DISABILITY AND DESERVEDNESS: THE LIVED EXPERIENCE OF WOUNDED, ILL, AND INJURED MEMBERS OF THE U.S. ARMED FORCES AT A MILITARY MEDICAL FACILITY

By

Deborah Murphy

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Chair:

Dr. William Leap, Ph.D.

Dr. Daniel O. Sayers, Ph.D.

Dr. Janice Agazio, Ph.D.

Dr. David Peterson, Ph.D.

Dean of the College of Arts and Sciences

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DEDICATION

I dedicate this document to Wayne Hochberg and Patrick Murphy for whom I created it.

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ABSTRACT

My work engages links between notions of disability and notions of deservedness; the ways in which they are consequential; and how they are constructed and sustained. For my dissertation research I studied a select group of people at two sites of high visibility and focused practice: I used ethnographic methodology to collect qualitative data among participants interacting in treatment and rehabilitation of wounded, ill, and injured Service members at a Military Treatment Facility–first, at Walter Reed Army Medical Center in Washington, DC; and then at Walter Reed National Military Medical Facility in Bethesda, MD. My research participants included Service members themselves, care providers, family members, and non-medical attendants. I observed and field-noted their interactions; participated as an interested party; recruited, screened, and consented subjects to be interviewed; conducted confidential interviews; collected pertinent media content; photocopied or gathered onsite material culture; and transcribed, mapped, and pondered my data. To understand their lived experience and to find whether perceptions about disability affected patients' and family members' recognition and access to resources, I asked respondents to recount their stories about being abruptly changed from an able-bodied to a disabled person; or, their stories about caring for such a person. I also asked them to talk about being recognized and obtaining access to resources. Then, using tools

and tenets of Critical Discourse Analysis and insights from Critical Disabilities Studies I examined the ways people refer to and interact with formerly able-bodied Service members who have been disabled; whether they regard different types and contexts of injury and modes of rehabilitation as more or less deserving of recognition; and how perceptions of themselves and others affect patients' and families' access to resources. My research indicates that the ways in which people co-construct notions of disability expressly affect the manner in which they and others constitute, confer, and accept notions of deservedness for recognition and access to resources. These findings show how notions of disability may affect notions of deservedness.

PREFACE

I am a public anthropologist, and my area of interest is linguistics. I study texts, by which I mean words, spaces, clothing, gestures, and other semiotics that convey and constitute meaning. And I am interested in *dis*ability and deservedness.

To gain a better understanding of whether there is felt link between constructions of *dis*ability and constructions of deservedness, for three years I studied a particular group of people within a circumscribed place: I conducted ethnography at two Military Treatment Facilities (MTFs), participating, observing, and field-noting social and material culture; and interviewing military Service members, family members, non-medical attendants, and care givers.

My choice of sites was driven by several factors, the most central of which is that to become a member of the military one must be perceived as "fit," or able; and when adventitious harm occurs, military Service members' fitness is altered. My sense was that these sites and these people might offer a locus for studying what occurs when perceptions of ability are unexpectedly altered. I thought that what I learned might apply elsewhere and would be significant to understanding structural and agentive mechanisms that result in uneven distribution of resources among people whose abilities change.

While I was conducting my research the term "wounded, ill, and injured" began to accompany and then to replace the use of the term "wounded warrior." These designations expressed a rhetorical strategy to acknowledge all active duty Service members who had been harmed. Wounded means hurt while in combat, ill means sick or diseased, and injured means hurt but not in combat, in a training accident for example.

I asked my respondents about their lived experience as someone who had been unexpectedly harmed, or someone who was caring for such a person. I also field-noted,

collected, and annotated events and material culture at the sites. If respondents indicated that they did perceive a link, I asked them about the consequences. And I asked them to talk to me about how the link was maintained. These three areas of inquiry comprised my research question: Is there a link between constructions of *dis*ability and constructions of deservedness; what are the consequences of that link; and how is that link maintained?

I mobilized concepts of fitness, power, and social reproduction to help me retrieve and ponder my data; and I used Critical Discourse Analysis (CDA) to interpret them. I also used insights from Critical Disabilities Studies (CDS) to help me reflect on and challenge my interpretations. My analysis focused on identifying Faircloughian genres, styles, and discourses within texts (Fairclough 2003:24-26); and to use these insights to understand the position of my data, and my respondents, with respect to the governing orders of discourse: the institutional/military order of discourse, and the rehabilitation order of discourse at a MTF. Genres are actional; styles are identificatory; and discourses are representational.

I located my respondents' positions as central, outside, or marginal in the orders of discourse governing practices at the site. These positions align with Pêcheux's good, bad, and dis-identifying subjectivities (Pêcheux 1982:157) and are useful for understanding how interpellating influences act on and are enacted by subjects: how people experience and reproduce subjection and authorization–and how they recognize themselves and others within systems of meaning. By gathering textual data and critically analyzing them I wanted to get at the mechanisms governing practices and experiences at my site. My aim was to gain insights into aspects of lived experience that are significant to people's inclusion or exclusion, and the degrees of deservedness we accept or deny or negotiate at these sites and beyond.

Using ethnography and CDA I confirmed many of the ways that participants in rehabilitation at a MTF experience differentiated levels of deservedness within a taxonomy of harm, and I dis-covered several unexpected findings regarding discourses-in-formation. My primary claim is that at a MTF, qualitative data support the finding that there are links between how people perceive altered levels of fitness and how they agree to accept, confer, or negotiate corresponding levels of recognition and access to resources. These enactments are intelligible with their shared system of meaning, or order of discourse. They signal embodiments of power and are powerful. And they are semiotically reproduced. I found that subjectivities and discourses are always-in-formation: they are contradictory and dynamic, and they express struggle that may result in transformation. In other words, they are dialectical (Harvey 2010:11,12).

My findings are that perceptions of *dis*ability are linked with degrees of deservedness; that these links have material consequences; and that they are sustained by means of semioses. I also found that visibly harmed Service members who are being visibly rehabilitated get more recognition and access to resources than invisibly harmed and invisibly rehabilitated Service members. In addition I found that *dis*ability in the military is a process not an identity. Service members and their families rejected my notion of *dis*ability: they did not identify as having been "able" and now being "disable"–they identified with having been fit and now seeking a bene-fit.

I also found that people in the military view themselves and their lives as different from civilians; that they are family members among themselves, and more significantly among a multi-tiered military family; and that they strive to maintain their status as lifetime athletes. In addition I found that "wounded" signals "amputee;" and that amputees are more visible, more recognized, and have better access to a broader range of resources than other wounded, ill, and

injured Service members. This is significant because since 2001, 2000 Service members have undergone amputations or have lost limbs and digits at the site of their injury; while 49,000 have become ill or contracted a disabling disease; and 400,000 have PTSD or TBI or both. Yet it is amputees that are iconic for military Service and sacrifice and the recognition that redounds thereto.

When I analyzed my data I found repeated shared themes of Loss and Recovery; Identification and Disavowal; Inside versus Outside; Service and Sacrifice; Individual compared to Group; and Sovereignty and Mortality. I view these as discourses-in-formation that underlie and co-constitute the rehabilitation order of discourse at two MTFs, and which in turn sustain the institutional/military order of discourse in the hierarchy of governing discourses at my sites. Stability in this discursive hierarchy degenerates from top to bottom: The institutional/military order of discourse is rigid, stable, fixed–and global; underneath it, the local military treatment facility or rehabilitation order of discourse is modestly flexible. For example while I was there, the term "wounded warrior" started to be replaced by the term "wounded, ill, and injured." The lowest order of discourse is the dynamic, unstable, personal order of discourse that always-already co-constitutes the order above it. Here, nascent orders of discourse, such as Loss and Recovery, are generated and expressed by individuals within groups.

By very deeply and repeatedly analyzing my data I confronted a question I had not originally posed: What is a Military Treatment Facility? I found that it is a liminal space-time of re-covery. Recovery of things lost, detached, missing–not just limbs and aspects of cognition, but also of ideals. A place where dis-membered people are re-membered. And finally, I found that a MTF is a state of exception in which human beings that have been to some extent stripped bare,

and the provenience and consequences of their harms, are re-dressed. My analysis led me to areas for further research, two of which are immediately compelling:

1. Does the taxonomy of harm I have studied, and the provenience of various wounds, illnesses, and injuries act to hypostatize degrees of responsibility for adventitious *dis*ablement during military active duty?
2. Do orders of discourse that govern social practices also underpin beliefs?

Regarding the significance of these findings: By accepting my findings as real, policy-makers, providers, and patients may be able to actually challenge, mitigate, and rectify inequitable treatment. If we actively and intentionally regard Service members who are incommensurably harmed as persons equally deserving of recognition and access to resources, we may be able to prevent divisive and potentially perilous outcomes for them, for their families and communities, and by extension to other people whose abilities have been adventitiously altered.

To conclude, I found that constructions of adventitious *dis*ability are sociocultural as well as environmental; the effects of these constructions are uneven and poorly understood; and they require further research. The lack of mutual knowledge and understanding between civilian and military cultures is divisive and costly at personal, familial, community, and national scales. Understanding the lived experience of military active duty including adventitious *dis*ablement is important to bridging the gap between civilian and military cultures; members of the military are people who are the same and different from civilians, and vice versa. Knowledge about the real and lasting effects of becoming wounded, ill, or injured while in active duty is critical to managing costs and consequences cross widening politico-economic, juridical, bio-medical and sociocultural geographies in military and civilian terrains.

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GLOSSARY OF TERMS

Texts, narratives, and discourses in and about the U.S. Armed Forces include numerous acronyms that work in multivalent ways. For example, military acronyms constitute jargon; prevent or garble outsider comprehension; allow insider comprehension; and support group bonding. They may also mask literal meaning; elide intention and potential consequence; reinforce hierarchies; efficiently signal meaning; save time in communicating; and provide limitless fodder for jokes, parody, resistance, and disregard.

