

SUPPORTING MILITARY MEMBERS AND THEIR FAMILIES

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With the onset of Operation Iraqi Freedom (OIF), the war in Iraq, and Operation Enduring Freedom (OEF), our presence in Afghanistan, our nation began to rely more heavily on members of the Reserve forces and the National Guard. Unlike active duty members, these men and women and their families face far more stressors and difficulties while serving our nation in uniform.

Active duty members face regular deployments. Depending on the service, these times away from home and families can last from four months for the Air Force, six months for the Navy and Marine Corps, to fifteen months for the Army. Support systems exist on military bases to help both service members and their families deal with deployment issues. Reservists, however, do not generally live at or around a military base and accordingly, those support systems are more difficult to access. While National Guard members reside within their state, reservists can live across many states.

Active duty deployment concerns are generally limited to three major areas:

(1) Pre-deployment issues:

- a. Preparing to leave and separate
- b. Legal issues – getting wills, powers-of-attorney, and other necessary documents up to date and in place.
- c. Financial issues – allotments, banking accounts, bill payment, etc.
- d. Family issues – childcare (especially for single parents), separation anxiety.

(2) Deployment issues:

- a. Safety – Where is s/he? Where is s/he going? What is s/he doing?
- b. Fidelity – Will my spouse cheat on me? (This affects both the deployed member and the family member remaining home.)

(3) Return and Reunion issues (examples include):

- a. Time during the deployment did not stop. Things changed over time. Schedule, child-rearing/discipline, bill paying, etc.
- b. New and reversed roles – The non-deployed member now is the family bill-payer. How does the deployment member react? Does s/he attempt to retake the old role? How does that affect the spouse who performed the task throughout the deployment?
- c. Money issues – During deployment there may have been additional allowances that stop when the deployment ends. How did the member spend money during the deployment? How did the remaining spouse use the “household” monies? Were decisions made well – i.e., the car broke and the remaining spouse bought a new car?

Adjusting to these changes is difficult enough when they are planned and anticipated. “Normal” deployments are generally planned far in advance and preparations for these concerns are addressed as part of the planning process. Reservists, on the other hand, can be activated as individuals on a few days notice. There is little, if any, time to prepare for the deployment and because the person is deploying as an individual, there is minimal unit level support. Even when the entire unit deploys, because the unit is comprised of members who often are scattered across many states, unit support is difficult, at best.

One typical difficulty facing Reservists and members of the Guard who are activated is financial devastation. Take for example, a young woman who is an information technology specialist. In her civilian job she earns \$120,000 per year (\$10,000 per month). In the military where she is a sergeant (E-5) with three years of service, she will earn \$2135 per month. Even with housing allowances added in, the salary becomes approximately \$3000 per month. Unless her company is “kindhearted” (and most are not), she and her family suffer a \$7000 per month loss in income. These figures become even worse for most service members.

Medical insurance also changes. Where in civilian life her family’s physicians accept her insurance coverage, once she is activated she is covered by the military’s Tricare program. Unless she happens to live around a military base or a place where there are numerous military retirees, in all probability her family will be forced to change physicians since many do not participate in or accept Tricare.

These changes generally do not affect active duty families as severely because they live in a military community on or around a military installation, near military medical providers. The active duty member does not suffer a loss in pay because his pay continues no matter where he is located. In addition, the military provides support groups on its bases to assist family members through the deployment.

The issues raised above are only the tip of the iceberg. These are the readily apparent concerns that face service members and their families. Now though, we must also consider the consequences of combat. Everyone who goes to war is affected by what they have seen and experienced -- even those who are in support units far away from the battlefield. Remember that truck drivers running convoys (a la Jessica Lynch) are prime targets. Remember that ships either in port (USS COLE) or underway (those in the Straits of Hormuz menaced by Iranian gunboats) are targets. Every service member sent to the theater of operations is subject to extreme stress, regardless of where they located.

The dictionary¹ defines trauma as follows:

- (1) A serious injury or shock to the body, as from violence or an accident.
- (2) An emotional wound or shock that creates substantial, lasting damage to the psychological development of a person, often leading to neurosis.
- (3) An event or situation that causes great distress and disruption.

¹ <http://www.thefreedictionary.com/trauma>

Using this definition, every service member who has gone to war or deployed in a wartime environment has suffered a traumatic event. Those who have been in or near a combat zone may well return with combat stress, or even worse, traumatic stress. A large number of those who have been in combat or survived an improvised explosive device (IED) may also suffer from some form of brain injury. These debilitating injuries are often called Post Traumatic Stress Disorder (PTSD) or Traumatic Brain Injury (TBI). Couple those injuries with members who return as amputees (or other severe injures) and the system established to deal with them is bursting at the seams.

