Introduction: Trauma and its Histories in Australia

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This Special Issue of *Health and History* addresses the various meanings of 'trauma'—that broad and contested concept—in Australian contexts. It has its origins in an interdisciplinary symposium at the University of Newcastle in May 2017, convened by the Centre for the History of Violence to coincide with the visit of Professor Mark S. Micale from the University of Illinois. The author and editor of several key works examining the history of trauma and related concepts, Micale had recently argued that the spread of the idea of trauma and its associated literatures 'registers a deepening understanding of the essential fragility of the human psyche' and that one key challenge for scholars grappling with the concept is to eschew 'a single, unidirectional narrative of trauma that culminates logically in present-day medical science' in favour of 'multiple, context-dependent histories'.[1] The symposium brought together scholars and practitioners in the humanities, social sciences, and medical sciences to test this proposition in the case of Australia and the near region. The articles and interviews in this special issue expand on the discussions from that day, which were framed by questions both broad and more constrained. What do we mean when we speak about 'trauma'? How does this differ between disciplines? What is the relationship between theory and clinical practice? How has trauma and its analogues been understood in the Australian past? How is trauma understood in the Australian present?

Such questions feed into wider discussions in the already crowded field of trauma studies, which is by its very nature interdisciplinary (if not always happily so). As Micale and other prominent trauma scholars have argued, 'trauma' now has multiple meanings, literatures, and genealogies beyond its medical origins.[2] It resides both within and outside the clinic: in an 'official' diagnosis like Post Traumatic Stress Disorder [PTSD] but also in popular parlance as a synonym for lingering pain or suffering. In an influential book Didier Fassin and Richard Rechtman argue that trauma 'is more a feature of the moral landscape serving to identify legitimate victims than it is a diagnostic category which at most reinforces that legitimacy'.[3]

Put another way, trauma is political: by identifying individuals who are traumatised and by qualifying events as traumatic, we engage in political acts; we also do so via the conclusions we draw from an individual's status as traumatised and the therapies and remedies we offer. As we will see, this political element is consistently evident in the contributions to this special issue, where the wrongs done to Indigenous Australia, the damage wrought by wartime, and the abuse of vulnerable children are governing themes. The list could, of course, be far longer and include the victims of domestic violence, detained asylum seekers, and the harms experienced by LGBTIQ Australians (often at the hands of the medical profession itself) as examples of other instances of traumatic experiences and histories.[4]

In Australia as elsewhere, the contemporary prominence of trauma can be directly linked to the entry of PTSD into the *Diagnostic and Statistical Manual*-III in 1980, a development that was connected both to the aftermath of the Vietnam War and the changing orientation of the American psychiatric profession. As Allan Young argued in his seminal *The Harmony of Illusions*, the advent of PTSD ought to be seen in the context of the watershed of the '*DSM-III* revolution' itself, in which the fuzzier, quasi-Freudian descriptive and largely hypothetical approach to mental disorders was replaced by a systematised neo-Kraepelinian nosology.[5] But the politics of the post-Vietnam era—the figure of the damaged veteran, speculations about so-called 'post-Vietnam syndrome' and the questions that lingered over the righteousness of the American involvement in that conflict—also played a role. As Fassin and Rechtmann outline, PTSD criteria did not necessarily distinguish between wartime victims and perpetrators; in this way, the diagnosis provided a mechanism by which all Vietnam veterans, regardless of the moral content of their actions during the war, could be viewed with sympathy and offered medical care, compensation, and compassion.[6] Vietnam veterans thus became PTSD's archetypal patients and as Young notes, for the next decade and a half, American research on PTSD tended to centre on studies of these men.[7]

