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“Anxious to Be Restored”: Managing War Neuroses in Interwar Canada

Heather Ellis

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Abstract: Using newly available records from the Veterans Affairs Pension Files, doctors' notes and Veterans' Hospital records, this article explores how war neurosis was simultaneously a personal and public event. Veterans were required to describe symptoms that breached masculine ideals to demonstrate that their disability impacted their daily lives. Ex-servicemen were caught in a delicate balance between following the soldier ideal and describing their symptoms accurately. War neurosis not only impacted veterans in the private examining room of the pension administrator it also affected their ability to find and maintain employment and the lives of their family members. The more public their symptoms became, the more difficult it was to contain their diagnosis. Family members worked tirelessly to assist returned men with their symptoms and took on new responsibilities in the home. When these symptoms could not be managed in the home, families and veterans began to look for new options, such as permanent hospitalisation at Westminster Hospital in London, Ontario, an institution specifically created for veterans with mental illnesses.

Robert G. reached the muddy fields of France in December 1915. After a month in the trenches, he was admitted to No. 4 Canadian Field Ambulance and diagnosed with neurasthenia, an acquired nervous disorder characterised by exhaustion, irritability and nervousness. He convalesced for a week at a rest station and returned to the front until March 1917 when his arm was injured

by barbed wire.[1] He was evacuated to England and returned to France in 1918 until the end of the war. Robert resumed his work as a blacksmith after his discharge in July 1919 but continued to suffer from nightmares and insomnia. In August 1922, Robert was unable to cope any longer and reported to Shaughnessy Hospital, a veterans' hospital located in Vancouver, British Columbia. During his medical examination with Dr. G.H. Manchester, Robert related how the conditions at the front impacted his life. He described being buried by a shell while he was sleeping, dug himself out, "but did not make any complaint at the time." Robert stated: "that he feels as if all the joy has gone out of life and he can't understand what is the matter with him but feels sure that it is the result of the war and he is more anxious to be restored if possible than to receive any pension." The Board of Pension Commissioners (BPC) awarded Robert a 10 per cent pension for nervous debility. His pension was cancelled in 1924 when his neurasthenia was deemed negligible. Robert continued working at various labour jobs but after a few months of employment he was forced to quit. In 1932, Robert re-applied for a pension after he was out of work for a year due in large part to the Great Depression. He complained of insomnia, weight loss and an inability to work at his previous occupation as a blacksmith. Robert's pension was never re-instated.[2] Robert's story is a common narrative of the experiences veterans with mental illness had with medical doctors and pension officials. Veterans with war neuroses often received small pensions for a few years, which were then discontinued when their war symptoms were deemed negligible.

In the past decade, historical scholarship has focused on the ways in which doctors and pension administrators limited ex-servicemen's

[1] Robert G. (500531), Canadian Expeditionary Force service file, RG 150, Accession 1992-93/166, Box 3467 – 3. Library and Archives Canada [LAC].
[2] Robert G., 500531, reel 333, Veterans Affairs Canada [VAC] pension files, Laurier Military History Archive [LMHA].

ability to receive a pension or medical treatment.[3] Canadian, British and Australian scholars have produced a variety of social and cultural histories of shell shock. Studies in all three countries have explored how gender impacted medical understanding of war neuroses and the pension process. They have also explored the legacies of shell shock by examining the pension process for these veterans as well as their post-war lives, with British work leading in this field.[4] In comparison to the British and Australian historiography on shell shock, the Canadian literature remains limited. The primary source base available to researchers, however, is not. Unlike British historians, who only have access to approximately 20,000 pension files, there are currently over 200,000 Veterans Affairs Pension Files, recently digitised at the Laurier Centre for Military, Strategic, and Disarmament Studies (now the Laurier Centre for the Study of Canada). These files offer researchers a valuable window into the medical and personal lives of disabled Canadian veterans.

[3] Mark Humphries, "War's Long Shadow: Masculinity, Medicine and the Gendered Politics of Trauma, 1914- 1939," *Canadian Historical Review* 91, 3 (2010): 503-31; Mark Humphries and Kellen Kurschinski, "Rest, Relax and Get Well: A Re-Conceptualization of Shell-Shock Treatment." *War & Society* 27, 2 (2008): 89-110; and Adam Montgomery, *The Invisible Injured: Psychological Trauma in the Canadian Military from the First World War to Afghanistan,* (Montreal-Kingston: McGill-Queen's University Press, 2017). Humphries' most recent research focuses on the treatment of shell shock at the front, Mark Humphries, *A Weary Road: Shell Shock in the Canadian Expeditionary Force, 1914-1918,* (Toronto: University of Toronto Press, 2018). Tom Brown wrote a brief history on the treatment of shell shock during the war, Tom Brown, "Shell Shock in the Canadian Expeditionary Force, 1914-1918," in *Health, Disease, and Medicine: Essays in Canadian History,* ed. by Charles Roland (Hamilton: The Hannah Institute for the History of Medicine, 1984), 308-332.

[4] Peter Leese, *Shell Shock: Traumatic Neurosis and the British Soldiers of the First World War,* (Basingstoke: Palgrave Macmillan, 2002); Peter Barham, *The Forgotten Lunatics of the Great War,* (New Haven: Yale University Press, 2004); Fiona Reid, *Broken Men: Shell Shock, Treatment and Recovery in Britain, 1914-1930,* (London: Continuum, 2010); Tracey Loughran, "A Crisis of Masculinity? Re-writing the History of Shell-Shock and Gender in the First World War," *History Compass* 11, 9 (2013): 727-38; Tracey Loughran, "Shell Shock, Trauma, and the First World War: The Making of a Diagnosis and its Histories," *Journal of the History of Medicine and Allied Sciences* 67, 1 (2010): 94-119; and Michael Robinson, "'Definitely Wrong?' The Ministry of Pensions' Treatment of Mentally Ill Great War Veterans in Interwar British and Irish Society," *War in History* 28, 1 (2021): 71-92.

