

“Due to His Abnormal Mental State”: Exploring Accounts of Suicide among First World War Veterans Treated at the Ontario Military Hospital at Cobourg, 1919-1946

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Relying on records of veterans' hospital admissions, and service and pension files of the Canadian Expeditionary Force, this paper explores authoritative accounts of First World War veterans' mortality attributed to suicide and accidental causes among veterans treated as mental cases at the Ontario Military Hospital at Cobourg, Ontario. Military and pension officials invariably ascribed veterans' suicide attempts and deaths to moments of temporary insanity or chronic mental illness, which were in turn attributed to hereditary or personal failing. Veterans' own statements within these files reveal discrepancies between the storylines authored by and about veterans, emphasizing the impact of war and the "tension of agency" in veteran deaths by suicide.

S'appuyant sur les registres d'admissions d'un hôpital pour anciens combattants ainsi que sur les dossiers de service et de pension du Corps expéditionnaire canadien, l'auteure se penche sur des sources fiables concernant le décès de vétérans de la Première Guerre mondiale attribués au suicide et à des causes accidentelles chez les anciens combattants traités pour maladie mentale à l'Ontario Military Hospital de Cobourg (Ontario). Les autorités militaires et les fonctionnaires responsables des pensions attribuaient invariablement le suicide et les tentatives de suicide d'anciens combattants à un moment de folie passagère ou à une maladie mentale chronique découlant d'une tare héréditaire ou personnelle. Les propres témoignages des anciens combattants dans ces dossiers révèlent des divergences entre la version des vétérans et celle des autorités, ce qui fait ressortir les effets de la guerre et la « tension de l'agentivité » dans les décès par suicide d'anciens combattants.

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ISSUES OF WAR trauma and suicide among Canada's veterans often reemerge into the public view when troops are returning home. The First World War was no exception, and the scale of the war effort was simply monumental; between 1914 and 1918, the Canadian Expeditionary Force (CEF) enlisted over 600,000 soldiers, of whom around 400,000 went overseas, and suffered a total of 59,544 fatal casualties and 172,950 non-fatal casualties.¹ In 1918, the Department of Soldiers' Civil Re-establishment (DSCR) began the task of demobilizing and reintegrating a staggering 350,000 soldiers.² At least 120,000 returned home with lasting trauma, ranging from fractures and amputations, to blindness, respiratory illnesses, and mental trauma—the effects of modern mechanized warfare.³

Although scholars have analyzed the hardships of veterans returning home with physical and mental trauma after the First World War, there is a dearth of writing on veterans' suicides in Canada.⁴ The barriers to studying deaths by suicide are multifold. Reliable national statistics on suicide in Canada are only available from 1921, making it difficult to situate postwar veterans' suicides within the context of suicide in Canada.⁵ Furthermore, beginning with the medicalization of suicide in the eighteenth century, suicide was reconstrued as pathology intimately linked to mental illness.⁶ Socially perceived as deviants, suicidal soldiers and veterans, and those with mental illness were institutionalized and marginalized, making it all the more difficult to reconstruct their histories.⁷ There is also a dearth

- 1 Gerald W. L. Nicholson, *Canadian Expeditionary Force, 1914-1919: Official History of the Canadian Army in the First World War* (Montreal & Kingston: McGill-Queen's University Press, 2015).
- 2 Desmond Morton and Glenn Wright, "The Bonus Campaign, 1919-21: Veterans and the Campaign for Re-establishment," *Canadian Historical Review*, vol. 64, no. 2 (1983), pp. 147-67.
- 3 Desmond Morton, "Resisting the Pension Evil: Bureaucracy, Democracy, and Canada's Board of Pension Commissioners, 1916-33," *Canadian Historical Review*, vol. 68, no. 2 (1987), pp. 199-224; and Desmond Morton and Glenn T. Wright, *Winning the Second Battle: Canadian Veterans and the Return to Civilian Life, 1915-1930* (Toronto: University of Toronto Press, 1987).
- 4 On physical and mental trauma, see Desmond Morton, *Fight Or Pay: Soldiers' Families in the Great War* (Vancouver: University of British Columbia Press, 2004), pp. 133-239; Morton and Wright, "The Bonus Campaign," pp. 147-67; Morton, "Resisting the Pension Evil," pp. 199-224; Morton and Wright, *Winning the Second Battle*; Mark Humphries, "War's Long Shadow: Masculinity, Medicine, and the Gendered Politics of Trauma, 1914-1939," *The Canadian Historical Review*, vol. 91, no. 3 (2010), pp. 503-531; Kellen Kurschinski, *State, Service, and Survival of Canada's Great War Disabled, 1914-44*, (PhD dissertation, McMaster University, 2015); and Peter Neary, *On to Civvy Street: Canada's Rehabilitation Program for Veterans of the Second World War* (Montreal & Kingston: McGill-Queen's University Press, 2011), pp. 3-59. On veterans' suicides in Canada, see Jonathan Scotland, "Soldier Suicide after the Great War: A First Look," *Active History* (2014), p. 1. <http://activehistory.ca/2014/03/soldier-suicide-after-the-great-war-a-first-look/>.
- 5 While census enumerators in Canada recorded deaths by cause as early as 1851, these are generally considered to be unreliable, with suicide deaths being under-reported. See Jacalyn Duffin, "Census Versus Medical Daybooks: a Comparison of Two Sources on Mortality in Nineteenth-Century Ontario," *Continuity and Change*, vol. 12, no. 2 (1997), pp. 199-219; and Yves Tremblay, "Du suicide, militaire et bibliographique," *Bulletin D'histoire Politique*, vol. 19, no. 1 (2010), pp. 115-27.
- 6 Ian Marsh, "Critiquing Contemporary Suicidology," in Jennifer White et al., eds., *Critical Suicidology: Transforming Suicide Research and Prevention for the 21st Century*, (Vancouver: University of British Columbia Press, 2016): pp. 15-30; Janet Miron, "Suicide, Coroner's Inquests, and the Parameters of Compassion in Ontario, 1830-1900," *Histoire sociale / Social History*, vol. 47, no. 95 (2014), pp. 577-99; Isabelle Perreault, Patrice Corriveau et Jean-François Cauchie, "While of Unsound Mind? Narratives of Responsibility in Suicide Notes from the Twentieth Century," *Histoire sociale / Social History*, vol. 49, no. 98 (2016), pp. 155-70; John C. Weaver, *Sorrows of a Century: Interpreting Suicide in New Zealand, 1900-2000* (Kingston: McGill-Queen's University Press, 2014).
- 7 Peter Barham, *Forgotten Lunatics of the Great War* (New Haven, CT: Yale University Press, 2007);

of information about veterans who did not apply for, or who were not granted pensions, since they were not monitored after demobilization and discharge from the army.⁸

Re-Constructing the Experiences of First World War Pensioners

Despite these challenges, it is possible to explore suicide among veterans who received or applied for pensions, because their lives and deaths were monitored by veterans' authorities.⁹ According to F. S. Burke, chief of the Medical Investigation Division of the Department of Pensions and National Health, between 1918 and 1936, 11.9% (n=1855) of all deaths among war pensioners were attributed to suicide and accidents.¹⁰ This statistic, however, reveals little about the experiences of the individuals behind the numbers (except that they served in the military, and incurred a service related disability), and even less about the social context in which these deaths occurred, which are paramount in studies of suicide.¹¹ Fortunately, the pension files of veterans of the CEF are currently under digitization at the Laurier Centre for Military, Strategic, and Disarmament Studies at Wilfrid Laurier University (LCMSDS).¹² These files contain a rich array of social, demographic, medical, and military information on each pension applicant, derived from military discharge documents, home visit reports, medical examinations, and letters to the Board of Pension Commissioners (BPC). The case files of psychiatric patients are an invaluable tool for social historians, revealing the perspectives of both patients and doctors.¹³ The digitization of these files has made an underutilized historical collection available for systematic inquiry, and they form the foundation for the present analysis of veteran suicides during the post-First World War period in Canada.¹⁴

Veterans with disabilities or illnesses that were attributable or aggravated by their military service were eligible to receive a pension to compensate them

Perreault, Corriveau, et Cauchie, "While of Unsound Mind?" pp. 159-60.

8 F.S. Burke, *Deaths Among War Pensioners* (Ottawa: Minister of Pensions and National Health, 1939).

9 The Department of Pensions and National Health became responsible for veterans benefits in 1927 when the Department of Health merged with the Department of Soldiers' Civil Re-Establishment. In 1933, the Board of Pension Commissioners was dismantled and replaced with the Canadian Pension Commission. For further insight into this transition, see Neary, *On to Civvy Street*, pp. 3-59; and Heather MacDougall, "Into Thin Air: Making National Health Policy, 1939-45," *Canadian Bulletin of Medical History*, vol. 26, no. 2 (2009), pp. 283-313.

10 Burke, *Deaths among War Pensioners*, p. 6.

11 Heidi Hjelmeland, "A Critical Look at Current Suicide Research," in Jennifer White et al., eds., *Critical Suicidology*, pp. 31-55.

12 "Through Veterans' Eyes," *LCMSDS Connect*, (Spring 2015) p. 2.

