WAR BEYOND WORDS: SHELL SHOCK, SILENCE, AND MEMORIES OF WAR

Frameworks of Silence

So far, we have entered into very varied domains in which those who lived through war tried to communicate what it meant to them. Painters, sculptors, photographers, filmmakers, poets, writers, men of faith, architects, and countless others have left us an extraordinary array of reflections of and on war. Most of them resemble what physicists find through the use of a cloud chamber – traces of a collision rather than elements of the collision itself.

In effect, representing war is a Sisyphean task, unavoidable, but (in a profound sense) unachievable. Many of those who fought never spoke about what they knew. There were many reasons they placed their memories of war beyond words. Some felt that civilians could not comprehend and did not want to hear what they had to say. Some wanted to leave their nightmares in the dark, where they belonged, and to go on living ordinary lives. Others went further and concluded that the horror of war was beyond speech, beyond images, beyond monuments. What war did was to place itself beyond utterance.

I am grateful for the comments of the following people on this chapter: Robert Dare, Joan Beaumont, Ken Inglis, Petra Ernst, Al Thomson, Harvey Mendelsohn, Antoine Prost, Paul Lancaster, and Alexander Macfarlane.
From this perspective, all of the creative work in art and architecture as well as in poetry, photography, painting surveyed in this book, were bound to hit a brick wall—the massive boundary separating what war does to human beings and what we can say about it. Any account of the cultural repercussions of war must admit the truth of this statement.

And yet it is an incomplete truth. One reason why this is so is that the silence men and women brought back from war had many different meanings. These survivors time and again brought us what I term performative nonspeech acts. By that term, I follow J. L. Austin, who posited that there are speech acts which are constitutive rather than descriptive; they establish the condition of which they speak rather than describe it. I go one step further and suggest that there are performative nonspeech acts through which some people tell us about war beyond words.¹

Some such nonspeech acts are relatively well known. The two-minute silence on Armistice Day or Remembrance Sunday is one of them. Liturgical approaches to mourning those who die in war are full of silences, since such losses profoundly challenge our sense of meaning or order or justice. Other silences are political in character; for instance, the Museum of Memory in Santiago de Chile is eloquent about the victims of the Pinochet regime but totally silent on the perpetrators, many of whom are still alive and very unlikely to answer for their crimes. There is still an embargo in Spain on calling to account those guilty of war crimes committed during and after the Spanish Civil War. These cruelties are beyond words (and deeds) because people chose to put them there.

Still other silences are essentialist, in that they are based on a claim that only those who have been there could talk about war. This accounts for the tendency of some veterans to open up only to other veterans, as if they had imbibed war with their rations, and could only speak with others just like them. Finally, there are family silences which are kept by fathers and mothers, sisters and brothers, to enable ordinary life to go on after difficult events. In some ways, all families are defined by the silences they keep.

¹ For a full elaboration of this position, see Winter, “Social construction of silence,” pp. 1–29.
Shell Shock

Many such families lived with a particular silence in the aftermath of war. That silence is the subject of this chapter. Silence is, among other things, what everyone knows and no one says. There has been a silence, I believe, lasting a century surrounding the extent to which the soldiers of the Great War suffered psychological injury. In part, this silence arose out of the stigma then and still now attached to mental illness in general, and to mental illness among soldiers in particular. Another contributory factor to this silence was the relatively underdeveloped diagnostic skills doctors and administrators had available to them when confronted with a mixture of somatic and emotional disorders that many tended to treat as malingering. In addition, there was a financial matter to deal with in the inclement weather of the interwar years. How could doctors be sure that the best use of state money was to give it to those who were still bearing the hidden wounds of a war which had ended long before? Surely, some believed, the physically disabled took precedence, and even then, their pensions and entitlements remained meager. These are questions to which we have no clear response in our everyday dealings with mental illness today; should we be surprised that the people in charge got it wrong in the years after the Great War?

How large is this underestimate? Only God knows. I will make a few educated guesses (some would say stabs in the dark) on this point, but the critical matter is to acknowledge that it is large, though no one will ever be able to be precise about it. This chapter is, therefore, about countless individual and collective silences, willful turnings away from men damaged in their minds in wartime, and unable in several respects to stand on their own two feet or to achieve emotional balance thereafter. The burial of this facet of the experience of war I term a categorical silence. That is, “shell shock” was a phenomenon systematically occluded by those who treated the injured or administered pensions sought by men with war-related psychological or neurological disabilities.

There was one occasion in 1918 when we can see British high command attempting to block medical officers from using the diagnosis “shell shock” as a category of combat casualties. The War Diary of General Headquarters, First Echelon, shows staff officers trying to maintain troop levels at the height of the German spring offensive of 1918. On April 13, with German troops still moving forward on many
points on the Western Front, GHQ made the “recommendation” to the War Office “that cases of shell shock should not in future be classified as battle casualties.” There were numerous conversations that preceded this finding. Ration strength in many British infantry units was falling rapidly under German pressure; conversely, casualty levels were rising rapidly. Getting more disabled men back to the front was an urgent matter, and so too was making the British War Cabinet and (in time) the public feel that the army had enough “backs to the wall,” as General Haig put it, to stem the German tide. That is indeed what happened, but achieving it was a near thing. One way High Command thought would help was putting the lid on “shell shock.”

It is difficult to know how this “recommendation” was implemented. In the chaos of the last major military crisis of the war, it may have sunk without trace. It is possible, though, that those who compiled statistics simply took matters into their own hands, and wiped the slate clean when there was any mention of shell shock in casualty reports. In any event, we can see this directive as one of a number of measures ensuring that the proportion of all battle casualties attributable to psychological or neurological injury would be underestimated. In effect, British High Command created a statistical silence, or a categorical silence, about shell shock in 1918 which has resounded to this day.

There is another important facet of silence we need to explore. It is the silence of soldiers themselves. I term this phenomenon communicative silence. On this point there is a wealth of indirect evidence. In how many cases have friends and colleagues turned to me and others and said I wish I had asked my grandfather about his war service? Or they say “my father or husband or uncle or lover never said a word about it,” but no one asked for their views either.

Some soldiers did not want to go over the ground again. Harry Patch, the very last Tommy, who died in 2009, at the age of 111, said that he never wanted to talk about the war. He kept his peace for eighty years, and then opened up at age 100 only when he was pestered by journalists who asked him about his centenarian’s thoughts on the war of which he was the last survivor. It was a miserable, pointless part of his

---

2 National Archives, Kew, War Office, WO/95/26/3. I am grateful to William Spencer, Principal Military Specialist at the National Archives, for drawing my attention to this document.

life, he said. His mates had died for nothing. He never watched war films or television documentaries, although he agreed to meet a German veteran on one such program in 2004 and appeared in another on his visit to Ypres in 2008. When he was drawn out in his last years, he spoke laconically and reluctantly. He did not commemorate the war; he commemorated the three men of his unit who died in the Ypres salient. “That day, the day I lost my pals, 22 September 1917 – that is my Remembrance Day, not Armistice Day.” He added, “I am always very, very quiet on that day and I don’t want anybody talking to me, really.” In Richard van Emden’s collection of interviews with Patch, published as his “life,” Patch’s resistance to remembering aloud the horrors of war and to leaving his words behind is palpable.

I am touching here on one of the things we historians do or are supposed to do. We speak for these men, not primarily (and certainly not solely) in our own words, but in theirs and through theirs. What do we do with their silences? We can try to understand them, and break the taboos surrounding them; we can talk about the frightening or the hideous without shrinking from them or fearing contamination. Above all, we have to make it plain to everyone that the silence of soldiers was not indifference, callousness, or just plain forgetting. Silence is a language of remembrance; it connotes meaning. It informs a special category of remembrance all of its own.

