

## The War Comes Home:

### Institutionalizing Informal Care and the Family Consequences of Combat Injuries

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As of February 2013, 50,444 service members were officially counted as surviving casualties of the wars in Iraq and Afghanistan.<sup>1</sup> Explosive weapons like Improvised Explosive Devices (IEDs) and Explosively Formed Penetrators (EFPs) have regularly accounted for the largest proportion of them, 60% in 2012.<sup>2</sup> In that year 1,848 American soldiers were blown up in Afghanistan. Nearly all of them, 1,744, survived to be counted among the wounded.<sup>3</sup>

Because of the nature of both the weapons and the armor that protects them, a surviving soldier's body is often affected in many ways at once (see MacLeish 2012). Because soldiers in Afghanistan patrol on foot more often than did their counterparts in Iraq, the rates of multiple amputation and genital injury are also on the rise (Dismounted Complex Blast Injury Task Force 2011). One explosion will usually leave a soldier with a whole array of wounds including burns, shrapnel or other infection-susceptible foreign matter wounds, broken bones, traumatic limb amputation, organ damage or rupture, concussively flayed skin and broken eardrums, along with the new "signature injury" of Traumatic Brain Injury (TBI).<sup>4</sup> This combination even has its own name: polytrauma. One event means multiple injuries to each surviving body. A single service member wounded in action can embody a whole proliferation of confounding wounds.

In the post-9/11 era, when the US has chosen to wage multiple wars with an "All-Volunteer Force" that is unable to provide the combat and support personnel such missions require, the picture of the returning wounded is no longer that of the communal military hospital ward; it is a picture framed by family.

In every major military conflict of the 20<sup>th</sup> Century, the United States implemented the draft to fill its ranks, ensuring that there were enough people not only to produce and be exposed to the violence that war requires, but also to manage the movements of their bodies as they lived, fought and returned, alive, injured or dead. The anti-Vietnam war movement that ended the draft in 1973 also offered an important military lesson: If the United States wanted to wage an unpopular war, it could no longer rely on conscription.

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<sup>1</sup> 18,223 in OEF; 295 in OND; and 31,926 in OIF as of February 1 2013. Numbers available at [https://www.dmdc.osd.mil/dcas/pages/report\\_sum\\_reason.xhtml](https://www.dmdc.osd.mil/dcas/pages/report_sum_reason.xhtml), accessed Feb 2 2013.

<sup>2</sup> "IED Casualties Dropped 50% in Afghanistan" *USA Today*, January 18, 2013. <http://www.usatoday.com/story/news/world/2013/01/18/ied-casualties-down-afghanistan-2012/1839609>, accessed Feb 2 2013.

<sup>3</sup> "IED Casualties Dropped 50% in Afghanistan" *USA Today*, January 18, 2013. <http://www.usatoday.com/story/news/world/2013/01/18/ied-casualties-down-afghanistan-2012/1839609>, accessed Feb 2 2013.

<sup>4</sup> TBI is increasingly displacing Posttraumatic Stress Disorder (PTSD) on this score. But the issue of PTSD, and of the broader array of experiences of post-combat distress that this diagnosis sometimes stands in for are no less relevant for veterans and their friends and loved ones. For more on PTSD in the context of families, see Finley, Pugh, and Jeffreys 2010 and Finley 2011.

In the 21<sup>st</sup> century, the US has thus had to find other ways to staff its wars. As is the case for its other effects, this new style of war making is implicating military families and communities in new ways (Howell and Wool 2011).

One result of this new way of war is that families have been actively incorporated into what the military now counts as its “Total Force” (Chu, Hall, and Jones 2007). As private contractors have supplemented the warfront needs of an overstretched military—constituting a private army which, at its peak in the Iraq war, exceeded the number of US military personnel<sup>5</sup>—the labor of family members and friends has shored up an overstretched military medical system unable to uphold its own standards of care for service members who, thanks to improvements both in armor and war medicine, are surviving combat with complex injuries that require equally complex and long-term care. This was the situation the Army dealt with by renting a dilapidated building to house injured soldiers a block away from its flagship facility, Walter Reed. And it is why it took a major exposé in the *Washington Post* in order for such a basic problem as adequate housing to be addressed.<sup>6</sup>