13 Lykke de la Cour and Geoffrey Reaume. "Patient Perspectives in Psychiatric Case Files," in Wendy Mitchison and Franca Iacovetta eds., *On the Case: Explorations in Social History* (Toronto: University of Toronto Press, 1998), pp. 251-74.

14 The pension files of the CEF represent a wide array of documents, averaging about 48 pages per file, with a minimum of 3 pages and a maximum of 186 pages in length. The documents contained in each file were not necessarily consistent between files. Pension files commonly included the results of medical and discharge boards, hospital and military service précis, the decisions of the Pension Board and correspondence between veterans', their families and the Pension Commissioners. Many files contain notices that "non-essential documents" were destroyed in the late 1940's. What was considered "non-essential" is unknown, although from items referred to but not present, I suspect this included letters from veterans and their families, photographs, duplicate documents, and perhaps other supporting documentation.

for their reduced ability to seek employment after the war.¹⁵ First World War pensions were administered by the BPC, a three member board appointed by the Parliament of Canada in 1916.¹⁶ At the height of demobilization, the BPC had seventeen branch offices in major cities across Canada, which were charged with receiving applications from veterans and their dependants, conducting medical examinations, responding to complaints, and sending home visitors to inspect veterans' living conditions.¹⁷

The number of pensions awarded to veterans each year fluctuated greatly, peaking immediately following the war, with 69,203 disability pensions in force in 1920.¹⁸ In 1921, many pensioners were offered one time final payments or gratuities, greatly reducing the number of disability pensions in force to 51,452.¹⁹ Pension applications peaked again in the 1930s, when veterans initially offered final payments or gratuities were reinstated as pensioners in 1931-32, during the Great Depression. In 1937, there were 79,789 veterans receiving disability pensions.²⁰

To receive a pension, veterans were assigned a percentage of incapacity for their disabilities—for example, the loss of both legs, arms, or eyes would be considered a disability of 100 %, whereas the loss of a thumb would be rated as a disability of 20 %.²¹ A 100 % pension was valued at \$720 per year for a private, although the majority of pensions were awarded at significantly lower rates.²² By 1920, only 5 % of all pensioners were rated with a pensionable disability of 100 %, whereas 80 % of pensions awarded were rated for disabilities rated below 49 %, and 56 % of pensions were rated for disabilities rated below 30 %.²³

This study makes use of veterans' pension files, hospital records, and service files coupled with newspaper accounts of veterans' deaths, asking: How did military and civilian medical officials explain veterans' suicide attempts and deaths by suicide after the First World War in Canada? What do the pension and service files of veterans' reveal about their own perspectives and experiences? Recognizing that veterans' lives were complex and multistoried, this paper explores how understandings and treatment of suicide and mental illness played out in the lives of First World War veterans during the first half of the twentieth century in Canada.

A Case-Study of Veterans Treated at the Ontario Military Hospital

To identify First World War veterans who had attempted or died by suicide, along with deaths attributed to accidental causes, I began by transcribing the Admission

15 J.L. Biggar, "The Pensionability of the Disabled Soldier," *Canadian Medical Association Journal*, vol. 9, no. 1 (1919), pp. 28–33.

16 Morton, "Resisting the Pension Evil," pp. 203-4.

17 Canada, Repatriation Committee, *Returned Soldiers' Handbook: Contains Valuable Information and Tells You Where to Get More* ([London]: St. Clements Press, [1919]), pp. 12-16.

18 Burke, *Deaths among War Pensioners*, pp. 1-2; *Report of the Work of the Department of Soldiers' Civil Re-Establishment* (Ottawa: King's Printer, 1921).

19 Burke, *Deaths among War Pensioners*, p. 24.

20 Burke, *Deaths among War Pensioners*, p. 5.

21 Morton, "Resisting the Pension Evil," p. 203; Humphries, "War's Long Shadow," pp. 503–31.

22 Morton, "Resisting the Pension Evil," p. 209.

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

and Discharge (A&D) books for the Ontario Military Hospital (OMH) at Cobourg (see Figure 1) into a Microsoft Excel database.²⁴ The military took over this hospital, known formerly as the Cobourg Asylum for the Insane, in 1917 to care for “nervous and mental cases” among returned soldiers.²⁵ The hospital A&D books contain information on veterans’ regimental number, rank, surname, name, age, disease or injury, date of admission, date of discharge, result of treatment, religion, and marital status. There were 1212 unique admissions to this hospital. Of these, the majority were from the rank and file (83%, n=991). Most admissions to hospital occurred between 1918 and 1919 (91%, n=1108).

Individual hospital admissions were then record linked to digitized pension files using soldiers’ regimental numbers.²⁶ There were 62,422 digitized and catalogued pension files from which I identified 209 possible matches between the OMH A&D books and the First World War pension databases. However, since duplicate regimental numbers in the CEF were common, only 152 matches were confirmed to be positive linkages based on the first and last names of individual soldiers.

After record linking soldiers’ hospital records to pension files, 84 individual pension files in the original sample of 152 contained mortality data, and 14 veteran deaths were attributed to suicide or accidents. Five veterans had attempted suicide at least once. Due to the overlap between suicide attempts and deaths, I studied a total number of 17 veterans, from their admission to the OMH at Cobourg, to discharge from the military, and then to their application for a pension (see Table 1 below).²⁷ Their service files, and newspaper coverage, where available, provided further background information on individual veterans’ experiences.

Following the methodology of Perreault and colleagues, who conducted archival narrative analysis of coroners’ investigations, I transcribed the explanations written in 17 individual veterans’ pension and service files, focusing on the narratives explaining their suicide attempts, deaths attributed to suicide and accidents, as well as their illnesses.²⁸ Where possible, I also extracted veterans’ personal statements as recorded by medical professionals. While none of these files contained suicide notes, the objective was not to determine why these veterans may have ended their lives—rather it was to shed light on the narratives constructed to explain their experiences.

24 Library and Archives of Canada (hereafter LAC), File Ontario Military Hospital, Cobourg RG 9 II-L-1, Volume 8.

25 Clarence B. Farrar, “War and Neurosis: With Some Observations of the Canadian Expeditionary Force,” *American Journal of Psychiatry*, vol. 73, no. 4 (1917), pp. 693–719. For information on this hospital before and after it was used by the army, see Lykke de la Cour, “‘She Thinks This is the Queen’s Castle’: Women Patients’ Perceptions of an Ontario Psychiatric Hospital,” *Health & Place*, vol. 3, no. 2 (1997), pp. 131–41.

26 I accessed the Microsoft Access database of digitized pension files at the LCMSDS on April 5, 2016, and at that time there were 62,422 pension files digitized and catalogued.

27 It should also be noted that many who enlisted in the CEF were recent migrants to Canada (with many Americans travelling to Canada for the sole purpose of enlisting). According to the attestation papers of the seventeen veterans examined closely in this study, seven were not born in Canada: two were born in the United States of America, three in England, one in Scotland, and another in Newfoundland, which was not yet part of Canada at the time of the First World War.

28 Perreault et al., “While of Unsound Mind?,” pp. 155–70.

Table 1. Details on veterans included in this study.²⁹

Rank/Name	Place of Birth	Enlisted	Age	Served In	Diagnosis	Year of Death	Brief Description of Case
Sgt. Harry L.	Canada	1915	19	France	Vertebral Fracture & Psychosis		Attempted suicide, jumped off bridge in 1919. Made a full recovery and had no contact with BPC after 1921.
Pte. William M.	Canada	1916	28	Canada/England	Dementia Praecox	1919	Escaped mental hospital, drowned, cause of death insanity, immediate cause accidental drowning.
L/Cpl. George R.	Canada	1915	28	France	Melancholia	1919	Attempted suicide, cut throat in 1918. Later, shot himself.
Pte. William K.	Canada	1914	26	France	General Paralysis of the Insane (GPI)	1920	Struck by train.
Dvr. George W.	England	1914	29	France	S S Dementia	1920	Found drowned. Cause of death ruled accidental drowning.
Cpl. George B.	Newfoundland	1915	32	France	Undifferentiated Depression	1922	Shot himself in the woods not far from his home.
Pte. William B.	England	1915	22	France	Exhaustion Psychosis	1922	Death attributed to accidentally drinking Lysof.
Pte. Valaire G.	Canada	1917	21	France	Dementia	1923	Died after being thrown from car in automobile accident.
Pte. George J.	England	1916	39	France	Manic Depressive	1927	Attempted suicide, cut throat in 1919. Later suicide attempt, drank muriatic acid, died in hospital.
Pte. Charles R.	Canada	1916	39	France	Mania associated with Epilepsy	1927	Found dead beside train tracks (struck by train, or fell off train).
Pte. Roy R.	Canada	1916	19	Canada/England	Dementia Praecox	1930	Hanged himself.
Pte. Michael W.	United States of America	1918	27	Canada/England	Moron	1932	Death ruled accidental, result of freight train.
Pte. Samford E.	United States of America	1917	35	France	Dementia Praecox	1936	Shot himself in his home.
Pte. Thomas M.	Canada	1916	26	France	Mania	1937	Extensive fracture of skull, was struck by a truck.
Pte. Edward B.	Canada	1914	31	France	Delusional Insanity/Depression	1944	Was found drowned, cause of death ruled accidental drowning, while walking along canal in an intoxicated state.
Pte. John M.	Scotland	1916	18	France	Dementia Praecox	1945	Cause of death ruled exhaustion due to schizophrenia, following suicide attempt of drinking iodine.
Pte. Gordon D.	Canada	1915	19	France	Dementia Praecox	1946	Attempted suicide, cut throat in 1917.