A word or two may be in order about the different dimensions of silence which have contributed to the radical underestimate of psychological injury in the Great War. Some doctors had faith in the category, that it described something that indeed had happened to men at war. One such physician was John William Springthorpe, a tireless medical advocate of humane treatment for shell-shocked men in Australia. But they also knew that some pension officials were less open-minded. When some physicians saw a soldier who had had either a psychological injury alone, or a physical injury alongside a psychological one, then reporting the physical ailment alone would

---

4 www.bbc.co.uk/news/local/somerset/hi/people_and_places/newsid_8186000/8186376.stm
ensure that the man had a good shot at getting a pension and keeping it. For the well-being of their own patients, some doctors misreported their full condition.

And then there is the case of the psychological damage of mutilating injuries. Can anyone honestly believe that someone who had had part of his face removed by shrapnel or his genitals shot off did not also face psychological conditions of multiple kinds?

Other doctors didn’t believe in the category of shell shock at all, and preferred the term “malingering” to describe those who may have sought cover or comfort under its protective shield. Underreporting in this field arose from varying medical opinions and strategies, which had only one thing in common: they tended to understate the proportion of the wounded who suffered from psychological or neurological injury, preferring to believe that soldiers were manipulating the system to save their necks or line their pockets. And some soldiers did do precisely that.7

In short, for a cluster of reasons, the medical profession created a silent protective box, a categorical silence, around shell shock, since while war was supposed to produce physical injuries, how did it lead to invisible psychological or neurological injuries? These were another matter. Who were these purists protecting? The army, the taxpayers, the army medical services, those men who had the courage to go back up the line even when haunted by nightmares and worse, sometimes even those shell-shocked men who faced destitution unless their army physicians did some creative adaptation of their condition to the rules and regulations of the pension system.

Creative thinking operated on so many levels. There was one more level of denial too. There were soldiers who had been buried alive or who had suffered some other traumatic event and yet who felt deeply the stigma of reporting their condition. Some even denied that they had had any psychological injury at all. Self-denial (or underreporting) is a well-known category. It comes under different names – a stiff upper lip; male stoicism or other gendered poses supposedly representing the martial spirit; or just plain shame.

Consider the following case as indicating a whole world of silenced psychological injury that emerged from soldiers’ own accounts.

---

of their war. In the course of researching the narratives of heroism imbedded in Canadian regimental histories of the First World War, Janet Cavell of Carleton University came across an annotated copy of the regimental history of the 4th Canadian Mounted Rifles. Banal stuff, but what made it special were the marginalia one working-class soldier, Dick McQuade, added to the book. By comparing his marginal comments with his military service record, Cavell showed that he had totally hidden the true story of his being buried alive and shell-shocked, and built over it an entirely invented story of steady participation in the bloody combat his unit, mixed with others, had endured, and which he conspicuously had missed. Here we can see that one soldier covered up shell shock through creating a fantasy tale, with which he could live.

True enough, McQuade had been buried alive on April 20, 1916, and left the line for follow-up treatment in London. Months later he was diagnosed at long last as having “neurasthenia,” one of the many terms for shell shock. He could not have been at Sanctuary Wood, or Hill 62 near Ypres, on June 2, 1916, when Canadian troops (including his unit) took devastating casualties: a total of 626 officers and men serving out of 702 had been killed, wounded, or taken prisoner. In the margins of the regimental history, McQuade added his comments as to how he had returned from England, where he was recovering from an unspecified ailment, “right into the Somme battle,” in July 1916. He then, he said, went through Vimy ridge, Passchendaele and the last hundred days. After the Armistice he and his surviving comrades had a “Good dinner and lots of fun” and “a big time at Mons.”

All of this is fiction. McQuade left the line for unspecified headaches, and never told his doctors he had been buried alive. Instead, he prolonged his stay in hospital until after the bloody destruction of much of his unit, and then returned to France, where he amassed an undistinguished record, including a long list of days gone AWOL and other forms of indiscipline which he also chose to forget about later. His annotations are remarkable in that they clearly indicate the way the regimental history, with all its noble words, provided him with the war story he wished he had had, and through his mendacious marginalia, he himself had provided his family with his (soi-disant) real war story,

8 Janice Cavell, “In the margins: Regimental history and a veteran’s narrative of the First World War,” Book History, 11 (2008), pp. 199–219. The regimental history with McQuade’s marginal notes is in the MacOdrum Library, Carleton University, Ottawa, Canada.
which is to say, the one he wished he had had. Next to illustrations, he wrote fabulously “1st time we seen a tank,” “I used Bayonet to good advantage here,” and most striking of all, next to a photograph of Canadians somewhere near Passchendaele in October 1917, “This is me.”

If only it had been he. Then his inventions might not have been necessary. There remains a doubt as to whether McQuade believed his own lies, but no doubt that fabricating enabled him to preserve a lifelong silence about his true military history. There is a Swiss case of a similar kind, where a prize-winning novelist, Binjamin Wilkomirski, on seeing a photograph of a child Holocaust survivor, decided “This is me.” 9 Wilkomirski could not be shaken from his firm belief that he indeed was the child in the photo. We will never know, but my guess is that McQuade’s story is simpler but almost as ingenious. A man deeply shamed by shell shock and its after-effects made up an entirely different war story to account for himself not only to his family, but also to himself. An invented heroic tale was infinitely better than the truth, and the truth was that he had been shell-shocked and remained so terrified about returning to the scene of that horror that he never saw combat in the great battles of 1916–18. And then for decades, he never admitted the truth to his family or possibly even to himself. The taboo surrounding shell shock remained; perhaps all soldiers’ war stories have fictional elements in them. 10 This one has more than most, and they served a purpose— to draw a veil of silence over his own breakdown.

There is another matter related to timing relevant here. Jim McPhee was a stretcher-bearer both at Gallipoli and on the Western Front. He kept his demons at bay, until old age caught up with him. The resistance we all have embedded in mid-life, in work, in the rhythms of family life, in raising children, all work for a time, and then there is retirement, more time, more space for reflection, and for the shadows to return. This is how he put it: “We thought we managed alright, kept the awful things out of our minds, but now I’m an old man and they come out from where I hid them. Every night.” 11

10 Hynes, Soldiers’ tale; see also Tim O’Brien, “How to tell a true war story” (1990), at www.ndsu.edu/pubweb/~cinichol/CreativeWriting/323/O'BrienWarStory.pdf
It is absurd to argue that all shell-shocked men couldn’t admit what had happened to them. Rather, in the First World War, and even in the Second World War and after, to tell the truth about psychological injury in combat, and about its prevalence in the casualty lists of war, was something only some of the people did some of the time. And no one has yet explored the implications of this open secret for the history of the First World War.

The great filmmaker John Huston made the film *Let There Be Light* in 1946 for the U.S. army. It is a documentary film about the way psychologically injured men were brought back to health and a functional life. What got him into trouble was the narrator’s statement right at the beginning of the film that 20 percent of all American combat casualties in the Second World War were psychological or neurological in character. This the U.S. army could not swallow, since, they believed, it would have compromised army recruitment. They thus banned the film. It was silenced, and only came out of the box of the unsayable in 1981, when it was screened in the Cannes film festival, just one year after the American Psychiatric Association published its DSM III, or third edition of *Diagnostic and Statistical Manual of Mental Disorders*, certifying that “Posttraumatic stress disorder” was a legitimate medical syndrome, with causes, treatments, and cures.

