

**The Australian experience of psychological casualties in war
1915 - 1939**

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Shell shock. How many a brief bombardment had its long-delayed after-effect in the minds of those survivors, many of whom had looked at their companions and laughed while inferno did its best to destroy them. Not then was their evil hour; but now; now, in the sweating suffocation of nightmare, in paralysis of limbs, in the stammering of dislocated speech. Worst of all in the disintegration of those qualities through which they had been so gallant and selfless and uncomplaining - this, in the finer types of men, was the unspeakable tragedy of shell-shock. . . . In the name of civilisation these soldiers had been martyred, and it remained for civilisation to prove that their martyrdom was not a dirty swindle.

From P. Fussell (ed.), *Siegfried Sassoon's Long Journey: Selections from the Sherston Memoirs*. (Oxford University Press, New York 1983), p. xiv.

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Abbreviations

AA	Australian Archives
AAG	Assistant Adjutant General
AAH	Australian Auxiliary Hospital
AAMC	Australian Army Medical Corps
ACCS	Australian Casualty Clearing Station
ADMS	Assistant Director of Medical Services
AFC	Australian Flying Corps
AGH	Australian General Hospital
AIF	Australian Imperial Force
ASH	Australian Stationary Hospital
AWM	Australian War Memorial
BEF	British Expeditionary Force
BMA	British Medical Association
CA	Commonwealth Archives
CCS	Casualty Clearing Station
CSB	Close Settlement Board
DADMS	Deputy Assistant Director of Medical Services
DAH	Disordered Action of the Heart
DC	Deputy Commissioner (Department of Repatriation)
DDMS	Deputy Director of Medical Services
DMO	Departmental Medical Officer
DRL	Donated Records List (AWM)
DRS	Divisional Rest Station
FA	Field Ambulance
LMO	Local Medical Officer
MJA	Medical Journal of Australia
MO	Medical Officer
NYDN	Not Yet Diagnosed, Nervous
OC	Officer Commanding
OIC	Officer in Charge
PB	Permanent Base
PCF	Personal Case Files
PMO	Principal Medical Officer
POW	Prisoner of War
PR	Private Records (AWM)
PUO	Pyrexia of Uncertain Origin
RAMC	Royal Army Medical Corps
RFC	Royal Flying Corps
RGHC	Repatriation General Hospital (Caulfield)
RMO	Regimental Medical Officer
RSSILA	Returned Soldiers and Sailors Imperial League of Australia
TB	Temporary Base
VPRO	Victorian Public Record Office
VPRS	Victorian Public Record Series

Introduction

Throughout history, psychological disorder has been a part of military experience. From at least the middle of the seventeenth century to the early 1900s, signs of mental disturbance in troops deeply troubled by their experiences have been recorded by observers.¹ But it was not until the First World War with its mass, conscript armies and immense destructive power that psychological disorder made a widespread military, medical and social impact. Because the numbers of such casualties - conservatively put at 80, 000 in the British Army by the time of the armistice² - posed a threat to military efficiency and, putatively, to discipline and morale, army authorities were eventually forced reluctantly to acknowledge the problem and take appropriate measures. The influence of psychological disorder transcended strictly military issues, however. It provoked medical debates which contributed to a re-casting of notions of sanity and insanity so that the middle ground - neurosis - was given greater recognition in such formulations. Psychotherapy - for so long on the fringe of psychiatry - gained greater acceptance because of its employment by the military during the war. The psychological disorders of soldiers also made a social impact - unemployment, poverty, demoralisation, alcoholism, divorce, violence - which was felt for decades after the last shot was fired.

Officially, 4984 members of the First AIF from all fronts were discharged from the service because of war-related psychological trauma.³ Probably, however, the true number will never be known as medics did not always recognise the symptoms so that many psychological casualties did not enter the historical record. Probably, too, many others did not approach authorities at all and so they will forever remain anonymous. More importantly, vital statistical evidence has been destroyed.⁴ Thus, any semblance of numerical precision will have to wait until the thousands of extant Repatriation Department Personal Case Files are analysed for this purpose.⁵

Based on 104 of these files and a wide range of further primary material, this dissertation explores the Australian experience of shell shock from 1915 until 1939. Apart from the 104 individuals whose plights are so thoroughly documented in the

¹ C. Feudtner, "'Minds the dead have ravished'": Shell Shock, History, and the Ecology of Disease Systems", in *History of Science, Volume 31, No. 94, Part Four* (Science History Publications Ltd., December 1993), p.1.

² Ibid.

³ A.G. Butler, *The Australian Army Medical Services in the War of 1914-1918. Volume III, Problems and Services* (Australian War Memorial, Canberra 1943), Table 57, p. 942.

⁴ Ibid, p. 928.

⁵ CA 879 (Deputy Commissioner for Repatriation, Victoria 1920-1976), B73.

Personal Case Files, this thesis also encompasses the experiences of another 264 Australian servicemen who either commented on or were victims of shell shock.⁶

Before outlining the concerns of this thesis, the sizes of the two major evidence samples and their overall numerical context must be explained in order to establish the limitations of the generalisations made herein. Firstly, the Personal Case Files. These were confined to the relatively small number of 104 partly because of logistical problems: the process of locating, extracting and transporting the documents from relatively remote suburban repositories to the centre of Melbourne where they could be read was particularly time-consuming. Very often, too, the files were several inches thick and consisted of two folders: an 'R' file and an 'M' file. The 'R' (Repatriation) file dealt with all matters in a soldier's relationship with the Department: pensioning, employment, complaints, applications and so on; while the 'M' (Medical) file was restricted to diagnosis and treatment. But before these difficulties could be overcome some method had to be found to discover which of the thousands of files dealt with cases of shell-shock. Unfortunately, these documents are not arranged according to soldiers' ailments, nor are they alphabetically ordered; they are, in fact, catalogued according to old Repatriation Department numbers issued to returned servicemen when their files were begun.

Thus it was necessary firstly to identify men afflicted with nervous disorders then to unearth their Departmental numbers which, it transpired, were available on a vast, alphabetically ordered microfilm list at the Department of Veterans' Affairs office

⁶ This group includes 77 diarists and letter writers whose offerings are housed in the Australian War Memorial Research Centre, Canberra, the La Trobe Library, Melbourne and the Mitchell Library, Sydney. It also includes 187 invalids whose cases are recorded in a wide range of documentation which, at a glance, gives broad hints as to their fates. These include 49 men whose cases are discussed in some detail in "History of War Neurosis Treated at Monte Video Camp Hospital, Weymouth, 1919" (AWM 25, 885/4); 47 men whose names appear on Army Form W3436 (AWM 23, Boxes 91-95); 21 ex-servicemen some of whose dealings with the Department of Repatriation are discussed in the minutes of the Medical Advisory Committee (Department of Veterans' Affairs, Library, Canberra); 11 cases of shell shock from Lone Pine who appear in "Copy of Casualty Return Form Submitted to 1st Inf Bde A.I.F. on 10/8/1915 for period - 6th to 9th August 1915 inclusive" and "Copy of Casualty Return submitted to 1st Infantry Brigade A.I.F. on 11/8/1915 for period of 48 hours preceding 5.30 pm on 11th August", " in the papers of Lieutenant L.H. Montague (AWM 3DRL/4037); 10 individuals in the papers of Dr. John Springthorpe (AWM 2DRL 701, AWM 41 and AWM 11); 10 shell - shocked officers from the Western Front whose symptoms and their causes, and disposal , appear on Army Form A45 "Proceedings of a Medical Board" (AWM 23, Boxes A12 and A13); 9 shell - shocked officers from Gallipoli whose names and details appear in the following records of No.2 Australian General Hospital, Cairo: "Weekly Reports on Patients shown on the Dangerously Ill List 16 July 1915" and "Weekly Reports on Sick Officers 22 March 1915 - 3 March 1916 (AWM 224, MSS 380); and five men whose cases are briefly discussed on Army Form B179 "Medical Report on an Invalid" (AWM 27, 370/25, Pt. 2). The list of 264 also includes five soldiers associated with five secondary sources and 20 sundry individuals who appear in the following primary material: "Progress Report from the Senate Select Committee on Intoxicating Liquor - Effects on Australian Soldiers. CPP 1917-1919, Vol. 1"; Report on soldier alcoholics (AA A 2487/1, 1921/13264); *Repatriation* , 26 June 1920, p. 18; Repatriation Commission correspondence on the difficulties of pensioning soldier invalids (AA A2421/T1, G1142); Repatriation Commission Correspondence on the likelihood of recovery from serious mental illness (Ibid) W.A. Osborne, "Shell Shock and War Strain" (AWM 27, 376/216); Department of Repatriation Annual Report 1924, p. 5; Report to the Chairman of the Victorian State War Council on soldiers granted assistance, 1917-1918 (AA 2479/1, Item 17/1546); Transcript of Resolutions adopted at a Conference of Medical Officers on the Treatment of Neurasthenic Cases (AWM 41 [290]).

in Melbourne. Because of the multiplicity of the same surnames and initials on this list, service and unit numbers were to be crucial in this identification process.

A major breakthrough was the discovery of the admission records for the Repatriation General Hospital, Caulfield during some routine searching in AWM 27. These contained surname, initials, rank, battalion, service number, ailment and date of admission for the years 1925-1936 inclusive.⁷ With this vital information it was thus possible to approach DVA's microfilm catalogue. Not all names from the admission records were present on the microfilm, however; nor, when individuals and their Departmental numbers were located here, were their files always traceable: staff at the suburban repositories were forced to rely on old card catalogues which were sometimes incomplete. For example, one order for 72 files contained 20 that were unlocatable by DVA archives staff. In this circuitous and laborious way, then, 250 Personal Case Files relating to shell shock were identified, retrieved and delivered. Of this number, 104 were used. All were cases of clear-cut mental disorder directly attributable to war experience. Such doubt and confusion surrounded the aetiology of the remainder (mostly cases of apparent psychosomatic disorder) that it seemed prudent to disregard them.

The second major evidential sample was the diaries and letters of combatants. When this dissertation was originally researched in 1993-1994, there was one entry under the heading "shell shock" in the Australian War Memorial Research Centre's personal records data base. This citation was for the diary of Corporal Leslie Blaydes who was evacuated from the Western Front with a serious nervous disorder in May 1918.⁸ Currently there are five such entries in this data base. Without any direct indexing, finding references to shell shock in personal diaries and letters therefore became a matter of trawling in likely areas: the writings of men in AAMC units, for example, and those involved in major engagements such as Pozieres. Occasionally, valuable finds were serendipitous. For example, during the early months of 1993, extracts from the personal writings of Lieutenant John Bourke,⁹ Captain Frank Hurley,¹⁰ and Lieutenant G.L. Makin¹¹ were on display in the War Memorial museum as artifacts; each one contained a reference to shell shock. Sometimes, primary quotations about nervous disorder in secondary sources, such as David Horner's *The Gunners*, were tracked to their sources. In this manner, revealing contexts were occasionally discovered: the comments, for example, of Captain Stanley Fox about a spectacular nervous breakdown at Mouquet Farm in 1916 were found to be part of a

⁷ No. 11 Repatriation General Hospital AGH Caulfield, Victoria. Sheets recording admission information. Parts 1-8. AWM 27, 371/73.

⁸ Corporal L. Blaydes, 24 Company, Australian Army Service Corps, Diary. AWM 3DRL/7524.

⁹ Lieutenant J. Bourke, 8th Battalion, Letter, August 1916 (no day). AWM 1DRL/0139.

¹⁰ Captain F. Hurley, Diary, 12 October 1917. AWM PR 291.

¹¹ Lieutenant G.L. Makin, 5th Battalion, Letter, 31 October 1915. AWM 1DRL/O473.

much fuller description of an incident highly germane to this thesis.¹² Invariably, however, assembling a suitable number of such sources in a reasonable time involved the simple and arduous technique of scanning likely material for discussions of "shell shock" or "nerves" or "nervous breakdown". Using the above methods, the writings of over 200 men were perused but only about one third of these - 77 - contained references to nervous disorder.

What is the overall numerical context for the 291 invalids whose experiences form the basis of much of this dissertation? Determining exactly how many Australian soldiers were rendered unfit for duty or made invalids by psychological wounding is exceedingly difficult because of the nature of the available statistics. Tables in the official medical history, for example, contain two kinds of figures. In some cases they show "the number of *woundings* or of 'sickness' and injury, not of wounded, sick or injured men . . ." because, as the official medical historian has remarked, "[i]t was common for men to be wounded or sick on several occasions."¹³ Other figures attempt to show with the best possible accuracy the actual numbers of individual soldiers. Thus, in the case of psychological casualties, there were 1508 admissions for the Mediterranean theatre in general (including troops stationed in Egypt throughout 1915) but these do not represent the number of individuals. Therefore it is not known exactly how many Australians became psychological casualties at Gallipoli.¹⁴ Western Front statistics are more complicated but similarly problematic. Thus, 9996 *cases* of psychological disorder were admitted to AAMC Field Ambulances during the AIF's service in France and Belgium while 7808 admissions were made to Expeditionary Base Hospitals for further treatment well behind the lines. As with the Gallipoli statistics these numbers include multiple admissions. By contrast, 3038 *individuals* with psychological disorder were sent to hospitals in the United Kingdom. Eventually, 4984 men from *all fronts* were returned to Australia unfit for military service because of mental problems attributed to war service.¹⁵ The total number discharged unfit in Australia from all causes was 113, 370.¹⁶

Some Repatriation Department figures deal with individuals rather than admissions so that it is possible to gain a clearer idea of the number of men suffering mental trauma in Australia after the war. During the post-war years the number of ex-servicemen seeking treatment from the Department of Repatriation for psychological problems steadily rose. In 1926, for example, it was 2922 (out of a total of 72, 128 returned soldiers under Departmental care)¹⁷ while in 1934 it was 3465 (out of 75,

¹² D. Horner, *The Gunners: A History of Australian Artillery* (Allen and Unwin, St. Leonards 1995), p. 133.

¹³ Butler, *op. cit.*, pp. 894.

¹⁴ *Ibid.*, pp. 88-89.

¹⁵ *Ibid.*, Table 57, p. 942.

¹⁶ *Ibid.*, p. 883.

¹⁷ Annual Report of the Department of Repatriation 1926, p. 47.

037).¹⁸ These figures, however, probably do not show the entire complement of former Australian soldiers suffering mental trouble in the 1920s and beyond as not every man sought treatment from the Department.

Despite the difficulties associated with these statistics they do help to contextualise the samples that form the basis of this dissertation and to establish the limitations of all generalisations based on these. Although these samples are relatively small, the experiences of the men concerned - and their remarkable consistency - remain valid.

This thesis encompasses the impact of war-induced psychological disorder on soldiers at the front and in the hospital and rehabilitative systems both during and after the war. It also assesses the effect of this problem on the social functioning of returned-soldiers during the 1920s and 1930s as well as its influence on Australian psychiatry during this period. It concludes that psychological disorder was one of the war's least obvious but most devastating consequences. Very little evidence of psychological disorder amongst the Light Horse in Palestine has been discovered so the discussion in this dissertation has been confined almost exclusively to Gallipoli and the Western Front for which primary material on shell shock is relatively abundant.¹⁹ The date range of the thesis represents the period from the sustaining of the first psychological casualties at Gallipoli to the beginning of the next war. By this time many psychological casualties from the first great conflagration had still not been cured.

Theoretical perspectives

The broad philosophical foundation of this dissertation is a presumption that individual experience is a proper and significant focus for historical investigation because of its ability to bring fuller understanding to very complex events that are sometimes oversimplified by historians. The chief inspiration for this conviction is the scholarship of three pioneers in military social history: Bill Gammage, John Keegan, and Denis Winter²⁰ whose work in the mid-1970s highlighted the intricacy of human experience during the First World War. Keegan's seminal work, *The Face of Battle*, demonstrated the inadequacy of conventional paradigms in military history, especially the tendency to reduce very unpleasant, highly involved experiences to clinical generalisations. Denis Winter's monumental *Death's Men* concentrated on how British soldiers responded to the vicissitudes of daily life on the Western Front during the Great War. Of particular

¹⁸ Annual Report of the Department of Repatriation 1934, p. 23.

¹⁹ Only one case of psychological disorder from the desert campaign was found amongst the 250 Repatriation Department Personal Case Files examined. Trooper Albert Regis of the 3rd Light Horse suffered chronic psychological problems as a result of his service in the Jordan Valley in 1918.

²⁰ W. Gammage, *The Broken Years. Australian Soldiers in The Great War* (Australian National University Press 1974); J. Keegan, *The Face of Battle* (Jonathan Cape, London 1976); D. Winter, *Death's Men: Soldiers of the Great War* (Allen Lane, London 1978.)

relevance was Winter's lyrical discussion of war neurosis amongst the Tommies and their officers together with his demonstration of how this subject could be explored by using servicemen's diaries and letters in conjunction with medical evidence. Winter's approach was a major inspiration for this dissertation. So too was Bill Gammage's *The Broken Years*. This book, a wide ranging study which, through their letters and diaries, traces the changing attitudes of Australian servicemen as they struggled to come to terms with the awfulness of modern warfare, has become the touchstone for any work on Australian individual experience during the First World War. In short, these historians have given military history a new perspective: the view from the bottom up, not as it had been until their advent, from the top down.

Following the lead of these writers, the emphasis in this dissertation will be on the experiences of over 300 Australian servicemen (most of whom were psychological casualties) during the Great War and within four larger structures: the army, the medical evacuation systems of the Mediterranean and European theatres of war; the Australian Repatriation Department and its predecessors, and Australian civil society.

The second major theoretical underpinning of this thesis is the notion that, in one sense, shell shock was socially constructed; in other words, that the experience of it (including how it was conceptualised and managed) was conditioned by social values. In this dissertation the terms "war neurosis" and "shell shock" are employed as useful, generic, contemporary designations for actual psychological symptoms and disorders. However the extent to which such conceptions (and other reactions to the psychological maladies of soldiers) were moulded by interactive processes between the disordered minds of soldiers and the values of various social groupings is also acknowledged and incorporated. This view owes much to historians Martin Stone²¹ and Chris Feudtner²² whose work on the British experience is outlined below.

"War neurosis" was a term formulated by Freud to describe the neuroses he observed in soldiers during the war.²³ It encompassed the full range of recognised clinical syndromes and was widely used by the medical professions and medical corps of many nations. In Britain, however, it did not enjoy the popularity of "shell shock". First coined in 1915 by the English psychologist Charles S. Myers, the term "shell shock" was designed to express what seemed most obvious about the mental disorders that he had seen in British soldiers on the Western Front: namely, that these difficulties had been caused by the war's immense destructive power. Myers suggested that the underlying causes were psychological. However, the term (possibly because it was loose and contained mechanistic overtones) was also appropriated by doctors who

²¹ M. Stone, "Shellshock and the psychologists", in W.F. Bynum, R. Porter, and M. Shepherd, *The Anatomy of Madness: Essays in the History of Psychiatry* (Tavistock Publications, London 1985).

²² C. Feudtner, *op. cit.*.

²³ D. Pick, *War Machine. The Rationalisation of Slaughter in the Modern Age* (Yale University Press, New Haven and London 1993), pp. 249, 252.

stressed that damage to the structure of the spinal chord and the brain were the chief causes. Although the psychological approach proved to be far more astute, the organic model was by no means abandoned by many of its adherents.²⁴

But shell shock had connotations that transcended diagnostic debates. Like the antagonistic medical theories mentioned above, these other meanings also reflected interpretations placed by various groups upon the psychological disorders of soldiers and the label "shell shock". The military regarded the term as a danger to discipline because it elevated fear and mental breakdown to the level of a dignified war disease and thus provided a legitimate excuse for men to leave the trenches and seek medical aid.²⁵ Thus British military authorities banned its use and coined their own versions of it: "shell shock 'w'" (wound) and "shell shock 's'" (sick). These terms reflected military suspicion of any man presenting for shell shock who had not been near a shell burst and their mistrust of psychological explanations. Those who had been near an explosion were given a wound stripe; those who had not were investigated with a view to a possible court martial on the grounds of malingering. Thus, these modified terms were used mainly in a disciplinary and administrative setting.²⁶

But the war did force the military "operationally at least" to alter its stance.²⁷ After the battle of the Somme, which produced a flood of mental casualties, the army grudgingly recognised the efficacy of psychotherapy and instituted special centres for prompt treatment several miles behind the lines. Although relatively enlightened psychotherapists were placed in charge, these centres represented a compromise in which investigation and disciplinary action for malingering were part of the regime. Here, two views of human accountability existed in the one location in an uneasy accommodation. One blamed the sufferer, the other placed responsibility on the unconscious mind. This situation represented the way in which developments had forced the military to accept a different view of human responsibility without totally abandoning its position.²⁸

Even though the progressive view of psychological disorder which saved many soldiers from disciplinary action is considered humane, it could, on occasions, also contain a strong moral dimension derived from prevailing bourgeois values. This morality included particular views on masculine identity, the legitimacy of the war, and the need for national efficiency. Thus a man's inner psychological battle might be presented to him as a failure to adapt to the requirements of national survival or inadequacy as a man. For these doctors, shell shock was a psychological disorder but

²⁴ Feudtner, *op. cit.*, pp.384-385.

²⁵ *Ibid*, p. 384, and Stone, *op. cit.*, p.249.

²⁶ Feudtner, *ibid*, and Stone, *ibid*, p.258.

²⁷ Feudtner, *ibid*, p.397.

²⁸ *Ibid*, pp.397-398.

it also represented an inability to adapt. The individual, therefore, was held at least partly responsible and treated accordingly: psychotherapy was aimed at convincing him of his downfall and of his responsibilities. The war itself was not criticised but the values associated with it had thus shaped a view of shell shock and determined its management.²⁹

These interpretations differed from battlefield realities. For soldiers, shell shock was a convenient expression of the terror and psychological dislocation caused by their experiences. However, a certain conception of shell shock also allowed the psychological casualty to maintain a semblance of dignity because the stigma of insanity was not implied in its meaning.³⁰ This relatively benign diagnosis was also a relief for civilians whose relations had been invalidated after a breakdown. For civilian society, shell shock also became something of an heroic new disorder which reflected a man's bravery as much as a wound.³¹

Thus, for medicine, civilians, soldiers and military authorities, psychological disorder and its most popular label, "shell shock", had different meanings. According to Feudtner and Stone these various interpretations resulted from developments in British society that impinged on the symptoms. For example, the medical debate reflected pre-war opposition between psychological theories of mental illness and those that emphasised organic causation, and individual culpability through inheritance and wilfulness.³²

These opposed approaches rested on differing opinions of human responsibility: the psychological view located the cause in the unconscious mind, thus relieving the individual of a certain degree of accountability. The physicalist position advocated the opposite view. Both were employed during the war. The kind of treatment a soldier received depended, therefore, on which hospital he entered.

According to Feudtner, the existence and development of the psychological approach and the shift towards it during the war reflected two trends. The first of these was the rise of the liberal state with its tendency to locate accountability in social conditions and the environment rather than blame the individual for his plight.³³ The second was the reluctance of some doctors to apply traditional paradigms of insanity (with their associated stigma) to patriotic soldiers.³⁴

The social construction of shell shock as presented above has identified certain processes and outcomes of crucial relevance to the Australian experience of

²⁹ Feudtner, *op. cit.*, pp.399-404.

³⁰ *Ibid.*, p.403.

³¹ *Ibid.*, p.399.

³² *Ibid.*, pp. 386-391, and T. Bogacz, "War Neurosis and Cultural Change in England, 1914-22: The Work of the War Office Committee of Enquiry into 'Shell-Shock'", in *Journal of Contemporary History* (SAGE, London, Newbury Park and New Delhi), Volume 24 (1989), pp.229-232.

³³ Feudtner, *op. cit.*, pp.393-5.

³⁴ *Ibid.*, p.392.

psychological disorder in the First World War. All groups associated with shell shock in Australian soldiers - the men themselves, the military hierarchy, doctors, politicians, bureaucrats, family members and work mates - ascribed it values. Thus, as they had in Britain, questions of human responsibility, of patriotism, of national efficacy and loyalty, of masculinity, and of military discipline all influenced how it was perceived and managed. How these questions influenced the experience of shell shock will be outlined in this introduction and fully explained in main body of the dissertation. But, amongst all of this, Chris Feudtner's summation must be remembered. He writes:

When shell shock is set in a larger context - of an epidemic that threatened military manpower and order, disrupted efficiency, and violated general masculine ideals - it must still be seen as a condition that devastated men's lives. It caused great suffering.³⁵

Historiography

In this introduction it will be argued that, although the situation is changing,³⁶ the historiography of Australian participation in the Great War does not include psychological disorder amongst soldiers as one of its principal themes. This differs markedly from the Vietnam War, which has become synonymous with psychological trauma³⁷ and the re-adjustment problems of veterans. The post-war difficulties of Great War psychological casualties bear a very strong resemblance to those of half a century later, however, and deserve equal recognition.

A few Australian historians have touched on shell shock but the existing literature contains important inaccuracies and omissions. This introduction will examine the central questions posed by the historiography and provide answers suggested by some rich primary material located *inter alia* in the Australian Archives (Canberra and Melbourne), the Australian War Memorial Research Centre and the Department of Veterans Affairs Library, Central Office, Canberra.

It will be contended here that there are eight major areas of the Australian experience of war neurosis between 1915 and 1939 which can be more fully illuminated as a result of this research: the experiences of soldiers at the front; their experiences in the evacuation and hospitalisation organisations overseas; the nature of the disorders from which they suffered; their experiences with the Department of Repatriation's predecessors; the attitude of the Department of Repatriation to war neurosis; how that attitude affected the Department's treatment of psychological

³⁵ Feudtner, *op. cit.*, p.405.

³⁶ See, for example A. Thomson, *Anzac Memories. Living with Legend* (Oxford University Press, Melbourne 1994).

³⁷ See, for example, S. Rintoul, *Ashes of Vietnam. Australian Voices* (William Heinemann Australia, Richmond 1987), p.xi.

casualties; the personal and social dislocation caused by war neurosis in post-war Australia; and the effect of the war on Australian psychiatrists and psychiatry. The dissertation's eight chapters conform sequentially to these areas.

1. *The battlefield experience of shell shock*

Psychological disorder amongst soldiers is hardly discussed in studies of Australia's military role in the First World War, although the practice is becoming more common. When raised, it is generally mentioned only in connection with operations at Pozières in July to September 1916. This tendency has led to some misconceptions. Although it is possibly true that the high incidence of emotional breakdown amongst Australian soldiers during this protracted engagement was an experience unequalled in first AIF history, such episodic treatment of the phenomenon creates the false impression that, for the diggers, severe mental trauma was largely confined to this one outstanding period. It seems that this view has passed into lore. This is not surprising, however, given that the idea received its heaviest - and probably initial - impetus from C.E.W. Bean, the most influential historian of Australian military participation in the Great War. In volume three of the massive and extraordinarily detailed twelve volume official history, Bean describes the emotional consequences of colossal bombardments directed onto Australian units which had captured important German positions at Pozières during the second phase of the Battle of the Somme.³⁸ Possibly because this was the Australians' first experience of such heavy shellfire and widespread psychological breakdown, and possibly because the cause and the effect were so spectacular, mental casualties received attention from Bean that was not repeated elsewhere else in the official history. Bean's treatment of the experience has created two vital misconceptions: firstly, that shell fire alone was responsible for psychological breakdown, and, secondly, that for the remainder of the war, the AIF was relatively untroubled by the problem. Neither of these propositions withstand close scrutiny.

Responsible for radically different interpretations of Australia's role in the war are more recent social histories intent on revising Bean's version of events. This trend began in 1965 with K.S. Inglis' "The Anzac Tradition".³⁹ Since then, many historians have engaged in a lively discourse about Australian participation in the First World War but few have discussed shell shock. Individual experience is an area of major interest in many of these recent histories of Australia and the Great War - as it was with Bean - but rarely is personal perspective of war neurosis canvassed. E.M. Andrews acknowledges the role of psychological trauma in the general experience of

³⁸ C.E.W. Bean, *The Official History of Australia in The War of 1914-1918*, Volume III, (First published 1929; this edition: University of Queensland Press, St. Lucia 1982), pp. 597, 724, 660.

³⁹ K.S. Inglis, "The Anzac Tradition", *Meanjin Quarterly*, No. 1, 1965, p. 44.

Australian troops without exploring the issue.⁴⁰ In *Pozières: Australians on the Somme* Peter Charlton provides individual viewpoints on shell shock but tends to rely on Bean and his sources, particularly aspects of the letters of Lieutenant R.G. Raws.⁴¹

As with all of these works the presence or absence of detailed explorations of the battlefield experience of shell shock is largely a question of focus. And so it is with *The Broken Years*. This book concentrates on an entire ordeal rather than on any single aspect of it and so shell shock is just one of many subjects considered. In the discussion of Gallipoli, "frayed nerves" are mentioned fleetingly,⁴² while elsewhere, shell shock is cited in connection with Fromelles⁴³ and, later, with the Third Division's introduction to the line early in 1917.⁴⁴ However, the five quotations on this subject are more lurid and disturbing than anything provided by Bean and strongly imply the seriousness of the issue.

In general, however, the brief references to the psychological disorders of Australian soldiers in most of these recent histories tend to reinforce the notion created by the official historian that mental stress and breakdown was not of great consequence and always manifested itself in highly dramatic guise. Such ideas cannot be sustained against an accumulating weight of evidence that allows investigation of major questions about personal experience of shell shock: How did mental disorder manifest itself on the battlefield? What was the reaction to shell shock of Australian soldiers at the front? Did they have opinions about it, and if so, what were they? Did they understand what was happening to themselves or their colleagues? What were the perceived causes? How did some men endure the strains that broke others? Answers to these questions will provide a deeper understanding of shell shock as experienced by Australian soldiers at Gallipoli and on the Western Front.

2. *The Experience of Evacuation and Hospitalisation Overseas*

The touchstone for any historical work on the medical care of Australian war neurosis patients is the *Official History of the Australian Army Medical Services 1914-1918, Volume III, Problems and Services*⁴⁵ by Arthur Graham Butler. This is a provocative work that straddles the Australian domestic sphere during and after the war as well as encompassing the medical aspects of the military conflict itself. Published in 1943,

⁴⁰ E.M. Andrews, *The Anzac Illusion: Anglo-Australian Relations during World War I* (Cambridge University Press, 1993), p.105.

⁴¹ P. Charlton, *Pozières: Australians on the Somme* (Leo Cooper in association with Secker and Warburg, Sydney 1986), pp. 62-63.

⁴² Gammage, op. cit., p.65.

⁴³ Ibid, pp.158,161,166.

⁴⁴ Ibid, p.186.

⁴⁵ A.G. Butler, *Official History of the Australian Army Medical Services 1914-18, Volume III, Problems and Services* (Australian War Memorial, Canberra 1943).

Butler's findings on the diggers' psychological problems are undoubtedly the most extensive secondary work on the subject but there is considerable room for further investigation. In particular, important aspects of personal experience can be more deeply explored.

The official medical history is not expansive about mental disorder on Gallipoli. In particular, personal experience and the manner in which medical authorities on the Peninsula coped are not represented, but with a range of fresh evidence, more light can be shone into these dark corners. Butler's work raises the following questions: what facilities, if any, did military authorities on Gallipoli provide for psychological casualties? What arrangements were made at the base hospitals in Egypt? How did Australian psychological casualties fare in these medical systems?

Butler's descriptions of the general arrangements for shell shock victims on the Western Front and his analysis of their shortcomings are similar to those found in the British official medical history.⁴⁶ Attention to the specific activities and experiences of individual Australians, however, is confined to the work of two medical units at Pozières and the experience of a few soldiers who exemplified the way Butler believed men should conduct themselves under fire.⁴⁷

Little is learned about the fate of Australian war neurosis sufferers within the British Army evacuation chain on the Western Front or, indeed, in England. Primary evidence suggests, however, a complexity of experience, knowledge of which would add substantially to the understanding of this aspect of AIF history. A great deal more, for example, can be learned about the experiences of Australians in the special system for psychological casualties developed by the British Army on the Western Front. In fact, examination of primary evidence described in detail below can add much to Butler's generalised description of this system.

Butler does not reveal a great deal about the experience of Australian psychological casualties in England. Although he cites the controversial "six months policy" as being responsible for the denial of specialist treatment to Australians in the best British hospitals,⁴⁸ exactly how it affected sufferers of war neurosis is not explained. In addition - and unfortunately for his reputation - the fine work of Dr. John Springthorpe in his neurosis clinic at No. 3 Australian Auxiliary Hospital, Dartford, is dismissed by Butler.⁴⁹ Springthorpe's energetic and compassionate commitment to the welfare of Australian shell shock patients has been ignored by history and correction of this oversight is possible and long overdue.

⁴⁶ Butler, *op. cit.*, pp. 112-113, 121-123 and W.G. Macpherson, *Medical Services. Diseases of the War* (His Majesty's Stationery Office 1923), pp.1-67.

⁴⁷ Butler, *Ibid.*, pp.105-106.

⁴⁸ *Ibid.*, pp. 630-631.

⁴⁹ *Ibid.*, pp. 133, 134.

3. Psychological disorders affecting Australians: Medical Explanations

The major secondary work on this subject - the disorders from which Australian psychological casualties were suffering as described and explained by doctors - is, once again, volume III, of the official medical history. Probably the most outstanding feature of Butler's work on this issue is its ambiguity. On the one hand it is able to present a value-free analysis of the environmental stresses that caused mental problems but in the next sentence - and elsewhere - assert that breakdown was a matter of character - a moral problem.⁵⁰ A soldier could either embrace the "spirit of courage, faith and self-confidence" or choose "defeat and dependence", a mentality that led to chronic neurosis - the "'broad and easy' way leading to moral and mental destruction."⁵¹ Butler also maintained that the neuroses of war were the same as those found in peace time except, principally, for the "obvious content of 'advantage' in the great majority." ⁵² In other words, he felt that most psychological casualties saw neurosis as a way of escaping duty and of gaining a pension.

This approach tends to counter-balance the effect of Butler's limited but relatively progressive discussions of specific disorders such as battle shock, hysteria, confusional and anxiety states, Disordered Action of the Heart and neurasthenia, all of which appeared in Australian soldiers. But the moral judgement is ever at hand. It seems to have been Butler's way of balancing scientific objectivity with the official history's thesis about national character and his own poisonous antipathy towards sufferers of war neurosis. This antagonism is evident in his private papers, especially in the drafts of chapter three. For him, war neurosis would always be a "failure of character",⁵³ and its history "the story of the descent of man to the weakness and the weapons of woman. An unpleasant but poignant report of self-revelation under torture."⁵⁴

So the reader is left to ask questions: what precisely were the disorders from which Australian psychological casualties suffered? What were their symptoms? How were these caused? Were Australians any different from their international counterparts? For how long were these men afflicted? How did these disorders affect men during the post-war years?

In addition to Butler, the only other major study of the war's medical side overseas is by Michael Tyquin whose *Gallipoli: The Medical War*, includes in chapter six a sub-section entitled "'Psychological' Problems". Apart from some instructive oral memoirs, this appreciation of war neurosis is confused about its causes and endorses

⁵⁰ Butler, op. cit., pp. 113-114.

⁵¹ Ibid, p.113.

⁵² Ibid, p. 124

⁵³ AWM 41, 376.31.

⁵⁴ AWM 41 [290]. Draft of chapter three, volume III. These phrases and others like them were not published.

the outdated view that so-called shell shock was a physical ailment caused by blast.⁵⁵ Clarification of these ideas is vital to a proper understanding of the Australian experience of war neurosis.

4. *The precursors of the Department of Repatriation*

Few historians have investigated the predecessors of the Department of Repatriation: the patriotic funds, the State War Councils and their associated apparatus, and the Australian Soldiers Repatriation Fund. Their political development has been examined by Ernest Scott in the official history,⁵⁶ by A.P. Skerman in 1958⁵⁷ in a study which focused on the relevant legislation, and more recently by D.I. McDonald,⁵⁸ and Clem Lloyd and Jacqui Rees in their history of the Department of Repatriation.⁵⁹ In general, however, these authors have had little to say about war neurosis in this period, thus prompting several general and specific questions about its handling: How did psychological casualties fare within this system? To what extent did the available benefits - pensions, medical (including asylum) treatment, convalescence and employment assistance - help to rehabilitate them? What were the military, medical, political and bureaucratic attitudes to these men? What problems did this early rehabilitative system bequeath to the Department of Repatriation?

5. *The attitude of the Department of Repatriation to war neurosis.*

In a paper based on her PhD research, Kate Blackmore has mooted the notion that an explicit ideology shaped the thinking and actions of the Department of Repatriation.⁶⁰ In "'What Australia is doing for you' The Early Australian Repatriation Scheme", she suggests that "a prevailing ideology mould[ed] a federal department" and seriously compromised the repatriation scheme's generosity. Her thesis about the Department's deliberate parsimony is at odds with conventional wisdom which assesses Repatriation

⁵⁵ M. B. Tyquin, *Gallipoli: The Medical War. The Australian Army Medical Services in the Dardanelles Campaign of 1915* (New South Wales University Press 1993), pp.145-149.

⁵⁶ E. Scott *The Official History of Australia in the War of 1914-1918, Volume XI, Australia During the War* (University of Queensland Press 1989).

⁵⁷ A. P. Skerman, *Repatriation in Australia: a history of its development to 1958* (Repatriation Department, Melbourne 1958).

⁵⁸ D.I. McDonald, "The Australian Soldiers' Repatriation Fund. An Experiment in Legislation, in J. Roe (ed.), *Social Policy in Australia. Some Perspectives 1901-1975* (Cassell Australia 1976).

⁵⁹ J. Rees and C. Lloyd, *The Last Shilling. A History of Repatriation in Australia* (Melbourne University Press 1994).

⁶⁰ K. Blackmore, "'What Australia is doing for you'. The early Australian Repatriation Scheme" (Australian War Memorial History Conference 1993).

benefits as particularly liberal.⁶¹ According to Blackmore, the absence of detailed policy in the initial legislation (September 1917) "greatly facilitated" control from the centre. Specifically, this was achieved by allowing the Minister and his senior bureaucrats to place like-minded men in all positions "with the explicit aim of ensuring sameness of purpose, identity of interest and commonality of values from the Minister down to the Accounts Clerks". In other words, such a practice promoted a "common, over-arching ideology", ⁶² which resulted in the wilful denial of benefits to those considered undeserving. ⁶³ Blackmore sees much of this ideology as originating in "liberality tempered by Christian morality", a "nineteenth century Poor Law mentality" and "economic rationalism." ⁶⁴ Her research compels the following questions: did such an ideology - or any prevailing frame of reference - influence the Department of Repatriation's attitude to war neurosis and, if so, how did it affect their actions on this matter?

In a further paper, "Aspects of the Australian Repatriation Process: War, Health and Responsibility for Illness", ⁶⁵ Blackmore claims that the repatriation process played a crucial role in "integrating" - ie controlling- elements of the working class, in this case returned soldiers. This subjugation, she maintains, was achieved by enlisting bourgeois medicine (with its victim blaming ideology and class interest) in the service of the state so as to reduce eligibility for pensions, especially in the highly problematic areas such as war neurosis. One point in this paper is of particular relevance for the study of Australian soldiers and war neurosis: Blackmore identifies "two major and inherently antagonistic aetiological [causative] strands . . . in medical theory" ⁶⁶ operating in the repatriation process of eligibility for benefits. One made pensions and medical treatment available, the other restricted their distribution. Originating in the "individualism which underwrote bourgeois liberalism" the first of these threads blamed the sick person for his plight and consigned him to the category of "undeserving". The second appeared in the mid to late nineteenth century when social conditions were cited as the cause of poverty and disease. According to this theory, the environment, not the individual, was the architect of misfortune. Thus, the idea of social welfare gained credence. ⁶⁷ The tension between these two notions of responsibility is clear in the Department of Repatriation's literature so it is therefore

⁶¹ For example, see B. Dickey, *No Charity There: A Short History of Social Welfare in Australia* (Thomas Nelson, Melbourne 1981), pp. 143-144; and M.A. Jones, *The Australian Welfare State: Growth, Crisis and Change* (Allen and Unwin 1979), p. 29.

⁶² *Ibid*, pp.135-136

⁶³ *Ibid*, *passim*.

⁶⁴ *Ibid*, p.138.

⁶⁵ K. Blackmore, "Aspects of the Australian Repatriation Process: War, Health and Responsibility for Illness", in J. Smart and T. Wood, *An Anzac Muster: War and Society in Australia and New Zealand, 1914-18 and 1939-45* (Monash Publication in History, No.4, 1992) pp.100-113.

⁶⁶ *Ibid*, p.102.

⁶⁷ *Ibid*.

important to investigate the extent to which such attitudes affected its approach to war neurosis.

Germane to this question of whether a prevailing ideology or attitude impinged on the repatriation process is the thesis of American psychiatrist Judith Herman that particular political and social climates over the decades have determined the levels of public and official sympathy for sufferers of psychological trauma. She writes that

investigation of . . . trauma has flourished in affiliation with a political movement. . . Its study began in England and the United States after the First World War and reached a peak after the Vietnam War. Its political context was the collapse of a cult of war and the growth of an anti-war movement. ⁶⁸

Although Herman's argument is flawed - it begs questions as to the post-war extent of interest in shell shock and the influence of anti-war movements after 1918 - it is relevant to this dissertation for its tacit, converse side: that the existence of an official, pro-war movement - a warrior cult - was responsible for marginalising certain experiences such as trauma.

In Australia such a warrior cult did - and still does - exist. Based on the heroic, nation-building interpretation of the First AIF's exploits, it is most commonly called the Anzac legend. Shaped and promoted by its principal creator, C.E.W. Bean, through the official history, the Australian War Memorial and publications such as *The Anzac Book*, ⁶⁹ the legend contends that the Australian soldier was a natural, superior fighter because of the influence of the bush and the prevalence of egalitarian values in antipodean society. Thus, the First AIF was a democratic institution in which the officers and men came (generally, but not always) from the same social background and in which the criterion for respect, leadership and promotion was competence not birthright. Binding the force was a particular form of social support - mateship - which informally enforced battlefield discipline, a quality otherwise lacking in the sardonic, anti-authoritarian Anzacs. The consequent outstanding performance of this citizen army on the battlefields of Asia Minor and Europe highlighted, according to Bean's version of its history, distinctive Australian characteristics in the greatest test of a people. Thus, the exploits of the AIF created a much more sharply defined national identity. ⁷⁰

It is held by many historians that this version of the Anzac experience was appropriated by the political right in Australia for purposes of social control. ⁷¹ The first of these specific aims was to minimise damage to the war effort. This was done by

⁶⁸ J.L. Hermann, *Trauma and Recovery* (Basic Books 1992), p.9.

⁶⁹ C.E.W. Bean, *The Anzac Book* (London 1916).

⁷⁰ J. Beaumont, "The Anzac Legend", in J. Beaumont, (ed.), *Australia's War* (Allen and Unwin, St. Leonards 1995), pp.149-180.

⁷¹ For example, Inglis, op. cit.; G. Serle, "the Digger Tradition and Australian Nationalism", in *Meanjin Quarterly*, No. 2 1965; M. Roe, "Comment on the Digger Tradition", *Meanjin Quarterly*, No. 3 1965; and Beaumont, op. cit..

"promoting Anzac as a focus of national unity" thereby masking division within Australian society and diverting attention from the war's terrible human cost.⁷² Lionising the Diggers was also seen by the Federal Government as a way of promoting recruitment. After the war the legend was also employed by governments to marginalise radicalism and defuse discontent amongst returned servicemen so as to preserve civil order and the political status quo. Together with the heroic and nation building aspects of the legend, glorification of the Anzacs was deliberately linked (with the co-operation of the RSSILA) to anti-radicalism and Empire loyalty. Any individual or group advocating an alternative interpretation was, therefore, immediately excluded from the dominant version of events. Thus to be a true Anzac - and a true Australian - was to be conservative.⁷³

In the light of the existence of this warrior cult in Australia, Judith Herman's thesis strongly encourages an investigation into its possible influence on the Department of Repatriation's attitude towards traumatised Australian veterans. Did this version of the AIF's experience affect the Department's thinking on the problems associated with war neurosis and, if so, how?

6. *War neurosis and the Department of Repatriation*

Some Australian historians have concentrated on the Department of Repatriation and the post war problems of rehabilitation.⁷⁴ In their discussions they have included war neurosis and have reached conclusions and made omissions that call for elaboration and correction. Three of these authors have focussed on the Department of Repatriation itself, or on aspects of its operation. The first, L.J. Pryor, completed his Master's thesis, *The Origins of Australia's Repatriation Policy 1914-1920*, in 1932 when the issues were more or less still contemporary. Hidden away in a small corner of his dissertation is the following appreciation of war's effects on the minds of Australian soldiers:

⁷² Beaumont op. cit., p.169.

⁷³ A post script to the legend, but one of its important elements nevertheless, is Bean's version of the AIF's civil re-establishment. His interpretation marginalises those who could not - or would not - merge "quickly and quietly into the general population". Bean asserted that the majority did so but wrote that the major exception to this process was "an unworthy demonstration in Victoria by some of the inevitable riff raff which was quickly disclaimed by a huge meeting of ex-soldiers immediately called for that purpose". He also maintained that even the severely handicapped were able to resume their usual occupations and carry on with "extraordinary courage and ingenuity". These were the "determined men" to whom a disability made little difference. (C.E.W. Bean, *Anzac to Amiens*, Australian War Memorial 1968, pp. 529-531.) For many psychological casualties this interpretation simply was not their experience but because they did not conform to the heroic version of events, they were not included in the Anzac Legend and might as well not have existed. This view is echoed almost *verbatim* in the Department of Repatriation's public stance on war neurosis. This is discussed in chapter four of the dissertation.

⁷⁴ The publications of Stephen Garton's *The Cost of War: Australians Return* (Oxford University Press 1996) appeared too late for consideration in this survey of relevant literature but its advent is further evidence of increasing scholarly interest in repatriation. The book includes a chapter on psychological casualties.

The most recurrent disabilities were tuberculosis, heart troubles, abdominal complaints, rheumatism and nervous disorders. The latter were numerous in the period immediately after the War, but the time gradually passed when many soldiers were affected by the bursting of balloons and motor tyres, gun shots and explosions. The new environment of civilian life generally proved the most effective type of curative treatment.⁷⁵

Pryor's general tone and conclusions about war neurosis and its treatment are unjustifiably sanguine especially in the light of qualitative evidence which clearly shows that many returned men suffering from psychological disorders did not benefit from "the new environment of civilian life". His rather lyrical treatment of their disordered states of mind, however, is sensitive and reasonably incisive. For example, he writes: "These men tended to drift anywhere. The [Convalescent] farms were designed to help those men on whom war had left an indelible imprint and who could not think except in terms of human conflict and inhumane destruction."⁷⁶ This idea and his conclusions can be explored at much greater length with newly available evidence which obliges a more pessimistic outlook than Pryor's general tenor.

Clem Lloyd and Jacqui Rees' *The Last Shilling*,⁷⁷ is a work that generally does not challenge the official Departmental line on any major issues, of which shell shock is just one example. The authors tend to accept uncritically Annual Reports and other Departmental documents intended for public consumption. Parts of these reports, however, are capable of disclosing something of the Department's moralistic and paternalistic attitudes to returned servicemen but Lloyd and Rees seem unwilling to employ the material to illuminate these tendencies. War neurosis is mentioned several times in *The Last Shilling* but because the authors are uncritical of their sources, any discussion of the phenomenon simply becomes a validation of the Department's preferred line. One anecdote about an apparently successful recovery is typical of many purveyed in Repatriation Department publications, and creates the false impression that outcomes for shell shock sufferers were generally positive. In this case, the literature in question was an issue of the Department's official journal, *Repatriation*, which almost unfailingly painted a roseate picture of the returned diggers' lives. Of this episode Lloyd and Rees write:

The Department was justifiably proud of its successes in the 'profound and aggravated problems' suffered by shell shock victims. One former private wore a silver plate in his head as large as a half sovereign piece after breaking his skull. His shell shock was so aggravated and persistent that for six weeks the only training he could do was to sort boxes of empty cotton reels according to their colour. The first time that he heard a buzz saw he 'tore hatless' out of

⁷⁵L.J. Pryor, "The Origins of Australia's Repatriation Policy 1914-1920", (M.A. thesis, University of Melbourne 1932), p.45.

⁷⁶ Ibid.

⁷⁷ C. Lloyd and J. Rees, *The Last Shilling. A History of Repatriation in Australia* (Melbourne University Press 1994).

the building and ran down the street 'in a perfect frenzy of terror.' Through careful nursing, he was gradually educated into the idea of possible usefulness.⁷⁸

As a representation of the treatment and fate of war neurosis sufferers, this impression is seriously misleading and requires correction.

Sometimes Lloyd and Rees are just plain wrong. For example, their assertion that "no special arrangements were made" in Australia for the treatment of war neurosis "before the end of 1916"⁷⁹ can be easily and successfully contradicted by referring to a variety of reliable primary sources such as the Annual Reports of the Inspector General of the Insane, Victoria, which show clearly that the Department of Defence established relations with all the State Lunacy Departments at least as early as 1915 in order to make "special arrangements" for mentally damaged soldiers.⁸⁰ Lloyd and Rees also state that psychological maladies were to "perplex and bedevil the repatriation system in later years" without later elaborating on or footnoting what research shows to be a true statement.⁸¹ Of greatest value to this thesis is their chapter on *Smith's Weekly*, a newspaper which regularly excoriated the Department for its cold and parsimonious attitude to returned servicemen, including shell shock victims whose pathetic plights received consistent exposure in inflammatory tabloid fashion. Such coverage provides the basis for further questioning: were the lives of psychological casualties as pitiable as suggested in *Smith's Weekly*?

Marilyn Lake's *The Limits Of Hope* focuses on soldier settlement, an important aspect of repatriation but, in the process, the mental damage wrought on Australian servicemen by the First World War also receives some attention. Lake argues that, along with other ailments, psychological disabilities - which were probably widespread - reduced the ability of many returned servicemen to work the land and thus helped to undermine the viability of the soldier settlement scheme.⁸² Mental trauma is by no means Lake's principal focus but her study does touch on some important related issues without exploring them in depth and thus raises significant questions which, with fresh evidence, can be given fuller treatment. These include the role of the State Lunacy Department in caring for mentally affected soldiers, the proposition that few men returned unscathed, the actual disorders from which they suffered, official attitudes to traumatised servicemen, and the pernicious effect of shell shock on the lives and work of soldier settlers. These matters can all be investigated more comprehensively so that some of their further intricacy may be demonstrated.⁸³

⁷⁸ Lloyd, op. cit., p.217.

⁷⁹ Ibid, p.143

⁸⁰ Annual Report of the Inspector General of the Insane, Victoria, 1915, p. 2.

⁸¹ Lloyd, op. cit., p.143.

⁸² M. Lake, *The Limits of Hope. Soldier Settlement in Victoria 1915-1938* (Melbourne University Press 1987), pp. 62-63.

⁸³ Ibid, pp. 62-63.

7. *The Experience of Social Dislocation*

Amongst Australian historians of the First World War it is generally accepted that psychological disorder was a major factor in disrupting the lives of many servicemen and their families. Usually, however, this topic is confined to an assertion in a wider study such as that found in Joan Beaumont's chapter in *Australia's War*.⁸⁴ In "The Anzac Legend", she states that "[m]any suffered mental breakdown. Suicides were not uncommon."⁸⁵ Similarly, Michael McKernan in *The Australian People and the Great War* writes: "Thousands, of course, were unfit for any kind of work; they bore the scars of war service on their bodies, or invisibly in their minds."⁸⁶

Focussing more intensely on this issue than the above authors is Alistair Thomson. In his oral history *Anzac Memories. Living with the Legend*,⁸⁷ he has acknowledged the important role of war neurosis in the lives of Australian ex-servicemen and contends that war trauma was widespread. He also argues that psychological disorder and consequent social dislocation were a feature of the 1920s and 1930s for many veterans and their families whose experiences with the Department of Repatriation were not positive. Documentary evidence relating to these issues is able to support and considerably augment the conclusions Thomson has based on oral evidence.

Another to have tackled at length the problem of social dislocation and adjustment difficulties arising from war neurosis is Judith Allen. In *Sex and Secrets: Crimes involving Australian Women Since 1880*, she argues that "the interpersonal brunt of the First World War and of public provision for this population of disturbed young men fell disproportionately on Australian women."⁸⁸ Although she acknowledges the psychological damage inflicted on Australian soldiers by their combat experiences, and lists some of the clinical syndromes noted by doctors, her major statements on this subject reduce diversity to insupportable simplicity. The image of the returning AIF created by *Sex and Secrets* is of a rapacious, sexually diseased horde whose chief activity and pleasure was committing violence against women.⁸⁹ These extreme conclusions are a distortion of a situation that was more subtle and complex

⁸⁴ Beaumont, op. cit..

⁸⁵ Ibid, p.166.

⁸⁶ M. McKernan, *The Australian People and the Great War* (Thomas Nelson, West Melbourne 1980), pp. 210-211.

⁸⁷ Thomson, op. cit..

⁸⁸J. Allen, *Sex and Secrets: Crimes Involving Australian Women Since 1880* (Oxford University Press Melbourne 1990), p.131.

⁸⁹ Ibid, pp.130-133.

than suggested above and which sources show to be incompatible with such generalisations. With a range of evidence this topic can be more fully investigated.

8. *The Effect of The First World War on Australian Psychiatry*

The work of several historians has influenced the manner in which this dissertation has investigated the effect of war on Australian psychiatry. Amongst social scientists at present, two competing theories exist about war - in particular the Great War - as an agent of change in psychiatric medicine. Based largely on evidence from post-First World War Britain, one theory maintains the war's unalloyed effectiveness as a major factor in reform while the other challenges this idea.

The first of these constructs, the so-called "diffusion" theory, asserts that it is the upheaval of war, not the logical evolving of psychological theory, that produces new views of human responsibility. Specifically, the diffusion theory states that wartime experience will influence peacetime psychiatry in two ways. Firstly, many medical officers will modify their views about psychiatry as a result of their encounters with large numbers of psychological casualties and these new perspectives will be incorporated into their civilian practice. Secondly, the diffusion theory asserts that the same war experience will increase community consciousness of, and sympathy for, mental illness and create returned soldier pressure groups demanding pension reform for their members.⁹⁰

In this way it is held by several historians that the epidemic of shell shock amongst combatants in the Great War made a dynamic and positive impact on civilian psychiatry and society. L.S. Hearnshaw, Martin Stone, and Ted Bogacz have articulated versions of this view. Hearnshaw argues that the First World War stimulated a wider acceptance of psychoanalytic ideas in Britain by producing large numbers of psychological disorders amongst combat troops which quickly discredited conventional beliefs about human nature, society and conduct. Resistance to psychoanalysis was thus lowered. Hearnshaw also says that the First World War forced the large-scale development of applied psychology to solve the serious problems of soldiers and munitions workers.⁹¹

More elaborate versions of this thesis have been advanced by Martin Stone and Ted Bogacz. Stone contends that psychiatric reform in Great Britain - such as the 1930 Mental Treatment Act that permitted voluntary admission to asylums - was the result of war experience. In particular, the war had demonstrated the efficacy of psychodynamic

⁹⁰ E.T. Dean Jr., "War and psychiatry: examining the diffusion theory in light of the insanity defence in post-World War I Britain", in *History of Psychiatry IV* (1993), pp. 63, 64.

⁹¹ L.S. Hearnshaw, *A Short History of British Psychology 1840-1940* (Methuen, London 1964), pp.167, 245.

approaches in the treatment of shell shock, which contained Freudian ideas such as mental conflict, and psychotherapeutic techniques like hypnotic suggestion.⁹² Stone argues that these developments were responsible for successful challenges to the dominance of asylum psychiatry and organic theories of mental illness. In addition, he maintains that the experience of shell shock was also responsible for expanding the concept of mental illness to include the idea that so-called "normal" people could be sufferers. Finally, he says that a major consequence of war neurosis was the creation of out-patient clinics and greater community acceptance of psychological illness.⁹³

Ted Bogacz argues similarly.⁹⁴ Like Stone, he says that the experience of war neurosis in Britain forced a professional and public re-appraisal of attitudes towards mental disorder and the workings of the mind.⁹⁵ Pre-war theories of mental illness had been characterised by certainty: a sharp distinction between the sane and the insane who were seen as irresponsible, unreasonable and lacking the necessary character and will power to control themselves; as a result, "therapy" in asylums often consisted of discipline, chastisement, even punishment; in addition, the organic view of insanity prevailed and acceptance of psychodynamic theories from the Continent was confined in Britain to just a few practitioners.⁹⁶ According to Bogacz, the war changed much of this backwardness and "brought . . . ambivalence where formerly there had been certainty."⁹⁷

Historian Tom Brown has argued that similar changes occurred in Canada. He contends that the "shell shock phenomenon" was greatly responsible for the transformation of Canadian psychiatry in the 1920s. The urgent demand for the services of psychiatrists and the clear demonstration that minor mental illness was a common problem enabled Canadian psychiatry to shed its stigma and assume a more exalted status in the community. In fact, Brown asserts that psychiatry world-wide, with its new-found energy and support from government, became one of the "most powerful arbiters of . . . acceptable social-political behaviour in Western society Indeed, it seems appropriate to conclude that the Therapeutic State . . . was first forged in the crucible of the Great War."⁹⁸

Eric T. Dean Junior has proposed an alternative view to the diffusion theory, what he calls the "process of denial/desuetude".⁹⁹ He concedes that war does lead to

⁹² Stone, op. cit., p. 255.

⁹³ Ibid, pp. 242, 245, 246.

⁹⁴ Bogacz, op. cit..

⁹⁵ Ibid, p. 227.

⁹⁶ Ibid, pp. 229, 230, 232.

⁹⁷ Ibid, p. 227.

⁹⁸ T. Brown, "Shell Shock in the Canadian Expeditionary Force, 1914-1918: Canadian Psychiatry in the Great War", in C.G. Roland, (ed.), *Health, Disease and Medicine. Essays in Canadian History* (Proceedings of the First Hannah Conference on the History of Medicine, McMaster University, June 3-5, 1982), pp. 322-324.

⁹⁹ Dean, op. cit., pp. 64-65.

new psychiatric understandings but doubts whether these necessarily translate into major social change; such fresh intellectual insights, he contends, may be deliberately rejected or simply forgotten as society - or powerful elements therein - attempts to protect itself from the "destructive and chaotic forces of war" in order to maintain social stability and particular values or interests. Denial, he says, might involve "romanticis[ing] the warrior as participating in a sanitised confrontation between the forces of good and evil in a 'just' war." ¹⁰⁰

These theories - and versions of the British experience on which they are based - provide an international context for this study of the war's impact on Australian psychiatry and prompt two general questions: Did the war lead to new understandings and major changes in Australian psychiatry? If so how and why? If not, why not? What contribution can the Australian experience make to the above interpretations of war and its influence on psychiatric medicine?

Three Australian historians have written recently about the effect of the Great War on Australian psychiatry: Stephen Garton in *Medicine and Madness*, Milton Lewis in *Managing Madness*, and Robert Finlay-Jones in "The Effect of War on the Theory and Practice of Psychiatry in Australia". Like Stone, Brown and Bogacz above, Garton and Finlay-Jones argue strongly that the war had a positive and noticeable effect on Australian psychiatry. Although acknowledging that the conflict made a contribution, Lewis, is less emphatic than his confreres. The work of all three has prompted several specific questions about the treatment of returned servicemen.

Of particular importance is Garton's assertion that Lunacy Department treatment of returned soldiers in New South Wales "met with immediate success." ¹⁰¹ To support this contention he uses Departmental figures which imply a degree of success not corroborated by other forms of evidence such as qualitative material and other statistics. Further, Garton suggests that the experience of psychological illness amongst returned soldiers of the first AIF accelerated major pre-war mental health reform impulses in New South Wales. He argues that it tipped the balance of the debate about causation and treatment away from those who favoured somatic theories towards doctors who accepted psychological ones. He contends that it thus gave further impetus to a growing concern with neurosis to the point where "psychiatry began to investigate the structure of every day life: unhappiness, depression, anxiety . . ." and, together with other professional groups that invaded the "domestic sphere", helped to create the "'therapeutic state'". ¹⁰² The lack of evidential connections between the psychiatric problems raised during the war and the post war changes to the therapeutic

¹⁰⁰ Dean, op. cit., p. 65.

¹⁰¹ S. Garton, *Medicine and Madness. A Social History of Insanity in New South Wales 1888- 1940* (New South Wales University Press 1988), p.76.

¹⁰² Ibid, p.188.

infrastructure - such as the provision of outpatients clinics - lead this line of reasoning dangerously close to a *post hoc ergo propter hoc* argument. It prompts the question: can any causal connection between the war and change in Australian psychiatry be demonstrated?

Of similar mind to Garton is Robert Finlay-Jones, the author of "The Effect of War on the Theory and Practice of Psychiatry in Australia." As Finlay-Jones states, his goal is to "outline briefly some of the surprises that war brought to Australian physicians involved in psychiatry."¹⁰³ Jones briefly describes several problems faced not only by Australian doctors in the Great War but by medics associated with many of the combatant nations: large numbers of soldiers affected by puzzling psychological disorders; the difficulty of how to classify the new syndromes; and the contradictory demands of medical science and military discipline. These points have all been discussed by Garton and Lewis and, like those authors, Jones has left room for further investigation.

Of greatest interest in Jones's paper, however, is his assertion that, in Australian military psychiatry, there was no "Solomon-like figure" comparable to the English psychologist W.H.R. Rivers.¹⁰⁴ Of this observation, it seems correct to acknowledge that no Australian medical officer working in the field of psychiatry was as well known as Rivers but it is wrong to suggest that there was no Australian with similarly expansive vision, enlightened attitude and energetic commitment to the advancement of psychological medicine and the cause of mentally damaged soldiers. In fact, several Australians - including most notably John Springthorpe, Clarence Godfrey and W. Ernest Jones - displayed all of these characteristics in long associations with the AAMC and the Department of Repatriation. Their contributions to this episode in Australian military, medical and social history were of great significance and, therefore, deserve adequate recognition.

More circumspect than Finlay-Jones and Garton about the war's effect on Australian psychological medicine is Milton Lewis whose comprehensive history of Australian psychiatry touches on the Great War's influence at one point and implies its lack of major effect elsewhere. Lewis states that "Australian psychiatry was faced with unprecedented challenges during World War 1 when the effective treatment of war neuroses demanded psychodynamic approaches which were at odds with the prevailing organic conception of psychiatry."¹⁰⁵ Like Garton and Finlay-Jones, he briefly describes some of the measures taken for dealing with psychologically disturbed

¹⁰³ R. Finlay-Jones, "The Effect of War on the Theory and Practice of Psychiatry in Australia", in Attwood, H., and Home, R.W., *Patients, Practitioners and Techniques* (Medical History Unit and Department of History and Philosophy of Science, University of Melbourne, and the Medical History Society, AMA, Victorian Branch, Melbourne, 1985) pp.43-53.

¹⁰⁴ Finlay-Jones. *op. cit.*, p.48.

¹⁰⁵ M.Lewis, *Managing Madness: Psychiatry and Society in Australia 1788-1980* (Australian Government Publishing Service 1988), p.39.

returned soldiers such as the use of State Lunacy Department facilities and military mental hospitals, the legal obviating of certification and the continuation of the State-Commonwealth relationship after the war. These are all matters that can be greatly expanded upon as can the assertion contained in the following statement. "The [Repatriation] Commission provided high quality medical treatment for servicemen through a system of repatriation hospitals, and psychiatric cases were treated within this system." ¹⁰⁶

A wide ranging article in *Sabretache* by Joanna Bourke, of the University of London, raises matters relevant to several chapters in this dissertation. ¹⁰⁷ In particular, several generalisations in this article are misleading. Bourke states that J.W. Springthorpe (a prominent medical officer in the Australian Army Medical Corps mentioned above) was "typical" of Australian military doctors who "prescribed a few days rest in bed, with careful attention paid to sleep, diet and the evacuation of the bowels." ¹⁰⁸ Springthorpe was by no means "typical". The approach of this feisty Australian to mental disorder amongst his countrymen was informed by the most progressive psychological theories current in Europe and Britain and is discussed at length throughout the dissertation. Bourke's statement that "sympathy was not the characteristic of military doctors or of civilians back home" ¹⁰⁹ is also inaccurate. In Australia the reactions to war neurosis from politicians, bureaucrats, doctors and family members were far more complex than this statement suggests and will be explored at length in the relevant chapters. Finally, to say without qualification that sufferers of war neurosis were "housed in asylums for civilian lunatics" ¹¹⁰ is to ignore the provision for special accommodation within these institutions and out-patient treatment at Repatriation General Hospitals, and the special wartime mental treatment Acts passed by State parliaments to eliminate certification for soldiers. These issues are clarified in chapters five and six of this dissertation.

Sources

The major conclusions about soldiers' experiences and the structures which moulded them are based on several main sources housed in the Australian War Memorial, the Australian Archives (Melbourne and Canberra) and the Department of Veterans' Affairs (DVA) Central Office Library, Canberra. Prime amongst these are Repatriation Department Personal Case Files which are held in the Australian Archives in each

¹⁰⁶ Lewis, op. cit., p.40.

¹⁰⁷ J. Bourke, *Shell Shock and Australian Soldiers in the Great War* (Sabretache Volume XXXVI - July/September 1995), pp.3-12.

¹⁰⁸ Ibid, p.5.

¹⁰⁹ Ibid, p.10.

¹¹⁰ Ibid.

state.¹¹¹ For reasons of privacy these records are normally closed; thus, special access through DVA, the controlling agency, was sought and granted provided the identity of the men concerned was fully protected. Pseudonyms and other changes have been employed for this purpose. In each personal case file (of about 250 from Victoria were perused and 104 selected) is a very large range of military, medical and social documentation associated with the interminable and tedious process of determining entitlement to Repatriation Department benefits. The files cover the period from a man's enlistment until his death and have a strong chronological dimension. The selection of these files was based on the Admission Records of the Repatriation General Hospital, Caulfield 1925-1934.¹¹² During this period, 1600 men were admitted to RGHC with some form of war neurosis. Thus in the records was a list of names, complete with rank, unit and service number with which to approach DVA. Otherwise there was no convenient method of identifying war neurosis sufferers amongst the tens of thousands of personal case files. Selection from the RGHC records was made alphabetically.

Contained in the personal case files are reams of doctors' reports including those from medical officers in France and England, and from Repatriation doctors and asylum officials in post-war Australia. Frequently, these describe in detail symptoms and treatment that lasted a lifetime. As with the medical reports, outgoing, incoming and intra-Departmental correspondence in these files (including memoranda and minutes) is associated with the accumulation of evidence to determine entitlement. This includes formal depositions by the man himself and by members of his family on "Form U, the Record of Evidence in Support of a Claim." In order to help establish cause and, therefore, worthiness, these often contain lengthy and detailed descriptions of symptoms, battlefield experiences, and domestic disharmony. Also included are letters of support from friends, employees, former comrades-in-arms, the RSSILA, Repatriation Department Local Committees and, sometimes, charitable organisations, describing the applicant's inability to function in civil society because of his disorder.

Apart from its role as evidence in a claim, correspondence often includes desperate appeals from wives for help or protection, or letters of complaint about the brusqueness and inefficacy of Departmental treatment. Also contained in the personal case files is correspondence and other documentation about pension decisions and the reasons for them. Thus, they demonstrate the manner in which a small group of doctors exercised enormous power over thousands of returned servicemen.

These files are an extraordinarily bountiful source and have been employed in the dissertation in discussions of battlefield and hospital experience, medical disorders and symptoms, doctors' attitudes, bureaucratic procedures and ideology, and social

¹¹¹ CA 879, (Deputy Commissioner for Repatriation, Victoria 1920-1976), B73.

¹¹² Admission Records, Repatriation General Hospital, Caulfield, 1925-1934, Parts 1-8. AWM 371-42 (3).

dislocation. In short, they are comprehensive records of the lives of ordinary individuals destroyed by a war.

Another rich source relevant to several of the themes in this dissertation are the papers of Doctor John William Springthorpe who worked extensively with Australian psychological casualties during and after the war both overseas and at home. Donated by his widow, these are contained chiefly in his own series in the Australian War Memorial Research Centre ¹¹³ and in the papers of the official medical historian, A.G. Butler.¹¹⁴ Springthorpe's private diaries are held in the La Trobe Library, Melbourne.¹¹⁵ The Australian War Memorial papers include a medical diary, correspondence with a great many people ranging from ordinary soldiers and their families to the Minister of Repatriation, as well as some meticulous statistics and a sociological analysis of patients associated with his work in England. They also comprise papers delivered to conferences, and reports requested by Repatriation authorities concerned about the problems associated with war neurosis and rehabilitation. Much of what Springthorpe wrote about the management of shell shock by British and Australian authorities was critical and revealing of areas which, otherwise, would have remained unilluminated.

Supplemented by Form U as mentioned above, servicemen's diaries and letters housed in the Australian War Memorial Research Centre are the chief source for the soldier's perspective on shell shock at the front. As their subject matter is not indexed, simple trawling was necessary and, from 250 perused, 77 were found to contain useful comments on shell shock.

Some of the most telling documentation for chapter two - the experience of evacuation and hospitalisation in the Mediterranean and European theatres of war - came from the records of the Deputy Adjutant-General's Department. These are located in AWM 23 and comprise a miscellany of material relating to medical and disciplinary matters. Of great importance amongst this evidence is Army Form W3436, of which 47 were eventually extracted from some very dusty and dirty boxes. Army Form W3436 was introduced in June 1917 by the British High Command. Briefly, its purpose was to determine whether a man was lying about the circumstances that produced his shell shock. Had he been close to a shell burst or had he not? Thus, there appeared on this form depositions from a number of individuals including the soldier himself, a doctor - who recorded symptoms - and the soldier's commanding officer who gave evidence about the man's veracity. The form is highly juridical in nature and very revealing of British Army attitudes to war neurosis and the manner in which 47 Australians were treated in this system. A few Army Forms A45 - "Proceedings of a Medical Board" -

¹¹³ AWM 2DRL 701.

¹¹⁴ AWM 41.

¹¹⁵ MSS 9898.

are also present in AWM 23 and describe the symptoms and immediate fates of 10 junior officers evacuated with psychological disorder. The records of No. 1 and No. 2 Australian Hospitals, Egypt, contained in AWM 224 (Unit Manuscript Histories) provided insight into the kinds of psychological disorders suffered by Australians from Gallipoli, and the duration of their hospitalization and, sometimes, their eventual fate within the AIF.

In addition to some of the material contained in the personal case files described above, much of the evidence for post-war bureaucratic processes and attitudes was found in Repatriation Department and Defence Department correspondence. Some of this documentation - the minutes of the Repatriation Commission for the 1920s and 1930s, the minutes of the Medical Advisory Committee for the same period, the correspondence of the Department's first permanent head, Nicholas Lockyer, and a desultory collection of early memoranda, are located in the DVA Central Office Library in Canberra. Until the early 1930s, Commission and Medical Advisory Committee minutes contained the history and symptoms of many (possibly all) men applying for benefits. The reasoning behind these decisions is usually supplied as well. Thus an understanding of the decision making process can be gained from this source. In addition, considerable insight can be gained into the thinking of Nicholas Lockyer from an enormous volume of carefully preserved correspondence comprising 1000 carbon copies of outgoing memoranda and letters.¹¹⁶

Supporting this evidence on the attitudes and actions of the government departments is material located in several Australian Archives series in Melbourne and Canberra. These are mostly correspondence files of the Departments of Defence¹¹⁷ and Repatriation,¹¹⁸ and the Prime Minister's Department.¹¹⁹ Many items in these series contain correspondence on war neurosis and its related problems both to and from Repatriation Department officials. Issues were generally related to procedure on medical care, entitlement, and other matters such as individual cases, alcoholism and employment. Further insight can be gained into bureaucratic attitudes and processes using this source and, finally, in the Repatriation Department's Annual Reports for the war years and the 1920s and 1930s. These reports also reveal the Department's public attitude to war neurosis and can be found in the Australian War Memorial.¹²⁰

Documentation on the reactions of Australian doctors to war neurosis was derived chiefly from the *Medical Journal of Australia*, Annual Reports of the Inspector-General of the Insane for Victoria, and the Transactions of the Medical Congress of

¹¹⁶ Repatriation Commission Correspondence 1-1000 A, DVA Central Office Library.

¹¹⁷ AA (Melbourne) MP 367/1.

¹¹⁸ AA (Canberra) A2427/1, A2421/1, A2481/1, A24831/1.

¹¹⁹ AA (Melbourne) A 457.

¹²⁰ AWM 27.

Australia, 1920. The private papers of John Springthorpe, Ernest Jones (the Inspector-General of the Insane for Victoria) ¹²¹ and Alfred Rowden White, a doctor with the Australian Army Medical Corps ¹²² were also important in this discussion. Together with contemporary books on the subject written mostly by former Royal Army Medical Corps therapists, ¹²³ and the Report of the War Office Committee of Enquiry into 'Shell-Shock', ¹²⁴ this Australian work was also one of the bases of the medical perspective on shell shock. Further insight into the kinds of disorders affecting Australian war neurosis cases was gained from the Registers of Military Patients in Victorian Mental Asylums held by the Victorian Public Record Office. ¹²⁵ These records are closed and required special access from the State Government.

Modern insights into trauma were gained from a variety of journal articles and from manuals such as the *Diagnostic and Statistical Manual of Mental Diseases III-Revised Edition* otherwise known as *DSM III-R*. ¹²⁶ The above collection of private and public primary material is the chief basis for the following arguments outlined below for each chapter.

Chapter Summary

In chapter one it will be contended that for many Australian soldiers at Gallipoli and on the Western Front shell shock was a part of general war experience. Not all were sufferers, however. Some simply recorded their impressions of this phenomenon. But for many, psychological stress and disorder were the most significant ordeals of the war and would blight the remainder of their lives. It will be shown in this chapter that disorders sometimes assumed spectacular guises at variance with the popular, officially sanctioned image of the stalwart digger. It will be argued, however, that this was just a measure of his humanity. Yet not all forms of psychological disorder manifested themselves in this fashion. Some men developed barely perceptible neurotic mannerisms. Others, trying not to transgress social codes that forbade emotional displays or loss of self-control, suppressed their emotions and symptoms and damned their own "weakness". It will be seen in chapter two that such suppression helped to create disorders. Although they could be self-critical in this way, Australians generally empathised with those who broke down and did not disparage their comrades. It will be

¹²¹ Held in the Clinical Services Library, Royal Park Psychiatric Institution, Melbourne.

¹²² Held in the Melbourne University Archives. Later Sir Alfred: Senior RMO at the Royal Children's and Alfred Hospitals and assisted many physicians before resuming private practice until retirement in 1959. Rowden White was a notable benefactor of Melbourne University where he had been a demonstrator in bacteriology. (University of Melbourne Guide to Collections, Archives Board of Management 1983, p.47.).

¹²³ For example, A. Hurst, *Medical Diseases of the War* (Edward Arnold, London 1917).

¹²⁴ Report of the War Office Committee of Enquiry into 'Shell-Shock' (His Majesty's Stationery Office 1922).

¹²⁵ Registers of Military Patients in Victorian Mental Asylums. VPRS 7512.

¹²⁶ *Diagnostic and Statistical Manual III-R* (American Psychiatric Association, Washington DC 1988)

seen in chapter one that Australian soldiers made intuitive attempts to understand and explain the processes that produced psychological disorder and their impressions confirm the highly stressful nature of trench warfare at Gallipoli and on the Western Front. Their conclusions provide a qualitative compliment to the systematic analyses of doctors explored in chapter three.

Chapter two argues that in neither theatre of war - the Mediterranean or Europe - were provisions for sufferers of war neurosis - including Australians - satisfactory. It will be shown how Australian military authorities permitted at least one man known to have a mental disorder to proceed to Gallipoli where he again broke down. It will be argued in chapter two that psychological disorder was common at Gallipoli where, without any proper rest areas, the strain was difficult to avoid. It will be shown that, in response, individual officers of the Australian Army Medical Corps improvised with rest camps and other measures but that these brief respites were frequently unable to counter the stress of life on the Peninsula.

Men were thus evacuated to Egypt where they entered a hospital system unprepared for such problems and which seemed unable to affect recoveries. It will be argued that the low priority given to medical problems by British Army authorities in general detrimentally influenced the treatment of Australian psychological casualties from Gallipoli. Their particular needs were almost entirely ignored except for the fortuitous presence of two AAMC officers with experience in mental diseases: A.W. Campbell and J.W. Springthorpe. Inevitably, many were returned to Australia as totally unfit for further service. Some, though, were sent on with the rest of the AIF to the Western Front where they broke down again.

On the Western Front and in England, Australian psychological casualties, although attended by their own medical units immediately behind the front line, eventually became part of the highly bureaucratic and juridical British Army system for dealing with shell shock developed to try to strike a balance between medical imperatives and military demands and suspicions. The remnants of the paper war (in particular Army Form W3436 mentioned above) fought over shell shock will demonstrate that a few Australians did not receive the wound stripes to which they were probably entitled; more importantly, they show in some detail how many individuals were repeatedly returned to the lines as cured when clearly they had not been. A follow up study of some of these men through their Repatriation Department Personal Case Files reveals that they took their war neuroses with them into civilian life. For them, the medico-military compromise over shell shock had been a failure.

Chapter two will also show that Australian invalid treatment in Britain was hampered by the Australian Government's highly controversial six months policy which returned men to Australia who would not be well after six months. This practice thus ensured the absence of Australian General Hospitals in England, and promulgated

an instruction that Australians should be collected from the English hospitals as soon as possible and taken to their own medical units - the three Australian Auxiliary Hospitals and the four Command Depots on the coast. This meant that Australian invalids were unable to take advantage of the expert treatment available in the English specialist hospitals.

War neurosis cases were no exception to this general situation; rarely, for example, were they admitted to the British hospitals around the country. However, of vital concern to these men was the neurosis clinic run at No.3 Australian Auxiliary Hospital, Dartford by Dr. John Springthorpe. The records of this unit - Ward A10 - reveal that Australian shell shock patients in Britain were often inaccurately diagnosed in the General Hospitals to which they were first sent, and spent far too long there so that their disorders had time to solidify. They also show that no Australian neurosis clinic - including ward A10, had the facilities of their British counterparts. It will be shown however, that this ward was a haven for many Australian psychological casualties who also forged strong links with the British civilians with whom, as convalescents, they boarded.

With the aid of recent insights into trauma, it will also be argued in chapter two that the lack of effective treatment - of which promptness was the most vital element - played a crucial role in consolidating disorders, thus making the task of later management very difficult.

Chapter three - the medical perspective on war neurosis - will considerably expand upon the soldiers' impressionistic view of psychological disorder to give a comprehensive description and analysis of the actual illnesses from which men suffered. It will be shown in chapter three that behind the generic terms "shell shock" and war neurosis was a full range of recognised contemporary medical syndromes the symptoms and causes of which demonstrate more clearly than the above labels the severity of the psychological damage suffered by Australians. In chapter three it will be seen that many men never recovered and so bore permanently the mental scars of their Great War experiences.

These understandings, which still enjoy considerable currency, will be supplemented by more recent studies of trauma. Symptom groupings in Australian servicemen of the First World War strongly resemble those comprising modern formulations such as Post Traumatic Stress Disorder (PTSD) which offer greater insight into the psychological disorders of war. For example, PTSD emphasises the stressful environment as the major cause of psychological damage, not individual predisposition which was prominent in even the most progressive contemporary explanations. As seen above, some of these approaches tended to present psychological disorder as an internal psychological struggle resulting from failure to adapt to the war environment. Thus, although battlefield conditions were cited as important, the

emphasis on individual responsibility, to some extent, discounted the war itself as an agent of disease. The correlation between contemporary and modern symptom groupings, however, makes it possible to take advantage of recent insights to argue the traumatising nature of the First World War battlefield environment. PTSD also stresses the long term consequences of trauma and gives further legitimacy to the chronic symptoms of Australian psychological casualties. So often these were dismissed by officialdom as malingering or attempts for "advantage".

Finally, all of the above insights into these disorders will make plainer the kinds of difficulties with which the Department of Repatriation and the relatives and friends of the soldiers concerned had to contend.

Chapter four, which examines the experiences of psychological casualties in Australia between 1914 and 1918, argues that the predecessors of the Department of Repatriation did not care adequately for sufferers of war neurosis and that many of these men were unable to exploit the benefits available to them. It will also be contended that the imperfect treatment received by Australian sufferers of war neurosis overseas - and the complete absence of treatment for those who remained undetected - probably made the task of repatriation authorities in Australia doubly difficult because disorders had been allowed to consolidate. It will be shown in chapter four that patriotism was responsible for the modification of stances on mental illness. In this case, Victorian and Western Australian politicians moved, through special War Mental Treatment Acts, to spare psychological casualties the indignity of certification. In debate, explicit attempts were made to distance the disorders of soldiers from civilians.

It will be shown in chapter four that specific official policies were probably responsible for the perpetuation and aggravation of disorders. Finally, it will be argued that the activities of its antecedents provided the Department of Repatriation with an unenviable inheritance.

The prevailing attitude in the Department of Repatriation to war neurosis is the subject of chapter five. Here it will be argued that war neurosis was perceived as a matter of critical importance by Departmental officials, especially its first permanent head, Nicholas Lockyer. He believed that mental damage would create significant problems not only for individual returned servicemen but also for the Department's various rehabilitative schemes (such as vocational training) and for the nation's economy. With justifiable pessimism, Lockyer also believed that adequate treatment for psychological casualties would be difficult to find. Nevertheless, he tried to hard to do so. It will also be shown in this chapter that shell shocked soldiers were believed to pose a threat to civil order and that this was the basis for certain measures. In addition it will be demonstrated that the problem of war neurosis was defined in strong moral terms which deliberately excluded certain kinds of mental casualties from the heroic interpretation of the AIF's exploits. It will be shown that such a formulation strongly

resembled nineteenth century attitudes to charity. It will be argued, however, that compassion and condemnation existed together in the Department's attitudes and reflected the tension between the two views of human responsibility mentioned above. The extent to which these perceptions and definitions of war neurosis led to action is the subject of the next chapter.

Chapter six, which discusses the experiences of psychological casualties at the hands of the Repatriation Department, will show that, in addition to subsidising military patients in State Lunacy Departments as Defence had done, a number of specific measures were taken by the Department to try to manage psychological casualties. It will be shown that within this therapeutic regime, they were subjected to a variety of treatments ranging from physical labour and Freudian psycho analysis to sedation with paraldehyde and bromidia, to which some became addicted. In addition to medical treatment, shell shock sufferers were also associated with every other benefit offered to returnees by the Department of Repatriation. It will be argued that psychological casualties were, because of their disorders, unable to take advantage of any of these.

It will be contended that the moral view of human responsibility was evident in the treatment of war neurosis and that it led to action, particularly the establishment of Convalescent Farms and certain pension decisions. It will also be demonstrated that the tension between these codes could cause professional disagreements between doctors trying to decide eligibility for pensions. It will also be contended, however, that inconsistency was a major feature of Departmental decision making and that the evidence does not support the view that an overarching ideology conditioned the actions of all Department employees. Certainly, an ideology existed but it was highly rhetorical and unevenly applied. In their dealings with Departmental bureaucrats and medical officers, psychological casualties met a very human mix of parsimony and generosity, and open mindedness and moral piety. Whichever medical measures were taken, however, and whatever attitudes they encountered, the results for victims of war neurosis were preponderantly negative.

Chapter seven will demonstrate that one of the major effects of war neurosis for Australians was social dislocation: disruption to patterns of work and life in families, businesses and small towns and damage to personal dignity. It will be shown that for the rest of their lives many men were unable to work or settle, that they were subject to extreme irritation and anger, and often resorted to violence and alcohol. This behaviour had a shattering effect on wives and families. Many men, however, were simply a passive, defeated presence in the home or on the street. It also will be suggested that in many returned soldiers, symptoms had not subsided and that, in some cases, they had worsened.

In chapter seven it will also be shown that many women did "bear the brunt" of their husbands' highly disturbed behaviour but the manner in which both partners

suffered with and responded to the consequences of war neurosis defies generalisation. Children, shop customers, employees, work mates, animals, and policemen also suffered as a result of soldiers' disturbed behaviour. And, of course, some men simply endured in virtual silence. It seems reasonable to conclude that the outcome of the First World War for some sufferers of shell shock, their families and associates was a bitter and complex one indeed.

Chapter eight will show that Australian psychiatry - a mixture of asylum treatment and private practice, with the former the dominant model - was influenced by war neurosis in two major ways. Firstly, the placement in asylums of many returned soldiers put a strain on the resources of the lunacy departments during the war and throughout the 1920s and 30s. Secondly, a small number of Australian doctors were inspired by their experiences with war neurosis patients to call for major changes to Australian psychiatry and to hope that psychological medicine would occupy a place of greater importance than it had before 1914. Some of these men had remained in Australia as Defence Department medical officers and worked in the asylums and military hospitals. Here, experiences with psychological casualties generally reinforced their pre-war commitment to progressive ideas which clashed with the crude asylum methods of patient management. These notions included the belief that neurosis was widespread in the general population and that psychotherapy was the most effective treatment.

Chapter eight will show how some Australian doctors who served overseas with the Australian Army Medical Corps and Royal Army Medical Corps also worked with war neurosis sufferers and, importantly, with many of the most progressive elements in British psychology and psychiatry. Like those doctors who had remained in Australia, these men either became more deeply committed to their pre-war beliefs or, in the case of converts, had their intellectual horizons considerably broadened.

Although the two groups mentioned above called for the reform of Australian psychiatry and for wider recognition of psychodynamic approaches to mental illness, they were to be disappointed. A few individuals created a vigorous intellectual discourse based on their military experiences but the numbers involved were small and this activity petered out in the mid-1920s; some applied wartime lessons to their civilian patients but, in general, it must be said that the hopes of these men for change remained unrealised and that war neurosis did not have the dynamic effect in Australia that it apparently had in Britain and Canada. Australian psychiatry remained impervious to innovation.

Chapter One

Shell Shock: The Australian Infantryman's Perspective

"If I believed that hell was a matter of physical torture I could not imagine it worse than this place . . . And yet the mental strain is almost the worst part of it."

Lieutenant K.S. Cunningham 5th Australian Field
Ambulance, Diary, 22 August 1916, Pozières. AWM
3DRL/1988.

Between 1914 and 1918 Australian servicemen fought in three major theatres of war and endured the tension of daily life and the intensity of many major battles. Of the 331,814 who served overseas, 59,342 were killed and 152,171 were wounded.¹ Amongst these numbers were many who witnessed or suffered war-induced psychological disorder. Their perspective on this subject - the focus of this chapter - shows that shell shock was a significant part of the general ordeal particularly at Gallipoli and on the Western Front. For many, psychological disorder was the defining experience of the war while for others it was just a temporary reaction or just one of many startling wartime curiosities. Whatever the case, shell shock was often mentioned in confidential diaries or letters home. As a result of these personal observations, it can be seen that war neurosis manifested itself in an assortment of unusual forms. In some cases, it was highly dramatic while in others it was barely perceptible except in subtle neurotic mannerisms. The attitudes of Australian soldiers to this phenomenon were mixed. Some men, out of sheer compassion, were sympathetic, pitying; many, recognising something of themselves in the victims of shell shock and, seeing their own possible fate in these unfortunates, were not quick to condemn; others saw it as a form of basic constitutional unfitness or were appalled by its resemblance to insanity. Australian soldiers comprehended and articulated the mechanics of psychological disorder in themselves and others in a variety of ways ranging from the basic and obvious to the intuitive and complex but such objective awareness did not always preclude a moral perspective on shell shock. And so, for some, mental breakdown was related to questions of strength and weakness. These men therefore made heroic attempts to stave off disintegration, for they felt the dictates of military, family and personal codes of behaviour that prescribed self-discipline and grace under pressure. They did not want to compromise their dignity or offend values that judged mental breakdown a form of feebleness. And so they hung on - or tried to.

¹ C.E.W. Bean, *The Official History of Australia in the War of 1914-1918, Volume VI: The Australian Imperial Force in France during the Allied Offensive 1918* (First published Canberra 1942; this edition University of Queensland Press, St. Lucia 1983), p.1098.

Was there any difference between psychological disorder at Gallipoli and that seen on the Western front, or between the stresses produced by the two theatres of war? The forms of disorder and breakdown at the Dardanelles and in Europe as reported by the soldiers themselves (and, indeed, by medical officers) were essentially the same but there were differences between the two theatres of operations. Because of the tiny beachhead at Gallipoli, the closeness of the two trench systems and the absence of areas where troops could rest out of range of bullets and bombs, there was a constant strain about service at Anzac that was not replicated on the Western Front. Bean, for example, said that at Armentières in April 1916, the "quiet" sector in which the Australians began their European ordeal, nothing "approaching the tension of Anzac" existed.²

The other main difference was scale. Everything on the Western Front was larger: the numbers, the proportions of the battle zone, and the size of the artillery bombardments. Thus, although the strain was constant at Gallipoli, it was probably more intense on the Western Front. Essentially, however, very similar sources of stress applied the same kinds of pressures to overworked minds and exhausted bodies on both the Peninsula and in France and Belgium. Thus, the two fronts will not be discussed separately.

Psychological disorder: its manifestations

Psychological disorder amongst Australian soldiers at Gallipoli and on the Western Front sometimes manifested itself in an assortment of highly dramatic forms. In France, for example, Captain R.A. Goldrick of the 35th Battalion noted:

One of our men . . . went suddenly demented. The s.s. [shell shock] had an electrifying effect upon him . . . [He] dropped his rifle and . . . rushed out over the front line trench into No man's land, the Germans blazing away at him: then he turned and ran down between the lines of the two armies: no one seemed able to bring him down. Then he turned again, raced into our system, down overland through the support trenches . . . where men from the Battalion overpowered him, and forcibly rolled him in blankets and tied him up with rope . . . He was unwounded but evacuated raving mad.³

Frenzied acts of unconscious bravery like the above were typical of those described as shell-shocked. At the battle of Fromelles in July 1916, Private Oliver Coleman saw "a boy in 'A' Coy. crying all the time in a sort of hysteria that he had no ammunition. He attacked seven Germans and after he had killed them all sat down and

² C.E.W. Bean, *Anzac to Amiens, A Shorter History of the Australian Fighting Services in the First World War* (First published Australian War Memorial, Canberra 1946; this edition Canberra 1968), pp.134, 205.

³ Captain R.A. Goldrick, 33rd Battalion, Letter, 13 April 1917, in B. Gammage, *The Broken Years, Australian Soldiers in the Great War* (First published Australian University Press, Canberra 1974; this edition Penguin 1975), p.186.

still cried he had no ammunition." ⁴ Perhaps subliminal doubts about their own courage determined the colour of some men's reactions. Captain Stanley Fox, a trench mortar officer in the Fourth Division artillery, related the case of a certain Sergeant Davison under his command who went berserk near Mouquet Farm in August 1916 after days of strain and a desperate search for cover:

Having arrived safely at the sap we all felt exceedingly thankful. Somehow I felt very weak in the knees and found difficulty in getting along. Sgt. Davison who was leading the way commenced to roll about in an uncontrollable manner, and at length broke into a frantic rush, cursing and swearing at the Huns. He was apparently suffering from over-strain, and the part of the trench from which we were had on the way thrown out one of our men just killed, started Davison on his headlong career. He at length fell exhausted in the trench, and recovered sufficiently to be able to walk. His memory had gone, and we had difficulty in getting along. He recognised me, and said 'Is that you, Captain Fox. I will follow you to death. No one ever yet found Davison a coward.'" ⁵

Fox and his detachment continued on their way to billets but the episode was not yet over. At the junction of the trench and a road Davison stubbornly insisted on sitting down and talking to a man who had just died on a stretcher. Fox's group also met a deranged infantryman who had lost his way and added him to their number. What an odd assortment of travellers they must have seemed, and how much more conspicuous they probably appeared when Davison turned his demented heroics on friendly troops. Fox once more:

Davison again started a charge all on his own, charging down the road at full speed, fortunately in the right direction. He came across some Tommy machine gunners whom he started to lash into; fortunately he was unarmed. When the others came up he set about them as well, and gave one man a vigorous smack in the mouth. I rode on ahead on a bicycle and obtained an ambulance wagon to take us all home to the billet. We were all considerably shaken and heartily glad to get back. ⁶

The behaviour of other shell-shocked men directly contradicted martial values but the circumstances were, at the very least, mitigating. Lieutenant G.G. O'Keefe, who was then a private, recalled in a post-war narrative of his experiences how one of his officers had cowered in a corner of a dugout during an attack: "I could get nothing, very little sense out of him for he was in a state of shell-shock ..." ⁷ Lieutenant K.H. McConnell reported a similar occurrence at Pozières:

MacKenzie . . . asked me to go and give McKell a hand . . . I looked up McKell and found him . . . very shaky at the bottom of a German dugout which was his company HQ. He had had a bad time with shelling and was himself suffering from shock. ⁸

⁴ Private O. Coleman, 30th Battalion, Letter, 22 July 1916, in R.G. Lindstrom, "Stress and Identity: Australian Soldiers during the First World War", thesis for Master of Arts, University of Melbourne, 1985.

⁵ Captain S. Fox, 4th Division Artillery, Diary, 14 August 1916, pp. 40-41. AWM 2DRL/0751.

⁶ Fox, op. cit..

⁷ Lieutenant G.G. O'Keefe, 2nd Battalion, Narrative, p.1. AWM PR 85/253.

⁸ Lieutenant K.H. McConnell, 1st Battalion, Diary, 23 July 1916. AWM2DRL/29. (Thanks to Dale Blair for this reference).

Under fire, some "terror stricken" Australians tried to bribe their superiors with "money, rations, jam etc." presumably in the hope of being allowed to escape the source of their torment.⁹ "Cases of genuine shock only do occur in fellows who have been buried by the upheaval of a shell or bomb," wrote Major F.L. Wall. "Sometimes these chaps are in a bad way and can't stand at all for a while."¹⁰ In France, Thomas Cleary wrote: "One young chap was taken out of the trenches in a state of collapse. He was drivelling like an idiot, his legs trailing behind as they assisted him, he was quite unharmed, just shock."¹¹ At the disastrous battle of Fromelles in July 1916, many Australians dissolved psychologically in ways which, like the previous descriptions, encourage the reader to contemplate afresh - and with renewed awe - the terrors of a modern battlefield. Soldiers were reluctant to describe such scenes but the power of the events that forced them - normally the most disciplined of men - to compromise their composure so publicly cannot be doubted. What but the most stupefying fear or sickening horror could cause a man to flee and hide for a whole day, blanch and shake with fright, babble incoherently, struggle in the compassionate but restraining arms of his comrades and cry out for his mother? Lieutenant L.J. Martin of New South Wales was a witness:

[O]ne or two of the chaps got shell shock and others got really frightened it was piteous to see them . . . One great big chap got away as soon as he reached the firing line and could not be found . . . I saw him in the morning in a dug out he was white with fear and shaking like a leaf. One of our Lieuts. got shell shock and he literally cried like a child, some that I saw carried down out of the firing line were struggling and calling out for their mother, while others were blabbering sentences one could not make out.¹²

Occasionally during heavy bombardments or major engagements, the front trenches looked like Bedlam as psychological breakdown occurred *en masse*. In September 1916 Lieutenant Colonel G.R. Short of the 17th Battalion recalled a conversation with three men on his staff who had been invalided out of front line service after Pozières:

[T]hey stated that the intensity of the German shell fire was very severe on the nerves, but when it suddenly ceased the utter stillness was more than they could stand. Then the real strain found them limp, dry-tongued from the fumes of Gas and sulphur, and many officers and men reduced to the terrible shaking of limbs which showed nerve control broken, some foamed at the mouth, some cried or swore, and some crawled about on all fours.¹³

⁹ Corporal A.G. Thomas, 6th Battalion, Letter, 9 May 1916. AWM 3DRL/2206.

¹⁰ Major F.L. Wall, 3rd Australian Field Ambulance, Letter, 16 August 1915. AWM 1DRL/592.

¹¹ Private T.J. Cleary, 17th Battalion, Diary, 31 July 1916, in Lindstrom, *op. cit.*, p.53.

¹² Lieutenant L.J. Martin, 1st Machine Gun Battalion, Letter, 31 July 1916, in Gammage, *op. cit.*, p. 158.

¹³ Lieutenant Colonel G.R. Short, 17th Battalion, Diary, 8 September 1916. AWM 2DRL/0201

Several months later Short reported a similar occurrence:

The conversation then turned to shellshock and Col. Davis told us he saw last month quite 20 men of his Coy in the trenches suddenly become affected ... some laughed and shouted, some wept and raved, some fell down, others opened their mouths and could not shut them. ¹⁴

Private Arthur Cubis vividly described comparable scenes at Pozières. On 27 July he wrote in his little diary: "Still this awful Bombardment continues day and night . . . Strong men stand and cry out with madness from our terrible time also to their God for relief from our trials . . . I feel we all shall go mad." ¹⁵ The next day he continued:

[W]e have won the village and more trenches from the Germans but oh God at a terrible cost. Strong men crying like children mad with Shock our officers are in a terrible state . . . ordered Back Up to give support to a charge. Up we came exhausted and mad with shock . . . as I write this at 9.30 am I am Broken down in the nerves. Worn out weary and hungry. ¹⁶

Cubis stated that afterwards, in billets, men were unable to obtain relief even in sleep as they were haunted by "Bloodthirsty dreams" while he himself could get no rest because a soldier near to him "was raving like a madman." ¹⁷ During this same battle Lieutenant J.A. Raws saw men desert their posts and wander the battlefield in temporary madness while others were "so badly broken they were immovable."¹⁸ In February 1917 Corporal A.G. Thomas described the effect of a heavy bombardment on a group of Australian soldiers: "[T]hen they started harder than ever the lads were unstrung and I feared a stampede from them." ¹⁹

Other forms of mental breakdown were frequently more passive as the effects of severe mental stress were partially hidden behind none-too-effective veneers of self-control. Some men did not crack up spectacularly but the consequences of prolonged strain eventually became evident nevertheless. Many managed to direct their emotions inwards and maintain a semblance of self-governance but gradually the internal tumult eluded restraint and seeped under the facade to appear in a variety of muted, peculiar forms. Lieutenant-Colonel Short described the effects of "shell shock" on one officer:

Lt. Morton came into Camp tonight he is now well from an accidental bayonet wound. He is thin, aged in the face as usual, and gone in the nerves rather. He left about 4 weeks ago, and has had his ordeal and got out alive. It has aged and partly crushed him but he will pull up with rest. This is the usual effect of fighting on an officer. ²⁰

¹⁴ Short, Diary, 15 June 1917.

