Nursing Our Wounds

By ELIZABETH ANN SCARBOROUGH

You can't treat a wound you don't realize is there, but invisible wounds can hurt and kill as surely as physical ones. Just as the effects of poisons sometimes don't appear until the patient dies, psychological wounds can cause irreparable damage before they are discovered. Perhaps a nurse should be the first one to notice his or her own symptoms. But nurses are trained to be stoic, to focus on what is harming others rather than themselves.

Treating psychological wounds is complicated, even once they're identified, when those in charge of authorizing treatment deny the wounds' existence. "Post-traumatic stress disorder (PTSD)? That's not a thing!" the government declared for years, despite documentation to the contrary. "Agent Orange-caused cancers and other diseases? Gulf War Syndrome? Traumatic brain injuries (TBI)? Veterans are making these things up!"

Yet somehow people who go to war young, bright, outgoing and in great health may return without so much as a scratch but nevertheless are dull, sick, depressed, reclusive, isolated and old before their time. Nurses are neither immune nor impervious to this kind of damage.

During a mass casualty "push," when a helicopter delivered 20 or more wounded to our emergency room in Vietnam, a young man, the bandaged stumps of his missing limbs still bleeding, told me, "I was just sitting there, and I hear a 'boom' and ask my buddy, 'Did you hear that?' Only he's dead, and when I look down at my legs, they're not there anymore."

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More than once, a fresh casualty with mortal wounds would say to us, "Don't worry about me now. Take care of my friend. He's in a bad way."

They didn't yet know what hit them. Maybe it was the shock, the pain meds or the adrenaline rush, but they didn't understand that they were as badly injured as their comrades — or worse.

On the other hand, when I worked with military orthopedic patients in the States, before I was deployed, the amputees (probably wounded during the horrific Tet Offensive of 1968) were angry, bitter, hostile and, under it all, fearful as they had not been in battle and grieving for losses of a magnitude they were only starting to understand. Coming home, for them and for other veterans with less apparent wounds, was much harder than they had anticipated. The initial relief and gratitude to be alive became complicated when they returned to a country as unlike wartime reality as Disneyland is unlike everyday life. Blending in was still every bit as important to them as it was in high school, but they'd lost the knack. In a war frowned upon by much of the country, combat veterans, whether or not their wounds were visible, did not blend.

I found the differences impossible to explain to my parents, my former classmates in nursing school or high school, civilians with whom I had

been close. I wanted desperately to rejoin them but was unable to manage it.

JUST FORGET ABOUT IT

Even at my first duty station after returning from the war, I was advised, "Forget about Vietnam. You're not there anymore." I gathered that for those in authority, other staff members who were 'Nam veterans had been a problem.

In Vietnam, we were less concerned with petty rules and regulations and more concerned with keeping our patients and ourselves alive and out of danger. We were organized and able to complete routine work quickly, the "hurry up" part of the old military joke about "hurry up and wait."

What we were always waiting for, no matter if it came sooner or later, was for the 15 minutes of sheer horror that followed the months of monotony. Some part of us was always ready to drop everything and run to the ER to cut off clothing, wash away blood, locate wounds, slap on dressings, start IVs, give medications and whatever else was required to stabilize patients, or to work shift after shift in the operating room, patching the wounded back together.

But we weren't supposed to talk about that. In addition to the cognitive dissonance between Stateside and wartime reality, as well as the patient confidentiality restriction, we all had signed papers for security clearances, so most of what we had done in 'Nam was probably classified. It did not make for congenial conversation.

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When I decided to write this article and wanted to include nurses from the Gulf Wars, I was frustrated to be unable to find much written by or about them, even on the Internet. But looking back on my first 20 years after 'Nam, I see it is perfectly reasonable that those nurses' stories are almost impossible to find. It's probably too soon.