Here is a story about silence, and the silencing of the story of shell shock (or whatever term we choose) as a central part of the experience of modern war. Many soldiers themselves hardly knew what had happened to them when they suffered particular symptoms. They looked to doctors to tell them what they had and then to cure them of whatever it was called. But what did they do if doctors didn’t believe that shell shock (however termed) was a real condition, or if doctors (following General Patton) doubted the manliness of those who suffered from it? Who knows how many simply dropped “shell shock” like a pair of shoes which didn’t fit, and put on another pair, another story which better fitted their own narrative about who they were and who they had been during the war. The distance between illness and health is by no means only located in narratives, but without a rigorous examination of

---


the full extent of psychological and neurological damage to men in uniform, the only alternative is another century of silence.

One argument more than any other has persuaded me that shell-shock casualty statistics in the First World War are in need of major revision. It is that we cannot ignore the disconnect between the level of psychological casualties reported for the First World War and those reported for later conflicts. No one would doubt that what happened on the Somme or at Verdun or at Gallipoli at times was matched in ferocity by later battles, in Normandy, Monte Cassino or during the Battle of the Bulge. And yet casualty statistics for the Second World War and for later conflicts register psychological casualties at levels between five, ten, and even twenty times higher than those in the First World War.

It is evident that we First World War historians can benefit from the greater sophistication of military medicine in general and military psychiatry in particular in the Second World War and in later conflicts. We can compare the incidence of psychological or neurological casualties as a proportion of all casualties in these later campaigns or battles and ask, is there any compelling reason why the levels reported for later wars are so much higher than those reported for the First World War? Of course there will be differences in nomenclature and taxonomies. But the gap between the estimates of the incidence of shell shock as a proportion of all casualties in the First World War and those for later wars is so vast that we must confront the possibility that something has gone wrong in the accounting of First World War losses. Radical underestimates are a form of medical and administrative silence.

In the British army, the statistics reported shortly after the final capture of Monte Cassino, in August 1944, indicated that 40–50 percent of all casualties suffered in the battle were psychological or neurological in character. Many of these men were wounded in other ways too. In the Yom Kippur war of 1973, a nasty shock if ever there was one, we know that 50 percent of all casualties were found to be psychological in character. As Jones and Wessely state, “Today there is a consensus that a constant relationship exists between the incidence of the total killed and wounded and the number of psychiatric casualties.”¹⁴ That is, the bloodier and more intense the battle, the higher the psychiatric casualties will be. The measure we are trying to refine – proportion of all

---

losses which are neurological or psychological in character – is thus a function of the intensity and deadliness of firepower. The best practice medical history today requires us to bring up to date existing and radically flawed underestimates of the incidence of shell shock in the First World War.

There is a second variable which increases the proportion of psychological casualties within all casualties: the improvement in medical and surgical care, which kept many men alive from 1939 on who would have died in 1914–18. The fear of death, a cause of profound anxiety in any war, might have been higher in the Great War, when survival rates were lower than those in the wounded in the 1940s, since those injured in the Second World War had a higher chance of surviving their injuries. And yet for many, survival meant another period of combat, and the stress and fear of death and dismemberment that went with it. Let us be cautious, then, and conclude that the terrifying firepower of the two world wars and of later conflicts yielded roughly comparable levels of psychiatric battle casualties. It is likely that more soldiers survived to be diagnosed with various infirmities, including psychological ones, after 1939, though this difference will only modestly affect our estimates.

To start this reconsideration of the incidence of shell shock during the Great War, I take a limited case. Tables 7.1 and 7.2 provide data on casualty figures for Allied combatants in just one theater of operations: the Gallipoli campaign of 1915–16. As we can see in Table 7.1, the Allies suffered 46,000 killed and about 86,000 men wounded in the campaign. There are scattered figures that refer only to British forces of 3,100 cases of shell shock or mental illness. Once again, adopting the 1922 estimate in official British publications, the incidence of shell shock, however defined, was between 2 and 4 percent of all casualties. This figure calculates as between 1,700 and 3,500 cases. The mid-point is 2,550.

15 *Statistics of the Military Effort of the British Empire in the War* (London: HMSO, 1922), p. 237. The Ministry of Pensions treated 63,296 “neurological cases.” Total wounded in British forces was 1,662,625; thus 3.7 percent of all British casualties were deemed neurological by the Ministry of Pensions. Joanna Bourke notes that the British army dealt with 80,000 cases of shell shock during the war. That would present an estimate of 4.8 percent of all casualties, a bit above the boundary of other estimates of between 2 and 4 percent. “Shell shock during World War One,” BBC Radio, October 3, 2011, www.bbc.co.uk/history/worldwars/wwone/shell shock absorbing.html
Table 7.1. *Allied casualties at Gallipoli, 1915–16*

<table>
<thead>
<tr>
<th></th>
<th>Killed</th>
<th>Wounded</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>British</td>
<td>26,054</td>
<td>44,721</td>
<td>70,775</td>
</tr>
<tr>
<td>French</td>
<td>8,000</td>
<td>15,000</td>
<td>23,000</td>
</tr>
<tr>
<td>Australia</td>
<td>7,825</td>
<td>17,900</td>
<td>25,725</td>
</tr>
<tr>
<td>New Zealand</td>
<td>2,445</td>
<td>4,752</td>
<td>7,197</td>
</tr>
<tr>
<td>India</td>
<td>1,682</td>
<td>3,796</td>
<td>5,478</td>
</tr>
<tr>
<td>Totals</td>
<td>46,006</td>
<td>86,169</td>
<td>132,175</td>
</tr>
</tbody>
</table>

* Thanks are due to Robin Prior for providing me with these figures. Needless to say, there are many other estimates of varying degrees of reliability.

** In addition the *Statistics of the Military effort of the British empire* lists about 2,000 non-battle deaths and 142,000 sick, but these figures are for British troops only.

Table 7.2. *Estimates of the incidence of shell shock, under different assumptions, at Gallipoli, 1915–16, and throughout the 1914–18 war*

<table>
<thead>
<tr>
<th></th>
<th>Wounded</th>
<th>2% Shell Shocked</th>
<th>10%</th>
<th>20%</th>
<th>40%</th>
</tr>
</thead>
<tbody>
<tr>
<td>British</td>
<td>44,721</td>
<td>894</td>
<td>4,472</td>
<td>8,944</td>
<td>1,788</td>
</tr>
<tr>
<td>French</td>
<td>15,000</td>
<td>300</td>
<td>1,500</td>
<td>3,000</td>
<td>6,000</td>
</tr>
<tr>
<td>Australia</td>
<td>17,900</td>
<td>358</td>
<td>1,790</td>
<td>3,580</td>
<td>7,160</td>
</tr>
<tr>
<td>New Zealand</td>
<td>4,752</td>
<td>95</td>
<td>475</td>
<td>950</td>
<td>1,900</td>
</tr>
<tr>
<td>India</td>
<td>3,796</td>
<td>76</td>
<td>380</td>
<td>760</td>
<td>1,520</td>
</tr>
<tr>
<td>Totals</td>
<td>86,169</td>
<td>1,723</td>
<td>8,617</td>
<td>17,234</td>
<td>34,468</td>
</tr>
<tr>
<td>Total for all</td>
<td>21,219,152</td>
<td>424,384</td>
<td>2,122,000</td>
<td>4,244,000</td>
<td>8,488,000</td>
</tr>
</tbody>
</table>