Sources: LAC, Service Files, Canadian Expeditionary Force (CEF), RG 150, Accession 1992-93/166; LAC, File 'Ontario Military Hospital, Cobourg' RG 9 II-L-1, Volume 8; and LCMSSDS, Veterans of the First World War Pension Files.

²⁹ Age is that reported upon enlistment, and diagnosis as entered in the Admission and Discharge books for the Ontario Military Hospital, Cobourg.



Figure 1. The Cobourg Asylum, c. 1930.³⁰

Source: Cobourg Public Library, 610-3.

Explaining Veterans' Suicides and Mental Illnesses

Suicide is a difficult topic for historical inquiry because, as Ian Hacking has argued, the meanings of suicide change so frequently across time and place that it is difficult to be sure that “suicide” is itself a meaningful category.³¹ Anthropologists Daniel Münster and Ludek Broz ascribe part of the difficulty of understanding suicide to what they call “the tension of agency.” Contemporary Western knowledge asserts that, on one hand, suicide is an intentional agentive action, which is different from other forms of death. We see this in the way suicide deaths were, for example, categorized with intentional forms of mortality such as homicide in Censuses and Dominion Bureau of Statistics Reports in Canada.³² On the other hand, however, individual agency is denied through attributing suicide deaths to factors outside of an individual’s control, such as mental illness.³³ In Canada, the roots of this understanding of suicide can be traced to the nineteenth century.

30 Formerly Victoria College, during the First World War this hospital was known as the “Ontario Military Hospital” at Cobourg.

31 Daniel Münster and Ludek Broz also argue that suicide is a difficult object of study, drawing on the work of Ian Hacking, which reminds us that there are inconvenient exceptions which complicate our understanding of suicide as individual pathology, such as “suicide as a weapon” in the case of suicide bombers. See Ian Hacking, “The Suicide Weapon,” *Critical Inquiry*, vol. 35, no 1, pp. 1-32. Daniel Münster and Ludek Broz’s work, “The Anthropology of Suicide: Ethnography and the Tension of Agency,” in Ludek Broz and Daniel Münster, eds., *Suicide and Agency: Anthropological Perspectives on Self-Destruction, Personhood, and Power* (Farnham, UK: Ashgate Publishing, 2015), pp. 3–23.

32 In the 1871, 1881 and 1891 Censuses of Canada, suicide deaths were classified under “Crimes” or “Violent Deaths,” which by the 1901 Census were known as “External Causes.” This was the category used in the 1921 First Annual Report of the Dominion Bureau of Statistics.

33 Münster and Broz, “The Anthropology of Suicide,” pp. 3-23.

While attempted suicide was technically a crime until 1972 in Canada, by the early nineteenth century, popular perception was shifting from understandings of suicide as religious sin, or legal crime, and suicide attempts and deaths were increasingly conceptualized as a medical problem with a physiological explanation—mental illness.³⁴ Suicide became inextricably linked to mental illness with the emergence of the psychiatric profession in the eighteenth century. This, in conjunction with the institutionalization of the mentally ill, brought patient suicides under the purview of asylum practitioners. Responsibility for the treatment of the suicidal was claimed by asylum physicians, alienists, and others caring for the mentally ill.³⁵

Officials in both the military and on the BPC upheld this authority over veterans deemed insane, and employed this rationale in their explanations of veterans' suicides and attempted suicides. Officials wrote that veterans attempted suicide while temporarily insane. For instance, M. F. D. Graham, the Canadian Army Medical Corps (CAMC) officer at Shorncliffe, wrote that Private George J. attempted suicide and "cut his throat one night. Had been acting strangely for a few days, but no one suspected that his mind was deranged."³⁶ Likewise, when Sergeant Harry B. L. attempted suicide by jumping off a bridge in Toronto in 1919, Major. A. A. Fletcher and Captain W. C. Givens agreed that, "In view of his psychotic attack he should not be held responsible for suicidal attempt."³⁷ Similarly, in Lance Corporal George Charles R.'s pension file, the medical officer at the OMH at Cobourg noted that after a suicide attempt by cutting his throat, he was "court martialled and [his] case dismissed by reason of mental condition."³⁸

Deaths by suicide were also ascribed to temporary moments of insanity, or chronic mental illness. For example, in one case, the coroner determined that the veteran's official cause of death was accidental, and that Private Walter B., "when he took the Lysol, had no formed intention of killing himself. It was just one of those unaccountable things he used to do because of the state of his mind. I find that he died from accidentally swallowing Lysol."³⁹ In a similar case, when George J. drank muriatic acid, the medical board of inquiry into his death concluded that he had consumed the acid "due to his abnormal mental state."⁴⁰ Likewise, writing to Corporal George B.'s father, the stipendiary magistrate explained, "The evidence showed that your son came to his death by his own hand, he having shot himself

34 Miron, "Suicide, Coroner's Inquests," pp. 577-99; Perreault et al., "While of Unsound Mind?," pp. 155-70; Rae Spiwak et al., "Suicide Policy in Canada: Lessons from History," *Canadian Journal of Public Health*, vol. 103, no. 5 (2012), pp. 338-41; see also Weaver, *Sorrows of a Century*.

35 Marsh, "Critiquing Contemporary Suicidology," pp. 15-30; Ian Hacking, *The Taming of Chance* (Cambridge: Cambridge University Press, 1990).

36 LAC, Service File, George H. J., Regimental No. 826430, Canadian Expeditionary Force (hereafter CEF), RG 150, Accession 1992-93/166, Box 4870 - 10, p. 58. Veterans' surnames are omitted out of respect for the families of these veterans. Suicide is still a stigmatized cause of death in Canada, and including surnames does not add significantly to the argument or narrative.

37 LAC, Service File, Harry B. L., Regimental No. 522555, CEF, RG 150, Accession 1992-93/166, Box 5545 - 14, p. 58.

38 Laurier Centre for Military Strategic and Disarmament Studies [hereafter LCMSDS], Pension File, L.Cpl. George C. R., Regimental No. 219672, File 1583-G-1, Reel 36, p. 10.

39 LCMSDS, Pension File, Pte. Walter B., Regimental No. 463239, File 201-W-7, Reel 235, p. 9.

40 LCMSDS, Pension File, Pte. George H. J., Regimental No. 826430, File 959-G-19, Reel 80, p. 28.

while temporarily deranged.”⁴¹ After recovering from his suicide attempt and being discharged from the OMH at Cobourg, George Charles R. returned home and according to Major Burgess he “committed suicide by shooting himself in the head 13/6/19.... In my opinion this occurred while in a state of depression.”⁴²

In this way, explanations of veteran deaths by suicide supported medical authority by confirming the idea that the veterans were insane in the first place.⁴³ At this time period in Canadian history, a similar rationale was used to explain civilian deaths due to suicide.⁴⁴ At first glance, attributing suicide deaths and attempted suicides to insanity appears sympathetic.⁴⁵ As the above highlights, this designation did absolve from guilt some veterans who were court martialled for attempted suicide. It is also possible that these rulings alleviated some of the stigma of suicide on grieving family members, although it is not clear that the shame of mental illness was a lesser burden.⁴⁶

The pension and service files of the veterans treated at the OMH at Cobourg also highlight medical understandings of veterans’ mental illness, emphasizing the deep-seated biological reductionism of neuropsychiatric medicine prevalent during the first half of the twentieth century. This train of thought, as Janet Miron has argued, “located the problem in the individual and his or her mental illness, not in a society that engendered uncertainty, instability, inequality and alienation.”⁴⁷ Within the veterans’ pension and service files, several common variations emerged concerning the cause or origins of veterans’ disabilities, which medical officers were required to note for a medical board review and for the consideration of the BPC.

