outer life**, which is manifest in the external tasks such as service duties, finding work, relationships, re-establishing a house, starting and supporting a family, engaging in recreation and community activities. Completing or attempting these tasks were not static activities and could undergo dynamic transformation at different life stages and changes, as individuals developed, family composition altered and economic circumstances changed.

The second strand is the **inner life**, which is a space for inner experience, including manifestations of the remnants of war events. These remnants can be observed self-reports or in other's observations, as well as thoughts, feelings, behaviour and war-related dreams, particularly nightmares. Evidence of this inner life can also be found in behaviours like avoiding watching a television report of war, or becoming teary at a war related topic. War remnants are manifest at different stages of the life span – immediately after discharge, at midlife and in later years. Of particular interest is their later life when memories suppressed at an earlier time can re-emerge. There are two possible patterns in memory in later life around which experience may revolve. The first is a diminution of the intensity of previously disturbing material.⁴ The second is a revival of memories that had been previously well controlled and had no intrusive capacity and have the capacity to disturb.⁵

The information in the collective life stories is reported largely in descriptive mode and quantitative analysis is limited to descriptive statistics, because of the nature of the information and the selective nature of the sampling. The sample is too small for example, to address such questions as any significant difference in psychological outcome between militia and AIF troops, or an analysis of the relationships between childhood trauma and later breakdown. Despite some limitations of sampling, the quality of information and the size of the sample do allow me to make some general

⁴ A classic example of this is CS, a company commander, who in the early 1990s would not be interviewed by Brune for *Those Ragged Bloody Heroes*, and only chose to give a very brief interview to me around that time. His wife died about this time. At that time any recall of the New Guinea period was too distressing for him and he chose to talk only about post-war life. At my approach in 1999 he was willing to talk about his experiences and no longer found it distressing. This appeared to be partly because he was beginning to experience memory loss and less emotional intensity associated with the memory. Nothing from the past could really distress him any longer.

⁵ HD, whose life will be described in the next chapter, is an example of this. He controlled his disturbing memories for years until retirement, after which they began to intensify.

observations about the 2/27 Battalion, which could be extrapolated to infantry battalions of similar structure and exposure.

The presentation of the collective life story will be in three parts. The first describes the characteristics of the sample, and summarises their war involvement. The second describes the general outcomes over time both in terms of inner and outer life. The third part categorises these life outcomes into four broad patterns.

CHARACTERISTICS OF THE SAMPLE

The sample comprised 65 veterans. Fifty six men participated in interviews or completed a questionnaire or both. The rest of the sample was made up of nine deceased veterans about whom I constructed posthumous histories, compiled from medical and other records, and interviews with family members. Other members of battalions were interviewed but were not included if they did not fulfil the exposure requirement or were considered to be unreliable informants. Of the 56 live informants, seventeen participants died before completion of the thesis. This was not an unexpected outcome, given the age of the sample, but in retrospect, it was fortuitous in that it provided an opportunity to observe the men at the completion of their life span and in some cases to gather information on their last days. Where possible and ethical, information on these deceased veterans was sensitively obtained from relatives on the manner of their death and whether there was evidence of war-related disturbance in their last days.

Two thirds of the men were from the 2/27 Battalion (n=44). The rest came from 39 and 53 militia units and two other units in 21 Brigade. Their common experience was the period of intense engagement against the Japanese army, at various times between February and December 1942. The sample is thus sufficiently coherent and their combat exposure sufficiently similar for me to make meaningful observations about the effects of war strain as well as the subsequent post war experience.

The sample appropriately reflects the structure of an army battalion, with all ranks and levels of commission represented. Twenty three percent were commissioned officers, 43 percent were non-commissioned and 34 percent were from the ranks, never having received a promotion. Both commissioned (e.g. Lieutenant Colonel, Captain, Lieutenant) and non-commissioned officers (e.g. Warrant Officer, Sergeant, Corporal) as well as privates, had front line fighting roles. Most organisational roles were represented, including commanding officer (1), adjutant (1), company commander (6), platoon commander (10), section leader (5), support roles such as stretcher bearer (2),

cook (1), quartermaster (2), signals (7), and intelligence (4). Specific combat roles included machine gunner (4), mortar operator (1), runner (1), sniper (1), and rifleman/infantryman (19).⁶ Even though in normal warfare not all these men would be exposed to front line conditions, in New Guinea both in the Owen Stanleys, and on the northern coast, all ranks were directly exposed to the enemy, even though not all were engaged in actual fighting.⁷

When they went into action at the beginning of 1942, most of the men were under 25, their ages ranging from 18 to 40 years. The average was almost 24 years. The age of men in the militia units was lower but they are under-represented here.

Table 10.1 Age on entry to New Guinea in 1942: AIF and militia

Age range	Frequency	Percent
18-20	11	17
21-25	36	55
26-30	13	20
31-40	5	8
	65	100

On enlistment all of these men had passed a basic medical examination and had been declared physically fit. Although their testimony could not be clinically evaluated they had also testified that they had not had a nervous breakdown and had never been diagnosed with shell shock or neurasthenia.⁸ Most of the men were educated in the 1930s, when opportunities for higher education were limited. About a third (32%) had completed primary school; 22 percent completed some secondary schooling and 32 percent had completed Intermediate; 3 percent had trade qualifications; and some had trained for professions with a university level education (11%). These men had survived the economic depression of the 1930s and 21 percent could recall an incident from childhood which was distressing, such as losing a parent or sibling or having a serious

⁶ As reported in Chapters 7 and 8 medical personnel and a chaplain were interviewed to complete the landscape of the site. They are not included in the life study sample. In addition a group interview was conducted with three additional members of the 2/27. Their ideas informed my observations. I also had access to eight additional Murdoch Sound Archive transcripts of veterans from the 53/55, 39th and 2/27 battalions. These transcripts, although not covering the whole of life, provided confirmatory information on conditions and experiences in New Guinea.

⁷ It was pointed out in Chapter 8 only one senior officer of the 2/27 Battalion was left unscathed at the conclusion of the battle for Gona Beachhead.

illness. They came from a variety of occupations including labourer, farmer, baker, butcher, school teacher, company manager, journalist, army officer, and salesman. The distribution of occupational categories is shown in Table 10.2. This table also shows the shift in occupation over time, about which more will be said later.

Table 10.2 Comparison between pre and post-war occupation

Pre/Post	Unskilled	Trade	Sales	Clerk/Acc	Manager	Profession	Total
Unskilled		5	8	2	10		25
Trade		2	1	2	1	3	9
Sales			4		17	2	23
Clerk/Acc					1		1
Manager					5		5
Profession						2	2
Total		7	13	4	34	7	65

EXPOSURE TO TRAUMATIC EXPERIENCE

This section summarises the exposure of men during their New Guinea campaigns 1942-43. For three-quarters of this sample, New Guinea was their second tour of duty. Their first exposure to battle conditions had been in the Middle East, where they were engaged in a number of campaigns mainly in Syria. These AIF units from the Middle East began arriving in Port Moresby in mid 1942 where the militia units (39 and 53/55) had been since February. Conditions in New Guinea have already been detailed in Chapter 8. That description conveyed the extreme danger and physical and mental strain that all men were exposed to for several months, in the Owen Stanleys, and at Gona, Buna and Sananander. In these conditions there was a high probability of wounds and serious illness and of being killed and even tortured. Participants experienced single traumatic incidents or a combination of incidents. The experience of one informant provides an example:

I find this question most difficult as I have several traumatic experiences. One of the worst was being overrun by the Japs at Isurava (Kokoda Trail). A small amount of mail had got through, [including] a letter for an 18 year old mortally wounded soldier from his mother. He pleaded for me to read it out, which I did, but he died in

⁸ AA Form D1 Medical History Sheet, Australian Military Forces, revised May 1939.

my arms. I will never forget the terror in his face, his thoughts of home and his mother.⁹

All men had their own version of similarly distressing experiences. Almost 70 percent could recall one specific event, such as seeing a friend killed, being strafed, finding soldiers who had been tortured by the Japanese, killing the enemy, recovering bodies, witnessing an atrocity, or being bombarded with artillery or mortar fire. The most serious events were being ordered to shoot a wounded enemy soldier, and, in an extreme case, being ordered to kill a fellow soldier.

At a physical level, only ten percent escaped being seriously wounded or contracting a serious illness. One in three were wounded seriously enough to require hospital treatment. Seventy six percent were treated (at least at an aid post) for serious illness such as malaria, scrub typhus, dengue fever, dysentery, and beri-beri. Of the total sample only two emerged unscathed with no wounds or illness at all and only eight had avoided serious wounds and illness. All of those involved in the withdrawal from Kokoda had lost significant body weight.

STRESS BREAKDOWN

With such a high level of exposure and strain was there evidence of breakdown in the field? In the official data, incidence of psychiatric casualties (see Chapter 8 in this thesis) was low and there was no evidence of an epidemic of stress breakdown or mental illness in the New Guinea campaigns. I did note, however, that in these campaigns, medical staff worked with very limited facilities and were pre-occupied with treating wounds, injury and serious illness, and that this probably resulted in failure to diagnose. Low incidence at the time could also be attributed to the strong probability that serious wounds and illness such as malaria and scrub typhus masked the evidence of strain.

Of the 65 respondents, seven men (10%) were identified as having had a breakdown experience during their New Guinea service. Breakdown experience, as previously defined, is a Combat Stress Breakdown (CSR), which causes the soldier to become dysfunctional in the field. It is manifest in behaviours like being overwhelmed by

⁹ Questionnaire, MKB, 39 Battalion.

emotion, or being unable to think or concentrate and perform duties.¹⁰ This is a distinct phenomenon from a soldier giving up out of fear. These men were unable to perform their duties and five of them were treated and evacuated. All continued to experience difficulties after they were discharged and all except one continued to receive treatment.

However, this does not truly reflect the level of strain and its immediate effects in the sample. A further 21 men (33%) were judged on the basis of their narrative to have had some form of stress problem during the New Guinea campaigns. This included a temporary breakdown or being so strained that they thought they could have broken down, or experienced some crisis that necessitated a transfer. This information was derived from self reports of experiences in combat areas, their own and other's assessment of their state on discharge. Assignment of a temporary breakdown experience or potential breakdown was made conservatively and was used as an indication of serious strain rather than a medical diagnosis. This type of reaction was quite different from being anxious or fearful, which most men acknowledged as normal, and which did not occasion any medical or other intervention. The following statement indicates what is meant by a minor breakdown:

During an advance at night time, two hours on, two hours restless sleep, my nerves became strained; saw things that no-one else saw; shaking uncontrollably; taken back for a couple of days then returned to front line again. No more trouble after that.¹¹

A personal crisis could be triggered by an experience indirectly related to battle conditions, such as finding a family photo on a Japanese soldier who had just been killed. This did happen to a 2/27 member, who then found he could no longer commit himself to front line fighting. After developing a serious skin condition, he was repatriated to Australia and continued to serve in a non-combat role.¹²

¹⁰ It is difficult to distinguish a breakdown from an outright fear reaction, when a soldier is just unable to face battle. One example was a young man who was overcome with fear and hid behind a tree until rescued by his older companion. The young man was not given any treatment, senior officers refused to allow him to be relocated and he subsequently 'suicided' by running into machine gun fire at Gona.

¹¹ Interview PW, 39 Battalion.

¹² Interview, JA, 2/27 Battalion.

THE OUTER LIFE

Transition to Civilian Life

Getting on with Life was a first priority and a common task for these men when they were discharged. After an unsettled initial period, generally the majority of men adjusted well and received their 'just rewards'. They went on to live fairly conventional lives, at least on the surface. The majority was able to find satisfactory work or resume old jobs and advance their careers. They also found stability in relationships and could enjoy their grandchildren in later life, and retire in relative material comfort. They were in their mid life in the 1960s and while the next generation was experimenting they remained settled in their marriages and jobs. They were too old for the social experimentation of the 1960s, and perhaps for many, as one informant put it, 'I'd had enough excitement for one life'.

The early post-war period was a critical time in the lives of veterans and warrants further mention. Men emerged from war after at least three years of service, including a number of tours of duty, and they had to make the transition back to civilian life. Laufer (1988) described this as a social transformation to a post-war self, during which there could be an 'antagonistic relationship between the encapsulated war self and the adaptive self of civil society' (p. 51). When men were formally released from the army, a central requirement was that they be examined medically and any details of disabilities noted on the Final Medical Board AA Form D2.¹³ Any medical condition arising during service was noted on the Service and Casualty Form AF B103, which was a record of every investigation and treatment that had occurred during service. When they enlisted they had been required to state on the Attestation Form AA1 D1 whether they had been diagnosed with shell shock or had experienced a nervous breakdown. On discharge there was no such questioning or examination about similar experiences during service. The final medical examination addressed only the soldier's physical condition – eyes, ears, nose, throat, cardiovascular, lungs, abdomen, nervous system. If any abnormality was detected the soldier could be sent before a Medical Board for examination and determination of his status. A key question was whether the 'member has any occupational restriction, or requires treatment'. If this was the case appropriate referral

¹³ There were five possible classifications: A1, fit for all duties; A2, fit for all where the disability is not a bar; B, Fit for restricted duties; C, Temporarily unfit for duty; D, Unfit for military service. See Walker (1953) pp. 435-436.

was made with a Medical Rehabilitation Advice Form. There were thus two decisions to be made; one relating to the need for rehabilitation and the other relating to whether the soldier could apply for some form of compensation.

At this exit point none of the veterans had any form of debriefing such as is frequently available in the armed services and other front-line agencies today. The men of 1945 faced a different Australia from the one they had left when they embarked for overseas. Most viewed their time in the service as being of some value. It had taught them skills, discipline and how to handle difficult situations. One veteran gave this example,

You have a lot of experiences. Despite a lot of them being unpleasant, they still add something to your being, to your person. We had a daughter who was born with one leg shorter than the other. She had a lot of time in hospital. That is a tragedy but it adds something if you like to look on the good side; added something to her character. The army was like that – it is not all credit and not all debit. Of all the settlers at W, the soldiers generally were more go-ahead than those who had never been.¹⁴

There were some financial and material advantages as well. They would be eligible to apply for low interest service housing loans and other repatriation benefits such as retraining allowances under the Commonwealth Reconstruction Training Scheme (CRTS). Allocation of land for farming was also available under the Soldier Settlement Scheme.¹⁵ These repatriation benefits all related to the external resettlement.

On their return to civilian life there were two tasks: to take up their civilian role again and to deal with remnants of war in their mind and body. Each task presented at least some difficulty for most veterans in this sample. Four out of five men found life difficult or very difficult for at least six months after discharge, some taking up to two years to feel as though they were back to 'normal'. Only four individuals claimed that it was a relatively easy time. For some the adjustment related to physical recovery from serious wounds or the effects of malaria, dengue fever or scrub typhus. Most were still recovering from some form of illness, with periodic bouts of fever from malaria, and a

¹⁴ Interview JA.

¹⁵ The Commonwealth Reconstruction and Training Scheme provided training allowances and fees to complete approved education and training. This might range from a trade course to a medical degree. The Soldier Settlers' Scheme opened up virgin country and granted blocks to returned men. The 'blocks' were provided cleared and fenced with some shelter such as a second hand hut.

few were adjusting to more serious losses such as an amputated leg or having had part of his scrotum shot away.¹⁶

A serious assessment of the relative effects of illness and intrusion from traumatic memory is very difficult from this distance in time. For example many nightmares in the early years could well have been induced by high fever, with the content supplied from memories of distressing New Guinea memories. This highlights the difficulty in making retrospective observations on psychological status. At this point then I make no attempt to diagnose but merely observe that the majority of veterans after discharge were still mentally and physically distressed. Part of their distress related to inner disturbance from traumatic experiences. The crucial question is whether this distress continued, and in what form and whether it contributed to ongoing disturbance, after discharge and in later years.

The tasks of demilitarising and adjusting to civilian life were equally difficult. When veterans returned to civilian life they had to start over again in several important areas of their lives. Housing was very limited and most had to make do with living with relatives or in shared housing. Parents had aged, possibly prematurely, during the war and were often at a stage in life when they needed care. By and large the strategy was to forget the war and 'get on with life'. This is what Mona Lenz, a wartime entertainer, called the 'let's settle syndrome'; soldiers had had enough of war and just wanted to settle back into a normal life.¹⁷ For some men this difficulty in starting again was the challenge that some needed to keep them engaged in life.

The distress and disturbance during the transition to civilian life was not just attributable to coping with the ongoing remnants of a traumatic past. An alternative or complementary view is that leaving a close battalion was distressing even though it meant leaving hardship and returning to the safety and comfort of civilian life. It was argued that this could have been as traumatic as reliving war memories. A very experienced campaigner, who was a platoon commander and winner of a Military Medal, explains this experience of leaving a cohesive military unit.¹⁸

I've got another theory, John. I wonder whether the trauma was as much going from the army environment, where you were owned by a unit. 'I'm a part of it,' - you

¹⁶ In this case the young man returned home to find his fiance no longer considered him a man and rejected him. He went bush for a few years until he eventually found a new partner and settled down. Questionnaire, JM, 2/16 Battalion.

¹⁷ Murdoch Sound Archives interview No. S704, p. 41.

¹⁸ RJ's individual story will be described in more detail in the next chapter.

were part of a body of men you were proud of. Whether transferring from that to the traumas of civilian life, not the war itself, and the change from one style of life, a disciplined proud life, to fight for yourself in the civilian life where there was a lack of feeling of purpose and pride - that was as much a trauma as the war itself.

Work

Finding satisfying work was a major factor in re-establishing a civilian identity. This was a most significant outer task and was closely linked with the male imperative to provide for the family. Some men had established positions or careers to return to but the majority had to start again. There was a wide diversity of vocational settlement patterns. In the long term the majority of men improved their status in terms of work and eventually moved into professional and managerial positions.¹⁹ On the surface the majority of the sample were successful and took up responsible positions in private companies or public service (see Table 10.2). No one lost status in the transition and the majority made significant gains, such as WR who started his working life as a wool classer in a stock and station firm and eventually managed a large finance company. After the war he worked his way into several managerial positions in different companies, and in the last phase of his working life took over a struggling teacher's credit union transforming the annual turnover from \$300 000 to \$20m. Others took a radical turn in their lives by taking up soldier settlement blocks and establishing themselves as successful farmers and graziers. HK turned his back on a successful law career and returned to the country to manage his father's property. He became a very successful and wealthy primary producer and retired in comfort to the city.

Relationships

All of these men married at some point, either marrying after the war or resuming marriages. Most remained married unless separated by death. These outcomes are summarised in Table 10.3. No assessment was made of the degree of satisfaction in the marriage, but the unsolicited narrative material on relationships suggests that most were satisfied²⁰. Fourteen percent remained in the same marriage while admitting to some tension. Only five men were divorced. Divorce only occurred in extreme cases, such as

¹⁹ I chose to classify managing one's own business or farm, as managerial.

²⁰ This was actually difficult to determine. One couple, both in their seventies, who expressed some surprise at the low divorce rate were actually going through a period of great tension in their marriage at the time. A widow, who had been abused and deprived by her alcoholic husband, admitted she still loved him despite his failings. A veteran did not want it to be known that he had actually been very unhappy for many years but remained loyal to his wife.

serious violence against a member of the family or in one case where the wife was an 'alcoholic'.

Table 10.3 Marriage outcomes of veterans N=65

<u>Status</u>	<u>N</u>	<u>%</u>
Divorced	5	8
Widowed	4	6
Divorced/remarried	5	8
Widowed/remarried	2	3
Original marriage-tension	9	14
<u>Orig Marriage/Satisf</u>	<u>40</u>	<u>61</u>
<u>Total</u>	<u>65</u>	<u>100</u>

Physical Health

Illness and debility are a normal part of aging so it is difficult to differentiate normal aging and illness from that which might be attributable to war trauma. One indicator of this is pension status, where veterans have subjected to rigorous scrutiny to determine eligibility for entitlement. Pension entitlement is a global indication of the direct effect of war service, not a measure of the effects of stressful experience.²¹ Entitlement on grounds of mental health could only be accurately assessed when I had access to medical files, so it was not possible to determine what proportion of any pension was allocated on grounds of mental illness. It also needs to be noted that pension status can change in a short time if a serious illness should develop. On the basis of examining a number of files I found that no pension was awarded solely on the grounds of mental ill health. Those I could identify were for disorders under old nomenclature such as anxiety neurosis or depression.

Only one case was found where a Totally and Permanently Incapacitated (TPI) pension, awarded in a review after 1980, included part entitlement for post-traumatic stress disorder. Seventy eight percent of the sample did have disability pension entitlement on grounds of physical illness and almost half of the men received either

²¹ Determining a connection with war service is governed by set protocols. In some cases however this can be questionable. A heart condition in later years, for example could be accepted if the veteran had smoked as a response to stress during service. If he did not smoke

100 percent pension (28%) or TPI/Extended Disability Allowance (EDA) (20%).²² Eighteen men (27%) were receiving part entitlement, which ranged from 10 to 80 percent. Five men received a service pension without a disability component and eight had no pension at all. A service pension is granted purely on the basis of service and is basically equivalent to an aged pension but has additional medical entitlements. The relationship between pension entitlement and original wartime illness is shown in Table 10.4

**Table 10.4 Pension entitlement and incidence of illness
during service. N=65
War-time Illness**

Pension	Very serious	Serious	Minor	None	Total
EDA/TPI	3	9	1	1	14
100% Pension	2	11	3	4	20
Part entitlement	3	12	2	1	18
Service Pens	1	2	1	1	5
None	2	5	1		8

It was not possible to find out the success rate in entitlement applications but from a few case studies it is reasonable to suggest that that a number had their applications rejected or allocated at a reduced rate. In a few cases men with serious illness did not seek pension entitlement, but in general, the seriousness of health problems emerging over the years correlated with pension grants. In effect this means that more than half of these men were recognised officially as being severely affected by war service. There was also the possibility that physical problems masked psychological problems.

during a specified period it could be deemed not related to war service. Other conditions such as tension headaches would be more difficult to assess.

²² In the most recent pension provisions there are four disability pension rates: Special rate (Totally and Permanently incapacitated); an Intermediate Rate; an Extended Disablement Adjustment); and a General Rate (ranging from 10–100%). The TPI and EDA provide the best security for veterans. A Service Pension is paid purely on the grounds of having served and carries no entitlement for disability.

Success in Life

On the basis of their self-assessment and observation of a number of markers, each man was rated on the degree of success they had achieved in life. Most men improved their economic status and there was a significant shift upwards in employment status. While this might be expected in a population that enjoyed improved economic conditions and a time of high employment, there are two factors that make their improvement noteworthy. The first is that all had a significant disruption in their lives by at least three years of war service and in most cases had no ready made career to return to. The second factor is that the majority had many residues of illness, wounds and mental scars to overcome which most of their civilian counterparts would not have experienced. Their degree of success in life is incorporated into one life indicator. An example of a lowest level of success was a veteran who had not held a steady job, was a heavy destructive drinker, had been rejected by his family and eventually suicided. Moderately successful were those who had their own home, were able to support themselves and had moderate levels of social contact.

Table 10.5 Degree of success in life

Success	N	%
Failure	2	3
Moderate success	15	23
Successful	24	35
Very successful	25	39
Total	65	100

When compared with their psychological life outcome there was a moderate correlation with their success in life, but a struggle for mental health did not necessarily mean material and social failure. For example, TK and CW had significant struggles with depression and anxiety respectively but retired in comfort with an interest in outside activities.

In terms of the major sources of identity then, such as work, relationships, and material stability, this sample of veterans generally achieved well in their outer lives. Only two would have been regarded as materially and/or socially unsuccessful. My task now is to explore the undercurrent of behaviour and inner experience that demonstrates

that there is a deeper discourse that has not been previously acknowledged even by the veterans themselves.

THE INNER LIFE

This section summarises the evidence for adjustment difficulties and continuation of traumatic memory in veterans after their discharge. While it does not fully convey the total inner experience there are clear signs of persistent residues of war-time experiences. These signs of an inner life are addressed under the following headings.

- Adjustment period
- Post-war breakdown experience
- Primary life problem
- Secondary problems
- Memory Intrusions

Adjustment Period

In addition to the physical and social adjustments after discharge described above there was evidence of inner disturbance. This was manifested in a number of ways. Individuals experienced more than one type of disturbance but the primary ones were nightmares (44%), war dreams (8%), severe sleep disturbance (5%), behavioural problems (16%), and alcohol abuse (13% - probably underestimated). Only six men were reported or were assessed as having no major difficulties with adjustment. Only in some cases was this early behaviour translated into long term dysfunction.

The experience of adjusting to civilian life with multiple layers of experience to deal with is shown in the following example. The 'incredible welcome' experienced by a soldier when he disembarked in Brisbane was only a memory when he returned home to his small country town a few weeks later. When he arrived in New Guinea he was only 18 at age 22, K was discharged from the army with no trade and no profession, and in very bad physical and emotional shape. During the war he had been a Bren gun operator and went through all the campaigns of the 27 Battalion. He contracted malaria and was seriously wounded. He had been lying naked alongside the Soputa Hospital when it was bombed and strafed ('I can still see the face of the pilot'). His narrative of his New Guinea experience indicates just how remnants of war were laid down in memory.

Just before sailing for New Guinea the first time we were told what to expect from the Japanese if captured. Previous escapees said prisoners were often tied to a tree and bayoneted. It became very real during the retreat from Efogi. During the 14

days the fear of capture had been on the mind for so long I suppose. Each night while in some sort of exhausted sleep the dream would become very real. Later when I was flown back to the front I received a very hurtful wound. A bullet struck my Bren Gun magazine and exploded in my stomach. Molten steel penetrated my stomach. I screamed with pain as I fell. Then the rot set in when the dream came true. I felt the bayonet and I felt the same pain as the bullet. I'd wake up very often with a loud scream. It was one helluva a nightmare which plagued me for many years. I have a very bad lung as a result. I have had pneumonia several times. In fever the dream would return. I suppose truth be known, in some part of my brain the bitch still exists. Next fever perhaps'.

When he was discharged he was a 'first class machine gun operator with a few pounds in my pocket' and displayed a number of disturbances that were never addressed. He 'settled down' somewhat when he married but when he first arrived home,

I just couldn't believe it was over. I was as rough as guts and still had some internal bleeding [from when his cartridge holder exploded at his side]. Whenever I had a fever the nightmare of being tied to a tree and being bayoneted by a Japanese soldier would return. There was no welcome home in the country. I was very angry and felt let down. I had a helluva temper and I got a reputation in the district. I did a lot of damage.²³

His temper remained for most of his life. Ten years ago he shot his horse in a fit of temper, and he has had 'hardly a day without thinking about' war experiences. His only contact with a psychiatrist was when he was being uncooperative during medical treatment at the Repatriation hospital and a senior psychiatrist was asked to intervene, but there was no treatment apart from a bedside chat.

Such was not always the case, as some men were able to leave the war behind them completely. WR., for example, left the army and never joined any veteran associations (something 'best left behind') and made a very satisfactory life in terms of wealth, career, family and community involvement. He had never 'enjoyed' killing although it was something 'you had to do on the spur of the moment'. Nor had he 'enjoyed' seeing mutilation such as a man in his unit shot with a mountain gun shell right through his head, or another man at Efogi who though still alive was sitting up holding his brains in his head. He recalled the piles of bodies from both sides at Gona that had to be disposed of somehow. In the heat of battle there was not much time to think about the reality of the battle and he does not recall being disturbed by memories after he was discharged.

He had never sought any help from the Repatriation Commission and his only complaint was a 'bit of arthritis'. His wife supported his testimony of being stable and free from reminders. She recalled how he had gone away a boy and come back a rough man after New Guinea. His main problem was coping with bouts of malaria for a short time after discharge.

Breakdown After Discharge

As noted above, only six men were identified as having had a serious breakdown during service. Five of these continued to experience difficulties and require some form of intervention at some stage during their lives. The relationship between Service breakdown and later life problems is shown in Table 10.6.

Table 10.6 Breakdown and other post war problems

Type of difficulty

Battle reaction	Breakdown	Serious symptoms	Minor symptoms	None	Total
Treated CSR	6	1			7
Symptoms/no treatment	1		1		2
No Difficulties	6	10	14	26	56
Total	13	11	15	26	65

Intervention was mostly provided within the repatriation system. One veteran described a breakdown experience during service (CSR) but was not treated, and had a serious breakdown after discharge. Seven more veterans, not identified as CSR, had some form of breakdown in their later lives and required medical intervention. A further ten experienced serious difficulties but had no intervention. In all, 24 men (36%) had serious mental health problems at some stage in their lives. This does not include another fifteen who experienced some symptoms such as mild depression, which did not affect their lives to any marked degree. It is clear that during service many veterans suppressed difficulties that emerged in later life. The outcomes for these men will be discussed below.

Primary Life Problem

The difficulties that men experienced were not always readily recognised as mental health problems. This is shown in a further breakdown of the problems they experienced

²³ Interview with KB, a machine gunner with the 2/27 Battalion. By 'country' he meant the rural area he went back to. There had been a grand march and welcome in Brisbane when they arrived.

in post-war years. A presenting problem might be alcohol abuse, but this could well have been a form of self-medication to mask haunting inner struggles. Other presenting problems were chronic non-life threatening illness (e.g. ulcers, dyspepsia) not related to normal aging, and relationship disturbances including family abuse. This was not necessarily their final outcome, although for some the presenting problem became a chronic and ongoing issue. Each veteran was classified according to the primary presenting problem and the secondary presenting difficulty. The composite picture of these indicates the extent of inner struggles experienced by veterans.

Memory Intrusion

An indicator of late life intrusion of war memories was derived from individual narratives. Of the 65 men 70 percent had some form of serious intrusion in their later years. Intrusive thoughts are memories of stressful events (e.g. A mate dying, finding photos of family on dead Japanese soldier, being strafed) that come into the mind involuntarily without active recall. Nightmares and battle dreams are more obvious intrusions. Battle dreams are not necessarily distressing. Table 10.7 shows the incidence of primary intrusion.

Table 10. 7 Incidence of Late life Intrusion

<u>Primary type of Intrusion</u>	<u>N</u>	<u>%</u>
Nightmares	14	21
Battle dreams	9	14
Intrusive thoughts	3	5
Other reminders (e.g. TV)	7	10
<u>Not Known</u>	<u>13</u>	<u>20</u>
<u>Total</u>	<u>65</u>	<u>100</u>

Collectively, these indicators are evidence of a residue of earlier experience that periodically intruded over a period of 50 years. These reminders are replayed in various forms, at different times and for varying periods of time. From a forensic viewpoint these represent potential indicators of disorder, but on another level they indicate a potential narrative of distress that has not been aired. These narratives generally remained within a closed social environment. One widow clearly remembered her husband's nightmares, which were mentioned outside the family, more particularly to doctors, 'in case you finished up in the funny farm'.²⁴ A complementary set of data from

²⁴ Interview with EG, whose husband was in the battles of Milne Bay and Sananander, returned home to eventually become a senior public official and repressed his war memories.

a survey of a sub set of 29 of the sample using a Memory Intrusion Scale confirms this view that 'normal' veterans are still disturbed to some extent by these memories.²⁵ Memories can emerge in unsolicited fashion (Intrusive thoughts 90 percent; reminder from TV/newspaper 86 percent) and can be upsetting. Most respondents preferred to talk about amusing memories when with other veterans (90%), and they were more likely to think about this after retirement (73%).

LIFE OUTCOMES

Further insight can be gained by focusing on the overall life outcomes of veterans. I have established above that most men had a period of adjustment immediately after discharge when they experienced a range of difficulties including personal distress. The focus on life outcomes established that there were long term and continuing levels of distress and disruption, which persisted for many beyond this initial adjustment period. The assessment of life outcome is derived from the overt and covert manifestations of post-war disturbance. This is an overall indicator of how the remnants of war impinged on their lives. In the absence of clinical measures, I chose to view each man holistically and make a judgement. The sources of data on which the judgement was made were personal testimony, health records, testimonies of others such as family, and other records that were available. The criteria for assignment to a category are set out for each one. This final sorting identified four distinct groups of men.

The least problematic of the sample are those in **Category A**, who have a positive life outcome and no evidence of life difficulties that can be related to war experience, nor any disturbance that impinges on their lives. A second **Category B** consists of men who also had a positive life outcome but had some inner disturbance that did not attract intervention. They have an undercurrent of memory disturbance that has never become a serious problem but has remained an important repressed record of their war experience. In this sense they have not quite 'put it behind them' even though they have not been overtly impeded in any important area of their lives

There is a third **Category C** of men who did have serious problems that emerged after discharge, and in some cases, much later in life. Their difficulties did not receive any specialist psychological treatment in the repatriation system and overall there was no effective intervention.

²⁵ See Appendix C. This is an adaptation of the Impact of Events Scale (Horowitz). Slight modifications improved the quality of response.

In the fourth **Category D** were those diagnosed at some point in their lives as having war related mental illness, and were subject to psychiatric intervention. In every case their difficulties seriously affected their ability to manage at least one area of their lives, such as work, family or social life. They were treated in the Repatriation system, but their difficulties were not adequately addressed. Table 10.8 shows the distribution of categories across ranks.

Table 10.8 Original rank of veterans in each category
Life outcome category

Rank	A	B	C	D
Commission	6	6	3	0
Non-Comm	10	10	5	3
Ranks	5	6	4	7
Total	21	22	12	10

Each category will now be described in detail.

Category A Positive life outcome: no disruption N=21

These men were successful in the outer world, but the key determinant for inclusion here is that they had no intrusion from war memories. While there was some intrusion during the post war adjustment this did not continue and did not interfere with social relations, personal comfort or work. Thus they had no continuing disturbance from battle dreams, intrusive thought, or nightmares, and no behavioural disturbance. These men were sober, had a steady work record and no indication of inner disturbance or continuation of traumatic experience. In this sense their lives lack drama, because there is no portrayal of struggle and no narrative of illness or distress. All ranks were represented in this category.

