‘Living in a citadel’:

the participation of
mentally ill war veterans
in Australian society

Dr Kristy Muir
Australian Social Policy Conference, 9-11 July 2003
Abstract

Mental illness may have a profound affect on an individual’s ability to fully participate in society. This is especially evident in the lives of Australian war veterans, who are more likely to suffer from mental illnesses than their civilian counterparts. As a result of their symptoms, mentally ill veterans often face difficulty functioning economically, domestically and socially. Some cannot cope in the civilian workforce, they have great difficulty maintaining relationships, and they socially isolate themselves, both physically and geographically.

The social inclusion of mentally ill veterans can only be achieved if the veterans’ illnesses are identified and sufficiently treated. Official recognition is a significant part of this process. While government policy has significantly changed over the last two decades with regard to the mental health of service personnel and veterans, it is still dominated by a history of parsimony and suspicion. Thus, the majority of mentally ill Australian war veterans receive neither compensation nor adequate treatment, and remain largely excluded from our society.
Mental illnesses significantly affect an individual's ability to participate in society. The Human Rights and Equal Opportunity Commission recognise the mentally ill as one of the most disadvantaged groups in Australian society. Mental illnesses affect 18% of Australians, almost one in five. For certain groups, however, mental illness occurs at higher rates. War veterans are one of these groups.

Prevalence of mental illness in veterans and the general community

An analysis of the Department of Veterans Affairs' (DVA) treatment population in 1997-1998 revealed that more than one in four were suffering from mental health problems. This figure only refers to those receiving treatment from the DVA; it does not include those who have not qualified for treatment, or those who failed to seek assistance from the Department.

The true prevalence of mental illness in the veteran community is masked. Limited research has been conducted on veterans who served in certain conflicts and because psychological problems are far more hidden, far easier to ignore, and far easier to underreport than physical ones. Yet, the figures that are available indicate that veterans have a higher prevalence of mental illness than their civilian counterparts.

The elevated rates of mental illness in the veteran community quickly become evident if only the PTSD figures are compared with mental disorders in Australian adults. O'Toole et al.'s 1996 epistemological study concluded that one in five Australian veterans have PTSD. So 18% of Australian adults suffer from a mental illness, while 20% of veterans have PTSD. The difference becomes more telling, however, once age and disorders are accounted for. PTSD is an anxiety disorder. Only 7.1% of all Australian adult males suffer from an anxiety disorder, and this fell for males over 55 years of age.

As the male and female population ages, the prevalence of mental illness decreases. Younger adults (18-24 years) have the highest rate of mental illness at 27%, but only 6.1% of those over 65 years have a mental disorder. The average age of veterans with an accepted mental health condition is 65.1 years. Therefore the prevalence of PTSD alone in the veteran community is over three times that of all mental disorders in the equivalent age bracket.

Yet PTSD is not the only mental illness veterans suffer from. Anxiety disorders, depression, and alcohol abuse are among some of the other disorders they are exposed to. In 1997-98 42.1% of people with a mental illness being treated by the DVA had an anxiety disorder and almost 10% suffered from depressive disorders. By 1999 alcohol dependence accounted for 15% of all the compensation claims accepted by the DVA.

While it is generally accepted that Vietnam veterans are more likely to suffer from mental illnesses than their civilian counterparts, veterans from other conflicts also suffer from increased problems. For example, World War One veterans had a higher suicide rate in the post-war years; World War Two veterans have elevated mental illnesses; Korean veterans are 2½ times more likely than civilians who did not serve to have a mental illness; and male and female Gulf War veterans suffer from more affective and anxiety disorders and alcohol and substance abuse than civilians of the same age.

Social Consequences of War: economic and social exclusion

Little is known about the mental health of veterans who served between the Korean and Vietnam wars, but what I want to demonstrate is that the social consequences of war can be equally debilitating for veterans who served in very different conflicts. To do this I'm going to compare the post-war experiences of a group of Second World War and Indonesian Confrontation veterans.

The Second World War is renowned for its carnage and misery. It was a long almost six year war that mobilised nearly a million Australians, sent 396,661 men and women overseas, and took the
Living in a citadel

lives of almost 45,000 service personnel.\textsuperscript{14} By contrast, the Indonesian Confrontation is still largely a conflict shrouded in silence. It lasted from 1963 to 1966. Some 3,500 Australians served overseas, twenty-three were killed (seven of which were battle related) and eight were wounded on operations.\textsuperscript{15}

Despite these differences, service personnel from both the Second World War and the Indonesian Confrontation were on active service in stressful situations; both carried weapons and were fighting an enemy equally willing to shoot. The threat of death in both situations was very real; and the life outcomes of those who returned with a mental illness are remarkably similar.

