Care of "Enemy Combatants" in the Wars in Iraq and Afghanistan: Meeting an Involuntary Ethical Demand

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Abstract

Using Interpretive Phenomenology, coded excerpts of interviews relating to care of Iraq and Afghan prisoners of war (enemy combatants), and civilians were examined. Nurse participants expressed anger and conflicted feelings about caring for enemy combatants who had inflicted harm on U.S. and Allied troops. Key factors contributing to the care of enemy combatants and Iraqi and Afghan civilians included the following: changes in the military transport system that required nurses to care primarily for enemy combatants and civilians rather than U.S. and Allied forces; shifting military interpretations on the definition of prisoners of war (POWs); working with patients experiencing extreme psychological trauma; and providing care across distinct cultural differences regarding gender and health. Nurses drew on the following moral sources: 1) their foundation as a nurse to alleviate suffering; 2) the Geneva Conventions; 3) respect for equal, fair treatment of the enemy; and 4) past experiences of caregiving. Forgiveness and compassion, ideals invoked in some theories of social reconciliation, were not discussed by the nurses as major moral sources.

Keywords: care of enemy combatants and civilians, moral sources in caring for the enemy, military transport, Geneva Conventions

Introduction

In war, nurses on all sides in the conflict are expected to care for the wounded "enemies," (their term, used throughout) as stated in the Geneva Conventions since 1949. However, this standard became particularly complicated during the wars in Iraq and Afghanistan, creating unprecedented demands on nurses. The authors provide a qualitative analysis of the first-hand experiences of a sample of nurses who commented on their experiences, juxtaposing the logistical, psychological, and cultural challenges they faced with the persistent moral and ethical struggles to care for the enemy as human beings in need while fulfilling caring practices deeply ingrained in their nursing practices. Nurses' narratives expressed felt ethical demands to provide care for the enemy rather than seek revenge or condone mistreatment of the enemy.

The wars in Afghanistan and Iraq raised novel, complex demands for caring for wounded enemies and civilians due to dramatic military logistical changes, as well as complex psychological, social, and cultural factors that impinged upon nurses' care. The manuscript begins by briefly describing several logistical factors that led nurses who had joined the United States (U.S.) military to serve and to care for U.S. forces, not necessarily Iraqi and Afghani people--many of whom were enemy combatants. Researchers explored major themes evident in the nurses' interviews regarding the moral challenges they faced in providing care for people they otherwise considered adversaries.

The narratives revealed that most of the nurses experienced some ambivalence, fear, and anger in caring for Iraqi and Afghani enemy combatants. In its mildest form, they experienced concerns that they were in some sense failing to provide similar advantages to the American and Allied forces. These feelings and thoughts sometimes led them to reserve resources and supplies for the Americans and the Allied forces, and, in many cases, led them to feel a sense of frustration with their job and a low-level resentment towards their enemy combatant patients. In other cases, nurses experienced anger at the patients themselves for their role in harming the U.S. forces on the battlefield before coming to the hospital. This situation and the accompanying

feelings sometimes led the nurses to display neglectful or punitive behaviors, which other nurses witnessed and found distressing. Perhaps the most difficult challenge occurred when a prisoner of war (POW) patient presented threats or overt hostility while in the hospital setting, creating an atmosphere of fear, which deeply compounded the nurses' anger.

A crucial discovery was that the fear and anger that nurses felt was not something inside their heads, but part of a shared social experience of circulating fear and hatred in which the perceived adversary POW patients themselves were extremely afraid, suffering from the psychological impact of such events as the American torture of prisoners at Abu Ghraib. A second theme that was identified was the focus on how war trauma in the patients combined with a severe lack of mental health treatment made enemy combatants' presentation more complex. Third, while the context of war and trauma were in the foreground, there were also considerable difficulties with providing care for patients from very different cultures and civilizations. The research team focused on the large cultural divide between Americans and Iraqis and Afghanis surrounding gender expectations and the illness roles of patients.

Overall, the interviews revealed how nurses held themselves accountable to care for the prisoners of war (POWs), officially, titled by the military as "enemy combatants." Their steadfast dedication to professional nursing practice played a vital role in their treating enemy combatants humanely. Notably, when nurses employed the moral calculus of "do unto others," they found it confusing--some of their patients had killed many Americans--whereas embedded practical habits of caring for humans in their suffering enabled nurses to act with clarity and integrity. The team concluded that habitual ethical comportment, grounded in nursing practice, provided "footing" for nurses in treating the enemy as vulnerable, embodied human beings whose suffering needed to be alleviated. Ethical dilemmas are pervasive for nurses in all practice settings. The ethical challenges and resulting moral distress and moral injury that nurses experience in war are heightened when their duty requires them to care for patients who are enemy combatants. These concepts are addressed in more depth in the discussion section.

Interpretive Phenomenology: The Study's Method

This study examined the first-person experience-near narrative accounts (Geertz 1977) given by nurses regarding their experiences in care of enemy combatants and civilians in Iraq and Afghanistan. Interpretive Phenomenology (IP) guided the design and conduct of this study. IP allows for the articulation and interpretation of the experiences through shared meanings, facilitating an understanding of the study participants' thoughts, feelings, values, and practices. The method aims to offer insights into how a given person, in a given context, makes sense of a given phenomenon (Benner,1984,1994; Taylor, 1985). IP is one of several approaches to qualitative phenomenology. IP is distinct from other approaches because of its combination of interpretative approaches used to uncover shared meanings, practical experience-based knowledge, and skilled know-how that has not been made effectively intelligible and public so that the experiential knowledge can be tested, learned, or extended (Benner, 1994). Interpretation of the phenomena focuses on understanding practical worlds, skilled "know how," situated understandings, and embodied, lived experiences. Rigor involves staying true to the text, engaging in consensual validation, and allowing the reader to participate in the validation process by presenting texts associated with the interpretations that the researcher identified. The interpreter uses participant observation, observation, first-person accounts of real events,

interviews, and all sources of text relevant to the lines of inquiry being pursued (Geertz, 1977; Benner, 1984; 1994; Chan, et. al. 2010).