¹⁵ Private A.J. Cubis, 18th Battalion, Diary, 27 July 1916. AWM 3DRL/7436

¹⁶ Ibid, 28 July 1916.

¹⁷ Ibid, 10-11 August 1916.

¹⁸ Lieutenant J.A. Raws, Letter, 8 August 1916. AWM 2DRL/487.

¹⁹ Thomas, Letter, 12 February 1917.

²⁰ Short, Diary, 27 July 1916.

As described above, the fighting at Pozières produced a great deal of unstifled mental collapse but it also yielded more discreet behaviour which, although relatively inconspicuous, was no less bizarre. Lieutenant-Colonel Short again:

Strange different men's experiences in the war. pte. Blair of my staff told me this afternoon that at Pozieres one of the biggest blackguards but best soldier in their platoon had a spell of two days heavy shelling in the trenches and this shook his nerves so much that Blair in passing, saw him sitting by himself shaking, humming quietly 'The Lord's my Shepherd.' ²¹

Captain Frank Hurley, the official war photographer, thought that there was little difference between the appearance of the dead and some shell-shocked soldiers near Passchendaele in 1917 so impassive were they:

I noticed one awful sight: a party of, ten or so, telephone men all blown to bits. Under a questionably sheltered bank lay a group of dead men. Sitting by them in little scooped out recesses sat a few living; but so emaciated by fatigue and shell shock that it was hard to differentiate. ²²

Some men became conscious of troubling changes in themselves and quietly communicated their concerns to relations at home. After the battle at Mouquet Farm, an extension of the Pozières slaughter, Captain Harold "Rollo" Armitage wrote in a letter:

Well - a queer reaction sets in after such fierce work, and I find it hard to concentrate on anything. I've found this letter extremely difficult to write. I believe leave starts soon and I am looking forward to it very much for I am getting very 'stale'. Physically I am O.K. - but a short relief from the constant strain of C.O. would do me good. ²³

One officer was actually irritated that the damaging effects of his service did not show for he wanted relief from the strain. Towards the end of 1916 he explained his condition to his wife:

As you've often told me, I had my limits, well I dam near found them this time, twas just a case of just wore out sort of business with a good nerve rattling. I know what nerves are, sometimes I don't think I do. Here are all these chaps have a shell burst near them and get shell-shock, result, some months doing it grand in Blighty. Card is having a fine old time I believe. But yours truly . . . can't even look sick, except for . . . looking a bit played out . . . I think it must be a bit of the nerves, they tell me so, the least thing out of the ordinary starts my head going etc., but each day improves things. ²⁴

The severe psychological problems of Private Robert Henry were not readily apparent to all those around him on the Western Front although his deterioration was cannily perceived by some. In April 1917, Henry was transferred from his usual duties

²¹ Short, Diary, 28 October 1916.

²² Captain F. Hurley, Diary, 12 October 1917. AWM PR 85/291.

²³ Captain H.E.S. Armitage, 50th Battalion, Letter, 9 September 1916. AWM 1DRL/53

²⁴ Major R.V. Morse, Australian Electrical, Mechanical, Mining and Boring Company, Letter, 5 November 1916. AWM PR 82/078.

as a stretcher bearer to traffic control because of the cumulative effects of severe psychological stress. For Henry, this process began at Gallipoli, continued in the trenches of the Western Front and really only ended with his admission to Melbourne's Royal Park mental asylum in 1928. At Lone Pine in August 1915 Henry was dazed by a bullet that struck the band of his "Tommy cap" and was then subjected to a heavy bomb attack in which a comrade standing beside him was killed. During the appalling European winter of 1916-17, he was buried by a shell burst on the Western Front but did not parade sick because, as he later said, he was not injured.²⁵ In addition to these events, the death of his brother on the Somme - news of which he took badly - also affected him severely.²⁶ Despite the general absence of histrionics from his behaviour, the psychological effects of war service were just as pernicious as on those whose demise was more obvious.

One of Henry's battalion medical officers perceived the mental damage in the young stretcher bearer, and attributed it to "very tough experiences that left their mark on his nervous system", and "the effects of prolonged strain." "Before I left the Battn. he was a changed man," wrote the doctor, "undoubtedly due to exposure under heavy shell fire combined with the hard work of stretcher bearing."²⁷ But, by contrast to the medical officer, fellow stretcher bearer F.W. Rolf felt that Henry, although "too young to be on active service suffering the horrors and hardships of war, stuck to the job gamely and was always in a normal frame of mind, taking his share of duties with all the cheerfulness possible under the circumstances."²⁸

Attitudes

Psychological deterioration and breakdown amongst Australian soldiers at Gallipoli or on the Western Front thus appeared in a number of different guises, some of it wild and unrestrained, the remainder subtle and quietly corrosive. Australian soldiers displayed a variety of attitudes to this phenomenon, some of which prompted major attempts to suppress emotion and present an image of invulnerability. Some men were sympathetic to mental breakdown; others, however felt that it was related to inherent weakness or insufficient internal fortitude. By contrast, many felt that, under the circumstances, breakdown was understandable in others but didn't allow themselves the same luxury. Thus, like many who commented on it, they felt the internal and external pressures that demanded resistance to a form of behaviour that was perceived to be neither militarily

²⁵ Private R. Henry, 7th Battalion, Form U, 8 August 1928, in PCF.

²⁶ Mrs. V. Henry to Repatriation, 14 June 1928, in *ibid.*

²⁷ Medical Officer to V. Henry, 7 July 1928, in *ibid.*

²⁸ F.W. Rolf to V. Henry, 18 June 1928, in *ibid.*

nor socially acceptable. Despite their best efforts, however, some succumbed although others managed to withstand the siege but paid a price later when nature presented her bill.²⁹

A few men thought that mental breakdown was related to basic constitutional unsuitability. In May 1917 the Regimental Medical Officer of the 60th Battalion, Keith Doig, described the demise of one of his colleagues: "One of the MOs of this Brigade went off his nut just before. I've moved up and I had to send him away. Poor chap, he was awfully good in the line but had a 'kink' always."³⁰ Lieutenant J.T. Maguire also believed that innate frailty caused breakdowns. He told his mother: "Judging by the quality arriving over here now, they seem to be passing anybody. Some of the new reinforcements are physical wrecks before they join up. A good many went dotty with shell shock. Nerves rotten."³¹

At least one Australian was revolted by the sight of a shell shocked man: "I saw one Tommy Engineer Sapper who had shell-shock. It is a terrible sight - just like a mad-man," wrote Lieutenant H.S. Allen in April 1917. But most were not as visceral in their responses. Some Australians were sympathetic to mental collapse in their comrades. Albert Facey, for example, felt that they couldn't help it³² while others did not find this reaction to war's awfulness at all surprising: after the Menin Road battle in July 1917 Corporal B.S. Arnold wrote: "The men from Gallipoli reckon they never had anything like this turnout to go through . . . there were some terrible sights . . . I saw a couple of poor fellows whose nerves had gone, and it was a great wonder there were not a number like them."³³ Under a violent barrage in France in 1918, Private Golding was frightened but overlooked his own fear while studying another man's reaction: "I wasn't windy at all, compared to him. I forgot myself in feeling sorry for him although I was sure the next one was ours."³⁴ At No. 1 Australian General Hospital Estaires, Captain Henry Maudsley, a medical officer with the AAMC, wrote: "We have a good many cases of shell shock. Very hard cases to deal with poor beggars, some of them utter nervous wrecks for the time being."³⁵ "Several of my

²⁹ This expression is based on one formulated by Lord Moran who, in his book on psychological disorder in the First World War, stated that some stress reactions were the result of "reason, jugged by memory . . . presenting her bill", a reference to the active imagination of men who had witnessed horror and thus knew roughly what to expect in forthcoming trips to the line. (Lord Moran, *The Anatomy of Courage*; first published Constable 1945; this edition 1966, p.112.) Modified as above, the expression is a reference to the harmful effects of suppressing emotion.

³⁰ Captain K.M. Doig, 60th Battalion, Letter, 15 May 1917, in R.S. Corfield, *Hold Hard Cobbers. Volume One 1912-1930. The story of the 57th and 60th and 57/60th Australian Infantry Battalions 1912-1990* (Published by 57/60th Battalion Association, Glenhuntly, Victoria 1992), p.83.

³¹ Lieutenant J.T. Maguire, 8th Battalion, Letter, 10 September 1916. AWM 2DRL/322.

³² A. B. Facey, *A Fortunate Life* (Penguin, Ringwood 1981), p.275.

³³ Corporal B.S. Arnold, 14th Field Company Engineers, Diary, 22 July 1917. AWM 2DRL/0167.

³⁴ Private A. Golding, Diary, 27 July 1918. AWM PR 91/060.

³⁵ Captain H.F. Maudsley, AAMC, Diary, 13 July 1916. AWM 3DRL/6008.

friends are raving mad," wrote Lieutenant J.A. Raws at Pozières. "I met three officers out in No Man's Land the other night, all rambling and mad. Poor Devils!"³⁶

It is therefore clear that some Australian soldiers felt that nervous breakdown was excusable and warranted sympathy or pity. Others did not, and a few were particularly severe on themselves. For these men, mental breakdown was associated with questions of strength and weakness, of duty, leadership, pride and honour, and right and wrong. That the psychological problems of some soldiers were not as noticeable as others was frequently due to social, military, family and personal codes that emphasised these values. As a result of such influences, some men made valiant attempts to control the psychological maelstroms that war experiences had whipped up in them. Occurrences that precipitated obvious breakdowns in some men simply imposed a heavy but tolerable mental burden on these soldiers. Unrelieved strain, nearby shell bursts, other close calls, horror, exhaustion and the death of comrades barely affected their military efficiency due largely to intense efforts of will. But in the long run - over periods of years, even decades - the disquiet created by these wartime incidents sometimes slipped the leash and consumed their lives.

During the Gallipoli landing on 25 April 1915 some men broke under the strain but others did not, despite the intense mental pressure. Throughout that awful day these men were sustained by a variety of "props" which included the traditional ones - hatred of the foe, exemplary leadership and a sense of duty - as well as others which centred upon individual temperaments. Some soldiers were apparently indifferent to events while others deliberately distracted themselves or became thoroughly absorbed in their tasks.³⁷ But although these supports were clearly important, they were not the only factors that encouraged men in their efforts to avert mental disintegration. As the war continued - both at Gallipoli and later on the Western Front - other influences were clearly apparent. One of these was the perception by some Australian soldiers that mental breakdown was a matter of weakness.

That psychological breakdown was often associated with questions of strength and weakness is suggested by the remarks of several other Australian soldiers who witnessed such episodes. Lieutenant F. Semple felt that the bombardment at Pozières "will break the strongest of men and the weak will simply collapse in an hour or two." Some witnesses were astonished - even horrified - that symbols of resilience such as Boer War veterans and sergeants could disintegrate. "Can you imagine a man who had seen service in the South African war going down a communication trench screaming at the top of his voice," wrote Sergeant W.H. Serle.³⁸ In his diary, Private Thomas

³⁶ J.A. Raws, Letter, 4 August 1916. AWM 2DRL/481.

³⁷ D. Winter, *25 April 1915: The Inevitable Tragedy* (University of Queensland Press, St. Lucia 1994), pp.166, 174, 179.

³⁸ Sergeant W.H. Serle, 60th Battalion, Letter, 7 July 1916, in Lindstrom, op. cit., pp.52-53.

Cleary described the case of a man who had deserted his unit in mid-November 1916 and returned one month later for only a day as he was unable to face the front line again. Cleary wrote:

[H]is nerves are quite gone. He is an Anzac too. He used to sleep alongside me and I could feel him shivering through the night at the thought of going up the line in the morning, none of us like it but it must be awful to be like him.³⁹

Taking a certain amount of smug pride in his own steadfastness (although it may have been generated by a sense of relief, a case of "There but for the grace of God go I") Corporal Arthur Thomas described the reactions of his comrades during a heavy bombardment on the Western Front in May 1916. Although he did not censure these men, the perceived incompatibility of mental breakdown with symbols of resilience is plain:

It was fearful yet awe-inspiring, for the first few minutes I felt sick, then as steady as a rock... I am sorry to say, some fellows nerves gave way and they became gibbering idiots Sergeants and all sorts, gad it was little wonder for it was awful.⁴⁰

The words of Lieutenant J.A. Raws about the bombardments at Pozières also suggest the perceived incongruence of mental disorder - a form of weakness - and certain models of toughness; along with the above remarks on the subject, his comments intimate further the pervasiveness of these attitudes. He told his brother-in-law: "I'd give anything to be out of it for good. All of us would. I saw strong men who had been through Gallipoli sobbing and trembling as with ague - men who had never turned a hair before."⁴¹ On the same day and of the same battle he wrote to his brother Lennon: "Only the men you would have trusted and believed in before proved equal to it. One or two of my friends stood splendidly, like granite rocks around which the seas stormed in vain . . . But many other men broke to pieces."⁴²

Raws' comments to Sir Lauchlan MacKinnon were similar and further suggest his convictions about strength and weakness: "[G]iants of physical strength were cowed and helpless and iron veterans of Gallipoli were gibbering lunatics."⁴³ Raws was relieved - almost buoyed - that he had managed to maintain what he called self-control throughout those awful days of August 1916 when others had not. For him, retaining his grip was a matter of pride. He told his mother: "Not once did I break, Thank God, and many braver and better men I saw collapse into gibbering lunacy."⁴⁴

³⁹ Private T. Cleary, 17th Battalion, Diary, 17 December 1916, in *ibid*, p.84.

⁴⁰ Thomas, Letter, 9 May 1916.

⁴¹ J.A. Raws, Letter, 12 August 1916.

⁴² *Ibid*, Letter, 12 August 1916.

⁴³ *Ibid*, Letter, 12 August 1916.

⁴⁴ *Ibid*, Letter, 9 August 1916.

Raws was only one man for whom resistance to breakdown involved questions of personal integrity and stamina. Private A. Kilgour of the First Australian Field Ambulance wrote in his diary at Pozières that to see men blown to pieces placed "a terrible strain on one's nerves."⁴⁵ Three days later he wrote: "Still going strong but my nerves are beginning to feel the strain. What with the terrible sights etc. oh! I am far from being my usual self. Still I will not give in."⁴⁶ Similarly, Sergeant W. Kirkland of the 5th Battalion reported that the heavy shelling at Pozières on 20 and 21 August had been "nerve racking ... Fortunately I am strong in this respect and did not give up even when I had that narrow strafe."⁴⁷ Sergeant Murray Hartley also considered it a matter of personal honour not to "lose my head, fearfully scared though I was."⁴⁸ In France Major E.L. Hutchinson wrote:

On suddenly getting out at night on a gas alarm, or extra heavy shelling, my teeth chatter so much that I don't speak for a bit so that it won't be noticed. I suppose some of the others are the same. We pretend that it is the cold, but it really is fright.⁴⁹

Professional demands rallied other men when they felt the pressure. For example, the weight of his responsibilities as an officer forced Captain G. Stobie into greater efforts at self-control in the trenches at Pozières:

My sensations during this bombardment were indescribable - I was at times in almost an agony of fear as I expected the parapet to fall in and bury me if the shell fire came down a little. I did not think before that I could be so terrified - each visit to the men needed some bracing up of the courage to enable me to get a move on.⁵⁰

Ten weeks later he elaborated on the psychology of his behaviour under fire:

I will never forget my first experience at Pozières and its first agony of fear so hard to disguise and keep hidden from the men. The danger of an officer or N.C.O. 'putting the wind up' the men ... is at times great . . .⁵¹

Sometimes family codes of honour played a crucial role in regulating a man's conduct in the face of immense psychological stress. For men like Major Geoff McCrae and Major W.G.M. Claridge family expectations were critically important in keeping them on the right side of the psychological watershed as they precariously trod the fine divide between desperate control and undignified crumbling. From Lemnos the wounded and shell-shocked McCrae wrote:

⁴⁵ Private A. McP. Kilgour, 1st Field Ambulance, later 2nd Battalion, Diary, 16 August 1916. AWM 2DRL/42.

⁴⁶ Ibid, 19 August 1916.

⁴⁷ Sergeant. W.A. Kirkland, 5th Battalion, Diary, 21 August 1916. PR 89/106.

⁴⁸ Sergeant J.W.M. Hartley, 12th Machine Gun Company, Letter, 11 December 1916. PR 85/360.

⁴⁹ Major E.L. Hutchinson, 6th Australian Field Ambulance, Diary 21 May 1916. PR 86/391.

⁵⁰ Stobie, Diary, 15 August 1916.

⁵¹ Ibid, 31 October 1916.

No one knows (who has not experienced the awful hours of standing in trenches under shell-fire, unable to do anything to help yourself; yet, having to stick to your post with 'Hell let loose' around you) how much we need our loved ones at home and, when you feel that they are looking to you (individually) to play the man and 'stick it', it becomes easier . . . ⁵²

During the heavy bombardments to which the Australians were subjected at Pozières between 23 and 25 July 1916, Major Claridge found himself motivated by a strong sense of shame and duty to keep a tight rein on the temptation to give in to his emotions. Even at such a remote distance he felt his family's potential disapproval. He confessed to his wife:

I am not going to tell a lie and say I wasn't afraid because I was ... I don't know how I stood it so long without breaking, but ... I knew you would be ashamed if I had played the coward, so I kept straight on at the head of my platoon.⁵³

For Claridge, a physical wound was the only excuse for an escape from the battlefield: "I was very thankful to get my wound as it got me out of the firing line for a while." ⁵⁴

As a result of such attitudes, the First World War became a mental endurance test for some men, a rigorous examination of their ability to resist psychological ruin. One of these was the Western Australian artist, Ellis Silas, who, on the morning of the landing at Gallipoli, realised almost instantly that he would have to undergo such a trial during every minute of his existence on the Peninsula. The noise of the naval guns as they bombarded Turkish positions, the sight of the dead and the dreadfully maimed tested his psychological equilibrium eventually to breaking point. But until 16 May when he was evacuated, a strong sense of duty and a desire that he would not be found wanting under fire pushed him to great feats of self-control and courage as a signaller that even saw him mentioned in despatches. ⁵⁵

But readers of these commendations could not have known of the self-goaded needed to execute such acts of bravery. On 25 April his ordeal began:

Wish there wasn't quite such a damned noise with the guns, it is sending me all to pieces . . . Now commencing to take some of the dead out of the trenches; this is horrible; I wonder how long I can stand it. ⁵⁶

Four days later Ellis confessed: "I don't think I can stand much more of it, my nerves seem to be going . . ." ⁵⁷ On 1 May he wrote: "Am glad to have done my duty." The next night, during an Australian attack at the head of Monash Valley, Ellis was required

⁵² Major G. McRae, 60th Battalion, Letter, 18 September 1915. AWM 3DRL/3623.

⁵³ Major W.G.M. Claridge, 8th and 22nd Battalions, Letter, 10 August 1916. AWM 2DRL/240

⁵⁴ Ibid.

⁵⁵ Signaller E. Silas, 16th Battalion, Diary, 6 April 1915, 29 April 1915. AWM 1DRL/566

⁵⁶ Ibid, 25 April 1915.

⁵⁷ Ibid, 29 April 1915.

to carry messages between the front and a command post. In his diary he recorded his reactions to the events of that evening:

[M]y nerves were quite gone. . . I continued on my way . . . all along the route I kept coming across poor shattered things crawling along in their agony, but I could not stop to help them . . . I went to Headquarters with my message, where I arrived in a state of collapse - the horrors of this night have been too much for me, I cannot get used to the frightful sights with which I am always surrounded. ⁵⁸

Despite his best efforts the trial rapidly overwhelmed him as the following entries in his diary show: "Little sleep - I dread being asleep more than awake as my dreams are so frightful." ⁵⁹ "Have been delirious all night, my nerves have quite gone to pieces" ⁶⁰ "I think if I am here much longer my reason will go - I do not seem able to get a grip of myself and feel utterly crushed and unmanned. . . " ⁶¹

Like Silas, other men also recognised very quickly that war would be a mental endurance test. After his first trip into the line in July 1918, Lance Corporal Len Clarkson sat on the steps of a church in the French village in which his battalion was billeted and wrote home: " Oh! the horror of it all . . . a chap shrinks from the inhumanity. I think I stood the ordeal as well as anyone else, although my nerves were on edge when I was blown out of my dugout. It remains to be seen whether I can 'stick out' the long-continued strain." ⁶² For the remainder of his service Clarkson thus watched for signs of disintegration in himself and was pleased to report that he could detect none. "I am feeling as fit as a fiddle and have shown no signs of the 'breaking up' predicted of all chaps under 21 years of age," he wrote confidently in September 1918. ⁶³ Throughout the war on the Western Front, Captain Stobie also wrestled continuously with his "nerves" in an attempt to remain in control and appeared to have succeeded. After Pozières he imagined that he was "getting much cooler and steadier under shell-fire, thank goodness" ⁶⁴ but by February 1917 had been disabused of that idea. After returning from the comfort of battalion school in England he found front line conditions once again testing his nerve:

The valley where our work lay was under fairly solid fire all night so things were uncomfortable for us, . . . I was glad to move away at midnight as my nerves are in a rotten state. It seems a normal thing for leave men to suffer the same thing and of course I have been away from the line for a long time. At any rate I had the 'wind well up.' ⁶⁵

⁵⁸ Ellis, Diary, 2 May 1915.

⁵⁹ Ibid, 7 May 1915.

⁶⁰ Ibid, 9 May 1915.

⁶¹ Ibid, 16 May 1915.

⁶² Lance Corporal L. Clarkson, 32nd Battalion, Letter, 1 July 1918. AWM 3DRL/7133

⁶³ Ibid, 1 September 1918.

⁶⁴ Stobie, Diary, 31 October 1916.

⁶⁵ Ibid, 5 February 1917.

Five days later he wrote:

After another bitterly cold night and day with its usual whizbang shelling I was relieved by Smith. I was tired out and quite finished after 48 hours of continuous shivering and exposure . . . I slept heavily in spite of the cold and had a chance to recuperate and settle my nerves. ⁶⁶

Over a year later he was just as stressed but still intact: "The constant exposure to shells is working upon everybody and our nerves are not by any means settled," he confessed to his diary at Croix Rouge, Caestre. ⁶⁷ Work in the reserve trenches at Sercus was, therefore, a relief." [T]he hours of work are longer than in the forward zone though of course the strain of shellfire is absent," wrote Stobie. ⁶⁸

But these victories over natural instincts were often short-lived, and, in some cases, of extremely doubtful value. From Gallipoli in July 1915 Major Geoff McCrae wrote home:

Please God, this trying time will soon be over. I am beginning to feel the effects of the continuous strain as regards nerves. The least little argument finds me horribly irritable and snappy. . . I try to keep a hold over myself, but only too often my frayed nerves expend themselves in anger." ⁶⁹

From the Western Front in 1917 Lieutenant J.T. Hampson wrote:

I suppose Alick you think I have gone right off my head altogether. Strictly speaking I haven't. But there is no one to talk to here. There is no one to whom I can confide my strange sentiments . . . I feel infinitely better when I have let my feelings go a bit, for this business is beginning to get very much on my nerves. ⁷⁰

As will be seen here and in later chapters, those who kept the lid on their impulses didn't always escape the consequences of psychological stress and some, in the 1920s and 30s, became just as debilitated as the "gibbering lunatics" who had been evacuated during the war. A minor example is J.A. Raws himself who, after his ten day stint at Pozières and news of his brother R.G.'s death, suffered three fainting fits:

His death has proved a far greater shock to me than I thought possible, since we came out of the line - probably due to nerves. I've kept going, however, and not had to report sick, though I've been rather disturbed by having three faints recently. I was terribly glad I was never even threatened with anything of the sort during those ten days in the line. The first I ever had was quite unexpected, the night before in an adjoining village. None of this for Father of course. ⁷¹

⁶⁶ Stobie, Diary, 10 February 1917.

⁶⁷ Ibid, 19-21 April 1918.

⁶⁸ Ibid, 26 May-2 June 1918.

⁶⁹ McCrae, Letter, 2 July 1915.

⁷⁰ Lieutenant J.T. Hampson, 19th Battalion, Letter, 18 August 1917. AWM 2DRL/0331

⁷¹ J.A. Raws, Letter, 18 August 1916.

A more serious case was Private Maurice Daniels. Throughout the war Daniels concealed his deteriorating mental condition by a major effort of will and although his psychological problems were not as evident as those of others at the front, the long term consequences of the mental strain that plagued him throughout his war service eventually destroyed his life.

For Daniels, the war entailed a very private perdition. In late December 1916 he was wounded by a sniper's bullet and evacuated to England but rejoined his unit, the 5th Machine Gun Battalion, in October 1917 and served throughout the severe fighting at Passchendaele. There, he said, the nervous strain was continuously "very great" whether he and his battalion were in the line or not. In the trenches the heavy shelling never ceased, while, at rest, aerial bombardment was a continual threat. During this period, and, indeed, at Flers in November 1916, he had several narrow escapes which, together with the constant strain, later produced very serious psychological consequences. At Flers, fragments from a nearby shell burst pierced the casing of his machine gun; at Passchendaele several of his close comrades were killed, and a shell landed without bursting between the feet of a man with whom he was having a conversation. "I was shaky afterwards," Daniels later told the Department of Repatriation, "in fact I was always nervous but I avoided showing it." ⁷² Further heavy fighting at Villers-Bretonneux aggravated this condition but Daniels persevered:

Towards the finish of the war I was all nerves and had to continually force myself to keep up. I was gassed in one of the last engagements . . . and lost my voice for a few days. I was discharged in 1919 in a highly nervous state. ⁷³

From the moment he arrived home after the war it was clear to friends and relations that Daniels had changed a great deal. During the 1920s his mental health gradually deteriorated and in 1930 he was committed to Melbourne's Mont Park mental asylum where he remained for the rest of his life. ⁷⁴

Soldiers' attitudes to psychological disorder thus varied but the necessity of resisting breakdown was a common theme that gave a semblance of rough unity to their opinions on this subject. Such a belief gave rise to much repression of emotion and attempts to create and maintain an appearance of control. Some comments, such as Stobie's, suggest that men easily saw through these endeavours. They knew, of course, that, like themselves, everyone was frightened and struggling for grip but such understandable frailty did not seem to count as much as the effort men made to assume a brave face no matter how transparent. They thus understood others as they

⁷² Private M. Daniels, 5th Machine Gun Battalion, Form U, circa 1930, in PCF.

⁷³ Ibid.

⁷⁴ Ibid, PCF, *passim*.

understood themselves. They were also in little doubt about the causes of this highly unpleasant aspect of their service.

Causes

As articulated by the participants themselves, the causes of strain and breakdown were numerous. Artillery fire, the sight of dead and mutilated men and animals, noise, fear, the demands of leadership, cold, mud and physical exhaustion either singly or in combination produced tremendous mental burdens which, in many cases, became unsustainable.

The conditions that produced mental deterioration and breakdown in Australian soldiers varied considerably but artillery fire was undoubtedly the greatest catalyst. It was the chief source of fear for Australian soldiers and a vexation that they often blamed for the nervous collapses around them and in themselves. It is understandable that psychological disorder in the First World War was widely known as "shell shock" because collapse and evacuation was often precipitated by a shell burst or blast of some kind.⁷⁵ In case after case of men presenting to the Department of Repatriation with psychological problems after the war, an explosion was invariably involved. But the concussive effect -while no doubt severe - was probably exceeded by the trauma of being repeatedly exposed to the numbing violence of this awful weapon. The psychological effects of being "blown up" or buried - and suffering the nightmare of total darkness and total silence under an immovable weight of earth - can barely be imagined by the uninitiated.

Single handedly responsible for three quarters of all wounds in France and Belgium,⁷⁶ (including Australians),⁷⁷ artillery fire was the scourge of the Western Front; in fact, in many ways (along with the machine gun) it was its creator, the principal reason for the existence of the "troglodyte world" which stretched from the North Sea to the Swiss border. As John Terraine has remarked: "The war of 1914-18 was an artillery war: artillery was the battle-winner, artillery was what caused the greatest loss of life, the most dreadful wounds, and the deepest fear."⁷⁸ Statistics are staggering. At Verdun 24 million shells were fired by both sides from about 2000

⁷⁵ For example, of 49 cases of anxiety neurosis treated in an Australian depot hospital in England during 1919, 21 had been "blown up", one man three times in a day. Another in this group stated that he had "never been blown up" but was close to several explosions. One man had been buried and three bombed from the air. ("History of War Neurosis Treated at Monte Video Camp Hospital, Weymouth 1919", AWM 25, 885/4.)

⁷⁶ Winter, *Death's Men*, op. cit., p. 117.

⁷⁷ A.G. Butler, *The Australian Army Medical Services in the War of 1914-1918, Volume III, Problems and Services* (Australian War Memorial, Canberra 1943), p.928. Here Butler extrapolated from British figures because Australian records had been destroyed.

⁷⁸ J. Terraine, *White Heat; The New Warfare 1914-18* (London, Sidgwick and Jackson 1982), p. 95.

artillery pieces which reduced that sacred strip of French soil to a surreal, pock-marked purgatory. The British *preliminary* bombardment on the Somme in 1916 dumped 1,732, 873 on the German lines; in the week following 2 April 1917, 50, 000 tons of shells pulverised the German positions at Vimy Ridge. Further battles continued to establish records. The opening barrage at Messines in July 1917 discharged 3, 258, 000 rounds into the German trenches while the preparatory shoot from the British artillery at Passchendaele exceeded all previous totals: 4, 283, 550 shells rained havoc on the enemy.⁷⁹

No man could live above ground within range of the cannon which created these typhoons of iron and steel . Aided by aerial observers, such weapons could fire over several miles and still be reasonably sure of hitting the target. Although artillery could be incisive in this way, it was also its capacity for mass destruction that determined much of Great War strategy and the cringing quality of soldiers' lives. As an instrument of daily control, it was supreme. Nothing was safe from random, searching fire that dominated roads - cross roads in particular - explored trenches, pounded suspected strong points and generally kept the troops "honest". In a battle, precisely orchestrated bombardments were needed to destroy the enemy's defences and to prevent the arrival of reserves. Thus, front lines, support trenches, gun emplacements and back areas were systematically hosed with thousands of shells from hundreds of guns lined up wheel to wheel according to timetables and maps painstakingly drawn up over weeks - even months - by diligent staffs. These prolonged barrages would obliterate whole villages, reduce woods to splinters and transform poorly drained farmland into swamp. Shell fire thus dominated the battlefield and forced armies underground where they underwent the torments of living in the dirt and mud under the eagle eye of their mechanical nemesis.

But if this omnipotent weapon were responsible for the majority of wounds and destruction throughout the war, it was also a highly important factor in the production of psychological disorder. And, as insignificant figures in ghastly, surreal landscapes dominated by artillery, men felt keenly the victory of material over flesh. One Australian wrote a poem to express this sense of helplessness:

The agony of waiting for the shells!
These iron monsters belching forth their hell
That hurtle, screaming through the star stabbed dark
Know well their power and chuckle as they bark.
A sudden sullen bark; a screaming sigh,
A deadly pause; a crash that shakes the sky!
Not us that time! Once more to face the strain
Of waiting for the shells to come again.⁸⁰

⁷⁹ Terraine, *op. cit.*, pp. 208, 210, 214, 218.

⁸⁰ Sapper W.M. Houston, 4th Division Signal Company, *Diary*, in Lindstrom, *op. cit.*, p.74.

Other men were more prosaic than this author but, in their pithiness, the sense of helplessness created by artillery and its dominating effect on the imagination is equally clear. In his diary, Sergeant Archie Barwick described that feeling:

When you are in a bombardment it makes you realise how small and puny a man's strength is when he is face to face with these powerful and terrible weapons . . . every minute you are expecting to get blown to pieces and you have a feeling of surprise that you are still alive, for you can feel the trenches and sandbags rocking and swaying and the air is all a tremble.⁸¹

"Rifles do not play a prominent part on this front, not the same as Gallipoli," wrote Private Thomas Gardener in France, "on this front they snipe at you with a 4 inch shell instead."⁸² For A.G. Thomas, artillery fire seemed to symbolise his entire war. "I have been six months under shell fire," he wrote in 1918.⁸³

Whether artillery fire was merely one element among many responsible for the creation of fear and anxiety, or whether a shell explosion was the crucial event that pushed a highly stressed man over the edge, it was, nevertheless, probably the major player in a process that scrambled the minds of thousands of soldiers in the two major theatres of war. "Eddington is useless here as he is terrified by the shell fire," reads an entry in the war diary of No.1 Australian Casualty Clearing Station on Gallipoli.⁸⁴ "During an attack one hears the reports and explosions of our own shells and ditto of the Hun artillery," wrote Bombardier Norman Mackie typically. "Can you wonder at us all suffering from an attack of jumpy nerves and shell shock."⁸⁵ "You can hardly realise how heavy artillery affects us," wrote Lieutenant W.A. Mann in France. "We get that shaken up, our heads splitting, every nerve strained to the utmost, your body working mechanically, you don't seem to care what happens to you."⁸⁶ Under fire some men sat in the trenches and ducked, winced, shivered and read their Bibles⁸⁷ or fidgeted,⁸⁸ while others needed a change of trousers.⁸⁹ Indeed, most soldiers found artillery fire "nerve racking". At 3am on 1 August 1918, after five days under heavy fire, Private Golding wrote: "They are sticking shells into us thicker and faster and still no relief. The game is beginning to tell on my nerves."⁹⁰ To Corporal W.I. Everard, artillery fire was far worse than even aerial bombs. "[N]ot so nerve shattering as big gun fire," he confessed in his diary.⁹¹

⁸¹ Barwick, Diary, 26 June 1916.

⁸² Private T.O. Gardener, 5th Division Pioneers, Letter, 26 November 1916. AWM PR 90/157.

⁸³ Thomas, Letter, 24 May 1918.

⁸⁴ War Diary, No.1. Australian Casualty Clearing Station, 23/24 June 1915. AWM 4, 26/62/1, Part 1. Roll 607, 23 and 24 June 1915.

⁸⁵ Bombardier N. Mackie, 2nd Division Ammunition Column, Letter, 3 September 1916. AWM 1DRL/0450

⁸⁶ Lieutenant W.A. Mann, 25th Battalion, Letter, 19 December 1916. AWM 2DRL/105.

⁸⁷ Thomas, Letter, 21 April 1917.

⁸⁸ Lieutenant H.G. Carter, 1st Battalion, Diary, 29 April 1915. AWM 2DRL/6418.

⁸⁹ Sergeant G. McLean, 11th Field Artillery Brigade, Diary, in Lindstrom op. cit., p.62.

⁹⁰ Golding, Diary, 1 August 1918.

⁹¹ Corporal W.I. Everard, 2nd Machine Gun Battalion, Diary, 3 September 1917. AWM 2DRL/ 1025.

Men like Everard might have been able to withstand such a siege but the mental citadels of many others were eventually breached by the sustained probing of artillery fire. "No definite shell shock but signs of strain: both mental and physical under heavy shell fire," read the medical report on Private J. McKeown, a 42-year-old skin buyer from Gilgandra in New South Wales. With poor sleep, nightmares and trembling he was rendered permanently unfit for general service and temporarily unfit for home service.⁹² Some soldiers could not cope at all with the horrible promises offered by the big guns and so absented themselves from the line. As Lord Moran remarked, "It frightened more men away from the trenches than anything else."⁹³ Such a man was Private F. Waugh who was evacuated from the front line in October 1917 with a nervous disorder. During the course of the obligatory army investigation into the case,⁹⁴ two comrades gave evidence about his morbid fear of shell fire. One of these men, Private C. Taylor, testified:

I was very near Pte. Waugh on the way into the line and he seemed very nervous. He was ducking from our own shells. I chaffed him about it. When Lieut. Naughton was wounded Waugh threw himself down and tried to crawl into a culvert. I saw Waugh at the apex by which time the shells were coming fairly close and he moved towards the left of the platoon. I have not since seen him.⁹⁵

For many Australian soldiers the relationship between artillery fire and mental breakdown seemed unequivocal. At Gallipoli, Colonel R.J. Millard of the AAMC wrote in his diary: "But at the trenches there was heavy shelling especially in the afternoon with big high explosive. 'Jack Johnson's Carter of 1st Battn. was blown up by one of these and came to my dugout considerably 'shocked'."⁹⁶ Carter⁹⁷ was evacuated to a hospital ship with "shock". He rejoined his battalion on 29 May but was hospitalised again after Lone Pine with "debility", a generalised psychosomatic disorder.⁹⁸ Towards the end of the Dardanelles campaign, Lieutenant Colonel G.F. Murphy recorded one effect of an enemy bombardment. "Violent Turkish demonstration at 1904. No reply from us. One man went silly in trench," he wrote in his diary.⁹⁹ References to the psychological consequences of artillery fire such as these are legion in diaries, letters and recollections. "Sometimes we have to sit in the trenches under a heavy bombardment," Lieutenant G.L. Makin told a friend in

⁹² Private J. McKeown, 45th Battalion, Army Form B179, "Medical Report on an Invalid". AWM 27, 370/25. Part 3.

⁹³ Quoted in Winter, *op. cit.*, p. 116.

⁹⁴ The juridical process that followed the evacuation of psychological casualties is explained in chapter two, pp. 81-87.

⁹⁵ Evidence of Private C. Taylor, in Lieutenant Colonel E. O'Neil, Officer Commanding 2 Stationary Hospital, to Deputy Assistant Adjutant-General, 2nd Army, 18 October 1917. AWM 23 [Box 91].

⁹⁶ Colonel R.J. Millard, Australian Army Medical Corps, Diary, 18 May 1915. AWM 1DRL/499.

⁹⁷ Lieutenant H.G. Carter, footnote 88 above.

⁹⁸ Carter, *op. cit.*, Army Form B103.

⁹⁹ Lieutenant Colonel G.F. Murphy, 18th Battalion, Diary, 9 December 1915. AWM 1DRL/528.

Australia. "This is a great strain on the nerves, even if you are not hit." ¹⁰⁰ In a narrative of his war experiences based on notes made at the time, Corporal L. Jones of the 3rd Battalion wrote: "He [the enemy] hit Pozieres with everything he had. Men were looking glazed. Some were going dilly." ¹⁰¹ "Continuous bombardment of village by Fritz all day, recorded Lieutenant J. T. Maguire in his diary. "It was nerve racking and some of our chaps went mad. It was reckoned a fiercer bombardment than Verdun." ¹⁰² During the same engagement Lieutenant G. Wilkins described a similar scene: "Shells falling like hail. Dick Warren cracked. Sick Shell Shock." Later that day Wilkins himself was evacuated for the same reason. Carrying bombs and water along a sap, he was bowled over by a nearby shell explosion which made him "sick and groggy." In the Canadian hospital at Etaples the next day he was "still shaky" and tried to read a paper but it only made his head spin. ¹⁰³ After a violent German bombardment of Australian trenches on the Western Front, Private Buchanan wrote the next day: "I was flinching all over and was for days after. Terrible lot sent away with shell shock." ¹⁰⁴

Two of the most disturbing aspects of artillery fire were its deafening sound and earth-moving ability. Countless numbers of shell shock victims were overwhelmed by the storm of noise and the terrible trauma of silent entombment following an earthen avalanche. In a letter home, Rollo Armitage described the terror created by noise and the possibility of burial at Mouquet Farm: "The earth literally shook and I was more afraid of the trench (9' deep) collapsing and burying us alive, than of the shells - but the roar!! it was awful !!! One of my Sgts. (Nuttall) had his eardrum split." ¹⁰⁵ One of the more enlightening accounts of the experience of burial was provided by Sergeant J.R. Edwards whose ordeal occurred at Pozieres towards the end of July 1916:

One came pretty close . . . then a 5.9 landed fair on the parapet above our 'possie'. It broke down the 3 or 4 feet of earth above the recess, and buried us. I could just hear Telfer calling out - I believe his head was free. I tried to raise a cry but the earth was over my face, and my hands were pinned across my chest by the weight, as I was lying on my back. I struggled like hell but could do nothing. All of a sudden the pressure became heavier; it was irresistible, and I was blotted out. I recollect thinking 'I'm gone', and knew nothing more until coming to in the Colonel's dugout some time later. One could not ask for an easier death. Bert and Jim were the rescuers. They were at us with shovels in a tick . . . and at last got Telfer out. To get him they had to pull out a wooden strut which had been holding up the ground. It was the fall of earth consequent upon the removal of this stick that finished me. Jim dug my feet clear and they yanked me out. The doctor thought I was gone but I soon revived when water was thrown on my face and it took four swaddies to hold me on the stretcher. I believe I yelled and screeched like mad. Evidently resurrection is a tougher ordeal than death. They got a light to examine me, and according to Bert, when I saw the light I 'went limp, and as mild as mother's milk.' However, something had been jarred inside my tough old nut, and my memory was

¹⁰⁰ Lieutenant G.L. Makin, 5th Battalion, Letter, 30 August 1916. AWM 1DRL/0473.

¹⁰¹ Corporal L. Jones, 3rd Battalion, Narrative based on notes, Part IV, p.6. AWM 2DRL/521.

¹⁰² Maguire, Diary, Pozieres, undated.

¹⁰³ Lieutenant G. Wilkins, 18th Battalion, Diary, 26 July 1916. AWM PR 82/129

¹⁰⁴ Private G. Buchanan, 18th Field Artillery Brigade, Diary, 22 August 1916. AWM PR 82/24.

¹⁰⁵ Armitage, Letter, op. cit..

affected. For instance, I would recognise the boys, but for the life of me could not recall their names. ¹⁰⁶

Edwards apparently recovered and returned to duty ¹⁰⁷ but, as will be seen below (and in later chapters), many men found the trauma of burial too much to bear and became chronic cases.

Many men diagnosed with war neurosis were the victims of shell blast. At Gallipoli, Private Frank Lee was making breakfast for his company on the beach when a Turkish shell exploded and knocked him unconscious. By 1916 he was back in Australia suffering the effects of shell shock. ¹⁰⁸ After being buried by a major fall of earth following a shell burst, Private A.C. Smith was also evacuated from Gallipoli. Gritting his teeth and hanging on trusting - his formula for survival ¹⁰⁹ - had not been enough on this occasion. As described by Smith from his hospital bed in Malta, burial in this manner was a very unpleasant experience. Little wonder it turned minds:

[T]he Turks poured the heavy guns into our trenches, one of which blew four of us off the firing step and buried us . . . The four were, Lieutenant Kuring, Gosden, Hamilton and myself . . . Mr. Kuring's nerves are bad and has been ordered on holiday. It is a nasty sensation being covered with earth and so helpless. My ankle was bent over and I expected it to snap any moment but the boys got together and dug as out all right. ¹¹⁰

In hospital on Lemnos he described some of the effects of what a doctor described as "a nervous disability which was caused from shock": ¹¹¹ "Still confined to bed again . . . I cannot sleep well at night and when I do it is only to dream of war." ¹¹² Later, from a hospital on Malta, he wrote: "Nearly all the time that I was there, I got to feeling worse and very weak. Too much trouble for me to do anything." ¹¹³ After he was sent to hospital in England in October 1915, it was recommended by a medical board that he be put on light duties for the duration of the war. ¹¹⁴

In October 1917, Private Wilfred Barber was buried several times during German bombardments. He told a friend in Australia: "I am at present in a Casualty Rest Camp, suffering from shell shock and bruising, the results of being buried." ¹¹⁵ Corporal L.R. Boulton who was also buried as a result of shell fire (once when his dugout collapsed) received four days rest. He wrote: "I'm getting 4 days with nothing to do in consequence, as my nerves are a little on edge. The sound of a rifle going off

¹⁰⁶ Sergeant J.R. Edwards, 27th Battalion, Diary, quoted in Butler, *op. cit.*, pp.114-115.

¹⁰⁷ Butler, *op. cit.*, p.115.

¹⁰⁸ Medical Report on an Invalid, in Private F. Lee, 5th Battalion, PCF.

¹⁰⁹ Private A.C. Smith, 7th Battalion, Diary, 7 July 1915. AWM PR 91/120

¹¹⁰ *Ibid.*, 12 July 1915.

¹¹¹ *Ibid.*, 12 October 1915.

¹¹² *Ibid.*, 18 July 1915.

¹¹³ *Ibid.*, 13 September 1915.

¹¹⁴ *Ibid.*, 14 December 1915.

¹¹⁵ Private W. Barber, 36th Battalion, Letter, 9 October 1917. AWM 1DRL/0088

makes me jump." ¹¹⁶ Lieutenant Warren Cooke felt that the shell fire at Bullecourt was worse than Pozières but tried to comfort his people at home nevertheless:

I wasn't exactly wounded that time I was reported. Was only blown up by a shell and somewhat shaken. Never left the Bn. at all but was kept three days in a dugout till Bn. came out of the line. Rotten experience, though. Made me very shell shy for a bit. Very narrow squeak. ¹¹⁷

At Pozières, following a sleep at battalion headquarters, Major J.R.O. Harris was climbing the stairs of the old German dugout when a 77-mm shell exploded on the parapet above and killed a man whose body knocked Harris back down the steps. In a narrative of the war, he recalled:

The explosion and the fall stunned me and my recollection of subsequent events was rather disconnected until I found myself on a motor ambulance on my way to the C.C.S. [Casualty Clearing Station] without a single wound on me but finished as far as further work was concerned for the time being. ¹¹⁸

In August 1916 Sergeant J.J. Makin was evacuated to the County of London War Hospital with shell shock. "I am in England recovering from the shock caused by one of Fritz's high explosive shells bursting alongside me, " he wrote in a letter home. He described the effects of this episode:

In a week or so, perhaps, I shall be able to concentrate my thoughts on England and write of its beauty, but now I can think of nothing but war, war, war, always night and day. I cannot think how long it is since I last wrote to you or where I was at the time. My memory is a bit strained. ¹¹⁹

Three days later he wrote: "I am very disheartened and do not feel much inclined to write these lines." ¹²⁰ Makin was placed on light duties in the Finance Section at AIF Headquarters, London, and remained in that position for the rest of the war. ¹²¹

Shell fire thus exercised a despotic rule over the minds of many Australian servicemen and, together with its concomitant - burial - was intimately involved with the production of strain and breakdown at Gallipoli and on the Western Front. It is not surprising, therefore, that this new war disorder was widely known as shell shock. But artillery was not the only mental oppressor. As has been shown, the responsibilities of leadership and the suppression of emotion also constituted major psychological tyrannies. In addition, several other common facets of trench life also became serious

¹¹⁶ Corporal L.R. Boulton, 33rd Battalion, Diary, 28 May 1917. AWM 1DRL/0136

¹¹⁷ Lieutenant W. Cooke, 18th Battalion, Letter, undated, circa May 1917. AWM PR 84/114.

¹¹⁸ Major J.R.O. Harris, 3rd Battalion, Narrative, p.23, AWM 1DRL/338; and C.E.W. Bean, *The Official History of Australia in the War of 1914-1918, Volume III The A.I.F. in France: 1916* (First published Angus and Robertson 1929; this edition University of Queensland Press, St Lucia 1982), pp. 553-554.

¹¹⁹ Sergeant J.J. Makin, 21st Battalion, Letters, 7 August 1916. AWM 1DRL/474.

¹²⁰ *Ibid.*, 10 August 1916.

¹²¹ *Ibid.*, Letters 10 August 1916 - 1 November 1918 *passim*.

mental encumbrances for Australian soldiers of the Great War. The physically uncomfortable environment together with fatigue and tension contributed significantly to emotional overload. So did aerial bombing, the zip of bullets, listening-post duty, the intensity of battle and horrors like the cries of wounded men; in fact, a shell explosion was, in many cases, likely to have been only the necessary precipitant that triggered the collapse of a man already heavily burdened by some of these stresses.

Listening post duty and tunnelling both at Gallipoli and on the Western Front were sources of unbearable strain that produced their share of mental casualties amongst Australian troops. Tunnelling and mining by the Anzacs at Gallipoli began in early May in response to Turkish attempts to blow up Quinn's Post by detonating explosives beneath it.¹²² Suspicion of this activity resulted in New Zealand engineers sinking three shafts twelve to fifteen feet deep in which men listened for the sound of enemy mining.¹²³ Thereafter, until the end of the campaign, a continuous underground war ensued as both sides tunnelled under the opposing front line in an effort to blow up vital sections of trench and each other's galleries. In Volume II of the Official History, Bean described the "unbearable strain" on a garrison which could hear the faint sound of mining and knew that the enemy was preparing an explosive charge directly below.¹²⁴ But it was those actually underground who were most likely to end up on bunks in a hospital ship, restrained and sedated.

And, of these soldiers, it was those manning the tiny, cell-like listening posts at the end of a tunnel who seemed to be most at risk of mental breakdown. Here, no more than two men at a time concentrated on what Bean called the "highly technical" task of listening for enemy mining and trying to judge its position.¹²⁵ In the darkness and silence, with hundreds of tons of earth above them and the enemy only a few feet away, these men strained to distinguish the muffled tapping of a pick from the knocking that indicated the charging of a mine which might at any time explode and inter them. And this did occur.¹²⁶ Trumpeter W.K. Hampson experienced listening post duty and described the ordeal:

The sentries in these saps do half an hour on and 4 1/2 hours off there are always two and they are forbidden to talk so that if men were left in that pitch dark unable to speak any longer they would be raving lunatics when they came out. one has no idea what the strain is until one has been in them I don't think that I shall ever forget it in my life.¹²⁷

¹²² C.E.W. Bean, *The Official History of Australia in the War of 1914-1918, Volume II, The Story of Anzac, From May, 1915, to the Evacuation of the Gallipoli Peninsula* (First published Angus and Robertson 1924; this edition University of Queensland Press 1981), p.199.

¹²³ Ibid.

¹²⁴ Ibid, p.203.

¹²⁵ Ibid, p.266.

¹²⁶ Ibid, p.278.

¹²⁷ Trumpeter W.K. Hampson, 5th Field Ambulance, Letter, 19 November 1915. AWM 1DRL/0331

On the Western Front, Australian tunnelling companies were involved in similar activity but on a much larger scale. In France and Belgium, particularly at Messines where several enormous mines were exploded before the attack, Australian tunnellers fought the same kind of tense underground war that they had on Gallipoli.¹²⁸ For at least one man, already severely stressed, the strain was too much. Sergeant Albert Dimond was buried three times in one day at Pozières¹²⁹ before being sent to assist the engineers with tunnelling work but although this spell was intended as relief, it was of little benefit. While on this detail he accidentally shot himself in the foot. "[T]his work played up with my nerves," he told the Department of Repatriation after the war.¹³⁰

Subterranean listening post duty had an open air equivalent which entailed a similar tension. This was usually associated with the need to monitor enemy activity or to provide information and guidance for Australian patrols and raiding parties. At Gallipoli, because of the proximity of the opposing lines, this duty was not common but it did occur and was extremely dangerous. An entry in the diary of Lieutenant K.S. Anderson describes one of its effects:

[M]y post was on the direct line of fire and as each shell exploded we were covered with dust, gravel and earth; on account of the nervous strain and the risk it was necessary to change the observer every twenty minutes, every other man taking what shelter he could find.¹³¹

Lying out near Frimicourt during the Allied advance to the Hindenburg Line in April 1917, Corporal A.G. Thomas wrote in his diary: "I fancy we will be relieved to night, I pray for it, the strain on a man on these outposts is awful, cold God how cold it is, no blankets, not safe to sleep, only just in snatches . . ." ¹³² Lance Corporal Clarkson, on the Western Front, described listening post duty as a "rotten job": "2 men have to go about 30 yards out in NO MAN'S LAND and watch and listen for any movement or sound of the enemy . . . I can assure you the job puts your nerves on edge." ¹³³ Lance Corporal Roger Morgan thought that such an assignment was

about the greatest strain of all on the nerves of the men. On one occasion we had a man at Fleurbaix (Wye Farm) who could not stand the strain and when brought in was as mad as a hatter and had to be sent to hospital. Have no recollection of his ever returning to the unit either (poor beggar). ¹³⁴

Accumulated stress only needed only one precipitant to force a collapse. It might be the death of a relative, a horrible sight, a shell blast - any such surprise could

¹²⁸ C.E.W. Bean, *Anzac to Amiens, A Shorter History of the Australian Fighting Services in World War One* (First published Australian War Memorial Canberra 1946; this edition Canberra 1968), pp. 209, 228, 351-2.

¹²⁹ Medical Case Sheet, in Sergeant A. Dimond, 24th Battalion, PCF.

¹³⁰ Form U, 3 July 1931, in *ibid.*

¹³¹ Lieutenant K.S. Anderson, 22nd Battalion, Diary, 18 September 1915. AWM 2DRL/151.

¹³² Thomas, Letter, 21 April 1917.

¹³³ Clarkson, Letter, 1 July 1918.

¹³⁴ Lance Corporal R. Morgan, 1st Australian Field Ambulance, Diary, 11 October 1916. AWM 2DRL/218.

force the victim's mind to critical mass. For example, Robert Henry, already heavily stressed, had a temporary collapse after his brother died on the Somme.¹³⁵ For Major Garnett Adcock the crucial event was an explosion. By late 1916 the mud and cold of Flanders, in addition to general exhaustion and the incessant threat from hugely destructive German trench mortar projectiles, began to exact a cost from him. His previously "cast-iron nerves" suffered terribly as these stresses built and he was unable to keep any food down except beef tea and rum, the latter serving to maintain his courage.¹³⁶ Front line service for him came to an end in January 1917 when a mortar blast bowled him over and he became an official shell shock case¹³⁷ who, by October 1918, was barely able to stand the stress of the office work to which he had been assigned.¹³⁸ Front-line duty was out of the question because, under shell fire again, his temperature and pulse rose and he could not articulate or remember anything.¹³⁹

Other men also found that a return to the front line caused a reprise of symptoms. Corporal Leslie Blaydes was blown up at a trench mortar shell dump on the Western Front in June 1917 and sent to England suffering severe shell shock, returned to his company four weeks later and experienced a recurrence of his original symptoms when he came under fire again. His commanding officer felt that he was not suited to work in forward areas.¹⁴⁰

Battle, with its intensification and unrelieved prolongation of these stresses pushed many Australians beyond breaking point. Colossal barrages that lasted for days or weeks, stomach-churning tension, the scything down of comrades, unimaginable chanel-house conditions, exhaustion, and a symphony of deafening noise every note of which represented a threat to life and dignity, combined to create nervous wrecks of many men. The landing at Gallipoli, and the battles at Lone Pine, Pozzières, Bullecourt, Messines, Passchendaele, Villers-Bretonneux and Mont St. Quentin created a crop of psychological casualties that began to grow during the earliest days at Anzac as the Australians and New Zealanders struggled to establish a beach head: "We landed at the Dardanelles 10 days ago," wrote Private E.C.N. Devlin, "our battalion was practically wiped clean out officers and all. Our dead are still out there unburied . . . Our officer Robinson was out of his mind and has been sent away."¹⁴¹ Not long after the landing, Lieutenant L.W. Street reported the disintegration of another officer. "As for B

¹³⁵ V. Henry to Repatriation, 14 June 1928, in Henry, PCF, op. cit..

¹³⁶ Major G. Adcock, 2nd Australian Tunnelling Company, addendum to letter, 12 November 1916, in Lindstrom, op. cit., pp. 68-70.

¹³⁷ Ibid, 1 January 1917, in Lindstrom, op. cit., pp.111-112.

¹³⁸ Ibid, 9 September 1918.

¹³⁹ Ibid, 20 January 1917.

¹⁴⁰ Report by Captain R.J. Fishbourne on Corporal Leslie Blaydes, 29 May 1918, in Corporal L. Blaydes, 24 Company, Australian Army Service Corps, Diary. AWM 3DRL/7524

¹⁴¹ Private E.C.N. Devlin, 18th Battalion, Letter, circa 5 May 1915. AWM 1DRL/0331

company, our second in command, Chester, broke down after the first few days," he wrote. ¹⁴²

At Lone Pine in August, psychological casualties officially comprised about three per cent (nine out of 278) of the Fifth Reinforcements, Sixth Battalion's losses. During and after the battle, Privates Farleigh, Lewis, Deery, Fletcher, Heppel, Kaill, Byars, Osborne and Ryder were evacuated to Mudros for "shock", "shock and bruise", "shell concussion", "shell shock and bruise", and "bomb shock." ¹⁴³ Earlier, Private E. Beresford had been sent to Mudros for "shock" while Bugler A.R. Wardrop had been evacuated for "shock" which had left him "deaf and dumb." ¹⁴⁴ Also at Lone Pine, Private Devlin wrote: "The slaughter is so terrible here that fellows try to get shot, so as to be out of it all. Some go crazy." ¹⁴⁵ An entry in the diary of 31-year-old Sydney surgeon, Lieutenant Colonel Hugh Poate, provides some idea of the conditions that drove men mad during this battle: a boy of 18 who had lost "his senses" staggered "white as ghost" into Poate's dressing station. One side of his head, face and body looked as though it was covered in vomit and bully beef "as though he had fallen into it." Upon questioning, the young soldier revealed that a high explosive shell had burst alongside him, bowling him over, blowing off his mate's head and scattering its contents over him. ¹⁴⁶

The abattoir atmosphere in the aftermath of Lone Pine affected the mental balance of many men within G.L. Makin's immediate vicinity. In October 1915 he told his mother:

The last position we took at Anzac. That is Lone Pine plateau, the bodies were so thick that for a week we had to walk on them, eat our meals and sleep amongst them. It was a real nightmare and several men broke down completely under the strain and smell. ¹⁴⁷

Captain H.G. Carter, who had returned to the Peninsula after earlier being evacuated with shell shock, also found the action at Lone Pine difficult to cope with. He wrote:

The strain of this last action has been worse than I thought and the sights and other such things have played on my nerves more than I expected . . . got up and wrote my diary while things were still fresh in my mind. ¹⁴⁸

¹⁴² Lieutenant L.W. Street, 3rd Battalion, Letter, 16 May 1915. AWM 1DRL/578.

¹⁴³ "Copy of Casualty Return Submitted to 1st Inf. Bde. A.I.F. ON 10/8/1915 for period 6th to 9th August 1915 inclusive." In papers of Lieutenant H.L. Montague 4th Battalion, AWM 3DRL/4037

¹⁴⁴ "Copy of Casualty Return Submitted to 1st Infantry Brigade A.I.F. on 11.8.1915 for period of 48 [hrs?] preceding 5.30 pm on 11 August", in *ibid.*

¹⁴⁵ Devlin, Letter, 30 August 1915.

¹⁴⁶ Lieutenant Colonel H.R.G. Poate, AAMC, Diary, undated, p. 20. AWM 2DRL/1225.

¹⁴⁷ Lieutenant G.L. Makin, 5th Battalion, Letter, 31 October 1915. AWM 1DRL/0473

¹⁴⁸ Carter, Diary, 11 August 1915.

Carter was once more evacuated, this time to Egypt with debility, a term frequently employed to describe puzzling psychosomatic disorders.¹⁴⁹

Of all the Australian battles of the First World War, Pozières is the one most synonymous with shell shock. Perhaps this is because of its historical treatment.¹⁵⁰ Nevertheless, the available figures for the 2nd Australia Field Ambulance (the only detailed ones for the entire war) demonstrate the high rate at which psychological casualties could occur in battle. During the period 22 July - 16 August 1916, 7183 "other ranks" and 79 officers passed through his unit and, of this number, 1610 and 10 respectively (or twenty-two and twelve per cent) were classed as shell shocked. Amongst these were men suffering an acute form of psychological disorder known as "battle shock" and who recovered after prompt treatment which usually involved sedation and rest; and those who became chronic cases.¹⁵¹ The following accounts provide considerable insight into the reasons for psychological breakdown not only at Pozieres but in other major Western Front battles in which Australians participated.

At Pozières, Arthur Cubis succumbed to the unceasing German bombardment which blew his friends to pieces, immobilised the survivors and prevented the arrival of food and ammunition supplies. "If hell is as terrible as that then God spare all humans from it. Our officer . . . was Blown to pieces," he wrote in his diary. "Men were going mad. I Broke down and the water ran from my eyes. I was half mad from shock."¹⁵² Later, Cubis described the case of a Sergeant at Pozières who "went to pieces" and would not help him dig a position or load his machine gun during the entire night on duty. Eventually the sergeant's hand was blown off but, for all practical purposes, shell shock had disabled him long before his injury.¹⁵³ Such breakdowns were a common and disturbing occurrence at Pozières. Archie Barwick recorded the following entry in his diary:

All day long the ground rocked and swayed backwards and forwards from the concussion of this frightful bombardment . . . any amount of men were driven stark staring mad and more than one of them rushed out of the trench towards the Germans, any amount of them could be seen crying and sobbing like children, their nerves completely gone . . .¹⁵⁴

The screams of the Australian wounded at Pozières made a deep impression on some men, one recalling them four months afterwards and writing: "We saw the 1st and 2nd battalions disappear in the darkness, driven as we were nearly mad by the cries and groans of our wounded."¹⁵⁵

¹⁴⁹ Carter, Army Form B103, 14 August 1915.

¹⁵⁰ See Introduction, pp. 10-11.

¹⁵¹ Butler, op. cit., pp.107-114.

¹⁵² Cubis, Diary, 29 July 1916.

¹⁵³ Ibid, 4 and 5 August 1916.

¹⁵⁴ Barwick, Diary, 24 July 1916.

¹⁵⁵ Lieutenant C.J. Mc Donald, 3rd Battalion, Letter, 14 November 1916. AWM 2DRL/146.

For some men, battle experience played a major role in the development of the mental trouble that was to dominate their post war lives. During the 1920s and 1930s all of the following men presented at the Department of Repatriation with war neurosis. At Bullecourt in April 1917 Driver Leslie Hall was resting in a sunken road with other men when a shell burst in the middle of the party, killing some and burying Hall who was severely shell shocked. He returned to duty and went through Third Ypres in 1917 and Amiens in 1918 where he was badly gassed. He did not, however, rejoin his battalion but was "kept at 1st Divisional HQs for some time owing to the deaths of my three brothers." ¹⁵⁶ Gunner Jack Greening left the fighting at Bullecourt with a fragment of high explosive shell in his shoulder but it was his misfortune to be bowled over by an explosion after leaving the dressing station. ¹⁵⁷

After the battle of Messines, which took place between 6-11 June 1917, ¹⁵⁸ Lieutenant Thomas Mosley of the Third Machine Gun Battalion was evacuated as a psychological casualty and later discharged. The violent events in his small corner of this Belgian battlefield were, for him, the last straw in a series of events that were characterised as "a very stiff time". ¹⁵⁹ In the line continuously since November 1916, he was blown over several times by shell fire and for about a week before Messines was not able to sleep much and "felt rather done up." During the battle - at 4am - he was bowled over by an explosion but carried on after a short rest. At 3pm he was again blown up and partially buried. He vomited, developed a severe headache and became "quite deaf" then rested in a shell hole for two hours before proceeding once more. He developed a "great thirst". At 10pm he collapsed, delirious, walked with help to an Advanced Dressing Station and was evacuated. ¹⁶⁰

At Passchendaele, (September-November 1917) Gunner Horace Jackson was buried twice by shell explosions and, when dug out, was sick and vomited for three days. ¹⁶¹ During the same battle the nerves of Gunner George Keen "went to pieces" and he was removed from the fighting. ¹⁶² Passchendaele - and later Villers-Bretonneux - also placed severe demands on Maurice Daniels' mental functioning. Incessant heavy shelling, aerial bombardment, close calls, the loss of comrades, the absence of relief, and his determination not to succumb to the subsequent psychological stress, did serious damage to his mind that only really told in the post-war years. ¹⁶³ In 1930 he described his ordeal to Department of Repatriation officials:

¹⁵⁶ AF B103, 22 April 1917, Form U, 12 November 1930, in Driver Leslie Hall, 6th Battalion, PCF.

¹⁵⁷ Proceedings of a Medical Board on an Invalid, in Gunner J. Greening, 60th Battalion, PCF.

¹⁵⁸ Bean, *Anzac to Amiens*, op. cit., pp. 345-356.

¹⁵⁹ Medical Case Sheet, circa 1917, in Lieutenant T. Mosley, 3rd Machine Gun Battalion, PCF.

¹⁶⁰ Ibid.

¹⁶¹ Army Form B179, in Gunner H. Jackson, 14th Field Artillery Brigade, PCF.

¹⁶² Medical Report on an Invalid, 30 January 1919, in Gunner G. Keen, 14th Field Artillery Brigade, PCF.

¹⁶³ see also chapter seven, pp. 227-228.

At Villers Bretonneux we were in action for twenty-five days. On one occasion an English unit was forced to retire and we had to counter attack. The 15th Brigade 'hopped over' taking the gun I was attached to and another. It was a silent attack and I consider was worse than one with artillery support. I was in pins and needles all the time. At daylight enemy 'planes came over and bombed us, continuing to do so for days. They flew very low and frequently we could see the bombs falling. It was a nervy time and owing to shortage of men we got no relief for days until everyone was shaky. I know I could not sleep and if I did lay down I just went off into a restless doze and woke up with a jump. When we were relieved my eyes were sunken. At this time seven or eight men were killed in front of me by a graze fuse shell. ¹⁶⁴

At Mont St Quentin in August-September 1918, Lieutenant John Steele showed outstanding coolness as he led bomb parties under heavy fire and captured ground from the enemy, drove them back and hindered their advance. But he paid a high price for his bravery and for continual exposure on the Western Front. In 1930, when applying for medical treatment and a pension to relieve his straitened circumstances, he told Repatriation:

[A]t Flers towards the end of 1916 I was blown up. I got a good shaking but did not have to report sick or receive any treatment . . . In May 1917 I was wounded in the back by a bomb but remained on duty. At Mont St. Quentin in 1918 I was again blown up and badly shaken. ¹⁶⁵

Like all of the above soldiers, Steele's post-war existence was dominated by the psychological legacy of these battles.

At the heart of many soldiers' insights into the causes of mental strain and collapse was a clear comprehension of the insidious role of fear, that unwelcome acquaintance which most men eventually came to know intimately. Fear "prised a man's grip from the helm of self-control" according to J.A. Raws who told his brother Lennon: "Everyone called it shell shock. But shell shock is very rare. What 90 per cent get is justifiable funk . . ." ¹⁶⁶ Lieutenant John Bourke felt that there were two types of shell shock; both were associated with an explosion but one, accompanied by fear, affected the mind while the other, through concussion, physically damaged the nervous system:

A wound may not be dangerous, but shell-shock to the nerves is aided by fear, and is always bad. I saw men that day [23 July 1916 at Pozieres] trembling like leaves - a shell bursting near them would ruin their nervous system. A concussion shock is quite another matter: with steady nerves a man may easily recover. One kind affects the nerves, the other the head. ¹⁶⁷

Albert Facey thought that fear was at the root of many of the "nerve cases" ¹⁶⁸ as did Private Thomas Cleary, who believed that the basis of that dread was the possibility of being shredded by high explosive. In November 1916 he described how

¹⁶⁴ Daniels, Form U, op. cit..

¹⁶⁵ Form U, 25 November 1929, in Lieutenant J.E. Steele, 23rd Battalion, PCF.

¹⁶⁶ J.A. Raws, Letter, 12 August 1916.

¹⁶⁷ Lieutenant J. Bourke, 8th Battalion, Letter, August 1916 (No day recorded). 1 DRL/0139.

¹⁶⁸ Facey, op. cit., p. 258.

the softer tissues of a sleeping English soldier had been blown into a nearby bag of nails by a shell blast "making a bloody ghastly hotch potch." Cleary remarked:

I could chronicle this sort of stuff indefinitely but have hitherto refrained . . . I mentioned these items to make clear this point. I don't think any of our fellows minds 'going west'... [b]ut the thought that one day you may be such a ghastly mess as I have just spoken of is very revolting and has a lot to do with the nervous cases (shellshock, Breakdown etc). I shan't allude to any of this sort of stuff again, too goulish. ¹⁶⁹

As Cleary stated, horror of this type was everywhere in the war zone. Lieutenant John Bourke, for example, impassively described a scene of indiscriminate slaughter at Strazeele in April 1918:

Three weeks ago we entrained here for the Somme. Now nothing but a pile of bricks and ... timber. Noticed two French soldiers blown to pieces. Must have come back for something and met their death. Cattle horses and pigs lying dead all over the place. ¹⁷⁰

At Zonnebeke in October 1917, the official photographer, Captain Frank Hurley, witnessed a similar spectacle: "This shelled embankment of mud was a terrible sight. Every 20 paces or less lay a body. Some frightfully mutilated, without legs, arms and heads and half covered in mud and slime." ¹⁷¹ Horror played on men's nerves by signalling the possible manner of their own demise or arousing feelings of pity and sorrow which knew little discharge. In such a situation it was the imagination that inflicted much of the damage. Captain Stobie, for example, thought that his nervous trouble under fire was partly due to "an imaginative and anticipative temperament." ¹⁷² In his diary Private C.A. Clements confronted similar feelings:

Our trench mortars got busy last night and blew up a hun listening post. The huns must have been badly wounded, never heard men scream so horribly before. It was heart trending and I still fancy I can hear the germans screaming. Hope I will never get like that. ¹⁷³

Horror tipped some men over the edge. The gruesome details of the event that provoked Driver Harold May's breakdown may be easily imagined:

Enemy shell burst close to column carrying ammunition to battery position on 22-10-17. Man in front of May killed - also four horses close to him. May lost self-control and was no longer fit for duty being in a nervous condition. ¹⁷⁴

¹⁶⁹ Cleary, Diary, 30 November 1916, in Lindstrom, op. cit., p.65.

¹⁷⁰ Bourke, Diary, 23 April 1918.

¹⁷¹ Captain F. Hurley, Diary, 12 October 1917. AWM PR/291.

¹⁷² Stobie, Diary, 31 October 1916.

¹⁷³ Private C.A. Clements, 54th Battalion, Diary, 16 May 1918. AWM 1DRL/961

¹⁷⁴ Army Form 3428: Report on Accidental or Self-Inflicted Injuries, Driver Harold T. May, 17 November 1917. AWM 23 [Box 92].

Other men attributed their psychological debilitation to a wearing out process,¹⁷⁵ or unrelieved strain: "[S]ince we first came down the Somme early in July we have been worked very hard," wrote Lieutenant T.A. Miles. "and this last trip . . . we have had thirty five days in the line, too long for any man in one stretch, I have steady nerves, as steady as the next man, but I was feeling the strain."¹⁷⁶ But thirty-five days seemed as nothing compared to the five months without a break experienced by some of the troops on Gallipoli. "We have at last been withdrawn as we are really worn out and to some extent run down," wrote G.L. Makin from Lemnos. "The nerves begin to feel the strain of 20 weeks of the sort of fighting we've been in."¹⁷⁷ Robert Raws expressed similar sentiments when commenting on the necessity of 48 hours rest from the Gallipoli trenches:

I don't think we could stand it otherwise. With constant bombing . . . and frequent artillery fire to which our position is open, there is a strain about it, and the 48 hours off is a God-send . . . Lieut. Ellerton, of whom you might know, somehow let the thing get on his nerves and lost his reason - he left here pretty bad.¹⁷⁸

Sleep deprivation also played a significant part in mental strain. At Gallipoli, Corporal J.M. Gibb wrote: "Nobody gets more than two hours sleep in 24, so that our fellows are just about done up and their nerves are all on end, I feel very shaky . . ." ¹⁷⁹

The inexorable wearing away of the stone by the general conditions of trench life was, therefore, of great significance in the production of mental disorder. At Gallipoli, where soldiers were generally unable to take genuine leave of the front line environment, the crazed were apparently a familiar sight: "They are lucky who get away from here wounded," wrote one man. "It is quite common for men to go mad here. The strain on the nerves is so severe."¹⁸⁰ "Now is the time we feel what *war is*," wrote another towards the end of the campaign. "Reaction is setting in - and I can notice several 'old hands' cracking up."¹⁸¹ In France the Australians witnessed scenes of mental decline that probably reminded them of their Peninsula ordeal: "Nervous breakdown under trench strain," stated Captain Henry Maudsley's medical report on Private W.J. Davis, a 25-year-old clerk from Melbourne. "Sent to the Q.M.'s store for four months."¹⁸² During the Third Battle of Ypres in August 1917 Gunner Ronald

¹⁷⁵ Morse, Letter, op. cit..

¹⁷⁶ Lieutenant T.A. Miles, 12th Battalion, Diary, Book V, 22 October 1916-10 February 1917, p. 45. AWM 2DRL/0554

¹⁷⁷ G.L. Makin, Letter, 15 September 1915.

¹⁷⁸ R.G. Raws, op. cit., Letter, 2 October 1915.

¹⁷⁹ Corporal J.M. Gibb, 6th Battalion, Diary, undated, in R. Austin, *As Rough as Bags, The History of the 6th Battalion 1st AIF 1914-1919* (McRae 1992).

¹⁸⁰ Devlin, Letter, 2 September 1915, quoted in Gammage, op. cit., p. 76.

¹⁸¹ Armitage, Diary, 24 November 1915.

¹⁸² Private J. Davis, 5th Battalion, Army Form B179 "Medical Report on an Invalid", 9 January 1917. AWM 370/25, Part 2. No 583.

Sinclair sympathetically watched the sad demise of one of his sprightly comrades and attributed his miserable reduction to several causes. He wrote:

We have a little chap here who used to be the life and soul of the Battery and now if a shell lobs within 100 yards of him, he is something awful to look at. He has absolutely not the slightest control of his nerves, in fact he's a broken man. All this the result of shelling all day and gas all night and consequently no rest for weeks on end. It must tell in the end." ¹⁸³

Thus the trenches and battlefields of the First World War were more than just tactically and strategically significant locations for the AIF. For many Australian soldiers they were places of unspeakable terror and interminable strain. Contained within these environments was a wide diversity of highly stressful elements which tested the psychological balance of many soldiers, some of whom became victims of a new form of warfare that unleashed the highly destructive products of modern industry on undefended human flesh. The trauma of shell fire, aerial bombardment, the prospect of horrible death and mutilation, sleep deprivation, tension, physical exhaustion and a strong sense of helplessness in the face of these terrible dangers and stresses produced a strain that many could not tolerate.

Front line conditions were, therefore, the main environmental causes of psychological stress and breakdown amongst Australian soldiers of the Great War. But, in addition to the fighting infantrymen, prisoners of war and pilots also suffered mental disorders which, in some cases, blighted their post-war lives. Altogether, 3,647 Australians were captured ¹⁸⁴ and, although prisoners of the Germans were considered more fortunate than those captured by the Turks, privation and cruelty were common to both. ¹⁸⁵ One Australian taken prisoner at Bullecourt in May 1917, Private John Hills, was forced to work behind the German lines within range of Allied shells and gas, and was not provided with blankets to keep warm at night. In Germany the food was inadequate, especially considering the 13 hours daily labour he and others were required to perform in coal mines. In total, he was twenty months a prisoner of war. "When being examined on discharge [in Australia] I told the doctors I was O.K. but my nerves were in a pretty bad state," he told Department of Repatriation officials in 1929. ¹⁸⁶ Subsequent medical examinations confirmed the mentally destructive effect of his captivity. ¹⁸⁷

¹⁸³ Brigadier R. Sinclair, 25th Australian Artillery Brigade 1916, 14th Australian Artillery Brigade 1916-1918, Letter, 13 August 1917. AWM PR86/226.

¹⁸⁴ P. Adam-Smith, *Prisoners of War: From Gallipoli to Korea* (Viking, Ringwood 1992), p.84.

¹⁸⁵ *Ibid.* pp. 30-32,43-46.

¹⁸⁶ Form U, 19 July 1929, in Private J. Hills, 3rd Field Company Engineers, PCF.

¹⁸⁷ *Ibid.*, *passim*.

Life as an aviator on the Western Front also entailed tremendous mental stress¹⁸⁸ to which at least one Australian fighter pilot fell victim. As a result, 22-year-old Captain Harold Walters became an alcoholic while on active service and remained dependent on this and other drugs for the rest of his short life. He died in 1945.¹⁸⁹

Psychological stress and breakdown produced a wide range of behaviour and symptoms in Australian soldiers that reflected the awfulness of a modern mechanised war in which the individual was made to feel small and weak. In the face of hugely destructive and impersonal forces that encouraged socially and militarily unacceptable behaviour, Australian servicemen tried to suppress their natural feelings but this kind of holding action often proved ineffective. Men hospitalised with shell shock, and those who remained, often suffered alike. It was just a question of degree as to whether a man was evacuated or not. As reported by themselves, Australian soldiers were aged, crushed, and exhausted by mental stress. Some "lost their reason" and were hospitalised while others affected escapes by inflicting wounds on themselves or deserting. Those who remained or returned to the trenches forced themselves to "keep up" but suffered anyway. Some men became "shell shy", lost their memories, had continual recurrences of symptoms or slept poorly as the horrors of the battlefield stalked them in their dreams; some were easily startled or experienced fainting fits; others found concentration difficult, shivered uncontrollably, jumped at the sound of a rifle, or flinched for days after a bombardment. Depression and apathy were also common. Sunken eyes, raised temperatures, weight loss and the inability to articulate or keep food down testified to the bodily effects of mental strain.

Shell shock and psychological deterioration were, therefore, important and profoundly destructive aspects of service life for many Australian soldiers of the Great War. Those considered sufficiently serious cases were funnelled into a military medical system that was confused, unsettled - even bewildered - by this major new consequence of modern war. The disorders of some men, however, were not even recognised at the time. As a result of medical inexperience and military suspicion of psychological disorder, many of these Australians were inexpertly treated and duly suffered the consequences together with their families and probably the nation as a whole.

¹⁸⁸ D. Winter, *The First of the Few: Fighter Pilots of World War I* (Allen Lane, London 1982), *passim*.

¹⁸⁹ Captain Harold Walters, Australian Flying Corps, PCF, *passim*.

Chapter Two

The Medical Care of Australian Psychological Casualties in the Mediterranean and European Theatres of War.

For psychological casualties in the major theatres of war, medical arrangements were hastily improvised, inept and, on the Western Front, unusually hostile. With the possible exception of some of the front line medical units which inadvertently discovered the importance of prompt, practical treatment, these systems were generally inimical to recovery. They were instrumental in creating a body of returned servicemen who, because of their entrenched psychological disorders, subsequently became a virtually insoluble problem for the Commonwealth Repatriation Department which was itself ambivalent towards war neurosis.

The semi-independent status of the AIF and Australian Army Medical Corps (AAMC) within the British Army was crucial in determining the fate of AIF shell shock victims both in the Mediterranean and on the Western Front. For the AAMC, this status meant that Australians were subject to British policies and attitudes at the level of operational control. At other levels, however, the AAMC was responsible for its own wounded and sick and this also detrimentally influenced the experiences of psychological casualties. Subordination to British policies meant that the AAMC was the victim of a medical catastrophe at the Gallipoli landing and at the Base throughout the entire Dardanelles campaign. Psychological casualties suffered along with the rest but their situation was exacerbated by the absence of a co-ordinated, specialised system of care for them both on the Peninsula and in Egypt. On the Western Front, arrangements for psychological casualties centred upon a highly juridical method of dealing with war neurosis which reflected the British High Command's suspicion of mental disorder. Australian psychological casualties became part of this system once they moved beyond their own Field Ambulances and, under this regime, were often returned to battle only to be re-evacuated later with greatly aggravated difficulties. The Australian Defence Department's highly controversial "six months policy" did not give invalids a full opportunity to recover or prepare for the voyage home or to receive the best specialist care. When proper treatment was arranged for a few very late in the war, the size of the pension bill was uppermost in the minds of Australian authorities. Political and military expediency were thus the controlling agents in the lives of the war's mental invalids.

One of the few uplifting episodes in this story was the unstinting attempts by Dr. John Springthorpe, AAMC, to apply his knowledge of psychological disorder to

mental invalids from Gallipoli hospitalised in Egypt, and to the patients in ward A10 at No.3 Australian Auxiliary Hospital, Dartford, England. Although the level of his success as a therapist is difficult to gauge, both his compassion and the gratitude of his patients serve to underline the paucity of treatment elsewhere in the military-medical system.

Medical Arrangements in the Mediterranean Theatre of War.

With very few exceptions, Australian psychological casualties from Gallipoli were treated within the general medical system of the Mediterranean Expeditionary Force. These arrangements and their development, which, for all kinds of wounded and sick were never satisfactory, are briefly described below as a necessary prelude to the discussion of how Australian psychological casualties from Gallipoli fared as invalids and convalescents in the Mediterranean theatre of war.

The shortcomings of the medical arrangements for Gallipoli casualties were the result of the British General Staff's tendency throughout the campaign to place a low priority on such matters. But the Australian Government must share some responsibility as well. Although it served under the command of the British Army throughout the First World War, the AIF and AAMC enjoyed semi-independent status due to the Australian Government's desire that its military forces retain a measure of autonomy.¹ The expression of that wish was the Australian Defence Act and an Order-in-Council which permitted the General Officer Commanding the AIF, amongst other things, to organise the removal of Australian invalids from the war zone to Australia.² Such an arrangement produced benefits and disadvantages for psychological casualties as well as for wounded and sick in general. In the Mediterranean, Australian medical difficulties occurred mainly along the lines of communication and at the base, especially during the Landing and its immediate aftermath. But although medical arrangements at Anzac became more systematised as the campaign wore on, problems remained elsewhere in the theatre. An insufficient number of hospital ships, overstressed hospital accommodation and staff, and inadequate convalescent facilities in Egypt plagued the AIF and the AAMC during the entire period of the Gallipoli expedition.

Medical arrangements for the 25 April landing at Gallipoli - including Anzac - were disastrous. Inadequate planning (in which Australian objections were ineffectual), compounded by the unexpected military reverse with its large numbers of wounded,

¹ A.G. Butler, *The Australian Army Medical Services in the War of 1914-1918, Volume 1, Gallipoli, Palestine and New Guinea* (Australian War Memorial, Canberra 1930), p.31.

² Ibid.

created a situation conspicuous for its inhumanity.³ Unclear orders, the presence of only one fully-equipped hospital ship at Anzac, hastily and poorly equipped transport vessels, a shortage of stretchers, the absence of a field hospital, insufficient small craft to take the wounded from the shore⁴ and the consequent accumulation of casualties on the beach produced scenes of suffering comparable to any debacle in the history of the British Army. Many of these men were not cleared from the beach until three the following morning after frantic improvisation by the navy.⁵

Although by mid-May the medical arrangements on Anzac had become systematised, treatment of the wounded during the August offensive resembled the April fiasco. A reasonable job was made of conveying casualties to the beach from the Nek and Lone Pine (an Australian responsibility) but the General Staff's failure once more to provide a sufficient number of ships and small craft created a backlog of casualties on shore similar to the one seen at the landing.⁶

Both of these debacles at the front nearly overwhelmed the two other major elements of the medical infrastructure in the Mediterranean: the lines of communication (hospital ships and transports, and medical units on the islands of Lemnos, Imbros and Malta) and the medical facilities at the base. In fact, throughout the entire campaign (except perhaps when several enormous Atlantic liners were pressed into service)⁷ there was not sufficient shipping to convey the wounded from the front to the base or to England, or, indeed to Australia. Such a shortage of transport, and the large numbers of wounded, placed tremendous pressure on hospital and convalescent accommodation in Egypt⁸ and Imbros, Lemnos and Malta.⁹

In Egypt the problem of insufficient hospital and convalescent accommodation arose from the failure of the Australian and British governments to define their relative responsibilities in these areas.¹⁰ Initially, Australia had not intended to supply any base or line of communication units at all. A request from the War Office to the Australian Defence Department in August 1914, however, saw the provision of two General Hospitals and two smaller and more mobile Stationary Hospitals.¹¹ These units landed in Egypt with the second convoy during January 1915 and created the impression at the War Office that Australia would see to its own hospital accommodation. Knowing that the Australian base units were only a partial quota, the Defence Department assumed

³ Butler, op. cit., pp.100-102,141-145.

⁴ Butler, op. cit., pp.142-145, and 161.

⁵ Ibid, p.145.

⁶ Ibid, p.179 and J. Robertson, *Anzac and Empire: The Tragedy and Glory of Gallipoli* (Hamlyn, Port Melbourne 1990), pp.196-197, 205.

⁷ Butler, op. cit., pp.332-333.

⁸ Ibid, p.254.

⁹ Ibid, pp.217-221, 285, 334-336, 337.

¹⁰ Robertson, op. cit., p 210.

¹¹ Butler, Volume I, p. 27.

that the War Office would make up the difference but it did not.¹² Australian hospital accommodation, therefore, was not able to cope well with the numbers of sick and wounded despite constant piecemeal expansion of facilities throughout 1915. Convalescents, in particular, felt the lack of adequate accommodation, medical and nursing attention, feeding, bathing and, in many cases, the complete absence of suitable clothing for day leave.¹³

Throughout this period the AAMC had been without decisive leadership of its own or proper administrative control largely because of the uncertain status and vacillating character of the Director of Medical Services, AIF, Surgeon General Williams. His position had been ill-defined at the outset by the War Office and not well supported by the AIF's commanding officer General Bridges who failed to recognise the importance of the base medical organisation.¹⁴ In June 1915 Williams' authority was completely abrogated by the War Office so responsibility for the running of the AAMC fell to a British officer, the Director of Medical Services for Egypt, Surgeon-General Ford and Australian subordinates. Ford's inability to control the personal animosities of several Australian medical officers resulted in an Army Council inquiry, the complete re-organisation of No.1 AGH and the return to Australia of several able officers.¹⁵

Australian concern with the lack of proper administrative control of its medical services and with the unsatisfactory arrangements for the wounded and sick during the Gallipoli campaign resulted in the appointment of Colonel Neville Howse, AAMC, to the position of Director of Medical Services, AIF, in January 1916, despite War Office opposition.¹⁶

Because of the overcrowding in Egypt and the lack (until August 1915) of any Australian hospital ships, Australian casualties from Gallipoli were also taken to Malta and England. Beginning in March 1916 with the opening of "Harefield Park", Middlesex, as a convalescent hospital, a complex Australian medical organisation was slowly developed and by January 1916 was comparable in size to the one in Egypt. Australian casualties were treated first of all in British General Hospitals then proceeded to Australian convalescent units and depots from which they were either returned to Australia or to military duty. But, as in Egypt, overcrowding (especially for convalescents) and confusion compromised this organisation throughout 1915. Nobody had anticipated the size of the casualty lists from the Dardanelles, and, until the appointment of Surgeon-General Williams to the position of Deputy Director of Medical

¹² Butler, op. cit., pp. 86-87 and 254.

¹³ Ibid, pp.90, 196, 201, 266, 268 and 269.

¹⁴ Ibid, pp.66, 67 and A.G. Butler, *Official History of the Australian Medical Services 1914-1918, Volume II, The Western Front* (Australian War Memorial, Canberra 1940), p.809.

¹⁵ Butler, Volume I, pp. 256-260 and 404-405.

¹⁶ Ibid, pp. 431-436.

Services, AIF, England, responsibility for these arrangements was divided - detrimentally - between three officers. Amidst all of this inefficiency, psychological casualties suffered too. Harefield Park, which received auxiliary hospital status in June 1915, became the centre for a variety of specialist cases - including psychological casualties - but, as the official medical historian has remarked " neither the staff nor the equipment were commensurate with the requirements." ¹⁷

These, then, were the medical arrangements under which Australian casualties from Gallipoli were treated. Confusion of purpose, overcrowding of facilities and general inadequacy typified this system. For the special needs of psychological casualties virtually nothing was provided either at the front, along the lines-of-communication or at the base.

The treatment of Australian psychological casualties : Gallipoli.

Amongst the troops of all nationalities on the Gallipoli Peninsula, psychological stress and disorder were common problems. Doctor Arthur Hurst, a specialist in "nervous diseases" and, later in the war, Officer-in-Charge of the Special Neurological Hospital, Seale Hayne, told the War Office Committee of Enquiry into Shell Shock that practically every man he saw arriving at Lemnos from the Peninsula was neurasthenic. According to Hurst, most were unable to hold their hands out straight without shaking and were in a state of "absolute exhaustion", the result of disease and because a "man never got away from the strain of shell fire." ¹⁸ Many Australians suffered in this way but treatment for them at the front, on the hospital ships and at the base in Egypt was, at best, perfunctory. ¹⁹

¹⁷ Butler, Vol. I, pp.499-510.

¹⁸ *Report of the War Office Committee of Enquiry into 'Shell-Shock'* (His Majesty's Stationery Office, 1922), p.25.

¹⁹ The crux of successful treatment for victims of psychological trauma is promptness so that the symptoms will not have time to pass the acute stage and consolidate to become chronic. This dictum was eventually recognised during the First World War but did not at that time become *de rigeur* in military medical practice. In any case, many patients were not diagnosed correctly and so were inadvertently excluded from specialised treatment. In 1985 American military psychiatrists Thomas R. Mareth and Alan E. Brooker wrote: "Proper treatment using easily understood principles can yield gratifying results for the patient and the nation. Improper care leads to loss of critical manpower when it is most needed and probable long-term morbidity for the psychiatric casualty. . . [During the First World War] British emotional casualties were evacuated to hospitals back in England, far from their units at the front . . . Individual soldiers paid for these errors in treatment with chronic disability." (T.R. Mareth and A.E. Brooker, "Combat Stress Reaction: A Concept in Evolution", in *Military Medicine, Volume 150*, April 1985, p.186). These assertions are supported by a wealth of literature derived from military and civilian experience, and have become conventional wisdom. For example, Captain L.P. Webber of the 1st Psychology Unit, Australian Army, wrote in 1990: "There is little evidence in the literature at this point . . . to show that CSR [Combat Stress Reaction - the acute phase of psychological breakdown] and PTSD [Post Traumatic Stress Disorder - the chronic manifestation of trauma] are directly related but it makes intuitive sense that they are. If this assumption is made, it therefore follows that the management of combat stress in the field will have a direct bearing on the manifestation and prognosis of PTSD." (L.P. Webber, "Combat Stress Reaction and Post Traumatic Stress Disorder", *Ist Psychological Research Unit, Commonwealth of Australia 1990*, p. 5.). Similarly, David Kentsmith, an American research and clinical psychiatrist, wrote: "When treated properly . . . the soldier who develops symptoms can be combat ready in 2-3 days. If the soldier is not treated properly, is identified as a psychiatric

Mental disorder made an appearance in Australian soldiers well before the Anzacs landed at Gallipoli. It is clear that the AIF had accepted mentally ill men into its ranks from the very beginning. It is also highly likely that it continued to do so despite advice from a renowned specialist in mental health that recruits needed to be judiciously screened. While visiting military camps in 1915, the Inspector-General of the Insane for Victoria, Ernest Jones, noticed large numbers of men he considered mentally unfit for military service. Consequently, he notified army authorities of the need for careful selection but "the proposition . . . was turned down on the grounds that the draft for overseas must be kept up and so many millions of pounds were wasted."²⁰ Evidence of this highly expedient policy surfaced in many places. Along with a number of sick men in the first contingent, two mental cases were put ashore in Western Australia when the convoy concentrated at Albany between 24 and 26 October 1914.²¹ In February 1915, 16 men were admitted to No. 1 Australian General Hospital, Heliopolis, Egypt, with nervous and mental disorders.²² Incredibly, at least one of the men who displayed signs of mental disturbance in Egypt before the landing was permitted to rejoin his unit and proceed to the front. Private Herbert Crane spent eight weeks in the mental ward of No. 1 AGH prior to the Corp's departure for the Dardanelles. At Gallipoli he served for two months before being buried during a heavy barrage and evacuated with shell shock in a manner that became typical for many Australian psychological casualties. Although he did not remember it, he was ferried from the beach at Gallipoli to a transport and then to Malta; following this stage of the journey he found himself at Harefield. Crane was shipped home to Australia in late 1916,²³ an unnecessary but utterly predictable addition to an evacuation and treatment system that was already severely overtaxed.

For the unfortunate Crane - and many like him - there were no formal arrangements either on the Peninsula or in Egypt, Malta and England; Australian psychological casualties simply became part of the general evacuation chain. As Butler wrote:

[N]o special instructions were issued for dealing with the minor mental (or "functional") disorders and medical officers faced the "mental" surprises that met them with the ordinary

patient, is placed in the medical evacuation system, he becomes a liability. He may become a permanent casualty unable to function in any other role than as a psychiatric patient the remainder of his life." (D. Kentsmith, "Principles of Battlefield Psychiatry", in *Military Medicine*, Volume 151, February 1986, p. 95.) Unfortunately, these dismal scenarios are precisely what developed in the cases of many Australian soldiers in the Mediterranean and European theatres of the First World War.

²⁰ W.E. Jones, Diary, circa June 1915. Located in Clinical Services Library, Royal Park Psychiatric Institution.

²¹ Butler, Vol. I, op. cit., pp. 37-38.

²² Monthly Returns, 1st Australian General Hospital, February 1915, AWM 224, MSS 361.

²³ Medical Report on an Invalid, AAH Harefield, in Private H. Crane, 7th Battalion, PCF.

equipment of the general practitioner. The experience of the R.M.O.'s [Regimental Medical Officers] can justly be termed surprise. ²⁴

Improvisation was, therefore the chief characteristic of the treatment and evacuation of psychological casualties from Gallipoli. The absence of standard procedure at Anzac - and the prevalence of psychological strain and disorder - is evident from the following communication received by the AAG, New Zealand and Australian Division from one of the two ADMSs at Anzac, probably Colonel N. Manders:

Would it be possible to obtain permission to give officers 48 hours leave to Imbros whose services can be temporarily spared? It has been brought to my notice that officers come out of the trenches suffering from nervous strain and signs of breakdown. I am of opinion that it would save a good deal of sickness if officers could get away for a short time when their regiment is 'resting'. The 'rest' at present is more nominal than real owing to all parts of Anzac being more or less under fire. ²⁵

It seems that the solution to this problem was to withdraw potential psychological casualties to the only nearby place where anything approaching genuine rest was available: the hospital ships *Sicilia* and *Gascon* anchored off Anzac Cove. These floating havens allowed the military "to send a few officers to rest on board" accompanied by their batmen. ²⁶ Space, however, was very limited so that doctors were urged to give permission for such escapes only rarely. For the fortunate few this treatment was considered by authorities to be a "real boon." ²⁷

With makeshift arrangements like these the "order of the day", commanding officers were often left to their own devices when dealing with psychological disorder. Some sufferers were simply kept in the tent hospitals on Anzac together with the wounded and physically ill. For example, a typed list, found in the diary of Colonel Hugh Poate, AAMC, records that on 31 August 1915 there was one case of shell shock amongst the 89 other patients in hospital at Anzac. ²⁸ During the battle of Lone Pine, Poate treated a shell shocked Australian by giving him a stiff drink and making him lie down in the dressing station where he slept for six hours before suddenly waking. Upon "recovering his senses [he] rushed off to his work in the trenches again," wrote Poate. ²⁹ Other officers attempted to provide makeshift havens for mentally and physically exhausted men. For example, Major E.L. Hutchinson of the 6th Australian Field Ambulance instituted a rest camp a short way down Walker's

²⁴ A.G. Butler, *The Australian Army Medical Services in the War of 1914-1918, Volume III, Problems and Services* (Australian War Memorial, Canberra 1943.), pp. 80-81.

²⁵ Memorandum, ADMS to AAG, New Zealand and Australian Division, 5 July 1915. AWM 27 Item 370 [3]. The other ADMS was Colonel Neville Howse of the First Australian Division.

²⁶ Brigadier-General B. Carruthers to GOC New Zealand and Australian Division, 15 July 1915. AWM 27 Item 370/7.

²⁷ Ibid.

²⁸ Lieutenant Colonel H.R.G. Poate, AAMC, typed extracts from diary, p.11. AWM 2DRL/1225

²⁹ Poate, Diary, op. cit., undated, p.20.