After all, other than a few little anecdotes I could tell friends, I just didn't talk about Vietnam. Up until around 1985, the whole experience receded into a big black hole in the middle of my life that I carefully walled off with more ordinary, superficial concerns. I left nursing in 1980 and started writing amusing fantasy novels. I wrote seven of them for Bantam Books, and then one day I told my editor one of my Vietnam anecdotes, and he insisted I write a book about that.

Searching for ways to understand that part of my life, I became friends with a Vietnam veterans' counselor, John Swan, who got me involved with a combat rap group. Up until then I hesitated even to call myself a veteran, much less a combat veteran. The guys in the group set me straight.

"I'd rather have spent my whole year in the field than be in that hospital one day," one of them told me. I didn't understand. He had already talked about fire fights and tripwires and had returned home only after being wounded.

He explained, "Only the one time did I see anybody get wounded. You saw all the wounds of everybody who survived."

RECOGNIZING FEELINGS

When General [William] Westmoreland's book about the war was published in 1975, I figured my security clearance was no longer an issue. And when Lynda Van Devanter, who, like me, had been an Army nurse in Vietnam, detailed her discovery of her own post-traumatic stress disorder in the book *Home Before Morning*, I recognized the feelings, although in many respects Lynda's experience sounded much more intense than mine had been. She told of having trouble relating to the profession she used to love, depression, problems with substance abuse and difficulty in her relationships.

Although my responses were somewhat different, I shared many of her problems. I remember feeling confused and disoriented a lot, without being sure why. I was detached from everything except misery and a sense of failure and inadequacy at odds with my past, being from a loving family, a supportive nursing school where I felt close to the other students and was second in my class rank. I had three car accidents in two months and wasn't aware of how irregular that was until USAA, an insurance company originally formed to serve military officers, wrote me a very kind letter pointing it out.

Later, when I said I didn't want to write about Vietnam because everyone was sick of hearing me talk about it, a very close friend I'd known for several years said, "until just now, I didn't know you'd

even been there. You never talk about it."

In the press, a veteran with PTSD was always a man having flashbacks causing him to lash out violently. I'd seen this in the hospital in 'Nam during the war. A patient would jump out of bed and start shouting and trying to hit people with his pillow, because nothing more lethal was handy. In other stories, vets shot random strangers, as well as friends and family, convinced they were once more "in-country" and under attack.

These days, with women taking part in actual combat, the same stories could be told about them. Another change: modern military nursing experience applies to men as well as women, because many more men have gone into nursing.

SCREENING FOR SYMPTOMS

Regardless of gender, PTSD in nurses is different because the mission and the job are different, but many of the more insidious symptoms are the same as those of men who were in combat. Here are some of the kinds of questions that the Department of Veterans Affairs uses to screen for the disorder:

Have you experienced or witnessed a life-threatening event that caused intense fear, helplessness, or horror, and do you re-experience the event by repeated, distressing memories or dreams, have intense physical or emotional distress when you're exposed to things that remind you of the event?

Do reminders of the event affect you so that you avoid thoughts, feelings or conversations about it or avoid activities, places or people who remind you of it? Do you blank on important parts of it? Do you feel detached from other people? Is your range of emotions restricted, and do you feel that your expectations for your future have shrunk? Are you troubled by problems sleeping, irritability or outbursts of anger, problems concentrating, feeling "on guard" and having an exaggerated startle response (both part of a condition known as "hyper-vigilance")?

According to the VA, symptoms also include: *experiencing changes in sleeping or eating habits and more days than not feeling sad or depressed, disinterested in life, and worthless or guilty. Use of drugs or alcohol, possibly resulting in failure to meet responsibilities with work, school or family, driving under the influence, getting arrested or causing problems for yourself and loved ones.*

In other words, it is a much more pernicious condition than we have been led to believe, and it also affects nonmilitary survivors of trauma such as domestic violence or first responders.

A NURSE'S NIGHTMARE

My nightmares about Vietnam weren't about being in combat. In my worst dreams, I walk alone into an endless ward filled with wounded, and I haven't a clue what to do for them.

