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### "Stress wasn't a word": Australian nurses' recollections of war-related trauma

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### Abstract

**Aim:** This research explores the recollections of Australian nurses in regards to psychological injury among those who served in World War II (WWII) and the Vietnamese conflict.

**Methods:** Existing oral histories from WWII and Vietnam held by the Australian War Memorial were explored for recollections of issues related to psychological injury. A constant comparative method was used to allow themes to emerge across both cohorts of interviews.

**Results:** Findings indicate that nurses from both conflicts witnessed trauma among their patients in the field and experienced it among themselves upon their return from service. Three main themes emerged which related to nursing practices, nursing attitudes, and nurses' experiences of stress or trauma during wartime. Underlying these themes were recurring concepts related to gender, stoicism and talking, which reveal that the required professionalism of nursing practice can sometimes act as a barrier to nurses dealing with, and admitting to, their own stress or trauma.

**Conclusions:** This study reveals a disturbing persistence of issues around gender and 'talking' in relation to the experience and treatment of trauma and post-traumatic stress disorder (PTSD) in returned service people, including medical personnel such as nurses. While nurses are quick to recognise the importance of talking as a form of therapeutic treatment for soldiers, they struggled to articulate their own trauma, revealing a complex negotiation of social expectations and gender roles. The ability of service personnel to talk about their own war experience has been linked to recovery from trauma, and nurses need to be included in this dialogue, for historical purposes and in relation to contemporary military service.

### Keywords

mental health, military, nursing history, oral history, post-traumatic stress disorder

### Disciplines

Medicine and Health Sciences | Social and Behavioral Sciences

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# **“Stress wasn’t a word”: Australian nurses’ recollections of war related trauma**

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## **Abstract**

**Aim:** This research explores the recollections of Australian nurses in regards to psychological injury among those who served in World War II (WWII) and the Vietnamese conflict.

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## **Introduction**

Nursing practice has a long relationship with war, from Nightingale’s efforts in Scutari and beyond, and the role of women as nurses in military history has become increasingly well recognised (Hallet, 2009, 2014; Harris, 2011; Lee, 2012; Norman, 1990; Scannell-Desch & Doherty, 2012; Vuic, 2010, 2013). There is much to be learnt from nursing experience in war zones about both technological and scientific advances and the role of nurses in the global transmission of ideas about empire, health and hygiene (Bashford, 2004; Connerton, 2013). What is less well understood, however, is the role that nurses have played in the treatment and care of conflict-related psychological injury, both at the front, and in repatriation, and how nurses themselves experienced and dealt with war trauma.

The impact of post-traumatic stress disorder (PTSD) in defence and service personnel returning from war zones is profound. The U.S Department of Veterans Affairs conservatively estimates that some 31% of Vietnam veterans, 10% of Gulf war

veterans, 11% of veterans from Afghanistan and 20% of Iraqi war veterans experience PTSD (NIH, 2009). In Australia it is conservatively estimated that 9.7% of the Australian Defence Force were diagnosed with PTSD up to 2010, representing a four-fold increase since Australian forces involvement in Afghanistan began in 2001 (Bale, 2014). It is also the case that figures such as these do not consider medical personnel and do not reflect the experience of trauma among non-combat troops.

In this paper oral history collections from Australian nurses in WWII and the Vietnam conflict are used to explicate the nurses' experience of dealing with stress and trauma. Despite the significant evolution in nursing practice and societal attitudes from one era to the other, there are interesting similarities between the two cohorts of women. Many of the issues they discuss revolve around ideas about gender, personal strength (or stoicism) and the significance of 'talking' for both nursing practice and personal therapy. These are all concepts that emerge as factors influencing nurses' attitudes, practices, and experiences of war, but are also concepts central to the professionalism of nursing itself. This suggests that the very nature of nursing practice can complicate nurses' approaches to the issue of trauma in war, both in their patients and in themselves.

## **Background**

Understanding the nature of mental health nursing practice in history can often prove difficult due to the sometimes elusive nature of sources (Boschma, 2003). This can often be attributed to nurses' attitudes towards their own work, which may seem to them self-explanatory: 'just nursing' and not worth recording. Sources can also be complicated by gender, class, and broader social constraints, which affect what is considered important to be recorded at any given time. The nature of women's nursing work has always been difficult to trace, embedded in the domestic; invisible because it is already everywhere (D'Antonio, 2010; D'Antonio, Baer, Rinker, & Lynaugh, 2007; Reverby, 1987). In mental health nursing history, 'practice' was historically constructed by men as it was male psychiatrists who were recorded as the agents responsible for reforming and professionalising the asylum system. Ascertaining what nurses were 'meant' to do in this system can be achieved through formal documents such as rules, asylum policies and training texts, but what is less

well known is how nurses negotiated these rules in their everyday practice (Boschma, 2003).

By exploring nurses' attitudes towards issues of mental illness in their patients, we can gather some sense of how these attitudes informed and translated into actual practice. An exploration of attitudes also reveals that the history of psychiatric treatments and the interminable persistence of stigma about mental health issues (Moxham, Robson, & Pegg, 2014), as well as issues regarding working within the 'asylum' system, affected women's willingness to speak about that work and how it impacted them.