Vietnam veterans also feature in the early Australian literature on PTSD but they sit beside other groups of trauma victims reflecting specifically Australian circumstances and calamities.[8] The emergence of PTSD as an official diagnosis coincided with the aftermath of a series of disasters—the 1977 Granville rail disaster, the 1983 Ash Wednesday bushfires and the 1989 Newcastle earthquake—through which practitioners could test the bounds of therapeutic interventions

and their efficacy on the effects of traumatic stressors. It was in this environment that the psychiatrist Beverley Raphael pioneered rapid mental health assessments as part of disaster response protocols.[9] By 1986 in the pages of the *Medical Journal of Australia* Professor Bruce S. Singh of Monash University could characterise PTSD as a disorder of potentially broad application for which clinicians had a 'dual responsibility':

> The first is to identify an individual who has experienced a highly stressful event; the second, to find out whether the patient suffers from recurring imagery of the event and shows a diminishing responsiveness to the outside world. By becoming alert to the signs of post-traumatic stress disorder, clinicians will be well on the way to breaking through the barrier of denial which inhibits the profession, the sufferers and the community from recognizing the disorder and dealing with it appropriately.[10]

The rising prominence of PTSD also impelled the reassessment of past events and patient cohorts. Surviving World War II veterans were convenient objects of scrutiny as old age prompted increased contact with the medical profession, but it was the former prisoners of the Japanese—particularly those men who had survived the ordeal of the camps of the Thai-Burma Railway—whose experiences during and after the war most resonated.[11] Just as Fassin and Rechtmann contend that PTSD served to both condemn the Vietnam War and console suffering veterans, in Australia Christina Twomey argues that the PTSD diagnosis 'fostered a rapprochement of sorts between baby boomers and their fathers', offering a lens through which to interpret intergenerational disagreements about white Australia's relationship with Asia and the moral status of warfare itself. This can be seen as part of a broader shift to 'reinvigorate' Anzac commemoration by positioning the Australian soldier as both sufferer and witness.[12]

The intertwining of Anzac memorialisation with the notion of trauma parallels the broader intersection of war and psychiatry in Australian history. While historians have tended to focus on the experience of shell shock in the First World War as pivotal for both the direction of psychiatry in the twentieth century and conceptions of masculine fragility, in this special issue Effie Karageorgos argues that the neglect of the Boer War has obscured the degree to which that conflict prefigured ideas of Australian manhood that shaped the approach to psychiatric casualties in subsequent

wars. As Karageorgos suggests, symptoms and behaviour that in the First World War may have satisfied criteria for shell shock or other adjacent diagnoses were interpreted in multiple directions: sometimes as evidence of a pre-existing madness, and sometimes more ambiguously as 'neurasthenia' (a diagnosis with its own contested history). While extant records are scant, there is clearly more to do to recover the stories of these ex-servicemen and their place in the history of Australian military psychiatry.

Like Karageorgos, Katie Mills and Michèle Horne also add another dimension to our understanding of Australian wartime medicine in their discussion of scientific improvisation on the Thai-Burma railway. The rigours of medical practice in what we would now term traumatic circumstances confirms the degree to which the care of the suffering POW body was the focus of effort and ingenuity. As Mills and Horne argue, the POW doctors had to improvise, to 'look back on the very earliest years of their training, including medical history': the surgeon Albert Coates compared his amputations of POWs' ulcerated limbs, performed with a butcher's saw from the kitchen, to those done on wounded soldiers during the Napoleonic Wars. But as Mills and Horne emphasise, the POW doctors also relied on the ingenuity of POW scientists in producing pharmaceuticals to support these interventions. At 55 Kilo camp, working alongside Coates, the Dutch pharmacist Christoffel van Boxtel 'was able to produce compounded medicines and drugs from first principles', aided by a contraband copy of the textbook *Pharmacopoeia* smuggled into the camp by the Australian pharmacist Bevan Warland-Browne. In seeking to ameliorate the diseases that plagued the prisoners, POW medicine was necessarily oriented towards the body; as we have seen, it was not until the 1980s that the impact of captivity on the mind received sustained attention.