In my dissertation I chose to use acronyms for three reasons: under American Anthropological Association (AAA), Chicago, and Turabian style guidelines they are commonly used after the first use is fully spelled out, for organizations, associations, and agencies that are likely to be familiar to the reader; I wanted to actively invoke and acknowledge the community of linguistic practice in which I conducted ethnography for three years; and, I wanted to comment on and actualize the contradictory effects of using acronyms in discourse. When used habitually, they are all of these: dense, confusing, off-putting, weak, powerful, efficient, and obtuse; and, most significantly for my work, simultaneously inclusive and exclusive depending on the subjectivity of the listener/speaker.

I intend their use here to be reflective and ironic.

Throughout the work that follows, I have used acronyms listed and alphabetized below. In first use, I spell out the phrase and enclose the acronym in parentheses; after that I use the acronym on its own. In this list there are several terms-of-art used in social science that are also often shortened into acronyms and similarly parlayed by insiders; and puzzled over, resisted, laughed at, or disregarded by outsiders.

AAA – American Anthropological Association
ACLU – American Civil Liberties Union
ACU – Army Combat Uniform
ADA – Americans with Disabilities Act
ADL – Activities of Daily Life
AE – Adverse Event
AI – Associate Investigator
AU – The American University
BLS – Basic Life Support (American Heart Association)
BRAC – Base Realignment and Closure
CAM – Complementary Alternative Medicine
CDA – Critical Discourse Analysis
CDR – Commander U.S. Navy
CDS – Critical Disabilities Studies
CNSCI – Center for Nursing Science and Clinical Inquiry
Col – Colonel U.S. Air Force
COL – Colonel U.S. Army
CRT – Critical Race Theory
CUA – The Catholic University
DADT – Don't Ask Don't Tell (policy)
DHHS – Department of Health and Human Services
DHS – Department of Homeland Security
DLA – Daily Life Activities
DNP – Doctors of Nursing Practice
DOD – Department of Defense
DODD – Department of Defense Directive
DODI – Department of Defense Instruction
Dr. – Physician
DNP – Doctorate in Nurse Practice
FOB – Forward Operating Base
GI – Government Issue
HIPAA – Health Insurance Portability and Accountability Act
HIV/AIDS – Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HPV – Human Papillomavirus
HUC – Human Use Committee
IED – Improvised Explosive Devices
IFC – Informed Consent Forms
INS – Immigration and Naturalization Service
IRB – Institutional Review Board
ISP – Internet Service Providers
LtC – Lieutenant Colonel in U.S. Navy
LTC – Lieutenant Colonel in U.S. Army
MAJ – Major U.S. Army
MAPA – Masters in Public Anthropology
MATC – Military Advanced Training Center
MD – Medical Doctor
MEB – Medical Evaluation Board
MHS – Military Healthcare System
mTBI – Minor Traumatic Brain Injury
MTF – Military Medical Facility
NATO – North Atlantic Treaty Organization
NCA – National Capital Area
NCM – Nurse Case Manager
NMA – Non-Medical Attendee, or Attendant
NNMC – Naval National Medical Center
OEF – Operation Enduring Freedom
OIF – Operation Iraqi Freedom
OPN- Operation New Dawn
OT – Occupational Therapy
PAO – Public Affairs Office
PCS – Permanent Change of Station
PEB – Physical Evaluation Board
PhD – Doctor of Philosophy
PHI – Personal Health Information
PHS – Public Health Service
PI – Principal Investigator
PII – Personally Identifying Information
PM&R – Physical Medicine and Rehabilitation
PT – Physical Therapy
PTS – Post Traumatic Stress
PTSD – Post Traumatic Stress Syndrome
QOL – Quality Of Life
RADM – Rear Admiral U.S. Navy
RCRS - Responsible Conduct of Research Studies
RPG – Rocket-Propelled Grenades
RTD – Return-To-Duty
SARS – Severe Acute Respiratory Syndrome

SCI – Spinal Cord Injury
SDS – Society For Disability Studies
SRC – Scientific Review Committee
SSA – Social Security Administration
TAMC – Tripler Army Medical Center
TBI – Traumatic Brain Injury
TOD – Time of Day
TSNRP – TriService Nursing Research Program
U.K. – United Kingdom
U.S. – United States
USCBP – US Customs and Border Protection Services
USCIS – US Citizenship and Immigration
USICE – US Immigration and Custom Enforcement
USUHS – Uniformed Services University of Health Sciences
VA – Veterans Administration
VOIP – Voice Over Internet Protocols
WII – Wounded, Ill, and Injured
WRAMC – Walter Reed Army Medical Center
WRNMMC – Walter Reed National Military Medical Facility
WTB – Warrior Transition Brigade
WTC – Warrior Transition Clinic
WTU – Warrior Transition Unit
WW – Wounded Warriors
WWP – Wounded Warrior Project

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CHAPTER 1

HOW PEOPLE EXPERIENCE REAL AND IMAGINED BOUNDARIES

Conditions of Experience

Introduction: Sign and Signification

On September 13, 2007 the Military Advanced Training Center (MATC) opened its doors at Walter Reed Army Medical Center (WRAMC), a Military Treatment Facility (MTF) in Washington DC (Coleman 2007:1). The 31,000 square-foot MATC offered state-of-the-art physiatry[1] to active duty military Service[2] members (SMs) who had lost limbs or digits or aspects of their cognition. Care providers from multiple Physical Medicine and Rehabilitation (PM&R) specialties including prosthetology, medicine, nurse case management, occupational and physical therapy, psychology, social work, and Department of Veterans Affairs (VA) benefits-counseling assisted patients in their rehabilitation, recovery, and re-entry into military or civilian life. Every Wednesday at 10:00 a.m. (1000 in military time) the MATC receptionist placed an 8.5 x 11" printed sign onto a tabletop easel on her counter. It looked like this:

Example 1.1

[1] People and technologies devoted to Physical Medicine and Rehabilitation (PM&R).

[2] I use "Service" advisedly and as it is commonly (if loosely) parlayed in the United States to denote service to one's country or to the nation through membership in the Armed Forces. I understand that many alternative models of service exist in contemporary American life: for example, teaching in service to students; offering medical and psychological support in service to human health; cleaning streets and buildings in service to improving public sanitation and human and vehicular traffic flows; providing food in service to patrons in restaurants; or to those who are without food or housing–etc.

In the MATC most patients were amputees. All were cut-off. Very few could walk in unaided, either by people, dogs, assistive technologies, or prostheses. When I pointed out the sign's wording to people in the clinic and elsewhere at the site they were surprised that I had noticed. A few were surprised that they had not. When I asked people what they thought about the sign they gave me various responses, from "You're over-thinking this Ma'am," to "That's appalling."

At WRAMC and later at Walter Reed National Military Medical Center in Bethesda MD (WRNNMC), many semiotic mechanisms dialectically erase and foreground the conditions that people at a military treatment facility (MTF) are grappling with every day. Every day in such a place, wounded, ill, and injured SMs, their families, non-military attendants[3] (NMAs), and care providers chose or refuse to grapple with their interdependent lived experiences. They do so in multivariable ways–sometimes with humor, other times with obliviousness; sometimes with expertise, sometimes with awkwardness. They do so tacitly and overtly; and everything they do there is reflected via texts.[4] There is nothing outside the text (Howarth and Stavrakakis 2002:5, quoting Derrida 1974[5]).

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[3] Variously spelled "non-medical attendant" and "non-medical attendee," this designation is used formally and informally within the U.S. Armed Forces to signify a designated care giver. *Dis*abled service members who are in rehabilitation at MTFs and who do not have or want immediate families (spouse or children for example) to support them in their recovery are permitted to designate other individuals as a care givers for periods of time that are renewable by means of application. The care giver may be a "friend, fiancée or fiancé, co-worker, member of the family who is not a military dependent, etc." By means of limited stipends, living expenses are paid for family-member and non-family-member NMAs. *Dis*abled service members who are in rehabilitation may also decide that they do not want to designate an NMA (DODI 2009; NCOPB 2011). People I met and listened to at my sites said "NMA" rather than using the entire phrase.

[4] I use "text" and "texts" to indicate things that people can read, apprehend, or interpret; and that connote meaning to their readers (or "receivers"). Texts include words uttered, written, and sung; performances, spaces, images, gestures, uniforms–and, as I propose here, prosthetics (Derrida 1974:158,1986:165; Hall, S. 1980: 167; Howarth and Stavrakakis 2002:5, Joseph 1986:20-22; Pêcheux 1972:156, Vološinov 1973:1). Gathering and thinking about texts animated my research and analysis because my respondents spoke incessantly about and expressly displayed gear, uniforms, badges, imagery, music, arms, legs, boots, scars, tattoos, assistive technologies (wheelchairs, crutches and canes for example), prosthetics and other "text artifacts" (Silverstein and Urban 1996: 6); and when asked and listened to, they indicated that the significance of these texts varied depending on the spaces in which they were uttered and displayed.

[5] J. Derrida, 1974:158. Of Grammatology. Baltimore, MD: Johns Hopkins University Press.

While conducting research I often used this example of a "sign" to help people understand my impetus to conduct qualitative research at their site (or anywhere for that matter). I used it to illustrate the meaning of "material culture." Moreover, I used this sign to point out the importance of considering texts and contexts in all we do and say and intend when we communicate within systems of meaning. Indeed, this sign is synecdochical for my research.

Research Prompts and Field Sites

Numerous prompts moved me towards the decision to conduct research at a MTF. Among them was a film. In fall 2007 I watched *Alive Day Memories*, a documentary about SMs returning from Iraq (HBO 2007). In it, ten severely *dis*abled[6] SMs discussed their "before, during and after" enlistment and deployment experiences. Those who self-identified as suffering from Traumatic Brain Injury (TBI) and Post Traumatic Stress Syndrome (PTSD) expressed themselves, their rehabilitation, and their positioning differently from those who were fitted with innovative soma-technical devices[7] and who self-identified as "wounded warriors." Each person described herself or himself as originally being fit, able, and willing. Now, after being grievously harmed, each was being asked about and was discussing his or her own rehabilitation, embodiment, and subjectivity.