A typical example is a senior officer, who was near to death from beri-beri in 1942, suffered extreme hardship, and faced front line combat in the Owen Stanleys. He returned to his family and resumed work. He adjusted successfully and worked until retirement. There was no family disruption, and he retired from work to travel, play sport and enjoy his family. He never sought assistance or compensation from the Repatriation Commission. The main medical intervention was for a serious illness shortly before his death.

Category B Positive life outcome: some inner disturbance N=22

These men have also had a successful life outcome; but there is evidence of inner disturbance that persists beyond the post war adjustment period. Within this category there were differences in degree or severity of disturbance and these were not consistent over time. They have not been chronically disturbed or disruptive but have struggled with remnants, such as disturbing memories or nightmares. A common example is that of a decorated soldier with many potentially damaging experiences who experiences ongoing and enduring nightmares. They did not become so dysfunctional that they needed referral to a treatment agency, and consequently their disturbance did not attract a label nor receive any treatment within a mental health framework, or even public scrutiny. Some did have serious intrusions but managed successfully. I do not suggest that their experience needed to be made into an illness category but that it could have been incorporated into a normal discourse about the effects of war. The main implication is that this group has had no forum in which they could present and validate this inner life.

Intrusions could be quite vivid as in the case of a veteran, who had never spoken of his experiences even to his family. He still could still sense the stench of the hundreds of dead Japanese in his nostrils, from the time he had been assigned to body retrieval following the battle at Gona in December 1943. Only 26 out of 90 men in his unit were left after a bayonet charge, and he grieves daily for the 200 young men who were lost in a year from his unit. He still experiences nightmares and intrusive thoughts. He retired at 66 after working all his life as a butcher and is still married after 56 years.

Table 10.9 Relationship between life outcome & outer success

Degree of Success	Life outcome category			
	A	B	C	D
Success				
Failure				2
Mod Success	4	5	3	3
Fairly Successful	8	5	6	5
Very Successful	9	12	3	
Total	21	22	12	10

Category C Serious disturbance: not adequately addressed N=12

Veterans in this category generally achieved in their outer life but they clearly had serious difficulties, both mental and physical, which were never addressed adequately. Their inner disturbance can be linked with traumatic memory. They returned home disturbed, nervous, experiencing nightmares, abusive, withdrawn, or developed physical symptoms such as dyspepsia, but kept all these symptoms very private, mostly within the family. Such symptoms and illnesses did not go away with time. Their physical illnesses were treated but their serious psychological disturbance was not addressed adequately. None of these men were detected as psychiatric casualties during wartime.

Men were assigned to this group conservatively (see Table 10.10). By this I mean that if there were doubts about their status I would only assign them to the more seriously disturbed category if they were badly affected over time. I did not attempt to give a diagnosis, nor could I determine if their current illness was directly related to toxic exposure in wartime. The illness or reported diagnosis was accepted as a description of their dysfunction. The group represents those who were never recognised as psychological war casualties, and many had their difficulties masked in physical illness. One consistent feature is evidence of traumatic memory in the form of nightmares, or intrusive thoughts, as well as overt dysfunction or illness. Men in this category were never diagnosed with any form of traumatic stress disorder. Most became involved in some form of medical discourse when they consulted their general practitioner or a specialist physician, but the war was not considered a relevant factor in their problems. One veteran had two serious breakdowns after the death of his partners and required psychiatric intervention, but these were regarded as reactive depressions.

The significance of the group is that they provide evidence of serious disturbance that has neither been identified nor addressed. None sought assistance for war-related problems. One consequence of this is the distress and some times shame of family members. For example a widow had spent all her married life accommodating a very anxious and sometimes physically ill husband. He never sought treatment, and even though he built up a sound family business, avoided confronting his distress and anger. She knew he was a very disturbed man after discharge but was never able to fathom what worried him. She experienced several breakdowns and even in late life was managing her distress with medication.

The terms used to describe the dysfunction are those used by the informant rather than as a clinical psychiatric label.

Table 10.10 Types of dysfunction in Category C. N=12

Subject	Dysfunction
LB	Chronic illness; withdrawal; died age 58
KB	Chronic disturbance and anger; residual wound-related illness
MB	Anxiety state; spinal condition
LJ	'Nervous condition'; memory loss; unable to coherently describe illness
JL	Chronic illness; depression; severe restriction in life; withdrawn
LS	Lifetime disturbance and anxiety; no treatment
CY	Mixture of chronic illness and untreated withdrawal/disturbance
HO	Chronic anxiety; withdrawal; isolation.
TK	Minor depression mid-life; GP prescribed anti-depressants; late life major depression
GR	Head wound; epilepsy; chronic illness; Suspected of malingering/psychosomatic
JM	Chronic intrusion, nightmares; headaches, migraines; distress
HD	Chronic disturbance; nightmares; battle dreams

This group signifies a serious level of submerged discourse about war. Most were not even recognised as psychologically damaged and had their problems masked by physical illness. One consequence was that the burden of support fell on their partners, who either shouldered responsibility or became their main emotional support. This was summarised by one wife:

I think the wives of returned men are the forgotten ones, as when the men returned home, it was the wives that had to pick up the pieces and be behind them and nurse them when they were ill and depressed. Not just when they are ill and depressed, not just one or two years, but for as many as they are spared.²⁶

A second consequence arose out of the way in which help was sought. Since physical illness was the primary reason for seeking medical help, psychological issues were not

²⁶ Questionnaire response from partner of JL.

explored, particularly any relationship between traumatic war experience and their dysfunction.

Category D Serious disturbance: psychiatric diagnosis and treatment

This group is made up of the most disturbed of all men (see Table 10.11). They experienced great disruption in at least one major part of their lives, either in their relationships or work. Some managed to achieve either materially or socially but they are characterised by periodic bouts of diagnosed mental illness requiring specialist medical intervention.

Table 10.11 Medical diagnoses and outcomes in Category D. N=10

Subject	Identified NG	Self-report	Outcome
MA /10	Yes	Nerves; depression; drink	Separation; Suicide; age 58.
Matt /27	Yes	Chronic alcohol	Work disruption/early death age 57
DC 2/6	No	Depression/obsession	Family distress/illness
TT 2/10	Yes	Anxiety/depression	Work limitations/social
CW /55	Yes	Early breakdown	Recovery/late life satisfaction
FB /27	No	Alcohol/depression	Divorce/early retirement/later recovery
RU 27	Yes	Alcohol	Divorce/early death
LH /39	No	Alcohol/aggression	Divorce/work disruption
JM /39	No	Depression	Chronic anxiety/work restriction
RF 27	No	Nerves	Divorce/social isolation

Only five were discharged diagnosed with war related mental illness. One representative case of this group is an infantryman discharged as unsuitable for service with anxiety neurosis who worked in a bank to manager level. In mid life he developed a drinking problem and caused great disruption in his family. Despite multiple referrals and psychiatric intervention in the Repatriation Dept, he did not resolve any issues and died aged 58 from oesophageal ulcers.

This is clearly the most problematic group and their lives have affected many around them. For most, their lives were characterised by long term psychological instability, chronic drinking behaviour, and disruptive relationships. There is one case of suicide and an early death induced by alcohol abuse. This group provides the best window on the application of ideas about mental health. In this sense they can show the life course

of long term pathological behaviour and the ideas and treatments applied to their difficulties.

Only one of these men could be regarded as having recovered from his psychological breakdown. In his case when he returned from New Guinea 'my nerves were gone and I was a wreck'. It took him several years and 'lots of pills' to recover. He worked hard to raise five children and held several responsible jobs in medical administration. This responsibility helped him adjust. In later years his life is 'pretty good' and he does not have the 'nerve trouble'.

All of these men were treated in the repatriation health system. Seven cases, whose medical files could be accessed, were analysed further to explore the nature of their treatment. This information is summarised in Table 10.12.

This table shows the range of diagnoses, labels and treatments applied to damaged veterans. They bear out all that was established in the review of literature on ideas in military and rehabilitation psychiatry. Neither trauma nor any war related term was used. For both Category C and D veterans, the only limited arena for exploring ways of relieving distress was within a medical discourse. There was no forum offered through public bodies such as RSL or veteran groups or the Repatriation Commission. The only limited forum offered was through the Australian Red Cross in a series of public lectures aimed at relatives of Prisoners of War for those who returned from the Pacific.²⁷ This policy severely constrained and contained the discourse and also marginalised the secondary participants, the families of veterans. It also maintained a medical dominance of any understanding of the experience of veterans.

The men in Category D had multiple admissions to outpatients' and in-patients' departments, either for physical or mental health problems. All were referred, either at the request of the wife or by their local medical officer, because of their disruption, alcohol abuse, violence or being a danger to themselves. There were no spontaneous self-referrals.

²⁷ An example is the lectures by W. A. Dibden delivered at Red Cross House March & June 1945.

Table 10.12 Summary of labels and treatments provided in Category D

Case	Medical labels	Treatment
MA ²⁸	Psychopathic personality 1943 Anxiety state 1945; Paranoid personality 1948 Anxiety state 1949; Anxiety state/alcoholism 1950; Suicide by hanging 1954.	Potassium Bromide; Discharged unsuitable; Occupational therapy, 2 week's hospitalisation; Sodium Amytal (sedation); Vitamin B; Psychotherapy; OT;
HM	Nervous disorder 1945; Anxiety state Alcoholism; depression 1960.	Sub coma Insulin (1945, New Guinea); Psychotherapy; Amitriptyline (1967)
DC	Somatic – diarrhoea, headaches, nausea etc; 1941; Mild anxiety state 1944; Nervous debility 1947; Severe psychoneurosis 1965; Depression 1972; Reactive depression 1979; Suicidal tendencies 1986	Explanation. Persuasion, suggestion; psychotherapy; Marital counselling, Occupational therapy; SNAID (1979); Pain Relievers, Temazepam, Diazepam
LH	Vaso vagal turns; nerves; 1962; Anxiety hysteria based on immature character disorder, Inadequate Personality, Inadequate personality complicated by hysterical outbursts and alcohol, psychopathic personality 1962; Typical psychopath with anti-social behaviour, 1963; Anxiety-depressive symptoms 1988.	Largactil (long term), Pentobarb, Occupational therapy; Group therapy; Inpatient and outpatient; GP
RU	Anxiety state connected with war service 1952; Anxiety state, neurasthenic reaction to suppressed trauma, Depressed, 1953; Anxiety state, secondary alcoholism 1955;	Sub Coma Insulin, Methedrine suggested; Inpatient treatment; Refused Atebrin; Persuasion; AA; Public mental hospital; Phenobarb, Phenytoin Sodium (Dilantin);
JM	Anxiety hysteria; Anxiety state with depression (1972); Reactive depression (family problems) - 1972; PTSD (1994)	Valium; Amitriptyline; Mogadon; Shock treatment ('well known to unit'); In and outpatients; Variety of anti-depressants
FB	Anxiety, hysteria, depression, neurasthenia	ECT, Insulin therapy; psychotherapy;

Becoming enmeshed in the web of disability often began with great expectations that the 'Repat' would have experts who would be able to understand the distress and prescribe a remedy. This did not happen. Some found temporary respite but few found a

²⁸ In his case little store was put on his considerable battle experience such as extended patrols in enemy territory. In his psychiatric examination, one of the more enlightened specialists concluded, 'His present breakdown would thus be a neurotic reaction to irritating, frustrating circumstances, in a man constitutionally predisposed'. RPGH assessment by Dibden 25/6/48.

permanent remedy. Was this because of the inherently stubborn pathology of the veteran or were the ideas and techniques inadequate? Was the problem just a matter of not having the proper diagnosis? These questions will be explored in more detail later but it is clear from the review of the facilities and ideas extant in the late 1940s and 1950s that the veteran's pathology was not the only factor.

The implications of this information are discussed in detail in the next chapter.

CONCLUSION

This review of evidence highlights a previously unidentified and unacknowledged part of veteran life. At one end of the spectrum is a group of men who have emerged over time relatively unscathed. At the other, there is a group of men who are very damaged and have at least received recognition within the repatriation treatment system. There is a substantial number between these extremes who have never been acknowledged as having any war-related disturbances.

The question is whether these troubles received and were accorded appropriate responses? The answer is that they were not because. The only group to receive direct attention were those diagnosed with psychiatric disorder. Others had nowhere to go. The only ticket to some form of acknowledgment, however inadequate was via a psychiatric label, which was a last resort, and imbued with shame. There were no discursive resources for those outside the medical diagnosis. The majority received neither lay nor professional attention.

In this study four distinct patterns of life outcome have been described. The majority of men were able to pursue their post war lives without major interference from their war-time experiences. The experience reported in this sample confirms epidemiological findings reported from other veteran populations (e.g. The National Vietnam Veterans Readjustment Study in USA, Kulka (1988, 1991) and studies of Australian Vietnam veterans, O'Toole, et al (1996)). On the other hand even when a combat period of similar intensity and duration is experienced, these ongoing effects exhibit differential patterns effects over time. This biographical and narrative material leads to the same conclusion as studies using clinical measures. In this case we have a substantial sample of men who experienced the same period of battle stress and yet displayed a wide variation in outcomes over time.

A number of other significant observations can be made. The first is that in this sample there is another virtually untouched field of discourse that would be missed in a

clinical study. This surrounds the narrative of men whose experience has been subsumed or masked by physical disease or some other dysfunction. The labels attached to the two most dysfunctional groups of men, who were seriously disturbed over time, even to the point of suicide and self-destructive behaviour, bore no relationship to their traumatic war experience. Their life-long signs of disturbance, grief, and intrusion were simply given the labels of civil disorder, anxiety, psychoneurosis or psychosis. This was a clear case of war presenting 'nothing new to medical science'.

Another observation is that the evidence clearly differentiates breakdown during service from some form of breakdown after service. The existing research on New Guinea veterans only established that a small number of men broke down during the campaigns. This sample reveals dysfunction and distress that emerged after discharge and persisted until old age. The diagnoses and labels accorded this distress I will make it clear in later discussions that these labels were inappropriate. Until 1980 there were no accepted labels for post-war dysfunction which made reference to war service or trauma. The labels used in war-time, which were predominantly types of neurosis, were applied. All breakdowns during service shared precipitating conditions and elements of fear, exhaustion, illness and vulnerability. In the narratives arising out of these experiences evidence was found of persisting traumatic memory. While my narrative and biographical data cannot quantify the extent of post war dysfunction, it certainly suggests that the distress and dysfunction were not adequately recognised in the narrow assignment of psychiatric disorder. Studies revealing evidence of post traumatic stress disorder (cf Kidson et al 1993) or depression, (Tennant 1986a) does not address this narrow diagnostic confinement.

Further observations can be made about stages in adjustment of veterans. A number of critical stages can be identified in the lives of these men. The first was in the immediate post war period when there were still elements of illness, particularly malaria and scrub typhus, while men were grappling with the immediate effects of combat experience and the transition to civilian life..²⁹ Many felt lost and confused and were caught between wanting to get on with life and still experiencing anxiety, nightmares,

²⁹ Many veterans reported that during a recurrence of fever bad dreams reappeared. The irony is that malaria was actually used as a cure for syphilitic induced psychosis from as early as 1917 and was used in South Australia in the 1940s. In the procedure, attributed to Wagner-Jauregg, blood was transferred from a patient with malaria to the infected patient, which produced high temperatures that were then reduced with quinine. The fevers cured the psychosis. Information

lack of concentration and other disturbances, as well as being attached to their units. If they survived this period and did not continue to be sick, drink heavily or need psychiatric treatment, the majority adjusted to rebuild their lives during their mid years. In the later years post war experiences began to reappear in different forms of earlier disturbances. Trauma-related memory intrusions were distinguishable from phenomenon such as grieving for lost comrades and the process of reminiscing to make sense of their war years.

In effect the study has revealed a submerged discourse of an inner life that has never been adequately addressed within the psychiatric paradigm, either administratively or clinically. A central dimension in this has been the presence of traumatic memory. The chronically disturbed had their symptoms appropriated and expressed in foreign medical terms. Those who were treated encountered alienating technologies, which were aimed at expunging memory rather than integrating distress and memories of events. Men who were not identified as chronically disturbed but were troubled by intrusions from traumatic memory have been indirectly marginalised: they were not dysfunctional enough to be referred for help but found no forum to explore their difficult memories. These processes of submergence and appropriation are explored in detail in subsequent chapters.

from Dr H. Southwood, former superintendent, Enfield Receiving House; also see Shorter (1997) *A History of Psychiatry*, p. 193.

CHAPTER 11

LIVES AND IDEAS: Merging Histories

In this chapter I explore how the ideas and practices described in the historical section of the thesis impacted on the lives of veterans. I have established in the previous chapter that a substantial number of men returned from the war with residual traumatic memories and adjustment problems but were not offered any discursive resources with which to integrate these memories, or to deal effectively with their issues. These were the men not seeking, nor being referred for specialised help. Discursive resources would have provided opportunities to ventilate, explore, and make sense of disturbing experiences. Assistance can be offered through formal or informal agencies, networks or organisations. However, the agency within which it is offered determines the way in which a service is provided. The only available material resource offered was to a relatively small group of men, who were not functioning in civilian life, and who became eligible for psychiatric treatment in the Repatriation Commission facilities. This resource was provided within a psychiatric/medical framework in which the dysfunctional experience had to be labelled pathological and construed as war-related, before sponsored help could be given.

Within the Commission the nature of the service was constrained by the prevailing medical views on the nature of war-related neurosis. In many cases invasive physical and chemical technologies were applied rather than an opportunity provided for discursive exploration through psychotherapy. Treatment of this kind was the most direct way in which ideas about mental illness impinged on individuals. However, there was a substantial number of men who were experiencing difficulties but were not provided with any resources, either because they did not fit within this diagnostic framework, or they were not regarded as mentally ill.

Men who were damaged but did not seek treatment, could also be indirectly impacted upon by ideas, in that they avoided official channels and found their own ways of avoiding or dealing with their post war difficulties, often unsuccessfully. Just how this could occur is demonstrated in the following series of case presentations. These case studies, even though reasonably comprehensive, still only provide glimpses of complicated lives, and the reader needs to bear in mind that the material presented is only a fraction of what is available. The narrative material in these accounts, rather than clinical measures, provides access to the complexity and diversity in veterans' lives.

The narrative also conveys a sense of the individual. Each veteran has a name and a personal history and cannot be reduced to a set of symptoms or diagnoses. The presentations will also give a sense of the life course and how a person can change over time.

The case studies have been selected from each of the identified categories of life outcomes. These four identified life outcomes were:

- CATEGORY A: Positive outcome, no disruption
- CATEGORY B: Positive life outcome, some inner disturbance, no intervention
- CATEGORY C: Serious disturbance, no effective intervention
- CATEGORY D: Serious disturbance, psychiatric intervention

In all, six cases are presented. The first four cases illustrate typical scenarios from each of the four categories. Additional case studies are presented from Categories C and D to illustrate more complex cases where the response to difficulties was not so straightforward.

One purpose of the detailed analysis is to further explore the nature of traumatic memory and the effect of post-war intrusion. Can the inner experience of severe disturbance and nightmares, overuse of alcohol, violence, inability to work, depression, somatic illness and suicide be attributed to, or be explained, by reference to their war experience? Were men enabled by their stressful experience? Did the responses to their distress address this inner experience? I will argue that traumatic memory provides a common link between later experience and war exposure and that the prevailing ideas failed to take such memories seriously.

CATEGORY A: Positive outcome, no disruption - the life of P

Men in this category successfully managed their lives over time and this is shown in the life of P. There is little drama in his story, and superficially, P's life might be accounted for in a few phrases: he grew up in Adelaide; he went to the war; he came back, married and settled down in his old job; eventually he retired to enjoy the benefits of a prudent and successful life. Because of this apparent simplicity it is important to record his life story in some detail in order to provide an insight into the experience of men in this category. He presented a narrative of a smooth and unruffled life, with only a slight indication of dissatisfaction when he returned to a job that was not as

demanding as being a senior officer. There was no evidence that a particularly traumatic period in his New Guinea service had affected him negatively.

P was born in country South Australia on 29 June 1920. His father was a bank officer and died when P was 9 years old, but he was able to complete a high school education. When he left school in 1935 during the Great Depression he took a job as an office boy in the state transport authority. Five years later he joined the AIF, having served in a militia unit since 1938. He had a feeling that 'something was going to happen', so when he turned twenty in 1940 he enlisted with his mother's permission.

He was originally drafted into the 2/43 Battalion in 1940 and sent to Officers' Training School at Duntroon. In May 1941 P was sent as a reinforcement to the Middle East where he undertook further training in the Training Battalion in Palestine. His capacity for leadership was recognised and he was promoted to Platoon Sergeant. While in the Middle East he was attached to the 2/27 Battalion in January 1942, by which time the Middle East action was over and the Battalion was soon to be on its way to Bombay.

In 1942 jungle training at Caloundra in Queensland was minimal preparation for the appalling conditions encountered in the Owen Stanley Ranges and he had to adapt his thinking to a new environment. He was a Platoon Sergeant in C Company and while in the field was promoted to Lieutenant. This period was probably the most stressful time of P's life. During the withdrawal from Efogi P developed dysentery and was left behind as part of the stretcher party during the retreat from Efogi described in Chapter 8. The stretcher party was left in a native garden while the rest of the Battalion made its way towards Moresby. P had contracted dysentery, probably from eating a tin of bacon from the limited rations, and subsequently developed beri-beri. In that state he did not know what was going on. Prior to that he was able to walk and get along with the help of another soldier. The two men assigned to guard and look after the stretcher cases, Burns and Zanker, had to attend to P's most basic needs. There was no medication and limited food, but ample clean water. They were also in danger of being found by the enemy, as well as dying from illness or wounds. Two men died in the garden. By the time they were found P's total period of chronic illness and threat was about thirty days, during which he lost five of his eleven stone.

He survived by determination.

It was just a matter of when everybody else moved you tried to keep up. There was one occasion when I knew I had to get to the top of a hill and I knew the only way I could do it was by crawling. So I did. It was probably an exercise in willpower.

Beri-beri affected the nervous system in his legs and he remained ill for some months. P was hospitalised in Port Moresby, Brisbane, Sydney and finally Adelaide. This meant he missed out on the battle at Gona where losses were heavy and many of his friends were killed.

I suppose that is the business we were in. You felt it fairly strongly but there was not a lot you could do. It does not pay to reflect too much on these things. That is what we were there for and if you were hit, well that was it - you were unlucky. I don't believe that I considered it to be a traumatic experience. I felt sad but not upset. Nobody likes to see anybody knocked. I lost Reg Bastyan up there, an old friend and my best mate at school.

After his recovery P wanted to rejoin the Battalion as soon as possible. 'The battalion was your home. You would do anything to get back to the unit'. After a period of recuperation, P went into action again in the Ramu Valley (1943-44), which was not quite as strenuous as the Owen Stanleys, but nevertheless very difficult terrain and the 27th was engaged in heavy fighting. In the Ramu Valley and Shaggy Ridge in 1943 he was mainly engaged in patrol work. As many troops went down with serious tropical diseases as were killed or wounded. P contracted another dose of malaria as well as hepatitis.

P's final engagement with the 2/27 was in the invasion of Balikpapan in Borneo. Even though this action was planned and executed extremely well with adequate support for the landing force, it was not an easy time. By this time many men were feeling the effects of five or six years of continuous service. P had now been promoted to Battalion Adjutant. He saw himself as someone who knew what he was doing, but regarded the appointment with characteristic modesty. 'I was fortunate enough to get the appointment'.

After the official end of hostilities in August 1945, P was part of the occupation force in the Celebes, where he assumed command of C Company for the duration of the occupation. Participants in this occupation describe it as an interesting cultural experience, and quite a change from the direct combat. P accepted the surrender of the enemy forces at Kendari on behalf of the allied forces.

With the hindsight of nearly 50 years he did not regard his army career as too exciting. He lost a lot of good mates and did not enjoy the withdrawal from Efogi. Campaigns that others would be prepared to boast about were something that he could

talk about somewhat dispassionately, and even though he achieved a high rank he does not recall the experience with any show of pride.

Most men found it very difficult to adjust to civilian life after 1945 and although not as affected as some, P did take a while to settle.

At that point most of us felt that the job was done and we had to get on with normal life. The war was over. That is not to say that I did not miss battalion life, but that only lasted a certain amount of time. Once the war was over everyone was relieved. Marriage certainly helped me to settle down. It would have taken a lot longer if I had not been married.

The 2/27 Battalion then had to take second place to family and career. There was no report from P or his partner that there were any disturbing elements at this time, such as nightmares, flashbacks, intrusive thoughts, anxiety, or psychosomatic illness. The only tangible remnants were some ongoing health problems. It took about three years to rid his system of the malaria, and he occasionally had a twinge in his legs from beri-beri, but neither of these problems restricted his work or other activity. He resumed playing cricket, his favourite sport, and continued his army career part time. He rejoined the Citizen Military Forces with the 10th Battalion, University Regiment and later commanded the 43/48 Battalion, as a Lieutenant Colonel. He reported all of this very modestly. The discipline of the army seemed to come naturally to him and was consistent with his internal discipline.

P's initial consideration was to get back to his job and build a support base for his new family. Leaving the war machine was not the difficult part. It was more difficult making the transition from a senior officer to a relatively junior clerk. He had gone away as a clerk and came back to the same job, having been a company commander and seen a great deal of action; 'There was a difference in responsibility. I was adjutant and senior officer - I came back as a relative junior'. The people now senior to him had not seen the sights that he had seen. Nor had they had his responsibilities, but this did not turn into a narrative of resentment or discontent.

As company commander you were responsible for 150 men - making decisions about whether they live or die. To come back and be subordinate to people who had not had that responsibility - making a big thing of minor issues. It took a little while to get used to this.

After this initial adjustment he gradually gained promotion in the government department. Life seemed pretty quiet to P during his mid-life period. He no longer craved for excitement and did not strive to climb the corporate ladder too quickly. 'I'm

one who accepts things as they occur and makes the best of them.' He moved up through Accounts branch then Traffic branch and was departmental head by the time he retired. He saw a lot of changes in the government department, as it became corporatised. His experience as an officer, particularly as adjutant, enabled him to contribute to the planning and executing of those changes.

For many veterans, marriage and family were an integral part of getting re-established. P was married soon after the war. Unlike many colleagues who married during the war, he had made the decision not to get married until it was over, even though he had already met his future wife. They became engaged by correspondence, married in 1946 and eventually had two sons. Although he continued his army association in the CMF he did not remain attached to his old unit as a member of the 2/27 Association. He did join the RSL.

P retired early at 60 in 1970 'with no regrets'. He got involved in a number of community organisations such as the Save the Children Fund and Meals on Wheels. He was secretary, later president of his bowling club. 'Service to the community should be seen as a form of service to the country rather than be just a drag.' His only regret in later life was that he thought that he could possibly have undertaken formal study. He did not think it had been a disadvantage but perhaps there was a twinge of regret about not having gone to university, and it was not something that he worried about. His priorities later in life were travel and play bowls. He and his partner travelled a lot (e.g. 12 months in England after he retired.) He had no interest in travelling back to the old battlefields. England and Scotland were more attractive.

Reflections

P was a taciturn man who did not enjoy talking about his war experiences, even with friends who'd had similar experiences. He had been able to leave it in the past. This may be a coping strategy but it does not seem to be a response to any serious disturbance, even though he was aware of this in others. 'It is history. I am fortunate I have been spared a lot of the problems others have had.' His WW2 experience seems to have been a time when P developed his character traits and honed his capacity to think constructively and achieve objectives. He believed he had always been able to think about a problem and come up with the answer even if it was the wrong one.

To achieve anything you must have self-discipline It is mainly a matter of thinking seriously about anything you do - working out the result an action will have - if you consider the aspects of any action you have to come up with a reasonable answer.

Do not rush into anything without due consideration. There are always standards for behaviour - most of them being fairly reasonable. Always consider the consequences of your actions.

Hardships of that nature [the New Guinea experience] tends to build character - I think that trying times bring out the best in people. You had a choice – you could have just lain down and died - it is as simple as that.

I must say that I did not suffer any trauma as a result of wartime experience.

Final Comment

P died during the course of this research, so I was able to make observations about his life as well as his final moments.¹ I interviewed P's widow two years after his death to discuss his final moments. Despite painful cancer P did not experience any distressing nightmares or dreams or intrusive memories prior to his death, as many other veterans had. She confirmed then that his life had been largely free of distress. He did not have nightmares or other intrusions and never sought compensation for mental stress. There is no evidence that the anxiety, fear, grief, and death of New Guinea had disturbing or socially disruptive effects that endured.

P remained well outside any discourse on war stress. He had no need to get involved and did not seek such discourse.

CATEGORY B: Positive life outcome, some inner disturbance, no intervention – life of R

On the surface this veteran's life closely resembles the life of P. Robert (R) grew up in a stable family and his father was a senior public servant. He obtained a secure job in a bank before enlistment and had a distinguished army career, achieving a commission as lieutenant. After discharge he worked his way up in a bank and retired as a branch manager. At the time of the research he was living in his own comfortable house with his wife from his only marriage. They spend part of each year travelling Australia in their caravan. The difference is that he did have significant intrusions from war experience and had articulated a much more extensive narrative about his war service. One factor distinguishes him from other informants in Category B. He created his own personal way of integrating his experience through his writing.²

¹ Final moments can reveal previously unrecognised remnants of traumatic experience. Experience with other veterans and a study of families (Raftery & Schubert 1995) has shown that the weakness of illness and debility can remove defences built up in earlier life.

² The account has been formulated from a number of interviews with the veteran. One interview was conducted jointly with his partner. A number of other texts were incorporated including his short stories and a novel based on his own career and a letter from his partner.

The most appropriate introduction to his story is a letter from his partner, which she wrote in response to a request for a statement on how she thought the war had affected her husband R. She was writing this at a relatively calm time in their lives, when they had retired, living in a comfortable seaside suburb. Beneath this exterior there were some tensions in their relationship, many of which were war related. In a series of interviews and his writings, R was determined to play down any negative effects from his war experience. His wife had not been given space to air her views during their life together. Her narrative is not one of complaint, but an attempt to portray a more realistic account of their lives, and of the impact of his service. One tension between them was their son, a survivor from the Vietnam War, who had 'dropped out' of conventional life and had struggled for much of his adult life. His war experience of less than a year had not been as successful militarily as his father and R was a harsher critic of his son's difficulties than was his wife F.

This letter is a life summary in itself. It describes the main features of R's life, including his war service, the effect it had on him, his difficulties adjusting to civil life, the problems facing a family in post-war Australia, and their later struggles and triumphs as they became established.

My husband went to War in 1940 equipped with a sense of high adventure, a natural physical alertness, a background of motor bikes, militia - a particularly well-trained soldier. I had not met him at this point, but I know that he was both brave and daring and that he was very highly thought of in his battalion and that his family was extremely proud of him. If there were any negatives at all, they were things he did his utmost to overcome. On transfer to the A.I.F. from the Militia (under age) he lost his rank of Sergeant and started again as private, but he soon regained his stripes.

I met him on his return from the Middle East in July 1942 [actually February]. It was a contrived meeting, but I was attracted to his liveness and his sparkling grey-green eyes and he liked my brown ones. On the first evening, after the pictures, he walked me home from the city to Westbourne Park and then walked home across country to College Park. We were engaged by September (when he came out of the Owen Stanleys they fed and watered his emaciated frame and handed him my telegram, 'Yes, certainly...'). His wound had not properly healed when he returned to his Battalion after a long period of togetherness.

When I stood on the platform at the Adelaide railway Station [mid-1943] and watched his white, strained face gradually disappearing with the train it was the nadir of my life experience to that point; from what he has told me since, his aspirations changed from War to houses with attics, etc, etc. When I saw him next, after the Ramu Valley Campaign where he had contracted scrub typhus, he had lost most of his hair, was highly irritable and erratic, thin and spun out. His depleted fitness was recognised and he was sent to the Jungle Training Camp at Canungra as

an instructor. Desperate at the thought that, as an experienced soldier, he would be used and re-used in the battle zones, I decided to join him.

The situation was officially frowned on, and it was necessary to have a low profile. We talked of everything but War, and he grew strong and I was happy ... and pregnant. Then I had to go home where I would be safe, and he was to return to his Battalion and the War.

The yearning for a dear little house with an attic and all of the peace and happiness, which he had so clearly earned, became intense. I was a Sunday School teacher, and I dipped into a little box of texts and came up with 'Thou shall not need to ht in this next battle'... One of the Senior Officers, noticing his strain, knowing about the baby, soon to be born, offered him avoidance of the action at Balikpapan in Borneo [July 1945]. He refused. I went into labour and he went into his last action of the War on the same day. There was a lot of waiting, after the War, although he was high priority for return.

He finally came home on a cold, grey, wet day, alone, to an empty Railway Station, met by his father and I and our son, a very young bundle, wrapped in a white shawl. We went home to his father's house! My husband's father died of cancer in 1949. His mother developed Parkinson's disease almost straight away after the loss of her husband. These illnesses, incipient at the time, would have contributed to the strains, which made it difficult for a raw-nerved young soldier and a crying baby to co-habit with them, in spite of their large house and garden.

Dreams were dissipating. There was no accommodation available. It seemed a shameful way to treat soldiers whose dreams had focussed on a house and happiness through all those years. Eventually we made a wretched sort of compromise. We accepted a 'flat' in Prospect that consisted of two rooms (not adjoining and the use of a kitchen). I remember that they were vegetarians and the lady used to ask me for a little bit of meat when I cooked a roast. They very quickly complained about Robbie crying. We did not get on very well, and since Robbie and I had to spend most of our time there, I found out that they were not even very nice. B had returned to the Bank. He did not intend to stay there, but his sense of responsibility kept him there for long, weary hours, and Saturday mornings, of course.

