AUSTRALIAN WAR MEMORIAL

Not yet diagnosed

Australian Psychiatric Casualties During the Kokoda Campaign, 1942

DAVID WOOLLEY

Cover image:
Frank Hodgkinson, Owen Stanley Trail, Alola (1942, charcoal and watercolour on paper, 35 x 26 cm) AWM ART28335

Not Yet Diagnosed: Australian Psychiatric Casualties During the Kokoda Campaign, 1942

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DAVID WOOLLEY

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Biography – David Woolley

David Woolley was born in Newcastle in 1991 and grew up on his family's cattle property in country NSW. He commenced Army officer training at the Australian Defence Force Academy in 2011, and graduated from the Royal Military College in 2014.

He completed a Bachelor of Arts, major in History with Honours First Class and the University Medal in 2015. His thesis on psychological injuries during the Kokoda Campaign achieved the highest mark ever awarded to a history Honours thesis at UNSW Canberra and was selected as the winner of the Bryan Gandevia Prize and CEW Bean Prize.

David has undertaken numerous postings within the Australian Army, as well as serving as a military advisor on overseas operations. David remains a serving Army officer, and during his spare time enjoys fishing, camping, and travelling with his wife Carla.

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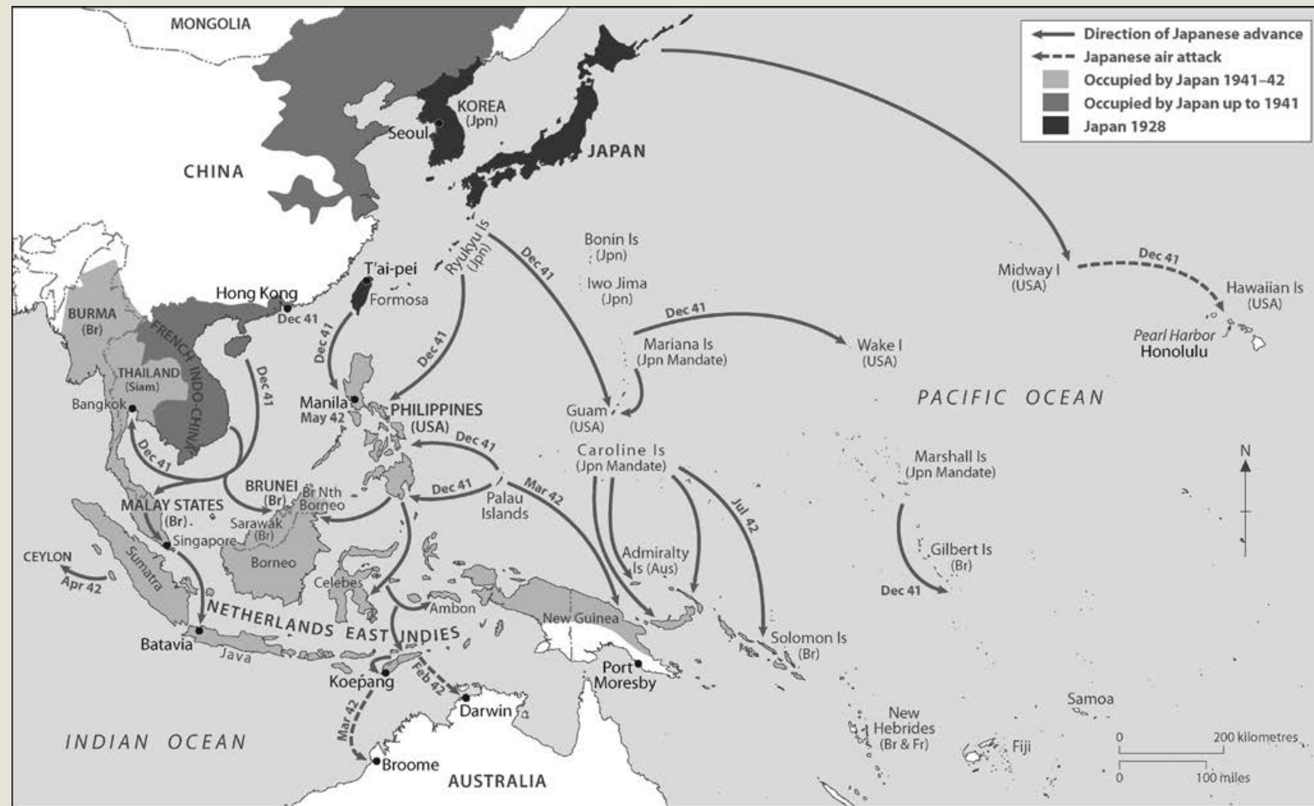
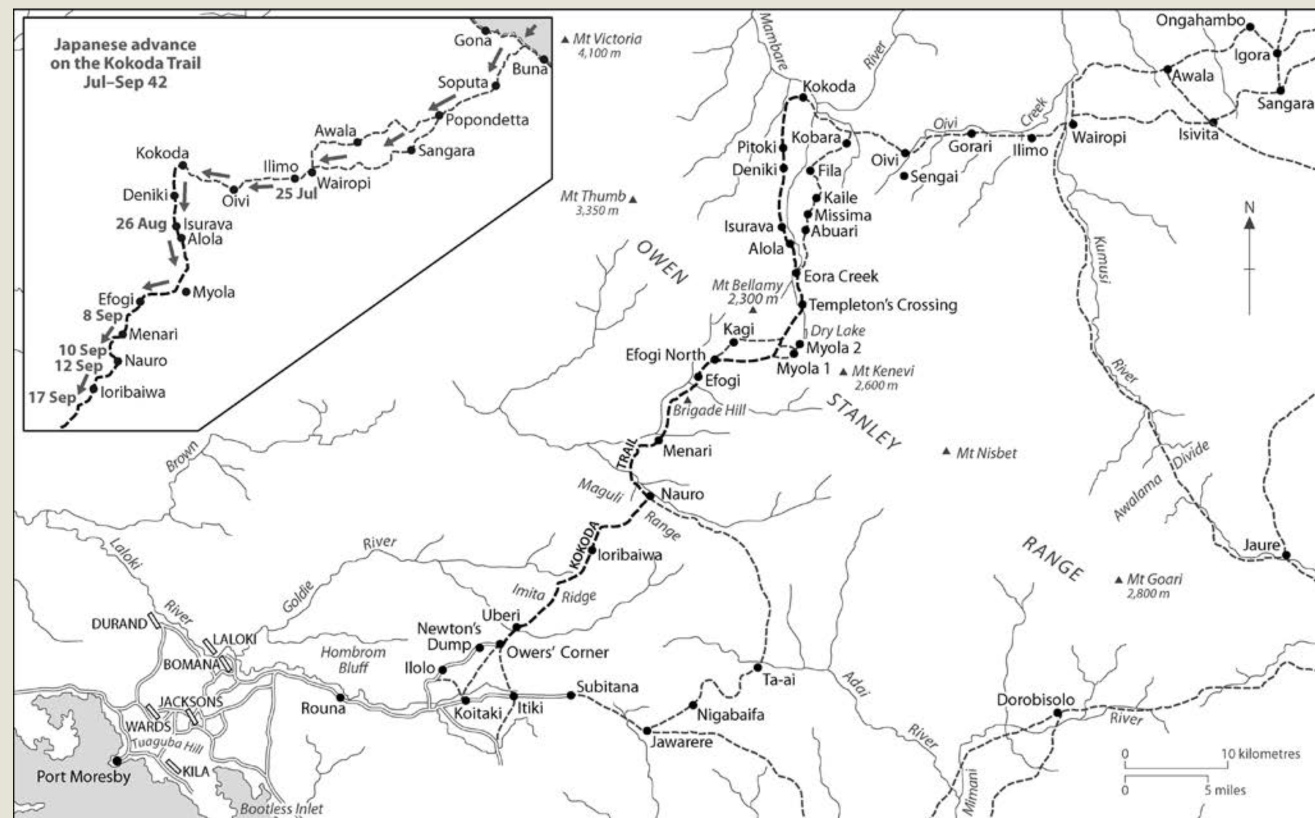


Map 2: The Kokoda Trail, 1942



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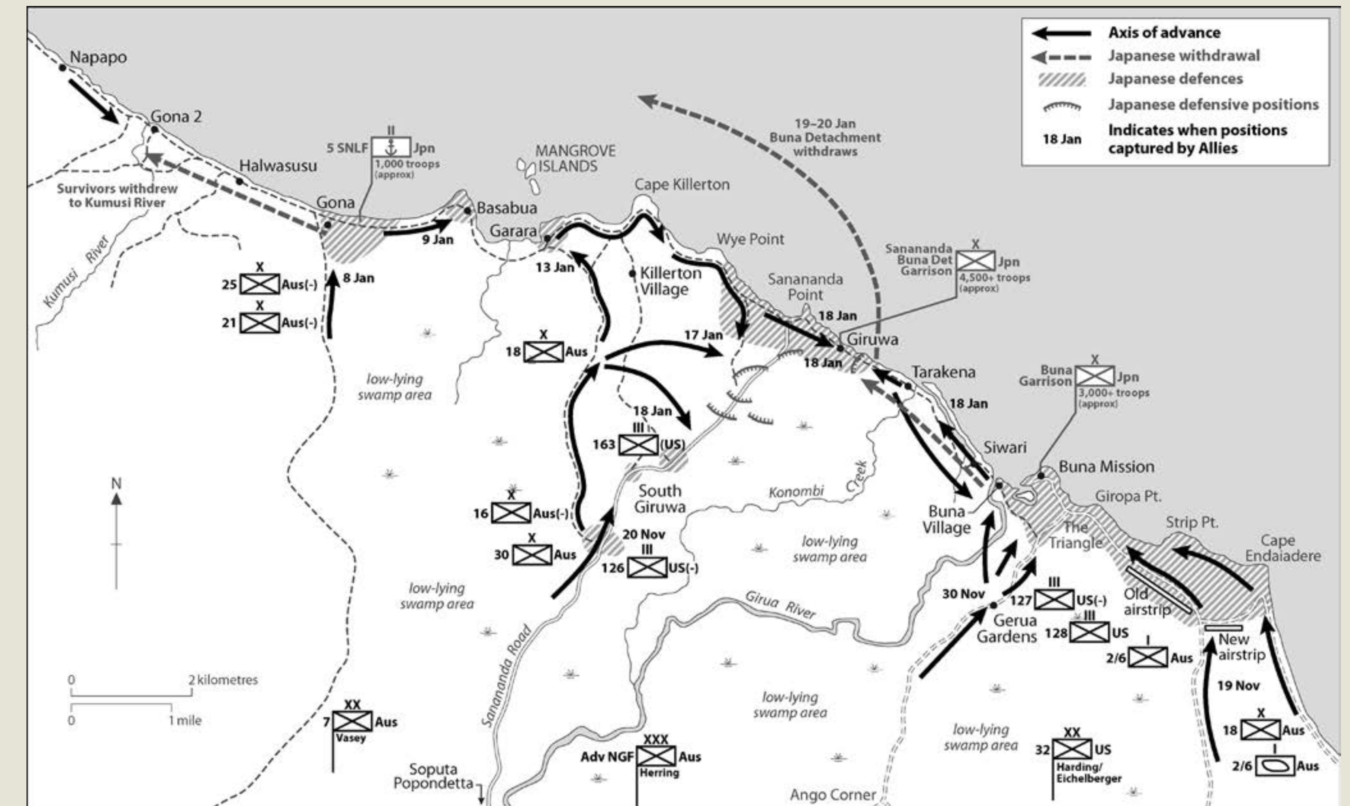

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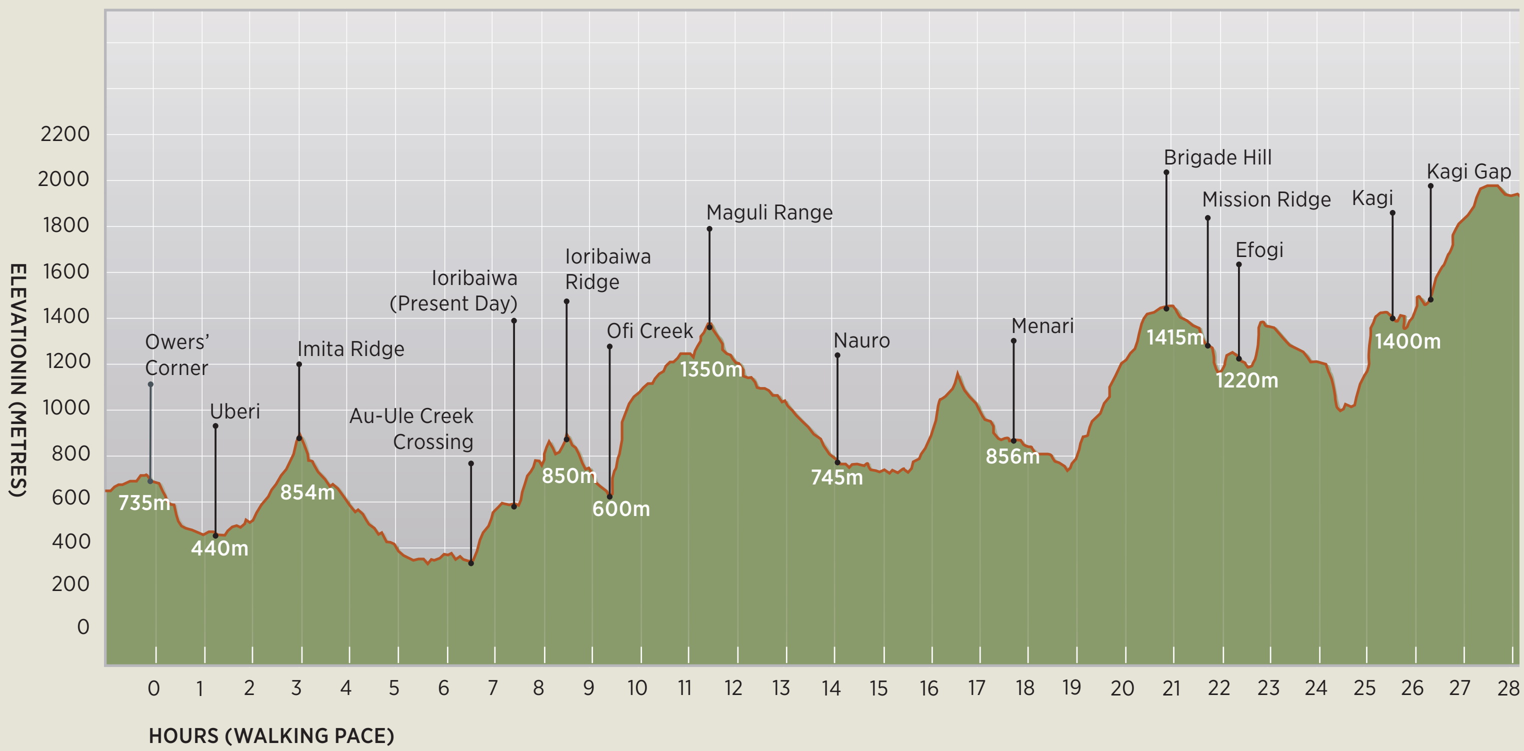
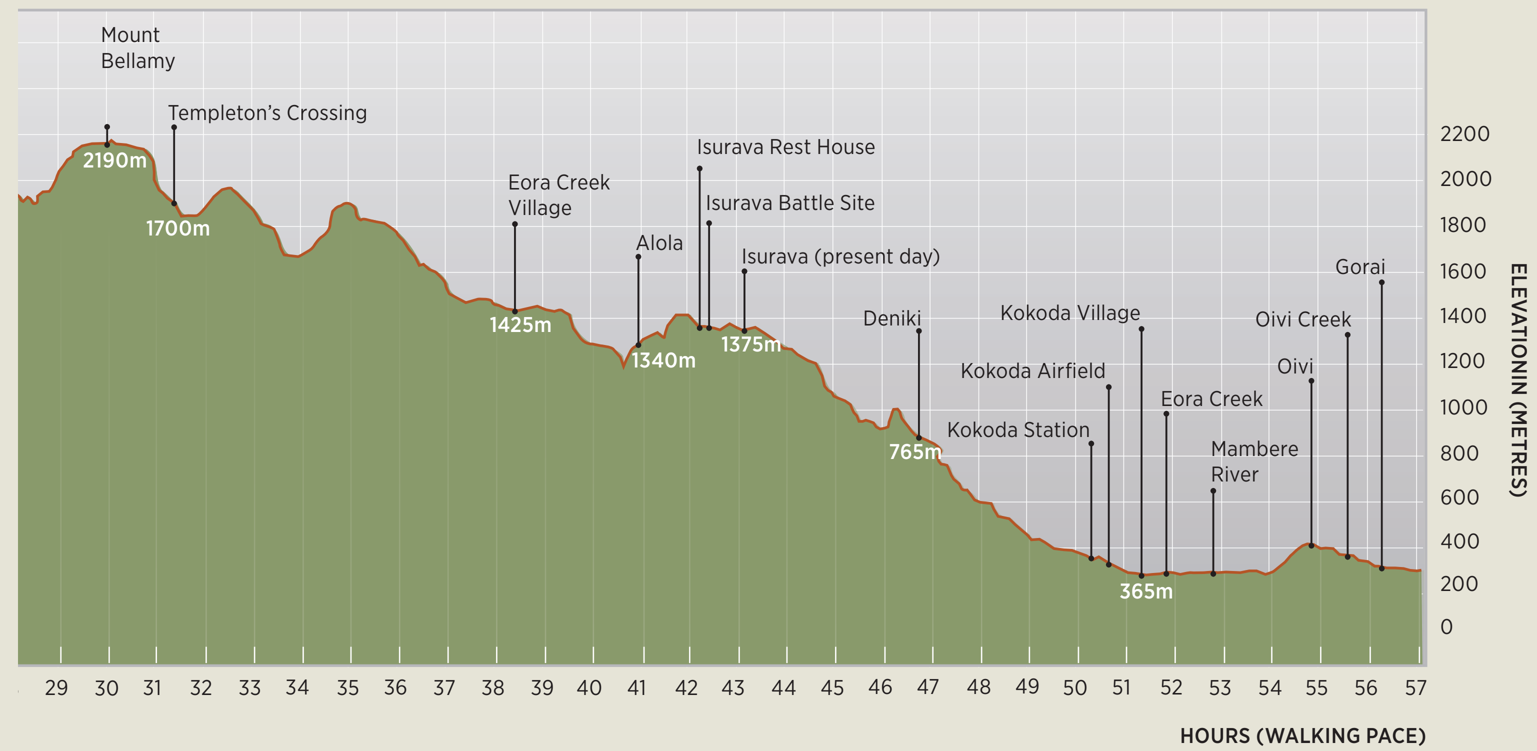




William Dargie, *Casualty* (October 1942, pen, ink and brush on paper, 20.8 x 14.8 cm) AWM ART25494

Introduction

An Undiagnosed Problem

The Kokoda Campaign is Australia's most iconic experience of the Second World War. The campaign involved a series of battles between Australian and Japanese forces in Papua, fought along what became known as the Kokoda Trail. Japanese forces landed along the north coast on 21 July 1942 with the intent of capturing Port Moresby, which lay across the Owen Stanley Range to the south. The defending Australian forces – initially outnumbered, outgunned, and outmanoeuvred – began an arduous fighting withdrawal over a series of rugged mountain ranges towards Moresby. As the Australians received reinforcements and the Japanese lines of communication lengthened, the Japanese force gradually weakened through casualties, sickness and lack of supplies. Its strategic position in the Pacific also deteriorated over the course of the campaign, especially after the American victory in Solomon Islands. Consequently, the Japanese thrust lost its momentum and their forces began a bitter retreat from Ioribaiwa Ridge back to the beachheads and eventual defeat.

The story of Kokoda has been told and retold since the end of the war. Kokoda occupies a key place in Australian history and national mythology. In 1992 Paul Keating, the then Prime Minister of Australia, attempted to redirect Australian nationalism away from Gallipoli and its imperial legacy by establishing the Kokoda Campaign as the nation's founding story.[1] Yet despite its importance in the national consciousness, academic understanding of one aspect of the Kokoda Campaign remains fragmentary – the occurrence of psychiatric casualties during the campaign.

The term "Not Yet Diagnosed Nervous" (NYDN) was a medical acronym often used by the Australian Army Medical Corps (AAMC) to denote psychiatric casualties. The term not only captures the complexity and ambiguity of the condition, but also the uncertainty which often accompanied its diagnosis and treatment. The problem of psychiatric breakdown during the Kokoda Campaign itself remains undiagnosed. Very little scholarly literature exists to shed light on the nature of the problem or how medical personnel dealt with it.

1 Tom O'Lincoln, "Can Kokoda Challenge Anzac?", paper presented at the Pacific War Conference, Monash University, 6 December 2011. Available at http://honesthistory.net.au/wp/wp-content/uploads/233-Can-Kokoda-challenge-Anzac.pdf , p. 2.

This work aims to further understanding of the causes, incidence, and reporting of psychiatric casualties during the Kokoda Campaign. It argues that psychiatric casualties presented a much greater problem to Australian forces than portrayed by medical reports or any subsequent literature.