This article explores the lives of shell-shocked veterans in post-war Canada.[5] Instead of focusing on the medical debates surrounding war neuroses in the interwar period, this study uncovers how mental illness was described and managed by individuals who were the most intimately impacted: veterans themselves. How did shell shocked veterans describe their symptoms? What was the role of the family and community in the lives of these men? How did these men experience institutionalisation? What is revealed is the experience of shell shock was simultaneously—and intensely—a personal *and* public event, with family members, doctors and state actors playing an important role in ex-servicemen's lives—and not always for good. Veterans and their family members readily described the symptoms and effects of shell shock on their daily lives, even if it breached masculine ideals.

Although male nervous disorders were not entirely novel, the number of men who returned from the Great War diagnosed with, and complaining of, mental symptoms was new.[6] Shell shock, along with other physical and sensory disabilities, required the intervention of the Canadian state.[7] In this system, men were required to report for medical examinations every six months to a year. Doctors re-assessed symptoms and made pension recommendations based on their examinations. These medical boards, as well as social service reports and War Veterans' Allowance investigative reports, offer detailed information about the post-war lives of shell-shocked ex-servicemen. These documents were written by employees of the DSCR, but veterans' voices can be found in these documents. Medical doctors were required to list veterans' complaints during

[5] Veterans were chosen from the small database of 5,000 pension files collated by the LCSC. I selected every fifth veteran who had a mental illness in the disability category of the database. In total, this yielded sixty-five pension records.

[6] Both Mark Humphries and Tracey Loughran argue in their respective studies of front-line psychiatry that psychological disorders did not bewilder nor surprise doctors. Mark Humphries, *A Weary Road: Shell Shock in the Canadian Expeditionary Force, 1914-1918,* (Toronto: University of Toronto Press, 2018); and Tracey Loughran, *Shell Shock and Medical Culture in First World War Britain,* (Cambridge: Cambridge University Press, 2017).

[7] For a more detailed discussion of pension policy see: Desmond Morton and Glenn Wright, *Winning the Second Battle: Canadian Veterans and the Return to Civilian Life, 1915-1930,* (Toronto: Toronto University Press, 1987); and Kellen Kurschinski, "State, Service and Survival: Canada's Great War Disabled, 1914-44," (PhD History, McMaster University, 2014).

each medical board and these complaints can be used to reconstruct how veterans understood and presented their disability.

In the private medical examinations, veterans described a variety of symptoms. Ex-servicemen complained of feeling dizzy, headaches, insomnia, bad dreams, fluttering heart, weakness, fainting, aversion to noise, asocial behaviour, perspiration, irritability, tremors and poor concentration. These symptoms were often subjective, difficult to describe and even harder to prove that they severely impacted their daily lives. Pensions were reserved for veterans who could prove that their war service had disabled them.[8] Coreen McGuire's recent work on measurement devices during the interwar period argues that "measurement became a crucial component of the process of measuring disability and measuring normalcy."[9] Most psychological symptoms were difficult or impossible to measure using specific scientific tests. "Normalcy" was measured through intelligence tests. Canadian doctors such as Clarence B. Farrar preferred the Princeton Condensed Scale to measure intelligence.[10] If veterans failed these intelligence tests, they were often diagnosed with hereditary mental disorders such as "feeblemindedness," "congenital mental defect" or "moron." Dr. Farrar suggested that mental defectives should be immediately discharged from service or hospital treatment and returned to civil life.[11] Veterans who were diagnosed with hereditary disorders were often refused a pension, as doctors and pension officials viewed these as pre-war disabilities and not attributable to service.

Some symptoms described by veterans required a delicate balance. Although veterans wanted to prove that their symptoms were attributable to service and impacted their daily lives, their symptoms were stigmatising because they breached masculine ideals. Descriptions of bad dreams, tremors, nervousness and crying flouted popular conceptions of men. Thomas A. was wounded twice in 1916 on the front and suffered a nervous breakdown in June of that year.

[8] Desmond Morton, "Resisting the Pension Evil: Bureaucracy, Democracy, and Canada's Board of Pension Commissioners, 1916-1923," *The Canadian Historical Review* 68, 2 (1987): 203.

[9] Coreen McGuire, *Measuring Difference, Numbering Normal: Setting the Standards for Disability in the Interwar Period,* (Manchester: Manchester University Press, 2020), 4.

[10] Clarence B. Farrar Records, Box 24, File 1, University of Toronto Archives.

[11] "Untitled Document," Clarence B. Farrar Records, Box 24, File 1. University of Toronto Archives.