Ridge where he sent men "whom I think might be improved in a few days ... By this means hope prevent [sic] so many evacuations to the Ambulance." Several weeks later he wrote: "This camp is doing good work and has been the means of curing and returning to the Battn a large number of men." ³⁰ In October 1915, R.G. Raws told his brother Lennon in Australia that his battalion occupied the most difficult position at Anzac:

The General told our O.C. so when we took over. In consideration of this we have 48 hours in and 48 hours out in reserve ... I don't think we could stand it otherwise ... little luxuries, trips to the beach for a swim, you are able to take your mind off the kind of war we are fighting and thus benefit ... With constant bombing ... and frequent artillery fire to which our position is open, there is a strain about it, and the 48 hours off is a God-send ... ³¹

At the end of June 1915, rest away from the Peninsula was instituted at nearby Imbros island where the troops were given respite for an average of four days. On 22 July this practice ceased in preparation for the August offensive. By that time, one quarter of all troops on the Peninsula had rested on Imbros. ³² In September, further relief for Anzac troops was made possible by the arrival of the 2nd Division. From Gallipoli between 7 and 21 September the 1st, 2nd, 4th and New Zealand Brigades accompanied by their medical units were sent to Sarpi rest camp on Lemnos; but instead of two weeks, they spent two months there, such was their exhausted condition. One of these men - Lieutenant G.L. Makin of the 5th Battalion - wrote to his brother from Lemnos: "[W]e have at last been withdrawn as we are really worn out and to some extent run down. The nerves begin to feel the strain of 20 weeks of the sort of fighting we've been in."³³ In November, the Third Brigade - the first to land on 25 April - was also finally given a rest but the damage had been done, as the official historian remarked:

It is hardly possible to exaggerate the evil effects of failure to give adequate relief to the formations on Gallipoli. Its influence as a factor in the physical and mental condition of the troops had been very great and was certainly imperfectly appreciated by the higher command.³⁴

Many shell shock cases were evacuated from Gallipoli. For example one shell shocked man - a Private Roberts - was taken to No.1 ACCS before being ferried to the waiting hospital ship. ³⁵ After being wounded, Albert Facey was evacuated by hospital ship to Lemnos, Egypt and eventually home to Western Australia. From his description of the journey to Mudros Harbour some idea can be gained of how psychological casualties were treated and of the reasons for their evacuation. Facey noticed that

³⁰ Major E.L. Hutchinson, 6th Field Ambulance, Diary, 24 September 1915 and 13 October 1915. AWM PR 86/391.

³¹ Lieutenant R.G. Raws, 23rd Battalion, Letter, 2 October 1915. AWM 2DRL/0481.

³² Butler, Vol. I., op. cit., p.250.

³³ Makin, Letter, 15 September 1915.

³⁴ Butler, Vol. 1, op. cit., p.395.

³⁵ War Diary, No. 1 Australian Casualty Clearing Station, 5 October 1915. AWM 4, Item no. 26/62/9

those sent away because their nerves had given out on them, were put in hammocks down in the decks below the water-line. This nerve sickness was very bad. The men who suffered from it couldn't help it. They were unable to sleep properly and from day to day they got worse. I have seen men doze off into a light sleep and suddenly jump up shouting, 'Here they come! Quick! Thousands of them. We're doomed!' We had to grab them and hold them down until a doctor or medical orderly could come and give them a needle to quieten them. The doctors wouldn't allow men with nerve sickness to stay at the Front because they would be upsetting to the others, especially those who were inclined that way themselves.³⁶

Medical officers in Egypt were just as surprised about the incidence of psychological disorder amongst Australian troops as doctors on the Peninsula. Major A.W. Campbell, AAMC, expressed his astonishment in *The Medical Journal of Australia*:

During a year of service with No. 2 AGH, comprising the time that operations were proceeding at the Dardanelles, it was vividly demonstrated to my fellow-officers and myself that neuroses and psychoses contributed to modern war casualty lists more heavily than we had previously supposed. There were times when the wards allotted to my charge were almost monopolised by such cases.³⁷

At the base there were no specialised arrangements for psychological casualties so men were fortunate if they were cared for by Campbell who was a neurologist with extensive experience of mental disorder both in England where he had been involved in pioneering research, and in Australia, where he had opened a private practice. In No. 2 AGH, Campbell employed all of his expertise on these men, gaining their confidence, placing them under tactful nurses and "attack[ing] with all the psychotherapeutic measures under command."³⁸

But even Campbell struggled against the absence of suitable facilities in Egypt. He wrote: "The treatment of mental disorders in general hospitals like those in Egypt is liable to be unsatisfactory, because, to obtain isolated and suitable rooms and exercising grounds is difficult, also skilled orderlies or a sufficiency are not always on hand."³⁹ Inaccurate diagnosis was also a problem in the treatment of psychological casualties. Lieutenant Colonel John Springthorpe, a Melbourne physician with considerable experience in the treatment of mental disorder testified to the difficulty of separating that kind of case from others when he wrote in his usual gesticulatory style:

³⁶ Facey, op. cit., p.281. Facey's observation about the reason for the removal of these cases from the front is supported to some extent by Major A.W. Campbell, AAMC, who stated that psychological casualties in No.2. AGH were separated from the other patients because of the risk of "contagion". (A.W. Campbell, "Remarks on some neuroses and psychoses in war", in *The Medical Journal of Australia*, 15 April 1916, p.323.)

³⁷ Campbell op. cit., p.319.

³⁸ Ibid, p.323.

³⁹ Ibid.

In my ward - as Rheumatics - find two enteric - two shock - one Pyopneumothorax, and one Haemo-thorax (what diagnosis!) Senior physician - yet given Chronic Rheumatics . . . work up family history, previous attacks etc. showing how stupid to send such to the trenches! ⁴⁰

The only specialised facility for mentally affected soldiers in Egypt was for the certifiably insane, a 20 bed institution next to the Government Asylum known as 'A' Auxiliary Hospital of which a report on all buildings used for military patients in Egypt stated: " Cases in this hospital, often several at a time, were under expert management. Mental cases could not be sent to the ordinary hospitals. The hospital was of great utility." ⁴¹

In fact, the insane were treated in General Hospitals along with the less severely affected psychological casualties. Campbell blithely remarked:

At no time did we have more than half a dozen cases [of insanity] under treatment. Nor was the Gallipoli landing or subsequent occupation followed by a special influx. Of course, some went to other general hospitals and a certain number to the State Mental Hospital at Cairo but, from enquiries made, we gathered that we received a full share. ⁴²

In fact, during 1915, No. 2 AGH treated 27 men classified mental, ⁴³ as distinct from those suffering from less serious forms of psychological disorder which constituted by far the most common kind of war-induced mental casualty in the Egyptian hospitals. Of the latter category, 136 passed through No. 2, although to this figure could probably have been added many of the 199 cases of debility treated at the same hospital throughout 1915. ⁴⁴

How did psychological casualties admitted to the Australian General Hospitals in Egypt fare? In general these men stayed in hospital for anything up to twelve weeks with little improvement before being sent home to Australia. One case of serious mental illness to be treated at No. 2 AGH was Lieutenant J.D. Christie who entered hospital on 15 May 1915 with shrapnel wounds to the throat and shoulder.⁴⁵ By the 28th of that month he was described as convalescent,⁴⁶ a condition that he maintained until early July when the doctors began to focus on his mental state. He was then described as suffering from delusional melancholia ⁴⁷ and "mental strain" ⁴⁸ and for several months

⁴⁰ J.W. Springthorpe, Medical Diary, 8 June 1915. AWM 2DRL 701, Item 2.

⁴¹ Report on Hospitals in Egypt. AWM 27, 370 (8).

⁴² Campbell, op. cit., p.322.

⁴³ No.2. AGH, "Report of Work Done by No. 2 General Hospital A.I.F. for the Year Ending 31st December, 1915, p. 3. AWM 224 MSS 368, Parts 1 and 2.

⁴⁴ Ibid. Debility was the name given to a state of exhaustion which doctors suspected was psychological in origin, Butler wrote of it: "But as a link between the mental and the physical sphere it may be held to afford perhaps the most tenable aetiological and scientific basis for the concept of the 'burnt out' soldier." (Butler, Vol. III, op., cit., p.838.)

⁴⁵ 2 AGH, "Weekly Reports on Sick Officers 22/3/1915-3/3/16", 21 May 1915. AWM 224 MSS 375.

⁴⁶ Ibid, 28 May 1915.

⁴⁷ Ibid, 2 July 1915.

⁴⁸ Ibid, 9 July 1915.

from July 1915 until October of that year fluctuated between "improving" , "unimproved", "progressing favourably" ⁴⁹ and "condition unchanged".⁵⁰ After three months without any real improvement, Christie was finally classified "permanently unfit for further service" and sent home to Australia. ⁵¹

The length of Christie's stay in hospital does not seem to have been especially unusual for Australians suffering the psychological ill effects of the Gallipoli fighting. In fact, it seems to have been quite common for these men (probably those more seriously affected) to have spent at least several weeks in this temporary institution. Lieutenant H.P. Brown of the 2nd Australian Battalion was listed to be invalided to Australia as "temporarily unfit for further service" on 2 October 1915, after six weeks in No. 2 AGH with "shell shock" ⁵² but spent until 29 October in hospital "convalescing" before disappearing from the record.⁵³ The name of Lieutenant V.G. Saunders appears on the list of sick officers between 29 October and 10 December 1915. Suffering from "shell shock and colitis" (the latter a bowel disorder) he was listed as "convalescent" and "boarded" for Australia". ⁵⁴ The names of a number of other officers with shell shock appear on the Weekly Reports of Sick Officers for periods from one to three weeks.- Lieutenants R.F. Cook of the 6th Light Horse,⁵⁵ A. Tullock, 24th Battalion,⁵⁶ and Captain C.W. Huxtable of the 6th Light Horse. Huxtable remained in hospital long after the fighting at Gallipoli had ceased. ⁵⁷ Sometimes, however, decisions about psychological cases were almost instantaneous. Lieutenant P.J.A. Murray of the 5th Battalion was admitted to No.2 AGH with shell shock and colitis on 1 October 1915. By the next day it had been decided that he was totally unfit for further service and should return to Australia. ⁵⁸ Other shell shocked officers appeared only briefly on the sick roll. On 17 December 1915 Lieutenant F.E. Boddington, for example, was listed there with shell shock and neurasthenia. He was said to be "improving".⁵⁹

Thus, if the above evidence is a guide, the chances of psychological casualties recovering while in the war zone were small. As for a return to the line, A.W. Campbell was totally pessimistic:

⁴⁹ Weekly Reports", op. cit., 2 July, 9 July 16 July, 30 July, 3 September 1915

⁵⁰ 2AGH, "Weekly Report on Patients Shewn on the Dangerously Ill List" 16 July 1915 AWM 224 MSS 380.

⁵¹ "Sick Officers", op. cit., 2 October 1915.

⁵² Ibid.

⁵³ Ibid, 29 October 1915.

⁵⁴ Ibid, op. cit., 10 December 1915.

⁵⁵ Ibid, op. cit., 1 October 1915-13 November 1915.

⁵⁶ Ibid.

⁵⁷ Ibid, 24 December 1915-7 January 1916.

⁵⁸ Ibid, op. cit., 1 October 1915, 2 October 1915.

⁵⁹ Ibid, op. cit., 17 December 1915.

Concerning the neuroses, recovery from the proximal and immediate disability could be expected, and many subjects might later prove useful on lines of communication, or at a base depot; but as regards further fighting, all, with one stroke of the pen might be crossed out as permanently unfit.⁶⁰

Those soldiers not returned to Australia often became convalescents in Egypt but facilities for this class of patient were notoriously poor. John Springthorpe did his best to alleviate the tribulations of convalescents by arranging outings for them (a practice he continued in England) but his efforts were undermined by official neglect which created embarrassment for all concerned. Springthorpe related the story of one wretched psychological casualty:

Young [Private] McKechnie temporarily [sic] speechless, motionless, and deprived of intelligence [sic] by shell shock - taken for a fortnight to a beautiful garden home by two charming well wishers (Mr. and Mrs. Draper) - on arriving, had only pyjamas, soiled stained tunic and breeches from the trenches, with very heavy boots, and a forage cap. His hostess was ashamed to let him be seen by any visitors - refused to let him wear the tunic, and lent him some of her husband's things, until he was sent down by special messenger a linen hat - a soft khaki shirt - some socks - slippers and a handkerchief - she considered his clothing disgraceful.

Another patient refused to go out for a trip on the Nile because his costume was so ridiculous that he was laughed at by his mates. One man left the hospital for a convalescent home without boots, socks shirt or hat - simply pyjamas. Springthorpe advised that these illustrations could be multiplied a hundredfold.⁶¹

Thus, in their makeshift nature, the medical arrangements for Australian psychological casualties of the campaign reflected the constantly improvised evacuation and treatment system of the Mediterranean Expeditionary Force in general. In addition, no particular provision was made for these men; special consideration of psychological casualties was therefore absent except where good fortune - in the form of doctors like A.W. Campbell and John Springthorpe - intervened. For some sufferers of psychological disorder, however, the acquaintance with shell shock did not end at Gallipoli or in the inadequate medical systems of the Mediterranean Expeditionary Force. Some Peninsula veterans hospitalised with psychological disorder, together with other sufferers who had escaped medical detection altogether, went with the re-formed AIF to the Western Front where their minds sustained further damage. Here, and in England, specialist treatment was available but due to the hostility of the military towards mental breakdown, and an Australian Government policy that denied their men access to the best treatment, the Gallipoli veterans as well as fresh psychological casualties entered a system that was equally as inimical to their chances of recovery as

⁶⁰ Campbell, op. cit., p.323.

⁶¹ Springthorpe, Medical Diary, 24 July 1915.

that in the Mediterranean. Political expediency and scepticism replaced bungling as the bane of the shell shock sufferer's life.

The Treatment of Australian Psychological Casualties in The European Theatre of War.

In Europe, Australian psychological casualties were treated within three military-medical spheres: in the "first aid" zone of the front line Regimental Aid Posts and the Field Ambulances; the highly juridical British Army arrangements further down the evacuation chain on the Western Front; and the medical structures in England which consisted of primary care in British general hospitals and convalescence in the Australian system. Treatment in the first aid zone could be prompt and sensible and was possibly responsible for successfully returning some men to duty. Further behind the lines, however, arrangements were less fruitful. Driven by political and military expediency, neither of these realms was able to affect recoveries in traumatised Australian soldiers who were often returned to duty with catastrophic personal consequences.

The short term treatment of Australian psychological casualties on the Western Front.

When battle shocked soldiers first began to arrive at Australian Regimental Aid Posts and Field Ambulances in large numbers during the AIF's first major engagement in the Battle of the Somme, medical officers - most of them neophytes in this area - were non-plussed. Left to their own devices in the absence of prescribed treatment, some, however, soon developed practical and apparently successful methods for dealing with the acute and less severe forms of nervous breakdown in exhausted, hungry and fearful men. In an intuitive, haphazard fashion these doctors - much like those at Gallipoli - grasped the need for immediate treatment.⁶² Temporary rest and recuperation, food, mild sedation and distractions such as light physical work seem to have helped some soldiers to return quickly to duty.⁶³ The apparent success of these trial and error methods may account for the discrepancy between the number of admissions to Field Ambulances throughout the war (9996) and those for Casualty Clearing Stations (5710).⁶⁴ Many soldiers who might have been evacuated and swelled the numbers in the CCSs further behind the lines were probably returned to duty by this prompt treatment.

⁶² See pages 72-73, note 19, for current thinking on the importance of immediate treatment.

⁶³ Butler, Vol. III, pp. 101-115.

⁶⁴ *Ibid.*, p. 942. The compilation and idiosyncracies of these figures is explained in the introduction.

The mental conditions of many men deteriorated significantly when they were removed from the front line and passed through the various stages of medical evacuation. Severe cases had to be withdrawn in this way but many less seriously affected men were evacuated - apparently unnecessarily - by inexperienced medical officers to the Casualty Clearing Stations, the bases near the French coast and the hospitals in Britain. In these remote institutions, with the implication of failure pervading, the conditions of both the mild and serious cases progressively deteriorated into chronic disability.⁶⁵

The development of the British Army system for dealing with psychological casualties.

It was not simply long periods in the British Army's hospital system that created long term medical problems for evacuees; the nature of this organisation and the quality of treatment within it must be held accountable. In France and Belgium, highly specific measures for the treatment of psychological casualties were gradually developed by the British Expeditionary Force. These arrangements directly reflected the high command's extreme suspicion of shell shock as a refuge for cowards, and a drain on manpower, euphemistically called "wastage". As a consequence of this attitude, control of wastage, return to duty and the disciplining of suspected malingerers (rather than genuinely reparative medical care) was the dynamic which, by late 1916, had turned the processing of trauma victims into a highly bureaucratic and juridical procedure. As the AIF was subject to British operational control, Australian psychological casualties on the Western Front were treated under this regime until invalided to England. Here, medical arrangements for Australian wounded and sick were based firmly on the Australian medical structure which had developed in England for the Gallipoli wounded in 1915: Australians were admitted directly to British General Hospitals then concentrated in their own incipient convalescent system.

The AIF arrived on the Western Front in March 1916 at a time when the British Army was beginning to make serious attempts to control the increasing wastage from psychological disorder. ⁶⁶ First appearing during the retreat from Mons in 1914, ⁶⁷ nervous maladies amongst British soldiers became increasingly common as the war progressed and reached epidemic proportions during the Battle of the Somme in the second part of 1916. ⁶⁸ During this period psychological casualties were usually evacuated rapidly from the Regimental Aid Posts and Casualty Clearing Stations at the

⁶⁵ Butler, op. cit., pp. 111-112 and A.M. Freedman, H.I. Kaplan, B.J. Sadock (eds.), *Comprehensive Textbook of Psychiatry - II*, Volume 2, Second Edition (The Williams and Wilkins Company, Baltimore 1975), p. 2356.

⁶⁶ Butler, Vol. III, op. cit., p.101.

⁶⁷ W. G. Macpherson, (ed.), *Medical Services: Diseases of the Great War, Vol. II* (His Majesty's Stationery Office 1923), p.1.

⁶⁸ *Ibid*, p.8.

front to the base hospitals near the French coast. From there they were transferred to England for treatment and were usually discharged by puzzled medical authorities.⁶⁹ In this way, large numbers of men left the front and military service. Special facilities were arranged for these cases throughout Britain so by June 1918 nineteen hospitals had been established, six for officers and thirteen for other ranks.⁷⁰

As already noted, military authorities were ill-disposed towards mental disorder in soldiers. In particular, they retained a strong suspicion of the term "shell shock", a name coined by the psychologist C.S. Meyers in February 1915 to explain psychological disorder in men who had been shelled but who were physically unharmed.⁷¹ Very quickly this term became popular among soldiers, medical officers, and the public as denoting a new war disease about which very little could be done.⁷² To many professional officers general acceptance of "shell shock" falsely legitimised a phenomenon akin to cowardice.

Treatment for psychological disorders at the hands of some Royal Army Medical Corps doctors reflected this official hostility as well as a pre-war civilian view of mental illness that blamed the sufferer for his plight. And so treatment regimes in some of the above mentioned special hospitals were harsh indeed. Rejecting psychological approaches to mental illness, many of the specialists employed in these centres used physical techniques on men whom they believed to be deliberately avoiding duty. One of these methods was faradisation (electric shock therapy) which was often employed as much for its psychological effect on others as for curing the individual in question. Patients at Aldershot, for example, would watch (and perhaps be encouraged to regain their voices) as the first in line received painful shocks to the larynx to aid recovery from psychosomatic loss of voice, called aphonia.⁷³ One man with psychosomatic mutism, a 24-year-old English private who had seen active service in France and Salonika, suffered this kind of treatment. He was strapped into a chair for twenty minutes at a time while strong electric current was applied to his neck and throat; lighted cigarette ends were applied to the tip of his tongue and hot plates placed at the back of his mouth.⁷⁴

More progressive treatment based on the idea that psychological disorder was the result of unconscious mental conflicts, not the genetic weakness or wilfulness of the patient, was available in some of the special centres in England. These units were

⁶⁹ T. Brown, "Shell Shock in the Canadian Expeditionary Force, 1914-1918: Canadian Psychiatry in the Great War", in C.G. Roland (ed.), *Health, Disease and Medicine, Essays in Canadian History, Proceedings of the First Hannah Conference on the History of Medicine*, McMaster University June 3-5, 1982, p.315.

⁷⁰ Macpherson, op. cit., pp.45-48.

⁷¹ Brown, op. cit., p.311.

⁷² Ibid, pp.10-11.

⁷³ M. Stone, "Shellshock and Psychiatry", in W.F. Bynum, R. Porter, and M. Shepherd, *The Anatomy of Madness. Essays in the History of Psychiatry* (Tavistock Publications, London 1985), pp.252-253.

⁷⁴ E.J. Leed, *No Man's Land. Combat and Identity in World War One* (Cambridge 1979), p.173.

staffed by men who, pre-war, had rejected the somatic, moralistic view of mental disorder and accepted the approaches of Europeans like Freud and Janet who emphasised the importance of the unconscious mind. With opinions like these, such practitioners - men like W.H.R. Rivers, C.S. Myers, and Arthur Hurst - were part of what was considered a radical movement in pre-war British psychiatry.⁷⁵ But although their approach to war neurosis was enlightened, it is more accurate to describe it as reformist rather than radical because therapy took place within a medico-military framework. The aim of this approach was to return men to duty, not necessarily to help them fully recover.⁷⁶ Thus, soldiers were made to realise their responsibilities to the state through reason, not pain.⁷⁷ Suitability for duty was made the measure of success; failure to achieve this goal was cast in terms of personal inadequacy.⁷⁸ Like their British and Commonwealth counterparts, Australians too were subjected to this regime.

Following the battle of the Somme and the deluge of psychological casualties, the British military was forced to recognise the need for psychotherapeutic treatment and so instituted a highly bureaucratised evacuation and treatment system. It was based partly on the apparently successful French system and was seen as a means of maintaining these casualties in France and returning them to duty as quickly as possible. Initially, the army was reluctant to set up such a system because, in its usual suspicious manner, it feared that formal acknowledgment of the problem (much in the manner that they believed popular acceptance of the term "shell shock" had done) " would create a flood of wastage from the army which no-one would be able to control."⁷⁹ But the large numbers of men being evacuated to England with shell shock necessitated its introduction. And so a chain of evacuation for psychological casualties was established, at the heart of which were five special centres located about a dozen miles behind the front, one for each army corps. Men came to these directly from the field ambulances and were sorted into groups according to their condition, allotted to wards where they were treated by specialists and later to convalescent blocks all within the special centre. Those who did not recover quickly were sent to hospitals at the base on the French coast where they were sorted once again: very serious cases went to the United Kingdom while others were assigned to non-combatant duty such as agricultural labour or sent to convalescent camps.⁸⁰

⁷⁵ For a fuller exploration of their work, its contribution to the war and to Australian psychiatry, see chapter eight.

⁷⁶ Stone, *op. cit.*, p.259.

⁷⁷ Leed, *op. cit.*, p.10.

⁷⁸ Stone, *op. cit.*, pp.264-265.

⁷⁹ MacPherson, *op. cit.*, p.10.

⁸⁰ *Ibid.*, pp.11-14.

The main purpose of this system was to prevent wastage and maintain discipline by treating men more promptly and expertly than previous arrangements had done. Psychotherapy (and other forms of treatment) at the special centres was one way of achieving this but the other method employed was purely administrative and reflected the army's suspicion of mental breakdown and its belief that psychological disorder was largely a disciplinary matter. It was designed to identify malingerers and halt their escape to the rear. Firstly, except in highly specified circumstances, the term shell shock was banned in the hope that what had once been a ticket to England would be eliminated. An order read as follows:

In no circumstances whatever will the expression 'shell shock' be made use of verbally or be recorded in any regimental or other casualty report, or in any hospital or other medical document except in cases so classified by the order of the officer commanding the special hospital for such cases. ⁸¹

Medical officers were not to record any diagnosis on the Field Medical Card of evacuees who were unwounded. The letters NYDN - Not Yet Diagnosed, Nervous - were to be entered and the man handed on to the above-mentioned special units which became known as NYDN centres. Here, by a process that was "more juridical than medical" ⁸² a man was, with official sanction, re-classified "Shell Shock 'W'" or "Shell Shock 'S' (Neurasthenia) [or] (Debility)" and processed accordingly. The first category denoted men who had been close to a shell blast and who were thus considered "wounded" (hence the "W") and, as a result, above suspicion. They were entitled to a wound stripe and were recorded as battle casualties. By contrast, the second grouping indicated that the provenance of the disorder was believed dubious and thus required further investigation with a possible court martial pending. The "S" stood for sick; thus, these men were not considered to be battle casualties and were not, therefore, entitled to a wound stripe.⁸³ Neurasthenia and debility were psychological disease categories and are discussed in chapter three.

The genesis of the NYDN system can be seen in a BEF order of June 1916 - before the Battle of the Somme - and in a revealing piece of BEF headquarters correspondence of October 1916. The difference between the two demonstrates how procedures and attitudes had become more severe in the intervening months. The order of June 1916 (which foreshadowed future instructions) reflected a concern with the imprecise employment of the term shell shock and specified that it should be applied only to men whose disorder was the direct result of "enemy action", namely a shell blast; all other troops with psychological problems were to be classified "sick" and not

⁸¹ Brown, *op. cit.*, p.316.

⁸² *Ibid.*

⁸³ *Ibid.*, pp.316-317.

to be recognised as battle casualties. The use of "shell shock" was not yet banned at regimental level, however.⁸⁴

The military's wariness of psychological disorder amongst soldiers was nowhere more evident, however, than in a letter from Lieutenant-General G.H. Fowke, Haig's Adjutant General, explaining the basis of future treatment of psychological casualties. In this missive such men were divided into two categories: those lacking in courage and those whose affliction resulted from "extraordinary exposure" to enemy fire. Men in the first group were not to be allowed to escape discipline on medical grounds such as a diagnosis of shell shock or neurasthenia. This had occurred too often in the past and would now be dealt with by the army's disciplinary machinery which must include thorough investigation of each case and a possible court martial. Soldiers in the second category were not to be classified as wounded (W) until reliable evidence had been provided by the man's commanding officer.⁸⁵ In these instructions can be seen the first faltering efforts to control the problem of shell shock.

The foundation of the system that sprang from these unforgiving sentiments was the feverish juridical and bureaucratic activity that surrounded a piece of ostensibly innocuous paper: Army Form W3436, introduced in June 1917. In this form can be seen quite plainly the Army's stance on a problem that it clearly regarded with a great deal of malevolence. Army Form W3436 was a "[r]eport to be rendered in the case of Officers and Other ranks who, without any visible wound, become non-effective from physical conditions claimed or presumed to have originated from effects of British or enemy weapons in action."⁸⁶

Such reports were treated as "Urgent and Confidential" and contained nine instructions to officers filling in the blank spaces. Of these, the most revealing of Army

⁸⁴ Director of Medical Services, Second Army to II Anzac Corps, 14 June 1916, in Butler, Vol. III, pp.100-101.

⁸⁵ Butler, Vol. III, op. cit., p.122. In order to reveal more fully the attitudes and assumptions that were operating at the highest levels of the BEF in relation to shell shock, Fowke's letter is hereby quoted in full: "Those who when engaged with the enemy fail to maintain mental equilibrium do so either - (1) Because they are lacking in the nerve stability which must be assumed to be inherent in all soldiers, or (2) Because they have been subjected to some extraordinary exposure not incidental to all military operations. Those who have committed themselves for the first of the above reasons cannot be allowed to escape disciplinary action on the ground of a medical diagnosis of 'shell-shock' or 'neurasthenia' or 'inability to stand shell-fire'. It has too often happened that officers and men who have failed in their duty have used such expressions to describe their state of non-effectiveness, and medical officers, without due consideration of the military issues at stake, have accepted such cases as being in the same category as ordinary illness. The undesirability of disposing of such cases in this way should be brought to the notice of Administrative Medical Officers, between whom and the 'A' Branch of the staff of the formation concerned should be close co-operation in dealing with each case on its merits. It should be for a Court Martial to decide whether the evidence as to the existence of actual disease is such as to justify absolving an offender from penal consequences. The Commander-in-Chief considers it desirable that all cases of nerve failure should be retained in the Army area until they have been carefully investigated and have been found to involve no disciplinary aspect. If the medical condition necessitates early transfer to the Base, all possible particulars that may be required for future disciplinary action should be obtained before the transfer is carried out. Nerve failure believed to belong to the second class of cases, those due to extraordinary exposure, should not be classified as a wound on medical authority alone. The diagnosis of 'shell-shock wound' should in no case be made until the evidence of the Commanding Officer or soldier affected has been obtained that his condition originated immediately upon his being exposed to the effects of a specific explosion." (Ibid)

⁸⁶ This example of Army Form W3436 was located in AWM 23, Box 94.

attitudes were numbers three to eight. Number three instructed commanding officers of the Special Hospital to which the soldier had been sent in the following way: "Time, date, place and assigned cause to be entered. *Facts* reported by a responsible officer on transfer *will* be noted and *clearly distinguished* from unsupported *testimony* of the soldier concerned." ⁸⁷ In accordance with point four, the O.C. of the soldier's unit was directed to send Army Form W3436 either to "Army Headquarters through the usual channels if O.C. Unit considers there was no exceptional exposure, or that the patient's conduct demands further enquiry or report, otherwise it will be returned direct to O.C. Special Hospital." ⁸⁸

Point five simply required the soldier's commanding officer to state whether the patient "was" or "was not" subjected in the course of his duty to exceptional exposure. The concept "exceptional exposure" and its employment in determining the fate and status of individual soldiers reveals the military's pre-occupation with the idea that a man could not be considered a proper casualty unless it could be conclusively demonstrated that the cause of his disablement was some kind of physical agent - bullets, shells, bombs or gas - and, of course, that these had not been administered by the soldier's own hand. It is clear that the Army required a demonstrable, unequivocal cause before the soldier patient was considered above reproach and deserving of the classification Shell Shock W (wound) (and, therefore a wound stripe) rather than the dubious - in military eyes - labels neurasthenia or debility. Instruction six read:

Exposure should not be regarded as exceptional if it was not of a specific nature, more intense or prolonged than that which others in the same area of operations endured without being similarly affected thereby. When this is so a brief account of nature of exposure eg. shell or mine explosion, or shellfire etc. will invariably be given. ⁸⁹

Point eight required the commanding officer of the Special Hospital to bring "any points which appear to require investigation . . . to the notice of the Army Headquarters before this form is disposed of." Such an investigation was, according to Consultant in Neuro-Psychiatrist in the Canadian Army Medical Corps Doctor Colin Russell, an attempt to decide whether to commence court martial proceedings or not.⁹⁰ Finally, officers were instructed to state how the patient had been disposed of, either "Discharged to duty . . . or Transferred to Base . . ."

Thus, a psychological casualty's classification was arrived at on form W3436 by stages, a series of steps which evaluated evidence, the most important of which was a superior's testimony that would either corroborate the man's own statement or contradict it. Clearly the medical evidence, supplied in Section One, Point Two, was

⁸⁷ Army Form W3436, op. cit.. (Original italics)

⁸⁸ Ibid.

⁸⁹ Ibid.

⁹⁰ Brown, op. cit., p.317.

the least important deposition in the process of deciding what kind of disorder a soldier was suffering from, whether he was malingering and how he was to be dealt with. What drove this approach was suspicion of the soldier's motives and the need to prevent wastage, to return men to duty and to maintain discipline.

The NYDN system and its associated processes were also part of a military justice structure in which the condition of an arraigned man's mind was often immaterial especially in cases involving severe breaches of discipline such as desertion, cowardice and self-inflicted wounds. Whether a soldier was responsible for his actions was not a consideration for senior officers whose chief pre-occupation was maintaining discipline and morale in the army as a whole. Individuals were dispensable when national survival was at stake. "How can we ever win if this plea is allowed?" Douglas Haig is reported to have written while refusing a recommendation for mercy in the case of an emotionally disturbed English soldier convicted of desertion.⁹¹ Thus, pleas of what amounted to diminished responsibility were frequently dismissed by courts martial despite clear, independent evidence from officers and comrades to show that defendants had been traumatised by their experiences.⁹² In accordance with this attitude to mental illness, shell shock was also dealt with through Army Form W3428, a report on accidental or self-inflicted injuries; occasionally, too, it was the subject of court martial proceedings. How, then, did Australian soldiers fare within this system?

The Treatment of Australian Psychological Casualties on the Western Front.

For Australian soldiers (and probably for British and other Commonwealth troops) the NYDN system as described above was adversarial and inconsistent. It was not effective in helping men to recover or in returning them successfully to duty for any length of time and thereby preventing the wastage of combat troops from their units. In fact, by returning some men to the line, it was responsible for the serious aggravation of existing disorders. The experiences of some 47 Australians clearly suggest the system's inadequacy while at the same time strongly highlighting the paradox involved in treating traumatised men as defendants in a legal case.

Until the introduction of Army Form W3436 in June 1917, Australian psychological casualties, like all in the BEF, were subjected to the first, rather unsystematic efforts to control wastage from shell shock. In late 1916 and early 1917, orders from BEF headquarters reflecting the increasing concern about (and suspicion of) mental breakdown began to appear at Australian Field Ambulances and battalions. It

⁹¹ A. Babington, *For the Sake of Example: Capital Courts Martial 1914-1920* (Leo Cooper, London 1983), pp.80-81.

⁹² *Ibid.*, pp.91-93.

is clear from these instructions that serious attempts were being made by army authorities to retain psychological casualties at the front⁹³ and to investigate them in a juridical manner with possible disciplinary action to follow.⁹⁴ Motivation was sometimes made explicit, as in the following directive received by the 9th Australian Field Ambulance in January 1917:

The ADMS desires that greater care be taken in evacuating of cases labelled 'shell shock'. From a perusal of the statements that accompany each case, it would appear that some cases might return to duty after a short rest, without being evacuated. Officers Commanding Field Ambulances will make this matter their special concern in order to reduce if possible, the sick wastage from this cause. . . . All medical officers of Field Ambulances should render themselves thoroughly conversant with the information issued on this subject and any tendency for men to shelter behind the diagnosis of 'shell shock' should be promptly checked. At the present time the loss may be small, but in the event of heavy fighting, a heavy loss would occur, unless a good system of checking is established now.⁹⁵

In keeping with this general philosophy, Regimental Medical Officers (usually the first doctors to make contact with casualties) were advised to harden their hearts. At a course of instruction, some Australians were told:

A good R.M.O. will prevent an enormous amount of ... wastage. Several of ours did excellent work at Pozières on that occasion. Men will come down more or less shell shocked and stand at the R.A.P. (Regimental Aid Post) waiting about to be evacuated, but if they can possibly be kept in the front line they should be sent back because every rifle taken away is a serious matter, and many escape to the rear who should not have done so. You must steel your heart and not let those men who are fit to carry on be evacuated back on any pretext except real illness. The same thing applies to stragglers, who apply to you posing as sick men.⁹⁶

At a medical officers training camp on Salisbury Plain, Captain R.H. Crisp of the 49th Battalion was told that sleeplessness was the only shell shock symptom which could not be simulated and that if a medical officer were at all doubtful he should send the "malingerer . . . to D.R.S. [Divisional Rest Station] to be observed by orderlies." Others, however were to be given a good meal, a good sleep in a dugout and, if not improved in 24 hours, to be evacuated.⁹⁷

Examples of how Australian psychological casualties were processed before the introduction of the NYDN system suggest that attempts to deal with this problem were unsuccessful, especially where the health of individuals was concerned. In July 1916 Sergeant Joseph Whitton, labelled "shell shock", was evacuated through the 14th Australian Field Ambulance and 1st Australian Casualty Clearing Station to the 30th General Hospital at the BEF base on the French coast. On 8 August 1916 he was

⁹³ Circular 115, 29 January 1917, in Instructions to Regimental Medical Officers and Medical Officers, 9th Australian Field Ambulance. AWM 27, 371/16.

⁹⁴ Circular No. 91, 16 December 1916, and Circular No. 43, 25 January 1917, in *ibid.*

⁹⁵ ADMS 26/21/17, 17 January 1917, in *ibid.*

⁹⁶ Major C.L. Chapman, Deputy Assistant Director of Medical Services (DADMS), "Lecture on Duties of a Medical Officer in Stationary Trench Warfare." AWM 224, MSS 290.

⁹⁷ Captain R.H. Crisp, 49th Battalion, Notes for Medical Officers' Training Camp, 1917 in Diary, pp. 30-31. AWM 3DRL/2871.

admitted to a convalescent depot with neurasthenia then transferred to a hospital in England.⁹⁸ He returned to France in October 1917 still in a highly excitable condition and served there for the rest of the war. Psychological disorder, however, dominated his post-war existence.⁹⁹ In April 1917 Private Leslie Hall was evacuated from Bullecourt with "NYD shell shock" (the term "shell shock" had still to be outlawed at regimental level) to a Divisional Rest Station then to the 47th Casualty Clearing Station where he felt "very nervy indeed."¹⁰⁰ He was returned to his unit in 1918 then withdrawn and assigned to duties at Divisional Headquarters following the deaths in action of his three brothers.¹⁰¹ He was still suffering the effects of these experiences in 1958.¹⁰²

In June 1917 the treatment, evacuation and investigative framework established by a series of BEF orders issued in late 1916 and early 1917 was superseded by the procedures associated with Army Form W3436. The adversarial atmosphere created by these earlier directives thus became more highly structured. Men became defendants while their superiors played the role of prosecutor.

Consistent with the requirements of Army Form W3436, the classification of Australian war neurosis sufferers was determined not necessarily by symptoms but by the opinion of superior officers whose testimony often flatly contradicted the victim's evidence, even when there seemed to be a plausible connection between those symptoms and the circumstances described by the patient. The Army, then, was decidedly more influential in this medico-military relationship than the doctors. In most instances when a man's superior officer stated that the soldier concerned had been subjected to exceptional exposure, he was classified shell shock (W); equally, when an officer denied that such exposure had occurred, the patient would be placed in a different category, although not always.

Clashes of testimony between men and officers are sometimes striking, especially considering the apparent congruence of symptoms (as recorded by a doctor) and precipitating circumstances (as related by the patient). When admitted to the New Zealand Stationary Hospital, on 20 July 1917 Driver R.C. Adamson showed "signs of nerve strain" and was "very tremulous". He claimed that one month previously he had been subjected to heavy shelling while clearing a salvage dump since which he had been "shaky." He also stated that six nights before his arrival in hospital he had been amongst some heavy shelling in the horse lines near Dickebusch and he had to report

⁹⁸ Army Form B103, in Private Joseph Whitton, 6th Battalion, PCF.

⁹⁹ Form U, 28 January 1930, in *ibid.*

¹⁰⁰ Army Form B103 and Form U, 12 November 1930 in Driver L. Hall, 6th Battalion, PCF.

¹⁰¹ *Ibid.*

¹⁰² Summary of Relevant Details of Application for Recreation Transport Allowance, 17 February 1958, in Hall, PCF.

sick the next morning.¹⁰³ In two notes to the Adjutant General's Department, Adamson's commanding officer, Lieutenant G.E. Hills, testified that there had been no heavy shelling actually in the horse lines at Dickebusch during the 4th DAC's bivouac there and that shells landing in the "vicinity were not of such close proximity as to give rise to shell shock in any form."¹⁰⁴ Adamson was classified "neurasthenia" and sent to a Base hospital.¹⁰⁵

One of the more obvious aspects of the processing of psychological casualties in this system is the inconsistency of classification. Three categories were available to Medical Officers in the Special Hospitals to which British or Commonwealth soldiers were sent: shell shock (W), neurasthenia and debility. Officially, placement in a category was to be determined more by the apparent cause than the clinical features of the disorder that faced doctors. And yet, soldiers who presented with similar symptoms and almost identical precipitating circumstances could be classified differently. On July 12 1917 Private D.D. Brown of the 37th Battalion was admitted to No.4 Stationary Hospital - a special hospital for psychological cases - with "marked stammer - pain over heart. some tremor - sleep disturbed by nightmares. Physical condition fair". Brown stated that two days after returning to his unit, an artillery battery had fired close to him and, as a result, he had lost his memory until in an Advanced Dressing Station. He said that since then, he had unsuccessfully attempted several times to eat and sleep; he was sent to a Field Ambulance on 24 June. Brown's Commanding Officer corroborated this story, stating that the evacuee had been subjected in the course of his duty to "exceptional exposure". According to one doctor, Brown's disorder was a kind of relapse. He stated:

whilst returning from fatigue duty in the trenches he was subjected to shell fire. One of his comrades being killed alongside of him. He was admitted into hospital, returned and admitted again in 2 days suffering from the same complaint. He was discharged from Hospital and sent to DRS [Divisional Rest Station].

Brown was classified "neurasthenia".¹⁰⁶

Although the circumstances associated with his symptoms were very similar to Brown's, Private F.M. Cooper was classified "shell shock W". On 25 September 1917 he was admitted to the New Zealand Stationary Hospital - another "Special" unit - by the hospital's CO, Lieutenant Colonel Eugene O'Neill. Thoroughly traumatised by his experiences, Cooper retreated into himself and was nearly unreachable. Only a whispered mantra passed his lips but in its chilling simplicity it was almost as eloquent

¹⁰³ Driver R.C. Adamson, 4th DAC, Australian Field Artillery, Army Form W3436, 30 August 1917. AWM 23, Box 94.

¹⁰⁴ Lieutenant G.E. Hills, Officer Commanding No. 2 Section, 4th Australian DAC, to Adjutant GHQ, 5 August 1917 and 24 August 1917. AWM 23 Box 94.

¹⁰⁵ Adamson, op. cit..

¹⁰⁶ Private D.D. Brown, 37th Battalion, Army Form W3436, 22 July 1917. AWM 23, Box 91.

an aetiological revelation as any medical diagnosis. His condition was described as "one of apathy with a vacant expression. He does not appear to understand what is said to him and murmurs 'Dead men' to all questions. Impossible to obtain even a written statement." Cooper's Commanding Officer, Lieutenant Colonel N. Marshall, certified that he was subjected to "exceptional exposure" and that

while in trenches near Glencourse wood on afternoon of 25th Sept. the enemy barrage fire was particularly severe and Pte. Cooper F.N. (sic) was affected by the close bursts of several shells. His condition became such that he was sent back. ¹⁰⁷

On 2 October 1917 Private A.J. Peart became heavily mentally dazed as a result of "very heavy shell fire" but was classified "neurasthenia". His Commanding Officer considered that he had been subject to exceptional exposure. ¹⁰⁸ By contrast Private Louis Malatzky, described as "very tremulous and generally shaky. Depressed and emotional," was classified "shell shock (W)". He too, though, had been subjected to artillery fire and buried for over an hour in a machine gun position at Polygon Wood. Buried alongside him was a comrade who had been killed by the explosion. Malatzky, after being dug out by a lieutenant and others from his company, had lost the power of speech, trembled all over and was unable to walk properly. This situation was regarded as "exceptional exposure". ¹⁰⁹ However anomalous these classifications may seem, it was not an uncommon occurrence for men who claimed to have been subjected to shell fire, and whose testimony was supported by their commanding officers, to be differently categorised.

Other classification decisions seem just as capricious and unfathomable. Driver W. Winnell of the 105th Battery, 5th Australian Field Artillery, was admitted to the New Zealand Stationary Hospital on 1 October 1917 via the 7th Australian Field Ambulance and 2nd Canadian Casualty Clearing Station. He was described as generally nervous with a tremor of the hands and fingers, and a headache. On the strength of the following statement by Lieutenant C. Morton on behalf on the Commanding Officer of the 105th Howitzer battery, Winnell was classified "neurasthenia": ¹¹⁰

Dvr. Winnell W. F. is well known to me. The statement attached by Capt. Crowe, R.M.O. 2nd D.A.C. is quite correct with the exception that one driver was killed instead of two. Two other men besides Winnell were severely wounded. There was no exceptional exposure as the incident occurred in the normal course of Ammunition Carting and the patients were quickly

¹⁰⁷ Private F.M. Cooper, 60th Battalion, Army Form W3436, 25th September 1917. AWM 23, Box 91.

¹⁰⁸ Private A.J. Peart, 58th Battalion, Army Form W3436, 4 October 1917. AWM 23, Box 91.

¹⁰⁹ Private L. Malatzky, 7th Machine Gun Company. Army Form W3436. 27 September 1917. AWM 23, Box 91. Brown, op. cit..

¹¹⁰ Driver W. Winnell, 105th Howitzer Battery, Australian Field Artillery. Army Form W3436, 15 October 1917. AWM 23, Box 94.

got to a Dressing Station. The incident was such that severe shellshock was almost inevitable.
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Contrast this case with the instance of Private G. Frewin of the 14th Australian Field Ambulance. On 24 March 1918 he was admitted to No.62 Casualty Clearing Station -a Special Hospital - in "fair Condition", with "Dilated pupils - normal speech " and "no injury". Despite much milder symptoms but similar precipitating circumstances in which he was flattened by a shell blast that killed a man beside him, Frewin was classed Shell Shock (W).¹¹² Thus, the NYDN system was legalistic and inconsistent.

The inefficacy of treatment and evacuation procedures.

The prime purpose of the various British Army attempts to deal with psychological casualties was to stem the wastage that was occurring through genuine illness and malingering. As far as Australians were concerned, the systems established to try to achieve these goals were not particularly effective. Men who were returned to duty often suffered relapses and had to be evacuated to the base hospitals or to England. Apparent successes were, in fact, only temporary victories.

Being treated mostly by British doctors, the kinds of therapies employed on Australian psychological casualties in the NYDN centres and base hospitals on the Western Front were probably the same as those applied to other British and Commonwealth soldiers. These methods included the use of drugs such as the ferocious sedative paraldehyde, psychotherapies such as hypnosis, persuasion and "exhortation." They also included coercive techniques such as seclusion and the highly expedient electric shock therapy, referred to above.¹¹³ Dr. Frederick Dillon of the RAMC, who worked on psychological casualties at No. 3 Canadian Stationary Hospital in France provided a clear idea of the reason for the employment of electricity: "But as, in treating large numbers of patients, saving of time and energy was essential, seclusion or faradisation was commonly employed."¹¹⁴

Australians were not spared the use of electricity and, along with the other methods, its efficacy as an enduring solution to a serious problem was doubtful indeed. Private Charles Green of the 37th Battalion was blown up by a shell in October 1917 at Ypres and rendered speechless. He also became "very shaky" and developed a fine

¹¹¹ Lieutenant C.C. Morton, for Officer Commanding 105th Howitzer Battery, to Officer Commanding New Zealand Stationary Hospital, 18 October 1917. AWM 23, Box 94.

¹¹² Private G.H. Frewin, 14th Australian Field Ambulance. Army Form W3436, 7 April 1918. AWM 23, Box 92.

¹¹³ Brown, op. cit., p. 321; and R. Leys, "Traumatic Cures: Shell Shock, Janet, and the Question of Memory", *Critical Inquiry*, 20, Summer 1994 (The University of Chicago 1994), pp.625-626.

¹¹⁴ Brown, op. cit..

tremor of the hands. For the speech disorder, "faradic battery" was applied to the throat ¹¹⁵ but Green never recovered the full use of his voice. Post-war he suffered from a major stammer as well as other nervous symptoms. ¹¹⁶ In September 1917 Private Harold Spears was blown up and sent to a hospital in St. Omer but was bombed there two weeks after his arrival. While running for a shelter with five others, a bomb dropped amongst them killing four and blowing up Spears who remained unconscious for 27 hours. He also lost his speech for five days but spoke after two days of faradisation. Together with other serious psychological symptoms, Spears took home to Australia a stammer which plagued his post-war life. ¹¹⁷

One of the chief forms of treatment for psychological casualties was a period of absence from the line following discharge from hospital. As therapy, however, this method was, like electricity, of dubious value: usually, those who returned to duty suffered a further debilitating relapse. For officers, such absences usually took the form of retention at the base followed by leave, usually to England. In May 1917 Lieutenant C. Jacobs was given three weeks leave in England for "nervous debility" following "continuous service at the front for the past couple of years." ¹¹⁸ At Etaples in October 1917 Lieutenant L.S. Marchant was recommended for three weeks sick leave in England due to "the effects of continuous service at the front both in this country and at Gallipoli." ¹¹⁹ In supplying evidence for the case, Captain J. Morgan of the AAMC wrote:

He was sent to the depot here suffering from shell shock. He has been under observation here for some time and has not improved very much. He still shows nervous excitability . . . Judging from what he is able to do here I do not think he is fit to return to his unit. ¹²⁰

In October 1917 Lieutenant A. Paull was withdrawn from his unit after 15 months service on the Western Front and assigned to instructing at a corps school. He was, however, finally overcome by the strain of active service and his duties at the school and "broke down and cried." A medical board at Le Havre recommended three weeks leave in England.¹²¹ Treated in the same way was Lieutenant J. Brett who, suffering from neurasthenia and debility was classified Bii ("unfit for general service") in June 1918. ¹²² Although three weeks sick leave in England was a common recommendation for officers suffering from psychological disorders, classifications of "unfit for General

¹¹⁵ Medical Case Sheet, 18 December 1917, in Private C. Green, 37th Battalion, PCF.

¹¹⁶ Form 71, in *ibid.*

¹¹⁷ 11AGH, Clinical History, 12 March 1918, in Private H. Spears, 30th Battalion, PCF.

¹¹⁸ Lieutenant C. Jacobs, 21st Battalion, Proceedings of a Medical Board, 12 May 1917. AWM 23, Box A13.

¹¹⁹ Lieutenant L.S. Marchant, 24th Battalion, Proceedings of a Medical Board, 14 October 1916. AWM Box 23, Box A13.

¹²⁰ Captain J. Morgan, AAMC, 12 October 1916. AWM 23, Box A13.

¹²¹ Lieutenant A. Paull, 26th Battalion, Proceedings of a Medical Board 20 April 1918, and Medical Case Sheet, 22 April 1918. AWM 23, Box A13.

¹²² Lieutenant J. Brett, 2nd Battalion, Proceedings of a Medical Board, 24 June 1918. AWM 23 Box A14.

Service but fit for service at the Base" were usual too but the periods of absence from the front line for men so categorised were much longer. Captain W.J. Dewar, disability "Shell Concussion (W)" was given T. B. (Temporary Base) duties suffering from "serious debility ... headaches, vomiting, depression etc." after being "blown up at Pozières on July 27th 1916."¹²³ In June 1917 Lieutenant L.S. Duesbury, suffering from "nervous debility" was given three months base duties.¹²⁴ Another officer was classified "P.B." (Permanent Base) and retained permanently at depots in France.¹²⁵

Those from the ranks were, in general, treated in ways that reflected the social divisions within the army and the military's suspicion of psychological casualties as malingerers. No "other ranks" were simply given sick leave as a primary palliative measure. Some privates and N.C.O.s were sent to "A.L." (Agricultural Labour) while others were ordered to convalescent camps. Agricultural labour was organised by the British Army agricultural officer who allocated "suitable" psychological casualties to local farms for a month's work after which they automatically returned to their units for duty. This was a way of preventing evacuation to the base and of ensuring "a probationary period . . . in which it became possible to see how a doubtful case was going to develop."¹²⁶ In August 1917 during Third Ypres, Gunner W.H. Carter was assigned to agricultural labour from Fifth Army's NYDN hospital at Haringhe, No. 62 Casualty Clearing Station.¹²⁷ Carter's commanding officer, Captain L. Cunningham, wrote:

[A]t the gun position a number of men went through a very heavy period and so many were blown about that it was not always possible to keep track of all cases. It is quite possible that this man received a severe shaking up during the bombardment of my position with heavy guns. In two or three cases I have found it necessary to get men away and off duty for several days to recover.¹²⁸

Some "other ranks" with psychological disorders were given less stressful duties for varying periods. In April 1917 Private Robert Henry was assigned to traffic control because of the effects of "nervous strain"¹²⁹ but returned to duty not long afterwards. In May 1917 Private Colin McRae was attached to the 1st Australian Division headquarters as a cinema projectionist following a recurrence of shell shock.

¹²³ Captain W.J. Dewar, 9th Battalion, Proceedings of a Medical Board, 9 December 1916. AWM 23, Box A13.

¹²⁴ Lieutenant L.S. Duesbury, 33rd Battalion, Proceedings of a Medical Board, 18 June 1917. AWM 23, Box A13.

¹²⁵ Lieutenant L.C. Symonds, 7th Battalion, Proceedings of Medical Board, 20 September 1917. AWM 23, Box A13.

¹²⁶ Macpherson, *op. cit.*, p. 41. Precisely the same motivation was behind the establishment of Repatriation Department Convalescent Farms in Australia. Many cases of war neurosis were placed on these properties then carefully observed for signs of disingenuousness. See chapter four.

¹²⁷ Gunner H.W. Carter, 102nd Howitzer Battery, Australian Field Artillery. Army Form W3436, 30 August 1917. AWM 23, Box 94, and Macpherson, *op. cit.*, p.10.

¹²⁸ Carter, *op. cit.*

¹²⁹ Mrs. V. Henry, to Repatriation, undated, circa 1928, in Private Robert Henry, 7th Battalion, PCF, *op. cit.*

Returning to duty in May 1918 he suffered a further relapse and was evacuated to England where he remained for the duration.¹³⁰ Private Edward Shelton was placed on light duties in the 1st Anzac Corps Canteen in May 1917 after he too had a recurrence of shell shock sustained in August 1916. He did not return to the line again.¹³¹ The later lives of all three men were marred by the consequences of the psychological disorders they sustained on the Western Front.

Many shell shocked Australians were returned to front line duty under the NYDN system but the bogeys of the trench world usually forced further crises for the mentally maimed diggers. The results were pitiful. In many cases when men returned to their units it was not long before the sound of artillery fire or other ready reminders of evil days triggered a relapse and another evacuation. Private J. Griffin was hospitalised with shell shock at Bullecourt in May 1917 but returned to the line on 28 August 1917. Less than one month later he was removed from the trenches west of Ypres "in a state of nervous tension" and "trembling violently".¹³² Similarly, Gunner C.C. Cooper was sent to the rear twice in July 1917 because of nervous breakdowns before being classified shell shock (W) on a third occasion and evacuated to a convalescent camp on 21 September 1917. In July 1917, near Ploegsteert Wood, Cooper had "lost control" when a Sergeant to whom he had been talking was killed beside him; a fortnight later, after a week's rest, he was ordered from the lines again "for vomiting and nervous condition." He rejoined his unit at rest near Merk St. Levin but was sent to hospital by the medical officer when his battery was recalled to the line on 8 September.¹³³ Private D. Brown lasted only two days in the trenches after returning from hospital to which he had been earlier admitted suffering from a marked stammer, pain over the heart and nightmare sustained when a comrade was killed alongside him. An artillery battery firing close to him prompted a return of the old symptoms so he was evacuated and re-admitted on 12 July 1917.¹³⁴

Several more examples show further the destructiveness of the NYDN system. Upon his return to France in October 1916, Lieutenant Llewellyn Symonds, 44 years old, didn't make it past the depôt where he was classified T. B. or "temporary base" by a medical board who subsequently examined him a further five times for neurasthenia. He was assigned to Base duties and found when conducting reinforcements to the line in June 1917 that the former symptoms of shell shock for which he had been evacuated to England in September 1916, returned under shell fire. As a soldier he had seen a

¹³⁰ Army Form B103, and Medical Report on an Invalid, 27 June 1918, in Private C. McRae, 7th Battalion, PCF.

¹³¹ Army Form B178 and Army Form B103, in Private E. Shelton, 24th Battalion, PCF.

¹³² Private J. Griffin, 54th Battalion, Army Form W3436. AWM 23 Box 91.

¹³³ Gunner C.C. Cooper, 7th Australian Field Artillery Brigade, Army Form W3436, 24 September 1917. AWM 23, Box 94.

¹³⁴ Private D.D. Brown, 37th Battalion, Army Form 3436, 22 July 1917. AWM 23, Box 91.

great deal of action in South Africa, at Gallipoli and on the Western Front ¹³⁵ but was finally marked permanently unfit for service. The board stated: "His appetite is very poor, he suffers from insomnia. He has been in practically the same state since being evacuated in September 1916 as Wound - Shock - shell . . ." ¹³⁶ From September 1917 (when he went before a medical board for the sixth time) until March 1918, he worked as Australian Disciplinary Officer at 39th General Hospital, Le Havre. ¹³⁷ Like Symonds, 23-year-old Captain John Shaw of the 20th Battalion was "unable to control his nervousness under shell fire" after returning to France in January 1917 from No 3 London General Hospital where he had been a patient for six weeks suffering the effects of shock. ¹³⁸ On 15 November 1916 a shell had burst inside the tent in which he had been lying with three other officers who were "blown to pieces." Shaw escaped with a knee wound and shock. After his return, he suffered for six months before being "boarded" at Le Havre on 24 September 1917 where he was given base duties for three months. ¹³⁹ When the Medical Board sat again for him on 24 December 1917 he still had "very little control over his emotions" and was awarded a further six months service at the Base. ¹⁴⁰ In June 1918 another medical board reported no change in Shaw's condition. ¹⁴¹

Some men on the Western Front had a history of shell shock stretching all the way back to Gallipoli but this did not prevent military authorities repeatedly returning them to the line. Lieutenant F.A. Clarke of the 44th Battalion was sent to France in July 1917 after two years convalescence in Egypt and England following evacuation and hospitalisation for shell shock sustained at Gallipoli in June 1915. During only his second day on the Western Front - July 4 1917 - he "was severely shaken by a heavy calibre enemy shell and later in the same day was buried for 15 minutes in a dugout by the explosion of another heavy calibre enemy shell." He bled freely from the nose and ears and was immediately evacuated through the usual chain - Australian Field Ambulance, Casualty Clearing Station, Special Hospital and finally transferred to the 59th General Hospital in England classified Shell Shock (W). ¹⁴² Gunner H. Ross was evacuated four times in six months during 1917 and on each occasion a recommendation accompanied him stating that he was unfit for service at the front due to psychological disorder. On Gallipoli he had been wounded twice, being buried the second time. In France, his unit's medical officer, Captain E.H. Loxton, AAMC, wrote

¹³⁵ Lieutenant L.C. Symonds, 7th Battalion, Medical Case Sheet, 18 September 1917. AWM 23, Box A13.

¹³⁶ Ibid, Proceedings of a Medical Board, 21 September 1917, in *ibid*.

¹³⁷ Captain P.C. Coleman, Permanent Supply Depot, to Australian Section, GHQ, 3rd Echelon, 19 March 1918, in *ibid*.

¹³⁸ Captain J.L. Shaw, 20th Battalion, Medical Case Sheet, 20 September 1917. AWM 23, Box A13.

¹³⁹ Shaw, *op. cit.*, Proceedings of a Medical Board, 24 September 1917, in *ibid*.

¹⁴⁰ Ibid, Proceedings of a Medical Board, 24 December 1917, in *ibid*.

¹⁴¹ Ibid, Proceedings of a Medical Board, 6 June 1918, in *ibid*.

¹⁴² Lieutenant F.A. Clarke, 44th Battalion, Army Form W3436, in *ibid*.

to the Casualty Clearing Station where Ross was a patient: "I am decidedly of opinion that he is quite unreliable under fire and that it is a real terror to him. Therefore I am evacuating him . . . I am of opinion that he is suffering from neurasthenia as a result of shell-shock and that he is not fit for service." ¹⁴³ Here, in the face of these relapses resonates the advice of Dr. Alfred Campbell who wrote from Egypt in 1915 that all cases of war neurosis from Gallipoli should be declared permanently unfit and given base duties. The aforementioned cases provide strong supporting evidence for this point of view.

Some Australian psychological casualties were made the subject of disciplinary action. Driver Harold T. May's reported shell shock was treated as an "accidental or self-inflicted injury" until an officer informed the necessary authorities that a shell had killed one man and four horses near May and that he had "lost control" and was not fit for duty. ¹⁴⁴ In September 1916, 2nd Lieutenant A.E. Harris of the 25th Battalion was admitted to the Liverpool Merchants Mobile Hospital at Etaples with shell shock. ¹⁴⁵ He returned to the line but was admitted to the 6th Australian Field Ambulance with neurasthenia on 8 October 1916. ¹⁴⁶ Not long afterwards he was admitted to the 1/1st North Midlands Casualty Clearing Station with an injury that was alleged to be self-inflicted and arrangements were made to bring him to trial at No. 12 Casualty Clearing Station, Hazebrouck, as soon as medical grounds permitted. ¹⁴⁷

Thus, although medical care based on a psychodynamic approach was provided within the NYDN system, the individual welfare of shell shocked soldiers was of secondary importance to British Army authorities. Of primary concern were manning levels and discipline which the military wished to maintain as expeditiously as possible. Clearly, this philosophy entailed returning soldiers to their units who had not fully recovered, thus seriously compromising their health. The shortsightedness of such a policy and the chronic problems it created made complete nonsense of its expedient intentions.

Australian Psychological Casualties in England.

Throughout the AIF's period of service on the Western Front, many of its psychological casualties were evacuated to England where they were cared for firstly in British General Hospitals then in the Australian auxiliary system. Denied treatment

¹⁴³ Captain E.H. Loxton, Medical Officer, 1st Australian DAC, Medical Report on Gunner H.J.W. Ross, 1st Australian DAC, 21 July 1917. AWM 23, Box 94.

¹⁴⁴ Driver H.T. May, Army Form 3428, Report on Accidental or Self-Inflicted Injuries, 17 November 1917. AWM 23, Box 92. See also chapter one of this thesis for further details of this incident: p.64.

¹⁴⁵ Inter-office minutes, 27 October 1916. AWM 23, Box 93.

¹⁴⁶ *Ibid.*, 30 October 1916.

¹⁴⁷ Captain D.F. Wyley, for Assistant Adjutant-General, GHQ, 3rd Echelon, to Officer Commanding 1/1st North Midlands Casualty Clearing Station, 10 November 1916. AWM 23, Box 93.

from the most progressive British specialists by the "six months" policy and often languishing in British General Hospitals for months without the correct care, these men, whose disorders had been allowed to solidify in the NYDN system, showed few signs of progress. Many of them became chronic cases.

Under Neville Howse, the AAMC in Europe expanded greatly to include two more auxiliary hospitals and three more command depots. It also gained greater stability and efficiency, and complete independence from the War Office as regards its internal working.¹⁴⁸ Thus, the Australian government's "six months policy" became the major influence on the treatment of Australian invalids (including psychological casualties) in England. Explained at greater length below, this policy caused many Australians to languish in British general hospitals for months receiving ineffectual treatment. It also effectively barred them from some of the best specialist care in England. Prominent amongst these men were psychological casualties for whom the only specialist care available was in small clinics in the Australian Auxiliary Hospitals and, after the war, at Monte Video Camp Hospital, Weymouth.

Because of the Australian Government's "six months policy", treatment from some of Britain's more enlightened and humane psychologists and psychiatrists in the special centres established to deal with psychological casualties was generally not available to AIF soldiers. Growing from the idea that Australia, not Britain, should be the medical base for the AIF, the six months policy originated in the Australian Defence Department's instruction (promulgated in November 1915)¹⁴⁹ that men too ill or too badly injured to recover in three months should be shipped home. It also built on the practices developed in 1915 for Australian wounded in England and was fully ratified at a conference of Anzac medical officers and War Office officials in April 1916. According to its terms, Australians (and New Zealanders) not likely to be fit within six months were to be returned home as quickly as possible.¹⁵⁰

This policy had several consequences. Firstly, it made the AAMC in England responsible for convalescent rather than primary care (the province of the British General Hospitals) and thus necessitated the establishment of a vast Australian intermediary base in England including three Australian Auxiliary Hospitals and four command depots. Secondly, it required the accumulation of a large sea transport system.¹⁵¹ Thirdly, by insisting on the rapid gathering of Australians from British hospitals and their concentration in the Australian auxiliaries and depots in preparation for the journey home, the six months policy forced some men from their hospital beds before they were ready to travel. This insistence on constant movement also precluded

¹⁴⁸ Butler, Vol. II, op. cit., pp.802-808.

¹⁴⁹ Butler, Vol. I, op. cit., p.506.

¹⁵⁰ Wyley, op. cit., p. 12.

¹⁵¹ Ibid, pp. 824-825.

the possibility of treatment in British special hospitals for many Australian invalids and convalescents including psychological casualties.¹⁵² In addition, the standard of care in the British hospitals to which Australians were sent for their primary care varied markedly.¹⁵³

The six months policy determined all the Australian medical arrangements in England¹⁵⁴ and set up antagonisms that often erupted in bitter argument. On one hand was the military and political desire for repatriation advocated by the Defence Department; on the other was "the professional impulse for delay in the interests of treatment" by the medical officers of the Australian Auxiliary Hospitals "whose clinical instincts were outraged by the tyranny of this military expediency."¹⁵⁵ In a report to parliament the Director of the Australian Army Medical Services, Richard Fetherston described the weaknesses of the six months policy as he saw them and advocated change. In this document he criticised the complete absence of any Australian General Hospitals in England. Australian soldiers requiring treatment in such institutions, he wrote, were tended in Imperial hospitals, some of which were very good and others of which were below standard. "It is a weakness in the chain of medical attendance upon members of the A.I.F. in that the Australian Medical Services are not responsible for the treatment of either officers or men," he wrote.

Fetherston also criticised the need for the continual movement of Australian invalids. According to him, these moves were opposed by English authorities and worked against effective treatment of Australians in Imperial hospitals because doctors lost interest in patients they knew would be moved once they were half way better. Fetherston wrote: "To move patients in the middle of their treatment is often not good for them, and the medical officers in charge do not get a fair chance to do justice to our men." Neither the South Africans nor the New Zealanders allowed their wounded and sick to be scattered all over Britain, he continued, and so concentrated them in their own hospitals or received them directly from France. Fetherston felt that the Australians must do the same and care for their invalids and that "general hospitals should be established in England by the Australian authorities ... I consider that in the Western sphere the attention to the Australian sick and wounded is not as complete as it might be in England."¹⁵⁶ Fetherston's opinions clashed with official policy and with the views

¹⁵² A.G. Butler, *The Australian Army Medical Services in the War of 1914-1918, Volume III, Problems and Services* (Australian War Memorial, Canberra 1943), p.631.

¹⁵³ *Ibid.*, p.627.

¹⁵⁴ *Ibid.*, p.628.

¹⁵⁵ *Ibid.*, p.630.

¹⁵⁶ *Report by Surgeon-General R.H. Fetherston, Director-General, Australian Army Medical Services, to the Honourable the Minister of State for Defence on 1) Australian Army Medical Services Overseas, 2) The Medical Services of Great Britain and the Allies, 3) Re-education and Re-Establishment of War Cripples in America, Europe and America, February- November 1918*, (Commonwealth of Australia, 1919), p. 18. AWM 2DRL 1351.

of General Howse which prevailed.¹⁵⁷ And, as so often occurred, it was the soldiers who paid the greatest price.

According to the official medical historian, Arthur Graham Butler, the dynamic produced by the interaction of the two views on the six months policy "constitutes the history of invaliding in the Australian Imperial Force on the Western Front."¹⁵⁸ Certainly the consequences of this policy were a major factor in the invaliding and convalescent process for many Australian sufferers of war neurosis.¹⁵⁹

Because the six months policy prevented Australian psychological casualties from gaining access to expert treatment in English clinics, virtually the only specialised care for these men in England was at two of the three Australian Auxiliary Hospitals: No. 1 at Harefield and No. 3 at Dartford, and, towards the end of the war, at Monte Video Camp Hospital, Weymouth. In addition to these, there were two small convalescent homes for officers at Cobham Hall, Kent, and Moreton Gardens in London. It was in these hospitals and homes that some of the Australian sufferers of war neurosis dispersed throughout the English hospital system were eventually concentrated. Of the Harefield ward, little historical evidence remains. In his 1918 Report, Fetherston wrote that shell shock cases there were segregated and that the Medical Officer in charge, Major Shaw, obtained "good results from suggestion and moral treatment." Fetherston also reported that at Cobham Hall Hospital for Officers, Kent, one wing had been set aside for Australians. Here, patients in the two main wards were crowded and there was insufficient room for baggage and gear. Amongst the inmates were a number of officers suffering from shell shock and, in the cramped and unsegregated conditions, "their asthmatic seizures at night" were apparently "disturbing to the other patients. Officer patients complained at these disadvantages ..." ¹⁶⁰

Only after the Armistice - when it became apparent that chronic war neurosis would pose a very expensive pensioning problem for the Department of Repatriation - did Australian military authorities in England react with any real urgency to the question of psychological casualties and explore more enlightened and efficacious methods of treatment. In February 1919 Colonel Douglas McWhae, Assistant Director of Medical Services for the AIF Depots in the United Kingdom, began to mobilise AIF resources in an effort to minimise the pension bill. He ordered that all Australian cases of war neurosis were to be examined by Australian medical officers trained in England or France and that other doctors required for such duties should be "trained in England as soon as possible at a hospital such as Seale Hayne Military Hospital, preferably this

¹⁵⁷ Butler, Vol.II, op. cit., pp. 427-428.

¹⁵⁸ Butler, Vol III, p. 630.

¹⁵⁹ Ibid, pp. 630-631.

¹⁶⁰ Fetherston, op. cit., p. 21.

hospital if it can be arranged." Information from Seale Hayne, provided by its Commanding Officer, Arthur Hurst, convinced McWhae that psychotherapy was one way of reducing government spending on veterans. Hurst had told McWhae that 310 English cases of war neurosis at Seale Hayne regarded as incurable would have received pensions of between 60-100 per cent if not "stopped". McWhae felt that the English experience was of particular relevance to Australia and suggested that all pensions be examined retrospectively with the curability of patients in mind. ¹⁶¹ As a result of these opinions, men like Major J.B. Lewis, AAMC, were seconded to Seale Hayne where they underwent precipitate courses in psychotherapy which were then hastily applied to Australian trauma patients in Monte Video Camp Hospital, Weymouth. ¹⁶² Although McWhae's interest in psychotherapy appeared indecently opportunistic, he, was, like some of his AAMC colleagues, heavily intellectually influenced by his experiences in England and, as a doctor in Western Australia during the post-war years, advocated and practiced psychodynamic approaches to mental disorder. ¹⁶³

Specialist treatment for Australian psychological casualties in England was thus confined to Monte Video Camp and three small clinics in the auxiliary hospitals. Although Australian shell shock cases were subject to British direction on the Western Front, it was the insistence of their own Defence Department on the six months policy that resulted in this unsatisfactory state of affairs in England. The damaging consequences of those arrangements stare plainly from the detailed records of Ward A10 at No.3 AAH, Dartford, the only Australian war neurosis unit to have bequeathed historical evidence of any quality.

The work of Dr. John Springthorpe, AAMC, at No. 3 Australian Auxiliary Hospital, Dartford.

"The faces of the 'Shell Shock' boys are clean, sweet, immobile young faces - faces that have looked into and tasted Hell - haunt me."

John Springthorpe, Personal Diary, 12 November 1916. La Trobe Library. MSS 9898.

The view that the British and Australian systems for dealing with psychological casualties were ineffectual both in returning men to the front as able soldiers and restoring them to mental health is considerably reinforced by the documentation relating to Dr. John Springthorpe's work in Ward A10 at No. 3 Australian Auxiliary Hospital,

¹⁶¹ Colonel D. McWhae, Report, 4 February 1919, AWM 25, 885/4.

¹⁶² McWhae to Senior Medical Officer, AIF: "Treatment of War Neurosis by Psycho-Therapy". AWM 25 885/4; Report by Major J.B. Lewis on 188 cases at Monte Video Camp, 11 February 1919; and History of War Neurosis Treated at Monte Video Camp Hospital, Weymouth 1919, AWM 25, 885/4.

¹⁶³ See chapter eight for a full discussion of the war's effect on Australian psychiatry.

Dartford. Indeed, the particulars of Springthorpe's endeavours at Dartford shed considerable light on the damaging consequences of lengthy sojourns in British general hospitals without specialist care, and on bureaucratic obstinacy which reduced the meagre levels of comfort that he was able to procure for the men in his care. But the record also shows that in at least one corner of the vast, grim military-medical maze, one man's compassion, leavened with a measure of psychiatric expertise, eased the pain of many Australian psychological casualties.

In Volume III of the *Official History of the Australian Army Medical Services in The War of 1914-1918*, A.G. Butler wrote that Springthorpe's clinic achieved only limited success because "the atmosphere in which the treatment was carried out precluded any hope of success."¹⁶⁴ Butler did not elaborate on this point but it has now become apparent that Springthorpe's accomplishments warrant considerable praise, although he too was dissatisfied with his work there. Despite these criticisms and reservations, it is clear that he achieved a great deal for the men in his care, treating them with skill, dedication and gentleness, and challenging army authority when he felt that the interests of his patients - and Australian autonomy - would be best served by such risks.

John William Springthorpe was born on 29 August 1855 in Wolverhampton, England, and came to Australia as an infant. Educated in Sydney and Melbourne, he became an MD in 1884 after a brilliant scholastic career which included becoming the first Australian admitted to the Royal College of Physicians. Before the war, Springthorpe was a private practitioner and university lecturer with an ardent interest in mental illness and psychotherapy.¹⁶⁵ After his period of service with the AAMC in Egypt, Springthorpe returned to Australia but by November 1916, was working in England where he was ordered to develop Ward A10, No. 3AAH, as a shell shock clinic.¹⁶⁶ There he immediately began to concentrate Australians with a variety of unfortunate experiences in the hospital system, two of which, he considered, were inaccurate diagnoses and over-long stays in non-specialist, English hospitals.¹⁶⁷ One of his papers starkly and dramatically reveals the deficiencies of the methods employed to treat Australian psychological casualties:

In many cases, as I know from sad experience, patients specially diagnosed become practically lost in the forest of General Hospitals for periods ranging up to four to six months - and in hundreds of cases, averaging over three - where general - shall I call it - unobservant neglect often takes the place of that individual expert attention which makes all the difference in duration and prognosis. The results are often disastrous. Is not the continuance inexcusable ?

¹⁶⁴ Butler, op. cit., Vol.III pp.133-134.

¹⁶⁵ J. Ritchie (ed.), *Australian Dictionary of Biography, Volume 12: 1891-1939 Smy-Z* (Melbourne University Press 1990), pp.38-39.

¹⁶⁶ J.W. Springthorpe, Report on Cardiac Cases and their treatment at No. 3 AAH Dartford - Nov. 1916 - July 1918, p.1. AWM 2DRL 701, Item 17.

¹⁶⁷ Springthorpe to Maudsley, July 1917. AWM 41 [279].

Other cases, apparently less fortunate at the beginning - because not expertly diagnosed - are even more unfortunate in their subsequent progress, and lay perdu in all sorts of places, under all sorts of non-neurological diagnoses, and treatment in numbers that are probably never known in their entirety . . . As I write I have just received a patient, eighty-five days after his shock, with, almost complete amnesia and other classic symptoms of shell shock who has been through six hospitals on the diagnosis of "P.U.O." [Pyrexia of Uncertain Origin] and "Trench Fever", and who has never been even questioned as to his memory, or treated for other than his fever. The case is typical of very many others. ¹⁶⁸

Like Fetherston, Springthorpe was a critic of the six months policy and felt that the medical staff of these English units would not care for Australians in the same way that their countrymen might and that the solution was to improve Australian facilities in England so that they approximated those of South Africa, Canada and New Zealand. Along with the ordinary medical patients, he felt that psychological casualties, too, suffered from these poor arrangements. In a report to the Director of Medical Services, AIF, he wrote:

A sharp difference exists in disposition of hospitals and reception of patients between ourselves and the other Dominions [who] have all their General Hospitals here, and up to the limit of their capacity, receive their own men direct from France. All our General Hospitals are in France, and we receive our patients more or less haphazardly from British Hospitals in England, which have no direct responsibility to Australia, and over whom we have practically no control ... [O]ut of 3 series of 30 consecutive patients received into my ward, A10, the average duration of stay in other hospitals has been 88, 90 and 92 days respectively, and of the last, 10 had been elsewhere for over 100 days, with an average of 149. From national, medical and individual points of view, there can, in my opinion, be no doubt as to the inferiority of our position, and we must, it seems to me, remain less satisfactory and even less efficient until we do somewhat as the other Dominions do in these respects. ¹⁶⁹

Springthorpe's knowledge of the Canadian, New Zealand and South African hospitals was gained at first hand for he toured them and in June 1918 provided a report on the Canadian Units to Neville Howse. ¹⁷⁰

To support his views that Australian shell shock sufferers were being seriously compromised by inaccurate diagnoses and inappropriate treatment within the English system of hospitals, Springthorpe provided four detailed case histories to Neville Howse. His purpose was to emphasise "the importance of securing recognised nomenclature, continuity of treatment, and early reception of War Neuroses cases into Special Departments in our own Australian Hospitals, ..." ¹⁷¹ Typical of the cases and "of very many others" was Lance Corporal W. Meadley who returned to France in October 1917 after previous physical illness for which he had been treated in the War Hospital, Birmingham, and at Dartford. On 3 March 1918 he was rendered

¹⁶⁸ J.W. Springthorpe, "Suggestions as to the Better Treatment of our War Neuroses", presented to the Inter-Allied Conference on the Treatment and After-Care of Disabled Men, June 1918." P. 3. AWM 2DRL 701, Item 3.

¹⁶⁹ Springthorpe, Report on the Recent inter-Allied Conference in Reaction to Treatment and After-Care of Disabled Men, 10 June 1918, p. 2. AWM 2 DRL, 701 [Item 3].

¹⁷⁰ Ibid.

¹⁷¹ Springthorpe, "Four Cases Illustration Delay, ETC." Copy 35, p.1. AWM 11, 1508/1/42.

unconscious by high explosives after which he displayed tremors, deafness and stammering. He then spent five days in a Field Ambulance, 21 days in No2 CCS, 14 days in No. 63 CCS, 7 days at Wimmereux and 21 days in Le Havre Camp. Diagnoses included NYDN, debility, concussion and neurasthenia but he was said to have been evacuated as "shell shock." In England he remained at No. 1 AAH Harefield for 35 days after which he was boarded by a consultant who recommended "intensive treatment at Queen's Square or Napsbury," both neurosis clinics. Meadley spent 80 days at Queen's Square - 219 days after the explosion and a further 25 days at Maudsley Hospital, another specialist neurosis clinic. On 15 October 1918 he arrived at ward A10, Dartford.¹⁷² Springthorpe wrote:

Had the case been sent there, so soon as the diagnosis 'N.Y.D.N.' had been confirmed and settled, it is not too much to say that he could have been promptly and correctly treated, boarded for Australia, and if transport had been available, left for Australia well without the period of his stay in Queen's Square and Maudsley Hospital. ¹⁷³

Springthorpe's familiarity with and high opinion of some of the specialist English war neurosis clinics led him to criticise further the Australian procedure for dealing with shell shock cases. He felt that the defects of the Australian position became more obvious after comparison with several laudable English units: Special Military Heart Hospital, Colchester; special neurological hospitals, Maghull, near Liverpool, Hospital for Officers, Kensington Gardens, Newton Abbot, Devonshire and Golders Green Home of Recovery. By implication, then, the Australian "position" lacked, in Springthorpe's view, the facilities - the room and the equipment - as well as the attitude - of the English hospitals. Springthorpe felt that the officers hospital at Kensington Gardens was an example that could "be well recommended for our adoption ." Here, since 1914, more than 2,500 officers had passed through, staying an average of three to four weeks and being given a separate room, "an advantage at first, though less so, later on." There were rooms for callisthenics and physiotherapy, and frequent outings with relatives.¹⁷⁴

Springthorpe wrote that in Ward A10 at No. 3 AAH he had done everything possible "under our circumstances, but I could do better if our methods could be, in spirit, though not necessarily in the letter, approximated to those referred to in (a) and (c)." ¹⁷⁵ Maghull hospital, ["(a)"], was a training institution for officers being schooled in war neuroses. It had a capacity of 500 patients under a staff of eight specially qualified medical officers as well as a gymnasium and facilities for agricultural work, physiotherapy, massage, electrical treatment and psychotherapy. Newton Abbot,

¹⁷² Springthorpe, "Four Cases . . .", op. cit..

¹⁷³ Ibid.

¹⁷⁴ Springthorpe, Report on the Recent inter-Allied Conference, op. cit., pp.7-8.

¹⁷⁵ Ibid, p.8.

["(c)"], was similarly equipped but the emphasis was on farm work in the surrounding 220 acres. None of these units, however, was without its difficulties or flaws: Maghull apparently received cases with stays of 90 days elsewhere. All, according to Springthorpe, returned patients to their units instead of boarding them "out of front line service."

Ward A10's records - meticulously handwritten by Springthorpe himself - reveal that No.3 AAH's war neurosis clinic ministered to at least 382 Australian soldiers afflicted with "neurological and cardiac" conditions.¹⁷⁶ These statistical sheets reveal the soldiers' family and personal history (in highly abbreviated form and only as these histories related to neurosis), symptoms, cause, the duration of periods in other hospitals, the number of hospitals through which the man had passed, diagnosis, age, length of service, occupation, heart sounds, loss or gain in weight, and army health classification. They also show "date of shock", symptoms on admission, symptoms on discharge, "other neurological symptoms" and dates of admission and discharge. As Springthorpe asserted, these men had spent a lot of time in several hospitals before arriving at No. 3 AAH. One man with shell shock, a labourer of 40 with 17 months service, had been 127 days in four different hospitals; another, with neurasthenia and trench fever, a flour miller of 22 years with nine months service, had spent 219 days also in four separate hospitals before becoming a patient in ward A10. These records reveal the usual tragic tale of mental and physical suffering experienced by shell shock victims: the precipitating events, burial, explosion or other causes such as a prolonged bombardment ("Nerves gave way during shelling") - continued strain; symptoms such as tremors, stammering, aphonia (loss of speech), insomnia, depression, physical wounds and illness associated with gas or trench fever.¹⁷⁷

This statistical record also adds a further dimension to the humanity of these men as it reveals their occupations - information which reminds the reader of the First AIF's social composition and suggests that this mixed bag of ordinary citizens - clerks, farmers, accountants, commercial travellers, labourers, dental appliance makers, graziers, station hands, firemen, signwriters, bootmakers, grocers, coachbuilders, machinists, orchardists, slaughtermen (the list goes on) - might never have found themselves in a clinic for psychological disorders had the war not put their mental resources to a very severe test. As can be seen, wage-earners and small businessmen predominated in this group and could probably ill-afford the deleterious economic effects of chronic illness. Unfortunately for many, war-induced psychological disorder prevented further full participation in the work force. Such inactivity must also have inflicted a severe loss on those sectors of the economy represented by the abovementioned occupations.

¹⁷⁶ Statistical Records of Ward A10, No. 3AAH. AWM 27, 371.1

¹⁷⁷ Statistical Records. op. cit..

Repatriation Department files show unequivocally the devastating personal effects of life-long psychological illness for Australian veterans of the First World War and their families.¹⁷⁸ In an oblique way the records of Ward A10 were harbingers of this approaching storm. The "symptoms upon discharge" column demonstrates that many men left Springthorpe's clinic after stays of a few weeks or a couple of months in a less-than-perfect condition. The majority were described as "improved" and others were said to be "improving", "in status quo", "much the same", "no marked improvement" or "not improved". Occasionally the symptoms-upon-discharge were described in greater detail so that we can gain greater insight into the sorts of burdens with which men returned to duty or home to Australia. Some were still very nervous and excitable while others continued to stammer or suffer from combinations of depression, insomnia, nightmares, headaches and tremors. As the histories on Springthorpe's statistical sheets show, very few - 29 out 394 - of his patients had a personal or family background of mental instability, suggesting that the war alone was responsible for their disabilities.¹⁷⁹

As part of his treatment, John Springthorpe began "boarding out" Australian shell shock cases with English families in the countryside for periods of up to five days as soon as he took charge of the ward.¹⁸⁰ By all accounts it was a popular and successful exercise: a relief for the patients, a satisfying patriotic and humanitarian exercise for the hosts and, overall, an increasingly rare felicitous episode in the deteriorating relations between Australian soldiers and English civilians. However, that there was a need for this kind of individual initiative reflects poorly on official provisions for war neurosis. So too does the decision of AIF authorities to dispense with the programme. For reasons which are not altogether clear, Australian military authorities ordered Springthorpe to discontinue the practice despite its apparent success. Typically, when faced with what he considered to be bloody-minded authoritarian behaviour inimical to the interests of his patients, he responded with belligerence.

Springthorpe's efforts to board convalescent psychological casualties met with enthusiasm from English civilians, one of whom, upon hearing of the scheme, immediately offered his home in Weymouth:

I have been entertaining Australian officers - and latterly privates - at my home (card enclosed) and it is the greatest pleasure to me to do what I can for these brave fellows for whom I have the greatest admiration in spite of what has led to their being unpopular when turned lose [sic] in our towns. When they are at a great disadvantage - anyway. I have been most fortunate by the men sent me, and if I can help any of the shellshock cases I shall be very glad, and could

¹⁷⁸ These are examined thoroughly in chapter five.

¹⁷⁹ Ibid. See chapter three, pages 131-133 for a discussion of pre-disposition.

¹⁸⁰ Springthorpe to Lieutenant-Colonel Sutherland, OC 3 AAH, 8 August 1917. AWM 41 [279]; High Commissioner's Office to DMS, AIF, 25 August 1917, in *ibid*, and Springthorpe to Sutherland, 11 September 1917, in *ibid*.

no doubt find other places where they could be taken in ... My home is suitable for nerve cases and I have been most successful with them.¹⁸¹

In early August 1917, moves were made by AIF authorities to cancel the special leave programme so Springthorpe felt compelled to take up the cudgels on behalf of "our deserving boys".¹⁸² Vigorous petitioning of Surgeon-General Howse,¹⁸³ the Australian High Commissioner¹⁸⁴ and his Commanding Officer at Dartford, Lieutenant Colonel Sutherland,¹⁸⁵ failed to have the project reinstated. To Sutherland he wrote:

I have continuously and repeatedly made use of Sick Leave for selected Shell-shock patients both to satisfactory friends and relatives and - in the case of the friendless - to approved English homes ever since I took charge of such cases last November. In this way - with ill effects on one occasion only - a large number of nerve-racked Australians, thousands of miles away from their own homes, after prolonged privations unprecedented strain, or indescribable shock, have been able to taste, for a short time, the comfort, pleasure and relaxation of something like their old home life. Should not this much at least be theirs, if, and whenever possible?¹⁸⁶

In further communications to army authorities, Springthorpe was unequivocal about the value of a project which, in its brief life and "in certain cases" was "the best weapon at my command."¹⁸⁷ He called the scheme "the most appreciated thing I have been able to do for many severe cases,"¹⁸⁸ and "an incalculable and at times ... indispensable therapeutic procedure" producing results which were "all that could be desired."¹⁸⁹ Despite this agitation, Surgeon-General Howse decided that "there do not appear to be sufficient reasons for departing from the order that no leave is to be granted."¹⁹⁰ And so the programme was cancelled.

Reacting to the scheme's demise, Springthorpe circularised the host families with a questionnaire in the hope that their positive written responses and their observations about the improvement in their guests, would help to force a reconsideration of the decision.¹⁹¹ The order was not rescinded, of course, but the replies of these philanthropists reveal something further about the experience of Australian war neurosis patients as well as the attitudes of some English civilians to the Diggers. Without exception, the cessation of special sick leave to private dwellings was

¹⁸¹ M. Metcalf to Springthorpe, 29 August 1917. AWM 2DRL 701/ Item 9.

¹⁸² Springthorpe, pro forma circular to hosts, 29 August 1917. AWM 2DRL 701/Item 9.

¹⁸³ Howse to Sutherland, 27 August 1917, AWM 41 [279].

¹⁸⁴ High Commissioner's Office to Howse, op. cit..

¹⁸⁵ Springthorpe to Sutherland, 12 December 1917. AWM 41 [279].

¹⁸⁶ Springthorpe to Sutherland, 11 September 1917. AWM 41 [279].

¹⁸⁷ Springthorpe to Sutherland, 8 August 1917. AWM 41 [279].

¹⁸⁸ Springthorpe to Maudsley, "Received 26 July 1917. AWM 41 [279].

¹⁸⁹ Springthorpe to Sutherland, op. cit..

¹⁹⁰ Howse to Sutherland, 27 August 1917. AWM 41 [279].

¹⁹¹ Circular to hosts, op. cit..

a terrible disappointment to the English men and women who had opened their homes to "our brave lads who have come so far to fight for us ... " ¹⁹² "I cannot tell you how sorry I am to hear that the authorities have stopped Sick Leave, " wrote Francis Tatham, a vicar from Wimbledon. " If they could only see the difference in our dear "boys" after 3 or 4 days of quiet house life in the little cottage in the garden I am sure they would be quite astonished." ¹⁹³

Altogether, there were ten respondents from various parts of southern England: from a vicarage at Wimbledon, from Shanklin on the Isle of Wight, from Essex, Shaftesbury, Alford, Holyhead and Sheringham. ¹⁹⁴ These families were also unanimous in their praise of the Australians' behaviour (which did not interrupt the rhythms of their households) and were all agreed about the therapeutic value of the visits. In recognition of this hospitality and kindness, many of the soldiers wrote regularly to their former hosts, as did their families in Australia who appreciated the compassion shown by these benevolent strangers to their unfortunate sons so far from home. Representative of the unanimity in these letters is a missive from Helen Tatham, wife of the vicar Francis Tatham:

I think it would be the most grievous pity if your shellshock cases cannot take advantage of these chances of recovery. I cannot tell you how they appreciate anything that is done for them. If you think it would be of any interest I could sent you some of the letters we have received from them after they leave, in which they say that they can never tell what it has done for them - how it has given them a new lease of life - and how they were pining for a touch of home - and a little respite from the military! Every single man we have had has behaved himself properly and some of them we are most attached to. They all write to me constantly even when they have returned to Australia and most of them have been back to stay with us when on furlough. I have had such very nice letters from their Mothers too which quite repays us for any trouble we have taken. We have had several with weak hearts, two more or less speechless ones who have spoken much better after quite a few days and a man called Stapleton with very bad concussion to whom the quiet of the country was everything. ¹⁹⁵

This minor chapter in the history of Australian soldiers in the Mother Country during the First World War contrasted strongly with the increasingly unhappy tenor of their dealings with English civilians. By 1917 the positive image of Australian troops in England - generated to a large extent by exceedingly constructive press coverage based on the Anzacs' Gallipoli exploits - had waned to be replaced with disenchantment. Petty crimes, brashness, insensitivity and occasional rioting in depot towns like Weymouth tarnished the reputation of Australian soldiers who, in turn, were equally irked by the prevalence of class distinction. More than anything, however, mutual disillusionment was, in the words of historian, Michael McKernan, the result of

¹⁹² K. Jackman to Springthorpe, 30 August 1917. AWM 41 [279].

¹⁹³ F.H. Tatham to Springthorpe, 30 August 1917, in *ibid*.

¹⁹⁴ H. Bound to Springthorpe, 30 August 1917; W.A Horn to Springthorpe, 29 August 1917; M. King to Springthorpe, 8 September 1917; G.A. Macdonell to Springthorpe, 1 September 1917; I. Olivier to Springthorpe, 31 August 1917; E.M Palethorpe to Springthorpe, 30 August 1917; S. Platt to Springthorpe, 2 September 1917. All in AWM 41 [279].

¹⁹⁵ H. Tatham to Springthorpe, undated.

"differences in temperament between host and guest." ¹⁹⁶ The Springthorpe boarding experience shows, however, that there was at least one digression from this general trend.

By some standards, John Springthorpe's clinic might have achieved limited success but the evidence suggests that attainment can be measured in more than one way. There is no doubt that at least a few of his patients and their relatives were extremely grateful for the compassion and commitment of this feisty little medico. Their letters of appreciation are testimony to his efforts to reconstitute their disturbed minds and broken bodies, and introduce an element of benevolence and efficiency into a system which, while probably not totally devoid of these, was not notable for such qualities.

During and after the war, Springthorpe - and occasionally the staff who had worked with him - received many communications reflecting the esteem in which he was held. From Monte Video Camp, Weymouth, a former patient wrote: "This is not a bad camp as far as camps go but we realise that we have left a home. I have been very shaky down here but I think it must be excitement ." ¹⁹⁷ On his way to Plymouth to embark for Australia, Private H.G. Wells wrote to Springthorpe thanking him for his care and attentiveness. "Am still unable to speak properly, " he said, " but live in hopes of it returning." ¹⁹⁸ One ex-serviceman working at a sawmill in Pemberton, Western Australia after the war (and still suffering the effects of his service on the Western Front) wrote to a friend: "I often wish it had been my fortune to be within reach of old Dad 'Springy' he did a man more good in five minutes than some of these 'dud' quacks would . . . in five years." ¹⁹⁹ From the Leichhardt Hotel, Rockhampton, another man wrote to Springthorpe:

I picked up a Australasian yesterday and read you were back in good old Aussie again - please allow me to welcome you home. I know you will remember me alright; because the boys in A10 always said "Old Springy always remembers every digger that comes through his ward" and I can say that every digger remembers the chap who fixed him up and put him on his legs again. I am very thankful to say I arrived back in "God's Country" some nine months ago - although still a bit queer in the head, but six months at the seaside fixed me up grand. Many times have I thought of the grand little man of A10 - Dartford and his great kindness to myself. ²⁰⁰

Although prickly when dealing with military authority, Springthorpe was much more approachable to soldiers in need. As a result, he received many requests for help from former patients and their families to which he acceded with the willingness of the

¹⁹⁶ M. McKernan, *The Australian People and the Great War* (Nelson, West Melbourne 1980), pp.116-149.

¹⁹⁷ Sapper H. Trebilcock to Sister McNulty, 30 May 1917. AWM 2DRL 701, Item 9.

¹⁹⁸ Private H.G. Wells, 4th Battalion, to Springthorpe, 26 January 1917. Ibid.

¹⁹⁹ "Dick" to "Bert", 24 October 1920. AWM 2DRL, 701, Item 1.

²⁰⁰ Unsigned to Springthorpe, 20 March 1919. AWM 2DRL, 701, Item 1.

genuine philanthropist. One invalid still in England and wanting to be useful despite his disability wrote:

I am improving rapidly now but . . . I am still having very bad nights but I can always sleep a few hours in the afternoon . . . [P]erhaps they might find me some useful work to do and then I would be more at peace in my mind. If you can help me I shall be guided by you entirely. ²⁰¹

Springthorpe received many appeals from relations unable to locate their sons and husbands in the labyrinthine hospital system ²⁰² and from men wanting references or work. In April 1917 one invalid asked for a position on the staff of 3AAH. "I know where the boys are concerned you are always willing to do your best. If our Colonel can't manage it well I'll give it up as a bad job," he wrote. ²⁰³ Another man requested and received support for his War Service Home application.²⁰⁴

Until his death at the age of 78, John Springthorpe continued to work with war neurosis patients. ²⁰⁵ When he returned home from Europe he agitated for their better care at the hands of the Repatriation Department and in the mental asylums to which many were committed. In 1920 he was appointed a consultant to Mont Park Mental Asylum ²⁰⁶ and No. 5 Australian General Hospital, St. Kilda Road, Melbourne. ²⁰⁷ Consistent with his attitude to authority, he fought with his employer, the Department of Repatriation, whom he believed was inexpert and insensitive in the treatment of war neurosis. ²⁰⁸ Nevertheless, almost until the day he died, Springthorpe travelled regularly to No. 5 AGH and Caulfield Repatriation Hospital to treat appreciative victims of war neurosis. In 1930, one patient at Caulfield (a Gallipoli veteran) remarked: "Dr. Springthorpe has been very patient and good but unfortunately he is deaf and I don't think he hears all I tell him." ²⁰⁹ John Springthorpe died on 22 April 1933.

The work of John Springthorpe and the experiences of his patients contain considerable significance for the understanding of how Australian psychological casualties in general were treated. Firstly, it illuminates - in a fashion only hinted at in other sources - the difficulties experienced by many such soldiers in the military medical system of the British Army in Europe. Secondly, it provides a pleasing contrast to the hostility and apparent indifference displayed by much of this system towards the personal sufferings of the shell-shocked.

²⁰¹ Unsigned to Springthorpe, undated. AWM 2DRL, Item 1.

²⁰² For example, Mrs. J. Lloyd to Springthorpe, 2 March 1919. AWM 2DRL 701, Item 4.

²⁰³ Private W.H. Owen, 24th Battalion, to Springthorpe, 5 April 1917. AWM 2DRL 701, Item 1a.

²⁰⁴ C.M. Wheare, late 25th Battalion and 2nd Pioneer Battalion, to Springthorpe, 9 October 1919 and 23 October 1919. AWM 2DRL 701, Item 4.

²⁰⁵ Interview with Mrs. G. Springthorpe, daughter-in-law of J.W. Springthorpe, 1 September 1993.

²⁰⁶ RSSILA to Springthorpe, 4 June 1920. 2DRL 701, Item 4.

²⁰⁷ Principal Medical Officer, 3rd Military District to Springthorpe, 23 January 1920, in *ibid.*

²⁰⁸ For example: Springthorpe, Report to Repatriation Commission, 14 July 1920. 2DRL 701, Item 16; A.G. Butler to Springthorpe 19 January 1933. 2DRL 701, Item 16.

²⁰⁹ Private H. Crane to Repatriation, 20 November 1930, in Private H. Crane, 7th Battalion, PCF.

With the emphasis on grand strategy and national causes during the First World War, the therapeutic needs of individual soldiers beyond their usefulness to the military were granted low priority. The emphasis was on rehabilitation to a combat-ready condition and, if this were not possible, on discharge from the army. Psychological casualties were also treated according to these principles and were generally handled poorly by military medical authorities who wished, primarily, to maintain the efficiency, discipline and strength of the army, not to restore individuals to perfect health. It is questionable, however, whether men returned to duty were of any military use so common were relapses. Thus the difficulties of Australian soldiers traumatised by their war service were exacerbated by British Army practice and the Australian six-months policy which helped to create long-term problems for the individuals concerned and for the Commonwealth Department of Repatriation, the government agency charged with their care.