At the Bank, young men had been given unusual promotion opportunities because of the staffing drain to the Armed Services. R, as a decorated and distinguished officer of the Australian Army was given menial tasks and a lack of concession to the traumas that had undermined his health.

I remember introducing him to one of my friends, and in the course of conversation, B began to shake uncontrollably and we had to excuse ourselves. There was that very amusing song, of course, 'I've got my Captain working for me now!'

To escape the situation, in which we found ourselves, we travelled north of Adelaide, where the Bank Manager had said there was a house available. When we inspected the house it had a dirt floor, so we made other inquiries and accepted the use of part of a house in return for caring for a local man with a bad heart - providing meals, etc.

It was a lovely house and we could have been happy there, in spite of some difficulties, except that I was pregnant again. So we bought a dilapidated, deserted house and refurbished it. So we had our house and our second child and then we were transferred back to Adelaide. There were still no houses to buy and we had a third baby when he returned. There were all sorts of regulations in place to cover

the shortage of housing. Consequently, when we were offered a house to buy which had unsatisfactory tenants, we had to find them a flat and store some of their furniture in the sitting room of the two-bedroom house. I remember, when our fourth baby arrived, I had created a cubbyhole by the window in the sitting room for the little bassinette. My mother-in-law, who had Parkinson's disease at an early stage, was in charge of the house with R., who had taken holidays, when I went to hospital for the birth of that fourth baby. When I came home with my dear little baby his mother was sleeping in the dining room and I would spend much of my time rocking the baby at night so that others could sleep. I soon became ill from exhaustion and it was not only the returned soldier who was over-stressed. In case you are yourself emotionally exhausted, reading this, I must stress that there is a happy ending. After four years of living in this small house and with five small children, we moved, in 1954, into a large house, with garden and a park next door. My mother-in-law had, for some time, been established in a nursing home.

I do not know at what point our 'settling in' became 'real life'. I also do not know whether a soldier who has suffered the traumas of War is more 'injured' if he is killed, wounded or emotionally scarred.

My father at age 78, talking about the First World War, wept. My eldest son, gentle, fond of books and music was conscripted for the Vietnam War. You have met him, I think. My husband still fights the Japanese at night and becomes stressed after Anzac Day services and at other times.

I have appreciated the contact with you and your interests in my relics of the Wars. Best wishes, F.

The concise narrative conveys a number of points. R was changed by his experience and still retains a traumatic past that can re-emerge. His struggle for adjustment was not just about these memories: there was a complex set of adjustments to make, such as job, housing, extended family, de-militarisation. What follows is a very contracted version of his life, but there is sufficient information to convey its complexity.

R admits to little personal strain in his narrative. This was reserved for his factitious biographical writing.³ He is proud of his military tradition and retains many symbols of this in his home. He has constructed a complex version of his life in his extended writing, which cover all stages from his childhood through his war experiences to later life. He has thought deeply about how he managed stressful times. Rather than concentrate on all aspects, I will focus on his views on adaptation to stress. He believed for example that this adaptation began before he was born. When he was in his mother's womb, he experienced the effects of sudden shock when his mother discovered her battered and bloodied husband (a policeman), who had just beaten up the town bullies. Shortly after, his mother was also terrorised by the same men bullies (returned WW1 veterans), while his father was away on patrol.

I'm sure the horrors of that night communicated themselves to the child my mother was carrying, and somehow that incident has always been part of my make up. The slightest noise in the night has always brought me to immediate wide-awake alertness, a facility that served me well on several occasions during World War Two.⁴

R explained his determination to succeed by referring to his early experience of 'failing' as a 14 year old cadet midshipman in the navy, which he left after being bullied and subjected to harsh initiation rituals. This failure to make it with the navy was 'traumatic and an early defeat', but it gave him the determination not to accept defeat. He readied himself for the army as a member of the 27 Scottish Militia. This did not quite prepare him for the 'the terrible reality of war' when in their first campaign in Syria, he discovered a mate of his in a pool of blood, who had been shot with a large calibre bullet. At the same time he was exhilarated and had a sense of his own indestructibility in the many charges and patrols he led with his platoon. Syria was 'good country for fighting', with cover and reasonable support. This campaign he described as 'fiercely enjoyable'. They had trained for it and they had had the thrill of being in action – 'at least for those who did not get bashed up'.

This reality intensified in New Guinea where as platoon leader he led many jungle patrols. On one of these patrols his action resulted in him being awarded the Military Medal for bravery. He made no secret of the fact that he had killed enemy soldiers, which was a case of 'kill rather than be killed'. Some of his exploits took him to the edge of self-control. Two personal incidents stand out in his post war recollections. The first was during the retreat from Efogi when the battalion was fragmented into small groups and forced to survive off the land for up to 18 days. One night he was on the point of exhaustion, many men had collapsed about him and he was faced with the same choice. In a dream he saw his future wife and a child playing on a grassy slope in his home city. As he approached she handed the child to him. (He had written to F before Kokoda to ask her to marry him.) He awoke from the dream determined to go on and from that time he had no further temptation to give in to strain. His fiancée and marriage became his focus for survival.

And running back to our platoon Joe was hit alongside me, poomp! Through the heart - massive hit through the heart, he hit the ground and he was dead when I

³ As stated in a previous chapter R wrote two novels and a number of short stories.

⁴ From his short story *The Full Circle of Fate*. One irony was that one of the men who was involved in the attack on his father, later joined the 2/27 Battalion, and actually could not cope with battle in the Middle East.

rolled him over. But that was Joe. And it was Joe on the boat, as I was telling you, on the boat coming up to New Guinea that time, I joined the battalion from having arrived back in Australia late. I arrived just before they went off to New Guinea and was given to Joe as his Sergeant and we became very good friends. And on the boat - he'd got married on his return from the Middle East - he was extolling the virtues of marriage and I told him I'd met F. He said, 'Get married! you know, the war, grab your chances while you can, get married'. I got his signature on the letter; I was his Sergeant ... I wrote to F, when we then got to Koi-Taki, prior to going into the Owen Stanleys. We talked about it further and then I wrote this long letter asking, 'Would she become my wife?' But I think he censored it. I think his signature's on it; we've still got the letter in there somewhere.

A second occasion was on Shaggy Ridge - the site of a particular heroic effort by R that resulted in a local landmark being named after him. On this occasion R had left his own foxhole to see if he could assist his platoon runner, but found instead only a mass of pulverised flesh. That incident required an immense effort to 'hold himself together'. This event remained in his subconscious and would visit him in later life when illness or stress weakened his defences.

By the time of the Balikpapan invasion in July 1945 R was severely weakened by illness and wounds and showing signs of being more careful. His first child was about to be born and he had not really recovered from the effects of scrub typhus and earlier wounds. His senior officer offered him the option of avoiding the action. R's commitment was so strong however, that he refused and went in as a platoon sergeant. By the end of the war he was very strained, as his wife had described.

years of living with his nerves screwed up and his body, pressed at times to the end of his endurance ⁵

His transition to the civilian world was very difficult. In the bank he was no longer a cocky young platoon leader with challenging assignments. He was then only a junior clerk. He had wanted to pursue a career in the army but damaged elbows, a legacy of wounds sustained at Gona on 29 December 1942, meant that he was discharged as D3 in health.⁶ From then on, the demands of a rapidly expanding family 'pinned him down' to the teller's counter for many years. He had to divert the energy of the warrior into more domestic pursuits with his young family in the relative serenity of suburban Adelaide. He wanted to break out of his routine life so he completed a land broker's qualification by the time he was thirty six. This spurred the bank into action and he was promoted to

⁵ From his unpublished novel *The Old Lieutenant*, p. 203.

⁶ Unfit for military service, discharge.

manager at the age of forty two. Together with his wife and family he settled on the River Murray, where the family then became his focus of happiness.

These years are recalled as a most satisfying period. He spent many hours on the water indulging his love for sailing and enjoying his children, especially the boys. He remained in the bank and retired as a manager at age fifty seven. It is all too easy to dismiss these long years of comparative calm as very ordinary. But Robert always took with him the philosophy that 'you always have the choice between submitting to life's challenges or facing up to them and surviving. As in the army you often had to make choices for your mates'.

Some of the skills learned in training and the characteristics developed as a platoon commander went with him into the bank. He wanted to provide strong leadership and did so by running a bank branch at a profit and developing a team spirit among his staff. He still believed that a unit never really pulled together until they are shot at, and demanded loyalty and commitment from all his 'troops'. None of this ever rivalled the challenge and resultant high of battle or being part of a combat unit.

R retired 'for family reasons' at fifty seven. His daughter needed a house so he and F moved out to travel around Australia and offered her their home. He was also having some differences with the bank, mainly to do with his son who was also in the bank. After a period of travelling in Australia and Europe, R took a position as a manager of an insurance company, from which he retired at age 65 in 1984.

Despite the strain referred to earlier, their marriage was central to their life stories. Their relationship had started while he was on leave from the Middle East but was confirmed at a most critical time. R recalled the time he decided to ask F to marry him - this was in the middle of one of the worst periods of the New Guinea campaigns:

There were some strains in the relationship as their own assessment reveals:

[R] But, looking back, when most of your life that you've led, it'd be all very well to get sympathy through your war service and all of those things but, people like F and I have really been very lucky, when you look back over it all. We've had some very good breaks. We've led a secure life. We had a secure job all the way through. We were able to bring the kids up well enough and give them the basic conveniences of life and holiday houses and taught them how to sail and we always had a boat somewhere, when they were growing up anyway. And we've had three trips to Europe on the Canberra and we've got a nice house by the sea. We've got our health, I mean, we can't really look back and say we need sympathy.

And so, therefore we have a mixed bag of a family and because we love them all - their difficulties are our difficulties. Now that we're not free of difficulties even though we have a lovely house by the sea and stuff. We've had lots of hard times

through our family. I think the family held us together when things got tough. Because we couldn't, I mean, you've got five kids and, I mean their dependant on you, you have to stand by them. But having five children wasn't easy on either of us because, five were in a row and towards the finish, F. was pretty spun out and she took a lot of holding together at about that time.

[F] I don't think you looked at the option, I don't think you even thought of the option of 'Maybe this is too tough. Maybe something else would be better. Maybe I should rush off and do something else'. Whether it was naturally there or whether you've, sort of, hung on through thick and thin 'cause, I can remember lots of thinness. It's all very well to say that we've been lucky. I think lucky is the wrong word. We at least didn't throw up our hands, like a lot of young people do now. We didn't throw up our hands but I think we had a different ethic in those days where people didn't expect to divorce or shoot off as soon as things got tough. I don't think you even thought of the option of saying 'Maybe this is too tough. Maybe something else would be better. Maybe I should rush off and do something else'. I think it was just, there you were and you had to make the best of it. I can remember a lot of years after the war, we were in fact struggling. Virtually all that housing difficulty and a lot of the other difficulties had actually settled down and we were there with five children. I can still remember R coming home from the bank; his face was like a white triangle, late at night. It's all very well to say that we were lucky, whatever, I think it was something different.

We've had lots of hard times through our family.

[R] I think the family held us together then. Because we couldn't, I mean, you've got five kids and, I mean they're dependant on you, you have to stand by them.

The short version of R's life clearly shows a strong life long influence from his war experience. He was exposed to a number of life threatening events and continued to experience remnants of his experience. His mates and wife especially were aware of the impact of the strain. The difference is that his experiences, as traumatic as any of his colleagues, never became a narrative of complaint or illness. He did not seek the help of doctors and was never referred to the Repatriation Commission (later Department of Veterans' Affairs) for assistance. In fact he remained healthy throughout life, until he was recently forced to seek medical help for a prostate problem – a normal expectation for a 76 year old man.

CATEGORY C: Serious disturbance, no effective intervention: life of LS,

Men in this category were clearly disturbed at some stage in their lives but were never recorded as mental health casualties. Some excluded themselves from treatment and others were not recognised. I will present a simple example of a man who never sought treatment. LS was born in 1920. His schooling and early life were relatively normal. He started school before the age of five in 1925 and left school eight years later,

having completed eighth grade. His experience of growing up during Australia's worst economic depression was positive, despite the family poverty. Prior to enlistment LS worked as a factory hand and assembly worker. Between November 1941 and May 1946 he served with three battalions in several theatres in New Guinea— the Owen Stanleys, Gona, Markham Valley and Ramu Valley and Bougainville. As an infantry soldier he was involved in front line fighting and could specify a number of critical experiences. He saw his own mates killed, was strafed by enemy fire, and involved in body retrieval and burial. He felt he'd generally been let down by his commanding officers. His most distressing experiences were being wounded, under fire in a heavy machine gun ambush, being caught in a bombing raid, particularly in Port Moresby, being under artillery fire, mortar fire, and grenade as well as rifle fire.

The most difficult thing to adapt to was not knowing the direction of sniper fire, having to kill or be killed, and losing his own mates. He received a serious bayonet wound and was out of action for two months. He also sustained a gunshot wound, ruptured kidneys, boils, a 'busted' nose, concussion and contracted malaria, dysentery, hookworm, and tinea. He did not report any stress breakdown.

He had never talked about these experiences to anyone since the war and had found adjusting to civilian life extremely difficult. He was initially very restless, with his mind always focusing on the war, but he was keen to get on with his life, even though he was anxious and had constant nightmares. His adjustment was hampered by residual debility from his wounds and illness. He could not find a permanent job. He thinks he has never settled down.

He took ten years to find stable work that he could manage. After a long struggle with temporary jobs he gained a permanent position as a salesman.

My brother, being in an executive position at Kodak Australia, got me a permanent job without much exertion, and finally I retired at sixty-two years of age, as I couldn't work any longer.

At the age of 79 he still has health problems related to his war service including osteoarthritis, numbness in the arms and legs, trouble with his back, deafness and neck troubles. He receives 100 per cent entitlement but is currently trying to obtain approval for the more secure Extended Disability Allowance. He has never received treatment for any psychological disturbance. His narrative suggests that he still has a chronic disturbance.

Yes, six nights a week of nightmares, seven nights a week of sleeplessness and whatever news nowadays brings about the thoughts of war, these thoughts and

images are bloodthirsty and gory dreams. No matter how much I win, they never lay down. Should I hack them up [enemy in dreams] each part grows again. I get up and walk around then back to bed. I never go to bed until midnight and whatever you think of, it always seems to get on the way back to war.

It is not clear exactly why LS has never sought, nor been referred for specialist help. He has continued to struggle with his anxiety and war dreams but nevertheless achieved in his outer world. His satisfaction in life has come in other areas - his marriage, family, and establishing a home. His wife has been his main support in his life, although he has not talked with her about his troubled inner life. His war experience and his lifelong disabilities, never really adequately addressed, conditioned him to such an extent he could not enjoy fully his family life, such as being able to play with his grandchildren.⁷ For LS there has been a constant tension between his inner and outer life and this is likely to continue until his death. He has remained outside the direct influence of mental health ideas, apart from the assessment of his eligibility for a pension. None of his narrative is part of the 39 Battalion Association discourse.

CATEGORY C: Serious disturbance, no effective intervention – life of HD

This is case of serious disturbance that was carefully suppressed and illustrates the complexity of the impact of war experience on the life outcomes. HD is an example of the veteran who carried a submerged memory of war experience that was never adequately acknowledged. The purpose of this presentation is to tease out the strands of a life trajectory with particular focus on an inner narrative that was initiated primarily in 1942.

⁷ When I learned of his situation, I suggested to him that he might benefit from some form of counselling and offered him the option of contacting a psychiatrist colleague of mine or the National Centre for Post Traumatic Stress Disorder which has a program catering for older adults. This he refused and it would appear that his knowledge of what had happened to other men who had given in to the difficulties was a major influence in this decision.

In HD's life story there are at least three clearly distinct narratives. The first is his personal narrative – his view of himself. The second is that constructed by the medical specialists who had examined him many times throughout his life. The third is the view of his life by family members and a close friend. The family members are his wife, who is now deceased, who provided brief input, and his daughter whom I interviewed twice. The other informant, his close friend (RW), grew up in the same town as HD, went to school with him, joined the same (2/27) battalion and remained a life long friend until HD died. Although they went somewhat separate ways in their middle years they were close during wartime and during retirement. RW visited him when he was hospitalised even when he was admitted to the high security mental hospital ward in his final months. I will describe HD's life by integrating these three narrative sources. RW is a very credible witness. He became a successful farmer and businessman after he was discharged and is still mentally able and living independently.

HD was born on a small farm in March 1914. His family were reasonably well off and he could not recall having to go without even during the depression. Like many people they had to 'make their own fun' and make the best of things sometimes. His family situation ensured that he had a sound secondary education in the city and was also initiated into military matters in a militia unit. He joined the bank, which was considered secure employment option. H was on annual leave from the bank in Waikerie and playing golf with his brother at Victor Harbor when the news of the Blitzkrieg hit South Australia. He was no coward but could not stand the sight of blood when on the farm, so entering the army was something of a shock.

HD had the sort of character suited to an organisation that was single minded and intent on achieving objectives ruthlessly. From his early days HD had, in the words of his lifelong friend, 'fought everything'. He was determined, straightforward, always expressed strong opinions, could be unforgiving and was often angry. He played life as he did a football game – 'go straight at the ball and look out anyone in the way'. His adopted daughter, who entered his life in 1955, remembers him as an excitable man, who was larger than life and could dominate a conversation or a room. These were the qualities that were noticed in the army where he won a commission and commanded a platoon.

Military Experience – Laying the Foundation of Traumatic Memory

In May 1940 HD was assigned to the 2/27 Battalion. He served in the Middle East, returned to Australia in April 1942 and was sent to New Guinea in mid 1942, by which time he was commissioned as a Lieutenant and assigned to the 39 Battalion. In the Owen Stanleys he was, along with the rest of the unit, exposed to serious physical and psychological strain. As an officer part of the strain stemmed from the responsibility of making decisions that would result in young men losing their lives. At Gona he distinguished himself with his fearless leadership and feats of courage and was awarded a Military Cross. When the 39th was disbanded he was appointed Captain and Company Commander in the 2/14. He had one more tour of duty in New Guinea and took part in the invasion of Balikpapan in 1945.

He first tasted battle in Syria with 2/27 Battalion and then in New Guinea, where he was assigned to the inexperienced 39th Battalion, the first unit to engage the Japanese in the Owen Stanley Ranges. His task there was to 'straighten the lines' and instil discipline in preparation for the Japanese assault. His peers believe he turned his men into 'wonderful troops'.

With the 39th in the Owen Stanleys and at Gona he was exposed to physically and emotionally demanding situations.

I walked out of Efogi in sandshoes. I don't think I was dry for the six weeks I was there - wet from arsehole to breakfast time. My boots fell off me. There were no supplies. The indentations in my feet were 1/2 inch deep. I could probably have pulled the skin off. Then there was the fear of being encircled. The idiots told us - and I hope the army never let people like that get into command again - Some of the senior command were just idiots, but at the fighting level there were some fine officers. They said a battalion of men could hold up an army in the gap in the Owen Stanleys. In the gap you could have put several divisions and nobody would have known they were there. The tactics became - the Japs would open fire on you, you did not try any stupid frontal thing - you went up to the high ground and went around to the extremities and then came down on top of him - and he did the same to us. It could take 3 or 4 days to test out the strength and depth. Before you knew where you were he [Japanese] was at your backside.

Do you remember the time we were cut off by the Japs - we were going up a ridge and I stopped and several bullets blew a hole through the butt of my rifle - ruined my oil can and pull through and did not touch me.

I made it back to the unit four days after being cut off at Deniki. We cooked food from native gardens. I had a Batman who could make a fire out of anything.

HD experienced four serious battles from 1942 until the end of his war. He was never wounded even though he was always fighting right at the front of his platoon, but he did contracted a number of illnesses. His was treated for malaria December 1942, which

recurred again in January 1943 and September 1944, and had a carbuncle removed from his neck on January 16 1943.⁸ After he had recovered from the Kokoda trek HD had led his platoon in series of attacks on Japanese outposts in which he had personally killed eight Japanese. His action, described below by his commanding officer Lt Col Ralph Honnor, earned him a Military Cross, the second highest award for bravery in the Australian Army:

HD, who had taken the first post in the capture of Gona Mission, led the [second] attack. Again his dash carried amongst the enemy ahead of his men. And again he made a machine gun his objective, killing the gunner and six others.⁹

The rest of his company 'completed the destruction, blotting out the remaining pockets of resistance'. H had 'led his platoon so dashingly' and 'was first in the rush on the first post where he killed the machine gunner and 7 other Japs'. In the final attack at Haddy's Village HD's platoon wiped out the post, which had about 30 Japanese. At the time hundreds of Japanese were killed, and at one time the Japanese were wearing gas masks to overcome the stench of their own dead. The Australian troops 'fighting in this stench couldn't bring themselves to eat – it was so sickening'.¹⁰

Even though he had distinguished himself in heroic acts and intense fighting, these did not sit well in HD's mind. In later years he reflected:

The manner of the attack at Gona was so unnecessary. After Gona Mission the 39th was detailed to go to Gona West and cut off a force of about 160 Japanese and we had to knock them off - at our own pace. We buried over 150 Japanese with about 20 casualties - it was murder at Gona Mission. We had to do an attack through Kunai grass and were mown down.

Other images formed part of his memory:

There was this 4 engine Yank plane taking off fully loaded with bombs and fuel and it just touched some trees and ploughed into a truckload of troops - it was devastating.

His memory was informed not just by haunting images of killing Japanese. He had also repressed his anger and sadness that so many men had been killed as a result of poor decision making.

Looking back it is easy to see that there were some very poor decisions made. At the time we took everything for granted. In fact it was only recently when Peter

⁸ DVA Medical file.

⁹ Austin (1988) *To Kokoda and Beyond: The story of the 39th Battalion 1941-43*, Melbourne, Melbourne University Press, p. 201.

¹⁰ Interview recorded by ABC Field Unit on location in New Guinea circa December 1942.

Brune started to uncover what really happened that I felt very angry and upset that so many men suffered and died - there were no plans and no intelligence.¹¹

HD acknowledged his fear in battle but had a distinct theory about how to manage this. Was he afraid at the time?

Responsible fear can be a survival strategy. It is necessary to have a realistic appraisal of the danger to yourself without letting it paralyse you. Fear started to creep in when you lacked support and were experiencing terrible casualties - When we got to Balikpapan & realised the support we were going to have that abject fear disappeared. If you don't fear things normally and sensibly you can overlook obstacles you shouldn't. If you said you did not experience fear you would be a liar.

This is the kind of experience HD went through many times and he lost many of his men. He had in his own words to 'turn himself into a monster' and he found it relatively easy to hate the Japanese soldier.

I had the approach that what had to be done I would do. I hated the Japs with their callous, brutal outlook - there was only one good Jap; wounded or alive, there was only one thing to do as soon as possible. When you saw what they did to some of our wounded - never mind we won't go into some of the dastardly part of it. At Gona every man [Japanese] was dead.

For HD there was nothing glamorous about killing. He reflected in later life that the most 'horrific thing to experience was killing men at close range. Their eyes just about turn up. They're just as frightened of dying. You can call on a wounded man to surrender but he puts a grenade up to his mouth and pulls the pin out and you shoot him'.¹²

Such experiences had sown the seeds of traumatic memory. When he was discharged he needed to consciously make the transition from 'monster' to civilian.

When the war was over and we were at Balikpapan [August 1945] I reckon I spent a sleepless night coming to terms with it. So the next night our company was bringing in several hundred Japs and one of our blokes got stuck into them. I went for him and everyone got the shock of their life because they all knew my sentiments. If there was a Jap down a foxhole you did not buggerise around - you put a bullet in his head. If you did not put a bullet in him then HD would. When we had a company parade I told them that I had changed and that they had to get the hate out of them.

¹¹ Interview November 1991. Peter was researching his book *Those Ragged Bloody Heroes*. HD's daughter and wife testified that after he was interviewed by Brune he became more disturbed.

¹² Interview in Australian Army Documentary, 1990. *Kokoda – The Bloody Track*.

Post Army Life

HD decided that he had experienced enough after his last campaign on Balikpapan. After the Armistice was signed he made a clean break – at least on the surface.

Colonel, I said I am a civilian at heart - I came here to do a job and now it is done; I'm going home. The sooner the better. I want to get back to civilian life and get back to normality - the quickest way I can.

After 5.1/2 years of service he was discharged in November 1945 and returned to his old job in the bank. Returning to this outer stable life still had an undercurrent of struggle to leave remnants behind.

And I think I did get the hate out of my system - it did take a long time. I don't really hate 'em. I found it very hard but I did stick to my principles. You can't hate someone without causing friction and friction causes war and *wars are no bloody good*.

My experiences were such that I was always ready to get back to peace and quiet. I was always a fairly volatile character. If somebody annoyed me you could hear me two hundred yards away. If I wanted somebody and they were a bit slow in coming they would get to hear about it. When you are in battle you don't have time to beat about the bush. I could not stand incompetence when life was at stake. I quietened down a lot - I think my wife is better able to comment on it.

The rest of his external story could be passed over with a few lines. He gradually worked his way up in the bank structure until he retired as a manager at the age of sixty two. He was able to support his family of two children and provide them with private education. He and his wife were financially secure in retirement and were able to enjoy lawn bowls until he was too ill to continue.

A significant task when entering civilian life was to deal with his memories, but HD simply pushed them 'down' into his subconscious and got on with family and working life. He carried the army attitudes of discipline and getting the job done into the bank. The transition to civilian life proved to be not so easy and even though he repressed the war memories they were not eliminated entirely from his mind. The war narrative continued in his subconscious until he died but remained a private experience.

I'm 76 [1990] and on the whole I think I'm pretty good. I have had a few nightmares. That is when I let my defences down and say 'The war's over, you can relax now. There is no need to stifle your emotions' - if you do that, that's fatal.

The worst one I had was lying in bed and I had this bloody Jap it was dark and I was watching him and when he got close enough I leapt at him - and I hit my head on the bloody chest of draws - he was a dead man there were no arguments about that - I had it all worked out. I was not going to shoot him - I was going to stick my bayonet up his belly button. And I was quivering like an aspirin. (laughter)

Doreen [wife] reckons I used to have nightmares. I would wake up strangling her. In this dream I had him [Japanese soldier] right close. I was going to get him with my bayonet - I had it all planned, had it all worked out. I was quivering like a leaf. That is the only real nightmare. I have had a few when I have woken up strangling Doreen or something.

These nightmares appeared immediately after the war but were suppressed through an act of will until his defences were dismantled after he retired and when he was ill.

In his post-war health record there are two strands. The first is the official medical narrative and the second is the hidden narrative, in this known only to his family and a close friend (RW). His medical history is found in two places. The first is in his medical and hospital files when he was assessed and treated in the Repatriation Commission facilities. The second is in the medical assessments associated with several claims for entitlement to war-related disability.

The medical discourse was initiated when HD enlisted in May 1940 and the Medical History Sheet (AA Form D1) recorded that HD had no pre-existing medical condition, but that his sister had completely recovered from a nervous breakdown in 1926. When he was discharged he was given the standard review by a medical board. The only psychological assessment came when he developed Parkinson's disease in later years. During his service he had been treated for a carbuncle on the neck, malaria and dysentery, but was otherwise unscathed. On discharge his ears, eyes, abdomen, throat, heart, limbs, chest, blood pressure and reflexes were examined to reveal only minor abnormalities. There was neither psychiatric examination nor any mention of mental status. As a result of his final review in November 1946 the Repatriation Commission accepted responsibility for treating any subsequent malaria, bilateral otitis externa (ear problem) and sciatica. His entitlement notifications followed him to his various banking appointments in rural South Australia, in the event that the local medical officer were to treat him.

There was no mention of mental stress even though his closest friend knew it was there. Two witnesses (RW and JR) who met him on the way out from Efogi in August 1942 recalled that he was very strained. After Balikpapan (1945) he was even more strained, but according to his close friend (RW) he would not admit that the stress was getting to him.

At the end [of the war] he was close to a mental breakdown. He was considered by most to be as hard as hell and any man that he lost gave him hell. I think that carried on in his life. It [discharge] was a let down really. His discharge was a kick

AUSTRALIAN



MILITARY FORCE

Classification Form D.I. (Revised May, 1939)

Medical History Sheet of Wray, J. (Army No.) 4130

Surname (in capitals) Wray, J. Christian Names J. Wray
 Age 26 years 2 months Date of birth 28. 8. 1914 Birthplace St. Aust.
 Occupation Bank Clerk Religious Denomination C of E
 Complexion Dark Colour of hair Dark Brown Colour of eyes Brown
 Distinctive marks, and marks indicating congenital peculiarities or previous disease Scar on front left knee edge of scapulae
Scar on long of parietal region
scar on right high costal margin

TABLE I.

1. Are you now suffering from any disease or disability? No.
2. Have you ever suffered from any of the following illnesses?

<p>NO EVIDENCE OF TRACHOMA</p> <p>Rheumatic Fever <u>No</u></p> <p>Weak Heart or Heart Disease <u>No</u></p> <p>Tuberculosis <u>No</u></p> <p>Spitting of blood <u>No</u></p> <p>Pleurisy <u>No</u></p> <p>Asthma or Shortness of breath <u>No</u></p> <p>Venereal Disease or Stricture <u>No</u></p>	<p>(h) Neurasthenia or Nervous Breakdown <u>No</u></p> <p>(i) Kidney Disease <u>No</u></p> <p>(j) Skin Disease <u>No</u></p> <p>(k) Malaria <u>No</u></p> <p>(l) Dysentery <u>No</u></p> <p>(m) Corns on the feet <u>No</u></p>
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3. Have you had fits of any kind? No
4. Have you had discharge from either ear? No
5. Have you had a broken bone or been seriously injured? No
If so, state nature and date.
6. Have you been operated upon? No
If so, state nature and date.
7. Has any member of your family suffered from Pleurisy, Tuberculosis, Diabetes, Stroke, Nervous Breakdown, or Mental Trouble? Yes
If so, give particulars Sister, nervous breakdown (1936) Complete recovery
8. Have you been rejected or deferred for Life Insurance? No
9. Have you been rejected or discharged as unfit for service in any branch of His Majesty's Forces? No
If so, give date and reason.
- *10. Have you been wounded, suffered from Shell Shock, or Gas Poisoning? No
If so, give particulars.

I declare that I have read the answers to the above questions, and that to the best of my knowledge they are true.

Station ADELAIDE

Date 24 MAY 1940

Signature of Recruit [Signature]

Examined on 24 day of May 1940
at ADELAIDE

Vision (Right 20/20 ✓) (Left 6/6 ✓) With glasses (Right ---) (Left ---)

Height 5 feet 10 1/2 inches

Vaccination Marks (Right No) (Left No) Number _____

Weight 165 lb.

When vaccinated _____

Chest Measurement (Girth when fully expanded 38 1/2 inches) (Range of expansion 3 inches)

Slight defects, but not sufficient to cause reaction _____

Examined by me and classified as follows:—

Classification Sue

Signature A. Stone Date 24 MAY 1940

Subsequent Medical Examinations:—

Classification _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Figure 11.1 Medical History Sheet at enlistment, AMF AA Form D1: HD.

in the arse and that was that. He gradually started to show signs of, not cracking, but being affected badly. It was a let down really over the years until finally he got the bladder cancer.

This mental breakdown did not surface. Ailments of unclear origin did appear and became the focal points of his contact with the Repatriation system. In 1958 he sought treatment for back pain, which was eventually diagnosed on 23/9/74 as sciatica. Further requests for treatment were made as his body continued to deteriorate with age. These ailments became the basis for compensation claims. The first of his applications came in May 1978, two years after he retired, when he applied for pension entitlement for his back condition and pain in his eyes. He was thoroughly examined by a number of specialists. H maintained that his complaints had affected his work but he had lost little time with sick leave. In March 1979 he was awarded a 20 percent entitlement, but it was noted on his report that 'there was no medical cause for the complaint. All pains in the eye and body have no medical or prognostic significance'. The question of whether there might be another explanation of his pain was not asked, and the search for prognostic significance remained in the physical domain. There was considerable discussion of the possible effects of a gelignite explosion sustained during training at Canungra in Australia in 1943. He was awarded a small entitlement for his deafness.

Was there a psychological explanation for his symptoms? This was never considered. It was significant that after he retired there had been an increase in his traumatic intrusions. Had they consulted HD's wife they would have gathered important information.

When his mind was full of the bank he was OK, but once he retired – nightmares. But he does not remember when he wakes up. I would have to wake him up. It was almost – he'd scream like it was terror you know – and shouting at people. It was terrible – a bit better lately.¹³

These signs of an inner traumatic and disturbed life, which might have had some bearing on his general and mental health, were never investigated. It was noted in the comprehensive report on his pension application for entitlement for peripheral vascular disease in October 1984 that he had experienced nightmares about the war. HD even admitted in that application that he had suffered nightmares, but neither of these leads was considered relevant. Instead the focus was on his smoking behaviour, which might have accounted for his disease. Unfortunately his application was not accepted, because

¹³ Partner's input to interview November 1990.

he had given up smoking in 1976. According to the Commission rules, the connection between strain, smoking and the vascular disease could not be established within the eligibility period. In this medical discourse there was no further mention of any psychological distress.

While this medical narrative was being recorded his friend and daughter were aware of his mental distress. His friend RW recalled that any illness brought on stressful behaviour. HD's most serious illness was cancer of the bladder that was first detected in November 1984. Another event occurred in 1986 when HD was referred to the VA hospital after experiencing chest pains while driving his grandson to a swimming pool. Physical investigations revealed some abnormality, which it was believed, could be managed with medication. Not recorded on the medical file, but revealed in his research interview, was that for HD, driving was a stressful task. He described this:

Me, I now drive the car on my nerves - if you relax for a second you can be dead, along with your passengers and others.