Nurses are considered noncombatants. They are trained to use weapons, but are not issued any. According to the Geneva Convention, a nurse who is captured should either be returned to his or her side, or employed by the enemy in a nursing job. (In guerilla wars like 'Nam, the opposition is not particularly concerned about the Geneva Convention.) Nurses traditionally experience actual combat secondhand through treating the wounds of their patients. A nurse's enemy is the injury or illness harming her patient, whether in a war zone or at home.

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Although I had satisfaction in what I was able to do for my patients, I still feel deep sadness and guilt that I often failed them. One of the hardest things for medical people in a combat situation is that they are the contrary little cogs pushing back to spare a little life in the midst of a big, destructive, steamroller of death.

There is a saying that there are no atheists on the battlefield. A drill instructor during my officer basic training course at Fort Sam Houston in Texas put it more graphically. In his command voice, he barked, "When you get to Vietnam, you will need a god. I do not care if it is Jesus, Yahweh, Buddha, Allah, or even Money. You must have a god. If you do not have a god, go to the quartermaster and he will issue you a god."

It amused me at the time, but many statistics show that soldiers who had something or someone to believe in fared better both in-country and on their return home. With soldiers in the field, faring better could mean surviving enemy attack

or having something to hang onto if life as they knew it was destroyed by a catastrophic injury. For nurses, I think it meant hanging on to the guiding principles, not only of church and Sunday school, if that was part of our upbringing, but also those from nursing school. For instance, Bethany Hospital School of Nursing taught that a "sick patient is a sick patient is a sick patient," and we were to care for anyone regardless of race, color, religion or creed. In Vietnam, this meant giving equally good care to American GI's and Vietnamese patients, even prisoners of war.

In some situations, having a firm grasp on your guiding principles and faith that you are adhering to them is obviously easier than in others. A new Internet friend of mine served in 'Nam at the same time I did. She was an operating room nurse, under the enormous stress of caring for gravely injured casualties, sometimes for days on end without rest. She told me she did not have post-traumatic stress disorder, which amazed me, because I felt that these nurses and the ER nurses would have more severe cases of PTSD than any of us.

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She told me that to her, the operating room felt more like a repair shop. She did not know her patients beforehand or much about them afterwards. She helped repair the damage but did not usually participate in the healing process. Her own emotional life was not bound up in theirs.

Working on the wards, it was different. Oddly enough, where I worked, my personal investment was more with the civilian casualties than with wounded GIs. The GI casualties were flown in by helicopters and, after a day or two, because of the toxic environment in wartime Vietnam, they generally were flown to a hospital out of country for further treatment and, eventually, back to the States. Very few were returned to duty. I didn't get to know them.

Civilian patients, on the other hand, had nowhere to go. Neither do Iraqis nor Afghan patients as the long, guerilla-fought wars in their countries grind down the infrastructure. In Vietnam, we nurses often were warned by our Vietnamese patients, whose safety depended on ours, if a rocket attack was planned for that night or if one of the other patients was actually a Viet Cong guerilla. In government operations that involved "winning the hearts and minds of the people," we were doing the most effective work, providing real help for real needs and being given real intelligence that would allow us to continue our work with our patients.

Nurses in the current conflicts also work with indigenous patients. I wonder if, as the current deployment yo-yos between in-country and out, they have an opportunity to follow up on previous patients or contacts when they are redeployed. Do their therapeutic relationships continue; do the friendships continue when and if they see the same patients again? If they do, maybe that's good news, because it means the patient has survived, but it may also mean they have been re-injured.

INJURIES AND PRESUMPTIVE CONDITIONS

As with PTSD, the existence of Agent Orange toxicity went unacknowledged until long after the Vietnam War. These days the VA has a registry for it, and everyone who was "boots on ground" in Vietnam (as opposed to those who were "veterans of the Vietnam era," and many Navy personnel at sea off the coast of Vietnam) may have been exposed. If these veterans manifest certain conditions known as "presumptives," the conditions are supposed to be attributable to Agent Orange exposure. As such, they are compensable with benefits from the VA.