Some of the interviewees claimed continued pride in having enlisted and wished to re-deploy (HBO 2007:10:45-21:37). Others expressed remorse or confusion about their military

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[6] Throughout this document I italicize prefixes "dis," "un," and "im" to complicate and collapse conceptual and lived contradictions. In my research, by using the designation "*dis*abled" I am indexing people whose corporeal or cognitive ability (or both) was unexpectedly altered during active duty in the U.S. Armed Forces.

[7] By using "soma-technical" I refer to advanced prosthetology in which human bodies are repaired using sophisticated replacement parts (prosthetics). I borrow the term from the field of "soma-technics", an "inter-discipline" and ontological approach that views corporeality as a state that is always-already bound up with a variety of technologies, technēs and techniques. Soma-technics examines the effects that technologies, technēs and techniques have on embodiment, subjectivity, and sociality, through understanding lived experiences in context. Its scholars critically examine relations at work between the body (soma), and the various technologies, technēs and techniques (technics) that shape it (Journal of Somatechnics 2011).

enlistment and re-entry into civilian life as unexpectedly altered people (2007:44:08-44:30). These contrasts stoked my interest in studying SMs who have been temporarily or permanently *dis*abled and those supporting or caring for them, as personifications of the continuous formation of ideas about *dis*ability, the ways these ideas are vouchsafed, and how they are linked with mortal[8] decisions about who deserves what.

In addition, I was interested in understanding what persuades some U.S. citizens (and non-citizens [Preston 2009:1; 2012:21]) to join the Armed Forces. My research and conversations with a range of civilians and SMs who were variously supportive, critical, and ambivalent about military enlistment revealed that powerful complexes of practical, ideological, emotional, spiritual, commercial, economic, familial, and psychological influences act in *un*expected ways to induce some people to join up, and others to vacillate, disregard the possibility, or resist recruitment overtures; and, for those who have enlisted or enrolled,[9] to remain or to leave.

What seemed missing in my literature searches and preliminary research was an explanation for why obvious mortal risk to themselves and others neither dissuaded some people from enlisting nor acted to quell or even scotch broad public support or tacit approval of waging war. In fact, to the contrary, some scholars note and my data confirmed that incidents of extreme risk and harm resulting from war that are mediated online, in newspapers, at museum exhibits, and via memorials may promote people to enlist in and support military service (Sontag 2030:38,39). Some respondents confirmed that exposure to the dangers of war was the

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[8] The word "mortal" is dialectical: At the same time, in English, it conjures "life" and "death." Mortal means subject to death, having a transitory life, of or pertaining to human beings as subject to death, human, belonging to this world, deadly or implacable, relentless, severe, dire, grievous, or bitter (*Random House* 2011).

[9] As was pointed out to me by an Army officer, officers "enroll;" enlisted personnel "enlist" (Jennings 2012, personal communication). After some consideration I chose to continue to use the words "enlist" and "enlistment" as they are popularly understood, rather than as they apply among active duty SMs to distinguish between Enlisted ("E"s) and Officers ("O"s). I wanted to keep in play enlists' sense of "entering into a cause or enterprise" (*Random House* 2011); and correlated questions of agency (who decides, who acts, who reacts?).

motivating factor of their enlistment, and that films and documentaries about war did not repel them–rather, such mediations kindled their commitment to enlist, or positively affected their receptivity to recruitment efforts (060a[10]).

My research was located at the nexus of discursive constructions of *dis*ability and deservedness. The people from whom I gathered data are members of the U.S. Armed Forces[11] who were considered able and then became *dis*abled, their families, their NMAs,[12] and the medical providers such as military and civilian therapists, doctors, case managers, and nurses with whom they interacted in rehabilitation at a MTF. I conducted several years of fieldwork at two MTFs: initially, at Walter Reed Army Medical Center (WRAMC) in Washington, DC, and subsequently at Walter Reed National Military Medical Center (WRNMMC) in Bethesda, MD. At these two sites I was a participant observer, ethnographer, and collaborating researcher, working with teams of civilian and military scientists, practitioners, and staff; and with SMs who were patients, their family members, and NMAs.

Complex and contradictory information that participants tacitly and overtly shared with me and my onsite observations of multivariable texts at amputee, wellness, and rehabilitation clinics as well as in eating facilities, hallways, paths, tunnels, passageways and gardens led me to explore whether and how notions of *dis*ability and notions of deservedness might be co-constituted, enacted, and sustained. To identify the complex ways in which they might be

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[10] I refer to transcriptions of interviews with research respondents by using the number I assigned them, followed by "a" or "b" to denote the first or second interview respectively, and by then enclosing the reference in brackets (e.g., 060a). I refer to content of conversations with respondents who agreed to my taking field notes by using 2 initials and the number I assigned them, also in brackets (e.g., FN140). Some transcriptions and field notes are in Appendix A.

[11] The U.S. Armed Forces are comprised of 5 branches: Army, Navy, Marine Corps, Air Force, and Coast Guard. Each Force has National Guard and Reserve contingents (DODD 2011).

[12] Following the everyday linguistic conventions of U.S. Armed Forces' texts, I acronymize oft-repeated phrases and terms; e.g., "NMA" for "Non-Military Attendant;" and, following Turabian Style I use acronyms for well-recognized entities. For lesser-known names I use the full expression first, followed by the acronym. In the Glossary I note some of the ideological and practical work that acronyms do.

intersecting, I mobilized concepts of fitness, power, and social reproduction.[13] These concepts were suggested by my literature review and animated by discourses at the site. Subjects and objects[14] like posters and audio-video content on screens invoked the words "fit" and "fitness," and referred to "power" repeatedly and explicitly. At the same time, examples of entextualization[15] continuously pointed to how fitness is understood, the ways in which power circulates and is productive,[16] and how notions become socially reproduced through language (Bourdieu 1977:170; Decena 2008:340; Fairclough 2003:23-27; Hall, S. 1980:175; Park and Bucholtz 2009:485; Urban 1996:21,22; Young, R. 2001:6,7). These entextualizations included insertions, references to, and re-emplacements of linguistic features from various discourses into other ones. For example, I noticed texts regarding exercises, images, gestures, ceremonies, uniforms, schedules, ranks, promotions, retirements, invocations, announcements, and daily practices[17] appearing in new formats and new contexts. I took the concepts of fitness, power, and

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[13] I mobilized these three concepts to frame my research and I use this phrase ("fitness, power, and social reproduction") throughout my dissertation. I use fitness to mean perceived wholeness, ability, and (self-) regard as appropriately adapted or adaptable to a setting; power to mean structural, systemic and agentive leverage that defines, acknowledges and confers recognition and access to resources; and social reproduction as *im*material forces and relations that combine to inculcate and perpetuate lived experiences, subjectivities, conditions, and perceptions.

[14] I generally prefer to use "person," "people," "participant," or "respondent" rather than "subject," or "subjects." In this work however, I am considering "people" and "things;" "subjectivity" as understood via Althusser (1971) and Pêcheux (1982); and "objectification" as understood via Marx (1988). For this reason, here I am arbitrarily and advisedly choosing to use "subject" and "subjects" for "person" and "people;" and "object" and "objects" for "things." These usages are intended to keep subjection and objectification in play.

[15] Entextualization includes insertions, references to, and re-emplacements of words, expressions, and other linguistic textual features (including images) from various originary discourses into other ones (Park and Bucholtz 2009:486).

[16] I intend "productive" in the Foucauldian sense of flowing back and forth, creating and sustaining power, affecting people (Foucault 1977:194). What is critical in Foucault's analysis is that power does not "happen" to one; it includes many and has influence among many–and it creates or "produces" subjectivities and materialities. In this sense it is "productive."

[17] One richly semiotic occasion that I witnessed was unique during my fieldwork: On July 27, 2011, after operating for over 102 years as an Army base and hospital, Walter Reed Army Medical Center (formerly "Hospital") in Washington DC was closed. Its Color Guard ("color" refers to "flag") lowered the flag for the last time, and "cased," or finally furled and encased it during a (broadly mediated) ceremony called "Casing of the Colors." In my dissertation I do not refer to all of the multivariable semiotics I observed and participated in at my sites, nor was I able to field note or capture many of them; this historic event however was broadly entextualized before, during, and after it occurred and it appeared to deeply move those who witnessed it–while it occurred, and afterwards via multi-media.. See Reuters online article at http://www.reuters.com/article/2011/07/28/us-casing-colors-hospital-idUSTRE76R4TS20110728

social reproduction as representations of semiotic mechanisms that undergird the interactions I was interested in comprehending (Chandler 2002:187).

During my fieldwork, the Department of Defense's (DOD's) restructuring edict and the subsequent Congressionally-mandated Base Realignment and Closure (BRAC) legislation 2005 round (DOD 2005) was enacted locally in the National Capital Area (NCA), merging WRAMC with National Naval Medical Center (NNMC) in Bethesda, MD, to form WRNMMC.[18] The sociocultural, politico-economic, and *im*material effects of the merger, my involvement in several parallel qualitative research projects, and my day-to-day presence in two MTFs over a period of three years combined to offer me unexpectedly penetrating and comprehensive access to the subjects and objects of my research: *Dis*abled SMs, family members, NMAs, care providers, and textual components including features of material culture.[19]

Geo-Historical Context

Contemporary Warfare

As of this writing, August 2012, American military intervention in Afghanistan and elsewhere[20] continues. The DOD and its associated agencies and forces, as well as many media refer to this fight as Operation Enduring Freedom (OEF), and the combat and associated activities are described by many people who report on it as comprising an asymmetric war–a war in which the sides are unevenly matched in numbers, in sophistication of weaponry, in tactics,

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[18] The Maryland facility, WRNMMC, is currently (August 2012) comprised of 243 acres and 88 buildings. To date WRNMMC is continuing to undergo massive re-construction and remodeling initiatives–a "rehabilitation" in its own right, and the object of another research study in which I am collaborating with some colleagues there. I am also involved in a study examining the ethics of conducting participant research among multiply vulnerable subjects; i.e., wounded, ill, and injured SMs being treated at MTFs.