Chapter Three

Symptoms and Syndromes: Medical Diagnoses and Soldiers' Experiences

Through their personal testimony - diaries, letters and other depositions - Australian soldiers provided poignant but limited insight into the experience of shell shock. Furnishing a considerably more methodical and exhaustive understanding of the disorders suffered by psychological casualties, however, is the perspective of the doctors who treated the problem during and after the war both at home and overseas. Their reports and papers - which describe war neurosis in terms of detailed symptoms and clinical syndromes - are able to embellish, complement and reinforce the impressions created by soldiers' personal writings. Medical evidence of this kind is able to show with scientific accuracy what psychological casualties were suffering from and how these disorders were caused. By revealing the full range of emotional, behavioural and psychosomatic disturbances, the medical perspective on these problems demonstrates conclusively that many Australian servicemen experienced a depth and breadth of mental damage only broadly delineated in diaries and letters. In addition, doctors' writings show clearly that, as well as their debilitating effects, one of the chief characteristics of these symptoms was their persistence over months, years and even decades. Many Australian soldiers who presented with war neurosis overseas took their symptoms home and lived with them throughout the 1920s, 30s and beyond; in some cases, new symptoms developed and relatively minor neurotic conditions deteriorated into serious mental illness.

The accuracy of these contemporary medical observations is strongly suggested by current thinking on stress and trauma which adds a fresh perspective. Although many of the contemporary theories used in this chapter could be considered progressive (and, in many respects, highly perspicacious) their tendency to employ existing civilian diagnostic categories and to cite individual predisposition as a major cause of war neurosis has the effect of reducing the importance of combat experience as the prime determinant of breakdown. Current, highly specific diagnostic categories such as Post Traumatic Stress Disorder place causal weight on the stressful environment and not on the individual. Thus they underscore war's role as a highly destructive agent and provide a strong counter-argument to the idea that flawed personal make-up was largely responsible for psychological casualties. The conformity of symptom groups of Australian soldiers with these distinct, highly-specific traumatic syndromes will show

that many Australian psychological casualties were, in fact, severely and chronically traumatised by their experiences at Gallipoli and on the Western Front.

And yet comment must be made about individual makeup despite the current emphasis on external factors as the major agent in breakdown. Why did some men become psychological casualties and others not? Were they inherently less able to cope than the men who remained apparently unmoved?

In order to facilitate these arguments and investigations, this chapter has been organised around two main sections. The first provides a general description and explanation of psychological disorders found in soldiers of the Great War by contemporary doctors; it also contains a brief explication of past and present trauma theories. This examination helps to make sense of the symptoms reported in Australian soldiers and to place their experience in a universal context. These disorders and their personally destructive effects are the subject of the chapter's second half.

Psychological disorders: general

The least serious of the disorders seen by doctors in the battle zone during the First World War was the acute stage of neurosis: simple emotional and nervous exhaustion which, with prompt, efficient treatment by alert Regimental Medical Officers was relatively easy to relieve.¹ Also called "battle shock",² the symptoms of this disorder included confusion, acute fears, phobias, amnesia, tremor and early hysterical conversions such as loss of speech or paralysis of a limb.³ Men might appear "stupid, dreamy and silent." Some appeared "terror-stricken with fear written on their faces, the pupils dilated and the eyes staring . . . the hands tremulous, blue, cold and sweating." Others gave "the impression of having lost their self-confidence and self-control." They "sat down violently tremulous, weeping or silent, staring or with tightly closed eyes and incapable of walking unaided."⁴ These signs of mental disturbance might be seen during a battle or particularly violent episode which, through strain, horror and lack of sleep, rapidly overwhelmed the emotions.⁵

More grave than simple exhaustion were the severe cases of recognisable psychiatric syndromes which did not respond to front line first aid: psychasthenia,

¹ A.G. Butler, *The Australian Army Medical Services in the War of 1914-1918, Volume III, Problems and Services* (Australian War Memorial 1943), pp.104-106, 110, 111, 115, and W.G. Macpherson, *Medical Services: Diseases of the War* (His Majesty's Stationery Office 1923), pp.19-20.

² Butler, op. cit., p.114.

³ Ibid.

⁴ *Report of the War Office Committee of Enquiry into "Shell-Shock"* (His Majesty's Stationery Office, London 1922), p.120

⁵ Butler, op. cit., p.110.

neurasthenia, hysteria and confusional states.⁶ Unfortunately, many of these cases developed from "battle shock" because of the inept handling discussed in the previous chapter: men were not attended to promptly and effectively but were evacuated to hospitals well behind the lines where, inexpertly managed, their disorders were allowed to consolidate.⁷ Psychasthenia involved major emotional disturbance and often amounted to what a South Australian doctor, Walter Reynell, called a "character change".⁸ Men became miserable, depressed, apathetic, irritable, absent minded, highly emotional, morose, solitary, and unable to make trivial decisions. They were overwhelmed by life's minor difficulties, afraid of contact with others, were plagued by nightmares, insomnia and headaches; suffered from poor self-control, lacked confidence, were anxious about their symptoms and sometimes overwhelmed by emotional crises.⁹ Other symptoms included restlessness, excitability, fears of imminent calamity,¹⁰ and anxiety.¹¹ Neurasthenia, a disorder that still appears in medical manuals with virtually the same meaning,¹² was used to indicate psychologically-derived mental and nervous exhaustion.¹³

One of the First World War's major neuroses was hysteria, a psychological disorder which impaired the functioning of the special senses, digestive systems and motor apparatus. These disorders were not attributable to organic causes and were at variance with knowledge of the way the body operated.¹⁴ Between 40 and 60 per cent of soldiers presenting with war neurosis were said to suffer these afflictions.¹⁵ Typical of this condition were paralysed limbs and muscles, contractures, spasms, anaesthesias and speech disorders. Other psychosomatic ailments included Disordered Action of the Heart (also called Soldier's Heart or Effort Syndrome) and various gastric illnesses. These differed from the above hysterical disorders because they involved organs under the governance of the autonomic nervous system not the control of the individual. Psychotic illness was rarely seen amongst soldiers but when it did appear it assumed the form of the civilian psychoses with a "war colouring".¹⁶

⁶ Butler, op. cit., p.125.

⁷ Ibid, p.124, and Macpherson, op. cit., pp.20-21.

⁸ W.R. Reynell, "The Psycho-Neuroses of War", in *The Medical Journal of Australia*, 7 June 1919, p.458.

⁹ Ibid and Macpherson, op. cit., pp.20-21.

¹⁰ A.W. Campbell, "Remarks on Some Neuroses and Psychoses in War", in *The Medical Journal of Australia*, 15 April 1915, p.322.

¹¹ History of War Neurosis Treated by Psychotherapy at Monte Video Camp Hospital, Weymouth, 1919, *passim*. AWM 25, 885/4.

¹² For example see *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Volume One* (World Health Organisation), F48.0.

¹³ J.W. Springthorpe, "War Neuroses and Civil Practice", in *The Medical Journal of Australia*, 4 October 1919, p.281.

¹⁴ *Fontana Dictionary of Modern Thought*, (First published Fontana Press 1977; this edition 1988), p.576.

¹⁵ Springthorpe, "War Neuroses and Civil Practice", op. cit., p. 279, and Reynell, op. cit., p.455.

¹⁶ Campbell, op. cit., p.322.

What were the causes of these disorders? Explanations of psychological disorder in soldiers ranged throughout the war - and after - from the somatic, through the moral to the psychodynamic. Those with "physicalist" views of mental illness averred that the concussion from exploding shells damaged brain tissues and spinal pathways and that this was the cause of war neurosis.¹⁷ It was soon clear, however, that large numbers of psychological casualties had never been near a shell burst. For many doctors, "tainted" heredity - the popular explanation for lunacy - was behind shell shock. This was also a flawed theory, considering that most men who broke down had no history of mental illness.¹⁸ For other medical officers, wilfulness and cowardice were the root causes of psychological breakdown.

Gradually, as the treatments associated with them proved more effective than any other therapies, psychological explanations of war neurosis gained currency. With some modifications these theories coincided with twentieth century understandings of trauma. At the heart of war neurosis was prolonged and intense mental stress created by a hostile environment: fatigue, mud, sleeplessness, wet and cold, misery, monotony, poor nutrition, horror and constant responsibility (especially in officers) created a heavy psychological burden for many men and possibly most.¹⁹ Added to this load was strong and frequently-repeated emotion: fear, sympathy with suffering comrades, anxiety, remorse for errors, anger, elation, depression and fear of being afraid.²⁰ Of these emotions, fear - and its suppression - was seen by doctors and other observers to be the greatest cause of neurosis. For many men, fear existed in the constant uncertainty of never knowing when a mine might explode under them, a sniper's bullet shatter their skulls or a shell obliterate any trace of their existence.²¹ In 1922 the English psychologist, William McDougall, explained the role of fear in the psychological deterioration of soldiers: "Fear, once roused, haunts the mind; it comes back alike in dreams and in waking life, bringing with it vivid memories of the terrifying impression. It is thus the great inhibitor of action, both present action and future."²²

What were the mechanisms by which the stressful environment and consequent emotional overload created neurosis in soldiers? Explanations of this kind varied according to the theoretical orientation of the doctor concerned. Some Freudians, such as A.A. Brill, emphasised sexual aetiology. He saw the basis of war neurosis in the

¹⁷ M. Stone, "Shell Shock and the Psychologists", in W. F. Bynum, R. Porter and M. Shepherd, *The Anatomy of Madness. Essays in the History of Psychiatry* (Tavistock Publications, London 1985), p.251.

¹⁸ *Ibid*, p.252.

¹⁹ *Report of the War Office Committee of Enquiry into "Shell-Shock"* (His Majesty's Stationery Office 1922), pp.24,43.

²⁰ G. Elliot Smith and T.H. Pear, *Shell Shock and Its Lessons* (University of Manchester Press, Manchester 1917), p.6.

²¹ *Report, War Office*, op. cit., p.62.

²² Butler, Volume III, op. cit., p.117.

army's "familial", "libidinous", command structure: sergeant as older brother, junior officer as father and senior regimental officer as distant "infantile" father; in fact, a cast of characters from a soldier's infancy that awoke repressed sadistic and homosexual impulses with which he was unable to cope.²³ In general, however, doctors who advanced psychodynamic theories of war neurosis tended to agree on a few basic workings by which the strain of service was transformed into a mental disorder. These theories were usually based on the less controversial aspects of European psychiatry such as ideas on mental conflict and the notion of dissociation as advanced by Freud and Pierre Janet during the late nineteenth century.²⁴

Prime amongst the psychological mechanisms posited by doctors treating war neurosis was the mental conflict which arose when soldiers repressed powerful natural instincts and emotions either consciously or unconsciously. The desire to maintain self-respect, the demands of military discipline and the inability of the mind to cope with severe stress was usually behind attempts at self-control. In trying to explain this phenomenon, the English specialist in mental disorders, Arthur Hurst, maintained that a horrible sight might be obliterated from the memory only to return in dreams or it could be voluntarily suppressed by a patient unwilling to confront it.²⁵ Bernard Hart, author in 1912 of *The Psychology of Insanity*, felt that the psychological battle between the instincts of self-preservation (the soldier's desire to remove himself from danger) and duty, discipline and patriotism produced unbearable tension that was only resolved by removal from the battlefield or in psychoneurosis.²⁶ One author described these battles as "conflicts between the instinctive tendencies of the individual and the forces of social tradition."²⁷ Prolonged exposure in static positions - such as remaining immobile under a bombardment - produce similar results.²⁸ Soldiers could not obey their natural desires to fight or to flee and so "the absence of manipulative activity" - man's normal reaction to danger - produced the symptoms of psychological disorder.²⁹

Repression of emotion created identical results. The English psychologist W.H.R. Rivers informed the War Office Enquiry into Shell-Shock: "If you think about the experience which men went through in France, seeing their friends at their side with their heads blown off and things of that sort, the process of repression is altogether unsuited for an experience of that kind, and yet that process was going on an enormous

²³ Stone, op. cit., p.263.

²⁴ M. Aitchison and A.C. McFarlane, "A Review of dissociation and dissociative disorders", in *Australian and New Zealand Journal of Psychiatry* 1994; 28, p.92.

²⁵ A. Hurst, *Medical Diseases of the War* (London, Edward Arnold 1917), p.1.

²⁶ *Report, War Office*, op. cit., p.29.

²⁷ P. Bassoe (ed.), *Nervous and Mental Diseases* (The Year Book Publishers, Chicago 1919), pp.17-18.

²⁸ *Report, War Office*, op. cit., p.78.

²⁹ *Ibid*, p.57.

scale." ³⁰ As suggested above, suppression had two major effects, one psychological, the other physical. In the opinion of Henry Head, a former neurologist with the Royal Flying Corps, repressed fear eventually "expressed itself in the form of tremor, crying, depression, or want of sleep, war dreams and the like." ³¹ Psychological specialists William Brown, William McDougall, Charles Myers and William Rivers thought similarly but went further, making specific references to "dissociation" or the process whereby traumatic events were banished to the subconscious only to re-appear as symptoms such as nightmares or physical impairment such as a speech disorder. ³² Similarly, another specialist explained that the war had demonstrated the importance of suppressed "bodies of experience" in the production of mental disorder. Although suppressed, these episodes continued "to exist in an active state" and produced "striking effects both mental and physical." ³³ The second consequence of suppression was physical: a serious disturbance of the circulatory, digestive and excretory systems which were over active anyway because of constant arousal. ³⁴

As a result of these two psychological processes, some men broke down gradually and were eventually evacuated when their neurotic behaviour and psychosomatic illnesses rendered them useless as soldiers. ³⁵ Others appeared to break suddenly, the apparent cause being a shell burst or event of ineffable horror; in fact, the violent episode was usually (but not always) just the precipitant - the "last straw" for men already heavily laden with a huge emotional burden. ³⁶

In thousands of men these disorders did not disappear with the signing of the Armistice but persisted for years afterwards or, in some cases, for entire lifetimes. How did doctors explain the mechanisms which caused war neurosis? What were the reasons causing these persistent symptoms? According to Abram Kardiner, a young American psychiatrist who tried to treat veterans of the First World War afflicted by psychological disorder, the answer lay, as it had for several of the above-mentioned British doctors, in the concept of dissociation. In 1922 Kardiner noticed intense psychological distress in returned United States soldiers. Startle reactions, hyperalertness, vigilance in expectation of the return of danger, nightmares, psychosomatic complaints, irritability, aggressive behaviour, intense grief, disrupted relationships and chronic depression were all common to men visiting a Veterans'

³⁰ *Report, War Office*, op. cit., p.58.

³¹ *Report, War Office*, op. cit., p.68.

³² Bassoe, op. cit., p.21; R. Leys, "Traumatic Cures: Shell Shock, Janet, and the Question of Memory", *Critical Inquiry*, (20, Summer 1994, University of Chicago), pp. 624-626; *Report, War Office*, op. cit., p.117.

³³ Bassoe, op. cit., p.17.

³⁴ Elliot Smith and Pear, pp.7-8.

³⁵ Macpherson, op. cit., pp.16-17.

³⁶ *Ibid*, pp. 16-17; *Report, War Office*, op. cit., p.58.

Bureau psychiatric clinic where Kardiner worked.³⁷ He explained these symptoms in terms that were almost identical to those employed by Freud³⁸ and Janet nearly 50 years before and which still enjoy considerable acceptance.

According to these theories the essential pathology of persistent traumatic symptoms was dissociation: those affected had lost the ability to integrate the memory of overwhelming life events which then became preserved in an abnormal, unresolved state separate from ordinary consciousness and which re-appeared as intrusive, truncated fragments of the traumatic experience. In his *Introductory Lessons* of 1917, Freud described this process as "an excessive magnitude of stimuli too powerful to be worked off in the normal way."³⁹ Despite psychological amnesias and voluntary suppression of the event, memories buried in the unconscious repeatedly intruded on the present in the form of nightmares and flashbacks which contained all the emotional power of the original episode. Hysterical conversions - speech disorders and paralyses with no physical cause - also featured prominently as did major behavioural changes. For example, the victim remained constantly on the alert and subject to extreme reactions to stimuli connected with the traumatic event or became explosively violent. The key to this entire process was complete helplessness in the face of terror and the consequent total overwhelming of the body's normal response to danger. When action was impossible during periods of extreme peril (while, for example, sitting tight under a bombardment) the hyperaroused autonomic nervous system, a variety of intense feelings and the extreme focus on the threat became disorganised - fragmented - and persisted in a chronic, maladaptive fashion when the danger had passed. Kardiner, for example, believed that the irritability and aggression he observed in veterans were the dissociated scraps of a "fight or flight" reaction completely demolished by irresistible danger.⁴⁰

The above psychological explanations derive much cogency from their compatibility with current conceptualisations of traumatic disorders, a consistency which further suggests the accuracy of the more progressive contemporary theories. The present formulations of Combat Stress Reaction (CSR) and Post Traumatic Stress Disorder (PTSD) equate with the acute "simple exhaustion" and chronic symptoms observed in sufferers of psychological disorder during the Great War. PTSD first appeared as a psychiatric classification in the 1980 edition of the Diagnostic and Statistical Manual of Mental Disorders produced by the American Psychiatric

³⁷ J.L. Herman, *Trauma and Recovery* (Basic Books 1992), pp.23, 35-36.

³⁸ J. Breuer and S. Freud, *Studies in Hysteria* (1895)

³⁹ In C.R. Figley, *Stress Disorders Among Vietnam Veterans: Theory, Research and Treatment* (Brunner/Mazel Publishers, New York 1978) pp.24-25.

⁴⁰ *Ibid.*, pp.34, 36, 37, 45.

Association⁴¹ and was developed in subsequent editions.⁴² Despite the striking similarities between some contemporary and current perspectives on stress disorders, the more modern classifications do, however, reflect a deeper and more discriminating understanding of trauma and its consequences and are generally a direct legacy of the Vietnam War.⁴³ Characteristic symptoms resemble almost identically those cited not only by Freud, Janet and Kardiner but also by other doctors associated with the treatment of war neurosis. These include "recurrent and intrusive distressing recollections of the event; sudden acting or feeling as if the traumatic event were recurring; intense psychological distress at exposure to events that symbolise or resemble an aspect of the traumatic event; persistent avoidance of stimuli associated with the trauma or numbing of general responsiveness [which might include the assistance of alcohol or drugs]; and persistent symptoms of increased arousal."⁴⁴

Other authorities support these findings. M.J. Horowitz, for example, found that "psychic numbing" of the kind described in DSM-III-R was characteristic of trauma disorders in a wide variety of people including Vietnam veterans. This concept included withdrawal of interest in life, behavioural constriction to a point where new situations cannot be dealt with effectively and blunted patterns of interaction with people including family, friends and work mates so that the individual becomes isolated.⁴⁵ Clinicians also described prolonged depression, anxiety, amnesia for a specific aspect of the traumatic episode, guilt and shame.⁴⁶ For some victims of trauma, especially those subjected to a single event only, the sequelae might linger for weeks or months but for those exposed to prolonged, repeated episodes, the symptoms may last for decades. "Chronic apprehension of imminent doom, of something terrible always about to happen" is considered, in addition to the usual symptoms of PTSD, to be one of the distinguishing features of the chronic form of this disorder.⁴⁷ Although the role of dissociation in the production of PTSD is not absolutely clear, it is

⁴¹ American Psychiatric Association, *Diagnostic and Statistical Manual, of Mental Diseases, Volume III* (American Psychiatric Association, Washington DC. 1980)

⁴² American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Diseases, Volume III, Revised Edition* (American Psychiatric Association, Washington DC. 1988)

⁴³ R.J. Ørmer, "Post-traumatic stress disorders and European war veterans", in *The British Journal of Clinical Psychology*, 31 (The British Psychological Society 1992), p.387.

⁴⁴ In L.P. Weber, "Combat Stress Reaction and Post Traumatic Stress Disorder", (1st Psychological Research Unit, Australian Military Forces, Commonwealth of Australia 1990), pp.1-2.

⁴⁵ M.J. Horowitz, "Stress-response syndromes: a review of post traumatic and adjustment disorders" in *Hospital and Community Psychiatry*, 1986, 37, 3: pp.241-269. In *ibid*, pp.3-4.

⁴⁶ *Ibid*; T.M. Keane, J. Wolfe, and K.L. Taylor, "Post-traumatic stress disorder: evidence for diagnostic validity and methods of psychological assessment, *Journal of Clinical Psychology* (1987, 43, 1:32-43); B.L. Green and M.C. Grace, "Conceptual issues in research with survivors and illustrations from a follow-up study", in J.P. Wilson, Z. Harel, B. Kahana (eds.), *Human Adaptation to Extreme Stress: From Holocaust to Vietnam* (Plenum Press, New York 1988). All in *ibid*.

⁴⁷ Herman, *op. cit.*, pp.86-87.

considered to play a significant role in the creation of some of the major symptoms associated with this disorder.⁴⁸

The greatest differences between contemporary and current theories of war neurosis and trauma are the relative roles ascribed to individual predisposition and the stressful environment in the production of disorder. Current appreciation of trauma has also advanced the notion of delayed sequelae (in addition to its acute and chronic manifestations)⁴⁹ and the idea that similar psychological mechanisms have been triggered by different wars.⁵⁰

To a great many of even the most progressive doctors treating shell shock during the Great War, pre-disposition in the form of "weakness" in the family or personal history, inebriacy, "sexual excesses", "racial characteristics" and social and educational conditions was the major cause. "An enormous proportion amongst the men who broke down had been neurotics previously," Doctor F. Burton Fanning told the War Office Committee of Inquiry into Shell-Shock.⁵¹ Such a view originated with European analysts who interpreted the symptoms of traumatised soldiers of the First World War in terms of Freudian psychoanalysis which stressed the importance of childhood memories and conflicts in the production of neurosis. This view led to a *post hoc ergo propter hoc* (ie "after the fact therefore because of the fact") fallacy which was exposed during the Second World War when screening in the US Army based on predisposition failed to prevent large numbers of psychiatric casualties. Predisposition of the kind mentioned above was never used again as a basis for the testing of recruits.⁵² While still ascribing a role to personality factors, recent theories on causation (including those found in DSM-III) hold that external factors, including most notably the stressful environment, are the major elements in this process, not so-called personality defects. This "multi-causal" view holds that the following factors influence the development of acute and chronic stress reactions: the nature, quantity and timing of the trauma; combat unit cohesion and morale; combat effectiveness; personality factors; the short and long term post-trauma environment of the stressed individual, and conveying to the affected soldier that he is expected to recover.⁵³ In 1990, Captain L.P Weber of the 1st Psychological Research Unit, Australian Army, summarised the differences in thinking:

⁴⁸ D. Spiegel, T. Hunt, H.E. Dondershine, "Dissociation and hypnotisability in post traumatic stress disorder", in *American Journal of Psychiatry* 1988; 145; pp. 301-305. In M. Atchison, A.C. McFarlane, "A review of dissociation and dissociative disorders", *Australian and New Zealand Journal of Psychiatry* 1994; 28, pp.591-599.

⁴⁹ Ørner, op. cit., p. 387, and C.R. Figley, op. cit., p.268.

⁵⁰ Figley, op. cit., pp. xix, 4, 22.

⁵¹ *Report, War Office*, op. cit., p.22.

⁵² Sonnenberg, S.M., Blank, A.S. and Talbot, J.A., *The Trauma of War: Stress and Recovery in Viet Nam Veterans* (American Psychiatric Press Inc., Washington 1985), pp. 81-82.

⁵³ *Ibid.*

Implicit to all attitudes of combat stress reactions; and long-term, persistent maladjustment, was the assumption that most soldiers could be exposed to all possible stressors of war without adverse symptoms developing. What we now call PTSD was held to be an abnormal reaction to the normal experience of combat facilitated by an individual's pre-existing psychopathology. . . . The primary cause of both acute and chronic combat stress reactions was still held to be the product of interaction between predisposing and precipitating events in the psychic life of the individual. . . . As a result of the lessons learned, and relearned, the combat environment is now generally accepted by clinicians as being an abnormal and traumatic one with the potential to overwhelm normal men.⁵⁴

While the causal emphasis has now shifted to the hostile environment, certain important questions are still contentious. In particular, predisposition⁵⁵ and the problem of variegated reactions to battlefield stress remain current issues. Why, for example, do some men break down and others not? What can account for the variety of symptom complexes in different psychological casualties? As has been shown, current solutions to these puzzles continue to advance a multi-causal view which includes factors such as "the intensity and duration of the stressor"⁵⁶ or the absence of emotional support such as that usually provided by a small group of close comrades.⁵⁷ But although the primacy of predisposition has been discounted, individual personality is still considered to be an important variable (but, it must be stressed, only one) in any explanation of why a soldier breaks down emotionally in combat and suffers chronic disorder thereafter. Evaluating the exact role of personality factors retrospectively is, however, very difficult.

While stating that psychiatry's traditional pre-occupation with "enduring and underlying disorders" had contributed to a neglect of environmental causes of trauma, Freedman, Kaplan and Sadock nevertheless agreed in 1975 that "pre-morbid disposition" could play a role in individual responses to the same disastrous events.⁵⁸ Such external factors, they stated, could be a "precipitating event . . . superimposed on longer-term personality difficulties and symptomatic disorders." These tendencies were, however, "notoriously difficult to evaluate reliably, especially retrospectively."⁵⁹ In 1992 Danish clinician, Roderick Ørner, cited the work of Feinstein and Dolan in maintaining that the trauma victim's individual inability to assimilate the disturbing event is at the heart of personal distress. He says that this study "points to a need to qualify" the DSM-III-R perspective on external factors.⁶⁰ Basing their findings on studies of American Vietnam veterans, Sonnenberg, Blank and Talbot concluded that,

⁵⁴ Weber, op. cit., pp. 7, 9, 15.

⁵⁵ Sonnenberg, op. cit., p. 15.

⁵⁶ DSM-III-R, as quoted in Ørner, op. cit., p. 400.

⁵⁷ Monajem, op. cit., p. 340.

⁵⁸ Freedman, op. cit., p. 1611.

⁵⁹ Ibid.

⁶⁰ A. Feinstein and R. Dolan, "Predictors of post traumatic stress disorder following physical trauma: An examination of the stressor criterion", *Psychological Medicine*, 21, 1991. Cited in Ørner, op. cit., p. 400.

although not as important as the trauma itself, predisposing factors had to be evaluated.⁶¹ Sonnenberg, for example, considered that normal developmental elements were of importance: older men with a "more integrated sense of self and purpose [have] greater insulation against serious trauma than does a late adolescent who is still in the process of more active maturation."⁶² In particular, the experience of terror and helplessness in very young soldiers seriously compromises the adaptative tasks of early adulthood such as the formation of identity and "the exploration of a wider social world."⁶³ Pre-war social factors such as the residual effects of an unstable early life in which poverty and uncertainty featured could also play a role in the development of stress reactions in soldiers.

Although perhaps not pre-eminent in creating stress disorders, individual characteristics are probably most important in determining their form.⁶⁴ In American Vietnam veterans, symptoms of PTSD were strongly associated with each man's childhood history, emotional conflicts and personal coping style. For example, men given to anti-social behaviour before the war were prone to symptoms of irritability and anger, while depression was characteristic of those with elevated levels of compassion for others and high ethical expectations of themselves.⁶⁵

Personal resilience can also, to some degree, affect the impact of traumatic events. Wide ranging studies have shown that a very small minority of people are comparatively immune to emotional breakdown in extreme situations and that they share three common characteristics when placed in peril: a careful, active coping style; "high sociability", namely the ability to interact with others, and "internal locus of control", that is, confidence that they are in command of their own destiny. These personal features were evident, for example, in a study of ten United States Vietnam veterans who did not develop PTSD despite exposure to heavy combat. These "extraordinary men" tried valiantly to give rational meaning to the military actions in which they were involved and impart that understanding to others. They also interpreted the war as a challenge to be faced and survived rather than as a plight in which they were helpless victims or a stage on which to prove their virility in some thoughtless piece of heroics. They became highly responsible for the welfare of others as well as their own safety and came to terms with fear in themselves and in others while attempting to master it by actively preparing for imminent danger.⁶⁶ Such self-reliant, resourceful men, however, constituted the minority. And even they were considered to be only "relatively invulnerable" rather than proof against the debilitating

⁶¹ Sonnenberg, op. cit., p. 6.

⁶² Ibid.

⁶³ J.L. Herman, *Trauma and Recovery* (Basic Books 1992), p. 61.

⁶⁴ Sonnenberg, op. cit., p. 38 and Herman, op. cit., p. 58.

⁶⁵ Herman, op. cit., p. 58.

⁶⁶ Ibid, pp. 58-59.

effects of trauma.⁶⁷ Usually, three out of four American servicemen exposed to heavy combat in Vietnam later developed post-traumatic syndromes.⁶⁸

By contrast to those least at risk, so-called "ordinary people" are "more easily paralysed or isolated by terror" while at the other end of the scale are the young and those with low sociability (both at the front and at home). Those with pre-existing psychological disorders are also considered to be vulnerable. As Judith Herman has remarked: "Traumatic life events, like other misfortunes, are especially merciless to those who are already troubled."⁶⁹

Everywhere in these studies, however, qualifications accompany conclusions about predisposition. Of the effects of instability in early life, researcher Ghislaine Boulanger stated:

These findings can be interpreted to mean that every man has his breaking point . . . Although individuals from unstable families of origin are more likely to manifest the symptoms of PTSD than are those from very stable families, if the stressor is sufficiently intense, even those from stable families can develop the syndrome.⁷⁰

Summarising the effects of similar pre-morbid factors, psychologist Robert Laufer also minimised the role of pre-morbid personality: "[P]redispositions do have an independent effect, but they do not suppress the effects of the war experience . . . Our findings suggest that the more fruitful line of inquiry is to explore the combined effects of pre-dispositional factors and war stress."⁷¹ Judith Herman prefaced all of her conclusions about individual traits with the following remarks:

The most powerful determinant of psychological harm is the character of the traumatic event itself. Individual personality characteristics count for little in the face of overwhelming events. There is a simple direct relationship between the severity of the trauma and its psychological impact . . . With severe enough traumatic exposure, no person is immune.⁷²

It is thus clear that predisposition as a player in short and long term reactions to combat stress may be just one of several factors, the most important of which is the intensity of the trauma itself.

As the second part of this chapter will demonstrate, the symptoms and syndromes of Australian psychological casualties conform very closely to the above

⁶⁷ Herman, *op. cit.*, pp. 58-61.

⁶⁸ *Ibid.*, p. 57. Perhaps this analysis of people less prone to traumatic reactions helps to explain why Lieutenant R.G. Raws, who remained calm, focussed, communicative and active during the chaos at Pozières, seemed to survive the ordeal better than some of his colleagues who may not have enjoyed these characteristics. (See pages 45-46.)

⁶⁹ *Ibid.*, pp. 59-61.

⁷⁰ In Sonnenberg, *op. cit.*, pp. 27-28

⁷¹ *Ibid.*, *op. cit.*, p. 38.

⁷² Herman, *op. cit.*, p. 57.

descriptions of serious mental disturbance in soldiers of the First World War and in trauma victims of later eras. Together with the clinical evidence of AAMC and Repatriation Department doctors, professional explanations - with their comprehensive descriptions and analyses - offer a much fuller understanding of the picture sketched by Australian sufferers in their diaries and letters. They also make possible a firmer grasp of the extent of the tragedy and provide a broader context for this aspect of the Australian experience of the First World War, showing quite clearly that it was not unique. Finally, it is possible to show tentatively how individual characteristics affected a small number of Australian soldiers subject to extreme stress. Conclusions drawn from the evidence are necessarily cautious but tend to support the current view that trauma - not pre-disposition - was the principal cause of war neurosis.

Symptoms and Syndromes: Australians

Amongst Australian soldiers, psychological disorders did not differ in appearance from the standard forms described by a great many doctors either at the time of the First World War or in the later decades of the twentieth century. As has been demonstrated, one of the most common classes of neurotic disorder was hysteria. Commenting on examples of these afflictions seen in soldiers evacuated from Gallipoli, Alfred Campbell wrote that he and his team in Egypt "seldom failed to find that the affectation was a neurosis."⁷³ In particular, the special senses - speech most often - were affected: aphonia, mutism and stammering were very common but as with the other forms of this disorder they "would not bear comparison with cases of organic [speech disorders] because they showed integrity of the higher factors concerned in speech."⁷⁴ John Springthorpe reported that many men from Gallipoli could neither "speak, see, nor hear for a month or more."⁷⁵ In cases of mutism, attempts to speak could be futile and doctors might see patients making a feeble movement of the lips resulting in a faint puffing, a barely audible whisper, severely laboured, low-pitched speech or gagging sound. One frustrated soldier from the Peninsula wrote on a piece of paper: "I can speak if the listener will be patient."⁷⁶ Many Australian psychological casualties from the Western Front suffered the same kinds of hysterical disorders as those from the Dardanelles. At No.3 AAH, Dartford, John Springthorpe reported several cases of

⁷³ Campbell, op. cit., p.319.

⁷⁴ Ibid, p.320.

⁷⁵ J.W. Springthorpe, "Twelve Months Services at the Front", reprint from the Medical Journal of Australia, 29 April 1916, p.7.

⁷⁶ Campbell, op. cit., p.320.

aphonia and stammering amongst his war neurosis patients. ⁷⁷ At Weymouth, speech disorders were very common amongst Australian psychological casualties in the process of returning home. One man was buried in August 1916 and stammered from that time until March 1919 when psychotherapy at Monte Video Camp Hospital cured him. ⁷⁸ Another man had been shell shocked in October 1917 and had stammered thereafter. Therapy at Monte Video in April 1919 improved his condition. ⁷⁹

According to doctors, psychosomatic paralyses, anaesthesias, contractures and spasms which impaired the function of an organ or limb also featured prominently amongst cases of hysteria. ⁸⁰ All of them differed in fundamental ways from similar organic complaints and often occurred in limbs or muscles that were not physically harmed at all. ⁸¹ In some cases a comparatively trivial wound or injury could lead to complete paralysis of an entire limb through the rigid contracture of particular muscles. ⁸² Campbell described this process as "contracture or paralysis grafted upon a wound." ⁸³ One of the chief causes was the patient's apprehension of the pain that might ensue from the movement of limbs long fixed in abnormal positions by splints or apparatus or by the "contraction of antagonistic muscles." ⁸⁴ Doctor A.C. Fraser, AAMC, called the psychological process that produced these organic results "auto-suggestion" - and described it as resulting from the same fears which Campbell had identified but also from an idea fixed in the patient's mind that, through long disuse, certain organs or limbs were useless. ⁸⁵ Other hysterical symptoms noted amongst Australian soldiers included vomiting, ⁸⁶ and pain in various parts of the body including the back and limbs. ⁸⁷

Dreams and irrepressible memories were a major component of the neuroses suffered by Australian psychological casualties. These were a prominent feature of psychasthenia cases but were also present in patients suffering neurasthenia and hysteria. At Monte Video Camp Hospital, Weymouth, nightmares were a consistent feature of the disorders of Australian soldiers waiting to return home. One man was awakened two or three times nightly by dreams in which he felt he was falling or in which someone was trying to stab him. While drifting off to sleep, he began thinking

⁷⁷ Statistical Records, Ward A10, No.3 AAH AWM 27, 371.1 (1)

⁷⁸ History of War Neurosis Treated by Psychotherapy at Monte Video Camp Hospital, Weymouth, 1919, p.3. AWM 25, 885/4

⁷⁹ Ibid, p.4.

⁸⁰ Springthorpe, "War Neuroses and Civil Practice", op. cit., p. 280, Reynell, op. cit., p.456, Campbell, op. cit., p.319.

⁸¹ Campbell, op. cit., p.319.

⁸² Reynell, op. cit..

⁸³ Campbell, op. cit..

⁸⁴ Ibid, p. 320.

⁸⁵ A.C. Fraser, "Notes on Three Cases of Functional Disease of the Nervous System Seen During the Voyage from England to Australia", in *The Medical Journal of Australia*, 22 November 1919, pp. 436-438.

⁸⁶ Reynell, op. cit., pp.455, 457.

⁸⁷ History of War Neurosis, op. cit., pp.29, 30.

of his war experiences and trembled as if they were recurring.⁸⁸ Still another dreamed that someone was pursuing him with a knife, that his mother was badly ill, that his sister's health had deteriorated and that his brother's ship had been torpedoed.⁸⁹ One man who had been buried by a shell at Pozières in August 1916 had been "dreaming continually and sleeping badly ever since." Regularly, he dreamt that his wife was dead.⁹⁰ A man blown up in August 1918 experienced what were described as "terrifying dreams", one of which involved being chased by a horse.⁹¹ A variation on the equine theme involved another soldier blown up at Pozières. He dreamt that he was being kicked by a horse and that his family had died.⁹² A prisoner of war, captured at Mouquet Farm in August 1916 and later buried in a German coal mine, suffered from night terrors in which he dreamed of being crushed; this was directly related to the mine incident.⁹³

Sometimes nightmares bore a more direct relationship to battlefield experiences. One man blown up in May 1918 dreamt of shells bursting near him.⁹⁴ Exploding shells featured strongly in the dreams of still another invalid.⁹⁵ A prisoner-of-war, who was blown up before being captured, dreamt about explosions. These nightmares woke him frequently.⁹⁶ Sometimes, however, night terrors and memories were not associated with shell fire and explosions. One soldier who suffered "terrifying dreams" had not been blown up but had, nevertheless, endured seven months service on the Western Front.⁹⁷ Another, after being wounded at Bullecourt in May 1917, found that he could think of nothing but the horrors of war by day and dream of them by night.⁹⁸ One man was kept awake by the "palpable bulbous nerve endings in his amputation stump" but when he did manage to sleep was afflicted with "frightful dreams".⁹⁹

Even away from the front in England seemingly innocuous incidents and circumstances brought the war back into sharp focus for some men. Traffic seemed to be the chief trigger for the recurrence of disturbing - even crippling - memories. One man was frightened to cross roads because the noise of motor vehicles reminded him of incoming shell fire.¹⁰⁰ Another with a similar fear of crowded roads was nearly run

⁸⁸ History of War Neurosis, op. cit., p.5.

⁸⁹ Ibid, p.6.

⁹⁰ Ibid.

⁹¹ Ibid.

⁹² Ibid.

⁹³ Ibid.

⁹⁴ Ibid, p.9.

⁹⁵ Ibid.

⁹⁶ Ibid, p.3.

⁹⁷ Ibid, p.13.

⁹⁸ Ibid.

⁹⁹ Ibid, p.8.

¹⁰⁰ Ibid, p.5.

over while trying to cross. ¹⁰¹ One man, wounded at Bullecourt, became very upset if he read anything at all about the war. ¹⁰² Company and the presence of strangers bothered others. ¹⁰³

In addition to dreams and memories, Australian psychological casualties displayed severe anxiety about a range of subjects. One man gassed at Ypres in October 1917 suffered attacks in which he felt he was going to die; he worried about his heart and could not concentrate well. ¹⁰⁴ Other men fretted about having to go home and face their parents. On the journey back to Australia, one of A.C. Fraser's war neurosis patients confessed that he was not concerned about the memory of the front but dreaded having to describe unpleasant battle scenes to his inquisitive parents. The prospect of such a conversation increased the strength of a tremor that had begun after an explosion at Messines. ¹⁰⁵ One man at Monte Video Hospital worried because he would soon have to go home and face his mother in his nervous condition. ¹⁰⁶ Another was concerned about his seriously ill wife and the dearth of letters from her and his four young children. ¹⁰⁷ One patient worried about going insane. ¹⁰⁸

The other symptoms common to psychasthenics were also present in Australians but they too could be found in patients diagnosed with the other kinds of neuroses. Startle reactions, for example, were common. One man, who "complain[ed] of nerves", jumped when spoken to loudly ¹⁰⁹ while another was described as very excitable and jumpy. ¹¹⁰ Others were easily irritated by noises ¹¹¹ or annoyed by "the slightest thing"; ¹¹² some were unable to stand any excitement, ¹¹³ or were completely shaken by sudden frights. ¹¹⁴ Inability to concentrate troubled a few Australian psychological casualties. One sufferer wrote letters a dozen times before perfecting them. ¹¹⁵ Another managed to learn a few verses of poetry but immediately forgot them. ¹¹⁶ Apathy too was noticeable. A man beset by nightmares, insomnia and anxiety about the poor health of his children in Australia felt "no inclination to go

¹⁰¹ History of War Neurosis, op. cit., p.14.

¹⁰² Ibid, p.13.

¹⁰³ Ibid, pp.5, 15.

¹⁰⁴ Ibid, p.10.

¹⁰⁵ Fraser, op. cit., pp.435-437.

¹⁰⁶ History of War Neurosis, op. cit., p.5.

¹⁰⁷ Ibid, p.9.

¹⁰⁸ Ibid, p.13.

¹⁰⁹ Ibid, p.5.

¹¹⁰ Ibid, p.6.

¹¹¹ Ibid, p.12.

¹¹² Ibid, p.11.

¹¹³ Ibid.

¹¹⁴ Ibid, p.14.

¹¹⁵ Ibid, p.6.

¹¹⁶ Ibid, p.13.

anywhere." ¹¹⁷ Another had lost all interest in his surroundings. ¹¹⁸ Still another was described as "mentally torpid" and unable to make any kind of decision. ¹¹⁹

The standard psychosomatic ailments associated with war neurosis were also seen in Australians. Headaches and tremors were common ¹²⁰ as were fatigue, ¹²¹ gastric complaints ¹²² and nervous perspiration. For example, the face and hands of one man blown up in May 1918 and later bombed in hospital perspired at the slightest excitement. ¹²³ Disordered Action of the Heart - a psychosomatic cardiac disorder - was also widely reported amongst Australians. ¹²⁴

Of course, not every one of these symptoms was present in each case of war neurosis; soldiers might only suffer a few of such distressing signs before they were diagnosed with one of the above syndromes. And neither was it at all common for only one symptom to be present. Nearly always, combinations of several symptoms existed in the one individual. In addition, there was often considerable overlap between classifications. Hysterical conversions, for example, were frequently accompanied by some of the symptoms associated with neurasthenia and psychasthenia. One man at Monte Video Camp Hospital was blown up and captured in France in July 1916. Whilst a prisoner, he was ill-treated by the Germans who hardly fed him for eight weeks, beat him with rifle butts and kept him in close confinement when he refused to work. He began to stammer, and developed a tremor and a fear of enclosed spaces. ¹²⁵

Several other individual cases will show how many of the symptoms mentioned above could be concentrated in individual Australians. In September 1917 Private David Kowal was blown up at Armentières. At No.1 AAH in England, and later at No.4 Command Depot, Weymouth, he was described as nervous, shaky and frightened; his other symptoms included insomnia, a speech disorder, and headaches. ¹²⁶ Lieutenant Thomas Mosley was blown up several times on the Western Front in 1916 and 1917 before being evacuated during the Battle of Messines. A Medical Board at the First Western General Hospital, Liverpool, found that he suffered from insomnia, poor appetite, nightmares in a half-waking state, diarrhoea, shakiness, weakness and "mental obfuscation." ¹²⁷ At Eaton Hall, an officers' hospital in Chester,

¹¹⁷ History of War Neurosis, op. cit., p.7.

¹¹⁸ Ibid, p.14.

¹¹⁹ Ibid, p. 15.

¹²⁰ Ibid, pp. 6, 8, 9, 10

¹²¹ Ibid, p.13.

¹²² Ibid, p.33.

¹²³ Ibid, p.6.

¹²⁴ Statistical Records, Ward 10, 3AAH, op. cit., *passim*.

¹²⁵ History of War Neurosis, op. cit., p.3.

¹²⁶ Medical Case Sheet, 1AAH, Harefield, 3 September 1917; Proceedings of a Medical Board, Weymouth, 20 September 1917, in Private D. Kowal, 14th Battalion, PCF.

¹²⁷ Proceedings of a Medical Board, 1st Western General Hospital, Liverpool, 21 August 1917, in Lieutenant T. Mosley, 3rd Machine Gun Battalion, PCF, op. cit..

he was troubled by headaches and was "unable to concentrate on anything for any length of time."¹²⁸ In August 1917 a Medical Board at the Australian Military Offices, London, reported that Lieutenant Mosley had "lost confidence in himself."¹²⁹ Private Edward Norman was also blown up in 1917. At Woking Hospital, England, he was jumpy and nervous, frightened of noises, unable to move or to turn over in bed. His medical history from Woking stated that he "sobbed like a child" and would never again be fit for general service. Norman was also afflicted with an hysterical walking disorder, concussion and headaches.¹³⁰

Psychoses

As typified by the above symptoms and case studies, psychological disorder amongst returned Australian servicemen usually took the form of a neurosis - a relatively minor psychological ailment. A few men, however, eventually developed very serious mental illness and were considered psychotic by doctors. Their symptoms included delusional ideas such as imaginary voices in the head,¹³¹ and a sense of being "not on the world".¹³² One man believed that he was dead.¹³³ Symptoms also comprised extreme suspicion of others,¹³⁴ persecution complexes,¹³⁵ disjointed and irrelevant conversation,¹³⁶ and extreme depression that sometimes led to attempts at self-mutilation.¹³⁷ The progress of these major mental disorders usually followed a well-defined path which began with mild neurotic symptoms that developed into something more serious. Frederick Leitner, for example, was blown up and buried at Gallipoli in September 1915 (where he also suffered a gunshot wound and enteric fever), was shell shocked on the Western Front in May 1916¹³⁸ and shipped back to Australia in early 1917. At No.5 AGH in 1918 he complained of general nervousness, frequency of urination, giddiness, vomiting and abdominal pain.¹³⁹ By 1928 he was described as "dull, apathetic, sub-normal" and defective in memory.¹⁴⁰ Later that year his daughter

¹²⁸ Medical Case Sheet, Officers Hospital, Eaton Hall, Chester, 23 August 1917, in Mosley, PCF, op. cit..

¹²⁹ Proceedings of a Medical Board at Australian Military Offices, London, 30 August 1917, in *ibid.*

¹³⁰ Medical History, 10 March 1918, in Signaller E. Norman, 5th Division Signals, PCF.

¹³¹ Clinical Notes, RGHC, 26 June 1919, in Private H. J. Tweed, 5th Battalion, PCF.

¹³² Clinical Notes, RGHC, 8 August 1933, in Private H.J. Sands, 5th Battalion, PFC.

¹³³ Report, Bundoora, 20 September 1945, in *ibid.*

¹³⁴ Application for Medical Treatment, 16 September, 1929, in Private M. Daniels, 5th Battalion Machine Gun Battalion, PFC.

¹³⁵ Note, undated, unsigned, op. cit., in Private A.E. Dimond, 4th Battalion, PCF.

¹³⁶ Medical Report, Receiving House, Royal Park, 22 August 1933, in Sands, PCF, op. cit..

¹³⁷ Memo for Medical File, Medical Superintendent, Receiving House, Royal Park, 19 January 1931, in *ibid.*

¹³⁸ Detailed Medical History of an Invalid, 29 June 1918, in Private F. Leitner, 8th Battalion, PFC.

¹³⁹ Medical History Sheet, No.5 AGH, June 1918, in *ibid.*

¹⁴⁰ Clinical Notes, RGHC, 1 October 1928, in *ibid.*

reported that her father was in the habit of getting up at 3 am and wandering around the house "frightening the inmates"; he followed his wife from room to room without any explanation; he ate in animal fashion and neglected his appearance and cleanliness.¹⁴¹ His symptoms included slurred speech,¹⁴² a "strange vacant look in his eyes every now and again", insomnia and violent fits of temper. It was common for him to stare and mumble to himself.¹⁴³ In 1929 Leitner was also described as morose, reticent and dreamy and "suppressing some delusional framework."¹⁴⁴

At least one Repatriation Department medical officer believed that it was quite common for neurosis to develop into insanity. In several cases he provided detailed analyses of how he thought such a decline could occur. In 1919 Maurice Daniels had returned to Australia with typical neurasthenic symptoms: restlessness, "irritation in the head" and a very short temper.¹⁴⁵ By 1929 his condition had worsened and his symptoms now included (in addition to the original ones) pain and numbness in the head, noises and ringing in the ears, occasional overall numbness, continual thirst, suspicion, depression, and constant rubbing of the face and hands.¹⁴⁶ The doctor's diagnosis was as follows:

This is a case of neurasthenia of a chronic type with exacerbations and seems to have been fairly continuous from the time of his discharge (or before) right to the occasion of the psychosis (confusional insanity) which resulted in him being placed in the Receiving House, Royal Park. The evidence of his relatives and of [the Local Medical Officer] is very clear and convincing. It is not rare to find a condition of confusional insanity occurring in the course of a neurosis such as this one.¹⁴⁷

Syndromes associated with psychosis in returned servicemen were those employed in asylum psychiatry and included "manic depressive insanity",¹⁴⁸ "depression psychosis",¹⁴⁹ "confusional insanity",¹⁵⁰ "alcoholic dementia and mania",¹⁵¹ "secondary dementia",¹⁵² "dementia praecox",¹⁵³ "melancholia"¹⁵⁴

¹⁴¹ Case Sheet, RGHC, 31 October 1928, in Leitner, PCF, op. cit..

¹⁴² Ibid.

¹⁴³ Form U, M. Leitner, in *ibid.*

¹⁴⁴ Memo for Medical File, 2 August 1929, in *ibid.*

¹⁴⁵ Form U, W. Daniels (father), op. cit..

¹⁴⁶ Medical Report, LMO, in Application for Medical Treatment, 16 September 1929, in Daniels, PCF, op. cit..

¹⁴⁷ Minute, 14 February 1930, in *ibid.*

¹⁴⁸ Memo, Repatriation Mental Hospital, Bundoora, 4 March 1930, in Henry, PCF, op. cit..

¹⁴⁹ Report, circa 1930, in Private J. Hills, 3rd Field Company Engineers.

¹⁵⁰ Minute, 14 February 1930, in Daniels, PCF, op. cit..

¹⁵¹ Minute, 2 March 1936, in Captain H. Walters, AFC. PCF.

¹⁵² M.O., Bundoora, to Deputy Commissioner, Victoria, 24 January 1935, in Private L. Lapin, 5th Battalion. PCF.

¹⁵³ Clinical Notes, RGHC, 8 August 1933, in Sands, PCF, op. cit..

¹⁵⁴ Dr. Seaforth to Deputy Commissioner, Victoria, 26 June 1928, in Henry, PCF, op. cit..

and "paranoia".¹⁵⁵

What role did individual makeup play in the response of Australian soldiers to the extreme stresses of the trenches? To what extent did personal disposition influence the development of war neurosis in Australian soldiers? As already noted, reliable, retrospective evaluation of the role of these dispositional features is "notoriously difficult to achieve"¹⁵⁶ even for qualified clinicians. Any such assessment of the invalids under study in this dissertation can only be attempted with extreme caution but one conclusion can be drawn with some confidence from 450 case studies: that environmental stress was a more important cause of war neurosis than predisposition. Some Australians carried pre-existing nervous temperaments and minor disorders with them into the AIF but it appears that these were merely exacerbated by the war and were not necessarily the cause of the traumatic syndrome since the symptoms of these men were remarkably similar to those of the soldiers who were reported to have had no previous nervous tendencies or disabilities. Moreover, the one characteristic common to all sufferers of war neurosis was subjection to highly stressful events such as burial, prolonged exposure to shell fire, protracted strain or the death of a relative at the Front.

The stories of sixteen individuals help illustrate this point. Of nine cases of stammering in Monte Video Camp Hospital, Weymouth in 1919, seven had suffered similar speech disorders in civilian life. One had "always stammered a little" and the war had merely aggravated this ailment.¹⁵⁷ Two had "always stammered" until explosions on the Western Front considerably worsened their problems. Another had stammered since 1914 but shell fire caused his condition to deteriorate. One patient had been flattened by a horse in 1913 and had stammered ever since but he became worse after being blown up in August 1916. Of the remaining two, one ("never previously nervous") began to stammer following shell shock in 1917 while the other had suffered similarly since a severe motor cycle accident on the Western Front in 1918. He too had not previously been the victim of any speech deficiencies.¹⁵⁸

Of the 49 cases of psychasthenia at Monte Video in 1919, six had previous neurotic tendencies or outright psychological disorders which were exacerbated by traumatic experiences on the Western Front. One man had suffered a nervous breakdown in Melbourne prior to enlisting; another could not shake pervasive memories of his father's death during the Boer War. One soldier was described as

¹⁵⁵ Clinical Notes, RGHC, 9 June 1939, in Lee, PCF, op. cit.. N.B. It is possible that returned soldiers assessed as psychotic may have been misdiagnosed, especially those deemed to have schizophrenia, then called dementia praecox. Iranian researcher, Roya Monajem, states that in severe cases of PTSD "semi-psychotic reactions seen in schizophrenia, especially the catatonic type, may be observed." R. Monajem, "War Neurosis According to Chinese Medicine: A Preliminary Survey", in *American Journal of Acupuncture*, Volume 19, No. 4, 1991, p.339.

¹⁵⁶ Freedman, op. cit., p. 1611.

¹⁵⁷ History of War Neurosis, op. cit., p. 9.

¹⁵⁸ Ibid, pp. 3-4.

"always nervous" since recovering from typhoid fever in 1904, while another, blown up in 1918, was said to have been of "nervous disposition."¹⁵⁹ Another man imagined he heard shell fire just as he was going to sleep and woke with a start ¹⁶⁰ but he also dreamt that he was falling off a bolting horse-drawn wagon but this seems to have been related to several spills he had as a steeple jockey in civilian life. ¹⁶¹ Similarly, of 394 Australian shell shock patients in No. 3 AAH Dartford, 29 were described as either "neurotic", "excitable", or "nervy" in civil life but all, regardless of so-called "pre-disposition", suffered nearly identical traumatic events and symptoms: burial, shelling, gassing, and strain followed by headache, tremor, dizziness, insomnia, excitability and speech disorders. ¹⁶² Events were thus more important than the soil in which the seed was sown. Whether these psychological casualties had pre-existing problems or not, the general traumatic symptoms were always the same: poor concentration, insomnia, nightmares, irritability, moodiness, anxiety, phobias, tremors, indecisiveness and, occasionally, speech disorders. Pre-existing difficulties seemed to suffer aggravation or to "colour" aspects of the symptoms - as, for example, in the case of the steeple jockey - but not necessarily cause them. Maybe they made men more vulnerable to stress but trauma - the common thread - was undoubtedly the catalyst.

As already noted, however, the multi-causal view of traumatic breakdown holds that there are several interacting elements to be considered in addition to overwhelming environmental stress and personality factors. Identifying the exact role of individual tendencies - and indeed furnishing a complete explanation - is thus very difficult to achieve retrospectively especially for historians who are not in possession of all the facts or the necessary clinical expertise. In the following case, for example, a 21-year-old clerk from Melbourne, Lance Corporal D. Stewart of the 13th Field Ambulance, was evacuated from the Pozières battlefield with "general nervous shock", and eventually classed "[p]ermanently unfit for all services". His symptoms included some of the usual afflictions: general tremor, insomnia, nightmares, excitability and depression. Doctors at Dartford - including probably John Springthorpe - constructed an explanation typical of the time: in May 1916 Stewart had suffered headaches and insomnia from gunfire and after four days in the line at Pozieres he broke down and was invalided to England and No. 3 AAH, Dartford. His mental history revealed that at 18-years-of-age he had suffered 10 weeks nervous breakdown as a result of "overstudy." Thereafter he was considered "never quite strong." ¹⁶³ A temperamental past may well have placed the young Australian serviceman at risk but what role might

¹⁵⁹ History of War Neurosis, op. cit., pp. 6, 10, 11, 12, 14, 15.

¹⁶⁰ Ibid.

¹⁶¹ Ibid.

¹⁶² Statistical Records No. 3 AAH. AWM 27, 371.1.

¹⁶³ Lance Corporal D. Stewart, 13th Australian Field Ambulance, Army Form B179: "Medical Report on an Invalid", 19 February 1917. AWM 370/25, Part 2, No. 680.

the cohesiveness of his military unit have played in his post-traumatic reaction? How might his own combat effectiveness have influenced the onset of this disorder? Or the short and long term post-trauma environment? Or pre-war social adjustment? What was the exact duration and timing of the stress? Identical questions could now be asked of many similar diagnoses made by British and Australian doctors during the Great War but answers would be difficult to elicit. Nevertheless, it is important to acknowledge the complexities of this problem.

It is plain that Australian psychological casualties from Gallipoli and the Western Front displayed many of the symptoms and clinical syndromes associated with war trauma. External factors in the hostile environment were crucial to the development of these complex and highly damaging problems but it must also be acknowledged that the individual psychological makeup of some men probably contributed to the onset of war neurosis as they were less able to cope with battlefield demands than others; in some cases war experience seriously aggravated existing psychological difficulties.

Some doctors, such as Major J.B.Lewis at Monte Video Camp Hospital, claimed considerable success in treating some of these men but in many others the symptoms showed absolutely no sign of abating either overseas or later in Australia. For many Australian servicemen, war neurosis had become a chronic problem.

War neurosis as a chronic disorder

In Australia the symptoms and syndromes reported in psychological casualties in the AIF overseas persisted with undiminished virulence. Some men remained affected throughout the period under study while others were plagued until the 1940s and beyond. Dreams and waking memories, severe emotional disturbances, psychosomatic disorders and hysterical ailments made their lives a misery. Although all of the symptoms reported in servicemen overseas appeared in Australia, a few new ones emerged as well. The most conspicuous and common of these were anger and extreme frustration, emotions that were not reported by medical officers or soldiers themselves in the theatres of war or evacuation centres. Sometimes these were repressed; often they were not and the results were personally and socially devastating.

At home, many returned servicemen still suffered severely from the memory of their experiences overseas. Sometimes they relived these occurrences in further dreams and nightmares which, in a few men seemed to persist for only a relatively brief time after the conclusion of their service. Twelve months after being blown up on the beach

at Gallipoli, Frank Lee was still troubled by nightmares; ¹⁶⁴ thereafter, this affliction was not mentioned in his medical records. After his discharge in January 1918, the shell-shocked A.E. Grant complained of terrifying dreams ¹⁶⁵ as did Thomas Edwards who had also been shell-shocked on the Western Front. ¹⁶⁶ Others, however, were haunted by nightly visitations from the battlefield for periods lasting much longer than just a year or two. Former private Leslie Hogg was still suffering from "night terrors and alarming dreams" in 1927. ¹⁶⁷ One of the few light horsemen whose psychological problems from the desert campaign have come to light was Trooper Albert Regis whose disorder originated in the highly stressful Jordan Valley. A doctor's report from April 1928 revealed that Regis slept erratically, had frequent nightmares - mostly about killing people - and awoke calling for his wife.¹⁶⁸ In 1931, Private Edward Harvey was still having "bad war dreams" ¹⁶⁹ as was Albert Marsh who had been experiencing that kind of torment since 1915 when he was shell shocked at Gallipoli. His dreams were described as "nightmare, amounting to terror - getting worse for the last two years." The resulting insomnia left him feeling exhausted and old. ¹⁷⁰

Occasionally, traumatic memories of the war were so successfully repressed by individuals that they were only released under hypnosis. Edward Harvey, for example, was diagnosed with hysterical vomiting but the cause of this symptom only became clear after abreaction (release) under hypnosis. A medical report stated: "Psychoanalysis utilised and history of his having bayoneted a German in the bowels and vomiting afterwards." ¹⁷¹ Further hypnosis disclosed additional repressed memories: "As stated in previous reports this is a case of repressed mental conflict . . . Under hypnoidal condition he was able to recall a repressed memory of being bombed in hospital and witnessing the murder of a German prisoner." ¹⁷² Other men also recalled harmful memories under hypnosis. Lieutenant H.R. Edgar, for example, was said to have recalled and abreacted all of his war amnesia. ¹⁷³ Sometimes these repressed memories expressed themselves in "flashback" episodes in which the subject relived or acted out the terrifying experience. In 1926 Leslie Hogg's mother reported that her son was suffering from delusions and talked constantly about the war. ¹⁷⁴

¹⁶⁴ Medical Report on an Invalid, circa 1916, in Private F. Lee, 5th Battalion, PCF.

¹⁶⁵ Officer Commanding 11 AGH to OC 16AGH, 18 October 1918, in Signaller A.E Grant, PCF.

¹⁶⁶ Form U, 19 July 1917, in Private T. Edwards, 58th Battalion, PCF.

¹⁶⁷ Out-Patients Notes, 22 July 1927, in Private L. Hogg, 37th Battalion, PCF.

¹⁶⁸ Doctor's Report, 19 April 1928, in Trooper Albert Regis, 3rd Australian Light Horse Regiment, PCF.

¹⁶⁹ Notes, RGHC, 19 October 1931, in Private T. Harvey, 22nd Battalion, PCF.

¹⁷⁰ Case Sheet, 5 November 1931, in Private A. Marsh, 22nd Battalion, PCF.

¹⁷¹ Medical Report in Memo for Officer In Charge Pensions Section, 22 November 1920, in Harvey PCF, op. cit..

¹⁷² Medical Report, 19 May 1922, in *ibid.*

¹⁷³ Memo for Medical File, 17 February 1925, in Lieutenant H.R. Edgar, 2 Field Artillery Battery, PCF.

¹⁷⁴ Clinical Notes, RGHC, 19 November 1926, in Hogg, PCF, op. cit..

Edward Harvey too was reported as "having hallucinations about war incidents."¹⁷⁵ Harry Sands' wife described similar behaviour in her husband. Soon after their marriage in 1922 she noticed that he acted strangely at times and that he developed a wild stare. On one occasion he approached her in a rage and crawled under the sofa, crying out: "The Germans are after me." After her return from hospital with their first child in 1923 he turned on her without any apparent reason, calling, "Look out, they are coming over the top; get out, you and your bundle." When he recovered, Sands had no memory of these two incidents.¹⁷⁶ The above occurrences are similar to those in which Frederick Leitner fought imaginary Turks with his walking stick¹⁷⁷ and in which Cedric Taylor believed that he too was again fighting the same enemy.¹⁷⁸

Private Barry Brown of the 22nd Battalion suffered gunshot wounds to the right arm, right eye, legs and abdomen in October 1917. In August 1926 he was admitted to Caulfield hospital in a "psycho-neurotic condition".¹⁷⁹ By 1929 he suffered what appears to have been a serious flashback episode in which, on admission to Caulfield Hospital, he struggled violently and shouted about machine guns, mowing men down and going over the top. Bromide and paraldehyde subdued him within half an hour.¹⁸⁰

Friends, family and neighbours all had to contend with former Private James Town's highly realistic reprise of episodes on the Western Front. Evacuated NYDN in September 1917 and later gassed and concussed, he exhibited a pre-occupation with the war in his post-war conversations in Australia.¹⁸¹ In August 1921 his wife told the Department of Repatriation: "The war strain seems to be on him greatly with his nerves. When he does join in any conversation it is all the war and the perspiration comes from his forehead."¹⁸² By 1928, however, harmless talk had been replaced with bothersome action. A doctor reported:

Patient is mental. Thinks he is in a Trench, repelling a German attack. Is lying in a shallow scoop in the ground at his own front gate, with a broom as a rifle. He has his iron ration and first-aid outfit also consisting of a tobacco tin and a single bandage. Thinks his opponents are 24th German division. Will allow no one to pass him along the street. Is taking everyone prisoners.¹⁸³

For some men, such deeply disturbing recollections occurred while they were fully conscious. Private Robert Henry made a rule that he would not discuss the war

¹⁷⁵ Medical Report, 19 October 1931, in Harvey, PCF, op. cit..

¹⁷⁶ Medical Report, 22 June 1933, in Sands, PCF, op. cit..

¹⁷⁷ M. Leitner to Repatriation, 12 February 1925, in Leitner PCF.

¹⁷⁸ Medical Report, RGHC, in Taylor, PCF, op. cit..

¹⁷⁹ Clinical Report, RGHC, 24 August 1926, in Private B. Brown, 22nd Battalion, PCF.

¹⁸⁰ Memo for Medical File, 13 March 1929, in *ibid.*

¹⁸¹ Army Form B103, in Private J. Town, 6th Battalion, PCF.

¹⁸² Letter, 4 August 1921, in *ibid.*

¹⁸³ Doctor's Report, 17 June 1928, in *ibid.*

with anyone, including his wife, but on one occasion almost ten years after the Armistice he revealed that guilt for having survived was one cause of his anguish. In June 1928 his wife wrote:

I remember about six months ago Mr. Henry was sitting thinking. When I asked him he said when he was in the lines he had been on over 48 hours [as a stretcher bearer] and he had just come off duty. he [sic] was asked to go back again and he said he couldn't stand any more without sleep. They sent a man in his place. The man was killed. He said I often wonder if I was the cause of that man's death. ¹⁸⁴

Eleven years after the war Herbert Mason also remained troubled by persistent, conscious memories. In 1929 a non-Repatriation Department doctor stated: " He seems to find it difficult to forget his war experiences. He seemed oppressed by his recollections and constantly referred to them." ¹⁸⁵

Conscious and repressed memories of combat experience were thus major components of the war neuroses that plagued Australian returned soldiers. But a wide range of further psychological and emotional symptoms, such as repressed anger and irritation, (which had not appeared in reports overseas) were also common. In 1930 Joseph Fry was "nowadays that irritable that the ticking of a clock upsets me. Many a time I have had to stop it." ¹⁸⁶ By 1933 his irritability had degenerated into periodic rages in which everything "went black" as an ungovernable temper assumed control.¹⁸⁷ Thomas Edwards told a doctor that he had a young baby at home and confessed that he sometimes felt like throwing it out of the window.¹⁸⁸ Soldier settler and former prisoner-of-war James Hook was similarly disturbed by the same kind of annoyance. A Closer Settlement Board officer informed the Deputy Commissioner:

This settler is a bundle of nerves and if proper treatment is not given treatment a serious tragedy is likely to happen. He has told me himself that something must be wrong with him when he feels irritated by his own children, and his wife is getting very nervous. ¹⁸⁹

At home in Victoria's Western District, former Trooper Albert Regis also had "mad impulses". Although he loved his baby he felt the urge to choke it when it started to cry. In fact, any noise affected him and his wife was often forced to walk away until he quietened down.¹⁹⁰

Some men were haunted by constant trepidation. In a few cases it was an unspecified fear but for other men it was highly particular. In July 1934 Harold Walters

¹⁸⁴ V. Henry, to Deputy Commissioner, Victoria, 25 June 1928, in Private R. Henry, 5th Battalion, PCF.

¹⁸⁵ Dr. H.J. Bolton to Repatriation, 20 May 1929, in Private M. Mason, 60th Battalion, PCF.

¹⁸⁶ Form U, 3 September 1930, in Trooper J.J. Fry, 13th Light Horse, PCF.

¹⁸⁷ Doctor's Report, 25 May 1933, in *ibid.*

¹⁸⁸ Form K, 23 January 1924, in Private T. Edwards, 22nd Battalion, PCF.

¹⁸⁹ CSB to DC, 26 October 1931, in Private J. Hook, 58th Battalion, PCF.

¹⁹⁰ Doctor's Report, 1 February 1928, in Regis, PCF, *op. cit.*

was reported as being overwhelmed by a general sense of dread.¹⁹¹ Albert Marsh was beset by an ongoing feeling of apprehension¹⁹² while Charles Ewell was "continually oppressed by a dread of some indefinable calamity."¹⁹³ Frederick Lamar, however, was obsessed with heart disease, although, according to medical reports, there was no rational basis for this fixation.¹⁹⁴ His Local Medical Officer wrote: "[A]s soon as he returned to this district just before Christmas there were two sudden deaths from heart failure and Lamar was nearly insane with fear that he would suffer the same fate."¹⁹⁵ In 1930 Thomas Edwards was reported as "frightened by his own shadow jumping at night."¹⁹⁶ Unlike those who could not stand company, some men were afraid to be left alone. William Hobbs, for example, frequently visited his local Returned Soldiers' Club simply because he feared solitude.¹⁹⁷

Depression was a common psychological symptom suffered by many returned servicemen diagnosed with war neurosis.¹⁹⁸ "His outlook seemed definitely gloomy, sometimes morose," wrote Doctor J.H. Bolton of Michael Mason.¹⁹⁹ Sometimes depression was directly associated with the longevity of illness. By 1932 Charles Lapin had assumed a hopeless view about ever being better.²⁰⁰ Charles James also developed a sense of futility because he never felt normal.²⁰¹ Occasionally, depression led to suicidal thoughts and attempts at suicide, some of which were successful. At Caulfield Hospital, Robert Henry tried to cut his own throat but was saved by another patient.²⁰² At Mont Park in 1930 Charles Lapin attempted to take poison because he thought he was insane.²⁰³ Others, like Angus McKay, simply entertained suicidal ideas without acting on the impulse.²⁰⁴ Most men expressed their anguish in less extreme ways, however. Some simply cried. In 1930 Walter Hammond was described as "easily upset."²⁰⁵ In 1934 Angus McKay still cried suddenly.²⁰⁶ At a session with a Repatriation doctor in 1929 John Hills wept when relating his experiences as a

¹⁹¹ Minute, RGHC, 25 July 1934, in Walters, PCF, op. cit..

¹⁹² Medical Report, 2 September 1932, in Private E. March, 5th Battalion, PCF.

¹⁹³ Out-Patient Notes, 12 January 1919, in Private A. Ewell, 29th Battalion, PCF.

¹⁹⁴ Report, Local Medical Officer, 28 June 1934, in Private. F. Lamar, 21st Battalion, PCF.

¹⁹⁵ Local Medical Officer to Repatriation, 19 January 1934, in *ibid.*

¹⁹⁶ Memo for Medical File, 8 January 1930, in Edwards, PCF, op. cit..

¹⁹⁷ H. George to Repatriation, 5 August 1938, in Private W.J. Hobbs, 35th Battalion, PCF.

¹⁹⁸ For example: "Application for Medical Treatment, Medical Report, LMO, 16 September 1929, in Daniels, op. cit., PCF op. cit.; Medical Officer, Mont Park, to Deputy Commissioner, Victoria, circa, 1930, in Lapin., PCF op. cit.; Case Sheet, RGHC, 31 October 1928, in Leitner, PCF op. cit.; Medical Report, 25 September 1918, in Norman, PCF, op. cit.; and Minute, RGHC, 25 July 1934, in Walters, PCF, op. cit..

¹⁹⁹ J.H. Bolton to Repatriation 20 May 1929, in Mason, PCF, op. cit..

²⁰⁰ Memo for Medical File, 5 September 1932, in Lapin, PCF, op. cit..

²⁰¹ Doctor's Report, 2 November 1935, in Sergeant C. James, 3rd Field Company Engineers, PCF.

²⁰² Report, RGHC, 1 January 1932, in Henry, PCF, op. cit..

²⁰³ Memo for Medical File, 19 July 1929, in Lapin, PCF, op. cit..

²⁰⁴ Memo for Hospital File, 12 April 1934, in Private A. McKay, 11th Battalion, PCF.

²⁰⁵ Clinical Notes, 12 May 1930, in Private F.W. Hammond, 60th Battalion, PCF.

²⁰⁶ McKay, *ibid.*

prisoner-of-war in Germany.²⁰⁷ When eating meals with a post-war host, Albert Regis would suddenly "be seized with a fit of crying and sobbing."²⁰⁸ Like the men who were distressed by an inability to support their families, others were perturbed by their general impotence. Harold Walters' wife told doctors at Caulfield Hospital that her husband became "emotional, especially when he finds out how weak he is."²⁰⁹

In addition to behavioural, psychological and emotional signs of illness, a wide gamut of physical symptoms was reported in returned Australian soldiers. Mostly, these were psychosomatic. They included insomnia,²¹⁰ nausea and vomiting,²¹¹ gastric conditions and ulcers,²¹² poor appetite,²¹³ diarrhoea,²¹⁴ palpitation of the heart,²¹⁵ rapid pulse,²¹⁶ dizziness and fainting attacks,²¹⁷ dermatitis,²¹⁸ urinary disorders,²¹⁹ and speech defects amongst which stammering was the most prominent. The Inspector-General of the Insane in Victoria, Ernest Jones, reported the case of a man who had become mute and deaf after being buried by a fall of earth at Gallipoli on 29 July 1915. In hospital at Malta he sat and stared into space; occasionally, he attempted to escape. On the return journey to Australia he became violent, noisy and disruptive and had to be put in a padded cell. Sometimes he tried to throw himself overboard. When Jones saw him in Melbourne he could not articulate, make a sound or hear anything and communicated through crude drawings that reflected his experience: a ship or gun, for example. He began to improve, however, and wrote a question for Jones: "Do you think I am mad?" When Jones answered no, "he appeared much relieved and shook hands heartily." Specialists found no organic damage. The man

²⁰⁷ Doctor's addendum to Form U, 19 July 1929, in Hills, PCF op. cit..

²⁰⁸ S.T. Flint to Repatriation, 13 February 1928, in Regis, PCF, op. cit..

²⁰⁹ Memo For Medical File, 10 February 1933, in Walters, PCF, op. cit..

²¹⁰ For example: Clinical Notes, RGHC, 19 October 1931, in Harvey, PCF, op. cit.; Army Form B179, 25 March 1918, in James, PCF, op. cit.; Medical Certificate, 1 March 1927, in Lapin, PCF, op. cit.; Memo for Medical File, 6 January 1938, in Lee, PCF, op. cit.; Dr. J.H. Bolton to Repatriation, 20 May 1929, in Mason, PCF, op. cit..

²¹¹ For example: Medical Case Sheet, No.1 AAH, Harefield, 20 September 1917, in Driver F. Loomis, 1st DAC; Summary of Case Sheet, 1 March 1928, in Walters, PCF, op. cit..

²¹² For example: Medical Report, 8 January 1935, in Private H. Brothers, 3rd DAC, PCF; Form U, 19 July 1929, in Hills, PCF, op. cit.; Medical History Sheet, 5AGH, 30 April 1918, in Sapper H.J. Tyson, 4th Division Signals, PCF; Minute, 25 November 1940, in Walters, PCF, op. cit..

²¹³ For example: Medical Certificate, 1 March 1927, in Lapin, PCF, op. cit.; Form K, 20-26 May 1925, in Loomis, PCF, op. cit.; Clinical Notes, 3 February 1931, in Private J.H. Rivers, 6th. Battalion, PCF; Summary of Case Sheet, in Walters, PCF, op. cit..

²¹⁴ For example: Medical Certificate, *ibid*, in Loomis, *ibid*.

²¹⁵ For example: RGHC, Clinical Notes, 25 February 1926, in Private A. Callaghan, 14th Battalion, PCF; Dr. Bolton to Repatriation, op. cit., in Mason, PCF, op. cit.; Form U, 25 November 1929, in Lieutenant J. Steele, 23rd. Battalion, PCF, op. cit.; Summary of Case Sheet, op. cit., in Walters, PCF, op. cit..

²¹⁶ For example: OC, 11AGH, to OC, 16 AGH, 18 October 1918, in Grant, PCF, op. cit.; Medical Certificate, LMO, 26 August 1925, in Norman, PCF, op. cit..

²¹⁷ For example: Clinical Notes, op. cit., in Callaghan, PCF, op. cit.; OC, 11 AGH, op. cit., in Grant, PCF, op. cit.; Form K, 18 June 1926, in Loomis, PCF, op. cit.; Clinical Notes, op. cit., in Rivers, PCF, op. cit..

²¹⁸ For example: Dr. Bolton to Repat., op. cit., in Mason, PCF, op. cit.; Medical Report, 22 June 1933, in Sands, PCF, op. cit..

²¹⁹ For example: Form K, op. cit., in Loomis, PCF, op. cit.; Clinical Notes, RGHC, 19 October 1931, in Harvey, PCF, op. cit.; addendum to Form U, op. cit., in Hills, PCF, op. cit..

regained the use of his impaired faculties after killing a snake while on a picnic in Warrandyte. ²²⁰

Clarence Godfrey reported many cases of hysterical speech disorders in the returned servicemen he saw at No.5 Australian General Hospital, Melbourne. Many of these men had been buried by shell explosions and emerged from their ordeals, which sometimes included periods of unconsciousness, able to utter no more than a gurgle. Dreadful stuttering or stammering usually followed. One man, for example, repeated the initial and intermediate consonants eight or more times at each attempt and became almost incoherent. Some, who had recovered under hypnotic treatment, experienced a recurrence of symptoms upon excitement or a shock. One man's stammer returned when the boat returning him to Australia was torpedoed. Contact with an epileptic in the country produced the same result in another. For others, traffic caused a return of symptoms. ²²¹ In all of these, however, Godfrey stressed the presence of symptoms associated with other syndromes, such as neurasthenia: "persistent muscular tremors, insomnia . . . and so forth." ²²² He also emphasised the concomitant emotional side effects of speech disorders for the men concerned and wrote:

But, whatever the mechanism producing these phases, there is governing it all the persistent self-consciousness and hypersensitiveness, the lack of confidence in a capacity to speak correctly, the dread of ridicule and shame, the suppressed emotionalism and, at times, even a mental confusion and flurry, all of which to my mind may act in many cases as a formidable obstacle to rapid recovery. ²²³

At No.5 Australian General Hospital Godfrey also saw many other cases of hysterical conversions that had not been treated effectively overseas. Spastic gaits, paralysees in both legs, contractures of the hand and fingers, In all of these, however, he stressed the parallel existence of other neurotic symptoms.

As well as these symptoms, coarse and fine tremors of various parts of the body (mostly of the hands but also of the tongue and legs) were common. Of John Hills, the former prisoner-of-war, one doctor wrote: "It is very difficult to thoroughly examine this man, he is so tremulous." ²²⁴ James Bradley was similarly affected: "Patient shaking violently in arms and legs, tremor exaggerated at the least move, unable to control voice," reported a Local Medical Officer. ²²⁵ A poor memory was another widespread symptom of war neurosis. ²²⁶ "I seem to be able to remember

²²⁰ E. Jones, "A Case of Shellshock", in *The Medical Journal of Australia*, 4 March 1916, p. 203.

²²¹ C. Godfrey, "Some Cases of Stammering from War Shock Treated by Psychotherapy", in *The Medical Journal of Australia*, 28 September 1918, pp.262-263.

²²² *Ibid.*, p.262.

²²³ *Ibid.*

²²⁴ Addendum to Form U, *op. cit.*, in Hills, PCF, *op. cit.*

²²⁵ Report, LMO, 21 October 1931, in Private J. Bradley, 7th Battalion, PCF.

²²⁶ For example: Medical Report, 27 December 1934, in Brothers, PCF, *op. cit.*; Form K, 11 July 1928, in Hobbs, PCF, *op. cit.*; Memo for Medical and General Section, 25 February 1938, in Lee, PCF, *op. cit.*;

different events but I am positively unequal to remembering details associated with such events," Albert Marsh told Repatriation in 1932 in a statement that was echoed by many psychological casualties during the inter-war years.²²⁷ Persistent headaches were also commonplace.²²⁸ In 1925 Charles James told the Principal Medical Officer that he had been forced to "work with it, play with it [and] go to sleep with it for years."²²⁹

In addition to their psychological and psychosomatic symptoms, a few war neurosis patient also bore the scars of physical wounds inflicted by bullets,²³⁰ shrapnel, gas²³¹ and suffered the after-effects of illnesses such as malaria and influenza.²³² Charles Gascoigne, for example, retained a persistent cough as a result of a dose of gas received in January 1918.²³³ In some cases it appears that these injuries and diseases either contributed to or helped to cause the psychological disorder. George Payne almost died during the 1919 influenza epidemic while stationed in Belgium after the armistice; this episode was held responsible for his post-war psychological disorder.²³⁴

Thus, it is clear that the symptoms affecting soldiers of the First AIF overseas during the war were virtually the same as those seen in Australia after the conflict. This persistence is further emphasised by an examination of the chronological aspects of war neurosis as seen in Australian servicemen.

From the time of their onset at the battlefield until middle or even old age, the war neuroses of many men were never successfully treated. In such cases, the disorders followed one or more of three major trends: extreme persistence with little alteration of symptoms, a general worsening of the condition with the possible appearance of new symptoms, and degeneration into psychosis. (In the latter case it is probable that the neurotic symptoms were the earliest signs of more serious mental illness.) Many of the dates quoted in the above discussion of symptoms strongly suggest the longevity (indeed, the incurability) of psychological disorder in many returned Australian servicemen of the First World War. It was not uncommon for symptoms that were first recorded during the war to persist into the post-Second World War period. Several examples of typical individual lives will show more starkly and

²²⁷ Form U, 23 February 1932, in Marsh, PCF, op. cit..

²²⁸ For example: Medical Report, 12 January 1932, in Bradley, PCF, op. cit.; OC 11 AGH to OC 16 AGH, op. cit., in Grant, PCF, op. cit.; Clinical Notes, 12 May 1930, in Hammond, PCF, op. cit.; Medical Certificate, LMO, 26 August 1925, in Norman, PCF, op. cit.; Clinical Notes, 3 February 1931, in Rivers, PCF, op. cit..

²²⁹ C.F. James to Repatriation, 16 June 1925, in James, PCF, op. cit..

²³⁰ Medical History, 24 April 1916, in Marsh, PCF, op. cit.; Clinical Card, 1AAH, 14 August 1918, in Harvey, PCF, op. cit..

²³¹ Medical Report on an Invalid, 25 March 1918, in James PCF, op. cit.; Clinical Notes, 16 AGH, 2 April 1919, in Tweed, PCF, op. cit..

²³² AF B103; Form K, 19 April 1920; Form U, 16 April 1931, in Lance Corporal J. Burns, 17th Battalion, PCF.

²³³ AF B179, in Corporal E. Gascoigne, 18th Battalion, PCF.

²³⁴ "Report on Case Under Treatment", 25 May 1929, in Private G. Payne, 8th Battalion, PCF.

completely the obstinacy of these ailments. It will also provide additional support for the argument that mental disorder was not a transient difficulty but a chronic ordeal for many veterans.

The following three cases are typical of dozens of returned servicemen who suffered the long-term effects of war neurosis but who were not considered psychotic. They were simply men whose neurotic ailments persisted for at least a decade after the initial diagnosis but which were sufficiently serious to disrupt significantly their well-being. The first of these was Private Charles Green who was blown up in October 1917 on the Western Front and rendered speechless; afterwards, he was described by medical officers as "shaky" with a fine tremor of the hands ²³⁵ and classified "Shell Shock. Incapacity Total." ²³⁶ In 1923 he still had a severe stammer ²³⁷ which persisted until at least 1958. ²³⁸ In June 1933 he remained nervy, easily upset, irritable, excitable, shaky and troubled by insomnia and stabbing pains in the head. ²³⁹ Sapper H.J. Tyson was blown up and buried at Ypres in October 1917. He returned to Australia in April 1918 where, at No. 5 AGH, he was described as "nervous": sudden noises made him shake, he vomited after meals and suffered headaches when reading. ²⁴⁰ In 1927 doctors described him as frightened of being left alone in the dark, and "nervy" with sudden noises; ²⁴¹ a year later he feared he was going insane and suffered fits of crying and insomnia. ²⁴² Towards the end of 1929 a doctor wrote that he was "trembling, agitated, easily exhausted. Impression of a man in a state of terror." ²⁴³ By 1930 worry or excitement nearly always created a sensation of pressure around the head and he suffered the indignity of "giddy turns" in the street induced by general traffic noise. ²⁴⁴ Like Tyson, Driver Francis Loomis was also blown up at Ypres in 1917. He was unconscious for several hours and lost his memory and speech for one full day. At No.1 Australian Auxiliary Hospital in England, he was described as tremulous and melancholy, slept badly and suffered from headaches, vomiting and bad dreams. ²⁴⁵ In Australia his memory remained poor, his hands shook and he was still generally depressed with a "tendency to become lachrymose." ²⁴⁶ Over the next eight years giddiness, diarrhoea, depression, nervousness and morbid fearfulness blighted much of

²³⁵ Medical Case Sheet, circa July 1918, in Private C. Green, 37th Battalion, PCF.

²³⁶ AF B178, 17 July 1918, in Green, op. cit..

²³⁷ Form K, 17 October 1923, in *ibid.*

²³⁸ Clinical Notes, 5 May 1958, in *ibid.*

²³⁹ Form K, 15 June 1933, in *ibid.*

²⁴⁰ Medical History Sheet, 30 April 1918, in Tyson PCF, op. cit..

²⁴¹ Memo for Repatriation File, in *ibid.*

²⁴² Application for Medical Treatment, 26 November 1928, in *ibid.*

²⁴³ Memo for Medical File, in *ibid.*

²⁴⁴ Case Sheet, RGHC, 26 June 1930, in *ibid.*

²⁴⁵ Medical Case Sheet, No.1 AAH, Harefield, 20 September 1917, in Loomis, PCF, op. cit..

²⁴⁶ Form K, 14 November 1919, in *ibid.*

his life.²⁴⁷ In 1927 new symptoms appeared: he began to lose consciousness and take fits; he would fall in the street and injure his head; he slept badly.²⁴⁸ But the old ailments still troubled him: he remained depressed and emotional, and the hand tremor recorded in 1917 lingered until at least 1927.²⁴⁹ Dozens - and probably hundreds - of similar cases could easily be documented in this way.

War experience and the inefficacy of treatment was the principal cause of such symptoms and their prolongation but post-bellum civil burdens also contributed to these disorders and helped to perpetuate and embellish them. As will be seen in chapter six, the mental burdens of some men were increased by their inability to earn a living and support their families. But, although it was of major importance, this failure to fulfil personal and societal expectations was not the only cause of further stress. Traumatic civil and natural events sometimes triggered serious relapses that immediately negated any minor progress which affected men might have made. These swift regressions serve to emphasise how brittle such gains were and how unyielding were the symptoms. Private George Bailey was buried by a shell on the Western Front in July 1916 and emerged from his ordeal with typical symptoms: severe headaches, giddiness, tremor, insomnia, nightmare and irritability.²⁵⁰ In 1922 whilst a railyard worker he was almost run down by an express train. This fright "induced a nervous relapse and he was totally incapacitated from work."²⁵¹ In August 1921 Thomas Harvey also suffered a regression but in his case the precipitant was a thunderstorm.²⁵² Similarly, the Henley fireworks and Anzac Day in 1928 caused the appearance of extremely serious symptoms in Robert Henry.²⁵³ In 1930 Arthur Ewell was said to have been "very shocked" following a nearby gas explosion.²⁵⁴ In 1931 J.H. Rivers collapsed after attending a meeting of the unemployed in Collingwood;²⁵⁵ in 1943, he received news of his wife's infidelity and was hospitalised with a recurrence of his old symptoms: dizziness, insomnia, tiredness, poor appetite, and tremulousness.²⁵⁶ In other men, ostensibly harmless things like the noise of city traffic were sufficient to stimulate dormant symptoms.²⁵⁷

²⁴⁷ Form K, 20-26 May, 1925; Clinical Notes, RGHC, 28 April 1926, and 3 May 1926; Form K, 18 June 1926, in Loomis, PCF, op. cit..

²⁴⁸ Special Board, 13 December 1927, in *ibid.*

²⁴⁹ *Ibid.*

²⁵⁰ Clinical History, RGHC, 27 December 1916, in Bailey, PCF, op. cit..

²⁵¹ Medical Certificate, LMO, 11 September 1922, in Private G.R. Bailey, 23rd Battalion, PCF.

²⁵² Clinical Card, 5 August 1921, in Harvey, PCF, op. cit..

²⁵³ Doctor's Report, LMO, 26 June 1928, and Form U, V. Henry, 14 June 1928, in Henry, PCF, op. cit..

²⁵⁴ Out Patients Notes, 14 May 1930, in Ewell, PCF, op. cit..

²⁵⁵ Report, LMO, 30 January 1931, in Rivers, PCF, op. cit..

²⁵⁶ "Hospital or Sick List Record Card", 13 December 1943, in *ibid.*

²⁵⁷ For example: Special Board, op. cit., in Loomis, PCF, op. cit..

Australian psychological casualties of the First World War thus suffered a full range of major symptoms and syndromes which reflected severe emotional disturbance, mental and nervous exhaustion, psychosomatic turmoil and which disrupted or destroyed the ability of victims to function socially. In broad terms, the cause of this tumult was the mind's inability to integrate the inordinate demands of a hostile environment. Modern perspectives suggest very strongly that the experience itself rather than any predisposing "weakness" in individuals was the primary dynamic at work here. The resultant mental conflict, voluntary and deliberate repression of emotion, and a sense of overwhelming helplessness which shattered the normal defences of mind and body against danger, produced traumatic disorders of great seriousness both acute, chronic and delayed.

Because of these disorders the lives of many Australian servicemen were permanently blighted. Many men would be stalked forever by fragments of experiences that regularly leapt from their lairs in the unconscious, as fresh and horrifying as the day they occurred. It is clear too that, in these mental disorders, Australian repatriation authorities and Australian psychiatry were faced with an unexpected problem. Mental illnesses that were once thought to be confined only to a small proportion of Australians were now seen to be common to many. The social dislocation that flowed from these problems and the manner in which governmental and medical authorities responded to these difficulties will be the subject of the following chapters.

Chapter Four.

The Development of a Legacy: The Treatment of Psychological Casualties in Australia 1914 - 1918.

Before April 1918, when the Department of Repatriation officially began its work, returning wounded and sick were cared for in a loosely organised medical and social rehabilitative system consisting of private and public patriotic funds, military and civil hospitals, Red Cross homes and the State War Councils whose task it was to provide a variety of services. These included furnishing ameliorative assistance and finding employment for returned men, and loaning money to those wishing to establish themselves in business. Specialist treatment was also available for psychological casualties in the State asylums according to emergency arrangements between the States and the Federal Government. For sufferers of war neurosis, who were treated in both the general organisation and in the asylums, neither the social nor the medical means of rehabilitation was effective. As a result, a highly problematic legacy was created for the Department of Repatriation. Prejudice, medical bewilderment, the severity of asylum treatment, Defence Department policies such as mandatory discharge from hospital after six months, and the tendency of the State War Councils to provide well-meaning but inappropriate assistance, contributed to a hopeless outlook for many psychological casualties.

During this period, the Department of Defence and its medical hierarchy became acutely conscious of shell shock, the shortcomings associated with its treatment, and its potential as a very large problem. It will argue that their frame of reference included a mild paternalistic and moralistic dimension that presaged the Department of Repatriation's more severe attitudes towards sufferers of war neurosis.

Pre-Department of Repatriation Arrangements for Psychological Casualties

As in other combatant nations, psychological casualties were unforeseen by Australians at the outbreak of the First World War despite their occurrence in previous conflicts including, for example, the American Civil War, the Sino-Japanese and Russo-Japanese Wars, and the Boer War.¹ Screening for mental unsuitability was not,

¹ R.J. Spiller, "Shell Shock", in *American Heritage*, May-June 1990, pp.78, 79, 80. One Australian Boer War veteran wrote: "The only nervous complaint I had prior to the Great War was after I returned from Active Service after serving 15 months in the Boer War but as time went on I recovered until I got more than I could

therefore, part of the AIF's enlistment procedure nor did it become so despite expert advice from W. Ernest Jones, the Inspector-General of the Insane for Victoria.² Indeed, the only provision for mentally ill soldiers was a standing order that prescribed a discharge for any man who had to be committed to a civil asylum for a minimum of one month.³ In 1915, for example, 40 men from training camps and military hospitals were admitted to institutions for the insane in Victoria. Ernest Jones felt that "unquestionably many of these men would have been rejected for enlistment by an alienist [psychiatrist] supplied with all the facts of their career and family history."⁴

Thus, under Standing Orders, decisions about a minority of mentally disturbed men who had not seen service overseas were simple to make. As the enormous scale of the problem on the Western Front was revealed, however, and when it became clear that Australians invalided home from Gallipoli were suffering psychological maladies similar to those seen in European troops on the Western Front, pressing questions about how to deal with traumatised returned Anzacs presented themselves to politicians, the Department of Defence and its medical branch, the Australian Army Medical Corps: how could the stigma of certification be avoided? How should these men be treated? Where should they be housed? Who should pay for their treatment and accommodation? For how long should they remain in the army? During the war, these were conundrums to which the above authorities responded with a mixture of vigour, compassion, parsimony, opportunism and sensitivity to public opinion. Unfortunately, however, these measures did not provide much relief for individual sufferers of war neurosis.

In July and August 1915, not long after the first Australian invalids returned home, the Department of Defence, through the office of the Director General of Medical Services, began to investigate how returned psychological casualties were being treated in the different states with a view to formulating policy on the matter.⁵ This preliminary exploration coincided with questions in the House of Representatives about provisions for psychological casualties. It also coincided with the Victorian Government's War Mental Treatment Act which obviated the need for sufferers of war neurosis to be certified.⁶

carry and my nerves have been bad ever since." Sergeant H. Brothers, 3rd DAC, to Repatriation, undated, circa 1935, in PCF.

² W. E. Jones, Diary, undated, circa 1915.

³ Colonel A.G. Sandford, Commandant, 4th Military District (South Australia) to Department of Defence, 18 October 1915, in "Mental Cases", AA, (Melbourne)MP 367/1, 500-5-15.

⁴ Annual Report of the Inspector-General of the Insane for Victoria, 1915, p.37.

⁵ Memo no. 37717: Director General of Medical Services to all Military District Commandants, 9 July 1915, in "AAMC Units in Australia. General Precis of Correspondence. Treatment of Military Mental Cases", AWM 32 [61].

⁶ Hansard, House of Representatives, 18 August 1915, and Victorian Parliamentary Debates, Session 1915, 12 August, Volume 140, p. 1809.

The reasons for Defence Department action on returned psychological casualties were a desire to dispense with the stigma of certification for soldiers, the wish to restrict expenditure and to obtain the best treatment. In November 1915 the Deputy Director of the Australian Army Medical Services, Colonel A.E. Shepherd, wrote:

[I]t is pointed out that there is a strong sentimental element associated with the treatment of soldiers who are mentally deficient on account of the stress of active service in the fighting line. The question of placing such men in the State Mental Hospital, popularly known as a Lunatic Asylum, is a matter of policy which should be referred for a definite ruling, as the expense of upkeep of a special permanent military mental hospital, either in one Military District or all Military Districts, is a heavy one. These mental hospitals require special staffing on a liberal scale, and specially trained attendants. Such an outlay would be justified only on a special ruling given by the Government that such a policy was to be pursued.⁷

With these aims in mind the Department of Defence was happy to learn that Victoria, influenced by similar British legislation and the progressive ideas of its Inspector General of the Insane, W. Ernest Jones, had passed a War Mental Treatment Act. This legislation removed the need for psychologically damaged returned servicemen to be certified before admission to an institution.⁸ Based on a British law made earlier in the war,⁹ this Act was inspired by a desire amongst Victorian politicians that returning war heroes not be subjected to the stigma of certification and the indignity of being housed with "lunatics".¹⁰ In their general approval of a special bill for the treatment of psychologically damaged soldiers, Victorian politicians were motivated by compassion and a sense of obligation that only war seems to have been able to elicit for the mentally impaired. The perceived righteousness of the military cause and the courage of those who had volunteered and sacrificed their sanity in its service, drew forth a great deal of rhetoric about Australia's indebtedness to these men and the need to provide them with the best possible treatment. The Chief Secretary, Mr. Murray, told the Legislative Assembly:

I think that the Bill is conceived in the best interests of those to whom we do owe a very great debt of gratitude. The services which they have rendered place us under the obligation of doing all that we possibly can to help them in their time of trial.¹¹

Similar laws were passed in South Australia in 1916 and Western Australia in 1917. Under pre-war legislation, certification for cases under observation was not necessary in New South Wales either and, during the war, this rule was applied to soldiers. Legislation in Victoria and New South Wales also made special accommodation

⁷ Minute, Deputy Director-General of Medical Services [DDGMS], 22 November 1915, in "AAMC Units in Australia", op.cit..

⁸ Defence Department Minute, August 1915, in "Mental Cases", op. cit.

⁹ Victorian Parliamentary Debates, Session 1915, Volume 140, p.1809.

¹⁰ Ibid, pp.1809-1819.

¹¹ Victorian Parliamentary Debates, 1915, Volume 140, pp.1811-1812.

available for returned servicemen. In Victoria the Receiving House at Royal Park was converted into a military mental hospital while in New South Wales a similar facility was opened in the grounds of its major asylum, Callan Park.¹²

In mid-1915 the Department of Defence realised that the number of psychological casualties would increase as the war progressed and that further facilities would be required. And so, in July 1915, it opened negotiations with the Victorian Premier, A.J. Peacock, asking him to assist further with special accommodation for sufferers of war neurosis. As a result, a newly completed block of 100 beds for female patients at Mont Park was loaned to the military as an auxiliary or convalescent hospital, to be known as the 14th Australian Auxiliary Hospital. In addition, it was agreed that a larger block then under construction and intended as a replacement for the old Yarra Bend asylum would, when completed, be made available for military use.¹³ It is clear that thrift was also a motivating force behind this arrangement. Ernest Jones reported:

As this building, when relinquished by the Military, will revert to its intended use, the country will be saved a very considerable amount of money which otherwise it may have to provide in the way of additional hospital and convalescent accommodation for our soldiers, and which would subsequently be comparatively useless for any other purpose than that for which it was originally contrived.¹⁴

On these foundations - the need to avoid certification, the desire to minimise costs, and the opportunities provided by the initiative of State Lunacy Departments - the Defence Department constructed its policy on the treatment of mentally affected servicemen: soldiers from states in which certification was still mandatory should be treated in Sydney or Melbourne from where they would be sent home when cured or if certifiably insane. It was also felt that most men treated in the special military mental hospitals would be fit for discharge after twelve months but that if cases were to last longer than this period, they should be certified and committed to an asylum. In addition to institutional treatment, the Defence Department also favoured home care except in the cases of "violent and dangerous lunatics, or in cases where the homes are poor and unsuitable for the treatment of mental cases."¹⁵

General Pre-Repatriation Department Arrangements for Returned Servicemen.

In addition to the special arrangements, sufferers of war neurosis could also avail

¹² Memo 80065, Secretary Defence to Secretary Repatriation 29 October 1917, in "AAMC Units in Australia", op.cit..

¹³ Secretary Defence to Secretary Prime Minister's Department, 27 July 1915, in AA (Canberra)A458/1, Item K3685), and Annual Report of the Inspector-General of the Insane, Victoria 1915, pp.37-38.