Nurse participants were recruited through posters, fliers, word of mouth, or information sessions at nine military medical treatment facilities or Veterans Administration Medical Centers within the U.S. and Europe. Participation was voluntary. Institutional Review Board approval was obtained for all recruitment sites. Interested nurse volunteers were screened for the eligibility criteria of having been deployed to combat zones in the Iraq and Afghanistan Wars and being cognitively and physically able to participate in the study. Eligible nurse participants signed written informed consent before participating in one-time small group interviews that included two to six participants and that lasted no longer than 90 minutes. Nurses were asked to give first person narrative accounts of their experiences in caring for patients. Reflections on their experiences in war were also disclosed, but interviews were redirected to focus on direct care experiences.

The transcribed data were entered into the Atlas.ti Qualitative Analysis Software, (version 7) for analysis. The research team was composed of military nurse scientists (Army, Navy, Air Force), VA nurse scientists, and civilian members of the research team experienced in IP. The research team checked the transcribed interviews for accuracy, conducted comparisons of topics and themes, and achieved agreement in coding the interviews. The distinctiveness of IP is the experiential understanding of the complex interrelationships among the phenomena and its interpretation of the experience. Credibility and conformability, dependability and transferability were enhanced by notes during the coding discussions, establishing agreement regarding the interpretations and themes among the research team. The analysis consisted of discussions, comparisons, and description that resulted in naming the 25 themes that emerged from the transcripts. This manuscript draws from the coded interview excerpts related to the text coded themes, Care of Enemy Combatants, Care of Civilians, and the code Anger--through numerous accounts of rage and resentment resulting from encounters with enemy combatants--or from observing the abuse of enemy combatants by other American or Allied military personnel.

Factors Leading Nurses to Care for Non-US Military

Several major themes were identified from the interviews. They are stated and explained below, including narrative examples for the themes from the nurses who participated in the interviews.

Factors that contributed to nurses unexpectedly caring primarily for enemy combatant patients, and a final factor that made their obligation to provide such care more ambiguous are briefly described. The first three factors are: 1) great improvements in expeditiously transporting wounded Americans out of the battlefield; 2) lack of demarcation of safe zones that made caring for the wounded occur in conditions of constant danger and risks from improvised explosive devices (IEDs) and mortars; 3) absence of safe long-term care options to discharge enemy combatant patients and Iraqi and Afghani civilians requiring prolonged hospital stays. 4) The fourth factor relates to shifts in definitions of the “enemy” with implications regarding Geneva Conventions protections.

An unprecedented, comprehensive, staged medical transport system was in place during the Middle East wars, designed to rapidly remove U.S. wounded service members (WSMs)

from the battlefield. In the Iraq and Afghanistan Wars, the U.S. embedded highly trained trauma healthcare teams in the troops and transported WSMs from the battlefield as soon as possible. The first 10 minutes of acute medical interventions for the injured were considered "golden" because they increased survival. From the combat arena, injured troops were sent to sophisticated medical facilities where the U.S. WSMs were treated to prepare them for evacuation by air to the closest and best-equipped medical facilities available, often in Landstuhl, Germany, or directly to the U.S. As one nurse explained:

> *Ninety percent of our patients we got out of there within 24 hours because we had to. We were waiting for the infamous mass casualties. We had no new beds that we could fill, especially ICU beds. The air evac [evacuation] system, as part of that, worked very well. The clinical care these guys [the medics embedded with the frontline troops] gave was very good. Second, while care of the wounded in combat is not new, most military personnel note that, even more so than in Vietnam, no clear front lines existed... There were no "safe zones" or combat-free zones.*

Caring for the wounded was fraught with constant dangers from IEDs and mortars. This reality ratcheted up caregiving stress and tensions. Providing care in the combat zone was also filled with ambiguity about whether patients were civilians or enemy combatants. Just as there were no clear front lines, no clear boundaries existed between civilians and enemies, including women and children. The following example demonstrates the lack of clarity nurses experienced with women and children, who were often paid to plant explosives and participate in combat:

> Nurse 1: *We had families with children involved in combat.*

> Nurse 2: *Or they're paid 500 bucks to set up an IED, and this is the money that's going to provide for their family for years to come. And who would say that one of us wouldn't do that?*

> Nurse 3: *Even the kids, the kids are there all the time, you get used to them. And they caught one of them who was nine years old, had figured out the combination [lock] to our area where we lived at, and was going in the gate, and they found some stuff on him. So, he was going to plant it in there because one of the insurgents had got to him. So, you just don't know.*

Nurses provided prolonged care for many Iraqi and Afghani civilians in the American and allied medical facilities because there were limited, if any Iraq or Afghanistan healthcare facilities. The complexity of care was compounded by mixed age groups, and the care needs of the civilians compared to the intense medical needs of WSMs. The following nurse describes some of the challenges of caring for the civilians across different age groups:

> *The mother gave birth there. And the infant-- the mom wouldn't feed the infant. And we couldn't figure out why. And there was the language barrier. And the nurse taking care of the infant and the mom didn't know anything about babies. I said, do you want me to go over there and take a look. And the baby had really poor capillary refill, (indicating dehydration and possibly other problems) and--just didn't look that great. Not real bad. But not that great. And I was asking her about feeding, and the kid wasn't peeing, and all I wanted to do was start an IV. But they were getting ready to send them out. I got a translator and talked to the mom. And she just didn't know how to hold the baby. She was a young mom. So actually, I remember this incident, because it was when we were issued our weapons. I'm in there, with all my weapons,*

my get-up, I had a lot of tools, I had knives, I was ready to go. And I'm showing this mom, with the translator, how to hold her baby, and--you don't have to be that gentle with a baby. You just have to hold them right, so I was showing her all the different stuff, and saying that she needs to breast-feed the baby...

This story shows the complexity of caring for mothers and babies, whose needs were so different from WSMs. We have many such examples of nurses delivering babies of civilian moms, while also caring for children badly burned from explosions. While children presented caretaking challenges, they also provided a source of seeing and connecting with the common humanity of the civilians caught in war, as detailed by the nurse:

I just cried the first time I saw a child, you know, my son was two, and it was probably after, you know, I hadn't seen my family for three or four months, so it was interesting. I don't regret the experience, but it certainly was, it enriched me, it was life changing, it enriched me as a nurse, and as a human.

Nurses became immersed in the toll of the war by caring for civilians, including women and children, as well as enemy combatants. The extreme suffering of innocent children caused by the war stimulated empathy and concern, and at the same time added to their moral distress. A third factor that shifted nurses towards caring primarily for wounded Iraqis and Afghanis was the absence of long-term care options. The lack of facilities in-country for complex or technology-dependent care meant that once wounded, enemy combatants and civilians who came into U.S. military hospitals could not be placed elsewhere. According to the nurse:

Finally, we did make an arrangement that they would take [enemy combatants] if we could get them extubated...They were also related to a terrorist group, too--so we had to guard the family, as well, that was in our compound, which was also challenging for us, and some of our people didn't like the idea of having to take care of Iraqis that were terrorists, and were using all our supplies.