For instance, when George B. went in front of the medical board at the No. 4 Canadian General Hospital at Basingstoke on November 30, 1918, before returning to Canada, Captain W. A. Scott wrote that his diagnosis should be changed to neurasthenia, and that the cause was “constitutional aggravated by stress of campaign.”⁴⁸ Likewise, Captain E. L. Pope at the Moore Barracks Canadian Hospital wrote that, Driver George W.’s mental condition, alternately diagnosed as delusional insanity and neurasthenia, was caused by the “stress of campaign + weak mentality.”⁴⁹ Others attributed no aggravation to military service, like Captain D. Davis, who attributed Private Thomas M.’s mental condition to a “DEFECTIVE NERVOUS SYSTEM [*sic*].”⁵⁰

41 LCMSDS, Pension File, Cpl. George N. B., Regimental No. 742205, File 72-G-4, Reel 215,” p. 6.

42 LCMSDS, Pension File, L.Cpl. George R., p. 27.

43 Miron, “Suicide, Coroner’s Inquests,” p. 592.

44 Miron, “Suicide, Coroner’s Inquests,” p. 592.

45 Miron, “Suicide, Coroner’s Inquests,” p. 592.

46 Perreault et al., “While of Unsound Mind?,” p. 158.

47 Miron, “Suicide, Coroner’s Inquests,” p. 578.

48 LAC, Service File, LCP George N. B., Regimental No. 742205, CEF, RG 150, Accession 1992-93/166, Box 335 - 51, p. 86.

49 LAC, Service File, George W., Regimental No. 86689, CEF, RG 150, Accession 1992-93/166, Box 10506 - 36, p. 41.

50 LAC, Service File, Thomas E. M., Regimental No. 718204, CEF, RG 150, Accession 1992-93/166, Box 6263 - 49, p. 72.

As Geneviève Allard has shown, before 1920, Canadian military medical authorities made a distinction between *la névrose et folie*, which translates to nervous, or neurological, and mental cases respectively.⁵¹ Nervous disorders were seen as less severe, and included diagnoses like shell shock and neurasthenia. Soldiers suffering these conditions were thought to be curable if treated properly. In contrast, mental cases were thought to be incurable, and included psychoses such as dementia praecox, depression, mania, manic-depression and paranoia.⁵² Once in hospital, the treatment regime for neuroses and psychoses were very similar, consisting of rest, nutritious food, hydrotherapy (continuous baths), therapeutic occupation, and sometimes electric shock therapy (see Figures 2 and 3).⁵³ Soldiers exhibiting symptoms of mental distress were first evacuated to hospitals in England, through clearing hospitals like the Royal Victoria Military Hospital at Netley, where they were evaluated to see which category of mental illness they fell under, and subsequently sent to other military hospitals in England.⁵⁴ Dr. Clarence B. Farrar, who was the chief psychiatrist for the Department of Soldiers' Civil Re-establishment, and who served as the president of many medical boards at the OMH at Cobourg reported that "all cases except those following mild, benign courses are returned sooner or later to Canada."⁵⁵ Once returned to Canada, the more stigmatized mental cases were treated by the DSCR, while the neurological group were treated by the Department of Militia and Defense.⁵⁶ The most commonly encountered mental illnesses among the CEF were neuroses, dementia praecox, and primary mental defect, which together accounted for four-fifths of all cases encountered in the army.⁵⁷

The short excerpts from veterans treated at the OMH at Cobourg further illustrate how, within the military, mental illnesses among veterans who attempted or died from suicide or causes ruled accidents were conceptualized primarily as inherited defect, or predisposition. This supports the research of Mark Humphries, who found that soldiers who suffered from neuropsychiatric ailments and were treated in military hospitals, but broke down shortly after returning to the front, or even long after the war—thus failing to conform to the dominant treatment narrative concluding with a quick recovery from the trauma of war—were cast as

51 Geneviève Allard, *Névrose et folie dans le Corps expéditionnaire canadien (1914-1918): Le cas Québécois* (Athéna Editions: 2012).

52 Allard, *Névrose et folie*, p. 111; Colin Kerr Russel, "A Study of Certain Psychogenetic Conditions Among Soldiers," *Canadian Medical Association Journal*, vol. 7, no. 8 (January 1917), p. 673; *Report of the work of the invalidated soldier's commission, 1918*, p. 38.

53 E.H. Young, "The Care of Military Mental Cases," *Canadian Medical Association Journal*, vol. 9, no. 8 (October 1919) p. 898.

54 Thomas W. Salmon, *The Care and Treatment of Mental Diseases and War Neuroses ("Shell Shock") in the British Army* (New York: War Work Committee of the National Committee for Mental Hygiene, 1917), p. 18.

55 Farrar, "War and Neurosis," p. 695.

56 Clarence B. Farrar, "The Neuropsychiatric Service of the Department Of Soldiers' Civil Re-Establishment, Canada." *American Journal of Psychiatry*, vol. 79, no. 4 (1923): pp. 665-83. During the winter of 1919-1920, the hospitals administered by the Department of National Defence were closed, or taken over by the Department of Soldiers' Civil Re-Establishment, with hospitals treating both "mental" and "neurological" cases.

57 Clarence B. Farrar, "Rehabilitation in Nervous and Mental Cases Among Ex-soldiers," *American Journal of Psychiatry*, vol. 76, no. 2 (1919): pp. 145-57.

deviant and abnormal.⁵⁸ Furthermore, this is in line with the prevailing discourse on almost all nervous and mental disorders within the military at the time. While nervous conditions, including such diagnoses as neurasthenia or shell shock, were believed to be less severe and treatable, military medical officials believed that there was almost always “an underlying nervous instability, disharmony, or defect, of hereditary or of constitutional character, which accounts alike for the readiness with which the neurosis developed, its resistance to treatment, and the facility with which symptoms recur.”⁵⁹ Military medical officials, like Dr. Clarence B. Farrar, did concede that nervous and mental disorders could be aggravated by the stress of active military service, however, Farrar maintained that military service was of minor etiological significance to the development of psychiatric illness.⁶⁰

While most of the literature on war trauma among soldiers of the CEF has focused on shell shock and neurasthenia (nervous exhaustion), these causes represented only a small percentage of the total illnesses under treatment at the OMH at Cobourg.⁶¹ Farrar, believed, in fact, that “‘neurasthenia’ was, and has been to this day, terribly over-worked, although to be sure it is a common enough tendency in general practice to dub off-hand as neurasthenic any neuropsychiatric patient who is not obviously a raving lunatic or terminal dement.”⁶² By the time veterans returned to Canada and were admitted to hospitals like the OMH at Cobourg, the majority of veterans were diagnosed under the dementia praecox group.⁶³ Others were admitted to this hospital as psychopathic inferiors, morons, defectives, or suffering from mania, depression and epilepsy.⁶⁴

The Canadian Army Medical Corps followed a Kraepelinian classification of mental disorders.⁶⁵ Under this framework, students and practitioners were advised that when making a diagnosis a patient’s family and personal history was of the utmost importance.⁶⁶ Farrar, asserted that among veterans treated at the OMH at Cobourg exhibiting shock symptoms, 90 % were “constitutionally predisposed.”⁶⁷ The discovery of a family member with a mental condition, or

58 Humphries, “War’s Long Shadow,” p. 503-31.

59 Shell shock was banned as a diagnosis in 1917. On shell shock, see Humphries, “War’s Long Shadow,” p. 515; Tom Brown, “Shell Shock in the Canadian Expeditionary Force, 1914-1918,” in Charles G. Roland, ed., *Health, Disease and Medicine: Essays in Canadian History* (Toronto: Hannah Institute for the History of Medicine, 1982), pp. 308-32; and Mark Osborne Humphries and Kellen Kurchinski, “Rest, Relax and Get Well: A Re-Conceptualisation of Great War Shell Shock Treatment,” *War and Society*, vol. 27, no. 2 (2008), pp. 89-110. Quote from Farrar, “Nervous and Mental Cases,” p. 146.

60 Farrar, “The Neuropsychiatric Service,” pp. 666, 672.

61 Humphries, “War’s Long Shadow,” pp. 503-31; Tom Brown, “Shell Shock in the Canadian Expeditionary Force,” pp. 308-32; Humphries and Kurchinski, “Rest, Relax and Get Well,” pp. 89-110; Matthew Barrett, “‘Absolutely Incapable of ‘Carrying On.’” Shell Shock, Suicide, and the Death of Lieutenant Colonel Sam Sharpe,” *Canadian Military History*, vol. 25, no. 1 (2016), pp. 1-31.

62 Farrar, “The Neuropsychiatric Service,” pp. 672-73.

63 Farrar, “War and Neurosis,” pp. 693-719.

64 Farrar, “War and Neurosis,” pp. 693-719.

65 H. Dover, “Medical Board Work on Psychiatric Cases,” *Canadian Medical Association Journal*, vol. 10, no. 6 (1920), pp. 543-47.

66 A. Ross Diefendorf, *Clinical Psychiatry: A Text Book for Students and Physicians, Abstracted and Adapted from the 7th German Edition of Kraepelin’s ‘Lehrbuch Der Psychiatrie’* (New York: The MacMillan Company, 1912).