* There were much lower estimates as well, especially among those produced by the Ministry of Pensions; consequently, the assumption in the postwar years was that between 2 and 4 percent of all British casualties were psychological, psychiatric, or neurological in character. See Peter Leese, “Problems returning home: The British psychological casualties of the Great War,” *Historical Journal*, 40, 4 (December 1997), pp. 1055–67. See Lord Southborough, “Shell-shock,” *The Times*, September 2, 1922, p. 5, for a discussion of the Southborough report’s estimates and dismissal of the term “shell shock.” For a new discussion, see Carol Alexander, “The shock of war,” *Smithsonian Magazine* (Summer 2010), www.smithsonianmag.com/history/the-shock-of-war-55376701/?no-ist=&c=y&page=3
If the high levels of psychological casualties as a proportion of all casualties applied, say that of Monte Cassino or the 1973 Arab-Israeli War on the Israeli side, then there were more than ten times that number, or nearly 35,000 men, who suffered from injuries of a psychological or neurological kind in the Gallipoli campaign. It is evident that we are dealing with nontrivial errors. A diagnostic error of 35 percent in accurately attributing causes of disability would raise eyebrows or hackles in medical and administrative circles today. Though we can understand how these underestimates arose, why should we tolerate them today?

My conclusion is simple: shell shock was not a marginal, but rather a common, at times a central, part of the experience of the wounded at Gallipoli, as it was at similarly lethal theaters of military operations in the two world wars and after. While we cannot offer a precise estimate, we can say that the problem of underrepresentation of shell shock in the official record of the toll the war took on Australian and all other soldiers is serious and substantial.

In C. E. W. Bean’s volume on the Gallipoli campaign in the official history of the Australian Imperial Force, there is but one reference to shell shock among soldiers in the 7th and 8th Battalions near Steele’s Post in mid July 1915. One reason for this silence is the division within the medical profession about shell shock, and how it had to be treated. This was true in all medical services among all combatant countries.

Medical opinion in both Britain and Australia was divided over what to do about shell shock. Virtually everyone, including the man who first coined the phrase, C. S. Myers, disliked the term, since it grouped together conditions of wildly different origins. But “shell shock” was such a brilliant metaphor for the terror of industrialized warfare that it could not be suppressed.

There were differences, too, in approaches to treatment. One of the most thoughtful reflections on these problems was authored by Grafton Elliot Smith, an Australian physician, distinguished anatomist, and anthropologist, then dean of the faculty of medicine of the

---


University of Manchester and a member of the General Medical Council in England. In 1916, he published an article on “Shock and the Soldier” in the *Lancet*, which showed deep sensitivity to the complexity of the subject and its implications for maintaining “the efficiency of the combatant forces.” He was not immune, though, to the prejudices of his times. While physically unfit people were being rejected by the thousands by the army, no effort had been made to exclude what Elliot Smith called the “mental weakling,” who broke down in combat to the detriment of his entire unit. Such men were troublesome in mixed wards, and rarely got the specialist treatment they deserved. Consequently, Elliot Smith and his assistant T. H. Pear sat down in late 1915 to survey the French and German literature and then to make recommendations for the treatment of this class of disabled men. He found that the initial interview with the patient frequently got nowhere; instead, Elliot Smith noted, a scrutiny of the patient’s dreams frequently got to the heart of the matter, which was the terror associated by the patient with various forms of combat or the anticipation of combat. Indeed, both Elliot Smith and Pear were open to the notion that soldiers who remembered a disturbing event actually relived or reinstated the emotion associated with it. However painful, it was better for doctor and patient to uncover these troubling emotions together than to bury them; no silence here. His view was that these men were not insane, and many had shown their courage time and again. They had just reached their limit. Some conspicuously brave men survived combat and returned to the line, only to break down after they were relieved. It was their fear of collapse the next time which had overwhelmed them. Those who doubted that shell shock existed at all should consider these men. They showed that for many men, “the real trauma is psychical, not physical.”

Elliot Smith went further and rejected a strategy of isolating these patients. In contrast, Alfred Walter Campbell, who served in the 2nd Australian General Hospital in Cairo, later worked at the Military


Hospital, Randwick, and advised the Department of Repatriation, took precisely the opposite view. The official historian of Australian medical services during the war, A. G. Butler, sided with Campbell. In his volume on Australian medical care at Gallipoli, he cited Campbell’s view published in the *Medical Journal of Australia* in April 1916 that doctors must try to avoid “psychic contagion.” Those suffering from mental disorders must be isolated from each other and receive “no sympathy” leading them, in his view, to turn a temporary disability into a permanent or long-term one. Such men, Dr. Campbell observed, had to be “guarded with the utmost tact and circumspection against themselves and their friends and a grateful country.” Otherwise, they might not recover.

In a later chapter of his medical history, Butler made it clear that he understood the plight of these men. He refers to the relaxation of Australian insanity laws, permitting shell-shocked men after the war to avoid the stigma associated with “lunacy.” And yet he recognized that “no special treatment” was made for such men who suffered from conditions grouped “under the unfortunate generic designation of ‘shell shock’, a term which had given to the Great War its most characteristic mental feature.”

Butler recognized too that conditions on Gallipoli itself insured that there would be a substantial number of men suffering from shell shock. Being pinned down on the beaches and first two ridges facing Anzac Cove, or at Cape Helles, or later at Suvla Bay, meant that most men had no respite from the strain of sniping, shellfire, and combat. The Western Front was deep enough to permit evacuation; men in Allied forces on Gallipoli were without this option by land, and evacuation by sea was limited mainly to those physically injured. Medical officers on the ground had to make decisions about how to handle individual cases without clear diagnostic categories to use. Did self-inflicted wounds mean that a man was a coward or that he had simply been pushed too far? Any full understanding of the acute effects of extended exposure to combat was unavailable at the time. Neither was the study of epidemiology in a state which could be of help in 1915.

21 Campbell, “Remarks on some neuroses and psychoses in war.”
23 Ibid., citing Campbell, “Remarks on some neuroses and psychoses in war,” pp. 319ff.
24 Ibid., part 1, p. 541.
The same is true, some have noted, a century later, further complicating or limiting effective postcombat care. Finally, the notion of delayed onset – the sense that combat stress could have effects which appear only years later – was beyond the medical paradigm of the early twentieth century. In effect, the underestimation of psychological casualties on Gallipoli (as elsewhere) was overdetermined.25

In sum, medical opinion disliked the term “shell shock,” since it was much too imprecise,26 but recognized that there was a cluster of disabilities of a psychological or neurological kind which had appeared during the war. How to treat these disabled men remained a matter of dispute, both during and after the war. Given this wide divergence of medical opinion, it was inevitable that many men were neither diagnosed nor treated for these disabilities at the time or in later years.

So far, my focus has been on published statistics which radically underestimate the incidence of shell shock in the First World War. These faulty calculations arose from many sources. Among them was a calculated silence, or a decision, taken silently, to look away from this form of war-related disability and accept what are almost certainly useless official statistics about its incidence. Now let us consider how our understanding of the war and of its aftermath is affected by the systematic occlusion of the condition known as shell shock. Here we confront both short-term and long-term suffering, which may actually have festered or worsened since no one wanted to talk about it. The silence surrounding what had happened to these men and their families, and the silence into which many of them retreated, added immeasurably to their fate.

