Trauma of Military Nurses

Charlotte Chang

Introduction

On the wall of the Vietnam Veterans Memorial in Washington D.C., eight of the 58,000 names of those who sacrificed their lives in Vietnam are female, all of whom had fallen as part of the Army Nurse Corps. The stories of nurses are part of the few and easily forgotten amongst the hundreds of thousands that exist from The Vietnam War. War time experiences and post-war experiences of American military nurses in war zones have traditionally been a neglected subject of Post Traumatic Stress Disorder (PTSD) research. In part, the small ratio of females to males serving in the military has resulted in an extremely small sample size for research, and also has made research funding difficult for a demographic of soldiers that seems comparatively insignificant. Females were unable to serve in combat zones until the Korean War, where 500 nurses served as Army and Navy nurses in combat areas. By the Vietnam War, a significant population of over 7,000 female nurses served in combat zones, finally warranting studies of PTSD occurring among nursing and medical personnel veterans. Arguably, military nurses are prone to suffer from PTSD due to their unique experience and role both as nursing professionals and roles in a majority female military corp. However, diagnosis of PTSD is often dependent on the understanding and definition of PTSD relative to its time period. Thus, this paper is divided into three main sections. The first begins with an overview of DSM's evolution in the understanding of PTSD in relation to military nursing, depicting how initial diagnoses and notions of PTSD resulted in minimal diagnoses of PTSD in nurses in the immediate years following Vietnam. The second part introduces various qualitative post-war studies regarding Vietnam nurse experiences, which were supplemented by first hand memories from nurse veterans to demonstrate the potential, risk, and relevance of PTSD in this particular population. The final section utilizes previous discussions of Vietnam era nurses as a foundation for comparison to 21st century understanding of PTSD and prospective diagnosis in modern military nurses in Afghanistan.

Relationship Between Military Nurses and PTSD

Studies on the relationship between Vietnam nurses and PTSD began in the 1980s, and have spanned research studies and theses over the past three decades. These studies indicate that the evolution in understanding of PTSD has affected the prevalence of PTSD diagnosis to military nurse veterans. Different studies conducted during different historical time periods have shown varying degrees of correlation of PTSD in veteran nurses from Vietnam. A study conducted in the early 1980s by the Department of Military Psychiatry and Walter Reed Army Institute of Research determined that PTSD diagnosis rates for Vietnam veteran nurses was 3.3%, while estimating that the rate of PTSD in civilian Vietnam veterans was somewhere between 18-53%.[1] In this study, PTSD was assessed through past and current difficulties in dealing with Vietnam memories, sleep disturbances, expressing feelings and emotions to others, emotional numbness, concentration,

and dealing with feelings of guilt. This criteria prevented nurses from fulfilling all the standards of PTSD populations. The Department of Military Psychiatry attributed the low PTSD diagnosis rates in veteran nurses in comparison to veterans of other branches to the higher prevalence of social support for nurse veterans during times of warfare. Another interpretation made by military psychologists was that Vietnam nurses experienced less direct danger and exposure to violence, resulting in lower levels of stress reactions leading to PTSD among nurses. Various primary interviews with nurses, however, both confirmed and contradicted these study findings. A significant number of nurses recounted high levels of positive social support while in Vietnam both at their base and in their healthcare teams. While direct exposure to violence was less common to nurses, indirect exposure to violent and destructive aftermath of combat was common. Indirect exposure was an important factor in the development of shell shock in war zones, a characteristic that was often noted among medics in World War II. Despite this existing evidence from WWII, it is interesting to note that the Department of Psychiatry thought that even the 3.3% diagnosis rate was an overestimation of the real proportion of nurses affected with PTSD, noting a lack of resources and the small sample size as confounding variables; had there been a sufficient sample size, they believed that the real proportion would be close to 0.85%.[2]