¹⁴ Annual Report, op.cit., p.38.

¹⁵ Memo 80065, op. cit., p.7.

themselves of services provided within a more generalised system of medical and social rehabilitation - the forerunner of the Department of Repatriation which only began its work in April 1918. Before this large and controversial department became operational, the work of pensioning returned AIF servicemen and re-establishing them in civil life was carried out in an extemporised, constantly changing system of re-instatement. This structure comprised a mixture of private projects and government initiatives - the plinth on which the new department was constructed. Recognising the inadequacies of this *ad hoc* system, the Federal Government gradually extended its control over repatriation activities through the Federal War Committee and by piecemeal legislation until, in late 1917, it decided to assume total responsibility for the re-integration of returned soldiers. Within this interim repatriation organisation, however, sufferers of psychological disorder did not fare particularly well.

In November 1914 the Minister of Defence, George Pearce, announced a War Pensions Bill which was enacted the following month.¹⁶ Recipients were to be incapacitated soldiers and their dependents as well as widows and children while the philosophical basis of the scheme was the idea of workers' compensation with its notions of commensurate remuneration for particular levels of incapacity.¹⁷ The Act established a Pension Board to assess and review pensions under Treasury officials who also administered invalid and old age pensions.¹⁸ In September 1915 this inefficient Board was replaced by a Commissioner and Assistant Commissioner of Pensions and, in each State, by a Deputy Commissioner. This arrangement continued to operate until these functions were assumed by the Department of Repatriation in 1920. Even though pension rates were raised in 1916, the scheme's basic benefits were so low that many returned soldiers were forced to seek additional help from the patriotic funds and State War Councils which were two of the interim repatriation system's most important elements.¹⁹

Of all the early efforts at repatriation it was probably the state of affairs associated with the patriotic funds that most influenced the Commonwealth to play a larger role in the civil re-establishment of AIF soldiers. The first patriotic funds - launched by the Lord Mayors of the Australian capital cities - were concerned to provide for the needs of servicemen's dependents in some way.²⁰ Soon many private funds emerged right across the country and these looked to comfort men abroad and their families at home by providing them with separation allowances, goods, and

¹⁶ A.P. Skerman, *Repatriation in Australia: a history of development to 1958* (Repatriation Department, Melbourne 1958), p.5.

¹⁷ C. Lloyd and J. Rees, *The Last Shilling: A History of Repatriation in Australia* (Melbourne University Press 1994), pp. 20, 22, 34, and Skerman, *op. cit.*, p.7.

¹⁸ Skerman, *op. cit.*, pp.8-10.

¹⁹ *Ibid.*

²⁰ D.I. McDonald, "The Australian Soldiers' Repatriation Fund. An Experiment in Social Legislation", in J. Roe, *Social Policy in Australia. Some Perspectives 1901-1975* (Cassel 1976), p.113.

generally ameliorating their condition in the period between hospitalisation and discharge. Eventually there existed 185 funds which raised about 14 million pounds.²¹ Federal government dissatisfaction with the inefficient management of these funds saw the adoption of J.C. Watson's suggestion for the creation of a pyramidal federal structure responsible for the rehabilitation and re-establishment of returned soldiers.

Below the Federal War Committee were to be the main instruments of this policy, the State War Councils, with War Service Committees at the local level forming the pyramid's base.²² Composed of men from both sides of politics in co-operation with eminent members of the business community, the Councils were given responsibility for a variety of tasks: to collect and distribute ameliorative money, to control the patriotic funds, to find employment for returned servicemen, to help organise, in conjunction with State Lands Departments, the settlement of soldiers on the land, to organise local committees as auxiliaries to the Councils themselves, and to provide vocational training.²³ Although they were given this wide-ranging brief, the Councils were not an outstanding success, apart, perhaps from their function as "quasi-labour exchanges" for returned soldiers.²⁴

Probably the most well-known of the early repatriation projects was soldier settlement. Representing the last phase of an 80 year plan to create a yeomanry in Australia,²⁵ this scheme was initiated early in the war by State Governments who felt that masses of returning soldiers would counter the problem of insufficient numbers faced by closer settlement programmes. Soldier settlement was also of interest to the Federal Government which regarded the idea as an incentive to recruiting and so appointed a sub-committee to investigate a role for the Commonwealth in implementing a scheme.²⁶ A major consequence of soldier settlement was the Australian Soldiers' Repatriation Fund which was raised in the name of the Federal Government by public subscription. Initially the fund was intended to aid soldiers financially in their attempts to settle on the land. Eventually, however, it provided sustenance payments to men awaiting employment, money for essential furniture, tools of trade, vocational training, farming equipment, seed and livestock, the purchase and erection of homes and for the establishment of small business.²⁷ The Fund's failure to raise satisfactory sums and its clumsy system of dual control under a Board of Trustees and the State War Councils

²¹ Lloyd, op. cit., p.25.

²² Ibid, pp. 30-31.

²³ *The Civil Re-Establishment of the A.I.F.*, Report to the Minister of Repatriation, E.D. Millen, September 1920, p.6. and McDonald, op.cit., p.117.

²⁴ Lloyd, op. cit., p.32.

²⁵ M. Lake, *The Limits of Hope, Soldier Settlement in Victoria 1915-1938* (Oxford University Press, Melbourne 1987), p.143.

²⁶ Lloyd, op. cit., p.45.

²⁷ Civil Re-Establishment, op. cit., p.6 and Mc Donald, op. cit., p. 124.

encouraged the Federal Government to assume full control of Repatriation matters through the Australian Soldiers' Repatriation Act of September 1917.²⁸

Before the Department of Repatriation's medical machinery began operating in early 1918, returned invalid soldiers relied for care and treatment on the medical branch of the Department of Defence with its military hospital system,²⁹ the Red Cross and its Convalescent Homes,³⁰ and the Medical Committees of the State War Councils which began work in 1916. Immediately upon their return, invalids were permitted two weeks leave - "boat leave" - with their families or in a convalescent home before entering a military hospital. Eventually, they might be declared fit then discharged from hospital and the army or, if requiring after-care, recommended to a convalescent home. Any treatment after discharge became the responsibility of the State War Councils and their local committees.³¹ Sufferers of war neurosis were often found in this general medical scheme as well as in the specialised one.

How did returned psychological casualties manage in this early system of social rehabilitation? A tart and impassioned report to the Chairman of the Victorian State War Council shows that this body and its operatives were well aware of the psychological damage inflicted on Australian soldiers by the war. It also reveals that measures taken by the Council to rehabilitate these men often failed even though they were well-intentioned. Usually, this was because they were based on ignorance, and seriously compromised by the mental and physical unfitness of the people they were designed to aid. This report also suggests that the kind of intelligence and compassion displayed by the writer, actuary James Graham, were not prevalent. He wrote, and it is worth quoting at length:

Our object is to do the best we can for each Returned Soldier. In certain cases the failure, which has resulted, is not entirely attributable to the soldier, but the responsibility must be shared by the Committee who, acting on the facts at their disposal, have agreed to assist men in directions which have not led to success. It does not follow that because a man has failed to make good in one direction that the Committee should not try to assist him in another and in a more suitable way. Repatriation will be a failure if in after years we have returned men, for whatever reason, reduced to a state of beggary. Men who have offered their lives for the Salvation of the Country must be assisted even in spite of themselves. Many of them have come back with their nervous systems shattered, and their will power impaired, and many who have hitherto been good servants are not fitted to be their own masters. They never were, and their experiences at the front have rendered them even less capable than they were before. This is one of the serious points calling for great consideration. There are men who have given way to drink to an extent to which they would never have given way but for their nerve shattering experiences in battle - experiences that we here are absolutely unable to appreciate, and in many such cases a very small quantity of alcohol is sufficient to produce a result in them

²⁸ McDonald, op. cit., pp.124-127.

²⁹ Butler, op.cit., p.746.

³⁰ Ibid, p.795.

³¹ Lloyd, op. cit., p.145.

which a much greater quantity would fail to produce on others who, like ourselves, have not been eligible to take part in the great conflict.³²

In support of his contention that the State War Council needed to exercise better judgement, the author cited the reports of six inspectors on seventeen men who had been given loans for commencement in business with little regard for their disabilities or lack of aptitude. One man, who in late 1916 was described as unable to work and who was discharged from "Melbourne Hospital suffering from nervous trouble", was granted a 45 pound loan from the State War Council to help start a "Hawking and Dealing" business which a doctor felt "ought to assist him better than most things." While waiting for his pension application and business loan to be approved he again approached the State War Council who advanced him three pounds over a period of three weeks, a necessity of which he was ashamed. Alcoholism, further hospitalisation, and the pilfering of his loan by acquaintances ensured that he was unable to take advantage of the money. The report continued:

[He] was never in a state of health allowing him to take up work as his own master, and he was very evidently not fit to work for anyone else. He was a physical and nervous wreck, and it is not surprising that when thrown on his own responsibility he broke down and took to drink. It all seems to follow quite naturally. He is one of a class who should be looked after in a home for Invalid Returned Soldiers, and not set up in any business. Our responsibility for this man's welfare has not ended, and I trust that steps of the kind I have indicated will be speedily taken.³³

Another man, twenty-two-year-old John Noonan - married with one child and suffering from shell shock - was loaned 50 pounds to buy horses and equipment for a carrying business but was not informed by an adviser to the War Council about the poor state of one of the two beasts he had purchased. He borrowed another horse from a returned soldier but this animal turned out to be inferior as well. Often, men were granted loans against the recommendations of Inspectors whose reports are full of stories about concerns that failed because the returned soldiers in question had no business aptitude or were dishonest enough to sell stock and equipment purchased with State War Council funds and disappear with the money.³⁴

How successful were the various arrangements for the medical care of psychological casualties? If statistics are any guide, it seems that a soldier's chances of recovery if admitted to a Victorian Lunacy Department Institution were a little over 50 per cent. Of the 77 men resident between 14 October 1915 and 18 September 1918, 31 were eventually certified and admitted to asylums for the insane.³⁵ One of the reasons for this dismal figure, of course, is the possibility that the disorders from which these

³² J. Graham, State War Council, to N. Lockyer, 13 October 1917. AA (Canberra) A2479/1, Item 17/1546, p.1.

³³ *Ibid*, p.3.

³⁴ *Ibid*, pp. 3,5,7.

³⁵ Registers of Military Patients in Victorian Mental Hospitals, VPRS 7512.

men suffered - such as manic depression, dementia praecox, "chronic mania", melancholia, "acute mania"³⁶ - had so solidified by the time they reached Australia that no amount of specialised treatment could alleviate the problem.

Some men chose to go their own way and so avoided the formalised rehabilitation system for as long as possible. They fared no worse than those who sought the aid of the War Councils and the Defence Department and their fates further suggest the inefficacy of the state apparatus. After a few weeks at Gallipoli, Trooper Cedric Taylor of the 4th Light Horse was evacuated with a nervous condition to Cairo where he remained for two months with little sign of improvement before being shipped to Australia. In 1931, after years of self-treatment, he told the Department of Repatriation: "[M]y nerves were in a shocking condition caused by the terrific bombardment. I also felt very weak and exhausted . . . I could not concentrate my mind to details."³⁷ In Australia he was admitted to Caulfield hospital, before being boarded and discharged in 1916. The resumption of civil life was very difficult for him as he was "too run down . . . to do any work and decided to rest and take things easy. My nerves were always on edge and I would jump at any little noise."³⁸ Although he received no medical help during this period, Taylor believed that the "spell" had improved his condition and so enlisted for Home Service. At the Seymour camp, however, he suffered "[i]ntermittent attacks of Heart Trouble and Nerves loss of sleep and occasional night sweats."³⁹ Military personnel who knew Taylor during this time testified to and elaborated on his condition. A Lieutenant McDonald described him as "a nervous wreck" who would have been discharged medically unfit if the staff at Seymour had not ministered to him.⁴⁰ Lieutenant R. Elms of the Signal School at Seymour told the Repatriation Department that Taylor had suffered severely

from the effects of his war service. On numerous occasions he would faint and even the sound of the machine guns at practice was sufficient to cause him to become highly excited . . . I knew him to arouse his comrades at night by beating on the tent floor in the belief that he was again fighting Turks . . . in my opinion (from later observation on Active Service) I judge now that his symptoms were very similar to a man suffering from shellshock.⁴¹

Major C. Samuels, a medical officer at Bendigo remarked in 1917 that Taylor's "nerves are in a bad condition as the result of shell shock. I am of opinion that this NCO is not in a fit state of health for any duty involving continuous strain and mental effort."⁴² Taylor was not the only shell shocked man to volunteer for Home Service

³⁶ Registers, op. cit..

³⁷ Form U, 19 June 1931, in Trooper. C. Taylor, 4th Light Horse Regiment, PCF.

³⁸ Ibid.

³⁹ Ibid.

⁴⁰ Lieutenant. McIntosh to Repatriation Department 25 June 1937 in *ibid.*

⁴¹ Lieutenant. R. Oaks to Repatriation Department 30 June 1931, in *ibid.*

⁴² Major. C. Samuels to Officer Commanding Headquarters Company, 14 September 1917, in *ibid.*

after his discharge from the AIF and find it too great a strain. Private Benjamin Clayfield, a camp guard, asked his Commanding Officer for a discharge because of his deteriorating health: "I feel that my general health is being undermined and my old complaint . . . 'Shell Shock' is telling against me," he wrote in support of his application.⁴³ Other men simply found small jobs that didn't entail too much stress. Private Crane, discharged in January 1918 with neurasthenia, told the Department of Repatriation: "When I was discharged there was no Repatriation only the War Council, and . . . I got work without troubling them . . . I got a temporary job at the Gen. Post Office as Temporary Assistant. An easy job I was able to hold till October 1919 when I and over 100 others were dismissed to make room for Permanent Officials returning from Active Service." ⁴⁴

A problem recognised: official acknowledgment of failure

During the war years, the treatment of mentally affected returned soldiers had not been satisfactory. Official thinking on arrangements for psychological casualties reveal some of the reasons for this situation, the motivation and attitudes of those responsible for the management of the difficulties associated with war neurosis, and the depth of concern over a question that had not been handled well at all. Official policy was held responsible but there are small hints that some of the men themselves - especially the alcoholics - were seen as blameworthy. This was an attitude that would become more manifest under the Department of Repatriation.

In October 1917, Thomas Trumble, the secretary of the Department of Defence, wrote to his counterpart in the nascent Department of Repatriation as the new bureaucracy was preparing to assume responsibility for psychological casualties: "[R]elative to the treatment of mental cases among men discharged from the Australian Imperial Force - I am directed to say that this matter has received the unremitting attention of this Department for some time, and has been attended with much difficulty." ⁴⁵ Trumble seems to have been referring to the problems associated with the discrepancies in State attitudes and laws but there were many other difficulties connected with the treatment of returned psychological casualties between 1915 and 1918.

At the Australasian Medical Congress of 1920, John Springthorpe told his colleagues that "the first arrivals were dismissed, without pension, as malingerers; the

⁴³ Private B. Clayfield, 25th Battalion, to Officer Commanding, 11 December 1918 in Clayfield, Attestation Papers.

⁴⁴ Taylor, Form U, op. cit..

⁴⁵ Memo 8005, op.cit., p.5.

next batch dealt with as requiring isolation and restraint." ⁴⁶ Treatment in a general hospital could sometimes leave psychologically affected soldiers with feelings of complete hopelessness, especially when they were told by the doctors there that they would never be cured. ⁴⁷ Clarence Godfrey, Consulting Psychiatrist to No.5 Australia General Hospital in St. Kilda Road, also told the Congress of this bleak outlook, referring to "the large number of apparently hopeless (from their own standpoint) soldier patients, drifting along from hospital to hospital without improvement . . ." ⁴⁸

Further revealing the major administrative ills associated with the domestic management of psychological casualties during the war and the attitudes of authorities towards the men for whom they were responsible, was a conference convened on 17 June 1918 at Defence Headquarters, Melbourne, by the Deputy Director-General, Australian Army Medical Services, George Cuscaden. Here, with one face looking to the past and the other to the future, authorities contemplated their failures and rare successes while preparing for the deluge of psychological casualties that they knew must come with the return of the AIF after the war. Assembled was a complement of medical officers who "had all for some time been intimately concerned with the care and treatment of returned soldiers suffering from the various types of disorders of the nervous system which are loosely covered by the terms 'Shell Shock' and 'Neurasthenia'". ⁴⁹ Members of this company reflected the variety of organisations and government departments overseeing the management of psychological illness in repatriated diggers. Amongst those present were Eric Sinclair and Ernest Jones, Inspectors-General of the Lunacy Departments of Victoria and New South Wales respectively (Jones was also heavily involved with Red Cross repatriation activities); Doctor Richard Stawell, representing the Repatriation Department's Medical Advisory Committee; Clarence Godfrey, and S.V. Sewell of the Victorian State Repatriation Board. Cuscaden represented the Department of Defence.

The mood of the conference was justifiably pessimistic but this gloom was balanced by the conviction that the previous lack of success could be remedied by a combination of authoritarianism and benevolence steered onto the right path. Chief amongst the issues discussed were boat leave and customary discharge from hospital after six months which, all agreed, had been inimical to a shell shocked soldier's chances of recovery and successful re-integration into civilian society. Boat leave was a brief furlough granted to medical cases (those who could manage it) when their ships docked at Australian ports - a period of time between their immediate arrival in the

⁴⁶ J. Springthorpe, "Psychology and Medicine", in *Proceedings of the Australasian Medical Congress 1920*, p.404.

⁴⁷ R.A. Noble, "The Treatment of Functional Nerve Disease during and after the War", in *ibid*, p.431.

⁴⁸ Godfrey, in *ibid*, pp.423-424.

⁴⁹ Transcript of Conference of Medical Officers on the Treatment of Neurasthenic Cases, p.1. AWM 41 [290].

country and their admission to hospital during which they were permitted to stay with family or friends. According to the testimony of Richard Stawell and a Colonel A.V.M. Anderson who was also present, boat leave was granted in mandatory fashion without any interval for medical observation .⁵⁰ Ernest Jones told the conference: "I think a large number of these men have suffered considerably through our giving them boat leave immediately they landed. I know a number of cases where boat leave had thrown men back very considerably."⁵¹ Sewell expressed a similar opinion but elaborated:

With regard to the question of Boat Leave I have also strong feelings. From time to time men are admitted to my Department as bedridden cases. They walk off the Boat feeling very well and all that sort of thing and they go to a theatre, and perhaps a gun is fired off, with the result that they immediately crack up. If these men are given Boat Leave, they are put back several months in regaining their health.⁵²

All who commented on this matter agreed that war neurosis patients should be admitted to military hospitals straight from the transport vessels for observation and perhaps given leave later according to the discretion of a medical officer. Jones declared: "I think we should devise more means of keeping these men longer."⁵³

And this was the same general solution that the conference agreed should apply to a similar difficulty: routine discharge after six months. Eric Sinclair advanced the idea that it would be necessary to keep war neurosis patients in the forces longer than other kinds of invalids.⁵⁴ S.V. Sewell informed his colleagues that he felt very strongly about this question. He was repeatedly seeing men whose mental condition was just as unbalanced as it had been since the day they had left the army in 1915 three years before; many of these returned soldiers were unable to stay in a job for any length of time, quitting after periods that varied from two hours to three weeks. They often asked to be returned to hospital. "I am quite right," remarked Sewell, "in saying that there are hundreds of men who are apparently going to be quite useless for the rest of their lives unless some action is going to be taken to hold them."⁵⁵ Jones, too, recounted how large numbers of men from the rest homes for whom he had tried to find employment were unable to remain in work. With typical paternalism he remarked:

I cannot help saying that a large number of these men are irresponsible and that we should not discharge them ... I have seen such a lot of men in Rest Homes and in other institutions connected with returned soldiers, whose condition is abnormal ... I think the majority of these men are released much too early from duty. I should like to see more means of keeping them under longer discipline, and in a way rather stricter, although at the same time mixed with kindness.⁵⁶

⁵⁰ Conference Transcript, op. cit., pp.2-3.

⁵¹ Ibid, p.2.

⁵² Ibid, p. 3.

⁵³ Ibid, p. 2.

⁵⁴ Ibid, p.1.

⁵⁵ Ibid, p.3.

⁵⁶ Ibid, p.2.

The other chief point at issue during the conference was the removal of psychological casualties from General Hospitals to specialist institutions and the segregation of men with mild mental disorders from those who were certifiable. Eric Sinclair opined: "Functional neurasthenia cannot be treated in the General Hospital, it requires men to be taken away from the sick, and sent to an Institution where Specialists are accustomed to deal [sic] with such cases." ⁵⁷

Clearly some shell shock cases were being admitted to ordinary hospitals and seriously ill men were being placed with those whose ailments were only mild. Such integration proved disastrous to the less greatly affected. Jones told the conference that there were some "very objectionable" patients at Mont Park and Royal Park and that they ought to be removed to a hospital for the insane. "Until we can get rid of the chronic mental cases at Royal Park, we cannot do the thing properly," he remarked. ⁵⁸ Godfrey agreed: "The association of neurasthenic patients with mental cases, I think should not be done. It is a night-mare to them. One man in No. 5 A.G.H. was told he would be sent to No.16 [Mont Park Mental Asylum]. He relapsed terribly." ⁵⁹ Conference members all concurred that the solution to this problem was specialist treatment and complete segregation in separate institutions designed for their particular disorders. Discussion on the matter of segregation centred upon what to do in Victoria, the State with the greatest number of neurasthenic cases; finally, in a compromise, it was resolved that the milder cases would be sent to special wards at No.16 AGH where they would be separated from each other "according to the various types and degrees of neurasthenia" and from the serious cases. ⁶⁰

Further concerns of the conference were widespread alcoholism amongst returning troops, and epilepsy. As seemed to be customary within governing circles, perceptions of these problems usually included a moral dimension that placed partial responsibility for his plight on the man concerned, sometimes added to which was incredulity at the individual's failure to appreciate State generosity. Jones told the Conference: "There seems to be a great number of men who cannot resist the temptation of alcohol, and men who have mild disorders, also epilepsy. We have tried to make arrangements for them but they refused to go to the Epilepsy colonies." ⁶¹ Anderson informed the conference similarly: "I also agree that inebriates are our worst cases.

⁵⁷ Conference Transcript, op. cit., p.1.

⁵⁸ Ibid, p.4.

⁵⁹ Ibid, p. 3.

⁶⁰ Memo of Resolutions adopted at a Conference of Medical Officers on the Treatment of Neurasthenic Cases, p. 2. AWM 41 [290].

⁶¹ Conference Transcript, op.cit., p.2.

They are constantly breaking leave and I cannot help thinking that some other treatment should be for them [sic] such as sending them to Lara." ⁶²

Official reflection on war neurosis and its treatment thus revealed the deep level of concern about the mismanagement of psychological casualties. For this debacle, Defence Department medical officers blamed policies such as boat leave, the association in asylums of sane men and psychotic, and the tendency to leave men to their own devices by discharging them from hospital prematurely. The comments of Springthorpe, Godfrey and Noble suggest that the ignorance and prejudice of some doctors also contributed to the misery of psychological casualties.

A missive directed to the Department of Defence in 1918 by W.A. Osborne,⁶³ Professor of Physiology and Histology at Melbourne University, reinforces the judgements of these doctors about official ineptitude in the management of war neurosis. It also confirms more strongly the existence in governing circles of paternalistic and moralistic attitudes towards sufferers. Thus, it forcefully suggests that the Department of Repatriation's rather harsh public position on chronic war neurosis was part of a wider set of values which encouraged people to judge harshly the behaviour of their social inferiors but to be selectively charitable nevertheless.

Osborne's analysis of the problem took place partly within a confident moral framework that appreciated "sane and insane actions" as matters of "right and wrong".⁶⁴ Shell shock and war strain, he alleged, had destroyed the self control that prevented soldiers from crossing the lines between these polarities. As a result, he said, many returned servicemen had become a public nuisance, an embarrassment, and their behaviour a threat to recruiting.

To illustrate his point, Osborne mentioned two cases, one of which was a returned soldier named O'Mara who had been arrested and charged with theft after robbing his mates in a Convalescent Home. This incident followed O'Mara's discharge ("permanently unfit, incapacity total") from the military and from Royal Park where he had spent five months after returning home in 1917. His father wrote to the Department of Defence requesting his son's admission to a Home from which he should not be allowed to venture, and blamed the Government for not looking after him. Displaying that combination of paternalistic sternness and compassion typical of some government officials dealing with returned soldiers, Osborne stated that the community owed these men a debt of gratitude and that it was its responsibility to their mental health by

placing them, with or without their consent or of their relatives, in a retreat, preferably in the country, where removed from the jangling and jarring noise of a city their shattered nerves can

⁶² Conference Transcript, op. cit., p.3. Lara, opened in 1907, was the Victorian Government's institution for alcoholics.

⁶³ University of Melbourne Archives, *Guide to Collections* (Archives Board of Management 1983), p.47.

⁶⁴ W.A. Osborne to Defence, "Shell Shock and War Strain", p.1. AWM 27, 376/216.

again resume their normal state by following a peaceful agricultural or other occupation. Unless they are violent or dangerous I do not think that they should be placed in an Insane Asylum nor should they I think be allowed to do just what they please, but a firm and kind control exercised over them and patiently taught to follow something useful.⁶⁵

Osborne felt that such responsibility should not be that of the Defence Department but the jurisdiction of a "separate Department altogether"; nor did he believe that it should be the Department of Defence's objective "to see how soon we can get them off the pay role"; rather, it should be its goal to see "how soon we can bring them back again to their normal state." Osborne predicted that the problem of managing shell shock patients would be difficult and marked by many failures but remarked that they could be satisfied knowing that they had at least done their "duty towards them." Finally, he told Trumble that he believed large numbers of shell shock sufferers had been discharged prematurely to the care of their relatives and would have to be collected again. He informed the secretary: "I feel sure their relatives after personal experience with them would welcome some form of Departmental control."⁶⁶ Osborne's memo therefore encapsulates some of the thinking behind the treatment of war neurosis: a desire to maintain public order and to make men useful to their nation again, and conversely, for the nation to realise its responsibilities towards these men even if the gestures were, in the difficult cases, just token.

Reading between the lines of the various official documents dealing with returned psychological casualties, it is relatively easy to imagine the bewildered chaos of their immediate post-service lives: how, in an odd kind of diaspora, they walked off the boats to confront an appalled public or baffled, grieving families who struggled to assimilate the pathetic spectacle of their drastically transformed soldier boys; how they wandered hopelessly from job to job and hospital to hospital, unable to cope with even the mildest ripples of civilian life; and how, with their drinking and aberrant conduct, they disrupted the established rhythms of the convalescent homes or shrank in terror and disgust from the psychotics with whom they were unjustifiably housed in state mental asylums. For these further sufferings, flawed administrative policies and ineffectual treatment were at least partly responsible. Ill-advised boat leave, mandatory discharge after six months, treatment in general hospitals, and the association of mild and severe cases in mental asylums helped to produce a body of men radically different from those who had sailed away. Although a problem of relative insignificance at the war's outset, the treatment of psychological casualties eventually involved the expenditure of much effort by the State War Councils, the State Lunacy Departments, and by senior bureaucrats and medical officers in the Department of Defence. It is also

⁶⁵ Osborne, op. cit., pp.1-2.

⁶⁶ Ibid, p.2.

clear that the problem was not defined in simple therapeutic terms but that it had, in the minds of governing groups, a moral, economic and national dimension as well. This frame of reference was to become much more sharply defined under the Department of Repatriation.

Chapter Five

War neurosis and the Department of Repatriation.

In September 1917 the Department of Repatriation came into being with the passage through Federal Parliament of the Australian Soldiers' Repatriation Bill. The new Department became fully operational on 8 April 1918. Under the terms of the Act, overall responsibility for its running was invested in the Minister (Liberal Senator E.D. Millen), below whom was a Commission of six members (headed by Lieutenant Colonel James Semmens) with absolute authority to formulate and administer regulations. Equivalent in function to the Commission were the State Repatriation Boards of seven honorary members while Local Committees comprised the base of this structure. In 1920 an amending Act made some major changes to this arrangement by reducing the size of the Commission and the State Boards to three paid members each and incorporating the pension administration formerly performed by Treasury. The bureaucracy was headed by a permanent secretary who was given the title of Comptroller. In 1921 the Department assumed control of all military hospitals, previously the domain of the Department of Defence which now relinquished any responsibility for repatriation. Within this framework was a medical service in charge of which was the Principal Departmental Medical Officer; under him were Departmental Medical Officers attached to each State Branch as well as hundreds of Local Medical Officers Australia-wide. The medical hierarchy also included a highly influential Medical Advisory Committee comprised of some of the most eminent doctors in Australia. Through this large network, the Department of Repatriation provided returned servicemen with a range of services: employment, housing, financial benefits, medical care, education for children and, in concert with State Governments, land for the soldier settlement scheme.

The primary concern of this chapter is the attitude of the Department of Repatriation towards war neurosis. Two main questions thus govern this discussion: To what extent was war neurosis perceived as a major problem by officials of the new Department? What kind of thinking did they then bring to bear on this issue?

In fact, within this new Federal Government Department, war neurosis was perceived as a matter of crucial importance. Top officials, including most notably the first Comptroller, Nicholas Lockyer, believed that psychological disorder amongst returning soldiers was widespread and that it would pose significant problems for post-war rehabilitation. In response to that perception, Repatriation authorities defined the problem in terms that went beyond simply the medical; indeed, war neurosis was

perceived as likely to endanger national economic prosperity and to threaten civil order, especially in the immediate aftermath of demobilisation. In addition to these beliefs, the problem of psychological disorder amongst returned soldiers was defined in strong moral terms in a way that deliberately excluded the chronic war neurosis sufferer from the heroic, nation-building interpretation of the AIF's experience.¹ In the Department's official, public view, such men were malingerers and spongers unworthy of sympathy or aid or of being awarded a positive role in the official interpretation of Australia's part in the war. Such a disparaging characterisation of psychological casualties was also probably due to the Department's inability to affect recoveries in sufferers of chronic war neurosis.

These judgements were highly reminiscent of the manner in which the undeserving poor were treated by nineteenth century charity workers and must be taken as further evidence that at least in the first third of the twentieth century, conservative resistance to the idea of state-sponsored social welfare was still strong and existed alongside the reforming impulse. It will be shown, however, that, despite the existence of such harsh attitudes, there was also a noticeable streak of compassion for victims of war neurosis. Thus, the Repatriation Department's instinct to help sufferers of war neurosis as a matter of right, but at the same time to judge and punish, may be seen as a microcosm of that larger struggle over social welfare. It can be seen as reflecting the antagonism between two views of accountability, one that blamed the victim for his plight, the other that held social conditions responsible for human misery.

The presence of these attitudes thus prompts the question: how did such views influence the Repatriation Department's actual treatment of war neurosis sufferers? Such an inquiry will be the chief concern of the next chapter.

Repatriation Department Awareness of War Neurosis

War neurosis was acknowledged as an urgent problem by many of those involved with the rehabilitation of returned servicemen. It was perceived as a matter of critical significance by the first permanent head (Comptroller) of the Repatriation Department, Nicholas Colston Lockyer, who tried very hard to cater for the difficulties he foresaw. Described by one writer as "a successful product of the public service career structure", Lockyer began his career in New South Wales at the age of 13 and had been a member of the Interstate Commission (which dealt with the commerce provisions of the

¹ This marginalising process is highly reminiscent of how C.E.W. Bean excluded from his version of AIF history those men who did not merge "quickly and quietly into the general population" and resume normal civilian life despite terrible handicaps. C.E.W. Bean, *Anzac to Amiens, A Shorter History of the Australian Fighting Services in the First World War* (Australian War Memorial, Canberra 1968), pp.529-531. See also the introduction to this dissertation, p.14.

Constitution) for four years when appointed to the position of Comptroller in September 1917.² Sharply aware of the war's effect on the human mind and the kind of problems this would create for Australia, the Anzacs and for his office, his compassion towards these men and the energy he displayed in trying to aid their recovery contrasts markedly with later attempts by other Departmental officials to deal with this problem. Lockyer believed that psychological disorder was common amongst the returning troops and, that as a result, many found it impossible to settle to any occupation, a problem not only for the individual - to whom he was highly sympathetic - but for the economic health of the country as well. Lockyer believed that inadequate records, poor co-ordination between the Departments of Defence and Repatriation, and the general lack throughout Australia of men suitably qualified in the field of psychiatric medicine, worked against a satisfactory solution. During his period as Comptroller, he vigorously tried to find solutions to these problems by calling for greater inter-departmental co-operation and searching for doctors who would be able to assess returning soldiers competently and compassionately. Lockyer's efforts resulted in two significant appointments: Dr. J.F. Agnew to the position of Principal Medical Officer (the Department's first) and Dr. A.H. Melville, who was to be highly influential in the futures of so many sufferers of war neurosis. In addition, the eventual amalgamation of the Defence Department's re-establishment functions with the Department of Repatriation received at least some of its impetus from the vital concern of the first Comptroller for the personal and economic consequences of psychological disorder caused by war.

It is clear that Lockyer was acutely conscious of war neurosis and sympathetic towards its victims. In October 1918, he and his Minister, Edward Millen, were concerned with how best to register the vital information of all returning soldiers before their arrival in Australia so as to facilitate a smoother, more satisfactory transferral back into civilian life. Lockyer felt that one of the chief difficulties in obtaining knowledge about the troops' aspirations was their state of mind. He wrote to Millen:

It will be necessary to obtain the information from the men whilst they are on temporary leave from the firing line, and their minds naturally will not be in a condition to calmly consider and specify their desires. They are temporarily away from the trenches, resting from the horrors of the conflict to which they will shortly return and as to the future their minds may well be disturbed.³

In April 1918, Lockyer told Departmental Medical Officers in all States:

² K. Blackmore, "' What Australia is Doing for You'. The Early Australian Repatriation Scheme." (Australian War Memorial History Conference 1994), p.136; and B. Nairn and G. Serle, (Gen. Eds.), *Australian Dictionary of Biography, Volume 10, 1891-1939 Lat-Ner* (Melbourne University Press 1986), pp. 130-131.

³ Lockyer to Millen, undated, circa 1918, in Repatriation Correspondence 1-1000A, 5 October 1917 to 4 March 1918. Department of Veterans Affairs Library, Canberra.

The number of men so affected is very large indeed, and the difficulties of this Department are immensely enhanced by the fact of the general mental upset which characterises so many who find it almost impossible to settle down in any continuous occupation. ⁴

Lockyer believed that "the severe hardships and terrific experiences in the trenches" ⁵ were responsible for this psychological disturbance which, he stated, would "take some time to subdue". ⁶ With great prescience, he feared that men so affected were in "grave danger of . . . being misunderstood and of their being treated as malingerers" ⁷ and dealt with unfairly by the Department of Repatriation. ⁸ In displays of sympathy, wisdom and even-handedness that were not always evident in later Departmental documentation and actions, Lockyer appears to have done his best to counter possible misconceptions about these men and to ensure the best treatment for them. In early April 1918, he became involved in the case of T.J. Harvey, a returned soldier who had complained of poor treatment at the hands of the Western Australian State War Council. Harvey took his grievance to the Honourable H. Gregory, MHR, who then questioned the State War Council about the matter. From the Council, Gregory received a terse reply in Lockyer's name - unauthorised - censuring Harvey's behaviour. Lockyer wrote to the parliamentarian:

I do not approve of that reply because, owing to the strain imposed on many of our men whilst at the Front, they return mentally, as well as physically, troubled. Their nerves are considerably upset and their actions should not be judged too hastily or too harshly. All that may be properly said about Harvey at the present time is that the evidence does not support his complaint of neglectful treatment.⁹

Lockyer's magnanimity towards shell shock victims was consistent with his benevolence towards returned servicemen in general. On the question of discriminating between those who reached the firing line and those who did not, Lockyer told the secretary of the Victorian State War Council that simply enlisting for active service was a sacrifice in itself and that it was perfectly possible for men to suffer serious injury and illness in training. He asked the secretary: "Is it suggested that these men are not entitled to equal consideration to those who, more fortunate in health and strength, have been able to get to the fighting line?" ¹⁰

⁴ Lockyer to Departmental Medical Officers, 18 April 1918, in Repatriation Department Correspondence, op. cit..

⁵ Lockyer to Deputy Comptrollers in all States, 11 April 1918, in *ibid.*

⁶ *Ibid.*

⁷ *Ibid.*

⁸ Lockyer to Director General of Medical Services, 25 February 1918, in *ibid.*

⁹ Lockyer to Gregory, 13 April 1918, in *ibid.*

¹⁰ Lockyer to Secretary, Victorian State War Council, 2 March 1918, in *ibid.*

But apart from the well being of the individual, Lockyer was also interested in maintaining the nation's economic health. He told Professor W.A. Osborne that

in addition to repairing a man's injuries some care and consideration throughout might be devoted to the economic factor - his re-establishment in civil life as a useful citizen . . . From the time a man is damaged his possible future, not only in his own personal interests, but for the economic benefit of his country should be kept in view." ¹¹

Lockyer saw Vocational Training as the means by which men could be made useful to themselves and their nation. He told the Returned Sailors and Soldiers' League in Perth that the aim of Vocational Training was to enable invalids to "depend upon their own resources and earn current rates of wages." ¹² Consistent with this attitude was his view that "secluding [war neurosis sufferers] in community settlements is not likely to be attended with much benefit. They are more likely to succeed in gradually being absorbed into the ordinary civil life of the country." ¹³ He declared that sympathetic doctors well versed in psychology and able to assess the physical and mental fitness of applicants would be a vital element in the success of this scheme. ¹⁴ This was an accurate prediction: such care was not taken and many individuals - and to some extent the scheme - foundered. In a memorandum to his Deputy Comptrollers, he quoted an unnamed authority on shell shock:

The patient must be approached without prejudice, and the doctor who wishes to be of real help to him must make up his mind to examine and ponder over the sufferer's mental wounds, with as much, nay, even more, care and expenditure of time than would be given to physical injuries. ¹⁵

He was, however, pessimistic about finding such men in Australia and felt that because few had the necessary experience and because military doctors had concentrated mostly on physical wounds and illness, hope should be placed in younger AIF medical officers, the group most likely to hold enlightened attitudes to "this . . . very important new feature in medical practice." ¹⁶ With such candidates in mind, he instructed his Deputy Comptrollers to consult the pre-eminent medical practitioners in their respective States to see whether they could nominate suitable colleagues. ¹⁷

In his search for such men, Lockyer contacted two Melbourne academics, Professor W.A. Osborne, Professor of Physiology, and Dr. A. B. Fitts lecturer in

¹¹ Lockyer to Osborne , 29 April 1918, and Lockyer, unaddressed, 18 April 1918, in Repatriation Department Correspondence, op. cit..

¹² Lockyer to A. Tyrell Williams, Returned Sailors and Soldiers' League, Perth, 23 April 1918, in *ibid.*

¹³ Lockyer, 23 April 1918, in *ibid.*

¹⁴ Lockyer to Millen, 12 February 1918, in *ibid.*

¹⁵ Lockyer to Deputy Comptrollers, 11 April 1918, in *ibid.*

¹⁶ *Ibid*

¹⁷ Lockyer to Deputy Comptrollers, 17 April 1918, in *ibid.*

psychology, both of Melbourne University. Fitts, who offered to examine men and instruct Departmental Medical Officers free of charge, was interested in the psychological condition of returned soldiers following physical injury or "due to the danger and other abnormal conditions of . . . life on active service." In response to Lockyer's inquiry about finding suitable doctors, Fitts told the Comptroller that because psychological disorder in war was a relatively recent problem, "competent assistance" might be hard to procure.¹⁸ Lockyer felt, however, that the dearth of medical specialists was not the only obstacle to a successful Vocational Training programme with its concomitant personal and economic dividends. Whether Fitts' was employed by the Department is not recorded.

It was a theme of Lockyer's correspondence that efforts to assess men for suitable employment were hindered by poor co-ordination between the Departments of Defence and Repatriation¹⁹ which truncated a soldier's records and caused the absence of any assessment in the same files of his suitability for particular classes of jobs. Lockyer was hoping that comprehensive records would counter-balance the dearth of psychiatric experts and obviate the need for great numbers of general practitioners to assess returned servicemen not only for Vocational Training but for other forms of assistance as well.²⁰ So, he fought hard to improve this aspect of the repatriation process by calling for specific reports on a soldier's mental and physical suitability for employment to be included in his records by all examining doctors.²¹ He also recommended that a lecturer in psychology be seconded to the Medical Advisory Committee, as was "suggested by the practice . . . in other countries in dealing with the very difficult question of the re-education of Disabled Soldiers";²² and the appointment of a well qualified doctor to head the Department's medical section. Such a man, said Lockyer, should have a "strong personality, have seen service in the present war, and have interested himself in the peculiar temperament of the men who have returned and whose minds, in many cases, have been disturbed by their severe experiences."²³ Both Lockyer and his Minister, Millen, considered the rapid appointment of a Principal Medical Officer a "matter . . . of grave urgency" as the "great difficulty in obtaining a Medical Man who has the peculiar qualifications . . . has involved us in serious delay."²⁴ Senator George Pearce, Minister for Defence, Surgeon-General Cuscaden, Millen, Lockyer, and the Secretary of the Defence Department who was asked to expedite his immediate transfer from the Pensions Board, were all involved in the eventual decision

¹⁸ Lockyer to Millen, communique No. 857, in Repatriation Department Correspondence, op. cit..

¹⁹ Lockyer to Osborne, 29 April 1918, in *ibid.*

²⁰ Lockyer, unaddressed, 18 April 1918, in *ibid.*

²¹ Lockyer to Secretary, Department of Defence, 22 April 1918, in *ibid.*

²² *Ibid.*

²³ Lockyer, unaddressed, 2 May 1918, in *ibid.*

²⁴ Lockyer to Secretary, Department of Defence, 2 May 1918, in *ibid.*

to appoint Dr. J.F. Agnew who had served with the AIF abroad during the war and whose son had been killed in action in September 1917. Recommended by Professor Osborne, his salary was to be 800 pounds per annum.²⁵

Nicholas Lockyer was sensitive towards the needs of returned servicemen and, it seems, towards psychological casualties in particular; he was also prescient, seeing the need for (but doubting the availability of) expert medical opinion in the assessment of returned soldiers for Repatriation schemes. Being as astute as he was, it probably would not have surprised him to learn that, in the ensuing years, most of his fears for these veterans eventuated but few of his hopes were realised.

After Nicholas Lockyer resigned as Comptroller in May 1918 to return to the Interstate Commission, concern with war neurosis continued at the highest levels of government. Evidence reinforces the contention that the measures taken to deal with war neurosis by the antecedents of the Department of Repatriation were unsatisfactory and that the incoming regime was urgently seeking ways to rectify these problems. The new Comptroller, Lockyer's former secretary, David Gilbert, had been made aware of the likely difficulties associated with psychological casualties during his time as Deputy Comptroller. Late in 1917 he received a missive from a Departmental official:

Owing to wounds, War's excitement and dangers and the hardships they have endured on Active Service, and, also, the use of such powerful artillery, high explosives, hellish gases, bombs etc. . . . our returned men have been affected mentally in a peculiar way not so noticeable in any previous wars . . . Almost all the men who have been in the firing line who come back are affected mentally and remain so for a long time . . .²⁶

Early in 1920, David Gilbert, now Comptroller, told the Secretary of the Defence Department that the Prime Minister had drawn his attention to an article on shell shock in the *Bulletin* together with a scathing treatise on the handling of Australian war neurosis sufferers, a detailed document that further suggests the unsuccessful management of psychological casualties in Australia during the war. This paper helped to raise awareness of war neurosis and its associated difficulties at the highest levels of government. In order to strengthen his later argument, the anonymous author of the treatise stated that, pre-war, many American and English civilians suffering psychological disorder had been saved from the "barbarism" of the asylum by the early recognition of their developing problems in special clinics, and by prompt, scientific treatment "as opposed to Asylum methods."²⁷ The author wrote favourably of how, in America, psychological knowledge gained in such clinics before the war had been applied to recruits, resulting in the rejection of 156,000 men deemed susceptible to war neurosis. Potential cowards, malingerers, thieves, the weak willed "and the man

²⁵ Lockyer to Deputy Comptroller, Melbourne, 6 May 1918, and Lockyer, unaddressed, 2 May 1918, in *ibid.*

²⁶ W. Fitzpatrick to D.J. Gilbert, 12 November 1917, in M. Lake, *The Limits of Hope: Soldier Settlement in Victoria 1915-1938* (Oxford University Press, Melbourne 1987) p. 63.

²⁷ Anonymous, "Shell-shock soldiers", p.1., MP367/1, 513/2/1592.

capable of valuable work as a civilian but who would certainly break down under stress of war and perhaps become permanently insane".²⁸ He argued that because screening was not carried out in Australia many unfit men were accepted and forced "to pay a bitter penalty in nervous wreckage, perhaps in actual insanity." Society, too, would suffer depletion of social value - both in this and subsequent generations. Neither the men themselves nor the doctors who passed them fit were to blame as their educations - inadequate in psychological medicine - had not prepared them to detect incipient mental flaws. Nor had it equipped them to rectify the damage post war. Only those who had undertaken an extra-curricular course in psychiatry or psychology overseas would be capable of such difficult work.

For this author, the culprits - in addition to the medical school curriculum - were the Repatriation Department, which rejected cases of war neurosis; the Red Cross homes, which didn't provide for them; and those who decided that the only course of action for psychological casualties was asylum treatment under the control of the various state lunacy departments whose directors usually adhered to the "theory that, if they are left alone, some of the patients may recover by accident".²⁹ Discipline was the prevailing ideology here so that when patients were discharged they were still in a very unstable condition. The author stated that the special Repatriation Department institutions soon to be opened at Five Dock, Picton and Exeter (the latter were most likely Convalescent Farms while the former was a hospital for alcoholic psychological casualties) were no more than convalescent homes for former asylum patients whose hope of recovery was small.

As a solution to these inadequacies, the author proposed the appointment of a qualified specialist experienced with shell shock patients. Under him would work suitably qualified subordinates of whom, in Australia, there were but a few. Further, he suggested that the Repatriation Department take advantage of the pressure being applied to the Senate by "several Women's Leagues" to use a portion of the 500,000 pound Sir Samuel McCaughey bequest for the establishment of a psychiatric clinic in which an academic would conduct research "to make impossible, in the event of another war, many of the tragic mistakes of this one".³⁰ Although there is no demonstrable connection between this paper and action taken by the Repatriation Department, it is probable that, at the very least, it contributed to the unease in government circles about the management of war neurosis.

Repatriating authorities, which, until June 1921, still included the Department of Defence, were sufficiently concerned about war neurosis to have sent an emissary around the country to investigate its handling in the various States, and to convene a

²⁸ Anonymous, op. cit..

²⁹ Ibid.

³⁰ Ibid, pp. 2-3.

conference on the subject.³¹ In response to the *Bulletin* cuttings and the critical treatise, David Gilbert asked Thomas Trumble, the Secretary of the Defence Department, to describe the kind of treatment available for war neurosis patients and whether any innovations were planned: "If there are any fresh suggestions or proposed new systems of treatment for nerve cases under consideration, or definitely contemplated, would you kindly inform me thereof," he wrote.³² In reply, Trumble told Gilbert that "a specialist in psychotherapy", Lieutenant Colonel C.R. Strangman, had been appointed to the staff of the Director General of the Australian Army Medical Services and that he had been sent Australia wide to organise "a system of education for incapacitated soldiers suffering from nervous diseases".³³ Gilbert wanted to know what that system was³⁴ and was told that the matter would "receive attention" when Strangman returned to Defence Headquarters, suggesting that no one was particularly sure what that system was or what it was going to be.³⁵ Four communiqués reveal that, between March and September 1920, Strangman toured the Australian capital cities with the full support of the Defence Department which informed the commanders of each Military District (State) that the psychiatrist with the roving commission was to receive all necessary support. Upon his return Strangman was expected to provide a report on his activities to the Chairman of the Repatriation Commission, James Semmens.³⁶ Because it did not reveal what system if any was planned - Strangman's paper is disappointing, consisting of little more than a 13 page disclosure of the methods he employed to treat war neurosis patients "during my stay at the Military hospitals of Queensland, N.S.W., Victoria, S.A. and W.A."³⁷ However, the document's conclusion was sagacious about the likely problems facing the Repatriation Department and probably provided little comfort to its readers. Strangman wrote:

I would like to point out, that the easy cases have now been cured and that probably only the difficult and more or less complicated ones remain. With patience and judicious handling, these men can be cured although perhaps, disciplinary measures may be necessary when dealing with a few of them.³⁸

Awareness of war neurosis and its associated problems penetrated all levels of the repatriation structure to the extent that, for some, psychologically scarred soldiers came to symbolise the war-damaged man. In September 1919 the Victorian State Repatriation Board held a conference with representatives of various "commercial

³¹ See chapter four, pp. 154-157.

³² Gilbert to Trumble, 14 January 1920, in AA (Melbourne), MP 367/1, 513/2/1592.

³³ Trumble to Gilbert, 25 March 1920, in *ibid.*

³⁴ Gilbert to Trumble 21 April 1920, in *ibid.*

³⁵ Trumble to Gilbert 30 April 1920, in *ibid.*

³⁶ Semmens to Trumble, 10 August 1920, in *ibid.*

³⁷ Strangman, Report to Cuscaden, 15 September 1920, in *ibid.*

³⁸ Strangman to Cuscaden, 15 September 1920, in *ibid.*

associations" (employer bodies) to determine the most efficient way of securing work for returned soldiers, many of whom were finding jobs difficult to get. At the time, nearly 4000 men had placed their names on the State Board books in the hope that the Department would be able to help them. In a statement that suggests the prominence of war neurosis amongst returned soldiers, one of the Conference members declared:

Every man who has gone over the top for us deserves a fair deal . . . It is a cruel thing for a man to have to walk the streets of Melbourne day after day, looking for something to do, even if he is drawing sustenance. . . . Our proposition is that we shall weekly, or perhaps bi-weekly, send to each Association a number of forms giving the name, age, record of experience and disability of all men in the trade which they represent, who are waiting for employment. That is to say, we would send a form to an Insurance Association

John Brown, Private
29 Years of age
5 years with Victorian Insurance Coy. as Counter Clerk
Disability - Shell Shock - Slight.³⁹

Repatriation authorities were, therefore, sharply conscious of war neurosis, the difficulties it posed for the absorption of returned soldiers into civil life, and the problems it raised for the country in general. In response they took a number of specific measures in addition to the general provisions contained in Repatriation legislation. However, it is clear that, within official ranks, the problem of war neurosis was defined not just in therapeutic terms; it was also linked to the economic health of the country as shown, for example, by Nicholas Lockyer's comments on Vocational Training. In addition, it also came to be associated with questions of public order, with questions of morality and attitudes to charity, social welfare and the poor, and conformity with the image of the AIF as a nation building force. All of these attitudes impinged deleteriously on the successful management of war neurosis, and helped to undermine the various measures which the Department of Repatriation had put in place which themselves were not value free. The problem of war neurosis was, in short, defined within a moral, economic and national framework as well as a medical one.

The next section of this chapter will discuss that frame of reference and argue that the heavily judgemental slant which the Department applied to war neurosis was, in an age when progressive principles of social welfare were supposed to be in the ascendancy, highly reminiscent of late nineteenth century attitudes to the "deserving" and the "undeserving" poor. In this respect, some returned soldiers were treated - and officially depicted - as no different from other Australian citizens who were either claiming or in receipt of social welfare benefits. Even though these men had undergone the same horrific experiences, they were denied, by the exercise of prejudice consistent

³⁹ Department of Repatriation - Victorian Branch, State Board Minutes, "Report of Conference of State Repatriation Board with Representatives of Various Commercial Associations", 19 September 1919, in AA (Melbourne), MP 5741/1, Vol.3, 3 June 1919-23 December 1919, Box 2.

with contemporary morality, the special status conferred on their more "deserving" comrades-in-arms.

War Neurosis: A Moral Frame of Reference

From Britain, Australia had inherited particular attitudes to social welfare amongst which was the evaluation of social distress according to moral criteria, a creed which maintained that certain types of individuals were responsible for their own plights. Such an analysis led to the division of the poor into the deserving - who were the victims of misfortune - and the undeserving who were the architects of their own troubles.⁴⁰ It is possible, however, that in Australia these attitudes were more strident than they had been in Britain: the undeserving poor in the colonies were perhaps seen as even less worthy because they failed to make the most of plentiful opportunities in a bountiful land and embrace the dominant ideology of thrift and self-help⁴¹ especially prevalent in the halcyon years of colonial prosperity after the gold rushes and the success of free-enterprise capitalism.⁴² The ethnic balance in Australia may have contributed to this sharpened distinction as well: Jill Roe has argued that "the traditional distinction between deserving and undeserving took on new bitterness in Australia, which had a Scottish-influenced upper class and an Irish-influenced labouring class." Roe maintains that the Scots had a more dogmatic approach to welfare than the English: in 1854, after the introduction of a Poor Law, Scottish authorities strenuously denied the right of the able-bodied to public relief. By contrast, the Irish demanded such benefits.⁴³ The British inheritance with its hardened colonial complexion was easily recognisable in the attitudes of charity workers, who, before the days of government intervention during the early 1900s, were largely responsible for social welfare in Australia.

Charity leaders during the 1890s in Australia depicted poverty in moral not economic terms; their goal was to reform the indigent rather than to alleviate want by altering social conditions so the poor were divided into two classes: the "clamorous indolent" who were either not needy or who were responsible for their own poverty, and those who bore their burdens in silence - the "deserving" poor whose requirements remained unsatisfied. Thus a stereotype (the "suffer-in-silence model") was created and any client who differed from it was considered unworthy of aid. Those who were

⁴⁰ T. Carney and P. Hanks, *Social Security in Australia* (Oxford University Press, Melbourne 1994), p.24.

⁴¹ J.Roe, (ed.), *Social Policy in Australia. Some Perspectives 1901-1975* (Cassell Australia 1976), p.18.

⁴² B. Dickey, *No Charity There. A Short History of Social Welfare in Australia* (Thomas Nelson, Melbourne 1981), p.95.

⁴³ Roe, *op. cit.*

classified as deserving also conformed to certain behaviour codes that won the approval of middle-class charity workers: an acknowledgment by the needy that their poverty was cause for shame, a willingness to go to any lengths to maintain appearances and the effusive expression of gratitude when receiving aid. By contrast, the working class poor had no such redeeming qualities. Every aspect of impoverished working class family life contradicted sacred middle class values: these people were seen to be profligate, dirty, intemperate, shameless in their poverty and the acceptance of charity in the pursuit of which they were also importunate; they were, in addition, portrayed as selfish, lazy and suffered the consequences of inferior heredity. In short, they were responsible for their own plights and lacked the virtues of respectability necessary to earn the "deserving" label.

Even to charity workers, however, it was obvious that the least deserving were the most needy. Such a dilemma was resolved by doling out aid in a punitive manner, to people whose plight was caused by their unwillingness to practice the virtues of thrift and industry. For example, in any assessment of an applicant's need for relief, a cross-examination - an investigation of moral or immoral qualities - was required, a process that aroused hostility and provoked criticism but not sufficient to counteract prevailing ideologies.⁴⁴

Most of these attitudes were prevalent in the pronouncements of Repatriation Department bureaucrats and doctors. It is clear that despite the spreading acceptance of universalism (non-discriminatory social welfare) and state provision of welfare in the early twentieth century (by, for example, the introduction of Old Age and Invalid Pensions), such ideas were not yet moribund. In fact, at certain levels of the Department of Repatriation they flourished and counterbalanced the new bureaucracy's stated commitment to such universalist principles as the "living wage".

The language of moral judgement reminiscent of the above attitudes makes a regular appearance in the pronouncements of many government officials and doctors associated with Australian psychological casualties of the Great War. In fact, in Repatriation Department literature, chronic sufferers of war neurosis were frequently characterised as malingerers and welfare bludgers who, because of social class, congenital deficiencies and general inclination were responsible for their own plight. Under no circumstances were these men considered representative of the AIF which, officially at least, embodied certain virtues that these men could not approach. As far as the Department was officially concerned, there were two types of returned men suffering from war neurosis: those for whom external, uncontrollable factors had been the cause, and those who were largely responsible for their own plight. These two groups could thus be seen as closely approximating the "deserving" and the

⁴⁴ G. Davison, D. Dunstan, C. McConville, (Eds.), *The Outcasts of Melbourne. Essays in Social History* (Allen and Unwin Australia 1985), pp. 92-112.

"undeserving" classes of nineteenth century morality. In the first group were men whose neurosis had developed "purely as the result of long continued battlefield service." These soldiers were considered of "good type" and had, by 1921, been mostly "cured". Such men formed a large proportion of the

shell-shock cases so frequently encountered during the closing months of the war, but most of these (and some of them whose misconduct was pitiable) have now regained civil, mental, and physical balance, and are repatriated. ⁴⁵

These were the men - "only a small minority" - with the intelligence, "determination . . . courage, and the depth of . . . desire to get better . . ." ⁴⁶ To this group - the least troublesome, since its members were most likely to help themselves - went all the sympathy the Department was able to muster. These men ("often . . . the very best of our soldiers") suffered from anxiety neurosis caused by external agents on the battlefield, the strain of re-adapting to civilian life, or the absence of "military discipline with its attendant appeal to the *esprit de corps* 'to stick it.'" ⁴⁷

By contrast, the maladies of the second group - those with chronic illnesses - were attributed to their inherent weaknesses and to the stimulus of pensions and other kinds of benefits. Laziness, congenital deficiency, immorality, inferior social class, lack of intelligence, poor education and "excessive sympathy on the part of Local Committees, members of social organisations etc" were deemed the prime causes of the troubles of a group of "chronic types" who would always be a burden on the community. "This comparatively hopeless outlook is due to the small natural powers of adjustment which many of these men have always had, and from such a state of mind it is difficult to raise any one," intoned the 1922 Annual Report. ⁴⁸ Some men were "of the so-called epileptic make-up, indicated chiefly by repeated changes of occupation and place of abode and the absence of fixed rules of life - the whole of their pre-war life showing lack of mental stability". ⁴⁹ The vicissitudes of military life were not to blame; these were "but the occasion and not the cause, of the disability manifesting itself." The final breakdown was usually precipitated by pre-existing domestic troubles "which were probably very largely the fault of the man himself" and from which he had tried to escape when he enlisted. ⁵⁰ Of a sample group of 70 patients, those with a hopeless future were described as "wasters . . . labourers, jockeys, shunters etc. . . . men of

⁴⁵ Department of Repatriation, Annual Report, 1922, pp. 35-37.

⁴⁶ Ibid, p. 36.

⁴⁷ Ibid, 1921, p.19.

⁴⁸ Ibid, 1922, p. 35.

⁴⁹ Ibid.

⁵⁰ Ibid.

poor education and intelligence" ⁵¹ who would be "either always unemployed or at best casually employed in much the same way as though there had been no war." ⁵²

For the Repatriation Department, then, explanations of war neurosis were firmly linked to questions of character. The cases that were not quickly resolved would "always be unreliable, unstable or inefficient in some way" and would always have to be "carried by the community." Lacking the self-reliance of the "good types" who had been cured soon after the war's end, these men were "not specially likely to be cured without considerable expenditure of other people's energy." ⁵³

In Repatriation Department literature, psychological casualties like those described above were deliberately excluded from the heroic interpretation of the AIF's experience. Depicted as a selfish group whose behaviour ran counter to the national interest, their attitudes to illness and pensioning were not considered representative of the AIF which had consisted of "the highest type of Australian manhood of its generation, both in its spirit of adventure and in its loyalty and devotion to a national cause." ⁵⁴ In general, the individuals who had comprised the first AIF were said to have continued their commitment to the country by returning inconspicuously to their former occupations to play a "worthy part in the industrial, social and political life of the people." ⁵⁵ A small minority, however, had been "relieved in some degree of self-reliance by a generous system of pensions" and were thus happy to contribute nothing to the well-being of the nation. Such selfishness, the report warned, should be borne in mind when planning for a national health service "lest the less industrious and less loyal should so use it to their advantage that they should in part become a burden upon their more conscientious fellow workers." ⁵⁶ It seemed as though the Department was trying every means possible to distance these men from the idealised version of the AIF including parlaying their disabilities into contemptible civilian ones:

An interesting feature of institutional experience throughout the Commonwealth is that the disabilities suffered by these men who served their country in battle areas do not differ in their nature at this period from those encountered in civilian general hospitals. Further, it can be said in general that the mental attitude towards their disabilities of the men who were temporarily withdrawn from the civilian population is now that of the civilian. ⁵⁷

It was these men, together with other categories such as "lazy" tuberculosis patients (as opposed to "plucky" T.B.s"), ⁵⁸ who needed "saving from themselves" ⁵⁹ preferably

⁵¹ Department of Repatriation, Annual Report, 1922, p.36.

⁵² Ibid.

⁵³ Department of Repatriation, Annual Report, 1922, op. cit., p.35.

⁵⁴ Ibid, 1925, p.11.

⁵⁵ Ibid.

⁵⁶ Ibid, pp. 11-12.

⁵⁷ Ibid. p.11.

⁵⁸ Department of Repatriation, Annual Report, 1923, p.12.

⁵⁹ Department of Repatriation, Annual Report, 1924, p.6.

by the denial of a substantial pension, an item considered "a hindrance to a satisfactory re-establishment in civil life inasmuch as, for the type of man concerned, the stimulus of the necessity for earning has been removed." ⁶⁰

The Department's tendency to evaluate returned soldiers according to moral criteria is well illustrated by the example of so-called "problem-cases" which included a number of shell shock sufferers. This category was broadly divided into those who helped themselves and those who did not. Problem cases were men on the border of being totally and permanently incapacitated (ie. "'incapacitated for life to such an extent as to be precluded from earning other than a negligible percentage of a living wage.") ⁶¹ but whom the Department was reluctant to classify as such because of the harmful effect it might have on their morale, their willingness to work - and, presumably, on the Department's budget. It was felt that special provisions would have to be made for these men as the normal procedures and benefits would be insufficient. Problem cases, along with their wives (who were considered an important factor in the rehabilitation of their husbands) were encouraged to discuss their individual difficulties with the Deputy Commissioner and the Departmental Medical Officer who would then assess his "character and his industrial possibilities" then recommend suitable employment to the Commission who would be the final arbiter. The most troublesome of the problem cases were the arm amputees, those with head injuries, men "mentally subnormal" and the neurasthenic cases. Of these, the greatest difficulty was allegedly experienced with uneducated men who did not have the capacity to adjust to altered circumstances and the men without the will to overcome their handicap. The "more he is pandered to the more he will degenerate," declared the 1924 Annual Report. "Fortunately this type is not numerous, and as a cheerful offset, there are the men who, though seriously handicapped . . . possess a determination to succeed . . . they are most grateful for the kindly interest maintained in them . . ." In addition to their severe disabilities, the seven successful cases cited in the 1924 Annual Report possessed, either humour, "a nice sensible woman who made a good wife", anxiousness to learn, or "initiative and tenacity of purpose." These were the men who were said to show the same spirit in trying to overcome their handicap

as they showed in their service for the Empire. They are men who were not afraid to face the full risks of war service, and now are not afraid to face the responsibilities of civil life, even with the grave handicap of grievous war injuries. ⁶²

By contrast, the "failures" were depicted as either disingenuous, as in the case of the man who pleaded war neurosis but who was seen behaving normally in the

⁶⁰ Department of Repatriation, Annual Report, 1924, p.7.

⁶¹ Ibid, p.5.

⁶² Ibid, p. 11.

street. They were also characterised as apathetic, or unlucky, as exemplified by the returned soldier compromised by a wife who embezzled the profits of their business. These were the men without the necessary resolve, ambition and willpower, the men who were "content to drift on and eke out a precarious existence with the aid of their pension."⁶³ Thus were many former members of the AIF excluded from the official interpretation of Australia's role in the Great War.

The attitudes expressed in these Annual Reports were intended for the eyes of the Commission's political masters and for the public so it would be errant to presume that this mode of thought led automatically to action. However, the minutes of the Medical Advisory Committee show that private and public opinion within the Repatriation Department about war neurosis were not necessarily divergent. In fact, in 1924, the moral view of war neurosis was employed as a basis for Medical Advisory Committee policy largely, it seems, in response to frustration. As the years wore on and the problem of war neurosis did not diminish, the Committee came to regard the phenomenon with deepening suspicion. At its thirteenth meeting on 24 April 1924, psychological disabilities were placed at the top of the agenda after the Chairman of the Commission, James Semmens, had asked for the Committee's opinion "as to the disposal of several patients suffering chronic nervous disabilities of a functional nature."⁶⁴ The Committee decided that in the best interests of the men concerned it was necessary to exercise a little economic stringency:

It was desired to do what was best for the welfare of these men but it seemed that what was sound medical treatment for the condition might be considered somewhat harsh economically . . . for the patient. The granting of total pension for this type of disability could be regarded in many cases as a factor retarding the patients [sic] co-operation in his treatment and even adversely affecting his wish to be well.⁶⁵

The Principal Departmental Medical Officer (PDMO), C.A. Courtney, felt that the very means employed to ameliorate the disabilities of these men was often responsible for prolonging their suffering: the very generosity of the Department encouraged some men to exaggerate or falsify their illnesses in order to keep or maintain a pension. The majority of functional cases had been repatriated, he said, and it was only the frauds and those bordering on lunacy that remained. In order to formulate policy on the pensioning and medical treatment of chronic war neurosis, the PDMO submitted six cases "as types".⁶⁶ All were considered refractory and responsible for their own positions. They occupied the Committee's attention for at least two more meetings. Trooper A.F. Marvin of the 10th Light Horse persistently refused

⁶³ Department of Repatriation, Annual Report, 1924, pp. 10-11.

⁶⁴ Minutes of the Medical Advisory Committee, 24 April 1924. Department of Veterans Affairs Library, Central Office, Canberra.

⁶⁵ Ibid.

⁶⁶ Ibid

treatment.⁶⁷ Private N. Morrow discharged himself from hospital in 1918 and only sought treatment - and then from a private practitioner - in 1923.⁶⁸ Private Houston of the Australian Army Medical Corps had displayed "moral turpitude" early in his military service. After six weeks he was discharged due to "fainting fits", then re-enlisted under a false name and lied about his previous service. Overseas he made various false claims about illnesses and was "on one occasion detected in self-mutilation and imputing the result to a fall whilst in a fit." In England and Australia he "imposed on several people . . . and borrowed money by misrepresentation."⁶⁹ Private E. Ryan of the 16th Battalion was guilty of "gross malingering . . . inasmuch as Dr. Bassett, Assistant Medical Officer, Western Australia, reported that he had seen him on more than one occasion engaging in work which he had claimed he was unable to do." This accusation was supported by a letter from a private citizen and also by a Dr. Joel who refused to pass him fit for enlistment because, he alleged, Ryan had "malingered in hospital prior to the war."

On the basis of these unfavourable character sketches, the Committee felt justified in stating that the allure of a Second Schedule pension or Living Allowance caused such men to prolong their disabilities and reduce their willingness to co-operate in treatment. In its summing up, the Committee revealed an understanding of war neurosis which suggested that some of the old prejudices against mental disorder in soldiers had not disappeared and that the idea of long-delayed reaction to trauma, acceptance of which in future decades proved vital in understanding war neurosis, did not seem to be current:

The general feeling of the Committee was that these functional cases are not now military but, civil cases. The fear and stress of war which caused the upset, have now disappeared, and other factors have taken their place. Unless there is an organic disability, coupled with the functional disability, the pensions should at no time be under Second Schedule for total and permanent incapacity, because the condition may clear up spontaneously even after long duration. The practical utility of a long continuance of treatment by psycho-analysis was considered to be very doubtful.⁷⁰

The tendency to apply a moral frame of reference to Repatriation problems - to blame the victim - was very obvious in the case of alcoholism which included amongst its victims many sufferers of war neurosis who had turned to drink to alleviate their torment. Almost since the beginning of the war, alcoholism had tested the resources of the Red Cross, the State War Councils and the Australian Soldiers' Repatriation Fund. In the military hospitals, where drunkenness created difficulties for staff,⁷¹ alcoholics,

⁶⁷ Minutes of the Medical Advisory Committee, 24 April 1924.

⁶⁸ Ibid, 6 May 1924.

⁶⁹ Ibid, 13 May 1924.

⁷⁰ Ibid, p.3.

⁷¹ B. Ford, *The Wounded Warrior and Rehabilitation Including the History of No. 11 Army General Hospital Caulfield Rehabilitation Hospital* (Amphion Press 1991), pp.56-57.

who were usually suffering in some additional way, were not treated with a great deal of compassion or expertise. In 1918, while searching for a solution to the problem of soldiers who had acquired this habit "under the influence of the hardships and excitement of active service, and also from the mistaken kindness of injudicious friends and admirers", ⁷² Nicholas Lockyer was told:

[N]o special provision was made by the Military Authorities for the treatment of soldiers who were addicted to the drink habit to the extent that their treatment in special homes or hospitals would be desirable . . . The men were generally such nuisances as the result of their drinking that the Hospital Authorities usually discharged them the moment their wounds were healed or they became convalescent. The disastrous effects of such a policy on the men will be quite obvious. ⁷³

Under the Department of Repatriation, men like these were differentiated according to criteria which contained a strong moral component. For the purposes of supplying financial and medical aid, the Department made the distinction between the "alcoholic", who had acquired his dependence as a result of war service, and the "inebriate", who had become addicted before the war, was "constitutionally diseased" and tended "towards mental and moral degeneracy, with loss of self-control." Alcoholics were given the opportunity to regain their health in a Repatriation Department institution where work was the chief therapy. Only one chance was given - the Department would not take responsibility for recidivists. Inebriates would be treated only in State institutions under State Acts of Parliament which enabled voluntary or compulsory admission. The Department would make sustenance payments for a period of no longer than twelve months after which "no further responsibility would be recognised." ⁷⁴ Further, the Department would accept no responsibility for inebriates who sought treatment twelve months after discharge from the AIF except, perhaps, in cases in which war service was deemed to be the cause of the alcohol abuse. ⁷⁵

The tendency to classify into moral categories - present in assessments of particular kinds of military invalids by repatriation authorities - resonates throughout official discussions on soldier alcoholics. Ernest Jones, who poured a great deal of his energy into aiding returned soldiers, told the Department of Repatriation in 1919: "I might say that patients we have received belong to a curiously irresponsible and difficult class, lacking in discipline and apparently with very little intention of remaining sober." He believed that only "unsound" men became helpless alcoholics as a result of their war service: "[I]t is almost inconceivable that any sound individual will have been

⁷² Lockyer to Major C.J. Cunningham, State War Council, Victoria, 2 April 1918, in AA A2487/1, Item 21/19415.

⁷³ J.E. Barrett, Deputy Comptroller Department of Repatriation, South Australia, to Lockyer, 18 April 1918, in *ibid.*

⁷⁴ Civil Re-Establishment, *op.cit.*, p.19.

⁷⁵ W.M. Ryan, Deputy Commissioner of Repatriation, to Secretary, Department of Repatriation, 28 June 1922, in AA (Canberra) A2487/1 Item 21/13264.

so affected by his war experience as to become an incurable or rather involuntary inebriate." Consistent with the strong paternalistic streak that pervaded his comments on these matters, however, Jones recommended that the Government be responsible for these men for periods of one to three years.⁷⁶ By contrast, a Departmental Medical Officer made the difference between the deserving, who were few, and the undeserving - who were legion - very clear in an astoundingly callous and revealing analogy :

For men whose alcoholism is a War service disability, and there are such, great consideration can be shown, but to most of these patients alcoholism was an old complaint, and actually saved them from service. The sociological conditions of war made it easy for them to indulge in alcoholism in a safe, easy and irresponsible manner, just as it made it easy for illegitimate motherhood, but no one regards the latter as due to or aggravated by service in War, nor does the disability earn any medical or financial help for the mother from the community as a right. A patient on going to Lara and again on my visits there is clearly told that there is only the one chance given him. . . The history of men needing a second chance will almost invariably be found such as not to justify any Departmental funds being spent on him . . . The 'R' [Repatriation] files of such men are I think good guides as to the worthiness of a first or second chance for each man, and in my experience the worthy man very seldom needs a second chance.⁷⁷

Finally, the moral dimension of the Department's assessment procedure was made explicit in a form sent to the employers of men applying for benefits. Amongst several routine questions about the returned serviceman's behaviour and attitudes was "habits and sobriety during employment" to which one employer, in the case of a psychological casualty, replied typically: "He again worked for me about two years after he returned from the war but was broken in health although he was not a shirker. Although he was not a teetotaler, was [sic] of sober, straightforward disposition."⁷⁸

The Department of Repatriation's suspicion of war neurosis was further reflected in the philosophy underpinning its Convalescent Farms. Official Departmental reports stated that malingerers would soon be discovered while under close observation in the relatively confined area of such a property. These documents also leave no doubt that Convalescent Farms were intended as a means of returning men to economic utility. By and large, these sentiments were reflected in the practical arrangements made for war neurosis patients on Convalescent Farms which were fully-operational grazing and agricultural properties of several hundred acres purchased by or leased to the Department of Repatriation. In New South Wales there were two such farms, one at Picton and the other at Exeter; both were owned and run by the Red Cross but the Department payed the cost of maintenance. In Victoria, the Convalescent Farm "Bundoora", north of Melbourne, was owned outright by the Department. "Broadwater" in Queensland, however, was leased from its owner A.J. Cummings, the

⁷⁶ W.E. Jones to Repatriation, 26 March 1919, in A2487/1, 21/13264.

⁷⁷ Anonymous to Repatriation, 21 December 1921, in AA (Canberra) A A2487/1, 21/13264.

⁷⁸ Report from employer to Repatriation, 28 April 1927, in Private I. Callaghan, 15th Battalion, PCF.

Queensland Government printer,⁷⁹ while the Western Australian Convalescent Farm, "Kalamunda", had been purchased by the Red Cross Society and leased to the Department.⁸⁰ In charge of each farm was a Departmental Medical Officer who visited regularly and prescribed the work which was supervised by an overseer - usually a returned serviceman with experience in farming and physiotherapy.⁸¹

Convalescent Farms were intended as "moral and physical energiser[s]" free from city influences.⁸² Here, shell shock cases and sufferers of the psychosomatic ailment "Disordered Action of the Heart", alcoholics, epileptics and other convalescents described as "mentally deficient either from congenital reasons or through war experience"⁸³ and unable to "settle down to employment",⁸⁴ could recover their ability to be useful citizens in an "atmosphere of work" by means of treatment "more psychological and physical than medical". This comprised "congenial occupation graduated according to their condition." In addition to its role as a mental distraction and restorer of physical health,⁸⁵ labour was to be a means of testing doubtful cases such as tuberculosis, and exposing "character deficiencies"⁸⁶ in deliberate malingerers as well as those unconsciously deceiving themselves and others. As the 1922 Departmental Annual Report delicately put it, Convalescent Farms were "availed of as the observation grounds for men whose claim for pensions for incapacity needed confirmation, and in such cases these farms have been invaluable for clinching diagnosis."⁸⁷ Suspicion and mistrust thus pervaded Repatriation Department thinking about those claiming to be psychological casualties. One report stated that associating cases of war neurosis together on Convalescent Farms was dangerous as "new tricks are learnt, and thus they constantly show new signs."⁸⁸

The Psychological Casualty as Public Nuisance

Convalescent Farms were also intended as a partial solution to the problem of idle returned servicemen seen by authorities as likely to constitute a threat to civil order. Included in this class were sufferers of war neurosis, a group considered particularly susceptible to city vice, especially alcohol. Depiction of the mentally affected soldier as

⁷⁹ *Repatriation*, 27 October 1920, pp.14-15

⁸⁰ Department of Repatriation, Annual Report, 1922, p.31.

⁸¹ *Repatriation*, 26 July 1920, p.12.

⁸² Department of Repatriation, Annual Report, 1922, p.30.

⁸³ "Convalescent Farms", pp 1-2. AA A2421 T1 G1600 Pt.1.

⁸⁴ *Repatriation*, 26 July 1920, p.12.

⁸⁵ Department of Repatriation, Annual Report, 1922, p. 30.

⁸⁶ "Convalescent Farms", op.cit., p.3.

⁸⁷ Department of Repatriation, Annual Report, op.cit..

⁸⁸ Department of Repatriation, Annual Report, 1922, p.36.

both victim and creator of civil disorder and immorality thus signalled a major shift in appreciation: from the defenceless invalid for whom the best was not good enough, ⁸⁹ a certain type of psychological casualty had become something of a bogey displaying the less desirable proclivities of the "lower orders".

Existing in government circles from at least 1916 was a concern about the possible threat to civil order posed by returned servicemen in the cities. Federal and State Governments alike were perturbed by the prospect of "cities congealed with idle men" and the "dangerous interregnum between the cessation of their martial duties and the assumption of their civil ones."⁹⁰ In 1917 Senator Edward Millen, Minister of Repatriation, urged that returning soldiers be dispersed as widely as possible to prevent the development of a troublesome "class consciousness" inimical to the individual and the community. ⁹¹

Psychological casualties were included as part of this threat. Professor W.A. Osborne, Professor of Physiology at Melbourne University, expressed some of these fears to the Department of Defence:

The sight of these men and their behaviour at times shocks the senses of the people and does much harm in our endeavours to obtain recruits, firstly by the sight of these men and the knowledge of their actions and secondly by those who wish to discredit military service by holding these men up as an example of what to expect and how the Department treats them. One case I have in mind is that of a shell shocked and discharged soldier who I was informed got into the hands of a female harpy and this creature apparently for monetary gain was inducing the man to cohabit with her on a beach and his endeavours were revolting. ⁹²

Amongst the many forms that this danger to the peace of the cities took in the minds of authorities was the drink-sodden, demobilised soldier, one of several fears that prompted a 1918 Senate inquiry into alcohol abuse amongst servicemen. ⁹³ Circulating in the Returned Soldiers and Sailors Imperial League of Australia, the Department of Defence and the Department of Repatriation was the notion that the dubious attractions of the city were exercising an adverse effect on many returned

⁸⁹ This favourable depiction was especially noticeable during the debate in the Victorian Parliament on the War Mental Treatment Act of 1915. Victorian Parliamentary Debates, Session 1915, Volume 140, pp. 1809-1821.

⁹⁰ C. Lloyd and J. Rees, *The Last Shilling. A History of Repatriation in Australia* (Melbourne University Press 1994), pp.48-49, 64.

⁹¹ *Ibid.*, p.77.

⁹² W.A. Osborne, "Shell Shock and War Strain", p. 1. AWM 27, 376/216.

⁹³ This inquiry's terms of reference and the many questions put by the Select Committee to a multitude of witnesses in several Australian cities reveal that, like some other areas of repatriation activity, it was more concerned with the broad military and social ramifications of alcoholism amongst soldiers than with individual distress. The threat that alcohol abuse posed to orderly demobilisation and repatriation, the effect of drink on the efficient functioning of the AIF, the role of alcohol in the contraction of venereal disease and the disruptive presence of drunken soldiers on city streets were all perceived as major problems to which the proposed answers were the restriction of the sale of liquor, the denial of drink to invalids - in particular to psychological casualties who were seen as particularly susceptible to alcohol abuse - and the introduction of anti-shouting laws. "Progress Report from the Senate Select Committee on Intoxicating Liquor - Effect on Australian Soldiers and Best Method of Dealing With Sale; Together With Minutes of Evidence up to 27th March 1918." Commonwealth Parliamentary Papers 1917-1919, Volume 1, pp. 459-865.

servicemen - especially those "deficient in moral character". The solution, according to the RSSILA, was a home in the country to which those most vulnerable to enticement would be sent until "restored to a normal state in body and mind." ⁹⁴ This suggestion was made in November 1917 to Nicholas Lockyer by Senator W.K. Bolton, President of the RSSILA, who wrote: "Any day, in certain quarters of the cities, returned men in uniform can be seen under the influence of drink, in the most vicious quarters". ⁹⁵ Lockyer told Bolton that both he, Lockyer, and Senator Millen shared his view that the situation was serious and destroying "many men of usual good conduct and sobriety. The evil is very real and it is to be hoped some means may be found to counteract . . . this wastage even if it cannot be altogether controlled." ⁹⁶

Amongst those considered most at risk were psychological casualties because they were believed to be particularly vulnerable to the effects of alcohol, as several witness before the Senate Committee on Intoxicating Liquor remarked. Captain C.R.W. Brewis, a Royal Naval Transport Officer, said that the most noticeable effects of alcohol were on "men suffering from shell-shock and other nerve trouble. In such cases very little drink produced a marked effect on the individual." ⁹⁷ This idea was particularly worrying because, in the opinion of one Inquiry witness, the majority of returning men were "not in their ordinary frame of mind." ⁹⁸ It followed, therefore, that psychological casualties, in their susceptibility to alcohol abuse, were one of the more serious ex- military threats to the orderly life of cities.

Thus, war neurosis was recognised as a major problem by Repatriation Department officials who responded with a multi-faceted frame of reference which included a victim-blaming official attitude as well as a more compassionate approach. This response also incorporated a belief that the debilitating effects of war neurosis would compromise national prosperity and civil order. The tendency to apply moral criteria in the assessment of returned servicemen sometimes resulted in the damaging oversimplification of complicated cases that required for their successful resolution the deft hand of enlightened science, not the heavy club of nineteenth century morality. On the one hand was the position exemplified by Nicholas Lockyer, a model of compassion who sagely anticipated the likely prejudice against such men. His fears were quickly confirmed when the Department of Repatriation readily displayed

⁹⁴ Lockyer to Bolton, 16 November 1917, in Repatriation Commission Correspondence 1-1000A, op. cit..

⁹⁵ In *ibid.*

⁹⁶ "Hostels for Permanently Disabled Soldiers and for Convalescents", Lockyer to Millen, 19 January 1918, in *ibid.*

⁹⁷ Senate Inquiry, op. cit., p. 477. See also, for example, the evidence of Sergeant A.J. Sims, Victoria Police, Port Melbourne, p. 482; and G. Cuscaden, Principal Medical Officer, Department of Defence, p.865

⁹⁸ Evidence of Dr. Frederick Dougan, Consulting Surgeon with the reserve forces, in *ibid.*, p.459.

judgemental attitudes highly reminiscent of those towards recipients of charity which placed the onus on the victim, not on the environment. Perhaps this was to be expected in a materialistic society that championed self-reliance. On the other hand, for the Department of Repatriation, a clear moral division existed within the larger group of war neurosis sufferers: those whose disorders were the result of service and battlefield conditions, and those who were the sole architects of their own plights. It was the starkest of moral dichotomies: the separation of psychological casualties into simple good and bad with no middle ground.

For the Department of Repatriation (and probably the government) this characterisation was a way of promoting a particular image of the AIF and excluding unwanted elements from the preferred version of events. It was also a way of explaining chronic psychological illness amongst returned servicemen, of rationalising a problem that they could not solve. In addition, it was a means of excluding men from benefits. Sufferers were thus portrayed as parasitical and disloyal - inefficient men of inferior stock and dubious moral values who were to be banished to the margins of the AIF experience and society, there to wallow with other outcasts and deviants. Their service, it seems, counted for nothing. By contrast, grace was extended to the "good types" who were thus incorporated into the nation-building version of AIF history. The extent to which the parallel existence of the above attitudes influenced the treatment of psychological casualties by the Department of Repatriation will be the subject of the next chapter.

Chapter Six

The Department of Repatriation and the Treatment of Psychological Casualties.

The Department of Repatriation offered returned soldiers a comprehensive variety of services and benefits. As seen in chapter four, it aimed to compensate men for their sacrifice and to re-establish them in civil life. In comparison to other forms of social welfare, the Department's scheme is considered generous by several commentators.¹ Also described in the previous chapter was a highly uncomplimentary official view of certain returned servicemen suffering from war neurosis and a frame of reference that transcended the simply therapeutic and incorporated moral, economic and national elements as well. Thus, many pertinent questions relevant to the treatment of psychological casualties in this system emerge. How were such men managed within this system? To what extent did the moral and economic frame of reference seen in the last chapter affect their treatment? How influential in the handling of shell shock victims was the compassionate attitude displayed by some Repatriation officials? How well were their needs met by the financial benefits, re-instatement schemes and medical treatment? Does the evidence support the Department's derogatory depiction of psychological casualties?

Generalisations made by the Department of Repatriation about high rates of recovery were inaccurate, and the damning characterisation of chronically ill psychological casualties highly misleading. None of the Department's provisions for returned servicemen in general - and for war neurosis sufferers in particular - met the needs of this group. Hampered by the consolidation of disorders in the military evacuation systems overseas, Repatriation Department medicine lacked the scientific means to affect recoveries in men burdened by psychological illness. Exacerbating this unfortunate inheritance was the moral and economic frame of reference that typified official policy and the approach of some Repatriation Department doctors. Under this ideology men were often, for example, dismissed as malingerers and refused pensions. This approach contrasts strongly with the attitudes of more sympathetic officials and progressive medical officers who adopted a far less judgemental view. Despite a more enlightened attitude, they too struggled to provide lasting relief for sufferers of war neurosis. Thus, throughout the period under study, these opposing views of war neurosis were very much in evidence and conditioned not only Departmental pronouncements on war neurosis but action on that issue as well.

¹ B. Dickey, *No Charity There. A Short History of Social Welfare In Australia* (Thomas Nelson, Melbourne 1981), pp. 143-144, and M.A. Jones, *The Australian Welfare State. Growth Crisis and Change* (Allen and Unwin 1979), p.29.

The failure of Repatriation medicine to cope with war neurosis affected every other aspect of the Department's attempts to restore these men to health and civic utility; they were simply too unwell to exploit any of the opportunities offered by employment schemes such as vocational training and soldier settlement. Thus, the fears of Nicholas Lockyer - that his schemes would founder on this shoal - were fully realised. So it is clear that the reasons for the continued illness of many psychological casualties did not lie necessarily within the victims' control, or with their social and genetic origins. Their horrendous front line experiences and the inability of medical systems and rehabilitative programmes to deal with its consequences must be held accountable.

Before examining these issues in detail it must be stated that little evidence of recovery from war neurosis amongst Australian soldiers has been found and that records - especially Repatriation Department medical evidence - deal only with the much maligned chronic class. Of course, the possibility exists that the records of those who recovered rapidly and who required little or no treatment are not extant or are scarce, thus making the Department's claim difficult to test fully by evidential means. Being left with the records of the chronically ill does, however, allow the Department's disparaging and damaging depiction of this group (which statistical evidence suggests was probably much larger and more representative of the AIF than the Department was prepared to admit) to be carefully examined. As dictated by the evidence, it is largely about that group of returned soldiers and their experiences that the above questions are asked.

Medical Treatment

Statistical and qualitative evidence suggests very strongly that the medical outlook for sufferers of war neurosis was poor, that the chances of recovery were slight and that Repatriation medicine was powerless to affect the course of psychological disorder. It is clear that Repatriation medicine had few answers to the problem and that some remedies, particularly the use of sedative drugs like paraldehyde, exacerbated difficulties rather than alleviated them. The evidence plainly shows the impotence of Australian psychiatric and Departmental medicine in the face of war neurosis.

Sufferers were treated by methods provided specifically for their particular disorders, as well as within the general medical framework provided by the Department of Repatriation. The general provisions for returned soldiers began with basic "bottle of medicine" treatment administered by Local Medical Officers. Care for more serious ailments was provided by Repatriation General Hospitals in each capital city - inherited from the military in June 1921 when the Australian General Hospitals were transferred from the Department of Defence. Within these institutions both in-patient and out-patient treatment was available as well as specialist attention such as the fitting of artificial legs.

Supporting these were 293 country hospitals - approximately 90 per cent of the total number in Australia. Appended to this system were the Convalescent Homes and Farms to which men would be sent for recuperation although the Farms had, as has already been noted, a coercive purpose beyond mere convalescence.

For those too ill to move from their beds, home treatment was also an option. Specialist provision for sufferers of war neurosis included the services of consultants who ran clinics in the Repatriation Hospitals and who sometimes treated men in their private surgeries. Institutions specifically for war neurosis included "Novar" and "Russell Lea" in Sydney, the Convalescent Farms, the Talbot Colony for epileptics at Clayton in Victoria, and, the State psychiatric asylums and receiving houses to which soldiers could be admitted either through the various State military mental treatment acts or certification. This was a vast medical network but for many psychological casualties it was ineffective - flawed by attitudes and therapies which often hung from a moral peg. It was also seriously handicapped by psychiatric disorders that a Royal Army Medical Corps evacuation system had only helped solidify by its apparent inability to appreciate the importance of time and the "tyranny of distance". Some shell shock victims for years ignored the Department altogether and treated themselves. Their results didn't differ a great deal from those produced by the professionals.

Medical Treatment: Statistical Evidence

Statistics contradict optimistic Departmental generalisations about the success of treatment for psychological casualties. Typical of these vague statements were the following declarations made in 1921, 1922 and 1923 respectively. "Cases occurring in physically healthy men and due primarily to war strain are usually curable, and many such cases who have been under treatment are now normal. There are a number of cases still under treatment whose outlook is hopeful." ² Another read: "Nervous diseases, mostly neuroses, have lessened as the patients have returned to work - " ³ Still another said: "These cases are markedly less in number, and those now under treatment are similar in type to those of civilian medical practice." ⁴

Statistical evidence clarifies and contradicts these assertions. Repatriation Department Annual Reports show that in the fifteen years between 1923 and 1938 (inclusive), the number of war neurosis cases ("including epileptics, neurasthenics, shell shocks, alcoholics, inebriates") ⁵ being treated at Departmental institutions rose

² Department of Repatriation, Annual Report, 1921, p.22.

³ Ibid, 1922, p.26.

⁴ Ibid, 1923, p.12.

⁵ Ibid, p.45.

appreciably: in 1923 1553 cases appeared on the records; ⁶ by 1930 there were 2820 ⁷ and by 1938 4578. ⁸ These figure did not include those classified as "mental" - the most seriously ill who were resident in asylums. Like those for neurosis, figures for these men also rose steadily over the years. In 1924, 341 returned soldiers had been admitted to Australian mental asylums ⁹ whereas by 1938 the number had risen to 824.¹⁰ Clearly, the problem was not diminishing with time and treatment.

Professional opinion supported by figures showed a poor prognosis for the most seriously ill psychological casualties. In 1927, Lunacy Department officials in each State were asked by the Repatriation Commission (because it was under pressure from returned soldier organisations to grant permanent pensions to all military mental patients) to give their opinions about the likelihood of recovery for returned soldiers. ¹¹ The replies of Lunacy Department officials to this request show that the prognosis varied according to the disorder - those with melancholia, for example, stood a better chance of recovery than those with dementia praecox (now called schizophrenia) ¹² and that the outlook in general was mixed. In South Australia, Dr. R.C. Bassett, Senior Medical Officer at No. 8 AGH, knew of three acute cases who had recovered "apparently completely": an "exhaustion psychosis" who regained mental balance quickly and without relapse when he reached Australia from Egypt, and two cases of "acute Mania" one of whom became employed in a Government Department in Perth. The other became a successful butcher. Bassett felt that the progress in "Alcoholic insanities" was favourable but that returned soldiers with manic-depressive psychoses were liable to frequent relapse. In addition, he stated that the cases of paranoia, dementia praecox, senile and organic insanity with which he had been involved had not recovered. He wrote:

A case of the first-named [paranoia], which is very well known to me denied the existence of the beliefs upon which the digenesis had been made, as soon as he reached an institution for the Insane, and was discharged in a few weeks; but I have definite information that the same delusions are still very evident to those in close contact with him socially, and up to the present he has not been able to re-establish himself in any employment. ¹³

Dr. Parkinson of the New South Wales Lunacy Department reported that for a large number of ex-soldiers discharged from the asylums, pensions had to be maintained at the full rate because "the residual disablement is severe, the chances of relapse are great, and the difficulty of finding suitable employment considerable." ¹⁴ Parkinson provided

⁶ Department of Repatriation, Annual Report, 1923, op. cit..

⁷ Ibid, 1930, p. 23.

⁸ Ibid, 1938, p.11.

⁹ Ibid, 1924, op.cit., p.48.

¹⁰ Ibid, 1938, op.cit..

¹¹ Semmens to Deputy Commissioners, all States, 9 November 1927, in AA (Canberra), A2421/T1, Item G1142.

¹² Dr. Parkinson, New South Wales, to the Secretary, Repatriation Commission, 18 November 1927, in *ibid*.

¹³ R.C Bassett to the Secretary, Repatriation Commission, 21 November 1927, in *ibid*.

¹⁴ Parkinson, op.cit..

statistical details of 50 cases taken from a general list of discharged and deceased returned soldiers. Of the 50, twenty-eight had not worked by 1927, the year of the report, but for those who had, the outlook was not as bright as the idea of being employed suggests: Parkinson revealed the personal details of twelve "outstanding cases of employability after admission to Mental Hospital" but their stories suggest a compromised future for these men despite the implied optimism of the writer. A.A. Sweet, for example, had suffered "[r]ecurrent attacks of Mania since 1917. In intervals has earned large income as a Dentist." C. Bird was "very insane in 1919-20. Then appears to have done a good deal of work before final breakdown in 1926." J. Hall, an "alcoholic case", worked "as a teacher after first attack and is not now entirely disabled." Finally, B. Malarkey had "Attacks of Mania on service, in 1923, 1925 and 1927. Has had good employment as Blacksmith and Tool sharpener in intervals." ¹⁵ The definition of employment was, in this context, extremely fluid. Figures from Mont Park further confirm the statistical unlikelihood of recovery. Of the 427 cases received up to 1927, 197 were deemed to have recovered while eighteen were said to have "improved"; forty-one died. Thirty-six were classified as not having improved, while 135 were "still in residence". ¹⁶ As if to confirm these statistics, Ernest Jones told the Deputy Commissioner in Victoria: "I do not believe that any individual who has suffered from a really severe attack of insanity has ever returned to full normal efficiency." ¹⁷

Repatriation medicine was singularly ineffective in cases of alcoholism involving war neurosis. For example, amongst the 95 soldier alcoholics treated at the Red Cross Hospital at Woolwich, Sydney, between March 1917 and September 1918, over forty were suffering from neurasthenia, shell shock and the psychosomatic malady, Disordered Action of the Heart. The claimed full recovery rate on discharge was thirty per cent of patients while forty-eight per cent were described as "improved" upon discharge; twenty-two per cent, however, were discharged "not improved" presumably of neither their alcoholism nor their neuroses. The average period of treatment was 65 days per patient. Qualifying these figures the Medical Officer at Woolwich, Dr. Ralph Noble, wrote: "It must be remembered that difficult cases are sent to Woolwich, such as would not be suitable in most other Convalescent Homes, and recovery rates do not, therefore, appear on sight to be so satisfactory." ¹⁸

Figures associated with the Queensland Convalescent Farm, "Broadwater", further suggest poor recovery rates for psychological casualties. Of 148 patients discharged from Broadwater after June 1922, only 60 were said to have "definitely improved". The remainder were described as having "improved slightly or not at all"; of these, eighteen

¹⁵ Parkinson, *op. cit.*.

¹⁶ W.E. Jones to Dr. H.E. Bird, Senior Medical Officer, Repatriation, Victorian Branch, 30 December 1927, in *ibid.*

¹⁷ *Ibid.*

¹⁸ R. Noble to N. Stephen, Australian Red Cross Society, 18 September 1918, in AA (Canberra), A2487/1, Item 21/19415.

were transferred to other Queensland institutions: "Rosemount" Repatriation Hospital, Brisbane General Hospital and Goodna Mental Hospital. Of this group, twenty-four were said to be alcoholics. When the Farm in Western Australia closed down, some of the convalescents had to be referred to the Departmental "Problems Committee" for suitable placing while others were admitted to institutions or recommended for further convalescence elsewhere.¹⁹

Even a specialist such as John Springthorpe found it difficult to produce encouraging figures. Of 396 war neurosis patients treated by him at his Mont Park Mental Asylum clinic between 1 May and 1 August 1919, 238 were discharged (whether recovered or not is unrecorded) but 158 remained, of whom thirty were "transferred". This mysterious classification probably meant that they had been committed to the asylum.²⁰

Caulfield Repatriation Hospital (RGHC) admission records show that approximately seven per cent of all out-patients and in-patients over a nine year period from 1925 to 1935 were psychological casualties. These included the following diagnoses: shell shock, neurosis, DAH, "neurosis with DAH", hysteria, neurasthenia, psychasthenia, psychoneurosis, anxiety neurosis, nervous condition, debility, nervous debility, nervous instability, mental depression, delusions, mental condition, delusional psychosis, and "fits". At no stage during this time did that proportion diminish and amongst that number were men who returned repeatedly for treatment. On average, 1700 returned servicemen per annum presented at Caulfield during the financial years mentioned, of whom an average of 100 suffered from one of the above mental disorders.²¹ Two sets of figures will clarify this situation. In the financial year 1 July 1927 to 30 June 1928, 1855 returned soldiers were admitted to Caulfield hospital with a range of injuries and illnesses of whom 149 were diagnosed with psychological disorders.²² Between 1 July 1933 and 30 June 1934, 1657 ex-servicemen were admitted to RGHC of whom 105 were psychological casualties.²³

Statistical evidence shows that the number of soldiers being admitted to Caulfield Hospital with war neurosis remained steady between 1925 and 1934, and that throughout Australia, the number of such sufferers actually rose during the 1920s and 1930s. Figures also demonstrate that the numbers of returned soldiers admitted to asylums with serious mental illness (psychosis) also rose in this period. Professional opinion supported by statistics suggests that the chances of recovery for neurotics and psychotics alike were slim. The overall picture, therefore, is of a rising population of psychologically damaged returned soldiers the prognosis for whom was poor. Qualitative evidence relating to Repatriation Department medical treatment will support, explain and give flesh to these

¹⁹ "Convalescent Farms", p.2. AA A2421 T1, G 1600 Pt.1, p. 3.