He complained about his nightmares in a 1923 neurological exam: "he dreams of his war experience and reacts violently to the same. He has to keep the sides of the bed boarded up to keep the clothes on the bed."[12] Sidney B. also described his dreams to medical officials: "wakes suddenly and is frightened. Dreams of war. Sometimes wakes at night and 'cries like a kid.'"[13] The content of these dreams was rarely described in the pension files. There are two possible reasons for this. First, veterans were reluctant to describe such dreams to physicians. The other potential explanation rests in the interests of the physicians themselves. Many neurologists and psychologists had little interest in psychoanalysis during the interwar period. Henry M. was the only veteran who described his dreams in any detail. In his Department of Pensions and National Health (DPNH) application statement, Henry wrote: "I had terrible dreams of shell bombs falling on me and would make me jump out of sleep [and] fall on my face on floor. This has been going on for years the last time was eight months ago." Henry also wrote in a 1931 affidavit that "after the war was over the silence made me have a peculiar and nervous feeling. At a sudden noise or movement around men, I would be startled like a frightened horse."[14]

Veterans' frightening dreams were private matters and could be contained within the home. Public outbursts were more threatening and concerning, and veterans frequently complained of their inability to control emotions in everyday life. The emotional outbursts and tears of veterans stood in contrast to the stoic masculine ideals of Canadian society.[15] Lesley F. traced his crying spells back to his treatment in a convalescent home in Bromley. He stated that he cried at least once a month and did not know why or what brought it on.[16] Lesley's crying spells continued in his postwar life. During a DSCR medical examination in September 1928, Lesley described how he broke down without provocation and felt "nervy" after these crying spells. Friends and employers also highlighted Lesley's inability to contain his emotions. L.J.S. one of Lesley's employers, wrote in December 1929 that he sent Lesley home "on four or five occasions as

[12] Thomas A., 117108, reel 161, VAC pension files, LMHA.
[13] Sidney, B., 504980, reel 1077, VAC pension files, LMHA.
[14] Henry, M., 334612, reel 502, VAC pension files, LMHA.
[15] Humphries, "War's Long Shadow," 507; and Montgomery, *The Invisible Injured,* 46.
[16] Lesley F., 454311, reel 866, VAC pension files, LMHA.

he will suddenly sit down in the midst of his work & burst out crying & sobbing & shaking all over."[17] H.B.L., who had known Lesley since he was a boy, admitted that Lesley was known "to cry for days at a time" and lost several jobs because of his crying spells. In addition to his irregular employment, Lesley was unable to convince pension officials that he was worthy of a pension. In 1930, he appealed the decision and was granted a pension tribunal. Pension tribunals were panels of experts hired by the DPNH to examine applicants who appealed the commissioners' decisions.[18] Veterans were represented by an advocate, who helped them navigate the appeal process and the tribunal. During Lesley's tribunal, various civilian and department doctors were interviewed, and they focused on his frequent crying spells and insomnia. Even before his cross-examination began, he broke down in tears. The tribunal did not find Lesley's testimony, nor the testimony of his doctors, family or friends convincing and they denied him a pension.[19]

Lesley appealed the Tribunal's decision in 1932 without success. He was examined by Dr. W.W. Barraclough prior to the hearing and the doctor noted that he found his emotional outbursts shallow in nature. Dr. Barraclough documented that his outbursts were "unaccompanied by any evidence of sympathetic chance such as disturbance of pulse rate, perspiring, tremor, etc." The doctor testified that he believed Lesley's symptoms were more likely due to his unhappy marriage and his poor relationship with his father-in-law.[20] Pension officials had little sympathy for veterans who endured challenging domestic conditions. The subjective nature of veterans' symptoms meant that they had a difficult time convincing officials that their symptoms were largely due to their war neuroses or external forces. Like the officials in Lesley's case, pension officials were more likely to attribute mental illness to domestic circumstances rather than the psychological effects of the war.[21]

Several veterans did not apply for a pension until the late 1920s and early 1930s. Late applications were initiated for several reasons.

[17] Underlined in source. Lesley F., 454311, reel 866, VAC pension files, LMHA.
[18] Pension Tribunals replaced the defunct Federal Appeal Boards that were created after the Ralston Commission in 1924. Morton, "Resisting the Pension Evil," 220.
[19] Lesley F., 454311, reel 866, VAC pension files, LMHA.
[20] Lesley F., 454311, reel 866, VAC pension files, LMHA.
[21] Humphries, "War's Long Shadow," 86; and Campbell, "We Who Have Wallowed in the Mud of Flanders," 143-144.

For most men the Great Depression, compounded with their war disabilities, made it almost impossible for them to find employment. However, they now had to prove to pension officials that they were not applying because of their financial concerns, but due to their war disabilities. In these applications, veterans described their war neuroses as an underlying current in their lives, one that they attempted to keep to themselves until they were no longer able to do so. These men were part of a surge applications after the BPC changed several pension rules. For example, in 1930, veterans who had chosen a commuted pension were now allowed to re-apply for a disability pension. Thousands of veterans across all disabilities applied for pension renewal.[22] The 1930 pension amendments also created a 'benefit of the doubt clause,' which stated: "it shall not be necessary for him to adduce conclusive proof of his right to the pension applied for, but the body adjudicating on the claim shall be entitled to draw and shall draw from all the circumstances of the case, the evidence adduced and medical opinions, all reasonable inferences in favour of the applicant."[23] However, as demonstrated through Lesley's experience, it was hard for those with war neuroses to obtain the benefit of the doubt from pension officials.