This study leads readers to focus on how the diagnosis of PTSD was based upon 1980 DSM-III Post Traumatic Stress Disorder criteria. Among the checklist of diagnostic criteria, the first publication of PTSD specifically required the individual to have experienced an event that was outside the range of usual human experience, and to have demonstrated at least three characteristics associated with numbed general responsiveness. As many nurses worked at mobile Army surgical hospitals (MASH) and not on the front lines of fire, few nurses in immediate post-Vietnam studies qualified as experiencing an event outside the range of usual human experience. Their experiences were indirectly associated to the horrors faced by the soldiers, thus not fulfilling DSM-III's criteria[3]; in contrast, these indirect experiences would qualify as a source of PTSD in today's DSM-V's understanding of PTSD. Additionally, few nurses grew unresponsive to their occupational duties, one of the necessary diagnostic criteria for PTSD, particularly due to the military capacity of their job. In a story recounted from Lorraine Boudreau, she expressed feeling increasingly depressed over the course of her tour, finally approaching the chief nurse in a desperate crying request for a different assignment or to be sent home. The colonel replied, "We'll have none of that, Captain. No, you will not be reassigned. You were specifically chosen for this particular position."[4] Thus, she could not and was not allowed to, even if she did have PTSD, demonstrate any signs of her symptoms, especially in her role as a military nurse. In fact, many nurses in Vietnam coped with their trauma and depression by suppressing emotional expression, and working even harder by serving more patients, by means of detaching themselves from the patients at hand. In this sense, obvious and outward expression of PTSD was uncommon, and that in itself made the diagnosis of PTSD by the DSM-III standard very difficult and challenging.

Contrary to the previous study, a second qualitative study conducted in 1994 found that PTSD was highly prevalent among veteran nurses, serving as additional evidence that PTSD diagnosis is relatively frequent.[5] Although a quantitative analysis of Vietnam-era nurses was statistically insignificant because of the small sample size studied,

many qualitative indicators of PTSD were acknowledged. Nurses in Vietnam showed frequent and recurring nightmares, as well as alcohol problems and ineffective coping mechanisms. Feelings of responsibility for the death of another, denial of emotions, inadequate preparation for Vietnam, and sexual harassment all contributed as factors to the development of PTSD symptoms. Due to lack of preparation for Vietnam and the close degree of relationships between nurses and casualties, the study determined that nurses had a high likelihood of developing PTSD. By the last decade of the 20th century, Vietnam-era nurses were acknowledged as a population with potentially high risk for PTSD, as the DSM-IV criteria was now applicable to the "trauma" experienced by these nurses. Nurses experienced the two specifications that defined stressful and traumatic events: they were exposed to "serious injury or threat to the physical integrity of others" and their "response involved intense helplessness or horror."[6] Thus, the same experience of nurses in Vietnam that previously did not qualify as PTSD now does, as the definition of PTSD evolved over the course of two decades.

Traumatic Experiences Specific to Vietnam War Military Nurses

Due to the ethical roles and responsibilities of nurses, the stressors they faced in military combat care were highly unique and individual to their occupation and background. Nurses spoke of how they were trained for holistic and compassionate care in nursing school, an aspect of care they felt like they could not perform in war time situations due to constrictions of military protocol, purpose, time, personnel, and equipment. Nurses recounted tales of how they received flak for their actions and were punished or denied promotions if they did not follow Standard Operating Procedures (SOPs) of the military doctrine.[7] One woman recounted the story of two Vietnamese twin infants who had passed away during a Viet Cong attack. Rather than placing each on its own stretcher, she placed the two together, believing that this arrangement would be preferred by the parents. She was then negatively counseled and reprimanded for this decision. Other nurses spoke of how the emergency nature of many medical situations meant that emotions would often obstruct their ability to critically think and follow SOPs. Jacqueline Navarra Rhoads, a nurse veteran, remembered how she could not ignore pain and how it became her ultimate focus, not only for the patient, but also to relieve her own agony. "We always worried about pain, alleviating pain. We'd do anything to alleviate pain."[8] Nurses spoke of how their immediate goals and desires to end suffering often countered SOPs and their duty as military health care professionals. Nurses also noted that they were indoctrinated in school that caring and compassion was the foundation of nursing. Thus, additional stress and pressure was put on themselves to take on roles beyond their professional roles as nurses, especially with such severely injured and young demographic of patients. As a consequence, nurses adopted new roles in Vietnam, representing "their girlfriends, their wives, their mothers."[9] This responsibility for the soldiers' holistic state contrasted further intensified feelings of helplessness that nurses felt throughout Vietnam.