If collectively the traumatised male war veteran comprised the single largest category of scrutiny in the post-1980 era, other potentially traumatised patients emerged in the Australian literature as the decades progressed. Holocaust survivors—so central to the formulation of trauma theory in the United States—can be put into this category.[13] Refugees—particularly those tortured in their countries of origin—were also seen in this light; refugees' adjustment to life in Australia was understood in psychological terms.[14] Disturbingly, the punitive dimensions of Australia's management of refugees—including the troubling presence of the detained asylum seeker—

can be seen reverberating well before the present crisis of mental health on Manus and Nauru.[15]

Bipin Ravindran addresses a number of these themes in his discussion of the concerns animating his clinical work and academic research. While he was drawn to psychiatry for 'the challenges and the extraordinary possibilities of working with people and families at a very personal level', his experience of working across and between cultures has been crucial in his appreciation of the complex cultural dynamics often at play in acute clinical settings. In Australia clinicians must be able to work with patients from diverse backgrounds, and approaches emphasising 'cultural competency' and 'cultural safety' are one means to counter structural inequalities in patients' encounters with the health system. At the same time, highly individualised western perceptions of trauma are often insufficient for understanding a patient's pain. 'Refugee mental health', argues Ravindran, 'needs approaches beyond the individual trauma lens, looking into the collective, the historical, and the global impacts of local events'.

The necessity of looking beyond individuals to the structural factors that make trauma possible is also elucidated in Kathleen McPhillips' examination of the recently concluded Royal Commission into Institutional Responses to Child Sexual Abuse. As McPhillips emphasises, the Royal Commission exposed both the troubling extent of the sexual abuse of vulnerable children within Australian institutions and the mechanisms by which certain institutions denied their own knowledge of and responsibility for these crimes. Moreover, in disclosing sexual abuse, survivors not only risked becoming stigmatised in their own communities but being re-traumatised by labyrinthine compensation and redress schemes. In this way, the Royal Commission has extended contemporary understandings of the impacts of trauma and the ways in which institutions can perpetuate pain; at the same time, in its public and private hearings the Royal Commission has modelled a 'humanistic and inclusive' process that treats survivor testimony with care and respect. In this sense it is likely to be an extremely significant milestone in the Australian history of trauma, not least because, as Catharine Coleborne and Tamara Blakemore make clear in their Afterword, the consequences of such 'institutional trauma' are consistently evident in both histories of psychiatry and in the practice of social work.

In its final report, the Royal Commission found that Aboriginal

and Torres Strait Islander children were particularly vulnerable to sexual abuse in institutions in which they were in any case over-represented due to historic policies of child removal.[16] Such vulnerability is just one iteration of a broader pattern of historic injustices which have had profound implications for Indigenous health policy and outcomes, as the contributions of Charmaine Robson and John Boulton make clear.[17] As Robson explores in her article, the treatment of Hansen's disease in Aboriginal communities in the middle decades of the twentieth century engendered significant distrust of white medicine as tied to the expansion of the colonial state. 'Knowledge about medical practices shared among families and down the generations has shaped and reinforced negative perceptions' of this intervention and is wedded to 'a history of physical and mental suffering in the context of mandatory detention in medical institutions, often involving children'.

The saliency of what Robson describes as 'intergenerational memory' is also evident in John Boulton's discussion of intergenerational trauma in Indigenous Australia and his reflections on his long career in general. For Boulton intergenerational trauma is partly about the transmission of memories but also about pain written on and into the body. In this way, Boulton suggests that we cannot understand the health status of Indigenous people without understanding the broader political context, including a nation unreconciled to aspects of its history. Similarly, therapeutic responses cannot simply reside in the clinic or in public health campaigns (though they have their place) but are intimately tied to social justice. In this respect, Boulton's reflections on 'the critical nature of an historical understanding' of the 'deep origins' of health outcomes for Indigenous people suggest the value of interdisciplinary dialogue between the humanities, the social sciences, and the medical sciences in forging that understanding.