When veterans applied to for pensions in the 1930s, their applications often required more evidence to prove that their current symptoms were from the Great War. Veterans enlisted doctors, family members, employers and members of the community to testify that they were unwell since their return from overseas. Pension applications in the 1930s required veterans to demonstrate that the public had knowledge of their symptoms, so their mental illness could no longer be a private affair. Joseph G. was one veteran who applied to the BPC in 1930. In his initial examination with Dr. C.T. Lundon in March 1930, Joseph complained of "dizziness, insomnia, nervousness, some pain [...] at elbow joint." Lundon described Joseph in his letter to the BPC as someone who "appears somewhat depressed and exhibits some nervous manifestations."[24] Although Joseph did not complain of his deteriorating mental health to the BPC prior to 1930, Lundon did not view his claims him with suspicion. He wrote that he had known Joseph for several years and viewed him as a competent

[22] An Act to Amend the Pension Act (1930). C. 35.
[23] An Act to Amend the Pension Act (1930). C. 35.
[24] Joseph G., 3081377, reel 453, VAC pension files, LMHA.

soldier, "not the type to remain [in] France only when compelled to do so." Lundon believed that Joseph had stuck out his service because he was a dedicated soldier in the field and was not forced to remain there.[25] Joseph's employer, the Windsor Hotel, advocated on his behalf. Mr. Mulligan, the Vice-President of the hotel, asked for him to be treated at Ste. Anne's Hospital, a DSCR institution located in Ste. Anne de Bellevue, Quebec, for a month to alleviate his symptoms. Joseph remained at Ste. Anne's from May to June and during this time he was treated for alcoholism. Joseph returned to his position at the hotel but was let go in the spring of 1931. The Vice President wrote to the DPNH later that summer to intervene in Joseph's case, but this time they were unwilling to treat him. The DPNH had determined during his hospitalisation in Ste. Anne's that Joseph's alcoholism was a post-discharge condition. His disabling condition was "due to his habits" which was therefore not a condition caused by service.[26]

Veterans with psychological illnesses struggled to find and maintain employment throughout the interwar period. Their cyclical emotions and nervous temperaments made them unable to secure long term jobs. This only worsened with the Great Depression. John L. described in several letters how his war service prevented him from obtaining an occupation. On 28 November 1930, he wrote:

> If I hadn't joined up – I'd most likely be a bank-manager making good easy money. But I did. So now I have to compete with big strong foreigners in a crowded labor market – and I can't do it. I don't use liquor and all I want is a chance to start a little business, get married and be a good citizen. I have no relatives in a position to aid me.[27]

Instead of working as a bank manager, John was employed as a bookkeeper. John claimed that working indoors was difficult and he tried to live "an open air life" when he was not working to help his nerves. His testimony demonstrates that he wanted to become a productive citizen. Veterans with psychological illnesses were often perceived as weak-willed and unwilling to work.[28] John, and other

[25] Joseph G., 3081377, reel 453, VAC pension files, LMHA.
[26] Joseph G., 3081377, reel 453, VAC pension files, LMHA.
[27] John L., 1000793, reel 294, VAC pension files, LMHA.
[28] Montgomery, *The Invisible Injured,* 48.

veterans, attempted to challenge this prejudice by demonstrating that although their illnesses made them unable to work, they still wanted to be productive members of society. This claim that veterans had missed out on important employment opportunities because of their war service was a common theme in broader veteran discourse during the 1930s.[29]

Family members were important pillars of support for mentally ill ex-servicemen. They advocated for ex-servicemen by writing to pension officials, interacting with doctors and visiting veterans in hospital. Women in all nations were expected to help the government rehabilitate the returning ex-soldier. Dr. H.R. Humphries wrote several advice columns for American women whose husbands suffered from shell shock. He advised that returning men have a quiet home with a strict routine and that these men should not be asked about their war service unless they brought it up. Dr. Humphries warned women to keep their husbands and sons away from alcohol because it could cause a relapse.[30] Amy Tector argues that women were given two contradictory messages by wartime novels: they were supposed to be "tender and submissive" as well as shoulder male responsibilities like employment and the household income.[31]

Wives shouldered emotional and physical burdens in their households. Sidney B.'s wife took care of their finances and their four children until her death in 1922.[32] Wives often managed veterans' pensions if the BPC thought that a veteran was irresponsible. When Alexander B. was hospitalised in Rockwood Mental Asylum, in Kingston, Ontario, in 1932, his wife was given control of his pension. She was described as a "quiet and unassuming lady like woman." Her description as a "lady like" woman by department officials shrouded

[29] Jessica Meyer, *Men of War: Masculinity and the First World War in Britain,* (Basingstoke: Palgrave Macmillan, 2009), 99; Neary, "'Without the Stigma of Pauperism,'" 39; Campbell, "'We who have wallowed in the mud of Flanders,'" 129. Eric Story, "The Indigenous Casualties of War: Disability, Death, and the Racialized Politics of Pensions, 1914-39," *The Canadian Historical Review* 102, 2 (2021): 301-02.
[30] "Home Treatment of Shell Shock (Part 1)" November 1918. The New York Academy of Medicine Library. Adam Mathew Digital. 112-13.
[31] Amy Tector, "'Mother, Lover, Nurse:' The Reassertion of Conventional Gender Norms in Fictional Representations of Disability in Canadian Novels of the First World War," in Sarah Glassford and Amy Shaw, eds., *A Sisterhood of Suffering and Service: Women and Girls in Canada and Newfoundland during the First World War* (Vancouver: UBC Press, 2014), 295.
[32] Sidney B., 504980, reel 1077, VAC pension files, LMHA.