Military history has also traditionally focussed on the masculine heroism of soldiers, usually symbolically central to national myths. In Australian history, this has taken the 'imagined' form of the ANZAC (Australian New Zealand Army Corps) legend (Anderson, 1983; Ward, 1970) which emerged from the great losses suffered (and alleged male stoicism displayed) at the battle of Gallipoli in World War 1. With its focus on death in the battlefield, women were necessarily excluded from this Legend, and still struggle to be recognised in Australian military history. As a result, female experiences immediately after the world wars were consciously or otherwise subsumed by the need to ensure 'their men' were successfully repatriated back into patriarchal Australian society (Garton, 2008). While extensive histories were written immediately after the wars about the nature of military life and work for Australian men, women as nurses were usually invisible in these histories, or if they were evident, portrayed as angelic handmaidens to psychiatrists and doctors (Damousi, 2007; Muir, 2009; Raftery, 2003).

More recently, the contribution of nurses to Australian war efforts has been documented by a number of publications, plays, television and film productions and exhibitions (Bassett, 1997; Biedermann, 2004; Biedermann, Usher, Williams, & Hayes, 2001; Harris, 2011; Hemmings, 1996; McHugh, 2006). In many ways, the Australian fascination with its own military history has facilitated the development of nursing history where it is connected to war efforts. This has done much to reveal the contribution of nurses to Australia's military history. The Australian War Memorial (AWM) houses an extensive collection, including oral histories which provide a rich

source of information about both the experience of Australian nurses and their practice in war zones. Recently these sources have been used in popular cultural events such as the exhibition *Nurses: From Zululand to Afghanistan* (AWM, 2012) and the television series *Anzac Girls* (ABC TV, 2014). The latter focused largely on the romantic personal experience and relationships of the nurses, whereas the former hinted at the complexity of nursing work during war (especially in relation to triage and wound care). In this study (which is part of a larger project tracing the history of nursing practices in relation to ‘trauma’), we were interested in what these same sources could tell us about the way nurses in past conflicts experienced and treated psychological trauma in their work. Our aim was to understand what they did, how they felt about what they did, and how they coped with their potentially traumatic service.

## **Method**

The oral history collections at the AWM have been recorded as part of official commissioned histories of the Royal Australian Army Nursing Corps (RAANC) or as part of broader conflict-specific oral history projects. The WWII interviews were conducted by Edward Stokes as part of the ‘Keith Murdoch Sound Archive of Australia in the War of 1939-1945’ collection and recorded in 1989-1990. The Vietnam interviews were conducted by Lynn Hemmings in 1990-1991 as part of the ‘Oral History of the RAANC’ project and used subsequently in her work on memory and Vietnam nurses (Hemmings, 1996). All interviews used in this study are the copyright property of the Australian War Memorial and are used and quoted here with express permission.

The questions in the original interviews were broad and covered topics from how the women became nurses, their travel experiences, impressions of foreign environments, their nursing practice and experiences, their relationships, social life and their return home, including post war experience and adjustment. Both collections, from WWII and Vietnam, included conversations about stress, trauma and psychological injury, although these issues were not the main focus at the time, and were often left unexplored.

The study in this paper is based on all available transcripts of interviews with nurses in these two collections. This comprises six transcripts from interviews with WWII nurses (stationed in the Middle East and the Pacific) and twelve transcripts from nurses who served in Vietnam. Nurses interviewed were all military nurses and therefore part of the Royal Australian Army Nursing Corps. They represented ranks of Corporal, Lieutenant, Captain and Major, and ranged in nursing practice from staff nurses to matrons. Ages at the time of service ranged from 25 to 45 years old.

Using oral histories comes with challenges, especially when they have been undertaken by previous researchers who may have had a specific focus or purpose (Wall, Edwards, & Porter, 2007). They do not record the entirety of the person's experience, and they are necessarily subjective and based on the ability to recall, or the need to forget. Memories are filtered by words and reconstructed in the telling in ways that may sometimes differ from what occurred years ago (Portelli, 2006). We do not therefore assume that these oral histories are definitive sources of information about nursing practice in the past; rather we see them as rich sources of personal perceptions and recollections appropriate for an explorative, descriptive study.

We did not conduct these interviews ourselves, but chose to use already existing oral histories. We did this because many of the World War Two interviewees are now deceased, and these are their only extant interviews. In relation to the nurses from the Vietnam War, we chose not to seek to interview them again, given that they had already given generously of their time and had spoken extensively about difficult and sensitive issues. Our approach was to undertake a deliberate re-reading of already existing sources and to analyse them for previously unexplored issues.

In doing so, we came to the interviews specifically looking for information related to the nurses' experience of psychological injury in their war experience and so paid specific attention to these sections of the interviews where this was discussed. We particularly hoped to find material relating to nursing practice in relation to psychological injury but otherwise had no *a priori* themes in mind. We did not conduct a thematic analysis of the entire interviews but only of those questions and responses related to psychological injury and trauma. We used a 'constant comparative method' (Strauss & Corbin, 1990) to draw out and code themes and

concepts related to psychological injury from the transcripts, beginning with the WWII collection. In this first stage, all WWII transcripts were read through once with notations made where specific questions and answers related to issues of psychological injury occurred. We maintained this focus throughout as our specific interest is on the issue of psychological trauma in nursing practice. The main themes emerging from the WWII interviews were identified and logged for comparison with the Vietnam transcripts. Similarities and differences between the two sets of transcripts were noted in relation to the three key themes which emerged from the transcripts: nurses attitudes towards soldiers experiencing psychological trauma; nursing practice in relation to psychological trauma; and nurses' own experience of psychological trauma. Across the two sets of transcripts, and within each of these three themes, recurring concepts related to 'stoicism', 'gender' and 'talking' emerged. Rather than existing as separate themes, these concepts form 'traces' across both sets of transcripts, existing as a kind of undercurrent that inform the way the nurses spoke about their attitudes, practice and experiences.