Current academic knowledge regarding psychiatric casualties is largely contained in the four volumes of the medical series of the official history of Australia in the War of 1939–1945.[2] In Volume One, *Clinical Problems of War*, Allan Walker devotes a single chapter out of 61 to military psychiatry. The small space given is perhaps symptomatic of the poor appreciation of military psychiatry at that time, yet Walker's coverage of the Kokoda Campaign betrays an even more rudimentary understanding. Walker devotes one short paragraph to Kokoda, concluding that psychiatric casualties were uncommon due to "the spirit of the men and their leaders".[3] In comparison, psychiatry during the Siege of Tobruk is afforded several pages with the conclusion that psychiatric casualties presented a significant problem.[4]

Walker's conclusions regarding psychiatric casualties at Kokoda are open to question. He had no personal experience of the campaign and bases his account on medical reports and a single postwar memoir by Bruce Robinson, a former regimental medical officer (RMO). While Robinson evacuated only three psychiatric casualties, his battalion did not actually experience combat during the Kokoda Campaign, and his account described later actions on the Papuan north coast.[5] Moreover, campaign medical reports paint a contradictory picture. While it is true that most reports make no mention of psychiatric casualties or assert that they were rare, two early reports from the campaign indicate that they were common, without specifying numbers.[6] A third report is more specific, showing that some 18 psychiatric casualties were recorded passing through a rear aid post between August and September 1942.[7] These contradictions within Walker's sources serve to undermine his conclusions regarding psychiatric casualties. On the basis of limited resources, it is possible that he underestimated the extent to which psychiatric casualties presented a problem to the medical services at Kokoda.

A number of other sources suggest that psychiatric casualties were far more common than Walker portrayed. An article published in the *Medical Journal of Australia* in 1943 by a psychiatrist serving in a military hospital in Port Moresby recorded a total of 310 psychiatric casualties treated at the hospital from September 1942 to January 1943.[8] In comparison, during the first three months of the Siege of Tobruk 207 men were treated for psychiatric breakdown.[9] Despite the many variables within this comparison, the figures suggest that the two campaigns deserve equal coverage.

Since the official history was written, a deeper understanding of combat stress has emerged. Veterans' memoirs and interviews also provide new insights. Moreover, as Australia's most iconic campaign of the Second World War, our lack of understanding of psychiatric casualties during the Kokoda Campaign is doubly due for revision and expansion. Yet no study has seriously questioned why psychiatric casualties were apparently so rare, nor sought to improve our understanding of cause and incidence. This work seeks to redress this imbalance.

Parameters

This study covers the specific period of the Kokoda Campaign, from July 1942 when the Japanese first landed, to mid-November 1942, with Australian victory in the Battle of Oivi-Gorari.[10] Psychological stresses during this period remained similar, making conclusions regarding the likely causes of psychiatric casualties more sustainable. This study concerns the units that fought along the Kokoda Trail and not those stationed in the rear areas near Moresby. It focuses on psychiatric casualties that occurred under combat conditions. This is not a study of post-traumatic stress disorder (PTSD) or the postwar mental health issues of veterans.

2 Allan S. Walker, *Clinical Problems of War*, Australian War Memorial: Canberra, 1952; Allan S. Walker, *The Island Campaigns*, Australian War Memorial: Canberra, 1957; Allan S. Walker, *Middle-East and Far-East*, Australian War Memorial: Canberra, 1953; Allan S. Walker and others, *Medical Services of the RAN and RAAF, with a Section on Women in the Army Medical Services*, Australian War Memorial: Canberra, 1961.

3 Walker, *Clinical Problems of War*, p. 689.

4 *Ibid*., pp. 679–82.

5 Bruce Robinson, *Record of Service: An Australian Medical Officer in the New Guinea Campaign*, Macmillan and Company: Melbourne, 1944, p. 71.

6 Medical notes on operations in the Owen Stanley area, Papuan Campaign, Medical report on Papuan Campaign submitted to ADMS 7 Div, 1942–43, Appendix D, p. 3, AWM 54 481/12/224; Collection and evacuation of wounded from the front line 1942, Appendix A: General conclusions of a report by Capt. W.W. McLaren, 14 Aust Field Ambulance on the Kokoda Area 1942 to 1943, p. 2, AWM54 329/2/4.

7 Medical Notes on Operations: Owen Stanley-Buna Areas, Annex D, p. 5, AWM54 481/12/50.

8 A.J.M. Sinclair, "Psychiatric Casualties in an Operational Zone in New Guinea", *Medical Journal of Australia*, Vol 2, No. 23, 4 December 1943, p. 453.

9 E.L. Cooper and A.J.M. Sinclair, "War neuroses in Tobruk: a report on 207 patients from the Australian Imperial Force Units in Tobruk", *Medical Journal of Australia*, Vol. 2, No. 5, 1 August 1942, pp. 7477.

10 This is officially recognised as the point of separation between the Kokoda Campaign and the battles for the northern beaches: Dudley McCarthy, *Australia in the War of 1939–1945, Series One: Army, Volume V: South-West Pacific Area – First Year: Kokoda to Wau*, Australian War Memorial: Canberra, 1959.

Methodological Challenges

The subject of psychiatric casualties in war is extremely complex and any study faces significant methodological challenges. The first challenge relates to terminology and definitions. The terms “psychiatric breakdown” and “casualty” are used in this study, but were not in regular use in the contemporary lexicon. Medical authorities attempted to define and standardise their approach to psychiatry from the early days of the war but this was only partially successful.[11] A bewildering range of official and unofficial terminology continued to be used, including “shell-shock”, “NYDN”, “bomb-happy”, “exhaustion-state”, “war neurosis”, “nerves”, and “troppo”. In part, the failure to group psychiatric casualties under a single term stemmed from the fact that medical practitioners were attempting to describe a wide range of conditions, of which most had only a rudimentary understanding.

At the time of the Kokoda Campaign, there was no universally applied definition or means of describing psychiatric breakdown in combat. Consequently, definitions must be applied retrospectively. The symptoms described in accounts of psychiatric casualties generally conform to what modern researchers have designated “Combat Stress Reaction” (CSR). Zahava Solomon, an expert on CSR and psychiatric epidemiology, defines CSR as a “psychiatric breakdown on the battlefield … during which the soldier ceases to function … and/or functions in such a manner so extreme that he becomes a danger to himself and his comrades”.[12]

Similarly, *psychiatric breakdown* is defined in this study as a mental state resulting in a temporary or permanent inability to continue to function effectively in combat. This definition takes into account that many men broke down temporarily and that breakdown was not always simply the product of fear, but a range of psychological pressures engendered by the combat environment. Strong emotions such as frustration, guilt and grief could also result in breakdown — the man who “cried like a baby” under the constant irritation of mosquitoes; the soldier who was evacuated after accidentally shooting his mate; and another who crumbled when given the task of burying his dead friends — all are encompassed by the term *psychiatric breakdown*.[13]

11 D.D.M.S. Conference, 4 July 1940, Part 1 of 2, AWM54 267/6/30.

12 Zahava Solomon, *et al.*, “From Frontline to Home Front: A Study of Secondary Traumatisation”, *Family Process*, Vol. 31, No. 3, 1992, p. 290.

13 *Stanley Barcham, 39th Battalion, unknown interviewer*, 11 December 2003, Australians at War Film Archive, available: http://www.australiansatwarfilmarchive.gov.au/aawfa/interviews/1297.aspx; Victor Austin, *To Kokoda and Beyond: The Story of the 39th Battalion*, 1941–1943, Melbourne University Press: Melbourne, 1988, p. 27; Roy Wotton, 53rd Battalion, 39th Battalion, unknown interviewer, 12 June 2003, Australians at War Film Archive, available: http://www.australiansatwarfilmarchive.gov.au/aawfa/interviews/852.aspx

Determining cause is another major challenge. Mental stress is a deeply personal experience and it is difficult to understand why some individuals broke down while others in the same environment did not. The analysis of internal psychological factors is the domain of psychiatrists and even for them it is extremely difficult to diagnose retrospectively. This work focuses on the external factors of the combat environment. Through comparison with other campaigns in which large numbers of psychiatric casualties occurred, it is possible to understand how similar conditions may have acted at Kokoda.

A final challenge lies in the difficulty of understanding psychiatric breakdown as both a medical and military problem. In the combat environment it is particularly difficult to separate the condition from disciplinary charges of cowardice, malingering, and self-inflicted wounds (SIW). Sympathetic medical officers or unsympathetic superiors acting within the military disciplinary system may have masked psychiatric breakdown. For this and other reasons, it will never be possible to know the exact number of psychiatric casualties that occurred during the campaign. Nevertheless, it is possible to analyse the effects of masking and distinct medical and military cultures on the reporting process.

Primary Sources

A comparison of the primary source material suggests that psychiatric casualties presented a greater problem than is generally understood. The starting point for this analysis remains the campaign medical reports. The major problem with these reports is that they present an incomplete and inconsistent picture. The unpreparedness of Australian forces and the immediacy of the Japanese threat meant that planning was rushed. Medical services were forced to participate in a chaotic withdrawal over extremely rugged terrain while trying to care for and evacuate casualties. Reporting was erratic and did not conform to a single system of casualty classification. While there are some reports that indicate specific numbers for certain time periods, consistent data is not available to form conclusions regarding the numbers of psychiatric casualties. Moreover, no psychiatrists were present at the front line, and no professional assessments were made of the psychological state of soldiers during the campaign.

War-era medical journals help to fill this gap in analysis. Articles in these journals, often written by serving medical officers, offer an insight into the contemporary understanding and contextualisation of psychiatric breakdown. They also shed invaluable light on the different cultures that existed within the military, and the procedures employed by the medical services in diagnosing and referring psychiatric casualties.

Numerous memoirs and unit histories have been published since the end of the war. These add important detail but also present difficulties. Veterans' accounts are coloured by their very participation. Many were understandably proud of what they and their units had achieved, and potentially downplayed or omitted events thought to reflect poorly on the unit. For example, the RMO of the 2/16th Battalion barely mentions psychiatric casualties in his memoir, stating he had to evacuate "some" men during the fighting at Ioribaiwa.[14] Yet his battalion suffered at least 12 psychiatric casualties in less than two weeks, even before the action at Ioribaiwa.[15] Additionally, traumatic experiences may for a number of reasons be deliberately embellished or excluded from recollections. The traditional sensitivities surrounding mental health issues exacerbate this problem. Few memoirs refer to psychiatric breakdown directly, but subtle indicators within the language often suggest its occurrence.

A second difficulty with veterans' memoirs lies in the potential inaccuracy of memory. Memory should not be thought of as "a passive depository of facts, but an active process of creation of meanings".[16] What is remembered is modified by subsequent experience and exposure to the recollections of others.[17] Consequently, memories tend to conform to a wider accepted narrative. To this end, the growing mystique of the Kokoda Campaign, fed by a steady stream of historical writing and representation, has seen perceptions of "what really happened" solidify.

A rich source of information can be found in oral testimony. While subject to the same limitations of memory and self-censorship, one advantage of interviews is that veterans' memories are continually engaged by an external source, prompting comments on subjects that may not have otherwise been discussed. Oral testimony is not constrained by a set format and provides a perspective on a diverse range of subjects on which the official record is reticent. This analysis uses two main oral sources, the Australians at War Film Archive (AWFA) and the Keith Murdoch Sound Archives (KMSA), online repositories of interviews conducted with Australian veterans from all conflicts. The AWFA contains 73 interviews of Kokoda veterans while the KMSA contains 24. Each offers unique insights into the Kokoda Campaign.

14 H.D. Steward, *Recollections of a Regimental Medical Officer*, Melbourne University Press: Carlton, 1983, p. 135.

15 Medical Notes on Operations: Owen Stanley–Buna Areas, Annex D, p. 5, AWM54 481/12/50.

16 A. Portelli, "What Makes Oral History Different", Robert Perks and Alistair Thompson (eds.) in *The Oral History Reader*, Routledge: London, 1979, p. 69.

17 John Tosh, *The Pursuit of History: Aims, Methods, and New Directions in the Study of Modern History*, Longman: New York, 2010, p. 313.

Secondary Sources

There has been a growing literature on the subject of military psychiatry since it first came to the fore during the First World War. This literature represents an evolution of thinking regarding psychiatric breakdown in combat. Jones and Wessely's *Shell-Shock and PTSD* presents a survey of military psychiatry from 1900 to the Gulf War, analysing changing attitudes and beliefs regarding psychiatric breakdown.[18] Likewise, Ben Shephard's *A War of Nerves* analyses the British and American experience of psychiatric casualties from the First World War to Vietnam and the Falklands War, highlighting many of the factors that precipitated psychiatric breakdown within these armies.[19] From the Commonwealth perspective, Copp and Humphries' *Combat Stress in the 20th Century* is an edited collection of articles that gives an insight into past practices and beliefs, and a modern perspective of the causes of combat psychiatric breakdown.[20]

Dudley McCarthy's volume of the army series of the official history, *Southwest Pacific Area: First Year*, provides perspectives on the conditions and context of the Kokoda Campaign but does not mention psychiatric casualties.[21] Neither do such well-known publications as Lex McAulay's *Blood and Iron* and Peter Brune's *Those Ragged Bloody Heroes*.[22] While John Raftery's *Marks of War* examines the postwar mental health issues of Kokoda veterans, it touches only briefly on psychiatric casualties in the field and draws few conclusions regarding their occurrence.[23]

18 Edgar Jones and Simon Wessely, *Shell Shock to PTSD: Military Psychiatry from 1900 to the Gulf War*, Psychology Press: Hove, 2005.

19 Ben Shephard, *A War of Nerves*, Jonathan Cape: London, 2000.

20 Terry Copp and Mark Osborne Humphries, *Combat Stress in the 20th Century: The Commonwealth Perspective*, Canadian Defence Academy Press: Kingston, 2010.

21 McCarthy, *Australia in the War of 1939–1945*, 1959.

22 Lex McAulay, *Blood and Iron: The Battle for Kokoda 1942*, Hutchinson Australia: Milsons Point, 1991; Peter Brune, *Those Ragged Bloody Heroes: From the Kokoda Trail to Gona Beach 1942*, Allen and Unwin: North Sydney, 1991.

23 John Raftery, *Marks of War: War Neurosis and the Legacy of Kokoda*, Lythrum Press: Adelaide, 2003, pp. 51–62.

Structure

Chapter One, “Breaking the Psyche”, investigates the conditions that have historically precipitated psychiatric breakdown in war. It examines examples from a number of conflicts, but focuses on the experience of the Western Allies during the Second World War. Its aim is to provide an understanding of the circumstances that precipitate psychiatric breakdown in combat.

Chapter Two, “The Case of Kokoda”, analyses the various psychological pressures of the Kokoda Campaign, quoting at length to provide and situate evidence of psychiatric casualties in context.

Chapter Three, “The Masking of Psychiatric Breakdown”, investigates factors that may have served to camouflage the true incidence of psychiatric casualties, seeking to resolve the tension between medical reports and other evidence.

Chapter Four, “Cultures of Silence”, explores the complex and often competing cultures that existed within the army, analysing the effect that this may have had on the reporting process.

This work seeks to break the silence of the past 70 years, drawing attention to the reality of psychiatric casualties during the Kokoda Campaign.

Papuan stretcher bearers stop at a river to give a drink of water to their patient, Private A. Baldwin, of the 2/33rd Battalion, Owen Stanley Range. Photograph by Thomas Fisher, September 1942. AWM 026856

Tactical lecture for members of the 39th Australian Infantry Battalion, rear areas, Owen Stanley Range. Photograph by Thomas Fisher, October 1942. AWM 027030

Frank Hodgkinson, *Owen Stanley Trail* (1942, pencil with watercolour and gouache on paper, 26 x 35 cm)
AWM ART28565

Chapter One

Breaking the Psyche - Why Soldiers Become Psychiatric Casualties

In 1952, Allan Walker mused that "the future may show that a fuller and juster comprehension of the 'mind-body' entity … began during the war of 1939–1945".[24] Nearly 70 years later, determining the causes behind psychiatric breakdown in war remains an extremely complex issue. Human individuality frustrates efforts to formulate cause, with different people having unique life experiences, personalities, and personal circumstances. The external factors that contribute to the psychiatric breakdown of one individual might not result in others being affected in the same way. Diagnosing the precise causes of psychiatric breakdown is a difficult undertaking, even for psychiatrists.

This chapter seeks to provide a broad framework of understanding within which the psychological conditions of the Kokoda Campaign may be recognised. The psychological effect of battlefield conditions is examined under three categories: combat stressors, environmental stressors, and mental resilience. Combat stressors relate to the effects of enemy weaponry as well as the psychological impact of the perceived military situation; the intensity, frequency and duration of battle; and the strain of hunger and fatigue. Environmental stressors encompass the impact of physical terrain and climate. Mental resilience refers to the effect that morale, leadership, and experience could have on the ability to cope. Although each category is examined in turn, it is important to recognise that they acted in concert and were by no means mutually exclusive in their effects.

24 Walker, *Clinical Problems of War*, Australian War Memorial: Canberra, 1952, p. 674.

Combat Stressors

The experience of deliberate mass killing makes the battlefield environment unique in its psychological effect. While the fear of death and wounding by any means is a natural instinct, certain weapons produce greater psychological effects than others. Artillery has long been recognised as a major source of combat stress. In his reminiscences of the Battle of Waterloo, Major Cavalie Mercer of the Royal Horse Artillery described the psychological reactions of British infantrymen coming under French artillery fire, 100 years before the same symptoms were described as "shell-shock" during the First World War.[25] By 1914, advances in armaments technology had transformed artillery into a far more lethal and terrifying weapon. The first reported cases of shell-shock in this conflict were believed to be, as the terminology suggests, the result of physiological damage to the brain from the close detonation of high explosives.[26] It soon became apparent, however, that shell-shock was occurring in many soldiers who had not been exposed to a near-miss by artillery.[27] In 1922 the British government concluded that the condition was a psychiatric response to stress rather than the result of physiological damage to the brain.[28]

Nevertheless, a correlation does exist between artillery fire and psychiatric casualties. This is evident in the recollections of many veterans. The sensory impact of shell-fire is aptly illustrated in the account of a First World War medical officer:

> *The detonation, the flash, the heat of the explosive, the air concussion, the upheaval of the earth, and the acrid suffocating fumes combine in producing a violent assault on practically all the senses simultaneously.*[29]

This experience changed little between the world wars. US Army Captain Laurence Critchell described artillery bombardment as "all-encompassing in its violence … with each roar the earth shakes … What is worse, each explosion is anticipated by a high, thin and unearthly shriek".[30] The physiological damage done by shrapnel and high explosives is uniquely horrifying. Having seen the damage done to friends and comrades, the sound of each new incoming shell brought the threat of mutilation, pain, and disfigurement. The experience of artillery fire could sometimes have a profound psychological effect on groups of soldiers. During the Monte Casino offensive in Italy during the Second World War, prolonged and concentrated shelling of the US 2nd Armored Division corresponded with a psychiatric casualty rate of 54 per cent of total casualties.[31]

The experience of aerial attack was also a significant cause of stress.[32] During the Allied retreat in Greece in 1941, the fear elicited by enemy air attack was apparently so great that one account tells of an Australian convoy scattering at the sight of an eagle.[33] A medical officer who served at Tobruk asserted that "there is no doubt that [close aerial attack was] an important factor" in the onset of psychiatric casualties during the siege.[34] Another noted that many mentally afflicted men displayed "morbid anticipation of bombing or shelling".[35] The term "bomb-happy" was often used to describe men who broke down under conditions of mental stress.

Artillery and bombing were terrifying not only because of their sensory impact and perceived lethality, but also due to the feeling of helplessness and loss of control they induced in soldiers. Under such fire, soldiers could not generally draw any psychological relief through retaliation as "no weapon, no missile, no human agent was visible to its targets".[36] Johnson argues that "the inability to retaliate against powerful weapons has been one of the chief sources of stress for twentieth-century soldiers".[37] Similar feelings of fear and helplessness resulted from other weapons such as landlines and booby traps.[38] Eric Bergerud notes that "most soldiers had a particular loathing for threats they had to face passively such as mortar attacks or snipers. If they were able to fight back adrenaline provided a powerful but temporary defence."[39]

25 Paul A. H. Morris, "Attitudes Towards Psychological Casualties in the 2nd New Zealand Expeditionary Force, 1939 to 1945", MA Thesis, University of Canterbury, 2013, available from: http://ir.canterbury.ac.nz/bitstream/10092/8035/1/thesis_fulltext.pdf

26 *Ibid.*, p. 316.

27 Ben Shephard, *A War of Nerves*, Jonathan Cape: London, 2000, p. 54.

28 *Report of the War Office Commission of Enquiry into "Shell-Shock"*, HM Stationary Office: London, 1922, pp. 39, 81.

29 *Ibid.*, p. 4.

30 Gerald F. Linderman, *The World Within War: America's Combat Experience in World War Two*, The Free Press: New York, 1997, p. 18.

31 Edgar Jones and Simon Wessely, *Shell Shock to PTSD: Military Psychiatry from 1900 to the Gulf War*, Psychology Press: Hove, 2005, p. 119.

32 Mark Johnson, *At the Front Line: Experiences of Australian Soldiers in World War II*, Cambridge University Press: Cambridge, 1996, p. 30.

33 Craig Stockings and Eleanor Hancock, *Swastika over the Acropolis: Re-interpreting the Nazi Invasion of Greece during WWII*, Brill: Leiden, 2013, p. 529.

34 Allan S. Walker, "Hospital Work with the Australian Imperial Force in the Middle East", *Medical Journal of Australia*, Vol. 2, No. 4, 25 July 1942, pp. 55––62, p. 61.

35 E.L. Cooper and A.J.M. Sinclair, "War neuroses in Tobruk: a report on 207 patients from the Australian Imperial Force Units in Tobruk", *Medical Journal of Australia*, Vol. 2, No. 5, 1 August 1942, pp. 74–77, p. 74.

36 Linderman, *World Within War*, p. 17.

37 Johnson, *At the Front Line*, p. 30.

38 Linderman, *World within War*, pp. 18–19.

39 Eric Bergerud, *Touched with Fire: The Land War in the South-Pacific*, Penguin Books: New York, 1996, p. 443.

Battlefield psychology is also influenced by the perceived military situation. The mental resilience of soldiers will often vary as an army advances, retreats, or defends. The perception of which side has the advantage at that moment and the perceived value of the military objectives being pursued are also important factors. A British officer observed that the incidence of psychiatric casualties in the desert campaigns of 1942 depended "to some extent on the nature of the action itself — for instance, it is likely to be higher during unsuccessful, purely defensive or unduly prolonged actions".[40] Immobile battlefields seem to have distinct psychological effects on soldiers, especially where "massed artillery could be brought to bear".[41] In contrast to the large numbers of psychiatric casualties on the Western Front during the First World War, Tyquin notes that there are few recorded cases from the highly mobile campaigns of the Australian Light Horsemen.[42] This could suggest that mobile actions were less conducive to psychiatric breakdown.