Mrs. B. in an aura of respectability and she gained control of her husband's pension because he was viewed as irresponsible.[33] When he was released in February 1933, his wife continued to administer Alexander's funds until she was too ill to do so.[34] Harry D.'s wife was put in charge of her husband's pension and War Veterans' Allowance (WVA) in 1939 because of his alcohol addiction. Between 1929 and 1934, Harry was arrested fifteen times for breaching the Liquor Control Act. His continual alcohol consumption threatened his pension and WVA. In April 1939, Harry was required to sign an affidavit stating that he would not indulge in alcohol again.[35]

The letters wives penned to the state described their husbands' symptoms as well as the emotional toll their husbands' disability had on their family. John S.'s wife wrote in 1920 that although her husband completed his course in mechanical dentistry, he "has been unable to hold a position on account of his health he is a nervous wreck and has a sore throat & a cough always." Mrs. S., like the wives mentioned above, entered the workforce to make ends meet. However, her own illness prevented her from working for long periods of time. She wrote, "I do not like to ask for help or charity as it is but we are in a crisis." The Pension Board advised convalescent treatment for her husband, but he refused. The couple moved to Bermuda for a period of time to try and alleviate John S.'s coughing and nervous trouble, but eventually moved back to the United States. How the couple coped for most of the interwar period is unclear because he did not re-apply for a pension until 1938.[36]

Wives' letters often demonstrated the destitute circumstances in which veterans' families found themselves. Ex-servicemen focused on the need to gain employment but did not always elaborate on the state of their domestic situation in their letters. Letters from wives also illustrate the amount of work required to take care of a family member. After the death of her husband in 1936, Cecil J.'s wife wrote

[33] Women's ability to gain control over their husband's pensions is in direct contrast to the rules surrounding relief cheques. If a husband was found irresponsible by the courts, the court would administer the cheque and give it to the wife. Lara Campbell, *Respectable Citizens: Gender, Family, and Unemployment in Ontario's Great Depression,* (Toronto: University of Toronto Press, 2009), 135. The requirement of female respectability is an extension of the requirements made by the Canadian Patriotic Fund during the Great War and subsequent post-war allowances.

[34] Alexander B., 636416, reel 1059, VAC pension files, LMHA.

[35] Harry D., 541820, reel 1369, VAC pension files, LMHA.

[36] John S., 201917, reel 486, VAC pension files, LMHA.

a detailed letter to the pension board. Cecil and his family lived in England after the Great War and like many other veterans with smaller pensions, chose to have his disability pension commuted in 1920. He had four children, the youngest of whom was born in 1929. Cecil re-applied for a disability pension in 1931 and was in and out of Queen Alexandra hospital for most of the 1930s. He was diagnosed with neurasthenia and his pension was re-instated at twelve per cent despite his intense symptoms and frequent hospitalisations. Cecil died at Queen Alexandra hospital in June 1936 from pneumonia and his wife was denied a pension.[37] Cecil never received a pension for pneumonia or any other lung condition, therefore his death was not attributable to service. A widow only received a pension if her husband died from a pensionable disability. Mrs. J. believed that his inability to recover from pneumonia was due to his neurasthenia. Mrs. J. wrote in vivid detail what it was like to live with her husband:

> as the years passed it gradually took a firmer and firmer hold upon him manifesting itself in what in what I can only describe as nerve or brain storms and insomnia [...] no one knows what I went through with him during these attacks – not even my husband himself – he could not sleep properly and had little or no desire to eat – no matter how I coerced him – finally he became afraid of himself – then came the temptation – or desire or whatever one can call it – for self destruction with this mood upon him he would glare at me with the eyes of a mad man – only a few days before his final illness I had to take open razor from him – only just in time – he was standing before the looking glass saying 'I'm not afraid to die – I'm not afraid to die' he talked of jumping through the window and going over the cliff 'after these terrific brain storms had passed [...] just weak and helpless as baby.[38]

The slow destruction of her husband's mental state and the care required to keep him safe from harm took a toll on Mrs. J. She wrote, "my own health and nerves gone through the continual strain of watching and tending him in his weakness." Despite the constant care her husband required, Mrs. J. still regarded him

[37] Cecil J., 434880, reel 149, VAC pension files, LMHA. Her children were granted a child's pension for one year after the death of their father.
[38] Cecil J., 434880, reel 149, VAC pension files, LMHA.

as "my very dearest possession."[39] Mrs. J.'s letter demonstrates the constant battle family members went through caring for ex-servicemen and that families also felt the psychological impact of the First World War.

The most common experience for shell-shocked veterans was a near constant interaction with the pension board and its medical boards. Yet those who were institutionalised for the entirety of their lives had a different postwar experience. In the sample of veterans selected for this article, only five men were institutionalised for a significant period. At the end of the war, the state of civilian asylums and broader public calls for a separation between civilian and military insane led the government to build their own institutions specifically for veterans. Captain (Capt.) Clarence B. Farrar and Dr. C.K. Clarke investigated civilian asylums across Canada in 1919. Both men were prominent neuropsychologists. Capt. Farrar had worked at Cobourg Military Hospital during the Great War and was promoted to chief neuropsychiatrist for the DSCR in 1919.[40] Dr. C.K. Clarke was chosen to accompany him due to his extensive experience in civilian asylums as well as his role in the creation of the Canadian National Committee for Mental Hygiene.[41] After their tour Farrar and Clarke did not think that the current civilian asylums would be suitable treatment centres for veterans.[42] Their reports lamented the use of seclusion and the restraints used in the Western Provinces and were disappointed that

[39] Cecil J., 434880, reel 149, VAC pension files, LMHA.

[40] F.H.L., "Clarence B. Farrar 1874-1970 and the History of Psychiatry in Canada," *Canadian Psychiatric Association Journal* 20, 1 (1975): 1.

[41] Edward Ryan, 'The Late Dr. C.K. Clarke, M.D. L.L.D," *The Ontario Journal of Neuro-Psychiatry* (Toronto: King's Printer, 1924), 5. Clarke's extensive experience did not always work in their favour. Both Ontario and Quebec refused the DSCR investigation because of Clarke's involvement. "Inter-Department Correspondence Inspections: Insane Asylums from Unit Medical Directors 'D' and 'F' Units to Director Medical Services," Treatment Services, Psychiatric Cases Inspection Reports Mental Hospitals, RG38-D-2, Vol. 217, LAC.