## **Results & Discussion**

The analysis was concerned with the interviewee's responses to questions about trauma, stress or psychological injury. These responses fell into the three key themes of: Nurses Attitudes (towards soldiers experiencing psychological injury, both during and after war); Nursing Practice (in relation to psychological injury and the immediate treatment and care of injured soldiers); and Nurses Experiences (of personal psychological trauma both during and after service). Permeating each theme were common threads related to ideas about stoicism, gender and talking. These concepts are explored within each of the key themes set out below.

### *Nurses Attitudes*

Recollections of actual nursing practices are entwined with the interviewees' feelings about and attitudes towards the men they nursed and reveal the complex nature of the discourses surrounding mental health and gender relations in both wartime and post war reconstruction. The ANZAC legend in particular is built on a myth of singularly Australian mateship, and the 'stoicism' inherent in discourses about Australian



masculinity. This idea is evident in the way in which the interviewees remembered the soldiers in their care and the relationships between them, which frequently centred around concepts of strength or weakness. As Moira (WWII) stated:

“...there was understanding. See, they’d been through it and fortunately they were probably just that little bit stronger but they were sympathetic towards him. Poor so-and-so, they’d say” (M. Atkins, personal communication, February 28, 1990).

Ann (WWII) also picks up on this camaraderie, and on the related issues of ‘strength’ or stoicism:

“it wasn’t judgemental and I don’t think that their fellow soldiers were judgemental either. I think that different people react in different ways...everybody was frightened I think. I mean, anybody who said they weren’t frightened was probably a liar, but I think some people can cope with things better than others. It’s nothing to do with cowardice, it’s just the way people are” (A. Macintosh, personal communication, February 28, 1991).

Ann’s comments reflect some of the prevailing debates about the cause of psychological injury in wartime, and its contested relationship to inherent personality:

“I don’t think anyone looked down on the people who were in the bomb happy ward at all. I think they just thought them most unfortunate, you know, that it was bad luck. I don’t think they regarded it as any more bad luck than a skin disease or anything else”.

Psychiatrists had learnt from the experience of WWI that ‘shellshock’ did not necessarily discriminate, and was a major consequence of, and problem for, the war effort. A great deal of effort had gone into weeding out men who might be susceptible to psychological injury, but these efforts proved largely ineffective (Grob, 1994). Nurses recollections from WWII demonstrate an awareness of these issues, especially in relation to the idea that an overt recognition of psychological injury would cause it to become ‘contagious’ and encourage malingering (Muir, 2009). Nurses needed to

negotiate these ideas in their practice and did so with sensitivity, as Moira (WWII) remembers:

“it’s a very ugly word, really, malingering, because it would be difficult for someone to judge someone when they haven’t been in that situation. If you were being bombed and shot at, it would be easy for you to want to stay in a comfortable hospital bed with someone minding you...it would be very easy to want to stay there”.

Yet the ‘spirit of the men’, exemplified by strength, stoicism and manly silence, was mentioned by many nurses. As Una commented:

“The men were very strong - mentally, on the whole, they were very strong. It just used to amaze me how much they could take and not crack” (U. Keast, personal communication, October 7, 1991).

Stoicism, however real, also acted to cover up, or silence, true fears and anxieties. Many of the WWII interviewees recollected that soldiers were more likely to confide in nurses about how they were really feeling, because they were nurses and because

“well, they were there with women, too, and I suppose they weren’t frightened to say to us, oh, you know, ‘I’m sick of it’ or ‘I’m tired’ or often they expressed the fear that they ‘Oh well, I hope it’s over soon’”.

This comment reveals the often unspoken effects of gender on psychiatric care at this time, the expectation that nurses as women could and should care in an emotional sense. Nurses would have been constantly required to negotiate often fierce social attitudes and judgements about the nature of psychological injury with the reality of their own in-the-field experience, and this required compassion. Nurses did not generally see their ability to act in this way as requiring strength and stoicism, rather they saw these as values particular to the soldiers they cared for, and took these as taken for granted necessities in their own practice.

Ideas about strength and weakness in the recollections of Vietnam nurses also reflect prevailing gender norms. Most of the nurses commented on the ‘courage’ of the soldiers they nursed, and draw on the same language of stoicism and bravery that informed the WWII nurses. As Patricia K recalled:

“some of them were very outstanding patients because of their injuries and because of their personalities. And I mean, people with these incredible devastating trauma, both mental and physical, and yet they coped so well” (P. Kennedy, personal communication, June 15, 1991).

This demonstrates the influence of social discourses about gender roles and masculinity on nursing practice, and on the way in which nurses related to their patients. A good patient was a strong one, one who coped, who did not cry out or make demands. This also reflects debates at the time about ‘genuine’ psychological distress. The issue of ‘malingering’ continued to be contentious in the Vietnam conflict, occurring in the context of public debates about conscription and conscientious objection, as well as continued expectations that men be stoic and silent. As Patricia K noted:

“...you had the ones who played up; you had the ones who were trying to put one over on people...you had your whingers and they were the ones that were usually, well, would have been whingers anyway”.

In this comment Patricia reflects debates in psychiatry about the issue of ‘pre-disposition’, and the argument that some men were unsuited to war and should be screened out beforehand to limit the risk to manpower, and to claims of war related injury (Menninger, 1948; Muir, 2009). This attitude was also reinforced by social attitudes about the nature of Australian masculinity, that it must be stoic and silent, not ‘whinge’ or complain, and to do so was a sign of weakness. While this weakness might be unacceptable on the battlefield, interviewees were also aware of the longer-term effects of psychological injury on soldiers.