67 Farrar, “War and Neurosis,” p. 702.

a history of alcoholism, sexual deviance, criminality, and even tuberculosis, was seen as evidence of mental disorder, and made a diagnosis of psychiatric inferiority more likely.⁶⁸ The indicators of mental inferiority were inseparable from conceptions of morality (e.g., immorality evidenced by the consumption of alcohol or deviant sexual encounters), and low socioeconomic status (e.g., the contraction of infectious diseases like tuberculosis from crowded living conditions and poor nutrition).⁶⁹

The idea of predisposition towards developing psychiatric illness also emphasized a failure to meet masculine ideals, such as a man's inability to adapt to the conditions of war. Military service, which doctors noted as the stress of the campaign or aggravation by shell fire, had merely "awakened some internal and pre-existing defect" that the veteran already possessed.⁷⁰ For instance, as Captain G. Paine noted in Private Valaire G.'s medical report, his "mental stupor" was thought to be caused by "active service conditions and in the presence of the enemy, activating a pre-existing tendency."⁷¹ Because the disability was seen as congenital, or due to an individual's predisposition, these veterans were not seen as deserving of compensation or treatment for their illnesses.⁷²

In spite of the medical framework upheld by doctors, including Farrar, which maintained the hereditary-constitutional background as the *condito sine qua non* of nearly all nervous and mental disorders, veterans continued to present themselves for treatment and pensions for neuropsychiatric illnesses.⁷³ Farrar upheld that as more time passed after the war, it became increasingly difficult to assess attributability and therefore eligibility for treatment or pensions.⁷⁴ Veterans, in contrast, felt that as they had been medically examined when they enlisted in the military, and were considered fit for military service, it was unconscionable that their medical conditions could be pinned solely on pre-enlistment conditions after the war.⁷⁵

At times, officials agreed with veterans, and there is evidence in the service and pension files of veterans treated at the OMH at Cobourg that doctors and members of the BPC were sometimes sympathetic. Take the case of Private William M., who was diagnosed with dementia praecox, for instance.⁷⁶ After an English medical board ruled that there was no aggravation of his illness due to his military service, the medical board at the OMH at Cobourg in 1918 agreed that William M.'s was a constitutional "case of long standing," but determined that his illness was nonetheless aggravated by his military service. The board

68 Diefendorf, *Clinical Psychiatry*, pp. 3-97, 485-551.

69 Mariana Valverde, *The Age of Light, Soap, and Water: Moral Reform in English Canada, 1885-1925* (Toronto: University of Toronto Press, 2008).

70 Humphries, "War's Long Shadow," p. 518.

71 LAC, Service File, Valaire. G., Regimental No. 120079, CEF, RG 150, Accession 1992-93/166, Box 3875 - 14, p. 61.

72 Humphries, "War's Long Shadow," p. 518.

73 Farrar, "The Neuropsychiatric Service," p. 679.

74 Farrar, "The Neuropsychiatric Service," p. 679.

75 Morton, *Fight or Pay*, p. 153.

76 Dementia praecox was made popular by Emil Kraepelin in 1893, and re-named schizophrenia in 1908 by Bleuler. The CAMC preferred the Kraepelinian term. See Allard, *Névrose et folie*, pp. 154-155.



Figure 2. Photograph of the continuous baths used to treat veterans at the Ontario Military Hospital, Cobourg.

Source: Library and Archives of Canada, M.H.C. 63, 1974-258 NPC.

recommended custodial care, and William was sent to the Rockwood Asylum in Kingston, Ontario. This is significant because it highlights the recognition that just because a veteran was diagnosed with what was believed to be an inherited condition, it did not mean that they did not suffer because of the war, or that they were necessarily poor soldiers. As Major Frankwood E. Williams of the American army explained about dementia praecox cases, “quite a number of these cases carried on as soldiers and had done well, having borne their share of being gun fodder.”⁷⁷

Even Lieutenant Colonel J. L. Biggar was at times lenient when he had reasonable grounds to deny medical treatment or pensions. After William M. escaped from Rockwood Asylum and drowned in 1919, Lt. Col. Biggar requested the opinion of his assistant medical advisor, Dr. Giddon. Dr. Giddon stated that, while the English medical board had found no aggravation due to service in William’s case, “In my opinion there has certainly been progression of the disease while on service as if this man were in the condition, which is evident from medical boards, on enlistment that he was on discharge he certainly would have never been taken into the army. Would consider that death was due to a condition which progressed on service and that dependents are therefore pensionable please.” Lt. Col. Biggar concurred, and this was their final decision on file. It

⁷⁷ Frankwood E. Williams, “Society Proceedings – The Academy of Medicine, Toronto,” *Canadian Journal of Medicine and Surgery*, vol. 45, no. 1 (June 1919), p. 69.

does not appear that William had dependents, but this ruling is one example of a case where Canadian pension officials could have ruled against the aggravation of military service, but did not.

As Farrar explained, in spite of the fact that medical officials believed many veterans were not suffering from disabilities due to military service, “it has been felt that federal responsibility in so far as treatment is concerned might legitimately be assumed.”⁷⁸ Pension officials decided that a veteran who fell ill within one year of military service should be treated free of charge, regardless of the origin of the disability. By 1923, if a veterans’ neuropsychiatric illness could be traced to origins within one year of discharge, they were taken on as a responsibility of the DSCR for treatment and maintenance.⁷⁹ This explains why so many veterans were treated in military hospitals following the war, even when the documentation within their files suggests that medical officials believed that their ailments were not in fact aggravated by their military service. While treatment may have been accessible, procuring pensions remained difficult as these veterans were still seen as undeserving of financial support out of hospital for their illnesses.⁸⁰

It is impossible to ignore the eugenic underpinnings of medical authorities’ understanding of mental illnesses. In fact, members of the Canadian National Committee on Mental Hygiene (CNCMH) maintained that heredity was the single largest contributing factor to mental illness.⁸¹ Soldiers were not exempted from the rationalizations of this movement; in fact, work with returned veterans was an area of expertise which helped the CNCMH to establish its professional legitimacy in Canada.⁸² Members of the executive committee of the CNCMH included prominent military medical officials, such as Dr. C. K. Clarke, the superintendent of the Toronto General Hospital, and Lieutenant Colonel C. K. Russel of the Canadian Army Medical Corps.

Members of the CNCMH inspected military hospitals, and started a training course for social workers among DSCR staff.⁸³ Social workers then assisted the committee by procuring the personal and family histories of veterans under treatment.⁸⁴ The CNCMH also advocated for updating the facilities at neuropsychiatric hospitals, providing adequate hospital staff to care for veterans, and for trained social workers to provide assistance with the transition to civilian

78 Farrar, “The Neuropsychiatric Service,” p. 680.

79 Farrar, “The Neuropsychiatric Service,” p. 680. I believe Dr. Farrar is summarizing the “insurance principle” of pension regulations, which was eliminated from pension legislation briefly in 1920, but reinstated 1923. The “insurance principle” allowed veterans to receive hospital treatment for medical conditions which occurred within one year of their discharge from the army, which officials believed could be argued to be linked to military service.

80 Humphries, “War’s Long Shadow,” p. 524.

81 Angus McLaren, *Our own Master Race: Eugenics in Canada, 1885-1945* (Toronto: University of Toronto Press, 2014).

82 Ian Robert Dowbiggin, *Keeping America Sane: Psychiatry and Eugenics in the United States and Canada, 1880-1940* (Ithaca, NY: Cornell University Press, 1997), p. 171.

83 “The First Year of the Canadian National Committee for Mental Hygiene,” *Canadian Journal of Mental Hygiene*, vol. 1 (April 1919-January 1920), p. 72-73..

84 Canadian National Committee for Mental Hygiene (hereafter CNCMH), *Reconstruction and the Canadian National Committee for Mental Hygiene*, ([Toronto]: s.n., [1919]), p. 7.

life after discharge from psychiatric hospitals.⁸⁵ The prevalence of psychological illnesses among veterans is believed to be the catalyst which sensitized many Canadians to the presence of such illnesses in Canada.⁸⁶

Eugenicists saw the discovery of the mentally ill through the war effort as an opportunity to segregate the “feeble-minded” in Canadian society. In an article in the *Toronto Globe*, the Great War Veterans’ Association and the Repatriation Committee, led by Lieutenant Colonel Hendrie argued that segregating the feeble-minded would “provide additional employment for the able and normal adults remaining, as well as relieving the defective from the hopeless task of competing in the struggle for existence.”⁸⁷ Segregating the feeble-minded was not enough for some, and by 1933 the lieutenant governor of Ontario, Dr. Herbert Bruce, advocated for the forced sterilization of the feeble-minded across Canada.⁸⁸

The danger presented by the feeble-minded, warned the DSCR in 1919, was that,

they are likely to be not only unproductive burdens, but in various ways a menace to the community. The war has revealed a weak spot in the social material, and it has furnished information individually concerning great numbers of defectives and other abnormal types among the population which might otherwise never have become available. From the social and economic points of view, it is greatly to be regretted that these individuals should pass from under observation and control and become lost again in the community. Action for their more advantageous disposal, based on information which is at hand, would seem to be indicated.⁸⁹

It is no wonder that in this social climate some veterans refused to answer questions about their symptoms or family history. As Dr. J. Rothwell stated when he was sent by the BPC to report on Private John M.’s condition after a mental breakdown at home, “The examination of the patient was not satisfactory. He knew who I was and I thought he knew for what I had come so he said he was not going to speak to me and he would not.”⁹⁰ The DSCR toyed with the idea of establishing a farm colony for epileptic, feeble-minded, and derelict veterans, although they were thwarted by the fact that they could not legally detain individuals for treatment against their will, especially when they had been discharged from the military.⁹¹

When veterans treated at the OMH at Cobourg attempted suicide, or died by suicide, medical and military officials invariably attributed their actions to a moment of temporary insanity, or long-standing psychiatric ailments. While medical authorities conceded that the war could aggravate or activate a preexisting tendency toward the development of veterans’ neuropsychiatric illnesses, for the

85 CNCMH, *Reconstruction*, p. 5.

86 CNCMH, *Reconstruction*, p. 5.

87 “Segregate Feeble-Minded,” *Globe* (March 9, 1919), p. 5.

88 Herbert A. Bruce, “Sterilization of the Feeble Minded,” *Canadian Medical Association Journal*, vol. 29, no. 3 (1933), p. 260.