[42] Morton & Wright, *Winning the Second Battle,* 132. Both Farrar and Clarke were active members of the Canadian National Committee for Mental Hygiene and were not the only doctors employed by the DSCR on the membership list. Dr. G.H. Manchester, who ran Shaughnessy Hospital, was also a prominent member. This connection between the mental hygiene movement and the DSCR gave the committee legitimacy. See Kandace Bogaert, "Due to His Abnormal Mental State: Exploring Accounts of Suicide among First World War Veterans Treated at the Ontario Military Hospital at Cobourg, 1919–1946," *Histoire Sociale/Social History* 51, 103 (2018): 112.

the asylums did not use hydrotherapy as the main form of treatment.[43] Westminster Hospital, located in London, Ontario, was already being built by the DSCR as a psychiatric hospital. Farrar was determined that this hospital become an example to other asylums across the country. Westminster was the only DSCR institution that specifically treated veterans with psychological illnesses. Ste. Anne de Bellevue, named after the town in which it was located, treated soldiers with mental and physical disabilities. However, soldiers with psychological illnesses were the largest patient population at Ste. Anne's. In the West, two DSCR hospitals also treated ex-servicemen with mental illnesses, but their wards were generally smaller and less specialised.[44]

Westminster and Ste. Anne's both opened in the spring of 1920 and began slowly receiving patients in April.[45] At the end of the year, Dr. Clarke was invited, along with several other DSCR doctors, to inspect Westminster Hospital. In his final report, he gave lavish praise to the institution, impressed by the voluntary admission rate of the hospital: "It is, in every sense of the word, an inspiration to those who have wished to see better things in the care of the insane developed in Canada, and the fact that it employs a voluntary admission system to such an extent, that practically fifty per cent of the admissions are of this kind, is one of the most admirable features of this institution."[46]

The voluntary admission rates further separated veterans' psychiatric institutions from civilian asylums. Veterans were encouraged to voluntarily report to the hospital for prolonged treatment instead of going through the legal committal process.[47] The 1919 *Pension Act* itself, encouraged hospitalisation over pensions.

[43] "Letter to Col. McKelvey Bell from C.B. Farrar and C.K. Clarke December 26, 1918," Treatment Services, Psychiatric Cases, Inspection Reports Mental Hospitals. RG 38-D-2, Vol. 217, LAC.

[44] Manitoba Military Hospital, located in Winnipeg, treated veterans from Northern Ontario, Manitoba and Saskatchewan. In Vancouver, Shaughnessy Hospital treated veterans from British Columbia and Alberta.

[45] Hospitals – Westminster Hospital, London, ON. 2001-01151-2, RG 38, Box 513, Vol. 7. LAC.

[46] *Report of the Work of the Department of Soldiers' Civil Re-Establishment,* (Ottawa: King's Printer, 1920), 10.

[47] The voluntary admittance of patients means that pension files are often missing crucial documents that would normally be present if a person was committed to an asylum. Doctors' notes, family letters and legal committal documents are rarely included in pension files. This could be due to the trimming of files before they were microfilmed.

Section 29 of the Act stated that veterans with functional or hysterical psychological illnesses "shall immediately be referred to a Neurological Centre for treatment."[48] Only extreme cases, where symptoms had not disappeared and there was a clear connection to their war experiences, would a pension be considered. The DSCR continued this policy of treatment over pensions throughout the interwar period. Furthermore, before 1923 any veteran could be admitted to a hospital, regardless of their disability. After 1923, veterans could only be admitted if they had a documented war disability or underwent observation.[49] Most veterans were initially observed and treated at neurological centres before they were admitted to Westminster. For example, Ernest H. was treated at Newmarket Hospital from March 1919 until May 1920. When he failed his out-patient probation, he was transferred to Westminster in June that year.[50] In 1921, 70 per cent of admissions to Westminster were voluntary; by 1922 this number rose to 82 per cent. Comparatively, Ste. Anne's had a voluntary admission rate of 94 per cent in the same year.[51] In comparison, of the 2,133 men and women admitted to provincial hospitals for the insane in 1922, there were no voluntary patient admissions. 1,659 patients (77.7 per cent) were admitted through medical certificates and 467 patients (21.8 per cent) were admitted through the legal courts.[52] One of the reasons for the disparity between civilian and veteran psychiatric institutions is the reasons for hospitalisation. Veterans entered hospitals like Westminster to be examined by doctors during pension applications. Some men such as Sydney C. begged to be examined by a doctor: "I may not live much longer unless I can get fixed up and would be very grateful for an examination by DSCR doctors, as although I feel myself slipping everyday I want to get well again."[53] Men wanted to go to these hospitals for treatment, which was viewed as a success by

[48] *Pension Act, Statutes of Canada* (1919), C. 43.
[49] Bogaert, "'Due to His Abnormal Mental State,'" 67.
[50] Ernest H., 3035799, reel 560, VAC pension files, LMHA.
[51] Clarence B. Farrar, "Neuropsychiatric Service of the Department of Soldiers' Civil Re-Establishment, Canada," *The Journal of American Psychiatry* 79, 4 (1923): 674.
[52] Annual Report of the Inspector of Prisons and Public Charities Upon the Hospitals for the Insane Feeble-Minded and Epileptic of the Province of Ontario, (Toronto: King's Printer, 1922), xii. Voluntary hospital admission rates to public asylums remained low during the 1920s. Patients who were committed were around 90 per cent of the admissions throughout the decade. These numbers do not include private institutions such as Homewood Sanitorium.
[53] Sydney C., 461191. reel 570, VAC pension files, LMHA.

the institutions' physicians, the DSCR administration and the federal government.