Many campaigns of the Second World War were also characterised by constant movement, yet resulted in high rates of psychiatric casualties. Periods of retreat often produced large numbers of psychiatric casualties, such as in the British Expeditionary Force at Dunkirk in 1940.[43] Large numbers also occurred in advance: British, Canadian, and American units reported psychiatric casualty rates from 11 to 30 per cent of all wounded during the breakout from Normandy.[44] In more recent conflicts, the general incidence of psychiatric breakdown has also been high. Israeli psychiatric casualties during the highly mobile (and short-lived) Yom Kippur War of 1973 constituted between 30 and 50 per cent of total casualties.[45]

Regardless of the momentum of events, the intensity, frequency and duration of combat have profound effects on the incidence of psychiatric breakdown. Wessely and Jones identify a constant relationship "between the incidence of the total killed and wounded and the number of psychiatric casualties".[46] Actions in which high numbers of men were killed or wounded showed a correspondingly high number of psychiatric casualties. US Army research from the Second World War supports this, noting that casualty rates were "by far the most important factor" in the appearance of psychiatric casualties.[47] Studies conducted by Israeli researchers sought to apply a mathematical figure to the ratio of psychiatric breakdown to other casualty types. The conclusion was that "a ratio of CSR [combat stress reaction] to KIA [killed in action] to WIA [wounded in action] is expected to be 1:1:4 in an 'average' battle fought with conventional weapons".[48] This ratio cannot be easily applied to other battlefield scenarios, however, due to innumerable variables. Nevertheless, this research suggests that numbers of psychiatric casualties increase with the number of killed and wounded.

The duration of battle has a cumulative psychological effect. A major contributing factor in operations of a long duration is the psychological impact of fatigue. The effect of fatigue is particularly felt when fighting in physically exhausting terrain, especially where soldiers' dietary requirements are not met.[49] Gabriel asserts that "[m]odern experience has clearly taught that fatigued troops – hungry, thirsty, tired – will very readily break under even moderate stress".[50] This is supported by the findings of Swank and Marchand's study on the onset of "combat neurosis" during the Second World War.[51] US Army psychiatrists were embedded with combat units as they landed on D-Day, recording the psychological effect of battle over a prolonged period of time. They found that while a proportion of men became psychiatric casualties within the first week of combat, most had a peak period of combat efficiency between seven to 30 days of combat. Beyond 30 days, more and more soldiers began to display signs of fatigue and "combat exhaustion", and soldiers were more likely to become psychiatric casualties when exposed to acute incidents such as a near-miss or witnessing the death of a friend. After 60 days in combat, many soldiers entered an emotionally vegetative state. The researchers represented these findings graphically, as reproduced below.[52]

40 Edgar Jones and Simon Wessely, "Psychiatric Battle Casualties: An Intra- and Interwar Comparison", *The British Journal of Psychiatry*, Vol. 178, No. 3, 2001, pp. 242–47, p. 244.

41 Michael Tyquin, *Madness and the Military: Australia's Experience of the Great War*, Army Military History Publications: Loftus, 2006, pp. 42–43.

42 *Ibid.*, pp. 42–43.

43 Shephard, *A War of Nerves*, pp. 169–70.

44 Jones and Wessely, *Shell-Shock to PTSD*, pp. 83––84; Shephard, *War of Nerves*, p. 254

45 Franklin D. Jones, "Psychiatric Lessons of War", in Sparacino *et al.*, *War Psychiatry*, TMM Publications: Washington, 1995, pp. 3–33, p. 21.

46 Jones and Wessely, "Psychiatric Battle Casualties", pp. 245–6.

47 Roy Swank and Walter Marchand, "Combat Neurosis: Development of Combat Exhaustion", *Archives of Neurology & Psychiatry*, Vol. 53, No. 3, 1946, p. 244.

48 Lars Weisaeth, "Military Stress in War and Peace", in Philip Morris, Beverley Raphael, and Alex Bordujenko (eds.), *Stress and Challenge: Proceedings of the RMA Consensus Conference, Brisbane 9–11, 1998*, Repatriation Medical Authority: Brisbane, 1998, pp. 99–110, 108.

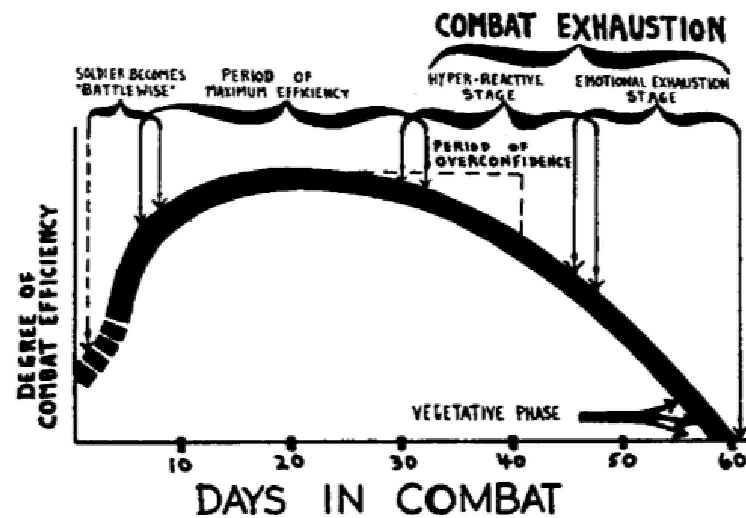
49 Allan S. Walker, *The Island Campaigns*, Australian War Memorial: Canberra, 1957, p. 69.

50 Richard A. Gabriel, *No More Heroes: Madness and Psychiatry in War*, Hill and Wang: New York, 1987, p. 52.

51 Swank and Marchand, "Combat Neurosis", pp. 236–47.

52 *Ibid.*, p. 238.

Figure 1: Combat efficiency over time spent in combat



Swank and Marchand, “Combat Neurosis”, pp. 236–47.

The study found a wide variation within the unit, noting that signs of combat exhaustion could begin as early as 15 days into combat and as late as 50 days. A small number of men appeared to be unaffected by continued exposure to combat.[53] While variation between individuals means that it is impossible to predict psychiatric casualty rates with certainty, the likelihood of breakdown seems to increase after long periods of combat.

Environmental Stressors

Terrain, climatic conditions and disease can have a cumulative psychological effect. Combat in difficult terrain requires greater exertion and hence continuous fighting is more likely to degrade physical and mental resilience.[54] While each terrain type has unique psychological effects that can vary under different combat conditions, open terrain is usually more conducive to feelings of security than close terrain, as it allows the enemy to be seen and engaged from a distance, generally with a reasonable amount of warning. In contrast, close terrain allows the enemy to strike swiftly and without warning.

The campaigns fought by Australian forces in North Africa and the Middle East during the Second World War were predominantly fought in open desert terrain, according to Linderman, “a circumstance of prodigious military and psychological significance”.[55]

53 *Ibid.*, p. 243.

54 Bergerud, *Touched with Fire*, p. 445.

55 Linderman, *World Within War*, p. 93.

He argues that many soldiers preferred fighting in the desert to urban or jungle environments for several reasons: it did not lend itself to sniping; there was little scope for booby traps; and the high visibility meant that the enemy was not conceptualised as an unknown lurking menace able to strike at any time without warning.[56] Warfare in open terrain was a team activity, allowing large-scale clashes of units in which individuals were borne along by group momentum. In contrast, close terrain, such as jungle and urban areas, can induce a heightened sense of claustrophobia and fear. An Australian RMO believed that the jungle environment produced mental strain because “much of the work had to be done by scouts or small patrols, so that the stimulating and encouraging effect of the unit acting as a whole tended to be lost”.[57]

In addition to terrain, harsh climates made life generally more miserable and uncomfortable. An American infantryman said of the tough fighting in Italy in 1944:

> *I know for certain that the worst part of the war was not the shooting or the shelling – although that had been bad enough – but the weather, snow, sleet and rain, and the prolonged physical misery which accompanied them.*[58]

Swank and Marchand claimed that “the degree of stress imposed by sheer physical discomfort” was underappreciated and that “[t]he effects of long-continued, multiple physical discomforts of this sort were intensely distressing”, over time becoming “well nigh insupportable”.[59] Similarly, Keating argues that,

> *it is misleading to measure battle exhaustion only in terms of frequency of battle, number of friendly casualties and kills inflicted on the enemy. Less dramatic exposure to the stresses of the combat zone, over a longer timeframe, could result in a breakdown just as easily as more recognisable causes.*[60]

56 *Ibid.*, p. 93.

57 Bruce Robinson, *Record of Service: An Australian Medical Officer in the New Guinea Campaign*, Macmillan and Company: Melbourne, 1944, p. 23.

58 John Ellis, *The Sharp End of War: The Fighting Man in WWII*, David and Charles: London, 1980, p. 23

59 Samuel A. Stouffer, *et al.*, *The American Soldier: Combat and its Aftermath, Volume II*, Princeton University Press: Princeton, 1949, p. 78.

60 Gavin Keating, *A Tale of Three Battalions: Combat Moral and Battle Fatigue in the 7th Australian Infantry Brigade, Bougainville, 1944–45*, Land Warfare Studies Centre: Canberra, 2007, p. 53.

The particular discomforts of fighting in tropical climates were almost universally remembered by veterans. In the tropics, humidity sapped strength while illnesses such as malaria, dysentery and scrub typhus could flourish.[61] Large numbers of insects, including malaria-infected mosquitoes, contributed to the discomfort of troops. Daily deluges of rain added to the misery of jungle warfare. Combatants were constantly soaked through, sweating through the heat of the day and drenched by rain in the evening. Mud added to the general discomfort of living and increased the effort of movement. Each of these factors served to physically and mentally weaken combatants in tropical environments. In such conditions, Bergerud argues that "[t]he interaction between fear, stress, exhaustion, and illness created a dreadful dynamic that threatened to break the spirit of fighting men".[62]

Mental Resilience

Military training and social structures can assist in fostering mental resilience, helping soldiers to deal with stressful situations and control fear in combat.[63] Armies facilitate resilience by fostering high unit morale and cohesion. Morale is essential to the ability of soldiers to function in combat, suppressing the natural instincts of men to flee danger.[64] This group solidarity can work both ways, however, as deteriorating morale has the potential to spread quickly. Copp and Andrew found that in the Canadian Army during the Second World War, "rates [of psychiatric breakdown] were directly affected by the state of the unit's morale, leadership, competence and esprit".[65] If unit confidence is lost, "a feeling of panic and despair can swiftly grow, persuading even those that were prepared to stand firm that all is lost".[66] During periods of poor morale the individual mental burden increases as fear, uncertainty and helplessness spike, increasing the likelihood of psychiatric casualties.[67]

The psychological effects of leadership, or lack thereof, have been analysed in several studies of the Second World War. In a comparative study of the performance of three Australian battalions during the Bougainville Campaign, Keating argues that competent leadership was a key factor in monitoring and preventing the occurrence of psychiatric breakdown.[68]

61 Bergerud, *Touched with Fire,* pp. 89–100.

62 *Ibid.*, p. 445.

63 Hew Strachan, "Training, Morale and Modern War", *Journal of Contemporary History*, 2006, Vol. 41, No. 2, pp. 211–27, p. 216.

64 Todd C. Helmus and Russell W. Glenn, *Steeling the Mind: Combat Stress Reactions and their Implications for Urban Warfare*, Arroyo Centre: Santa Monica, 2004, pp. 26–7.

65 Terry Copp and Bill McAndrew, *Battle Exhaustion: Soldiers and Psychiatrists in the Canadian Army, 1939–1945,* McGill-Queen's University Press: Montreal, 1990, p. 82.

66 Ellis, *The Sharp End*, p. 255.

67 Helmus and Glenn, *Steeling the Mind,* p. 54.

68 Keating, *Tale of Three Battalions*, p. 12.

The absence, death or wounding of officers, especially battalion commanders, often had a devastating impact on unit morale and cohesion. Army psychiatrists supporting the breakout from Normandy noticed that "a sudden influx of [psychiatric] cases following the death or wounding of the commanding officer was a common story".[69] If the leadership vacuum is not promptly filled in such cases, the confidence and mental resilience of individual soldiers can be greatly undermined. An example of this occurred in New Georgia where US forces experienced a large number of psychiatric casualties. An investigation by army psychologists found that there was a correlation between individual breakdown and officer casualties.[70]

The level of combat experience of soldiers and units also affects the ability to cope with battle-related stress. Some accounts suggest that inexperienced troops are more likely to break under combat conditions. Army psychiatrists partially ascribed the large number of psychiatric casualties among the US 43rd Division on New Georgia to the inexperience of the troops involved.[71] Likewise, Walker claimed that during the Syrian campaign, "[s]ome of the inexperienced suffered fear states, especially when under air attack to which reply was not always available".[72] A number of medical officers reinforced the conviction that combat experience served as a preventative factor, arguing that soldiers became accustomed to battlefield conditions.[73]

Despite this evidence, there are many examples of high incidences of psychiatric breakdown in experienced soldiers, as is illustrated by the fighting in Normandy in 1944. From 17 June to 1 July, the seasoned 51st Highland Division reported 18 per cent of its total casualties as psychiatric; another similarly experienced division suffered 21 per cent psychiatric casualties. The British War Office noted that many of these soldiers "were experienced veterans with excellent past records".[74] In contrast, the largely inexperienced 6th Airborne Division recorded only four per cent psychiatric casualties, while suffering comparable casualty rates under similar combat conditions.[75] While many variables may be at play, the above example demonstrates that combat experience did not equate to psychiatric immunity.

69 Shephard, *War of Nerves*, p. 253.

70 Bergerud, *Touched by Fire*, p. 446.

71 *Ibid.*, 446.

72 Allan S. Walker, *Middle-East and Far-East*, Australian War Memorial: Canberra, 1953, p. 311.

73 Medical Notes on Operations: Owen Stanley–Buna Areas, RMO 2/2 Aust Infantry Bn Capt A. McGuinness – Report on New Guinea Campaign 4/10/42–10/12/42, p. 3, AWM54 481/12/50; Robinson, *Record of Service,* pp. 71–72.

74 War Office, *Psychiatric Disorders of Battle*, HMSO: London, 1951, p. 7.

75 Jones and Wessely, *Shell-Shock to PTSD*, pp. 83–84.

Indeed, according to US Army research, the most and least experienced of the unit were at highest risk of psychiatric breakdown.[76] Ultimately, the stresses of combat can erode the mental resilience of even the toughest, most experienced soldier:

> *The key to the understanding of the psychiatric problem is the simple fact that the danger of being killed and maimed imposes a strain so great that it causes men to break down ... There is no such thing as "getting used to combat".*[77]

• • •

The causes of psychiatric breakdown in combat are extremely complex. Ultimately, psychiatric breakdown must be understood as the result of an interaction between numerous external and internal factors. The fact that every person responds differently to stress, and that so many different sources of external stress exist on the battlefield, means that there is no single determining factor. Yet empirical evidence suggests that certain external factors increase the risk of breakdown. The feeling of helplessness in not being able to escape from or respond to enemy fire has a major impact. While weapons such as artillery and airpower were notable sources of psychological trauma, psychiatric casualties could arise from being subjected to any weapon that induced strong and stressful emotions. Periods of defeat and retreat, high casualty rates, frequent engagements, and long operational duration often coincided with increased numbers of psychiatric casualties. Environmental conditions served to exacerbate the psychological effects of battle, with the prolonged experience of extreme terrain, climatic conditions and disease eroding mental resilience. Low morale and the absence of positive leadership also served to degrade the psychological resilience of soldiers. Battle experience offered no immunity; both new soldiers and veterans were at risk.

76 A.J. Glass, "Lessons Learned", in A.J. Glass and W.S. Mullens (eds.) *Neuropsychiatry in World War II, Vol. 2: Overseas*, US Government Printing Office: Washington , pp. 989–1027, p. 1025.

77 J.W. Appel and G.W. Beebe, "Preventative Psychiatry: An Epidemiological Approach", *Journal of the American Medical Association*, Vol. 131, No. 18, 1946, pp. 1469–75, p. 1469.

Three members of 55th Battalion at a Bren gun emplacement on Uberi Ridge. Photograph by Thomas Fisher, September 1942. AWM 027007

Papuan bearer arriving at the top of a ridge with a load of supplies. Photograph by Thomas Fisher, October 1942. AWM 026864

Chapter Two

The Case of Kokoda

The consensus of medical reports from the Kokoda Campaign is that psychiatric casualties were rare, a view reproduced in the medical series of the official history. However, there is an inherent tension within this consensus. While primary sources, including medical reports, universally acknowledge the psychological strain imposed by the conditions on the trail, most remain silent on the topic of psychiatric breakdown. This chapter explores the causes of stress for soldiers during the Kokoda Campaign, analysing the degree of psychological strain presented by campaign conditions.

Combat Stressors

One of the greatest differences between the Kokoda Campaign and other Australian campaigns of the Second World War was the limited use of artillery and offensive airpower. Where campaigns in the Middle East and North Africa were characterised by armoured manoeuvre and the clash of large units with air and artillery support, the mountainous, jungle-clad terrain of the Owen Stanley Range lent itself to a more personal war of small, isolated groups of men fighting across a narrow frontage. The extremely steep and rugged terrain restricted the use of heavy weapons, while the cover provided by the jungle foliage largely precluded effective aerial bombardment. Captain Vernon of the Australian New Guinea Administrative Unit (ANGAU) remarked that with the "absence of heavy armament on this front, the ghastly wounds seen elsewhere were rarely met with".[78] Psychological trauma resulting from the shock and horror of seeing comrades blown to pieces by high explosives occurred on a smaller scale. Some medical officers raised the possibility of a relationship between the lack of explosive projectile weapons and the apparent low number of psychiatric casualties. Captain Joseph of the 2/6th Field Ambulance wrote, "A few cases occurred but they were not common. Is this accounted for by the limited used of HE projectiles?"[79] The RMO of the 2/14th Battalion was more certain, arguing that the absence of artillery was a significant factor in the prophylaxis of psychiatric breakdown.[80]

However, as the campaign progressed the Japanese made increasing use of a number of artillery pieces specifically designed for mountain warfare. Known as mountain guns, such weapons were relatively light and manoeuvrable. The Japanese eventually brought a total of 16 mountain guns, mostly 70 and 75 millimetre in calibre, and a lavish supply of ammunition into action during the Kokoda Campaign. A recent reassessment of the campaign by Peter Williams suggests that these weapons played a far greater role in early Japanese successes than has been recognised.[81]

Such a small number of light artillery pieces might seem relatively insignificant in comparison to artillery use during the North African or Middle Eastern campaigns, but the frontages and depths of positions during the Kokoda Campaign were also much smaller. The mountainous terrain and low visibility of the jungle forced units to adopt tightly compressed formations. This meant that the effects of Japanese artillery fire were concentrated into a relatively small area. At the siege of Tobruk, each Australian battalion was spread across a frontage and depth of several kilometres.[82] In contrast, during the battle of Isurava, the combined forces of the 39th and 2/14th Battalions were subjected to an artillery barrage from eight mountain guns in an area of barely 700 meters by 400 meters.[83] An Australian soldier who was present at the time recalled the experience:

> *High ground to the front, west and rear at Isurava allowed the Japanese to shell the confined Australian defensive position with artillery and rake them with machine gun fire as they wished. The Australians had no means of returning fire.*[84]

The mountain guns were therefore disproportionally effective. That they had a significant psychological effect on soldiers is confirmed by a medical officer who reported, "[p]sychiatric cases were uncommon until the enemy used a mountain gun".[85]

The nature of the terrain and inability of Australian forces to return fire meant that the Japanese often employed artillery at point blank range in a direct fire role. One platoon commander reported, "the guns could be fired with pinpoint accuracy and casualties were frequent at all points of our defensive position".[86] Soldiers had little protection from the mountain guns which, despite their relatively light calibre, could still produce horrific wounds:

> *[A]t an angle of perhaps 40 degrees, I saw the flash of the gun. Almost simultaneously, the sensation I felt was something like being in a dumper wave ... It had blown Charlie Lintot and John Baker to shreds ... and I was covered with their human tissue.*[87]

78 A War Diary by Capt G.H. Vernon – The Owen Stanley Campaign July––November 1942, p. 16, AWM54 253/5/8.

79 Medical notes on operations in the Owen Stanley area, Papuan Campaign, Medical report on Papuan Campaign submitted to ADMS 7 Div, 1942–43: Medical Report, part 5, 17 Aug–11 Sep, p. 27, AWM 54 481/12/224.

80 John Raftery, *Marks of War: War Neurosis and the Legacy of Kokoda,* Lythrum Press: Adelaide, 2003, p. 62.

81 Peter Williams, *The Kokoda Campaign: Myth and Reality*, Cambridge University Press: Cambridge, 2012, p. 3.

82 See map of battalion dispositions: Allan Walker, *Middle East and Far East*, Australian War Memorial: Canberra, 1953, p. 186.

83 Bill James, *Field Guide to the Kokoda Track: An Historical Guide to the Lost Battlefields*, Kokoda Press: Lane Cove, 2006, p. 343.

84 William L. Grayden, *Kokoda Lieutenant: The Triumph of the 21st Brigade – Recollections of an AIF Platoon Commander, 1942*, Hesperian Press: Carlisle, 2015, p. 50.

85 Medical notes on operations in the Owen Stanley area, Papuan Campaign, Medical report on Papuan Campaign submitted to ADMS 7 Div, 1942–43, Appendix D, p. 4, AWM 54 481/12/224.

86 Grayden, *Kokoda Lieutenant,* p. 86.

87 *Ibid.*, p. 88.