89 “Segregate Feeble-Minded,” *Globe* (March 9, 1919), p. 5.

90 LCMSDS, Pension File, Pte. John M., Regimental No. 911022, File 1277-J-135, Reel 131, p. 22.

91 F. McElvey Bell, “Medical Services, Department of Soldiers’ Civil Re-Establishment,” *Medical Quarterly*, vol. 1, no. 1 (January 1919), pp. 43–48.

most part, such ailments were linked to hereditary predisposition. This is not surprising given the undercurrent of the growing mental hygiene and eugenics movement in Canada following the First World War. It is also true that pension officials were sometimes sympathetic, and that the government legislated that veterans were entitled to receive treatment and maintenance in veterans' hospitals even though officials believed their illnesses were the result of heredity, if their illness manifested within one year of discharge from the army. Within the OMH at Cobourg veterans' pension and service files, medical authorities consistently attributed suicide deaths to mental illness or temporary insanity, emphasizing individual pathology, while drawing attention away from the difficult social reality following demobilization and discharge from a psychiatric institution.⁹²

The Absence of Veterans' Voices

Veterans' voices are scarce within the pension and service files for soldiers hospitalized as "mental cases" at the OMH at Cobourg in this sample. This is not surprising—the BPC prioritized a particular kind of medical authority evident in Lt. Col. J. L. Biggar's advice to medical examiners about how to evaluate veterans' symptoms:

Every physician is accustomed to assay the value of the patient's complaints, of his symptoms as he tells about them. Certain of these one accepts as being actual and truthful. Others one knows to be grossly exaggerated and of such a character that no importance should be attributed to them. If all the symptoms the man complains of, whatever the value placed upon them by the Examiner, are written down without differentiation, the pensioning body has no means of assessing their individual importance. It is suggested that this difficulty might be overcome by a statement to the effect that he 'suffers' from those symptoms of the existence of which the Examiner is sure, and he 'complains of' or 'he states that he has,' those symptoms of the existence of which the Examiner is doubtful.⁹³

Clearly, Lt. Col. Biggar, assistant medical director of the BPC, had little regard for veterans' statements about their illness and symptoms. This fact was quickly confirmed within the pension and service files. For example, J. MacKenzie, a medical officer writing from Colchester Military Hospital on October 30, 1918, described George B. as follows: "Patient is in a very nervous state of mind states he cannot live two weeks, would rather be shot than carry on."⁹⁴ Later, in November 1918, Captain E. Lewis, another medical officer, elaborated on George B.'s condition, "He feels 'nervous.' Complains of pain in the precordium which he describes as burning—it is not constant.... He feels in the evening as if there were 'a great strain on his nerves and heart.' At such times he says quite frankly that he contemplates self-destruction."⁹⁵

⁹² Miron, "Suicide, Coroner's Inquests," pp. 577-99.

⁹³ J. Biggar, "Practical Points in the Examination of Disabled Men," *Medical Quarterly*, vol. 1, no. 2 (April 1919), p. 82.

⁹⁴ LAC, Service File, LCP George N. B., p. 48.

⁹⁵ LAC, Service File, LCP George N. B., p. 18.

In 1919, Capt V. A. Worsley, one of the medical officers at OMH at Cobourg wrote after reviewing George B.'s case files, "In my opinion the symptoms complained are simply exaggerated as such would be expected from a neurasthenic."⁹⁶ In a single, authoritative statement, a veterans' suffering could be dismissed and delegitimized. The multiple layers of tragedy in this case study were only revealed after George B. shot himself in the head in the woods near his home; the BPC recorded that his doctor had discovered he was suffering from a fatal heart condition, the symptoms of which he had complained of in the military, along with his suffering and suicidal ideation.⁹⁷

During the early twentieth century, even among civilian patients, it was common for doctors to ignore or dismiss psychiatric patients' complaints as being unreliable because of their mental condition.⁹⁸ Among former soldiers, this behaviour could also be partially explained by the view that complainant and pension seeking behaviour were considered aberrant.⁹⁹ Thus, denying that a disability or aggravation due to war service existed, and subsequent denial of treatment or a pension were part of the cure.¹⁰⁰ On top of this, the responsibilities of the medical branch of the DSCR had expanded significantly. By December 31, 1919, they were in charge of the care of 8,031 veterans for in-patient care, and treated 126,057 outpatients, while also managing medical reports, requests for advice, special examinations, and BPC examinations and interviews.¹⁰¹ As a result, veterans were given little time to discuss their cases in front of the medical boards, where expediency was the chief concern. In January 1917, for example, the medical board at the discharge depot in Quebec cleared 1,442 soldiers. The board was in session each day from 9:00 a.m. to 6:00 p.m. with a short break for lunch, meaning that each veteran would likely have received less than fifteen minutes before the board.¹⁰²

The only document consistently authored by veterans within these files are the last will and testaments contained in their service files, which were drafted before ever leaving Canada. These were usually short, simply naming next of kin along with their address. After being designated as insane, veterans were often not even permitted to sign their medical board forms, where they could agree or disagree with the board's findings.

In spite of the obvious power disparity between medical authorities and veterans within these files, there were some veterans' statements recorded by medical officers.¹⁰³ Recognizing that these statements were filtered and recorded through the lens of individuals in a position of power over veterans, and that

96 LAC, Service File, LCP George N. B., p. 11.

97 LCMSDS, Pension File, Cpl. George N. B., p. 7.

98 de la Cour and Reaume, "Patient Perspectives," p. 249.

99 Humphries, "War's Long Shadow," p. 525.

100 Morton, "Resisting the Pension Evil," p. 211.

101 *Report of the Work of the Department of Soldiers' Civil Re-establishment* (Ottawa: King's Printer, 1920), p. 12.

102 Farrar, "War and Neurosis," p. 695.

103 Marnie Sather and David Newman, "'Being More Than Just Your Final Act': Elevating the Multiple Storylines of Suicide with Narrative Practices," in Jennifer White et al., eds., *Critical Suicidology*, pp. 115–32.

medical officers undoubtedly condensed and interpreted symptoms before transcribing them to be intelligible to other practitioners, these statements nonetheless highlight some clear tensions between storylines crafted by and about veterans.¹⁰⁴

While medical officers authored narratives of veterans' deaths by suicide as occurring in moments of insanity, or chronic mental illness, some veterans had evidently previously thought about suicide. As one medical officer wrote of George Charles R., "Still has headaches + cannot stand a crowd is very nervous + irritable. Fidgets all the time he is being examined. Has had the symptoms ever since his head wound. Volunteered for France the second time with the idea of getting 'done in.'"¹⁰⁵ Lieutenant E. W. Burnbury, writing about Private Charles R., wrote, "This man states he suffers from epileptic fits and that these become more frequent if he is worried or under the excitement of gun fire up the line."¹⁰⁶ Captain H. Dwyer added, "This morning he told me he was working up for a series of fits which he described as the horrors, and stated that if they came on again he would do away with himself."¹⁰⁷ These men clearly linked their symptoms with their military service, which contradicts authoritative accounts of inherited or personal failing. Furthermore, the veterans' expressions of suffering in conjunction with their desire to get "done in" or "do away with" themselves suggest a more complicated history than a moment of temporary insanity.

While George Charles R.'s thought to reenlist, and get "done-in" contrasts with other soldiers who used self-inflicted wounds to escape the trenches, it nonetheless echoes the element of agency in self-inflicted wounds, and a defiance of military order.¹⁰⁸ Allard describes a similar case in her work on veterans admitted to the Saint-Jean-de-Dieu military hospital in Quebec. Life in the trenches became unbearable for Private Michael Purcell, who simply could not take it any longer, and attempted to jump over the parapet and leave the trench.¹⁰⁹ His comrades held him back, and he was sent to a psychiatric hospital for suicidal ideation and suspected dementia praecox. It is impossible to know how many soldiers attempted or succeeded in similar actions to get "done in" on the front.¹¹⁰ As Humphries has argued, soldiers in the CEF were not hapless victims—they made difficult choices, and some chose to self-inflict wounds.¹¹¹

104 Todd McCallum, "The Great Depression's First History? The Vancouver Archives of Major J. S. Matthews and the Writing of Hobo History," *The Canadian Historical Review*, vol. 8, no. 2 (2006), pp. 79–107.

105 LAC, Service File, LCP George C. R., Regimental No. 219672, CEF, RG 150, Accession 1992-93/166, Box 8576 - 55, pp. 41-42.

106 LAC, Service File, Charles W. R., Regimental No. 920165, CEF, RG 150, Accession 1992-93/166, Box 8469 - 20, p. 57.

107 LAC, Service File, Charles, W. R., p. 65.

108 Mark Humphries, "Wilfully and With Intent: Self-Inflicted Wounds and the Negotiation of Power in the Trenches," *Histoire Sociale / Social History*, vol. 47, no. 94 (2014), pp. 369–97; Ashley Ekins, "'Chewing Cordite': Self-Inflicted Wounds Among Soldiers of the Great War," in Ashley Ekins and Elizabeth Stewart, eds., *War Wounds: Medicine and the Trauma of Conflict*, (Wollombi, AU: Exisle Publishing Ltd., 2011), pp. 41–59.