H had a total cystectomy in September 1991 and his recovery was complicated by a Myocardial infarction. These hospital admissions were always accompanied by psychological distress. As RW reported:

I saw HD at the time [cystectomy] and he was completely distressed - not the normal Hugh. He fought everything. Contradicted everything that was said. I thought it might have helped him - knowing Hugh's background in the army. He went through Hell. Gave him a M. C. From then on they kept him working right through the islands. He was a Captain and although he was considered hard as hell any man he lost it gave him hell. I think they carried on in his life. I met him on the way out of Kokoda and we had a chat. He would never admit that the stress knocked him.

When he got the bladder cancer, I used to take him down to Flinders [Medical Centre] for chemotherapy and that was a humiliation. After they operated on him at Daws Rd he always had the idea that some one was going to get him. He would sort of become more or less unconscious at times. When he was coming around in the intensive care unit one of the nurses came in and he cracked her and I said 'what the hell went wrong?' He said 'I though they were going to cut my arms off'. He had sunk so low. He was crushed really. I think the happenings during the war, particularly on the islands set up got to him. He lost men. And I think it got to him.

In 1992 he was diagnosed with Parkinson's disease. It was noted in his medical notes that he was, among other things, hallucinating, probably a side effect of Sinemet, the medication for the condition. A few months after his first admission for this, a psychologist noted that he was 'much more positive', but still with presenting problems of 'fear of illness and dying, and depression'. He was not doing well at 'being assertive

with his wife', but the psychologist still encouraged him to do so. It was at this point that some account was taken of his strenuous war service. In his claim for a pension entitlement for a heart condition and Parkinson's Disease HD stated that he had 'experienced some pretty rough conditions in Syria, Owen Stanleys, Gona, Ramu Valley and Balikpapan'. Here HD introduces a delayed stress response explanation for his physical deterioration. He considered that his heart condition was due to the 'rigorous campaigns I served in. I was subjected to rigorous conditions that no doubt also affected me mentally and physically'. In the 'Lifestyle Questionnaire' he had to complete for this application he also admitted that when he retired at 62 he was 'tired out mentally and physically'. Only Ischaemic Heart Disease was accepted as war-caused. He did not qualify for an Extended Disability Allowance.

In the whole of this investigation there was no rating of the severity of his experience in wartime. He was assessed by a psychologist for depression and cognitive functioning but not for any condition that might be attributable to his war stress. Even though the PTSD diagnosis from DSM-III-R had been available for some time this was not used as part of the diagnostic battery. In the psychologists and physician's report he was given ratings for Impairment (65/100 points) and lifestyle (6/10). HD continued to deteriorate and was eventually admitted to a nursing home, the ultimate ignominy. His wife had suffered a stroke and HD became increasingly paranoid about her absence. He was convinced that she had left him for someone else.

During any illness the memories of his time in the islands, where he had lost many men, returned to him. 'He was ruthless in losing them and ruthless in fighting but it got to him later'. When RW did share moments with HD they talked little about the stressful times but more about the adventures and the humorous events such as getting into trouble with military police. There was no counselling for post-war strain and his friend RW compared this with the counselling that had been offered to the British army after Dunkirk.

The last few months of HD's life were the most distressing. This was the only time he was treated as a mentally ill patient, even though any prior bout of physical illness had brought on psychological distress and a return to his traumatic war memories. A short time before his death he became violent and according to his daughter had a psychotic episode while an in-patient at the veteran's hospital. Shortly before he died he was admitted under a detention order (*Mental Health Act, 1995*) to the high security

wing of the geriatric ward of the local mental hospital. In the ward it was noted in his file that he was suffering from dementia and psychosis and was required to be restrained under high security. He'd been sent there because of a bureaucratic requirement that if there was a ward available in a public institution, he couldn't go to the more dignified surroundings of a private mental health clinic.

The ward he was sent to was described by the consulting psychiatrist as one of the 'best in the world', but I perceived it as a stark, locked ward with no way out. Patients share the four bed wards with other demented men or women, and if they're particularly aggressive they are allocated a single ward which actually looks like a cell and can be locked when necessary. The ward is sterile with little decoration and a jail-like atmosphere. The nights are particularly bad because the patients become more vocal and violent and as the consultant stated, it 'becomes bedlam'. There are small courtyards with high fences leading off the lounge area but these are locked and can only be accessed under the supervision of a nurse. Straightjackets are no longer used and medication is the main form of containment of aggression. A shortage of staff restricts what can be done with these old people and it seems to be largely a matter of containing them and providing some activity. The visiting section, where RW and HD's daughter came to visit, is a small rectangular, unattractive room, open at one end with chairs lining each side of the wall. There is no privacy for conversations.¹⁴

In the medical notes relating to HD's stay in this ward, there is no mention that he was a senior officer or that he'd had intensive war experience. Consequently there was no connection made between his paranoid ravings, aggressive behaviour in the ward, and his traumatic past. While there he continued to defy the staff and would make aggressive stands in the corridor. He thought there was a machine gun post at the entrance to the ward (friends' testimony) and he thought he was a prisoner of war. He 'wanted a stoush' and to get this 'sorted out now'. He would stand to, stand fast on the floor, and challenge the nursing staff, but his military demeanour and his aggression were not regarded as significant. While he was in the ward he was unable to respond lucidly to any of the questions that were asked of him. After four days he was released from the mental hospital at the request of the family, but he never recovered mentally or physically. In the nursing home he broke a hip and he died shortly after an operation.

¹⁴ I visited this centre and interviewed the psychiatrist who admitted and treated HD.

His final days were tormented as he swung from a comatose state to distressed consciousness. In lucid moments he would return to war episodes.

The crucial point of HD's life story is that his traumatic war experience was never taken seriously by the treating agencies. The undercurrent from this experience was certainly known to the key people in his life, but his wife and daughter (a qualified clinical nurse consultant) were never consulted nor involved in addressing his difficulties. His case not only graphically illustrates the life course of a submerged traumatic memory, it also confirms the culture of the repatriation system which seemed unable to address war and psychological distress as a relevant issue in treatment, unless a veteran was extremely disturbed or dangerous. His war record was only considered relevant in determining compensation and not in trying to address the seat of HD's health problems.

The most significant feature of all of this is that in the medical notes, there is no mention of the high esteem in which he is still held by members of his unit and the three battalions where he served. In that forum his name is still revered as a great soldier who had done much to contain the anxiety of his young charges when they first faced the Japanese. There was no justice and no dignity in these final days. He was no longer captain and war hero. He was a demented dangerous old man.

One feature of this case study that might have some explanatory value relates to medical history taking. Medical history taking is a stock method employed by doctors to construct a medical narrative of a patient. The product of a medical history is the version of the person's life (usually illness-oriented) that the practitioner has heard. It is recorded predominantly in the words of the medical observer. The resulting clinical history can differ significantly from the personal history and this is clearly shown in the case of HD. At least four significant medical histories were taken when he was either admitted for treatment or assessed for pension eligibility but specialists never once addressed the distress that was clearly known by those who shared his private narrative. This is what I call *parallel discourse* – the different narratives do not entwine. The discourse found in the medical files is quite separate and does not incorporate the discourse or narratives in the private lives of veterans. This is partly the consequence of a long tradition of not including family members in the therapeutic process.

It is relevant to ask whether an understanding of traumatic stress might have made difference to HD's life and treatment within the veteran system? I would argue that it

could have, with one qualification. That is it would have been helpful if it had provided a framework to open up a free discourse about his distress, not as a forensic tool to assign him to an illness category. A concept of trauma and stressful effects would have provided a number of benefits. In the first place it would have provided a rationale for exploring below the surface of his symptoms very early in his medical history. The whole culture of veteran health had militated against this. As described earlier, the relevant organisations made sure from the early post war days that any discussion was carefully excluded in the immediate veteran world of HD. His active suppression of New Guinea memories was as much an act of conformity to the rules of veteran culture as an act of psychological protection for himself. As he aged and became more vulnerable his New Guinea terrors became more present.

I argue that HD would have been better served if the medical lens had been focussed on past understandings rather than on modern views. Whatever the limitations of the concept of neurosis, the specialists of WW1 (e.g. Rivers or Myers) did acknowledge the enduring effects of memory. In HD's case remnants of his war experiences kept emerging in unguarded moments but were mostly kept sealed in a mental box. In this sense the doctors of the empire had not learned the lessons of WW1. Even a reference to a standard inter-war text would have given them a clue to the dynamic of repression, even though the recommended Freudian analysis may not have helped.

These symptoms of fear that incapacitated him would have been hard to explain had it not been realised that there were antecedent causes; the fear was not in fact the result of any present-day experience but was the revival of that experienced in the trenches or elsewhere some time, perhaps a long time previously.

The inability of these patients to control and maintain the repression of their fear was illustrated also by the fact that they practically all suffered from war nightmares, and anxiety dreams, due to the emergence of unconscious anxiety in sleep. As soon as the controlling hand was removed from the lid of the box the 'Jack-in-the-box' could emerge, looking more frightening and alarming than it had previously appeared.¹⁵

In the final analysis HD was poorly served by the ideas and practices in the Veterans' Affairs (DVA) system. Had he been of the Vietnam generation he may have been recognised as suffering from some form of post-trauma reaction. The Younger Veterans' Program introduced in the 1994-95 Budget accepted PTSD as a major focus of its research program for Vietnam Veterans. This brought an expansion of psychiatric services and a dedicated PTSD program for Vietnam Veterans. In the Veterans' Affairs

psychiatric programs a distinction is made between WW2 veterans, who are regarded as psycho-geriatric patients and Vietnam veterans who are primarily diagnosed with PTSD. In HD's case a number of factors coincided to prevent him from having effective help. His own personality and strong sense of independence would have made seeking help a last resort. The administrative and diagnostic framework within the DVA was designed to assist only those clearly assigned as mentally ill. The whole context of mental health and war framed mental problems as a source of shame. The construction of psychological distress in war ensured that mental problems were perceived as a source of shame, and this may have been a factor in the failure to address his inner distress until he became a 'demented old man'.

CATEGORY C: Getting it wrong - organic lesion, not nerves. The case of GR.¹⁶

The experience of another 2/27 veteran who died prematurely is an misdiagnosis. In this case the veteran's symptoms were for many years labelled neurotic, and doctors regarded his condition as 'Not Yet Diagnosed (NYD)'. It was discovered too late that he did have an organic lesion. GR died before this study was undertaken and his story was constructed from medical files and the testimony of his widow (R) and sister. His sister also married a veteran who had served in New Guinea at the same time as GR. His life illustrates how symptoms of illness can be passed off as psychosomatic. Unfortunately despite multiple investigations the actual cause of his symptoms was not detected until it was too late.

GR was a lieutenant in the Intelligence Corps. He served in all of the 2/27 campaigns in the Middle East and New Guinea, and was a member of the advance party in Morotai before the landing at Balikpapan in July 1945. As an intelligence officer he played a key role in the 'saving' of the 2/27 battalion when it was forced to withdraw from Kokoda. His senior officer (Capt. Jack Reddin) recalled an occasion in New Guinea when, even though G had dysentery, he agreed to lead a three-man patrol to contact all remaining remnants of the unit before the withdrawal.¹⁷

¹⁵ Gordon, Harris & Rees (1936) p. 157.

¹⁶ Case study compiled from interviews with G's widow, sister and Dept of Veterans' Affairs Medical and Hospital files.

¹⁷ Their desperate situation is illustrated by the fact that GR, as part of the advance party in the withdrawal literally provided a paper trail with the Salvation Army Red Shield toilet paper left along the way. There was no medication and little food.

After his discharge he qualified as an accountant and went back to work for a period in New Guinea with Steamships & Co. He returned to Australia and worked for a large pastoral company, becoming a company director before he retired with poor health. This career path was a significant change from his pre-war years when he had been unable to get work and went to the Riverland picking oranges and delivering ice and water. He died in 1976 after a long illness.

New Guinea service had a serious effect on G's health. He was badly wounded and contracted dysentery and malaria. His partner recalls a time just before they were married in 1943.

G was brought home to a hospital in Enfield just before Christmas 1942. I was in the air force so courting was rather difficult. However, we decided to get married before G rejoined his unit in New Guinea. We were married at St Margaret's Church Woodville on 10th April 1943 and G left a few weeks later [for Shaggy Ridge and Ramu campaigns].

When he came back here for that Christmas, we went down to the station to meet him. He wanted to come home - he came home in an ordinary carriage - and struggled off. He just had hospital blues on and he had been sitting up.

He was discharged in 1945 and declared by the Medical Board that his health was A1 despite a record of malaria, a fractured skull, a burst eardrum, broken teeth, gunshot wounds, nerves of the stomach, and epilepsy. He was entitled to a small pension and free medical treatment. When G settled back into civilian life, he is reported to have done it extremely well. His wife recalls, 'We had a short holiday, then he got straight down to studying and living a normal life'. Most of his energy was put into getting started again. He rarely talked about the war.

G didn't talk a great deal about the war experience except with other returned friends, but he did say that the New Guinea tour of duty was far worse than the Middle East. When he came returned from the war, all she knew was that he'd had a very bad experience, but learned few details. [R]

His sister recalled that occasionally after a few drinks her husband, who was also in New Guinea, and G 'would tell each other how frightened they were - they did lots of campaigns together - but he [G] was not a man to talk about himself - very quiet man not on to talk about how he won the war - quiet'.

Within a few years G had completed an honours degree in accounting at the University of Adelaide and then spent several years working in New Guinea as an auditor. He returned to Adelaide and began a successful career that culminated as a

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MX 62525 (E11)

21 APR 1966

Dear Sir,

As a result of a recent medical examination, your accepted disability "Ruptured Left Tympanic Membrane" has now been amended to read "Ruptured Right Tympanic Membrane".

Treatment for this condition may be obtained at Departmental expense from Dr. Dow, of Fremantle.

You will be advised separately regarding a pension grant.

After careful examination of your claim, the Repatriation Board also recorded the following decisions:-

Claim in respect of .HOT.SWEATS,.NIGHTMARES,. . refused under Section .101. NERVOUSNESS

The member is not suffering from HOT SWEATS,.NIGHTMARES,.NERVOUSNESS nor incapacity therefrom.

Under the Repatriation Act you have the right of appeal to the Repatriation Commission against this decision. Should you desire to appeal, the enclosed form should be completed and returned to this office.

Yours faithfully,

(A.H. PANTON)
DEPUTY COMMISSIONER
A.H.

secretary of a large company in Perth, but his health gradually deteriorated. In his mid years his epilepsy worsened and investigations of his complaint at Repatriation hospital failed to find a cause. The medical specialists he consulted had attributed his seizures and failing health to stress and psychosocial factors. War injuries were never considered as a cause. As his sister said, 'for many years he had been treated as hypochondriac'. G's first encounter with psychiatry occurred in 1966 when he was examined by a Repatriation psychiatrist. G had been referred because of his recurring headaches and ear trouble and complaints of a feeling of emptiness in his stomach. It was here that he revealed a disturbed inner world that could have been interpreted as a psychiatric condition. He was considered a 'poor, rather vague, informant – everything had to be dragged out of him'. He had been edgy for 3-4 years, had experienced temper tantrums, and was disturbed by noise and pain in his ear, by which he believed he could predict his epileptic attacks. His most disturbing experience was experiencing a 'nightmare during the day', when he 'saw a vision, it was horrible – can't remember what was – lasted five seconds'. These occurred several times a month, and sometimes occurred when he was going to sleep, when 'he had an aura and empty feeling in his stomach, then the vision flashes up'. The nightmares he'd had after the war were 'different from these 'visual hallucinations''. Nothing was made of his original post-war nightmares and temporal lobe epilepsy was accepted as the explanation for his symptoms. While his childhood and earlier life were subjected to scrutiny, his war experiences were left untouched, although it was noted that his brother John had been killed in action in 1942.¹⁸

There was some argument between the specialists in ENT, neurology and ophthalmology. Much of the argument centred on whether he had sustained a head injury in a motorcycle accident in 1941. The specialist Dr F. concluded that he could not 'support the suggestion that the current upset is the result of an alleged fracture of the skull sustained in 1941 when on war service'. The administrative decision was then made not to accept his symptoms and distress as war-related. The claim in respect of hot sweats, nervousness, and nightmares was rejected, and in fact the Deputy Commissioner concluded that 'the member is not suffering from hot sweats, nightmares and nervousness'. G appealed against this decision, and pointed out that the only way he

¹⁸ All the details of his medical treatment are found in the Medical and hospital files MX.CX.HX.62525. Family information was compiled from interviews and correspondence from His surviving partner and sister.

could validate his experience of hot sweats or nightmares was to have a medical practitioner present at the time of their occurrence. He was 'unable to produce physical evidence such as a hole in the eardrum, missing teeth, a gun shot tear or even a heart murmur, which could be detected by a stethoscope'. It was decided that an earlier diagnosis of ruptured tympanic membrane was in error.

At this stage G was only fifty two. Even though he was well educated and had been a company secretary he was described only as an 'easily excitable man, who gives a very inadequate history'. The Repatriation Commission Officer in Charge of Entitlements regarded him as 'not an easy person to interview as he alternates between laughter, morose silence and periods where he becomes quite garrulous'.¹⁹ G's cause was not helped by his poor opinion of the Department, which was formed when he was first interviewed in 1945. His appeal was disallowed in October 1966, because the 'present symptoms stated are due to your rejected disability Temporal Lobe Epilepsy'. (Letter from the Deputy Commissioner.) G made a further declaration, in his own writing, 12 December 1966, where he again set out his case for acceptance that his life time symptoms had originated from the head injury of 1941. He also pointed out that from at least 1944 he had attributed symptoms of dizziness, or odd feelings in the head, to malaria.

Fisher reviewed his condition on 8 September 1969, and it was reported that there was no significant deterioration, and that he should continue his anti-convulsant medication. By 1971 his seizures had increased along with headaches. He was not eating regularly and was 'taking alcohol'. The specialist considered that 'much of his current disturbance was self-inflicted'.²⁰ By April 1975, he had deteriorated further, with complicating conditions of chronic airway obstruction, some deterioration in cognitive and motor function, and dilation of left ventricle. The detailed report on his assessment was the first comprehensive narrative to connect his symptoms with his initial injury. The specialist conclusion (Dr Stokes) was that he had 'communicating hydrocephalus'.

A ventriculo-atrial shunt (device inserted in the cranium) was carried out on 2 January 1975, and by 20 March there was significant improvement. The opinion was that he 'was suffering from normal pressure hydrocephalus which was probably caused originally by his head injury in August 1942 (sic)'. In April 1975 he applied for

¹⁹ Letter, Repatriation Commission, 28 July 1966.

acceptance of this condition, and in June the acknowledgment he sought in 1966 was granted. The chair of the Repatriation Commission confirmed this. The history contained in the service documents, and the medical opinions that have been expressed, 'support the veteran's claim that the condition is related to an accident on service'. He then became eligible for treatment, mostly occupational therapy, but no major improvement could be achieved. He was largely confined to his home until his death in hospital on 23 January 1982 (acute myocardial infarction).

While an organic cause had been the fundamental cause of his illness, there is evidence that he also had mental intrusions from his war experiences. The early disturbances and intrusions, particularly nightmares, were well known to R, who 50 years later still found it too upsetting to talk about at length. It was 'always the same dream of being chased by a Japanese soldier and being unable to get away from him'. These nightmares persisted for many years and he was never able to talk about them to her. 'He didn't talk about it much and we didn't let it interfere with our daily lives.'

I never saw him really well - he struggled and achieved a lot. He did achieve but it was really grim. G coped extremely well after the war except for a few epileptic seizures, but as the years passed they seemed more difficult to control until at fifty-nine he had partial paralysis, was operated on and a shunt inserted into his head. After the shunt he was never right. There was so much brain damage the doctor said he had a brain of an eighty three year old man and was never able to work again. He was granted TPI.

Despite his years of struggling for recognition and his apparent irritability and problems with medical staff, at home,

He was a wonderful provider, husband and father - a real family man who could turn his hand to so many projects - a very fair man who never asked anyone to do a job he wasn't willing to do himself - and above all a very unselfish man who for the last years of his life spent most of his time either in hospital or sitting in a comfortable chair. For an active man this must have been frustrating, yet not once was there a word of complaint or 'why me?' He really was an inspiration to us all.

Initially it was assumed that his symptoms were neurotic, but even if this had been the case there was no attempt to provide specialist help. Again his partner and sister knew that the war had deeply affected him and that this had persisted over time, but they were excluded from the therapeutic loop. In the final analysis these psychological aspects were well and truly suppressed and eventually overtaken by physical illness. Finally his symptoms could be clearly explained by an organic lesion. Like Alice James

²⁰ Letter, A Fisher, 2 July 1971.

this was a 'palpable malady' that 'lifted him out of the formless vague' but it was discovered too late. His strategy of keeping things to himself, getting on with life and focusing on the outside world of family and work was successful as long as he remained able.

I really can't say we 'suffered' at all – had a very happy, normal life as a family until the last 7 years of G's life. I have no doubts he suffered at times, but he kept this very much to himself. I think the saddest time was after the surgery, to see a man who had made such a success of his life, become virtually a vegetable.

G's life brings together all the themes of this study: the interruption of life course by war related trauma; the struggle for recognition of war-related symptoms; presentation of symptoms that could be interpreted as organic or psychologically based; expert argument about attribution to war service; administrative decisions that reflect policy; the possible influence of personal bias on administrative decisions.

CATEGORY D: Serious disturbance, psychiatric intervention – Life of LH, exposed to multiple treatment intervention

This case study recounts the life experience of LH who is still alive and striving for mental and physical health. He contrasts with most of the men in this category, in that he has 'recovered' in later life and no longer depends on the VA mental health system. In this latter phase of his life he is searching for healing outside mainstream medicine. For example, at the time of my first interview he was living in a caravan and experimenting with a range of natural healing methods, including massage, diet, and hypnosis. The second interview took place shortly after he had survived another physical health crisis (stroke) and was revisiting the similar methods of healing that were outside the bounds of conventional medical practice. This search for health was a consistent theme of his narrative in my later meetings with him in the 1990s. In these experiments he was pushing himself well beyond the boundaries of the treatment regimes which had been central to his earlier treatment in the army and in the repatriation systems.²¹ Most of his post-war life has been a struggle to maintain his mental balance. He was violent, drank a lot in the early years and struggled with his

²¹ The life story has been collated from a number of contacts and sources: several telephone contacts and interviews (May 1995 and August 1999), a questionnaire; exchanges of letters, and interview with his daughter August 1999, the Murdoch Sound Archive transcripts, the text of a television interview and the medical and hospital files from the Department of Veterans Affairs. LH has found it difficult to provide a coherent narrative. It was up to me to draw on each source and weave the information into his story.

marriage. He fathered two children but the married relationship was never a settled one and ended in divorce. He now has a good relationship with one daughter who is very supportive. He still lives alone in a caravan.

LH now believes he has discovered the alternative to the psychiatric paradigms and other medical interventions he had experienced in 'the bughouse' [Rockingham Psychiatric Centre, 1962]. At the time of the first interview in 1995 he had 'thrown away his pills' and rejected mainstream medicine. This was after years of trying to find remedies for his problems. He was only prepared to accept treatment for physical problems like cardiovascular disease. His story is long and complicated.

To explain how he arrived at this point we need to go back to the beginning. As one of 19 children, LH had experienced a poor childhood – 'a lot of hard work and little to eat. We had the arse out of our pants and very little education'. At the age of 6 he was made to work in his father's market garden every day before going to school. His father drank a lot – 'most of the income from the market garden went on grog and racehorses'. L left school at 14 and worked in his father's garden. At the age of 18 he applied to join the navy but was not accepted. He was too young to volunteer for the AIF but shortly afterwards was conscripted into the 52nd Battalion. After initial training he volunteered for the 39th Battalion which was being formed as a militia unit to go to New Guinea. LH could have stayed home and grown vegetables for overseas troops but convinced the hierarchy to accept him for overseas service. 'They said, "If you are that keen to go and get yourself killed, you go"'. 'How many times I wished I had stopped home and grown veggies for all you other jokers'.

LH was in Port Moresby for his 21st birthday on 15 March 1942 in an anti-aircraft crew. In mid-1942 he was sent over the Owen Stanleys as a reinforcement machine gunner. This is a crucial time in understanding the dynamic of the effect of war experience on him. Until then his attitude had been rather blasé and full of bravado, but when his unit was ordered to fix bayonets after they had been fired on at Deniki, 'it really dawned on me at that moment that this is what soldiering is all about. I think that stage was the first time I was really frightened'. In his period in New Guinea from March to December 1942 he experienced a number of serious incidents that had the potential to unseat him.²² These included:

- Being strafed
- Being caught in a Japanese bombing raid
- Seeing his close friend killed.
- Close fighting against the Japanese in the jungle
- Killing an unspecified number of Japanese with a machine gun
- Being left by his section, exposed to the enemy
- Night patrols in dense jungle
- Witnessing his company commander accidentally shoot himself.
- Being ordered to kill a Japanese soldier who had been wounded.

This last incident is the most deeply ingrained in his memory and has been recounted publicly by LH in his Murdoch Sound Archive interview in November 1988 and in a film by the Training Command of the Australian Army.²³ One version of this was reported at the beginning of the previous chapter.²⁴ There is supportive evidence for the veracity of his recollection and that it was not a product of a fevered imagination. Another witness who was there at the time described the same event.

We were attacking Kokoda and we had to go round to the right and we got to this village ... You can't start firing off in the ... because you can't see very much and it all quietened down, we had to move forward and that's when I saw my first enemy soldier. He was laying on the ground beside the track, he had been hit across the buttocks with a burst of Thompson sub-machine gun bullets and they're about half inch round, you know they're all lead, and all his feet were laying beside his head and he was nearly dead. His eyes were rolling around ... It turns your stomach to think about it.

Well, one officer there said finish him off, put him out of his misery or something, but nobody would do it. Then one fella did. (pause) I think it upset him quite a bit.²⁵

A number of elements began to add to his feelings of vulnerability and fear. A senior officer, who had earmarked him for the promotion for his efforts on the Track,

²² The most coherent narrative of his war experiences is found in a biographical profile written by LH in November 1982. This account only concentrates on the Owen Stanleys period.

²³ LH had gone on record in at least three other places – an ABC Four Corners program. And Australian Army historical production of the Kokoda campaign, and an interview for the *Australian* newspaper Saturday Magazine. In each he delivered the same story.

²⁴ This piece of his narrative does not differ significantly over time. In the *Australian Magazine* of 1993 he described it again. 'One Japanese bloke had his arse shot away with machine gun fire. The officer at the time didn't have the guts to kill him so he said to me 'Righto Smoky finish him off'. I have lived with those eyes from that day to this. I shot him in the bloody head. Bloody terrible. But I still done it because I was ordered to do it. His eyes were rolling and looking at you and everything. I dreamed about it for twenty years or so – well. I've been a nut case a couple of times and I was very bad with me nerves at the end of the war'.

²⁵ Interview Jack Boland, 39 Battalion; Murdoch Sound Archive. November 1988

accidentally shot himself on the way out. The unit was in single file in the dark and the only way to keep in touch was to link each other up with their rifles. They did not have safety catches on and the officer was killed when his rifle discharged. From his experience of leadership LH developed a general cynicism about those in command. At times he felt let down by officers whom he thought only looked after their own interests.

This is the thing that used to shit me. You are put in charge, and us little fellas down there had to stand up and take the brunt because there were other blokes you had to stand up for. They were too scared. Same as anybody else, you're all scared until the firing starts. I was fighting rearguard there and one day I pushed me blokes around the track and I had to wait ten minutes or so. And I turned around and said 'righto, let's get out of here'. And I looked around and there was not a joker in sight. 'Holy mackerel', here I am down there with them all. I go flying up the hill and over a bit of a creek. Bloody new colonel came along and said 'I want all machine gunners up there to get Bill Merrit out'. All he wanted was to get the officers out. Just like that.

One event that later proved to be significant was being caught in a bombing raid on the retreat from Efogi. He recounts that 'half the bombs fell close to me and I copped a blast from one of them'. When he was finally back in safety he was admitted to hospital and 'two days later I get a couple of holes bored in my upstairs department to let lots of pressure fluid out'.²⁶ He does not have a clear narrative of the period between his early experience in New Guinea and his discharge in October 1945. It is possible he had amnesia from some of that period. He claims to have been put on to non-combat duties, and as part of this was assigned to hearse driving, and records show that he was assigned to driving duties when the 39 Battalion was disbanded in May 1943. He recalls he was required to collect bodies, some of which had been subject to autopsy. He thought that the brains of deceased mental patients were sent back to mainland Australia for analysis. From the end of 1942 until 1945 he had multiple admissions to hospital in Queensland and Victoria with malaria, appendicitis and a number of undiagnosed conditions (NAD). There is no record of a psychiatric diagnosis during service.

LH was discharged in Victoria on 31 October 1945. He had married in September 1945 and children arrived in 1947, 1949, 1953 and 1957. His first child, the eldest daughter, recalls that from the time she was five (1952) she knew him as a violent unpredictable man, of whom she was very afraid. These years are difficult to reconstruct. Initially he had returned home to his own family but he did not tell them

²⁶ There is no record of this operation on his medical file, but his subsequent behaviour would suggest that he had some form of brain damage.

about his experiences. 'I think they probably summed the situation up a bit themselves and just laid off and didn't ask too many questions'. Readjustment was difficult and 'as time went by things just seemed to boil up inside more'. He recalled that the image of shooting the soldier returned in nightmares and 'flashbacks'. A rehabilitation training program (CRTS) enabled him to qualify as a carpenter. He did get married and started work as a builder, but he was never at ease. The reaction to his war was delayed.

One continuous thing right up to this last year [1987] as a matter of fact. I been in the - I call it the bughouse - you call it 'ward 7' or ward '8', it was a special place for special people when they gone of their rocker (sic). I been there a couple of times, been in 'repat' here and there

You just went about what you were doing and you know, you're still chock-a-block with whatever is inside of you because you had so much of it. When you went through so much and got a lot of build-up in there it takes a lot of bringing it out and that's where I think I remarked before, where four or five years after the war is the problem time and then your wives and family suffer.

The troubled life of LH resulted in a long history of medical involvement. His first recorded contact for medical treatment in the repatriation system after discharge occurred in November 1945 was a bout of malaria, which he had contracted along with dengue fever in New Guinea. He'd had several periods of hospitalisation in New Guinea and Victoria while still in service, but all of his symptoms could not be explained by malaria.²⁷ The only official record of him receiving treatment after discharge was in 1956 when he presented with 'vaso-vagal turns with giddiness, sweating and sick feelings'. He was described then as a 'healthy man with curly brown hair', and 'very rapid speech'. It was decided that he 'had no organic disease' and the cause of his problems was 'neurogenic'. In November 1958 he was treated for tinea in both feet and this was accepted as a disability.

Even though he was drinking heavily before this and was clearly disturbed, he was not referred for psychiatric treatment until 1962. In August of that year his local medical officer wrote to the repatriation Commission:

Herewith Mr. H of Clayton, who states he is entitled to treatment for nerves and headaches under Repat. I treat his wife and family and I am writing to you about Mr. H as he is always belting them up. His wife has left him for a week to try to bring him to his senses about it.

²⁷ As mentioned in a previous note, malaria was used as a treatment for syphilitic psychosis. In the case of LH his borderline psychosis must have been an unrelated entity.

The stated purpose on his admission form was to investigate 'Vaso Vagal Turns', which are vascular restrictions through the vagal (neck) area resulting in dizziness, blackouts and fainting. At the Rockingham psychiatric centre he had a number of investigations including EEG, x-ray and psychometry.²⁹ This psychometry included a Thematic Apperception Test, which led to a conclusion that under LH's brash exterior he was actually insecure and had 'quite genuine disturbance'. The main outcome of the psychiatric assessment was that there was no organic basis for his symptoms and the diagnosis of vaso vagal turns was changed to 'Inadequate Personality'. The examining psychiatrist, Dr E., decided that he had anxiety hysteria and that his 20 percent pension entitlement was 'generous'. He was treated from 31/10/63 to 21/11/63.

He was discharged, but the treatment appeared not to have lasted because he was re-admitted in July 1963 in a very aggressive and abusive state. Again his complaints were somatic with 'headaches and nerves in the stomach', and he was observed to be 'tense, and irritable'. He had also been gambling and drinking and only working spasmodically. He had also been self-medicating on his wife's sedatives. He was prescribed 50mg Largactil, 100mg Pentobarb and 200mg Sodium Amytal (short acting barbiturate often used in front line sedation in WW2). He remained in Rockingham treatment centre from 19/10/63 until 4/11/63. He had no recollection of his violence, suggesting he may have been experiencing some type of fugue state. In August he was described as a 'typical psychopath' exhibiting antisocial behaviour 'which will not easily respond to treatment'. Treatment consisted, apart from the drug regime, of occupational and social therapy. It was observed that he worked 'enthusiastically in the carpentry shop', but was 'boisterous' and easily antagonised instructors and other inmates.

It was here that the experienced the control that could be achieved with the new generation of anti-psychotic drugs.

Any time if you started to get a bit excited – up goes your dosage (hang on just get a bit settled) – up goes your dosage. One particular time – hmm. Settle down in a minute. They used to have a bit of a get together – they had a bit of a dance amongst the nurses and the family. You get on the dance floor and start skipping around and get a bit excited. After the dance is over you line up for your cocoa and

²⁹ Rockingham was a former Red Cross Convalescent Home for chronic personality disorders and remitted psychosis (see Whitaker 1954). The centre was used to introduce the therapeutic community ideas of Maxwell Jones. Under this regime patients, through a democratic committees system, had more control over the management and program in the centre. Group and individual therapy (including hypnosis) and recreational activities were a central part of the program. It was claimed that these ideas improved motivation and general behaviour and reduced the length of stay.

your pills. And you come to so and so, and oh, Mr. H. - 250 extra for you tonight – this is Largactil and all that sort of thing. That fixed you. Quietened you down. You got a bit excited – they really stick it in. There was a bloke called Dick who was a builder too.³⁰

[What would they do if you did played up?]