Employment difficulties, social isolation, communication problems, relationship difficulties, insomnia, nightmares and addiction are some of the complexities these veterans deal with on a daily basis and these problems exclude them from ‘normal’ participation in Australian society.

To demonstrate the difficulties mentally ill veterans have participating in society case studies will be used (these are drawn from twenty-six interviews that were conducted with Second World War and Indonesian Confrontation veterans and their families). These case studies’ experiences are a reflection of how the veteran interviewees feel and how they perceive their situation.

Working

Some mentally ill veterans never re-adjust back into the civilian workforce. Second World War veteran Tommy is one example. Tommy stayed in the same job for seven years before he enlisted, but after he was discharged his state of unsettledness was so severe that he lived in thirty-five different townships after the war, moving on from job to job.\textsuperscript{16}

It would be easy to dismiss Second World War veterans’ constant job changes as characteristic of a society that enjoyed almost full employment. For the majority of years between 1946 and well into the 1970s less than 2% of Australians were unemployed.\textsuperscript{17} The healthy number of positions available in post-war Australia may have made it easier for these veterans to change jobs, but their problems in other aspects of their lives and their explanations for their continued changes, such as restlessness, loneliness, aggression and an inability to tolerate civilians, suggests something more. This is further corroborated by the employment problems experienced by some of the Indonesian Confrontation veterans into the 1980s, at a time when there were no assurances of securing another job if they left their employer.

Indonesian Confrontation veteran Rob estimated having forty different work places since he left the army in 1969.\textsuperscript{18} Most of these jobs were lost because Rob got into fights with people who ‘got in my way, who I didn’t agree with, or tried to be smart’.\textsuperscript{19}

Social isolation

Social isolation is recognised as a problem for some mentally ill veterans, not only for those diagnosed as suffering from PTSD, but also for those suffering from other clinically diagnosed illnesses.\textsuperscript{20} This phenomenon was evident in the case studies although its degree varied. Many found it impossible to resume pre-war friendships, especially with civilians; they cut ties with their families; they refused to participate in sporting activities; many avoided crowds and some geographically isolated themselves.

Percy became annoyed with civilians as soon as he came home because he felt, ‘As soon as the war’s over they’ve got the knife into us’.\textsuperscript{21}

The Indonesian Confrontation veterans were also very aware of their inability to relate to civilians. Most of the Indonesian Confrontation veterans who were interviewed had, and still have, significant problems relating to civilians. For Greg, the return to civilian life did not involve re-establishing or initiating friendships with any civilians because, as he bluntly admitted, ‘I hate civilians’ for their ‘shallow [and] superficial’ natures.\textsuperscript{22} To avoid confrontations with civilians he seeks isolation: ‘It’s best if I find a little space somewhere and don’t involve myself with people,
Living in a citadel

unless they’re [ex-servicemen]. Then there’s no problem, because they think the same as I do’.23

Some veterans refuse to socialise with civilians and ex-service personnel. Allen’s family is his only social contact. He does not spend time with civilians and he stopped all contact with the men whom he served with in the RAN.24

Avoiding civilians was a part of the reason many veterans did not resume leisure activities that they had enjoyed in their pre-war lives. For some veterans, these activities became meaningless and superficial after they had been to war. Three of the Second World War veterans gave up all of their leisure activities when they returned home.25 James was a ‘fitness fanatic’ before the war, cycling, running, boxing, and playing football and cricket. When he returned home he did not take up any of these activities.26

The lack of interest in leisure activities was more prevalent among the Indonesian Confrontation veterans. Five of the interviewees still do not enjoy these activities. Greg did not resume any leisure or sports when he came home.27 Michael tried to participate socially when he came home and pointed out, ‘I’m not a quitter [but] I just lost everything. I’ve exhausted all I’ve got left’.28

For some veterans the inability to relate to and associate with civilians was far more marked. Some had major problems just functioning in the community. All of the veterans tend to avoid crowds to different extents, mainly because they suffer from paranoia about people surrounding them who are a possible threat. Some cannot stand to be in a crowded situation, others can handle it at times.