The gap between American, Iraqi, and Afghani healthcare and technology capabilities created major ethical dilemmas in caring for both civilians and enemy combatants. Nurses knew that long-term care and rehabilitation could not be provided in the local Iraqi and Afghani healthcare facilities. For example, ventilators were typically not available in Iraqi hospitals, a fact that led the military healthcare providers to transfer Iraqi patients with American ventilators despite nurses' ambivalence about the use of extensive, expensive resources for Iraqis. Additionally, once the patient was transferred to the Iraqi hospital, nurses knew that there was no respiratory therapist to maintain the ventilator. The issue was highlighted by the nurses:

Nurse 1: *Right. Placement was the biggest problem. So, we would have the U.S. soldiers for a couple of days. We would have wounded Iraqi military for weeks.*

Nurse 2: *A lot of our ethical issues that we talk about had to do with how they want everybody to have the same treatment, obviously, and the Geneva Convention dictates that. And when practicality takes in, like if you save an Iraqi soldier with a head injury, what are you going to do? Are you going to send him to rehab? They don't have a rehab. So, when you're making a decision -- you got five people here, we can save four of them, which one don't you want to save?*

This excerpt points to a chronic predicament about the practical use of technology and resources in an impoverished Iraqi healthcare system with few resources, coupled with a culture that lacked resulting practices for rehabilitation. Nurse 1 above also spoke about the need to be fair, treating patients equally, but was conflicted about the harshness of the circumstances of care and the limited medical supplies. As a direct response to this dilemma, nurses created training programs for Iraqi healthcare teams to improve the hand-off of Iraqi patients to Iraqi hospitals as the war progressed.

Interviewer: *So (the effectiveness of Iraqi ambulance transport to Iraqi hospitals) really improved with the training and length of relationship?*

Nurse: *Oh yeah. It improved significantly. And we also brought in their physicians and nurses and would train them at our facility. We also had to secure $250,000 to build a classroom where we could have trauma mannequins, so we could set up basically a trauma simulation center with the classroom, so when we brought the Iraqi doctors and nurses in, we had a place to educate them, have classes, and then bring them into the hospital for clinical training.*

This nurse also captures the common expectation nurses held that enemy combatants were to be treated as POWs, entitled to the rights detailed in the Geneva Conventions Agreement. However, a fourth issue was a political factor that made nursing care for injured combatants morally complex. There was, in fact, a reduction in the rights accorded POWs with the reformulation of the status of "enemy combatant. Geneva Conventions rights for POWs were officially nullified in the George W. Bush Administration's redefinition of "enemy combatant" as "other than prisoner of war." The rationale given for this change was that war had not been officially declared.

The Geneva Conventions provide specific rules to safeguard combatants and members of the armed forces, who are wounded, sick or shipwrecked, POWs and civilians, as well as medical personnel, military chaplains, and civilian support workers of the military. The Geneva Conventions offer a binding moral force for all troops involved in a war (American Red Cross, 2011). However, the term "enemy combatant" was used to refer to an enemy soldier captured in the Middle East conflicts by Vice President Dick Cheney and the Bush administration as follows:

In the United States the phrase "enemy combatant" was used after the September 11 attacks by the George W. Bush administration to include an alleged member of al Qaeda or the Taliban being held in detention by the U.S. government as part of the war on terror. In this sense, "enemy combatant" refers to persons the United States regards as unlawful combatants, a category of persons who do not qualify for prisoner-of-war status under the Geneva Conventions [a term used in the past for "unlawful combatants" outside a declared and defined war] (https://www.definitions.net/definition/enemy+combatant).

Historical re-definitions may not have been explained to the nurses, but their interviews make clear that in practice, nurses blurred the distinction regarding the status of the enemy in their care, sometimes using the term "enemy combatant," other times EPW (Enemy Prisoner of War). More importantly, nurses did not seem to view either "enemy combatants or EPWs" as exempt from the Geneva Conventions' moral mandate to care for all POWs, nor exempt from the American Nurses Association (ANA) Nursing Code of Ethics and their specific Army, Navy, or Air Force Nursing Corps' values to care for the wounded and suffering (ANA, 2021).

The following demonstrates the clarity that many nurses had about their moral duty to care for enemy combatants:

> *When you get that many people together there's going be those who believe everybody should be helped, first-come-first-served, as needed, and those who were totally against expending supplies and money on the Iraqis, whether it is Iraqi forces, Iraqi police, or insurgents. And so sometimes it was really hard to make people understand that--we're here as a medical team, not as a combatant team, and so we take care of everybody.*
>
> Interviewer: *It sounds like you've had a lot of clarity on that?*
>
> Nurse: *Oh yeah. I have no problem with that. Never have. Whether I like it or not, sometimes--that's a different story. Our purpose is to take care of the patients. I remember one morning; this guy had a baseball bat. He was a technician. He had a baseball bat, and he had his name tag on, The Enforcer. And he was kind of going around hitting the baseball bat in front of all the patients. I'm thinking...what! I took the baseball bat away from him and went over to the commander's office, and gave it to him and explained the situation, and afterward talked to the guy about it.*

This nurse also captures the perspective that American abuse of power towards patients is reprehensible and must be curbed. These significant factors shaped nurses' experiences. They joined to care for Americans yet were put in a position to primarily care for perceived adversaries, with a lack of mental health resources, under threat for their safety, and with no explicit reassurance to follow the Geneva Conventions. The next section focuses on the nurses' reflections on the moral complexities this created for them.

Professionalism and Ethics in Nursing Care

The intensity of the above-described conditions and the confrontation with insurgents as the ever-present "Other" prompted nurses to highlight the human and ethical complexity of the care responses (Dreyfus, 1990; Butler, 2005). Their war-based ethical encounters required them to manage both their judgments about their patients' accountability for causing harm to Americans and more difficult situations in which patients posed ongoing threats or expressed hatred towards them as Americans. Nurses talked candidly with us about the challenges this raised for them. A primary challenge was the conflict they felt about who should be provided limited resources.

Nurses' reflections on their own ambivalence, anger, and fear, and related challenges to humane, ethical professionalism.