Case Studies

Here we turn from aggregates to individuals. What do we know not about the amplitude or the incidence of shell shock, but about what it did to those who suffered from it? In what follows, I restrict my discussion to one campaign, simply to suggest where research in future needs


26 Butler, Official History, part 1, p. 417, n. 28.
to go. I will describe a number of instances in which men broke down, and then died of their condition. I then turn to men damaged during their service at Gallipoli who either spoke only indirectly about their condition, or withdrew from the spoken word. Some used physical language, including the language of violence, to express something about their fate; others, walled up, used no language at all. And still others, by virtue of their impenetrable silences, left traces which their children spoke for them. I shall analyze this last case through the poetry of the British poet laureate Ted Hughes.

Lieutenant Colonel W. G. Patterson was Assistant Adjutant and Quartermaster General of the 1st Australian Division. In a photo taken by Charles Bean in Egypt, he is third from the left in the front row, in a formal portrait of the staff officers of the division (Illus. 7.1). 27 A member of Melbourne’s elite Athenaeum Club, he had served in the army for twenty-six years. On the day of the landings in Gallipoli, Patterson had control over the giant chessboard of supplies and transport in the landing areas. He went mad at the worst possible time. Col. John Gellibrand, Deputy Adjutant, and Col. E. William Smith, Assistant Provost Marshal, were so troubled by his bizarre behavior that they placed him under guard. He had been seen wandering around looking for General Bridges, whom he was intent on killing. What preceded this breakdown we do not know. He was evacuated to Alexandria, and told a medical board that he suffered from tremors and an inability to speak. He said he had had “a sudden nervous breakdown on 25th–26th 1915, from which he says that he recovered.” The doctors did not agree with his self-prognosis. He was diagnosed as still suffering from “neurasthenia” and was invalided back to Australia on July 3, 1915, and died a year later, on May 19, 1916, aged 53. 28 The cause of death was neurasthenia. Whether he had any other neurological or medical problems during his last months, is not disclosed in the records.

In Albany, Western Australia, there is an Avenue of Honor of trees planted in 1921 in honor of the men who died in the war. One of

27 www.awm.gov.au/collection/G01606/, photo taken by Charles Bean. See also www.awm.gov.au/collection/A00712A/?image=1#display-image, for another image of Patterson, fourth from the left in the front row. Bean is the hatless man on the left in the back row.

28 http://vic.ww1anzac.com/pa.html, WWI Pictorial Honour Roll of Victorians, p. 6. I am grateful to Bruce Scates for providing me with a copy of his Medical Board of June 19, 1915.
them was Royce Baesjou. He had joined the 28th Battalion and had fought at Gallipoli. He was invalided out after heavy bombardment on Russell’s Top. The diagnosis was “shell shock” (Illus. 7.2).

Baesjou had the bad fortune to be hit by a bombardment a second time, after recovery and redeployment in France. This time while manning a machine gun, he got a direct hit which blew him yards away from his gun emplacement. It also left him senseless. A report of this incident in the *Albany Advertiser* of August 12, 1916 cited him as saying “My nerves are shaky and my eyes not too good,” but he was sure rest would bring him back to battle readiness.

Baesjou never recovered from his wounds. He died of a cerebral hemorrhage at the 8th Australian General Hospital in Fremantle on May 19, 1918. Here is an incident where the initial understandings of shell shock seemed to have been confirmed. From the time the term was invented in 1915, doctors took shell shock to mean a serious concussion, one which followed a direct hit by artillery or similar explosion hurling the soldier’s body in the air. This diagnosis pointed to a physical insult or injury which had neurological or psychological consequences. Doctors had little trouble with this sequence of events, since unseen damage in the inner ear or the brain was physiological in character nonetheless. It is also possible that his psychological condition could have led to hypertension, which in turn led to his stroke. We will never know.

It was not surprising, therefore, that Baesjou’s condition was treated like all other physical injuries. Nor is it surprising that his family put on the memorial tree planted in his memory, and similarly on his tombstone in the Fremantle cemetery the following epitaph:

Died from Shell Shock  
Base Hospital Fremantle  
May 19 1918

Thomas Dowell was among the first contingent of Anzac troops who landed at Gallipoli. He fought through the first months of the

---

29 A brief (digital) narrative of Baesjou’s story can be found on the 100 Stories website, http://future.arts.monash.edu/onehundredstories/. The full text appears in Bruce Scates, Rebecca Wheatley, and Laura James, *A history of the First World War in 100 Stories* (Melbourne: Penguin, 2015), p. 82. I am grateful for the authors’ permission to use these stories, which they have unearthed from a wide variety of sources.

30 I am grateful to Dr. Alexander McFarlane, for his suggestion on this point.
campaign, and took part in the night attack in August towards the summit of Sari Bair. His unit got lost, and subsequently was exposed to flanking fire. Dowell was almost killed, but was pushed to safety during a Turkish attack. His fall had broken his leg, leaving him unable to move for hours. The following day, he was captured, and put on a boat to Constantinople. His wound had developed an abscess. On board, there was little medication and morphine was a rarity. Thirty years later, this is how he described his operation:

Four Turks put me on the table and held me while the Doctor used his knife; after each cut he would ask “Good, Australia” then go on some more and do the same again ... I was again held down while the doctor opened the abscess and cut it out then the bone was scrubbed with a wire brush.³¹

As with many other men, the traumatic incidents were not over when incarceration began. Dowell was transferred to a prison camp at Afion Karahissar (Illus. 7.3). Hunger was constant, alleviated occasionally by Red Cross parcels. Discipline was hard, backed up by the images of hanged criminals on display in the camp. Fear festered, along with loneliness and boredom.

Dowell was freed when the war came to an end. He returned to Australia in December 1918. One decisive step he took was not to apply for a pension. He wanted to live on his own. And yet his war service had left its marks on him. Here is a significant silence in Dowell’s life, one with consequences. Later he wrote that “I feel like a spring wound up, and I can’t unwind.” Nightmares recurred, along with nerves and even hallucinations. Twenty years later he claimed: “Even at this distant time, I can mentally see the whole scene as clearly as possible.”³² He spoke of his fears of disaster of an unspecified nature.

His wife had no doubt that his mental state was due to his incarceration in Turkey. He was, she said,

Subject to extreme mental aggravation by the Turks; and strain of being surrounded by wounded and dead; cut off from all his own ...  

³¹ Appellant’s statement, September 16, 1935. Thomas Dowell repatriation file, National Archives of Australia, B73, M41646, as cited in Scates et al., 100 stories, p. 123.
³² Letter dated March 12, 1935, Dowell to Repatriation Department, NAA, B73, M41646.
unable to understand speech or custom without difficulty, nor they him, his increased suffering from neglect and unskilful [sic] treat-
ment of the war wounds . . . His body . . . was covered with scurf and
large sores, jaundice . . . to accompany the nervous trouble.

By “nervous trouble,” she meant violent moods, leading to threatening behavior to farm animals and even to his family. He built explosives to “bomb the place.” Dowell’s wife never left the children alone with him. The nervous state he had suffered in Turkish prisons was still with him.

As in many other cases, the difficulty was to identify what was war-related in this sad state of affairs. The Repatriation Department saw his case for assistance as “doubtful,” and his need for medical care “transient.”33 Nevertheless, twenty years after Gallipoli, the Reparations Department granted him a partial pension. Can we read between the lines that the partial pension referred to recognition of his physical injury at Gallipoli, and not the psychological troubles which plagued him and his family for decades?