75mm ammunition is examined by an Australian intelligence office. AWM 026832

The effects of high explosive weaponry featured prominently in the fixations of those psychiatric casualties who were evacuated. Captain Alex Sinclair, a psychiatrist working in a base hospital near Moresby, wrote:

> *Commonest objects of fear were high and low level bombing, automatic weapons, trench mortar fire, and mountain gun fire. It occurred more regularly in men who were "pinned down" for long periods or were in such a position that retaliation was impossible.*[88]

The psychological impact of powerlessness in the face of danger is reinforced in another medical report: "The fact that this [mountain gun] was fired at point blank range with practically no means of retaliation had a most demoralising effect".[89] That the experience of mountain gun fire features so prominently in the recollections of many veterans speaks to its psychological impact. Mountain guns were perceived as particularly lethal. One veteran remembered the guns being "fired to magnificent effect. Every time it went off it seemed to knock over somebody."[90] Another recalled a small group of men from his unit breaking in the face of sustained shell-fire and rushing past their commanding officer, heedless of his efforts to stop them.[91]

88 A.J.M. Sinclair, "Psychiatric Casualties in an Operational Zone in New Guinea", *Medical Journal of Australia*, Vol. 2, No. 23, 4 December 1943, pp. 453–60, p. 458.

89 Medical notes on operations in the Owen Stanley area, Papuan Campaign, Medical report on Papuan Campaign submitted to ADMS 7 Div, 1942–43, Appendix D, p. 4, AWM 54 481/12/224.

90 Albert Fry, 39th Battalion CMF, 2/8th Battalion, Date Interviewed: 4 December, 2003, Australians at War Film Archive, available: http://www.australiansatwarfilmarchive.gov.au/aawfa/interviews/1195.aspx

91 Robert Thompson, 2/14th Battalion, Date Interviewed: 5 March, 2004, Australians at War Film Archive, available: http://www.australiansatwarfilmarchive.gov.au/aawfa/interviews/1804.aspx

Other weapons also had a major psychological impact. Fire from Japanese Juki machine-guns often elicited a sense of helplessness, as during the initial phase of the campaign Australian troops had no equivalent weapon to match its range.[92] One veteran recalled, "we were under continuous fire from the enemy woodpecker [Juki] machineguns, the emotional pressure was enormous".[93] Japanese grenadiers also carried 50 mm "knee mortars", which fired half-kilogram explosive projectiles. Each company of infantry carried three mortars and the many accounts of Australian soldiers who were on the receiving end are testimony to its effectiveness.[94] John Burns recalled the psychological effect that these weapons could have: "a mortar landed very close to our place of abode and it gave the lads a terrible fright. We did our best to cheer them up but a couple of them appeared to lose all nerve".[95]

The author pictured with a Japanese Juki ("woodpecker") machinegun, now located in the war museum at Kokoda. Australian forces initially had no equivalent to this weapon.

92 Adrian Threlfall, *Jungle Warriors: From Tobruk to Kokoda and Beyond, How the Australian Army became the World's most Deadly Jungle Fighting Force*, Allen and Unwin: Sydney, 2014, p. 100.

93 Robert Johns 2/27th Battalion, unknown interviewer, 26 November 2003, Australians at War Film Archive, available: http://www.australiansatwarfilmarchive.gov.au/aawfa/interviews/1127.aspx

94 James, *Field Guide to the Kokoda Track*, p. 246.

95 John Burns, *The Brown and Blue Diamond at War: The Story of the 2/27th Battalion AIF*, 2/27th Battalion Ex-Servicemen's Association: Adelaide, 1960, p. 125.

Veterans frequently recall that aerial bombardment was a significant factor in the onset of psychiatric breakdown, despite its limited use in the jungle. Many combat units were bombed in the Port Moresby area as they prepared to move up the Kokoda Trail. Several veterans of the 39th Battalion recalled soldiers going "bomb-happy" during Japanese air raids.[96] A former sergeant of the unit remembered, "for the first six months we were bombed day and night, strafed and this didn't improve the mentality or the strain of stress, etcetera. Although we didn't call it stress in those days, you just went 'Bomb-happy'."[97]

Another veteran recalled that the unit's first RMO was himself evacuated as a psychiatric casualty during this period.[98] It is likely that this sustained bombing had a psychological influence on many soldiers even before they were involved in ground combat, potentially lowering their mental resilience to the stress of encountering the Japanese.

Several operational factors had a profound psychological impact on soldiers. During the first phase of the Kokoda Campaign, Australian actions were purely defensive. Initial contact between the 39th Battalion and Japanese forces precipitated a long period of withdrawal under pressure. The mentality of retreat; the initial perception of being outnumbered, alone, and losing; and hunger, physical exhaustion, and lack of sleep were all sources of stress. The 39th and 53rd Militia Battalions were the first Australian units to engage the Japanese and their introduction to warfare was harsh, fighting a numerically and tactically superior enemy. A veteran of an Australian Imperial Force (AIF) battalion recalled his first encounter with the militiamen: "they were absolutely bedraggled, undisciplined looking, haggard, in poor physical shape and obviously in poor mental shape."[99] Some sense of their emotional strain can be gauged from this excerpt from a postwar memoir:

96 Donald Daniels, 39th Battalion, Date Interviewed: 10 June 2003; Australians at War Film Archive. Available at http://www.australiansatwarfilmarchive.gov.au/aawfa/interviews/1640.aspx

Lawrence Downes, 39th Battalion, Date Interviewed: 5 December 2003, Australian's at War Film Archive. Available at http://www.australiansatwarfilmarchive.gov.au/aawfa/interviews/1197.aspx)

Arnold Forrester, 39th Infantry Battalion, Date Interviewed: 26 March 2004, Australian's at War Film Archive. Available at http://www.australiansatwarfilmarchive.gov.au/aawfa/interviews/1384.aspx

William Gleeson, 39th Battalion, Date Interviewed: 16 April 2004, Australian's at War Film Archive. Available at http://www.australiansatwarfilmarchive.gov.au/aawfa/interviews/1437.aspx

97 Donald Daniels, SGT 39th Battalion, 2/2nd Battalion, Date Interviewed: 10 June 2003; Australians at War Film Archive. Available at http://www.australiansatwarfilmarchive.gov.au/aawfa/interviews/1640.aspx

98 Ronald Halsall, 39th Battalion, unknown interviewer, 22 August 2003, Australians at War Film Archive. Available at http://www.australiansatwarfilmarchive.gov.au/aawfa/interviews/907.aspx

99 Harry Katekar, 2/27th Battalion, 6 March 1990, interviewed by Rob Linn. Available at https://static.awm.gov.au/images/collection/pdf/S00903_TRAN.pdf p. 15

> *In these initial experiences of war at the front line ... these militiamen had been unnerved by the apparent superiority of their enemies in numbers, training and weaponry ... [there was] a feeling that the odds were always overwhelmingly stacked against the soldier, alone in a great loneliness where nobody cared about him.*[100]

The constant pressure applied by the pursuing Japanese forces left scant opportunity to sleep for soldiers already exhausted from physical exertion, sickness, and insufficient food. A 39th Battalion medical orderly, Sergeant Wilkinson, recorded in his diary for 28 July 1942: "We have 77 men all battle weary and suffering from exposure. Have had no sleep for three nights and feel rotten".[101] Three days later, Captain McLaren of the 14th Australian Field Ambulance noted, "Many troops suffering from exposure and war neurosis arrived during day. None had any medical authority to come back".[102] McLaren later commented that "[t]he type of warfare and lack of sleep and inadequate food were the predisposing factors".[103] Less than two weeks since the Japanese landings, psychiatric casualties were already becoming a problem. A 39th Battalion veteran recounted the breakdown of a soldier during this initial period: "I don't blame him, we were all on the verge, I'd say, every one of us ... It is a wonder that we didn't all feel like it. It was a terrible experience."[104] The psychological aspects of the retreat are perhaps best summed up in the words of one who did not actually participate in it, a veteran who took part in the eventual victorious advance:

> *It was bad enough for us, but I think of those poor beggars that did the retreat. It must have been worse for them because we at least were going forward. They were going back and it is psychological, it creates a psychological state of mind.*[105]

100 Frank Sublet, *Kokoda to the Sea: A History of the 1942 Campaign in Papua*, Slouch Hat Publications: McCrae, 2000, p. 25.

101 James, *Field Guide to the Kokoda Track,* p. 376.

102 Report of No. 1 Medical detachment 14 Aust Field Ambulance Kokoda Area 24/7/42 to 08/9/42, AWM54 481/12/15.

103 New Guinea campaign extract from medical appreciation of Captain Vernon on the Kokoda Trail, Collection and evacuation of wounded from the front line 1942, Appendix A: General conclusions of a report by Capt. W.W. McLaren, 14 Aust Field Ambulance on the Kokoda Area 1942 to 1943, pp. 2–4, AWM54 329/2/4.

104 Leslie Simmons, 39th Battalion, interviewed by Harry Martin, 04 January 1989, Keith Murdoch Sound Archive. Available at https://static.awm.gov.au/images/collection/pdf/S00518_TRAN.pdf p. 58

105 Neville Lewis, 2/33rd Battalion – Signals, Date Interviewed: 1 July, 2004, Australians at War Film Archive. Available at http://www.australiansatwarfilmarchive.gov.au/aawfa/interviews/1054.aspx

Logistics was a major problem for the Australian forces throughout the campaign, with a manpower shortage and rugged terrain making it difficult to supply forward troops with adequate nutrition. Fred Williams, a private with 2/25th Battalion, recalled that the toughest part of the campaign "wasn't the fact of the fighting, it was the fact of the pervasions [sic] and things you had to suffer ... Food was, as I say, eleven or twelve days it's nothing to go without a bite ... you finished up you're compulsively eating things off the trees."[106]

With many soldiers already suffering sickness and exhaustion, the lack of food further degraded physical and mental resilience. One soldier recalled a mate who broke down, developing a fixation with food after returning from several weeks of being cut off from the main force:

> *[B]y this time he was, virtually couldn't walk, he'd packed right up. I think the reaction of realising that he was safe ... when we got to put him on the stretcher he's got a sandbag half filled with food. And I said, "You can throw that away" ... And he said, "I'm not getting caught again" ... He wouldn't let go of that sandbag half full of food. That's how his mentality was working.*[107]

Psychological stresses increased with the mounting intensity of the fighting as the Japanese advanced. By the time of the Battle of Isurava (26–31 August), the remaining militiamen were utterly exhausted. The arrival of the 2/14th and 2/16th AIF Battalions did little to slow the retreat or improve the conditions on the ground. During the fighting at Isurava, 99 Australians were killed and 111 wounded, most from the 2/14th Battalion. Within the space of a week, the 2/14th had suffered casualties far in excess of all its previous actions combined.[108] The Kokoda Campaign saw many battalions suffer their heaviest casualties to that point in the war.

106 Frederick Williams, 2/25th Battalion, unknown interviewer, 3 February 2004, Australians at War Film Archive. Available at http://www.australiansatwarfilmarchive.gov.au/aawfa/interviews/1229.aspx

107 Robert Iskov, 2/14th Battalion, Date Interviewed: 6 May, 2004, Australians at War Film Archive. Available at http://www.australiansatwarfilmarchive.gov.au/aawfa/interviews/1466.aspx

108 James, *Field Guide to the Kokoda Track*, p. 354; see also: Ian Hopley, 2/14th Battalion, "Roll of Honour", viewed 20 Aug 2015. Available at http://www.2nd14battalion.org.au/roll-of-honour.html

Table 1: Infantry casualties during the Kokoda Campaign

	Killed in Action or Died of Wounds		Wounded in Action		Total Battle Casualties	
	Officers	Other Ranks	Officers	Other Ranks	Officers	Other Ranks
16th Brigade						
2/1st Bn	2	60	8	114	10	174
2/2nd Bn	2	42	2	91	4	133
2/3rd Bn	0	39	5	106	5	145
	4	141	15	311	19	452
21st Brigade						
2/14th Bn	8	111	6	131	14	242
2/16th Bn	4	67	4	75	8	142
2/27th Bn	1	42	3	44	4	86
	13	220	13	250	26	470
25th Brigade						
2/25th Bn	1	46	12	116	13	162
2/31st Bn	4	46	7	83	11	129
2/33rd Bn	3	26	4	75	7	101
	8	118	23	274	31	392
Militia						
3rd Bn	1	35	2	33	3	68
39th Bn	5	49	3	68	8	117
53rd Bn	3	10	3	20	6	30
	9	94	8	121	17	215

Source: McCarthy, *Australia in the War of 1939–1945*, p.334

Table 1 shows casualties from the Australian infantry battalions during the campaign.[109] To place these figures in perspective, the Militia battalions had an average initial strength of around 430 men, battalions of the 21st Brigade and 25th Brigade averaged 550 men, while battalions of the 16th Brigade had around 590.[110]

109 Dudley McCarthy, *Australia in the War of 1939–1945, Series One: Army, Volume Four: South–West Pacific Area – First Year: Kokoda to Wau*, Australian War Memorial: Canberra, 1959, p. 334.

110 Sublet, *Kokoda to the Sea*, p. 27; McCarthy, *Australia in the War of 1939–1945*, pp. 245, 228, 280, 435.

Battle casualties were extremely high in some units: 29 per cent in 39th Battalion; 31 per cent in the 2/1st and 2/25th Battalions; and 47 per cent in the 2/14th Battalion. Even in the 2/27th Battalion, the AIF battalion with the lowest number of casualties, a veteran recalled:

> *the death rate was a lot higher ... In the Middle East, we didn't lose many from battle. As soon as we got to New Guinea we lost them in droves. And I think that probably affected me.*[111]

Battle casualties give a sense of the intensity of the fighting, but do not convey the severe manpower drain inflicted by the conditions of the campaign. Two to three men were evacuated sick for every battle casualty.[112] This rate was sometimes higher: the 7th Division suffered a sick-to-wounded ratio of seven to one from October to November.[113] Under the effects of battle and disease, the 2/14th and 2/16th Battalions left the Owen Stanleys with a combined force of 152 men from a starting strength of over 1,100.[114]

The duration of the fighting in the Owen Stanleys also had a major psychological effect. The campaign lasted nearly four months, from July to November 1942. While most units spent between one and two months in combat, the 3rd Militia Battalion spent over three months in continuous action.[115] In early October, a little over two weeks after the 25th Brigade entered combat, Brigadier Eather "informed Division that the Brigade might only be able to remain in the field for a further two weeks because of depletion of strength and difficulties so far encountered"'.[116] The brigade would remain in combat for a further six weeks. The combat efficiency and mental resilience of most soldiers begins to wane after one month of action. The conditions that troops were forced to endure over these periods were almost certainly the worst faced by any unit to that point, a fact that likely accelerated the decline of combat efficiency and increased the likelihood of psychiatric breakdown.

111 Robert Johns, 2/27th Battalion, unknown interviewer, 26 November, 2003, Australians at War Film Archive. Available at http://www.australiansatwarfilmarchive.gov.au/aawfa/interviews/1127.aspx

112 McCarthy, *Australia in the War of 1939–1945*, p. 335.

113 Deputy Director Medical Services HQ New Guinea Force, Appendices: November 1942, AWM52 11/1/49.

114 Malcolm Uren, *A Thousand Men at War: The Story of the 2/16th Battalion, AIF*, Heinemann: London, 1959, p. 123; see also: Grayden, *Kokoda Lieutenant*, p. 84.

115 Colin Kennedy, *Port Moresby to Gona Beach: 3rd Australian Infantry Battalion 1942*, Practical Group: Canberra, 1991, p. 6.

116 Allan W. Draydon, *Men of Courage: A History of the 2/25 Australian Infantry Battalion 1940–1945*, 2/25 Infantry Battalion Association: Chermside, 2000, p. 125.

The Kokoda Campaign pitted Australian forces against an enemy of far greater brutality than any faced before. Frightening, perfidious, and sometimes suicidal Japanese tactics bred in Australian soldiers a "deep rooted fear that you feel for some monstrous, venomous animal" and the belief "that the only good Japanese was a dead Japanese".[117] This was in contrast to the perceptions of Australian soldiers toward every other enemy faced during the Second World War.[118] The campaigns fought in North Africa and the Middle East against the Germans, Italians and French are remembered by veterans as being almost chivalrous, with the rules of war equally observed.[119] Both sides knew that captured soldiers would be treated with respect in accordance with the Geneva Convention. In contrast, attitudes towards the Japanese were almost unanimously of hatred, fear, and distain. This outlook is epitomised in the words of an Australian private: "My regard for Tony [Italians] was always impersonal and for Fritz [Germans] ... tinged with admiration, but none of us know anything but vindictive hatred for the Jap."[120]

The nature of battle against the Japanese elicited a radical fear: the knowledge that the only two options were kill or be killed and that, if captured, a soldier faced the almost certain prospect of death, quite possibly in a slow and painful manner. In the words of one veteran:

> *If you were in an action and there was no end but to be captured by the Germans I don't think you would have the same fear in you as if you knew you were going to be captured by the Japanese.*[121]

117 Dennis Williams, 2/3rd Battalion, unknown interviewer, 7 May, 2004, Australians at War Film Archive. Available at http://www.australiansatwarfilmarchive.gov.au/aawfa/interviews/277.aspx

118 Mark Johnston, *Fighting the Enemy: Australian Soldiers and their Adversaries in World War II*, Cambridge University Press: Cambridge, 2002, pp. 132–33.

119 *Ibid.*, p. 44.

120 Mark Johnston, "Yet they're human just as we are": Australian Attitudes to the Japanese", in Steven Bullard and Keiko Tamura (ed.) *From a Hostile Shore: Australian and Japan at War in New Guinea*, Australian War Memorial: Canberra, 2004, p. 116.

121 Matthew Power, 2/14th Battalion, unknown interviewer, 12 March, 2004, Australians at War Film Archive. Available at http://www.australiansatwarfilmarchive.gov.au/aawfa/interviews/1319.aspx

Another veteran claimed that "the biggest fear there [Kokoda] was the chance of being injured and taken prisoner. Not killed."[122] The effect of this brutal style of warfare was an increased psychological strain on soldiers. As one medical officer wrote: "There is no doubt a severe nervous strain from night raids".[123] Ultimately, the fanatical battle ethos of the Japanese army and the experience or hearsay of their atrocities served to reinforce racial preconceptions of the Japanese, initiating "a vicious circle of violence where no mercy was asked or given [and] creating ... a war of annihilation"'.[124] The fact that fear and hatred lingers in so many veterans to this day speaks to the bitterness of the war with Japan.

Environmental Stressors

The physical environment of the Kokoda Trail undoubtedly presented significant psychological challenges to the men involved in the fighting. It is worth quoting at length from Frank Norris's *No Memory for Pain* as he paints a most vivid picture of the conditions in which men lived and fought:

> *Imagine an area approximately one hundred miles long; crumple and fold this into a series of ridges, rising higher and higher until seven thousand feet is reached, then declining again to three thousand feet; cover this thickly with jungle, short trees and tall trees tangled with great entwining savage vines; through the oppression of this density cut a little native track two or three feet wide, up the ridges, over the spurs, around gorges, and down across swiftly flowing mountain streams ... In the morning, flicker the sunlight through the tall trees, after midday and throughout the night, pour water over the forest, so the steps become broken and a continual yellow stream flows downwards, and the few level areas become pools of putrid mud. In the high ridges about Myola, drip this water day and night softly over the track and through a foetid forest, grotesque with moss and glowing phosphorescent fungi and flickering fireflies.*[125]

122 Robert Iskov, 2/14th Battalion, unknown interviewer, 6 May, 2004, Australians at War Film Archive, available: http://www.australiansatwarfilmarchive.gov.au/aawfa/interviews/1466.aspx

123 Collection and evacuation of wounded from the front line 1942, Appendix A: General conclusions of a report by Capt. W.W. McLaren, 14 Aust Field Ambulance on the Kokoda Area 1942 to 1943, p.4, AWM54 329/2/4.

124 Eric Bergerud, *Touched with Fire: The Land War in the South Pacific*, Penguin Books: New York, 1997, p. xii.

125 Frank Kingsley Norris, *No Memory for Pain: An autobiography*, Heinemann: Melbourne, 1970, p. 147.

The rugged terrain of the Owen Stanley Range. AWM: P02018.125

This environment took a toll in physical and mental exhaustion. Veteran Trevor King claimed that "the strain of the Kokoda Track has got to be experienced to be believed; at night you would completely collapse, absolutely physically and mentally exhausted".[126] In the words of another, "that first day at the bottom of the Kokoda Trail broke more hearts than any other exercise could do. We was [sic] nearly up to our knees in mud ... it was absolutely shocking."[127]

126 Trevor King, 53rd Battalion, interviewed by Daniel Connell, 14 June 1989, Keith Murdoch Sound Archive, p. 11. Available at https://static.awm.gov.au/images/collection/pdf/S00590_TRAN.pdf

127 Robert Matten, 2/27th Battalion, interviewed by Rob Linn, 22 March 1990, Keith Murdoch Sound Archive. Available at https://static.awm.gov.au/images/collection/pdf/S00929_TRAN.pdf

Many described the campaign conditions as being the most extreme of any theatre of the war. Damian Parer, an experienced war correspondent, remarked that "Greece was a picnic compared to this".[128] Walker concluded in the official history:

> *In the considered opinion of many experienced officers who have taken part in other campaigns in all theatres of war – Middle East, Europe and New Guinea – there was no campaign in which the stamina and endurance of the troops was so overstrained as in the second advance across the Owen Stanley Range between Ioribaiwa and Kokoda.*[129]

The physical strain of the terrain weakened the mental resilience of soldiers. Harold Walter recalled that the terrain alone was enough to have a significant emotional affect on soldiers, recounting the sight of young militiamen struggling over the trail: "kids of only about 18 or 19 … trying to get up some of those hills … it's the first time I've seen young men crying".[130]

As well as the rugged terrain, soldiers also had to contend with the climate. Frequent heavy rain and tropical heat made for miserable living conditions while creating energy-sapping mud. Almost every day, "torrential rains fell all through the afternoon and night, cascading into their cheerless weapon pits and soaking the clothes they wore".[131] Sergeant Joseph Dawson related some of the discomforts and frustrations of fighting in this climate:

> *Rain, rain, rain. You got wet, you're shagged, it rained all the time. Everything was wet. You were in wet clothes, and when you got around you were covered in mud. Terrible. Then you had the mozzies … and there were leeches, spiders, you name it.*[132]

128 H.D. Steward, *Recollections of a Regimental Medical Officer*, Melbourne University Press: Carlton, 1983, p. 114.

129 Allan S. Walker, *The Island Campaigns*, Australian War Memorial: Canberra, 1957, p. 70.

130 Harold Noal Walter, New Guinea Volunteer Rifles, interviewed by Daniel Connell, 30 Aug 1990, Keith Murdoch Sound Archive, p. 37. Available at the Australian War Memorial.