The following interview shows that the nurses engaged in a moral dialogue about equal treatment and fairness to the insurgents:

> Nurse 2: *I don't think the care was ever compromised because they were insurgents--or Iraqi--they would do [clinical interventions]--all the blood [donations].... They never would withhold stuff and say, "Well I can't do this." And by rights they could.*

Nurse 3: *I don't know why, if they're depleting our supplies, why don't they say okay, let's stop because--I mean, it's an insurgent, he's trying to kill us, or has killed us.*

Nurse 1: *But we're nurses. We're there to take care of the patients. I know. And I did, but it was frustrating when you get into the morals of all that because you want to save an American over an Iraqi and ... And then you get to the insurgents, and you want to save an Iraqi civilian over an Iraqi insurgent. And it shouldn't be like that. They should all be equal. ...*

Nurse 5: *Did you ever think about giving like 10 or 20 CCs of air when some guy with an IV that was spitting at you while you were taking care of him? An insurgent?*

Nurse 1: *I would curse under my breath and would talk to other people.*

Nurse 6: *They're trying to kill us.*

Nurse 3: *I don't think the care was ever compromised because they were insurgents. They would give all the blood, and you mentioned something about the blood supply too. They would never withhold stuff and say, well I can't do this, or he has tried to kill us.*

This group interview reveals that nurses are influenced by dehumanizing views of the "other" during war but also hold a commitment to "doing right" by all patients. Conflict and ambivalence over caring for Iraqis and Afghanis were woven into hour-by-hour care. This narrative also demonstrates the ongoing ethical demands in situations where the only life-prolonging resources available to Iraqi and Afghani citizens or combatants were through the Americans. While this moral clarity was shared by most nurses most of the time, the number of hours and length of time that nurses spent caring for insurgents was a source of stress that sometimes eroded their professionalism. This took a significant toll on nurses who were called upon to care for patients whom they often feared and at times hated for injuring Americans. Nurses were conscious of the conflicts embedded into their work. They noted that their motivation to sign up for deployment to the in-theater hospitals was to care for their own:

The majority of our patients were Iraqi... But then you also look at it like, well, I came over here to take care of [our] soldiers and I'm over here taking care of people who don't even want us here.

While most nurses thought that enemy combatants and civilians received adequate care, many nurses commented on abusive and callous behavior of some nurses.

Interviewer: *What were the problems you ran into?*

Nurse: *The problems were being callous, I think, and... Maybe not wanting to give them a bath. Not wanting to make sure they have fresh water, not wanting to provide adequate pain management.*

Interviewer: *So how did you deal with that? How did you turn that around?*

Nurse: *We had kind of a group session together, and, at first, they were hurt, I mean it was very uncomfortable for everyone, because there's a line where you want to be fantastic, but you can't be too fantastic because they're the enemy. See, and you can't. There's that constant struggle.*

Nurse interviewees were honest about their participation in both disturbing acts of dehumanization and neglect, as well as attempts to prevent them. None pretended that it was easy to care for such a high volume of enemy combatants in a war zone. Further, establishing whether any patient was an enemy combatant versus a U.S.-aligned warrior was seldom immediately clear. While a patient's status was being established by military personnel, nursing care was fraught with uncertainty because of the potential for attack by wounded enemy patients. This fear was exacerbated by the large numbers of WSMs arriving at any one time, as illustrated in the following excerpt:

> *So, they come in, and this is just protocol with shields over their eyes, and of course, handcuffed. And we were not to have any identifiers on us, so we took our ID off before we entered. And surprising, too--it was weird, because the guards are always there, and they have to be hard with them. Strict. Because, if not, they'd be all over you and all over us. ... The reason why he stood out was, you know what? For a while, about a couple of days, we treated him like an EPW [Enemy Prisoner of War]. The guards did, too. Not that we would mistreat them, of course. But he was under that [very strict protocol] --with eye goggles and--you know. I don't know how it came about, but we found out that he wasn't actually an EPW. He was a good person.*

This nurse explained that for safety, if a patient's status was unknown, he was first labeled and treated as an Enemy Prisoner of War. After an investigation, a patient's true identity or role could be determined. The placing of eye goggles (or other restraints) on patients was not only dehumanizing for the patients themselves, but also made it more difficult for nurses to respond to the humanity of the patient.

> Interviewer: *So that shifted sort of how you dealt with him?*
>
> Nurse: *It did. It did, yes, because handcuffs were off. Ankle cuffs were off. No restraints. We took off his blinds, we introduced ourselves, hi, and I'm so-and-so.*
>
> Interviewer: *Did he get moved to a different ward as well?*
>
> Nurse: *Yes. Which is good. [She explains that there were no complaints from Iraqis for the period of misidentification.] So yeah, we had, I would say, a couple of those. ...And I remember there was another Iraqi soldier. He looked so mean, and I thought for sure, god, he's going to give me a hard time during my shift. And you know what? He was like a teddy bear. He came in on--they did an external fix on him, on his lower extremity. And he was there for less than one week. Very respectful. Surprised all of us. Spoke very good English. Respectful. Said, "Thank you." And we weren't used to that from Iraqi soldiers. We weren't used to the thank you and the please...And he was also one of the ones I took pictures of. They loved having their pictures taken. So, before they'd go home, we'd take a picture, print it out, and give it to them as their souvenir of being in the hospital with us.*

This conversation exposes both nurse biases and low expectations regarding Iraqi soldiers, but also their relief when they could feel a more friendly and respectful connection. It also demonstrates how this nurse responded with openness and empathy, rather than a defensive response of walling off any emotions or feelings. Nurses vacillated between humane empathy towards the individual patient and fear of combatants en masse who could still be dangerous. In fact, nurses found it painful to see patients as potential threats, not only because of fear of

harm but also because they wanted to give humane care and treatment. Nurses commented on experiences of rapprochement with enemy combatants and welcomed such experiences in contrast to hatred and threats of harm. Nurses' receptiveness to a captive's humanity exemplified their efforts to articulate their own ethical response to a vulnerable and suffering human being. This effort to give an account of their actions shows the moral sensitivity and strength of character in the nurses' responses. Perhaps experiences of the enemy's civility tempered and mollified their experiences of danger and threats of harm when the majority of their patients were enemy combatants.