²⁰ Springthorpe to Defence, 12 November 1919 in AA (Melbourne) MP 367, 500/8/78.

²¹ Admissions to Repatriation General Hospital, Caulfield, July 1925 - July 1934. AWM 27 371.42 (3), Parts 1-8.

²² Ibid, Part 2, 1 July 1927 - 30 June 1928.

²³ Ibid, Part 8, 1 July 1933 - 30 June 1934.

statistical trends and show the inaccuracy of the Department's highly unflattering characterisation of chronically ill psychological casualties.

Local Medical Officers and self-help.

The experiences of Local Medical Officers (LMOs), who were often the first to attend cases of war neurosis, highlight the difficulties of treating psychological casualties in the bush during the 1920s and 1930s, and the disadvantages of specialist services being located only in major cities; they also elucidate further the hopeless plights of many returned soldiers. Finally, the general sympathy shown by LMOs to sufferers of war neurosis accentuates the frequent aloofness of the upper bureaucracy and further emphasises its remoteness from the daily circumstances of many veterans.

Local Medical Officers were usually general practitioners resident in city suburbs or country towns who had to apply to, and be nominated by the relevant Local Committee which then submitted the application to the Commission for final sanctioning.²⁴ Preference was given to returned officers of the Australian Army Medical Corps such that civilians were required to resign their posts as LMOs if a returned medical officer became available.²⁵ Local Medical Officers were required not only to provide medical treatment for returned soldiers²⁶ but to examine applicants for pensions as well; in addition they were empowered to perform operations, call in non-Repatriation doctors to assist if necessary and to recommend trips to metropolitan hospitals. They were payed according to scales formulated by the British Medical Association and the Department.²⁷ The practice was to appoint more than one Local Medical Officer per Local Committee as long as they lived in separate towns; in Victoria, for example, 178 country LMOs served the 114 Local Committees.²⁸

LMOs were often faced with emergencies involving sufferers of war neurosis who were so ill that they had to be detained in the surgery until a private car could be found to take them to Melbourne, who were so afraid of their own violent impulses that they asked to be immediately admitted to an institution, or who had just emerged from the bush, suicidal, after years of solitary living. In ministering to these men some LMOs were prepared to represent their soldier patients as favourably as possible to the grandees of the

²⁴ "Local Medical Officer and War Pensions Referee - Submission by Deputy Commissioner, New South Wales", 22 April 1921, in AA (Canberra) A2487/1, 21/18419.

²⁵ The Secretary, Local Repatriation Committee, Wauchope, to the Deputy Commissioner, New South Wales, 9 April 1921, in *ibid.*

²⁶ *Repatriation*, 25 April 1919, p.10.

²⁷ Department of Repatriation, Annual Report 1919, *op. cit.*, p.10, and *op.cit.*, 1920, p.19.

²⁸ Department of Repatriation, Annual Report, *op. cit.*, 1919, p.9.

Department of Repatriation in a way that was often lacking at the remote upper levels of that bureaucracy.

Representative of that kind of LMO was Dr. E.S. Charles of Belgrave. He treated many shell shocked returned soldiers including Captain Harold Walters after the neurasthenic, alcoholic former fighter pilot had moved from Benalla and Kangaroo Ground to the Dandenong Ranges east of Melbourne. Demonstrating some knowledge of psychology, Charles told the Department:

He [Walters] is a typical case of psycho neurosis of the 'fear' or 'dread' type. I would earnestly suggest that . . . he should receive psycho-analytical treatment . . . from a specialist . . . He is genuinely anxious to get well and while under my care has rarely touched alcohol.²⁹

Rather optimistically, Charles felt that Walters would be permanently cured.³⁰ Later, however, the Belgrave doctor modified his opinion but still retained a sympathetic attitude. A memo in Walters' file reads: "Dr. Charles considers he [Walters] is a genuine shell shock case and that when he gets these turns has to resort to alcohol."³¹ Although some LMOs knew the terminology of psychiatry and recognised certain syndromes, it seems that, like many other Departmental Medical Officers, they used sedatives rather than psychotherapy to treat returned soldiers suffering from war neurosis. Dr. Charles, for example, said that Harold Walters "improved considerably" on sedatives.³² For one frustrated doctor, store-bought remedies were the last resort. Former private Edwin Dale, whose nerves finally went "to pieces" in 1923 after a terrible time on Gallipoli, recalled: "I remember Dr. Green saying that he could do no more for me and advised me to take tonics . . . I bought tonics and patent medicines from various chemists and storekeepers every year."³³ Sometimes, however, LMOs had to admit total defeat - often after long periods - and send their patients to a major city. Of former Private James Bradley, Dr. Anthony of Kyneton wrote: "The patient appears a bad neurasthenic and admit that I am doing him little good of any permanent nature with tonics and sedatives. Would suggest referring to Repat. Melb for psychotherapy - possibly hypnotic suggestion."³⁴

Occasionally, for no good reason, the Department could be particularly inflexible with those at the local level. Sometimes a shell shocked returned serviceman wished to change from one LMO to another but found Departmental Officials adhering unwaveringly to the regulations as they blocked the request. Edward Norman wanted to attend a medical officer two-and-a-half miles from his Avoca home as the usual LMO was a highly inconvenient nine miles distant. He told the Deputy Commissioner in Melbourne:

²⁹ Report, Charles to Repatriation, 8 May 1931, in Walters PCF, op. cit..

³⁰ Ibid.

³¹ Memo, 7 October 1931, in Walters, op. cit.

³² Report, Charles, op.cit..

³³ Form U, 4 October 1929, in Private E. Dale, 4th Light Horse, PCF.

³⁴ Dr. Anthony, LMO Kyneton, in Memo for Hospital File 27 April 1938, in Private. J.R. Bradley, 7th Battalion., PCF.

[S]ometimes when I get a return of shell shock I cannot travel as my nerves seem to suffer from the travelling." ³⁵ Permission to switch LMOs was refused. ³⁶ After he had moved to Ferntree Gully from Upwey, Private Charles Lapin wished to remain with Dr. Charles of Belgrave despite leaving his designated region. Dr. Charles protested to the Deputy Commissioner that a returned soldier should be able to choose his own LMO but was told curtly that the Department's policy on this matter was "definitely fixed" and that Lapin's wish would not be granted. ³⁷

Local Medical Officers were often the first point of contact for returned soldiers seeking aid from the Department of Repatriation. Despite their general sympathy towards sufferers of war neurosis and their willingness to champion the ex-servicemen with whom they had regular personal contact, they seemed to have been just as unsuccessful in treating men with these highly problematical disorders as doctors at the highest levels of the Department.

Many men for a long time chose to treat their own neuroses or ignored them altogether until their deteriorating conditions drove them to seek Departmental aid. They delayed their approach to the Department for a variety of genuine reasons that mock the derisive characterisation purveyed in official publications. These portrayals often placed grave doubt on the veracity of returned soldiers who made delayed pension claims or sought treatment months or years after the war, particularly during the Depression. For example, the Department's Annual Report for 1931 stated: "Unemployment, with its consequences, compels search for relief, and this search by ex-soldiers, very understandably, if not appropriately, commences with the Repatriation Department." ³⁸

Individual cases show that there were exceptions to this generalisation. Trooper Joseph Fry was blown up and buried on Gallipoli in November 1915 and later suffered heavy concussion after a large calibre shell hit his pill-box at Broodseinde. In April 1918 he was gassed while holding the line during the great German offensive. His stomach and nerves were seriously affected by these experiences and, although he had received out-patient treatment at a base hospital after the war, he also relied on remedies purchased from a storekeeper near his home in Skipton, western Victoria.³⁹ Corporal H.W. Jackson of the 14th Field Artillery Brigade was buried three times in October 1917 and eventually discharged with a psychosomatic stomach complaint. ⁴⁰ "I did not treat my stomach condition seriously as I was under the impression it would improve," he told the Repatriation Department in 1933. ⁴¹ Another man, Private J.L. Nelson, formerly of the

³⁵ Norman to Deputy Commissioner, 25 August 1929, in PCF, op. cit..

³⁶ D.C. to Norman, 10 September 1929, in *ibid.*

³⁷ Charles to Deputy Commissioner, 18 December 1930 and Repatriation to Charles, 22 December 1930, in *ibid.*

³⁸ Repatriation Commission, Annual Report, 1931, p.5.

³⁹ Form U, 3 September 1930, in Trooper J. Fry, 13th Light Horse, PCF.

⁴⁰ AF B179 and Form U, 20 July 1933, in Corporal H.W. Jackson, 14th Field Artillery Brigade, PCF.

⁴¹ Form U, in *ibid.*

59th Battalion, felt similarly. From 1920 until 1925 he had treated his nervous condition with "patent medicine from different chemists" ⁴² and in 1934 informed the Department that he did not ". . . lodge any pension claim as I felt that I would be able to carry on without a pension." ⁴³ In the same year, former gunner Harry Campbell, suffering with "nervous troubles", also told Repatriation: "I did not apply before as I thought I would get all right eventually." ⁴⁴ Private Leslie Hall was shell-shocked at Bullecourt in April 1917 and "suffered with . . . nerves" soon after discharge but only purchased "nerve tonics" as a remedy. He did not seek medical help from the Department until 1930. ⁴⁵ Former Sergeant Francis Hammond also treated himself and purchased his "tonics and medicines" from chemists and grocers. ⁴⁶

Some returned soldiers only sought treatment when absolutely desperate or when their families and friends forced them to do so. Maurice Daniels resolutely refused to see any Repatriation Department doctors until 1929 despite suffering from mental trouble since his return from the war. ⁴⁷ His father advised him to apply for a pension and medical aid but he always stubbornly replied that he would eventually "get alright" and that "there was nothing wrong with him." ⁴⁸ Some men deferred an approach to Repatriation because of "a feeling of complete hopelessness" ⁴⁹ while others struggled on for long periods by themselves, apparently unaware that they were entitled to apply for benefits. Not knowing his rights, ⁵⁰ Albert Marsh was supplied for eleven years with "neurophosphates" by a chemist in Collins Street, Melbourne, who told the Department in 1932: ". . . [A]lthough I have often strongly advised him to have proper medical attention he has not done so. He has complained to me about Shell Shock and severe Bronchitis and looked so bad that I considered expert advise necessary." ⁵¹ R.G. Bailey, who had been treating himself for shell shock with "tonics and hypnotics" since his discharge in 1919, did not know he was entitled to apply for Repatriation benefits until 1922. ⁵²

For the aforementioned men the Department of Repatriation had been an irrelevancy until circumstances eventually obliged them to seek help there. It is open to question, however, whether the "expert" treatment available from the Department was any more effective than the self-ministering which had, in most cases, sustained these men, however dubiously, for more than a decade.

⁴² Form U, 19th June 1934, in Private J. Nelson, 59th Battalion, PCF.

⁴³ Ibid.

⁴⁴ Form U, 24 October 1934, in Gunner H.J. Campbell, 1st Field Artillery Brigade, PCF.

⁴⁵ Form U, 12 November 1930, in Private L. Hall, 6th Battalion., PCF.

⁴⁶ Hospital Memo, undated, in Sergeant F. Hammond, 60th Battalion., PCF.

⁴⁷ Michael Daniels, brother of Maurice, Letter, 21 October 1929, in Private M. Daniels, 5th Battalion Machine Gun Battalion PCF.

⁴⁸ William Daniels, father, Form U, 7 November 1929, in *ibid.*.

⁴⁹ Form T.A. ("Grounds of Appeal"), 14 April 1935, in Private. C. James, 3 Field Company Engineers, PCF.

⁵⁰ Application for Medical Treatment, 19 November 1931, in Private A.E. Dean, 5th Battalion, PCF.

⁵¹ Chemist to Repatriation, 4 January 1932, in Marsh PCF, *op.cit.*.

⁵² LMO, Dandenong, to Repatriation, circa 1922, in Private R.G. Bailey, 23rd Battalion, PCF.

Institutionalised Assistance

Institutionalisation as either in-patients or out-patients in a variety of hospitals and homes was one of the Department's major means of treating cases of war neurosis but, in many individual instances, this approach was not successful. Men became part of an interminable cycle of admission and discharge from Repatriation General Hospitals, Convalescent Homes, Convalescent Farms and eventually from psychiatric institutions which were usually overcrowded. William Grant ("run down, very nervy, and unfit for anything")⁵³ spent three months at the Ballarat Convalescent Home in 1921 but did not improve.⁵⁴ The neurasthenic Thomas Harvey spent a month at Aberfoyle (a Red Cross Home at Healesville near Melbourne) but did not make any progress either.⁵⁵ Francis Lee was discharged from Aberfoyle in July 1920 as "improved in health"⁵⁶ but spent the remainder of his life in and out of Caulfield Hospital and various Victorian psychiatric institutions.

Convalescent Farms were a variation of the convalescent principle but instead of rest, work was the chief therapy as described in chapter four. Opinions differed as to their efficacy. On the one hand a certain Dr. Steel was confident that "a great deal of benefit has resulted from farm treatment"⁵⁷ while it was reported in 1922 that in "many cases the results . . . have been satisfactory - many men have been rehabilitated."⁵⁸ By contrast, Dr. Ralph Noble, a Sydney psychiatric specialist, suggested that although some patients from New South Wales Convalescent Farms were able to resume their old occupations or become soldier settlers, some were still too frail to do so; upon their discharge, these men were directed towards employment - preferably "country pursuits" - or vocational training that would not precipitate "future breakdowns." Some, for example, were employed as "undergardeners" on the Convalescent Farms where they cultivated vegetables to be supplied to other Red Cross Institutions.⁵⁹

As with other Repatriation institutions, however, there are examples of returned men there who had not benefited from their time in the country or who were discharged from these Farms unfit. These instances, together with the above statistics, suggest a different picture from the roseate view portrayed in the Department's official organ *Repatriation*. For some residents of the Convalescent Farms, the war was never far away

⁵³ Medical Certificate, 25 May 1921, in Grant PCF, op. cit..

⁵⁴ Memo, Loans Officer, 2 August 1921 in *ibid*.

⁵⁵ Clinical Card, 17 December 1920, in Corporal. T. Harvey, 22nd Battalion, PCF.

⁵⁶ Matron, Aberfoyle, to Repatriation, 3 July 1920 in Private F. Lee, 5th Battalion, PCF.

⁵⁷ "Convalescent Farms", p.3, AA (ACT) A2421 T1, G1600 Part.1.

⁵⁸ *Ibid*, p.2.

⁵⁹ R. Noble, "The Treatment of Functional Nerve Disease during and after the War", in Proceedings of the Australasian Medical Congress, 1920, p.433.

and the methods employed to banish it from their minds seemingly impotent. In June 1921 an 80 foot tall redgum located near the temporary dormitory of the Kalamunda Convalescent Farm was shattered by lightning, some of the fragments being carried on to the tiles of a house half a mile away, while the roof of the carpenter's shop was holed and a section of the building moved off the ground. *Repatriation* reported: "Four of the shell-shock inmates were temporarily put out of action for a few hours. The noise was described as that of a high explosive shell." ⁶⁰

The disjuncture between official pronouncements on the success of Convalescent Farms and the evidence is further suggested by the case of Herbert Crane. There are few stories extant of individuals associated with Convalescent Farms so his brief experience at Bundoora Farm is of some importance. Crane, who had been evacuated from Gallipoli with shell shock, resided at Bundoora for over twelve months during 1921 and 1922. He informed *Repatriation*: "This farm is a good home for a single man, whilst getting treatment, without dependents. I feel much better since I came here . . ." ⁶¹ By contrast, a medical report from the visiting doctor stated: "The abovenamed has been here for some time and is getting more melancholic and miserable every day. He is physically fit to do quite decent manual work but his mental condition is very poor." ⁶²

The Department of Repatriation used State mental asylums and inebriate institutions in the same manner that Defence had done. Returned soldiers could still be admitted under the various War Mental Treatment Acts unless they were so ill or violent as to be certifiable in which case they were admitted in the manner of civilians. If their disorders were attributable to war service, Repatriation paid for their maintenance. Returned soldiers from the Great War continued to be admitted to mental asylums until well after the Second World War. Sometimes returned servicemen admitted to psychiatric institutions were unable to live at home ⁶³ or were a menace to their families; in the latter case, the policy of the Department was to have two doctors - either private or Departmental - certify them so they could be committed to an asylum. ⁶⁴ Although men were often discharged from these places as "cured", it was not long before they were re-admitted. Robert Henry, for example, was admitted to Bundoora in June 1928 and was discharged in August as recovered. ⁶⁵ In the same year, however, he was re-admitted and by 1930 had developed manic depressive insanity. ⁶⁶ He spent the remainder of his life there.

Even if disorders that had long since solidified and inadequate therapeutic methods are disregarded, certain endemic problems within the asylum system might help to account

⁶⁰ *Repatriation*, 26 June 1920, p.18.

⁶¹ Crane to Repatriation., Letter of Appeal, 7 September 1921, in Private H. Crane , 7th Battalion, PCF.

⁶² Memo for OIC Vocational Training Section, 28 November 1922, in *ibid*.

⁶³ Mrs. V. Walsh to Repatriation, 12 April 1934, in Private F. Walsh , 5th Battalion, PCF.

⁶⁴ Deputy Commissioner to Semmens, 7 February 1928, in Private C. Lapin, 5th Battalion, PCF.

⁶⁵ Report, 14 August 1928, in Private R. Henry, 7th Battalion, PCF.

⁶⁶ Memo, Bundoora, 4 March 1930, on *ibid*.

for the poor recovery rate amongst returned soldiers. Overcrowding was a major problem in Victorian mental institutions. Robert Henry, for example, had to be treated in the civilian institution at Mont Park when he was re-admitted in 1928 because the military section was overcrowded.⁶⁷ Although details of conditions for Australian soldiers in mental asylums are difficult to find it is clear that overcrowding was not the only problem. In 1921, the Medical Superintendent of Mont Park, Kenneth Hollow, wrote to Repatriation Headquarters and said:

The increase of staff asked for in 1 [ie point 1 of his report] will enable better individual treatment to be given. At the present time there are certain very noisy and destructive chronic patients under treatment and their behaviour and habits militate against the improvement of the curable patients. These men should be removed to a refractory ward.⁶⁸

Poor clothing was also a difficulty. In 1945 the son of a shell-shocked Gallipoli veteran resident in Bundoora since 1933 telephoned Repatriation headquarters and told them he wanted his father removed to a civil institution because he considered him ill-treated and poorly clothed.⁶⁹ The issue of adequate clothing, however, was not a new one. In 1921 Ernest Jones told the Principal Medical Officer of the 3rd Military District (Victoria) that after inspecting the Military Mental Ward at Mont Park he found that the patients had an insufficient supply of clothing and that requisition for replacements ordered three months previously had still not arrived. Jones also spoke to the Defence Department's quartermaster who apparently "admitted that the condition of the clothing was shameful." Jones considered the matter extremely important.⁷⁰

In May 1919 John Springthorpe was asked by the Department of Defence to conduct a clinic for war neurosis patients in Mont Park Mental Asylum. As shown above in his own figures, the level of success over four months in 1919 was dubious. His report to Defence reveals something of the conditions prevailing at Mont Park and some of the possible reasons for lack of progress with psychological casualties. Springthorpe told his employer that, before his arrival, sufferers of war neurosis had been scattered throughout the asylum's various blocks "under many guises, diagnoses and treatments." He also wrote that the proximity of "lunatics" and the "nearness and openness of the Female Block [was] an everpresent disadvantage." Records, he said, were "practically useless", while a large proportion of patients were idle "with individual loss and all round deterioration." Commenting on the asylum's atmosphere, he declared that the place was a "dead end" as men knew "little of their destination and nothing as to their pensions or repatriation possibilities."⁷¹ Even after he had taken charge, Springthorpe still felt that too much

⁶⁷ Medical Superintendent, Mont Park, to Deputy Commissioner, 15 November 1928, in Henry, op.cit..

⁶⁸ K. Hollow to Repatriation., 21 October 1921, in AA (ACT), A2487/1, 21/18169.

⁶⁹ Memo, unaddressed, unsigned, 26 November 1945 in Sands, PCF, op. cit..

⁷⁰ Jones to Principal Medical Officer 3rd Military District, 15 April 1921 in AA (Melbourne), MP 367/1, 609/31/1419.

⁷¹ Springthorpe to Defence, 12 November 1919, op. cit..

emphasis was placed on physical treatment - baths, electricity and massage - and insufficient on psychological methods. Finally, in a comment that again reflects poorly on the asylum, he wrote: "It was soon evident that a number of cases were not suited to our institutional treatment." Thus, suitable cases from this group were selected for "home treatment" the results of which were claimed to be excellent.⁷²

Apart, then, from the difficult disorders that faced medical officers and the frequent ineffectiveness of their methods, adverse conditions in the asylums also worked against recovery. It is not surprising that some men had no wish to be patients in such institutions. A further indication of conditions in asylums is, therefore, an adverse reaction to the possibility of committal. In 1936 the wife of Francis Walsh wrote to W.M. Hughes about her husband: "I was wondering, Mr. Hughes, if something could be done to get him a change but not to Bundoora, as he has been there and has a dread of it."⁷³ One Repatriation Department specialist in mental disorders used the threat of institutionalisation to intimidate a violent man and it had the desired effect, if only temporarily. The man's wife wrote: "After that he was much quieter and very kind and loving to me."⁷⁴ Asylums were also employed occasionally by Repatriation Department Medical Officers as places where mentally ill returned servicemen might recover by means of prolonged removal from the "damaging" sympathy of their relatives and friends to the company of strangers.⁷⁵ Except that recovery was the missing element in the equation, it seems that they were ideal for this purpose.

In-patient and out-patient treatment was available at the Repatriation General Hospitals in the various states but even these could display the unnerving, Gothic atmosphere of the asylums, especially for the shell shock cases. Already "on edge", they were often seriously agitated by the violent behaviour of their own kind when they were admitted at night to the darkened, dozing wards with their mixed bag of patients. Referring to the example of one "psycho-neurotic" returned soldier refused entry to Caulfield Hospital because he had required restraining by a policeman, one doctor reported:

[C]onsidering the number of very sick and nerve-strained men now in Hospital violent cases should not be admitted at night in the interest of the other patients, who are greatly distressed and disturbed when such cases are brought in when settling down for the night.⁷⁶

Within all of these institutions a variety of therapies was employed to treat returned soldiers suffering from war neurosis. Bewildered by the problem, some LMOs and other Repatriation Department doctors came to rely on drugs - particularly the sedatives

⁷² Springthorpe to Defence, op. cit..

⁷³ V. Walsh to Hughes, 4 December 1936, in Walsh PCF, op. cit..

⁷⁴ V. Ewell to Repatriation, 23 August 1935, in Private A. Ewell, 29th Battalion, PCF.

⁷⁵ Memo for Medical File, 5 September 1932, in Private C. Lapin, 5th Battalion, PCF.

⁷⁶ Doctor's evidence in the case of Private B. Brown, 22nd Battalion, 14 September 1926, in B. Brown, PCF.

paraldehyde and bromide - which seem to have created more difficulties than they solved. Some men, for example, became addicted and at least one doctor blamed the medical profession's free and easy use of them for this growing dependency. As early as 1917 Clarence Godfrey, then Inspector of Inebriate Institutions for Victoria, reported:

[I]t appears to me from personal experience that there is an increasing use of sedatives to the extent of definite misuse, and some of our returned soldiers exhibit this failing - the worst cases being amongst those who have suffered most definitely from 'shell-shock'. One cannot help the uncomfortable feeling that the medical profession is responsible - maybe quite innocently - for many cases of drug habit, inasmuch as the placing in the hands of a prescription containing one or more sedative drugs will provide the means whereby the habit may be acquired and administered to.⁷⁷

But, in the absence of more effective remedies, these drugs were the sole means of pacifying the more violent psychological casualties. They were primarily a means of control - a palliative - not a method by which recovery could be achieved. In some instances, drugs were the means by which "home treatment" could be carried out and in such cases the burden was usually shouldered by wives who collected prescriptions from Departmental Medical Officers and administered the necessary doses. A report on one returned soldier read: "Man is irritable, suspicious and jealous. He is a drug addict and his wife is begging for more Bromidia - refused point blank. A pitiful tale is hers. Nervy and worse when he runs out of Bromidia."⁷⁸ On 8 August 1929 Harold Walters' wife telephoned Caulfield Hospital requesting urgent admission for her husband who had been "bad with nerves for days." She had to give him an overdose of sedatives to quieten him and he was too weak to walk.⁷⁹

Physiotherapy such as baths, massage, hot air and electricity were also used on many war neurosis patients at facilities like No. 5 AGH in St.Kilda Road, Melbourne;⁸⁰ sometimes these methods were employed on men whose minds some doctors felt would not respond to psychotherapy.

Various kinds of psychotherapy were also favoured by Repatriation doctors. These included Freudian psychoanalysis, persuasion (an appeal to the patient's reason, explanation of the disorder); waking suggestion (implanting ideas in the patient's conscious mind which he unconsciously accepted in order to be receptive to the therapist's further efforts), and hypnotic suggestion in which ideas were introduced while the patient was in an hypnotic state.⁸¹ Although practitioners claimed a reasonable success rate with these

⁷⁷ Report of the Inspector of Inebriate Institutions in Victoria, 1917, p. 2.

⁷⁸ Memo for Medical File, 2 May 1939, in Walsh PCF, op.cit..

⁷⁹ Memo for Medical File, 19 August 1929, in Walters, PCF, op.cit..

⁸⁰ *Repatriation*, 30 November 1920, p.16.

⁸¹ Transcript, Australasian Medical Congress, Brisbane 1920, pp.420-421. For an evocative depiction of the practice of different forms of psychotherapy in 1917, see P. Barker, *Regeneration* (Penguin 1992).

methods⁸² they were also aware of their limitations. One Departmental medical officer abreacted (released) several disturbing war memories from the mind of Thomas Harvey but was unable to make much progress beyond that point.⁸³ Several months after the initial breakthrough the doctor wrote: "Has been hypnotised daily, don't think much improvement."⁸⁴ When he treated Francis Lee, another Departmental specialist reported similarly: "I tried to treat him by hypnosis but he did not respond."⁸⁵ This doctor, a Freudian, had little faith in the power of psychoanalysis to improve the mental condition of many of the returned soldiers he examined, a belief that seems to have sprung from contempt for his patients, not a lack of conviction about psychoanalytic methods. For example, of Harry Morris, formerly of the 37th Battalion, he wrote:

This man has a bad neuropathic history, there is both a mental deficiency and epilepsy in his ancestors. He is mentally deficient and is suffering from a neurosis . . . Psychotherapy not indicated, he is totally inadequate to react to any mental therapy. Try physical measures and encouragement.⁸⁶

Several weeks later the same practitioner recommended a solution to which more than one frustrated doctor resorted for stubborn cases: "To be disch. on 21/12/23. Treatment of no avail. He is not amenable to suggestion nor analysis."⁸⁷ Similarly, the Resident Medical Officer at Caulfield Hospital in 1919, washed his hands of a difficult shell shock case: "This man is not looking after himself properly and will do no good in hospital. Recommend discharge to Civil Life."⁸⁸ So the solution of some doctors to the problems posed by difficult cases of war neurosis was to relinquish responsibility altogether.

Drugs, work, psychotherapy and asylum methods were all applied with equal inefficacy to chronic psychological casualties by the Department of Repatriation which often portrayed these difficult cases as responsible for their own predicaments. Evidence plainly shows, however, that these men were not the architects of their own difficulties and that they were genuine casualties of war.

⁸² Clarence Godfrey, "War Psycho-Neuroses and their Treatment, in *ibid*, pp. 419-424, and T. Garnet Leary "Stammering as a War-Neurosis" in *ibid*, pp.424-426.

⁸³ Report, Godfrey, 19 May 1922, in Corporal T. Harvey, 22nd Battalion, PCF.

⁸⁴ Clinical Record, RGHC, 14 August 1922, in *ibid*.

⁸⁵ Hospital Notes, RGHC, 9 June 1939, in Walsh, PCF, *op. cit.*.

⁸⁶ Clinical Notes, RGHC, 29 November 1923, in Private H. Morris 37th Battalion, PCF.

⁸⁷ Clinical Notes, RGHC, 17 November 1923, in *ibid*.

⁸⁸ Resident Medical Officer, RGHC, to Repatriation, 14 May 1919, in Harvey, *op. cit.*.

Medical Treatment: Shell Shock and Alcoholism.

"It is reasonably probable that in the future a large number of soldiers suffering from the nerve-racking effects of warfare will attempt to seek relief in alcohol."

Clarence Godfrey, Inspector of Inebriate Institutions, Victoria, 1916. ⁸⁹

One of the significant problems faced by the Department of Repatriation was alcohol abuse amongst returned soldiers many of whom were sufferers of psychological disorder. Alcohol dependence and psychological disorder were, for many Australian soldiers of the Great War tightly linked in a cause and effect relationship. Although the Department of Repatriation attempted to offset the negligence of the early war years by providing special arrangements for alcoholic ex-servicemen, the inefficacy of treatment for individual cases made a nonsense of these provisions - however well-intentioned - and belittled bureaucratic and political posturing on the issue. The inter-departmental and Federal-State wrangling about financial responsibility for alcoholic ex-servicemen, the moralistic approach of some authorities to the problem, and excessive official concern about the deleterious effect of drunken soldiers on civil order seem niggardly and out of touch in comparison to the disastrous personal circumstances of some of the men concerned. Such a contrast between public pronouncements and private needs demonstrates very effectively the large gap between what was thought to be necessary for returned servicemen suffering from alcoholism and psychological disorders, and what was actually required.

The above attitudes were evident in a niggling dispute between the Department of Repatriation and the Victorian Government over who should meet the cost of maintenance for soldiers resident at the Lara institute for alcoholics. In Victoria, alcoholic soldiers were received into Lara via base hospitals, particularly No. 5AGH and No.1 Rest Home in St.Kilda Road, as well as civil hospitals. Others were admitted to the Receiving House at Royal Park where "many cases of Alcoholism in returned soldiers, produc[ed] temporary mental disorders." ⁹⁰ The question of who would pay for the men at Lara was raised in 1916 by Clarence Godfrey who told the Chief Secretary: "How far the Defence Department will regard itself as responsible for their care and treatment is a matter you, sir, will doubtless consider." ⁹¹ Only in August 1917, following pressure from the Victorian government, did the Department of Defence agreed to maintain undischarged alcoholic soldiers at Lara. Until then, they had maintained themselves from their pensions or had been paid for by friends. Defence made it clear, however, that discharged servicemen were

⁸⁹ Report of the Inspector of Inebriate Institutions for the Year Ending 31 December 1916 (Victorian Government 1917), p.10.

⁹⁰ W.E. Jones to Lockyer, 6 December 1917, AA (Canberra) A2487/1, Item 21/19415.

⁹¹ Annual Report, Inspector of Inebriates Institutions, Victoria, 1916, op. cit., p.10.

the responsibility of the Australian Soldiers' Repatriation Fund and its successor the Department of Repatriation which was quite prepared to maintain men in State institutions as long as they conformed to the rather strict criteria laid down in Departmental policy.

In June 1922 the Victorian Government requested that Repatriation pay for the increasingly large number of discharged soldiers who were being admitted to Lara by civil procedure well after the allowable twelve months following discharge, and for whom the Department - standing by its regulations - would accept no responsibility. In reply, the Victorian Chief Secretary argued that the inebriacy of these men was due to war service. He argued that they ought to be maintained by Repatriation⁹² which, finally relented in only four cases out of the thirty-four presented, most of whom had psychological difficulties.⁹³

Against the personal suffering of the men concerned, some of these official pre-occupations seem remote. They were also harmful to a soldier's chances of recovery. Of the thirty-four men over whom Repatriation and the Victorian Government argued in 1922, many were suffering various kinds of psychological disorders that were directly associated with their abuse of alcohol. None, it was alleged by the Victorian Government, had a drink problem before the war. One man lost the use of his left arm at Pozières and, as a result of this disability and the "stress of war" drank to excess. By June 1922 he had spent at least 337 days at Lara. Another, who "hardly drank at all before the war developed neurasthenia after a wound in the head and developed bad headaches and depression", drank to overcome his problems. He had been resident at Lara for 86 days. In others, "war strain", "war conditions", and "shell shock" were cited as reasons for their alcoholism.

Some, like the man who lost his leg after being struck by the casing of an 18 pounder shell at Gallipoli, tried to cope with their physical wounds by drinking while one man imbibed to excess in an attempt to erase memories of being torpedoed at sea.⁹⁴ Despite this evidence (supplied by the Chief Secretary's office) Repatriation denied responsibility for most of these men.⁹⁵

Witnesses before the 1917 senate inquiry into alcohol and soldiers provide further insight into the relationship between liquor and psychological disorder amongst returned servicemen. Some witnesses testified that many - if not the majority - of returned soldiers were "not in their right frame of mind" and that their "mental condition" had been affected by war experience."⁹⁶ For example, Matron Margaret Shoobridge of the Red Cross Hospital, Hobart, stated that some of the men there suffered from insomnia, depression and idleness and so took to drink.⁹⁷ Several witnesses commented that liquor affected the

⁹² Under Secretary, Victoria, to James Semmens, Chairman Repatriation, 1 June 1922, in AA (Canberra), A2487/1, Item 21/13264.

⁹³ Repatriation, Internal Memo., 6 February 1923, in *ibid.*

⁹⁴ "List of ex-soldier patients who have received treatment at the Inebriates' Institution, Lara, and who are considered by the Chief Secretary's Department to be war cases", in *ibid.*

⁹⁵ Repatriation, Internal Memo., *op.cit.*

⁹⁶ *Ibid.*, pp. 459,882.

⁹⁷ *Ibid.*, p.461.

"men suffering from shell-shock and other nerve trouble more than any other kind of invalid. In such cases very little drink produced a marked effect on the individual." ⁹⁸ Sergeant McKenzie, president of the Returned Soldiers Association (later the RSSILA) told the inquiry:

Being brought almost daily in contact with men suffering from shell shock, I have noticed that beer seldom harms them, while on the other hand a small quantity of spirits drives them almost mad. Strange to say, a great many men returned from active service drink it neat without water or soda. ⁹⁹

McKenzie stated that in many cases it was difficult to differentiate between symptoms of shell shock and the appearance of drunkenness. He had, he said, seen men whom he could have sworn were inebriated but were actually cases of war neurosis; he had heard, too, of shell shocked men who, mistakenly believed to be intoxicated, were dismissed from employment. Finally, McKenzie related the story of a man who rose to speak at an Association meeting: "Now, any person not knowing that the man was suffering from shell shock would have thought that he was tight . . . He is an excitable man and the slightest thing sets him off." When asked if there were many similar cases, McKenzie replied: "I am afraid there are." ¹⁰⁰

Exemplifying the plight of alcoholic psychological casualties in the hands of government authorities was former Private Charles Lapin. The role played by alcohol in his neurasthenic and gastric condition produced contradictory opinions in five doctors, two of whom attributed his problems to "long-continued excessive indulgence in alcohol, causing gastric trouble and nervous exhaustion." ¹⁰¹ One of these was a Dr. Bird, who seems to have conducted a personal campaign against soldiers with drink problems, while the other was the Departmental Medical Officer who, on the basis of Lapin's file and his personal knowledge of him, was happy to concur with Bird's opinion. On the grounds that his disabilities were not considered to be due to war service but to indulgence in alcohol, Lapin was denied further sustenance. ¹⁰² The Deputy Comptroller accepted the views of Bird and the DMO over the contrary opinions ¹⁰³ expressed by two Local Medical Officers attached to the Frankston Local Committee. These men contended that Lapin was "suffering from Neurasthenia following Shell Shock and chronic dyspepsia aggravated by active service", ¹⁰⁴ and that his condition was the result of "infection and strain of active service on a nervous system never too stable previous to enlistment." ¹⁰⁵ Still another

⁹⁸ Captain. C.R.W. Brewis, R.N., Naval Transport Officer in Senate Inquiry, op. cit., p.460.

⁹⁹ Ibid, p.477.

¹⁰⁰ Ibid, p.776.

¹⁰¹ Medical Officer, Repatriation, to Deputy Comptroller, 6 May 1920, in Private C.Lapin, 5th Battalion., PCF, op. cit..

¹⁰² Deputy Comptroller to Local Committee, 5 January 1920, in *ibid*.

¹⁰³ Deputy Comptroller to Secretary, Frankston Local Committee, February 1920, in *ibid*.

¹⁰⁴ Letter, Local Medical Officer Frankston, unnamed, 20 April 1919 in *ibid*.

¹⁰⁵ Medical Certificate, Dr. Maxwell, in *ibid*.

doctor advised that Lapin was a "case of Depression result [sic] of Insomnia brought about by War Stress." ¹⁰⁶ In response to this clash of testimony, the Secretary of the Frankston Local Committee made an inquiry of particular relevance to this study. Indignantly, he wrote to Repatriation headquarters:

This Committee is at a loss to know how it is that the abovenamed Doctors have decided that Lapin's disabilities have been aggravated by war service while the Departmental Medical Officer declares the disablement not the result of war service. ¹⁰⁷

This was a pertinent query and one to which the answer might have been found in the uncomplicated morality of Repatriation Department policy. In 1925, as Lapin's condition seriously deteriorated and he was admitted to the Royal Park Receiving House, the Department of Repatriation was forced to recognise the view that his problems were not due to chronic alcoholism "but merely that alcohol taken in moderate quantities [to aid sleep] excited and aggravated the attacks referred to above." These included anxiety, insomnia, and fits of depression with suicidal and homicidal tendencies. ¹⁰⁸ In June 1925 his condition was accepted as due to war service and the Department agreed to pay for his maintenance in the Royal Park Receiving House and at Mont Park. ¹⁰⁹

The lives of some men were totally ruined by neurosis-related addiction to alcohol. In September 1918, 22-year-old Captain Harold Walters was discharged from the Royal Flying Corps with "chronic alcoholism", a condition that developed after he sought relief from neurasthenic symptoms - which included "terrifying dreams, tremulousness and general unsteadiness" - following three air crashes on the Western Front between September 1917 and August 1918. ¹¹⁰ In Australia he told Repatriation Department doctors that "towards the end his nerves went and he started to drink to help himself." ¹¹¹ His soldier settler block in remote country near Benalla in north-eastern Victoria was not a success due to poor health and bad seasons. When asked by the Repatriation Department to support Walters' claim for medical assistance after he finally asked for it in 1927, his observant and sympathetic acquaintances in the bush offered some distressing opinions. Wangaratta stock and station agent, Henry Dale, for example, had never considered the former pilot a strong man. He said: ". . . in fact, I think his wife was the one who mainly worked the farm . . . some time back he told me he would have to leave the land." ¹¹² A neighbour, Thomas Litchfield, wrote:

¹⁰⁶ Notes of Dr. Hendry, 30 May 1920, in *ibid.*

¹⁰⁷ Secretary, Frankston Local Committee, 3 February 1920, in *ibid.*

¹⁰⁸ Report of Dr. Charles, Local Medical Officer, Belgrave, 26 May 1925, in *ibid.*

¹⁰⁹ Deputy Commissioner, Repatriation to Inspector General of the Insane, Victoria, 19 June 1925, in *ibid.*

¹¹⁰ Royal Air Force Form 47: "Notes of Medical Officers in reporting the proceedings of a Medical Board", undated, and Royal Air Force Form 47, 20 September 1918, in Captain. H. Walters, PCF, *op. cit.*

¹¹¹ Repatriation Commission Minute, undated, in *ibid.*

¹¹² H. Dale to Repatriation, 12 July 1927, in *ibid.*

He seemed to be very nervy and I would put him down as a general war wreck. I may add that he refused to go to any Doctor and did not seem to want to be bothered with any body or anything. . . [W]hen he was in a state bordering on a breakdown, he would get a bottle of brandy. ¹¹³

In July 1927 after the Closer Settlement Board finally recalled its advances to Walters, he and his wife left the district and took up a small poultry farm at Kangaroo Ground. ¹¹⁴ Later that month, however, Walters' wife took him to Caulfield Repatriation Hospital where he collapsed on arrival, too ill to move. For the remainder of his relatively short life (he died in 1945), alcohol and sedatives dominated an existence that seems to have been a continuous cycle of substance abuse episodes followed by periods in mental institutions and hospitals during which he continued to drink. For example on 1 September 1929 Walters was wheeled back to his ward in Caulfield Hospital "helpless with C₂H₅ OH." (alcohol) ¹¹⁵ During the last years of his life he was diagnosed with alcoholic dementia, delirium tremens, ¹¹⁶ "neurasthenia aggravated by alcohol", duodenal ulcer, "nerves and general debility" and manic depression. ¹¹⁷ On 3 December 1945 he was admitted to Caulfield Hospital from a house in Richmond where he was reported as "living under very poor circumstances." ¹¹⁸ Five days later he died of lobar pneumonia in the hospital that had been his second home for 18 years. ¹¹⁹

When Repatriation doctors unanimously agreed that Private Leslie Hall's alcoholism was due to war-related neurosis, the Department accepted responsibility for his treatment at Caulfield and later at Mont Park. Hall's father told staff at Caulfield that he was afraid his son might injure himself or his family, that he suffered from delusions and talked constantly about the war during which he had been gassed. ¹²⁰ In July 1927 a Repatriation Medical Officer, who treated Hall as an outpatient at Caulfield, wrote: "[H]e suffers from night terrors and alarming dreams. I am satisfied his alcoholic manifestations are the product of his neurasthenic state." ¹²¹ He felt, however, that treatment wasn't of much use ¹²² as Hall was congenitally feeble-minded, a condition that contributed to an unbreakable downward spiral:

A vicious circle seems to have been established, with the interaction between established, the consequences of the poor mentality and the neurosis rendering his inability to refrain from alcoholic excess greater than would otherwise have been the case, and the alcoholism causing the nervous defects to become greater. ¹²³

¹¹³ T. Litchfield to Repatriation., 18 July 1927, in *ibid.*

¹¹⁴ Minute, Repatriation, undated, in *ibid.*

¹¹⁵ Memo. for Medical File, 15 September 1929, in *ibid.*

¹¹⁶ RGHC, Minute, 4 March 1936, in *ibid.*

¹¹⁷ Minute, Repatriation., 30 July 1940 in *ibid.*

¹¹⁸ Advice of Admission, RGHC, 28 November 1945, in *ibid.*

¹¹⁹ Minute RGHC, 3 December 1945, in *ibid.*

¹²⁰ Clinical Notes, RGHC, 19 November 1926, in Private L. Hall, 37th Battalion. PCF.

¹²¹ Outpatients Notes, RGHC, 22 July 1927, in *ibid.*

¹²² Outpatients Notes, RGHS, 5 June 1929, in *ibid.*

¹²³ Minute, RGHC, 18 September 1937, in *ibid.*

Hill died at Bundoora mental institution in 1947.

Medical treatment for many sufferers of war neurosis was ineffective at all levels and in all settings. Neither Local Medical Officers nor the most exalted consultant specialist was able to effect recoveries for some chronically ill men whose existence the Department of Repatriation acknowledged but whom they characterised publicly (and sometimes privately) as unworthy and unrepresentative of the heroic AIF, responsible either through genetic inheritance, social class or personal proclivities for their own conditions. A wide range of evidence shows, however, that these men were genuine casualties of war who posed complex problems for the Repatriation Department's medical machinery which was either unable to cope, despite the best of intentions, or simply unprepared to persevere with "hopeless" cases.

Social and Economic Rehabilitative Schemes.

Under the Department of Repatriation, soldiers were offered a variety of practical means designed to help re-establish them in civilian life. These included vocational training, land settlement, business loans, and an entire employment section within the Department dedicated to the finding of work. Many shell shocked men were not, however, able to benefit from these schemes as they were simply too ill or too pre-occupied with the social and financial difficulties that their disorders had created. In addition, many of these programmes were completely inappropriate to the needs of mentally disturbed returned servicemen. The ill-matching of psychologically disabled men to land settlement ventures that depended on at least a fully able man for their realisation, and to apprenticeships, jobs or business ventures that required calm nerves and minds able to concentrate, must, in part, account for the Department's lack of success in these areas.

One of the Repatriation Department's stated aims was to return men to their former occupations or to find them other suitable work.¹²⁴ It attempted to achieve this by encouraging employers to give preference to returned servicemen; by trying to place men directly into employment; by making gifts and loans available to men who wished to start in business; and by training ex-servicemen to a rudimentary standard in a multitude of trades and professions through the Vocational Training scheme. Many sufferers of war neurosis were amongst the returned soldiers for whom the Department tried to find work or whom they attempted to train. In many cases, however, these men were too distracted by their disorders or too disabled to take advantage of any of the aforementioned schemes and,

¹²⁴ The Civil Re-Establishment of the A.I.F.. A Summary of the work of the Department of Repatriation (Commonwealth Government 1920), op.cit., p14.

thus, to participate in the economic life of the country and to fashion an independent existence. Sometimes, too, employment was either not available or was simply too transient to be of much practical use. For men who had these kinds of experiences, the Department's attempts at restitution and economic re-habilitation, while not totally irrelevant, were not particularly successful.

The appointed tasks of the Repatriation Department's Employment Section were to search for positions and allocate them to individuals, to calculate sustenance payments for those awaiting employment, to organise transport for men having to travel long distances to work, and to find alternatives for veterans difficult to place. In endeavouring to achieve its goals the Employment Section utilised a wide range of sources - trade unions, employers' organisations and the press. Rapid demobilisation, strikes and the influenza epidemic adversely affected these projects so, in response, the Department attempted to establish "reserve employment" such as forestry and other "new works" such as the construction of the Great Ocean Road along Victoria's south-west coast. By June 1920 108, 949 jobs had been found for 190, 662 applicants but these figures are deceptive because many men fell into and out of jobs easily.¹²⁵ In addition, some applications did not process "through the soldier being in need of medical treatment . . . by reason of his war disabilities."¹²⁶ Starts in small business were also provided by the Department but with reluctance, given the disappointing experience of pre-Departmental attempts at similar schemes.

Results suggest that Departmental scepticism about the idea of business loans to returned servicemen was probably warranted. Repatriation Commission documents show large numbers of failures and grave doubt about individual loans that were granted nevertheless. Some of this money was awarded to shell shocked veterans by the Commission against their better judgement¹²⁷ and, in many cases, these loans had to be written off after the ventures failed.¹²⁸

But business loans were not the only Repatriation Department employment programme unsuitable for sufferers of war neurosis. Vocational training too was undermined by the debilitating consequences of shell shock. The objective of vocational training was to give returned servicemen basic skills in a trade or profession in a reasonable time so that they could re-enter civil life able to earn an independent living.¹²⁹ Although the scheme was initially open only to the badly wounded,¹³⁰ it was extended in April 1919 to incorporate widows and a wider range of returned servicemen including apprentices whose indentures had been interrupted by the war.¹³¹ As in the days of the

¹²⁵ Civil Re-Establishment, op. cit., and Department of Repatriation, Annual Report 1921, p.7.

¹²⁶ Ibid.

¹²⁷ Repatriation Commission Minutes, 10 April 1922, p.8.

¹²⁸ Repatriation Commission Minutes, 10 March 1923, p.3.

¹²⁹ *Repatriation*, 25 October 1919, p.5.

¹³⁰ Repatriation Annual Report, 1921, p.8.

¹³¹ Department of Repatriation Interim Report upon the organisation and activities of the Repatriation Department, 8 June 1918 to 30 June 1919, p.8.

State War Council, the training programme was carried out in technical schools under salaried instructors with the co-operation of State education authorities, and in fifteen special trade schools built to accommodate increasing numbers; the secondary phase of instruction occurred under normal working conditions with an employer subsidised by the Department. In each trade, training was supervised and assessed by District Industrial Committees comprising employers and union representatives from the relevant trades, in addition to a chairman appointed by the Minister.¹³² After training 27, 696 men from a total of 74, 343 applications, the scheme concluded in 1932.¹³³

Vocational training was seen by the Department of Repatriation not only as means of personal re-instatement in civil life, but also as a form of psychotherapy as well as an avenue through which returned servicemen could contribute to the economic vitality of the nation. But in the opinion of Nicholas Lockyer, the Department's first permanent head, vocational training would succeed only if the mental suitability of applicants was taken into account. As has been noted in the previous chapter, he believed that the war had disturbed the minds of the majority of soldiers and worked hard to find suitably qualified doctors to make the necessary individual assessments so that the coupling of man to occupation would be as compatible as possible under the difficult circumstances. He did, however, harbour a none-too-private fear that such expertise could not be found in Australia and that vocational training would suffer as a result. Subsequent events show that Lockyer's own assessment of what was required was astute and that his apprehension about the insidious role of war neurosis in vocational training was fully justified.

Major difficulties experienced by the vocational training Scheme were the economic recession of the early 1920s, which created a shortage of materials and brimming waiting-lists; in addition, poor organisation, unsuitable instructors and lack of co-operation from some employers who were unwilling to retain the ex-servicemen once the wage-subsidy was finished hampered the smooth running of the programme.¹³⁴

For some men, vocational training was of major benefit.¹³⁵ For others, however, it was a waste of time. Its failure to provide a satisfactory trade for these men lay in the above-mentioned reasons but it also resided in the idea of trying to train returned soldiers who were so deeply psychologically scarred that they were simply unable to exploit the chance to learn new skills or to hone old ones; many of the war neurosis cases who enrolled in classes were unable to return to their pre-war occupations¹³⁶ and it is a sign of

¹³² Interim Report, op. cit., p.9.

¹³³ Repatriation Department Annual Report 1932, p.11.

¹³⁴ A.Thomson, *Anzac Memories. Living with the Legend* (Oxford University Press, Melbourne 1994), p.113, 162 and 167.

¹³⁵ Ibid, p.113.

¹³⁶ For example, James Johnson, a draughtsman in South Australia before the war, was unable to resume his old occupation. Described as "too unstable as to nerves", he became a trainee cabinet maker under Vocational Training but had difficulty reaching the required standard despite a twelve month extension. (Repatriation Commission Minutes, 24 April 1922)

supreme optimism - or ignorance - that Repatriation authorities imagined that these men would be able to benefit from a change of job or that work would be adequate therapy. Some men were able to toil at their new trades for a while but they too succumbed eventually: Terry O'Neil, a former private in the 31st Battalion, completed a course in massage in 1921, and worked in that profession for three years before being admitted to a mental hospital in 1924.¹³⁷ Private Albert Salmon learned boot repairing under Vocational Training and set up his own business in Bendigo which he ran for twelve months until "fits" prevented any further work.¹³⁸

Some men, however, reaped no benefit at all from the training scheme. Brutally frank Industrial Training Committee assessments (which contrast strongly with the optimistic reports of Local Committees on the same men) clearly show the hopelessness of many such cases. For example, in an undated report to the Deputy Comptroller on several Vocational Trainees at the "Brighton Re-adaptation School", the secretary of the Local Committee wrote:

R. Cooper has been very badly shell shocked which makes him rather slow at picking up things. He is making good headway taking this into consideration.

E. Young is in rather a bad state of health but is picking up nicely now. He should be fit to go out in three months.¹³⁹

By contrast, the Industrial Committee said of the same men:

R. Cooper Bad Case of shell shock. May become a tradesman if condition improves, but otherwise no prospects.

E. Young Bad shell shock. Frequently falling down. Will never be fit for trade.¹⁴⁰

Of the two assessments, the Industrial Committee's report was the more realistic. Ernest Young, for example, had been shell shocked at Polygon Wood in 1917 and never properly recovered. At Caulfield Hospital in early 1918 he complained of terrifying dreams, frontal headaches and fainting attacks. Described by the Principal Medical Officer, Dr. J.F. Agnew as "still very nervy and shaky", he was unable to resume work as a clerk.¹⁴¹ In May 1919 the Departmental Medical Officer recommended to the Officer in Charge of Employment at Repatriation that Young undergo vocational training "as he would be better to have some mental occupation of a light nature such as wood working."¹⁴²

¹³⁷ Minutes of the Medical Advisory Committee, 4 June 1925.

¹³⁸ Form U, 11 March 1930, in Private A. Salmon, 37th Battalion, PCF.

¹³⁹ Secretary, Brighton Local Committee to Deputy Comptroller, Melbourne, undated, in Signaller E. Young, 37th Battalion, PCF.

¹⁴⁰ Secretary, Soldiers' Industrial Committee, "Visit to Brighton Readaptation School 24 July 1920", in *ibid.*

¹⁴¹ O.C., RGHC to O.C. Mont Park, 18 October 1918, in *ibid.*

¹⁴² Departmental Medical Officer to Disablement and Training, 3 May 1919, in *ibid.*

Ostensibly intended as the basis of a cabinet making business for Young, it seems from this comment that the therapeutic value of the training - rather than any practical benefit - was to the fore in the Departmental Medical Officer's thinking. Neither the expected practical or medical gains eventuated, however, as Young, did not meet the minimum 40 per cent efficiency standard required despite a twelve month extension. By 1932 he had not improved in mental health and was still being treated for traumatic neurasthenia. When the cost of continuing to train a man became unacceptable to the Commission (as, for example, in the case of Young), it was faced with its own failure to recognise the inadvisability of enrolling psychological invalids in what turned out to be completely unsuitable apprenticeships. ¹⁴³

Under the vocational training scheme, some traumatised men were taught trades that were completely unsuitable for their unsteady nerves. Badly shell shocked in 1917, Edward Nolan, a clerk from Avoca, was unable to tolerate city noises and jumped when doors were shut. Unfit for his old job but passed suitable for Vocational Training in February 1919, he trained as a motor mechanic. Although finally considered unsuitable for that occupation, he was deemed fit enough to undertake vocational training in dairying which he duly completed and put to practical use. Life on the land was difficult for him, however, and when his disorder got the better of him, he was forced to employ extra labour. Throughout the 1930s he was a regular patient at Caulfield Hospital where he was described as depressed, weak and emotional ¹⁴⁴ and suffering from "severe anxiety neurosis". ¹⁴⁵ Former gunner Michael Bowe returned to Western Australia a "nervous wreck" and was unable to take up his pre-war profession as a mining engineer. Refused training as an assayer, he was, he said, practically forced to undertake metalcraft which he described as "the most nerve wracking trade" possible. Even after a twelve month extension he did not reach the required standard and was thus "finalised" in March 1923. ¹⁴⁶

One of the major difficulties perceived by those administering the Vocational Training scheme was a class of men known as "sub-efficients". These were returned soldiers who were so seriously disabled either mentally or physically that they could not either be placed or retain their positions in the "industrial training" stage of vocational training and who had to be re-instated in school classes and maintained on sustenance rates as well as a pension - or simply "finalised". These men were described as the "residuals of the training scheme" and included a number of war neurosis sufferers whose futures were bleak. ¹⁴⁷ Former Private A.G. Black of Perth, who suffered with hysterical spasms of the right hand and neurosis, was unable to follow his pre-war occupation as a wharf

¹⁴³ Repatriation Commission Minutes, 16 May 1922.

¹⁴⁴ Memo for Medical File, RGHC, 18 January 1934, in Young PCF, op. cit..

¹⁴⁵ Clinical Notes, RGHC, 22 January 1934, in *ibid.*

¹⁴⁶ Minutes of the Repatriation Commission, 13 March 1923.

¹⁴⁷ J. Nangle, "Sub-Efficients", in AA (Canberra) 2487/1, Item 21/16779.

labourer and so in August 1919 commenced (incredibly) a French polishing course but was transferred in December to the cabinet makers' class as he was considered unsuitable for his first choice. A report stated:

He is one of those cases that does not seem to show any return for the intensive training given by the Instructor, and also seems to suffer from trouble in his head which causes him to be mentally dull at one time, and extremely boisterous at another . . . [I]t is not considered that he will ever be in a position to compete with tradesmen in any trade at all. On more than one occasion he has been reprimanded for peculiar attitude towards the Pay Clerk. ¹⁴⁸

Another "permanently industrially sub-efficient" returned soldier, Arthur Downes, suffering from shell shock and nervous debility, had been a miner in civilian life but was enrolled in painting classes under the vocational training scheme. He was considered "unsuitable if his nervous condition is correct, on account of the climbing . . . He is of low mentality and not likely to become efficient as a tradesman, but is fit for the general labour market." ¹⁴⁹

Unsuited to the demands of industrial training, the mental condition of many psychological casualties precluded any possibility of their successful participation in Department of Repatriation employment schemes. The Department was eager for all returned servicemen to contribute to the economic life of the nation but its lack of discrimination on the matter of war neurosis consigned many men - and aspects of the economic rehabilitation programme - to demoralising failure.

Soldier Settlement.

Will they never fade or pass!
The mud, and the misty figures endlessly coming
In file through the foul morass,
And the grey flood-water lipping the reeds and grass,
And the steel wings drumming.

The hills are bright in the sun:
There's nothing changed or marred in the well-known places;
When work for the day is done
There's talk, and quiet laughter, and gleams of fun
On the old folks' faces.

I have returned to these:
The farm, and the kindly Bush, and the young calves lowing;
But all that my mind sees
Is a quaking bog in a mist - stark, snapped trees,
And the dark Somme flowing.

"The Farmer Remembers the Somme." Vance Palmer. ¹⁵⁰

¹⁴⁸ Summary of Particulars of Application for Assistance, 16 November 1920, in *ibid.*

¹⁴⁹ "Sub efficient", in *ibid.*

¹⁵⁰ In George Mackaness, ed., *An Anthology of Australian Verse* (Angus and Robertson Sydney; first published as *Poets of Australia* 1946; this edition 1952), p. 290.

As with the various employment schemes run by the Department of Repatriation, the soldier settlement programme attracted many psychological casualties. Perhaps the most notorious of all the major repatriation projects, soldier settlement represented the last phase of an 80 year plan to create a yeomanry in Australia ¹⁵¹ and was initiated early in the war by State Governments who felt that masses of returning soldiers would counter the problem of insufficient numbers faced by closer settlement programmes. In 1917 the Federal Government, viewing soldier settlement as a possible incentive in AIF recruiting, promised to underwrite a scheme of cash advances to returned servicemen if the States provided the land. Although soldier settlement was not a complete failure, many men and their families had to leave the land, defeated by a number of impediments.

The work of Marilyn Lake shows that much of the land available for selection was frequently unsuitable for agricultural development in both quality and size; often, individuals were under-capitalised, a state of affairs that led to a spiral of borrowing and indebtedness which had forced many settlers off their blocks by 1938; seasons were often unfavourable; economic conditions throughout the 1920s and 1930s were also not conducive to profitable business ventures. As well, the contradiction inherent in the idea of yeoman farmers trying to work according to the sophisticated methods demanded by market-oriented, commercial agriculture also seriously undermined the scheme. Virtually anyone who applied for a block was granted one, so strong was public pressure on the government to compensate the diggers for their sacrifices. This rash policy permitted those to take up land who, because of training and temperament, were unsuited to the hard labour and hard business of modern agriculture. ¹⁵² Finally, soldier settlement was also compromised because many aspiring farmers were still suffering the detrimental effects of war service including many mental casualties whose experience of soldier settlement was, in many cases, pitiful. For them, this experiment in social engineering and restitution was a debacle. ¹⁵³

Many shell shocked manual labourers, tradesmen and professionals tried their hands at farming under the soldier settlement scheme, some of them after drifting from job to job or being unable to avail themselves of the Repatriation Department's employment programmes, and all of them unfit to return to their former occupations. In addition to the factors that drove other soldier settlers from the land, these men were forced from their

¹⁵¹ M. Lake, *The Limits of Hope Soldier Settlement in Victoria 1915-38* (Oxford University Press Melbourne 1987), p.143.

¹⁵² Ibid, passim.

¹⁵³ In his review of *The Limits of Hope*, Charles Fahey suggests that although Marilyn Lake shows soldier settlement was a financial disaster for Victoria and that "the scheme condemned hundreds, possibly thousands, of settlers to miserable poverty", she disregards the possibility that "a substantial proportion of the settlers actually succeeded." This he attributes to her selective use of evidence and "her failure to understand the process of compromise by the bureaucrats from 1932" which extended largesse and consequent prosperity to "thousands of settlers". C. Fahey, Review: M. Lake, *The Limits of Hope: Soldier Settlement in Victoria, 1915-1938*, in *Historical Studies* No. 90, April 1988, pp.140-141. Jaqueline Templeton in her review of Lake makes similar but more detailed criticisms. J Templeton, "Set Up to Fail? Soldier Settlers in Victoria", *Victorian Historical Journal*, Volume 59, No. 1. March 1985, pp. 43-50.

blocks by war-induced psychological illnesses which eliminated any hope of success. Several examples will show how war neurosis could sabotage soldier settlers.

After returning to Australia in 1919, former prisoner-of-war John Hills was granted a block by the Closer Settlement Board in 1920 following a year of enforced idleness. Mechanical farming did not suit him, however, as the vibration of the machinery upset his nerves; every year he was forced to employ labour to do the cropping, a necessity for many sick men who saw their expenditure rise further as a result.¹⁵⁴ In 1929 Hills "broke down completely"¹⁵⁵ and was admitted to Caulfield Hospital in a "very unstable emotional condition".¹⁵⁶ By November 1930 he was a patient in the Receiving House, Royal Park.¹⁵⁷

In July 1918 Private Charles Green was discharged with "Shell Shock Incapacity total"¹⁵⁸ and for the next two years spent time at No.5 AGH and Mont Park¹⁵⁹ before taking up a block near Echuca which he was not fit to work. Having to endure stammering, nervousness, a fine hand tremor, sleeplessness and faintness on exertion, he too lost time "through nerves"¹⁶⁰ and, like Hills, was forced to employ labour to do the hard work.¹⁶¹ In July 1930 he became a regular visitor to Caulfield Hospital after it was recommended that he receive "special psychotherapy".¹⁶²

Unable to settle after his return from the war, and looking for a place to forget his terrible experiences on the Western Front, former carpenter Robert Henry began working a soldier settler block at Mildura in 1922 but, burdened with depression, suicidal tendencies, suppressed rage and guilt about surviving when others had not, he abandoned the farm in 1924. His wife told the Department of Repatriation:

On one occasion he was carting sand to the irrigation channels and came home with his hands bleeding. He told me that one of the horses would not go and he beat it and after stating this he burst out crying. He was fond of the horses and they followed him about like dogs. He was too restless to stay in the house of an evening and walked about the block and occasionally went to the camp at Mildura. The block was not a success due to my husband's restlessness.¹⁶³

¹⁵⁴ Costs like these, when combined with the other detrimental factors, contributed to many a negative balance sheet. One woman, whose shell-shocked husband was forced to employ extra labour and who was in debt by 39 pounds, told the Deputy Commissioner: "As to our income it is just an existence." (Mrs. E. Norman to Deputy Commissioner Repatriation, 2 March 1934, in Private. E. Norman, 5th. Division Signals, PCF.)

¹⁵⁵ Form U, 19 July 1929, in Private J. Hills, 3rd Division Signals, PCF.

¹⁵⁶ Medical Report, RGHC, 26 July 1929, in *ibid.*

¹⁵⁷ Medical Superintendent, Royal Park to Deputy Commissioner, Repatriation, 19 January 1931, in *ibid.*

¹⁵⁸ Final Board, 17 July 1918, in Private C. Green, 37th Battalion, PCF.

¹⁵⁹ Medical History Sheet, No.16 AGH, Clinical Card, in *ibid.*

¹⁶⁰ Form K, 3 January 1924, in *ibid.*

¹⁶¹ Form K, 28 October 1924, in *ibid.*

¹⁶² Clinical Notes RGHC, 13 January 1930, and Clinical Findings, Appeals Tribunal, 5 August 1929, in *ibid.*

¹⁶³ Form U, Evidence of Ann Henry, 14 June 1928, in *ibid.*

In 1928, after persevering with a number of jobs around Victoria, Henry became a patient at Mont Park where, in 1930, he was described as suffering from "manic depressive insanity".¹⁶⁴ He remained there until his death in 1961.

The struggles of soldier settlers and their families to overcome the handicaps foisted on them by their disabilities were not aided by some members of the Closer Settlement Boards who seemed ignorant and unsympathetic, and only able to see failure in terms of idleness. Their reports contributed to the cancellation of leases and the demise of several soldier settlement ventures. Of Robert Henry, the man who had beaten his horses, an official wrote: "While at Mildura his capacity for work did not seem to be impaired by health reasons . . . He was unsuitable as a settler as he did not work the holding."¹⁶⁵ In 1916 Cedric Taylor was invalided from Gallipoli to Australia with shell shock and after giving up several jobs because of "nerve trouble",¹⁶⁶ eventually occupied a fruit growing block in northern Victoria on July 1921. A Closer Settlement Board report maintained:

Taylor's lease was cancelled 10.3.26 and he has not been in this district since. Reasons for non-success were lacking application necessary to enable him to succeed in a fruit block and generally unreliable. The Supervisor does not mention his health as being a factor.¹⁶⁷

The yeoman ideal and the need to repay Australians who had sacrificed so much for the noblest cause in its brief history were the two most powerful incentives behind the soldier settlement scheme; perhaps these motives blinded authorities to all rationality for it is clear that a great number of would-be farmers - including many shell shock victims and their dependents - struggled unsuccessfully to come to terms with the ridiculous and heartbreaking idea of the cripple as farmer.

Pensioning

War neurosis provided particular conundrums for the Department of Repatriation's pensioning machinery. It belonged to that category of disability - along with tuberculosis, venereal disease, alcoholism and a range of other illnesses - that was sometimes not immediately obvious to authorities as due to war service. As a result, its handling was surrounded by a degree of uncertainty that had to be counterbalanced by general measures such as "benefit of the doubt", specific devices like the two year time limit¹⁶⁸ and the occasional employment of experts to adjudicate. In addition, psychological disorder was

¹⁶⁴ Memo, Repatriation Hospital, Bundoora, 4 March 1930, in *ibid.*

¹⁶⁵ Closer Settlement Board to Deputy Commissioner, 6 July 1928, in Henry, PCF, *op. cit.*.

¹⁶⁶ Form U, 19 June 1931, in Taylor, PCF, *op. cit.*.

¹⁶⁷ Closer Settlement Board Report, 28 September 1931, in *ibid.*

¹⁶⁸ The Department of Repatriation's 1920 Annual Report stated: "In tubercular and mental cases the manifestation of symptoms of disease within two years after discharge might establish the claim to have the condition recognised as a war disability." (Civil Re-Establishment, *op. cit.*, pp.19-20.)

accompanied by such a weight of prejudicial cultural "baggage" that a fair hearing for some applicants was simply out of the question - they were judged rather than examined.

The chief characteristic of pension administration under the Department of Repatriation was inconsistency. Parsimony and the tendency to moralise were both present in entitlement decisions but so too were leniency and generosity. As a result, it was not unusual for returned soldiers whose circumstances were virtually identical to be awarded pensions of vastly differing rates: some were denied pensions altogether despite their seemingly obvious eligibility while others were awarded gratuities although they did not meet any of the necessary criteria. In short, the pensioning process was inequitable. Overarching all of this was the Department's perception of itself as exceedingly generous, a sentiment that makes a pointed contrast with the opinions and the poor material circumstances of some applicants. For many war neurosis victims, the paucity or complete absence of pensions increased their anxiety about the degradation of their standard of living and their roles as breadwinners. Battling with a vast bureaucracy further taxed their physical and mental resources; thus, their disorders were compounded instead of relieved.

From November 1914, when a war pensions Bill was first announced, until July 1920 when Repatriation assumed the function, the pensioning of returned soldiers was the responsibility of the Treasury which first discharged this duty through a Pensions Board and then, after July 1915 through a decentralised Pensions Commission. The Board was deemed to be inefficient and, under the Commission, its schedules were reviewed: beneficiaries were exactly defined and payments made more precise. By 1916 the fundamental elements of war pensioning in Australia were in place: graduated scales based on levels of incapacity, assessment of eligibility controlled by medical opinion, questionable adequacy of benefits ¹⁶⁹ and the creation of a sense of grievance in some soldiers who felt that they had been unfairly treated.

Entitlement to a pension - and, therefore, to medical treatment - was dependent on whether a man's disability was accepted by the Department of Repatriation as due to war service, and, as in the days after May 1916 when Treasury and Defence were in charge of pensioning, the people who decided this question were the Department's medical officers. Returned soldiers were, first of all, given a medical examination after which a recommendation was made by the senior medical officer in each State as to whether the disability was due to war service and what proportion of a full pension the invalid should receive. The case was then adjudicated by the State Board and, if any doubt arose, it went to the Commission itself and the Medical Advisory Committee and, after 1929, to a

¹⁶⁹ One man, Private James Rivers of the 17th battalion, was evacuated from Gallipoli with "nervousness" and discharged in 1916, incapacity 25 per cent. In order to supplement his meagre pension Rivers worked as a miner but over a period of sixteen months experienced worsening neurasthenic symptoms including speech difficulties and loss of memory. In 1918 he became a fruit hawker but developed tuberculosis; eventually, he was not able to work at all. (Minutes of the Medical Advisory Committee), 10 November 1924.

specially created War Pensions Assessment and Appeal Tribunal.¹⁷⁰ Pensioning was, therefore, largely a medical matter, and so gave enormous power to a relatively small group of doctors who wielded their influence with a variety of attitudes ranging from cautious compassion to outright contempt.

Until 1943 the onus of proof rested on the person making a claim for Repatriation Department benefits. This requirement was offset by Departmental policy of "benefit of the doubt" which, if there were any, should go to the claimant.¹⁷¹ To a large extent, the success of a claim rested, in theory, on what was contained in a returned serviceman's medical records: if no evidence of a disability appeared in these documents then the case was not officially recognised. Fortunately, however, the Department, acknowledged that in, many cases, such records were incomplete and, therefore, were inadequate as a basis on which to make a decision; it recognised also that many men continued to serve rather than go to hospital so the disabilities for which they made claims in Australia that did not appear on file. David Gilbert, Nicholas Lockyer's successor as Comptroller, felt that his Department had a "moral responsibility in providing treatment for these disabilities which will naturally be unrecorded - since they have never been reported."¹⁷² Under these circumstances - the absence of detailed records - the Department believed that it would be "difficult to refuse treatment"¹⁷³ and so made provision to have these cases considered by the Departmental Medical Officer who would make a decision either to accept the claim, reject it or have it investigated by a higher authority.

When trying to assess whether war neurosis was due to military service, pensioning authorities - and in particular the Medical Advisory Committee - employed a variety of criteria in addition to those made familiar to the public in official Departmental literature. All of these criteria were applied unevenly. "Benefit of the doubt" and "treating each case on its merits" were important but they were often counterbalanced by other standards such as an applicant's moral integrity, a measure that the Commission and the Medical Advisory Committee sometimes seems to have employed in preference to the complicated problem of unravelling and assessing knotty psychiatric symptoms. This difficulty was acknowledged during a meeting of the Medical Advisory Committee in November 1924: "It was a matter for comment that it is difficult to know how to differentiate between war and post-war factors in the causation of these cases which primarily come under notice so long after discharge."¹⁷⁴

¹⁷⁰ Butler, Vol III, op. cit., pp.805-806 and 814-816. Butler says that the Assessment and Appeal Tribunal "removed the ultimate responsibility and authority from the medical to the legal profession." Further, he says that the Medical Advisory Committee "ceased to exist. As a permanent appeal board it was unworkable." The Minutes of the Medical Advisory Committee after 1929 show, however, that it did not "cease to exist" and that it remained an active administrative body.

¹⁷¹ Civil Re-Establishment, op.cit., p.20.

¹⁷² Submission by Comptroller D. Gilbert to Medical Advisory Committee, in Minutes of the Medical Advisory Committee, 17 October 1919.

¹⁷³ Memo, anonymous, undated, in Minutes of the Medical Advisory Committee, circa 1919.

¹⁷⁴ Minutes of the Medical Advisory Committee, 10 November 1924.

Despite these difficulties the Medical Advisory Committee resisted the idea of summoning expert opinion. When Sir Neville Howse, Minister for Repatriation, suggested that a psychiatrist be employed in every case claiming war neurosis, the Committee replied that it was satisfied with its own level of expertise and would employ the services of Sydney psychiatrist Sir John MacPherson, only when its members could not agree.¹⁷⁵ Further criteria (which suggest the ascendancy of the moral over the medical) employed by the Commission and the Committee included inability to work, which told in a soldier's favour,¹⁷⁶ and, perversely, whether he had actually worked and thus demonstrated moral fitness.¹⁷⁷ The quality of a soldier's war record,¹⁷⁸ and whether a veteran or anyone in his family had a history of mental illness or alcoholism were also taken into account.¹⁷⁹ One man even received credit for enlisting under eighteen years of age.¹⁸⁰

Many examples exist of war neurosis cases being favourably assessed according to the aforementioned criteria. Some cases were simple to judge because they fell easily within Departmental guidelines. Private R.G. Lane, for example, was discharged medically unfit in July 1919, travelled to Canada, and spent 30 months there in a mental asylum. Returning to Australia in 1924 he purchased a farm in New South Wales but was unable to carry on and became unemployed. The Medical Advisory Committee recommended acceptance of the claim because "there was no doubt that mental condition arose within two years of discharge."¹⁸¹ Other cases, however, were not as easy to adjudicate but pensions authorities still found in favour of the applicant. For example, although a pre-war history of mental illness seriously prejudiced some cases, others were given the benefit of the doubt. Former Private Edward Quick was said to be of poor mental development and had always found it difficult to adapt to his environment. Seriously wounded and practically unemployable, he made a claim for psychological damage caused by war service and was accepted "on the grounds that war service had greatly restricted his already serious limitation."¹⁸² Mental symptoms were first diagnosed in Sapper H. Stewart in 1925 when he was 27-years-old. The Medical Advisory Committee recommended acceptance of his claim because the balance of probability was in his favour: "Although it was recognised that the inherited tendency was a factor that could not be ignored, it was regarded that the strain of long service had probably aggravated or accelerated his mental break-down . . ." ¹⁸³

The suggestion of alcoholism or a family history of mental illness could also - but not always - undermine a claim. Private Gregory Collins, discharged in July 1918 with a

¹⁷⁵ Minutes, Advisory Committee, op. cit., 4 August 1925.

¹⁷⁶ Ibid, 24 June 1925.

¹⁷⁷ Ibid, 4 June 1925.

¹⁷⁸ Ibid.

¹⁷⁹ Ibid, 29 October 1925.

¹⁸⁰ Ibid.

¹⁸¹ Ibid, 19 February 1926.

¹⁸² Ibid, 10 November 1924.

¹⁸³ Ibid, 4 June 1925.

gunshot wound of the right knee, applied for acceptance of acute melancholia after he was admitted to the Receiving House, Royal Park in August 1925. The Medical Advisory Committee regarded the claim as problematical because of an "hereditary defect" but accepted Collins as a case of material aggravation.¹⁸⁴ Martin Vaughan, formerly of the 21st Battalion, had a history of alcoholism and a brother who was receiving treatment for a psychological disorder. His claim, however, was accepted as one of material aggravation because the Medical Advisory Committee felt that "long war service probably accelerated his mental disability."¹⁸⁵

The Medical Advisory Committee also occasionally restored pensions that had been cancelled by other authorities. Former Private William Orpington of the 60th Battalion developed serious psychological symptoms in 1922 but his claim was rejected by the Department because it believed his condition was caused by alcohol; in 1925, however, his case was reconsidered and he was awarded the benefit of the doubt.¹⁸⁶ Private Donald Warner was discharged in 1919 with a twenty per cent pension for the shrapnel wound in his left arm. In 1923 he began the first of many visits to a variety of mental hospitals but his attempts to have his condition acknowledged as due to war service were rejected by the Department. The Medical Officer of the Ballarat Receiving House mentioned alcoholism in his report but the Medical Advisory Committee believed this to be a "sign and not the cause of his mental breakdown" and so accepted the claim.¹⁸⁷ Private R.J. Douglas returned to Australia in 1919 and was admitted to an asylum in 1924. His twenty-five per cent pension was cancelled in February 1921 and his appeal rejected in July 1925. A further appeal (to the Medical Advisory Committee) was accepted in view of mental symptoms during and after service.¹⁸⁸

When continuity of symptoms or other mitigating factors did not exist, the Medical Advisory Committee sometimes found in favour of the applicant if he had been unable to work for long periods. For example, Corporal G.H. Smith was discharged with a gun shot wound in June 1916 but was admitted to an asylum in 1923 and 1925 with a psychological disorder. The Committee recommended that his disability be accepted as due to war service "in view of his continued incapacity for work."¹⁸⁹ In one case being a former prisoner of war in Turkey seems to have carried with it an almost automatic right to a pension. Martin Neal, a former trooper in the 10th Light Horse Regiment, was admitted to a mental asylum more than two years after discharge suffering from alcoholic insanity which a Departmental Medical Officer attributed to "domestic worries, war stresses and an attack prior to the war." In contradictory fashion he reported that although Neal "had good

¹⁸⁴ Minutes, Advisory Committee, 22 December 1925.

¹⁸⁵ Ibid, 12 May 1925.

¹⁸⁶ Ibid, 11 February 1925.

¹⁸⁷ Ibid, 12 September 1925.

¹⁸⁸ Ibid, 29 September 1925.

¹⁸⁹ Ibid, 21 November 1925.

service" at Gallipoli and in Palestine it wasn't likely that war experience had caused his mental trouble; he revealed, however, that, in addition to a kick from a horse, appendicitis and jaw wound and malaria, Neal had been a prisoner of the Turks. In response, the Commission wrote: "In view of the fact that this man was a prisoner of war in Turkey the Commission will attribute his insanity to war service." ¹⁹⁰

The self-image of Repatriation Department officials makes a sharp contrast to some of their harsh decisions. In addition, these judgements further underline their inconsistency and remoteness from the mass of returned soldiers. Many officials involved with Repatriation Department pensioning took the idea of benefit of the doubt seriously, a commitment that can be seen not only in their decisions but in some of their private comments as well. For example, in July 1924 the Medical Advisory Committee was struggling to decide whether the neurosis of Private William Francis was due to syphilis or war service. In response to the debate that took place between Committee members, the Principal Departmental Officer, James Courtney, said: "We make such a lot of giving the benefit of the doubt and here we have the opinion of two Sydney consultants in his favour . . . That creates the reasonable doubt of which he should get the benefit." ¹⁹¹ On the strength of this doubt the Committee resolved to accept the claim as due to war service. Courtney's remark typifies the Committee's image of itself as a liberal body with the interests of returned soldiers at heart. This self-perception was evident, for example, when attempts were made by the Minister, Sir Neville Howse, to hasten the manner of the Committee's proceedings and to force it to articulate some "hard and fast" rules that might help other pensioning authorities expedite a rising backlog of cases. Howse wanted the Committee to use a precis of each case rather than the full complement of medical and military records. Stubbornly, the Committee resisted this attempt on the grounds that such a move would threaten its liberal approach: "It was pointed out by Dr. Stawell that this method has been discarded as the present method had the advantage of bringing the members into closer contact with the circumstances of each case." ¹⁹² In February 1925 the Medical Advisory Committee expressed the fear that it was becoming too generous, allowing, as it did, virtually no time limit on a claim as long continuity of symptoms existed:

During discussion it was advanced that the difficulties of eliciting and weighing the merits and demerits of an application for acceptance many years after discharge from service had caused the Committee, in giving the benefit of any doubt to the soldier, to interpret most liberally the signs and symptoms, claims and facts so that they will operate in the favour of the soldier. . . The Chairman added that we seem to be drifting towards being guided by 'possibility' [rather than by 'probability'] - this as years pass would mean that almost every applicant for war pension would be granted. ¹⁹³

¹⁹⁰ Minutes of the Repatriation Commission, 23 June 1922.

¹⁹¹ Minutes of the Medical Advisory Committee, 17 July 1924. pp. 9-10.

¹⁹² Ibid, 11 February 1925.

¹⁹³ Ibid, 27 February 1925.

That benefit of the doubt was implemented and that the self-image of the Medical Advisory Committee was at least partly justified is born out by the positive results of many applications to the Department of Repatriation for benefits, including the above examples. Such a view is contradicted, however, by many cases in which prejudice against mental illness became apparent and in which the aforementioned criteria were not applied. Such uneven application of principles gives rise to the conclusion that another major characteristic of the Repatriation Department's pensioning process in the 1920s and 30s was inconsistency that amounted almost to capriciousness. It is probably not too much to say that it was inequitable, even unjust. Many soldiers who became frustrated and embittered by the Repatriation bureaucracy and its failure to recognise or alleviate their straitened circumstances, would have responded with derision to the Medical Advisory Committee's view of itself. The discrepancy between this self-image and the everyday realities of shell shocked soldiers' lives serves to emphasise further the distance between the bureaucracy and the men it was supposed to be serving.

Although magnanimous in many instances, the Medical Advisory Committee and other pensioning authorities were also capable of harshness and almost unfathomable inconsistency; such action made the leniency of these officials especially galling for those rejected: these bitter men and their families were unable to understand why they were less deserving than those who had received the favourable gaze of the Repatriation Department for disorders similar to their own. Controversy was not limited, however, to the relationships between returned servicemen and the Department. Within Repatriation itself, individual doctors clashed over diagnoses in a manner that shows that the old prejudices against mental disorder were active in more than just Departmental literature. In these instances it was whole frames of reference - world views - not just simple differences of opinion that were incompatible. And, of course, the major effect of these rejections and disagreements was not a closed file or a temporary souring of professional relationships, but continued or increased indigence (with all the consequences which that entailed) for the returned servicemen in question.

It is clear that some men claiming mental disorder due to war service were attempting to defraud the government and that pensioning authorities were probably right to reject their applications. One man, for example, said that he was wounded three times on Gallipoli - bayoneted, shot in the toe, blown up and buried unconscious for ten hours - and claimed shell shock. Later, he admitted that he'd never been at Gallipoli, and his case was dismissed.¹⁹⁴ Some rejections, however, seem less understandable, especially in the light of those that were accepted. Private A.J. Green of the 26th Battalion was discharged medically unfit with melancholia in June 1918. Before he left the AIF he spent some time in Mont Park; afterwards, he was unable to work a soldier settlement block because of his

¹⁹⁴ Advisory Committee, *op. cit.*, 3 October 1925.

mental condition but the Medical Advisory Committee stated that it was unable to establish a causal connection between Green's disability and his war service.¹⁹⁵ Similarly, Trooper R.L. Meadows of the 1st Light Horse Regiment was discharged in 1917 with neurasthenia but his incapacity was deemed "not greater than before enlistment." In January 1919 Meadows' twenty-five per cent pension was cancelled then restored to fifty per cent, reviewed again at the end of the year and halved to twenty-five per cent. In 1921 the pension was cancelled altogether. Meadows was admitted to various mental asylums between 1921 and 1925 when he appealed against his cancellation; the Medical Advisory Committee found, however, that his disability was not due to or aggravated by war service and rejected his application.¹⁹⁶ H.L. Wilson was discharged in September 1919 with a gunshot wound to the left leg but by 1924 was suffering from melancholia which the local doctor felt had developed only that year, a time when he had also suffered a blow to the head with a piece of timber. Despite a supporting statement that Wilson's nerves had steadily deteriorated from the time of his discharge, the Commission could find no evidence connecting his disability with war service and so rejected the claim.¹⁹⁷

Alcoholism was sometimes given as a reason for nullifying, restricting or not awarding a pension (and, of course, it was forgiven on other occasions). Private Edward Dobbs, for example, had his pension cancelled in 1920 due to chronic alcoholism.¹⁹⁸ Like Dobbs, the moral transgressions of Lieutenant C.J. Samuels cost him dearly. Within two years of his discharge from the AIF, he began to drink heavily to alleviate insomnia and nervousness; he developed alcoholic psychosis. The Medical Advisory Committee accepted that no pre-war alcoholism existed, that his war record was "exceptionally good" and that he became "nervous and depressed during the latter part of his service." And yet they attributed his alcoholism more to "want of self-control" than to war service and so awarded only a partial pension.¹⁹⁹

Detailed records of medical disputes over individual cases of war neurosis applying for benefits help to suggest answers to the Department's erratic decisions on pension entitlement. It was not unusual for Repatriation Department Medical Officers to disagree over diagnoses of all kinds, including war neurosis, but some doctors required a standard of proof that suggests they were simply unwilling to extend the benefit of the doubt even in cases that seemed beyond reproach to their colleagues. In these instances the old prejudices against mental illness surfaced and were all the more obvious when contrasted with the progressive approaches that favoured acceptance of the claim on scientific grounds, not rejection founded on a moralistic or legalistic basis. A minor example is the case of

¹⁹⁵ Minutes, Medical Advisory Committee, 5 November 1925.

¹⁹⁶ *Ibid.*

¹⁹⁷ Minutes of the Repatriation Commission, 18 March 1925.

¹⁹⁸ Deputy Commissioner Repatriation, Victoria, to Secretary, State War Council, 24 September 1926, in Private. E. Dobbs, 28th Battalion, PCF.

¹⁹⁹ Minutes of the Medical Advisory Committee, 1 November 1933.

Corporal Edmond Johns who was discharged in April 1918 with Disordered Action of the Heart, a common psycho-somatic ailment which, in him, produced pains over the heart, back and arms, shortness of breath and headaches. Despite this record, an eight week stay in Royal Park Mental Hospital, a continuous history of nervousness and intermittent attacks of melancholia, a prominent Repatriation Department doctor doubted the role of military service in the disability and recommended rejection of the claim. Fortunately, he was overruled by the Principal Department Medical Officer who accepted the condition as due to war service.²⁰⁰

A more fully-documented example - in which, unusually, there is a verbatim record of a bitter exchange between the two medical officers most heavily involved - is the case of Private Albert Marsh who was discharged medically unfit in 1916. Marsh did not seek Repatriation Department help until 1931 but in the preceding years had been unable to work, suffered a nervous breakdown and experienced night terrors which had increased in severity after 1929. The only treatment he received was self-administered doses of nerve tonics which he purchased at pharmacies.²⁰¹ For some doctors the chief problem with Marsh's claim was the absence of definite documentation to support his assertion that he had been knocked unconscious and shell shocked at Gallipoli in November 1915, evacuated and treated for neurosis at Gibraltar where, he said, "I felt very sick and my nerves seemed to be completely gone. I could not stand the slightest noise and had to be held down in bed."²⁰²

In the years between his discharge and 1931 Marsh was examined by several private doctors, the majority of whom supported the idea that war experience had caused his neurosis; contrary opinions were in the minority but the resulting doubt seemed to be so greatly in his favour that he should have received the benefit. Dr. Fredericks of the Homeopathic Hospital in Sydney reported that Marsh "had shell shock badly"²⁰³ while Dr. John Moore of Collins Street, Melbourne, told the Repatriation Department: "[H]is present physical and mental condition are largely due to shell shock sustained during the late war."²⁰⁴ These opinions were supported by other private doctors: D. R. Atkinson,²⁰⁵ and Dr. Jeremiah of Sydney, who had treated him for "shell shock" in 1918, and by the records of No. 5 AGH where the "condition does not seem to have been doubted."²⁰⁶ and most importantly, by Dr. Clarence Godfrey who found himself at serious odds with some of his colleagues in the Repatriation Department.

²⁰⁰ Minutes of the Repatriation Commission, 12 March 1925.

²⁰¹ RGHC Case Sheet, 5 November 1931, in Private A. Marsh, 22nd Battalion, PCF.

²⁰² Form V, 23 November 1931, in *ibid.*

²⁰³ Clinical Notes, Homeopathic Hospital, January 1932, in *ibid.*

²⁰⁴ Report from Dr. J.K. Moore, 23 March 1932, in *ibid.*

²⁰⁵ Report from Dr. D.R. Atkinson, 12 August 1932, in *ibid.*

²⁰⁶ Report from Dr. C. Godfrey, 2 September 1932, in *ibid.*

Their clash over Marsh did not represent a difference of medical opinion so much as a major collision between two vastly different approaches to mental illness. Godfrey drew his conclusions from Marsh's symptoms: tremor of the hands and tongue, a restless nervous manner, nightmares, physical fatigue "out of all proportion to effort", depression inexplicable on any known grounds." ²⁰⁷ He wrote:

When admitted to No.5 A.G.H. ... the symptoms recorded appear to amply confirm the nervous state ... My conclusions in this case are that the evidence justifies the claim that Marsh was shell shocked when sent out of the line on 29.10.15 and that the nervous signs noted at Gibraltar ... were the sequelae of shell shock; that for some years after, the nervous disorder persisted to a partially incapacitating extent, and was probably much in abeyance between 1920 to 1928 or 9; that he has a constitutional tendency to neuropathic conditions; that war conditions initiated the nervous disorder (neurasthenia) which never entirely left him and is readily achieved by extraneous conditions which would otherwise have no effect on him. To this extent, therefore, I consider he has a war-caused disability." ²⁰⁸

By contrast, Dr. V.A. Cato, stated in a superior manner reminiscent of the juridical approach taken at the NYDN centres behind the lines in France ²⁰⁹ and Belgium:

I cannot agree with Dr. Godfrey that the evidence justifies the claim that Marsh was shell shocked when sent out of the line ... and that the nervous signs noted at Gibraltar were the sequelae of shell shock. There are no notes whatever from Gibraltar, so that there are no nervous signs noted at Gibraltar ... The first mention of shell shock was on 18.1.16, 2.5 months after evacuation. Does Dr. Godfrey know that the symptoms are quite compatible with convalescence of a man of neuropathic constitution after influenza. The sequence of events as in this case is not at all uncommon. The neuropathic who broke down on service without any wounding or with only mild illness almost invariably subsequently gave a history of having been "blown up." They felt that they had to give a good reason for the break down ... And in 1916 the diagnosis of shell shock was very readily retained in neuropaths who had simply been unable to stand service. So little was known of shell shock in Australia in 1916. In my opinion this is a case of constitutional neurasthenia, temporarily aggravated by service, with recovery and subsequent civil breakdown. ²¹⁰

Dr. S. Callow also opposed acceptance of the claim. He stated:

History of ex-member and his family suggests congenital Neuropathic tendency. [His mother spent four years in Mont Park; his brother spent time at Lara] His statement on 23.11.31 re shell shock followed by several days of unconsciousness must be discounted on account of (a) its late appearance (b) lack of confirmation ... The first mention of shell shock is 18.1.16 at a medical board at Wandsworth. ²¹¹

Although Godfrey's opinion forced the case back to the Commission for re-consideration after it was initially rejected, the claim was eventually dismissed by the Medical Advisory Committee which agreed with Cato's negative assessment. Despite the level of doubt that existed in this case, the benefit was not awarded to the returned

²⁰⁷ Godfrey, op. cit..

²⁰⁸ Ibid.

²⁰⁹ See chapter two, pp.80-97.

²¹⁰ Dr. V.A. Cato, 14 September 1932, in *ibid.*

²¹¹ Dr. S. Callow, Report, 15 March 1932, in *ibid.*

serviceman, the authorities basing their decision on medical opinion founded on scepticism and a propensity to judge rather than diagnose.

The reluctance of some Repatriation Department officials to award pensions was based not only on medical and moral considerations but also on the belief that financial benefits were likely to encourage some men to try to maintain their symptoms and so retain their pensions. Thus it was felt that pensions could be used as a means of social control. Very early in the Department's history, Senator Millen remarked that pensions and other fiscal rewards - what he called "material considerations" - were, in fact, the only form of control that civilian authorities had over returned soldiers.²¹² The Chairman of the Repatriation Commission, James Semmens, thought similarly, and explained to the Deputy Commissioner, New South Wales, why full pensions were not granted to occupants of Convalescent Farms, irrespective of their degree of incapacity. He pointed out that the goal of the farms was to rehabilitate men through graduated work so that they could eventually take up a civil occupation and that payment of a full pension would counteract the stimulus of a graduated income "and militate against the successful graduation of patients through the several grades." He maintained that "unless some stimulus is given them, and they are prepared to assist themselves by working under the graduated farm scheme, the usefulness of these farms is defeated."²¹³

A Freudian psychotherapist working with returned servicemen at Caulfield Hospital also believed that pensions were sometimes a hindrance to recovery. Highly irritated with one shell shocked man, he wrote: "I do not think he is as bad as he tries to make out in the past. In my opinion his condition can in no way be attributed to war service ... The only treatment I could suggest is to try to reduce his pension to about twenty per cent and try to get him to work."²¹⁴ Similarly, Clarence Godfrey, whose responses show that progressive attitudes (vide the Marsh case) and old dogmas could easily co-exist in the one person, said of one returned soldier who still suffered an hysterical contracture of the left leg and hallucinations about war incidents: "This man is a constitutional neuropath - never likely to do any good - as long as pensions and manifestations of sympathy by others exist."²¹⁵ Returned soldiers who refused hospital treatment could also be denied financial benefits as was the case with one man who did not want to attend Ballarat Hospital. In the manner of an affronted school master, Departmental Medical Officer wrote: "As this man's condition is due to his own wilfulness I do not feel justified in recommending sustenance. Before finalising him I suggest he be given another chance to accept treatment."²¹⁶

²¹² Minutes of the Medical Advisory Committee, 18 February 1919.

²¹³ J. Semmens to Deputy Commissioner, NSW, 16 September 1921, in HQ Memoranda, 23 April 1921 - 26 January 1922. Department of Veterans Affairs, Central Office Library, Canberra.

²¹⁴ Clinical Notes, RGHC, 23 March 1932, in Private H. Tweed, PCF.

²¹⁵ Clinical Notes, RGHC, 18 May 1933, in Harvey, PCF, op. cit..

²¹⁶ Courtney to Deputy Commissioner, Victoria, 1 July 1919, in Private A. Taylor, 38th Battalion, PCF.

Recognition of a mental disability as due to war service did not automatically bring with it full benefits; in fact, the granting of a pension did not necessarily deliver financial stability or comfort to the recipient and his family at all. Economic and personal insecurity created by the inability of war neurosis sufferers to work, and the inadequacy or absence of the pension, became one of the chief causes of family breakdown and the destruction of self-esteem in the returned servicemen concerned. These manifestations of social dislocation will be the subject of the next chapter.

Within the Department of Repatriation the two major philosophical impulses that governed the attitudes and actions of bureaucrats and medical officers towards war neurosis - the moralising, judgemental approach and the progressive, scientific view - both co-existed and competed in the treatment of psychological casualties. To say, however, that one prevailed over the other would be to oversimplify the subtlety and complexity of their interaction and to ignore the role of other elements such as bureaucratic capriciousness or solidified disorders in the Department's failure to solve the problems associated with chronic war neurosis. The dynamics of the Department on this issue cannot, therefore, be understood as a simple dichotomy founded on a mutually exclusive opposition between regressive nineteenth century morality and more enlightened twentieth century psychology. Neither triumphed. It is clear, from the pronouncements of doctors such as Clarence Godfrey that both propensities could be reasonably compatible in the one person and exercise their influence alternately. More importantly it is evident that neither of these positions - either together or singularly - was efficacious when faced with the difficulty of trying to rehabilitate sufferers of war neurosis medically, socially or economically. No doubt some psychological casualties did recover, as Departmental literature argues; others, however, were unfit to take advantage of anything Repatriation offered to the returned serviceman. Success at vocational training, placement in meaningful and gainful employment or a felicitous life on the land were beyond the reach of many psychological casualties because of their illness and the weakness inherent in the idea of exposing unrecovered invalids to the competitiveness of civil society.

Chapter Seven

War Neurosis and Social Dislocation: A Hidden Postwar Tragedy

He has a good heart, and since he came home with shell-shock, or whatever it was, he has not been quite the same. Poor boys, I saw only yesterday in the paper, where a shell-shocked soldier killed his wife and two little children. Terrible, terrible, and he had been given a farm by the government, too. It is terrible.

Christina Stead, *Seven Poor Men of Sydney*.¹

In Australia the Great War either exacerbated or was directly responsible for major political, economic, industrial and social dislocation.² Pre-war divisions between capital and labour, government and unions, middle class and working class, and Protestant and Catholic became more pronounced as the result of Australia's involvement in the world conflict.³ For these antagonisms the war was only a catalyst that released deep tensions; it was, however, more or less entirely the major cause of arbitrary labelling of so-called "loyal" and "disloyal" elements in the community and gratuitous persecution of "shirkers", "slackers" and "cold footers";⁴ it also created an unbridgeable distance between soldiers and civilians, as well as hostility between returned servicemen and trade unionists,⁵ pro and anti conscriptionists,⁶ and the war generation and its children.⁷ Several major events typified these disruptive trends: the strikes of 1916 and 1917, the Labour Party split over conscription (which also divided the nation); the soldier riots of 1919, and Prime Minister W.M. Hughes' explicit rhetorical division of the population into "sheep" and "goats": those who had contributed to the war effort and those who had not.⁸

Into this fragmented community at the end of the war was injected another component just as unsettling as any of these other divisive elements: the psychological casualty. Unlike the conflicts already mentioned, however, the resulting disruption

¹ C. Stead, *Seven Poor Men of Sydney* (Angus and Robertson 1934; this edition Pacific Books 1971), p.64.

² See, for example, R. White, "War and Australian Society", in M. McKernan and M. Brown (eds.), *Australia Two Centuries of War and Peace* (Australian War Memorial in association with Allen and Unwin Australia 1988), pp.391-423; and R. Evans, *The Red Flag Riots. A Study of Intolerance* (University of Queensland Press 1988), pp.4-6; J. Beaumont, "The politics of a divided society", in J. Beaumont (ed.), *Australia's War, 1914-1918* (Allen and Unwin, Sydney 1995), pp. 35-63.