131 Ralph Honner, quoted in James, *Field Guide to the Kokoda Track*, p. 330.

132 Joseph Dawson, 39th Battalion, unknown interviewer, 16 March 2004, Australians at War Film Archive. Available at http://www.australiansatwarfilmarchive.gov.au/aawfa/interviews/347.aspx

Worse still, the climate facilitated the onset of debilitating diseases such as malaria and dysentery. These diseases were far more prevalent than in any other campaign and their physical and emotional ravages further eroded mental resilience. In his study of psychiatric casualties Sinclair noted:

> *The greatly increased hazard of physical illness contrasted with that met with in desert fighting, combined with early difficulties of food supply, it helped to induce a physical debility upon which psychological disorder could flourish more readily.*[133]

Contracting disease did not guarantee evacuation to a safe area, a constraint which exacerbated emotional stress. Neville Lewis of the 2/33rd Battalion described the all-pervasive physical and emotional demands of disease:

> *Don't imagine that you went back to hospital when you got malaria because you didn't. If you could still walk you carried on because if we'd have all gone back to hospital there wouldn't have been any of us left. So then, combined with the conditions and the food, we all suffered bad attacks of diarrhoea and that was the worst thing. I don't think, I really honestly don't think that anybody who wasn't there can comprehend the hardships and the miseries of the Kokoda Trail.*[134]

One of the greatest environmental impacts of the Kokoda Campaign was the psychological effect of jungle warfare. The close vegetation increased the frequency of hand to hand engagements, adding to the bitterness of the fighting while presenting unique psychological pressures. Medical officers were conscious of this. Captain Joseph of the 2/6th Field Ambulance commented on the feelings of claustrophobia that the jungle induced, with "its intolerable quietness rent by eerie sounds".[135] Another reported that "[a] feature noted by men on numerous occasions has been the constant sense of strain imposed upon them in this type of warfare by the fact that the enemy is always unseen".[136]

133 Sinclair, "Psychiatric Casualties in an Operational Zone in New Guinea", p. 454.

134 Neville Lewis, 2/33rd Battalion, unknown interviewer, Signals, 1 July, 2004, Australians at War Film Archive. Available at http://www.australiansatwarfilmarchive.gov.au/aawfa/interviews/1054.aspx

135 Medical notes on operations in the Owen Stanley area, Papuan Campaign, The Papuan Campaign: Observations on the Medical aspects based on experiences in Light Sections of the 2/4 and 2/6 Field Ambulances and as RMO 2/3, Capt L.H. Joseph AAMC, AWM 54 481/12/224.

136 Medical Notes on Operations: Owen Stanley–Buna Areas, RMO 2/2 Aust Infantry Bn, Capt A. McGuinness – Report on New Guinea Campaign 4/10/42–10/12/42, p. 3, AWM54 481/12/50.

Sinclair noted that some psychiatric casualties “previously immune in the desert, claimed that the different type of fighting – the hunting, hiding, listening part of jungle warfare – was more intolerable than open desert fighting”.[137] Veteran Bill Crooks recalled that a combination of the “filth, mud, exhaustion, and dread found in the jungle as we went over the Kokoda Trail drove some of our less strong soldiers, many medal winners in the desert, to total nervous breakdown”.[138]

For soldiers accustomed to open desert warfare (or with no experience of war) the strangeness of this new environment and its reduced visibility further undermined feelings of security. Matthew Power, a 2/14th Battalion sergeant, remembered the impact of “being used to open conditions in the Middle East and suddenly find[ing] this dense, rain-sodden jungle. It was quite a shock.”[139] Philip Rhoden, a 2/14th company commander, made a similar comment:

> *Well it’s something new and if you can’t see your enemy, it’s pretty grim ... See in the desert fighting, open fighting, you can see what’s happening ... [in the jungle] you couldn’t see them, you didn’t know where they were, you didn’t know in what strengths they were. The only time you knew something was when their guns went off ... somebody died or collapsed before your eyes.*[140]

An operational report from the 21st Brigade in September stated that some men were “too frightened to venture into the jungle at night even for the relief of discomfort caused by nature”.[141] Bill Crooks reflected on the emotional impact:

> *The men became very wary and receded into themselves ... Looking back, I think it was a little psychotic too. We never mentioned our feelings about the jungle among ourselves until long after the war. Most were scared of the strangeness and the eerie continual darkness ... But worse we felt hemmed in: the all-pervading closeness of the deep impenetrable forest green jungle.*

137 Sinclair, “Psychiatric Casualties in an Operational Zone in New Guinea”, p. 456.

138 Bill Crooks quoted in Bergerud, *Touched with Fire*, p. 240.

139 Matthew Power, 2/14th Battalion, unknown interviewer, 12 March 2004, Australians at War Film Archive. Available at http://www.australiansatwarfilmarchive.gov.au/aawfa/interviews/1319.aspx

140 Philip Rhoden, 2/14th Battalion, unknown interviewer, 1999, Australians at War Film Archive. Available at http://www.australiansatwarfilmarchive.gov.au/aawfa/interviews/2000.aspx

141 Reports on Operations in New Guinea, 28 September 1942, AWM52 8/3/14.

In this manner, the jungle itself was often characterised as the enemy:

> *The jungle oppressed with its brooding malevolent silence; danger lurked in its dark recesses; death struck without warning from an unseen source; the cracking of a twig could cause panic; the almost incessant rain and the pervading clinging, dragging mud brought on a feeling of helplessness against an enemy who could be everywhere at once.*[142]

The jungle also had the detrimental psychological effect of breaking up large units into small, relatively isolated groups of men. According to Sinclair:

> *This robbed the soldier of the helpful momentum imparted by the movement of a large body of men in action. The difficulties and dangers of the track therefore became to a large extent a personal affair.*[143]

This sense of isolation is a recurring theme in the accounts of veterans. Eric Sambell of the 2/27th Battalion remembered,

> *it was a lot more pressure on the individual man, when the enemy could bob up just there or it was so pitch dark too in the jungle ... you had to depend on you hearing an awful lot and I think it was much more nerve racking. I think there was far more people where their nerves went on them in the jungle ... than they did in the open warfare, that’s just how I saw it anyway.*[144]

Such testimony speaks for itself.

142 Sublet, *Kokoda to the Sea*, p. 25.

143 Sinclair, “Psychiatric Casualties in an Operational Zone in New Guinea” , p. 453

144 Eric Sambell, 2/27th Battalion, unknown interviewer, 19 July 2004, Australians at War Film Archive. Available at http://www.australiansatwarfilmarchive.gov.au/aawfa/interviews/233.aspx

Mental Resilience

Unit morale could have a major impact on the onset of psychiatric breakdown. High morale fostered mental resilience while low morale had the opposite effect, undermining individual confidence. Morale varied among the battalions that fought during the Kokoda Campaign. The Militia battalions were poorly trained and equipped in comparison to the AIF battalions, and had no prior combat experience. Preparation for the campaign had been slapdash. The 53rd Battalion had no jungle warfare training, having spent its first six months in Port Moresby unloading ships. Although a number of modern Bren machine-guns arrived immediately prior to they went into action, members of the 53rd Battalion had little time to familiarise themselves with the weapon; not a single round was fired prior to the battalion encountering the enemy.[145] The experience of the 39th Battalion was not much better, although it did have the opportunity for slightly more training than the 53rd Battalion. Initial logistical disorganisation served to heighten perceptions of mismanagement throughout the battalions, with long-term demoralising effects. Veterans still lament the lack of food and ammunition as "a shocking example of planning and staff management".[146]

Each of these factors served to lower morale within the Militia battalions, particularly the 53rd. It is not surprising that the battalion remains notorious for its poor performance during the campaign. At least one of its companies reportedly "broke and scattered" on contact with the Japanese, with 70 men "later found to have 'taken to the bush' and deserted"'.[147] Similar accounts reflect ill-discipline and poor morale within the 39th Battalion, with some men reportedly fleeing in panic at first contact with the Japanese.[148] Captain Vernon of ANGAU remarked on having seen "a small party of [39th Battalion] infantry under escort who had gone back to Efogi rather hurriedly and were being brought back to the front".[149] References to "stragglers" – soldiers who left the front line without permission – permeate early medical reports from both Militia battalions.[150]

145 F.M. Budden, *That Mob: The Story of the 55/53rd Australian Infantry Battalion, AIF*, F.M. Budden: Ashfield, 1973, pp. 21–22.

146 John Henry Burns, 2/27th Battalion, interviewed by Rob Linn, 27 March 1990, p. 16, Keith Murdoch Sound Archive. Available at https://static.awm.gov.au/images/collection/pdf/S00920_TRAN.pdf

147 21st Brigade war diary, August–October 1942, Report on Operations: Owen Stanley Range, 16 Aug–20 Sep 1942, p. 7, AWM528/2/21.

148 James, *Field Guide to the Kokoda Track*, p. 379.

149 A War Diary by Capt G.H. Vernon – The Owen Stanley Campaign July–November 1942, p. 15, AWM54 253/5/8.

150 Report of No. 1 Medical Detachment 14 Aust Field Ambulance Kokoda Area 24/7/42–8/9/42, AWM 52 11/1/19; Report of ADMS Visit to Maroubra Force Owen Stanleys: Additional notes as a result of operations in the Maroubra area up to September 1942, p. 1, AWM 54 577/7/13; Deputy Director Medical Services HQ New Guinea Force (appendices): Medical arrangements for evacuation of sick and wounded from Maroubra force (visit by DDMS to Ilolo on 6 September), p. 1, AWM52 11/1/49.

While the morale of the AIF battalions was initially high, the unexpected onslaught of the enemy and dismal physical conditions likely served to gradually undermine it. Evidence suggests a significant number of desertions from members of the 2/27th Battalion at least, with one veteran recalling dozens of men from the battalion "deserting under fire":

> *every night fellows were just shooting off, and they all got back to Moresby … I wanted to do it myself, [but] a friend of mine … said, "Wait until tomorrow night" … But the next day we got down on the flat, and were on our way back to Koitaki.*[151]

Leadership is inextricably linked to morale. Strong and competent leadership can engender high unit morale, even in adverse conditions. Conversely, the absence of positive leadership can result in plummeting unit morale and the onset of psychiatric breakdown. Leadership within the Militia battalions was generally not of the same quality as AIF battalions. The original officers of Militia battalions were inexperienced or ageing First World War veterans. Although a quota of experienced captains, lieutenants and sergeants was later reallocated from the 6th and 7th Divisions, most were sent to the 39th and 49th Battalions, with the 53rd Battalion receiving the least.[152] This may help explain the poor morale and performance of the battalion, and might also indicate a threat to the mental resilience of soldiers.

Given their role as leaders, officer casualties could have a disproportionate effect on the occurrence of psychiatric breakdown. During the Kokoda Campaign a large proportion of officers were killed or wounded across all the battalions. At an average of 30 officers per battalion, approximately 360 officers served during the Kokoda Campaign, of which 103 became battle casualties – around 29 per cent.[153] In comparison, the approximate percentage of casualties among other ranks was 27 per cent. A large proportion of battalion commanders became casualties. The commanding officers of the 39th, 53rd and 2/14th Battalions were all killed. The battalion commander of the 3rd Militia Battalion was evacuated for exhaustion.[154] Likewise, the battalion commander of the 2/25th Battalion was evacuated "due to exhaustion and illness".[155] The commanding officer of the 2/31st Battalion was evacuated after it became "obvious that his strength and powers of endurance were failing".[156] Veteran Griffith Spragg of the 2/3rd Battalion claimed after the war that his

151 Frank McLean, 2/27th Battalion, interviewed by Rob Linn, 8 March 1990, Keith Murdoch Sound Archive. Available at https://static.awm.gov.au/images/collection/pdf/S00905_TRAN.pdf p. 24

152 Budden, *That Mob*, p. 18.

153 McCarthy, *Australia in the War of 1939–1945*, p. 334.

154 Kennedy, *Port Moresby to Gona Beach*, p. 34.

155 Draydon, *Men of Courage*, p. 125.

156 John Laffin, *Forever Forward: The Story of the 2/31st Infantry Battalion, 2nd AIF 1940–45*, 2/31 Australian Infantry Association (NSW Branch): Newport, 1994, p. 94.

commanding officer, Colonel John Stevenson, was diagnosed and evacuated as NYDN after coming under shell-fire during the battle for Eora Creek.[157] Although this was ostensibly due to a slight shrapnel wound to his ear, other veterans (including the RMO of the 2/1st Battalion) claimed that his physical injury "wasn't serious enough to warrant his evacuation", a belief confirmed by Stevenson's medical records.[158]

The loss of a commanding officer could be especially devastating to morale, often resulting in sudden influxes of psychiatric casualties. An operational report from 1945 noted "the only time the soldier becomes so exhausted as to feel incapable of further action is when the officer in command succumbs to fatigue".[159] The fact that seven battalions out of 12 lost a commanding officer during the campaign — three of whom succumbed to exhaustion and one most likely to psychiatric break down — indicates a situation in which psychiatric casualties were more likely to occur. Many veterans remember the shock of losing their battalion commander and the effect that this had on the unit. Reginald Markham of the 39th Battalion recalled the traumatic experience of seeing his commanding officer, Colonel William Owen, as he lay dying: "That was a big shock to me and knowing that I may not survive to get out of this situation and yeah, yeah, I was just pretty, you know, stressful then".[160] A veteran of the 53rd Battalion recalled the death of Colonel Ken Ward as "a dreadful shock to the Battalion … it's incredible how swiftly the news gets around and of course I think I would be safe in saying that all of us who were up there were in a state of shock when we heard that the Colonel had been killed".[161]

Following Ward's death, "numerous men sought protection in the jungle and were later found wandering – some without weapons".[162]

Individual and unit experience has a complex relationship with mental resilience. Where inexperienced units often produced psychiatric casualties soon after entering combat, research suggests that the effect of combat was also cumulative. The units that fought at Kokoda included militiamen with no war experience and, at the other end of the spectrum, highly experienced soldiers of the AIF battalions. In both cases, this may have increased the risk of psychiatric breakdown. The RMO of the 39th Battalion, Captain Shera, believed that "the longer a man served, the more likely he was to have psychological problems".[163] A medical report from September 1942 categorised all casualties evacuated from the Kokoda Trail over a one month period. It indicates that the experienced 2/16th Battalion had the largest number of soldiers evacuated "NYDN", producing 12 of the 18 cases.[164] The following two chapters will explore these issues in more depth. Where interviews of veterans indicate the perception of a higher rate of psychiatric casualties among the Militia battalions, the AIF battalions were by no means immune.

True to the title of Peter Brune's account of the Papuan campaigns, Kokoda in 1942 was a bastard of a place to fight a war.[165] It is clear that the experience was in almost every respect highly traumatic for the men involved. The enemy's highly effective use of mountain guns, mortars and medium machine-guns and the inability to respond to these weapons often produced situations of intense fear and helplessness. Months of Japanese bombing in the Port Moresby area prior to the commencement of the campaign served to degrade mental resilience in some soldiers before they even entered combat. The experience of retreat during the initial period, coupled with hunger, fatigue and heavy casualties against an extremely brutal enemy, further undermined the mental resilience of soldiers. The prolonged duration of the campaign for some units also served to increase the risk of psychiatric casualties. Soldiers perceived the jungle itself as an enemy, and the psychological impact of jungle warfare resulted in feelings of claustrophobia, fear and dread. All of these factors had a major impact on the morale of units. A high proportion of officer casualties, especially commanding officers, served to further undermine individual mental resilience. While the troops involved were a mix of inexperienced and veteran soldiers, they were all susceptible to psychiatric breakdown. While it cannot be said that any one factor was more or less important in facilitating the onset of psychiatric breakdown, each combined to create a context of high risk. This conclusion presents another question: if the conditions of the Kokoda Campaign presented a high risk of psychiatric casualties, why were so few reported?

157 Griffith Spragg, 2/3rd Battalion, unknown interviewer, 16 May 2003, Australians at War Film Archive. Available at http://www.australiansatwarfilmarchive.gov.au/aawfa/interviews/162.aspx

158 Dr. Lynn Joseph, quoted in S.P. Ramage, *Kokoda Secret – Ian Hutchinson: Australian Hero,* Eora Press: Wahroonga, 2014, pp. 126, 307 fn40.

159 Margaret Barter, *Far Above Battle: The Experience and Memory of Australian Soldiers in War 1939–1945*, Allen and Unwin: Sydney, 1994, p. 243.

160 Reginald Markham, 39th Battalion, unknown interviewer, 17 September 2003, Australians at War Film Archive. Available at http://www.australiansatwarfilmarchive.gov.au/aawfa/interviews/926.aspx

161 Keith Irwin, 53rd Battalion, unknown interviewer, 6 May 2003, Australians at War Film Archive. Available at http://www.australiansatwarfilmarchive.gov.au/aawfa/interviews/26.aspx

162 Sublet, *Kokoda to the Sea,* p. 41.

163 Raftery, *Marks of War,* p. 60.

164 Medical Notes on Operations: Owen Stanley–Buna Areas, Annex D, p. 5, AWM54 481/12/50.

165 Peter Brune, *A Bastard of a Place: The Australians in Papua,* Allen and Unwin: Crows Nest, 2004.

Australian soldiers cross a narrow bridge.
Photograph by George Silk, 1 December 1942.
AWM 013704

Chapter 3

The Masking of Psychiatric Breakdown

A close reading of medical reports in conjunction with other primary sources reveals contradictory evidence regarding the occurrence of psychiatric casualties during the Kokoda Campaign. The aim of this chapter is to resolve this tension through the exploration of factors that potentially masked psychiatric breakdown. Seeking to understand how unpreparedness, operational pressures, and the challenge of terrain complicated the reporting process, this chapter analyses the effect of disease and exhaustion on the reporting of psychiatric casualties before addressing the relationship between psychiatric breakdown and the issues of desertion, malingering, and self-inflicted wounds (SIW).

Reporting and Evacuation

At the time of the Japanese invasion, Australian medical arrangements were rudimentary and ad hoc. A single company of the 39th Battalion was in position on the trail at this stage, while the RMO remained with the rest of the battalion in Port Moresby. The role of RMO was temporarily filled by Captain Vernon of ANGAU, who dealt with casualties from early encounters with the enemy. Captain McLaren and a detachment of the 14th Field Ambulance were dispatched from Port Moresby to bolster medical arrangements, while a staging post was established at Ilolo, on the southern side of the Owen Stanley Range. Few other trained medical personnel were available until the arrival of the 7th Division in mid-August. This enabled a series of aid posts to be established between Ilolo and Deniki to assist in the evacuation of wounded.[166] Until this occurred, however, the ability of medical personnel to diagnose, treat and evacuate casualties was limited. Even after the arrival of the 7th Division, the pressures of the rapid Japanese advance and the nature of the terrain often made medical procedures a chaotic undertaking.

There was no consistent or systematic process of medical reporting during the early period of the campaign. The demands of treating wounded and sick in the context of continual withdrawal likely relegated the writing of detailed reports to a lower priority. Casualty reports often lacked specific numbers and categories, designating "battle casualties" and "sick" but offering no further analysis. While psychiatric casualties were sometimes mentioned, overall casualty reports give little quantitative or qualitative data. McLaren produced one of the first detailed medical reports of the campaign, listing the chief complaints as "persistent diarrhoea with blood mucus, foot disabilities and psychiatric cases" but gave no indication of the actual numbers.[167] It is possible that the true number of psychiatric casualties may have been disguised through the ambiguity and disorder of the reporting process.

Those soldiers who were evacuated from the frontline for psychiatric reasons may not have been recorded as such in rear aid posts. By the time casualties reached clearing stations or hospitals where consistent casualty data could be collected, psychiatric conditions could have been masked, consciously or otherwise, by wounds or disease. Given the chaotic nature of the fighting, especially during the retreat phase, keeping track of casualties was difficult, especially as many were not provided with field medical cards explaining their condition. Lieutenant Colonel Nugent, the officer in charge of the rear aid post at Ilolo, complained about the lack of casualty classification labels on many of the men coming back from the front line, stressing "the importance … of sorting out genuine casualties from stragglers and from those suffering physical fatigue".[168] Frequent references to "stragglers", "waifs and strays" and "'deserters" in medical reports attests to the lack of control military authorities had over the movements of men, and the difficulty they had in classifying them once they reached rear areas.[169] Given the sensitive nature of mental health issues, soldiers evacuated for psychiatric conditions had motive to conceal it and medical staff may also have been complicit. With patients suffering psychiatric breakdown concurrently with physical injury or illness, diagnosis of the physical condition may have presented an attractive alternative.

The corporate knowledge of the Australian medical services was built on tactics and procedure developed in the Mediterranean, North Africa and the Middle East. The pressures of combat, sickness, and strained logistical lines led to unique medical challenges during the Kokoda Campaign. Walker makes the point that "[m]any of the practices found helpful in the Middle East had to be learnt afresh in New Guinea".[170] Movement over the Kokoda Trail could only be made on foot, meaning that casualties were separated from established hospitals by days or even weeks of travel. Psychiatric casualties could not be evacuated by ambulance and sent to special psychiatric wards, as had been possible in other theatres.