War resulted in conflicts of values, an additional psychological stressor for nurses. Karen Bush was a nurse completing her Psychiatric doctorate degree when she signed to volunteer in Vietnam after her graduation. She had joined for adventure, but quickly realized that caring for this young, vulnerable population was much more demanding than she had anticipated.[10] There were young men who had come into the psychiatric ward on their

own, who merely pretended to be crazy because they were scared of war and losing their lives. Like Rivers in Regeneration, Bush acted upon her duty to the military, sending these men back to war and reprimanding their cowardice, yet also questioned the ethics of sending an unwilling boy to a potential death. Similarly, nurses felt conflicted on the dilemma of sending physically recovered soldiers back to battle, a conflict that manifested in personal guilt and shame. Additionally, many nurses questioned the morality of saving patients with multiple amputations, brain damage, or quadriplegia, believing that quality of life would be so significantly decreased that life may no longer be worth living. One unnamed nurse spoke of repeated nightmares where a young man she once saved cursed her for leaving him with such an unrecoverable, debilitating handicap as a spinal cord injury.[11] Other nurses suffered moral dilemmas of placing injured soldiers into the 'expectant' section of a hospital, a section for those deemed likely to die. Multiple nurses spoke of the extreme guilt they felt after placing individuals in the 'expectant' category, yet how it was necessary for them to utilize resources on those with a higher likelihood of survival.[12] Soldiers were not called patients because SOPs indicated that they were to be called casualties, creating a falsified distance between the nurse and the patient as an attempt to reduce nurses' guilt.

Nurses in Vietnam were further stressed by suffering from conflicts of interests between their roles as nurses and hatred for the enemy. Lorraine Boudreau, a lieutenant appointed to take over a ward of Viet Cong POWs, found it difficult to place nursing ethics over her personal hatred and disgust. Other subordinates below her would improperly care for Viet Cong patients, kicking them in the process of care. As the supervisor, she would have to reprimand these nurses and ensure proper care to the Viet Cong patients, despite despising them herself. Maintenance of moral and professional principles became even more difficult as war wore on, taking the lives of more and more young men.[13] Bourdreau spoke of her feelings of shame and self-condemnation in taking care of the enemy who were murdering American soldiers and suffered recurring nightmares of enraged, dead American soldiers.

One of the most common stressors recounted by nurses was the physical and emotional exhaustion, and the lack of recovery time between traumatic events. In a qualitative study of interviews collected from a sample of 24 women who served as nurses in Vietnam, cluster themes were formed by coding overall commonalities in these interviews.[14] Most of the nurses in Vietnam volunteered for duty, and recounted being the only female in their 'hooches,' or improvised shelter. These nurses worked 12 hour shifts for 5 days a week, describing the patient load as "heavy and exhausting," with nurse to patient ratios averaging 1:18. Nurses described themselves as a machine that "worked, slept, and went back to work." Besides mere moral and ethical exhaustion, many of the medical and physical aspects of working as a medical personnel in Vietnam was traumatic in itself. Nurses recounted how it was the first time many of them had handled injuries borne from parasitic diseases, malaria, and the plague, which were nonexistent in the United States. One nurse spoke of a particularly horrifying memory of inserting a nasogastric tube to a patient, and watching an intestinal worm slither out of the patient's nose. One of the memories that united almost all the nurses was what they called the "smells of Vietnam."[15] These "smells" consisted of blood, burning flesh, pseudomonas-infected tissue, and burning human waste. Another nurse recounted her contrasting memories of Vietnam: witnessing a beauti-

ful countryside, and standing ankle-deep in blood while accompanying bodies to "grave registration."[16] Traumatic memories could often be triggered by sounds or environments; one nurse veteran expressed how the whirr of a helicopter could trigger overwhelming panic attacks of past memories of bloodied patients. Yet, these memories became so firmly rooted in the process of self-identification that these nurses refused to let go of these recollections, despite the trauma they caused.

The rigor and trauma of Vietnam necessitated emotional coping mechanisms, resulting in what nurses called the "play hard, work hard" lifestyle. The social atmosphere in the military camps was intensely filled with parties and USO shows. Alcohol, drugs, parties, and sex were rampant among nurses, and they were necessary for stress management in the disheartening war environment.[17] Demoralizing was one of many coping mechanisms for the constant stressors that they faced in Vietnam, which manifested as a concept they called "compassion fatigue." The more involved and immersed nurses were within the war effort, the more detached nurses would become in order to cope with stress on shift. They would stop talking or looking directly at patients, and obsess over nursing tasks and duties until the shift ended. "You are supposed to be caring and healing the sick, yet you are helpless in the eyes of a soldier whose head is blown off or a patient that dies from malaria."[18] This guilt was so overwhelming that nurses recounted trying to depersonalize their patients and became increasing workaholics over the course of their duty. Karen Bush had been trained to talk and question patients in a psychotherapeutic manner in her doctorate program. But in Vietnam, she had to place these ethical considerations aside in light of more pressing limitations of time, where she would immediately medicate the patient without question.[19] Overtime, the suppression of guilt became routine and habitual, and she no longer questioned herself in the process of this immediate medication, another example of nurses' suppression of feelings. Nurses spoke of how it was psychologically necessary to believe that everyone who left the hospital actually lived, or they would risk losing all hope in continued work in Vietnam.