In the hospital unit, the combatants were separated from American WSMs and civilians by sheets, and tent walls that served as social demarcations, but were not effective barriers. According to this nurse's experience shared below:

> *We had two wards. They had the American ward, and they had the Iraqi women and children in the back with a curtain. And then they had the Iraqi ward where they had the insurgents up at the front so the guards could watch them, then they had all the other Iraqi [male] civilians in the back.*

The space was not easily separated. There were no sound barriers or significant distances between the care areas. Yet the demarcations by sheets, tent walls, and protocols in each of these makeshift separations operated as barriers, constructing distinct social expectations and boundaries for the treatment of each patient group.

Nurses spoke candidly about how, when faced with challenges of short supplies and rationing resources, they overtly favored American WSMs. We include the detailed examples because they demonstrate how nurses were ambivalent about providing equal care. The following illustrates using supplies to provide non-critical advantages to their own military more than to the enemy.

> Nurse: *We only had a few sheets, and we would use sheets to cover the beds and stuff for our guys, whereas when it came to the "foreigners," and more so on [adults], then we would use plastic bags to cover the operating tables. Initially it would be a little colder for them, or a little less comfortable. But nothing that was detrimental to them long-term in any fashion. It was only an item or two that was in very short supply that we said absolutely we're saving these for our guys. We really didn't run into circumstances while I was out there that (medical) supplies that were absolutely necessary weren't available. And supplies that were not absolutely necessary could become in short supply. For instance, Betadine preps kits. We would like to have a kit that we were able to do a scrub and then a paint with the Betadine for every patient. But when we got on short supply of those, then we weren't able to do anything but just the Betadine paint. And we would save maybe the Betadine prep scrub in order to do our guys, and then, because we had such a small amount of it, then we would use the paint on everybody else. And the paint, in all essence, is doing just as good.*

According to the nurse, supplies that were limited were not lifesaving supplies but rather items that provided marginally more comfort or convenience:

> *I don't think I saw anybody voice any more sympathy for civilians or enemy combatants than we did [for] our [own] guys. We pretty much had across the board where everyone did*

everything they possibly could for our guys. But we may spare some of our valuable supplies when it comes to the Iraqi people. In other words, not lifesaving supplies but things that might've made our guys a little more comfortable.

While there was clear favoritism for Americans, nurses did not typically demonstrate overt hostility or failure to provide care for enemy combatants. However, there were several other sources of stress and fear that did sometimes create hostile incidents. Nurses were affected by living in a state of ongoing fear of patients who were combatants, constant threats of IEDs and mortar attacks, and by their extended deployments (Kelley, Kenny & Donley, 2017).

Long deployments in theater hospitals, where all the stresses of working in a combat zone, caring for U.S. WSMs briefly and enemy combatants for extended periods, the sense of constant personal threat, and the ethical dilemmas fraught with caring for the enemy compounded the nurses' challenges. The amount of time spent deployed in theater significantly taxed nurses' ability to sustain professional identity, as has been found during previous wars (Hollinger, 2017). Nurses who found themselves wearing thin after more time in combat zones described how the tradition of the Geneva Conventions of caring for POWs remained a moral force they took seriously, even as they struggled. The nurse describes this below:

I remember when we first got there, the Army guys; they'd been there eight months. There was an EPW that came through. And I remember them saying, they were so jaded that--oh, another damn EPW coming through and I was like--I'm not going to be like that, I'm a good nurse, I'll never get like that. But I'll tell you, towards the end of my rotation, and seeing American after American blown up, and seeing these guys that are doing it to them, and you're--in the situation, you're forced to take care of this person. You don't have a choice. And you have to smile while you're doing it, no matter what they've done--you can get jaded. You just do. I still provided care. I still did what they needed. But I didn't have a smile on my face all the time.

Nurses described declines in quality of care, particularly the verbal abuse by guards and nurses towards the enemy combatants. Usually, there was countering by nurses, physicians, or guards in an attempt to mitigate such threatening behaviors.

Nurse 1: *And sometimes you learned the stories of the detainees. A lot of them we found out, shoot first, ask questions later. Some of them really weren't bad people, and you can kind of tell. But some of them. I mean, we had this one guy; you could just see it in his eyes that he hated us, and if he could find a way to kill us, he would. And it was really tough to even look at him because he just had that look in his eyes, and it was awful.*

Nurse 2: *It was hard. And I actually--the guy I was talking about earlier, he actually tried to hit me once. And the guards are right at the front of the ward. And I didn't even realize that he was trying to hit me. He had reached behind me and--the water bottles, they're like a liter and a half--and he had reached behind me and grabbed a water bottle and was going to hit me, and luckily the guard saw him before [he could strike] and were on him really fast and had him in cuffs and stuff. So, the guards are really pretty good at making sure no one gets hurt. And they had rules, [for the prisoners]. They couldn't talk to each other, they couldn't pass things around to each other, they weren't allowed to talk to us unless we talked to them first, and they were supposed to raise their hand if they wanted to talk to us. Of course, most of those rules weren't really kept.*

The description of both parties--the nurses being directly threatened and also the presumed enemy combatant being physically and socially restrained and controlled conveys a dehumanizing context far from the scenario of a caring nurse providing respectful care of a patient. Nurses further contextualized instances of direct physical threat within their American focus on how many American and Allied forces had been killed and wounded by the enemy. The requirement by the Geneva Conventions to care for the enemy and the nurses' own sense of moral obligation to care for vulnerable, suffering human beings were repeated themes in the nurses' interviews. Yet, caring for enemy combatants was a source of conflict, confusion, distress, and ambivalence for many, if not most, nurses:

> *I found myself--when we would get enemy patients in--I didn't know how to respond to them. Because part of me is saying, I'm a nurse, the man's lying on the bed crying, and --my split personality's coming out. Which way do I go? You want to go, oh, gee, I'm so sorry. Smack! [Makes sounds of hitting enemy patient].*

Such disturbing wishes--to hit a patient who is vulnerable and unable to protect himself juxtaposed with genuine concern for the patient--was very disturbing for the nurses. They were unprepared for the demands, cultural differences, and conflicted feelings they had when their primary patient population consisted of enemy combatants and civilians. While we focus on nurses in this article, there is abundant evidence that the patients themselves were subject to terrible trauma, leaving them terrified. Patients' dangerous behavior must be understood in this context of mortal threat they experienced. Thus, there was a pervasive atmosphere of threat and fear for both patients and nurses.