The intersection of trauma theory and the experience of Indigenous Australians raises important questions about the political potency of the PTSD diagnosis and the broader concept of 'trauma' in contemporary Australia. If PTSD functions to make certain kinds of suffering visible, it still relies on a degree of cultural consensus about what suffering ought to count as well as on sufficient political will to render that suffering legitimate and compensable. The ongoing debate over the designation of the violence of the early colonial frontier as a war bears the imprint of these calculations. So too does the recent advocacy for the release of detained asylum

seeker children on psychiatric grounds.

Yet it is also worth emphasising that what we say PTSD 'is' is changing. Models of epigenetically-mediated intergenerational trauma are one example of biomedicine's shaping of trauma theory to account for the complexities of interconnected symptoms, behaviours, and biological markers. In a 2017 article leading Australian PTSD researcher Alexander McFarlane described PTSD as a 'systemic illness', its complexity long obscured by researchers' 'failure to attend to the somatic pathology' of the condition.[18] A 2016 article noted the 'growing evidence that PTSD, along with other mental disorders, is strongly associated with somatic, lifestyle-related comorbidities' such as diabetes and cardiovascular disorder.[19] In many ways, these suppositions are reviving old debates about the precise aetiology of shell shock and other wartime psychiatric conditions. As MacFarlane argued in 2015:

> The battle during World War I between organic and psychogenic models of post-traumatic stress was misguided. PTSD is a multifaceted disorder, in which biological, psychological and social components are intertwined in its aetiology, and must therefore be considered in any recovery strategy.[20]

Therapeutic responses to PTSD are also shifting. Alongside various drug therapies there is a growing emphasis on post-traumatic growth and resilience and on repudiating the certainty of insuperable damage.[21] In military medicine the concept of 'moral injury' is also growing in popularity by positioning certain elements of PTSD symptomatology as a response to a moral crisis in terms reminiscent of early theorising around post-Vietnam syndrome.[22] In western militaries the increasing popularity of both concepts cannot be separated from the experience and course of the wars in Afghanistan and Iraq, which call for multiple deployments on the one hand (resilience) but occupy disputed moral territory on the other (moral injury). In this regard it is worth continuing to consider the ways in which ideas about trauma are formed by context and contingency as well as clinical evidence, in Australian as well as global contexts. This special issue seeks to contribute to this debate.