During the Vietnam War, there were few immediate psychiatric services available for soldiers, and even less for medical personnel. Nurses were not seen as a population who had experienced "real enough" trauma to culminate in physical and psychological symptoms. An unnamed nurse described her difficulty in seeking counseling from an Army psychiatrist, despite her symptoms of extreme depression, hopelessness, alcoholism, and detachment from work and comrades. The Army psychiatrists who met with her said that they did not have time for her as they had too many patients of a higher priority. She then booked herself with a non-military affiliated psychiatrist by paying out of pocket, yet found that many of these psychiatrists were Freudian-oriented and wanted to look back at childhood memories. This specific nurse felt more frustrated, believing that these Freudian methods were inconsistent and entirely unhelpful in assisting her with psychiatric problems that arose directly out of the war.[20]

The threat of death was also a constant source of stress. In a series of letter entries to his family by Lt. Odom, a nurse who was in Vietnam from November 1967 to August 1968 speaks of multiple close incidents to death. There is a very real fear, that in the case of an attack to their MASH or medical facility, the nurses would be of more use to physically fight to protect patients than to be caring for the patients themselves. In one particularly dismal letter,

he speaks of a night when all the nurses collected together after a shift and spoke of how they "would react if we had to fight and how we felt about death," only to realize that he "might have to."[21]

Military nurses also faced unique stressors when coming back to civilian life and work as consequence of their war experiences. The lack of medical personnel in the military during Vietnam meant that nurses often worked independently, supervised large numbers of people in over-packed wards and hospitals, and performed duties above their scope of practice. Upon return to the U.S., nurses who had served in Vietnam were often scolded for acting like a 'mini-doctor' and not 'being in their place.' In combat zones, actions such as putting in tracheostomies and chest tubes were all permitted, yet in the States they were considered duties beyond their legal scope of practice. Some military nurses became feminists after the war, as they felt pride in their accomplishments and were angered by the lack of responsibility they were allotted post-Vietnam.[22] Nurses also felt a lack of camaraderie and teamwork in civilian hospitals, especially because they viewed the hierarchy and nurse-doctor feuds as hindrances to their ability to provide care. Back in the States, "my main job was to get coffee" and "you weren't allowed to do anything… Your judgment wasn't trusted, you didn't have any smarts."[23] This transition to State-side nursing was difficult. Many missed the excitement and challenge of Vietnam, while others felt underutilized, devalued, and under appreciated in peacetime nursing. In retrospective studies of Vietnam-era military nurses, nurses averaged over 17 years in active duty, as many opted to return to the military and serve time post-Vietnam. Vietnam-era military nurses are also highly educated, with 53% of Vietnam Army nurse veterans holding a Masters degree.[24] This has been attributed to an ambition to work harder in order to prove that they were capable, a drive that they credited to working as a nurse in the army.

The camaraderie and teamwork was professionally satisfying and completely unique in Vietnam. Nurses spoke of intense bonding and closeness with patients similar to that of the 'philia' described in "War of Nerves." Nurses experienced a closeness greater than 'brotherly love,' as their occupation necessitated them to be closer than comrades, closer than family, in order for them to fulfill their duty and profession. Veteran nurses strongly identified themselves with the military. They were unable to explain their experiences to their friends at home or the other nurses in civilian hospitals, who often dismissed their experiences in Vietnam. Shirley Menard recalled how the other nurses did not understand that the stress of a mere five patients admitted in one night in a city hospital was very different from having 100 patients delivered at once in a war zone with limited supplies. They were angered that no one seemed to be "proud of the soldiers and nurses and doctors there."[25] Many nurses also felt a sense of guilt about going home when so many others had to stay. Feelings about the war tended to be favorable before nurses were deployed, and support for the war generally increased during and after their service.[26] While many did question the intent, there is only record of one nurse who became fully disenchanted by war, while all others recounted becoming more supportive. Despite the horror, stressors, and aftereffects of war, nurses were generally proud of their military experience. Regardless, there is strong evidence from a variety of sources that military nurses exposed to war stress have the potential for mental health problems related to their experience, due to their consistent exposure to severe combat casualties, self-blame, death, workload extremes, personal

deprivation, loss, and danger.