It is in relation to the idea of post-traumatic stress that a significant difference between WWII and Vietnam nurses can be seen, indicating changes in language,

psychiatric practices and broader social contexts, although gender expectations remain remarkably similar. WWII nurses are noticeably less vocal about the long-term effects of war trauma on soldiers under their care. Marjorie (WWII) noted that

“the people that were mentally affected, I think, was the most, one of the most traumatic because it was fairly permanent. It turned out with a lot of cases to be a permanent thing” (M. Tomlinson, personal communication, March 29, 1990)

However, she was the only WWII interviewee who articulated this long-term concern or awareness. There may have been sympathy for soldiers, but it was also the case that those with irreparable psychological injury were quickly returned home: “people would disappear every now and again”. While society was yet to use the term, the repatriation of soldiers with PTSD was a significant problem for the defence forces after WWII, as soldiers and nurses returned to a nation concerned with celebrating its victorious, masculine, heroes (Raftery, 2003). Nurses’ silence on this issue then, occurs in the context of a society desperate to reconstitute masculinity in the post war era (Garton, 2008) and its frantic removal of soldiers to specialist institutions, often run by the military (Muir, 2009).

In contrast, the Vietnam nurses were extremely articulate and cognisant of the psychological issues affecting returned soldiers from Vietnam. Again, this reflects changes in nursing and psychiatric practice and language, but also a growing social awareness of the issues veterans faced. The Vietnam nurses recognised the reality of psychological injury from war activity itself, and were articulate about special complicating factors surrounding Vietnam veterans, who were vilified for participating. As Patricia G recalled:

“There was shell shock and ...battle fatigue and now it’s called PTSD...I don’t think it’s any different from the other wars except they were made to feel guilty” (P. Gibbons, personal communication, June 16, 1991).

The hostility and social conflict surrounding the Vietnam War added a layer of complexity to both soldiers and nurses’ mental health upon their return. Many of the nurses interviewed continued to practice as nurses when they came back to Australia

and in their practice saw men struggle to rebuild their lives. Colleen, who worked with the Veterans Counselling Service after Vietnam, was well aware of the long-term implications of unresolved stress:

“... a lot of the Veterans remarry and have very unstable family lives...a lot of this stress that the men have gone through is rubbing off on the children now and the children are suffering now. I mean, there are just so many of the kids out there whose father is suddenly violent or doesn't cope or is an alcoholic and it's rubbing off on the children and the children are acting in the same way. You know, sudden outbursts, just hard to manage and it's terrible. So I don't know where it's ever going to end” (C.Thurgar, personal communication, September 19, 1991).

These nurses were compassionate in their attitudes towards soldiers after Vietnam, clearly able to see and understand the long-term effects of the horrors of war, compounded by the hostile and unsympathetic environment into which soldiers returned:

“ I felt very angry at the Australian government...the wicked things they did to those boys, who were you know, ordered to go up there and then did not support them when they came home. That was...that was unforgiveable, really unforgiveable” (D. Badcock, personal communication, June 15, 991).

This was the same environment in which nurses attempted to care for soldiers with obvious psychological injury, and these broader social discourses and attitudes required careful negotiation in the nurses' practice.

### *Nursing practice*

An exploration of nurses' attitudes demonstrates that the main therapeutic tool available to the wartime nurse in relation to psychological injury was in fact themselves. Perhaps because of this, in all of the oral histories surveyed, the interviewees tended to downplay their role in the treatment and care of soldiers with trauma or psychological injury. This could be the result of both their own, and broader perceptions, of nursing at the time, where emotional care may have been

considered something which just came naturally (and therefore not considered an element of 'practice'). It may also relate to the fact that the nurses interviewed were not specialist mental health nurses but came from general or surgical practice: none of the nurses interviewed had any specialist mental health training. Generally, they did not talk about themselves as providing mental health care specifically, even though there were specialist psychiatric units in place, particularly in WWII, which Australian nurses were rostered to.

One of these nurses was Ann, who worked with the renowned Army psychiatrist Alan Stoller (Cunningham Dax, 1989). She assisted with a variety of somatic treatments in the field although she is vague about the specifics:

“we had what they call the bomb happy ones who had...just reacted that they couldn't cope with it for a time and so on, and they were put in the psychiatric ward...Other than give them sedatives, I think... I don't remember them doing any shock treatment in the Middle East. I do remember shock treatment up in Borneo” (A. Macintosh, personal communication, February 28, 1991)

Ann's comments indicate the difficulty of memory, especially when more than 40 years after the event, but also indicate a hesitance to talk about her own role in these practices. These were in fact complex and innovative treatments. Medical and psychiatric historians have documented the advances in treatments for psychiatric injury after WWI, which demonstrate the complicated political and social contexts of psychiatry at the time (Damousi, 2007; Garton, 1988, 1991, 2003; Grob, 1994; Raftery, 2003). Debates about terminology, causality and treatment of mental illness were effected by government concerns for manpower in the first instance, and in the second, an unwillingness to pay pensions for psychiatric injury after war (Muir, 2009). This meant that nursing practice, nominally based on care and compassion, was forced to negotiate a complex discursive environment which was hesitant to posit any direct cause and effect relationship between war and trauma and tried to make mental illness or psychiatric injury a problem of personal (pre-existing) weakness (Grob, 1994). Nursing language reflects this tension, using terms like 'bomb-happy' to explain what might later become known as 'shellshock', 'combat neurosis' or even 'post-traumatic stress disorder'.