Presumptive conditions include Parkinson's disease, ischemic heart disease and multiple kinds of cancers, including prostate cancer — but no cancers specifically affecting female reproductive organs. (For a complete list, search VA.gov under "Agent Orange Presumptives.") Also, Agent Orange reportedly breaks chromosomes. If men father children who have some birth anomalies, it is considered a compensable condition. The same does not apply to female veterans who bear children with those anomalies.

Veterans of the conflicts in Iraq and Afghanistan may have contracted some of the diseases that are presumptives of Gulf War Syndrome. The criteria for these is more complicated, but those who have been exposed to the chemical agents used in these zones and the burning oil wells, etc., should register with the list at their VA facility and

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be aware of what conditions are associated with service in those areas. Nurses are just as vulnerable to these diseases as other veterans.

Even people not in combat roles may be subject to traumatic brain injuries from explosions or arthritic conditions caused by too-heavy, ill-fitting body armor. Traumatic brain injuries are difficult to differentiate from PTSD sometimes and can be misdiagnosed. One of my friends, a returning female vet who was a gung-ho "lifer" (career soldier) before her deployment, wrote interesting emails about her career with the military postal service. She now is 100 percent disabled from TBI. On her return, she was confused and uncommunicative for a long time until she acquired her little service dog who accompanies her everywhere, calling her back to the world when she enters a TBI-caused fugue state.

Another problem for nurses and other female personnel (as well as some males) is military sexual trauma. Military nurses are officers, and in Vietnam, our rank afforded us a modicum of protection. Still, sexual harassment was commonplace, and I knew of some nurses who were raped. We were all aware that some of the men wished to believe we were actually there as prostitutes rather than as nurses.

Some women in the Gulf Wars, who often were side-by-side with the men in combat, have had worse wounds inflicted upon them by their comrades than the ones they faced from the enemy. This is a huge problem that seems to grow worse as time goes on, and it is impossible to cover in the scope of this article, closely related though it may be.

Nursing is a paramilitary profession that gained prominence under Florence Nightingale, who would have made an excellent general. She set the bar high, not by wafting around with a lamp but by being strong and tough, a model that remains a necessary part of the makeup of a nurse, especially a combat nurse. Well before going near a war, nurses become accustomed to death and the dying process, unlike many soldiers who go into battle right out of high school.

INJURED BECAUSE THEY CARE

But like Nightingale did before them, combat nurses get injured precisely because they do care, under circumstances that would be easier to bear if they could look at injured people as "personnel," "collateral damage," "necessary losses" or even "casualties." Because their pain results from trying to absorb and treat the pain of others, they may fail to realize when that pain has become their own.

Combat nurses are injured because they are in a war, which is unhealthy for all concerned. The first step to treating their injuries and illnesses, both physical and psychological, is to recognize the symptoms and seek appropriate treatment. Not every treatment mode is going to be appropriate for all cases, but there are a wide variety available. Just being aware that there's a problem, and drawing attention to it is half the battle.

- For information about PTSD, treatment and research, the VA's National Center for PTSD website is a place to start. The site map explains what is available: www.ptsd.va.gov/about/about-website/site-map.asp.
- If you think you might have PTSD, this checklist can help you record symptoms and organize your thoughts in order to talk with a doctor, counselor or other professional about treatment. www.ptsd.va.gov/public/assessment/trauma-symptom-checklist.asp.
- If you need help arranging for VA assessment for PTSD or filing a claim for treatment, your nearest service officer (Disabled American Veterans, Veterans of Foreign Wars, American Legion and other organizations have them to assist veterans in obtaining their benefits) can help you navigate the paperwork. VA hospitals also have patient advocates to assist patients who run into conflicts. If these resources fail, write to your congressman.

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