Caring for patients subject to psychological trauma, hostility, and fear

As reported by Hersh (2004) Major General Antonio M. Taguba provided an internal report and conclusions about the institutional failures of the Army prison system. Specifically, there were numerous instances of "sadistic, blatant, and wanton criminal abuses" at Abu Ghraib. Both nurses and enemy combatant patients were aware of the abuses that occurred at Abu Ghraib:

> *They actually have a hospital that was associated with Abu Ghraib. And it was awful because once they [enemy combatants] learned they were going' there--because the only thing they knew about Abu Ghraib was the Americans abused the prisoners. And they're like "No, no." And they would cry, "no, no" and cry...*

It is difficult to imagine the horrors that Iraqis faced in an American prison, and of the widespread terror this created among the patients who heard about it. While combative behavior towards nurses is entirely understandable in this context, it still created challenges for the nurses who had to protect their own lives, given incidents like a potential attack with razor blades. And nurses' primary allegiance to American WSMs who were distraught, disoriented, and who lashed out at enemy combatants also influenced their thinking on a daily basis. It fell to the nurses to somehow keep separated the enemy combatants, civilians, and injured POWs, who were angry and frightened. The proximity of U.S. and Allied forces and wounded POWs and civilians made the care of each much more challenging. Privacy on all levels was not possible. When asked about threats they had experienced, nurses recounted the anger of enemy combatants.

Nurse 1: *Well, for the most part, they [injured Iraqi] don't like Americans. They don't like me because I'm a female, and I'm trying to tell them what to do, what we feel is best for their health, and they don't understand. They see a female and they're like-- "Whatever." So, whenever we received a patient, we were always told to pat them down and make sure they didn't have anything on them that could harm us or anyone else. We took care of a lot of insurgents, and that was very difficult because we had to be on guard all the time. And most of the time they did come in with guards, and then they were sheeted (screened by hanging sheets) off. ...So, it was kind of hard because you don't know why this person is in custody. You don't know what they did, and it's kind of scary. ... They're injured. But people do things anyway. The hate that they have for us is that much. ...And then of course you've got the mortars that are coming...I can remember twice where mortars landed right outside of our facility. And thank goodness they didn't detonate. And then you're wondering: ... and is that one going to detonate?*

Nurse 2: *I took care of--we both took care of this guy who was an--almost successful suicide bomber, who tried to blow up a convoy. The vehicles stopped and he got out and boom the vehicles blew up and he got a concussion. And he got hypoxia with a high CO2. We had to resuscitate him. And it was kind of odd to bring back a guy who had tried to kill us. And we poured all that blood into him, too. He was a bad guy. He went to surgery. They had a big blood drive, we put like 20 units of blood into him. It's ironic that the blood that he tried to spill was the blood we tried to return. And that was just--for me--you've got to be kidding! Are we a benevolent country or what? How could we be doing this?*

Nurses acknowledged being affected by the factual threat of IEDs and mortars but seemed less aware of how for Iraqis and Afghanis, the poor mental health context created by torture, death threats, and lack of mental health resources created a terrible atmosphere of psychological trauma which nurses, too, could not help but feel in some way. Lacking such awareness, they did their best to endure and take care of their patients in the ways they would have in any hospital. However, this normalizing approach undervalued the psychological strain under which they were functioning. The cultural differences impacting the patient-nurse relationship was another significant source of stress and frustration for the nurses and are addressed in the next section.

Caring for patients with culturally distinct beliefs about gender, patient role and health

Nurses experienced added stress because POWs patients were not accustomed to being cared for by female nurses nor did not believe that women should be in the military. In a culture where privacy between genders was highly valued, care of the body by a female nurse upset Iraqi soldiers. Unfortunately, there were frequent reports of the Iraqi patients' distrust leading to overtly hostile acts of frequent spitting, attempted hitting, and verbal derision. Nurses were also ill prepared for the different cultural expectations with respect to patient participation in their own care and rehabilitation. The socio-cultural customs about being a good and "responsible" patient were completely different for the Afghanis and Iraqis who were not accustomed to the American cultural emphasis on patients owning elements of their care and actively contributing to their own recovery.

In the nurses' view, Iraqi and Afghani male patients believed that they should assume a completely passive role in their health and well-being. They expected that the injured should be waited on, move as little as possible, and be kept pain-free. These cultural beliefs

collided with American notions of the value of early mobility and activity as part of successful recovery strategies. American nurses expected patients to do as much self-care as possible to accommodate for limited staffing, and to promote effective rehabilitation. Iraqi and Afghani patients would confront nurses with suspicion and anger about "rehabilitation and mobilization" expectations.

Addressing patients' pain was a particular area of conflict. Pain experience and expression are socially and culturally taught (Zborowski, 1952; Anderson, Reynolds Losin, 2016). There are discrepancies between pain experience, expression, and management for Iraqis and Americans. For example, in Iraq, pain medication is readily available in pharmacies without a prescription. As a result, injured Iraqis self-medicate with narcotics and became accustomed to high doses. Consequently, Iraqi POWs requested and required higher doses of narcotics for pain medication. Nurses became accustomed to hearing shouts of "ana ata-alam" (I am in pain), an Iraqi expression of pain. As the nurse recounts:

> *Every time you would touch the Iraqi insurgent, they would scream alam, alam [Pain, Pain]! The doctors actually at one point ordered saline flushes for him because--placebo works very well in that case because they just have no tolerance for pain. But if they think that they're getting something, they will be quiet. And if you don't give them something, though, if they say that they're hurting and you don't give them something, every time--"alam"! Like every two seconds. Alam and they won't stop until you give them something.*

This disturbing injection of saline and withholding of pain medication shows how large is the gap in empathy in the context of the dehumanization of war and cultural conflicts. Individual nurses, reacting emotionally to what they perceived as overly demanding patients, lacked sufficient safeguards against further dehumanizing those patients. This shows how important it is to educate nurses about cultural differences pre-emptively and systemically. All of this worsened when nurses were subject to the hostile and threatening behaviors of their patients. This led the nurses to feel, at best, ambivalent towards the enemy combatants, and at worst, openly hostile:

> *This patient got a big, huge bed sore that got infected. So, they brought him to us, basically because we shot him and injured him. So, he was our liability. That patient created a lot of hostility among the nursing staff. Some of the nurses I worked with were very mean, made some very mean comments--He's an Iraqi. Why are we wasting money? Why are we taking care of him? Nurses were ridiculing his language, the way he was acting, and it really made me feel uncomfortable. Because you have to, in combat, step back and put your personal feelings aside and say, okay, doesn't matter who, I'm here to take care of people. Which is very hard to do, considering the majority of our guys are being injured by these boys?*