While some WWII nurses like Ann were well aware of the specialist medical and psychiatric techniques used to treat and care for psychiatric injury, they may not have overtly acknowledged their own practice as ‘psychiatric’. They were however, articulate about the importance of ‘talking’ as an essential element of treatment and care:

“Well the main thing was to try and talk – counsel them.” (U. Keast)

“We would talk to them as much as we could and sort of bolster them up” (J. Cameron, personal communication, February 20, 1991)

Talking as a practice also involved a level of emotional engagement:

“...they just wanted to be given a little bit of love or care or something you know” (A. Penman, personal communication, February 15, 1991).

This expectation of love or care as part of nursing practice speaks to the emotional nature of nursing practice, and would have implications for the way WWII nurses themselves dealt with the often traumatising nature of their work (explored below).

In Vietnam, specific operational issues for Australian nurses meant that nursing practice in relation to psychiatric injury was different in many ways from WWII, although Pacific theatre operations were renowned as particularly horrific. Australian nurses deployed to Vietnam were primarily involved in theatre or intensive care nursing at the single operating unit, the 8<sup>th</sup> Australian Field Ambulance (later the 1<sup>st</sup> Australian Field Hospital), which was primarily involved in ‘dust-off’ operations. That is, injured soldiers were airlifted directly from the field by helicopter and could be on the surgeon’s table within 20 minutes. They could then either be returned to active duty or transported home. Despite these different conditions, some medical and nursing practices remained the same from WWII to Vietnam.

As with Ann from WWII, Patricia K. demonstrated a familiarity with the multitude of issues experienced by soldiers and the role of the unit psychiatrist in the Vietnam setting:

“personality disorders, alcoholism, transient situational disturbance... we had a psychiatrist up there with us, he really got down and treated the boys well...they used to try and bring those people home as soon as possible”

Despite the focus on tirage and surgery at the Australian unit in Vietnam, interviewees were aware of the psychiatric issues experienced by incoming wounded and their need for care and support. As Colleen recalled of even the most traumatised:

“We never put them in a room and closed the door or pulled the curtain. We sat with them, we never left them” (C. Thurgar).

Patricia K also hinted at apparent complicating factors in relation to psychiatric cases in Vietnam:

“A lot of the psychiatric cases went into the stockade didn't they? The military police used to look after them”.

Patricia's comments reflect the social and political context of service in Vietnam, where the government reintroduced conscription through the National Service Act (1964), meaning any male aged 18 or over could be forced into service. The Act came with a virulent 'conscientious objection' movement, with less than 40% of the Australian population supporting the nation's involvement in what was seen as an “American” war. Conscription was ended in 1972 as one of the first acts of the incoming Labor government but returning veterans were treated with open hostility for many years (Twomey, 2012). Interestingly, this is the same environment into which nurses themselves returned. Nurses had similar horrific experiences in both WWII and Vietnam, yet there are marked differences in the way they articulate their own experience of war related stress and trauma. This difference may be related to the social and political contexts of the various conflicts.



Nurses' recollections of their own experiences of war, and how they dealt with stress and trauma, are interwoven with thoughts, overt or implied, about gender, strength and talking. These are all concepts which underpin the very idea of what it is to be professional, what it is to be a nurse, and make it harder for nurses to articulate the sometimes traumatic impact of their work. Initially, the WWII interviewees seemed reluctant to talk about their personal experience of stress. While the interviewer in these studies did not have stress or trauma as a specific focus, it is also the case that when he did ask specific questions about this, the nurses tended to deflect, not answer, or talk about something else. Without variation, WWII interviewees talked about how busy they were, how the work was all consuming, and state that this busy-ness shielded them from stress. At one level this is the essence of nursing professionalism. As Joan stated:

“well it was very tragic really to see them and you just had to be...you had to, sort of, switch off in a way, you know, and just get on with the bare facts of the thing and do your best for them”.

But this practice did not come without a cost. Una described the general approach of WWII nurses well:

“I think one learns that very early...to hide one's feelings, and I think we were often – people would say we were hard – but we weren't hard, we just had to hide emotions. And after one would retire from work of an evening, you know, then maybe the tears would flow, and the emotions would take over – but never on duty – one would never show it. Self-control, I think one might call it”.

WWII interviewees then, perhaps without realising it, tend to articulate and replicate the masculine expectation of stoicism, especially in public. In their case, they see it simply as professionalism, not necessarily the strength of character they had seen in the soldiers.

While this focus on the work, and the need for emotional control and regulation, this 'contained self' (Hallet, 2009), was equally compelling in the recollections of

Vietnam nurses, this later cohort were more able to talk about the private emotional impact of their practice. As Jean (Vietnam) explains:

“when something like that, terribly bad you know, you just wander off, off this track, you know, there’s a path there, you can wander off in the dark and have a cry and then just come back into it, because you must get back into it, because you’ve got to sort it out (J. O’Neill, personal communication, December 19, 1991).

Colleen (Vietnam) remembered a particular instance when all the staff were struggling to retain control and how they coped:

“she didn’t want to cry in front of the others, so she went into the little theatre and...she just burst into tears. As soon as she burst into tears, everybody. It was like a pack of cards, and it took us a couple of days to get back on our feet again after that. And we pulled ourselves up and got on with it”.