They would give you a needle, if the drugs weren't quietening you down. [He also related a story about the use of the straightjacket to control patients]

All those things – that's how bad you was. They were just making you worse. If you ever survived out of one of those places you were lucky. Don't know why I am here today actually. The amount of drugs I have had is unbelievable. And Mick's gone blind [now]. Whether it is the drugs or not? Wasn't so bad with two of us there.

LH was discharged with the diagnosis of psychopathic personality. He took up self-employment in building but continued to return regularly for treatment until 1968. He periodically experienced blackouts, worked spasmodically and was still aggressive, although this seemed to mitigate, possibly because of the continued prescription of Largactil. By the end of 1968 he was considered to be 'going along fairly well' and had 'no specific problems'.³¹

Somatic symptoms continued to emerge, and in October 1978 he was admitted for investigation of chest pains. His examining physician noted that he had a 'history of nervous state'. No serious abnormality was detected but Angina Pectoris was diagnosed. He was diagnosed with stress angina but according to his examining physician this could not be attributed to his war stress.

I have examined the service history relating to the member. None of the events which occurred during war service could have caused or contributed to the incapacity claimed by the member.

By 1979 this diagnosis had changed to 'coronary insufficiency'. These chest pains became the dominant presenting symptom in the early 1980s and in 1985 he was again examined for 'nerves, anxiety and chest pains'. In this assessment it was noted that he had 'returned from the war in a sorry state'. This was the first mention of the war, but it was not attributed as the cause of his problems. On 16 January 1985 his diagnosis was modified to 'explosive personality, anxiety angina and untreated hypertension'. His blackouts, which had first appeared during wartime were again noted but not explained. LH was still not happy with the psychiatric label and requested to have the psychopathic

³⁰ L was actually on Largactil for a long period. He was prescribed the barbiturate from at least the middle of 1963.

personality removed. A change was made to chronic anxiety disorder in November 1985. The medical report relating to this was lost, but there was a letter from a senior officer stating how stressful the New Guinea campaign had been. This was the only record of his war experience on any official documentation. In February 1986, just before LH turned 65, his pension entitlement was increased to 100 percent. By this time post-traumatic stress was available as a diagnosis but not applied to him.

His symptoms and treatments continued to be physically oriented but there remained an element of mystery. In 1987 his blackouts were taken seriously and he was given a complete assessment. It was found he had 50 percent stenosis of a carotid artery and in October 1987 he underwent coronary bypass surgery. His physical symptoms were not simply passed off as hysterical and he had developed serious illnesses, but he often displayed some unusual behaviour. Sometimes diagnostic tests sparked off severe psychological reactions, and in many situations he still experienced anxiety and fainting spells.

At one investigation he panicked when entering a MRI machine.

‘Cause when he come in I said, ‘Listen, I don’t have to go through that MRI scan again do I? I’m not going because I refuse. That was what sent me off. I got all panic attacks and that. Finish up I had to ask them to give me a needle one day [going into the machine]’.

I said, ‘I’m not very happy in here’. The first time, I don’t feel good, and I said I’d probably be right. I had been in it before a fair while back. Anyhow they stopped the second time and they had to drag me out and put the gas on me.

The heart surgery, although bringing physical relief, did not relieve his disturbance and he remained troubled. In his final analysis he does not think that the medical profession has been able to help with his problems.

I know you have got to have them (doctors) - you have to have someone to sign the death certificates - but they are a closed shop. And that, If I ever write a book. I’ll be opening up – I don’t care a bugger what they do to because they haven’t proved anything at all to me that they know what they are doing.

By 1996 he had a further carotid artery blockage and underwent angioplasty surgery. Psychiatric terminology and investigation was no longer a feature. In the most recent episode of medical investigation he was diagnosed as having had some form of stroke, but there was again an overlay of mystery. Here is his account of this episode.

³¹ All of the psychiatric treatments took place in the Repatriation facilities. Some later treatments were undertaken in public and private facilities.

I heard this explosion and I went outside and I said the bloody gas stove has exploded. The next thing the ambulance pulls up and they say how are you and I said 'nothing wrong with me. I'm all right. Hop in here and we will take you down and give you a check. Anyhow I agreed to go with them and the cart me down there to the bloody hospital. They lay me there on the stretcher there. [Of] course I had a load of cash on me, and I was more interested in the thousand bucks I had on me [than my health]. They kept me there and eventually a doctor came about three hours later and he give me a few checkouts and pushed me in a corner for another hour or so. Anyway eventually another doctor came in and said you're ok to go now. This is about one o'clock in the morning. So I got taxi and took me back to this place. I get to the door of this bloody place and he [mate] comes out and I said have they told you yet about the gas? He says no everything is all right. All of a sudden I took off – I says can't you smell it? I hopped in the car and went down near Seaford in the scrub and I eventually finished up sleeping in the car there. I come back next morning and go back to Norm's again and I say I don't know how you can stand that bloody gas. I could not bear to be in the house. So I headed up to my local doctor [over 200 kms away] and I stopped a couple of times on the way because I was getting a bit blurry. Anyhow I get in there and she says 'how did you get here?' And I said I drove and she gets on the phone to this one [daughter] and the doctor says 'he is not to drive'.

At the present time (August 1999) he is not as disturbed by dreams or nightmares as he was in 1995. He sleeps well and only becomes mildly upset when relating war experiences. His daughter confirmed this and reported that he had made an almost perfect recovery from what had been diagnosed as a stroke by his doctor.³² LH was keen to demonstrate that he had made the recovery. He is determined not to be placed in a nursing or rest home (the 'knacker yard') and avoid the fate of many of his mates.

Better off letting them die as they are. Look how big all these places are getting [aged hostels] now with all the respites and what have you. That's all they are. They are only knacker yards [old term for animal disposal plants] for people and I could see I call in from time to time at Rosebud [institution] they even put fruit out at the table for me. They are that pleased to se me but all the ones I know there personally you can see them going down, like coming down a stairway, one step at a time. Most of them are at the bottom – I don't if that's the way to put it or not. Yeah so I'm convinced, may be I'm a bit hard on a couple of them. [This is a reference to his view that all doctors are very little help.

³² His daughter is still uncertain about his recovery. She has her own scars from experiences in childhood. She stated in 1999; 'I remember as a little girl of five being very afraid. He was very violent. He would switch so quickly – I could not second guess him. He treated my mother very badly he was very cruel and she still has the mental and physical scars. He still has a bit of that switching. Recently he came to stay and was having trouble with the electric blanket. I went in to help him and I saw that look, as though you were not there. I was shocked. He would like to come and live with me but I would still be afraid and not sure of him. He is better but it is still close to the surface. The same with his diet – he is very determined and there is no discussion. I only look back and remember them arguing. They never looked happy together. All my life I look back and see friction.'

In LH's complex medical story a number of features are relevant:

- There is a significant delay between his army discharge experience and presentation for treatment of psychological and social problems.
- He was only assigned psychiatric labels – nerves, anxiety hysteria, immature personality, typical psychopath, character disorder, inadequate personality, psychopathic personality, angina anxiety,
- There is no mention of his traumatic war experience in any medical assessment
- There is no appropriate label available for war related disability
- Identifiable organic stress-related diseases replace overt psycho-social disturbance as presenting problems as he ages
- There is a major prescription of Largactil over a long period and no trial of more recent drugs.
- There is no perceived improvement from psychiatric intervention from 1956-1996.

One key question is whether his anxiety, fainting spells, agitation, drinking and aggression can in any way be explained by what happened to him during his war service. Forensically it is impossible to give a definitive answer to this question. His own story does make a connection – he clearly accounts for his disturbed life by referring to the order to shoot the Japanese soldier. He also sustained a head injury. There is no record that he used this story or the injury to gain entitlement for pension or argue a case for compensation. His trauma story was firmly a part of his narrative at least as far back as 1982. Clearly he was a man with serious psychic pain and most probably undetected organic injury. There was no connection made between this and any stress reaction.

There are a number of assertions that can be made on the basis of evidence:

- He sustained a head injury that might have accounted for persistent disturbance and experience of pain
- He retained a firmly embedded unresolved traumatic memory which could certainly account for nightmares and most probably for anxiety and guilt
- This traumatic memory could also account for drinking behaviour as a form of self-medication until 1962

The most significant feature of his entire interaction with the psychiatric world was that the war does not seem to have been mentioned. It may have been in some of the

group programs in Rockingham, but if so this was not translated into official diagnoses. In his case the dictum of 'nothing new to medical science' was certainly applied. By the time he may have been helped by an understanding from a PTSD framework (post-1980), which does take account of traumatic exposure, he had become primarily a problem for physical medicine.

Long before the development of antidepressants, Methedrine, a stimulant, was used to lift his depression

CATEGORY D: Serious disturbance, psychiatric Intervention - the case of R, traumatic memory unlocked

I have previously established that a number of men developed serious problems after they were discharged. These problems had not been identified during war service. In this case I introduce R, who died in 1976. His story has been constructed from two distinct narrative sources. The first is the medical narrative that is the Repatriation Commission version of his life, derived from the administrative and medical records. R's Repatriation medical files contain summaries of his encounters with the medical system from his entry into the army until his death. Because he was awarded entitlement on psychiatric grounds there is also a brief account of his treatment when he was admitted to the public mental hospital. These files contain useful biographical detail and a dramatic record of his deterioration over time. In this version he is a recipient of treatment and must conform to the criteria for treatment and receive that treatment in the manner designated by the agency. In this he becomes an object to be examined and treated according to certain requirements. Many different writers contribute to the text – local medical officers, admission officers, administrators, physicians, social workers and

psychiatrists. The texts record his medical treatment during wartime and his various contacts with the Repatriation Commission between 1945 and 1975.

The second is the narrative of R's surviving second wife. This was summarised from a letter, two interviews and several telephone contacts. His wife's story essentially begins four years after his discharge when they were married in 1949. They separated in 1967 and were divorced shortly afterwards.

The medical story begins when R enlisted in June 1940 at the age of 31 (DOB 27/2/09). In the medical testimony at enlistment he answered 'no' to questions on whether he had contracted various diseases (TB, Pleurisy, VD etc) and testified he had never had a nervous breakdown, shell shock or neurasthenia. There was no other psychological examination. He was physically sound and a strong man of 12 stone and 5 foot 7 inches in height. He served in all campaigns of the 2/27 Battalion including the Owen Stanley Ranges, the Ramu Valley and Gona, and was discharged as a sergeant in May 1945, having served 853 days overseas and 771 days in Australia. He was treated on two occasions for malaria, a common complaint, in January and July 1943. The first serious medical intervention was for a gunshot wound in the left calf sustained in October 1943 during the Ramu Valley campaign. He did 'not receive surgical treatment until about 60 hours later when wound was offensive, discharging pus and bubbles escaping from wound. Was in hospital for 17 weeks'. He never regained full mobility and was unable to stand for long periods or march. In the examination for reclassification on 4 November 1944, the Regimental Medical Officer, Jim Fairley noted that he had a 'good record' [i.e. a good soldier] and had no abnormality apart from the scarring of his left leg. It was recommended that he return to industry and do no more marching.

He was discharged in May 1945, at the age of 36 with a medical classification of B2, not suitable for service as a result of gunshot wounds.³³ He had previously been declared (22/2/45) by a Medical Board to be unfit for further service because of residual aches and pain in his left leg. He was left with a 'large dog-leg scar' over upper half of the left calf. He was considered to have a 10 percent 'incapacity in the general labour market from his disability'. There was no mention of mental strain. He was granted eligibility for treatment for any recurrence of malaria, which subsequently occurred and was treated at the Repatriation General Hospital on 1 May 1945.

³³ For medical classifications see Chapter 10, p. 244, f/n 13.

There is a gap in the story between discharge and his marriage to his second wife G, in 1949, who is the main informant in this case study. He had previously married at the age of 16 before he enlisted, and fathered three children in that marriage. The marriage ended before he left for the Middle East when his wife was unfaithful. From G's account, and scrutiny of his Repatriation medical files the rest of his life has been pieced together. Even though there was nothing on his Repatriation file there are indications he was having difficulties in the early post-war years. R and G were married in 1949 and T, their only child, was born in 1951. In the early years they had been 'been very happy together'. And 'we were so happy for a few years, and my son was born about two and half years after we were married'.

Even though she had married again, G's narrative indicated that she still loved him and was sad that they had not been able to work things out. She had known him as a neighbour before the war, so she could make a comparison between his pre-war and post-war condition. She acknowledged, for example, that he did 'like a drink' before she married him, and she later learned that his father, a WW1 veteran, was a heavy drinker, but she did not have a concern about his drinking behaviour at the time. He started drinking heavily after 1951 and the struggle with his drinking and unreliability went on for many years.

She was aware from the beginning that he was somewhat disturbed. Her narrative gradually unravels the possible cause of his disturbance:

He was a nervous wreck when I met him. There were times when he had problems at work and he would get uptight. If he had any problems he would go away for half an hour and forget it all and be himself. Once he had the accident [1951] he could not even talk with me. Only when he went to ANZAC Day and talked with his mates would he come home and talk to me. It was one of these conversations when he felt like talking and he told me about this friend whom he had to shoot. And that was behind it all. This is just what you see afterwards. At the time I did not know where to turn. He would be lovely one day and next day he would be impossible. When he got really bad he would pack up and go away for six months. He had a terrible life and I realised it more later. He was a lovely man and was very well liked but he was – two people. It was disappointing to me the treatment he received in Repat. I battled so hard to get him there [1952].

G maintains that his troubles began after a vehicle accident in 1951. This was not recorded on his repatriation medical file, but his admissions for treatment for non-physical symptoms did occur a few months after this event. She recalled that he had 'gone through the windscreen' of his utility three months after T.'s birth.

Three months after T was born we were happy. The weather was good and we'd planned to go, he was a cricketer you see, and we planned to go on this cricket picnic. With a young baby I didn't think it was good but, I was going, and the morning it just poured and poured with rain and so of course I didn't take the child. So R went on his own, and he had a flat tray top vehicle at the time and being so wet the water got into the works and they had trouble starting it. So one of the young lads stayed behind to give him a push, so which meant they had three in the front instead of two and coming down from it was up at National Park coming down the hills of Belair they overturned.

Now I don't know how our marriage would have been if it hadn't have been for this incident but for two years afterwards, well for years afterwards, he vomited every time he put his feet to the ground. It was not for two years later that this young lad (K) that stayed behind to give them a push came to stay with us one weekend and it was then that I heard about the accident. I hadn't heard about it before. R. didn't remember anything about it. He was concussed and he went under the steering wheel and through the windscreen and that injury I'm sure is the cause of all his troubles it brought the war back to him, and he would get very quiet, and he was able to control it to a point. From that time on R was different.

He seemed to be pretty right before that, because he worked very hard and he'd get tired and probably get to sleep at two or three in the morning. But at five o'clock every morning you could guarantee that he was awake working out his days work, and he'd have the whole roof worked out in his head before he went to work and he didn't put anything on paper. He always worked it out in his head.

[So he had a good mind?]

Oh yes, he was really quite brilliant in some ways, but it just seemed to be the nerves that overcame him and he'd drink to get rid of these visions of the past.

What might have accounted for such chronic behaviour? G's explanation for his drinking and dysfunction was his experience in New Guinea. It is impossible to verify this particular incident but there is no reason why she or he would manufacture such a story. As described in an earlier chapter, even though there was no official record, there were reported instances of soldiers being asked to finish off another soldier (colleague or enemy) because of the extreme conditions in the Owen Stanley Ranges. In her eyes, the incident provided a reason and justification for his distress in later years.

Well during the war experience it was in PNG somewhere the Japanese were right behind them and it must have been pretty bad period and the men were being shot all around him and this one young fellow was so badly shot that they couldn't take him because he would have died anyway but they couldn't leave him there to be tortured. So it was up to the captain to finish him and he just couldn't do it so R did. Only a couple of times he got down to talking about it and he could always see that man's eyes looking at him.

Well, his main impression, I think he may have lost a little of the memory of the war because of the accident, but his main impression was this young fellow that he killed, that he had to shoot, that was the thing that seemed to disturb him more.

From that time on, R began to drink more and was less capable in his work. It may have been that the extra responsibility of self-employment added to his strain.

But then he went away to work. We had a house at O'Halloran Hill working on a farm, rent-free. Mr Sheidow owned the property, and we had this little house and that's where our troubles really started because he was a very good carpenter and builder and started to work for himself and it was the worst thing he every did because he'd go to work in the morning very often go to the hotel before he went to work and then had itchy feet at lunch time that would be the end of work.

In her eyes, the drinking was a response to his 'nerves' and an attempt to self-medicate his painful memory rather than unexplained irresponsible action. He may have been susceptible to excessive drinking because of earlier established patterns of alcohol use.

I reckon we had shares in the pub, and this is where the trouble started. He could control the drink before the accident he always did like a drink but having had concussion, people can't drink any more, one or two drinks and after that you see the change in them their eyes and everything, it was definitely a brain injury.

But that seemed to be when his nerves got bad that he had to drink to overcome it; that's what it seemed to me.

So whether our life would have been different without that accident I just don't know, but there it was and I didn't realise that there was a history of alcoholism in the family. His father although he worked until he was seventy five or something, he was a bit of a problem with the drink, and even now his son is going a little bit that way, he's a lovely boy, they've got a beautiful home, not T. that's our son by the first marriage.

As the alcohol took over, G's life became very difficult for the new family, as she testified.

Yes, he [son] was only 18 months old when we came here, and R worked really hard and we were really happy for two years and then probably his nerves got the better of him. And he was working seven days a week, which I was not happy about to help us and I think it was too much for him and at that stage he would have been fortyish and having the war years which added to his life. He would have breakdowns and he wouldn't give in he would keep going instead of having a rest he was very determined. But then he met up with a young fellow and he took him home to his home and that is where the trouble started again because they'd have the wine there. Every Sunday he would go there in the morning at about ten o'clock and I wouldn't see him till about eight or nine at night and he wouldn't have any money left in his pocket. They would just get him drunk and take his money and then he would blame me that I'd used his money.

His problems became so bad that G sought help from the Repatriation Commission, and he was assessed at the Outpatients Clinic at Keswick 20 May 1952. The Case sheet

indicated that he was only entitled to treatment for malaria, and that his anxiety state had not been accepted. This changed after his examination by a psychiatrist, who stated:

Sleeps v. poorly and dreams a lot – has nightmares and wakes up in a sweat. Has frequent headaches. Becomes upset over trifles and work gets him down; has no appetite. This is an anxiety state that he says was present in New Guinea and subsequently, but is becoming worse. I think his condition is connected with war service.³⁴

As a result the Deputy Commissioner for Repatriation approved that Anxiety State be accepted as due to war service. He then had three conditions accepted – malaria, gunshot wound and anxiety state. In September he was ‘struck off the Out Patients Record’ and assigned for treatment from his General Practitioner, Dr DS., who was an approved Local Medical Officer. The reason for this was not clear but it could have been that he did not like the treatment in the hospital setting, which was indicated by his wife in her statement.

This intervention did not work and G wrote to the Commission after this first contact seeking further help. In her letter to the Repatriation Hospital she stated:

Mr ... is the type of man who will not report sick while he is able to get about and he certainly did his share at the war and I feel the only hope for him to get well is to have some treatment. I had an appointment Dr F last Friday 20 May. He gave me some tablets for him but they didn't agree with him. The following day he was worse than he has ever been and violent; which is not his nature.

We have been very happy together but now I just can't say or do anything to please him and will have to leave him and break up the home if something is not done.³⁵

He continued to have difficulties and Dr S. requested that R be admitted for treatment and psychiatric examination again on 15 April 1953. On 17 April the admitting officer at the outpatients' clinic noted that he ‘has great difficulty with sleeping – wakes about 3 am and cannot go to sleep again. Also complains of tenseness and fatigue. A carpenter – can manage pretty well’. The same psychiatrist F assessed him again and after noting that ‘it is a great effort for him to carry out a day's work,’ and ‘has very little energy’, recommended that he be admitted for sub coma insulin treatment when convenient. This was reported to have commenced on 11 May 1953, but his wife maintains that he never received this treatment. Insulin induced coma therapy was normally used to boost a depleted physical and nervous system, or relieve anxiety.

³⁴ Form 83B, 10 May 1952.

³⁵ Letter medical file MX7193

The notes for 13 May 1953 add some biographical material as well as a clinical picture. He was described as a 'depressed bald man who began to cry during an interview on discussing war experiences'. At this stage he would have been aged 44 and it was noted he had come from a happy family of eight children. He was 'now in a happy marriage'. The notes reinforced the earlier report that for some time he had 'complained of depression with crying fits, inability to concentrate, restlessness, insomnia with night mares of the war, anorexia and fatigue'.

The psychiatrist was interested to hear his war experiences, but on 19 May he was still 'lachrymose' (tearful), 'unwilling to discuss his war experiences' and refused to be treated with Methedrine.³⁶ Despite this he was still considered a 'good type', but with a 'neurasthenic type of reaction to some suppressed trauma' (Dr E.). There was some attempt to understand his dysfunction in terms of previous war experience. On 29 May he had gained half a stone (probably as a result of the sub coma insulin treatment) 'and is symptomatically much better, but still has much repressed material'. Dr E was the only one to introduce a psychodynamic focus on the effects of traumatic material into the treatment plan, but he appeared to lose interest as R intransigently persisted with alcohol overuse. G's perception is that the specialist was not competent and did not understand either her or her husband.

No, well this is something I'd like to tell about. One stage he was really bad and I did talk him into going to the Daws Road to the doctor in fact I think it was our doctor I spoke to and he sent him to Daws Road. We were unfortunate the doctor in charge of that ward was a Doctor L. I didn't know at the time but about six months later I nursed his wife in Hospital and she was in there because of his alcoholism. But he was hopeless and he just asked me in to interview him. He interviewed R. first then called me in on another occasion and all he talked about was sex; I think he must have thought every soldier was a sex maniac, he was terrible.

Yes, he was a psychiatrist, and R just wouldn't speak; he wouldn't answer his questions because he was so rude and he got so frustrated in the end and he said right take your wife out to lunch and that was our interview.³⁷

I only had the one [interview] with him, but R wouldn't go back to Daws Road again and you see this was our problem. Who do you turn to for help? And my problem was finance because he would just drink the wages. When we got the house over here for two years he was wonderful. He put tons and tons of soil into the front and really worked hard and had a lovely garden.

³⁶ Before the introduction of antidepressants, the stimulant Methedrine was used to treat depression.

³⁷ L was known to have a drinking problem and his wife had a breakdown under the strain. From another source I learned that Dr L took his own life (Interviews with former nurse and intern).

Over the next two years R's condition deteriorated and the degree of sympathy offered by medical assessors seemed to diminish. His next admission was 21 July 1955 for another SCI treatment, at the recommendation of the LMO. The referral from Dr S. on 25 May stated that the husband was only allowing her 3 pounds 10 ounces per week from the 25 pounds he earned and was running up debts. According to his wife, by this stage he was 'not reliable' and 'not a good father'. She was at the end of her tolerance and this was a last chance for him to improve or she would have to leave. 'She is prepared to allow him one chance if he could be admitted and would accept therapy'. She recalled that he had refused treatment the previous admission (presumably 1953) and 'will not take Atebuse'.

A significant shift in diagnosis and treatment occurred in 1955. After a period of in-patient treatment he was discharged to his Local Medical Officer with a diagnosis of chronic alcoholism, which he had 'no desire to give it up'. This raised an administrative problem. While R was in hospital he could not earn money and requested sustenance allowance. A decision had to be made on whether the alcoholism was part of the 'accepted Anxiety State'. The psychiatrist admitted that in his opinion 'chronic alcoholism is secondary to his anxiety and (reluctantly) I recommend payment of sustenance'. He was discharged on 11 August 1955 and did not reappear on record until 1963. What happened during this time – did he remit or get worse? R worked erratically and would escape to the country. He could no longer support his wife and child.

Every weekend and then it got to the stage every morning he would go to the hotel before work to have a drink then he would go to W where he got a job in W.

Yes, he'd be there 18 months or two years and come home and he'd be a different man and oh yes were going to be right, 12 months sometimes six months, you know it was all on again and then he'd go away again. In the early stages he'd send me money but then when he got really bad they wouldn't have him back at W because he started fighting when he was drunk. So he got a job at Katherine and I didn't hear from him for six months.

The heavy drinking eventually affected R's physical health and the next recorded admission to the VA hospital was to Ward 4 in 1963 with stomach and liver complaints. No psychiatric treatment was offered and when sent home he was not vomiting and was 'less jaundiced'. He was drinking heavily and spending at a rate of 10 pounds a week. He was considered to have alcohol gastritis rather than an ulcer and was given good advice on 'the value of a good diet and abstinence from alcohol'. He 'says he will never drink again'. G resorted to Alcoholics Anonymous for help.

I got them [AA] to come here one day and of course they prefer not to come unless the husband knows but I talked the man into coming and R. was home this night. The chappy pulled up at the front gate and he went over to R. and he said I'm from Alcoholics Anonymous. R gave him 'you know what', but it was cute, it was witty. He wasn't bad tempered but he let the man know he was not interested anyway but he had a really witty nature he was really good, but yes the chappy didn't stay of course.

A crisis in their marriage led to their separation. G had been able to tolerate R's behaviour for many years but the turning point came when he became violent for the first time with their son. She left him in 1965.

Well we sold the house and I still tried again by taking a flat but then because we had a little bit of money he just wouldn't work and he drank all the time and then he started to abuse T. They were so fond of each other this was the one reason why I couldn't part earlier and T was 16 by this time. Yes, on his 16th birthday T. had sprained his ankle and he was on crutches and was at home a lot and he saw and heard more than he did otherwise. This particular night R. had been drinking all day. T came home from school at about five o'clock that night and heard the way his father was speaking to me and he never let T hear before. T came in and said 'look leave mum alone' and he just turned around and gave T a terrible smack across the face. Next day T. said 'mum we can't live with this'. But I'd lived with it for 16 years.

During the separation, out of desperation G arranged for him to be admitted to the public mental hospital at Hillcrest. It was then under new management and was beginning to experience the benefit of the reforms to the mental health system introduced by Dr Bill Cramond. At this time the Medical Superintendent was Dr Bill Salter, who had supervised the opening up of the hospital, made possible by the availability of the major tranquillisers. Salter had introduced AA as the primary treatment program in the hospital.

Bill Salter was a good chap. I interviewed him once and he said that in years to come they'd be able to tell a child of eight or nine if they were going to be an alcoholic but they can only help them if they want to be helped. And we had sold the home by this time and I really thought he [R] was going to try.³⁸

³⁸ Salter was a very religious man. He was familiar with the origins of the AA philosophy and its links with the Oxford Group and the Moral Rearmament Movement. He was listening to a radio program in Adelaide one Sunday afternoon in which Lilian Roth was interviewed and talked about AA. He believed that this was 'the Lord telling me to use the program', and soon after that he introduced the AA program into Hillcrest (personal interview).

REPATRIATION GENERAL HOSPITAL, SPRINGBANK.

Writer: PJR R. No. x7193 C. No. X7294

REPORT ON DISCHARGE.

Ward: 13/16 Date Admitted: 11.5.53
 Entitled to Treatment for: G.S.W. LEFT CALF. MALARIA. ANXIETY STATE.

NAME: [REDACTED] Reg. No. SX [REDACTED] Unit 2/27 Bn. Age: 44

11.5.53 ADMIT I.P. : ANXIETY STATE.

Weight on Admission : 12 stone 13 $\frac{1}{2}$ lbs. RECEIVED

Urine : S.G. 1010
 React. Acid
 Colour Lemon
 Alb. -
 Sug. -

S.C.I. commenced.

13.5.53

This man came from a happy family - the middle of 8 children. Prior to enlistment he was a carpenter and at the age of 16 he married a girl aet 26 who was unfaithful before he left for the Middle East. On return he divorced her. He saw all the campaigns through except Tarakan as a rifleman. On return to Australia he married a girl 7 years younger than himself and has one child, a happy marriage. He is a carpenter and has his own home.

However he has for an indefinite period of years complained of depression with crying fits, inability to concentrate, restlessness insomnia with nightmares of the war, anorexia and fatigue.

O.E. : Depressed bald man who began to cry during the interview on discussing war experiences. *Sgt R*
 Eyes - N.A.D.
 Teeth - N.A.D.
 Tongue - N.A.D.
 B.P. - 140/90.
 Heart - N.A.D.
 Lungs - N.A.D.
 Abdomen - N.A.D.
 Reflexes - N.A.D.
 G.S.W. calf left leg.

Summary : Anxiety state. S.C.I. and perhaps methedrine later.

19.5.53 Refused methedrine. Is unwilling to discuss war experiences. Lachrymose. A neurasthenic type of reaction to some suppressed trauma. A good type, I think.

29.5.53 Discharged to O.P.C. To see me at 2.30 p.m. on 1.7.53. Unfit to Work 2 weeks.

Diagnosis : Anxiety State.
 I would continue to assess his disabilities at 50%.
 He has gained half a stone and is symptomatically much better, but still has much repressed material.

Sgd. P.S. [REDACTED]

Appt. Dr. [REDACTED] O.P.C. 1.7.53, 2.30 p.m. Form 135 completed.

*Stimulant.
Anti depression*

Red
 A.B. ANDERSON
 MEDICAL SUPERINTENDENT.

Figure 11.4 Discharge Report for R, Repatriation General Hospital May 1953

R was admitted to Hillcrest Hospital on 29 July 1965 at the age of fifty six. He had arrived at Hillcrest hospital during a more enlightened period in the history of the hospital. The case notes at this hospital provide another narrative account of his life at that point. He had been 'sent by his wife because of drink'. R was 'under the weather' on admission and had not responded to any treatment or AA intervention. He was judged to be unsuitable for the AA groups even though 'he has an idea of a power outside himself, and thinks this power and other people can help him'.³⁹

Treatment consisted of abstinence, detoxification, supervised care and counselling. He was often observed to be 'very confused and tremulous', and R stated that he had suffered 'from nerves for years', and that alcohol had helped him with this. He'd had a normal childhood, had 'got on well with both parents', that there were no alcoholics in the in family and had 'no neurotic childhood traits'. At this stage he was living in the country by himself. He worked for an employer and had earned £1 200 in 1964. War service was noted as part of his history but there was no mention of any distressing events. He was still in receipt of a 50 percent Repatriation pension. He was once happily married but 'drink affected it'. Most of the report is about his drinking behaviour, and his good intentions of changing his life.

About a month later when he was 62, he was again admitted to Hillcrest Hospital on 2 September 1971, in the hope that this would enable him to 'return to his wife'. The case notes are similar to earlier entries, but he was now described as a 'rather depressed elderly man who can see no future for himself in Adelaide. His wife runs a nursing home. They are separated'. The only comment on his war service was that he was not a POW. The bottom line was that 'he blames himself for things that have gone wrong with his life'. There was another detailed account of his drinking history and patterns of behaviour, but the investigations officer thought that his primary reason for admission was 'accommodation more than sobriety'. (14/9/71)

This final stay at Hillcrest did not produce positive change. Instead his health deteriorated, and as other medical problems developed he was admitted to the Repatriation Hospital, after a wound from an attack by a dog turned septic. By this time he was working on a pastoral station in the North of the state, and it was noted he had a 'long history of Anxiety State, with recent loss of confidence and exacerbation of

³⁹ Case notes by R. Leaver 14 April 1965.

alcoholism'. The case notes recorded that he had developed epilepsy and was being treated with 'Dilantin and Phenobarb'. No cause had been found for the epilepsy.

The Repatriation Commission was again involved in December 1974 when he was referred to the social worker for assistance after he was evicted from his boarding house. The medical officer stated in his referral that 'medical investigation is now complete and his problems are now mainly social'. His problems did not go away. A letter was sent to Dr S., who had been his local medical officer since January 1975 informing him of the state of treatment for R. The medical officer in charge of outpatients at the VA hospital at Daw Park noted that R had a 'constant dull pain' and a 'terrific headache ever since EEG,' but 'clinically he is well' and present therapy should be continued.

The end came in 27 August 1976 when at the age of 67; R died as a result of burns received in a fire in the workman's cottage he occupied on a property in a small country town. By this time he was subsisting on a pension and was cut off from family and friends. He had been drinking and had fallen against an electric radiator around midday on a Friday afternoon. His former wife recalled the occasion:

He was living at G. Firstly he was living at [city address] and when he left there he asked me would I take him to the station because he got this job at G. So when I saw his room it was such a disgrace I told the people to close the door and I'd come back and clean it and after scrubbing out that room I said that was the last time. So he didn't keep in touch, but yes I did. I still saw him, but when I decided to marry G [current husband]. I told him I was going to be married and he wanted to know was it to a nice fellow. He took it quite well, but he found out who it was and he was so upset that he just drank himself... he came down to me this particular time and called in to my daughter in law to find out where I was. She wouldn't tell him and she said 'G is going to make a new life and you have got to leave her alone', so he went back that night and...

He fell on a radiator that night and about five days later his son found out where I was and contacted me and I had all the wedding arrangements for the next week. It was terrible. So he was buried on the Tuesday and I was being married on the Wednesday - it was a terrible time.

Comment

R's life story is a tragedy that had begun to unfold two years after the war after when he sustained a head injury in a motor vehicle accident. He had been a competent person in many parts of his life in sports (football and cricket) until he was wounded. He was a skilled worker and able to manage building projects independently. In the early days of marriage he was a good husband. The wife's narrative about his and their lives is much softer than the medical file. In the latter only his symptoms and dysfunction are the focus. No psychiatric intervention worked and his life became progressively worse. In

his treatment there was some early attention to his traumatic experience in New Guinea, but it was never a primary focus.