By the time this grudging recognition of his war-related difficulties came, he was a physical and nervous wreck. His leg never healed, and for days on end he would lapse into silence. Can we separate that silence from his sense of the injustice of his treatment, both during and after the war? To be sure, both Dowell and his wife spoke time and again of his plight, and railed against the bureaucratic obstacles he faced. What rendered his family speechless was official doubt about the long-term psychological consequences to a soldier of his having faced combat, having been injured, having been incarcerated in an Ottoman Turkish prisoner-of-war camp when the Turks were running out of food, and then, on his return to Australia, finding it virtually impossible to live a “normal” life, whatever that might have been. Yes, other soldiers faced the same or worse, and went back intact to the world they had left behind. They were the lucky ones. The question is, why is there not more place in the narrative of Gallipoli for both sides of this story, the ones which unfolded successfully over the long term, and the ones which didn’t?34

Dowell’s case raises another facet of the long road medical science had to travel before gaining an understanding of the psychological effects of incarceration in prisoner-of-war camps. To be sure,

33 Dr. Godfrey to Repatriation Department, November 26, 1934, NAA, B73, M41646.
34 See Scates et al., 100 stories, for further details; for the online course related to the 100 stories, see http://future.arts.monash.edu/onehundredstories/
Dowell’s injury was traumatic, and his imprisonment brutal. But there is now an extensive literature on the long-term effects of military incarceration on the mental health of former prisoners-of-war which offers a different reading to parts of Thomas Dowell’s enduring history of “nervous trouble.” No one used the term “posttraumatic stress disorder” (PTSD) at the time; in considering the story of Thomas Dowell and many others, perhaps it is time to do so now.

The difference between shell shock, as understood in the period of the Great War, and PTSD, is that between those manifesting symptoms of psychological injury immediately or shortly after combat, injury, or incarceration, and those whose conditions develop years, and sometimes decades, after an apparently successful return to civilian life after war. We shall have more to say about this latter set of conditions below, but it is now clear that a loss of language capacity, or an inability to put into words the stresses veterans faced, is a feature of the late-onset illness not recognized at the time of Thomas Dowell’s troubled life. For him, angry, frustrated silences may not have been a choice, but rather a symptom of his condition.35

So far I have discussed three instances of shell shock. Two had immediate and fatal consequences. The third case was more representative, reflecting the story of a man whose wartime troubles, physical and psychological, left traces which lasted a lifetime. Due to underreporting, we do not have reliable statistics about how many men recovered from shell shock. And yet the scattered evidence available suggests that most did not die of the condition, and many recovered rapidly. Others, though, were like living time-bombs, and exploded in later years, with devastating consequences for themselves and for their families.

Instead of further cataloging these sad life histories, I want to probe more deeply the long-term legacies both of shell shock and of silences surrounding it. I want to turn to the well-documented case of a soldier devastated by his time at Gallipoli and at Ypres, a man whose son has left us much evidence as to the silence of the survivors and the transmission of that silence to the generation born after the war.

Here it is important to distinguish between two kinds of silence. The official, medical, and administrative underrecognition of shell

shock constitutes what I term a “categorical silence,” a willful blindness to including in the number of men disabled by war those who suffered from psychological or neurological conditions. A second kind of silence was communicative. That is, those suffering from the condition and its sequelae either were unable or unwilling to speak about it. Their silence was heavy with meaning. One way in which we can hear the reverberations of these silences is to examine the writing of one soldier’s son, the British poet Ted Hughes.

Ted Hughes was born on August 17, 1930, in West Yorkshire. His father William served in the Lancashire Fusiliers on Gallipoli, and was one of the few local men who came back alive and intact. When the 1st Battalion of the 5th Lancashire Fusiliers transferred to HMS Eurylus at 6 p.m. on 24 April 24, 1915 at Tenedos to prepare to land at Gallipoli, their strength was 25 officers and 913 other ranks. At 6 p.m. on April 26 it was 15 officers and 411 other ranks. Over 500 men, or half the battalion, had been killed or wounded in one day. And that was just the beginning of the wastage. It is difficult to be sure if the figure William Hughes gave of 17 survivors of his unit who came back from Gallipoli is accurate, but there is no doubt that the Battalion that landed at Gallipoli was torn to pieces, and remained a hollow shell, filled with new drafts from anywhere and everywhere, by the time they evacuated the peninsula in January 1916. Without this watering down of the regional composition of infantry regiments, they would have simply vanished. Instead, they lived on, thereby upholding local traditions hardly any of the new men in them shared.

William Hughes and his unit next went to the Ypres salient, where once again he was in the midst of heavy fighting. He lived through some of the worst combat conditions in the war, and was awarded the Distinguished Conduct Medal for helping evacuate wounded to casualty clearing stations. He even claimed to have had a “lucky war.” One tale which dated from that period was about a ration book kept in his breast pocket, which apparently saved his life. It stopped a piece of shrapnel, which hit him, but did no further damage. The ration book had pride of place on the mantelpiece for decades thereafter.36 This kind of story was common in the war. Mustafa Kemal Atatürk told the same story, though the lucky object which stopped a piece of shrapnel was his pocket watch.

As he was growing up, young Ted Hughes found out soon enough that the price of his father’s survival was high. Ted heard about his father’s war from others. While some local men might regale their families with tales of the war, William Hughes said nothing about it at all. In “For the duration,” written in the 1980s, ten years after his father’s death, his son recaptured the puzzlement of a child faced with the immovable face of a silent father, damaged in the war. War talk like artillery shells approached William, threatening to bring back the horrors, details of which his young son Ted had heard from others, but never from his father. He knew that a shell burst had lifted his father heavenward, and then had deposited him back on the earth, shaken, injured, but alive. But what was worse was his father’s silence. He never uttered a word to his son about his ordeal.

Perhaps his father did not want to terrify his son, but his silence did precisely that. His son felt too ashamed to ask, of what, he never knew, though peering at his father’s suffering could easily have accounted for it. His father’s silence made the child pose the question why his father’s war was unspeakable, beyond the ordinary language of an ordinary family. No, the child looked at his father’s still face, and his cigarette, and remained rooted to the spot. Numbness made deeper when this paternal silence was broken later, at night, not by words but by shouts emerging from his father’s dreams, in which the war went on and on as if his father could not find a way to protect his family, transported in dream-time to the trenches.

Survivor’s guilt with a vengeance: that was part of William Hughes’s burden. But his son too had his nightmares; among them was his sense of clinging to his shell-shocked and wordless father. As his son saw it in his poetry, trapped in no-man’s-land, still searching for his damaged son, William Hughes staggered on clasping him silently to his body for the rest of their lives. This is a dark motif evident

37 Ted Hughes, “For the duration,” in Collected poems, ed. Paul Keegan (London: Faber & Faber, 2003), pp. 760–61. Having applied for, but not received, permission from Faber & Faber to cite Ted Hughes’ poetry, I have described the poems, but urge readers to return to the original texts. This problem adds another level of meaning to the title of this book; War Beyond Words.

38 Ibid., p. 761.
throughout Ted Hughes’s long life as a poet, from Yorkshire outsider to Poet Laureate.

At times the references to his father’s internalized war, raging silently within him for decades after 1918, were direct, at times transformed into verse about the sea and the coast at Holderness on May Day. There stretched the North Sea, leading to the Western Front and beyond to Gallipoli. Beneath the sea lay the shouts of those torn to pieces in battle.39

In “Ghost Crabs,” he follows the creatures coming ashore, uncannily resembling the helmets of Tommies in the trenches, murderously climbing all over each other. These crabs return to England like ghosts, who dominate our lives just as we never escape their deaths. They are, Hughes concludes, like Lear, playthings to God.40 Here are the words of a son living his father’s near death and sharing his not complete survival. This poetic merging of the violence of crabs and birds and other living things with the violence of men in war is one of Ted Hughes’s most striking themes.