By December 1921, Westminster and Ste. Anne's were responsible for 741 patients.[54] Veterans were also treated in other DSCR hospitals as well as civilian asylums if they were unwilling to move. There were some restrictions in patient admittance during the 1920s. This coincided with the hiring of J.P.S. Cathcart as chief psychiatrist. He believed that too many men were being admitted to departmental hospitals.[55] Despite Cathcart's concerns, the total patient population of institutionalised veterans remained around 1,000 throughout the interwar period.[56] Canada's relatively stable hospital population led the Canadian government to maintain and even expand veterans' hospitals, which contrasts with Britain's slowly declining patient population.[57] Instead, charitable societies like England's Ex-Services Welfare Society, which treated and rehabilitated shell-shocked ex-servicemen outside of the asylum, were established. Equivalents in Canada did not exist.[58] Canadian mental institutions also accepted ex-servicemen who were diagnosed with congenital mental disorders, especially prior to 1923. Great Britain refused to treat such men and they were institutionalised in civilian asylums, as "Ministry facilities

[54] *Report of the Work of the Department of Soldiers' Civil Re-Establishment,* (Ottawa: King's Printer, 1921), 10.

[55] Humphries, "War's Long Shadow," 525.

[56] Annual reports by the Department of Pensions and National Health outlined the number of men treated in hospitals according to physical and mental disability. *Report of the Work of the Department of Pensions and National Health,* (Ottawa: King's Printer, 1931), 14.

[57] Michael Robinson, "'Definitely Wrong?' The Ministry of Pensions' Treatment of Mentally Ill Great War Veterans in Interwar British and Irish Society," *War in History* 28, 1 (2021): 84-85.

[58] Fiona Reid, *Broken Men: Shell Shock, Treatment, and Recovery in Britain, 1914-1930,* (London: Bloomsbury, 2014), 100-04. Veterans could apply to other financial programs like the Soldiers' Aid Commission and the Canteen Fund. These programs had limited scope and funds for veterans and their families. For a history of the Soldiers' Aid Commission see: William and Jeannette Raynsford, *Silent Casualties: Veterans' Families in the Aftermath of the Great War,* (Madoc: The Merribrae Press, 1986). Jonathan Scotland's dissertation explores the history of the Canteen Fund: "And the Men Returned: Canadian Veterans and the Aftermath of the Great War," (PhD Dissertation, Western University, 2016), 231-265.

were reserved for 'nerve shattered soldiers.'"[59] Moreover, Canada's psychiatric hospitals treated more men with psychoses than neuroses. Psychoses were mental disorders that markedly altered a veteran's personality, whereas neuroses were milder mental disorders such as neurasthenia, neurosis and psychasthenia. Dementia praecox, an early twentieth century term for schizophrenia, was the most common diagnosis in both hospitals throughout the interwar period.

Hospitals were important sites of care for shell-shocked veterans because they separated ex-servicemen from civilian institutions. When veterans were admitted to civilian asylums, they often wrote asking to be transferred if there was a department hospital close by. In April 1930, John H. was committed to the Toronto Psychiatric Hospital after experiencing persecutory hallucinations. This was not the first time he was committed to 999 Queen Street; however, he was not immediately moved to Westminster Hospital. John wrote a letter in May 1930 expressing his dissatisfaction: "the above address is an institute for mental defectives into which I have been incarcerated for which I deem unjustly. I am making this appeal to you because being a Returned Soldier I am sure you will intercede on my behalf." John's letter illustrates the importance of preferential treatment in letters to the department. His argument that he was unjustly treated at an institute for mental defectives also demonstrates that he did not see himself as such. Veterans and their relatives used language of preference and entitlement to argue that they deserved treatment in a special hospital.[60] This argument for preference and treatment often extended beyond hospital treatment. Lara Campbell's work on veterans during the Great Depression demonstrates that veterans believed they should receive government assistance because of their service.[61] John H. was eventually transferred to Westminster because the BPC ruled in 1924 that his dementia praecox was aggravated due to service. If John did not have this in his file, he would have stayed

[59] Robinson, "'Definitely Wrong?,'" 78. Canada introduced a clause that all ex-servicemen were allowed to seek treatment from department hospitals within one year after discharge, even if their disability was not attributable to service. Many of these men were committed or voluntarily admitted to DSCR hospitals. The physicians at these hospitals and the department did not want to remove them because of their mental illnesses. The issue of attributability only becomes an issue when Dr. Cathcart was hired by the department in 1924. The Department also refused to move veterans if there were no civilian beds available in their hometown.
[60] Larsson, "Families and Institutions," 111; and Larsson, *Shattered Anzacs,* 153.
[61] Campbell, *Respectable Citizens,* 151.

at Toronto Psychiatric Hospital.[62] John remained at Westminster until his death in 1953.