R's contact with the Repatriation system began at about the time the RSL was denying that there was a problem with mental casualties of war. (See chapter 2) It was also the time when medical authorities were struggling to develop coherent ideas about the problem of damaged soldiers and effective methods of treatment. Over his life R had run the gauntlet of treatment options both in the veteran and public health systems. None of the treatment interventions - ICT, Methedrine, psychotherapy, Alcoholics Anonymous - had worked, and even the most well-meaning doctors were unable to penetrate his problems. Alcohol was his most consistent form of self-medication. He had not been identified as a psychological casualty while in service even though he had been treated for very serious wounds. At the time of his initial crisis none of the mental health reforms were in place and there were no comprehensive theoretical underpinnings to rehabilitation practice.

I think it is important to also report on the final resolution of this case. This will illustrate the complexity of the impact of a disturbed man on his partner's life story and how she constructed her knowledge in order to try to understand him. I re-interviewed R's wife in 1998. The only change was that she reported, on reflection that she had known something was not quite right with R from the moment she met him. She had learned about war damaged (war neurosis) veterans before when she had been nursing in the Repatriation Hospital between 1940-45. She was in a transition ward where all soldiers were placed before being sorted before allocation to a special treatment ward. A number of these men were psychologically damaged. Even though she was not involved in the treatment of these men she did observe them and learned how they were different from other patients. She observed the same anxiety, moodiness, nightmares and disturbance in R when they were first married. Until the accident this was manageable but after the head injury he got progressively worse until his tragic death.

G had never reconciled herself with the manner of R's death. She had worried for years that she did not know the state of his grave or the exact circumstances of his death. A short while before I was in final contact with her, she had accompanied her current husband on a tour to a country town where the Rats of Tobruk (survivors of the siege of Tobruk in 1941) attended a dedication ceremony of an archway war memorial at a local sporting ground. This was the town where her first husband had been buried.

She had never seen his grave, but knew that his funeral had been organised by the members of the 2/27 Battalion Association. She had imagined the grave as uncared for and overgrown and had often woken in the night worrying this. To her surprise a time had been allocated at the local cemetery tour and she was able to find R's grave and see that it was in excellent condition with a headstone displaying his name and serial number. This meeting allowed her to close one part of the final chapter on her former husband. Since that time she has not worried about R and no longer becomes disturbed at night.

So you see it was different times than now – I could have managed the home on what they get now. I tell you what – in April we went to ... I've always had in here (pointing to chest) 'I should have gone to the funeral, I should have been there.' And more so I was concerned as to where his grave was. I imagined it on a field with grass this high. Whenever I thought of R I had that picture of a grave. Now I have hardly worried about it since. Until I knew where he was buried I could not be happy. Now I don't worry. I was so thrilled. All these years I have not been able to shed a tear over R dying. But immediately I saw that I just broke down. From then on I have been all right. I wrote to the mayor and sent him a cheque for the rose garden. I was so happy someone was looking after it.

There was one more issue to resolve. What were the circumstances of his death? The coroner's report of 27 August 1976, which I had obtained, revealed that there had been four witnesses to his last days. They were the local police officer who confirmed the identify of the body; the owner of the property where R was living; an employee who first assisted him after the fire; the medical officer who rendered assistance and pronounced him dead; and the ambulance officer who attended him and witnessed his death in transit to hospital. It was important for R's widow to know that he had not been alone and was conscious. The medical officer reported that R was extensively burned and there was a moderate smell of alcohol on his breath. Intravenous saline was administered in the ambulance but the patient became restless and died before reaching Adelaide. The police officer confirmed there were 'no suspicious circumstances'.⁴⁰ The papers on his death allowed the widow to place the final piece in the jigsaw and reconcile herself to his death.

R's widow's narrative is consistent. She maintains that in all the medical interventions nobody had addressed the central issue of his experience in New Guinea. She reported that her husband had been repeatedly seeking help or she had been soliciting help herself on his behalf, all to no avail. Admission to hospital or approval

for treatment from a number of specialists and other providers did not effect a 'cure'. At this retrospective level it is impossible to adequately evaluate the effectiveness of the interventions, but certainly none worked. The ideas were not able to translate into salvation for a troubled man.

R's widow's explanation does have merit because it allows a logical connection between memory and the demise of R. Her explanation is that he was tormented with traumatic memories and tried to dampen these with alcohol. Some early attempts were made by one psychiatrist to access memory, but he did not consult G. R had always reacted negatively to the environment of Ward 17. Psychiatric intervention shifted the focus on to the current stresses of work, family life and sexual problems. While she did not elaborate on this and there are no case notes it is feasible to suggest that this is compatible with a Freudian interpretation of unresolved sexual identity, or confusion in object relations. Whatever the intention of the psychiatrist, this intervention was not welcomed, nor was it helpful to the couple. She argued that her husband's were always somehow related to his traumatic experience:

I did not have the hands on experience of neurosis. I did not have experience of this part, the neurosis part. Once I knew that he had the accident I did understand that it was all the war back again. But it was unfortunate that I did not know for two years that he'd had the accident. It did something to his brain and I would be interested in the autopsy because he had the severe bang on the forehead.

The management of R's problems exemplifies the way the problems of war were transformed into a private individual pathology. This individual pathologising was enhanced by the general context of the culture surrounding war and mental health. Apart from a minor flurry of public concern that I have recorded in Chapter One, which was soon dismissed by the RSL and Repatriation Department, there was no public discourse on war-related mental health problems. Any individual problems were managed privately by experts within the Repatriation Department. R's story had been confined to the medical and administrative files, which were hidden behind the veil of confidentiality in until 1998. His wife had nowhere she could explore her concerns, or offer her explanations of his problems. She thus became marginalised in the treatment process. On at least one occasion she was singled out as a possible cause. Despite initially being 'a good type', R became increasingly non-compliant patient. He refused treatment and resisted many attempts to understand his distress and so could be pushed

⁴⁰ South Australian Coroner's report H2/28145.

further into the difficult patient category. As his alcoholism became more manifest he became more readily categorised a social problem, beyond the scope of medical intervention. This process took the issue well out of the public health arena and further away from the initial pathogen – traumatic war experience.

CONCLUSION

These case studies illustrate just how far lives can diverge over time after experiencing a similar series of traumatic series events. All these men shared the same period of history but their life trajectories diverged significantly after 1942. In their encounter with the original experience each man developed his own way of coping, and each carried his own perception and inner narrative of his war experience. The common link of these men was the lack of any constructive forum in which to explore their distress associated with events.

Of these six reported cases, the first saw no need to revisit his memory and it did not emerge as a problem in his own life or within his family. The second created his own space in books and short stories to create a coherent narrative, but under a pseudonym, thus setting a distance between his memory and his public self. A third actively suppressed his experience and was fearful of allowing it to emerge. His experience was never allowed to become part of the medical discourse that attended him for much of his post war life. The fourth informant did find two places to speak of traumatic memory. The first was in a number of media interviews and the Sound Archive interview, where he did create a narrative, but this was not explored beyond the interview or report. The second forum was in psychiatric treatment system that failed to connect his war memory with observed symptoms. In the fifth case, which ended tragically, the veteran never found a safe place to ventilate his war experience, apart from rare self-revelation to his wife. In the sixth and final case the traumatic past was suppressed and not considered relevant at all, both by the veteran and the specialists who tried to unravel the mystery of his symptoms.

In these cases we can observe the whole spectrum of reactions to an experience, but in no case were ideas about neurosis, and the available interventions, seen as relevant or helpful at any stage. Encounters with diagnoses, when they did happen were counterproductive and the veteran remained alienated from those with good intentions of helping.

Some of these cases also show how a disturbed life can affect a wide circle of people, not just the individual veteran. In these brief accounts the circle has mainly consisted of immediate family and a few friends. The family members knew existence of traumatic memory and in at least two cases their theorising about what was happening to the veteran was more coherent than that of the medical specialists. Family members were not an integral part of the therapeutic milieu, and rehabilitation policy on treatment outlined in Chapter 7, actively discouraged having family members as integral parts of the healing process.

Another feature of the veteran experience is the appropriation of symptoms. Protocols developed in physical medicine were applied equally in psychiatric medicine. A veteran would present with a worrying experience such as persistent nightmares or physical or dizzy spells. These would be construed as a symptom and appropriated for another purpose – to apply a foreign label. So instead of working on a problem such as difficulties controlling anger at home and threatening violence to his spouse, the veteran was labelled psychopathic.

Thus a veteran might describe his return home in the following narrative:

When I first came back – oh I'd be in bed and out of bed, you know, and me wife used to nearly die of fright and I'd be standing on me feet then I open me eyes. Probably a noise, just a bang or something – a crack, you know, or something, slam a door – and you ... When in action there was a rifle shot that used to warn you of an impending air raid ... And I came back very badly affected by war neurosis. Of course, being on an Observation Post with the mortars. I think, you know, the shelling probably did some of that, I don't know... I couldn't work. I was sick you know. My nerves were gone and I was a wreck. I've still got trouble with my stomach, you know. I've still got an ulcer which they said was from war service but still I get very bad pains and it's anxiety state; that's what they call it, anxiety state.⁴¹

This veteran's experience was translated into a different language and removed into another level of discursive space, which was understood by the expert but remained foreign to the veteran, who was a lay person. His distress was assigned a label of Anxiety State, and if solutions were offered they would come from another foreign medical domain – shock treatment, hypnosis, medication. He did not get the opportunity to explore his life within a framework developed out of his own experience and using his own language.

The implications of these identified themes will be discussed in the final chapter.

⁴¹ Interview from Murdoch Sound Archives April 1989. SS63.'

CHAPTER 12

CONCLUSION: Moral and Mental Dilemmas¹

OVERVIEW

This thesis has been organised around a history of ideas about war-related stress and a narrative history of the post-war lives of a group of men who fought in New Guinea in WW2. These two strands have been explored against a background of the relatively recent interest in the psychological consequences of traumatic events. Before discussing the implications of my findings I will review the spine of my search for understanding.

The quest of both researchers and practitioners in the trauma field this century has been to explain why some people who are exposed to traumatic events continue to experience distress and dysfunction well after the event, in the absence of any organic lesion. Explanations have been sought mainly within psycho-medical frameworks, in which this post-event distress and dysfunction has been constructed as a psychiatric condition. The dominant view impacting on traumatic-stress related illness in both major wars this century that it has been a form of neurosis. Psychodynamic Freudian ideas, under various interpretations, have been a major influence on the conceptualisation of the psychological mechanisms underlying this construction of neurosis. I have established that these constructions had deep social and cultural roots, and incorporated into the operational structure of military medical services.

The First World War, when large numbers of psychological casualties had to be understood and treated, was the first site in which these ideas were tested, and became an occasion for ideas on traumatic shock previously aired in civilian life to be brought into sharper relief. The 1922 Shell Shock Inquiry arising out of WW1 confirmed a view that psychological casualties were primarily functional rather than physiological in origin. The Inquiry rejected the concept and term 'shell shock', adopted functional disorder and neurosis as the primary diagnoses, and incorporated standard psychiatric nosology into military nomenclature. The historical roots of this nosology can be traced well back into the eighteenth and, particularly, the nineteenth centuries. The most significant feature of these diagnoses is that their initial development had nothing to do with war and in most cases little connection with psychic trauma. Psychological

¹ Butler (1943) *op cit.* used 'moral and mental disorders' to depict the disorders of WW1 soldiers.

problems of WW1 veterans did not cease at the end of the war. High rates of pension allocation to war veterans for psychiatric illness in both Britain and Australia highlighted the fact that psychic wounds did not heal with time.

The beginning of WW2 in 1939 sparked another search for efficient diagnostic and disposal strategies for psychological casualties, and Australian authorities again relied on British ideas. Military authorities maintained that war presented nothing new to medical science that had not been learned in civilian life. By the 1940s a new crop of physical treatments had emerged in the civil field and these were adapted for the treatment of war casualties.

The application of medical ideas and treatments to the Australian WW2 psychiatric casualty occurred in three arenas affecting the lives of veterans. The first was in the field in treatment, disposal and discharge protocols. The second was in the rehabilitation system established to facilitate readjustment to civil life. The third was in the system of compensation through disability pensions in the Repatriation Commission.

The constructions of mental illness adopted in WW2 involved the same labelling as in earlier times – hysteria, neurasthenia, anxiety and other forms of psychopathology. No radical new explanations emerged and diagnoses and terminology bore no semantic relationship to wartime experience. Consequently none of this labelling incorporated any war-related terms or the concept of post-trauma dysfunction. The thrust of medical reasoning was away from any theory of toxic shock to the inability of individuals to either stand the strain, or healthily integrate their experience. The advances made in working with traumatic memory during WW1, which encouraged patient unravelling of war experience, were virtually lost by the end of WW2, when more credence was given to physical means of treatment.² One consequence of this was to shift the focus to more immediate problems of anxiety, anger, aggression, relationships and work, and the abuse of alcohol, rather than unresolved traumatic war experiences. As late as 1962, post-war dysfunction came under the labels of psychoneurosis, psychosis, and character disorder.³ Furthermore, WW2, even though it did expand understanding of how individuals and organisations cope with stressful situations, contributed little to the

² This was actually against the trend of psychiatry, particularly in the United States, where there was a strong revival of psychoanalytical practice in psychiatry in the civil field. This development seemed to have little influence on thinking about traumatic stress, which remained marginalised in psychiatry - see Kandel (1998) A new intellectual framework for psychiatry. *American Journal of Psychiatry*, 155,4; 457-469.

³ See Hurt & Nettle (1962) op cit.

broader psychiatric discourse on traumatic stress. The shift to the recognition of psychological damage as a war wound, a considerable advance from the early days of WW1, came about against the advice of the medical community. Along with this came a commitment to a more systematic and informed rehabilitation service, which incorporated psychiatric rehabilitation. In this, few new ideas appeared and treatments followed civil and military lines. One experimental adaptation was Maxwell Jones' concept of the therapeutic community, and the use of group psychotherapy.⁴

I established in Chapters Six and Seven that psychiatric medicine was not adequately prepared for responding to casualties either in wartime or the post-war years. There were several reasons for this, not the least of which was the academic neglect of the experiences of WW1 veterans and the parlous state of mental health provision in general between the wars. Those who did have problems were treated with invasive treatments of the time from sub-coma insulin therapy to leucotomy, to either calm them down or to remove their sources of distress. On the other hand constructive efforts were made to re-integrate men back into civilian life.

Against this background of ideas and practice I explored the life stories of a sample of WW2 veterans. I concentrated on WW2 for two reasons. The first is that it was a significant source of experience. The second is that the surviving population of combatants were able to provide a life span perspective on the experience of the war. The battles in New Guinea were selected as the primary sites of experience because they fulfilled all of the criteria for an extreme war-zone stressor. I outlined in detail in Chapter 9, that I chose to rely on eliciting narratives and constructing a life story, rather than collecting clinical measures of pathology. This allowed me to step outside the current dominant paradigm of pathologising the experience of trauma within a medical framework. These narratives were elicited in a climate where any reference to the psychic trauma in both WW1 and WW2 had been carefully suppressed in public and personal discourse on war. Any narrative of distress and dysfunction had been

⁴ Jones, M. (1968) *Beyond the Therapeutic Community*. New Haven: Yale University Press, and Jones, M. (1968) *Social Psychiatry in Practice*. Harmondsworth: Penguin Books. His ideas were implemented at the Rockingham Centre in Victoria. See Whitaker, H. (1954) Group therapy: a review and report on its use in a therapeutic community. *Medical Journal of Australia*. 2; 899-904.

contained within a private medical psychiatric discourse when a veteran presented for treatment or applied for compensation.

The 65 life stories that I analysed reveal four distinct patterns of life outcome, three of which related in some way to this constrained discourse on mental health and war. These life stories, which are exemplified in detailed case presentations, are an important documentation of a previously well-concealed discourse. These lives provide a window on psychological functioning over time, and open up a wider discourse than has previously been acknowledged or made available through clinical studies or in the recorded histories of their units.

The four patterns of outcome reflect the full spectrum of the consequences of traumatic experience. The first pattern was in a group (Category A) where there was no evidence of war-related distress over their life span, including during later life. A second group (Category B) experienced some inner disturbance but had no serious distress or dysfunction, and experienced no interference in their social and work lives. They were not offered any opportunity to explore their disturbing remnants. A third group experienced serious internal intrusion (Category C) which was often masked by diagnoses ranging from life threatening somatic-oriented illness, to major depression, none of which were ever attributed to war experience. In each case there was evidence of unresolved traumatic memory experienced in some chronic form (e.g. disturbing nightmares). Those in the most seriously disturbed group (Category D) were officially diagnosed with psychiatric illness and treated within the repatriation system. Their psychiatric disorders were marginally attributed to war experience, but they benefited little from their treatment and the key deficiency was the lack of attention to their traumatic war memory.

There were two strands running through most lives, even of the most seriously disturbed. The first is that the majority of veterans maintained a positive view of their war service and their involvement in their unit. This outcome cuts across the full range of outcomes. Positive effects include comradeship, broadening outlook through travel; developing problem solving skills, a sense of having participated in an important part of military history which 'saved' Australia, and developing some technical skills. Such positive experiences would even lead a soldier who had experienced a serious wartime breakdown to say that he 'would not have missed it for quids'. The second strand is the apparent outward success, which occurred in all but a few cases, such as chronic alcohol

abuse or suicide. Veterans maintained a façade over their inner lives, which was rarely removed for any outsider.

The other significant observation is that for most of the veterans whatever their experienced degree of war-related disturbance, their distress fluctuated over time. A veteran admitted periodically for treatment would have periods of productive work and family life. The 'disease' did not pervade all aspects of his life at all times. This observation questions a disease model of post-traumatic stress, where distress or dysfunction becomes appropriated into a permanent pathology.

In terms of these observed effects over time, my most pertinent observation is that appropriate discursive resources have not been available to the majority of this population. A primary reason for this is the way the experience of distress has been medicalised within a broad social context in which mental breakdown is at odds with a national psyche of memorialising war. The way in which experience was medicalised followed a pattern identified very early in my study (see Chapter 3 p. 73). This was the notion of a **restricted therapeutic loop**, in which medical diagnosis only focuses on the individual 'patient', not the 'source of contagion'. The appropriation of individual experience inherent in this process will be discussed more fully below. The adoption of neurosis as the primary diagnostic category is central to this restricted medical framing of dysfunction.

This study makes an important contribution to the psycho-history of WW2. Until now war history has mostly concentrated on military aspects of the war years. My work extends the boundaries of this psycho-history well beyond 1945. It is a rich history because it documents the experience of the resilient and unscathed survivors as well as the temporarily, periodically, or permanently damaged.

Any human distress or illness requires an ethical and informed response from practitioners and researchers. There are two fundamental imperatives in this field. The first is to be equipped to respond appropriately and provide adequate help for individuals who are distressed or damaged following traumatic experience. The second is to address the origin of their difficulties. Each of these imperatives requires sound etiological analysis. I argue that these imperatives cannot be addressed within the medical frameworks that have been used or developed up until now. A broader view is needed.

To explore this broader view I will address four areas:

- The medicalising of experience
- The importance of traumatic memory.
- Alternatives to the diagnosis of PTSD and Neurosis
- Public health and war trauma

Finally, I will return to some pertinent case studies and speculate on whether my observations might have been of benefit to the WW2 'neurotic causality'.

MEDICALISING EXPERIENCE

We have observed a century of medicalisation of reactions to war, but how has this helped the men of WW2 and what has it contributed to the broader understanding of responses to stressful experience? Forensically it has been helpful because it provided a mechanism for recognition of war-related psychological damage and appropriate compensation, which in turn provided a degree of financial security. This compensation occurred against the advice of the medical experts in both WW1 and WW2. It is appropriate at this point to reflect on the nature of the medicalisation process inherent in the elaborate repatriation system in place in Australia. In repatriation the condition has the added element of chronicity, in that a veteran's dysfunction persists well after the actual period of service. Post-traumatic stress disorder has provided a rationale for this chronicity but a number of issues about post-traumatic stress remain open to question. These are canvassed throughout this thesis.

At the end of the century repatriation systems have been unified conceptually through internationally accepted diagnostic frameworks such as the ICD-10 and DSM-IV.⁵ One might expect that these modern ideas and systems are benign and beneficial but this is not necessarily the case. Participation in diagnostic and treatment encounters in these systems means entering a complex web of ideas and administrative policy and practices over which the consumer has virtually no control. Policy and practice have changed markedly since 1914, and are currently underpinned by legislative provision such as the Australian Veterans' Entitlement Act 1986, but many of the principles remain the same. I would argue that the repatriation system described in Chapter Seven does not differ significantly from a modern repatriation facility (see Appendix G).

⁵ ICD-10, the Tenth Edition of the *International Classification of Disorders* is the European convention for mental disease, published by the World Health Organisation. The DSM-IV is American convention published by the American Psychiatric Association (see Appendix A).

The framework for the current management of claims for stress related disorders is what is now referred to as the 'stress cascade model' (see Raphael Morris, & Bordujenko, 1999). In this model there are four levels at which measurements and observations can be made. The first is the stressor event, the second the physiological and psychological stress response, third is the perception of the event by the participant, and finally the application of a diagnosis at some point in time after the event. An event qualifies as a stressor relevant to military service if there is one of the following present: engagement with the enemy; witnessing casualties or atrocities or being involved in casualty clearance; acute or chronic threat to serious injury or death; or prolonged experience of malevolent environments. The critical decision to be made is about the relationship between the experienced symptoms and the stressor event. It is here that research findings, ideas and theories are translated into policy in an effort to bring the 'objectivity of science' to bear on decision-making. The application of these ideas is not value free, and can be influenced by political, economic, social and even personal factors. In this application, academic and professional territory is contested to decide who has most influence in making these policy decisions and where funds are to be allocated for programs. Research and practice have brought forth heroes and protagonists and extensive networks, within which struggles for hegemony take place.⁶

A central feature of the medical involvement in this system is appropriation of personal experience. Appropriation of individual experience has been used for a number of purposes but it essentially confirms the 'patient' status of the casualty and allows him to be treated as a medical object. This is achieved by taking a self-description or clinical observation and turning it into a clinical diagnosis. When patients describe their post-traumatic experience and behaviour, their ordinary language is reinterpreted according to a predetermined set of medical criteria. The consequent labelling occurs at level four of the cascade, where a constellation of symptoms, such as the experience of nightmares, battle dreams or intrusive thoughts can be re-labelled as PTSD. This in effect is no different in principle from historical precedents when Alice James in the nineteenth century, or Robert Graves in WW1, were diagnosed as neurasthenic (refer to Chapter Three).

⁶ Raphael, B, Morris, P. & Bordujenko, A. (1999) Executive Summary and conference overview. In Morris, P., Raphael, & Bordujenko, A. (eds) (1999) *Stress and Challenge: Health and Disease*. Brisbane: Repatriation Medical Authority.

Appropriation of personal narratives is perhaps less sinister in peacetime, but the process is the same in the administrative and clinical decision-making for the purpose of compensation. The evidence from this study is that this type of appropriation severely constrains the narrative elicited from the applicant or patient. If they are sought at all, accounts of war experience are and have been only fitted into repatriation assessments within the constraints of a diagnostic category and available treatments. For the WW2 veteran this usually applied to men who were considered a danger to themselves or so dysfunctional that they could not function safely in society.

To illustrate this further, I return to one of the participants in this study, FB, a 2/27 veteran who was assigned to Category D, a case of serious disturbance with extensive psychiatric intervention. He joined the AIF when he was 38 years old and served for six years before being discharged with the rank of Captain in October 1945. In 1953 he presented to the Repatriation authority complaining of 'stomach pains, loss of confidence and unaccountable tiredness'. He was unable to teach and his wife was concerned about him. After a psychiatric assessment he was granted a compensation of 20 percent of the full pension for 'Functional Bernhardt's Neuralgia, which is covered by Anxiety State'. As Intelligence Officer FB had developed skills in critical analysis of information and so subjected himself to scrutiny, writing profuse letters for his psychiatrist, outlining his symptoms and insights. One of these insights was that his difficulty in concentrating 'must be subjected to some unconscious hindrance'. Several years of treatment with sub-coma Insulin, individual and group psychotherapy, abreactive therapy, CO₂ inhalation therapy and 'special drug treatment', did not improve his condition. His diagnosis changed from anxiety state to neurasthenia, hysteric depression and anxiety, neurastheniform reaction, hysteria, and even 'some elements of menopause and melancholia'. At one stage 'abreaction produced 57 pages of material of no particular psychiatric significance' and there was 'not much in the subconscious still to come up'. Leucotomy was considered as a last resort in 1955.⁷ At this point the psychiatrists gave up and he was discharged with a recommendation that he be assessed for a TPI pension, which was eventually granted.

FB's life outcome was eventually positive even though his life up until at least age 60 was characterised by excessive drinking and regular psychiatric referrals. He was divorced and separated from his family but described his later life as satisfactory. His

story is relevant in this context in that he provided articulate accounts of his experience, including his war history, which were translated into medical diagnoses that increased his compensation but only served to replace his personal narrative with a medical diagnosis. He was variously described in the medical notes as ‘an hysteric and quite lacking in insight’; a ‘patient who settled down to work quite well’; and, a ‘patient whose general condition is quite good’. He is always referred to as ‘this man’ or this ‘patient’, never by his given or surnames.

In wartime the political and administrative purposes of medical activity are clear. A political influence can be seen, for example, in the use of a diagnosis of war neurosis to dispose of a soldier considered not up to standard. In WW1 and WW2 war neurosis became a convenient label for the psychologically inadequate male and was a central plank in the administrative measures to control men during wartime.

This medical labelling aided continuation of the war because it discouraged dissent and shamed those who were struggling. In this purposeful appropriation, there is a strange medico-legal paradox. Acts of war (assault, killing and maiming, mutilation) that in peacetime might be subjected to forensic psychiatric examination and be labelled as psychopathic, in fact become heroic acts. In wartime succumbing to fear or losing control, can be classified a psychiatric disorder.

Most medical specialists would not have acted with any sinister intention and generally displayed concern and compassion for those who did ‘genuinely’ break down. In essence, how different was their position from that of the physicians and psychiatrists who supported the Nazi regime where they openly participated in acts of annihilation in their pursuit of dominance in the new industrial age?⁸ The medical men who supported the allies would not have seen themselves comparable with their German counterparts, but perhaps the difference is in degree not kind. Sinclair (1944) defined the psychiatrist’s role as,

To keep men fighting, as well as to care for those who are mentally incapacitated. Every patient whom he handles represents a potential unit of fighting power. The army psychiatrist returns his patient into a rude world peopled by men whose business is warfare.⁹

⁷ Information from medical and hospital files for FB, SX3995. This may have been what he referred to in a questionnaire as the ‘repat’ taking all his nightmares away.

⁸ See Cocks, (1998) and Lerner, (1995, 1997), for the German position.

⁹ Sinclair, A. (1944) Psychiatric Aspects of the Present War, *Medical Journal of Australia*, 1; 28: p. 562.

IMPORTANCE OF MEMORY

I have made the claim that the medical interventions with WW2 veterans discouraged examination of traumatic memory even with men who had been clearly identified as psychological casualties. In their interviews reflecting on memories and how stressful they are or have been, informants seemed torn between the intense loyalty for the cause they served, and acknowledging the intensity of their emotional experience. Each preserved his memory of the time in his own way, and some did not even find it necessary to revisit that memory unless pushed. They had become absorbed in the lives they had created for themselves. Their experience of managing memories can provide further insight into the nature of memory and this will be described here.

To elucidate this issue further, two questionnaires (see Appendices C and D) focussing on the construction of their experience, were administered to 26 men, a sub-set from the larger sample. The first was a Memory Intrusion Scale, and the second was a Belief Questionnaire, each of which contained items on the construction of past experiences. This sub-set actually represents the full spectrum of memory experience; from those who have no disturbance and a coherent story to those who have been chronically disturbed since the 1940s. Their construction of the past needs to be viewed within the context of military experience and their whole lives.

The first observation is that a large majority of men considered that soldiering was a worthwhile part of their lives, even though almost half regretted they had volunteered in the first place. Despite their loyalty and commitment as soldiers, they overwhelmingly concluded that war was not a reasonable way to resolve disputes. They could distinguish between war experiences and stressful memories and the latter were generally avoided in private and personal reminiscence. Even in the company of veterans they preferred to talk of amusing incidents rather than distressing times. War had not been an easy part of their lives to put behind them and almost all re-experienced earlier events in bad dreams in the immediate post-war years. Most considered their partners were the most helpful influence in getting through the early post-war years. They were all definite in their view that war had negatively affected their health, and they now think that it should be more widely known that war had caused distress and contributed to their poor health. Here they made a distinction between the personal and collective experience. While the

majority thought that more should have been said about the stress of war in general, they did not necessarily express a personal need to discuss their own experiences.

It will therefore be helpful to try to re-conceptualise the nature of memory. The model presented in Figure 12.1 is a combination of information processing and psychodynamic modelling. It is introduced as a schematic framework for a discussion of the memory processes observed in this study, and not as a definitive model. The consensus among memory experts is that a current memory is not a replica of the past but a construction tempered by intervening experiences (see Roth & Friedman 1997). It is more like an edited replay than a faithful representation of every dimension of the transformation of experiences into internal representations that can be stored and retrieved. The model in Figure 12.1 accounts for most of the activities associated with the storage and retrieval of memories. It can account for some of the more complex processes such as dreaming, which is an integral part of the memory process. It is a valuable basis for trying to recreate what happens to information that is encountered in the environment. The model partly illustrates the complexity of memory processes and the consequent difficulty of helping individuals recreate their past.

The body of memory is the long-term store where representations of experience are retained. The process of entering these experiences into the personal register involves a number of filtering and censoring devices. Simple memories such as a telephone number that is readily recalled is a transfer of information and once registered can be recalled when required. A more complex experience that could be highly emotional and require the processing of a number of pieces of complex information simultaneously, such as surviving a dangerous incident, involves more complex processing. In this processing, salient elements of the event may be either eliminated or stored accurately or even distorted in a short period of time.

The notion of a schema has a central place in an information processing model of memory and is defined as an internal representation of some external experience or action in the outside world and the actions that one can effect within it. A prominent theme in trauma writing is that a traumatic experience overwhelms the existing repertoire of skills or knowledge, and emotional repertoire (schemas). This means that the trauma experience, with its intense sensations, extreme behaviour, threat to life and existing values, cannot be assimilated into an existing schema and a new schema cannot be developed quickly to accommodate the new experience within existing cognitive

structures.¹⁰ During a traumatic experience two mechanisms can contribute to distorted processing of experience. The first is dissociation in which participants can separate themselves mentally from the event and from the intense feelings generated. The second is repression, which occurs during and after the event, and involves repressing not only knowledge of the event but also the intense feelings associated with it.¹¹

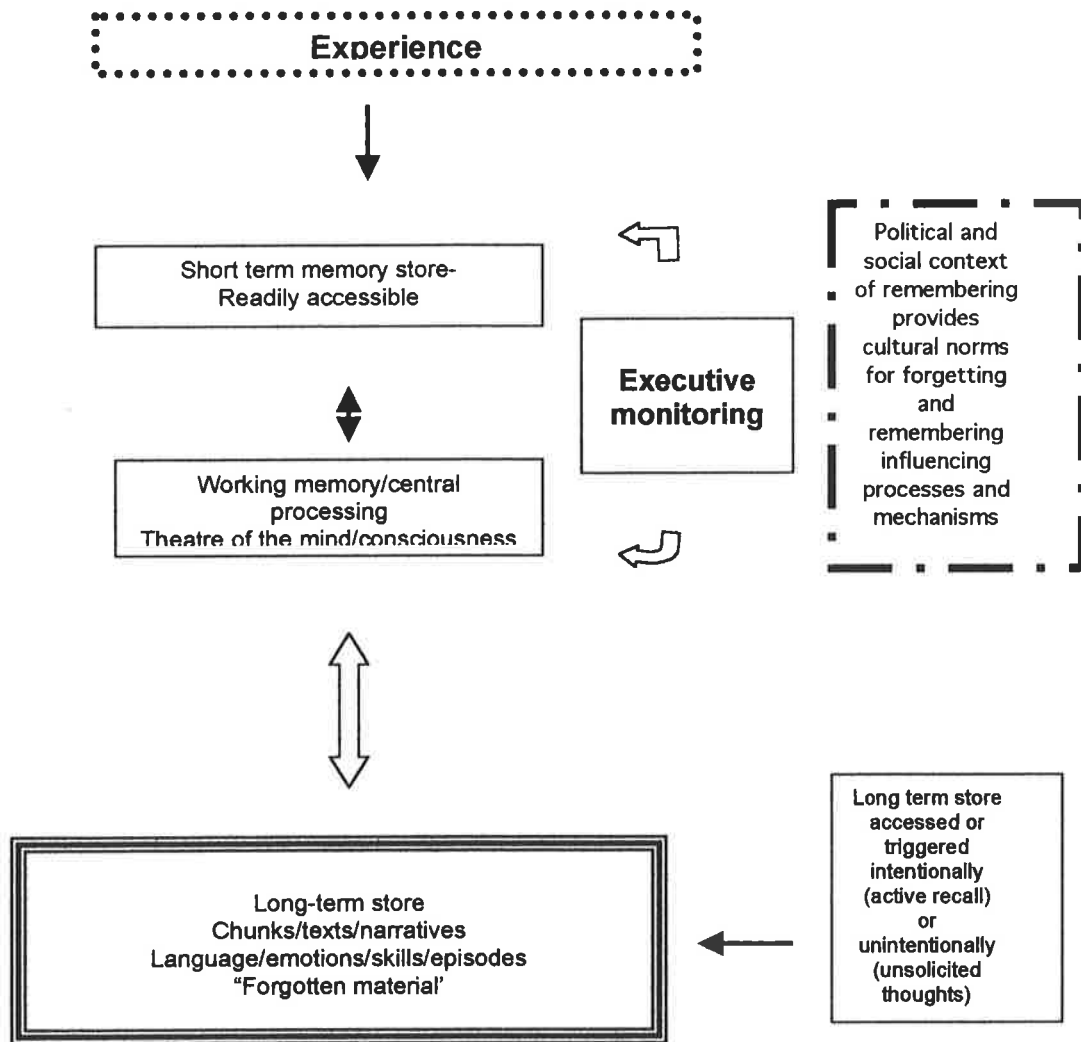


Figure 12.1 Information Processing/psychodynamic Model of Memory

Hunt (1997) proposes a model in which there are three levels or phases - *implicit memory*, which contains traumatic memories, *conscious awareness*, where memories are experienced and monitored, and *explicit memory*, where memories are formed into a

¹⁰ Cognitive is used here in the broad sense of the complement of mental structures that one has to operate within the one's world. It includes strategies that one could use to handle complex situations as well as less tangible structures like values and ideals.