109 Allard, *Névrose et folie*, p. 165.

110 Humphries, "Wilfully and With Intent," p. 376.

111 Humphries, "Wilfully and With Intent," p. 397.



Figure 3. Photograph of a nurse and veterans at the Ontario Military Hospital at Cobourg. The veteran in the centre is being treated in an electric heat cabinet.
 Source: Library and Archives of Canada, 1974-258 NPC.

Other veterans felt guilty and ashamed for being hospitalized with mental illness. While he was hospitalized at Moore Barracks, the Canadian hospital at Shorncliffe, a medical officer reported that Private Gordon D. “has the idea that he is wasting his time here + that he should be in France.”¹¹² Later, Captain J. M. Nichol wrote that Gordon D. was “depressed, ashamed of himself and not anxious to be returned to his friends.”¹¹³

Many broke down long after returning to Canada. John M.’s parents reported to Dr. O. E. Rothwell who visited on behalf of the BPC in 1926, that their son “expressed his wish to die as he felt he was of no use in the world having made a failure of life.”¹¹⁴ John M.’s parents’ writings and statements to the BPC remind us that many veterans went home to mothers, fathers, wives, and children.¹¹⁵ John was offered a final payment in 1920 for his neurasthenia, contracted on active service, but suffered a subsequent break down in 1925. John was alternately diagnosed with melancholia, mental derangement, dementia praecox, and finally schizophrenia in the years following the war. John’s aging parents insisted that their son be allowed to stay at home, rather than be treated in an institution. They

¹¹² LAC, Service File, Gordon, W. D., Regimental No. 89098, CEF, RG 150, Accession 1992-93/166, Box 2343 - 19, p. 43.

¹¹³ LAC, Service File, Gordon, W.D., p. 84.

¹¹⁴ LCMSDS, Pension File, Pte. John M., Regimental No. 911022, File 1277-J-135, Reel 131, p. 21.

¹¹⁵ Morton, *Fight Or Pay*.

cared for him, and managed his financial affairs until his hospitalization for a suicide attempt in 1945.¹¹⁶ John's father wrote an affidavit stating that before his breakdown, his son "was in every way normal and enjoyed the best of health."¹¹⁷ While John survived the war, his parents effectively lost the son who had enlisted with the CEF.

George B. later recanted his statements about contemplating self-destruction. The medical officer at Cobourg reported in George B.'s service file that, "He denies ever stating that he contemplated self destruction—States that he is just as anxious to live out his life as the next man."¹¹⁸ This quote highlights how George B. was conflicted with both contemplating suicide and the desire to live out his life, emphasizing the intricacies of human experience.

In a rare letter to the BPC from a veteran treated at the OMH at Cobourg, Charles R. inquired, "I would like to know if you are going to do anything for the loss of the use of my left hand and the abuse I received from hands of English Soldier please look into this matter I am sure you will find where the trouble lays in regard to me over in France I do not ask for much."¹¹⁹ While Charles R. referred directly to his physical disability (the loss of the use of his left hand), he only alluded to his mental illness, telling the board to "look into" the other troubles he had in France. It is clear that Charles R., like many Canadian veterans of the First World War, felt the government owed him recognition and remuneration for his injuries and his voluntary service during the war.¹²⁰

It is also important to note that not all veterans who attempted suicide later died by suicide, and that not all veterans who were diagnosed with mental trauma were suicidal. For instance, after Harry B. L.'s suicide attempt, he was treated for his spinal injuries and psychosis in military hospitals for seven months, and was eventually released from hospital and discharged from the army. He went back to college, received funding to continue his studies and graduated in 1920. According to the BPC, by all accounts, he was established in his profession and had started his own business. While his pension was discontinued in 1921, there is no indication that he died by suicide or accident, rather it appears that he thrived after being discharged from the military.¹²¹

The Portrayal of Veterans' Suicides and Accidental Deaths

While recent research has emphasized the sympathetic public portrayal of veterans who died by suicide as casualties of the war, including the death of Lieutenant Colonel Sam Sharpe, this study reveals some interesting exceptions to this pattern.¹²² For instance, among transient or alcoholic veterans, their military

116 LCMSDS, Pension File, Pte. John M., pp. 56-57.

117 LCMSDS, Pension File, Pte. John M., p. 13.

118 LAC, Service File, LCP George N. B., p. 76.

119 LCMSDS, Pension File, Pte. Charles R., Regimental No. 920165, File 1566-C-9, Reel 261, pp. 31-32.

120 Morton, *Fight Or Pay*, pp. 133-200; Humphries, "War's Long Shadow," p. 505.

121 LCMSDS, Pension File, Sgt. H. B. L., pp. 1-36.

122 Matthew Barrett, "Absolutely Incapable," pp. 22-7; Matthew Barrett and Allan English, "Fallen on the Field of Honour? Attitudes of the Canadian Public towards Suicides in the Canadian Military~ 1914-2014," *Canadian Military Journal*, vol. 15, no. 4 (2015), pp. 22-29.

service and manner of death did not seem to matter as much as their social circumstances. For instance, on September 6, 1932, Toronto's *Globe* reported that Michael W. "met a transient's death beneath the wheels of a train."¹²³ Was Michael's death accidental, or a suicide? The newspaper did not comment, and the death certificate lists his cause of death as, "Fracture of spine from falling off freight train."¹²⁴ While it is impossible to determine intent (or lack thereof) behind deaths in this context, it is worth noting that the media emphasized Michael's transient status and the implication that it was common knowledge that a transient should meet their death "beneath the wheels of a train." This portrayal of certain veterans fits within what we know about the way transients were treated during the 1930s in Canada—they were pushed to the margins of society.¹²⁵

Alcoholic veterans, like Edward B., were also marginalized. Edward B.'s death certificate attributes his death to accidental drowning, but a note on the side of the certificate adds that subsequent information was found after the death was registered, and that his death occurred "while walking along the canal in an intoxicated condition."¹²⁶ Edward B., like Michael W., had spent a number of years as a transient. His pension file highlights that in 1934 he was living in a "jungle," and that between then and his death, was jailed at intervals for crimes including intoxication.¹²⁷ Pension officials wrote, "he appears to be a hopeless booze artist" and threatened to cut off his Veterans' Allowance payments if they received further reports of bad behaviour.¹²⁸

Discrepancies between media reports and official military correspondence also illustrated the BPC's concern that the media would portray veterans' deaths as suicides. For example, on the May 29, 1920, Private William K. was struck by a train while walking the grounds of the Westminster mental hospital in London, Ontario. The medical superintendent of the hospital, B. T. McChie, wrote that the "Toronto and London papers called the hospital repeatedly during Sunday the 30th, for news regarding the accident and as the reporters were under the impression that patient had suicided, I gave them some information with a view to preventing such statements from appearing in the papers."¹²⁹ The *Globe* reported the next day that William K. was picking flowers, and because of his bad eyesight,

123 "Body of Man Found on C.N.R. Tracks is Identified," *Globe* (September 6, 1932) p. 2.

124 Archives of Ontario [hereafter AO], Registration of Death, Michael, W., Registration No. 026731, RG 80-10, MS 935, (1932).

125 The term transient generally refers to homeless people, who were sometimes classified further as hobos, tramps, or bums. It was common for transients to ride the railways between cities during the Great Depression. For additional context, see Todd McCallum, "Vancouver Through the Eyes of a Hobo: Experience, Identity, and Value in the Writing of Canada's Depression-Era Tramps," *Labour/Le Travail*, vol. 59, (Spring 2007), pp. 43–68; Todd McCallum, "The Great Depression's First History?," pp. 79–107.

126 AO, Registration of Death, Edward B., Registration No. 051424, RG 80-08, MS 935, (1944).

127 Temporary, makeshift housing on the margins of many cities in Canada became known as "hobo jungles" during the Great Depression. Veterans, in fact, helped establish the hobo jungles in cities like Vancouver, and many residents of these jungles were destitute veterans. For more information see McCallum, "Vancouver Through the Eyes of a Hobo," pp. 43–68; McCallum, "The Great Depression's First History?" pp. 79–107.

128 LCMSDS, Pension File, Pte. Edward, B., Regimental No. 22935, File 159-E-3, Reel 48, pp. 1-64.

129 LCMSDS, Pension File, Pte. William, K., Regimental No. 37347, File 993-W-30, Reel 153, p. 13.

“walked in front of the car without being aware of its approach.”¹³⁰ Readers were left to puzzle over the likelihood of William K. being able to see flowers, but not an oncoming train. Again, it is impossible to say whether William K.’s death was accidental or suicidal, but military officials did not want the public to think a veteran had committed suicide under their care, which is telling of the negative perception of suicide in this context.