[19] Such as posters, announcements, framed artwork, magazines, sculpture, prosthetics, assistive technologies, and other objects.

[20] In an October 2, 2011, *Washington Post* report by Magda et al, about "U.S. troops killed recently in the Afghanistan war," locations for total American military service member deaths in "Operation Enduring Freedom" or OEF, the "war in Afghanistan," included: Guantanamo Bay, Cuba; Djibouti; Eritrea; Ethiopia; Jordan; Kenya; Kyrgyzstan; Pakistan; Philippines; Seychelles; Sudan; Tajikistan; Turkey; Uzbekistan; and Yemen. The news source was listed as "Defense Department's www.defenselink.mil/news" (Magda et al 2011:11, 2012:14).

and in types and rates of mortality (CNN 2010; Kusiak 2008: 65; Stepanova 2008:14; Tanielian and Jaycox 2008:3-6, 25-29; Wool 2011:103,n.72). Yet as casualty figures attest, this asymmetry does not imply or predict outmatching by one side or the other, nor result in an end to the fighting. On the contrary, U.S. engagement in Afghanistan has spanned over ten years, and until 2007 extreme injuries to members of the military (on all sides), as well as to civilians, including children, continued to escalate in numbers and severity.[21] This is largely due to the use of rocket-propelled grenades (RPGs), land mines, and other explosives such as Improvised Explosive Devices (IEDs), and the damage they do to those who inadvertently detonate them in this theater (Vogel 2012:1). IED makers' access to and more sophisticated use of ammonium nitrate[22] contribute to the severity of damage these devices effect (Sabir 2011:1,2); so too do incursions into tribal strongholds, troops' inconsistent access to and use of protective equipment, repeated deployments, and inadvertent (sometimes referred to as "innocent") civilian entanglements.

Technological and practical advances in onsite military medicine that are prompted in part by complex IED injuries are resulting in enhanced survivability: State-of-the-art military medical interventions are saving people who just a few years ago would have perished in the moment due to massive losses of tissue, blood, and limbs (Caravalho 2011:10-15; CNN 2010; HBO 2007:00.04-02.37; Reiber et al 2010:275,276; Shute 2004: 40-41; Tanielian and Jaycox 2008:5; Zoroya 2009:1). This means that today unprecedented numbers of grievously harmed

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[21] Depending on the source, the number of U.S. troops deployed to Operation Iraqi Freedom, or "OIF," and to OEF since 2001 is reported to range up to 2.1 million (DOD 2010a:iii; Tanelian and Jaycox 2008:xix). Of those, 2101 have been killed in Afghanistan and 4474 killed in Iraq (Magda et al 2011:11, 2012:14); alongside unknown numbers of dead Afghans and Iraqis.

[22] The explosive fertilizer used by numerous terrorists, both domestic (Oklahoma City, U.S.A. 1995) and international (Delhi, India 2011).

SMs are not only surviving but are being rehabilitated successfully enough that they can be returned to civilian life; and some are even returned-to-duty (RTD) or re-deployed.[23]

As recounted by practitioners, journalists, policy-makers, researchers, and SMs themselves, rehabilitation interventions are undertaken with the objective of returning SMs to service or to civilian life (Aliff 2010:1; Dao, Carey and Frosch 2011:1; Dao and Frosch 2010:1; Sheftick and Holzer 2007:1; USAP 2010:24; USHCVA 2007:1-32, 45-82; Wool 2011:100,n.70; WWP 2010a,b). Medical practitioners, therapists, family members and NMAs cooperate with patients to make *dis*abled SMs whole,[24] using surgeries, prosthetics, and therapies; drugs, complementary alternative medical (CAM) interventions; care from providers and others; and support for the management of their daily life activities (DLAs). These interventions can combine to enable some but not all to re-claim their fitness for resumption of military or civilian roles and responsibilities. The techno-scientific practices, medical practitioners, and patients in rehabilitation who co-enable these outcomes are often recognized by observers as heroic, extraordinary, and exemplary (Mockenhaupt 2007:76; Wool 2011:177; WWP 2010a,b; 2011). Moreover, some subjects who are made whole may be proffered as exemplary beneficiaries of advances in modern military medicine–advances whose benefits civilians will also reap (Barnes

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[23] Up to 20% of active duty amputees were RTD between 2001 and 2010, according to Reiber et al 2010:287.

[24] The notion of "making whole" is a subject to be explored in its own right, elsewhere. This phrase was appropriated from the financial sector (in which it refers to a kind of rarely-invoked call provision to pay off certain kinds of debt), and the law (in which it refers to compensation for injury or loss) when it was used repeatedly in 2010 by BP, other oil companies, governmental representatives and organizations, and even journalists and commentators in marketing efforts and reporting that followed the BP oil spill in the Gulf of Mexico. The phrase was rapidly adopted into other discourses and deserves some sociocultural and linguistic anthropological exegesis of its own, especially because of its obvious resonance with notions of corporeal dismemberment and prosthetic intervention being referenced above in the discussion of *dis*ability and rehabilitation. For an example of media (and marketing) usage see New York Times article "Should BP's Money Go Where the Oil Didn't?" at: http://www.nytimes.com/2010/10/24/business/24claim.html

2010:1) and whose apparent utility is therefore endorsed and underwritten by private and public funds and administered by non-profit foundations.[25]

Having worked at two MTFs, I can attest that the acts of bravery, prowess, and expertise co-enacted by *dis*abled SMs and their medico-rehabilitative practitioners invoke awe, inspiration, and gratitude, emotions expressed and shared by staff, visitors such sports figures, politicians, and celebrities,[26] volunteers, researchers, and others. Yet what may be muffled by extraordinary manifestations of corporeal recovery, like bi-lateral amputees running on advanced hi-tech prosthetic legs, is the lived experience of some people who can not or will not–or are not asked to–sign on to techno-scientific or other athletic "sports" models of rehabilitation (Messinger 2009a16,b4: Vogel 2012:1; Wool 2011:). Such models demand and reward astonishing feats of soma-technical achievement over heretofore deadly or *dis*abling corporeal losses. Some SMs' brains or psyches or both have been damaged during training and deployment, sometimes because of detonations and other debilitating exposures to asymmetric combat and war. Others are incapacitated during active duty by disease; cancer, diabetes, Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS), and arthritis, for example. For some of these subjects, neither the damage, the possibly restorative interventions, nor their incremental advances (if any) in recovery seem as obvious, familiar, broadly recognized, or rewarded with

[25] For example, the Congressionally-Directed Medical Research Programs (CDMRP), National Institutes of Health (NIH), and the TriService Nursing Research Program (TSNRP); and grant administering foundations such as The Geneva Foundation (GenevaUSA), and The Henry M. Jackson Foundation (HJF).

[26] While I was at my sites numerous famous people "visited," and throughout the spaces there posters, photographs (often autographed with personal messages), announcements, site-wide e mails, flyers, and audio/video content refer to past, present, and future visits of sports figures, politicians, and celebrities. These sites are also the facilities in which Presidents, Senators, and other dignitaries and their beneficiaries are treated, sometimes for years, when hospitalization is required.

access to special resources. Moreover, advances in their treatment and subsequent survival do not get as broadly "cast" in various media (Wool 2011:177).[27]

Since September 11, 2001, as a result of Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF), and Operation New Dawn (OND), as many as 400,000 male and female SMs may have been diagnosed with TBI, debilitating depression, PTSD, or a combination of these conditions (Tanielian and Jaycox 2008:9). According to Fisher 2010, between 2003 and August 2010, 49,390 SMs were medically evacuated from OIF; of these, 30,053 were ill, and 10,383 had "non-hostile injuries."[28] By contrast, depending on the source consulted, it appears that approximately 2000 male and female SMs have suffered amputations (Fischer 2010:4). Yet it is the "visibly" *dis*abled SMs whose altered corpo-realities seem to garner attention in the public sphere and even at MTFs (Davenport 2010:2; Pincus 2012:11; Reiber et al 2010:292). During active duty of all kinds, including training, some SMs and civilians may be killed, dismembered, or grievously corporeally harmed; while others survive with limbs intact, their faces and torsos unaltered, their vision and hearing largely unaffected. In the meantime though, their cognitive, psychological, conative,[29] sensory, and affective abilities may have been damaged, perhaps beyond repair; certainly beyond on-demand repair at the site of the explosion, and sometimes beyond subsequent organized repair, or physiatry,[30] at military

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[27] Although as of this writing, August 2012, attention to these plights has increased; see for example Kristof 2012:1-7; Pincus 2012:11.

[28] Fischer 2010 explains, "The Department of Defense defines a non-hostile injury as an injury that is not directly attributable to hostile action or terrorist activity, such as casualties due to the elements, self-inflicted wounds, or combat fatigue" (2010:7,n.a).

[29] The part of mental life having to do with striving, including desire and volition (*Random House* 2011).