Think back for a moment to the fictional identification Dick McQuade sought with Canadian soldiers at Passchendaele he never knew at a battle he never fought, and now consider the force of Ted Hughes’s evocation of one of his father’s photos in his poem of the lost generation of the Great War, “Six Young Men.” Six months after the photo was taken, all were dead, in Ted Hughes’s words, holding the worst, their own deaths beyond all their hopes. This is the diametrical opposite of McQuade’s prevarication, since the silence of the photo and the silencing of these young voices were essential parts of the story Ted fashioned out of his father’s silences on the Great War. In “Six Young Men,” Ted Hughes is speaking both of them and for them; he did the same when meditating about his father’s refusal to talk about the war.

The eerie presence of his father’s silence in Ted Hughes’s poems is part of what gives them their power. In the first part of his poem “Out,” entitled “Dream Time,” Hughes tells of seeing his father rendered speechless, just sitting in his home, recovering from a war which was, for him, beyond words. While his bodily wounds healed, he continued hearing the voices of the past, and remained, in a profound sense, chained to the dead, while his son Ted looked on, puzzled and troubled by it all.

39 Ibid. 40 Ibid., pp. 149–50.
William Hughes’s silence about the horrors he lived through was the opposite of forgetting; silence was a kind of brooding acknowledgment of unbearable memories and deeply hidden injuries. Seeing them without hearing his father uttering a word is what made his son “his luckless double,” doomed to return to the scene of the crime in perpetuity.

In the second, untitled, part of the poem, Hughes meditates on a dead soldier put back together somehow returning to life hesitantly, walking in fits and starts like a baby with the face of a very tired man. Could this be a reference to the mingling of father and son, the binding together of babe and clerk, the reassembly of a half-alive father, tied to the son who tried to understand his silences?

In “Remembrance Day,” the third part of the poem, Hughes develops his identification with his father. No easy commemoration rituals for either of them. The poet damns the poppy, the symbol of so much suffering, and of so many unshakable memories from which no one escaped. Then he brought his mother into this silent landscape of remembrance. These ghosts, the poet saw too, also haunted his mother. There was no room for poppies in a home where survival was mocked by dreadful, unspoken and yet terribly ubiquitous memories of war.41

Growing up in the presence of a man shell-shocked at Gallipoli, then again nearly killed at Ypres, Ted Hughes was one of an unnumbered population of men and women who came of age in the shadow both of the Great War and of the silent generation of veterans it left behind.42 William Hughes was never diagnosed as shell-shocked. He is one of the millions of men throughout the world whose disabilities were hidden and unacknowledged officially. Their families dealt with their injuries as best as they could. And his son was exceptional in finding a way to break the silence, to register the suffering in words his father never uttered.

This personal and silent identification of father and son has recently been challenged by Ted’s sister Olwyn. Theirs was a tempestuous relationship, and her acting as literary executor for Sylvia Plath raised another level of family secrets and family silences to public view. Olwyn claimed that her father did indeed tell Ted and her of his war experiences, but that Ted had no memory of these

conversations. As in many family histories, both versions may be true or shadings of the truth. What matters for our purposes is that Ted heard his father’s silences and turned them into poetry. Instead of choosing between siblings, the best way to handle such delicate differences in remembrance is to let Ted Hughes speak for himself (Illus. 7.4).43

Ted Hughes’s poetry moves us to ponder two unanswerable questions. The first is, how many other men were like his father, trapped in a terror of the trenches all of their own, unrecognized psychological casualties of the Great War? The second is, how many families, how many wives and children, were marked indelibly by these silences, these inner scars of combat? Michael Roper has begun a study of the transmission of war narratives, and the emotions attached to them, among families of First World War soldiers. The results of this research should throw considerable light on the darker corners of family life in the aftermath of the Great War.44

Geoffrey Moorhouse’s close study of Bury, a military garrison town, and the shadows cast over it by Gallipoli,45 reinforces the view that the underestimation of British casualties of all kinds, including psychological ones, was a general phenomenon. The 1st Battalion of the Royal Lancashire Fusiliers, based in Bury, won six Victoria Crosses on the first day of the landing at W beach at Cape Helles on April 25, 1915. They were withdrawn from Gallipoli and served alongside the 2nd Battalion on the Western Front. They fought over the difficult terrain of Beaumont Hamel on the Somme. One of their number was the author J. R. R. Tolkien.

The unit’s war service was heroic by any measure. Postwar commemoration in the town has kept that story alive for a century. And yet, as Moorhouse shows, this narrative occluded another much darker story, one of suicides and criminal acts committed by damaged men, whose misery had no place in the collective memory of the town or the regiment. Indeed, the reluctance of young men from Bury to enlist in

43 Jonathan Bate, _Ted Hughes: An unauthorized biography_ (London: HarperCollins, 2015), pp. 33, 41. Olwyn Hughes withdrew the family’s “authorization” of this biography. The quarrels besetting this unfortunate family are best left outside any account of Ted Hughes and his father.
44 For information on Roper’s project, “The Generation Between: Growing up in the aftermath of war, Britain 1918–1939,” see www.essex.ac.uk/sociology/staff/profile.aspx?ID=138
the Lancashire Fusiliers in the Second World War points to stories and silences exchanged in pubs or homes about just how bad was the aftermath of the Great War in this one town.46

These additional references to widespread trauma among soldiers reinforce my plea that we stop underestimating both the number and the significance of the hidden story of shell shock in the Great War. Unacknowledged by doctors, bureaucrats, friends, even perhaps at times by themselves, an unspecified, but a very large number of men never overcame fully the psychological or neurological damage they sustained in the war. The women who cared for them on their return knew the truth; it is time we listened to them too.47 In the interwar years and after, these women knew all too well how some men retreated into the defensive redoubt of silence, never to emerge again. When the talk turned to war, they turned to the wall. Now, a century later, it is surely the right time to make audible and legible what these veterans did not say. Let us not ignore their silences, since through silence they spoke deeply and movingly about the consequences of a war we still barely know today.

William Hughes died in 1981. His son Ted died in 1998, having served as Poet Laureate for fourteen years. By then many, though by no means all, of the silences surrounding shell shock and about the men who endured it during and after the Great War had been broken. In part this was a function of a sea change in many countries leading to public recognition of the psychological damage suffered by both civilians and soldiers in wartime, especially during the Second World War and in the Holocaust.