Tommy has been constantly on guard since he returned, always ‘expecting something might happen’. As such, he is easily startled, is wary of other people and avoids crowds as much as possible.29 Indonesian Confrontation veteran, Michael, cannot ‘hack crowds’.30 Allen suffers from anxiety attacks in crowded situations.31 Rob avoids all places where people can stand behind or around him. When he catches the train he sits on the long seats near the doors to ensure he can see everyone, places a tissue on the seat next to him so no one will sit down, and will only travel at five o’clock in the morning to ensure that the train is relatively empty.32 Rob also isolates himself in an effort to maintain control. He avoids birthday, Christmas or any other parties, because he does not feel he can control his drinking and aggression under those circumstances.33

Half of the veterans interviewed are so wary of other people that they refuse to sit anywhere but in the corner in public places to ensure they can see everyone around them. Allen is very startled if he is approached from behind.34 Greg is alert and on guard all the time.35 Michael is excessively paranoid. He often feels that he is being watched:

I’ve got a built in thing. Let’s say there’s a tree. I have a thing that I know there’s a tree and until I see behind the tree there’s someone there. I make sure no one’s watching me. I’ll leave my house and then back track to see if someone’s there. I do behind the scenes surveillance. I won’t do it for a week or so and then I’ll do it three or four days in a row, “That bastard’s following me”, but he’s not really.36

There is also a geographical twist to this. Social isolation can be buttressed by geographical isolation.

In 1997-98, 32% of mentally ill veterans who were receiving treatment from the DVA lived in rural or remote areas.37 The 1996 Australian census, however, recorded only 14% of the total population living in rural areas.38 This figure, of course, begs the broader question of mental illness in rural areas where male youth suicide rates are higher and where access to professional help is virtually nil. But it does reflect the fact that those with PTSD often choose to live away from crowded places. Social isolation is reinforced by geographical isolation.

Three veteran interviewees, Tommy, Joe and Michael, live in geographically isolated locations. Joe is the most isolated. He lives on a property miles from a small rural country town. He increases his isolation by not driving and he rarely has contact with people other than his family. Michael lives in a rural area and he has little contact with anyone other than his immediate family
Living in a citadel

and his brother-in-law, who is a Vietnam veteran, and he finds it incredibly difficult to go into his small country town. He reflected, 'Even today we live in a virtual citadel'.

Domestic

The impediments the interviewees face on a daily basis rule their lives. Every time they have to leave the house they are forced to face their symptoms in tangible ways. Life is a battle for them and everywhere they go there are underlying threats, which lead to a constant state of heightened anxiety. The problems persist not just in the working and social world. They also prevail inside the home.

Mentally ill veterans often have great difficulty maintaining health relationships. Veterans were, and still are, more likely to be divorced than their civilian counterparts. Indonesian Confrontation veteran Rob has been divorced three times, he rarely sees his four children and he has resolved to live alone. While the majority of the interviewees remained married, staying entrenched in a relationship did not necessarily mean a sound home life. The interviews with mentally ill veterans' wives quickly revealed some mentally ill veterans’ inability to participate sufficiently in home life.

Thelma’s husband Jack returned from the Second World War with schizophrenia. His ‘nerves’ were such that he would pace up and down the family home. He could not even sit through a meal with his wife and children. Thelma described the situation:

He’d walk up and down. Up and down, and up and down, and up and down. He’d sit for thirty seconds and then he’d be up and down the room again. He’d stomp around and then he’d sit in the chair and he’s start jumping outward all over again, with his face twisting up and jiggling around, and biting on the pipe all the time. … He couldn’t sit still long enough to eat a meal. He’d literally throw his knife and fork onto the plate. Everyone would leave their seats jumping and then he’d sort of stomp out. He’d come back a few minutes later and sit down calmly and start eating again and then he’d do it again. He was an impossibility. You couldn’t live with him, you couldn’t sit and eat with him, [and] you couldn’t go out with him.

Jack could not even pour himself a cup of tea because he could not hold the teapot still. Many of the Second World War veterans and their wives relied on Valium to ensure that at least the family got some sleep, but even sleep evaded some veterans.

One of the most debilitating and frustrating aspects of post-war stress disorders is the lack of sleep and the nightmares that come when sleep sets in. All but two of the Second World War veterans who were interviewed sleep poorly and suffer from nightmares or flashbacks relating to their service experiences. James had to be ‘scrapped off the wall’ every night for years after he returned home because of his nightmares. Almost sixty years later, he still has nightmares, takes hours to fall to sleep and then wakes at about two or three in the morning, unable to sleep again. Thelma’s Second World War veteran husband, Jack, often paced the hall at night, and when he was up no one in the family slept – the kids went to school exhausted and often had naps after school.