³ F.K. Crowley (ed.), *A New History of Australia* (William Heinemann, Melbourne; first published 1974; this edition 1977), pp.343, 345, 354.

⁴ T. King, "Telling the Sheep from the Goats: 'Dinkum diggers' and Others, World War 1", in J. Smart and T. Wood, (eds) *An Anzac Muster. War and Society in Australia and New Zealand 1914-18 and 1939-45* (Monash Publications in History, No. 4, 1992), p.88.

⁵ See especially Evans, op. cit..

⁶ M. Lake, *A Divided Society*, (Melbourne University Press 1975).

⁷ Crowley, op.cit., p.354, and M. McKernan, *The Australian People and The Great War* (Thomas Nelson, West Melbourne 1980), pp.219-221.

⁸ King, op. cit, pp.97-99.

occurred mainly at the level of the family and was, therefore, largely hidden. Although the effects of neurosis amongst returned servicemen were not as conspicuous as some of the other upheavals created by the war, it was, in fact, the cause of terrible social dislocation. War neurosis made emotional cripples of many returned soldiers, who, unable to settle down or engage in normal social intercourse, found peace of mind and regular employment virtual impossibilities. Consequently, low incomes and reliance on Repatriation Department pensions resulted in a serious reduction of living standards for many families. Often, the entire responsibility for the well-being of families fell to wives. These women and their children also had to endure high levels of violence and terrorisation from frustrated and worried men whose disorders and aberrant behaviour were aggravated by alcoholism, drug abuse and loss of self-esteem. But not all war neurosis sufferers were violent; many were simply a withdrawn, passive presence in homes and townships throughout the nation. Under these various stresses many families disintegrated and scattered despite strenuous efforts to maintain respectability and cohesion. War neurosis - a hidden tragedy - was, therefore, a highly divisive influence in Australian society during the 1920s and 1930s.

The Psychological Casualty as Social Misfit

For the community at large there were few hints of the rents inflicted on society's fabric by the tragedy of shell shock. This was especially the case for those who had no contact with the individuals and families concerned. In the press the problem was not widely reported but when it was covered, reports ranged from the sober and sensible to the highly sensational. Occasionally they were contemptuous. Usually, coverage concerned individuals and not their families or communities so there was little sense of the wider picture. In February 1919, for example, the Melbourne *Argus* reported the activities of John Springthorpe in Europe during the war and included a straightforward account of the symptoms of shell shock as well as an assertion that it should not be confused with insanity.⁹ Almost three years later, by contrast, the same paper published a highly misleading, defamatory account of the dubious 'motives' of 'neurasthenics' and the rehabilitative success of the Bundoora Convalescent Farm. The Repatriation Department could not have wished for more strident propaganda nor shell shock victims for a worse press. Under the frightful heading "Treatment of War Derelicts" the article intoned:

Among the thousands of cases which have been dealt with by the Repatriation Department, none have presented greater difficulty than those of men, who as a result of the strain of war, have been classified on their return to civil life, as 'neurasthenics.' These men have been shellshocked, gassed, or weakened by trench fever, and they have returned to Australia 'bundles

⁹ *Argus*, 3 February 1919.

of nerves', shattered and debilitated. There is a definite link between the idle soldier who haunts the unemployment bureau, preferring financial doles to work and the neurasthenic soldier. . . . Too few nerve-shattered former soldiers have taken advantage of the institutions which have been provided by the Government, but the 50 men at the Bundoora convalescent farm . . . are gratifying proof of what can be accomplished if the man is willing to be treated . . . When a man whose only difficulty is his inability to 'pull himself together' enters Bundoora he is graded . . . Dr. James says that the average man requires four months at Bundoora. At the end of that period the listless, nerve wracked 'digger' has learned how to work once again, and has been transformed into a healthy, industrious labourer ready to take his place on civil life.¹⁰

Prompted by individual tragedies, the reporting of shell shock could also be the standard, highly colourful, tabloid fare. "Nerve-Stricken, After-War Tragedies, 'Torments of the Damned'" headed an article in the *Sydney Sun* which was a response to the suicide of a shell-shocked soldier. The piece opened with a quote from a "well-known Sydney nerve specialist", Dr. Benjafield of the Department of Repatriation:

Walking about Sydney's streets are scores of men who outwardly appear to enjoy life. But behind the mask their conscious and unconscious selves are in constant conflict. They are the war's crop of neurotics, and they suffer silently the torments of the damned.¹¹

The article also included some frightening individual examples which could have aroused equal measures of sympathy and revulsion in an ignorant public:

There is a man who, apparently normal, could not take three steps in the street. Before him there always yawned a huge shell hole. A non-commissioned officer who went through the early stages of the war, was wounded twice and gassed, went home on leave, and suddenly collapsed, and has ever since been the subject of acute neurasthema [sic].¹²

In July 1922 the *Argus* could not help reporting that the pistol with which former Lieutenant Phillip Smith, DSO, committed suicide had nine notches on the stock, each one representing a German killed in the course of winning the medal. The paper stated: "Dr. Cole decided that death was due to a gunshot wound in the head, self-inflicted. 'There is evidence of mental illness at the time,' he added."¹³

Perhaps, however, the most florid accounts of shell shock appeared in *Smith's Weekly* during its long campaign against the perceived parsimony of the Department of Repatriation. An example:

Have you ever seen a man possessed of devils? A man who by day or night, sleeping or walking, talking or weeping, will never know a moment's rest until he dies? - A man whose tongue shoots out, whose knee shoots up, whose giant hand shoots forward, whose hand jumps about like a sort of gigantic parched pea? Have you ever seen a shell-shock case?¹⁴

¹⁰ *Argus*, May 20 1922.

¹¹ *Sun*, 26 February 1923.

¹² *Ibid.*

¹³ *Argus*, 11 July 1922.

¹⁴ *Smith's Weekly*, 4 November 1922, quoted in C. Lloyd and J. Rees, *The Last Shilling: A History of Repatriation in Australia* (Melbourne University Press 1994), p. 201.

Whatever the intent of these accounts they probably helped to create a social context in which the realities of social dislocation caused by war neurosis were little understood except by its victims and those associated with their care.

One of the major consequences of the Great War for Australian psychological casualties was social maladjustment. This manifested itself in a variety of forms. One of the most common was a nomadic lifestyle, the result of an inability to settle and to cope with people or the bustling life of the cities. Some sufferers of war neurosis therefore fled to the bush. One of John Springthorpe's former patients in ward A10 at No. 3 AAH in England headed for the timber country of Western Australia in February 1919 to work in the State Saw Mills. He found however, that he could not avoid his illness. Disillusioned with life after discharge from the AIF, he wrote to a friend:

Take my tip old mate and swing the lead for all its worth for once the military discharge you its a sorry time . . . and although a man doesn't look to be molly-coddled yet he does deserve some recognition in preference to those who kept the home fires burning but in very rare instances is appreciation shown. . . Well am at a loss as to how my memory is myself and there are heaps of things I know nothing about which I was conversant with prior to my dust-up. ¹⁵

Another man, Angus McKay, sought solace in the isolation of the back of beyond but found only further torment because the solitude worked detrimentally on his mind. For years after the war he had lived alone in the hills near Bruthen in Gippsland but remained nervous and restless. Fearing that he might become insane if alone for much longer, ¹⁶ he finally emerged in 1934 and told the Local Medical Officer at Bairnsdale (who described him as a "tall, wild looking man") that he had a strong urging towards suicide. ¹⁷ Like him, many more men were unable to put down permanent roots upon their return. Robert Henry, for example, could not remain in one place for any length of time. One week he might be in Melbourne, the next in another State altogether but according to his wife there was "no good reason" as he was a very competent plumber with the ability to obtain plenty of work. ¹⁸ Maurice Daniels, from the time he returned to Australia in 1919 to his admission to Mont Park in 1930, was restless to the point where he was not even able to sit for any length of time. He moved from farm to farm, working, and in 1921 travelled to New South Wales from his home near Red Cliffs, Victoria, to which he only returned in 1926. He obtained employment as a PMG linesman but found the work difficult because he could not concentrate and often became dizzy; as a result, he had to take care to strap himself to the telegraph

¹⁵ "Bert" to "Dick", 24 April, in Springthorpe Papers, AWM 2DRL 701, Item 1.

¹⁶ Clinical Notes, RGHC, 12 April 1934, in Private A. McKay, 11th Battalion, PCF.

¹⁷ Memo for Hospital File, 7 April 1934, in *ibid.*

¹⁸ Form U, 14 June 1928, in Private R. Henry, 7th Battalion, PCF.

poles. ¹⁹ In 1928 Maria Leitner told the Deputy Commissioner of Repatriation in Victoria that her husband, Frederick (who had been shell-shocked in France) "had never stayed long at any employment since his return from the War he always wants to be roaming around." ²⁰ Later, she told the Commission that he was in the habit of staying away for "long periods" without contacting her. On one occasion, for example, he was absent from home for two years and ten months without sending word. ²¹ William Fieldhouse, a grocer in Melbourne before the war, was wounded in the knee in France but on the way to the dressing station was caught by an enemy barrage on a sunken road and buried. He became a "nervous wreck" and after the war was unable to maintain his sandwich business or his later position as editor of a sporting newspaper. In 1927 he was admitted to Caulfield Hospital "for my nervous condition" and in 1928 went to the Murray River District working for his food only on farms and stations. ²²

Sometimes the wanderlust that enthralled sufferers of war neurosis when they returned involved their immediate families as well as themselves; frequently, they would uproot their entire households and move from suburb to suburb or from city to city as the fancy took them or as circumstances created by their disorders dictated. In what seems like a pattern typical of severely disturbed returned servicemen, the alcoholic Captain Harold Walters and his wife travelled within Melbourne, throughout Victoria and also interstate over a period of twenty-five years. After losing their soldier settler block near Benalla in 1927, they briefly took up a poultry farm at Warrandyte before trekking to Mildura and then to the Dandenong Ranges. ²³ From that tranquil setting they established themselves in Melbourne so that Harold could attend hospitals there but lost their home when a financial institution foreclosed on the mortgage. ²⁴

Occasionally, domestic infelicity caused by war trauma forced men from their homes and away from the big cities. Private H.J. Tweed of the 5th Battalion was gassed and shell-shocked in 1916 and returned home "sullen and discontented" in 1917. At home he thought he was going mad. ²⁵ Descending into "mild delusional insanity" ²⁶ he had, by 1932, been ejected from home by his wife who found his irascibility impossible to live with. ²⁷ In February of that year he found himself near Ballarat living alone in a dirty hovel, a source of worry to his neighbours. ²⁸ Of all those Australians for whom a wandering lifestyle was one of the Great War's major outcomes, these men

¹⁹ Form U, circa 1930, in Private M. Daniels, 5th Battalion, PCF.

²⁰ M. Leitner to D.C., Vic., 23 October 1928, in Private F. Leitner, 25th Battalion, PCF.

²¹ M. Leitner, Form U, 29 November 1928, in *ibid.*

²² Form U, 6 May 1931, in Private W. Fieldhouse, 58th Battalion, PCF.

²³ Captain H. Walters, AFC, PCF, *passim*.

²⁴ Department of Repatriation, Minute, 21 February 1933, in *ibid.*

²⁵ Clinical Notes, 11 AGH, 2 April 1919, in Private H.J. Tweed, 5th Battalion, PCF.

²⁶ Clinical Notes, RGHC, 29 June 1930, in *ibid.*

²⁷ Case Sheet, RGHC, 30 June 1932, in *ibid.*

²⁸ Memo for Hospital File, 17 February 1932, in *ibid.*

were the most pathetic. Private David Reynolds, a veteran of the Western Front - most notably the Battle of Messines - quickly became an alcoholic upon his return to Australia. Inoffensive and respectable when not on a drinking bout, he rapidly became violent and quarrelsome when under the influence of alcohol. He was imprisoned on several occasions for being drunk and disorderly and, in 1921, came before a Hobart court where he was sentenced to two months gaol for similar offences.²⁹ In 1939 Reynolds, who still had no fixed place of abode or any permanent work, carried his swag and went wherever he could obtain an odd job. In 1940, in a poignant gesture that merely emphasised the extent of his degradation, he attempted to join the Second AIF. A military doctor described him as "unshaven, boozed and begging, a poor mut."³⁰ By 1961, when he died, he still had not found a home and often slept in culverts and sheds. He remained a chronic alcoholic and was in the habit of adding spirits to the wine he drank, presumably to increase the effect.³¹ Martin Ford, a former member of the 5th Battalion, also became a civic nuisance. Shell-shocked at Gallipoli and discharged in 1916 with neurasthenia, he turned to alcohol. A doctor in central Victoria reported: "This man has been about Bendigo for many months, he is usually more or less dopey and will persist in taking alcohol although he can't stand it. He is becoming a nuisance to the people of Bendigo always asking for help or food."³²

Although men like David Reynolds lingered in their post-war agony for almost half a century, other wanderers - probably mercifully - did not have much time at all to reflect on their penury, the victims not only of the war but of other momentous events like the 1919 influenza epidemic. Oliver Stoneham, for example, was discharged from the army in June 1917 with neurasthenia and, although he returned to his former work as an industrial chemist, he quickly left it and applied to the New South Wales State War Council for a "light labouring job".³³ Despite an apparent aversion to his old occupation he eventually gained a position - through the efforts of the Repatriation Department - as a chemist with a firm in Castlereagh Street, Sydney. Ill-health, however, forced him out of this job after several weeks and he travelled to Melbourne where, unemployed and existing on Repatriation Department sustenance, he took up residence in the Salvation Army Home in La Trobe Street.³⁴ In July 1922 he died at the Old Colonists' Home, Brunswick - possibly of complications related to the

²⁹ Deputy Commissioner, Repatriation, Tasmania, to Signor Bernachi, Maria Island, 13 May 1921, in Private D. Reynolds, 14th Battalion, PCF.

³⁰ Summary of Clinical Notes, RGHC, 27 March 1941, in *ibid.*

³¹ Form KE3, "Report of a Medical Practitioner upon the Death of the above Member", 12 May 1961, in *ibid.*

³² Medical Case Sheet, 4 December 1915, AF B103, 13 August 1916, Form 71, 3 May 1929, in Private M. Ford, 5th Battalion, PCF.

³³ Application for Employment, circa 1917, State War Council, New South Wales, in Private O. Stoneham, 31st Battalion, PCF.

³⁴ Form 20, "Application for Assistance", 28 October 1920, in *ibid.*

influenza which he had caught in the epidemic of 1919 - in "indigent circumstances" with no relatives, friends or estate. The Repatriation Department paid for his funeral. ³⁵

Like many of those who fled the cities, other men were unable to cope with even the minor emotional requirements of everyday life. Sometimes, therefore, they gave shell-shocked servicemen high public visibility. ³⁶ Exaggerated responses to normally insubstantial demands disrupted their private lives in significant ways. Many became social cripples. Private Harold Spears, for example, walked off the boat in Melbourne shaking "only slightly" in the head and right leg. He was given boat leave ³⁷ and attended the theatre where, as part of the performance, ten rifles were fired which made him jump and he fell off his seat. Thereafter, he was carried unconscious into the cloakroom. ³⁸ Former light horseman Albert Regis, who had developed a nervous disorder in the Jordan Valley, became afraid of the dark so that even sacred places offered insufficient protection for him. In 1928 during a service in a Collins Street church he collapsed and had to be carried out. ³⁹ Mixing with other people and coping with the noises of a city became considerable - indeed insurmountable - challenges for some men. Leslie Hogg entered Caulfield Hospital in May 1929 but found immediately that he had become even more nervous and unable to "face people". ⁴⁰ Angus McKay, who had isolated himself in the bush for many years after the war, was, when he sought help in 1934, irritated by small noises and cried suddenly when talking to people. He continued to avoid company. ⁴¹

Sometimes fear of life beyond the garden wall lasted for years - even decades - and crippled any hope of a normal existence. Fifteen years after his discharge, Edward Norman still found that the least excitement upset him and that he could not venture out alone. ⁴² Leslie Hall was wounded at Pozières in 1916 and shell-shocked at Bullecourt in May 1917 ⁴³ but the experience lived with him for the rest of his days. In 1949 he suffered a "nervous collapse" at work ⁴⁴ and even in the late 1950s dared not venture out by himself as his "nerves" were still so highly strung that he remained afraid of motor vehicles and crowds in the city. ⁴⁵ For other men, similar terrors could be found

³⁵ Form 14A, 29 June 1921, in Stoneham, *op. cit.*.

³⁶ As has been shown in chapters five and six, the high public profile of shell-shocked soldiers worried State and Federal Governments. Reflecting that concern was a statement in the 1921 Department of Repatriation Annual Report. It read: "The nervous diseases (war neuroses) due to war service have also ceased to be the prominent feature in hospitals and in the streets that they were in previous years." (Department of Repatriation, Annual Report, 1921, p.15.)

³⁷ See chapter four, pp. 154-155, for medical objections to the practice of boat leave.

³⁸ Clinical History, RGHC, 12 March 1918, in Private H. Spears, 30th Battalion, PCF.

³⁹ Form U, 1 January 1928, in Regis, PCF, *op. cit.*.

⁴⁰ Out-patient notes, RGHC, 5 June 1929, in Private L. Hogg, 37th Battalion, PCF.

⁴¹ Clinical Notes, RGHC, 12 April 1934, in McKay, PCF, *op. cit.*.

⁴² Memo for Medical File, 22 January 1934, in Signaller E. Norman, 5th Divisional Signals, PCF.

⁴³ Form U, 12 November 1930, in Driver L. Hall, 6th Battalion, PCF.

⁴⁴ "Emergency Treatment Form", 19 January, in *ibid.*

⁴⁵ "Summary of Relevant Details of Application for Recreation Transport Allowance", 17 February 1958, in *ibid.*

in private. During electrical storms, Ian Callaghan walked the house at night and at times was unable to sleep.⁴⁶ Henry Rider was similarly disturbed by wind howling down the chimney, a sound that reminded him strongly of the war. On these occasions he would sit up and smoke for hours.⁴⁷ Thus, the war had created men who were socially dysfunctional. This largely unforeseen consequence was to have major ramifications on their employability and on the viability of their family life.

War Neurosis and Unemployability

At the heart of much personal and household dislocation faced by psychological casualties and their families was economic hardship created by the former breadwinner's inability - mostly through the kinds of disorders described above but sometimes in conjunction with larger events such as the Depression - to earn a regular or adequate wage. Because of their disorders, many men found it impossible to return to their pre-war occupations and, as a result, had to endure drastic reductions in pay. Before the war, James William Blight had been earning £240 per annum as a station overseer.⁴⁸ Shell-shocked at Gallipoli, he struggled to obtain comparable work and pay upon his return to Australia early in 1916. In June of that year he told the State War Council of Western Australia: "I am at present employed at the Midland Workshops as fitter's labourer which is not too good for wages 9/- for as you know is a lean living for 2 people these times with no prospect of bettering myself."⁴⁹ In 1922 he and his wife moved to Victoria but Blight did not find any suitable employment and so existed on Repatriation Department sustenance payments (which amounted to £32 over twelve months) until his death in indigent circumstances later the next year. Amongst those who were unable to work effectively were many soldier settlers. Charles Lapin (who had been discharged from the AIF with nervous debility in 1919) and his family took up a block at Gembrook east of Melbourne in 1922. But, as the Local Medical Officer reported in 1926, Lapin could not stand any strain or excitement and found continued hard work impossible.⁵⁰ A year later he had to let the farm⁵¹ and in 1933 he was forced to sell it.⁵²

⁴⁶ Ellen Callaghan to Deputy Commissioner, Repatriation, Victoria, 9 May 1931, in Private I. Callaghan, 14th Battalion, PCF.

⁴⁷ Form U, wife, 14 June 1928, in Rider, PCF, op.cit..

⁴⁸ "Application for Assistance", 26 January 1922, in Private J.W. Blight, 16th Battalion, PCF.

⁴⁹ Blight to War Council, Western Australia, 25 June 1916, in *ibid.*

⁵⁰ E.S. Charles to Repatriation, 22 April 1926, in Private C. Lapin, 5th Battalion, PCF.

⁵¹ War Pension Medical Report, 25 July 1927, in *ibid.*

⁵² Chairman, Sir Samuel McCaughey Bequest, to Deputy Commissioner, Victoria, 10 August 1933, in *ibid.*

Gunner George Keen, for example, sustained hysterical impairment to his sight on the Western Front in September 1917 and was unable to work again as a book keeper. He informed the Department of Repatriation:

Before enlistment my vision was quite all right. I was employed by a lithographer in Flinders Lane as a ledgerkeeper and was able to work long hours on the books . . . I could stand at the Victoria Market and see the time on Flinders St. Railway Clock. ⁵³

Some men worked only intermittently throughout their post-war existence. Corporal Thomas Scott, a dairy farmer from Mooroolbark (east of Melbourne), was shell-shocked at Pozières in 1916. ⁵⁴ As a result, he was unable to resume his old occupation when he returned to Australia in 1919 so he took up labouring on roads and drains for the Mooroolbark Shire Council and carting for local bakers and dairies. He carried on these occupations more or less simultaneously for at least ten years during which his twenty-five per cent pension was cancelled because he was deemed fit for work. ⁵⁵ He was, however, often away from both jobs through "head trouble". ⁵⁶ In 1923, for example, he was absent from his council job throughout February, March and August. ⁵⁷ In 1930 he told the Department:

I have my own milk-round and lost three months in 1926, in 1927 and 1928 and I had the help of a boy to relieve me, in 1929 I lost two months and I have done no work since 15th June 1930. ⁵⁸

An associate reported that Scott had collapsed while working "four or five years ago" and had to be carried home. ⁵⁹

The employment resumes of other men were similarly desultory. Due to his restlessness and poor health, Robert Henry failed at both soldier settlement and in a Melbourne fruit business. Following a consequent period of unemployment he worked with Victorian Railways for three years ⁶⁰ before entering Mont Park asylum in 1928. ⁶¹ In 1922, the shell-shocked Cedric Taylor was compelled to relinquish his position with the NRMA "owing to Nervous Trouble". After walking off his soldier settler block he was never again regularly employed. He told Repatriation: "I cannot rest . . . my nerves are always on edge." ⁶² Mick Daniels informed Repatriation that his brother Maurice had not been able to follow any steady occupation since his return

⁵³ Form U, 29 November 1929, in Gunner G. Keen, 14th Field Artillery Brigade, PCF.

⁵⁴ Form U, 23 July 1930, in Corporal T. Scott, 14th Battalion, PCF.

⁵⁵ "Summary of Evidence", in *ibid.*

⁵⁶ Form K, 20 March 1923, in *ibid.*

⁵⁷ Extract Report, Shire Secretary, in *ibid.*

⁵⁸ Extract, Claimant's Statement, 23 July 1930, in *ibid.*

⁵⁹ E.R. Kerry to Repatriation, 26 July 1930, in *ibid.*

⁶⁰ Mrs. Rider to Repatriation, undated, in Henry, PCF, *op.cit.*

⁶¹ State Secretary, RSSILA to Deputy Commissioner, Repatriation, Victoria, 17 May 1928, in *ibid.*

⁶² Form U, 19 June 1931, in Trooper C. Taylor, 4th Light Horse, PCF, *op. cit.*

and that he often worked when he should have been in bed.⁶³ This lack of consistency was directly due to persistent psychological disorder for, as his former employer in Shepparton stated:

He had altered very considerably both in appearance and manner. He was then thin, haggard and unable to concentrate on most topics of conversation, was very restless and solemn, and he most certainly would not have made an efficient employee from my point of view.⁶⁴

Former Private Harry Sands told Repatriation that after his return from the war he had been unable to sustain any effort and although he might be able to start a job he found it impossible to finish.⁶⁵ Even "quiet" jobs were too much for some psychological casualties. In 1917 former Private James Bradley, who had returned to Australia after being shell-shocked at Pozières, drove a horse and dray for six months but relinquished it because he couldn't maintain the necessary effort.⁶⁶ Also shell-shocked at Pozières was Albert Dimond, formerly of the 24th Battalion. Although when he returned in 1919 he was re-employed as a draper's assistant at Payne's Bon Marche in Bourke Street, Melbourne, he was eventually forced to give up his old job due to "recurring Shell Shock."⁶⁷ In 1932 Frank Lee, whose employment record after the war was sporadic at best, had not worked for four years because, as his wife told W.M. Hughes, "no one will employ a man who is only one-third fit."⁶⁸ Dairy farmer Edwin Dale developed serious nervous symptoms five years after the war, largely because of his Gallipoli experiences. Following his discharge he was unable to work for three years and was eventually forced to sell his dairy herd in favour of sheep.⁶⁹

For those psychological casualties who were self-employed, absenteeism (their own) was more serious than for returned servicemen whose jobs were often kept open during bouts of serious illness by sympathetic employers. Albert Marsh, whose case was the subject of such bitter disagreement between Clarence Godfrey and some of his Repatriation Department colleagues in 1931,⁷⁰ had been one of two partners in a Melbourne billiard saloon in the mid 1920s. Because of his psychological illness, however, he was unable to accept his share of responsibility so the association lapsed. Marsh's former partner informed Repatriation:

During that time he always appeared to be suffering from nerves and many a time he had to go home during the day being too unwell to work . . . [N]ervous breakdown or some sickness or

⁶³ Mick Daniels to Deputy Commissioner, Victoria, 6 November 1929, in Private Maurice Daniels, 5th Machine Gun Battalion, PCF.

⁶⁴ C. Taggart to Repatriation, 6 January 1930, in *ibid.*

⁶⁵ Medical Report, 22 June 1933 in Private H. Sands, 5th Battalion, PCF.

⁶⁶ Form U, 5 April 1918, in Private J. Bradley, 7th Battalion, PCF.

⁶⁷ Form U, 3 July 1931 and Note, undated, unsigned, in Private A. Dimond, 24th Battalion, PCF.

⁶⁸ Daphne Lee to W.M. Hughes, 4 December 1936, in Private F. Lee, 5th Battalion, PCF, *op. cit.*

⁶⁹ Form U, 4 October 1929, in Private E.T. Dale, PCF.

⁷⁰ See chapter six, pp. 219-222.

other made him absolutely helpless for weeks on end. . . I am honestly sorry that such a splendid principled man should have such bad luck.⁷¹

After the dissolution of this venture, Marsh worked occasionally as an insurance agent.⁷²

The 1930s economic depression added markedly to the employment difficulties faced by some psychological casualties. Harold Dunstall, who had been discharged from the AIF with Disordered Action of the Heart, was a retail fruiterer in Malvern until 1929 when he noticed a decline in trade and left the business. In October 1932 he engaged in canvassing from door to door more, he said, to entertain himself than for profit for he was well aware of the large number of unemployed men trying their hands at hawking. Early in 1933, however, his health forced him to abandon this popular enterprise.⁷³ Thereafter until the Second World War when, in a nice irony, he worked steadily in a munitions factory, Dunstall's major occupation was listed as "odd jobs".⁷⁴

Shell-shocked men were often obvious in the work place where colleagues and employers noticed the unusual behaviour and impaired health which stifled their ability to work. Maurice Daniels was described as a good workman but was notable because of his quietness. According to one employer he hardly spoke all day. Ian Callaghan's former employer, W.H. Darragh, reported: "He again worked for me about two years after he returned from the war, but was broken in health, although he was not a shirker."⁷⁵ The workmates of Frederick Lamar, who had been discharged from the AIF with Disordered Action of the Heart and neurosis, noticed his unusual behaviour and described it to the Local Medical Officer at Birchip who wrote: "He is . . . very neurotic but I feel sure from what his workmates tell me that he is genuine."⁷⁶ Similarly, the fettlers in Camp 465 of the Trans-Australia Railway were well aware of the nomadic Frederick Leitner's ill-health. One man wrote to Leitner's wife in Melbourne: "Mr. Leitner had been in bad health for some time but refused to go to a doctor. Then his head seemed to be affected and he did not appear to understand what was going on around him."⁷⁷

Although simple incapacitation like Leitner's prevented men from procuring a full and adequate wage, severe anti-social behaviour in the work-place - the product of their psychological disorders - impaired the earning ability of others. With their

⁷¹ Former business partner of Marsh to Repatriation, 24 November 1931, in Private A. Marsh, 5th Battalion, PCF.

⁷² Form U, 23 November 1931, in *ibid.*

⁷³ Dunstall to Deputy Commissioner, Repatriation, Victoria, 21 February 1933, in Private H. Dunstall, 23rd Battalion, PCF.

⁷⁴ Form 135A, "Application for Payment of Sustenance Allowance During Out-Patient Treatment", 7 September 1939, and *ibid.*, 23 June 1941, in *ibid.*

⁷⁵ W.H. Darragh to Repatriation, 28 April 1927, in Daniels, PCF.

⁷⁶ LMO, Birchip, to Repatriation, 6 April 1933, in Private F. Lamar, 21st Battalion, PCF.

⁷⁷ A. Beech to M. Leitner, 18 October 1928, in Private F. Leitner, 8th Battalion, PCF, *op. cit.*

irascibility and aggression, these men were sometimes a highly visible and disruptive element to which employers and workmates responded in a variety of ways. Sergeant Charles James, who had been discharged from the AIF with gas poisoning and Disordered Action of the Heart, returned to surveying but was very bad tempered and quarrelled with all of his associates in the bush camp that was their home for many months. ⁷⁸

The intemperate behaviour of Arthur Ewell, who had been blown up three times on the Western Front, ⁷⁹ destroyed his upholstery business and later ruined all chance of future employment. One of his employees, H.W. Fitter, told the Department of Repatriation that Ewell suffered from neurasthenia [Fitter's word] and did very little work. He said that the shop and factory hands knew that he was a returned soldier suffering from shell shock and that, during one of his "turns", the senior girl left as she was always frightened of him. ⁸⁰ William Miller, another employee, confirmed Ewell's unsuitability for business: "Mr. Ewell always impressed as being a victim to nerves and was quite incapable of managing a business for that reason," he wrote. ⁸¹ After Ewell's death in 1935, Mrs. Ewell, on whom responsibility for the business had ultimately fallen, informed Repatriation: "I closed up as my late husband quarrelled with the Customers and was abusive to Warehousemen and Repatriation Inspectors . . . I then insisted he should work but he walked out of 8 positions without any reason." ⁸² In fact, amongst other jobs, Ewell had been employed at Payne's Bon Marché in Bourke Street, Melbourne, for four months . . . during which he left work over two hours early every day to come home. His worried family expected that he would be dismissed immediately but this did not eventuate. His employers, knowing that he was a returned serviceman suffering from shell shock, overlooked much of his behaviour as did his workmates who, under interactions, simply walked away when he tried to quarrel with them. ⁸³ Some employers were not as tolerant as others, however. Frank Lee, for example, received many offers of work, but no one would suffer his testiness so he quickly squandered a succession of opportunities. ⁸⁴

It can therefore be seen that during the post-war years, the various effects of psychological disorder - mental and physical illness, unsettled and anti-social behaviour - precluded regular employment for many returned soldiers. For these men and their families the results were calamitous. Firstly, the absence of regular employment considerably diminished household incomes to the point where they could not

⁷⁸ Clinical Notes, RGHC, 8 June 1933, in Sergeant C. James, 3rd Field Company Engineers, PCF.

⁷⁹ Medical Case Sheet , 7 November 1919, in Private E. Ewell, 29th Battalion., PCF.

⁸⁰ H.W. Fitter to Repatriation, undated, in Ewell, op. cit..

⁸¹ W. Miller to Repatriation, undated in *ibid.*

⁸² "Grounds of Appeal", undated, in *ibid.*

⁸³ M. Ewell to Repatriation, 23 August 1935, in *ibid.*

⁸⁴ Memo for Medical File, RGHC, 3 December 1937, Lee PCF, op. cit..

approximate even the Commonwealth basic wage which in 1920-21 stood at £4/2/- per week.⁸⁵ In 1933 the Commonwealth census included statistics which purportedly demonstrated that returned servicemen were economically better off than the men who had not enlisted. This conclusion was reached by comparing the incomes of ex-soldiers with those of male breadwinners over the age of thirty who had not enlisted. Richard White has shown, however, that such a finding was erroneous and that returned servicemen enjoyed no advantage. He showed that approximately twenty-five per cent of old diggers and male breadwinners between 30 and 60 years of age both received under £52 per annum; that approximately forty-eight per cent of soldiers and male breadwinners between 30 and 60 years of age earned £156 or more per annum, and that about twenty per cent in the same groups enjoyed a yearly income of over £260.⁸⁶ On the strength of these figures, White concluded that "there was very little difference at all between their [the soldiers'] income and what they might have expected had they not enlisted."⁸⁷

This statement, however, does not go far enough in describing the income status of returned soldiers, particularly that of some psychological casualties who throughout the 1920s and 1930s were earning considerably less than they had been before the war. This evidence shows that of the soldiers whose stories appear in this dissertation, nearly all were receiving incomes of less - in many cases much less - than £120 per annum. For example, Edward Norman's weekly income was 17/6 (seventeen shillings and sixpence per week). This was all pension money and represented the total paid to himself (10/6 per week), his wife (4/6 per week) and a dependent (2/6).⁸⁸ In 1925 his weekly income was £2/4/- which, represented the total pension benefits doled out to he and his family.⁸⁹ In October 1918 the unemployed Percy Maxwell and his family had to manage on a pension of £2/1/3 pence per week⁹⁰ while in mid-1931 J.L. Nelson and his family tried to make end meet on a total weekly pension income of 39/-. To Nelson 25/-, 11/8 for his wife and 3/- for a dependant.⁹¹ Herbert Crane was at Bundoora Convalescent Farm in 1921 and 1922 when, concerned about his finances, he wrote to Repatriation: "My wife and two children cannot get along on 1/5/9 per week (total pension) and I am now in debt."⁹² During this period Crane was earning £1/15/- per week for work done on the Convalescent Farm but clearly the combination of

⁸⁵ Crowley, *op. cit.*, p.370.

⁸⁶ R. White, "War and Australian Society", in McKernan, and Browne, *op. cit.*, pp.401, 402.

⁸⁷ *Ibid.*

⁸⁸ "Application for Medical Treatment or Surgical Aids", 23 May 1922, in Norman PCF, *op. cit.*.

⁸⁹ *Ibid.*, 22 February 1928.

⁹⁰ "Application for Sustenance", 21 October 1918, in Private P. Maxwell, 46th Battalion, PCF.

⁹¹ "Application for Payment of Sustenance Allowance", 10 August 1931, in Private J.L. Nelson, 59th Battalion, PCF.

⁹² Crane to Repatriation, Letter of Appeal, 7 September 1921, in Private H.J. Crane, 7th Battalion, PCF.

incomes was insufficient to meet the family's needs. In 1930 and 1931 he was unemployed; he and his family drew Repatriation pensions amounting to £2/11/6.⁹³

Pensions and sustenance were, in many cases, totally ineffective in the face of straitened circumstances. Although their disorders were highly debilitating, many psychological casualties were not granted full benefits because in many cases the men were deemed fit for partial employment. "Incapacity 100 per cent" was a rare judgement by Departmental Medical Officers. Thus, psychological casualties awarded full pensions were few in number and usually included those who were totally helpless like Captain Walters, who was intoxicated most of the time, frequently comatose as the result of drug abuse, and a regular patient at Caulfield Hospital and various psychiatric institutions.⁹⁴ "Material aggravation" might entail a twenty or thirty per cent pension although some benefits might fall as low as a negligible fifteen per cent on the recommendation of the doctor who made the final assessment.

By contrast to Walters - and because he was able to work occasionally - Private Frank Lee, who had been evacuated from Gallipoli with shell shock, was assessed as only 55% incapacitated but, in general, was a miserable, violent drug addict who terrorised his family when he wasn't at Caulfield Hospital for extreme irritability and a gastric condition. As has been noted, his attempts to maintain himself in a job were largely abortive.⁹⁵ Sapper Michael Mason lost eight months work in 1929 due to neurasthenia but an appeal for an increase in his twenty-five per cent pension was rejected despite strong medical evidence in his favour.⁹⁶ Another neurasthenic, William Percival, was assessed at twenty per cent incapacity⁹⁷ despite finding work extremely difficult and being the subject of a very pessimistic prognosis.⁹⁸ Private Charles Green was discharged in 1918 with "shell shock, incapacity total"⁹⁹ but, by 1924, his pension had been reduced to forty per cent.¹⁰⁰ He was able to work only half the necessary time on his soldier settler block and was forced to employ labour to make up the deficit. Similarly, Edward Norman's thirty-three and a third per cent pension for severe shell shock was insufficient to balance the losses sustained on his soldier settler farm.¹⁰¹ He too was forced to employ labour and by 1924 was 39 pounds in debt. His wife told the Repatriation Commission: "As to our income, it is

⁹³ "Application for Pension", 19 March 1931, in Crane, PCF, op.cit..

⁹⁴ Walters, PCF, op. cit., passim.

⁹⁵ Lee, PCF, op.cit., passim.

⁹⁶ Application for Assistance, circa September 1929, in Sapper M. Mason, 60th Battalion, PCF.

⁹⁷ RGHC Notes, 21 October 1932, in Percival, PCF, op. cit..

⁹⁸ RGHC Notes, 7 October 1932, 21 October 1932, 7 May 1934, in *ibid.*

⁹⁹ Final Board, 17 July 1918, in Private C. Green, 37th Battalion, PCF, op. cit..

¹⁰⁰ Decision of Commission, 21 January 1924, in *ibid.*

¹⁰¹ Medical History, 10 March 1918, in Norman, PCF, op.cit..

just an existence." ¹⁰² Mrs. A.E. Grant, whose husband had not succeeded at vocational training, told Repatriation that it was

an utter impossibility for two people to live on 30/- per week, as we had to until this week when my pension of 15/- per week was granted, which now brings our joint income to 2/5/- weekly. Even this amount is inadequate during these times . . . ¹⁰³

Sporadic employment also had a deleterious effect on morale. In 1933, former Private Harry Sands was exhibiting violent behaviour reminiscent of outbursts seen twelve years previously. A medical report on him stated: "He has often been depressed of late, talking of ending things in the Yarra. Mrs. Sands believes unemployment has helped to make him so much worse." ¹⁰⁴ A similar sense of responsibility forced the restless Robert Henry to seek employment continually despite contrary instincts. In 1928 he explained his internal conflict to Repatriation. He told the Department that he could not settle down to work his soldier settler block at Mildura and that "after struggling against my feelings" abandoned it in 1924. He said that his nerves did not improve until 1926. He then felt able to resume work but remained agitated. "I forced myself to continue on account of my wife and child," he wrote. "I was employed by the Victorian Rlwys. and carried on until May 1928 when I broke down." ¹⁰⁵ Unemployment and unwanted reliance on their wives therefore created further anxiety for men who clearly took their familial responsibilities seriously and for whom this enforced idleness was a further mental burden to carry. ¹⁰⁶ With an optimism that gradually acquired a penetrating poignancy, the Frankston Local Committee made urgent representations to Repatriation Headquarters on behalf of Charles Lapin, arguing that a Living Allowance would free him from

the nervous strain of having to provide for his family, and rent payments, which we feel is greatly militating against his health. He can potter about at home [and] do little matters to keep his mind occupied and gradually regain his strength. ¹⁰⁷

The meagreness of pensions - and, in some cases, their complete absence - helped to create highly worrying financial hardship for many soldiers and their

¹⁰² Mrs. E. Norman to Deputy Commissioner, Repatriation, Victoria, 2 March 1934, in Norman, PCF, op. cit..

¹⁰³ Mrs. A. Grant to Deputy Commissioner, 14 September 1918, op. cit., in Signaller A.E. Grant, 37th Battalion, PCF.

¹⁰⁴ Medical Report, RGHC, 22 June 1933, in Private H. Sands, 5th Battalion, PCF.

¹⁰⁵ Form U, 8 August 1928, in Ryder, PCF, op. cit..

¹⁰⁶ The despair that men felt at losing their roles as breadwinners might have stemmed, at least partially, from the "doctrine of separate spheres". Developed during the nineteenth century, this ideology explicitly defined separate but complementary work roles for men and women: husbands worked in the 'rough outside world' as breadwinners while wives toiled in the home where they ruled supreme. Because it also dictated that working in the fields was shameful for women, this dogma may also have created difficulties of conscience for soldiers' wives, especially those on soldier settler blocks. (M. Lake, *The Limits of Hope*, op. cit., p. 179.)

¹⁰⁷ Secretary, Local Committee, Frankston, to Repatriation, 4 July 1919, in Lapin, PCF, op.cit..

spouses. In concert with the other effects of war neurosis, the lack of an adequate income and its consequences helped to destroy families.

The Wife's Burden

As the above figures have suggested, household incomes for many returned soldiers mentally affected by their war experiences were pathetically small and hopelessly inadequate. The social ramifications of these poor material circumstances were several and were all linked in a cause and effect relationship which destroyed many individuals and families. One of the chief effects of unemployment and low incomes for psychological casualties was the further erosion of their morale and sense of identity as men. Financial worry thus became a further source of anxiety for returned soldiers already deeply psychologically troubled: not only were they concerned for the well being of their families, they were also anxious about their reduced roles as breadwinners. Charles James was admitted to Caulfield Hospital in June 1933 and immediately expressed concern that his wife would not continue to receive a pension if anything untoward happened to him. About this matter he was described as "very worried".¹⁰⁸ Financial worry stimulated some alcoholics to imbibe even harder. Harold Walters, whose pension had been cancelled in 1921 when he took up his soldier settler block near Benalla in the same year, was unfit to work the farm. His income suffered so he drank to alleviate the uneasiness and, therefore, further reduced his ability to labour.¹⁰⁹

Such incapacity invariably placed enormous responsibilities in the hands of wives who often, therefore, became chief breadwinners as well as mothers and nurses. These burdens, together with the anxieties and physical danger associated with their husbands' often unruly behaviour, seriously impaired their health. Although they looked to Repatriation for relief, the Department proved ineffective as a means of alleviating domestic distress.

The dependence of some families on wives created more disquiet and further demoralisation for men who perceived themselves as not fulfilling their appointed roles as breadwinners. These men were not happy to see their women shoulder a load they believed should be shared or exclusively their own. Arthur Ewell's inability to resume upholstering forced him to rely on his wife to run the business. "I do not think it is fair to have to depend on my wife," he told Repatriation.¹¹⁰ Cedric Taylor felt similarly. Since 1922, when he had been forced to relinquish a job "owing to Nervous Trouble," he had been unemployed. In 1931 he took over a confectionery business but, because

¹⁰⁸ "Advice of Admission as In-Patient", RGHC, 6 June 1933, in Crane PCF, op. cit..

¹⁰⁹ T. Snowden to Repatriation, 18 July 1927, in Walters, PCF, op.cit..

¹¹⁰ Pension Appeal Form, 27 December 1928, in Ewell, PCF, op. cit..

of continued psychological illness, had to allow his wife to run it. In despair, he complained to Repatriation: "I am a spare part." ¹¹¹ In 1925 Charles Lapin's wife informed the Deputy Commissioner, Victoria, that her husband tried "hard to work but soon gets exhausted he gets so melancholy being unable to earn a living for my children and I." ¹¹² In 1928, after Lapin tried to commit suicide, a Repatriation Department medical officer reported: "When I questioned him as to the reason of his attempted suicide he replied that he was very worried financially, also at not being able to work, the fact of his wife having to go out to work to keep things going." ¹¹³

While many men felt keenly the loss of their roles as providers, the women on to whose resilient shoulders the load shifted would also, no doubt, have preferred circumstances to have been different. Theirs was an unenviable task that did not allow much time for reflection on their "proper" roles in life. For Mrs. Robert Henry, the intermittent employment and committal of her husband to Mont Park Mental Asylum was a disaster because, as she explained to Repatriation, she was finally left with the entire burden of their difficult post-war life together: "We have been able to save a deposit on our little home with the hope of being settled for life. So now I have to battle with a home and two children three years and five." ¹¹⁴ Although Mrs. Henry put a brave face on her plight, an independent source described her as "practically destitute" and in need of food orders from the Essendon Distressed Diggers Fund. ¹¹⁵ When Percy Maxwell left home in search of "help or work" after breaking down at his job in the Jolimont Railway car shop, ¹¹⁶ he left behind a pregnant wife and one child on a Repatriation pension of six shillings and threepence per week. ¹¹⁷

Sometimes, wives were left with the sole responsibility of running soldier settlement blocks. After returning from the war in 1919, Ian Callaghan had gradually lost his ability to farm and by 1931 was insolvent. Accordingly, the Closer Settlement Board cancelled the lease which was then obtained by his wife. By 1932 Callaghan was totally incapacitated as a breadwinner so the family had to rely on a pension and a weekly cream cheque of 10 shillings. ¹¹⁸ His wife wrote:

I have all the worry of the family he assists in no way. all the help I get is the allowance I receive from the repatriation I have taken over 45 acres of land under Closer Settlement and I find it a Hard Battle to make ends meet with this awful worry he has threatened at times to take his own life and do for the rest of us. ¹¹⁹

¹¹¹ Form U, 19 June 1931, in Taylor, PCF, op. cit..

¹¹² V. Ewell to Deputy Commissioner, Victoria, 24/25 February 1925, in *ibid*.

¹¹³ Memo for Medical File, RGHC, 2 February 1928, in Lapin, PCF, op. cit..

¹¹⁴ Mrs. R. Henry to Repatriation, undated, circa 1928, in Henry, PCF, op.cit..

¹¹⁵ Town Clerk, Moonee Ponds, to Repatriation, 18 June 1928, in Henry, PCF, op.cit..

¹¹⁶ Carlton and Central Local Committee to Deputy Comptroller, Victoria, 19 December 1919, in Maxwell, PCF, op.cit..

¹¹⁷ Minute, Repatriation, 11 December 1919, in *ibid*.

¹¹⁸ Memo for Deputy Commissioner from RGHC, 29 September 1933, in Callaghan, PCF, op. cit..

¹¹⁹ Mrs. Callaghan to Repatriation, 22 March 1932, in *ibid*.

In 1927 Harold Walters and his wife were forced to walk off their soldier settler farm near Benalla largely because his alcoholism and neurosis precluded the possibility of a full day's work. His wife, who supported him faithfully throughout their long marriage, was left to fight an unequal battle. The local stock and station agent, Harold Dale, told Repatriation that he had never considered Walters a strong man: "I think his wife was the one who mainly worked the farm . . . some time back he told me he would have to leave the land." ¹²⁰

Many psychological casualties stubbornly refused to visit doctors (so eliminating any chance of a pension) and although such apparent stoicism appears admirable it also created further financial difficulties for families already short of money. Shell-shocked in 1916, Joseph Whitton resumed bootmaking after his discharge from the AIF at the end of the war but, after four months, had a spectacular breakdown and never worked again. His wife, Vida, became the sole provider for the family which included a small child. They could not afford medical attention but for over ten years Whitton would not apply to Repatriation despite Vida's best efforts to persuade him. In 1930, however, he relented. His wife explained their plight to Repatriation:

I have wanted my husband to apply for treatment from your Department but he would not do so. I have had a strenuous time of it these 10 and a half years trying to make ends meet . . . I had a great job to get him to come in to the Repatriation as he seemed afraid he would be put into hospital. ¹²¹

Because of the debilitating effects of war neurosis, wives were often required to be nurses as well as mothers and chief providers. Almost every night, Albert Dimond's wife, Emma, massaged his aching back and neck. ¹²² The wife of the shell-shocked J.H. Rivers looked after her husband for many years but in 1931 during the last stages of her pregnancy was unable any longer to perform this task. ¹²³ When former POW John Hills was permitted trial leave from Royal Park in 1931 (against medical advice), his wife accepted the responsibility of ministering to him and of escorting him back to their home at Numurkah in Victoria's north. ¹²⁴ This kind of responsibility eventually exacted a price as Violet Lee explained to Repatriation in 1934:

I have been looking after him as well as I can, but as I am suffering from Pernicious Anaemia myself I do not feel in the condition to give him the attention he should be getting.

¹²⁰ H. Dale to Repatriation, 12 July 1927, in Walters, PCF, op.cit..

¹²¹ Form U, V. Whitton, 28 January 1930, in Whitton, PCF, op. cit..

¹²² E. Dimond, to Repatriation, 7 July 1931, in Dimond, PCF, op. cit.,

¹²³ Minute, Repatriation, 26 January 1931, in Private J.H. Rivers, 6th Battalion, PCF.

¹²⁴ Senior Medical Officer, Royal Park, to Repatriation, 31 March 1931, in Private J. Hills, 3rd Field Company Engineers, PCF.

His appetite is poor and I have trouble in inducing him to eat. I have to get up at all hours to keep him company as he does not sleep. ¹²⁵

As carers, some wives either took it upon themselves to administer sedatives to their shell-shocked husbands or were entrusted with this task by Repatriation Department doctors. These drugs were chiefly paraldehyde and bromide, substances widely employed and prescribed by medical officers of the Repatriation Department at all levels. They were, however, not without side-effects. One of these was addiction resulting from the large doses apparently needed to pacify violent men in the home. In such cases, therefore, wives contributed to the dependency of their husbands. They cannot, however, be held culpable for this state of affairs which was more the result of professional inability to solve the problem, the need to resort to drugs and the tendency sometimes to shift the burden of care to amateurs. Telephoning for and receiving prescriptions from medical officers was, therefore, a major component of the relationship that some women built with the Department of Repatriation. As indicated by the extensive "lady called . . . prescribed for" notation in his personal case file, it is clear that Harold Walters' wife was in frequent contact with Caulfield Hospital over supplies of sedatives. Reports also indicate that she was responsible for administering large doses of these drugs to her husband which she was apparently advised not to do. ¹²⁶ These made him very ill. ¹²⁷ No doubt they complicated his alcoholism. While he was in hospital Mrs. Walters also secretly provided her husband with large quantities of "sedatives or hypnotics" ¹²⁸ about which his brother was very angry when he discovered this subterfuge. He requested that Mrs. Walters authority to supply Harold be revoked ¹²⁹ but this does not seem to have eventuated. The need for such massive doses appears to have arisen around 1929 ¹³⁰ (when Walters had to be "quietened") and continued so as to feed his dependency. It appears, therefore, that Mrs. Walters was trying to provide for their mutual comfort.

Judging from the same kind of notation in her husband's file throughout 1929 and 1930, the wife of former Lieutenant H.R. Edgar had a similar relationship with Repatriation. Together with prescription forms for bromide, this documentation suggests that securing of sedative drugs was a major part of Mrs. Edgar's interaction with the Department. ¹³¹ Sedatives were one of the few means of curbing Frank Lee's temper and violence. Brief periods of tranquillity in the Lee household were invariably

¹²⁵ V. Lee to Repatriation, 12 April 1934, in Lee, PCF, op. cit..

¹²⁶ Memo for Medical File, RGHC, 16 June 1932, in Walters, PCF, op. cit..

¹²⁷ Memo for Medical File, RGHC, 28 October 1932, in *ibid.*

¹²⁸ Clinical Notes, RGHC, 28 January 1932, in *ibid.*

¹²⁹ Memo for Medical File, RGHC, 9 February 1933, in *ibid.*

¹³⁰ Memo for Medical File, RGHC, 19 August 1929, in *ibid.*

¹³¹ Lieutenant H.R. Edgar, 2 Field Artillery Battery, PCF, *passim.*

followed by panic when the drug supply expired ahead of schedule. Violet Lee therefore spent much time in urgent consultation with Departmental medical officers either in person or on the telephone. "Wife wants more dope - says it only lasts three weeks," is typical of doctors' notes on this case.¹³² So is the following revealing remark from another doctor: "Man is irritable, suspicious and jealous. He is a drug addict and his wife is begging for more Bromidia - refused point blank. A pitiful tale is hers."¹³³

Violence as a consequence of war neurosis

Thus, the sole responsibility for maintaining a household was often assumed by the wives of psychologically damaged returned servicemen when these men proved to be incapable of working effectively or participating positively in family life. This arduous but relatively straightforward undertaking was not, however, the only tribulation that these women had to endure. Further complicating matters was their husbands' tempestuous and violent behaviour. In various combinations, war neurosis, unemployment, drug addiction and alcohol abuse created distressed households which, under the strain, often fragmented despite the determined efforts of wives to maintain family cohesion. Sometimes, violent episodes occurred only occasionally. Percy Maxwell's wife reported that her husband would sit still in one place for hours on end staring vacantly and that one night after going to bed - and after a few drinks - he became excited and threw things about shouting that he would kill her. Subsequently, he became quieter.¹³⁴ As described by his wife, Joseph Whitton's breakdown four months after being discharged was similarly dramatic: "He frothed at the mouth and was just like a raving animal, he smashed the windows, crockery and anything he could lay hold of."¹³⁵ In June 1928 James Town - the man who had repelled German attacks at his front gate in Eltham - threatened his family with a hatchet and had to be overpowered by the local constable.¹³⁶ In August 1939 Albert Regis was regularly chasing his wife and children with a poker.¹³⁷

Although deranged behaviour amongst psychological casualties was sometimes limited to isolated occasions such as these, it could also be regular and frequent. After returning from Gallipoli, Frank Lee terrorised his family with his temper and dominated

¹³² Memo for Medical File, RGHC, 20 September 1938, in Lee, PCF, op. cit..

¹³³ Memo for Medical File, RGHC, 13 December 1938, in *ibid.*

¹³⁴ Extract from medical record, Military Mental Hospital, Royal Park, 16 March 1920, in Maxwell, PCF, op. cit..

¹³⁵ Form U, 28 January 1930, in Whitton, PCF, op. cit..

¹³⁶ Doctor's report, 17 June 1928, in Town PCF, op. cit..

¹³⁷ Memo for 'M' File, in Regis, PCF, op. cit..

the household by dictating its routines for over 20 years. In a letter to W.M. Hughes, Lee's wife, Violet, pleaded with the Minister:

You see he is strictly regimental in everything, I have to ask him when I can do my work, washing etc., and he gives me a certain time to do it, and I must do it in that time. We are not allowed friends of any kind, or have anyone calling. He does not make friends himself, and will not allow me to; he does not like anyone. We have to agree with him in anything, he takes no responsibility at all. ¹³⁸

Over the next seven years Frank Lee's behaviour became increasingly more violent and bizarre. Gradually the family disintegrated: in September 1938 Violet Lee reported that, after a week of sleeplessness, her husband had gone berserk and chopped down the tree ferns and aspidistras in the garden; ¹³⁹ in May 1939 their daughter "packed up and got out", ¹⁴⁰ and in 1942 Frank and Violet were divorced.

Dorothy Lapin and her children were subjected to a similar kind of tyranny. In 1919 she reported that during the afternoons her husband was able to work a little but at other times he was maniacal, going for many days and nights without sleep during which he would not speak to anyone. If anything was not to his liking or if a noise made him jump and tremble, he behaved "like a madman" and more than once threatened to commit suicide. In a letter to Senator Millen his wife confessed: "I am in dread of my life also that of my child. I have to stay awake at night time in fear." ¹⁴¹ Six years later the situation had not altered as confirmed by Doctor Charles of Belgrave who told the Deputy Commissioner of Repatriation Victoria, that his patient still "exhibited suicidal tendencies and occasionally threatened people in the house or the children." ¹⁴² Frederick Leitner displayed similar fits of temper to those of Lapin and Lee, grabbing his children by the throat and telling them he wouldn't tolerate their backchat then forcing them to wear rubber soled shoes because he couldn't bear any noise. H.J. Tweed, who was alcoholic and delusional, ¹⁴³ attacked his wife after a drinking bout in late November 1924. ¹⁴⁴ In February 1930 Tweed's brother rang Caulfield Hospital reporting that H.J. was "becoming mental" and had threatened to knife members of the family. ¹⁴⁵ Not long afterwards, he and his wife separated as Mrs. Tweed would not live with her husband. ¹⁴⁶ He then took up residence with his nephew (who described him as "queer") ¹⁴⁷ but his temper did not improve and he

¹³⁸ V. Lee to W.M. Hughes, 4 December 1936, in Lee, PCF, op. cit..

¹³⁹ Memo for Medical File, 20 September 1938, in *ibid.*

¹⁴⁰ Memo for Medical File, 2 May 1939, in *ibid.*

¹⁴¹ D. Lapin to Millen, 28 June 1919, in Lapin, op.cit..

¹⁴² Charles to Deputy Commissioner, Victoria, 26 March 1925, in *ibid.*

¹⁴³ Clinical Notes, RGHC, 30 September 1930, in Tweed, PCF, op. cit..

¹⁴⁴ Clinical Notes, RGHC, 29 November 1924, in *ibid.*

¹⁴⁵ Memo for Medical File, 25 November 1930, in *ibid.*

¹⁴⁶ Case Sheet, RGHC, 30 June 1932, in *ibid.*

¹⁴⁷ *Ibid.*

continued to "slam things down such as cups." ¹⁴⁸ Joseph Fry's wife found her husband's rages impossible to live with and several times fled home to her mother. She always regretted this action, however, and, realising what he went through during the war, returned and [did her] best for him." In February 1933 she left him again after a particularly violent attack but went back to face more: in 1939 it was reported that he was chasing her and the children with a poker.¹⁴⁹

To help alleviate household turmoil and to relieve them of some or all of their responsibilities, wives and other family members often looked to Repatriation, the police, clergy, members of parliament and the RSSILA. The striking aspects of women's letters to these instrumentalities and individuals are not only the conditions that they had to suffer but their personal resilience. Occasionally, authorities like the Department of Repatriation were their first resort; generally, however, women (like their husbands) persevered for years before appealing for help. The reasons for this are not totally clear but it seems that a desire to maintain respectability and independence coupled with the refusal of some men to allow any approach to doctors lay at the heart of these long delays. Unfortunately, the people and bodies to whom families looked for protection and in whom they placed a trust that now seems naive, were mostly ineffectual. They were not able to provide permanent - or, in some cases, even temporary - solutions to the domestic trouble faced by sufferers of war neurosis and their families. In response to this inefficacy, the frustrations of wives sometimes boiled over. In 1928 Ian Callaghan's wife wrote to the Deputy Commissioner:

I do not know if it is nerves or if he is mentally affected. some time ago I wrote to you about medical treatment which he received and naturally thought he would be better but now he has refused treatment. the way he carries on like a raving lunatic I have asked Returned Soldiers Police and Clergymen to make peace which only lasts a few week's and things are a bad as ever. ¹⁵⁰

Twice in January 1928 Charles Lapin's wife, Alice, appealed to officialdom. In fact , in her rising desperation, she demanded rather than beseeched:

My husband is suicidal owing to the neurasthenia which he suffers from . . . I wish to again point out that the responsibility of his future welfare rests with your Dept. My husband is in such a condition through his war disability that I cannot be his guardian any longer as he is in need of constant care. ¹⁵¹

To Neville Howse, the Minister of Repatriation, she wrote:

I wish to inform you that I shall not take charge of him again. His state of mind through war service is such that he is too dangerous to allow him to remain at home with me and my

¹⁴⁸ Case Sheet, RGHC, 30 June 1932, in Tweed, PCF, op. cit..

¹⁴⁹ Mrs. J. Fry to Repatriation, 4 September 1930; Doctor's report, 25 February 1933, and Memo for 'M' File, 23 August 1939.

¹⁵⁰ Mrs. Callaghan to Repatriation, 3 January 1928, in Callaghan, PCF, op. cit..

¹⁵¹ A. Lapin to Repatriation, 3 January 1928, in Lapin, PCF, op. cit..

children . . . I am notifying General Blamey, Commissioner of Police, of the state of affairs. I am determined that your Department shall accept the responsibility of my husband's safe-keeping for the future. ¹⁵²

For at least seven years, May Ewell had to suffer the violent behaviour of her husband, the shell-shocked, erstwhile upholsterer. In addition, some of this anti-social behaviour was very public and so undermined her attempts to maintain respectability. Like Dorothy Lapin, she too was insistent:

Please send out an officer of your Department as soon as possible as I want your help and advice about my husband. He is suffering from delusions mostly sexual and murderous attacks on me. He has started on other respectable citizens. I am suffering from a Black Eye and Bruised Nose and I may be murdered any day and I am afraid to leave the house. I bear an unblemished record in Ormond and I have worked and looked after him for years. I want him bound over for medical observation. ¹⁵³

Her black eye was confirmed by a Repatriation doctor. ¹⁵⁴

One of the chief characteristics of the relationship that wives established with the Department of Repatriation and other authorities was furtiveness. Their clandestine overtures were, in addition to explicit declarations like the above, a further reflection of the fearful, melancholy environment that war neurosis had created in some Australian households. "Please don't let him know I have written," is a major refrain of women's letters. "I am writing this without his knowledge," wrote Violet Lee to W.M. Hughes in 1936. "I cannot carry on much longer . . . and dread Xmas . . . as I know it only means sorrow for me and my little ones . . . Please keep this letter confidential." ¹⁵⁵ Dorothy Lapin craved similar discretion from Senator Edward Millen: "[H]e does not know I am writing this letter he is very despondent today," she wrote. ¹⁵⁶ Behind this anxious desire for secrecy was the unwillingness of some men to visit the doctor either because they were fearful, or perhaps because they felt a sense of hopelessness or a need to maintain a stoic posture. In these cases the urgent need for relief (a vain hope in any case) clashed with a personal obduracy and anger which, in the end, seemed to silence all protest within the home. In December 1928 May Ewell contacted the Department of Repatriation, writing while her husband slept. She told the Deputy Commissioner that he would not visit the doctor that day and that he became angry if she mentioned it. She finished the letter by saying: ". . . so will you please make an appointment and write for him to come in. I am not letting him see this part." ¹⁵⁷ Revealing a similar intransigence in her own husband Maria Leitner wrote to Repatriation requesting a pension review:

¹⁵² A. Lapin to Repatriation, 25 January 1928, in Lapin, PCF, op. cit..

¹⁵³ M.Ewell to Deputy Commissioner, October 1928, in Ewell, PCF, op. cit..

¹⁵⁴ Memo for Medical File, 16 December 1928, in *ibid.*

¹⁵⁵ V. Lee to W.M. Hughes, 4 December 1936, op.cit., in Lee, PCF, op. cit..

¹⁵⁶ D. Lapin to E. Millen, 28 June 1919, op. cit., in Lapin, PCF, op. cit..

¹⁵⁷ M. Ewell to Deputy Commissioner, Victoria, 17 December 1928, op. cit., in Ewell, PCF, op.cit..

[H]e seems to be acting very strange and at times seems to go out of his mind and I think he is mentally affected he is very sick and can't work and it is worrying him a lot . . . also he won't go to a doctor and I am afraid of the way he behaves. Please don't let him know that I have written to you. ¹⁵⁸

From the small Victorian rural community of Eltham, the wife of James Town tried to establish the same kind of secretive relationship with Repatriation. In 1920 she wrote:

It is on my husband's behalf that I am writing. I would like you to know since he is attending you, that he should have the care of someone skilled, as my poor husband seems very much affected by the war. He will sit and imagine things and also meditate and all of a sudden he will jump up like mad and at bedtime it is awful. . . . Hoping you will keep this letter in good faith as he may not like this to be known. ¹⁵⁹

The reaction of Repatriation to the entreaties of harassed and battered wives was cool and formal. Usually, it entailed an explanation of the Department's legal position, the limits of its powers, and the procedures that veterans' families should follow if they wished the law to take a hand in their domestic affairs. Sometimes, these processes merely added to the humiliation and demonstrated once more that the machinery for dealing with war neurosis and its consequences was ineffective. In response to May Ewell's adjuration of October 1928, in which she reported her black eye and bruised nose, the Deputy Commissioner replied that the Department could take no action and that if she considered her husband's condition warranted being placed under restraint, she should contact the police who would make the necessary arrangements. ¹⁶⁰ Taking this advice, Mrs. Ewell had her husband committed and in July 1929 reflected on the experience. "I had to go through that dreadful ordeal myself, and to go to Court," she wrote. ¹⁶¹ In March 1932, after she reported her exasperation at the inability of authorities to make permanent peace, Ian Callaghan's wife was similarly advised. ¹⁶²

Occasionally the violent behaviour of psychological casualties became very public and made the careful attempts of some women to maintain respectability seem pathetic. More importantly, these incidents demonstrate again that the Department of Repatriation's treatment of psychological casualties was ineffectual. Despite May Ewell's appeals to Repatriation and the medical treatment provided for her husband, Arthur Ewell's condition did not improve and in 1935 he and his war neurosis were the cause of a major incident. In 1930 Mrs Ewell had put a small deposit on a property at Mount Waverley, hoping to settle her husband on the land where it was quiet and she

¹⁵⁸ M. Leitner to Repatriation, 25 October 1928, in Leitner PCF, op.cit..

¹⁵⁹ Mrs. J. Town to Repatriation, 7 July 1920, in Town, PCF, op. cit..

¹⁶⁰ Deputy Commissioner, Victoria, to M. Ewell, 5 October 1928, in Ewell, PCF, op. cit..

¹⁶¹ M. Ewell to Deputy Commissioner, Victoria, 1 July 1929, in Callaghan, PCF, op. cit..

¹⁶² Repatriation to Mrs. Callaghan, 29 March 1932, in Callaghan, PCF, op. cit..

could sell some stock and give him a "restful holiday".¹⁶³ The experiment failed, however. On 30 March 1935 two policemen were called to the Ewell property "as a result of a complaint that there was a lunatic at large." After harassing a young man at his place of work, Arthur Ewell had finally assaulted him when he arrived at the Mount Waverley house hoping to see their daughter. To exacerbate matters, Ewell also threatened to shoot his wife and girl with a gun he kept by the bed. When the police arrived, they found both men alive but with blood staining their clothes. They described Arthur Ewell as thin and drawn and on the verge of a nervous breakdown.¹⁶⁴ He was taken into custody but later released.

As a result of household tension and the break up of families, the health and the fortunes of children sometimes suffered severely. In some cases, however, the Department of Repatriation was of valuable assistance, mainly through the Sir Samuel McCaughey Bequest. Officials of the Bequest agreed that it should help to support the education of Charles Lapin's children who were considered eligible because of their father's psychological disability. By 1933 he was assessed as 100 per cent incapacitated. His son, James, was apprenticed as an electrician¹⁶⁵ while his daughter, Alma, attended domestic arts school and was paid maintenance of £13 per annum and given assistance for her books and fares.¹⁶⁶ In 1939, after her father's death, Alma became a trainee dress maker with a Flinders Lane firm at 13/6 per week. The Bequest continued to pay her 8/- per week maintenance allowance during the apprenticeship.¹⁶⁷

Not so fortunate were Harry Tweed's children who were "orphaned" when their mother died in 1933. (Harry had been committed to Mont Park in the same year.) They were placed in a Melbourne orphanage except for the eldest girl, Wendy, who had turned sixteen and whose pension had been stopped as a result. She was sent to a distant relation of the family in Ballarat who had several children of her own. The situation, however, was unsatisfactory. Apparently, the woman was a drinker "who lives with a man who brings drink into the house, and young Wendy has had a bad time indeed." She was told to "clear out" but was taken in by a neighbour, Mrs. Hardy. After some urging from the RSSILA Wendy's pension was restored by Repatriation and she was allowed to remain with Mrs. Hardy.¹⁶⁸ What became of the other Tweed children is not recorded.

¹⁶³ Grounds of Appeal, undated, and W.M. Forster to Repatriation, circa 1935, in *ibid.*

¹⁶⁴ Police Report, 26 July 1935, and M. Ewell to Repatriation, 23 August 1935, in *ibid.*

¹⁶⁵ "Decision of the Trustees", 31 August 1933, in Lapin, PCF, *op. cit.*

¹⁶⁶ Chairman, Sir Samuel McCaughey Bequest to Deputy Commissioner, Victoria, 10 August 1933, in *ibid.*

¹⁶⁷ "Decision of the Trustees", 14 July 1939, in *ibid.*

¹⁶⁸ Ballarat Branch RSSILA, to Deputy Commissioner, Victoria, 16 February 1938, in Tweed, PCF, *op. cit.*

Psychological Casualties: A Mute Presence

Although severely troubled, not all Australian psychological casualties were violent or abusive like the cases mentioned above. Many men were a disturbing but relatively unobtrusive presence in the home, much like Gabby Dixon, the mutilated New Zealander in *My Brother Jack* who sat alone in a darkened room of the Meredith house and sobbed as he mourned the destruction of his face.¹⁶⁹ Similarly, Percy Maxwell would remain in one place staring vacantly for hours. His destructive outburst in 1919 was, therefore, unusual.¹⁷⁰ Maurice Daniels was never violent, just irritable, short-tempered,¹⁷¹ or, as his brother, Mick, put it, moody.¹⁷² Albert Dimond was generally depressed, unable to concentrate and fearful of being left alone. With every passing year he became worse and in 1931 began returning to his mother's house on weekends. His bewildered wife wrote: "This is quite un-natural for a married man, wanting to get away from his own home."¹⁷³ In 1928, the shell-shocked William F. Hobbs cried almost continuously for an entire day.¹⁷⁴ Sapper H.J. Tyson, who had been blown up and buried at Ypres in October 1917, simply felt frightened at being alone in the dark, and reacted nervously to sudden noises.¹⁷⁵ Corporal Thomas Harvey talked constantly of the war, mostly about Bullecourt, at times screaming.¹⁷⁶ Albert Marsh, the failed billiard saloon proprietor who treated himself for years before seeking Departmental help, had been married for two years by 1931. During that time, one of his wife's pregnancies was voluntarily terminated at an early date because Marsh felt that his psychological problems rendered him unfit to be a father.¹⁷⁷ Peter Cherry, a friend of former Private Francis Hammond, testified that the former soldier experienced long bouts - five to six weeks - of nervousness and sleeplessness. "I have first hand information," he wrote, "as he lived in the same house with me during eight years up till six months ago."¹⁷⁸

Other men endured their disorders unobtrusively. On one of the few occasions when his war experiences seemed to have bothered him, Lieutenant Thomas Mosley came home from work in a bath of perspiration, complained of feeling faint and went to bed. He would not allow his wife to call a doctor, remarking that it was a recurrence of

¹⁶⁹ G. Johnston, *My Brother Jack* (First published in 1964 by William Collins; this edition, Collins 1982), p.13.

¹⁷⁰ Extract from Medical Record, op. cit., in Maxwell, op. cit., See p. 232

¹⁷¹ Form U, father (William), 7 November 1929, in Daniels, PCF, op. cit..

¹⁷² Mick Daniels to 'Jack' Holland, 21 October 1929, in *ibid.*

¹⁷³ Wife to Repatriation, 7 July 1931, in Dimond, PCF, op. cit..

¹⁷⁴ Form K, 11 July 1928, in Private W.F. Hobbs, 35th Battalion, PCF.

¹⁷⁵ Memo for R File, 10 May 1927, in Tyson PCF, op. cit..

¹⁷⁶ Clinical Notes, RGHC, undated, circa 1933 in Harvey, PCF, op. cit..

¹⁷⁷ Report, 11 December 1931, in Marsh, PCF, op. cit..

¹⁷⁸ P. Cherry to Repatriation, 2 June 1930, in Private F.W. Hammond, 60th Battalion, PCF.

shell shock and that he would be well the following day.¹⁷⁹ When Victoria Henry first met her future husband, Robert, in 1921 she thought he was highly strung and nervous.¹⁸⁰ During the early days of their relationship he sometimes sat pondering or brooding and did not answer when spoken to. If asked what he was thinking he replied "nothing".¹⁸¹ Henry would not discuss the war because, as he himself said, it upset his nerves.¹⁸² Apart from the time he beat his horses on the soldier settler block at Mildura,¹⁸³ the only occasion on which his behaviour was even moderately intemperate occurred on Anzac Day 1928. His actions, however, were so irrational that they precipitated his entry into Mont Park asylum. On that morning he rose and went to get the newspaper. Soon afterwards, Mrs. Henry found her husband pacing backwards and forwards in the yard appearing to read the paper aloud when, in fact, he was simply repeating what was on his mind. He said that someone had to go and sacrifice themselves for those who had fallen at the front and he was the one appointed to "save us all". He declared that he was going to march at the head of the procession and that he would not return; then he relived all he experienced and witnessed at the front, and remained that way all day. A few weeks later he was a resident of Mont Park.¹⁸⁴ Robert Henry was never violent towards his family; in fact, he was said to have been a good husband and father.¹⁸⁵ He was, however, typical of psychological casualties for whom introspection and quiet desperation, rather than uncontrollable violence, were the characteristic responses.

Social Dislocation: A Novel Experience.

As we have seen, historians have suggested that much of the political, economic and social dislocation associated with the Great War was an exacerbation of existing trends in Australia.¹⁸⁶ As discussed in chapter six, some Repatriation Department Medical Officers argued similarly when diagnosing returned servicemen making pension claims for war-caused psychological illnesses. These doctors contended that the mental disorders of such men were only aggravated by the war, not caused by it, and that, in some cases, service had played no part in their maladies. On these grounds, claims were much reduced in legitimacy and sometimes dismissed altogether. It seems apposite,

¹⁷⁹ Form U, Mrs. Mosley, 21 December 1928, in Lieutenant T. Mosley, 3rd Machine Gun Battalion, PCF.

¹⁸⁰ V. Henry to Repatriation, undated, in Henry PCF, op. cit..

¹⁸¹ Memo, 14 June 1928, in *ibid.*

¹⁸² Form U, 8 August 1928, in *ibid.*

¹⁸³ See pp.

¹⁸⁴ V. Henry to Repatriation, undated.

¹⁸⁵ Town Clerk, Moonee Ponds to Repatriation, 18 June 1928, op. cit., in *ibid.*

¹⁸⁶ For example R. White in McKernan and Browne, op. cit., pp.391- 423; and R. Evans, *The Red Flag Riots*, op. cit..

then, to ask to what extent post-war social problems of the kind discussed above - alcoholism, violence, unemployment, withdrawn, anti-social and nomadic behaviour - might simply have been an amplification of pre-existing problems. Relevant testimony (the statements of friends, relatives and acquaintances in support of pension claims) suggests very strongly that, on balance, such jolting social fragmentation was a new experience for many individuals, families and communities.¹⁸⁷ For these people, the social tumult which followed in the wake of shell shock was both novel and bewildering; for them, it cannot be said that such developments were an extension of pre-war trends.

Although it was sometimes less clear to Repatriation, the war's influence on the changes to a man's mental state was usually obvious to those around him. Often, for example, a returned serviceman's aberrant behaviour had a strong war colouring. In November 1928 Maria Leitner affirmed that, before he enlisted, her husband, Frederick, had been a miner in good health. When he returned, however, she said he was very thin, and, that when the family met him at the barracks, he collapsed. She wrote: "He began to suffer with his nerves shortly after his discharge . . . I first remember him being queer just after his return from active service. He would often fight imaginary Turks with his walking stick and had other queer notions."¹⁸⁸ Some women, like Percy Maxwell's wife, simply reported that their husbands acted "very strangely" after their return from the war.¹⁸⁹ Others avowed that their spouses had, under no circumstances, behaved badly prior to enlistment. Violet Lee attested that Frank, whose prolonged tantrums terrified his family for over twenty years following his return from Gallipoli, displayed no such bad temper before the war.¹⁹⁰ In addition to wives, other family members also testified to the mental and behavioural metamorphosis of their soldier relations. Writing of his brother Maurice, Mick Daniels told the Department of Repatriation that the war had "turned a 100% efficient man into a human wreck."¹⁹¹ Before the war, R.J. Douglas had been a "brilliant and brainy youth" but returned a "nerve stricken wreck" according to his father. Resigning his position as a school teacher in December 1923 he became a labourer, then a clerk and was admitted to the Sydney mental institution, Callan Park, in December 1924.¹⁹²

Independent verification of soldiers' behavioural transformation came from a variety of people and supported the opinion of close relatives. In rural communities, for

¹⁸⁷ It is possible that loyalty and advantages that might have accrued to families could have coloured their testimony. One of the strengths of this evidence, however, is the extent of independent corroboration. Collusion and partiality seem, therefore, unlikely.

¹⁸⁸ Form U, M. Leitner, 29 November 1928, in Leitner, PCF, op. cit..

¹⁸⁹ Extract from Medical Record, Military Mental Hospital, Royal Park, 16 March 1920, in Maxwell, PCF, op. cit..

¹⁹⁰ Memo for Medical and General Section, RGHC, 25 February 1938, in Lee PCF, op. cit..

¹⁹¹ Mick Daniels to Deputy Commissioner, 6 November 1929, in Daniels PCF, op. cit..

¹⁹² Minutes of the Medical Advisory Committee, 29 September 1925.

example, adverse psychological changes in formerly dynamic young men were easily noticed and the loss of such vitality to the district was keenly felt and readily commented upon.¹⁹³ Maurice Daniels' father, William, indicated that the war had somehow nullified all of his son's civic achievements. He said that, pre-war, Maurice had reached eighth grade, been a "splendid athlete", won many handicap foot races and played for the Shepparton football team. Following the war, he "looked different altogether . . . He was restless and could not sit still and lost his temper very quickly."¹⁹⁴ Friends and former employees of Daniels confirmed this view. For example, M.E. Pettitt wrote: "Before the war he was a good all round athlete - Since his return from Active Service he has completely changed, and not been able to take his place in the activities of the Town."¹⁹⁵ Harold C. Green, a Shepparton baker, described Daniels as having been a "fine specimen of manhood,"¹⁹⁶ while his former employer, grocer Colin Taggart, depicted him as energetic, bright, happy, conscientious and well-liked by all customers. Post-war, however, Taggart said that Daniels was emaciated, morose and unable to concentrate - an unsuitable employee.¹⁹⁷ R. Gowers supplied independent testimony to the altered mental condition of Albert Dimond, the man who had developed the habit of returning to his mother's at the weekend. Gowers said that Dimond was a "shadow of his former self."¹⁹⁸ Peter Cherry provided similar support for his friend of 18 years, Francis Hammond, whom he described as having been sleepless and nervous since the war. Of Hammond's pre-war health, Cherry commented: "I did not hear of him having a day's sickness."¹⁹⁹ Father V.E. Stoney of Casterton in Victoria's Western District was well-placed to observe the transformation of former 13th Light Horse trooper, Joseph Fry. Before 1914 Fry had boarded with the priest who informed Repatriation in 1930: "After his return from the war I was shocked to notice how he had changed and kept him at the Presbytery for 3 months as a guest to give him a chance to recuperate somewhat."²⁰⁰

Former comrades-in-arms also testified to dramatic alterations in a returned soldier's manner. In order to strengthen his case for a pension and medical treatment, Victoria Henry, who had not known her husband before the war, contacted his old mates in the medical unit to which he had belonged as a stretcher bearer. Confirming what she probably already suspected, W.F. Rolf of Strathbogie in central Victoria told

¹⁹³ The adverse effect of war neurosis on communities was not confined to Australia. Perhaps the best work on the Great War's impact on a town (in this case, Bury in Lancashire) is Geoffrey Moorhouse's *Hell's Foundations. A Town, its Myths and Gallipoli* (Hodder and Stoughton 1992). Chapter five of this book documents the post-war influence of shell-shock and other disorders.

¹⁹⁴ Form U, W. Daniels, 7 November 1929, op. cit., in Daniels, PCF, op. cit..

¹⁹⁵ M.E. Pettitt to Repatriation, 8 November 1930, in *ibid.*

¹⁹⁶ H.C. Green to Repatriation, 8 August 1930, in *ibid.*

¹⁹⁷ C. Taggart to Repatriation, 6 January 1930, op. cit., in *ibid.*

¹⁹⁸ R. Gowers to Deputy Commissioner, Victoria, 8 July 1931, in Dimond, PCF, op. cit..

¹⁹⁹ P. Cherry to Repatriation, 2 June 1930, op. cit., in Hammond, PCF, op. cit..

²⁰⁰ Father V.E. Stoney to Repatriation 7 October 1930, in Fry, PCF, op. cit..

Mrs. Henry that, in France, Robert had always been "in a normal frame of mind". Rolf said, however, that he had noticed a radical change in his friend post war:

He was always restless, at times nervous and I thought something was worrying him greatly. At times he would seem like his old self but mostly he was fidgety . . . I emphatically state that the Bob I knew in France was a different Bob to the one I met on his return to Victoria. ²⁰¹

Another former comrade, however, detected a change in Robert Henry before the war's end. Robert Allan of Adelaide described him as being initially "bright, strong and keen" but remarked: "[B]efore I left the Battn. he was a changed man undoubtedly due to exposure under heavy fire combined with the hard work of stretcher bearing." ²⁰² Dr. Leon Deller, one of the 7th Battalion's medical officers, also perceived a change in Henry on active service. He described him as "mentally normal" at first but commented that the effect of big battles had "left their mark on his mind and body." ²⁰³

Undoubtedly the mental problems of some men had existed prior to the war, an event which merely aggravated their difficulties. But it is equally clear that other men had not experienced even the slightest psychological malfunction beforehand so that its later appearance shocked not only themselves, of course, but friends, family and community too. This well-documented astonishment and distress can be seen as one measure of how much they had changed.

Thus, although the war had helped to create much obvious political, social, economic and industrial chaos, it was, through shell shock, also responsible for a less prominent form of upheaval: the undermining of pre-war assumptions and patterns of life that had sustained individuals, families and communities in Australia for decades. The psychiatric legacy of the Great War created veterans unable to adjust to the demands of civilian existence. Restlessness, isolation, alcoholism, violence, divorce, unemployment and vagrancy characterised the lives of many psychological casualties. As a result of their inability to function socially or to work consistently, many of these men became alienated from post-war society and estranged from their families. These highly damaging domestic dramas and personal tragedies were played out not in the public arena, like their more conspicuous counterparts, but behind the neat privet hedges of suburbia and in the back blocks of the bush. They were, however, no less destructive in their own corrosive way and should be rated as one of the war's most appalling consequences.

²⁰¹ W.F. Rolf to V. Henry, 18 June 1928, in Henry PCF, op. cit..

²⁰² R. Allan to V. Henry, 25 June 1928, in *ibid.*

²⁰³ L. Deller to V. Henry, 7 July 1928, in *ibid.*

Chapter Eight

War Neurosis and Australian Psychiatry.

Throughout the Great War and in the two decades that followed, the Federal Government called upon the resources of Australian psychiatry to manage many of the problems created by war neurosis. The administrative, intellectual and medical conundrums produced by psychological disorder created new difficulties for the six state lunacy departments and for individual doctors, several of whom were exposed to dynamic new theories on trauma and its treatment. Given these trends it would be reasonable to expect war neurosis to have made a major impact on psychiatry in Australia. But its effect was only minimal. The consequences of the First World War for Australian psychiatry were, in fact, twofold: firstly, it increased the pressure on State Lunacy Department facilities both during the conflict and throughout the 1920s and 1930s; secondly, it inspired optimism in a small group of doctors who, as a result of their war experience overseas and at home, had become disciples of psychodynamic theories of mental illness and their associated therapies. For these men shell shock and the perceived efficacy of psychotherapy were an affirmation, a vindication of their pre-war opinions. Within this group, war neurosis became the basis of fantastic optimism, raising hopes for major changes and elevating the idea of real reform in Australian psychiatry from pipe dream to possibility. Due to their post-war evangelism, neurosis became the subject of lively but limited intellectual ferment in the 1920s. War neurosis also had practical consequences: it is clear that several of these doctors applied psychodynamic principles not only to soldiers treated by the Department of Repatriation but to civilians as well. Although these practitioners made a difference within their own spheres of influence, war neurosis did not prompt the kinds of general reform for which many of them had hoped. These small pockets of gentle agitation were ignored by authorities who chose to manage the problem within existing structures and paradigms.

Australian Psychiatry 1860 - 1940: an overview

Before attempting to assess the war's impact on Australian psychiatry, a definition of terms is necessary. In one sense the term "Australian psychiatry" is a misnomer because the management of the insane was a matter for the states, each of which produced a particular character in its Lunacy Departments. Despite this diversity, it is

still possible to make generalisations based on factors common to all states. It is also necessary to show that Australian psychiatry consisted of two basic elements: the asylum systems staffed by medical officers employed by the State, and a handful of private practitioners who were usually physicians with an interest in psychological medicine.

Before the First World War, Australian psychiatry was a medical backwater located largely in the asylum systems run by the various state governments which had inherited this responsibility as a colonial legacy. At this time there were few psychiatrists in private practice and they tended to be former asylum doctors. Private institutions also existed but they too were few in number. Although conditions varied from state to state (and before that from colony to colony) certain generalisations can be made about the environment of Australian psychiatry and the reasons for this state of affairs.

Heavily influenced by British traditions, psychiatric institutions in Australia tended to perform a custodial rather than a therapeutic function in which patient docility and the smooth running of the asylum were paramount. In the earliest days of the Australian colonies, cases of mental illness were gaoled, an action that reflected the British attitude of associating insanity with criminality and other deviant behaviour. It was only in the 1850s that the medical profession in Australia gained control of asylums and had insanity recognised as an illness rather than a crime. Asylums were large but always seriously overcrowded, and the staff were few and poorly trained with the result that abuse of inmates and chronic illness were common.¹

Serious reforms began in New South Wales (which was generally recognised as the leader in these matters) in 1868 under Frederick Norton Manning and continued for the next ten years, with the other states following suit. Thereafter, a pattern of reform - driven by periodic public outrage and pressure from psychiatrists - and stagnation persisted throughout the country. Although a humanitarian impulse drove some of these activities, they were essentially legal and administrative, not therapeutic. Manning's reforms, in which the emphasis was on central control and regulation, set the pattern of lunacy management in Australia for at least the next eighty years. These changes introduced the offices of Inspector-General of the Insane, which would oversee the asylum system, and Master-in-Lunacy, which would administer the estates of patients. Both of these appointees were answerable to the Chief Secretary. According to these reforms, attempts were made to locate institutions in rural or outer urban settings; patients were categorised into acute, chronic, criminal and idiot; inspection by a board of visitors was to supplement the Inspector-General's tutelage;

¹ M. Lewis, *Managing Madness: Psychiatry and Society in Australia 1788-1980* (Australian Government Publishing Service, Canberra, 1988), pp. 5-14.

and legal procedures covering committal, admission, administration of estates and patients' rights were more precisely defined.²

During the early twentieth century, therapeutic concerns began to emerge in the writings of asylum psychiatrists advocating reform. Reacting adversely to the legalistic conception of insanity that drove the state system, they recommended the authorisation of voluntary admission and the opening of early treatment centres so that mental disorder could be treated in its nascent stages without the need for certification. Opened in 1910 the Royal Park Receiving House in Melbourne was one of the first such institutions.³

The advocacy of voluntary admission and early treatment followed a worldwide trend that had begun in the late nineteenth century. But unlike the United States, Britain and Germany, whose clinics tended to be private and independent of the asylums, Australian facilities remained firmly attached to the state psychiatric services. In the early 1920s, after the Great War, Australian reformers continued to concentrate on trying to introduce voluntary admission and stressed the need for outpatient clinics in the major hospitals. By the 1920s such clinics existed at the Melbourne and Alfred Hospitals in Victoria; by the 1930s similar units had appeared at the Royal North Shore and Parramatta Hospitals in Sydney, while in country New South Wales, Newcastle, Goulburn and Orange Hospitals were also equipped in this manner.⁴

Despite these attempts to improve the Australian asylum system, reform did not alleviate the lot of the majority of patients either during the late nineteenth century or the first fifty years of the twentieth century. New legislation was often the result of public pressure and official inquiry which followed some scandalous revelation. The resultant changes were usually followed by long periods of stagnation in which facilities decayed and overcrowding once again became a major problem.⁵ Throughout this period - the 1860s to the 1950s - custodial care and control of patients remained the chief imperatives within this system. Sedative drugs, restraint,⁶ cold showers, and electricity for therapy and discipline were the principal means of managing the patient population.⁷ Some improvement in treatment did occur during the late 1930s with the introduction of insulin and cardiazol for schizophrenia and manic depression. However, the poor doctor to patient ratios in the asylums meant that alternative

² Lewis, *op. cit.*, p.15.

³ *Ibid.*, pp.34-36.

⁴ *Ibid.*, p.37.

⁵ *Ibid.*, p.33.

⁶ Like other inmates, soldiers too were subjected to restraint. A committee inquiring into the running of Western Australia's Claremont Mental Hospital in 1919 found that a shortage of attendants forced the use of an undesirable level of this method of control and that Sergeant O'Meara, V.C., was kept in a straightjacket for approximately 14 hours per day. *Ibid.*, p. 46.

⁷ *Ibid.*, pp.12.

treatments such as individual or group psychotherapy were simply impossible to employ.⁸

Psychiatry in Australia was not a profession that enjoyed a high standing in the community or within medicine generally during the period under study. Despite gradual progress towards a more humane system, the treatment of mental illness existed on society's fringes. University instruction was minimal; in fact, no undergraduate training in lunacy practice or theory took place in Australian medical schools until 1888 when Frederick Norton Manning began lecturing at Sydney University. Similar lectures began at Melbourne University in the 1890s and at Adelaide in 1888. As in New South Wales, teaching was undertaken by asylum doctors. The first Australian chair of psychiatry was established at Sydney University in the 1920s but the other states did not create such a position until the 1960s.⁹

Within the profession itself, theoretical change was also slow. As it had in Britain, Freudian psychoanalysis made only a small impact in Australia both before the First World War and afterwards. Freud, Jung and Havelock Ellis sent papers on psychoanalysis to the Australian Medical Congress of 1911 while in 1913 the Australian Medical Journal reviewed the work of Freud and Jung, supported psychoanalysis as a treatment for neurosis but ridiculed its sexual aetiology and dream analysis. During the 1920s and 1930s, psychoanalysis was the subject of acrimonious intellectual debate amongst some members of the Australian medical profession. Supporters claimed that it effectively shed light on mental disorder while detractors generally attacked libido theory. Within Australian psychiatry, psychoanalysis and other psychodynamic ideas did gain some influence as an approach to mental illness but in general were only marginally influential. Mainstream practice, which continued within the asylum system, retained its organic orientation. This trend suited institutional imperatives and shortcomings: psychotherapy was time-consuming and "labour intensive" and the small asylum staffs were simply unable to devote any of their energies to group or individual treatment amongst the large patient populations.¹⁰

Why was psychiatry such a neglected area of Australian medicine? Psychiatry occupied a lowly position in the Australian community and medical profession because of attitudes inherited from Britain combined with colonial values and political indifference. For a long time in Great Britain, lunacy had been associated with social deviancy, in particular criminality, immorality and pauperism.¹¹ In Australia, these inherited views of insanity were compounded by the attitudes of a materialistic, bourgeois society which believed that failure in the land of opportunity was the result of

⁸ Lewis, *op. cit.*, p.43.

⁹ *Ibid.*, p.105.

¹⁰ *Ibid.*, pp. 52-55.

¹¹ *Ibid.*, pp. 8-13.

personal irresponsibility and moral defectiveness. In a community which emphasised individual responsibility and self-reliance, the mentally ill were dependent and, together with other deviants and social outcasts, seen as responsible for their own lack of prosperity. Although these opinions were clearly not held by all, and weakened a little as the nineteenth century progressed, the stigma attached to insanity persisted during the twentieth century. This disposition contributed greatly towards the ostracising of the mentally ill and the marginalisation of the profession that managed them, even during the 1920s and the 1930s. Political indifference naturally followed public apathy.¹²

Australian psychiatry before the First World War also consisted of private practice which served large working-class and small middle-class markets. Doctors in this field comprised asylum-trained medical officers (alienists), general practitioners and unregistered quacks all of whom dealt chiefly with nervous complaints such as hysteria, neurasthenia, insomnia and nervous debility. Treatment included the standard somatic methods and the usual nerve "cures": potassium bromide, chloral hydrate, opium, electricity and herbal remedies. The exception to this situation was a small group of physicians (and, it must be said, some Lunacy Department medical officers) interested in mental functioning, progressive ideas and reform who employed psychotherapeutic techniques such as suggestion and hypnosis.¹³ Involvement with shell shock patients both in Australia and overseas later became crucial in the post-war activity of some of this latter group and in the development of their thinking on psychological disorder.

The impact of the First World War on the Australian asylum system

What impact, if any, did the war have on the Australian asylum system as described above? One of the major consequences of the war for Australian asylum psychiatry was a practical one that centred on perpetual overcrowding and dilapidated accommodation. The war did not, in fact, re-orient this system at all. It simply added to its problems by placing extra demands on highly stressed facilities and staffs both during and after the conflict. Although alternative paradigms were known and advocated by a small band of crusading doctors, Australian officialdom - politicians, and the Departments of Defence and Repatriation - relied on the existing model of psychiatric care to manage the victims of war trauma. As a result - and despite preferential status through segregation - Australian psychological casualties entering the asylum system were forced to endure very similar conditions to those that plagued civilian mental cases.

¹² Lewis, *op. cit.*, pp. 41, 123, 191-192.

¹³ S. Garton, *Medicine and Madness: A Social History of Insanity in New South Wales 1880-1940* (New South Wales University Press 1988), pp. 65-69.

When the Gallipoli campaign began producing significant numbers of psychological casualties, it was recognised by State and Federal authorities that facilities in Australia would be needed to house these men and others upon their return. Between 1915 and 1917, special War Mental Treatment Acts were passed in the parliaments of Victoria, Western Australia and South Australia allowing the uncertified admission of traumatised returned servicemen to Lunacy Department institutions. Provision for such action already existed in New South Wales. Before returning to their home states, soldiers from Queensland and Tasmania were sent to New South Wales and Victoria respectively upon their arrival in Australia. Under these arrangements the Department of Defence retained control of returned servicemen but the Lunacy Departments were saddled with the burden of care. After the war, the Department of Repatriation assumed Defence's former responsibilities.

As has been seen, overcrowding in Australian asylums was a perennial problem but the States' acceptance of responsibility for the management of psychological casualties placed an extra burden on already overtaxed facilities. Victoria was a case in point. In 1915 a military mental hospital was opened at Royal Park Hospital for the Insane in the female section of the Receiving House, an early admission facility.¹⁴ In 1916 the entire Receiving House was devoted to military mental casualties and, in his Annual Report, the Inspector General of the Insane, Ernest Jones, advised that this occupation made the rest of the work at Royal Park very difficult.¹⁵ In 1917 and 1918 Jones revealed that the situation was deteriorating with the increasing numbers of military patients.¹⁶

Victoria's difficulties had intensified when the Lunacy Department agreed in 1915 to hand over the new Mont Park Asylum to the Defence Department not only for psychological casualties but for general medical convalescents as well. Mont Park, for which the land had been purchased in 1910, was intended as a replacement for the antiquated Yarra Bend Asylum but the Victorian Lunacy Department did not gain full use of its 1000 bed capacity until 1933 when the last of the military mental casualties was transferred from the two special wards there to the Bundoora Repatriation Hospital. Largely because of the war and the military's occupation of Mont Park, Yarra Bend was not finally closed until 1925.

Through the operation of preference in employment for returned soldiers, the war also adversely affected the quality of asylum staff. The general policy of preferential treatment for servicemen was a controversial issue in Australian society mainly because it affronted the labour movement's advocacy of preference to

¹⁴ Report of the Inspector-General of the Insane, Victoria, 1915, p.1.

¹⁵ *Ibid*, 1916, pp. 1, 27, 38, 39.

¹⁶ *Ibid*, 1917, p.1 and 1918, p. 19.

unionists.¹⁷ Legislated for in every state except Queensland,¹⁸ its efficacy was questionable in the private sphere but in the Victorian Lunacy Department it enjoyed dubious success. In the employment of asylum attendants, absolute preference was given to returned soldiers but these men were not required to undergo any training whatsoever.¹⁹ As they became older and the policy continued to operate, they became a serious hindrance to the running of the Victorian Lunacy Department. Dr. Catarinich felt that the efficiency of Mont Park was being seriously compromised by the inability of these untrained attendants to deal properly with the violent behaviour of patients: aggressive arguments and attempts at escape, suicide and homicide were too much for them. In 1934 he tactfully reported: "[T]he staff is becoming too old to regard these matters with equanimity."²⁰ He also stated that filling positions at the higher levels of the asylum was difficult because of the lack of suitably qualified people. "Each year these difficulties will become more accentuated, and one feels that the time has arrived when some relaxation of the preference should be made," he continued.²¹ In a sharp irony, some of these veterans were also placed in charge of their former comrades in the military mental wards at Mont Park. A few chose to become qualified but immediately moved from their junior positions to better paid employment in the State Lunacy Department. The military wards therefore lost their best junior attendants whose places were then occupied by totally untrained men.²²

In Melbourne, the Receiving House at Royal Park, two wards at Mont Park and a Repatriation Hospital at Bundoora were set aside or specially built for psychological casualties. However, these men were, in reality, admitted to the old asylum system with its usual problems. Descriptions of conditions at the Bundoora facility resembled the perpetual criticisms of the Australian asylum system and suggest that very little had changed in the management of mental illness. Occupied in 1933, the new buildings immediately began to show signs of poor construction as the Medical Superintendent, Dr. J. Catarinich, reported:

Unfortunately it was soon found that numerous defects existed in the buildings, and several alterations will be necessary to bring them to a state suitable for accommodating mental patients. Under present conditions it is almost impossible to keep these wards in a cleanly [sic] state, and the walls generally should be reconditioned as soon as possible.²³

Twelve months later, conditions were still the same. In a very revealing passage, Catarinich wrote: "The wards are showing evidences of poor construction and

¹⁷ F.K.. Crowley, (ed.), *A New History of Australia* (William Heinemann, Melbourne 1977), p. 354.

¹⁸ *Ibid.*

¹⁹ Report of the Inspector-General of the Insane, Victoria, 1925, p. 37.

²⁰ *Ibid.*, 1934, p.16.

²¹ *Ibid.*

²² *Ibid.*, 1925, p.26.