Post Traumatic Stress Disorder in 21st Century Military Nursing

It has only been a little over a decade since the start of the War in Afghanistan, yet extended studies on the lived experiences of U.S. military nurses have already been published. These accounts have been similar to the lived experiences of nurses in Vietnam. For example, caring for the enemy and POWs remains as difficult an ethical decision for nurses in the 21st century as it was in Vietnam. A nurse reported having a severely injured U.S. soldier in one bed and an Iraqi insurgent on the next to him.[27] Both were on different ends of the same firefight, yet due to her ethical duties as a nurse, she had to care for both with equal detail and compassion. Like Vietnam, the blood and gore could be too much for the nurses to handle. One nurse recounted how she and her comrades would attempt to "wiggle my way out of ER" because of the traumatic memories that resulted from the large amount of shocking trauma they had to see. An army reservist nurse recalled a memory where she arrived on scene to a soldier as young as her son inside a blown up Humvee, and watched him panic stricken, look down at where his legs used to be and scream "Oh my God, I don't have any legs."[28] She had to take a few steps away, vomit , and immediately return to the scene to care for him. This nurse had to suppress her maternal feelings and detach herself from reality in order to take care of immediate duties, a suppression reminiscent of that of Vietnam-era nurses.

However, there are also distinct stressors in Afghanistan that did not exist in Vietnam. America's war in Afghanistan has resulted in extended and lengthy interactions with the local population, resulting in many medical interactions with local civilians. While communication through language and interpreters has improved, cultural barriers have remained a huge stressor for military nurses. Nurses recounted how Afghan nationals expected the American medical personnel, with their greater technology and services, to be capable of solving any medical issues. Thus, nurses felt escalated guilt and frustration when an individual passed away, as their personal feelings of guilt and responsibility were exacerbated by blame and accusations by Afghani families.[29]

While there has only been one published study on the correlation of PTSD and military nurses in the War in Afghanistan, experiences from the Vietnam War can serve as both a predictor and basis for understanding future PTSD diagnosis in military nurses. In 2013, the American Psychiatric Association published an updated understanding of PTSD in DSM-V. The criteria for the origin of stress, or 'stressor' in DSM-V now encompasses an even more vast selection of events than those illustrated by DSM-IV; new criterion may potentially increase the number of diagnoses in military nurses. For example, "Repeated or extreme indirect exposure to aversive details of the event, usually in the course of professional duties" now constitutes a potential stressor and fulfills the criteria for PTSD.[30] In contrast, the criteria in DSM-III for a 'stressor' was limited solely to an individual who had "experienced an event that is outside the range of human experience and that would be markedly be distressing to almost anyone."[31]

Alternatively, it may be suggested that SOP improvements in the War in Afghanistan have decreased the presence of risk factors for PTSD development. Nurses reported better and more adequate training in Basic Officer Leadership Course (BOLC) for potential stressful situations before

deployment, whereas nurses in the Vietnam War reported that they were flown out within 15 days of volunteering for the military.[32] Many nurses who served in the Vietnam War volunteered out of a nationalistic sense of pride or duty that may have contributed to idealistic naivety about War. In contrast, the 21st century military nurse corps consisted of nurses who were already either in active duty or activated from the reserves. Despite increased preparation and maturity, nurses still felt that they were in "harm's way more than I bargained for" in Afghanistan. Now that the combat operations in the War in Afghanistan have officially ended, perhaps retrospective studies on active duty nurses can be completed, and a modern day conception of military nurse diagnoses and risk factors of PTSD can be evaluated.

Conclusion

Military nurses have only become a recent focus in the past half century, with studies expanding simultaneously with the developing understanding of PTSD. This is seen in the rapid evolution of the prevalence of PTSD diagnosis and risk factors in military nurses. Military nurses are an easily overlooked population with enormous potential for PTSD due to their distinct experience and role as a nursing professional in highly stressful combat situations. As the military continues to expand and fight in future wars, proactive approaches in the prevention, identification, and treatment of PTSD in nurses must be developed. Proper training before responding to traumatic events on field, as well as conducting debriefings after intensive combat care and mass casualty incidents are steps towards proper coping mechanisms for these military nurses. The Army Nurse Corps is the backbone of any military unit. Thus, the military must adapt to view nurses as individuals with potential military service related PTSD and develop nursing specific PTSD treatments and strategies. Only then, can the Nurse Corps remain strong and resilient in performing their ultimate duty of care for those who protect this nation.

ENDNOTES

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