All of the Indonesian Confrontation veteran interviewees sleep very poorly and all but two still have service related nightmares. Michael suffers from insomnia, when he does sleep he often has nightmares, he sleeps with the television on to help with the nightmares, and he often wakes up ‘with an awful start’. This is to the extent that he almost strangled his wife when they were first married and his children know they are not to go near him while he is sleeping.

Most of the Second World War and Indonesian Confrontation veterans who were interviewed have been suffering from the symptoms of psychological problems since they were discharged from the military. These problems have affected their working, social and home lives.
Social Inclusion

So how do we overcome the problem of social exclusion for mentally ill veterans? For any level of social inclusion to occur mentally ill veterans need to receive adequate treatment from mental health professionals, but another essential and interrelated step is official recognition. That is mentally ill veterans need recognition from the Department of Veterans’ Affairs that their illnesses are war related. This recognition plays an instrumental role in encouraging veterans to accept and seek treatment for their condition.

Veterans are not the most proactive help seekers. For a start, service personnel are imbued with masculine traits in training, and masculinity hardly encourages help seeking. Secondly, Australia’s cultural commitment to Anzac and notions of the gallant, heroic, cheerful and cheeky digger hold no place for mentally ill veterans. And finally, the idea that mentally ill service personnel and veterans are inherently weak has prevailed throughout Australia’s military history.

An emphasis on predisposition, the belief that individuals were responsible for their psychological condition, rather than their war experiences, began to dominate during the First World War. In 1921 the Medical Journal of Australia pointed out, ‘the war and its aftermath have taught the great lesson that there is a large number of men and women who have acquired or inherited neuropathic temperament’.

Between the world wars, war was defended as innocuous in relation to mental health and throughout the Second World War the predisposition theory was largely upheld and reinforced by military and government policy. In 1941 an AIF advisor in psychiatry wrote to the Director General of Medical Services, Major-General F.A. Maguire, and reinforced the idea that ‘The vast majority of [psychiatric casualties] are not caused by war service and would have become insane in civil life’. The RAAF had a policy where its members could be dishonourably dismissed as ‘lacking moral fibre’ if they succumbed to the stress of war.

In the 1970s and 1980s mentally ill Vietnam war veterans were denied pensions because of the prevailing belief that they were responsible for any psychological problems they returned home with. In 1983 Dr Solomon Rose, then recently retired as a senior medical administrator in the DVA, told the Senate Standing Committee on Science and the Environment that from the DVA’s viewpoint [PTSD] is not a disease which is relevant to Vietnam. Another DVA psychiatrist blamed the veteran for his own distress arguing:

[he] has suffered at his own hand by not allowing his memories of Vietnam to fade with time ... As such, his mild anxiety state is not related to his war service. ... His time in Vietnam could not really have been as traumatic as he now tells.

Predisposition would shape both military and government policy from its beginnings in 1916 to its loss of influence seventy years later.

There has been a shift on the government’s part regarding mentally ill service personnel and veterans over the past twenty years. Attitude changes can be seen in the increase in granted pensions and in the implementation of treatment programs and other initiatives.

The opening of the first Vietnam Veterans Counselling Centre (now known as the Vietnam Veterans Counselling Service - VVCS) in Adelaide in January 1982 marked the beginning of an increasing acceptance and attitude change toward mentally ill service personnel and veterans.

Centres throughout the rest of Australia followed, along with the introduction of a toll free after-hours telephone service.

While the establishment of the VVCS was of significant importance to mentally ill Vietnam war veterans, it was the 1990s that represented the most progressive years in implementing initiatives to help a larger number of mentally ill veterans. For a start, the VVCS was made accessible to veterans from all conflicts. In 1995 the National Centre for Post-traumatic Stress Disorder (NCPTSD) was opened as a research and information centre for veterans with PTSD. In 1996, under the Younger Veterans’ Program, all veterans became eligible for treatment for PTSD.
whether the DVA accepted their problems as war caused or not. In July 2000 the NCPTSD was renamed the Australian Centre for Posttraumatic Mental Health and its responsibilities were expanded to include all mental illnesses. This centre, along with other medical organisations, provides in-patient and day-patient programs for mentally ill veterans.54