A comparison with Tobruk, where the principle of forward psychiatry was practised, is particularly illuminating. Forward psychiatry was pioneered during the First World War and rediscovered by British and Commonwealth forces during the Second World War. Its core tenets were "Proximity, Immediacy, and Expectancy" (PIE), grounded in the belief that if psychiatric casualties were promptly treated close to the front with the expectation of returning to duty, most could be "cured" and returned to battle.[171] A proportion of psychiatric casualties were treated by RMOs in forward positions and not diagnosed and recorded in hospitals.

However, forward psychiatry was not always practiced as it was intended. During the defence of Tobruk, efficient lines of communications expedited the process of evacuation to the point where casualties could be evacuated within hours of their wounding.

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166 Allan S. Walker, *The Island Campaigns*, Australian War Memorial: Canberra, 1957, pp. 17–23.

167 Medical notes on operations in the Owen Stanley area, Papuan Campaign, Appendix D: Medical report on Papuan Campaign submitted to ADMS 7 Div, 1942–43, p. 3, AWM 54 481/12/224.

168 Medical arrangements for evacuation of sick and wounded from Maroubra force (visit by DDMS to Ilolo on 6 September), p. 1, AWM52 11/2/49.

169 Report of ADMS Visit to Maroubra Force Owen Stanleys: Additional notes as a result of operations in the Maroubra area up to September 1942, p. 1, AWM 54 577/7/13; Medical Notes on Operations: Owen Stanley–Buna Areas, p. 8, AWM54 481/12/50; Report of No. 1 Medical detachment 14 Aust Field Ambulance Kokoda Area 24/7/42 to 08/9/42, AWM54 481/12/15.

170 Walker, *The Island Campaigns*, p. 41.

171 Edgar Jones and Simon Wessely, "Forward Psychiatry in the Military: Its Origins and Effectiveness", *Journal of Traumatic Stress*, Vol. 16, No. 4, August 2003, p. 413.

In analysing the treatment of psychiatric casualties in the field, medical officer Harold Love noted that while the mildest of psychiatric cases were treated in forward units "others with disorders of all degrees of severity were evacuated direct to hospital".[172] He made the further point that medical officers were not trained or equipped to deal with psychiatric casualties, with the result that such casualties were "regarded as the mysterious and inalienable preserve of the psychiatric specialist" and promptly evacuated for treatment in specialised psychiatric wards.[173] In the opinion of Sinclair (who served as a psychiatric specialist at Tobruk and Moresby), the majority of medical officers at Tobruk were too quick to evacuate psychiatric cases: "patients suffering from war neurosis [were regarded] as hopeless problems; the patient's condition is labelled 'shellshock' or 'bomb happy' and nothing is done to help him."[174] It is possible that a correlation exists between the large number of psychiatric casualties documented at Tobruk and the ease with which such casualties could be evacuated and recorded. This is in stark contrast to the medical situation at Kokoda. Oddly enough, the difficulty of evacuation during the Kokoda Campaign may have forced medical officers to embrace forward psychiatry to a greater extent than elsewhere, resulting in fewer reported casualties.

In line with the vastly different conditions of the Kokoda Campaign, Raftery contends that "treatment [of psychiatric casualties] in the field was far more pragmatic" than had been offered in earlier campaigns.[175] The evacuation of psychiatric casualties presented an added problem to medical personnel already overwhelmed by the more pressing concern of treating the seriously wounded. Several medical officers commented on the requirement of "absolute ruthlessness" in the prioritisation of casualties for evacuation.[176] A report from late August illustrates a careful criterion for evacuation in which a casualty was "considered as to whether he will be an asset within a week. If so, he is treated and as soon as possible returned to duty … If evacuation is not considered reasonable, casualty is held in rear dressing station."[177]

172 Harold R. Love, "Neurotic Casualties in the Field", *Medical Journal of Australia*, Vol. 2, No. 8, 22 August 1942, p. 137.

173 Allan S. Walker, *Middle East and Far East*, Australian War Memorial: Canberra, 1953, pp. 196–197.

174 E.L. Cooper and A.J.M. Sinclair, "War Neuroses in Tobruk: A Report on 207 Patients from the Australian Imperial Force Units in Tobruk", *Medical Journal of Australia*, Vol. 2, No. 5, 1 August 1942, p. 74.

175 John Raftery, *Marks of War: War Neurosis and the legacy of Kokoda*, Lythrum Press: Adelaide, 2003, p. 34.

176 ADMS 7 Division Whole Diary, July to December 42, Appendices Only: Medical Service 7 Aust Div during Papuan campaign Jan 43, p. 3, AWM 52 11/1/19; Medical notes on operations in the Owen Stanley area, Papuan Campaign, Medical report on Papuan Campaign submitted to ADMS 7 Div, 1942–43, p. 27, AWM 54 481/12/224.

177 ADMS 7 Division Whole Diary, July to December 42, Appendices Only: Report on existing hospital capacity as of 21 August 42, p. 2, AWM52 11/1/19.

The recollections of Keith Viner-Smith, RMO 2/27th Battalion, illustrate this procedure while further reflecting on the difficulty of assessing psychiatric cases in the field:

> *In the rather torrid conditions I certainly had no time to diagnose and treat … I would try to assess the man concerned. If there was any hope of him regaining his nerve I would keep him in a relatively safe position, keep him busy and hope that he would regain control. If there was no hope, I would try to evacuate him from the area.*[178]

Although referring to later actions on the north coast, comments made by Robinson, RMO of the 53/55th Battalion, may reflect more generally on the practice of retaining psychiatric casualties in forward areas during the New Guinea campaigns:

> *[T]he great majority [of psychiatric casualties] could be treated on the spot with roughness or kindness … [they] merely needed time and help to adjust themselves with perhaps a little sedative in some cases.*[179]

It is probable that many psychiatric cases were retained in dressing stations on the Kokoda Trail to determine if they could recover or provide further useful service instead of being evacuated. The shortage of troops may have encouraged this further. Some men who had suffered psychiatric breakdown were returned to their unit after a period of rest, although, as McLaren remarked, "[m]ost cases relapsed upon returning to the line".[180] It is also possible that a number of these men were killed without having been officially diagnosed. Death may even have occurred as an act of desperation or escape for some. Raftery found evidence of at least one soldier committing suicide by deliberately running into machine-gun fire.[181]

178 Raftery, *Marks of War*, p. 59.

179 Bruce Robinson, *Record of Service: An Australian Medical Officer in the New Guinea Campaign*, Macmillan and Company: Melbourne, 1944, p. 71.

180 General conclusions of a report by Capt. W.W. McLaren, 14 Aust Field Ambulance on the Kokoda Area 1942 to 1943, p. 2, AWM54 329/2/4.

181 Raftery, *Marks of War*, p. 53.

Psychiatric casualties were more likely to be redeployed into non-combat roles, however, as noted in this medical report:

> *If they had an upsetting effect on their immediate associates, use could be made of them at BHQ [Battalion Headquarters] in carriage of food, ammunition, etc. rather than to evacuate them.*[182]

Raftery contends that temporary breakdowns were likely not recorded at forward aid posts.[183] The fact that medical officers at Kokoda were forced to deal with the majority of psychiatric casualties themselves almost certainly meant that fewer cases were reported.

Without psychiatrists present, medical treatment and diagnosis lacked specialist focus and understanding. The terrain over which the fighting occurred precluded the use of "mobile groups of experienced physicians and psychiatric specialists"' as had occurred in other theatres.[184] In contrast to Kokoda, Walker noted that in dealing with psychiatric casualties at Tobruk, RMOs "had opportunities for constant contact with seniors; clinical conferences were held … and if explanation, help or criticism was necessary, action was taken".[185] Until the arrival of Sinclair with the 2/9th Australian General Hospital in Port Moresby in August (over a month after the Japanese landings), no psychiatric specialist was available.[186] Thereafter, the isolation of distance and time likely undermined Sinclair's influence on the conduct of medical operations. The decreased influence of specialists during the Kokoda Campaign may have exacerbated under-reporting of psychiatric casualties.

182 Medical notes on operations in the Owen Stanley area, Papuan Campaign, Annex D: Medical report on Papuan Campaign submitted to ADMS 7 Div, 1942–43, p. 4, AWM 54 481/12/224.

183 Raftery, *Marks of War*, p. 53.

184 Allan S. Walker, *Clinical Problems of War*, Australian War Memorial: Canberra, 1952, p. 677.

185 Walker, *Middle East and Far East*, p. 204.

186 Sinclair arrived with the 2/9 AGH, see: Joan Crouch, *A Special Kind of Service: The story of the 2/9 Australian General Hospital, 1940–46*, Alternative Publishing: Chippendale, 1986, pp. 57, 82.

Disease and Exhaustion

In 1943, Sinclair published a study of psychiatric casualties treated in Port Moresby during the Kokoda Campaign which identified disease as a major factor in masking instances of psychiatric breakdown. The unpreparedness of the medical services to deal with tropical disease resulted in some of the highest rates of illness of any campaign of the war, with two to three men evacuated sick for every battle casualty.[187] Such a large proportion of sick afforded an unprecedented opportunity for diagnostic masking. Sinclair acknowledged this, arguing that while "[t]he relation of psychiatric admissions to all admissions to hospital was 2.1% … this percentage does not represent a true proportion because many patients were doubtless treated for general medical or surgical conditions, when in fact a closer study would have revealed significant neurotic disorder."[188]

While serving as consultant physician to land headquarters, Walker similiarly hinted at the probability of diagnostic masking following a visit to Port Moresby: "Not many cases of neurosis or psychosis were seen in hospital considering the number of troops involved, but this is probably reflected more accurately in medical boards than in admissions to hospital."[189]

Since medical boards involved a physical and psychological examination, psychiatric symptoms were more likely to be detected here than on admission. Sinclair later argued that "of all men discharged from the army as medically unfit, at least fifty per cent have in fact, a predominantly psychological disability".[190] Restrictions on access to personal medical records means that medical board records remain unavailable to further scrutiny, making definitive conclusions difficult.

Medical diagnostic procedure may also have served to prioritise physical symptoms over the psychological. A 7th Division medical instruction from late 1941 states: "It is the duty of medical officers to make a physical examination in all cases and not label a man anxiety neurosis or NYDN because the mental condition is the most obvious factor."[191] It is likely that this order was still in effect during the 7th Division's involvement in the campaign several months later. Even at Tobruk, where rates of sickness were much lower, Sinclair believed that

187 Dudley McCarthy, *Australia in the War of 1939–1945, Series One: Army, Volume Four: South–West Pacific Area – First Year: Kokoda to Wau*, Australian War Memorial: Canberra, 1959, p. 335.

188 A.J.M. Sinclair, "Psychiatric Casualties in an Operational Zone in New Guinea", *Medical Journal of Australia*, Vol. 2, No. 23, 4 December 1943, pp. 453–60, p. 453.

189 ADMS 7 Div Whole Diary January–June 1941, Report on Medical disabilities in New Guinea October 1942, Appendix VII: Diseases encountered, AWM52 11/1/19.

190 A.J.M. Sinclair, "The Psychological Reactions of Soldiers", *Medical Journal of Australia*, Vol. 2, No. 9, 1 September 1945, p. 263.

191 ADMS 7 Division Whole Diary July–December 1941, Medical Admin Instruction No. 13, p. 1, AWM52 11/1/19.

physical symptoms masked psychiatric conditions. He notes that, "[f]or every [psychiatric] patient admitted to hospital, at least one was retained and treated in a forward unit" for somatic symptoms.[192] During the Kokoda Campaign, where soldiers were more isolated and the disease rate much higher, it is likely that significantly more diagnostic masking occurred.

While it is impossible to know exactly how many psychiatric casualties may have been masked in diagnosis, a report on casualty types passing through an aid post at Ilolo sheds light on the issue. The report represents all casualties received from 7 August to 8 September 1942. A reproduction of the figures appear below in Table 2.[193] Reports of this manner were not made for other months, so the evidence is fragmentary. Nevertheless, a close analysis of the casualty types is enlightening.

Table 2: Casualty types recorded in a Rear-Aid Post, August–September 1942 – from AWM54 481/12/50

	Illness and Accidental Injury				Battle Casualties (first arrived 18 Aug)		
	Exhaustion	Diarrhoea	Malaria	Other	NYDN	GSW	**Total**
39th Battalion	2	10	64	66	4	55	**201**
53rd Battalion	32	-	7	19	1	19	**78**
2/14th Battalion	2	11	2	10	1	69	**95**
2/16 Battalion	2	6	4	22	12	34	**80**
Misc	3	7	7	24	-	2	**43**
Total	**41**	**34**	**84**	**141**	**18**	**179**	**497**

Source: Medical Notes on Operations: Owen Stanley–Buna Areas, AWM54 481/12/50.

Casualty types vary significantly between units. Nearly 80 per cent of all recorded cases of exhaustion came from the 53rd Battalion. Yet the 39th Battalion, with only two exhaustion cases, was engaged for a much longer period and subjected to greater continual stress. Both were Militia battalions that shared a similar demographic, the soldiers of each having an average age of 18-and-a-half years.[194] AIF battalions recorded low exhaustion rates but were also physically fitter than Militia battalions. More significantly, they had not been engaged for as long. Even so, the extremely large discrepancy between the 53rd Battalion and the other units demands further explanation.

192 A.J.M. Sinclair, "Psychiatric Aspects of the Present War", *Medical Journal of Australia*, Vol. 1, No. 23, 3 June 1944, p. 504.

193 Medical Notes on Operations: Owen Stanley–Buna Areas, Annex D, p. 5, AWM54 481/12/50.

194 Peter A. Thompson and Robert Macklin, *The Battle of Brisbane: Australians and the Yanks at War*, ABC Books: Sydney, 2000, p. 135.

Exhaustion carries particular psychiatric connotations. A conference of army physicians in Palestine in July 1940 agreed that the term should "be used for acute neurotic casualties arising in action".[195] Walker remarked that during his time as a medical officer in the Middle East: "The term exhaustion was used for men with acute neuroses who were expected to recover quickly".[196] A measure of differentiation certainly existed between physical exhaustion and psychiatric illness during the Kokoda Campaign, with the term "NYDN" used alongside "exhaustion". However, the experience of the 53rd Battalion was such that it was comparatively less likely to produce cases of physical exhaustion and, given its low morale, more likely to produce psychiatric casualties. Despite this, only one case of NYDN was reported from the 53rd Battalion. It is highly possible that the 53rd Battalion RMO used the diagnosis of exhaustion to describe at least some cases of psychiatric breakdown.

Exhaustion cases are not the only discordant figures in this report. The 39th Battalion produced 76 per cent of all malaria cases for the month but had been no more exposed to malaria than the 53rd Battalion, which contributed just eight per cent of cases. (AIF battalions had been relatively less exposed.) Likewise, while every other battalion evacuated a significant number of diarrhoea cases, the 53rd produced none. The number of NYDN recorded from the 2/16th Battalion is also surprising, constituting a quarter of the battalion's battle casualties for the month and two-thirds of all cases of NYDN. Yet it had no more identifiable stressors than any other battalion. It had been in action for the least time and suffered significantly fewer wounded and killed. Each of these factors should have resulted in a reduced risk of psychiatric casualties, yet the battalion incurred the greatest numbers.

Interpreting these wide variations between units is difficult. It is possible that the RMOs of different battalions varied in their inclination to attach different diagnoses. Given that many men may have been suffering from differing combinations of physical exhaustion, malaria, diarrhoea, and psychiatric conditions, RMOs may have demonstrated a preference to attach one label in favour of another. The RMO of the 2/16th Battalion may have been inclined to label all men suffering from psychiatric conditions as NYDN, regardless of physical symptoms. In contrast, diagnosis may have favoured non-psychiatric conditions in many men from the 39th, 53rd, and 2/14th Battalions, even when psychiatric symptoms were present, resulting in the apparent higher rates of malaria, exhaustion, and diarrhoea within these battalions. It is possible that many cases of psychiatric casualties were disguised in this manner.

195 Walker, *Clinical Problems of War*, p. 677.

196 Allan S. Walker, "Hospital Work with the Australian Imperial Force in the Middle East", Medical Journal of Australia, Vol. 2, No. 4, 25 July 1942, p. 60.

Desertion, Malingering and SIW

One of the most opaque ways in which psychiatric breakdown may have been camouflaged was through acts classed as indiscipline, particularly desertion, malingering and SIW. Desertion was a significant problem during the campaign in both Militia and AIF battalions. The chaotic military situation weakened the control of the military hierarchy and afforded many opportunities for self-masking by individuals who could not cope mentally. McLaren reported:

> *One problem the medical section was up against was the deserter ... no check was kept on the comings and goings into the various camps. Commonly they presented themselves to the last medical post, without any authority for leaving the line, except that they were cut off or told to report back by their platoon sergeant. Many such cases were able to get through in times of great activity.*[197]

There is also the possibility that many soldiers suffering from psychiatric complaints were accused of malingering and not recorded. Captain Vernon reported during the initial phase of the fighting that many soldiers "wasted my time with imaginary complaints or clever attempts at malingering".[198] Another veteran recalled a soldier reporting to the RAP during an intense artillery bombardment at Gorari:

> *"I've got a bit of shrapnel in my wrist, in my arm, and it's bleeding like anything." And Cherry [the medical NCO] ... got the thing and he unwound it and unwound it and unwound it and there was no blood. When he got down to the thing just on the inside there was a little bruise about as big as a sixpence or a 5 cent piece ... So Cherry choofed him off and sent the poor bugger back.*[199]

197 Report of No. 1 Medical detachment 14 Aust Field Ambulance Kokoda Area 24/7/42 to 08/9/42, AWM54 481/12/15.

198 A War Diary by Capt G.H. Vernon — The Owen Stanley Campaign July–November 1942, p. 16, AWM54 253/5/8.

199 Neville Lewis, 2/33rd Battalion – Signals, unknown interviewer, 01 July 2004, Australians at War Film Archive. Available at http://www.australiansatwarfilmarchive.gov.au/aawfa/interviews/1054.aspx

It is possible that men who could have benefitted from psychological treatment were denied it in such instances.

SIWs are an indication of extreme conditions in which psychiatric casualties are likely to occur and a potential masking factor for the condition. While self-harm can be a calculated act to escape the front line, it is often the result of psychiatric breakdown. Modern studies with a focus on military psychiatry regard SIW as a manifestation of psychiatric disturbance: Copp, Converse, and Johnston have each drawn a strong connection between SIW and psychiatric breakdown.[200] Gabriel likewise argues that SIW is but one of "a large constellation of behaviours that can comprise CSR [Combat Stress Reaction]".[201] This seems to have been borne out in the Australian experience of the Second World War. Love recalled that at Tobruk some psychiatric casualties, "if not evacuated from the line, sought relief in a SIW or even suicide".[202] Walker noted that SIWs and psychiatric breakdown generally went hand in hand and, by implication, acknowledged that many men who deliberately caused themselves harm may have been suffering from psychiatric conditions; "it is a pity", he lamented, "that no systematic psychiatric investigation of these men was undertaken".[203] In such cases, the physical wound may have masked psychiatric symptoms in diagnosis, despite the latter being the underlying cause of the injury.

Some medical officers recognised SIW as a significant problem during the Kokoda Campaign. Captain McLaren reported this to the ADMS of the 7th Division, Lieutenant Colonel Frank Norris:

> *SIWs were very common. At the start the left great toe was selected, but owing to the fact that they had to walk, the left hand came into favour. It was estimated that during one battle involving AIF and AMF [Militia], nearly one-third of the wounds were SIW. The AIF showed greater variation and more cunning.*[204]

200 See Battle exhaustion: Terry Copp and Bill McAndrew, *Battle Exhaustion: Soldiers and Psychiatrists in the Canadian Army*, McGill-Queen's University Press: London, 1990, pp. 65, 68; Allan Converse, *Armies of Empire: The 9th Australian and 50th British Divisions in Battle, 1939–1945*, Cambridge University Press: Cambridge, 2011, pp. 46, 85–86; Mark Johnston, *At the Front Line: Experiences of Australian Soldiers in World War II*. Cambridge University Press: Cambridge, 2002, pp. 56–57.

201 Richard A. Gabriel, *Military Psychiatry: A Comparative Perspective*, Greenwood Press: New York, 1986, p. 133.

202 Harold R. Love, "Neurotic Casualties in the Field", *Medical Journal of Australia*, Vol. 2, No. 8, 22 August 1942, pp. 137–143, p. 139.

203 Walker, *Clinical Problems of War*, p. 684.

204 Report of No. 1 Medical detachment 14 Aust Field Ambulance Kokoda Area 24/7/42 to 08/9/42, AWM54 481/12/15.

McLaren made the point that during one period the rate of SIW from a particular (unidentified) battalion was one per day. While it is impossible to be certain about the actual numbers of SIWs occurring during the campaign, some further deductions may indicate a significant number. In the battle in which he reported SIWs as constituting one-third of all casualties, McLaren noted that both Militia and AIF forces were involved. The only time AIF and Militia forces fought together was during the battle of Isurava (26–31 August), with the depleted Militia battalions withdrawn soon afterwards. It is likely that Isurava was the battle to which McLaren referred. The Department of Veterans' Affairs records that around 111 Australians were wounded during this period of the campaign.[205] McLaren's estimate of SIWs constituting one-third of all wounds may indicate a number as high as 30–40 such casualties. Reports of SIW caused great controversy during the campaign as some medical officers disputed its occurrence.