> *So, this was a patient that [they] took to the O.R. [Operating Room] overnight...and his blood pressures weren't all that great. I noticed that he was on the same sheets from the O.R. when he came back at ten o'clock the previous night. I said to them, I said, did you roll him or check him, to see how that wound is? Well, no. Why? He's got a low blood pressure, he went into OR, he's probably exsanguinating all over the bed. And I think part of it was--granted, this was a different nurse--I think he [the nurse] still had some hostile feelings towards this patient. I turned him and looked at his back and let the doc know, that, we probably need to be thinking about giving this guy some blood, or hydrating him, or what have you. And then I talked to the*

chief nurse. I said, these guys were in here a couple days ago, ridiculing this guy, and granted, he may or may not be able to understand what we're saying, but it's just wrong. And I don't know if the chief nurse ever said anything to the other personnel. But I felt better knowing that I'd stood up and said, "Hey, this is wrong."

This story reveals abusive and menacing behavior that some nurses engaged in. Conversely, some nurses felt an ongoing ethical and professional obligation to limit or curtail this behavior. Given the magnitude of the challenges the nurses reported in this study faced, not only culturally, it was unfortunate to learn about how little preparation they received. Nurses reported that they did not receive any pre-deployment preparation for the psychological and cultural challenges that were pervasive in their practice during deployment.

Discussion

Collectively, the nurses' interviews demonstrate the conflicts that nurses had in caring for civilians and enemy combatants when their primary motivation for deployment had been to care for injured American troops. Ethical challenges were commonly present for the nurses who participated in this study. While all nurses are held to the ANA Nursing Code of Ethics, nurses in the military face additional ethical expectations including being bound by the Uniform Code of Military Justice, and their specific Army, Navy or Air Force Nurse Corps' values. Though not overtly labeled, their narratives reveal their moral distress. Moral distress was first defined in 1984 by Jameton and refers to the psychological distress when one is refrained from acting on what one knows to be right (Morley et al, 2017). Nurses felt an inner conflict of knowing what feels "right," yet at times acting contrary to this knowing. Moral injury is a related term, often equated with the violence and atrocities one experiences in war. These concepts were not identified and discussed in our results but are relevant to how future deployments proactively manage, prepare nurses for practicing in war and caring for enemy combatants. Mitigating moral distress and moral injury should be part of these efforts, which are raised in the conclusion.

The nurses were hindered by having little or no preparation for caring for enemy combatants or Iraqi or Afghani civilians. They were unprepared for the cultural and language differences. They needed practical, reflective education in advance about the terribly dehumanizing context they were about to enter, in which they would face fear and threat from some of the enemy combatants, and find themselves defensive and at times hostile in the context of American war time dehumanizing views of the "other."

While unprepared, the nurses participated in an honest and nuanced dialogue about the temptations for "callousness, which they experienced in caring for patients whom they perceived as the "enemy." Crucially, the ethically challenging demands evident in the nurses' interviews, were not alleviated by a commitment to an abstract principle like "the Golden Rule: do unto others." In fact, the opposite was the case. They were asked to care for those who had caused death or who at times still intended to cause harm. Even though the new term "enemy combatants" coined by the Bush Administration was intended to place the terrorist insurgents outside the protections of the Geneva Conventions, these nurses still felt the ongoing moral obligations of caring for the "enemy" and repeatedly cited the Geneva Conventions Standards of Care of POWs.

Perhaps our most important finding is that, however tenuous for some, caring for the wounded "enemy" felt like an imperative for most of the nurses who put it into practice on a daily basis. How can we understand the practical expression of this commitment given their ambivalence and the atmosphere of dehumanization? One way may be to look beyond nursing itself to consider the circumstances in which people in general are able to "rehumanize the other" despite being on opposite sides of a violent conflict. That one can see one another as collective members of humanity is the condition for the possibility of empathy and recognition of the commonalities among fellow human beings. But in our view, it is also the condition of the possibility of the forms of mistreatment that people carry out when they are outraged and seek revenge on others after violence. One is furious at another because the other is seen as a human being who has committed a wrong, not as an inhuman entity.

Contrary to Levinas' account of seeing another's face (Levinas and Kearney, 1986; Butler, 2004) as a moral source of compassion and care, in this context of war, the human face, was not sufficient to engender compassionate care. The human faces of the enemy combatants and the American soldiers who the nurses identified with, were too often distorted by hatred and anger. Thus, it was difficult for the nurses to reconcile their conflicting opinions and feelings when caring for the POWs. This is precisely why the "do onto others" approach was insufficient from the start for nurses caught in caring for enemy combatants who may have killed the Americans the nurses had come to protect and serve.

Seeing the co-humanity in the faces of the POWs was sometimes a moral source, but not typically. What was found to be crucial were the ways that perceiving and addressing the suffering of human beings provided the footing or foundation of nursing actions, embedded practices of caring for *human bodies* not as things but as the loci of suffering. Seeing what the bodies needed may sound dehumanizing, but instead was a powerful humanizing moral source. Even lacking training that prepared nurses for the care situations they experienced with enemy combatants and civilian casualties, nurses responded:

> *I don't know of any particular training that I had that led me to deal with it. But I just didn't seem to have any problem. I mean, an injury coming into the OR to me is the same whether it's one of the civilians or whether it was one of our guys. ... first, I might've had a twinge ... well, this is the enemy, and he's not worthy of getting the exact same kind of care that our guys get. After everyone starts doing what it is that they do, what we normally do on an everyday basis, and then you just start doing whatever is necessary to take care of it as a human being.*

While the word "it" may sound dehumanizing, it is likely that the "it" the nurse refers to here is the strong situation of seeing a human being who is badly injured, and knowing of the pain, suffering, and future disability that could accompany such injury. It was likely easier to treat the anesthetized patient in the O.R. as the "same" as any other patient. However, nurses were able to provide needed, empathic care even during encounters with angry, hostile enemy combatants. In this instance, the nurse's actions were experienced as "automatic" because she was somewhat surprised that her routine skills and coping mechanisms in caring for severe war casualties surfaced with this patient as they have with other non-enemy patients. However, surprising to the nurse was the involuntary response resulting from years and years of practice with alleviating human suffering. The ability to know how to recognize and attend to human suffering is like an opera singer perceiving a note that is off key. It is a form of perception that

comes with a normative moral (or aesthetic) commitment. Even before reflecting upon, it felt "off key" to nurses when they observed patients treated inhumanely. Thus, it seems less likely that principles or standards were the basis of the nurses' capacity to recover and provide empathic care for their "unchosen" patients. Rather, the essence of nursing practice, alleviating suffering and restoring injured human bodies was a powerful guide that drove their actions.