Other initiatives have also been established for mentally ill veterans. In 2001 the DVA published a mental health policy and strategy document, Towards Mental Health For The Veteran Community. The Men’s Health Program, introduced in October 2002, provides information both electronically and in hard copy on men’s health problems, including mental illness (topics include, ‘Being a digger and a bloke’, ‘Clinical Depression’ and ‘Anxiety and Anxiety Neurosis’).55 In 2002 an Alcohol Management Project for veterans and service personnel, called The Right Mix: Your Health and Alcohol, was implemented.56

In recent years, the DVA has also taken proactive steps towards improving the pension application process for mentally ill veterans.57 Compensation is now seen as important for mentally ill veterans, not only for ‘the economic well being of veterans and their families’, but also because compensation is ‘tangible evidence of recognition and acknowledgement’.58 Consequently, DVA Claims Assessors have been given some training on mental health disorders and the likelihood of applications being accepted has increased significantly over the last decade.59

Since the mid 1990s the DVA has also implemented programs to help the families and carers of mentally ill veterans.60 In August 1994 the DVA ran a ‘Lifestyles Program’ offering education, support and skills training for veterans and their partners.61 A Women’s Support Group Program was also established specifically to deal with problems faced by veterans’ wives and to improve their ‘quality of life’.62 Families are now entitled to counselling, information sessions and booklets relating to mental illnesses.63 Veterans’ children are mainly assisted through the Veterans’ Children Education Scheme, which assists financially with their education.64

While these changes represent a significant shift in government policy, they have their limitations. The past continues to influence contemporary decisions and policies. Pensions for mental illnesses are still more likely to be denied than accepted and resources are insufficient to deal with the number of mentally ill veterans.

PTSD programs, for example, have been insufficient. Although PTSD was the most commonly diagnosed disorder in veterans throughout the 1990s, by 2000 less than one-tenth of recognised veterans with war-related PTSD had participated in a PTSD program.65 Therefore 90% of those with accepted conditions await this type of treatment and an unknown number of those who have not been accepted as having a war caused PTSD.

The use of the resources that are available for mentally ill veterans are dominated by Vietnam war veterans. This trend started in the 1980s with the introduction of the VVCS and it persisted throughout the 1990s and it still continues. Vietnam war veterans have remained the most studied and most funded group of all mentally ill veterans. The 2000/2001 federal budget funded a number of initiatives to help this group.66 For example, in 2000 all Vietnam war veterans became eligible for treatment for clinical depression and severe anxiety conditions whether their illnesses were recognised as war caused or not.67 This was not offered to veterans from other conflicts. Further study into the mental health of veterans who served in other conflicts is essential because mental illness is not confined to Vietnam war veterans.

Although some progress has been made in regard to the compensation system for mentally ill veterans, past ideologies persist. The majority of veterans who apply for a pension for a mental illness are still refused. Less than one in two, 46%, of veterans with a mental health disability were approved between 1995 and 2000. This equates to between three and four hundred new cases a year.68 Of the 87,874 people with a mental health problem in the DVA’s treatment population in 1999, only 42.5% (37,305 clients) had an accepted mental illness.69

Poor acceptance rates are largely a result of old parsimonious ideas staying entrenched in the department. In their 2000 report on Issues and Options for a Mental Health Policy: Towards a ‘Whole Person’ approach to Veteran mental health care the DVA dredged up old suspicions by
questioning whether some veterans were fabricating PTSD for financial gain.\textsuperscript{70} They also expressed the prevailing idea that pensions inhibit regaining sound mental health:

For some veterans the existing models of compensation and treatment reward illness behaviour. Fears that improvements in functioning will lead to compensation payments being stopped or reduced may provide a disincentive to engage fully in treatment.\textsuperscript{71}

The pensions that are granted to mentally ill veterans are dominated by Vietnam war veterans. Vietnam veterans are more likely to have a mental illness accepted as war caused than veterans from other conflicts. While they only consisted of 13\% of the overall DVA treatment population in 1998, they accounted for 38\% of the all accepted mental illness cases.\textsuperscript{72} Veterans from the Second World War comprised of only half of the 1997-98 accepted mental health clients,\textsuperscript{73} but make up 69\% of all veterans,\textsuperscript{74} ex-service personnel from conflicts in the Far East made up a mere 5\% of the accepted cases and 3\% were from peacekeeping forces.\textsuperscript{75}