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A number of contradictions exist in the evidence concerning the incidence of psychiatric casualties during the Kokoda Campaign. There is much to support the contention that, in many cases, psychiatric casualties were either not reported or were masked by other diagnoses. The unpreparedness of Australian medical provisions and the severe conditions in which the campaign was fought served to circumvent normal reporting and evacuation procedures. Methods learned in the Middle East had to be relearned, resulting in deviations in reporting. The absence of psychiatric specialists during the campaign may have resulted in less recognition of psychiatric casualties. Meanwhile, the comparatively high rate of disease and other conditions likely facilitated diagnostic masking of psychiatric breakdown. Reports of desertion and malingering may also indicate instances where the psychiatric causes of such actions were not recognised, being treated as primarily disciplinary issues. Evidence suggests that a significant number of SIWs occurred during the campaign, potentially indicating a corresponding number of unrecorded psychiatric casualties.

205 Department of Veterans Affairs, "The Stand at Isurava: 26–31 August 1942", accessed 01/06/2015. Available at http://kokoda.commemoration.gov.au/into-the-mountains/stand-at-isurava.php

Flying fox constructed by 2/6th Field Company, Royal Australian Engineers, to carry supplies to the start of the track to Uberi, Papua. Photograph by Thomas Fisher, October 1942. AWM 027033

William Dargie, *Stretcher Bearers in the Owen Stanleys* (1943, oil on canvas, 144 x 235 cm)
AWM ART26653

Chapter Four

Cultures of Silence

Army culture is not as homogenous as is often assumed. This was especially so during the Second World War, with the Australian Army employing regular volunteer units and conscripted Militia units. Several cultures existed within the Australian Army during the Kokoda Campaign and each informed the perception of psychiatric casualties. Soldiers were members of a wider Australian culture within which mental health issues were highly stigmatised. Soldiers were also a part of the aggressive and masculine culture of the army, within which the connotations of psychiatric breakdown were an uncomfortable fit. Yet more subcultures operated within the army itself. Distinct cultures functioned within various units; strong unit identity fostered cohesion and morale. Psychiatric breakdown was detrimental to this, separating the individual from his peer and unit group. There was also a distinct culture governing the medical corps, but even this had various facets. Medical staff were obligated to provide the best care to patients. Yet medical personnel were also soldiers required to perform a variety of military functions. It was the duty of medical officers to maintain the fighting force; this included a role in maintaining discipline and morale. Military–medical culture was complicated by the reality that what was best for the individual patient was not always best for the army. Cutting across this complexity of cultural tensions, officers and soldiers at all levels of the hierarchy were individuals engaged in myriad social interactions that sometimes contradicted their professional role within the army.

This chapter seeks to understand how these cultures may have inhibited acknowledgement of psychiatric breakdown during and after the Kokoda Campaign. Given the many factors that hid psychiatric breakdown at the time, it is difficult to penetrate the veil of the following 70 years. The postwar silence of veterans regarding psychiatric casualties is yet another complication for the historian. However, changing attitudes towards mental health issues has allowed fresh insights to emerge. This chapter highlights the complexities and tensions that existed within the cultures operating during the Kokoda Campaign. While these cultures may not have been unique, the conditions of the campaign saw them operate in unique ways. The second part of the chapter analyses the SIW controversy, providing an insight into the effect of competing cultures and processes in shaping the reporting of stigmatised issues. In this, SIW and psychiatric breakdown were closely linked. The chapter then examines how under-reporting of psychiatric casualties during the war was perpetuated by the silence of veterans, as well as a lack of public understanding and scholarly interest.

A Clash of Cultures

Experience of the Great War had exposed society to the effects of war trauma. Many soldiers of the Second World War had grown up amidst a generation of traumatised men – fathers, uncles, neighbours, and teachers. Attitudes to psychiatric breakdown had softened somewhat, however, archaic notions of insanity lingered in military culture. Psychiatric breakdown continued to be seen as a product of lax morals, inherent weakness and feminine characteristics.[206] A diagnosis of psychiatric breakdown carried other connotations at odds with the masculine and aggressive culture of the army – mental backwardness, delinquency, and homosexuality.[207] Australian officers were instructed to stay vigilant for signs of homosexuality in the belief that it was linked to psychiatric breakdown.[208] Military–medical practice at the time used labels such as "inferior" or "poor personality" to identify psychological problems, reinforcing a stereotype that only the mentally weak or morally defective suffered mental breakdown.[209] This may have reinforced a general assumption that mental problems were hereditary or an indication of poor family background or upbringing. The stigma of mental breakdown was great. A medical officer involved in the rehabilitation of neurotic soldiers after the war acknowledged the stigma which, he wrote, "has as its foundation the general public's recognition of the hereditary element in mental disorder".[210] Few men who suffered psychiatric breakdown would have wanted it to be known and many may have tried to hide it.

Many people involved in the reporting process throughout the military hierarchy may have been complicit in masking psychiatric breakdown. Sympathy for men unable to bear the strain was common within units, especially among those who knew each other well. "You were always very reluctant to write someone off as a psychiatric case", recalled one medical officer, "comrades, NCOs, the RMO and other officers kept a lot of men off the psychiatric casualty lists … the affected man might weep, become incoherent, have tremors, vomit and be unable to eat" and still not be recorded as a psychiatric case.[211] Efforts to disguise instances of psychiatric breakdown were perhaps more frequent within the tightly knit social groupings of the AIF battalions, in which relationships had been forged in the crucible of years of continuous warfare. When questioned by an interviewer regarding SIWs and the fate of men who went "bomb-happy", veteran Ken Bedggood responded, "I have no doubt that on the few occasions I saw it, it would not have been reported."[212]

Such attitudes and practices challenged notions of cowardice and military discipline. There was often no clear distinction between combat refusal and psychiatric breakdown and the latter was often seen as a disciplinary rather than medical issue, especially by the military hierarchy. One soldier observed in his war diary that the acting commanding officer of the 39th Battalion was "very bitter towards men who had fled. Says they are cowards."[213] While these men may or may not have suffered psychiatric breakdown, such hard judgements were common among senior officers. The commanding officer of the 9th Battalion during the later Bougainville Campaign of 1944–45 seemed rather exasperated by the medical interpretation of combat refusal, writing in his diary, "Once cowardice was punished by death but now we give them medicine!"[214]

206 See: Joseph Pugliese, "The Gendered Figuring of the Dysfunctional Serviceman in the Discourses of Military Psychology", in Joy Damousi and Marilyn Lake (eds.) *Gender and War: Australians at War in the Twentieth Century*, Cambridge University Press: Cambridge, 1995, pp. 162–77.

207 Harold R. Love, "Neurotic casualties in the field", *Medical Journal of Australia*, Vol. 2, No. 8, 22 August 1942, pp. 137–43, p. 138.

208 Summary of prevention and treatment of war neuroses, 10/7/41, Psychological warfare – general: psychiatry in the Australian army, case histories and reports, 1939–1945, p. 1, AWM54 804/1/4.

209 E.L. Cooper and A.J.M. Sinclair, "War Neuroses in Tobruk: A Report on 207 patients from the Australian Imperial Force Units in Tobruk", *Medical Journal of Australia*, Vol. 2, No. 5, 1 August 1942, pp. 74–75.

210 H. Hasting Willis, "The rehabilitation of war neurotics", *Medical Journal of Australia,* Vol. 1, No. 26, 29 June 1946, p. 915.

211 Jim Fairley as quoted in John Raftery, *Marks of War: War Neurosis and the legacy of Kokoda*, Lythrum Press: Adelaide, 2003, p. 59.

212 Kenneth Bedggood, 2/5th Field Company, unknown interviewer, 21 April 2004, Australians at War Film Archive. Available at http://www.australiansatwarfilmarchive.gov.au/aawfa/interviews/1495.aspx

213 Sergeant Jack Wilkinson's diary, as quoted in Bill James, *Field Guide to the Kokoda Track: An Historical Guide to the Lost Battlefields*, Kokoda Press: Lane Cove, 2006, p. 379.

214 Lieutenant Colonel G. Matthew's diary, 29 Jan 1945, AWM PR89/079 Item 5.

The position of medical officers within the military hierarchy was particularly complex. As members of a unit, as professionals, and as officers, medical personnel operated across several cultures and were subject to a number of competing priorities. They operated not only under an obligation of care to their patients, but also the duty to maintain the fighting force and discipline of the army. The Hippocratic values of the medical profession were often subjugated to the hard necessities of military service and discipline. In describing the role of an RMO, an experienced medical officer serving in the Middle East argued:

> *In order to carry out his duties effectively an RMO must forget most of his ideals and much of his ethics. All his previous training teaches him to ask himself "what is the best that can be done for this man?"... In the theatre of operations however he must ask: "can this man fire a rifle? Can he march?" and he must modify his treatment accordingly.*[215]

Around the same time, another seasoned RMO implied that the diagnosis of psychiatric breakdown was often treated as a last resort. "The aim of every RMO", he wrote, "should be a nil return of nervous casualties". He argued that RMOs should be capable of treating the majority of psychiatric casualties at forward aid posts, and returning them to duty.[216] The pressure to keep men fighting was great and this could challenge professional medical diagnosis and treatment. The duty to maximise the number of soldiers in service during periods of high tempo may well have led medical officers to retain psychiatric casualties for military purposes, circumventing reporting.

The DDMS of the 7th Division distributed a technical instruction to this effect during the Kokoda Campaign, emphasising the military functions of medical officers:

> *It must be impressed on all RMOs that it is their duty to keep a maximum number of reasonably fit men in the front line ... the most important duties of the RMO are a) to care for the health of the troops and b) to assist in maintaining discipline and morale.*[217]

215 P. Braithwaite, "The Regimental Medical Officer", *Medical Journal of Australia*, Vol. 1, No. 7, 13 February 1943, p. 137.

216 Love, "Neurotic Casualties in the Field", p. 142.

217 Deputy Director Medical Services HQ New Guinea Force (appendices), DDMS NGF Tech Inst No. 3, 12 Oct 1942, AWM52 11/1/49.

In maintaining discipline and morale, RMOs performed a key leadership function within battalion headquarters.[218] This may have served as a further impetus for under-reporting. Low unit confidence increased the likelihood of individual breakdown but psychiatric casualties were also seen to be a "very infectious" source of poor morale.[219] This vicious circle saw the duty to maintain morale come into conflict with the responsibility of professional diagnosis. This tension was perhaps further informed by attitudes within the highest levels of the army: the general staff had been reluctant to allow the publishing of articles describing psychiatric casualties at Tobruk in medical journals, arguing that they "might disturb morale".[220]

The impetus to maintain morale may have particularly affected the evacuation of officers for psychiatric reasons since the removal of leaders under this label could have serious implications for unit cohesion. The issue seems to have been treated as a highly sensitive military problem. Walker claims that at Tobruk, "[n]o officers were sent back with this diagnosis [NYDN] except with the sanction of the ADMS", a senior divisional medical officer.[221] Sinclair noted that "[i]t has been the practice to find a niche for such men in base positions" without drawing attention to their mental condition.[222] Pratten identifies an "old-world ethos"' permeating the officer corps, noting that it sought to look after its own by preserving the reputation of officers mentally unfit for command. He cites this as a potential source of under-reporting among commanding officers in particular, arguing that "[e]xhaustion and other psychological conditions were routinely disguised by other medical diagnoses".[223] It is probable that this unofficial code was also practised at Kokoda, both at the command level and for lower ranking officers.

The personal relationships between RMOs and their patients added an extra layer of complexity to the diagnosis of psychiatric casualties. In May 1942, an experienced medical officer wrote '"[t]he medical officer who knows his unit is like the family doctor who knows all his patients, their histories and their constitutions".[224] By the time of Kokoda, the majority of RMOs in the AIF battalions had more than two years of wartime service and were likely on close and sympathetic terms with many of the soldiers. The desire to protect men from the stigma of mental health issues may have served as an additional impetus for RMOs to mask psychiatric symptoms under other medical conditions, especially for officers and NCOs, with whom RMOs needed to maintain close relationships.

218 Braithwaite, "The Regimental Medical Officer", pp. 138–39.

219 Summary of prevention and treatment of war neuroses, 10/7/41, p. 6, AWM 54, 804/1/4.

220 Allan S. Walker, *Clinical Problems of War*, Australian War Memorial: Canberra, 1952, p. 680.

221 Allan S. Walker, *Middle East and Far East*, Australian War Memorial: Canberra, 1953, p. 204.

222 A.J.M. Sinclair, "Psychiatric Aspects of the Present War", *Medical Journal of Australia*, Vol. 1, No. 23, 3 June 1944, pp. 501–14, 502.

223 Garth Pratten, *Australian Battalion Commanders of the Second World War*, Cambridge University Press: Cambridge, 2000, pp. 224–25, 304–305.

224 S.F. McDonald, "Military Medical Emergencies", *Medical Journal of Australia*, Vol. 1, 16 May 1942, p. 578.

A Self-Inflicted Silence

The sensitive issue of SIW illustrates the complexity and tensions within the military–medical culture. In September 1942, Captain McLaren submitted a report in which he claimed a large number of SIWs were occurring among Australian forces.[225] The report provoked a strong reaction from the ADMS 7 Division, Lieutenant Colonel Norris, who circled the paragraph referring to SIW and wrote, "Don't believe it!" in the margin. Norris's response was to "put a stop to vicious conjecture by ordering that no such tag [SIW] could be applied to a soldier unless a medical officer actually saw the injury happen".[226] This was essentially an order that no SIW was to be reported. A medical officer was never likely to observe such an injury as they were usually located well to the rear of the fighting. After conferring with Norris, Major Magarey, the Senior Medical Officer of Australian forces, also responded strongly, later reporting that:

> *Accidental but no wilfully intended wounds were seen. It is regretted that one medical officer in particular made many unpleasant remarks about the nature of some of the limb wounds. We maintain that his accusations were unfounded and damaging to the work and reputation of the AAMC ... had I known at the time that this was occurring, the ADMS would have been asked to replace the officer or officers concerned.*[227]

Magarey's claim that "no wilfully intended wounds were seen" is unconvincing. Even if some wounds were accidental, it seems unlikely that a large number of men, potentially as high as 30 to 40, could have managed to accidentally shoot themselves in the hands and feet during the five-day period of the battle of Isurava. This is especially true of the AIF battalions which, for the most part, consisted of seasoned troops, well-versed in weapons handling after nearly three years of continuous service.

The prospect of being censured or replaced could well have induced medical officers to misdiagnose SIWs. Some medical officers identified "accidental wounds" as "very prevalent" and occurring at a "'high rate" following Norris's order.[228] At least one medical officer agreed with Norris. Steward, RMO of the 2/16th Battalion, claimed he never had the slightest suspicion of SIW among his men and that "the imputation was all too often cruelly and loosely made by people in no position to judge".[229] Steward's contention is contradicted by at least one veteran who recalled multiple cases of SIW in the 2/16th Battalion.[230] Field ambulance officers, such as McLaren, who treated casualties from every battalion were in a better position to judge the overall trends of wounds than RMOs who generally saw casualties only from their own battalion. They were also in a better position to form impartial opinions than RMOs, who may have known the men in question and felt that such casualties would reflect poorly on their unit.

It is difficult to imagine any motive that would have led McLaren to exaggerate or erroneously classify wounds as SIW. McLaren's diagnosis is corroborated by further evidence. Paul Ham reports that Captain John Oldham of the 2/6th Field Ambulance (the same unit as Magarey) believed that between ten and 25 per cent of all hand and foot wounds he saw during the campaign were intentional.[231] Captain Vernon reported seeing "at least three cases of Australian soldiers suffering from injuries caused by our own bullets", although it is unclear whether he was referring to SIW or friendly fire.[232] The most concrete evidence comes from Colonel Hailes, Director of Surgery, after he made an inspection tour of Australian hospitals containing patients evacuated from Kokoda. One month after Magarey's rejection of SIW reports, Hailes wrote a report entitled "GSWs [Gunshot Wounds] of the left hand and left foot", addressed to the Director General of Medical Services (DGMS), Major General Burston:

> *I saw a very considerable number of cases of GSWs of the hand and foot.... For the total number of wounded seen the number with wounds of the hand and foot only was considerable. There was no record on the AF 3118 [Field Medical Card] that any of them were even suspected of being SIWs and no note that any court of enquiry had been held.*[233]

225 This has been discussed in Chapter Three: Report of No. 1 Medical detachment 14 Aust Field Ambulance Kokoda Area 24/7/42 to 08/9/42, AWM54 481/12/15.

226 H.D. Steward, *Recollections of a Regimental Medical Officer,* Melbourne University Press: Carlton, 1983, p. 145.

227 Report on Medical Services of Kokoda area and L of C by Maj J.R. Magarey SMO Maroubra 17 Aug–10 Sep 42, p. 1, AWM54 481/12/20.

228 Medical Notes on Operations: Owen Stanley–Buna Areas, p. 8, AWM54 481/12/50.

229 Steward, *Recollections of a Regimental Medical Officer,* p. 145.

230 Eric Williams, 2/16th Battalion, unknown interviewer, 19 November 2003, Australians at War Film Archive, available: http://www.australiansatwarfilmarchive.gov.au/aawfa/interviews/1703.aspx

231 Ham does not indicate the source: Paul Ham, *Kokoda*, Harper Collins: Sydney, 2004, p. 206.

232 Deputy Director Medical Services HQ New Guinea Force (appendices) August 1942: Appendix E Account given by Capt. G.H. Vernon of arrangements and conditions on road between Kokoda and Ilolo, 28 August 1942, AWM52 11/2/49.

233 Note to DDMS NGF: Reference your memorandum dated 13 October 1942 [dated 21 October], AWM 52 11/1/19.

In response, Burston sent a note to the DDMS New Guinea Force, Brigadier W.W. Johnson, suggesting that "drastic action" be taken, and recommending that all hand or foot wounds be classed as SIW until proven otherwise.[234] Johnson reported that "no such diagnosis in any particular case has been made by the medical services, but we have sent round to the different medical units asking for particulars in such cases where such a diagnosis might be regarded as probable".[235]

The outcome of this dispute is not known, but it seems that the issue was never officially resolved. Historian Mark Johnston notes that only 62 cases of SIW were recorded in official casualty registers throughout the entire war, 40 of which were fatal.[236] The correlations between McLaren's and Hailes' observations suggest that SIW was occurring in significant numbers while the fact that no such diagnosis was officially recorded implies that all these casualties were misdiagnosed.

The testimony of veterans also supports McLaren's claims. Veterans from six different battalions, both Militia and AIF, recalled SIWs occurring.[237] When asked if SIWs had occurred, a veteran of the 2/25th Battalion responded: "Oh, yes, oh yes. I don't know how many but I know a couple of our blokes put a bullet through their foot."[238] Veteran interviews also inform deliberate under-reporting of SIWs. One veteran recalled finding a man who had shot himself in the foot: "I reported it as an accident and [he] got away with it. I think the 2IC knew very well it wasn't an accident, he just couldn't stand it any longer, poor beggar."[239] Doug McClean similarly remembered,

> *My officer jokingly said one day, "I'm going to have a form roneoed [copied], I didn't know the gun was loaded", to take care of the odd bloke that just couldn't take it anymore ... they were sent home, and depending on the time they'd been there it was overlooked occasionally because they weren't of sound mind when they did it.*[240]

234 July to December 42, Note to DDMS NGF: Reference your memorandum dated 13 October 1942, AWM 52 11/1/19.

235 July to December 42, Letter to DGMS, p. 3, AWM 52 11/1/19.

236 Mark Johnson, *At the Front Line: Experiences of Australian Soldiers in World War Two*, Cambridge University Press: Melbourne, 1996, p. 56.

237 Kelvin King, 3rd Battalion; Raymond Coombes, 2/2nd Battalion; Bernard Kuschert, 2/3rd Battalion; Eric Williams, 2/16th Battalion; Gilbert Simmons, 2/25th Battalion; all interviews are available at the Australians at War Film Archive. Available at http://www.australiansatwarfilmarchive.gov.au/aawfa/search.aspx; Jack Flanagan, 39th Battalion, interviewed by Harry Martin, 29 Nov 1988, Keith Murdoch Sound Archive. Available at https://static.awm.gov.au/images/collection/pdf/S00504_TRAN.pdf

238 Gilbert Simmons 2/25th Battalion, unknown interviewer, 25 November 2003, Australians at War Film Archive. Available at http://www.australiansatwarfilmarchive.gov.au/aawfa/interviews/1111.aspx

239 John Sim, 39th Battalion, unknown interviewer, originally filmed for the television series, *Australians at War in 1999–2000*, incorporated into the Australians at War Film Archive in 2007. Available at http://www.australiansatwarfilmarchive.gov.au/aawfa/interviews/2003.aspx

240 Douglas McClean, 39th Battalion, unknown interviewer, 30 May 2003, Australians at War Film Archive. Available at http://www.australiansatwarfilmarchive.gov.au/aawfa/interviews/961.aspx

This suggests that elements of the military hierarchy were sometimes sympathetic to those who self-harmed, and were complicit in covering-up some instances. Allegations of SIWs could certainly raise strong emotions: Steward recalls a colleague flying into a rage at the suggestion that the wound of one of his patients was self-inflicted.[241]

Others, perhaps like Norris and Magarey, regarded SIWs as potentially scandalous to the units involved. The desire to preserve collective identity and reputation may have had a considerable impact on reporting, especially where those concerned had a long affiliation with the unit. Norris and Magarey were heavily invested in the 7th Division, having served in the formation for more than two years prior to the Kokoda Campaign.[242] Brigadier Johnston noted that the hierarchy of the 7th Division felt that "a stigma has been cast on some of the units in that formation by the suggestion that there has been an unusual number of such wounds [SIWs]".[243] Despite the agitation caused by allegations of SIWs, the war diary of the ADMS makes no reference at all to the issue.[244] Norris was similarly selective in his description of his wartime experiences; his aptly titled postwar memoir, *No Memory for Pain,* omits the whole saga.[245]

Attitudes towards SIW and the dispute in the 7th Division inform the silence surrounding psychiatric casualties. Apart from a probable overlap in the two categories, there is definite evidence of a desire to protect unit reputation, morale and individuals from such stigmatised categories. The cultures that sought to deny SIWs may also have facilitated under-reporting of psychiatric casualties under similar rationales.