While men were expected to be ‘good’ and seek help only through the rational act of talking, nurses were also expected to be good in a professional sense, and to contain their emotions behind professional boundaries. All Vietnam nurses recollect needing to get on with the job, to remain professional, and to control themselves around others. At the same time, Vietnam interviewees also talked about smoking, drinking and casual sex (traditionally seen as masculine pursuits) as part of their experience. These recollections are significant in that they reveal changing social mores about the acceptable public behaviour of military women as nurses, but also that these activities can be seen as both a reaction to, and relief for, stressful circumstances. It is rare that the nurses themselves considered these activities as stress-related; rather they used more neutral terms like “letting off steam” or “letting our hair down”. This tendency to normalise or talk down potentially stress-related behaviour demonstrates the difficulty for nurses to articulate the stressful circumstances of their own wartime practice.

While both cohorts of nurses talked about the need to ‘just get on with it’ as an essential part of their nursing practice, there are significant differences in the way the

nurses talked about the effects of service on their lives once the war was over. Interviewees from WWII were noticeably less vocal or articulate about the impact of the war on themselves personally. They all evaded the question. They said that it had had no impact, that they had tremendous lives after the War, that it was a fantastic experience, or that they had just been there to do a job, as a nurse, and that helping ‘our boys’ was its own reward. These types of responses are underscored by sometimes unspoken assumptions about gender and stoicism. For these particular nurses, as women of a generation imbued with the mythology of the special stoicism of the ANZAC legend, there was not the language by which to articulate any long-term effects. At the same time, that very legendary nature of Australia’s involvement in the World wars in fact served as a kind of therapeutic outlet. All the WWII interviewees, as members of the RAANC, talked about their long-standing connections with each other after the war, their participation in memorials, parades and the role of commemoration in making them feel that they had been part of something larger than themselves. They were able to reconnect with their peers, to talk and laugh (and drink) together.

This does not mean there were no ill effects of their war service, however. For example, when pressed, they made the following comments:

“I can’t...I can’t recall what it did to me. I think it made me more aware of the suffering that the world goes through...it’s something I’m not really able to come to grips with now”.

“I suppose it made me think more deeply about a lot of things I hadn’t worried about before”.

“Perhaps I’m a little intolerant of trivialities”.

“Perhaps”, “suppose,” “can’t recall”...all these terms minimise the impact of nurses’ memories on both themselves and their interviewer. There is no doubt the reactions noted above are all normal human reactions to the inhumanity of war, not necessarily symptoms of PTSD, but they do signify impact which nurses are sometimes hesitant

to admit. They also signify the difficulty of talking about that impact for women as nurses involved in war.

Interviewees who served in Vietnam have somewhat more complicated recollections, with similarities to WWII experiences and but also with marked differences. At first, most of the Vietnam nurses denied that the war had any immediate or prolonged impact on them. As elucidated above, they emphasised how hard they worked, how busy they were, and how they needed to just get on with the job. If being stoic and silent demonstrated masculine heroism, the women tended to emulate this, subconsciously or otherwise. Some, like Patricia K, were particularly keen to avoid the word 'stress':

“Oh I don't think we used the word stress in those days. It wasn't one of the 'in' words, it wasn't one of the ways that you used to describe things. I think we were under pressure...stress wasn't a word, I don't think I ever used that word there. You were tired, overworked, or worn out or...”

It is true that 'post-traumatic stress disorder' may not have been part of the nursing lexicon at this time, but Patricia was extremely concerned here to dissociate herself from that term. Interestingly, however, Patricia went on to describe her experience on her return in the following manner:

“I found it very difficult to adjust when I came home. I didn't really want to talk to anybody...I can remember just wanting to be by myself a lot and I can remember thinking What's the use in talking to anybody...So they thought I was withdrawn, which I probably was, but I really felt I didn't really want to talk about it”

In this instance, Patricia adopts the stereotypical masculine approach, the 'good patient' who doesn't "whinge" (as she had herself suggested earlier). Other interviewees, also denying stress, described what might now be considered PTSD symptoms. The most profound example is Elizabeth, who described being traumatised by sound:

“I was walking down Elizabeth Street and I heard a sound and I had no idea what this sound was and it sounded very dangerous to me and I wanted to lie down...I wanted to hit the footpath...” (E. Healey, personal communication, July 5, 1991).

and by the laughter of other people in a cinema watching the Korean War movie MASH:

“I was so angry I wanted to get up and punch everybody in the head...I mean I was still so terribly involved in all that you know, reacting to it... (I know) laughter is a way to diffuse all that sort of anger and grief and stuff. But I remember how uppity I was and how angry”.

Elizabeth is apologetic about her reactions, attempting to minimise them as though she had no right to them, and goes on to deny that her service had any long-term effect on her.

This is common to the Vietnam nurses, who struggled with the need to talk, versus the perception that society would rather they be silent. While WWII nurses all mention the camaraderie of their fellow nurses and officers both during and after their service, and the significance of routine and annual commemoration, the Vietnam nurses came home in secret, under cover of darkness, to a nation divided in its approach to the conflict. The eventual ‘loss’ of that war did nothing to facilitate repatriation of service veterans, and in the same way it effectively silenced the nurses who had been there. Every interviewee mentions the difficulty of talking about their experience upon their return. There was no organised support for them, and they all withdrew to some extent from their families, at least in the short term. They remember not only feeling like they couldn’t talk, but that they weren’t allowed to talk, that mentioning that you had been in Vietnam was like some kind of social death. Patricia G remembered an incident of meeting the brother of a friend she had served with, who had been a conscientious objector:

“when we were sitting at the table he said ‘How do you know Colin?’ and I said ‘I went to Vietnam with him’ and he turned his back on me and just turned away and that was all he said to me”.