²³ *Ibid.*, 1933, p.16.

already need renovation. A more generous attempt to make the institution homelike by way of additional furnishings, pictures, and floor coverings should be made." ²⁴ For soldiers and civilians alike, overcrowding was also a major difficulty throughout the war and into the 1920s and 1930s. In 1924 a Repatriation Hospital for psychological casualties was opened on the site of the old Bundoora Convalescent Farm ²⁵ and, along with the Mont Park wards, constituted the second specialist facility for soldiers used in Victoria during the inter-war period. Under an agreement with the Federal Government, the State Lunacy Department assumed responsibility for the management of these men while Repatriation retained the right of inspection. ²⁶ Neither unit, however, was able to cope with the constantly increasing numbers of cases. In 1932 accommodation at both places was filled to capacity: 90 at Mont Park and 68 at Bundoora; excess numbers were forced to wait in the civilian block.

The war and its aftermath also increased the strain on South Australia's mental health resources. By 1922, accommodation at Parkside, the state's main asylum, was barely adequate for civilian patients and certainly insufficient for military cases whom the Repatriation Commission desired should be segregated. Suggestions were made to the Inspector-General of the Insane, Dr. Bedlington Morris, that the Receiving House at Enfield might be used exclusively by the Commission. It was pointed out, however, that civilian requirements were so urgent that such a "suggestion could not be entertained." ²⁷ As a result, the Commonwealth Government agreed to fund the construction of an entirely new hospital for the segregation of military mental patients in South Australia. As it seemed to be for civilians, "therapy" for soldiers only involved "looking after their comfort, and in attending to any physical ailments which may arise." ²⁸

Far from precipitating any kind of transformation in approaches to mental illness, the war tended to emphasise and even reinforce certain negative aspects of Australian psychiatry. The precipitate passing of the War Mental Treatment Acts in Victoria, Western Australia and South Australia conformed to the crisis mentality that surrounded mental health administration and reform in Australia: a hue and cry had been raised, therefore a response was necessary. Inspired by similar British war time legislation, which was itself based on a Scottish civil law, ²⁹ the Australian Acts also demonstrate the continued influence of Great Britain in matters of mental illness. Equally as revealing as this eleventh hour reaction was the parliamentary debate on

²⁴ Report of the Inspector-General of the Insane, 1934, p.17.

²⁵ F. O' Neill and D. Taylor, *Psychiatric Institutions in the Mont Park Area: A Preliminary Assessment* (Heritage Management Branch, Department of Planning and Development 1993), p.10.

²⁶ Annual Report of the Inspector-General of the Insane, Victoria, 1925, p.1.

²⁷ Prime Minister to the Premier, South Australia, 4 September 1922, AA (Canberra) A458/1, Item 0368/5.

²⁸ Prime Minister to Premier, South Australia, op. cit., p.26.

²⁹ Victorian Parliamentary Debates, 12 August 1915. Vol. 140, p.1809.

these Bills which highlighted not only the stigma attached to mental illness but the fears and prejudices connected with it as well. As revealed by Chief Secretary Murray, the avoidance of the shame associated with certification was the primary motivation behind this legislation. He stated:

People generally look upon it as a stigma if a person has been certified to as a lunatic. . . . The Bill will enable a soldier who has been on active service, and who is suffering from mental derangement, to receive proper treatment under proper supervision without being certified to. . . . Under the Bill we will have the power to set aside an asylum, or any part of an asylum, for the purpose. . . . After their recovery there will be no unpleasant recollections that they have been confined in a lunatic asylum and stamped as lunatics.³⁰

The popular fear that sane people were committed to asylums also revealed itself during this debate, as did contempt for government asylums in which it was thought no hope of recovery was possible. The perennial concern with unnecessary expenditure encouraged one MLA to advocate the treatment of psychological casualties in their own homes by their own families.³¹ As has been shown in chapters four, five and six, home treatment was employed by the Department of Repatriation and was thus a reality for some men and their relations.

It is clear from this debate that conditions prevailing in existing mental institutions were considered unacceptable for soldiers in the service of God and Empire but adequate for ordinary civilian patients. This attitude received its clearest expression in the desire that soldiers be segregated from civilians in separate facilities. First raised during the war in debates about the War Mental Treatment Acts, segregation continued to be an issue throughout the 1920s and 1930s as lobby groups such as the RSSILA and fathers associations pressured the Department of Repatriation to enforce this principle. All states complied except Queensland, which strenuously and successfully resisted every Federal Government attempt throughout the inter-war years to create separate accommodation and treatment for soldiers.

Pressure for segregation showed that the war had done very little to remove the stigma attached to mental illness. Initiated by the War Mental Treatment Acts, segregation of soldiers from certified civil patients became Repatriation Department policy and continued after the Armistice into the 1920s and 1930s. It was actively supported by the RSSILA which lobbied successive ministers throughout the inter-war years. It could be said that because of the emergence of segregation, the war helped to reinforce the taint associated with mental illness rather than remove it.

Events and discussions associated with the provision of segregated, improved accommodation for returned soldiers also yielded many revealing - and depressing - comments on attitudes to and conditions prevailing in civilian mental health care. These

³⁰ Victorian Parliamentary Debates, *op. cit.*, pp.1809, 1810.

³¹ *Ibid.*, pp.1811, 1812, 1813.

revelations were one of the chief indicators that the war had not altered the sentiments surrounding mental illness in Australia. In 1921 plans were announced to return Mont Park from military control to Lunacy Department jurisdiction. Military patients were to remain segregated in two special wards but this seems to have escaped the notice of the RSSILA and soldiers' fathers groups who panicked when they imagined that returned servicemen were to be placed in "civil lunatic asylums."³² The RSSILA, fathers organisations³³ and some Federal politicians protested strongly. Amid discussion and debate about Commonwealth responsibility, segregation and the medical advisability of keeping soldiers together, the question of stigma was prominent. In Federal Parliament, J.H. Scullin expressed concern about the unpleasant effects on the returned soldiers' relatives if the veterans were transferred to civil institutions.³⁴ In particular, he emphasised that the relatives of soldier patients in military mental hospitals did not feel the same sense of shame experienced by the families of civilians in "ordinary lunatic asylums."³⁵

Some of the reasons for this stigma may be gauged from the reaction of a contributor to the *Age*. He wrote that soldiers must not be placed under State control. He knew of one returned serviceman who had been "placed in the worst ward amongst criminals and Asiatics. The conditions in that ward were of the most wretched."³⁶ As if to allay such fears, the Victorian Chief Secretary, Sir Stanley Argyle, made assurances that there was "no question of keeping the military cases in the same quarters as the civil cases."³⁷

In response to its enquiries about this matter, the Repatriation Commission was informed:

The new block is no more a civil institution than was No.16 A.G.H. Both are occupied, exclusively, by soldier patients, and both will be under the medical authority of the Inspector-General of the Insane. No objection has been raised regarding No.16 and it is a little difficult to understand the objection therefore being raised to the new block designed and built especially for military patients.³⁸

It is clear that the writer expected a rational response to a subject about which some members of the public were extremely sensitive. Such an emotional reaction should not have surprised him.

The circumstances surrounding the segregation of soldiers in States other than Victoria also revealed the persistence of prejudice against mental illness and illuminated

³² Repatriation Department Press Release, 13 June 1921, in AA (Canberra) A2487/1, Item 21/9338.

³³ *Argus*, 2 April, 1924 and the *Age*, 25 June 1924.

³⁴ *Ibid*, 3 April 1924.

³⁵ *Age*, 3 April 1924.

³⁶ *Ibid*, *op. cit.*.

³⁷ *Argus*, 4 April 1924.

³⁸ *Ibid*, *op. cit.*.

the poor conditions associated with the management of civil cases. Possibly with the Mont Park episode in mind, the Repatriation Commission strongly urged the South Australian government to complete a facility that had been planned for seven years. Chairman of the Commission, James Semmens, told the Prime Minister:

The Repatriation Commission is particularly anxious that their patients enter into occupancy of the new quarters as early as is practicable, especially as the accommodation at Parkside Mental Hospital is far from satisfactory . . . I should add that my Commission is always expecting an outbreak of complaints as to the unsuitability of Parkside for accommodating ex-soldier mental patients. ³⁹

In May 1929 the Prime Minister's Department wrote to the Premier of South Australia emphasising that the Repatriation Commission was "anxious to avoid an outbreak of complaints as to the unsuitability of Parkside for accommodating ex-soldier patients." Accordingly, on 11 September of that year the first patients were transferred to a newly-completed Northfield Repatriation Hospital. ⁴⁰ Some of the deficiencies in the Western Australian mental health system were revealed by comments on the segregation process there. Three miles from Perth an entirely new institution, Lemnos Repatriation Hospital, was provided for psychological casualties because the existing accommodation was deemed "wholly inadequate. The space available, especially for recreation, was far too confined and no system of proper classification could be introduced." ⁴¹ Further reinforcing the wretched status of mental health management in the community was the Repatriation Department's desire that their own institutions bear as little resemblance as possible to state asylums. At Lemnos there was no confined space, high walls or large fences. "It has not the appearance of a confined institution," wrote the RSL to the Minister for Health and Repatriation in 1937. ⁴² The men at Bundoora were similarly unrestricted but this concession to image created more problems than it solved. Reporting to the Victorian Parliament in 1934 on the Bundoora Repatriation Mental Hospital, Ernest Jones stated:

It will be seen that there is a relatively large number of escapes. The house at Bundoora constitutes an open ward and the patients are free to walk wherever they wish. Some of these patients unfortunately are subject to occasional alcoholic bouts. They leave the grounds and are sometimes brought back by the police. ⁴³

Thus, the Great War made no positive changes to the asylum system, the mainstay of psychiatry in Australia; rather, through such contentious issues as segregation, it revealed that long-standing prejudices and fears were still active in the

³⁹ Semmens to Prime Minister, 27 April 1929, in AA (Canberra)A458/1, Item 0368/5.

⁴⁰ Prime Minister's Department to Premier, South Australia, 8 May 1929, and Premier, South Australia to Prime Minister, 12 September 1929, in *ibid.*

⁴¹ HVC Thorby for PM, W.M. Hughes, to RSSILA, 15 April 1937, in AA (Canberra) A2421, G74 Pt.4.

⁴² RSSILA to Minister for Health and Repatriation 26 February 1937, in AA (Canberra) A 2421, G74, Pt.4.

⁴³ Annual Report of the Inspector-General of the Insane, Victoria 1934, p.17.

community. People were forced to declare their hands on mental health because of this issue, and the result was not encouraging for those who felt that the war might have altered attitudes towards psychological disorder. The modifications that the war did force were profoundly negative and placed further pressure on a system which, in all States, suffered perennially from overcrowding, antiquated facilities and inadequate staffing levels. The First World War did not change the direction of Australian asylum psychiatry at all. It simply added to its existing problems.

The influence of the First World War on the thinking and practices of Australian doctors involved with psychological medicine

In addition to the State Government-administered system of institutions, the other major elements of Australian psychiatry were the asylum medical officers and the doctors who practised privately. It was a small element of this component of Australian psychiatry - its practitioners - that was most altered by the war.

The majority of Australian psychiatrists were asylum doctors (called "alienists": those who treated the alienated mind) and physicians who had developed an interest in mental disorders. Amongst these was a small group of reformers and crusaders who, in the decade or so prior to the Great War, had been emphasising the importance of the mind in disease and advocating changes to medical curricula and the asylum system. For them, the First World War was a crystallising event that vindicated their stances on these issues. Those who travelled with the AAMC overseas came under the sway of some British doctors later labelled "eclectic depth psychologists". This group had long stressed the need for psychodynamic approaches to mental illness and became very influential when their services were called upon during the shell shock crisis. It was within the war neurosis hospitals run by these practitioners that several Australian doctors either had their views about psychology confirmed or were formally trained in psychotherapy, albeit in expedient fashion. When they returned home after the war, several of these men, together with a few of the asylum medical officers who had already treated hundreds of returned psychological casualties, excitedly related their experiences in professional journals or at conferences and lectures, while some pushed more vigorously for changes they had advocated pre-war.

Reformers and crusaders

Post-war enthusiasm for changes to psychiatry was part of a minor pre-war trend in Australia which advocated lunacy reform based on developments in Britain, the United

States and Germany. Events associated with this trend also revealed a growing awareness in Australia of the importance of neurosis - minor psychological disorder that impaired everyday functioning. At the 1914 Australasian Medical Conference, held in Auckland, New Zealand, two papers advocating change in psychiatric practice appeared: "The Universal Recognition by Medical Schools of Psychology and Mental Disorders as a compulsory subject", and "Methods of Early Treatment of Insanity." These argued for the inclusion of psychology in the medical curriculum and that such instruction should be carried out by specialists in clinics and wards attached to the teaching hospitals. The authors (now unidentified) contended that such facilities should be reserved for the study and treatment of the neuroses: hysteria, neurasthenia and psychasthenia, disorders of which there was a growing consciousness. An American textbook of the time, which featured a large and detailed section on neurasthenia and hysteria, ⁴⁴ was favourably reviewed in *The Intercolonial Medical Journal* of 1909 and suggests at least some acceptance of innovation. "We have nothing but commendation for this work which we regard as one of the very best text books on the subject," wrote the reviewers. ⁴⁵

Two of the most dynamic and outspoken doctors associated with the attempted reform of Australian psychiatry in the years before the First World War were the Inspector-General of the Insane for Victoria, W. Ernest Jones, and John Springthorpe. Before the war - and, indeed following it - both men were vocal and active proponents of change although, until 1913, when a rapprochement took place, they had been enemies. As an official visitor to the asylums, Springthorpe openly criticised Jones as Inspector-General of the Insane while Jones described his antagonist as a "dirty fighter . . . not above subtle misrepresentation of facts." ⁴⁶ When Jones arrived in Australia in 1905 to take up the position of Inspector-General, he was disgusted at the state of the Victorian asylums and immediately recommended the expenditure of 250,000 pounds to improve their condition. After hearing this recommendation, Premier Tommy Bent apparently told Jones that it would be less expensive for the State if it were to pay his fare to England and he return immediately. ⁴⁷ Whether this offer was serious or not is unclear but Jones stayed and commenced what became his life's work. In addition to his attempted improvements to the institutions, Jones advocated certain progressive ideas which he continued to push during the 1920s and 1930s without a great deal of success. The war's role in reinforcing his thinking on these matters was crucial.

One of the chief items on Jones' pre-war reform programme was the provision

⁴⁴ A. Church and F. Peterson, *Nervous and Mental Diseases* (Sixth Edition, Philadelphia 1909).

⁴⁵ *The Intercolonial Medical Journal*, 20 August 1909, p. 432.

⁴⁶ Jones, "Diary", page numbers absent, circa 1907. Clinical Services Library, Royal Park Psychiatric Institution.

⁴⁷ *Ibid*, circa May 1905.

of a receiving house and early admission procedures, innovations which were inspired by similar developments in New South Wales.⁴⁸ This idea was based on a recognition that there were degrees of mental illness and that it was undesirable always to certify or to mix the "curable" and the "incurable"; it was also anchored in serious doubts about the efficacy of the British style of lunacy management with its recourse to legal intervention and which had, said Jones, severed the study of mental disorder from general medicine and science, and relegated it "to the realms of pastoral pursuits and partial oblivion."⁴⁹

Receiving houses were institutions in which patients, some of them voluntary, were observed before being divided into the curable and the incurable, and if necessary, certified. Although claimed that they represented progress, he also maintained that these facilities were only a partial solution to the difficulties facing mental ill-health in Victoria. Only a maximum of two months residence was legally allowed, a period that Jones considered insufficient for effective treatment of the curable. Neither, he asserted, did receiving houses cater properly for the voluntary patient: these people were unlikely to present themselves if they imagined that they were to be associated with the incurably insane. In fact, of all classes, Jones felt that the voluntary patients were at the most serious disadvantage. Rejected "at most general hospitals" and prevented by the absence of certification from being treated in State asylums and private institutions, these people were "compelled to submit to the treatment of quacks, advertising hypnotists, unregistered so-called private hospitals, and sanatoria *et hoc genus homine*."⁵⁰ The answer, according to the Inspector-General, was a psychiatric clinic like the one at Munich or the Central Hospital for the Insane at Indianapolis, or the Mental Hospital at Baltimore. Allowing non-certified admission, such a facility must be staffed by experts and a wide range of consultants; it should also perform a teaching function. Further, Jones proposed the inclusion of out-patient facilities and provision for the treatment of neurosis "so that the study of nervous and mental diseases may be prosecuted side by side."⁵¹

Before 1914, John Springthorpe had been active in several medical spheres including the reform of psychiatry. He was an official visitor to Victorian asylums and, although not formally trained in these fields, he criticised current lunacy practice⁵² and urged greater recognition of psychology and psychotherapy. In several campaigning articles, he tried to demonstrate the effectiveness of these theories and methods by exemplifying many cases of neurosis that he had treated in Victorian hospitals and

⁴⁸ Jones, *op. cit.*, circa 1909.

⁴⁹ Annual Report of the Inspector-General of the Insane, Victoria, 1909, p. 41.

⁵⁰ *Ibid.*

⁵¹ *Ibid.*, 1909, *op. cit.*.

⁵² J.W. Springthorpe, "The Early Treatment of Mental Cases in a General Hospital", in *The Intercolonial Medical Journal*, 20 April 1902, pp. 197-202.

asylums. In the *Intercolonial Medical Journal* of April 1907, for example, he lectured his colleagues:

Even in ordinary cases it is more than doubtful whether the profession generally makes use of suggestion as a therapeutic agent in any continuous manner . . . It is, however, its neglect in the exceptional, though still common, conditions classed as neurasthenia, neuromimesis [hysteria], hypochondriasis, and mental disease, that is more patently discrediting the profession, glorifying the quack, and damaging the health of numberless individuals.⁵³

Like Ernest Jones, Springthorpe too called for uncertified early treatment and the provision of receiving houses.⁵⁴

In addition to these two prominent figures, other Australians amenable to progressive ideas in psychology before the war included Clarence Godfrey, a medical officer with the Victorian Lunacy Department; Paul Dane, a protégé of Godfrey; L.C. Strangman of the South Australian Lunacy Department; and Elton Mayo, founder of the Mayo Clinic in the United States.

The effect of the First World War on the promotion of psychodynamic ideas amongst Australian doctors

The war noticeably raised the level of enthusiasm for psychodynamic theories and psychiatric reform amongst certain Australian doctors in two different ways. Although they were given honorary rank in the AAMC, lunacy department medical officers like Ernest Jones, Clarence Godfrey and L.C. Strangman stayed in Australia and treated shell-shocked soldiers within the asylum system; they apprised themselves vicariously of overseas developments in the treatment of neurosis. Others, like John Springthorpe, joined the AAMC but they accompanied the AIF overseas and worked with shell-shocked soldiers in the special hospitals run by the British eclectics and witnessed first hand the successes and the mistakes of the British (and, to some extent, French and American) arrangements for sufferers of war neurosis. The influence of the British experience was later very obvious in the writings and other post-war activities of these Australians. In this small way, the war helped to reinforce British influence in Australian medicine and to maintain the imperial connection.

Although the above events occurred on opposite sides of the world, the consequences that flowed from them eventually coalesced and produced an upsurge of vain hopes and a rash of futile pleas for reform.

⁵³ J.W. Springthorpe, "The Therapeutic Use of Suggestion", in the *Intercolonial Medical Journal*, 20 April 1907, p.200.

⁵⁴ Springthorpe, "The Early Treatment of Mental Cases", op. cit., pp.197-198.

The effect of war neurosis on doctors treating psychological casualties in wartime Australia.

In Australia during the war, doctors who treated returned psychological casualties were usually - but not always - Lunacy Department medical officers given honorary rank in the AAMC. Overcrowding of asylums (which the war exacerbated) and other administrative problems remained major difficulties for these men but, for at least a few, contact with shell shock victims provided affirmation of their pre-war views, revelations and professional opportunities: Clarence Godfrey, Ernest Jones and Ralph Noble, a private Sydney doctor working in Red Cross Homes, were all markedly affected by their work with war neurosis sufferers. For the first two men, the war created hope for change; for the other, it provided an avenue to a career.

Clarence Godfrey, received his medical training in Scotland and England where he specialised in mental disorder and inebriacy. Upon his return to Australia in 1891 he became Honorary Consultant Psychiatrist to the Royal Melbourne Hospital and a medical officer with the Victorian Lunacy Department. During the war he was given honorary rank in the AAMC and placed in charge of the military mental hospital at Royal Park where he was already medical superintendent; in 1915 he joined the consultant staff at No.5 AGH as a specialist in psychological disorders.⁵⁵ Throughout the Great War, Godfrey, as medical superintendent at Royal Park, was concerned with the usual Lunacy Department problems: increasing pressure on accommodation, the need for early admission, the physical health of inmates, the state of the buildings, the use of restraint as a procedure and so on.⁵⁶ Because of his military duties, however, he met dozens of returned soldiers suffering mental disorder amongst whom were many cases of neurosis which he treated with psychotherapy. His apparent success using this method,⁵⁷ together with his interpretation of the war neurosis experience in general, convinced him that the war would produce a revolution in psychiatry.⁵⁸

The war created similar expectations in Ernest Jones, but it also modified his opinions on the roles of heredity and predisposition in mental disorder. It seems also that the war, through Clarence Godfrey's effective use of hypnosis and persuasion, alerted Jones to the value of these techniques. His response to Godfrey's success certainly suggests surprise. He wrote in his diary:

⁵⁵ *Medical Directory of Australia*, 1948, p.187; *Bulletin*, 18 December 1919, p. 40; *The Medical Journal of Australia*, 28 September 1918, p. 262; *Transactions of the Australian Medical Congress*, 1920, p. 419.

⁵⁶ Annual Report of the Inspector-General of the Insane, Victoria, 1917, pp. 31-32.

⁵⁷ In December 1919 the *Bulletin* told readers of its society page (much in the way goals are attributed to a footballer or victories to a fighter pilot) that Godfrey had "150 shock cures to his credit." *Bulletin*, op. cit., 18 December 1919.

⁵⁸ *Transactions*, op. cit., pp.423-424.

The first shell shock cases returning from Gallipoli were placed under my observation but as it was near impossible for us to find time to do them justice, I put Godfrey on to the staff at No.5 AGH and he had some amazing results with hypnotic suggestion . . . There were very many of the emotional and hysterical cases which responded to suggestion sometimes without hypnotism but often more rapidly after mild hypnosis. ⁵⁹

Ernest Jones was a man of definite opinions about race and mental health. In response to perceived mental degeneracy in some sections of the Australian population, he advocated eugenic solutions; he was also scornful of some non-Anglo-Saxon races, in particular the "low class Roman Catholic Irish" in whom he saw an "inherent lunacy". ⁶⁰ Early in the war he interpreted the incidence of psychological casualties amongst the First AIF - and other armies - in these terms but later modified his opinion when it became apparent that those who appeared the strongest were seriously affected by the external mental stresses of war.

Initially, Jones was not surprised by the incidence of psychological illness in the new mass armies because, as he put it, every population had its "weaklings" and "degenerates" and that there was no screening of types unsuited to this war of unprecedented violence. "[W]e must recollect," he wrote, "that in this war all . . . kinds of temperament . . . are engaged, and not merely, as was the case in our other wars, those who by inheritance and instinct have taken to soldiering as a matter of course." ⁶¹ By 1918, however, he had altered his views to the point where they resembled those of the more progressive British psychologists:

These neuroses and psychoses are chiefly produced by the excessive "emotion" to which all people are subjected, but none more so than those who go into the firing line; no matter how admirable may be the temperament of the individual, his resistance is more or less complete only in relation to the severity of the strain or shock put upon him. . . Loss of sleep, hunger, and anxiety will soon produce irritability and emotionalism which are with difficulty suppressed; indeed, often suppressed to the detriment of the individual. Ultimately a mental collapse occurs . . . Any of these things may happen amongst both well-seasoned soldiers or sturdy country-bred volunteers alike, men in whom it would be impossible to suspect any form of mental degeneracy. ⁶²

Thus, as a result of the war, Jones recognised the pervasiveness of neurosis amongst the general population. This insight, coupled with a perception that other countries had responded to the shell shock crisis with the kinds of initiatives that he had long been recommending for Victoria, filled him with the hope that such changes might now come to pass in Australia. Jones' conviction that the lessons to emerge from such a monumental catastrophe should not go unheeded, shaped his immediate post-war recommendations for reform in Victoria. He was, however, to be disappointed.

⁵⁹ Jones, Diary, op. cit., circa 1915.

⁶⁰ J. Ritchie (Gen. Ed.), *Australian Dictionary of Biography, Volume 12:1891-1939, Smy-Z* (Melbourne University Press 1990), p.521.

⁶¹ Annual Report of the Inspector-General of the Insane, Victoria, 1916, p.38.

⁶² Ibid, 1917, p.38.

War neurosis proved to be the seminal factor in the career of at least one private doctor, Ralph Noble of Sydney. His experience with shell shock patients initiated a highly distinguished career in psychology, much of which was spent, unfortunately for Australia, in England and the United States. Graduating from the University of Sydney in 1916, and being medically unfit for military service, he began general practice in the suburb of Five Dock. As a result of contact with war neurosis patients in Red Cross Homes across Sydney, he developed an interest in psychiatry. In 1921 he became the first person to be awarded the newly-established post-graduate diploma in psychological medicine from Cambridge University. After returning to Australia he began practising as a specialist and was appointed honorary demonstrator in neurological anatomy, University of Sydney; honorary assistant physician to the department of psychiatry at the Royal Prince Alfred Hospital and honorary neurologist and psychiatrist to the Lewisham Hospital, also in Sydney.⁶³ An interest in the Mental Hygiene movement took him to the United States in 1930 to preside over the First International Congress for Mental Hygiene.⁶⁴ The following year he returned to America to become Professor of Clinical Psychiatry at Yale University and in 1933 moved to England. During the remainder of his long career, Ralph Noble continued to practice privately and occupied several important positions including head of the psychiatry department at Addenbroke's Hospital and lecturer in psychiatry at Cambridge University. He died in 1965 at his home in Cambridge.⁶⁵

The influence of the "eclectic depth psychologists" on Australian doctors.

While some Australian doctors remained at home to treat returned servicemen, others joined the AAMC and accompanied the AIF overseas. During this period they made personal contact with the so-called "eclectic depth psychologists", a group of British doctors and psychologists committed to a psychological view of mental illness. For these Australians - small in number - this association was a major consequence of war service. It was the approach of the eclectic "school" of British practitioners to war neurosis - and neurosis in general - which informed the post-war opinions of that small group of vocal, returned AAMC officers who attempted to communicate their beliefs to the wider medical profession. Very rarely before 1918 had the theories and therapies

⁶³ R.A. Noble, "Report on The First International Congress on Mental Hygiene May 5-10 1930", in AA (Canberra) A1928/1, Item 195/74.

⁶⁴ Noble applied to the Federal Government for his fare to Washington but was informed by the Director-General of Health, Dr. J.H.L. Cumpston, that no funds would be forthcoming. The Government was happy, however, to appoint him its official representative at the conference without cost to itself. (Noble to Cumpston, 19 March 1930; Cumpston to Noble, 25 March 1930; Memorandum, Cumpston, 28 March 1930, in AA (Canberra) A 1928/1, Item, 195/74.)

⁶⁵ W.S Dawson, Obituary for Ralph Athelstane Noble, in *The Medical Journal of Australia*, 3 July 1965, p.41.

expounded in post-war Australian journals, medical conferences and lectures made any kind of appearance in this country. With the return of those medical officers who had spent time at the special "neurological" hospitals in Britain, however, the language of those who embraced ideas from a variety of European schools - the so-called "eclectics" - peppered the pages of Australian medical publications. Through journals like the *Lancet*, which carried many articles on war neurosis (and which were read by at least one Australian psychiatrist),⁶⁶ the views of the eclectics were also disseminated in Australia but it was those Australians who saw these practices at first hand who seem to have been most affected.

The group later labelled "eclectic depth psychologists" began to take shape in the years immediately preceding the outbreak of the Great War with the slow infiltration of psychoanalytic ideas into the thinking of some British psychologists and doctors. This group included such eminent names as William Brown, Hugh Crichton Miller, William McDougal, C.S. Myers, T.H. Pear, and W.H.R. Rivers.⁶⁷ All of these men became heavily involved in the treatment of shell shock.

The foundation of the London Society of Psychoanalysts in 1913 and the publication of Bernard Hart's *The Psychology of Insanity* in 1912 were probably the signal events in the history of this group. Hart's book was important because it epitomised the general British approach to depth psychology in the pre-war - and post-war - years. Borrowing from various sources such as Janet, this popular treatise was not pure Freud but effectively introduced many vital Freudian concepts such as mental conflict, repression, projection and identification.⁶⁸ Thus, as its name implies, British eclectic psychology was a hybrid of ideas drawn from a wide variety of mainly European theoretical systems which, in their entirety, attracted few adherents in the United Kingdom. The intellectual turmoil associated with the division of psychology into dissentient groups between about 1910 and 1940 - structuralists, functionalists, behaviourists, psychoanalysts - skirted Britain and, it would seem, Australia also.⁶⁹ There was, therefore, little consolidated dogma in the eclectic tradition but it did display some common features: a reluctant acceptance of certain Freudian principles (and the rejection of its "'improper'" concepts such as libido theory) and a willingness to assimilate useful notions from elsewhere. Thus, ideas such as the dynamic

⁶⁶ In a paper delivered to the Australasian Medical Congress of 1920, Clarence Godfrey quoted a passage from a *Lancet* article by Charles Myers, the progressive British psychologist who had coined the term "shell shock" in 1915. Myers' article argued the effectiveness of psychotherapy for war neurosis, and Godfrey used it as support for his own position on that subject. (*Lancet*, 8 January 1916, p. 69, quoted in C.G. Godfrey, "War Psycho-Neuroses and their Treatment", in *Transactions of the Australasian Medical Congress, 1920*, p.423.

⁶⁷ L.S. Hearnshaw, *A Short History of British Psychology 1840-1940* (Methuen, London, 1964), pp.179, 192-193.

⁶⁸ *Ibid*, pp.165-167.

⁶⁹ *Ibid*, p.212.

unconscious, repression, sublimation and mental conflict - the chief mental mechanisms - bound the eclectics together.

Amongst this group was a general acceptance of other theories such as Trotter's "herd instinct", Jung's "complexes", Adler's "inferiority feeling" and Janet's "dissociation".⁷⁰ In short, this group accepted the importance of the mind in the production of mental illness. Propagated by the eclectics, these views were all to become prominent in Britain during the war and impress several AAMC doctors who worked and learned in the more enlightened British neurological hospitals.

Throughout the First World War, many cases of shell shock in the BEF were treated in the general military hospitals scattered throughout the United Kingdom but many more were sent to specialist units that gradually grew in number as the problem became larger. In December 1914 there were four special hospitals for shell shock cases but by June 1918 that had grown to 19: six for officers and 13 for other ranks.⁷¹ Within this system the organic approach that had dominated pre-war British psychiatry tended to prevail: diet, hard work, and punitive electricity treatment were emphasised.⁷² The majority of specialists employed to deal with shell shock despised concepts like hysteria and neurasthenia, and rejected the psychological approaches developed in Europe.⁷³

Some special hospitals, however, became centres of enlightenment which influenced not only British practitioners but Australians as well. Run and staffed by many of the above-mentioned eclectic depth psychologists - later named "The School of Integral Psychology" by one of its prominent members, William McDougall - these centres employed the very European theories that were most despised by traditional British psychiatrists. For example, those of the "integral" school who suspected that mental factors might be at the heart of shell shock but who were dubious about Freud were influenced by French neurologists Babinski, Leri, Dejerine, Marie and Janet. Their methods included suggestion and persuasion, techniques that became the hallmark of treatment at the Seale Hayne Hospital in Devon,⁷⁴ run by specialist in nervous diseases, Arthur Hurst. Psychodynamic in his professional orientation,⁷⁵ Hurst became a major influence in the thinking of some Australian medical officers. As they had in civil life, many of the doctors who took a psychological approach to shell

⁷⁰ Hearnshaw, *op. cit.*, pp.238-239.

⁷¹ W.G. MacPherson (ed.), *Medical Services. Diseases of the War, Vol. II* (His Majesty's Stationary Office, 1923), pp. 45-48.

⁷² T. Bogacz, "War Neurosis and Cultural Change in England, 1914-22: The Work of the War Office Committee of Enquiry into 'Shell-Shock'", *Journal of Contemporary History* (SAGE, London, Newbury Park and New Delhi), Vol. 24 (1989), p.235.

⁷³ M. Stone, "Shellshock and Psychiatry", in W.F. Bynum, R. Porter, and M. Shepherd, *The Anatomy of Madness. Essays in the History of Psychiatry* (Tavistock Publications, London 1985), p.251.

⁷⁴ *Ibid.*, p.253.

⁷⁵ *Report of the War Office Committee of Enquiry into 'Shell-Shock'* (His Majesty's Stationary Office, 1922), pp.23-26, and A.F. Hurst, *Medical Diseases of the War* (Edward Arnold, London 1917), pp.1-24.

shock also drew heavily on Freud's theories, employing such concepts as repression, the dynamic unconscious and mental conflict but rejecting the sexual aetiology. Instead, Myers, McDougall and Brown explained shell shock in terms of the conflict between fear and duty, a struggle that caused the Freudian "flight into illness".⁷⁶

Several other hospitals run by the eclectics also became nuclei of progressive activity. The Red Cross Military Hospital, Maghull, formerly the Moss Side State Institution, and the Royal Victorian Hospital, Netley, were two such places. Here, doctors sympathetic to the psychological explanation of shell shock gathered to discuss theory and treatment.⁷⁷ The officer-in-charge at Netley, C. Stanford Read, was a neurological specialist who believed that mental dissociation (one of Pierre Janet's major contributions to psychiatry) was the major mechanisms involved in shell shock.⁷⁸ Psychotherapists at Maghull and Netley based their treatment on cathartic or "abreactive" techniques in which patients re-lived and re-experienced uncomfortable, sublimated emotions.⁷⁹

For these doctors, the consequences of war neurosis were twofold: firstly, several of them made their reputations from the work they undertook with shell shock victims and the publications that followed; secondly, they hoped that this war experience and their own agitation for change would undermine orthodox British psychiatry with its organic bias and legal basis. This cautious confidence and contempt for the status quo were expressed, for example, in a volume entitled *Shell Shock and its Lessons* by G. Elliot-Smith and T.H. Pear, a lecturer in Experimental Psychology at the University of Manchester. Richard Rows, officer-in-charge at Maghull, and W.H.R. Rivers, chief medical officer at Craiglockhart, also helped with the production of the book.⁸⁰ In it are to be found the following sentiments:

It is because we believe that a . . . probing of the public wound - the British attitude towards the treatment of mental disorder - though painful, is justifiable and necessary, that we have written the concluding chapters of this book . . . the shifting and unstable blend of apathy, superstition, helpless ignorance and fear with which our own country has too long regarded these problems is rapidly becoming our exclusive distinction . . . The war has forced upon this country a rational and humane method of caring for and treating mental disorder among its soldiers.⁸¹

The authors also called for major reforms of the lunacy system in Britain including the relaxing of the need to certify patients before they could receive specialist treatment in an institution.⁸²

⁷⁶ *Report of the War Office Committee*, op. cit..

⁷⁷ Stone, op. cit., p.254.

⁷⁸ *Report of the War Office Committee*, op. cit., p.21.

⁷⁹ Stone, op. cit., p.235.

⁸⁰ G. Elliot-Smith and T.H. Pear, *Shell Shock and its Lessons* (Manchester University Press 1917).

⁸¹ *Ibid*, pp.xiv-xv.

⁸² *Ibid*, pp.78-79.

Because of their experiences in these hospitals and their association with the more progressive elements in British psychological medicine, several Australian doctors were heavily influenced by the eclectic approach to psychology, particularly by its application to the problems associated with war neurosis. Their medical opinions and their aspirations for change resembled very closely the approach of the British progressives and were for these Australians - but, unfortunately, not for Australian psychiatry in general - a significant outcome of the war.

Australian medical officers serving overseas became familiar with the British eclectic approach in two main ways. Firstly, there were those who had volunteered for overseas service in the AAMC and travelled to Great Britain with the AIF; then there were those like Walter Reynell who had done their medical training in England before the war and joined the Royal Army Medical Corps while still in Britain. Occasionally there was an anomaly like T. Garnet Leary, the Irishman who received his medical schooling at Edinburgh University and joined the Australian Army Medical Corps before making a life in Australia.⁸³ But whatever the manner of acquaintance, the effect was similar: these men returned to Australia invigorated with the zeal of the convert.

Walter Reynell, a member of the South Australian wine making Reynell family, and a Rhodes Scholar, travelled to England in 1906 and graduated M.A., M.D. from Oxford in 1913 at the age of 28.⁸⁴ During the war he joined the RAMC and worked with Arthur Hurst at Seale Hayne. This experience made a heavy impact on him. "The war has taught the physician many things," he confessed before a meeting of the South Australian branch of the British Medical Association in 1919, "taught him to realize as never before how immense is the influence of the mind upon the body."⁸⁵ In championing that idea in his paper, Reynell also revealed that the tutelage of the eclectic Hurst was a crucial formative influence. In particular, Reynell's acceptance of certain mental mechanisms and his views on Freud are pure eclecticism and mirror Hurst's own position on these matters. Reynell told his fellow South Australians that mental conflict was at the root of many war neuroses. In a view that further acknowledged Freud, he stated that consciousness was divided into three segments: the conscious, the "liminal"(or subconscious); and the "sub liminal"(or unconscious). Repressed unpleasant thoughts - a process that spared the individual major distress - were stored in the unconscious but created "pathological complexes" when they forced their way into the active consciousness through, for example, dreams.⁸⁶

⁸³ See below pp. 278-279.

⁸⁴ *Licensed Victuallers Gazette*, December 1948.

⁸⁵ W.R. Reynell, "The Psycho-Neuroses of War", (Read at a meeting of the South Australian Branch of the British Medical Association, 24 April 1919), in *The Medical Journal of Australia*, 7 June 1919, p.455.

⁸⁶ Reynell, op. cit., p.459.

But in a further statement that reflects the eclectic group's ambivalent position on Freud, Reynell wrote: "However much we may disapprove or be disgusted with the methods and theories of the psycho-analytical school, we must allow that in the treatment of the neuroses we owe much to the researches of Freud." ⁸⁷ Reynell also offered tepid endorsement of other Freudian concepts such as dream analysis and free association, ⁸⁸ while, at the same time, acknowledging further eclectic influences including Babinski, Roussy, Dejerine, Janet, Dubois and Trotter. ⁸⁹ In addition, Reynell also explained the flight into neurosis in terms of a conflict between fear and duty ("fight or flight"), just as Myers, McDougall and Brown had done. ⁹⁰ For Walter Reynell, then, the eclectic approach to psychology, facilitated largely by duty as a medical officer at Seale Hayne, had been a major hand.

Several other Australians had their intellectual horizons widened at the special military neurosis centres. For these men, as well as for Reynell, the eclectic approach that dominated some of these hospitals was strong enough - or therapeutically effective enough - to play a major role in shaping their philosophies. Of this group, the most energetic and voluble was John Springthorpe. In Europe, in his indefatigable fashion, he visited the most advanced British, French and American neurosis units, consulted their expert staff, read their publications and tried to apply their techniques in his own ward at No.3 AAH, Dartford. ⁹¹ Between November 1917 and October 1918 he penned four reports on war neurosis to the Australian Department of Defence and contributed a lengthy paper - "The Better Treatment of Our War Neuroses" - to the Inter-Allied After-Care Conference of May 1918. ⁹² Among the major influences on his thinking were Hurst and Myers in England, and Babinski, Marie, Briand, Boisseau and Roussy in France. Amongst the reading he recommended to students were various volumes of the *Seale Hayne Neurological Studies* and *Shell Shock and Its Lessons* by Elliot Smith and Pear. ⁹³ It is also clear that he approved of the psychotherapeutic techniques employed at Maghull. ⁹⁴

Given these influences, it should not be surprising to find that Springthorpe's opinions were the same as the eclectics. His view of Freud, for example, is typical of the eclectic position and closely resembles that of his compatriot, Walter Reynell. At Melbourne University, he informed post-graduate students:

⁸⁷ Reynell, op. cit., p.458.

⁸⁸ Ibid, p.459.

⁸⁹ Ibid, pp.456, 457, 458, 459.

⁹⁰ Ibid, p.459, and Stone op. cit., p.255.

⁹¹ See chapter two, pp.101-110.

⁹² Springthorpe, "War Neuroses and Civil Practice", op. cit., p.284.

⁹³ Elliot Smith and Pear, op. cit..

⁹⁴ Springthorpe, op. cit., *passim*.

It is not too much to say that the war neuroses have completely shattered the original perverted notion of a sexual basis and driven such Freudism to oblivion. It is also true that everyone who has made extensive use of psychology in his treatment, has been acting on psycho-analytical lines, without, in most cases, finding it necessary to resort to its official formulae and, indeed, gaining satisfactory results more speedily and less objectionably by individualising his inquiry in response to the personal character in each case. . . In England [this method] flourishes at its best at Maghull.⁹⁵

The mental mechanisms and eclectic philosophy articulated by Springthorpe and Reynell were also the basis of Dr. A.E. Rowden White's approach to war neurosis. White, a Melbourne practitioner, was granted permission by Neville Howse (Director of Medical Services, AIF), in the war's closing months to visit the Ashurst Hospital at Oxford "to see the recent methods used in the treatment and management of War Neuroses."⁹⁶ This hospital was a specialist unit for psychological casualties opened in 1918.⁹⁷ Addressing the psychology section of the 1920 Australasian Medical Congress, he reported that each medical officer at Ashurst employed his own *modus operandi* but would make use of his colleague's methods if they were seen to be effective. White's eclectic orientation is further suggested by his explanation of the mental processes that caused neurosis in soldiers and the therapies recommended to cure it. He told his colleagues that repression of unpleasant thoughts and the worry these caused the subconscious mind "produced the trouble."⁹⁸ Psychoanalysis and "hypnoanalysis" were the most effective methods of treatment, according to White; he told his audience that, while using these methods, doctors needed to ensure the co-operation of the patient "who must be encouraged to divulge all of his anxieties."⁹⁹

Men like Springthorpe, Reynell and White accumulated their knowledge of eclectic methods "on the job". Some Australians, however, were formally instructed in these therapies. During and after the war, medical officers belonging to many of the Allied armies were given short courses in eclectic psychotherapy at the major British war neurosis units.¹⁰⁰ Amongst these men were Australians, one of whom was Major J.B. Lewis. In 1918 Lewis, as part of an urgent attempt to train Australian medical officers in this field, was sent to the Seale Hayne School of Neurology by his Commanding Officer, Colonel Douglas McWhae, AAMC, so that he would be able to employ psychotherapy on war neurosis cases at Monte Video Camp Hospital, Weymouth. On his return from Devon, Lewis put this new found knowledge to the

⁹⁵ Springthorpe, *op. cit.*, p.280.

⁹⁶ A.E. Rowden White, "A Record of a few cases of Functional Nervous Disorder treated at the Ashurst Hospital, Oxford." In the papers of A.E. Rowden White, Melbourne University Archives. Judging from the close correlation between the précis of White's speech in *The Medical Journal of Australia* and this paper, the latter seems to have been the one he delivered at the Australasian Medical Conference of 1920.

⁹⁷ "Australasian Medical Congress, Brisbane 1920", in *The Medical Journal of Australia*, *op. cit.*, p.324, and MacPherson, *op. cit.*, p.49.

⁹⁸ "Australasian Medical Congress, Brisbane, 1920," in *The Medical Journal of Australia*, *op. cit.*,

⁹⁹ *Ibid.*

¹⁰⁰ MacPherson, *op. cit.*, p.49.

test, treating at least 188 cases along typical Seale Hayne lines. Although he laboured under some difficulties - patients had to be treated in open wards for weeks before cubicle accommodation was provided - Lewis reported "uniform success". Using "mental analysis", suggestion and persuasion, he reportedly "cured" many cases of shell shock, neurasthenia, psychasthenia and a range of hysterical and psychosomatic ailments.¹⁰¹

Experience with war neurosis and the eclectic approach to psychology also made an impression on Douglas McWhae. In private practice after the war he applied what he had learned in England to the neuroses he encountered in civilian patients and returned soldiers in Western Australia. As stated in a lecture to the Western Australian Branch of the British Medical Association in 1919, his intellectual mentors were Hart, Hurst and Trotter, major figures in the eclectic pantheon. His conceptual framework included the eclectic syndrome grouping of psychasthenia, neurasthenia and hysteria, while his therapeutic approach was founded on the techniques of suggestion and persuasion, Seale Hayne's hallmark.¹⁰² As will be shown below, McWhae's post-war treatment of civilian neuroses in Western Australia was heavily influenced by his experiences in England.

Perhaps the motives that resulted in the exposure of some Australians to eclectic depth psychology were diverse. Ranging from chauvinism and humanitarian concern, to a cold pre-occupation with the pension bill,¹⁰³ they did, nevertheless, help to create considerable familiarity with progressive psychological notions for a small group of Australian medical officers. Whatever the reason, it is clear that the war was of prime importance in a process that saw several Australians look to and absorb new ideas on psychology from the United Kingdom and, indirectly, from Europe.

A deviation from this trend, but one which again underlined the war's importance as a conduit for ideas coming from Europe to Australia, was T. Garnet Leary, an Irish M.D. who came via the AIF and Gallipoli to Australia where he practiced an eclectic approach to psychology. Born in Castlederg, Northern Ireland, in 1879, Leary received his medical training at Edinburgh University before joining the Australian Army Medical Corps on the outbreak of war. At Gallipoli he became commander of the 15th Field Ambulance but from 1916 until at least 1920 he was employed by the Defence and Repatriation Departments as a psychotherapist. Specialising in speech disorders, he worked closely with Clarence Godfrey. From that

¹⁰¹ "Treatment of War Neurosis by Psycho-Therapy": Colonel. D. McWhae, ADMS, AIF Depôts in UK, to SMO, AIF, AWM 25, 885/4; Report by Major J.B. Lewis on 188 cases at Monte Video Camp, 11 February 1919, and History of War Neurosis Treated at Monte Video Camp Hospital, Weymouth 1919, AWM 25, 885/4.

¹⁰² D.M. McWhae, "Neuroses". Read at a meeting of the Western Australian Branch of the British Medical Association, 10 June 1919, in *The Medical Journal of Australia*, 2 October 1920, pp.337-342.

¹⁰³ See chapter two, pp. 100-101.

time until his death in February 1954 he enjoyed a distinguished medical career in Australia and participated actively in the Citizen Military Force. ¹⁰⁴

Leary's approach to war neuroses was conditioned by his commitment to the idea that dissociation was at the heart of neurosis in general and that psychotherapy should be the major therapeutic tool for these disorders. ¹⁰⁵ As outlined earlier, the concept of dissociation was first articulated by Pierre Janet and was generally accepted by the eclectics in Britain where Leary trained. It is, therefore, reasonable to assume some connection between the eclectic approach to depth psychology as practised in Great Britain and Leary's acceptance of both dissociation as a major mental mechanism, and psychotherapy as an effective method of treatment. His address to the neurology and psychology section of the Australasian Medical Congress, 1920, suggests the validity of this interpretation of his chief intellectual influences. He told his colleagues of "the success of suggestive methods in almost all neuroses" and that "stammering as a process of 'dissociation' is not different in essence from that in other neuroses, i.e., a dissociation of certain more or less highly specialised psycho-physical processes from the main personality." ¹⁰⁶ Leary informed the session that such dissociation was more likely to occur as a result of the psychological shock of warfare and, as an example of this proposition, he cited the case of a 24th Battalion private who after being buried at Gallipoli and wounded in France, developed anxiety symptoms and a major speech defect. In the process, Leary revealed his approval of the mental mechanisms, structure and therapies articulated by some of the principal European influences on the eclectics:

Abreaction or acting over again his emotion brought to light the repressed fears when his mind 'split' or became dissociated by the repression of the horrors into the deeper levels of consciousness. It was necessary to apply psychic treatment several times before rhythmic drill enabled him to co-ordinate his speech mechanism again. ¹⁰⁷

In the case of T. Garnet Leary, the war had acted as a channel for the importation to Australia of psychological theories and practices from Britain, and, indirectly, from the continent.

Thus, experience with psychological casualties during the Great War had helped to mould a group of Australian doctors familiar with - and, in some cases, committed to - depth psychology. For some, the war gave sharper definition to views already held; for others it was a transforming event, while for a few, it opened entirely fresh vistas. How did they respond to their experience during the inter-war years? For some, the encounter with war neurosis and everything it entailed was a liberating experience that

¹⁰⁴ *Bulletin*, 17 March 1954, p. 10; *Who's Who in Australia, 1950*, p.4.; and T. Garnet Leary, "Stammering as a War Neurosis", in *Transactions . . . 1920*, op. cit., p.426.

¹⁰⁵ Leary felt, however that hysterical speech disorders of the kind he saw in both soldiers and civilians required rhythmic vocal exercises as well as psychotherapy. In Leary, op. cit., p.425.

¹⁰⁶ *Ibid.*, p.424.

¹⁰⁷ *Ibid.*, p.426.

created a heady promise of better days for their speciality. For them - reformers like Ernest Jones and John Springthorpe - it inspired an expectation of major change. To facilitate such innovation, they and other like-minded, former AAMC officers attempted to enlighten the rest of the Australian medical profession about the grand truths that the war had revealed to them. In publications and various other forums they related their illuminating experiences and attempted to convert any who would listen. Some, in their attempts to reorient medicine in this country, badgered authorities and berated their myopic colleagues - without success.

Because of their pre-war training and inclinations towards progressive ideas, these practitioners were receptive to the lessons that war neurosis and the more radical British psychologists offered them. Together with the medical officers who had remained in Australia, they created a small, clamorous band who called for changes that they felt must surely follow the revelations of war.

Post-war proselytising

Towards the end of the war and after the Armistice, the interpretation that Australian medical officers placed on their encounters with war neurosis - both overseas and at home - was given insistent expression at lectures and conferences, and in official reports and journal articles. Colleagues, students and governmental authorities were the chief targets of these intending reformers whose message was generally sanguine: the war had revealed deep insights into human behaviour so the medical world should take note and act.

At a lecture before the Melbourne Hospital Post-Graduate Course in August 1919, John Springthorpe berated inadequate British Army procedures dealing with war neurosis and advocated wider acceptance of psychology as an academic discipline and therapeutic tool. For him, the efficacy of psychotherapy had been the one outstanding medical feature of the war and he predicted an upheaval in psychiatric medicine:

A revolution may also be expected in lunacy practice. The unfortunate insane will no longer wait until their false beliefs have altered their whole outlook or crystallised down into delusions. Ancestry will receive its due, education and environment receive special attention and a rational psycho-analysis seek, discover and set right wherever possible, the mental conflicts which are so often the necessary antecedents. In addition, early treatment without certification is no longer the dream of a few enthusiasts: it has become the practice in confusional and other more distinctly mental war conditions. Even the present, so often almost chronic asylum patient may at times find in an improved, extended psycho-therapy a new, refreshing and efficient mode of treatment. . . . Henceforward these experiences become the possession of the general practitioner and if he fails to avail himself of its invaluable assistance, it will be at his own peril and to the detriment of the patient.¹⁰⁸

¹⁰⁸ J.W. Springthorpe, "War Neuroses and Civil Practice", in *The Medical Journal of Australia*, 4 October 1919, p.283.

Springthorpe's colleagues generally did not practise their advocacy with the same vehemence but their interest in change was just as clear. At a meeting of the Victorian Branch of the British Medical Association in August 1918, Clarence Godfrey related his experiences with neurotic speech disorders amongst soldiers at No.5 AGH. Throughout his address he stressed the importance of the mental element in these ailments; in a circumspect manner that was designed not to give offence, he also emphasised the superiority of psychotherapy (in this case hypnotism and suggestion) over the recognised physical methods of treatment. In effect, his paper was a plea for the recognition of the psychodynamic approach to illness and was, by its thrust, a tacit acknowledgment that such theories and methods had been generally ignored.¹⁰⁹

One measure of the momentary but exciting impact of shell shock in Australia after the war was the number of papers delivered on that subject at the Australasian Medical Congress of 1920 held in Brisbane. Of the eleven presented in the neurology and psychological medicine section, nine dealt with aspects of psychological disorders amongst servicemen and how the war had confirmed beyond doubt the workings of certain mental mechanisms and the efficacy of psychotherapy. In 1920 the war still cast a long shadow but, as memory waned, shell shock - and, indeed, mental disorders generally - steadily lost their prominence at Australasian Medical Congresses. Never again during this inter-war period would psychological illness be so thoroughly covered.

The overall theme of the papers delivered in Brisbane was that valuable lessons could be learned from the war experience and applied to civil practice in peacetime. Clarence Godfrey told his colleagues that, in the past, psychotherapy had been regarded with suspicion by leaders of the medical profession but that the war had done much to dispel such doubts and to promote the judicious use of "this powerful therapeutic agent." He suggested that there were "probably few among those who have investigated it who are not converts."¹¹⁰ The theme of Dr. Ralph Noble's paper was similar to Godfrey's. Basing his recommendations on experience with war neurosis patients, Noble urged the provision of clinics, particularly at the university hospitals because, as he put it, "the proper teaching of neurology and psychiatry is by practical demonstration." Noble maintained that these clinics should be staffed by experts in neurology, lunacy and psychology "able to apply psychological analysis, hypnotism etc. to patients who require these methods of investigation." He felt that the attachment of clinics to the general hospitals would eliminate the repeated use of drugs on ordinary patients who were found during the course of their time in hospital, to be neurotic.

¹⁰⁹ C. Godfrey, "Some Cases of Stammering from War Shock Treated by Psychotherapy", in *The Medical Journal of Australia*, September 28, 1918, pp. 262-264.

¹¹⁰ C. Godfrey "War Psycho-Neuroses and their Treatment", in *Transactions of the Australasian Medical Congress*, Brisbane, 1920, p.423.

They would simply be transferred to the clinic; he also advised that such clinics would save early cases from certification and the mental asylum where, among advanced cases, they would only deteriorate.¹¹¹ In recalling his period at the Ashurst Hospital, Oxford, Alfred Rowden White offered advice - and hope - for the future:

In the short period in which I had the privilege of seeing this work at Ashurst I cannot help feeling that these methods of analysis and treatment by suggestion will take their proper place in time in Medicine . . . It is up to us to prevent this work passing into the hands of charlatans, and we should, as a profession, be able to give information and even treatment to suitable cases to anyone seeking advice because it must be remembered that the general public during these past four or five years has heard and read much (some of it true and some of it fantastic) of these 'wonderful advances' of medical treatment.¹¹²

With typical tendentiousness, John Springthorpe castigated his medical colleagues for their unwillingness and inability to see the light: "Civil practitioners, however, have yet to learn the lessons which the war has made prominent to their military brethren. The same rich field of practice awaits them, and a similar dissatisfaction will follow failure to enter in and occupy."¹¹³

Like John Springthorpe, Ernest Jones used the same conference to advance pre-war views which had been bolstered by his experience with shell shock victims and his understanding of its impact overseas. Once more citing Australian backwardness when compared to Great Britain and, in particular, the United States, he continued his push for the establishment of clinics, special wards in hospitals and treatment without certification. In his arguments for reform, the war had become a powerful influence. He told the conference that it had altered the "British viewpoint" on neurosis and that the success of lunacy department medical officers treating "nerve-shattered soldiers" in Australian military hospitals was a powerful argument for the appointment of specialists to civilian general hospitals.¹¹⁴

In a sense, the experience of Ernest Jones symbolises the personal and professional journey that this small corps of Australian doctors interested in psychotherapy and lunacy reform took during this period: the pre-war urgings, the war time epiphany and brief post-war proselytising followed quickly by frustration and resignation. Like Springthorpe, Ernest Jones continued to push for the reforms that he had so tactfully urged before 1914. In the first year of the war he suggested the addition of psychiatric wards and out-patient divisions at the major hospitals to improve the quality of treatment and teaching. In his understated manner he also ventured a criticism of the general medical profession which he claimed was indifferent to and ignorant of

¹¹¹ R. Noble, "The Treatment of Functional Nerve Disease during and after the War", in *ibid*, pp.434-435.

¹¹² Rowden White, "A Record of a few cases . . .", *op. cit.*,

¹¹³ J.W. Springthorpe, "Psychology and Medicine", in *ibid*, p.404.

¹¹⁴ E. Jones, "On the Necessity for the Establishment of Psychiatric Clinics", in *Transactions*, *op. cit.*, pp.410-413.

psychology, an attitude that had helped isolate psychiatry from "the other branches of medical science." 115

At that early stage, however, the war had not made a significant impact on Jones' thinking but by 1917 his normally temperate tone had been briefly supplanted by an unprecedented fervour. Inspired by what he had seen, Jones believed that the pandemic of mental disorder amongst the troops of all nations, and the methods adopted to try to combat it, would surely prove an awakening for the Australian medical profession and public alike. Further, he also saw these developments as a vindication of his pre-war stances on the pressing need for uncertified, early treatment and psychiatric clinics employing the most advanced methods. Most importantly, perhaps, he saw the war experience as providing the necessary spur to - and justification for - reform in Australia.

In his Annual Report for 1917, Jones ardently informed the Victorian Parliament of the developments taking place on "the other side of the world." He wrote:

Shell-shock institutions, neurological hospitals, psychopathic clinics, call them what you will, are being organised in which, without the restricting influence of the law and certification, such cases are being cared for by the alienist, the neurologist, the clinical pathologist, or any other specialist whose association is desirable; wherein electrical treatment, special baths, exercises, and purely mental treatment, such as suggestion, hypnotism, occupation, can be obtained to the best advantage. Such an advance will leave its mark permanently on the treatment of insanity, and will serve to show us how necessary are such methods for each institution or department dealing with this variety of wreckage. 116

Jones reminded his political superiors of his pre-war position on the establishment of psychiatric clinics and wards in general hospitals, stressing that "experience gained in the Military Hospitals confirms this opinion." He finished his report on this topic with unusual vehemence tinged with realistic pessimism: "At the present time, our overtaxed and understaffed hospitals for the insane can only grapple with these subjects in a feeble, inefficient manner, inasmuch as long-standing prejudice has put them outside the social pale." 117

Thus, Jones saw the possibilities that shell shock had created for psychiatry but was only too aware of the hurdles facing anyone like himself who wished to exploit these opportunities. From time to time during the 1920s and 1930s, Ernest Jones repeated his calls for the implementation of psychiatric clinics, more and better graduate and under-graduate instruction, and greater acceptance of psychiatry. But never again were these appeals made with the intensity of his immediate post-war entreaties.

This return to his pre-war composure seemed to reflect an inner acknowledgment that such reforms would not eventuate. In 1924 Jones stated that,

115 Annual Report of the Inspector-General of the Insane, Victoria, 1914, p.60 and Lewis, op. cit., p. 37.

116 Ibid, 1917, p.38.

117 Ibid, p.39.

although a welcome appointment had been made, only minimal progress had occurred in arousing the interest of the general hospitals in the teaching of psychiatric medicine and the provision of out-patient facilities. He was happy to report the appointment of Dr. Morris Gamble, a senior Lunacy Department officer, to the Melbourne and Alfred Hospitals at the latter of which he had established an out-patient clinic, but considered this change only a "slight advance."¹¹⁸ Citing the recommendations of the British Royal Commission on Lunacy and Mental Disorders of 1925, Jones once more urged the establishment of psychiatric clinics. And, in a criticism that echoed to the last note his evaluation of 1909, he again stated that receiving houses were not the entire answer.¹¹⁹ His message of almost twenty years duration had, despite the upheaval of the war, fallen on stony ground. In 1932 he reported that only then, after constant efforts, was a little progress being made in the teaching of psychology and psychiatry with the introduction of compulsory attendance at twelve lectures on normal psychology for third year students. This brief course was to be added to the usual twelve lectures delivered by officers of the Lunacy Department. At the 1929 Australasian Medical Congress, Jones was still pressing for the same reforms he had advocated in 1920 at Brisbane.

The influence of war neurosis on the application of psychodynamic principles in post-war Australia.

Despite the clamour of these former AAMC officers, the general direction of Australian psychiatry did not change a great deal during the 1920s and 1930s. However, it can be shown that psychodynamic ideas enjoyed some currency during this period and that the war was largely responsible for this raised consciousness. Book reviews, the nomenclature in the reports of Repatriation Department doctors, and topics of discussion at medical association meetings all demonstrate clearly that concepts associated with depth psychology had gained a measure of acceptance in certain quarters of Australian medicine and that the war had played a role in this process.

In addition, it can also be demonstrated that some of this theory was put into practice and that the war, through some of the doctors who had dealt with shell shock victims, made a difference to private practice within the radius of their immediate influence. As will be shown, it is abundantly clear that many of these doctors applied their expertise when treating returned servicemen under the Department of Repatriation; what is less obvious is the extent to which this new awareness was applied elsewhere.

¹¹⁸ Annual Report of the Inspector-General of the Insane, Victoria, 1924, pp. 36-37.

¹¹⁹ Ibid.

Evidence suggests, however, that some former army doctors saw unequivocal connections between the neuroses of soldiers and civilians, and did not hesitate to adapt the lessons of war to peacetime problems. Along with the intellectual changes that occurred, this barely detectable shift in Australian psychiatric practice was one of the war's more admirable outcomes. In both of the above contexts - the infiltration of ideas and their application - neurosis and its treatment became a minor but important current in Australian medicine, not just the basis of vociferous proselytising.

The influence of psychodynamic ideas within the Department of Repatriation

The process of diagnosis and treatment within the Department of Repatriation clearly demonstrates that ideas associated with depth psychology had affected the thinking - and, indeed, the practices - of some Australian doctors. Although nomenclature in the Department was dominated by the bureaucratically convenient, generic category "neurasthenia", more specific terminology was also evident. Use of these more refined concepts in Repatriation reports denotes a subtlety of appreciation not always obvious in other sources. Employment of these principles - in particular by the occasional Local Medical Officer - suggests that psychodynamic ideas had made an impression at various levels of Australian medicine: not only had some of the more exalted government medical officers internalised these notions; general practitioners, too, had absorbed and used them.

As well as this optimistic picture, a less encouraging one also existed at Repatriation. Confusion over terminology, lack of refinement in diagnostic categories and hostility to new ideas were also evident. This side of the war neurosis revelation was generally not present in journals and papers trying to convert a sceptical medical profession. In this way the Repatriation experience balances the more roseate view gained from other sources.

In dealing with returned psychological casualties, some Repatriation Department medical officers employed psychotherapeutic ideas and diagnostic concepts that indicate considerable familiarity with psychodynamic theories. By some doctors, neurasthenia was divided into sub-categories which reflected convictions about aetiology and duration. These included "acute neurasthenia", ¹²⁰ "sub-acute neurasthenia" ¹²¹ and "traumatic neurasthenia". ¹²² Symptoms here were more or less identical to those associated with neurasthenia as employed for administrative purposes. So too were

¹²⁰ Case Sheet, RGHC, 2 December 1930, in Lieutenant H.R. Edgar, 2 Field Artillery Brigade, PCF; Memo for Medical File, 2 May 1939, in Private F. Lee, 5th Battalion, PCF.

¹²¹ Memo for Medical File, 6 January 1938, in *ibid.*

¹²² Memo for Medical File, 6 December 1932, in Signaller A.E. Grant, 37th Battalion, PCF, *op. cit.*

those connected with "anxiety neurosis", a Freudian term that enjoyed some popularity with Repatriation Department doctors.¹²³ Occasionally this classification was accompanied by other terms such as depression.¹²⁴ This tendency to refine syndromes was also noticeable with the classification "psychoneurosis", another Freudian term. Although this category and its associated nuances were not widely employed, their occasional use by a doctor at Caulfield Hospital and a Local Medical Officer in the shire of Ferntree Gully, Victoria, suggest increasing discernment in Australian medicine regarding matters psychological. In one of his soldier patients the aforesaid LMO diagnosed "psychoneurosis of the 'fear or dread syndrome type'",¹²⁵ while at Caulfield the same veteran, who had threatened to kill people, was classified by another doctor as "psychoneurosis of the compulsion or obsessional type with strong sadistic symptoms."¹²⁶ Despite the obvious presence of these refined concepts in some corners of the Department of Repatriation, their employment was minimal and overshadowed by the blanket use of the term "neurasthenia", a diagnostic category that had been explicitly converted into an administrative convenience in 1918.¹²⁷

Repatriation Department evidence also shows that acceptance of psychodynamic principles was less than universal. As seen in chapter five, doctors sometimes engaged in heated disagreements about the validity of psychodynamic interpretations of soldiers' illnesses. In one instance a Collins Street doctor told Repatriation that former Private Michael Mason's dermatitis was psychosomatic with "its basis in his war experiences" and, therefore, required a psychiatrist. The case seemed to be a compelling one: Mason was deeply troubled by the memory of his war service to which he constantly referred, and he also presented with other psychological symptoms: vague gastric disorders, insomnia and occasional irritable outbursts.¹²⁸ Despite the apparent strength of Mason's claim, it was rejected by a Departmental doctor who could "find no evidence of anything connected with War Service to account for this skin condition."¹²⁹ In Clarence Godfrey's obituary, Paul Dane confirmed the existence of the kind of scepticism that had contributed to these contradictory assessments. Commenting on Godfrey's work at No.5 AGH, Dane wrote: "Not only did he use hypnotism as a means of 'suggestion' but he made use of this method for abreaction and recall of

¹²³ Medical Report, 15 June 1931, in Private C. Lapin, 5th Battalion, PCF; Medical Report, 29 May 1934, in Lee, PCF, op. cit.; Memo for Medical File, 22 January 1934, in Private E. Norman, 5th Division Signal Company, PCF.

¹²⁴ Notes, RGHC, 7 October 1932, in Private F. Hammond, 60th Battalion, PCF; Report, 3 February 1928, in Lapin, PCF, op. cit..

¹²⁵ Report, LMO, 8 May 1931, in Captain H. Walters, AFC, PCF.

¹²⁶ Notes, RGHC, 26 April 1931, in *ibid.*

¹²⁷ Anonymous "The treatment of 'neurasthenia' in soldiers", in *The Medical Journal of Australia*, 7 December 1918. pp.480-481.

¹²⁸ Medical Report, 20 May 1929, in Private M. Mason, 60th Battalion, PCF.

¹²⁹ Medical Report, 4 September 1929, in *ibid.*

amnesia. He did very valuable work along these lines - notwithstanding the scoffing of some of his colleagues." ¹³⁰

Despite the presence of this doubt, interest in psychodynamic ideas generated by the war provided the material for a lively professional discourse and became incorporated into the civilian practices of some Australian doctors.

Private practice

During the early 1920s *The Medical Journal of Australia* reviewed several new books on neurosis and psychotherapy (all written and published overseas) and showed no prejudice against the psychodynamic ideas contained therein; in fact, texts on these subjects generally met with approval by their anonymous reviewers. "We can all agree with the author when he states in his closing chapter . . . that 'the future of psychotherapy is assured'," wrote the reviewer of one book. ¹³¹ Usually, too, the *MJA* adopted the standard eclectic view of neurosis, preferring the selective approach to the doctrinaire ¹³² and a qualified opinion of Freud. ¹³³ In some of the critiques there is no evidence that the war played a role in shaping the reviewers' frame of reference. Occasionally, however, its influence was plain. The reviewer of W.H.R. Rivers' *Instinct and the Unconscious*, for example, felt that the author's war service contributed to his authority in the field of psychological medicine, and wrote:

[D]uring the great war [sic] he was enabled to study the psycho-neuroses and practice psychotherapy at the Maghull Military Hospital. Therefore, his experience as a teacher and investigator and we may say now as a practitioner puts the mark of quality on whatever he thinks fit to publish. ¹³⁴

In assessing I.G. Cobb's *A Manual of Neurasthenia*, another reviewer remarked:

Not only has he done his work well, but it is important that we should have a book on neurasthenia which is brought into line with recent advances in the study of the functional neuroses. Moreover, the war has produced a host of sufferers from this disorder, hence it behoves us all to gain acquaintance with the most modern views on diagnosis and treatment. ¹³⁵

¹³⁰ P. Dane, Obituary for Clarence Graham Godfrey, in *The Medical Journal of Australia*, 12 February 1949, p.224.

¹³¹ Review: H. Brown, *Advanced Suggestion (Neuro-Induction)* (Bailliere, Tindall and Cox, London 1918), in *The Medical Journal of Australia*, 27 August 1921, p.162.

¹³² Review: I.G. Cobb, *A Manual of Neurasthenia (Nervous Exhaustion)* (Bailliere, Tindall and Cox, London 1920), in *The Medical Journal of Australia*, 16 October 1920, p.380.

¹³³ Review: H. Somerville, *Practical Psycho-Analysis* (Bailliere, Tindall and Cox, London 1922), in *The Medical Journal of Australia*, 30 September 1922, p.386.

¹³⁴ Review: W.H.R. Rivers, *Instinct and the Unconscious: A Contribution to a Biological Theory of the Psycho-Neuroses* (Cambridge University Press 1920), in *The Medical Journal of Australia*, 28 May 1921, p.441.

¹³⁵ Review: Cobb, op. cit..

It is clear, therefore, that the war had partially conditioned the attitudes of at least two reviewers to their tasks; moreover, the last passage indicates consciousness of the war's significance for a substantial section of the Australian population, and, indeed, for medicine in general. Its influence here is unequivocal.

Psychology and psychiatry made regular appearances as subjects for lectures and discussion at the meetings of medical associations throughout Australia, particularly in Victoria where, in 1922, a "section" of neurology and psychiatry was formed. This association (possibly a subsidiary of the Victorian branch of the British Medical Association) was chaired by Paul Dane, a disciple of Clarence Godfrey and Repatriation Department psychologist, and was scheduled to meet on the third Monday of each month.¹³⁶ Usually present at these meetings were the major figures involved in the treatment of war neurosis - John Springthorpe, W. Ernest Jones, T. Garnet Leary, R.C. Withington and others - and the effects of their war-related experiences were unmistakable. At a meeting of the Victorian Branch of the British Medical Association held in October 1920 at the Medical Society Hall in East Melbourne, the lessons of 1914-18 occupied much of the programme. For example, R.C. Withington, who had treated psychological casualties during the war, used returned soldiers with hysterical disorders as exhibits throughout a presentation on psychotherapy in which he demonstrated several techniques including suggestion, hypnosis, persuasion and psychoanalysis.¹³⁷

At some other meetings the war influence was not as overt but a connection can be tentatively assumed. In February 1922 Elton Mayo, then a professor at the University of Queensland, addressed the Victorian Branch of the BMA on "Psychology in Relation to PsychoAnalysis and Applied Psychology". Mayo, who had worked extensively with psychological casualties during the war, expounded an eclectic line on these matters, emphasising the importance of Europeans such as Janet and tentatively endorsing Freud. Present, amongst others, were Springthorpe, Jones, Withington and Dane. Although the war was not mentioned in the *Medical Journal of Australia*'s brief report on the gathering, it would be rash to suggest that it was not a factor in proceedings or in the thinking of those in attendance.¹³⁸

It is plain that neurosis and psychotherapy were of intellectual interest in certain quarters of Australian medicine during the 1920s and that the war had been elemental in promoting these subjects. To what extent did this cerebral pursuit translate into action in private practice and how influential was the war in this process?

¹³⁶ "Section of Neurology and Psychiatry", in *The Medical Journal of Australia*, 16 September 1922, pp.339-340.

¹³⁷ "British Medical Association News", in *The Medical Journal of Australia*, 22 January 1921, pp. 78-80.

¹³⁸ "Psychology". Report on a meeting of the British Medical Association, 24 February 1922, in *The Medical Journal of Australia*, 1 April 1922, p.365.

For the Australian doctors in question, interest in neurosis had always been of a practical nature and, in some cases, there is direct evidence that they applied the knowledge they acquired in wartime to civilian practice. R.C. Withington told his colleagues that he found civilian patients more difficult to hypnotise than soldiers. He believed that this was because servicemen had been taught to obey. Paul Dane expressed similar sentiments,¹³⁹ while T. Garnet Leary also made comments about the relationship between war neurosis and civilian mental disorders.¹⁴⁰ Like these doctors, Ralph Noble made the transition between the military and civilian spheres. In 1920 he made the following remarks: "The experience gained amongst returned soldiers suffering from functional nervous diseases is applicable to many cases of civilians who are suffering from very similar disorders due to anxiety and stress in civil life. . . "¹⁴¹

Of those Australian doctors who dealt with shell shock, Douglas McWhae, former ADMS, AIF Depôts, UK, has left the most explicit record of how war experience influenced his post-war practice. In June 1919 McWhae told a meeting of the British Medical Association, Western Australian branch, that "[w]hat has been said regarding the causation of war neuroses applies to the neuroses of civil life."¹⁴² Referring to the work of a number of major figures in the eclectic "school" (including Hart, Hurst and Trotter), McWhae explained psychological disorder in precisely the same terms as W.R. Reynell, who, like himself, had experienced considerable contact with Arthur Hurst at Seale Hayne. McWhae even employed the same analogies as Reynell - and probably, therefore, as Hurst.¹⁴³ McWhae's was a standard eclectic interpretation that saw the mind structured in three levels, the conscious, the liminal and the sub-liminal, that viewed mental conflict as the root cause of neurosis and which regarded hypnosis, persuasion, suggestion, dream interpretation, and free association as essential therapeutic instruments.

McWhae told his audience that the same mental mechanisms operated in civilians as in soldiers, although in the former, they were less obvious:

Civilian psychasthenia differs from war psychasthenia in that the nature of the repressed conflicts may be very variable and they are often difficult to detect, whereas in war the conflict is always between the herd instinct and the instinct of self-preservation.¹⁴⁴

He drew on his war experiences to elucidate several cases of civilian neurosis. Two of these examples were a 27-year-old man burned in a brewery vat and a 22-year-old woman who, at 19, had not been able to cope with strenuous office work and broke

¹³⁹ "British Medical Association News", 22 January 1921, op. cit., p.79.

¹⁴⁰ Ibid.

¹⁴¹ Noble, op. cit., in *Transactions of the Australasian Medical Congress 1920*, op. cit., p. 434.

¹⁴² McWhae, "Neuroses", op. cit., p.340.

¹⁴³ Ibid, p.338.

¹⁴⁴ Ibid, p.341.

down. McWhae described the first patient as "a typical case of anxiety neurosis" and likened the condition to "shell shock": the man was tremulous and nervous; he perspired freely; at night he awoke in terror after dreaming of being burned in fires; his ability to concentrate and make decisions had been impaired and he was unable to think of his accident "without great distress." The woman's disorder, he said, was another example of repressed mental conflict in operation: a clash between knowledge of her inability to cope at work and the need to support a large family. Since the time she had left her job three years before, the cause of the breakdown and the memory of it had disturbed her dreams, hindered her ability to make decisions and destroyed her self-confidence.¹⁴⁵ McWhae cited several further cases and it is apparent from all of these examples that his appreciation of civilian psychological disorders had been extensively influenced by his understanding of war neurosis. Like several of his colleagues in the medical profession and the AAMC, the war had made a major impact on Douglas McWhae's thinking.

For Australian psychiatry, the war was not the transcendent event that some hoped it might be. Despite the lively discourse that surrounded the issue in post-war Australia, the overall outcome of the shell shock experience for Australian psychiatry was minimal: the marginal expansion and consolidation of a minor pre-war intellectual and therapeutic tendency. The theories of Freud, Janet and other Europeans - in their British guise - certainly enjoyed wider currency in Australia because of the war, but the extent of this influence was probably limited. In public discussion and debate the same names recurred with only occasional additions to the list: Jones, Springthorpe, Dane, Godfrey, and Withington seemed to dominate the scene in this backwater of Australian medicine. But these indicators do not mean that psychodynamic ideas were confined to reformers; it simply means that these men were the most vocal. Evidence suggests that some GPs and specialists whose names did not appear in lights were also attracted to psychotherapy. Still, by comparison to the volume of material published on other medical subjects in journals like the *MJA*, psychology and psychiatry seem under-represented.

In particular, the linchpin of Australian psychiatry - the asylum system - remained impervious to depth psychology and to the demands of the reformers. Here, the pleas of men like W. Ernest Jones were wasted and the hopes created by the war dashed as lunacy practice continued - undaunted - on its pre-war course. In fact, if anything, the war only exacerbated existing problems in the management of the insane. The presence of soldiers added to the pressure on accommodation while the

¹⁴⁵ McWhae, op. cit..

employment of returned servicemen as attendants debased the quality of the staff. The First World War presented Australia - and, indeed, other countries - with a vast, living laboratory, an opportunity that only a handful of relatively powerless people recognised. Instead of selecting therapeutic and intellectual solutions to the puzzles posed by war neurosis, those in authority - those in charge of the institutions and bureaucracies - chose expedient, administrative ones. But for this choice they can hardly be blamed; the asylum method of management was, after all, the dominant model. Innovation, it seems, was not welcome.

Conclusion

What has this study contributed to the understanding of shell shock and its impact on Australians between 1915 and 1939? It has been the central argument of this thesis that war neurosis was a destructive influence in the lives of many Australians not all of whom were soldiers. This dissertation has shown that, for many men, the experience of war was genuinely traumatic and that responses to the resultant psychological disorders by the military, the medical profession and the apparatus of rehabilitation in Australia hindered recovery and created further difficulties. Even the soldiers themselves, constrained by military discipline and conceptions of strength and weakness, repressed their emotions and thereby contributed further to the creation of neurotic symptoms. Despite the enormous personal and social difficulties that war neurosis created for Australians, and the large amounts of energy spent on its management by government, it was not the agent of positive change that some doctors hoped it might be.

This study has shown that shell shock and the debilitating effects of nervous strain were a more common part of battlefield experience than has been suggested in some histories of Australia and the First World War. It has demonstrated that men often reacted to extreme stress in ways that are at variance with the more common image of the Digger: the resemblance of some sufferers to helpless rag dolls, trembling marionettes and bawling children contradicts the usual portrayal of the Anzac as steadfast and phlegmatic, a stranger to histrionics. By contrast, some men under stress remained outwardly impassive, compelled by strong social pressures to seem in control. Value judgements, however, should not be applied to either of these reactions as both simply revealed the humanity of the men in question, faced as they were with environments of extreme hostility. Terrifying artillery barrages, unimaginable horror, sleeplessness, exposure to the elements, and a sense of insignificance and helplessness overwhelmed many men. These experiences produced a range of recognised disorders the symptoms of which show clearly that many Australian soldiers were traumatised by their war service.

The difficulties of Australian psychological casualties were generally not alleviated by military medicine. Hamstrung by prejudice and with its more enlightened elements constrained by military imperatives, medicine in very real ways even exacerbated the problems of shell shock victims; in fact, by suppressing their symptoms and returning men to duty, it probably did them irreparable harm. None of this, of course, was conducive to recovery. Even the more progressive therapists seemed impotent in the face of disorders which were only treated after long delays had allowed them to consolidate.

At Gallipoli, psychological casualties were unexpected by military and medical authorities although the AIF's tendency to allow those with disorders to enlist and proceed to the battle front might have prepared them for this minor epidemic. In response to the rash of shell shock at Anzac, AAMC officers and, indeed commanders of fighting units, improvised with rest, rotation, and "common sense" remedies. Often, however, the practice was to evacuate these men (with what was considered a contagion) to Egypt, Malta or England. There seems little doubt that, managed in this way, disorders solidified and became extremely difficult to alleviate. In Egypt, where medical facilities were under constant pressure, psychological casualties suffered with other invalids. For cases of war neurosis there were no special facilities so, as it had been on Gallipoli, care became a matter of improvisation for the few Australian doctors with specific knowledge of mental illness. Despite the fortuitous presence of these practitioners, the prognosis for psychological casualties evacuated to the base was generally poor.

In the Mediterranean, confusion typified the treatment of shell shock. On the Western Front and in England, this tendency was also present but became exacerbated by official mistrust amounting almost to malevolence. Australian psychological casualties were treated by their own medics up to Field Ambulance level but, beyond this stage, entered a British Army system designed to solve a serious "wastage" problem. Reflecting military suspicion of war neurosis as a form of malingering and pre-war values that denigrated the mental patient as a wilful pest, this system virtually put psychological casualties on trial. When the circumstances that precipitated their symptoms are considered, the bureaucratic pettiness of this process seems highly insulting to the individuals concerned. It was also highly damaging: the employment in this system of more enlightened psychotherapists aided the return of some psychological casualties to battle where their condition deteriorated further.

In Australia during the war and throughout the 1920s, the management of shell shock was handicapped by disorders which had been allowed to solidify in the military medical systems overseas. But the domestic frame of reference was itself not conducive to recovery. Medical uncertainty, a tendency to moralise, dependence on the asylum model of mental care and unrealistic attempts to make these men self-reliant compounded the problems of psychological casualties. Every response to this conundrum was coloured by the perspective of the group, agency or individual involved. Even compassion was not value-free: it was dependent on whether men conformed to certain models of behaviour considered desirable by government. Anyone transgressing these conceptions could be denied a pension and medical care, or excluded from the official version of what it meant to be an Anzac.

In the years before the Department of Repatriation assumed the responsibility for their management, shell shock sufferers were treated in a variety of unsatisfactory

ways. Initially, they were calumniated as malingerers and awarded no pension. They were also admitted to general hospitals where their conditions baffled doctors who discharged them to convalescent homes, to the care of relatives - or to the streets. Official policies such as boat leave and mandatory discharge from military hospitals after six months exposed men to the uncompromising rigours of civilian existence. As a result, they often relapsed. Also ill-conceived were the notions of trying to "cure" war neurosis through work or returning victims to efficient citizenship before they had recovered. Thus, attempts by the Closer Settlement Boards and the State War Councils to make shell shock cases self-reliant only increased the strain of life for these men and many failed miserably on the land or in business. Some turned to the bottle for relief.

In moves that highlighted the pre-war stigma attached to mental illness and which demonstrated the power of jingoism to modify public stances on this issue, three state legislatures waived the laws on certification for returned servicemen. Wanting to avoid the cost of building its own facilities, the Department of Defence took advantage of these conditions and agreed to subsidise servicemen in these institutions. Thus, many were admitted, uncertified, to mental asylums where they were sometimes housed with the regular inmates. Not surprisingly, many shell shock cases relapsed in these conditions.

Under the Department of Repatriation, war neurosis was treated with the utmost seriousness and the wider frame of reference that had been evident in its predecessors became much more sharply defined and clearly articulated. Repatriation Department officials did not perceive war neurosis simply as a medical problem for returned servicemen. Their thinking on this matter transcended the pain of individuals and encompassed broader social, national and economic concerns in a way that reflected the ongoing strength of highly moralistic views on mental disorder and human responsibility. The Department's conceptualisation of war neurosis was also testimony to the manner in which the nation-building version of the AIF's exploits coincided with conservative interests. Thus, the Department's eventual definition of the problem reflected a conviction that the individual was responsible for his own fate. Sufferers of war neurosis were, therefore, divided into two groups: those who had recovered quickly through personal determination, become self-reliant and resumed their civilian lives unobtrusively; and those who had remained ill and become a millstone around the country's neck and a threat to national prosperity. This group was characterised as dependent, wilful, lazy, disloyal and inefficient, their disorders the result of inherent weakness and personal sloth. Chronic war neurosis was thus explained in terms that strongly resembled attitudes to the "undeserving" poor of nineteenth century morality. In the Department's publications, such men were excluded from the heroic interpretation of AIF history which had no place for those who did not make a smooth

transition from military to civilian life and continue the commitment to the nation which they had shown during the war.

Why did the Department insist on this characterisation? Ostensibly, such a depiction justified the denial of pensions. In reality it was the Department's means of rationalising its inability to solve the problem of chronic psychological illness and of constructing a particular version of history. Additionally, blaming the victim diverted attention from the horror and destructiveness of what was supposed to have been a positive experience for the nation. Nineteenth century morality obviated criticism of social conditions and thus protected the status quo. Similarly, the Anzac Legend and Repatriation Department rhetoric did not hold the war responsible for chronic invalidism and thus prevented the dissemination of another interpretation of events.

To a certain extent, this rhetoric became fact. Men were denied pensions by the Repatriation Department for moral crimes such as inebriacy; in addition, measures were put in place to detect malingerers and return them to the habit of work. The Department's depiction of these men was, however, highly misleading, even defamatory. Evidence shows that they were victims of repeated trauma and that their "failure" to succeed at farming or vocational training was the result of incapacity and the inability of Departmental medicine to deal effectively with difficult disorders. Neither out-patient treatment, nor drugs, nor the regimes in psychiatric institutions and on Convalescent Farms produced recoveries in sufferers of war neurosis. Thus, it was not the bloody-mindedness of the returned servicemen but the nature of their maladies and the ineffectiveness of Departmental medicine that compromised the success of rehabilitative schemes.

Although its rhetoric implies the existence of an omnipotent, unifying ideology, two tendencies intimate the presence of unresolved tensions within the Repatriation Department. These were inconsistency in pension decision-making, and the existence of a more compassionate approach by some bureaucrats and doctors. The latter especially suggests the increasing strength of a newer, more forgiving view of human accountability based on psychology. Doctors like Clarence Godfrey generally cited the effect of battlefield experiences on the mind as the cause of war neurosis whereas some Repatriation Department medical officers usually blamed the victim's inherent weakness and the temptation of a pension. These contradictory impulses must be seen as reflecting wider social conflicts over the nature of human responsibility which, in turn, vitally influenced the management of war neurosis.

For many men, however, much of this activity was an irrelevancy as it did not substantially alleviate their symptoms or the disastrous social consequences of their ailments. For these returned servicemen and their families, war neurosis was a profoundly dislocating influence. Men displayed all the dysfunctional behaviour and adjustment problems of chronic trauma sufferers: restlessness, fearfulness, inability to

concentrate or to remain employed, and a reluctance to socialise. Alcohol and drug abuse, aggression, moodiness, violence and divorce also blighted their lives. Extreme frustration and depression followed mental and physical depletion and the consequent loss of their identity as breadwinners. As the standard of living for families dropped, the burden fell entirely to wives who tried to maintain the integrity of the household but, too often, the forces compelling disintegration were overwhelming.

War neurosis thus made a major social impact but, despite the hopes and urgings of a small group of reform-minded doctors, there was no commensurate effect on the profession most intimately associated with its management: Australian psychiatry. The influence of war neurosis on this branch of medicine was generally negative and minimal. The mainstay of Australian psychiatry - the asylum system - remained brutal, overcrowded and stigmatised. In fact, military use of the asylums increased pressure on accommodation and, because of the employment of returned servicemen, even diluted the quality of the staff. Public debate about the War Mental Treatment Acts and the segregation of soldiers from civilians highlighted the shortcomings of the asylum system and the contempt in which it was held.

A small group of doctors, however, saw in war neurosis more than just a psychological disorder. They fervently believed it would be a catalyst for change in Australian psychiatry and thus made it a *cause celebre*. Work with shell shock cases in Australia and with the most progressive British specialists in England increased the strength of their pre-war hopes for greater public and professional acceptance of neurosis and psychodynamic principles. In addition, the positive effect of war neurosis on asylum reform in Britain and the United States created an expectation of similar results in Australia. But little of this eventuated. The asylum system remained impervious to enlightenment while the penetration of psychodynamic ideas and therapies was generally confined to a few converts and their disciples. In private practice and in their work with the Department of Repatriation they employed these ideas and even developed a spirited intellectual discourse during the immediate pre-war years. It is clear, however, that the main outcome of shell shock in Australia was not creative. For many Australians, this consequence of participation in the First World War was injurious and disruptive - a major tragedy.

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¹ A.G. Butler, *The Australian Army Medical Services in the War 1914-1918, Volume I, Gallipoli, Palestine and New Guinea* (Australian War Memorial 1930), p. 107.

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 Armitage, Cpn. H.E.S., 50th Battalion, Letters. (AWM 1DRL/53)
 Barber, Pte. W.W., 36th Battalion, Letters. (AWM 1DRL/088)
 Boulton, Cpl. L.R., 33rd Battalion, Diary. (AWM 1DRL/0136)
 Bourke, Lt. J., 8th Battalion, Letters. (AWM 1DRL/0139)
 Buchanan, Pte. G., 18th Field Artillery Brigade, Diary. (AWM PR82/24)
 Carter, Capt. H.G., 1st Battalion, Diary. (AWM 3DRL 6418)
 Claridge, Maj. W.G.M., 8th and 22nd Battalions, Letters and Diary. (AWM 2DRL/240)
 Clarkson, L/Cpl. L., 32nd Battalion., Letters. (AWM 3DRL/7133)
 Clements, Pte. C.A., 54th Battalion, Diary. (AWM 3DRL/961)
 Cooke, Lt. F.M.W., 18th Battalion, Letters. (AWM PR84/114)
 Crisp, Capt. R.H., 49th Battalion, Diary. (AWM 3DRL/2871)
 Cubis, Pte. A.J., 18th Battalion, Diary. (AWM 3DRL/7436)
 Cunningham, Lt. K.S., 5th Australian Field Ambulance, Diary. (AWM 3DRL/1898)
 Devlin, E.C.N., 18th Battalion, Letters. (AWM 1DRL/0241)
 Evans, Maj. W., 9th Light Horse Brigade Field Ambulance, Letters. (AWM 2DRL/14)
 Fox, Capt. S, 4th Division Artillery, Diary. (AWM 2DRL/0751)
 Everard, Cpl. W.I., 2nd Machine Gun Battalion, Diary. (AWM 2DRL/1025)
 Gardner, Pte. T., 5th Division Pioneers, Diary. (AWM PR90/157)
 Gellibrand, Col. J., Diary. (AWM 3DRL 6541)
 Golding, Pte. A., Diary. (AWM PR91/060)
 Hampson, Lt. J.T., 19th Battalion, Letters. (AWM 1DRL/0331)
 Hampson, Trumpeter W.K., 5th Field Artillery Brigade, Letters. (AWM 1DRL/0331)
 Hampton, Sgt. R.L., 5th Battalion, Diary. (AWM 3DRL/2310)
 Harris, Maj. J.R.O., 3rd Battalion, Narrative. (AWM 1DRL/338)
 Hartley, Sgt. J.W.M., 12th Machine Gun Company, Letters. (AWM PR85/360)
 Hurley, Capt. F., Official Photographer, Diary. (AWM PR 85/291)
 Hutchinson, Maj. E.L., 6th Australian Field Ambulance, Diary. (AWM PR86/391)

Jones, Cpl. L., 3rd Battalion, Narrative. (AWM 2DRL/521)
 Kilgour, Pte. A. McP., 2nd Battalion, Diary. (AWM 2DRL/42)
 Kirkland, Sgt. W.A., 5th Battalion, Diary. (AWM PR 89/106)
 McConnell, Lt. K., 1st Battalion, Diary. (AWM 2DRL/29)
 McCrae, Maj. G., 60th Battalion, Letters. (AWM 3DRL/3623)
 McDonald, Lt. C.J., 3rd Battalion, Letters. (AWM 2DRL/146)
 MacDougall, Lt., G.R., 3rd Battalion, Letters. (AWM 1DRL/434)
 McNair, L/Cpl. L., 17th Battalion, Diary. (AWM PR/00470)
 Mackie, Bbdr. N., 2nd Division Ammunition Column, Letters. (AWM 1DRL/0450)
 Maguire, Lt. J.T., 8th Battalion, Letters. (AWM 2DRL/322)
 Makin, Lt. G.L., 5th Battalion, Letters. (AWM 1DRL/0473)
 Makin, Sgt. J.J., 21st Battalion, Letters. (AWM 1DRL/474)
 Mann, Lt. W.A., 25th Battalion, Letters. (AWM 2DRL/105)
 Maudsley, Lt. Col. H., 14th Australian Field Ambulance, Diary. (AWM 3DRL/6003)
 Miles, Lt. T.M., 12th Battalion, Diary. (AWM 2DRL/0554)
 Millard, Lt. Col. R.J., AAMC, Diary. (AWM 1DRL/499)
 Moorehead, L/Cpl. E.W., 5th Battalion, Diary. (AWM 3DRL/7253)
 Morgan, L/Cpl. R., 1st Australian Field Ambulance, Diary. (AWM 2DRL/218)
 Morse, Maj. R.V., Letters. (AWM PR82/078)
 Munro, Pte. E.C., 5th Australian Field Ambulance, Diary. (AWM 1DRL/526)
 Murphy, Lt. Col. G.F., 18th Battalion, Diary. (AWM 1DRL/528)
 O' Keefe, Lt. G.G., 2nd Battalion, Narrative. (AWM PR85/253)
 Poate, Lt. Col. H.R.G., AAMC, Diary. (AWM 2DRL/1225)
 Raws, Lt. J.A., 22nd Battalion, Letters. (AWM 2DRL/0481)
 Raws, Lt. R.G., 23rd Battalion, Letters. (AWM 2DRL/0481)
 Semple, Lt. F., 18th Battalion, Letters. (AWM 2DRL/278)
 Short, Lt. Col., 17th Battalion, Diary. (AWM 2DRL0201)
 Silas, Pte. E., 16th Battalion, Diary. (AWM 1DRL/566)
 Smith, Pte. A.C., 7th Battalion, Diary. (AWM PR91/120)
 Smith, Sgt., C.J., 20th Battalion, Letters. (AWM 2DRL/ 0243)
 Stobie, Capt., G., 6th Battalion, Diary. (AWM 2DRL/196)
 Street, Lt., L.W., 3rd Battalion, Letter. (AWM 1DRL/578)
 Thomas, Cpl. A.G., 6th Battalion, Diary. (AWM 3 DRL/2206)
 Thompson, Pte. N.E., 5th Machine Gun Battalion, Diary. (1 DRL/0580)
 Weymouth, L/Cpl. A.E., 13th Australian Field Ambulance. (AWM PR 85/171)
 Wall, Major F.L., 3rd Australian Field Ambulance. (AWM 1DRL/592)
 Wilkins, Lt. G., 18th Battalion, Diary. (AWM PR82/129)

The writings from a further five soldiers were utilised from R.G. Lindstrom, "Stress and Identity: Australian Soldiers during the First World War" (MA thesis, University of Melbourne 1985)

Soldiers whose names appear on Army Form W3436 (AWM 23)

Box 91

Adam, Pte. B.G., 24th Battalion
 Bower, Pte. A., 34th Battalion
 Brown, Pte. D.D., 37th Battalion
 Cooper, Pte. F.M., 60th Battalion
 Gregory, Pte. H.E., 3rd DAC
 Griffin, Pte. J. 54th Battalion
 Hart, Dvr. J.P., 11th Battery, 4th Brigade Australian Field Artillery
 Hussey, Pte. R.H., 43rd Battalion
 Kennedy, Dvr. L.J.R., 25th Battery, 7th Brigade Australian Field Artillery
 King, Pte. A.V., 5th Australian Pioneer Battalion
 Langsford, Gnr. H.S., 111th Howitzer Battery, 11th Brigade Australian Field Artillery
 Malatzky, Pte. L., 7th Machine Gun Company
 Norman, Pte. J.W., 31st Battalion
 Peart, Pte. A. J., 58th Battalion
 Williamson, Pte. J., 11th Battalion

Box 92

Brown, Pte. L.E., 2nd Battalion
Frewin, Pte. G.H., 14th Battalion
Hovell, Pte. H., 4th Australian Pioneer Battalion
Matthews, Sgt. F., 11th Battalion
Norman, Pte. O.M., 20th Battalion
Osborne, Pte. V.R., 58th Battalion
Rogers, Pte. H., 30th Battalion

Box 93

Ryan, Pte. F.A., 24th Battalion

Box 94

Adamson, Dvr. R.C., 4th. DAC
Booth, Sgt. E.J., 29th Battery, 8th Field Artillery Brigade
Carter, Gnr. W.H., 102nd Battery, Australian Field Artillery
Cashel, Spr.W., 1st Australian Tunnelling Company
Clarke, Lt. F.A., 44th Battalion
Cooke, Cpl. H., 58th Battalion
Cooper, Gnr. C.C., 7th Australian Field Artillery Brigade
Hayes, Dvr.W.H., 102nd Battery, Australian Field Artillery
Lewis, Spr. W.E., 17th (Anzac) Light Railway Company
Lyons Gnr. H.P.C., (No rank or unit given.)
McCormick, Pte. F., 16th Battalion
McIntosh, Dvr. H.J., 1st Australian DAC
Ross, Gnr. H.J.W., 1st Australian DAC
Sackman, Pte. M.L., 44th Battalion
Seeligson, Pte. J.H., 32nd Battalion
Tyzack, Lieut. T.W., 10th Australian Machine Gun Company
Wishart, Pte. D., 60th Battalion
Winnell, Dvr. W., 105th Battery, 5th Australian Field Artillery

Box 95

Hamilton, Pte. L.J., 59th Battalion
Mason, Pte. A., 36th Battalion
Pardey, L.Cpl. R.E., 53rd Battalion
Ryan, Dvr. B.F., 47th Battery, Australian Field Artillery
Wilson, Pte. J., 53rd Battalion
Young, Pte. A.E., 4th Battalion

Names of soldiers whose names appear on Army Form A45 Proceedings of a Medical Board. (Includes some Medical Case Sheets) (AWM 23)

Box A 14

Brett, Lt. J., 2nd Battalion (M.C.S.)
Hopkinson, Capt. A., 7th Battalion (M.C.S.)

Box A13

Carlisle, Lt. R., 28th Battalion
Dewar, Capt.W.J., 9th Battalion
Duesbury, Lt. L.S., 33rd Battalion (M.C.S.)

Jacobs, Lt. C., 21st Battalion
Marchant, Lt. L.S., 34th Battalion
Paull, Lt. A., 26th Battalion (M.C.S.)
Shaw, Capt. J.L., 20th Battalion (M.C.S.)
Symonds, Lt. L.C., 7th Battalion (M.C.S.)

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