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Experiences of vulnerability and uncertainty during the Iraq and Afghanistan wars: Stories of wounded service members and the nurses who cared for them

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ABSTRACT

Background: The findings reported in this paper were derived from a secondary analysis of selected data from a large clinical knowledge study designed to document the experiential learning of military and federal nurses caring for critically wounded service members (WSMs) of their experience of care from point of injury in the combat zone through their rehabilitation.

Findings: This article describes a picture of vulnerability and uncertainty in both WSMs and their nurses throughout the health care continuum. The concepts of vulnerability and uncertainty had distinct meanings for each group. In many cases, nurses who were deployed revealed a dual encounter with the vulnerability of war along with personal uncertainty about themselves and their patients.

Discussion: To support optimized health care of WSMs and the well-being of caregivers, health care professionals and policy makers must understand the effects and dynamics of serving in a warzone.

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And I didn't feel anything else but just thirst and a kind of a cool chill in my body. And at that moment, nobody was near me, and instead of calling out "medic," I started praying. Our squad leader one time told us, if we were gonna die, might as well get right with Jesus 'cause you never know when you're gonna go. So at that moment I started praying, and they heard me from a distance because I was 50 meters away from where we were walking, and it was high vegetation, high grass. So to find me, they had to have heard me. And my hearing felt like I was under water, like I was underneath the pool. I couldn't hear clearly. So I started hearing from a long distance my last name. But at that moment I started praying even harder, louder. And just remembered- I remembered my prayer. I looked up in the sky and I was convinced, I was to die, I asked God for forgiveness and to remember me and put my name in the book of life …. and I kept repeating that over and over and over until they finally approached me and started getting me here. Wounded service member.

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Introduction

Since 2001, more than 1.9 million U.S. military members have been deployed in 3 million tours of duty in Iraq and Afghanistan (Institute of Medicine [IOM] Committee, 2010). The number of active duty service men and women injured in combat continues to grow. Unlike previous wars having a distinct beginning and an end, *Operation Iraqi Freedom* (2001) and *Operation Enduring Freedom* (Afghanistan) (2003) constitute the longest sustained military encounter in recent memory (IOM Committee, 2010). After President Obama proclaimed in August 2010 that the American combat mission in Iraq had ended, a transitional force, *Operation New Dawn*, remained until mid-December 2011 (Fischer, 2014). Then, a new military operation initiated in Iraq and Syria was named, *Operation Inherent Resolve*. The authors of the IOM study (2010) noted a surprising fact: despite the length of the wars and multiple individual deployments, wounded service members' survivability rates were much higher than in past conflicts. They explained these findings by discussing enhanced equipment, protective armor, improved triage, and treatment at the time of injury and during transport. A highly developed transport-based health care system brought wounded service members to appropriate treatment facilities in very short timeframes, usually within 24 hours. These innovations enabled seriously injured active duty service members to survive critical injuries (Kelley, Kenny, Gordon, & Benner, 2015). Unlike those injured in Vietnam, where 86.5% of the injured came home; 90.4% of those injured in Iraq and Afghanistan returned to the United States for definitive care (Goldberg, 2014). Many returning service men and women experienced injuries that would likely have been fatal: brain traumas, blast injuries, hearing and vision losses, amputated limbs, and respiratory distress. There was also a large percentage of invisible injuries, including mild-to-moderate traumatic brain injury (mTBI) and a range of posttraumatic stress (PTS) syndromes (Benner, Halpern, Gordon, Popell, & Kelley, in press; Goldberg, 2014). These service members saw tanks and jeeps destroyed and their buddies killed. Others survived ambushes that killed members of their companies (Tanielian, Jaycox & RAND Corporation, 2008).

The affected population included the deployed nurses caring for the wounded service members (WSMs). The nurses, while caring for very injured patients, also came under attack. They dealt with trying to save others' lives, while protecting both the WSMs and themselves. All these individuals are wounded warriors, a term that best describes human conditions where injuries, even those that are not visible or immediately apparent, are deeper and more pervasive than is evident from first impressions on hospital wards and clinics, the workplace, or reviews of patients' medical records.

Background

The term "wounded warrior" describes members of the armed services who were willing to make the ultimate sacrifice to protect and defend the United States but have suffered visible and invisible injuries. It may be possible for wounded warriors to conceal their psychological and spiritual injuries for a period. However, when returning home to family and friends does not relieve their inner struggles, they may inflict violence on themselves and those whom they love or turn to self-medication with drugs or alcohol (Donley, 2013). A study by the RAND Corporation (Tanielian et al., 2008) reported that about 18.5% of Veterans of these wars experienced depression or PTS disorders (PTSDs); 19.5% had postdeployment brain injuries; and another 7% met criteria associated with mental health disorders. They also found that not only were these illnesses invisible, they often had delayed onsets and were under or inadequately treated. Service men and women with invisible injuries are at higher risk of suicide, are less productive at work, and have impaired relationships with others, especially spouses and children, because their injuries and symptoms affect their choices and judgments. Problems with access and quality of care present major obstacles for wounded warriors and their loved ones. It does not matter if barriers to care or treatment are perceived or actual; they prolong the suffering and vulnerability of wounded men and women (American Psychological & Association, 2007).

Many service men and women cannot find a way to talk about their war experiences or share their guilt, anger, disappointment, or shame. What they experienced does not make sense; their anguish is beyond language. They know that the families and communities that they left behind are different, but they are changed. Their pain is emotional and spiritual as well as physical. They are wounded. Sherman (2015) writes movingly of the moral injuries to the conscience of warriors who are tortured by their efforts to reconcile their sense of goodness, a good person or solder, with what they did and what they failed to do during the Iraq and Afghanistan wars. Tick (2013) describes soul wounds as the signature injury of the Iraq and Afghanistan wars. Noting that PTSD may be described as an illness or syndrome, persons with PTSD carry spiritual wounds that bring with them sadness and an inability to find safety and peace. Paquette (2012) observes that the modern military trains its military personnel for war; however, it is less adept in turning "trained killers" into will-adjusted service members after returning from the War zones or on discharge from the military.

This article presents an analysis of secondary data selected from a large clinical knowledge study. The primary study documented the experiential learning of military and federal nurses caring for critically WSMs from point of injury to their return home; it also described the narrative memories of WSMs'