[30] Physiatry means physical medicine and rehabilitation (PM&R). It is an area of practice and medical specialty treating "disabilities" through physical means. Its objectives are pain relief, functional improvement or maintenance, training in essential activities, and functional testing of areas such as strength, mobility, breathing capacity, and coordination. Physical medicine may use diathermy, hydrotherapy, massage, exercise, and functional training; i.e., learning to work with a guide dog or a prosthesis or learning new ways to carry out everyday activities with a limb missing, sometimes by using assistive devices. Often, physician specialists head rehabilitation teams, including a physical therapist, rehabilitation engineer, rehabilitation nurse, psychological counselor, and sometimes a respiratory or speech therapist (*Random House* 2011).

rehabilitation clinics and facilities. Others become ill and are sent to military medical units to be treated. These *dis*abled people are subjects for whom rehabilitation is invisible and private, often taking the form of drug, psychiatric, or CAM therapies; post-operative care; dialysis; radiation and chemotherapy; and sometimes not occurring at all.

Some of these SMs may be discharged and expected to recover on their own and they may be excluded not only from sanctioned treatment at MTFs, but they and their families may also be excluded from ongoing recognition and access to many kinds of resources, including extended after-care, incremental pension benefits, training and employment opportunities, and public praise (Minear 2010:164; Tanielian and Jaycox 2008:149-152; VA 2011:6; Woolhandler 2007:7). Significantly, when discussing *dis*ability claims and retirement benefits, without being prompted, several subjects at my sites told me that just being in the service is *dis*abling. This was notable because I and others have speculated, and some SMs have indicated (on blogs, within other online social networks, and in discussions with photojournalists and contemporary historians for example), that the rigors of enlistment,[31] training, and active duty in any of the U.S. Armed Forces may be not only strengthening and bolstering with regard to athleticism, skill-building, readiness, and even self-esteem, but also inherently damaging, even *dis*abling (Goldsmith 2009:16,28,42; Herman 1997:20-27; *Home Fires* [blog] 2009, 2010, 2011; Meekosha and Dowse 1997:58; Minear 2010:193).

Notwithstanding the fact that the purpose of war is to injure and kill more effectively than the opponent (Clausewitz 1976:16,28,75-77; Herman 1997:33; Scarry 1985:63; D.L. Smith 2007:xv,xvix,148), extreme injury effected via asymmetric warfare is challenging the resources

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[31] As of 1973, enlistment in the U. S. Armed Forces is voluntary; there is no draft (no required military service for U.S. citizens). This is important to consider when thinking about who joins, and why.

[31] The U.S. Armed Forces are comprised of 5 branches: Army, Navy, Marine Corps, Air Force, and Coast Guard. Each Force has National Guard and Reserve contingents. Department of Defense Directive (DODD) 1235.10 2011 accessed April 4, 2011 online at: http://www.dtic.mil/whs/directives/corres/dir.html

the U.S. military health-care system and exacting real politico-economic and sociocultural costs and consequences that are not as yet fully calculated, across an expanding terrain of individual, familial, community, and national fields of experience (Minear 2010; Reiber et al 2010; Tanielian and Jaycox 2008). Unprecedented rates and unfamiliar embodiments of survival have overlaid often unmanageable–and for some, unimaginable–burdens onto those that SMs, their care providers, families, and communities have traditionally borne under multiple demands of active duty and training, and deployment into war. By being included in highly visible and broadly mediated medical and physiatric interventions, some SMs' bodies are apparently successfully repaired (or re-fitted) and their *dis*abilities or *dis*ablement honored; yet alongside these soma-technical achievements, not-so-apparent recoveries and their trajectories may be under-recognized.[32]

How does this work? What are the ways in which instruments of *un*intentional exclusion and under-recognition do their work? Do texts that bespeak violence, injury, and repair–including narratives, weapons, bodies, uniforms, gear, medals, exercises, surgeries, scars, prosthetics, and other assistive soma-technologies–co-constitute and maintain boundaries between those who are deemed deserving and those who are not? Is the able-bodied SM's corpus an intelligible text that is inscribed with factors of inclusion even–or perhaps particularly–when it is obviously damaged and repaired; whereas apparently able-bodied but medically *dis*abled SMs' illnesses, altered cognition, and damaged psyches are unintelligible texts whose original

[32] I am using "apparent" here to complicate notions of what kinds of recovery are obvious, which are easily "read," and which may be mis-read. While it may seem obvious that modes of repair and rehabilitation that are *visible* are more readily *apparent*, what I was interested in understanding was whether various harms were unequally perceived and valorized depending on the kind and provenience of damage and subsequent repair, and their degrees of *apparentness* or intelligibility. Indeed, the very idea of *obviousness* is problematized by Althusser as a means of simultaneous subjection and recognition–by self and others, particularly by "subjects" and by "state apparatuses" such as the Army (1971:139,140,172). "Apparent" means readily seen; exposed to sight; open to view; visible. It also means capable of being easily perceived or understood; plain or clear; obvious. Moreover, "apparent" indexes "according to appearances, initial evidence, incomplete results; ostensible rather than actual" (*Random House* 2011).

wellness or subsequent damage cannot be easily deciphered, and whose *dis*ablement and rehabilitation are not only less noticed but perhaps less notable? And if so, how are these uneven outcomes explained and understood? How are they experienced? Are they experienced broadly; that is to say, in military and in civilian life?

During fieldwork and research I noticed puzzling phenomena of inclusion and exclusion among *dis*abled SMs, as well as uneven outcomes in recognition and redistribution, or access to resources (Butler 1997:275; Fraser 1997a:68, 1997b:280; Oswin 2007:654,655; Swanson 2005:89). To understand what I observed and what subjects related to me, I turned to Critical Discourse Analysis (CDA) and Critical Disabilities Studies (CDS) in which textual and social constructions of subjectivity, *dis*ability, and deservedness, and their *im*material effects are identified, examined, and explicated–or, unpacked (Davis 2010c:301; Fairclough 2003:203,204,207; Ingstad and Whyte 1995:10; Shuttleworth and Kasnitz 2004:140; Williams 1977:165). Analytical insights in these canons indexed to me a particular locus of intersecting and sometimes competing interests that demanded further inquiry: The intersection at which *dis*abled SMs, their families, and care givers appear to compete in a "tournament of value" for their respective claims to recognition and access to resources, within a "regime of value" which is in turn nested within a particular political economy (Appadurai 1986:21),[33] and governed by orders of discourse (Fairclough 2003:24-28).

[33] Appadurai explains: "Tournaments of value are complex periodic events that are removed in some culturally well-defined way from the routines of economic life. Participation in them is likely to be both a privilege of those in power and an instrument of status contests between them. The currency of such tournaments is also likely to be set apart through well understood cultural diacritics. Finally what is at issue in such tournaments is not just status, rank, fame, or reputation of actors, but the disposition of the central tokens of value in the society in question." In the passage's two footnotes the author notes: "In coining the term tournaments of value I was stimulated by Marriott's use, in a very different context, of the conception of tournaments of rank (Marriott 1968);" and, "In his recent discussion of world's fairs and expositions, Burton Benedict (1983:6) has noted the elements of contest, competitive display, and status associated with these events" (1986:21, n.7,8).

Research Grounding and Hypothesis

My study's hypothesis was that some SMs may appear to be excluded from widely-endorsed and -mediated[34] rehabilitative regimens because of their invisible and "inadmissible" injuries; they may be tacitly constructed as ineligible for or may be excluded from the benefits that accrue to subjects who seem to be granted access on the basis of visible or "admissible" *dis*ablement. To get at the discursive mechanisms at work in this terrain, I plumbed scholarship that examines constructions of fitness, power, and social reproduction. In these catchments, scholars and other researchers problematize notions of *dis*ability and deservedness, positioning fitness and eligibility/ineligibility, ability/*dis*ability, and deservedness/undeservedness as textually and socially constructed notions which are reproduced and operationalized to maintain forces and relations of power (Adkins 2003:2; Davis 2010b:17; Linton 2010:235; McRuer 2006:151; Meekosha and Dowse 1997:67; Rapp and Ginsberg 2001:545; Shuttleworth and Kasnitz 2001:8). This work, as well as that of analysts who unpack ideological and hegemonic inculcations of citizenship and belonging (Boellstorff 2005:7; Douglas 1994:227; Leap 2004:136,137, 2005:417, 2007:30; Maurer 1996:1997:150,166; Ong 2006: 215-221; Peterson 2010:260-267), and of value, service, and commoditization (Appadurai 2010:56,57; Douglas 1994:163,168,179), helped me examine how military rehabilitation, retention, and re-assignment activities (e.g., re-deployment, retention in non-combat active duty, or discharge and re-entry into civilian life) valorize embodiments of fitness and re-fitting as key attributes of readiness and eligibility for recognition and access to resources; while under-recognizing the existence and consequences of cognitive, psychological, and physiological "unfitness," and mis-appropriating,

[34] By which I mean disseminated in various media.

mis-allocating, or even dismissing access to particular modes[35] of rehabilitation (Messinger 2009b:4; 2010:284,285).

Based on what I observed, what respondents told me, and what other researchers and ethnographers have posited, it seems that semiotics of posture, gait, uniforms, salutes, medals, and even prosthetics and assistive technologies may actively mediate messaging that rewards particular kinds of *dis*ablement and modes of rehabilitation; and that these privileged valuations rest on visible expressions of corporeal re-integration. Some literature and study respondents postulate that even earlier, in the process of military enrollment, similar semiotic mechanisms may also mask risks of active duty, combat, and war; even mystifying[36] the axis of responsibility for harm and rehabilitation. And, when SMs are *dis*abled, a seemingly irrepressible taxonomy of sacrifice appears to emerge as some people distinguish themselves from others using nomenclature that hierarchizes degrees of sacrifice. "Wounded," "Ill," and "Injured" have become terms-of-art that are replacing the phrase "Wounded Warriors" in many texts.[37] After 2002 the genesis and mediation of the term "Wounded Warrior" itself were the outcomes of a rhetorical strategy "to reflect the warrior ethos and spirit of our wounded soldiers" (Krull and Haugseth 2012: ix; U.S. Army Posture Statement 2008:1; Pincus 2012:11). This hegemonic naming process dodges who was or is responsible for harm, rehabilitation, and re-integration into life after *dis*ablement. Particularly, in the noisy space of re-naming who has been harmed and how, uneven outcomes and degrees of recognition and access to resources may be elided: Questions regarding who deserves what and why may become muffled. Is the SM responsible?