Even for nurses, who had been sent to care for the wounded, not to fight, this was the case. Partly this is due yet again to the invisibility of women in Australian military history. For example, June and her husband were both in Vietnam, and she articulated this gendered invisibility clearly:

“I don’t know, unless they ask me if I was there too I tend not to say anything. Sometimes we go through this funny sort of situation where we have these great long conversations with friends about Michael’s experiences there and I keep serving the dinner, if you know what I mean. In other words, ‘Hey, I was there too’. But I mean, unless people ask I just don’t say anything” (J. Naughton, personal communication, December 18, 1991).

It is also important to note that halfway through this interview, June was joined by her husband Michael who then began to dominate the conversation and at times answer for her. If it is hard enough to talk about your wartime experiences, it was even harder for a nurse, a woman, like June.

June was not alone however. All Vietnam nurses talk about talking or not talking. The social and cultural factors of their return meant there was an ever present feeling that talking was off limits, as Patricia G explains:

“I didn’t talk about...well, I think I went on my first Anzac march in 1984 or something. All the seventies I didn’t talk about it...It wasn’t acceptable to talk about it...I can remember once at...a function some fellow next to me found out and he said to me ‘Oh look, there’s a really good lot of people here tonight. You can get up and publically apologise for being there, if you like’. So you know, you just retreat after these comments”.

More than this, talking or not is complicated by the belief that no one would think that what they have to say is interesting or important, or that there are no words with which to describe it:

“when people say what was it like, I mean, there’s so many things that come into your brain. Do they mean the hospital, do they mean the work, mean the dust-off, do they mean the wounded, do they mean the climate? What was it like? Where do you start? I felt so frustrated because I knew I wasn’t getting across what I wanted to say so after that I just clammed up and said nothing because I used to be left feeling so frustrated after it. I hadn’t told them what it was like at all.”

### **Conclusion**

This study demonstrates the complex contexts within which nurses’ must negotiate approaches to psychological injury, especially during wartime. Australian nurses have had to forge their practice at the intersection of strong social discourses of mythological nationalism, gender and stoicism, which are further reinforced by the demands for professionalism of nursing work itself. In the past, these varied contexts have impacted the ways in which nurses dealt with patients with war related psychological injury, and have made it difficult at times for nurses to articulate, and possibly treat, their own trauma. These recollections also demonstrate the centrality of the idea of talking for both soldiers and nurses themselves as a therapeutic practice.

By studying nurses from two different conflicts separated by twenty years, we can see the changes and consistencies in nursing practice (and social forces) over time. In this study, while WWII nurses had more time to ‘talk’ to the soldiers as patients, and this may have constituted a therapeutic practice, they were shielded from ‘post-traumatic stress’ to some extent by the culture and atmosphere of a victorious celebration, and the way in which soldiers were repatriated (that is, largely removed from mainstream health services). The broader social context reinforced gender roles, and women in the 1950s were encouraged to celebrate their femininity in order to restore wounded manhood.

In contrast, the Vietnam conflict resonates strongly with contemporary scenarios and occurred in the context of shifting gender roles as a result of the civil rights and women's liberation movements (Shay, 2002). While modern defence forces may be more informed about PTSD and strategies for its prevention and treatment (Kearney, Creamer, Marshall, & Goyne, 2003), current approaches cannot be considered a success. Veterans returning from Iraq or Afghanistan face many of the same social and political debates and policy technicalities (especially in relation to disability pensions) as their Vietnam counterparts. Despite Defence Force efforts, veterans (of all kinds: armed, support, medical) when diagnosed with PTSD are largely discharged from services and find themselves at the mercy of understaffed and under-supported mainstream health services. In this scenario, nurses are again often the primary support, often with little or no specialist skills in trauma-informed care. Similarly, support structures for nurses themselves are often lacking – clinical supervision and debriefing continue to be seen as burdensome or trivial. In Australia, the culture of masculine stoicism continues to pervade efforts to encourage 'talking' as a form of therapy, exacerbated by continued stigma about mental illness more broadly.

Interestingly, Vietnam conflict interviewees talk about the role of the eventual recognition of Vietnam vets as a kind of cathartic moment which facilitated the rebuilding of lost connections and has helped form a post-war community that strives to support each other, including among nurses. Vietnam nurses are now part of an active commemorative culture, often supported by organisations such as the RAANC Association. In these settings nurses may feel more free to talk, and can safely speak a common language. While many nurses may continue to believe that their stories are not interesting for the rest of us, or that words cannot convey what they really need to say, this should not preclude us from listening. The experience and significance of war zone trauma continues to be a pressing issue for both nursing practice, and society at large.