The support available for the families of mentally ill veterans also has its limitations and inequities. Vietnam war veterans’ children have far more support available to them than the children of other veterans. Under the Youth Services Project Vietnam war veterans’ children are entitled to free psychiatric assessment, counselling and the Veterans’ Children Education Scheme up until they turn thirty-five years of age.\textsuperscript{76}

In general, families do not feel they have been given adequate support to help them cope with and understand their spouses or fathers’ mental illnesses.\textsuperscript{77} In 2000 a number of veterans’ wives reported concern over the mental wellbeing of their children, other parenting problems, alcohol and substance abuse in their spouses, difficulty dealing with anger in their spouses, and their own poor self-esteem and depression.\textsuperscript{78}

The DVA admits that it does have a relationship problem with veterans and their families (veterans simply do not trust them).\textsuperscript{79} The lack of trust was reinforced by the interviewees, even those who have been accepted as suffering from a war related condition. It was decades before the majority of the veteran interviewees were diagnosed with a mental illness and accepted by the DVA. This has left most of them with a lingering bitterness toward the department. Rob was accepted as having war caused PTSD in 1999, over thirty years after he returned home, but, as he explained:

No one held out the welcome hand to me and said, “You’ve got a problem son and we’re the ones responsible.” ... No one even gave me a form to fill out ... We all have problems that have never been addressed, simply because no one ever stopped us. By thirty years down the track it’s too late to try and stop you, you’re just gone,... In a way I want to be better. I want to feel better, but I think it’s gone on too long. The period of time sets in. I don’t think I could ever live, what I’d call, a normal life.\textsuperscript{80}

It was also over thirty years after Greg returned with mental health problems from the Indonesian Confrontation that he was diagnosed with PTSD and accepted as suffering from a war related condition. His passionate contempt for the DVA has stayed with him:

Most public servants are ... blood-sucking assholes who go into a job that they can’t lose ... I don’t believe the DVA are there to help veterans. I believe the DVA are there just to enhance, foster or maintain careers of public servants, that’s all. And they resent having to deal with people like me. They hate it; they just hate it.\textsuperscript{81}

It is not surprising that the veteran interviewees who have been refused pensions harbour the most animosity toward the government. Ineligible veterans are especially upset because for them government rhetoric does not meet government action. Indonesian Confrontation veteran Peter has been unsuccessful in his attempts to attain financial compensation for his poor mental health. He receives a pension for his physical ill health, but the DVA have rejected his TPI application for mental illness four times because the DVA psychiatrist reported, ‘There is no emotional instability
Living in a citadel present and doesn’t appear to have been’. Peter has all of the symptoms of PTSD and many of
the associated problems listed in the fourth edition of the Diagnostic and Statistics Manual,
except for the first criteria. A PTSD sufferer must respond to a traumatic situation with ‘intense
fear, helplessness, or horror’, but Peter told the psychiatrist that he was not scared while he was
on active service. Peter is frustrated with the DVA and after many years of being blamed for his
mental illness he has also started to question the cause of his problems:

    I’ve been told that I couldn’t handle it and I suppose in a way it’s right because if I
could handle it properly I wouldn’t be having [problems]. I could see the government’s
side of it [but] I reckon that it is because of my service … because I wasn’t like it
before.82

As a result of his visit to one of the DVA’s psychiatrists, Peter has not sought any further mental
health support.83 This lack of help seeking is a major obstacle in overcoming the social exclusion
of mentally ill veterans.

The families of mentally ill veterans from the Second World War and the Indonesian
Confrontation were also disgruntled with the lack of assistance from the DVA. Four widows of
mentally ill Second World War veterans are ‘war widows’, but their pensions were granted for the
physical health problems of their husbands. They never received the assistance they needed
while their mentally ill husbands were alive.

Future prospects for the social inclusion of mentally ill veterans and their families will be
determined by whether veterans seek help and are adequately treated for their problems, but this
largely hinges on whether old attitudes undermine new ones, or whether progressive ideas are
embraced. There are numerous strategies that the DVA are considering. Its report Towards
Better Mental Health for the Veteran Community: Mental Health Policy and Strategic Directions
suggested a number of initiatives to further assist mentally ill veterans, their carers and their
families.84

While changes have come about over the last twenty years in relation to mental health support
and financial compensation, the past continues to influence the present. Pensions may be easier
to attain, but past notions of veterans fabricating illnesses for financial gain and ideas of pensions
inhibiting recovery persist. Consequently, the DVA still eludes granting the majority of applications
submitted by mentally ill veterans. Numerous programs have been implemented to help mentally
ill veterans and their families, but the demand is greater than the number of support places
available.