In addition, medical opinion itself shifted over time in many different countries. In the immediate aftermath of the Vietnam War, the American Psychiatric Association, in its Diagnostic and Statistical Manual of Mental Disorders of 1980 (DSM III), recognized “Posttraumatic stress disorder” as a legitimate medical syndrome, with causes, characteristics, and regimes of care.48 Central participants in the five-year period preparation of DSM III recount how difficult it

46 I am grateful to Adrian Gregory for bringing this reference to my attention.
47 Scates et al., 100 stories; Marina Larssen, Shattered Anzacs: Living with the scars of war (Sydney: University of New South Wales Press, 2009).
was for them to persuade colleagues in the late 1970s that mental disorders were medical. Through a series of over a hundred field trials, the authors made revisions to their protocols reflecting actual medical treatment of mentally ill men. Finally, the category Post Traumatic Stress Disorder was specified. It was defined in this way:

In this disorder, sometimes referred to as Traumatic Neurosis, symptoms of re-experiencing stressful events, numbness toward and reduced involvement with the external world, and other affective, physiological and cognitive symptoms develop after a psychologically traumatic event that is outside the range of usual human experience.49

The positive acceptance of DSM-III in the United States and elsewhere, made it easier for mentally ill men to get treatment and file for pensions in the same way as their physically injured comrades. In the aftermath of the 1973 war, Israel adopted the same criteria as the United States in the aftermath of the Vietnam War.50

In many countries from the 1980s on, what I have termed a categorical silence, meaning an administrative reluctance or refusal to accept as legitimate some war-related mental disabilities, had diminished, and yet the social stigma attached to mental illness among soldiers endured. Older notions of masculinity, courage, and stoicism were difficult to square with a recognition that all soldiers had their breaking points, psychologically as much as physically.

Over time, though, the cumulative effect of publicly reported cases of soldiers’ breakdowns, all too frequently with attendant violence to themselves or to their families, was to reduce the silence surrounding the need to help those suffering from PTSD.51 In the period of professional rather than mass armies, the numbers in uniform declined, and so did the cost of treating those who needed care for mental illness. Better psychological screening on entry into the service helped reduce the number of such vulnerable men in the armed services. By the last decades of the twentieth century, there was a consensus that however positively motivated, however brave, men in combat will break down,

49 Ibid., p. 159. 50 I am grateful to Emmanuel Sivan for his advice on this point. 51 For a first-person “biography of PTSD,” see David J. Morris, The evil hours. A biography of post-traumatic stress disorder (Boston: Houghton Mifflin Harcourt, 2015). Note that the title comes from the memoirs of Siegfried Sassoon.
either immediately or over time. This was no reflection on them; the risk of mental injury was simply built into war.

This normative change was significant, though, like other similar shifts in opinion, it was incomplete. Many people refused to be guided by the new tolerance of mental illness in the military. Still, by the time of the wars in Iraq and Afghanistan, the taboo against even mentioning this subject was gone. The volume of publications, fictional and nonfictional alike, on the topic became an avalanche. Film and television dramatized (and overdramatized) PTSD among soldiers, and among other civilians who suffered the after-effects of extreme violence.

The terrifying silences of Ted Hughes’s childhood still recurred within some soldiers’ families, but now there were many groups within civil society willing and able to help. There are organizations like the British PTSD Resolution which from 2010 offered what they term a “resolution network” to help veterans recover from symptoms.\(^{52}\) In the United States, a veterans’ support organization, DAV, claimed in 2015 that they were there to help the estimated nearly 50 percent of returning American soldiers diagnosed with PTSD.\(^ {53}\) “Soldier’s best friend” even provides American veterans with service or therapeutic companion dogs to help the men rebuild their sense of trust.\(^ {54}\) A parallel group working in Australia is entitled Picking up the Peaces.\(^ {55}\) There are dozens of such associations around the world which operate on the assumption that combat puts men’s minds as well as their bodies at risk.

Yet, there is work still to be done to persuade ex-soldiers to seek psychiatric help when they need it. One British organization working with veterans, the Mental Health Foundation, reported that “only half of those ex-soldiers suffering from mental health problems sought help from the NHS [National Health Service], and those that did were rarely referred to specialist mental health services.”\(^ {56}\) What I have termed “communicative silence,” the silence of soldiers carrying the weight of war with them, dies hard. All too many men and women who have

\(^{52}\) www.ptsdresolution.org/index.php
\(^{53}\) https://secure3.convio.net/dav/site/Donation2;jsessionid=00000000.app315a?df_id=10800&10800.donation=formentNONCE_TOKEN=0F94CoF38CBD5FAD25Do9E9392BCC55A&gclid=CKnJu6iymcgCFVUTHwoduywL3g
\(^{54}\) http://soldiersbestfriend.org/?gclid=CMOd991lycgCFdcZGQod7NMKbQ
\(^{55}\) www.pickingupthepeaces.org.au/
\(^{56}\) Mental Health Foundation, www.mentalhealth.org.uk/help-information/mental-health-a-z/a/armed-forces/
served still refuse to talk about their depression or alcohol and drug abuse as symptoms of a war-related illness. Many of their children follow in the footsteps of Ted Hughes, and carry their fathers’ or mothers’ injuries with them. They have more help today than the Hughes family had in the 1930s, but the heavy shadow of war still falls on children growing up in soldiers’ families.57

Silence and Remembrance

This chapter is about certain kinds of silence and about certain kinds of silence-breaking. Some of this story unfolds in wartime. Much of it happens in families, long after the termination of armed conflict.

One conclusion seems unavoidable. During the Great War, there was a general unwillingness to recognize that psychological injury in wartime was a very common occurrence, much more prevalent than official statistics suggested.

A second conclusion is that this silence about shell shock was an enduring one. Indeed, there is a school of thought that the delayed onset of mental illness related to military service – now termed PTSD – entails a loss of language capacity. Alexander McFarlane terms it a kind of “speechless terror.”58

It is impossible to say if Ted Hughes’s father suffered this fate. But what is clear is that the poetry of Ted Hughes captured the reverberations of war and injury in war long after the end of the conflict. Many commentators on war have discussed variations on what he saw in his father’s face. I have termed this gaze, one rich in “communicative silence,” a socially reinforced ban on words, a blockage of conversation, even (or especially) in intimate family circles, about the long-term psychological injuries veterans bear. We can still hear such silences today, and we still need silence-breakers to enable us to communicate from generation to generation what we see and what we know about the ravages of war. If William Hughes thought that by not speaking of his war, he was sparing his son or wife from confronting some its horrors, he was profoundly mistaken. Silence can be full of meaning. It has

57 For one such organization addressing this problem, Mental Health America, see: www.mentalhealthamerica.net/military-mental-health
58 Once more my thanks are due to Dr. McFarlane for his valuable advice on this point.
When we unpack the meanings of silence, we turn its powerful emotive force into something else, something spoken, something preserved in what we call auditory memory.\textsuperscript{59}

I have claimed above that silence operates in different domains: the liturgical, the political, the essentialist, and the familial. In each case, performative nonspeech acts proliferate, about theological questions without answers, about unglorious episodes in a nation’s or group’s history, or about shameful or divisive acts of family members.\textsuperscript{60}

When we turn to shell shock and the silences it engenders, we can add two additional forms of performative nonspeech acts to the discussion. The first is diagnostic silence, a way of bypassing the taking of official, financial, or public account of a condition most doctors and many patients do not want to acknowledge. The vast underestimates we have uncovered in the official statistics of shell shock arise from many sources; diagnostic silence is one of them.

Secondly, I have followed Jan and Aleida Assmann’s pioneering work on communicative memory by positing an additional category of performative nonspeech acts, which may be termed communicative silence. Just as family stories told around the dinner table establish narratives of a shared past, so in subtle ways do silences around the dinner table. They transmit messages about distressing or suppressed incidents about which everyone knows but nobody speaks.

For students of war and remembrance, perhaps the most important implication of this chapter is the way it helps us to see that silence is a language, a constitutive part of the way we imagine war. As in so many other domains, silence is not an empty space but, under certain circumstances, a powerful mode of conveying meaning. It is a great mistake to equate silence with forgetting; on the contrary, silence remains an essential part of our landscape of memory. All we need are eyes and ears to see and hear it.

\textsuperscript{59} I owe this point, and much else, to Robert Dare.