## References

- Anderson, B. (1983). *Imagined communities: reflections on the origins and spread of nationalism*. London: Verso.
- Bale, J. (2014). *PTSD and Stigma in the Australian Army*. Army Research Paper No. 3. Canberra, ACT: Department of Defense.
- Bashford, A. (2004). *Imperial Hygiene: A Critical History of Colonialism, Nationalism and Public Health*. London: Palgrave Macmillan.
- Bassett, J. (1997). *Guns and Brooches: Australian Army Nursing from the Boer War to The Gulf War*. Melbourne: Oxford University Press.
- Biedermann, N. (2004). *Tears on my pillow: Australian nurses in Vietnam*. Sydney: Random House.
- Biedermann, N., Usher, K., Williams, A., & Hayes, B. (2001). The wartime experience of Australian Army nurses in Vietnam, 1967-1971. *Journal of Advanced Nursing*, 35(4), 543-549.
- Boschma, G. (2003). *The Rise of Mental Health Nursing: A History of Psychiatric Care in Dutch Asylums 1890-1920*. Amsterdam: Amsterdam University Press.
- Connerton, W. (2013). American nurses in colonial settings: Imperial power at the bedside. In P. D'Antonio, J. Fairman & J. Whelan (Eds.), *Routledge Handbook on the Global History of Nursing*. New York: Routledge.
- Cunningham Dax, E. (1989). The first 200 years of Australian psychiatry. *Australian and New Zealand Journal of Psychiatry*, 23, 103-110.
- D'Antonio, P. (2010). *American Nursing: A History of Knowledge, Authority, and the Meaning of Work*. Baltimore, Maryland: The Johns Hopkins University Press.
- D'Antonio, P., Baer, E., Rinker, S., & Lynaugh, J. (Eds.). (2007). *Nurse's Work: Issues Across Time and Place*. New York: Springer Publishing.
- Damousi, J. (2007). Australian medical intellectuals and the Great War. *Australian Journal of Politics and History*, 53(3), 436-450.
- Garton, S. (1988). *Medicine and Madness: A social history of insanity in NSW 1880-1940*. Kensington: UNSW Press.
- Garton, S. (1991). Places for the Unfortunate: Lunatic Asylums in NSW 1800-1940. *Journal of the Royal Australian Historical Society*, 76(4), 297-312.
- Garton, S. (2003). Asylum histories: Reconsidering Australia's lunatic past. In C. Coleborne & D. MacKinnon (Eds.), *Madness in Australia: Histories, heritage and asylum*. St Lucia: University of Queensland Press.

- Garton, S. (2008). 'Fit only for the scapheap': rebuilding returned soldier manhood in Australia after 1945. *Gender and History*, 20(1), 48-67.
- Grob, G. N. (1994). *The Mad Among Us: A History of the Care of America's Mentally Ill*. London, New York: The Free Press.
- Hallet, C. (2009). *Containing Trauma: Nursing Work in the First World War*. Manchester: Manchester University Press.
- Hallet, C. (2014). *Veiled warriors: Allied nurses of the First World War*. London: Oxford University Press.
- Harris, K. (2011). *More than bombs and bandages: Australian army nurses at work in World War I*. Sydney: ABC Press.
- Hemmings, L. (1996). Vietnam memories: Australian Army Nurses, the Vietnam War and oral history. *Nursing Inquiry*, 3, 138-145.
- Kearney, G., Creamer, M., Marshall, R., & Goynes, A. (2003). *Military stress and performance: the Australian Defence Force experience*. Carlton: Melbourne University Press.
- Lee, J. (2012). *War Girls: The First Aid Yeomanry in the First World War*. Manchester: Manchester University Press.
- McHugh, S. (2006). Minefields and miniskirts: the perils and pleasures of adapting oral history for the stage. *Oral History Association of Australia Journal*, 28, 22-29.
- Menninger, W. C. (1948). *Psychiatry in a troubled world: yesterday's war and today's challenge*. New York: Macmillan.
- Moxham, L., Robson, P., & Pegg, S. (2014). Mental health care in the Australian context. In P. LeMone, K. M. Burke, T. Dwyer, T. Levett-Jones, L. Moxham, K. Reid-Searle, K. Berry, K. Carille, M. Hales, N. Knox, Y. Luxford & D. Raymond (Eds.), *Medical-surgical nursing: critical thinking for person centred care (2nd Ed)* (pp. 1831-1853). Sydney: Pearson Education.
- Muir, K. (2009). 'Idiots, imbeciles and moral defectives': Military and government treatment of mentally ill service personnel and veterans. *Journal of Australian Studies*, 26(73), 41-47.
- NIH. (2009). PTSD: A growing epidemic. *NIH Medline Plus*, 4(1), 10-14. <http://www.nlm.nih.gov/medlineplus/magazine/issues/winter09/articles/winter09pg10-14.html>
- Norman, E. (1990). *Women at War: the story of fifty military nurses who served in Vietnam*. Philadelphia: University of Pennsylvania Press.

- Portelli, A. (2006). What makes oral history different? In R. Perks & A. Thomson (Eds.), *The Oral History Reader, 2nd Ed.* (pp. 32-42). London: Routledge.
- Raftery, J. (2003). *Marks of War: War neurosis and the legacy of Kokoda*. Adelaide: Lythrum Press.
- Reverby, S. (1987). *Ordered to Care: The dilemma of American nursing 1850-1945*. Cambridge: Cambridge University Press.
- Scannell-Desch, E., & Doherty, M. E. (2012). *Nurses in war: Voices from Iraq and Afghanistan*. NY: Springer.
- Shay, J. (2002). *Odysseus in America: Comat trauma and the trials of homecoming*. New York: Scribner.
- Strauss, A., & Corbin, J. (1990). *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*. Newbury Park CA: Sage Publications.
- Twomey, C. (2012). The National Service Scheme: Citizenship and the Tradition of Compulsory Military Service in 1960s Australia. *Australian Journal of Politics and History*, 58(1), 67-81.
- Vuic, K. D. (2010). *Officer, Nurse, Woman: The Army Nurse Corps in the Vietnam War*. Baltimore MD: Johns Hopkins University Press.
- Vuic, K. D. (2013). Wartime nursing and power. In P. D'Antonio, J. Fairman & J. Whelan (Eds.), *Routledge Handbook on the Global History of Nursing* (pp. 22-34). New York: Routledge.
- Wall, B. M., Edwards, N. E., & Porter, M., L. (2007). Textual analysis of retired nurses' oral histories. *Nursing Inquiry*, 14(4), 279-288.
- Ward, R. (1970). *The Australian Legend*. Melbourne: Oxford University Press.