241 Steward, *Recollections of a Regimental Medical Officer,* p. 145.

242 Andrew J. Ray, "Norris, Sir Frank Kingsley (1893–1984)", Australian Dictionary of Biography, National Centre of Biography, Australian National University, accessed 24 April 2015. Available at http://adb.anu.edu.au/biography/norris-sir-frank-kingsley-15825/text27024 ; South Australian Medical Heritage Society Incorporated, "Sir Rupert Magarey", accessed 22 September 2015. Available at http://samhs.org.au/Virtual%20Museum/Notable-individuals/Magarey/magarey.htm

243 ADMS 7 Division Whole Diary, July to December 42, Appendices Only: [Untitled – report from DDMS to DGMS 16 Oct 1942), p. 3, AWM52 11/1/19.

244 ADMS 7 Div Whole Diary, AWM 52 11/1/19.

245 Norris, *No Memory for Pain*, 1970.

Piercing the Silence

In contrast to instances of SIW, or indeed other categories of casualty, the mental scars of psychiatric breakdown were invisible and left few traces for history. Jay Winter has described the reticence of First World War veterans to discuss shell-shock as a "generation of silence".[246] Veterans of the Second World War were similarly reticent when it came to acknowledging the occurrence of psychiatric casualties, although understanding and acceptance of the phenomenon had increased. Soldiers were unlikely to recount the experience of psychiatric breakdown in postwar memoirs or recollections, or to confide in their families. For many, the secret of their inability to cope mentally may have stayed with them for the rest of their lives. Likewise, those veterans who witnessed such occurances may have been reluctant to recount the experience out of respect for the sufferer. Others may have regarded such experiences as not worthy or of sufficient interest to their audience. Few veterans' memoirs include details of psychiatric casualties. Lack of public understanding and scholarly interest in psychiatric casualties also meant that the subject was rarely raised with veterans in early postwar interviews. The perception of psychiatric casualties as having been rare during the Kokoda Campaign began with under-reporting, but was perpetuated by the continued silence of veterans.

In more recent decades, society has come to show a greater interest in the psychological effects of war. When prompted, many veterans proved willing to reveal details of psychiatric casualties. Such details would probably never have come to light had veterans not been asked directly. Table 3 depicts veterans' recollections of psychiatric casualties at Kokoda during two sets of interviews: the first conducted for the Keith Murdoch Sound Archive (KMSA) from 1988–1990; the second for the Australians at War Film Archive (AWFA) from 2003–2007.[247]

246 Jay Winter, "Shell Shock, Gallipoli, and the Memories of War", paper presented at the Australian War Memorial Conference *Gallipoli: A Century On*, 18–20 March 2015.

247 Twenty-four Kokoda veterans were interviewed for the KMSA. The AWFA records 85 Kokoda veterans, however, 13 were excluded from this analysis because they did not have direct experience of the Kokoda Campaign. Two were from an Independent Company operating elsewhere in Papua, another served in the RAAF, and several more were stationed in rear areas around Port Moresby. Others served in the units that fought at Kokoda but were not present for the campaign and were mistakenly recorded in the archive as Kokoda veterans.

Table 3: Veterans' recollections of psychiatric casualities during the Kokoda Campaign

	Total number of veterans interviewed	Recalled occurence	Recalled no occurrence or not mentioned	Positive percentage
Keith Murdoch Sound Archive (1988–1990)				
39 Bn	8	5	3	62%
53 Bn	3	2	1	66%
2/27 Bn	13	0	13	0%
Total	**24**	**7**	**17**	**29%**
Australians at War Film Archive (2003–2007)				
3 Bn	2	0	2	0%
39 Bn	20	15	5	75%
53 Bn	3	2	1	66%
2/1	4	1	3	25%
2/2	5	3	2	60%
2/3	8	3	5	37%
2/14	12	5	7	41%
2/16	4	1	3	25%
2/25	2	0	2	0%
2/27	4	2	2	50%
2/33	2	1	1	50%
Miscellaneous	6	5	1	83%
Total	**72**	**38**	**34**	**53%**

Fifty-three per cent of those interviewed for the AWFA recalled instances of psychiatric breakdown during the campaign. A further seven, nearly ten per cent, recalled instances of SIW, so overall rates of recalled psychiatric breakdown may have been higher.[248] Results from the KMSA were less conclusive, with an overall positive percentage of 29 per cent. A number of factors may help explain the discrepancies between the two sets of interviews. The earlier KMSA interviews usually lasted about two hours while the later AWFA interviews ran for an average of six hours, with some running as long as nine. The AWFA interviews are more detailed and free-ranging. Of the 17 veterans in the KMSA who did not mention psychiatric casualties, none were directly asked about its occurrence.

248 Kelvin King, 3rd Battalion; Colin Richardson, 3rd Battalion; Douglas McLean, 39th Battalion; Raymond Coombes, 2/2nd Battalion; Bernard Kuschert, 2/3rd Battalion; Eric Williams, 2/16th Battalion; Gilbert Simmons, 2/25th Battalion; all interviews are available at the Australians at War Film Archive. Available at http://www.australiansatwarfilmarchive.gov.au/aawfa/search.aspx

In contrast, the subject of psychiatric casualties was broached in more interviews in the AWFA. The Australian experience of post-traumatic stress disorder (PTSD) in soldiers returning from the conflicts in Afghanistan and Iraq may have served to increase interest in mental health issues during the period in which these interviews were conducted. Even so, of the 34 veterans who did not recall psychiatric breakdown in the AWFA, the subject was raised in only seven instances. Only two specifically denied the occurrence of psychiatric casualties, including the former commanding officer of the 2/1st Battalion, who claimed that "in those AIF Battalions [in which he served] … the situation has never arisen".[249] Interestingly, four veterans of the two battalions in question recalled that psychiatric casualties had indeed occurred while a fifth related instances of SIW.[250]

The KMSA interviews represented a small range of battalions, while the AWFA obtained interviews from every infantry battalion except the 2/31st Battalion. The overall percentage of positive recall in the KMSA was kept low by the zero return from members of the 2/27th Battalion. This battalion was comparatively less exposed to psychological stresses than the others as it spent the least amount of time in action (barely two weeks) and suffered relatively few casualties (as shown in Table 1). The majority of the battalion's casualties were sustained in just two days, however, and during its engagement with the enemy it was cut off from the main force without supply, so the men of the battalion still suffered from significant, if short-lived, stress.

Although a small sample size, 50 per cent of 2/27th Battalion veterans interviewed for the AWFA recalled psychiatric casualties. A member of the 2/27th Battalion, Raymond Baldwin, was interviewed for both the KMSA and the AWFA. In the KMSA he was not asked about psychiatric casualties and did not mention them occurring. In the AWFA, however, he was asked, responding that he had witnessed them occurring on at least two occasions during the Kokoda Campaign, as well as revealing that he had suffered a psychiatric breakdown during a later campaign.[251] Raymond's willingness to discuss the matter in the later interview may reflect the gradual opening of attitudes and removal of stigma. It also confirms that while some veterans may not have brought up the issue of psychiatric casualties if left to themselves, many were willing to discuss it when invited. It is possible that many other veterans may have broken their silence had they been asked. When asked why veterans like himself "just don't talk about some things", Neville Blundell replied: "Nobody introduces the subject … you just say incidents like that which are just a bit funny in a sense. That's all we talk about."[252] Keith Irwin remarked:

> *In a lot of cases you'll find that most infantry men never ever talked a great deal about the war in the early days. It's only these last few years that people are interested now and want to know these things. They want to know answers to questions and incidents that have taken place. They want to know in detail what happened. That's why I'm sitting here talking to you now like a lot of other people.*[253]

• • •

Many cultures and subcultures operated within the Australian forces during the Kokoda Campaign. These interacted in complex fashions at all levels of the military hierarchy to influence the perception and treatment of psychiatric casualties. Each contributed to the silence surrounding the issue. The whole system was involved: from the individual overcome with shame; to the sympathetic mate, superior or medical officer; the leader responsible for the practical considerations of morale and unit cohesion; to the harsh disciplinarian who did not believe in the legitimacy of the condition. The example of institutional under-reporting of SIWs within the 7th Division provides an example of how individuals acting within this culture could disguise the occurrence of stigmatised issues. Under-reporting created an impression that psychiatric casualties were rare during the campaign, while the reticence of veterans in the decades following the war served to perpetuate this perception. As seen in the analysis of the postwar recollections of veterans, time has gradually allowed us to penetrate these cultures of silence. The number of veterans who recalled psychiatric breakdown is remarkable considering the supposed rarity of the condition. Those who were interviewed represent a small portion of the men who fought in the campaign. It is likely that many other stories reflecting the occurrence of psychiatric casualties have been forever lost to history with the gradual passing of the Second World War generation.

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249 Paul Cullen, 2/1st Battalion, unknown interviewer, 22 August 2003, Australians at War Film Archive. Available at http://www.australiansatwarfilmarchive.gov.au/aawfa/interviews/1591.aspx

250 John Lupp, Bernard Moore, Frederick Williams, Bill Smith; interviews available from the Australians at War Film Archive: http://www.australiansatwarfilmarchive.gov.au/aawfa/search.aspx

Raymond Coombes, 2/2nd Battalion, unknown interviewer, 16 January 2004, Australians at War Film Archive. Available at http://www.australiansatwarfilmarchive.gov.au/aawfa/interviews/1173.aspx

251 Raymond Baldwin, 2/27th Battalion, unknown interviewer, 24 November 2003, Australians at War Film Archive. Available at http://www.australiansatwarfilmarchive.gov.au/aawfa/interviews/1167.aspx

Raymond Baldwin, 2/27th Battalion, interviewed by Rob Linn, 23 March 1990. Available at https://static.awm.gov.au/images/collection/pdf/S00926_TRAN.pdf

252 Neville Blundell, 2/3rd Battalion, unknown interviewer, 30 April 2003, Australians at War Film Archive. Available at http://www.australiansatwarfilmarchive.gov.au/aawfa/interviews/57.aspx

253 Keith Irwin, 53rd Battalion, unknown interviewer, 6 May 2003, Australians at War Film Archive. Available at http://www.australiansatwarfilmarchive.gov.au/aawfa/interviews/26.aspx

Members of the 2/14th Battalion which was cut off from other Australian troops near Myola during the withdrawal in August, and used native-made rafts to get back to safety. Unknown photographer, Kalikodobu, Papua, October 1942. AWM 069243

Conclusion

The Problem Diagnosed

The issue of psychiatric breakdown during the Kokoda Campaign has for too long remained shrouded in silence. The perception of psychiatric casualties as rare derived from under-reporting in medical records. Even at the time, the apparent low incidence was belied by the universal acknowledgement of the nerve-wracking conditions of the Kokoda Trail. In taking medical reports at face value, the official medical historian, Allan Walker, was perhaps led to a simplistic explanation of this tension, with his assertion that the low number of psychiatric casualties was due to "the spirit of the men and their leaders".[254] The prolonged silence of veterans and a lack of popular and scholarly interest saw this limited understanding perpetuated over decades. Where campaigns such as Tobruk have been recognised for the psychological impact they had on soldiers in the field, this has not been the case with Kokoda. Psychiatric casualties presented a much greater problem to Australian forces than was portrayed at the time or since. This problem has remained undiagnosed for the past 70 years.

254 Allan S. Walker, *Clinical Problems of War*, Australian War Memorial: Canberra, 1952, p. 689.

This study has sought to understand the occurrence and causes of psychiatric breakdown at Kokoda and how evidence was masked or lost in the conditions and culture that prevailed on the trail. There are many challenges to achieving this understanding. It is premised on long-buried evidence. The difficulty in determining what caused psychiatric casualties lies in the complex interplay between myriad internal and external psychological stressors. It is impossible to say which factors were more important in precipitating psychiatric breakdown, yet it is safe to conclude that the campaign presented a highly traumatic set of conditions for the men involved. A comparison with the experience of psychiatric casualties in other campaigns reveals significant cause for psychiatric breakdown. The Japanese use of heavy weaponry, for which Australian forces had no equivalent, frequently placed soldiers in situations of intense helplessness and fear, while the gradual but continuous effects of the extreme physical environment and climate eroded mental resilience. Heavy casualties exacerbated the emotional effects of hunger, fatigue and miserable living conditions over an extended period of time. The psychological effect of jungle warfare and the brutality of the Japanese served to summon in soldiers the most primitive instincts of survival. These factors interacted to present a high risk to mental health.

There is a high probability that many psychiatric casualties were not reported for a number of reasons. Proving and analysing under-reporting is difficult because the contention is premised on a dearth of evidence. It is clear, however, that many factors served to mask psychiatric breakdown, including reporting procedures, disease, exhaustion, ill discipline, and SIW. The interplay of cultures at all levels of the military hierarchy facilitated the masking of psychiatric breakdown. The interaction between cultures was highly complex and sometimes acted in contradictory ways. As medical professionals, medical officers were expected to make accurate diagnoses and provide the best possible care for the patient; as military officers, they were expected to sustain the fighting force and assist in maintaining discipline and morale. Psychiatric casualties were considered bad for discipline and morale, and saw physically fit and otherwise healthy men leaving the pool of available manpower. Less formal and personal relationships meant that many men felt reluctant to apply the label of psychiatric breakdown to a patient that they knew.

The issue of SIW informs the roles played by military–medical cultures in subverting the reporting process. When SIW became an issue during the Kokoda Campaign, the response of medical authorities provides tangible evidence of institutionalised under-reporting of stigmatised issues. The same cultural pressures may have suppressed evidence of psychiatric casualties. It should be acknowledged that the cultures operating within Australian forces during the Kokoda Campaign were not unique, but were rather a reflection of the wider cultural milieu of contemporary society. Under-reporting of psychiatric casualties probably occurred in other Australian campaigns of the Second World War and other conflicts. The Kokoda Campaign presented a unique interface between cultures, causes, and masking factors, however, which combined to further facilitate the occurrence and under-reporting of psychiatric casualties.

It remains impossible to know exactly how many Australian soldiers became psychiatric casualties during the Kokoda Campaign. However, the consensus of veteran recollections suggests that psychiatric casualties were a reasonably common experience, occurring on a scale much wider than previously understood. The responses yielded by the AWFA interviews are particularly startling. The positive rate of 53 per cent across a broad range of units is highly at odds with the supposed rarity of psychiatric casualties. Kokoda was largely a small group experience, and this consensus may indicate that psychiatric casualties were widespread, with each individual recollection possibly representing a distinct small group experience.

As the most iconic Australian campaign of the Second World War, second only to Gallipoli in popular culture, the Kokoda Campaign deserves to be understood in all its facets. This work has not sought to undermine the achievements and record of Australian forces in any way, but rather to provide a better understanding of the emotional effect of this war on the men who fought it. Yet more work remains to be done. The Kokoda Campaign must be placed in the context of other Australia campaigns of the Second World War. Braudel once compared the limits of historical understanding to the dim light exuded by fireflies in the Amazonian jungle, each insect burning bright yet only dimly penetrating the surrounding darkness. Though this work be but a small firefly casting its own modest light in the jungle of 1942 Papua, it is hoped that in some small way it may encourage further research into the experience of psychiatric casualties in all our campaigns.

Australians with a captured Japanese mountain gun. Photograph by George Silk, 23 November 1942.
AWM 013644

Appendices

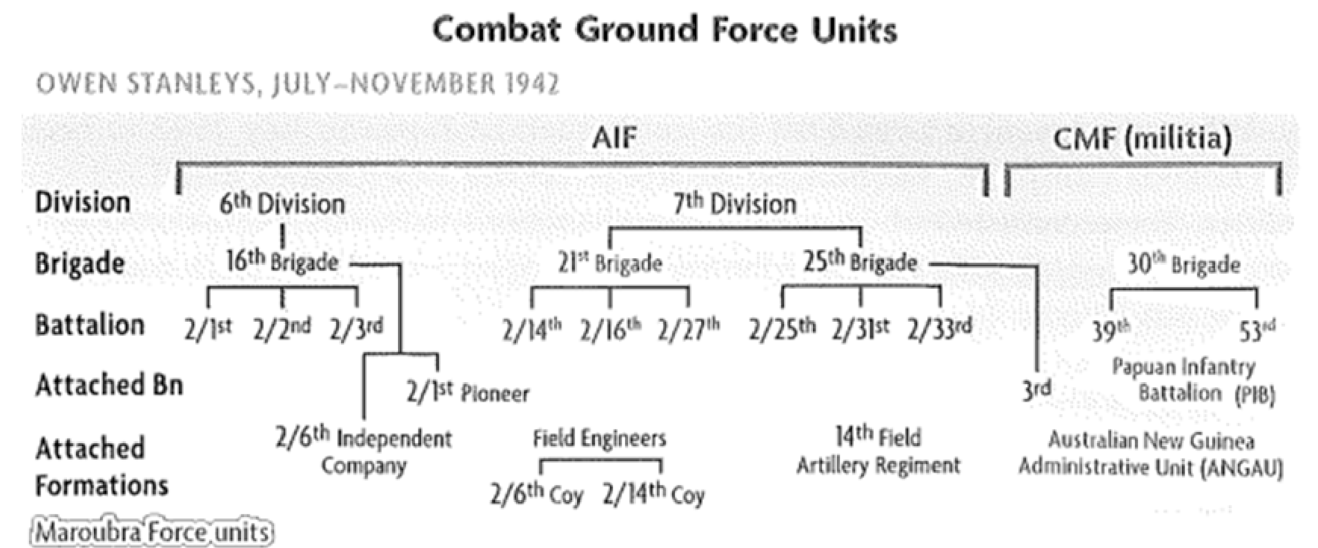
Appendix A:

Timeline of the Kokoda Campaign, July to November 1942

Month	Date	Event
July	7	Australian troops begin operations along the Kokoda Trail.
	21	Imperial Japanese Army and naval forces land near Gona and Buna.
	22	First contact between Australian and Japanese forces at Awala, 40 km north of Kokoda.
	28–29	Japanese forces capture Kokoda.
August	8	The 39th Battalion recaptures Kokoda unopposed.
	12	Japanese forces capture Kokoda for second time.
	14	Battle of Deniki. The 39th Battalion withdraws.
	26–31	The 39th and 53rd Battalions are reinforced by the 2/14th and 2/16th Battalions. Battle of Isurava. Australian forces suffer heavy casualties and withdraw. The 39th and 53rd Battalions are withdrawn from the frontline.
September	7–8	The 2/27th Battalion arrives. Battles of Mission Ridge and Brigade Hill. Australian forces suffer heavy casualties and withdraw.
	13–16	The 3rd Battalion arrives. Battle of Ioribaiwa Ridge. Australian forces withdraw to Imita Ridge.
	24	Japanese forces receive orders to withdraw.
	27	The 25th Brigade advances with the 3rd Battalion attached. Australian forces occupy Ioribaiwa Ridge unopposed.
October	1–14	Australian forces advance virtually unopposed to Templeton's Crossing.
	15–21	First concentrated Japanese resistance to the advance is encountered. The 25th Brigade sustains heavy losses advancing to Eora Creek. The 16th Brigade arrives.
	22–29	Battle of Eora Creek. The 16th Brigade suffers heavy casualties.
November	02	Australian forces reoccupy Kokoda.
	6–12	Battle of Oivi-Gorari. Australian forces suffer heavy casualties but inflict over 1,000 casualties on Japanese forces.

Appendix B:

Australian Ground Force Units – Kokoda Campaign



Source: James, *Field Guide to the Kokoda Track*, p. 343

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Alex Lochhead	Jack Boland	Lawrie Hawson
Donald Simonson	Jack Flanagan	Leslie Simmons
Sydney Heylen	Victor Austin	

53rd Battalion		
Bill Elliott	Trevor King	Walter Button

2/27th Battalion		
Alex Little	Bert Ward	Bruce Deering
Charles Sims	Frank McLean	Harry Katekar
Jack Reddin	John Henry Burns	Raymond Baldwin
Robert Innes	Robert Johns	Robert Matten
Thomas Spencer		

Australians at War Film Archive

Note: many of these men served in multiple battalions over the course of the war. For the purpose of this study, they have been listed with the unit they fought in during the Kokoda Campaign.

3rd Battalion		
Colin Richardson	Kelvin King	

39th Battalion		
Albert Fry	Arnold Forrester	Arthur Garland
Don McKay	Donald Daniels	Douglas McClean
James Waters	Gordon Bailey	Joseph Dawson
John Sim	Kenneth Phelan	Lawrence Downes
Peter Holloway	Reginald Markham	Ronald Halsall
Stanley Barcham	William Mahney	William Guest
William Gleeson	William Bellairs	

53rd Battalion		
Keith Irwin	Ronald Plater	Roy Wotton

2/1st Battalion		
Basil Catterns	John Lupp	Paul Cullen
Carlton Parrott		
2/2nd Battalion		
Bernard Moore	Bill Smith	Frederick Williams
Raymond Coombes	William Devine	
2/3rd Battalion		
Dennis Williams	Donald Wilson	Francis Stanton
Griffith Spragg	Neville Blundell	Bill Jenkins
William Booth	Bernard Kuschert	
2/14th Battalion		
Cyril Allender	George Collins	James Cooper
Lindsay Mason	Leslie Cook	Matthew Power
Lionel Smith	Robert Thompson	Philip Rhoden
Robert Iskov	Stanley Bisset	Thomas Bolton
2/16th Battalion		
Colin McRostie	Eric Williams	James Mackenzie
John Corbett		
2/25th Battalion		
Frederick Williams	Gilbert Simmons	
2/27th Battalion		
Clive Edwards	Eric Sambell	Raymond Baldwin
Robert Johns		
2/33rd Battalion		
Harry Cullen	Neville Lewis	
Miscellaneous		
Roy Dockery (14th Field Regiment)	John Routley (7th Division, unknown unit)	Herbert Watton (7th Division Signals)
Frank Patterson (7th Division Signals)	John McIntosh (1st Papuan Infantry Battalion)	Kenneth Bedggood (2/5th Field Company)

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