When service members are medically evacuated from a warzone, the severity of these new kinds of complex injuries mean they must often be treated at one of a few specialized military medical facilities like Brooks Army Medical Center in Texas or Walter Reed National Military Medical Center in Bethesda, MD. When soldiers arrive in these places, sometimes within 48 hours of a truly catastrophic injury, their vital signs may be stable but the full emergency of injury is still unfolding. They may spend years at hospitals like Walter Reed. There, in a disorienting space between the intensities of combat and a civilian world that feels forever changed (Wool forthcoming), they undergo scores of surgeries to repair, reconstruct, or remove the affected parts of their bodies, moving through a process of rehabilitation marked by so many setbacks it can be hard to know when things are getting better and when they are getting worse (see Messinger 2010). And now, for the first time in the history of American military medicine, the vast majority of them are sharing this experience with a family member, sometimes a rotating roster of family and friends, whose presence is subsidized by what is known as the Non-Medical Attendant (NMA) program (Wool and Messinger 2012).

Back in the US but often far from home, service members’ loved ones anxiously rush to their bedside from around the country, overjoyed that their soldier is still alive and overwhelmed by uncertainty about what will happen next. Many had imagined the possibility soldiers might die in combat, but they had almost never contemplated what a serious injury would mean. As days stretch into weeks, the scale of what lies ahead begins to emerge. It is no less a task than the remaking of life itself. The ties of kin that brought family members to Walter Reed also mean they can stay there as NMAs. And as NMAs, they must file paperwork to receive the official “orders” that grant them that status every 30 days. This entitles them to a per diem (\$60 in 2008). The per diem is not intended to ‘compensate’ family members for their labor nor for the lives they leave behind, and it does neither. One mother from the mid-west talked about abandoning her husband to single fatherhood when she came to be with their injured son, missing her daughter’s cherished high school competitions and falling short for payroll for the small business she owned back home, despite the exhausted generosity of their community

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<sup>5</sup> “Contractors outnumber Troops in Iraq” *LA Times* July 4, 2007  
<http://articles.latimes.com/2007/jul/04/nation/na-private4> accessed Feb 10, 2013.

<sup>6</sup> Priest, Dana, and Anne Hull. “Soldiers Face Neglect, Frustration At Army’s Top Medical Facility.” *The Washington Post* 18 Feb. 2007.

and church. A single mother came from California to be with her son, and while \$60 a day would have been a decent wage given her frequent unemployment, it also meant that her older daughter had to take of the care of her younger son. And NMA's who were not military 'dependents' (generally, a soldier's spouse or child) were not entitled to the medical expertise that surrounded them. The per diem may be enough for a person's minimal daily needs at Walter Reed, but it was certainly no more than that. And while it may enable one person to remain, it simultaneously subjects them to the logic of a military medical institution that absorbs their labor as a necessary supplement. According to clinicians, these family members are filling the roles that would have been taken by paid, trained, military health care personnel if only all the military personnel hadn't been deployed (Wool and Messinger 2012).

Without any certainty about how long they will be at Walter Reed or what, exactly, a soldier's rehabilitation will entail, family members cum NMAs move into cramped on-post rooms with injured soldiers as those soldiers transition from inpatient to outpatient, sometimes with young children in tow. They change wound dressings, help with bathing, feeding and toileting, keep track of scores of medications, daily appointments, and endless paperwork. All the while, they make arrangements for the work, people, and lives they've put on hold back home. They may also be the ones updating friends and family about a soldier's condition, doing the emotional work of managing others' concerns. At Walter Reed, they often become just as drawn into the public eye as are injured soldiers themselves, confronted with an endless stream of grateful strangers, from politicians to well-meaning volunteers. But within the clinical spaces of Walter Reed, NMAs are also treated as pseudo employees, people who are present in the service of a clinical program of rehabilitation, the priorities of which may be opaque or at odds with family members' own sense of their role as loved one (Wool and Messinger 2012).

Here is just one example: A soldier developed a limb infection that waylaid his progress and left him doing little more than sit-ups in physical therapy. His fiancée shared in his frustration saying, "I know he should probably do more work here, but how strong does his gut need to be? I mean when he can walk, he'll work his ass off, but now he's upset, and how will it help if I nag him too?" His physical therapist thought otherwise: "She should try to push him, otherwise what's she doing here?" (Wool and Messinger 2012, 27). Being a good wife or brother sometimes means being a bad NMA, and when these roles are most at odds, clinicians can, in effect, "fire" family members, a rare but not unprecedented occurrence (Wool and Messinger 2012, 28).