Veterans did not experience institutionalisation alone. They were often in touch with family members and the outside community. When veterans were on parole wards, they were allowed day passes into London or Ste. Anne's and applied for extended leave to visit their family members during holidays like Christmas.[63] Choosing to enter a hospital could also have financial consequences for a veteran's family. When a veteran entered a DSCR hospital, their pensions were suspended, and their family members were given pay and allowances. Pay and allowances only covered hospitalisations for pensionable disabilities. If a veteran was an (A) class patient, their wife would receive the equivalent of a widow's pension per month. Wives of veterans classed as (B) patients, would receive a portion of a widow's pension, depending on the degree of disability. Veterans who were classed (C) patients did not qualify for any pay and allowances for their families, as their disabilities were not due to service.[64] Wives did not have to prove dependency, they were automatically given pay and allowances. However, parents had to prove that their son had financially supported them prior to their hospitalisation.

Family members were important actors during transition from patient to out-patient. William D.'s family readily accepted the responsibility of taking care of a parole patient. William's mental trouble began when he went absent without leave in France in November 1918. After his return to Canada, he was treated at Cobourg Military Hospital but eventually transferred to Newmarket Hospital in May 1919. Doctors described William as withdrawn, maintaining "an unbroken silence except for a fixed phrase which he repeats when asked about his health. [...] Patient is quite inaccessible and no information can be obtain[ed] from him. He works well on the ward and understands what is said to him."[65] Due to his good behaviour,

[62] John H., 195096, reel 635, VAC pension files, LMHA.

[63] The central files for Westminster Hospital contain lists of patients on parole who were allowed to leave for holidays. "Lists of Holiday Leave Granted to Neuropsychiatric Patients," *Hospitals – Westminster Hospital, London, ON,* BAN 2001-01151-2, RG 38, Box 515, Vol. 26., LAC.

[64] "Authority under which the Department of Soldiers' Civil Re-Establishment may deal with insane ex-members of the Forces PC 1993," *Report of the Work of the Department of Soldier's Civil Re-Establishment,* (Ottawa: King's Printer, 1920), 148.

[65] William D., 3033717, reel 1305, VAC pension files, LMHA.

he was treated as an out-patient and put under the supervision of his sisters until January 1920. A few months later, William was living with his parents in Kenora, Ontario. Though veteran outpatients still received pay and allowances from the hospital, William's was cancelled in July 1920 after having not reported to Westminster Hospital once his three-month probation was over. William's parents explained that they could not spare time to accompany him to Westminster at the end of his probation and that he could not be trusted to return to the hospital alone. William was the only son in his family, so it is probable that they needed him to remain at home, even with his mental illness. A social service nurse was eventually dispatched to Kenora in September 1920 and William returned to Westminster that same month. William would never return to his parents' home, remaining at Westminster until his death.[66]

Like civilian asylums, DSCR institutions were also important spaces for family members who struggled to cope with the illnesses of ex-servicemen.[67] Cecil J.'s wife, mentioned above, accompanied her husband to the Alexandra Hospital in Portsmouth in January 1935 after he complained of "jumping at the slightest sound, depression and thoughts of suicide." Cecil stated that he was "losing interest in everything in life" and that he "cannot go near the cliffs now." Hospital authorities interviewed Cecil's wife at the end of the month and Mrs. J. demanded that her husband remain in the hospital for another thirty days. Since Cecil and his wife were living in England, Canada House in London had to approve this request. The Canadian government refused the extension and Cecil returned home, though he was re-admitted to the Queen Alexandra Hospital in February 1936. Mrs. J. encouraged her husband to return to hospital as she was ill and "didn't like the responsibility of looking after him."[68] Having her husband in the hospital allowed Mrs. J. to focus on rearing their children and let her know that her husband was safe and far away from the cliffs he liked to walk on.

Shell shock and other war neuroses affected veterans in both private and public spaces. In medical spaces, men were caught between demonstrating the symptoms of their disability and being

[66] William D., 3033717, reel 1305, VAC pension files, LMHA.
[67] Cheryl Krasnick, *Moments of Unreason: The Practice of Canadian Psychiatry and the Homewood Retreat,* (Montreal: McGill-Queen's University Press, 1989), 64.
[68] Cecil J., 434880, reel 149, VAC pension files, LMHA.

perceived as a man with a pre-war mental illness. These symptoms were often difficult—if not impossible—to measure, which meant that shell-shocked veterans had difficulty demonstrating how their disability affected their everyday lives. Although veterans' symptoms flouted dominant codes of masculinity, they felt compelled to describe their symptoms to receive a pension. Shell shocked veterans believed that they had pensionable disabilities and tried to adequately demonstrate how their symptoms interfered with their ability to obtain employment. Family members remained important actors in veteran's lives, and the wives of these men were instrumental to the financial health of the family. They and other family members took on the burden of children as well as home care for veterans with mental illness.

The lives of institutionalised veterans require further investigation. Their treatment in federally-funded institutions demonstrated their special patient status. The small group of veterans examined in this article shows that family members were often involved in the care and treatment of psychologically ill ex-servicemen, especially if they wanted to leave the hospital. When parents and siblings were no longer able to supervise parole patients the men remained at the hospital for the rest of their lives. Institutionalisation could also offer some reprieve for family members struggling to take care of ex-servicemen and fulfill other familial obligations.

Ultimately, shell shocked veterans and their families refused to be silenced by the pension bureaucracy. Veterans were persistent in their quest for compensation throughout the interwar period. They were determined to prove to pension officials and medical doctors that they deserved financial compensation for their war service. Pensions remained an important financial and symbolic means of assistance for shell shocked veterans. Those who received pensions were viewed as legitimate casualties of war, even if their wounds were invisible.

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ABOUT THE AUTHOR

Heather Ellis is a PhD Candidate at Western University in London, Ontario. Her research explores the postwar lives of shell-shocked Canadian veterans and their families. Heather's work examines how family members were impacted by shell shock and their important role as caretakers and advocates.