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[35] Modes, i.e, in the Marxian sense of systemic "forces" and "relations" (Marx 1978e:4,5).

[36] I use "mystify" in the Marxian sense of obscuring the wellspring, source, or mechanisms of particular socio-economic and material effects (Marx 1978a:320-329).

[37] In posters for example: In the lobby of a central building at WRNMMC, posters are regularly displayed to announce monthly Town Hall meetings for SMs, family members, care givers, and NMAs. Over the course of my research the wording on these Town Hall posters changed from inviting "Wounded Warriors," to inviting "Wounded Warriors and Wounded, Ill, and Injured Service Members;" to, most recently, inviting "Wounded, Ill, and Injured Service Members."

Are policy-makers? The enemy?[38] Health-providers? Families? Constituents who tacitly support funding for wars with which they have no corporeal or cognitive connection? Or, all of us?

Other researchers, journalists, and activists have commented on the apparent inequity between those who do and those who don't receive recognition and access to resources in the political economy of military *dis*ability and rehabilitation (Hoge et al 2006; Hull and Priest 2007; Priest, Hull and de Cille 2007a,b,c; USHCVA 2007:1-32). So too have veterans who are resisting policies and practices in military recruitment, rehabilitation, and re-entry (DAV 2010; Gutmann and Lutz 2010; *Home Fires* 2010).[39] Some trenchant onsite ethnography and analysis of SMs in rehabilitation have also been conducted by medical anthropologists, notably Messinger, who posits that mis-recognition of some *dis*abled SMs' progress or "success" in rehabilitation and recovery may result from their *un*intentional refusal to participate in techno-medical and athletic models of rehabilitation (2006; 2009 a,b; 2010a,b; 2011). Wool 2011 has examined hegemonic discourses of "normal" and "ordinary" in rehabilitative regimens at MTFs (specifically WRAMC during 2007-2008) and their un- or misrecognized (albeit powerful) destabilizing consequences.

My work acknowledges and elaborates this reporting and scholarship by probing for connections linking types of *dis*ablement and modes of rehabilitation with successful recovery outcomes. By referring to "successful outcomes" I am indexing more than mental and physical recovery; I am also referring to recognition and access to resources which permit acceptance, acknowledgement, accolades, and other sociocultural and politico-economic benefits.

What do I mean by this? SMs who are visibly *dis*abled and are selected to sign on to techno-scientific and athletic models of rehabilitation seemed to me to be recognized and rewarded in ways that others were not. For example, in clinics that I attended three times a week

[38] SMs routinely refer to past, current, and future opponents as "the enemy."

[39] I use *re-entry* to mean re-entering civilian "life" after disablement, rehabilitation, assessment, and discharge or separation.

at a MTF, SMs whose *dis*abilities were palpably corporeal and who were able to adapt to or agree to adopt prosthetic devices, assistive technologies, and athletic regimens of recovery were more "successful" in being recognized and being granted access to resources than those who were invisibly and more confoundedly wounded–those whose minds and psyches were damaged, or who had become ill, and who could not, or would not agree to, or were excluded from, highly visible techno-scientific interventions.

Respondents informed me of kinds of recognition and access to resources, and I also observed mechanisms of inclusion and exclusion. For example, I noticed that people who were users of prosthetics received a lot of attention and praise while others who self-identified as improving their balance, or memory of names and dates; or reducing their over-consumption of drugs; or scoring better in measurements of metabolic functions, went unnoticed. Visibility of the attributes of some SMs' recoveries seemed linked with the attention they received. Indeed, visible and invisible harm is the subject of much current scholarship (*viz* Tanelian and Jaycox 2008). What seemed under-examined were linkages between obvious and unobvious modes of rehabilitation and levels of recognition and access to resources. Among the kinds of recognition and access to resources that respondents performed or pointed out to me were:

- greetings, curiosity, interest in, and inquiries about subjects' and their families well-being
- encouragement and praise regarding perceived improvement
- friendly and formal military gestures, expressions, and salutes
- conferring of gear, gifts, and emblems
- recruitment for participation in activities and groups, on- and offsite
- welcomed and acknowledged ability to respond to calls, signals, and invitations

- on-time and courteous delivery of care
- access to service animals
- fieldtrips and photo opportunities with celebrities, politicians, and noteworthy guests
- rides, lifts, and assistance with conveyances
- various other semiotic signs and signals of eligibility, belonging, and deservedness

Respondents told me that such recognition and access to resources can extend beyond rehabilitation to include economic and social benefits such as parking privileges and discounted prices, acknowledgement of service and sacrifice while having been "in uniform,"[40] extended health care benefits, training and career opportunities, and praiseworthiness and visibility.

My literature review and early fieldwork indicated that sociocultural constructions of deservedness may mystify corporeal, cognitive, psychological, and physiological consequences of enlistment, may mask the risks of sustaining *dis*abling harm during active duty, and may attach eligibility for recognition to facsimiles of able-bodiedness. Additionally, these sociocultural constructions may do so in unexpected ways. Based on what people told me and what I observed during the course of my research, orders of deservedness at two MTFs seemed to be sustained in discourses whose palpable consequences SMs, their families, NMAs, and care providers express, reflect, and experience in their spatio-temporal interactions: "In other words, empirical data are viewed as sets of signifying practices that constitute a 'discourse' and its

[40] Being "in uniform" is a phrase that SMs and former SMs use frequently to signify a complex of responsibilities, expectations, burdens, and rewards that (may) accompany and signify membership in the U.S. Armed Forces.

'reality,' [41] thus providing the conditions which enable subjects to experience the world of objects, words and practices" (Howarth and Stavrakakis 2002:5).

Beyond their utility in challenging *in*equitable health care policies and practices for *dis*abled SMs, my research findings may be significant to social justice advocacy for people elsewhere who are *un*intentionally relegated as undeserving–people who are excluded through naturalized, or normalized, or neoliberal mechanisms of recognition and redistribution (diLeonardo 2008:7,8; Duggan 2003b:71,72; Fraser 1997:82,83; Lancaster 2003:291,292; Simpson 1998:1-7; Warner 1999:180,181; 2008:63,64).

Who Deserves What

Socioculture and Political Economy at the Site and in the Moment

While neoliberal policy-makers and practitioners in the late modern moment in the U.S. continuously attempt to transfer responsibilities from the state[42] to the individual[43] (Brenner and Theodore 2002:350, 358, 365; di Leonardo 2008:5; Duggan 2003a:178; Harvey 2005:2; Lancaster 2006:xi-xii; Leitner et al. 2007:2,4; Ong 2006:3,4), individuals who enlist or enroll in one of the U.S. Armed Forces appear to have been persuaded to voluntarily relinquish their

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[41] See also J. Derrida (1986). 'But beyond...(Open letter to Anne McClintock and Rob Nixon)'. Critical Inquiry 13:165.

[42] Throughout this document, rather than following Althusser (who follows Marx and Gramsci), to explicitly signify Ideological and Repressive Apparatuses, when I use the word "state" (not "State"), I follow Foucault: "The state is not a universal nor in itself an autonomous source of power. The state is nothing else but the effect, the profile, the mobile shape of a perpetual stratification (*étatisation*) or stratifications, in the sense of incessant transactions which modify, or move, or drastically change, or insidiously shift sources of finance, modes of investment, decision-making centers, forms and types of control, relationships between local powers, the central authority, and so on. In short, the state has no heart, as we well know, but not just in the sense that it has no feelings, either good or bad, but it has no heart in the sense that it has no interior. The state is nothing else but the mobile effect of a regime of multiple governmentalities" (2008:77-78). My distinction here (between state and State) may not be "obvious" because I am informed throughout by Althusser's (and Marx's, Gramsci's, and Pêcheux's) incisive theories regarding the workings of ideology and hegemony. For a productive collection of essays regarding *state* and *State*, see also Hansen and Stepputat 2001.

[43] Hacking (1996:222-236); Foucault (1977:190-191); and J. Thomas (2004:119-148) denote "the individual" as a post-enlightenment construct of autonomous personhood. In this schema, the individual is constructed as an independent person with agency who identifies choices as being available to her; and who believes she can make mindful decisions about her own welfare and well-being. I understand this construct to be productive *de jure*, and not *de facto*. Wikan 1995 offers a nuanced interpretation of The Self (not as an individual–rather as a distinct sensorial entity) that pertains: She identifies a sense of Self as relying on (being bound up in) lived experience rather than narrative (1995:276-277).

autonomy and its attendant risks and responsibilities back to the state. They formally waive responsibilities that have been routinely thrust upon civilian U.S. citizens, renouncing their perceived, suggested, or imposed self-sovereignty (Agamben 1998:24,25; Hansen and Stepputat 2001:2, 2006:297; Mbembe 2003:11-13,26; Rose 2007a:2; A. T. Smith 2011:419) in exchange for belonging, recognition, and benefits that are authorized, mediated, granted, and extended by the state into the community of the Armed Forces (Appadurai 2010:26; Douglas 1994:227; Rose 2007:2).

For example, under the aegis of the state, the DOD promises or contracts to provide enrollees with benefits such as enlistment bonuses, regular pay, defined roles, acknowledged ranks, health, and pension benefits (Holtz-Eakins 2005:7); and it offers additional unofficial rewards which are attached to attributes[44] that the state and others recognize, such as prestige (*viz.* at ceremonies and events in the public sphere, and amidst mediated rescue, protection, and defense activities [GoArmy.com 2011; WWP 2010 a, b]). The state, its agents, and people in the U.S. Armed Forces define and control these attributes using various semiotic mechanisms and communicative means: for example, placement of recruiting advertisements as movie trailers, or distribution of licensed gear and clothing for civilians; via content in video and online games; and posting (in various media) of active duty opportunities and requirements, exercises, uniforms, gestures, stances, salutations, promotions ceremonies, accoutrements, and fitness testing that includes corporeal, cognitive, and psychological measurements (Dertouzos and Garber 2003:14, 2006; O'Connell 2012:27; Sackett and Mavor 2006:127-133; Turse 2009:119,120; USAP 2005, 2010).