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1 Mark S. Micale, "Toward a Global History of Trauma", in *Psychological Trauma and the Legacies of the First World War*, edited by Jason Crouthamel and Peter Leese (New York: Palgrave, 2017).
2 *Ibid.,* 289.
3 Didier Fassin and Richard Rechtman, *The Empire of Trauma: An Inquiry into the Condition of Victimhood*, translated by Rachel Gomme (Princeton: Princeton University Press, 2009), 284.
4 For a useful overview see Michael Robertson, Edwina Light, Wendy Lipworth, and Garry Walter, "The Contemporary Significance of the Holocaust for Australian Psychiatry", *Health and History* 18, no. 2 (2016): 109–111.
5 Allan Young, *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder* (Princeton: Princeton University Press, 1995), 89–107.
6 Fassin and Rechtmann, 94–5.
7 Young, 111.
8 See for example Bruce Boman, "The Vietnam Veteran Ten Years On", *Australian and New Zealand Journal of Psychiatry* 16 , no.3 (1982): 107–27; Wayne Hall and Donald McPhee, "Do Vietnam Veterans Suffer from Toxic Neurasthenia?", *Australian and New Zealand Journal of Psychiatry* 19, no. 1 (1985): 19–29; Jan Westerink and Leah Giarratano, "The Impact of Posttraumatic Stress Disorder on Partners and Children of Australian Vietnam Veterans", *Australian and New Zealand Journal of Psychiatry* 33, no. 6 (1999): 841–7.
9 See Beverley Raphael, "Editorial Comment: Psychiatric Consultancy in Major Disaster", *Australian and New Zealand Journal of Psychiatry* 18 (1984): 303–06; Beverley Raphael, "Psychosocial Aspects of Disaster: Some Australian Studies, and the Ash Wednesday Bushfires", *Medical Journal of Australia*, 141, no. 5 (1984): 268–9. See also Alexander C. McFarlane, "The Ash Wednesday Bushfires in South Australia: Implications for Planning for Future Post-Disaster Services" *The Medical Journal of Australia* 141(5) (1984): 286–291 and Paul Valent, "The Ash Wednesday bushfires in Victoria", *Medical Journal of Australia* 141, no. 5 (1984) : 291–9. The conclusions drawn from these experiences were applied in the aftermath of the Bali bombings and the Black Saturday bush fires. See Garry J. Stevens, Julie C. Dunsmore, Kingsley E. Agho, Melanie R. Taylor, Alison L. Jones, and Beverley Raphael, "Coping Support Factors among Australians Affected by Terrorism: 2002 Bali Bombings Survivors Speak", *Medical Journal of Australia* 199, no. 11 (2013): 772–5; and Richard A. Byrant, Elizabeth Waters, Lisa Gibbs, et al., "Psychological Outcomes Following the Victorian Black Saturday Bushfires", *Australian and New Zealand Journal of Psychiatry* 48, no. 7 (2014): 634–43.
10 Bruce S. Singh, "The Long-term Psychological Consequences of Disaster", *Medical Journal of Australia* 145 (1986): 555–6.
11 On World War II veterans see Malcolm A. Kidson, John C. Douglas, and Brendan J. Holwill, "Post-Traumatic Stress Disorder in Australian World War II Veterans Attending a Psychiatric Outpatient Clinic", *Medical Journal of Australia* 158, no. 8 (1993): 563–6. For examples of renewed medical attention to POWs see D.C. Hinden, "Prisoners of War: Long-term Effects", *Medical Journal of Australia* 11, no. 1 (1981): 565–6; Ian L. Duncan, "Life in a Japanese Prisoner-of-War Camp", *Medical Journal of Australia* 7, no. 1 (1982): 302–06; Kerry L. Goulston, Owen F. Dent, Pierre H. Chapuis, et al., "Gastrointestinal Morbidity among World War II Pris-

oners of War: 40 Years on", *Medical Journal of Australia* 143, no. 1 (1985): 6–10; Christopher Tennant, Kerry Goulston, and Owen Dent, "Australian Prisoners of War of the Japanese: Post-war Psychiatric Hospitalisation and Psychological Morbidity", *Australian and New Zealand Journal of Psychiatry*, 20, no. 3 (1986): 334–40; Ian P. Burges Watson, "Post-Traumatic Stress Disorder in Australian Prisoners of the Japanese: A Clinical Study", *Australian and New Zealand Journal of Psychiatry* 27, no. 1 (1993): 20–9.

12 Christina Twomey, *The Battle Within: POWs in postwar Australia* (Sydney: NewSouth, 2018), 213–40; Christina Twomey, "Trauma and the Reinvigoration of Anzac", *History Australia* 10, no. 3 (2013): 85–108.

13 See Elizabeth D. Paratz and Benny Katz, "Ageing Holocaust Survivors in Australia", *Medical Journal of Austrlaia* 194, no. 4 (2011): 194–7; Paul Valent, "Holocaust Traumatology in Australia", *Holocaust Studies: A Journal of Culture and History* 16, no. 3 (2010): 95–111. Valent argues that this may be because 'Australian Jewry is more close-knit and Holocaust-identified' than other Jewish communities (see p. 104). See also Michael Robertson et al., 99–120.