1 This paper is based on research conducted as a part of my PhD thesis, The Hidden Cost of War: the psychological effects
2 Australian Bureau of Statistics (ABS), (1998), Mental Health and Wellbeing: Profile of Adults, Australia, ABS Cat No. 4326.0,
Canberra: ABS.
3 This is based on the 1997 National Survey of Mental Health and Wellbeing of Adults. ABS (1998), 4326.0.
4 26% or 87,874 people. In 1997 the DVA client population numbered 527,941. The treatment population consists of ex-service
personnel and their dependants who have a gold or a white card. To obtain these cards veterans must have a mental or
physical disability accepted as war related. Commonwealth DVA (2001), Mental Health Disorders in the Veteran Community and
their Impact on DVA’s Programs: An Analysis of Available Data, Canberra: Commonwealth DVA, p. 4.
Disorder in a Legal Context’, Australian Psychologist, vol. 31, no. 3, p. 220. The NCPTSD stated that 12 to 15 per cent of
veterans on active service and in peacekeeping roles will develop PTSD and another 12 to 15 per cent will have some of its
symptoms. NCPTSD, Posttraumatic Stress Disorder (PTSD and War-Related Stress: Information for Veterans and their
Families), West Heidelberg: NCPTSD, 1999, p. 4. O’Toole et. al.’s figure is higher than the rate in the ‘traumatised’ community,
while the NCPTSD’s estimate is slightly lower. It has been estimated that PTSD will affect 2% of all Australians at some stage in
6 12% of women suffer from anxiety disorders. ABS (1998), 4326.0.
7 ibid.
8 The overall average age of veterans is 74.4 years. DVA (2002), Treatment Population Statistics, Quarterly Report – December
2002, Canberra: DVA Strategic Support Branch, p. 3.
Living in a citadel


10 Bonwick and Morris estimated the prevalence of PTSD among Second World War veterans to be between 15 and 20 per cent. Richard Bonwick and Phillip Morris, Post-Traumatic Stress Disorder in Elderly War Veterans, draft copy, NCPTSD, unpublished, no date. The prevalence of PTSD in prisoners of the Second World War veterans has been found to be even higher. In a study of 426 former prisoners Eberly and Engdahl found 70.9 per cent of these veterans had a lifetime prevalence of PTSD and 34.5 per cent were suffering from PTSD at the time of the study. Paul Collier (1999), Outcome Study of an Outpatient Post-Traumatic Stress Disorder Group Program for Elderly War Veterans, Supervisor: Dr Malcolm Hopwood, A minor thesis for the Master of Medicine (Psychiatry) degree, University of Melbourne, p. 15. In another smaller study of American POW from the Second World War and the Korean War Engdahl and Eberly found 53 per cent of their 262 veteran sample suffered from lifetime PTSD. Brian Engdahl and Raina Eberly (Winter 1994), ‘Assessing post-traumatic stress disorder among veterans exposed to war trauma 40-50 years ago’, NCP Clinical Quarterly, p. 13.

13 Department of Epidemiology and Preventive Medicine and Health Services Australia, Monash University (2003), Australian Gulf War Veterans’ Health Study 2003, Canberra: Commonwealth of Australia, p. 293.
15 Grey’s figures have been used here. Jeffery Grey (1999), A Military History of Australia, Melbourne: Cambridge University Press, revised edition, p. 229. The number of Australians killed in the Indonesian Confrontation, however, differs between reports. The AWM also lists twenty-three killed in the conflict on their website, www.awm.gov.au/atwar/confrontation.htm. Yet, the AWM’s other web pages and archival documents list fewer killed. The AWM237, Roll of Honour cards, supplementary sources, Casualties (Army), Korea – Malaya – Confrontation, expunged copy, compiled by CARO 1969, Item 746/2/1; AWM 151-152, Roll of Honour Cards, Indonesian Confrontation (Malay Peninsula, 1964-66, Sabah/Sarawak, 1962-66); and the AWM, Information Sheet 19, ‘Australian War Casualties’, www.awm.gov.au/research/infosheets/war_casualties, 15/2/02, cites fifteen killed. The Roll of Honour Database posted on the AWM’s website, www.awm.gov.au/database/roh.asp, listed eighteen as having been killed in the Confrontation when the site was accessed on 17/02/2000 and seventeen when the site was accessed on 15/10/2002. The one missing on the latter date was a Royal Australian Air Force (RAAF) serviceman who died in an aircraft accident. Like the number killed, the number of wounded in the Confrontation is also not clear. Grey recorded eight service personnel as wounded in action. There were also another one hundred wounded in non-operational situations, but this included some of the ill in the Royal Australian Navy (RAN). McKernan and the AWM report nine as wounded in battle. Jeffery Grey, p. 229; Michael McKernan, p. 414; and AWM, Information Sheet 19.