The nurses in this study were always action oriented. They had to respond professionally to the immediacy of emergency care and their skills and knowledge took precedence over contemplating the ethical demands of caring for the enemy. The strains of doing what needs to be done in the face of severe trauma left little discussion of the human burdens of caring for the enemy. The challenges of caring for the enemy were discussed; however, with descriptions of hostility, disrespect, threats of harm, and cross-cultural conflicts and misunderstandings. According to the nurses, the immediate demands of critical and lifesaving work of caring for extreme injuries defined the nature of the situation, challenges and roles for nurses and physicians. Nurse interviewees indicated that their initial ethical questions of care of "enemy versus our own," soon became focused on dealing with the needs of the injured irrespective.

Giving an account of one's actions and responsibility to others diverges when one is not responsible for harm to another, but rather is the subject of harm from an "enemy," a person experienced as "Other" rather than "Same." What is unique about these nurses' dialogue is the repeated themes of an ethical sense that one must treat the "Other" as a human being deserving of care. Judith Butler (2005, p. 13) points out that "life entails a certain amount of suffering and injury that cannot be fully accounted for through recourse to the subject as a causal agent." The nurse finds her or himself in the position of facing ethical demands, not in terms of owning personal moral responsibility for injurious acts upon others, but because of the complex causality of war. The nurses' discourse reveals a sense of the unchosen responsibility of caring for the enemy. Nurses repeatedly confront and affirm the need to care for "the enemy," not to abuse, retaliate, or withhold care, even when they are being threatened. Their dialogue takes the form of "giving an account of oneself" in the face of an ethical responsibility, is reminiscent of Heidegger's claim that "human beings are the kind of beings that take a stand on the kind of human beings they are" (Dreyfus, 1991, p. 334).

While the circumstances of caring for enemy combatants is extreme, in civilian life nurses face related ethical challenges about caring for others who they perceive as threatening to their values and beliefs. This may include people who have committed heinous crimes including murder and child abuse. In such instances, nurses uphold the standard that it is unacceptable for a professional to withhold care to any injured or suffering human being. Nurses do not accept any reason for withholding care to the critically ill or suffering.

In a world of increasing polarization, the honest accounts of these nurses regarding the work they did to face and overcome their own resistance to care for the "enemy" serves as a notable reminder of the ethical commitment to care for the injured, suffering, and vulnerable, regardless of their race, social identifications, perceived moral infractions, or criminal actions. The requirement for attentive and effective care of embodied human beings who are injured and vulnerable is central to nurses' professional codes of ethics and is deeply embedded in their daily routines of practice. Placing any "moral," religious, or political requirements for entitlement to care must be resisted.

Conclusion

Despite the logistical, psychological, and cultural factors that made nursing especially difficult during the Middle East wars, the strength of the moral norms embedded in nursing practice sustained nurses and helped them provide appropriate care. In our interviews overall, the nurses talked about four main moral sources (Taylor, C. 1989. Pp. 12-24): 1) their formation as a nurse created a felt moral responsibility to respond with caregiving to the injured and suffering embodied person, 2) the tradition of the Geneva Conventions and its injunction to care for POWs, 3) respect for equal, fair treatment of the enemy similar to caring for their own troops, and 4) their experiences of practicing as a nurse provided a commonly held self-understanding that they, as nurses, were morally mandated to care for the injured and suffering regardless of their social identity.

While sustaining their commitment to care overall, nurses faced constant psychological pressures that created enduring harms to themselves and nurses were sometimes directly harmful to patients. Much of this could have been avoided if nurses had been prepared for the complexity of caring for enemy combatants rather than having to learn in the tense situations they encountered. Indeed, the real possibility of caring primarily for enemies and civilians needs to be addressed prior to deployment to avoid the frustrations and shock that many of the nurses experienced in the war zone. Pre-deployment advanced preparation would allow for anticipatory coping and provide a framework for understanding some of the inevitable demands and challenges they would face as caregivers in a combat zone. Included in the training should be discussions with experienced nurses who had been deployed in a war and discussions of coping strategies and the preparation for the grave and unsafe environments that the nurses would be working in (Kelley, et al., 2017). Cultural education would better prepare nurses to care for patients who hold radically different expectations of women's roles, the patient's role in healing and rehabilitation, and pain expression and management. Finally, preparation for dealing with enemy patients with intent to do harm to Americans may have helped nurses to anticipate these situations and thus draw more effectively on their professional practices, ethical concerns, and actions.

While the nurses described abuses of enemy combatants by American nurses and guards, in these accounts they typically spoke of their advocacy to end the abuse and provide adequate care to them. They pointed out repeatedly that as nurses, their responsibility was to provide care, not to punish. Amidst the common dangers in an active war zone, with enmity, mistrust and cross-cultural conflict on both sides, the moral mandate to care for the enemy presents an ultimate moral mandate to treat the "other" as other, but not wholly other (Levinas, 1981). The "prisoner enemy combatant" was described as a human being, embodied, with common humanity who was injured and suffering. The desire expressed by nurses to be "fair" and respond with a sense of common humanity for the enemy is compelling, exemplifying an ultimate "ethical demand" (Logstrup, 1981). The nurses' accounts of their struggle to live up to the mandate to care for the perceived enemy, though compromised by ruptures, exemplify the nurses' recognition of the others and their own humanity in the most volatile, dangerous moral contexts. Every example of triumph of caring practices over destruction and animosity, in that context, provides a beacon of hope and moral courage worth recognizing and emulating.

It is naïve to assume that conflicts will not increase in the future, and no one leaves war or a disaster deployment unaffected. Therefore, it is imperative to educate, prepare, and

train medical personnel to be prepared to deal with the complexities of providing healthcare to patients who are different than oneself and see the humanity of others even in the most dangerous environments. Realistic preparation through simulation, role-playing, and other training strategies can better prepare healthcare providers to cope and understand the social isolation, uncertainty, and vulnerability one experiences in war (Moon, 2019).

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