As the number of US troops on the ground in Iraq and Afghanistan dwindles, and the number of injured soldiers living in the US continues to rise, it is all the more important to note that "rehabilitative challenges" continue long after family members leave facilities like Walter Reed and long after injured service members leave the military.

While issues around long-term in-home care in other contexts have been studied, especially among older adults, the injured soldiers and their care giving friends and families may constitute something of a 'special population'. Not only are soldiers overwhelmingly young men in a military world rooted in ideals of bodily fitness and masculinity, but their injuries also have a public significance that may bear little resemblance to the meaning of these events in their own or their families' lives. Indeed, the "family sequelae of wounds and injuries" in this context are only just beginning to be understood: they include the issues of "caregiver burnout," the impacts on children, and

the redistribution of responsibilities and dependencies across extended families (Wadsworth and Riggs 2011).

What is already clear is that the injuries sustained by soldiers in Iraq and Afghanistan will continue to affect soldiers' intimate partners and other family and friends in ongoing and unique ways due to the intersection of factors such as the complexity of injuries, the social and cultural weight those injuries have, and the ways that family members are implicated in sharing the burden of that weight. This is not only because they love and care for service members, but also because the overtaxed institutions of military and VA health care harness that love and care for those institutions' own needs. While the VA has created four new rehabilitation centers specializing in the unique clinical challenges presented by polytrauma, these new centers continue to rely on the labor of family members, overwhelmingly women and especially the mothers of service members (Griffin et al. 2012).

The clinical structures that rely on loving care extend well beyond hospital walls. Recent legislation, like the 2010 Caregivers and Veterans Omnibus Health Services Act and its expansion in 2011, has sought to address the problem of "informal" care not by giving veterans and family members access to more options for redistributing this work and responsibility, but by formalizing it. By offering training, respite relief, and health services for caregivers and, in some cases, monthly stipends, such legislation offers support in a way that makes certain family members responsible for the health of injured veterans. Like the NMA program at Walter Reed, such initiatives can turn family bonds into pseudo employment. They also officially recognize family members only in their capacity as veteran caregivers. These kinds of compensation are a double-edged sword; supporting family members in continuing to care for those they love by supplementing lost income and facilitating their care-work and simultaneously subjecting them to medical models of rehabilitation and confining them within a limited range of options for both medical care and the configuration of family life.

The general impact of war on military families has come to greater public attention in recent years, especially through the efforts of Michelle Obama and Jill Biden, who is herself a "military mom."<sup>7</sup> Although attention to the quality of military family life after physical injury is increasing, it is overwhelmingly construed as a problem worthy of intervention only because of the ways family life might affect soldier rehabilitation (Badr, Barker, and Milbury 2011), further subjecting questions of love, intimacy, kith, and kin to the logics and practices of these medical institutions.

This attention is couched in a language of sacrifice that construes family hardship and service member caregiving as a sacred patriotic duty, rather than as the outcomes of decisions the United States has made about who will and will not be responsible for producing and managing the effects of its chosen wars. Couched in this moral language, more flexible and resource intensive models of medical and non-medical care, for example those that would provide in-home health aids and support workers or otherwise allow veterans, family members, and friends to choose the particular arrangements that best suit all their needs, easily go unconsidered.

In the post 9/11 landscape of American war injury, technical innovations are saving lives that military institutions are not fully equipped to care for. Under these conditions, the responsibility for, and work of, care is being placed ever more squarely within veteran

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<sup>7</sup> <http://www.whitehouse.gov/administration/jill-biden>, Accessed Feb 10, 2013.

households. As family caregivers have become “critical partners with VA”<sup>8</sup> in providing a lifetime of hands-on services that injured veterans may require, the shape of family life in these households may become ever more defined by the limits of military and veteran medicine.

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<sup>8</sup> Secretary of Veterans Affairs Eric K. Shinseki, quoted in “Enhanced Caregivers and Veterans Health Services Act”, *San Francisco Chronicle*, Feb 10, 2011, <http://www.examiner.com/article/enhanced-caregivers-and-veterans-health-services-act>, Accessed Feb 3, 2013.