Recently the news media including the Washington Post (31 January 2008) and The New York Times (31 January 2008) reported on increased levels of suicide and PTSD among returning Soldiers. Often these symptoms do not appear until months after homecoming. These episodes of PTSD have been linked to concussions received during battle. When explosive devices detonate near service members they suffer from concussions when their brain continually hits the sides of their skulls. New helmets prevent death and enable people to survive the blast, but they still suffer from concussion. This data is alarming because it shows itself long after return from the battlefield.

Our field medical care today has improved to such a point where many who would have died in previous wars, have returned alive, albeit injured, from this war. Our military treatment facilities such as Walter Reed Army Medical Center, National Naval Medical Center--Bethesda, and Brooke Army Medical Center are doing a yeoman job in caring for these young men and women. Our Veterans Affairs Hospitals are working above capacity dealing with these issues. Yet, many return to their home town, released from active duty, with a minimal support system, at best.

Problems begin once the Reservist has returned home. Usually away from a military base, the returning Reservist lacks the infrastructure the active duty member has. Without a base, military medical facilities are scarce, a VA center may or may not be nearby, and individuals with unique military concerns have no place to turn. Most civilian agencies, health care, religious, or other, are not familiar with the special stressors military members face. They are not familiar with a military mindset that always places mission first. And, they are not attuned to the types of experiences the returning member faces. Despite the best of intentions, civilian practitioners are not equipped to deal with issues similar to these:

(1) In war, we have created a topsy-turvy world. While killing in society at large is punished, killing during battle is encouraged and rewarded. The returning service member faces a moral reeducation to try to deal with understanding why they were rewarded for doing something that is generally condemned.

(2) Post-Traumatic Stress Disorder (PTSD) often does not reveal itself until weeks or months after return. Recognizing PTSD symptoms is not generally taught at our medical schools.

(3) Return and reunion issues are often complicated by one or both party's actions and behaviors during the separation. Coupled with the "normal" reintegration issues, these stresses become even more intense.

(4) Reintegration into civilian work may be difficult. Employers do not always follow the law and hold jobs for the service members. Even when they do, there may have been other changes that affect where the person works or the job title itself. Medical insurance may change once again, from military to civilian policies. Continuity of care becomes an issue.

Even if a VA Medical Center is located in proximity to the service member, the member may have difficulties accessing services for several reasons:

(1) Although “seamless transition” between the military departments and the VA has been created, there are still difficulties in the implementation. Active duty units have a better chance at truly integrating their retiring/separating members into the VA system than do reserve units or, even worse, individually returning Reservists.

(2) Access to the VA medical system is based on service connected conditions and disabilities. If the returning Reservist does not fall high enough on the VA strata, s/he may be denied service at a VA facility or be placed lower on a waiting list than other individuals.

(3) There are not enough providers who are expert in PTSD issues. Although both the VA and the military are straining resources to get more expertise in this essential area, they are not yet there. (It may not be certain that this expertise is available in the civilian community either.)

Others who often fall through the cracks in the system include single parents, serious wounded veterans (i.e., amputees, etc.), and those with Traumatic Brain Injury (TBI). While outstanding rehabilitation work is being done in Military Treatment Facilities to deal with these people, problems develop when they return to their communities.

In general, the religious community has voiced support for military service members regardless of their perceptions or feelings about the war itself. We, as chaplains, have an obligation to put our political feelings aside and deal with these hurting people. Traditionally, members of all faiths have fought in every war in which the United States has been involved. We continue to do so, and do so proudly.

Our communities have organized drives to collect cards, letters, and other sundries to send to service members. These gestures are very much appreciated. They are not, however, what military members really need. The most pressing need is helping family members who stay home. A family for example whose husband has deployed, whose wife is at home with three young children, may well need help doing chores the husband did, for example mowing the grass. Instead of collecting cards, we can and should be reaching out to all our military families finding ways to help make their lives easier.

State Adjutants, local reserve units, the JWB Jewish Chaplains Council and other religious bodies are eager to provide information on contacting local reserve units. They welcome assistance from community professionals in helping meet the needs of these service members. As professional chaplains we are obligated to reach out to these young men and women and their families. It is now time for us to act.

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