[44] I use "attribute" to describe characteristics, components, qualities, symbols, or properties that are attached to people to limit, identify, particularize, describe, or supplement their constructions as actors.

Many SMs at WRAMC and WRNMMC told me that they refer to themselves as "lifetime athletes" and that their qualifying and subsequently routinely quantified attributes rest on constructions of able-bodiedness and their capacity to rotely respond to orders, to meet well-delineated expectations, and to perform, at least while in uniform, according to entrenched and broadly mediated guidelines (Bacon 2011:1; DOD 2011; Messinger 2010a:282; Sackett and Mavor 2003:28; USAP 2005, 2010; Wool 2011:7,n.7). In addition, the athletic or "sports" model of rehabilitation instituted first at WRAMC in 2005, and subsequently at WRNMMC, was developed to optimize recovery by associating particular therapeutic regimens and gear with demanding–even extreme–sports (Messinger 2009a,b; Vogel 2012). This innovative model has been heralded as highly effective by many participant SMs, family members, and NMAs, as well as by a range of military and civilian multi-disciplinary and critical observers, who note its foundation on the principles and rewards of athleticism in the military forces, and the motivation for SMs to retain or regain their essential athleticism, and to compete (Vogel 2012:1,2).

When such measurable attributes are removed, or the SM's ability to respond appropriately is compromised by wounds, illness, or injury, mutually-contracted terms and conditions of sovereignty also appear to be adventitiously[45] altered. At this point, the state and the SM appear to re-calibrate their responsibilities and obligations in a multivalent evaluative and rehabilitative process. When the SM's attributes are no longer intact, the state no longer

[45] "Adventitious" means "unexpected." Throughout this document I use adventitious advisedly because it is often linked with the word "disability" to index acquired rather than genetic or congenital *dis*ability. I mobilize this term (and concept) centrally as I scrutinize changes in subjectivity that people who were formerly regarded as "able-bodied" may experience when they unexpectedly or opportunistically become, or are viewed as, *dis*abled.

considers her[46] as wholly productive, compliant, or fit; and in turn, the benefits that would have redounded to her must be re-calculated.

For her part, in this calculus the *dis*abled SM may or must collaborate to be rehabilitated–returned to a near-normal condition[47]–a process through which she may try to reclaim a facsimile of her rights, roles, responsibilities–and even rank. In this moment, both the agencies of the state and the SM re-view the rights, responsibilities, and rewards they are *un*expectedly obligated to offer, perform, or renounce, and motivated to claim, resist, or renegotiate. The SM's body and mind and psyche have been reorganized, and so the benefits that were formerly attached to it or them must now be reorganized as well. In turn, dynamic tension may interrupt and destabilize the relationship linking agencies of state and the *dis*abled SM because of the difference in what they have tacitly and overtly understood as being owed or as having been promised in exchange for enlistment; i.e., benefits, recognition, and access within circumscribed fields (DODI 2009; Douglas 1994:151,192).

This tension may show up at sites of rehabilitation and be expressed in multiple ways, some relatively benign and others mortal. For example, alongside acts of extraordinary courage, self-discipline, effort, therapy, and support, violence, suicide, drug abuse, depression, anger, apathy, failure to thrive, and other forms of abjection and self-inflicted or other-directed trauma may be evident among patients, family members, NMAs, and care providers. In addition, protective institutional strategies may obscure transparency of and entry points to modes and

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[46] While men outnumber women in the military and many of my respondents were men, I chose to use "her" rather than "him" and "she" rather than "he" so that I do not privilege masculine standpoints nor tacitly naturalize membership in the U.S. Armed Forces as only as a male privilege or lived experience.

[47] Informed by foundational concepts of Althusser (1971), Foucault (1995), Gritzer and Arluke (1985), and Marx (1986), I posit rehabilitation at a MTF as a discursive complex: A State apparatus, a productive and powerful discipline relying on prescribed sets of skills and knowledges, a division of labor within a political economy, and a mode (formed by forces and relations) of *re*production. Rehabilitation is commonly understood to denote practices that attempt or serve to restore *dis*abled persons (and animals) to conditions of good health and ability to work; to re-establish their "good reputation," characters or names; and, significantly, "to formally restore to former capacity, standing, rank, rights, or privileges" (*Random House* 2011).

sites of care; families may be disrupted; communities sundered; and policy-makers, case managers, therapists, and SMs themselves criticized–even vilified (Dao and Frosch 2010; Dao, Carey and Frosch 2011:1; Hoge et al 2006: 1023-1032; Priest and Hull 2007a:1-5; Wilson 2011:1,15).

Additionally, *dis*abled SMs who can not or will not sign on to state-sanctioned rehabilitative regimens may be overlooked, ranked poorly in evaluations for further treatment, or discharged without adequate support systems in place (Benedict 2009 a,b; Messinger 2009 a,b; Minear 2010; Tanielian and Jaycox 2008:314-316; Woolhandler 2007:1-26). For their part, care providers may feel overwhelmed, inadequate, thwarted by conflicting demands, and helpless (Miller and Zwerdling 2011; Pine 2011; Priest, Hull and de Cille 2007a,b,c).

The extent of benefits and services that do accrue to *dis*abled SMs may be mis-interpreted, mis-read or rendered illegible. This should not be surprising: The contract struck during recruitment and enlistment harbors overt and tacit understandings of the mutual rights, responsibilities, opportunities, perceived sacrifices, and risks that each party signs on to. While the enlistee may have some comprehension of the actual experience of military life (and many, even most, do because their families or friends are members of the military [Kleykamp 2005:14; NPP 2011; Rose 2007a:3,4;b:16,17]), much of the existential, psychological, corporeal, cognitive, and emotional risk of military membership may be mystified in mediated representations, resulting in under- or misrecognition during training and deployment, and even throughout active duty.[48] Messages that emphasize adventure, skill-building, educational support, service, courage, heroism, enhanced citizenship,[49] equal opportunity,[50] duty,

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[48] Personal communication with a former Army enlistee at WRAMC during a promotion ceremony for two SMs who are amputees. Please see APPENDIX A, field note 251FN.

[49] N.B. Citizenship is variously described and experienced. In this document I follow Leap 2004, 2005, 2007; Maurer 1996; and Meekosha and Dowse 1996 to position citizenship as state-sanctioned full participation in recognized activities among its

recognition, and access may mask other very real conditions and requirements such as extreme physical training; environmental and social deprivation; vulnerability to death in training, during all aspects of active duty, and in combat; and loss of limbs, cognition, and psychological well-being (American Civil Liberties Union [ACLU] 2008; O'Brien 2005; Pérez 2008:118,119; Sackett and Mavor 2003:217; Smithsonian & Navy Medicine Institute Ethics Conference Series [S&NMIECS] 2010). And, while some people who join the military are risk-takers, prone to behaviors that may deny, elide, or contest their own mortality, many others are not (Rose 2007a:6).

Among People in Organizations, Where Does Power Reside?

The Capacity to Act and React

In late modernity, most U.S. civilians are at least indirectly exposed throughout their lifetimes to conditions and consequences of military combat;[51] yet there is an apparent broad sociocultural neglect or denial of the human and *im*material risks and results of waging war (Armed Forces Press Services 2011a,b; Astore 2008; Bacevich; Jaffe 2011; Kronke and Feaver 2001; Maddow 2012; Pincus 2012). Year after year, legislators fund war, constituents support or abide its funding, and some sign on to or participate in events, initiatives, and various kinds of signifying activities that "support our troops,"[52] all without necessarily acknowledging,

officially acknowledged population. See also Preston 2012:A21 which describes U.S. Armed Forces' change in recruitment policies, after a 3-year suspension in policy, to once again encourage healthcare professionals who are also immigrants to enlist by offering them accelerated granting of U.S. citizenship.

[50] Equal opportunity that is, with respect to gender, race and ethnicity, but not (until September 2011 when Don't Ask Don't Tell policy enacted under the Clinton Administration in 1993 was overturned under the Obama administration), with respect to sexual orientation (DOD 2011d; HBO 2011).

[51] *via* numerous media including daily newspapers, video games, movies, television, blogs, online social networks, memorials, parades, and ceremonies; and personal experiences as when co-workers, classmates, or colleagues are or were SMs.

[52] *Viz.* car bumper stickers and magnetized decals; printed wrist bands; yard signs; and other signifying public displays of support and solidarity, often in iconic form as yellow ribbons.

confronting, or directly accepting responsibility for the correlative costs and consequences of military enlistment, training, active duty, and combat (Jaffe 2011:16).

In their analyses of who does what to whom and how, many authors who scrutinize mechanisms of power also survey and comment on war, violence, and trauma (Agamben 1998; Appadurai 1986; Arendt 1998; Clausewitz 1976; Das 2007; Figley 2006; Foucault 1976; Herman 1999; Scarry 1985; Sontag 2003; Stolorow 2007). These invocations appear to have a kind of inevitable and resonant intra- and intertextuality; in other words they make sense and are meaningful in relationship to and with reference to each other (Chandler 2002:201; Johnstone 2008:164-68; Kristeva 1980:68); Ideas and observations about power considered in this canon acknowledge and problematize action, agents, and agencies; subjects, targets, and objects; citizenship, eligibility, and belonging; state apparatuses; resistance, suffering, and pain; subjectivity, sovereignty, and nationalism; rights and responsibilities; risk; and modes of production and destruction. And they query *in*justice.