16 Tommy Jackson, Letter to K Muir, 20/3/00.
17 In 1961 the unemployment rate hit a high of 4.1 percent, but by the 1966 census it had returned to 1.3 percent. See Glen Withers, Anthony M. Endres and Len Perry, ‘Labour’, in Wray Vamplew (1987), pp. 152, 154.
18 Before Rob joined the army he had been in the same job since he left school, for four years. Rob Thomas, Interview, 27/10/99.
19 ibid.
21 Percy Roberts, Interview, 21/1/00.
22 Greg explained that he could relate to me because of the topic I was dealing with. Greg Simpson, Interview, 22/11/99.
23 ibid.
24 Allen Reynolds, Interview, 16/11/99. Michael also refused to talk to those he served with in the RAN about his problems because of the training he received, ‘We don’t talk shop when we go ashore. This is drilled into you and I didn’t talk about it’. Michael Reid, Interview, 1/12/99.
25 George Hill, Interview, 12/12/99 and Les Stephens, Interview, 11/1/00.
26 James O’Brien, Interview, 13/1/00.
28 Michael Reid (1999).
29 Tommy Jackson (2000).
30 Michael Reid (1999).
31 Allen Reynolds (1999).
32 Rob Thomas (1999).
Living in a citadel

33 ibid.
34 Allen Reynolds (1999).
36 Michael Reid (1999).
37 Commonwealth DVA (2001), Mental Health Disorders, p. 13.
39 Michael Reid (1999).

Sleep disturbance has been correlated with mental illnesses such as PTSD, anxiety disorders and depression. Charles Reynolds, ‘Sleep disturbance in posttraumatic stress disorder: pathogenic or epiphenomenal?’, American Journal of Psychiatry, vol. 146, no. 6, June 1989, pp. 695-696.

44 Michael Reid (1999). Weary Dunlop also awoke one night with his hands around his wife’s throat. On other restless nights he would ‘kick and lash out’ in his sleep. Michael McKernan (2001), This War Never Ends: The Pain of Separation and Return, Queensland: University of Queensland Press, p. 145.


47 ‘Memorandum on the Disposal of Members of Air Crews who Forfeit the Confidence of their Commanding Officers’, September 1941, p. 2, NAA A2217/1, HQ RAAF UK, Correspondence files; Item 1137/8/P1, Disposal of aircrews who forfeit the confidence of their C.Os – Lack of moral fibre cases – Policy.

48 Mentally ill Second World War veterans who were denied pensions by the Repatriation Commission were entitled to a two pound and ten shilling weekly pension from the Department of Social Services. But this could only be claimed thirteen weeks after discharge (AWM54, Item 838/1/1 part 1, pp. 6 and 8) and it was only granted for a ‘maximum period of 3 months’.

50 ibid.


59 ibid, p. 22.
60 Commonwealth DVA (2001), Towards Better Mental Health for the Veteran Community: Mental Health Policy and Strategic Directions, Canberra: DVA, p. 12.
62 ibid, pp. 157.
Living in a citadel

69 *ibid*, p. 13.
71 *ibid*, p. 16.
73 *ibid*.
75 *ibid*.
79 The DVA noted that a vast number of veterans who had accepted mental health problems used private mental health services, rather than those provided by the DVA. *ibid*, p. 12.
80 Rob Thomas (1999).
82 Peter Martin (1999).
83 *ibid*.
84 For example, helping carers of mentally ill veterans properly understand their conditions and support available; establish a ‘Jobs in Jeopardy’ program to help those veterans who could potentially lose their job; and ensure veterans from conflicts other than the Vietnam war and those with mental health problems other than PTSD are given sufficient support. Furthermore, in their ‘Strategic Directions for Health 1999 to 2007’, the DVA pledged to encompass a holistic view of health and to work at preventing mental health problems and help those with poor mental health by developing ‘partnerships with the veteran and defence community’. Commonwealth DVA (2001), *Towards Better Mental Health*, pp. 8, 14-15.