¹¹ This was well established early this century by authors such as Rivers.

narrative. The distinction between explicit and implicit is a useful one but does not take into account cultural and social constraints on memory. The model stays situated within the individual internal construction of the world, where traumatic memory is mediated at a personal, not a social level.

If traumatic experience contributes to fragmented representations, narrative is an important element in situating the experience within a time frame and chronological order (it happened at this time and in this order). Narrative can help sort out the characters, plot and dramatic features of the event – who was there, what happened, how people felt etc. This is particularly relevant in combat situations where everything happens very quickly and the mind is attending to a number of pieces of information at the same time.

A further dimension of memory is that it is not just an individual experience. Individual memory is, as Darian-Smith suggests (1993), set within a collective memory and is influenced by the context in which memories are formed. She argues that:

It is through memory that we frame our sense of individual, group and national identities, give meaning to our own life history, and understanding of our social past. Our individual memories, however, are constantly supplemented, altered and mediated by the circulation of representations and articulations of the past that constitutes collective memory.¹²

In both the laying down of memory and retrieval there are individual, institutional and social gatekeepers. Individual gate keeping occurs when the individual internalises social and cultural norms, which influence him to moderate his storage and recall. He can also do this to protect himself or others from distress associated with remembering. Social gate keeping operates through restrictive social norms about what is acceptable. Institutional gate keeping is achieved in the veteran field through organisations like the Department of Veterans' Affairs and ex-servicemen's organisations, like the RSL, which can control the personal narrative. Earlier in the thesis I described the carefully orchestrated control over any public discussion of the 'nervous' soldier by the RSL and affiliated agencies. Kleinman (1988) points out that illness narratives, (narratives of perceived psychiatric illness) are culturally defined by the medical context in which they are elicited. Treatment centres on memory, either in eliciting material that can be used in therapy, or in treatment aimed at suppressing memory.

¹² Darian-Smith, K. (1993) War Stories: Australian Home Front during the Second World War, in Darian-Smith K & Hamilton P., *Memory and History in Twentieth Century Australia*, p. 137

This was a central part of the work of many WW1 therapists including W. H. R. Rivers, whose key insights are relevant to this discussion of memory. Rivers maintained that repression was both a process and a state. It was a *process* by which a person tried to 'thrust out of his memory some part of his mental content' and it was the *state* that ensued when, 'either through this process or by some other means, part of the mental content becomes inaccessible to manifest consciousness'. Repression was not of itself pathological, as it was mechanism necessary to adapt in the extreme conditions of war, and provide the only effective way of coping with the emotions aroused by these conditions. Pathology developed when the soldier tried to banish disturbing memories from his mind after battle. Rivers called this pathological state a form of anxiety neurosis. He 'is encouraged by family and friends and many experts to forget his war experiences but in reality he cannot, and they re-emerge in dreams and nightmares'.

Active repression kept the painful thoughts under a 'kind of pressure' during the day, building up energy that 'burst forth in the quiet of night'.¹³ For Rivers, the remedy, although not recommended for all patients, was to bring the content of the repressed experience into consciousness and facilitate a cathartic experience. Further re-education, or what might now be called cognitive behavioural therapy, could help the patient re-adjust to reality and release his repressed emotions and thoughts. Rivers was quick to point out however that a 'cure' might not always be attributable to the treatment, and there might be other factors operating such as faith in the physician, and autosuggestion. In practice, Rivers advocated a middle course. Lifting the 'veil of repression' needed to be done carefully and it was imperative for the therapist to find a balance between encouraging 'morbid and obsessive' concentration on thoughts and memories, and the constructive integration of memory through the release of repressed material.

This advice is just as relevant now as it was in 1916, when Rivers treated Siegfried Sassoon at Craiglockart, but it only addresses the issue at the individual level. In effect Rivers 'persuaded' Sassoon to return to the front and do his duty, not follow his pacifist conscience. Sassoon was not given permission to question the prosecution of the war he had publicly challenged, and eventually returned to fight. Rivers earned a reputation as a therapist that is now still revered, but his insight served only to inspire a more humane treatment of the neurotic soldier than that imposed by the Faradists, rather than examine the nature of war as a stressor.

¹³ Rivers, W. H. R. (1918) The repression of war experience. *Lancet*. February, 173-177.

Traumatic content in memory has been a central feature of the narratives in this study. Its neglect by medical authorities in the past 50 years of work with veterans has reduced the effectiveness of the response at both the individual and systemic level.

ALTERNATIVE DIAGNOSIS

This study has provided an opportunity to view a sample of men over their life span, in which all possible life outcomes have been observed from early childhood to death. These outcomes have been described in detail in earlier pages. I will now revisit some of the issues and themes that emerge in the aging process.

The pertinence of developing a new perspective on the life course of traumatic stress is highlighted in a recent article describing a therapeutic intervention in the life of a 71 year old British WW2 veteran referred to a specialist PTSD clinic in the UK.

He had experienced distressing flashbacks of war incidents and disturbed sleep, and had previously been prescribed Fluoxetine (antidepressant) to aid sleep. The veteran had participated in 30 bombing missions over Germany and had been captured after being shot down. He had a long history of anxiety problems that began shortly after his discharge. When he arrived at the clinic in January 1995 clinicians could offer the veteran a much greater array of theories, diagnoses, treatment modalities and medications than were available in 1945. A selection of these was subsequently tried over a period of about two years. He was diagnosed with PTSD, on the basis of his hypervigilance, chronic arousal, intrusive memories and so on. 'Treatment set out to link contemporaneous reactions to past experiences and develop new repertoires of coping strategies'. Over a period of about 18 months the patient was encouraged to articulate a coherent narrative of his traumatic memories and develop insight. Aversive stimuli were linked with causal events and explained to make them less intrusive.¹⁴

Diagnostic checklists such as the SLR-90-R Positive Symptom Distress Index were used to monitor his symptoms, but 'psychotherapeutic change occurred at the level of symptom intensity rather than symptom elimination'. There was no significant improvement in the patient's experience of nightmares, violent temper, irritability, anger, and startle responses. He had been reluctant to commence drug treatment on the grounds that he would lose control, but when he did not improve, he agreed to a course

¹⁴ Ormer, R. J. & Loos, W. S. (1998) Second World War Veterans with Chronic Post-traumatic Stress Disorder, *Advances in Psychiatric Treatment*, 4: 211-218. A commentary by Leigh A. Neal was appended to this article.

of pharmaco-therapy. After two months of Fluoxetine (a selective serotonin re-uptake inhibitor – SSRI) a widely used and recommended drug for PTSD patients, the treatment was concluded. The consensus seemed to be that the treatment had at least helped the patient avoid suicide, and enabled him to survive, but there had been no cure: his re-living of his traumatic war continued unabated, despite the therapeutic alliance and flexible treatment approach.

A commentary on the article pointed out that evaluations of complex interventions later in life are problematic and plagued by methodological problems. In this case Neale, (1998), suggests that the SSRIs may not be effective and that the new generation monoamine oxidase-A (third generation MOAIs) may be more effective. It would seem, however, that veterans in 1999 are no less subject to uncertainty in treatment outcomes than others had been in 1949. Indeed, some of the new generation drug treatments can exacerbate the existing symptoms, such as SSRIs which ‘have the potential for anxiogenesis’ in the early weeks of treatment. Psychotherapeutic intervention seems also to be fraught with the same uncertainty and dilemmas as those faced by thoughtful therapists like W. H. R. Rivers in 1917.

A local case study (DM) will further exemplify the problematic nature of chronicity and a traumatic past. In October 1998 the wife of a veteran contacted me to inquire about *A Very Changed Man* (Raftery & Schubert 1995), which she thought might assist her to understand her husband who had been a ‘nerve case’ since 1945. He had been treated for anxiety since discharge after 1945 with a range of tranquillisers, from Phenobarbitone to the modern agents such as Xanax. On the surface DM has managed his life by taking delight in his house and garden and his black Labrador cross which he walked on the nearby beach. His wife was trying to solve the riddle of his mental illness that had been a lifetime struggle and had recurred recently. In her search for understanding she found a book (*An Unconventional Woman*, by Joan Tahija) in which the author described the life of a member of Z force, the same unit as her husband’s. A reference to barbed wire as she was reading to her husband caused him to weep and lose control.

‘Barbed wire’ was a reminder of the compound where he was based in Morotai, an island off Borneo where the Australian Army had established a base to support the activities of Z Force. This was a special unit that infiltrated behind Japanese lines. DM would decode information that would be used to launch bombing missions into the

region. He was sworn to secrecy, which meant he never spoke to anyone of his experiences, then or later. This was further complicated by the fact that as a conscientious objector he chose not to bear arms but was aiding the killing of others by directing bombing raids.

DM had carefully guarded against entering the past by not talking with his wife and family or joining any veterans' organisations. He had described his symptoms to his general practitioner, as well as some of his fragmented narrative. He was prescribed tranquillisers, but not referred for psychotherapy. The drug he was prescribed appeared to have added to his anxiety and reinforced his repression of his whole narrative.

DM provides a good example of an older veteran, who had been influenced by cultural expectations to suppress his past, but revisited it in later life. His life highlights the way the Australian experience of war related 'neurosis' has been marginalised and hidden. His experience is recorded on DVA files and with the local doctor but he and his wife have had to largely deal with it in their own way.

What does this add to the understanding of the post-war life? In the first place it confirms what has been known since 1915 – similar traumatic events can have differential effects over time. Secondly, the memory of that traumatic time is managed idiosyncratically by individuals. Each of the men had their own constellation of internal dynamics to enhance or inhibit this process. What we don't know and can only speculate on is the effect of medical intervention in DM's case. We do know it has not worked in the sense of relieving DM of his distress. It may have saved him from suicide. We could speculate that part of the reason for the lack of success was inappropriate intervention and a lack of knowledge. No attention seems to have been paid to the problem of intrusive memory¹⁵. Perhaps Rivers would have engaged him in a process of removing the repression of his memories and integrating them into current schemas. Rivers would also have been cognisant of the potentially harmful effects of the advice and interventions of the previous fifty years.¹⁶

One of the central issues in this excursion into lives is why certain symptoms attract psychiatric labelling, but other behaviours do not cross an arbitrary line into an assigned pathology. It has been shown that a significant number of veterans who could have

¹⁵ In his most recent communication, DM reported that he had taken my advice and sought a referral to a trauma-focussed psychiatrist. After a several appointments he was helped 'to talk things out', and had also talked to his children and made contact with other veterans.

¹⁶ Rivers, W. (1918), *op cit*.

attracted a label of mental disorder, as defined in the DSM, remained outside a formal diagnosis. They self-diagnosed and decided, not overtly or even consciously, that they could manage their intrusions from war. If the narrative of one of the key informants who appeared in the first pages of this thesis had been examined medically in his early days, he might have been labelled a psychiatric casualty. He was jumpy, reacted to the slightest provocation or stimulus, and had nightmares. In his survey interview he admitted that he had taken a long time to adjust to potentially intrusive remnants, which he chose to ignore. 'My wife will tell you I used to wake up for the next ten years [after discharge]; you would sometimes dream about it – but it would never affect you; something there would wake it up. In the last twenty years I might have dreamed twice. The big cure-all for trauma and all that malarchy [sic] is to be busy'.¹⁷

PUBLIC HEALTH PERSPECTIVE

War has been part of the social fabric of all nations and represents one of the greatest threats to the health of the public. As well resulting in death of civilians and combatants, war destroys the infrastructure essential to normal health, creates disease and introduces foreign diseases, and causes long term physical and psychological damage. Cumulatively it is the greatest contributor to trauma and social dislocation and brings into sharp relief the short and long-term threats to the health of society from catastrophic events.

The impact of war on the health of communities can be measured in a number of ways. Although I did not set out to identify or classify within a pathological framework, their period of service did clearly leave some participants damaged. In this study I have focused only on participants in war and I have demonstrated that the events of war can result in persistent and serious dysfunction over time by introducing an element of personal narrative specifically focused on war experience. However, such war experiences act as toxic agents for the families of veterans as well as the veterans themselves, and secondary effects were observed in members of families. Families experienced the traumatic effects vicariously, secondarily and primarily. Vicarious traumatisation occurs when the veteran introduces his own images and traumatic stories which exposes family members to external stressors, even though they have not experienced these directly. Secondary traumatisation occurs when the behaviour of the

¹⁷ Interview JR.

veteran revives an earlier trauma in the life of a family member, such as the abusive behaviour of the spouse's father. It is possible that the father could have been damaged in WW1. Primary traumatisation occurs when the behaviour of the veteran, such as choking a wife during sleep, or violence against children, is the primary stressor. The experience of serious mental breakdown, attempted or actual suicide, and hospitalisation of the veteran can also introduce major stressors into family life. The ongoing psychological effect on veterans is supported from data on pension allocations for both WW1 and WW2, in Australia and allied countries. There is no reliable indicator of traumatisation of family members.¹⁸

Documenting these effects has been overshadowed by psycho-medical activity focussed more on maintaining war efforts, and maintaining the fighting capability of the military unit. This mandate is translated into a concerted effort in psychological medicine on prophylactic and preventive measures in ensuring that psychological casualties are kept to a minimum. These measures have now developed into comprehensive manuals for military command and medical personnel.¹⁹ While comprehensive measures to both prevent casualties and meet their needs after discharge are necessary and praiseworthy, this stance does not lead the specialist to question the stressor, but only to treat the stressed victim and contribute to the efficiency of the war machine. The continuing classification of victims of trauma as mentally ill, whatever the nosology, maintains the victim of trauma in a cycle of individual pathology. One of the consequences of the DSM-IV construct of traumatic stress is that it has, as Gersons and Carlier (1992) point out, remained:

behind the closed doors of an institution or medical practice, unbeknown to an uninformed society outside ... where psychotherapeutic intervention did indeed take place and was often divorced from a traumatic wartime background.²⁰

One major consequence of the medical hegemony in the discourse in this field is a restriction of scrutiny of any public health effects of war. In effect this means that there has been virtually no examination of the toxic agent, or source of 'infection'. This has been achieved by concentrating only on the individual effects and pathologising the

¹⁸ For discussion on various dimensions of vicarious and secondary traumatisation, see Rosenheck (1986), Raftery & Schubert (1995) and Harkness (1993).

¹⁹ For example, the US Department of the Army detailed its requirements in *Combat Stress Control in a Theatre of Operations: Tactics, techniques and procedures*, Headquarters Department of the Army, Washington DC September 1994.

symptoms as has been clearly shown above. Research efforts and treatment regimes have been focussed on the individual participants or victims and there has been little focus on examining the nature of the toxic agent. Any examination traumatic event has been to determine the relative contribution of different types of Criterion A to post-traumatic symptomatology.

Medical and psychological ideas play a major role, in developed countries at least, in the maintenance of the military establishment and the pursuit of war. Medical psychiatric services not only provide treatment, but also play a part in preparation for stressful events. They are also an integral part of the treatment and compensation systems in post-war life. In both research and practice, PTSD remains the dominant diagnosis through which psychiatry maintains hegemony in the development of policy and the determination of claims. PTSD has replaced shell shock, neurosis, hysteria, and neurasthenia, as the primary diagnosis for those who cannot sustain the pressure of battle conditions, as well as those who have some sort of post-discharge dysfunction.²¹ When grappling with the fundamental question of what can be done about minimising or even eliminating the primary toxic agent, war itself, there has been little thinking outside this carefully prescribed medical square. Such a task is not without moral and intellectual dilemmas. To question the place of medical ideas which have been firmly entrenched in the Australian Army since WW2, and in the veterans' administration in the post-war period, would have meant questioning national security needs, patriotism and the Hippocratic oath.²²

This is quite a curious contradiction. In the pursuit of war, medical and legal principles are reversed from their application in civil life. In war, killing human beings is sanctioned and medical and other experts actually assist by studying human factors and the psycho-dynamics of withstanding the stressors of war. In this sense they are ensuring that the perpetrators are able to carry out their work in the first place. These

²⁰ Gersons, B. P. R. & Carlier, I. V. R. (1992) Post-traumatic Stress Disorder: history of a recent concept. *British Journal of Psychiatry*, 161; 746.

²¹ The Repatriation Medical Authority, a body within the Repatriation Commission, currently determines the policy on medical compensation. Investigations of pension entitlement are carried out under the requirements of the Veterans Entitlement Act (1986), that authorises the RMA to determine the presence, or absence, of causal relations between service-related factors and disease, injury or death.

²² This is the same dilemma that Robert Graves faced when he wanted to support his friend Sassoon during WW1. At that time there was a strong Pacifist Movement but Graves helped to persuade Sassoon to submit himself to a Medical Board and be labelled neurasthenic rather than pursue his objections to the war. See Graves, R. (1929) *Goodbye to All That*. London: Penguin.

same experts never ask how it is that what is regarded as normal in one situation (killing in wartime) is abnormal in another (civilian murder).²³ Badness in one arena is goodness in another and if a person experiences revulsion or distress when required to conform to this reversal of values, they can be accommodated within a diagnostic category. Medical experts do not examine the sickness in those who make the decision for violence to be perpetrated with military force. This is in some ways similar to what occurs in the case of an epidemic or outbreak of disease in society. The history of public health is replete with examples of blaming the victims rather than addressing underlying causes in other epidemics.

DISCUSSION

In October 1942, Lawrence Kolb, one of the more influential American psychiatrists during WW2, stated in a landmark paper at a conference of psychiatrists at Ann Arbor, that 'sanity and security are two exceedingly wholesome words to hear in a chaotic world'. Kolb reminded his audience that the federal US government was at that stage still paying pensions to those mentally damaged in WW1. This was to continue in the 1939-45 war where similar damage was being observed. But he argued that war would add to the major public mental health crisis facing America, where there was only one psychiatrist to 57 000 of the population. He argued for preventive measures and a campaign of mental hygiene in that 'the obligation of psychiatry, as of all medicine, is to prevent rather than to patch up'. Such thinking was not readily applied to combat related disorders, other than to provide advice and training on how to make men more resilient in the face of battle.²⁴

Kolb did not advocate examining the madness of the central acts of destruction and mayhem in war. This type of academic interest is rare and there is no equivalent in post-war Australia. Most academic interest has been focused on the mental illness of veterans. There are some historical precedents for efforts to address the fundamental causes of war. The whole pursuit of psychiatry since WW1 has been to examine the 'madness' of the men who could not cope, rather than the leaders who made decisions

²³ This contradiction was acknowledged circa WW2 by Henderson (1945) *DK Journal of Mental Science*, 389, XCII, 667-681; and Bostock (1942) The place of history in war and post-war problems. *Medical Journal of Australia*, 2, 23; 493-499.

²⁴ Kolb, L. (1943) Post-war psychiatric perspectives. In Sladen, F. (Ed.) *Psychiatry and War*. New York: Erlbaum.

to wage war or who gave the orders to subordinates. Interest in perpetrators is primarily reserved for war crimes tribunals.

Similarly, in relation to civilian trauma such as incest and rape, 'the mental health service has once again lost its neutral position against traumatic reality so many people live and work in'.²⁵ The DSM-IV has provided the ultimate expression of the attempts to classify what is regarded as abnormal in the human condition. Before World War Two there were fewer categories of human illness. The war served to entrench the illusion that experience could be neatly divided into identifiable categories.

Another disadvantage in the PTSD diagnosis is that it is a focus on a clinical condition, at the expense of the viewing the person in a social and historical context. A clinical diagnosis can mask the other sources of dislocation particularly with an event like war. For example, there has been no significant interest in experiences such as contracting venereal diseases in wartime and the effect this may have on later life adjustment. Other issues, such as grief at the loss of comrades, can also be pathologised and hidden under a psychiatric label. This pathologising can place the healing that needs to be done outside the family and community and situate it within a clinic. These clinical interventions do not always effect a 'cure', as recent evaluations of the extensive US veterans programs have shown (Johnson, 1997). Medication, for example, does not empower people to gain control over their lives and re-establish a sense of identity any more than the induced narcosis or electroshock treatment of the 1940s and 1950s.²⁶

Modern diagnoses have not contributed to a shift in thinking. The introduction of the PTSD diagnosis has been increased sophistication of diagnosis and treatment and but in recent work the focus has moved back from a psychogenic to a physiological base (Gersons & Carlier 1992). As Gersons & Carlier point out, the PTSD diagnosis has removed some of the stigma associated with other psychic disorders and moved it from tags such as hysteria. To some extent, especially in civilian trauma, PTSD has normalised the reaction to abnormal events of a significant proportion of the

²⁵ Gersons & Carlier, (1992) op cit. p. 747.

²⁶ 'As outcome data became available during the early 1990s ...the field has reluctantly discovered that the SIPUs have not produced significant or sustained improvement in veterans' symptoms, especially at 4 and 12 months' follow-up. Collectively, these papers raise the question whether, for combat veterans of PTSD, the intensive examination of war and traumatic experience within the SIPU was beneficial' (p. 357).

population, but the treatment interventions are still within the psycho-medical paradigm.

The experiences of men and women who have encountered these ideas about mental health have received very little public examination. 'Sufferers' have been labelled and treated privately, or in some cases they have received no treatment and they, with their friends and families, have suffered in silence. The clinical rooms and corridors of administration are silent about the effects of war. As members of the WW2 generation die off the post-war experiences of the damaged veterans have been almost entirely covered over. The large amount of reminiscing that has occurred is very selective, and most veterans have not articulated the complete story of how the war affected their psyche and lives. The professional trauma community has only been informed by narratives of those who became dysfunctional and were treated, not of successful survivors. In clinical encounters with such men the clinician or researcher has made notes that have the primary purpose of classifying the madness or illness of the individual or determining his or her eligibility for compensation. There is no examination in these files, or in the few studies of post-war lives of veterans, of the madness of the stressor and the practice of using violence to resolve complex human problems.

There is a case for psychologists to examine their position on war and other 'man-made' stressors and to ask whether we want to be totally identified with the role of pathologising victims of those stressors and the politics of that process. Continuing to label and treat pathology could reinforce a long established mode of viewing and labelling the personal consequences of traumatic events as medical disease, which is rooted in the neurosis discourse of the nineteenth century.

Few researchers or therapists have addressed the issue of the 'madness' of war itself, particularly in response to WW2. One attempt came from W. E. Mickleburgh at the Third Annual Congress of the Australian & New Zealand College of Psychiatrists in Sydney, October 1966. Mickleburgh argued that 'understanding the genesis and control of wars is among the most urgent and important problems of today,' and that 'psychiatrists should have valuable insights to contribute to the subject'. In his view social psychiatry should expand to 'embrace the study of maladaptive international behaviour of all kinds'. He further argued that psychiatrists were well placed to understand the dynamics of war because 'armed conflict lends itself to analysis'. Mickleburgh based his analysis on a motivational model explaining why seeking social

goals could lead either to conflict or harmony. He optimistically suggested that adjustments to technological, economic, political, legal and educational factors could minimise the likelihood of conflict. Prevention could be achieved through 'education, international communication and the provision of moral equivalents of war'. More specific psycho-medical intervention could be effected through screening out those unsuited to political or military leadership. He even advocated epidemiological surveys to elucidate the 'warlike or peaceful propensities of populations'.²⁷

Even though some of his foundations for understanding the dynamic of war might be questionable, Mickleburgh does offer an alternative to the persistent focus on a clinical study of the victims of war. His reference to the capacity, even in 1966, of 'mankind' to destroy itself many times over is still relevant today. Over thirty years ago he was urging immediate action to tip the balance in favour of survival of the human race.

There was been little movement in psychiatry or psychology to take up these concerns and no significant research along the lines suggested by Mickleburgh. Relatively recent movements such as Physicians for Peace and Psychologists for the Promotion of World Peace tend to function at the fringe of professional groups. In the post-WW2 years there was no equivalent of the Oxford Group in Australia, and those who had been involved in the mental health of soldiers continued their work by providing treatment and assessments for compensation purposes.²⁸ As the search for post-war peace expanded to movements such as Moral Re-armament, and Peace Studies, the Cold War climate of the early 1950s ensured that those who supported these movements were frequently branded as communists. Any serious examination of the nature of the psyche in the pursuit of war was lost in political considerations. There seemed to be a general strategy of forgetting about the trauma, both professionally and individually.

What is the scope for an alternative view? This question needs to be addressed at a number of levels. A deconstruction of the ideas that have informed attitudes and practices for reactions to war demands more than improved methods of diagnosing and

²⁷ Mickleburg, W. (1966) Psychopathology and war. *Medical Journal of Australia*, 24 December; 1247-1251.

²⁸ Klerman (1987) claimed that the lessons learned from the mass screening of US soldiers in WW2 stimulated an increase in epidemiological studies of the mental health of the general population in the USA. The focus was on social precipitants of mental illness such as poverty and social change, and was at least an advance in public health thinking. This did not, however, translate into epidemiological studies of war itself.

treating casualties. An alternative would require a radical shift not only in paradigms but also in research policy and allocation of resources. Psycho medical responses to war are now focussed on the maintenance of stable military forces and minimising the post-war effects. This could be achieved through practices like stress inoculation training and more efficient intervention, and has been a central part of modern armies. I am proposing much more radical approach on primary prevention, which examines the social context of war.

An alternative theoretical framework of this type is emerging in writing about the problems of civilian casualties of war. In 1998 the Save the Children Fund sponsored a conference on the discourse on trauma that has emerged around the needs of traumatised civilian populations. The monograph on this conference (Bracken & Petty) is an attempt to develop an alternative to the framework of trauma relief that has emerged from the developed countries. They maintain that the 'models developed in Western psychiatry with regard to the effects of trauma [centred on the diagnosis of PTSD] should not be exported uncritically' (p. 4). One of the principal contributors, Derek Summerfield, drew attention to the concept of 'social memory' which provides a broader focus for intervention than 'traumatic' memory that is the basis for the notion of PTSD as a 'disease of memory'.²⁹

At the individual level, people damaged by war will still need healing. Conventional interventions have been based on labelling experience and symptoms as some form of pathology and treating the person as a medical entity. Even at this level, I am proposing that the mental health model of assessment, diagnosis, classification and treatment in a clinical setting is too narrow to meet the needs of the person emerging from traumatic experience. Guided by the experience of the veterans in the study, I suggest that new opportunities for personal narrative need to be opened up. This could take place not just in clinical settings but in the family, veteran, and community networks.

A broader perspective would do away with the alienation imposed by the medical appropriation described above. This appropriation has ensured that the only forum for exploring past experience is in a medical clinic. There has been no broader educative, developmental forum, not framed by medical diagnosis. In the family, for example, the spouse has been the primary target and bearer of suffering of the veteran, but there has been no forum for learning for her. She would encounter expert help only if she

experienced some form of breakdown herself. No early assistance was provided to learn how to constructively participate in healing. The wife of DM for example, was still searching in 1999 for a coherent explanation of her husband's life long distress, but had been kept outside the professional discourse. She was still seeking knowledge from sources outside this discourse, in her own reading and informal discussions.

Working at this community level demands more than the expert advice or instruction that was imposed on the veteran community in the post-war years, such as the Red Cross lectures by Dibden or the Lighthouse series in New Zealand. This type of public education is still carried out by agencies such as the Department of Veterans' Affairs and the Australian National Centre for War Related PTSD³⁰. However, these agencies still situate their advice and information within a medical model, and have little community focus. The fundamental model is still that veterans have an illness and they will be best helped if they come to hospital based programs supervised by medical personnel.³¹

The experience of war veterans is both similar and different from the experiences of civilians who have their lives interrupted by traumatic events. It is similar in the way personal narratives are appropriated into a psychiatric diagnosis to determine treatment and settle litigious issues. It is different in that the violent acts are perpetrated under the guise of good world order and pursuit of national goals and the good of the people. When responding to the psychological casualty in war-time, medical specialists claimed that they were not dealing with any new disorder. Their focus for most of this century has been on the host, in the disease triad of host, environment and pathogen. Labels of psychiatric disorder for victims have reflected this, and the primary explanation for breakdown and dysfunction has been the inadequacy of the individual. This has been

²⁹ Bracken, P. & Petty, C. (1998) *Rethinking the Trauma of War*, London, Free Association Books.

³⁰ The National Centre for War related PTSD distributes leaflets explaining in simple terms the problems of aging and offers services through its units. DVA publishes *Veterans Health* twice a year, featuring information-based articles, a small number of which deal with mental health. The most recent educative document, a booklet on Post-traumatic Stress Disorder listing common PTSD symptoms, (Commonwealth Dept of Veterans' Affairs (1999) *Posttraumatic Stress Disorder (PTSD) and War-related Stress*) is modelled closely on the DSM-IV, and a list of other possible pathologies such as anxiety, depression and alcohol overuse. The discussion is very clearly framed around these pathological responses. It describes standard methods of treatment such as exposure therapy, psychodynamic psychotherapy and cognitive restructuring, all dependent on experts within the Veterans' Affairs system. No alternative approaches are discussed or encouraged.

translated into individual private therapeutic solutions. I have demonstrated that the focus needs to be much broader if more adequate solutions are to be found.

The deconstruction of these medical interventions in war requires much more than a search for effective diagnosis and creative healing. It implies a radical shift away from pathologising individuals to a more fundamental examination of the social context of mass organised violence. There has been little deconstruction this century even though some of the architects of ideas in WW2 did express concern about the madness and medical dilemmas that war evokes.

The persistent claim that there was 'nothing new to medical science' in the neuroses of war was a valid statement but for reasons other than those given by the medical experts. There was 'nothing new' in that psychiatric effort was focussed on treating the individual in the same way in both civilian and military settings and not questioning fundamental causes of the 'disease'. The mode of operating was the same in both fields. In terms of the imperative to address the root cause of disease and disorder this has been a mistake. The mistake was the failure to recognise that the toxic stressor of deliberately perpetrated mass violence was 'man-made'. Health in society may have been better served if the same degree of intellectual effort and clinical insight had been applied to critiquing and finding alternatives to the use of violence to achieve social goals, as had been applied to identifying, labelling and treating dysfunctional individuals.

³¹ See for example brochure No. 9 *PTSD in the Elderly*, National Centre for War Related PTSD, Heidelberg, Victoria. 1998.

APPENDIX A: POST TRAUMATIC STRESS CRITERIA.

Diagnostic and Statistical Manual of the American Psychiatric Association.

(PTSD is situated within Anxiety and Other Disorders. If the respondent does not meet criteria the diagnosis shifts to other anxiety disorders)

Criterion A

A person is exposed to a traumatic event in which both of the following were present:

- (1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
- (2) The person's response involved intense fear, helplessness, or horror.

Criterion B [at least one]

The traumatic event is persistently re-experienced in one (or more) of the following ways:

- (1) Recurrent & intrusive distressing recollections of the event, including images, thoughts, or perceptions.
- (2) Recurring distressing dreams of the event
- (3) Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated)
- (4) Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
- (5) Physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

Criterion C [at least three]

Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

- (1) Efforts to avoid thoughts, feelings, or conversations associated with the trauma
- (2) Efforts to avoid activities, places or people that arouse recollections of the trauma
- (3) Inability to recall an important aspect of the trauma
- (4) Markedly diminished interest or participation in significant activities
- (5) Feeling of detachment or estrangement from others
- (6) Restricted range of affect (eg unable to have loving feelings)
- (7) Sense of a foreshortened future (eg does not expect to have a career, marriage, children, or a normal life span)

Criterion D [at least two]

Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

- (1) Difficulty falling or staying asleep
- (2) Irritability or outbursts of anger
- (3) Difficulty concentrating
- (4) Hypervigilance
- (5) Exaggerated startle response

Criterion E

Duration of disturbance (symptoms in criteria B, C, D) is more than one month

Criterion F

The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning

Note: The World Health Organization (1993) *ICD-10 Classification of Mental and Behavioural Disorders* includes a contains diagnostic category of Reaction to severe stress. This includes Post-traumatic stress disorder. The criteria are similar to the DSM. These are being exposed to an 'exceptionally' stressful event, which is followed by intrusions, avoidance, and amnesia or increased arousal. Criteria must be met within six months of exposure.

APPENDIX B: Consent forms, letters and questionnaires.**Family letter and consent form:**

As discussed on the telephone I would like to obtain a copy of confidential family documents which will help me in my research into the effects of war service. As I explained this is part of my research for a PhD at the University of Adelaide. This will be sent to the Dept of Veterans' Affairs and I can then obtain the documents from the National Archives, or the Department. A copy of the letter that will be sent from my department to the Dept of Veterans' Affairs is enclosed. To do this I will need your written permission.

I have enclosed a consent form and if you are still agreeable I would appreciate it if you could complete the form and return it to me in the enclosed reply paid envelope.

I appreciate your help and will contact you when I obtain the papers from the Archives. Please give me a call on 83732256 if you have any queries.

CONSENT FORM

Name: .

Address:

Telephone:

Signature:

Witness:

Name

Address:

Signature:Date / /

VETERAN CONSENT FORM

I am undertaking a Doctor of Philosophy thesis on the effects of war service on World War Two veterans. I am a registered psychologist, and have been involved in this field for a number of years. I am known to officers of The Dept of Veteran's Affairs and served for a number of years as a member on the Board of the Veterans' Children Education Scheme.

I have already carried out extensive interviews with a large number of surviving veterans and their partners.