There are other cases where the BPC’s internal investigations revealed circumstances highly suggestive that a suicide occurred, which military officials categorized as accidents. For example, after the war, George W. settled in Toronto, and was found deceased in the slip at the foot of Cherry Street in Toronto, Ontario on May 9, 1920. The military’s Circumstance of Casualty report simply lists George W.’s cause of death as “drowning,” which would fall under the ICD 3 cause of death 182, “Accidental drowning.”¹³¹

The BPC interviewed George W.’s landlady. She reported that in the days leading up to his death, George W. had been acting strangely. He had told her that “his old girl had come to town, and had promised to meet him at Queen & George Streets.”¹³² George W. would wait for her each night, but she did not arrive. The *Globe* reported that he had “apparently, thrown himself into the water while of unsound mind.”¹³³ That George W. had died by suicide was supported by the fact that two boys found George W.’s coat, hat, and a pair of gloves on the channel edge above the water. The *Globe* also reported that police investigators also found a letter enclosed within his jacket pocket, although the contents of this letter were not made clear.¹³⁴ The medical officer advised the BPC that he believed the death was related to service.¹³⁵ However, it appears that the coroner did not hold an inquest into George W.’s death, and his body was turned over to the Great War Veterans’ Association for burial, even though the newspaper account and statements of George W.’s landlady suggest a more complicated set of circumstances than a clear cut case of accidental drowning.¹³⁶

In 1930, George W.’s widowed mother applied for a pension, and since her son’s death was ruled service related, she could have been granted his pension payments. However, since George W. had not assigned his mother part of his military pay while he was in the service, nor materially contributed after his discharge from the military (even though he was hospitalized for a significant period of time, and in school leading up to his death), the BPC ruled that there was insufficient evidence that George W. would have contributed to her maintenance,

130 “Returned Man Fatally Hurt by L. & P. S. Car: Thought to Have Not Seen It While Gathering Flowers,” *Globe* (May 31, 1920), p. 4.

131 LAC, Circumstance of Casualty Form, George W., War Graves Registers: Circumstances of Death, Box 261 (1920).

132 LCMSDS, Pension File, Dvr. George W., Regimental No. 86689, File 1956-G-1, Reel 184, p. 33.

133 “Soldier’s Body Found by Life-Saving Crew: Discovery of Hat, Coat and Gloves Lead to Explanation of Man’s Disappearance on Friday Last,” *Globe* (May 10, 1920), p. 8.

134 “Soldier’s Body Found by Life-Saving Crew,” *Globe* (May 10, 1920), p. 8.

135 This is significant, because how could a true accident, such as an accidental fall from a bridge resulting in drowning, be related to military service? This ruling suggests that the medical officer believed the death was a suicide, linked to Private George W.’s war-related mental illness.

136 LCMSDS, Pension File, Dvr. George W., p. 33.

and his mother's application was denied.¹³⁷ The odds of receiving a pension were stacked against family members, including elderly parents, since they had to prove that they could not support themselves, and that beyond a doubt that their sons would have supported them in their old age, which was difficult if they had not assigned them part of their pay whilst overseas.¹³⁸

The treatment of alcoholic and vagrant veterans' highlights the discrepancy between some veterans, like Lieutenant Colonel Sam Sharpe, whose deaths were commemorated as if they had fallen on the battlefield, and others where it simply did not seem to matter.¹³⁹ Vagrants and alcoholics were marginalized members of society, and their deaths did not warrant the morbid curiosity attributed to other suicides. It is also apparent that military officials actively suppressed information about veterans' deaths that occurred under suspicious circumstances, and were likely to rule in favour of an accidental death in spite of evidence to the contrary. The case studies of veterans originally admitted to the OMH at Cobourg further emphasize the need to reconsider deaths officially ruled as accidents and to delve more deeply into individual veterans' life histories, considering the contrasting representations of deaths by suicide presented by the BPC, media, and official registers of mortality.

Divergent Perspectives on Veterans' Illnesses and Deaths

This study was limited to the examination of a small number of suicide attempts and deaths among a very particular group of veterans designated as "mental cases" and treated at the OMH at Cobourg. It would be difficult to generalize the findings of this research to the wider veteran population. This is in part because the veterans treated at the OMH who applied for pensions were seeking financial assistance, state sponsored medical treatment, or both—veterans who were not ill, or did not need financial aid would be unlikely to apply for such government assistance. Furthermore, one question this research cannot answer, because of the small hospital sample, is whether or not rates of suicide were higher among veterans than their similar aged nonveteran compatriots.¹⁴⁰ The deaths of sixteen veterans, out of a total of eighty-four deaths among those treated at the OMH at Cobourg may seem high. However, rates of suicide are typically higher among men precisely within the Cobourg veterans' age cohort, during economic recessions, and among the chronically ill.¹⁴¹

The numbers of deaths attributed to suicide and accidents among pensioners circulated by F. S. Burke reveal little about the actual social context in which these veterans' deaths occurred.¹⁴² Rates of suicide are instructive, but they

¹³⁷ LCMSDS, Pension File, Dvr. George, W., p. 38.

¹³⁸ Morton, *Fight Or Pay*, p. 159.

¹³⁹ Barrett and English, "Fallen on the Field of Honour?," pp. 22-29.

¹⁴⁰ John Weaver identifies this question as the first question that must be asked in any study of war trauma and soldier suicides. See Weaver, *Sorrows of a Century*, p. 154.

¹⁴¹ Ian Sakinofsky, "The Epidemiology of Suicide in Canada," in Antoon A. Leenaars et al., eds. *Suicide in Canada* (Toronto: University of Toronto Press, 1998), pp. 37-66; See also Weaver, *Sorrows of a Century*, pp. 125-66.

¹⁴² Burke, *Deaths among War Pensioners*, p. 6.

cannot reveal individual perspectives, which can be gleaned from psychiatric case files. For instance, while John Weaver found that rates of suicide among First World War veterans in New Zealand were significantly higher than similar aged nonveterans, he also found that veterans' motives were not absolutely attributable to the war. While many coroners' witnesses in New Zealand mentioned First World War veterans' war trauma, witnesses also reported that veterans experienced troubles not unlike the rest of the population—such as economic hardship and the dissolution of romantic relationships.¹⁴³

Based upon a close reading of individual veterans' service and pension files, it is still possible to make a few tentative inferences based upon the experiences of veterans treated at the OMH at Cobourg. The BPC was particularly concerned that suicides not be reported among veterans of the First World War, protecting their reputation and highlighting the persistent perception of mental illness and suicide as pathology. Discrepancies between the public media portrayals of veterans' deaths and their treatment within individual veterans' pension files further complicate our understanding of how veterans' deaths were understood. The dismissal of certain veterans' experiences, including vagrants, further highlight the schism between whose deaths warranted explanation, and whose did not, in Canadian society.

Official explanations of deaths attributed to suicide and accidental causes contained in veterans' pension and service files, among those treated at the OMH at Cobourg, stressed veterans' mental illnesses, which focused attention away from the possibility of state responsibility, the effects of military service, the social stigma of mental illness, and, not least, the economic and social hardships that returning veterans and their families faced after the war. These veterans' mental illnesses were understood to be the result of inherited defect or personal failing, and this emphasis on individual inadequacies was not unlike blaming poor women for their infants' deaths, or poor people for their poverty—common features of the cult of blame in the early twentieth century.¹⁴⁴ The eugenic underpinnings of this representation of mental illness in the first half of the twentieth century in Canada are clear in writings about the problem of feeble-mindedness among returned veterans.

While suicide is conceptually differentiated from other causes of mortality by its intentionality, ascribing attempts and deaths by suicide to moments of insanity or chronic mental illness denies agency.¹⁴⁵ In contrast, the veterans treated at the OMH at Cobourg described their personal suffering, and their files revealed a wider range of complex storylines and histories, beyond their patency as the mentally ill. Recognizing that it is impossible using these sources to determine exactly *why* some veterans took their own lives, the brief statements gleaned from these sources were nonetheless illustrative.¹⁴⁶ Veterans stated that their symptoms were linked to their military service, and reveal that many had attempted or talked

143 Weaver, *Sorrows of a Century*, pp. 155-64.

144 Helen H. Ball and Alan Swedlund, "Poor Women and Bad Mothers: Placing the Blame for Turn-of-the-Century Infant Mortality," *Northeast Anthropology*, vol. 52 (1996), pp. 31-52.

145 Münster and Ludek, "The Anthropology of Suicide," pp. 3-23.

146 Weaver, *Sorrows of a Century*, p. 6; Perreault et al., "Narratives of Responsibility," p. 169.

about taking their own lives. It would be remiss to dismiss the statements of the veterans treated at the OMH at Cobourg simply because many were diagnosed with what were thought to be hereditary conditions, such as dementia praecox.¹⁴⁷ The disconnect between individual agency, and the denial of intention through attributing such a death to causes beyond an individual's control (i.e., an inherited mental illness), has been called the "tension of agency in suicide."¹⁴⁸

The tension of agency is certainly evident between the statements authored by and about First World War veterans treated at the OMH at Cobourg in the post-war period in Canada. These multiple storylines coexisted, and highlight the complexity of individual lives, further supporting Sather and Newman's call to develop a wider range of perspectives in studies of suicide.¹⁴⁹

¹⁴⁷ Like de la Cour and Reaume, "Patient Perspectives," p. 263, I would argue that veterans' statements about psychiatric illness can provide insight into their own perceptions of their subjective experience, whatever their diagnosis might have been. Furthermore, patients could be confined to mental hospitals based upon questionable diagnoses, and diagnoses were likely to change several times as patients progressed through the hospital system.

¹⁴⁸ Münster and Ludek, "The Anthropology of Suicide," pp. 3-23.

¹⁴⁹ Sather and Newman, "Being More than Just Your Final Act," pp. 115-32.