14 Bruce Boman and Maurine Edwards, "The Indochinese Refugee: An Overview", *Australian and New Zealand Journal of Psychiatry* 18, no.1 (1984): 40–52; Janice C. Reid and Timothy Strong, "Rehabilitation of Rrefugee Victims of Torture and Trauma: Principles and Service Provision in New South Wales", *Medical Journal of Australia* 148, no. 7 (1988): 340–5. Patrick Morris, Derrick Silove, Vijaya Manicavasagar, Robin Bowles, Margaret Cunningham, and Ruth Tarn, "Variations in Therapeutic Interventions for Cambodian and Chilean Refugee Survivors of Torture and Trauma", *Australian and New Zealand Journal of Psychiatry* 27, no. 3 (1993): 429–35; Robert Schweitzer, Fritha Melville, Zachary Steel, and Philippe Lacherez, "Trauma, Post-Migration Living Difficulties, and Social Support as Predictors of Psychological Adjustment in Resettled Sundanese Refugees", *Australian and New Zealand Journal of Psychiatry* 40, no.2 (2006): 179–87.

15 See Derrick Silove, Philippa McIntosh, and Rise Becker, "Risk of Retraumatisation of Asylum-Seekers in Australia", *Australian and New Zealand Journal of Psychiatry* 27, no.4 (1993): 606–12. See also Shakeh Momartin, Zachary Steel, Marianio Coello, Jorge Aroche, Derrick M. Silove, and Robert Brooks, "A Comparison of the Mental Health of Refugees with Temporary Versus Permanent Protection Visas", *Medical Journal of Australia* 185, no. 7 (2006): 357–61.

16 Royal Commission into Institutional Responses to Child Sexual Abuse, *Final Report: Preface and Executive Summary* (Commonwealth of Australia, 2017), 2122.

17 For specific discussion of the impact of western psychiatry on Aboriginal and Torres Strait Islander people, see Robertson et al., 106–07 and Milton Lewis and Stephen Garton, "Mental Health in Australia, 1788–2015: A History of Responses to Cultural and Social Changes", in *Mental Health in Asia and the Pacific: Historical and Cultural Perspectives*, edited by Harry Minas and Milton Lewis (New York: Springer, 2017), 300–04.

18 Alexander C. McFarlane, "Post-Traumatic Stress Disorder is a Systemic Illness, not a Mental Disorder: Is Cartesian Dualism Dead?", *Medical Journal of Australia* 206, no. 6 (2017): 248–9. For an earlier example in the Australian literature of speculation about the relationship between PTSD and bodily systems see I. Patrick Burges Watson, H. Konrad Muller, Ivor H. Jones, and Adrian J. Bradley, "Cell-Mediated Immunity in Combat Veterans with Post-Traumatic Stress Disorder", *Medical Journal of Australia* 159, no. 8 (1993): 513–16.

19 Simon Rosenbaum and Zachery Steel, "Breaking SDown the Silos of Treatment for Post-Traumatic Stress Disorder: Integrating Mind and Body", *Medical Journal of Australia* 204, no. 9 (2016), 337.

20 Alexander C. McFarlane, "The Journey from Moral Inferiority to Post-Traumatic Stress Disorder", *Medical Journal of Australia* 202, no. 7 (2015): 348–50.

21 See for example Brenda J. Morgan and Sandra C. Garmon Bibb, "Assessment of Military Population-Based Psychological Resilience Programs", *Military Medicine* 176, no. 9 (2011): 976–85. On the concept of resilience more broadly see Philippe Bourbeau, *On Resilience: Genealogy, Logics and World Politics* (Cambridge: Cambridge University Press, 2018).

22 See for example Kent D. Drescher, David W. Foy, Caroline Kelly, Anna Leshner, Kerrie Schutz, and Brett Litz, **"**An Exploration of the Viability and Usefulness of the Construct of Moral Injury in War Veterans", *Traumatology* 17, no. 1 (2011): 8–13. See also Kenneth MacLeish, "On 'Moral Injury': Psychic Fringes and War Violence", *History of the Human Sciences* 31, no. 2 (2018): 128–46.