If you agree to participate further your information will be kept strictly confidential and I will not publish your name or identify you in any way in my research writing. None of this information will be conveyed to the Dept of Veterans' Affairs.

John Raftery,

I have read the above and agree to be interviewed according to the conditions set out above.

Signed: Name:

.....

Date:/...../.....

World War Two Questionnaire
Veteran Life History

This questionnaire is designed to give you an opportunity to tell your story of your war experience and how this has influenced your life. Many veterans have found that completing the questionnaire is very worthwhile exercise them. There are a lot of questions, some of which may be either distressing to answer or may be seen to be too intrusive. You may choose to leave some questions if you wish. Your story is very important part of the history of WW2 in Australia.

The questionnaire will be used to write a thesis on the psychological effect of war on veterans. This thesis has been approved by the Dept of Public Health in the Medicine Faculty at the University of Adelaide and is approved by the Ethics Committee of the university. If you have any concerns at all you may contact my supervisor, Dr Neville Hicks on 8303 3586.

A return envelope is provided for the return of the questionnaire.

I will be happy to answer any questions or give any assistance in completing the questionnaire. I can be contacted on 8363 9198.

John Raftery
Dept of Public Health
University of Adelaide.

LIFE HISTORY QUESTIONNAIRE WW2 VETERANS

[Some segments truncated for display purposes]

Name: [optional]

BIOGRAPHICAL DATA

[Please fill in the details as much as you can remember]

Event	Year
Born at	in
Started school at	in
Left school after completing grade	in
Left home	in
First job at	in
Joined the unit	in
Discharged at	in
Started work at	in
Got married to	in
Lost partner	in
Divorced	in
Remarried	in
Retired from	in
Had first serious illness of	in
No of children from marriage:	
1. Mother's Occupation	
2. Father's Occupation	
3.a) Did your father serve in WWI? Yes [] No []	
b) If yes, what effect do you think this had on him?	
4.a) Did you have any disturbing experiences as a child (eg. family tragedy)? Yes [] No []	

b) If yes, please describe the experience:

.....

5. Overall how would you describe your childhood?

- Very happy 1
- Happy 2
- Miserable 3
- Very miserable 4

6. Do you recall an interesting story of childhood?

.....

7. What do you recall about how you survived the Depression of the 1930s?

.....

8. a) Your pre-war employment history

<u>Employer</u>	<u>Type of work</u>	<u>Years</u>
.....
.....
.....

b) Your pre-war education/training

<u>Institution</u>	<u>Course</u>	<u>Qualification</u>
.....
.....

WAR EXPERIENCE

9. Month and Year of enlistment

10. Unit

11. Highest rank

12. Role (ie machine gunner)

13. Number of Campaigns

14 Countries served in

15. Decorations

16. Month and Year of discharge.

17. Health on discharge

b) This may be painful, but could you say what that was like, how you were treated and how long it took you to recover? .

.....

c) Was there anyone whom you felt really understood what was happening to you and was able to help?

.....

.....

AFTER THE WAR:

25. What did you learn most from your experience in wartime?

.....

26. Could you briefly describe your homecoming

.....

.....

27 Please list any government assistance you received on your return to civilian life (ie Vocational Training Scheme, rural resettlement)

.....

.....

28. Listed below are problems that some veterans experienced immediately after the war and through their life time. Please tick the statements that apply to you, and identify the period of time.

	after war 1945-50	middle years 1951-75	recent years 1975 -
preoccupied with war	[]	[]	[]
spent lots of time with other veterans	[]	[]	[]
drank a lot	[]	[]	[]
rarely expressed affection	[]	[]	[]
kept to myself	[]	[]	[]
worried unnecessarily	[]	[]	[]
was upset by war memories	[]	[]	[]
wanted everything neat and tidy	[]	[]	[]
often lost my temper	[]	[]	[]
had nightmares/war dreams	[]	[]	[]
became distressed talking about war	[]	[]	[]
slept badly	[]	[]	[]
was very anxious/nervous	[]	[]	[]
had difficulty concentrating	[]	[]	[]
often felt depressed	[]	[]	[]
was very moody	[]	[]	[]

29. How was it settling back into civilian life?

Very difficult	1
Fairly difficult	2
Fairly easy	3
Very easy	4

30. How long did you take to get back to normal? Years months

31. Who/what helped you most in the resettlement?

- war service mates
- parents
- other family members
- other mates
- other (please state)
- wife
- employer
- medical people
- church members

32.a) Did you complete any education after the war?

- yes
- no

b) If yes, please specify.

Institution Course Year completed

33. Could you describe your post war employment record

Employer Type of work Years

FAMILY

34. Could you comment on the effect your war service might have had on your family.

35. Listed below are statements describing some veteran's experiences of sharing war experiences with his family. Please tick the statements that apply to you.

	after war 1945-50	middle years 1951-75	recent years 1975-
I talked openly about my experiences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I could not stop talking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I only shared selected stories	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I found it too upsetting to talk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I wanted to forget, so I didn't talk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I was advised not to talk about my experiences	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

36. How do you rate your achievement in the following?
(circle one of the number from 1 to 5 for each question)

	very low				very high
As a father	1	2	3	4	5
As a husband	1	2	3	4	5
As provider for the family	1	2	3	4	5

HEALTH:

45. What best describes your current health?

Excellent	1
Very good	2
Good	3
Poor	4
Very poor	5

46.a) Have you had any health problems related to war service?

Yes No

b) If yes, can you briefly describe the problems

.....

c) How did this impact on your work and family life?

.....

47.a) Have you ever sought or been referred for psychological help?

Yes No

b) If yes can you give details:

.....

48. What is your current pension status?

TPI	1
100% entitlement	2
Part entitlement	3
War pension	4
None	5

49. a) Did you have any difficulty applying for the pension or increases in the pension?

Yes
 No

If yes please comment

.....

LOOKING BACK ON YOUR LIFE

How do you rate your achievement in the following?

(circle one of the number from 1 to 5 for each question)

	very low				very high
Work or business	1	2	3	4	5
Social and sporting life	1	2	3	4	5
Community service	1	2	3	4	5
Financially	1	2	3	4	5

What advice would you give to a young man or woman starting out on adult life?

.....
.....

56. What is the most satisfying thing that you have done in your life?

.....
.....

57. Is there anything else you would like to add that would help me understand your life experience?

.....
.....

Thank you for completing this section of the questionnaire

APPENDIX D: BELIEF QUESTIONNAIRE

Below are number of statements on what veterans might think.

Please tick [√] the statement that best reflect your point of view or belief:

- | | | |
|---|---------|--------|
| When I'm with other veterans we only talk about the amusing stories | Yes [] | No [] |
| I would like to be able to talk to someone about my stressful memories | Yes [] | No [] |
| After I was discharged I did not talk much about war | Yes [] | No [] |
| I do not regret that I volunteered in the first place | Yes [] | No [] |
| I would have been a lot healthier if I had not gone to war | Yes [] | No [] |
| Despite the losses I believe on balance my service was worthwhile | Yes [] | No [] |
| There should be more said about the distressing effects of war | Yes [] | No [] |
| In the early days after the war I used to have a lot of bad dreams | Yes [] | No [] |
| I think it is a good idea to talk to your partner about war experiences | Yes [] | No [] |
| War is still a reasonable way to resolve disputes | Yes [] | No [] |
| A supportive partner or family is essential for getting over war | Yes [] | No [] |
| Older veterans do need some support in dealing with memories | Yes [] | No [] |

End of questionnaire
Thank you for your help

APPENDIX E Analysis: Elements in Life Story Summary

1. NAME
2. ID
3. FINOUT Finout
Final outcome of psychological life – Evidence of psychological disturbance over life time
 - 1 Positive no disruption
 - 2 Some intrusion but no serious dysfunction
 - 3 Seriously disturbed – No war – related or Repat diagnosis
 - 4 Serious disturbance – war related or Repat diagnosis
4. LIFEOU Life outcome

Estimation of success made of life in terms of relationships, career, social involvement.

- 1 Failure
 - 2 Moderate success
 - 3 Fairly Successful
 - 4 Very successful
5. LLINTR Late Life Intrusion

Type of war-related intrusion in later years – last five years of life.

- 1.00 Nightmares
 - 2.00 Battle dreams
 - 3.00 Intrusive thoughts
 - 4.00 Intrusion not defined
 - 5.00 Not available
6. CSR Combat Stress Breakdown
Evidence of combat breakdown during New Guinea campaign.
 - 1.00 Breakdown treated medically
 - 2.00 Breakdown or serious disturbance but not treated
 - 3.00 No breakdown
 7. UNIT
Main military unit in which they served identified by number.
 8. AGE at the beginning of 1942
 9. PREWARDED Pre War Education
Level of education before enlistment
 - 1.00 primary
 - 2.00 secondary
 - 3.00 Comp sec
 - 4.00 Trade
 - 5.00 Tertiary

10. CHTRAUM Childhood Trauma/experience

Evidence of some form of childhood trauma such as a parent dying before the child was ten years old, abused physically.

- 1.00 yes
- 2.00 No

11. PREWEMP Pre Ware Employment
Employment type before enlistment.

- 1.00 unskilled
- 2.00 trade
- 3.00 Sales
- 4.00 Clerical/Account
- 5.00 Managerial
- 6.00 Professional

12. OCCUPATION

13. POWEMP Post war employment

- 1.00 Unskilled
- 2.00 Trade
- 3.00 Sales
- 4.00 Clerk/acc
- 5.00 Managerial
- 6.00 Professional

(1) RANK

Rank during early New Guinea campaigns

- 1.00 Commissioned Officer
- 2.00 Non Comm Officer
- 3.00 Ranks

15. ROLE

Role while in New Guinea eg infantry, stretcher bearer, adjutant etc.

16. YRSSER Years of Sevrice
Number of years served in the army

17. ILLNESS Illness

Illness during New guinea campaigns

- 1.00 Very serious
- 2.00 Serious
- 3.00 minor
- 4.00 None

18. WOUNDS Wounds

Severity of wounds sustained in New Guinea.

- 1.00 Very serious
- 2.00 Serious
- 3.00 Minor
- 4.00 None

19. CRITIN Critical events
Report of events during New Guinea. A critical event is some life threatening event in which the subject experiences extreme stress.
1.00 Reports unnerving event
2.00 Several events
3.00 General exposure
4.00 No report
20. PSYCHOU
The psychological impact of service in NG. A major breakdown is a serious dysfunction which prevents him from carrying out his role.
1.00 Breakdown CSR
2.00 Minor breakdown
3.00 Hidden problem
4.00 None
21. MEDINT
Type of medical intervention
1.00 Evacuation/hospital
2.00 Medical intervention/reassign/return
3.00 Non-medical support
4.00 None
22. POWADJ Post War Adjustment
The experience of the adjustment to civilian life.
1.00 Extreme difficulty
2.00 Very difficult
3.00 Difficult
4.00 Little difficulty
23. POWPRO
Primary problem experienced by the veteran during adjustment period. One choice only.
1.00 Nightmares
2.00 War dreams
3.00 Sleep disturbance
4.00 Behavioral disturbance
5.00 Alcohol
6.00 No reported problems
24. PSYOUT Psychological outcome
Psychological history – evidence of diagnosable dysfunction over time
1.00 Serious breakdown - treated
2.00 Serious problems - not treated
3.00 Minor symptoms
4.00 No reported difficulties
25. RELOUT Relationship outcomes
Outcomes of their relationships – all subjects start married.
1.00 Divorced
2.00 Widowed
3.00 Divorced/remarried
4.00 widowed/remarried

- 5.00 Original marriage/strained
 - 6.00 Orig Marriage/Satisfac
26. PENSIO
Department of Veterans' Affairs pension allocation.
- 1.00 TPI/EDA
 - 2.00 100%pension
 - 3.00 Part pension
 - 4.00 Service pension
 - 5.00 None
27. HEALOU
Life health outcome
- 1.00 Serious health problems
 - 2.00 Fairly serious illness
 - 3.00 Minor problems
 - 4.0 Good health
 - 5.0
28. POWPRO
Post war difficulties
29. SEVPR SevPr
Severity of this life problem
- 1.00 Chronic
 - 2.00 Serious
 - 3.00 Moderate
 - 4.00 NA
30. SECPRO
Secondary problem experienced over time
- 1.00 Chronic illness
 - 2.00 Alcohol
 - 3.00 Psych disturbance
 - 4.00 Relationships
 - 5.00 None
31. MORBID Morbid
The morbidity status of veteran at time of writing
- 1.00 Death -suicide
 - 2.00 Premature death
 - 3.00 Death expected
 - 4.00 Stress related death
 - 5.00 Alive
32. AGEDEA
Age at which veteran died.

33. MEMINT
Memory intrusion in late life - 65+.
- 1.00 None
 - 2.00 Little
 - 3.00 Moderate
 - 4.00 Serious
 - 5.00 Chronic

APPENDIX F: The interface of autobiography and the pursuit of knowledge.

There is a personal history weaving in and out of this thesis, and my argument is that the production of the knowledge in whatever form, is part of the personal history of the researcher. The personal pursuit of knowledge and the objective search for understanding inform the other and a thesis becomes part of my personal history and my personal history influences the outcomes of research. The conduct and articulation of the thesis is therefore not an abstract exercise but a part of my personal narrative and contributes to the construction of my own identity. In this lengthy project there have been times when I considered it might lead to a fragmentation or breakdown of my own identity but as the narrative took shape this improved my confidence and sense of place within an academic community.

Timing is critical. McAdams (1988) described the writing of his first major work *Power Intimacy and the Life Story* as coinciding with the revival of the personological approach to studying lives. His thesis is that people make sense of their lives through narrative. In my case a central part of identity is finding a place within the community of scholars and practitioners in the traumatic stress field, in which I initially felt a sense of marginalisation. This sense of marginalisation comes from two sources. The first is the need to be incorporated into the international community, in which the entry ticket is a higher degree. The second is my personal preference for non-reductionist paradigms and a personal discomfort with depersonalised studies, which are two characteristics in the field of traumatology. My orientation was at odds with the majority view within the trauma community that a reductionist, 'hard-data' mode is preferred. At a personal level the thesis is part of unravelling a mystery about mental health. Initially I thought the need to do this may have been to do with the need to understand my father and his war story. As my understanding of WW2 unfolded it became clear that I was seeking understanding of my own reactions to stress and of making sense of the many psychological casualties in my immediate family.

Some biographical detail may help to put the foregoing in perspective. I have been conscious throughout this research of my father having served in WW1. He served as a private in the First World War and therefore experienced one of the most stressful events in the history of Australia. William George Raftery was born in 1894 and died when he was 87 in 1982. He was an ordinary bloke who went away and 'did his bit', did not receive a commission and was issued with service medals when he returned. Men like him made no great fuss and got on with their lives to put those years behind them, and apart from a few who wrote about their experiences, said little about what had happened or how the war had affected them.¹

¹ For example, Bert Bishop (1991) *The Hell, the humour and the heart break. A private's view of World War I*. Kangaroo Press. Kenthurst NSW.

As he said himself, my father was 'no hero'. He waited until he turned 21 before joining the Third Light Horse Brigade on 29 January 1916, knowing that his mother would not have given her permission to go while he was under age. His older brother, Jack, had already enlisted in August 1915. William sailed for Egypt on 2 May 1916 and returned to Australia via Southampton on 12 May 1919. His paybook records 1 199 days of service. He spent time away from the front in London, Scotland, Ireland and parts of France. William and Jack each had 3/- per day deducted and sent to their mother Mary in Tarcowie. Jack and William eventually met up in Egypt. It was army policy that an older brother could 'claim' a younger brother so that they would be in the same unit. Jack had been with the 9th Light Horse but transferred to a trench mortar unit and was sent to France. From there he 'claimed' my father.² They were never united in the same unit. A rebellious Aussie streak in my father resulted in him being sent to the front line sooner than he expected. As he explained later:

I was only in Egypt about four weeks and they were calling for volunteers for France. Brother Jack, who had already been in Egypt five months, volunteered. Muggins Jack, like a lot more of course, thought there would be no war in Egypt. We left there for Salisbury Plains to train for artillery. After about a week I failed to salute an English officer. I had a little felt hat I got in France and was wearing this in camp. He asked me if I was civvy or soldier. Muggins me again said "civvy". He said "I'll make you a soldier" and I was put on the next lot for France. Jack could still have claimed me but as it was tough in France we thought it was better to separate and so I went to a camp in Le Havre and trained as a gunner, 4th Division Artillery.³

Young men like my father and his brother Jack went to France, where the terrible slaughter and war of attrition on the Western Front was continuing. As a gunner, my father contributed to shelling those on the other side of the line which seemed to achieve little politically and strategically. After nearly three and a half years overseas he returned to Australia in 1919 to take up his life in Bullyacre, a small settlement in the mid-north of South Australia, eager to leave behind the memories of Amiens, the Somme, and Ypres ('a real hot spot'). This classic understatement of this tragic piece of our history, when over 45 000 young Australian men died, masks a terrible reality. It also filters the stories emerging from war, making them more palatable to those who did not experience it.

I only knew my father as a kind and gentle man, not someone who would deliberately kill another human being, but he had participated in some of the worst slaughter of this century. I don't know if he ever talked to his mother or father about his experiences when he came home in 1919. The framed photograph of the handsome young soldier of 1916 was always on the wall of our home but we were never subjected to unsolicited tales of his war. Nor did he complain about any

² In the AIF, older brothers could submit an application or claim to have a younger brother transferred into the same unit.

treatment he received. He was more likely to tell stories about the Pommies and their lack of courage, or officers like General Birdwood who were too far above their station for the unpretentious boys from the bush.

In fact over the years, he talked very little to us about his war. We had no unit history on the family shelves and I cannot recall any other veteran coming to visit us to talk about old times. He did not have the words describing the horrible scenes in the trenches as did Siegfried Sassoon after he returned from the same front, nor was there any discussion of the shell shock that has been written about by many authors since.⁴ Towards the end of his life, however, after some prompting, he talked a little about the terrible conditions in France and Belgium in 1917 and 1918, and about coming home to a small farming community in 1919. Pressed little further for some of his life story, he revealed some cameos of his experience of conflict and why he persisted under extreme conditions.

I was in 47 Battery of the 12 Australian Field Artillery Brigade. Our guns were 18 pounders.... We used to get a two page leaflet with any jokes etc and cartoons. One I still remember was the Aussies sitting down bareback picking chats (body lice) from their shirts. It was headed 'A chat by the wayside'. Believe it or not we used to run our nails along the seams of our singlets and kill the lice, turn them inside out for a while and then back again. That's dinkum.

He served on the Somme, and at Arras, Amiens, Villers-Brettoneaux and Armentieres. It was at Armentieres that he was gassed for the first time.

Thought they were dud shells at first. It smelt like pineapple but it was tear gas.

In the artillery he was somewhat removed from the trauma of the trenches but he had one personal encounter with an enemy soldier after a barrage:

In the artillery you fired from 300 to 1 000 yards so you just didn't know what damage [you had done] from where you were. But from communications (and land line when it was working) you found out if you were on or off target. When you moved forward after a hop-over and saw the dead you either said 'poor bugger' or a silent prayer. There was only one (German) that I knew I could have killed who was mortally wounded and begged me by actions to shoot him but I couldn't come at that. Anyhow he soon died.

In the same letter he repeated the sentiment of the commitment to the cause, a major motivator to men in the war effort.

I was no hero. You just did things rather than show the white feather⁵

³ They had stopped off at Marseilles on their way from Port Said to "Blighty".

⁴ The most popularised version of this is in the works of Pat Barker, who focussed on the work of W H Rivers at Craiglockart Military Hospital. The development of the term Shell Shock will be discussed later. Sassoon, who decided he no longer wanted to participate in an inhumane act expressed his revulsion for war many times in his poems.

⁵ Raftery, William George. Recorded conversation and letter October 9 1978. During the war, white feathers were sent to men who did not volunteer and were accused of shirking their duty. My father used it here as a symbol of cowardice. The white feather tradition was continued into the Second War.

My own reading confirmed in more detail his brief references to sights such as men ending their lives with little dignity and no ceremony such as falling off the duck boards into the frozen mud. From his filtered stories we learned that he survived one of the worst winters on record in France and would wake up with icicles on his nostrils after sleeping out with only a greatcoat and a groundsheet. He did not dwell on the fear and horror of being involved in artillery barrages with 18 pounders, nor on such sights as the mutilated bodies which he no doubt had to retrieve as a driver. Like so many other veterans, he died without ever telling the whole story of his war and how it might have influenced his life. He was just another young man who did not want to have the worst of labels of being a coward and did not want to appear to shirk his duty to his country.

After my father died, I was shocked to find out from service records that he had spent a significant period in hospital. A change from gunner to driver occurred in January 1918. It sounded like a demotion and a blow to his self-image that he never really explained. Between October 1917 and January 1918 he spent 103 days in the Australian General Hospital in Le Havre. This may have been one of the shared convalescent hospitals. There may have been a hint in this when he wrote to us with a promise to tell how his role had changed. Unfortunately he was never able to complete this part of his narrative.

Some day I when I feel in the mood [I will tell you] how I changed from gunner to driver [horses] again, and then cook's cart driver - which wasn't as good as it sounds.

Unfortunately the mood never took him and when I discovered the record of his sojourn in hospital it was too late (in 1993 he had been dead for over ten years) to find out what had really happened. Was he suffering from the effects of gas or had he experienced some form of shell shock like so many young men? Was it something else?

My father's narrative also had another side of war that we never explored – his personal life away from the front. He did not talk about this perhaps out of consideration for my mother. As with all soldiers, his service was not always in the stress of battle. Along with thousands of others he took leave, and some of that was outside France. In September 1917, for example, took his leave in the England. It was either then or at the end of 1918 when he was in England after the Armistice had been signed, that he visited Ireland, the birthplace of his mother. But it was in France that something significant must have happened.

After he died, I discovered two letters that had been written by French women, indicating that he'd had contact with French families and may even have been billeted with some. There is also a strong suggestion of intimacy with one of the women. A woman called Blanche wrote to "her dearest friend" while he was awaiting embarkation in England in December 1918, regretting she had not seen him before he had left, hoping he had not forgotten her and saying how good he had been to her and her friends. She thanked him for the little gift he had left and vowed "I shall always be

thinking of you, I can't forget you, you always so good for us and plenty respect", signing off with "Goodbye Little Aussie. Your B xx." Later she had sent him a photograph with a further message of lasting friendship.

A second woman, Parisian Therese de Ferron, was more subdued in April 1920 when replying to a letter William had written from Tarcowie, a small town in South Australia. She would be 'delighted to hear from him again' and 'here we do not forget what you have done'. Her 'poor country was recovering slowly' and she thought that the Allies had not always been just towards France in their interpretation of the peace treaty. This gratitude may have been a less personal expression by someone who had been 'saved' by the foreign soldiers. This gratitude was still evident in residents of Villiers Brettenaux when I visited there in 1992. After the war he never talked about these women nor what they meant to him. This omission may have been as significant a loss to our understanding of him as not talking about his traumatic war experiences. It also raises the issue of the need to know the full war story in order to understand its impact on a person's life.

The effects of his time of extreme hardship were evident in some of his habits, over thirty years later. As children, he would never allow us to waste any food and encouraged a tolerance of hardship. This may also have been a product of having been poor for most of his life. He was very compassionate and I recall the times he would deliver broth to the poorer people in our small town during winter. His compassion had been tested as a young man when he had nursed his father who died slowly and prematurely. As far as I can tell his father had a difficult death and had in his earlier years been brain damaged after being kicked by a horse. Perhaps his time in hospital at Le Havre in 1917, as well as his experience as an ambulance driver, had given him some skills and greater compassion for the sick and wounded. His grand-daughter recalled an occasion when she was very ill as a child when and he sat by her bedside until the crisis had passed. He seemed to know just what to do.

For most of his post war life my father was generally fit and healthy, working full-time well beyond the normal retiring age. But he smoked heavily and in his later years he developed serious emphysema only a short time before he died at the age of 87. His aging body also caused him pain. I remember many mornings towards the end of his life when he moved very painfully after a night disturbed by fibrositis. Perhaps this was the result of sleeping out in that terrible winter of France in 1917. Or was it unresolved traumatic experience or guilt that was stored in the body? He was deaf in later years, more than likely caused by firing 18 pounders in the artillery. He was sometimes irritable but for the most part he was a quiet, honest and physically healthy man. The only professionals he consulted were the local country physician about various ailments later in life, and a hearing specialist for his deafness. He avoided hospital as far as possible and refused to have an operation for a hernia. The only other time he was admitted to hospital was when he broke a leg

in a work accident. He worked as a ganger on the railway and never aspired to wealth nor promotion. If he did have disturbing memories of parts of those war years he kept them well hidden. Most of what he really experienced died with him. The many books and recent documentaries about the Western Front provide a framework for conjecture do not convey the essence of his personal experience.

My father was one of the thousands of men who came home from World War One who never told the whole of their war story nor were encouraged to make sense of that potentially disturbing part of their lives. There was no adequate exploration of the effects of those war years on their lives. Their children, like me, can only make assumptions from a few personal anecdotes or historical accounts which generally do not provide a complete narrative.

A sudden about turn in my own life in 1982 set me on a course of exploration about his experience which is only now becoming clear. My father was ill in hospital when I left a comfortable but rather unchallenging job in education Australia to teach in Papua New Guinea in 1982. I was teaching in Lae on the northern coast, an area where Australian troops had been fighting the Japanese from 1943. I started to make some connection with the war when I read Timothy Hall's *New Guinea 1942-44* and Peter Ryan's *Fear drive my feet* which portrayed images of Australians fighting a very difficult war against the Japanese at places such as Shaggy Ridge. This was not an intentional search for understanding of the war but just part of general reading about the history of a nation, in whose history I had become a participant. The remnants of WW2 were still evident in rusting buildings and the occasional souvenir or unexploded bomb unearthed in the jungle near Lae. With my family I had visited sites like Finschhafen and Rabaul where the signs of the Japanese occupation and fighting were still very visible.

From my current standpoint I can now make more sense of events in my own life that at the time were isolated experiences. One of those events was my father's death in October 1982. On my flight back to Australia to be with him before he died, I fortuitously found a copy of Bert Facey's *A Fortunate Life*. Some of Facey's experiences paralleled those of my father. They were born in the same year, they both served in the Great War and both settled back into rural life in later years. Facey landed on the beach at Gallipoli in 1915 and was eventually repatriated after he was crushed by a shell blast. The interesting feature of his account is that he devoted the same number of pages to his army career of about one year, as to his sixty one years after discharge. Most of his text describes his life of hardship and survival before the war. Gallipoli is described in detail, but if there was any re-experiencing in later life of that sorry landing or the grief he felt about the death of his brother at Gallipoli, or the dead of Shrapnel Gully, he made no mention of it. He did mention the strain of battle which produced 'a lot of nerve cases', but this was not part of his own experience of recovery from injury, getting married, finding work and getting resettled in civilian

life. I believe that my avid reading of Facey at the time prepared me to become intensely involved in the life story as a genre.

When I arrived at my father's bedside he was very weak and was unable to talk to me coherently. He died after a few days of painful lingering. He could no longer tell me of his time on the Western Front or how it affected him. Only when I embarked on this research did I realise the significance of his story.

I returned to Lae shortly after his funeral without really processing my own grief nor talking about my own life with him. I have grieved over time but I have found that this grieving and processing takes years and I have been doing it consciously and subconsciously since 1982. Now I can see that there was a connection between my life experiences and my research into the lives of veterans of World War Two.

The next major event that contributed to my exploration of the effects of war was my decision to leave Papua New Guinea late in 1983. By then my life had been significantly changed. While in Lae I had been ill in a way that I had never experienced before. For example in the first week I contracted Dengue Fever, which was quite debilitating. Dysentery was an almost constant companion. So when I arrived back in my home city in December 1983 I was still recovering from the effects of tropical illnesses and mental strain and had lost weight and fitness. I could not return to my previous employment but eventually obtained a temporary university post that required me to teach adult development. Little of the research at the time had any grounding in Australian lives so I began to inform my teaching through my own research. Because of my own experience of traumatic events, such as a major disastrous flood while we were in Lae, I was interested in how such events might influence the course of a person's life, especially their inner world.

This was a time of rebuilding my life and I needed a project that would somehow bring together the events of my life and help me make sense of the New Guinea experience and also be relevant to my teaching. Exploring the lives of people who had gone through a potentially traumatic time appeared to be the best option. It was too late to focus on WW1 so I decided to explore the lives of men who had experienced New Guinea during war-time. After much searching I discovered a group of veterans whose site of traumatic experience was in New Guinea around 1942. These veterans were ideal informants to give a life perspective on the influence of war. The recreation of the past, particularly their inner experience was not an easy task, especially when working with an aging population. For many participants this was the first time they had been asked to reflect on their lives and many were keen to concentrate on the war years because they assumed that was what I wanted to hear. It was very tempting to be trapped into just listening to these more dramatic and gruesome stories of war and its aftermath. The product was neither a clinical history nor a detailed war story, but a collation of their narratives.

In listening to narratives of war service and trying to piece together my father's story, I was scraping away at a large part of Australian psychological history that had been sealed over. This sealing was not just an individual act. It was part of a larger national act of submerging experiences of violence. This history has generally been closed to wives and children who were not allowed into the inner world of veterans at any time, even in the reminiscence of later years. Within my father's life context there was no space to explore the other interesting part of his life away from the ugliness of the Front Line. In the pots-war lives of Kokoda survivors I found an experience of veteran life my father had never had. He never identified with his unit and never relived his experiences with fellow veterans later in life. He avoided any public display of his 'Digger' status, a symbol of ANZAC courage. He died before being elevated to the hero status, that is now being accorded to the few lone survivors of the remaining WW1 generation.

APPENDIX G: The modern VA psychiatric ward, 1999.

Observations based on an interview with the medical director of the Repatriation General Hospital Psychiatric unit in South Australia, 1 August 1999.

The complex is a 24 bed unit established as a purpose built ward for psychiatric patients. It is in the same location as the WW2 psychiatric rehabilitation unit. The centre is staffed by a senior psychiatrist and 2.5 consultant psychiatrists, three psychiatric registrars, a resident medical officer, a social worker, an occupational therapist and two psychologists. Authority essentially resides with the psychiatrists. The patient body is made up 80% Vietnam veterans who are considered to fulfill the requirements of a diagnosis for PTSD, and report the classic symptoms of flashbacks, nightmares and intrusions. The rhetoric of the Vietnam veteran is very familiar. Vietnam is referred to as a different war where men were exposed to traumatic experience or might have even perpetrated atrocity themselves. When they returned they were spurned and reviled by society and in particular by the WW2 veterans and the RSL.⁶ Their psychiatric diagnosis, almost invariably PTSD, is a medical diagnosis that apparently explains their alcohol abuse, disturbed sleep, nightmares, violence, uncontrolled anger and dysfunctional relationships. Their condition is complicated by co-morbidity and well-established dysfunctional patterns. They are described as chronically disturbed men. The older WW2 and Korean veterans attract different diagnoses of depression, anxiety, and alcohol overuse. These older men are classified as geriatric patients with complex physical and mental problems and are offered drug treatments or ECT rather than psychotherapeutic therapy.

The majority of clients attend as day patients. There is strict segregation between WW2 and Vietnam patients which is established informally by patients but sanctioned by staff. The forms of treatment do not differ significantly from those of the 1940s. Major differences are the use of a variety of specific purpose medications (e.g. anti-depressants) and fewer invasive treatments such as narcolepsy and leukotomy. There are no straightjackets and more sophisticated mental health options are available outside the hospital. The centre-piece of the program is a PTSD treatment group program which primarily consists of exposure therapy. In this patients are invited to articulate their story including traumatic material. Exposure is supplemented by a range of techniques such as anger management and cognitive behaviour therapy. These treatment programs are run by clinical psychologists. The outcomes of the treatment program are evaluated by the National Centre for War Related PTSD which monitors effectiveness with surveys of symptom behaviour at regular intervals. The evidence to date suggests that the outcomes of these programs are similar to those in

the United States VA programs, in that no one is 'cured' but there is a reported lower symptom intensity and improvement in coping skills.

Other interventions include prescribed drug treatment, individual talk therapy, and more invasive interventions such as ECT for severe depression. Full-time day attendees and resident patients require activity, so there is a daily program of largely diversional activity coordinated by an occupational therapist. There are crafts, computer activities (mostly games), recreation such as pool, hobby activity such as working on motorbikes. There is a lot of small group informal chat, which is a feature of the Vietnam veterans' behaviour in the centre. Democratic self-help programs are encouraged and patients take responsibility for meal preparation.

This environment provides a safe place which is free from responsibilities and the pressures of outside life and an opportunity to adopt a sick role. Rehabilitation in the true sense of restoring to previous function is not a goal, as there are no vocationally oriented programs and there is an in-built imperative to only improve enough to function in the outside life, and not lose any pension entitlement. This is the most obvious structural impediment to recovery, and implies a vested interest in remaining ill. In former times this may have been referred to as compensation neurosis. Suicide is not a feature of the modern Ward 17.

It is difficult to pinpoint the underlying paradigm informing the work here. PTSD as defined by the DSM-IV is the prevailing diagnosis. There is no clearly articulated professional development program. When staff begin their work here they have to learn that Vietnam veterans are volatile and have to be treated carefully. Training is informed to some extent by the ideas and programs in place at the National Centre for War Related PTSD, which in turn resemble those in the United States National Center for PTSD. I have a sense of the RGH centre being caught up in a much broader political enterprise to maintain the Vietnam War ethos, which is conveyed as a dirty unpopular war which permanently damaged those who participated. What is not clear is whether trauma of war is an explanation or a cause of their dysfunction.

⁶ There has never been a thorough documentation of this view of the Vietnam veteran. A recent study of the American experience by Lembcke (1998), suggests that the image of the universally reviled veteran is a constructed myth.

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