Each of these tropes is inherent to or interrogative of discourses of military rehabilitation and constructions of *dis*ability and deservedness: Who deserves to live? Who deserves to die? What does service mean? Who is eligible for serving? What is served? Who benefits? Who suffers? Who fights? Who resists? Who surrenders? Who decides?

When I critiqued military rehabilitation and unpacked schema of fitness, power, and social reproduction at my sites, instrumentalizing theories of lived human experience, sovereignty, and potentiality was central to my methods and analysis; and applying their tenets helped me to identify and qualify discursive constructions of *dis*ability and deservedness. Furthermore, these theories led me to complex examinations of the experience of trauma, including work about post traumatic stress; inflicting and suffering harm; rescuing; and

rehabilitating (Arendt 1979;1998; Herman 1997; Gritzer and Arluke 1985; Scarry 1985; Stolorow 2007; 2010; Wool 2011).

What connects arguments about power is their implicit and explicit engagement with structure and agency–the relative presence and influence of determining factors versus, or as compared to, factors of perceived individual choice within performances of embodiment and emplacement, and assignations of risk and blame. At particular junctures, in rehabilitation centers for example (Gritzer and Arluke 1985), or health clubs (Linder 2006), or during rock-climbing activities (Hill 2005), this dynamic debate foregrounds overlapping issues regarding constructions of fitness, levers of power, and mechanisms of social reproduction; and gets at the ways in which individuals react to and against the demands of the state, what impels them to do so, and how their subject positions are formed and re-formed in the process. At some axes, central ideas about individual responsibility and agency may be reinforcing, or productively co-existent (Bourdieu 1971; Hill and Irvine 1993). At other axes, structural determination and individual agency remain in dialectical tension (Giddens 1979; Ortner 2006).

Claims for Recognition and Access

Many scholars, researchers, practitioners, and policy-makers are connected in multiple and sometimes contradictory ways in their explications about struggles for recognition and access that continue to unfold under neoliberal conditions in late modernity (di Leonardo 2008; Duggan 2006; S&NMIECS 2010; Ong 2006). Their analyses position these struggles as complex and dialectical: always-in-(trans)formation,[53] reflexive, contradictory, and unstable. And they disclose an under-studied area for inquiry that would build on their work: researching the outcomes for affected subjects of unexpected shifts in sociocultural, politico-economic, and

[53] I follow Leap 2004:134-162 to mobilize the idea that subjectivity and other aspects of lived experience are always-in-formation.

corporeal and cognitive sovereignty. At sites of rehabilitation such as MTFs, subjects have had the experience of originally, as civilians, being largely required to provide for themselves; then, after enlistment into the Armed Forces, being provisioned by the military in exchange for foregoing their self-sovereignty.[54] However, after being grievously harmed and while being rehabilitated, SMs may receive contradictory or opaque messages about the scope of their service and sacrifice, and the degree to which they have become responsible for their own reclamation of status and rank (Appadurai 1986:21).

The Work That Words Do

Rhetorical Strategies

After the 9/11 attacks on the World Trade Center in New York and The Pentagon in Virginia, after the crash of United Airlines flight 93 in Shanksville, PA, the same day; and throughout the courses of OIF, OEF, and OND, many people–including SMs, military and civilian medical practitioners, researchers, consultants, and policy-makers–have used the term "Wounded Warrior" to refer to active duty members of the military who have become *dis*abled. Cafeterias, clinics, and brigades at WRAMC and WRNMMC incorporated the term in their titles (for example "Wounded Warrior Café," "Wounded Warrior Clinic," "Wounded Warrior Brigade"); and care givers routinely referred to their patients and clients as Wounded Warriors. Some associations and organizations included the term in their titles, mission statements and descriptions of the constituencies they serve (Sheftick and Holzer 2007). For example, the Wounded Warrior Project (WWP) one of the largest advocacy groups for *dis*abled SMs, describes itself this way on its online home page:

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[54] At least to some extent: The degree of support and provision of benefits to SMs varies among ranks, and across "abilities" (Jennings 2012, personal communication).

> Founded in 2003, Wounded Warrior Project's purpose is to raise awareness and enlist the public's aid for the needs of injured service members, to help injured service members aid and assist each other, and to provide unique, direct programs and services to meet their needs.
>
> – WWP Mission, *Wound Warrior Project*

The contemporary use of the term "warriors" to denote military service members has a long history, including "weekend warrior" to mean members of the Reserves or National Guard who are not active duty; i.e., those who typically work in civilian jobs yet who may be called to serve, or "called up," on demand, and who stay "ready" by training once a month, on the weekend.[55]

After 9/11, combined military actions by the United States (U.S.), the United Kingdom (U.K.), and a number of other North Atlantic Treaty Organization (NATO) countries against Al Queda[56] were dubbed the "War on Terror" (and subsequently, the "Global War on Terror" [GWOT]) by various mediators.[57] In his October 7, 2001, address to the nation, U.S. President

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[55] On a recruiting website for the Reserves and National Guard, the roles and responsibilities of members of these military branches are described in a Frequently Asked Questions section which includes an allusion to the source of the term *weekend warrior*: "As a reservist or guardsman…you will serve 'one weekend a month, two weeks a year.' You will be required to complete 40 unit training assemblies or 'drills,' and two weeks of annual training." (http://www.military.com/join-armed-forces/guard-and-reserve-faqs.html). Since the U.S. invasion of Iraq, enlisted members of the Reserves and National Guard have been called on to serve much more regularly and centrally than prior to 2003. Respondents indicated to me that more active engagement by cadres of people who did not plan to become active duty nor to be deployed, combined with the inception of the All-Volunteer Armed Forces in 1973, has altered the conditions of enlistment for many SMs, while not necessarily or commensurably altering civilian and military personal perceptions of risk. At the same time, more active engagement of Reservists and National Guardsmen and -women has unexpectedly burdened families, communities, businesses, and federal agencies such as the Veterans Administration and the Department of Health and Human Services.

[56] Among U.S. media, this organization's name, meaning The Base, is variously transliterated from Arabic القاعدة to English; for example: Al Queda, Al-Qaeda, al-Qaida, and al-Qa'ida.

[57] For example, see this usage in "Memorandum For The Files Re: Status of Certain OLC Opinions Issued in the Aftermath of the Terrorist Attacks of September 11, 2001" issued by the Office of the Principal Deputy Assistant Attorney General U.S. Department of Justice Office of Legal Counsel Washington. DC 20530 January 15, 2009; and available online at: http://www.justice.gov/opa/documents/memostatusolcopinions01152009.pdf

Bush announced the joint U.S. and U.K. "campaign against terrorism, another front in a war" (White House Archives 2001). However, in January 2009, President Obama rescinded official use of the term "war" for continuing U.S. military actions against terrorists, and replaced it with "operations to defeat terrorists" (Priest 2009). Lakoff comments on the metaphorical and strategic usage of the term "war," noting first that language matters because it can determine how we think and act, and further (2006:1):

> Literal–not metaphorical–wars are conducted against armies of other nations. They end when the armies are defeated militarily and a peace treaty is signed. Terror is an emotional state. It is in us. It is not an army. And you can't defeat it militarily and you can't sign a peace treaty with it.
>
> – Lakoff *Five Years After 9/11: Drop the War Metaphor*

Nonetheless, since 9/11 many active duty U.S. SMs have been wounded, become ill, or sustained injuries while deployed to Iraq or Afghanistan. For several years their altered status officially consigned them to the Wounded Warrior group. The DOD uses the term in its declarations, notifications, policy statements, definitions, and assessments to indicate the entire population of SMs and veterans who have

> …incurred a wound, illness, or injury for which the member was awarded the Purple Heart or whose wound, illness, or injury was incurred as a direct result of armed conflict; or while engaged in hazardous service; or in the performance of duty under conditions simulating war; or through an instrumentality of war …
>
> – *Combat-Related Special Compensation (CRSC), Section 1413a, Title 10, United States Code, as Amended. Revised Program Guidance January 2004*[58]

[58] As described in the DOD document entitled "Combat-Related Special Compensation (CRSC), Section 1413a, Title 10, United States Code, as Amended. Revised Program Guidance January 2004." Online document available at: http://militarypay.defense.gov/benefits/docs/CRSC_Guidance_104.pdf

In turn, the designation "disabled" is a long-standing term used in military discourse that points to deficits that can be assessed and linked with compensation. It indicates a broad variety of changes in status that may lead to assessments, treatment, hospitalization, rehabilitation, rewards, special treatments, discharge, and altered benefits through two rigorous parallel processes: the "Medical Evaluation Board" and "Physical Evaluation Board," referred to colloquially by SMs, care givers, family members, and NMAs as "MEBs" and "PEBs" (DODI 2009; VA 2011c).

Since 2004, DOD, VA, and various other agencies, along with *dis*abled SMs themselves, have increasingly referred to SMs who have been harmed as specifically "wounded," "ill," or "injured." When asked, people say they use these words to designate types and contexts of harm and to distinguish subjects *dis*abled in combat ("wounded"), as a result of disease ("ill"), or during non-combat active duty ("injured") (S&NMIECS 2010). And while these terms have not been officially adopted into legislation or policy, the DOD and VA have published documents that elucidate them (DODHRM 2008; NCOPB 2011; VA 2011b).

"Wounded Warrior" is still used in many conversations and publications, and by people that have a relationship with *dis*abled SMs. While this term is in use and still attached to people, associations, organizations, military units, clinics, and rehabilitation facilities, its popular usage is being superseded by the ostensibly specifying designations "wounded," "ill," and "injured." Understanding why this textual shift has emerged and been taken up, what it means, how it is being sustained, and what are its consequences were central to my research. While some subjects told me the newer terms were adopted in order to stop glossing SMs who are invisibly *dis*abled—those, for example, who have brain damage, cancer, or were harmed during regular active duty versus during combat—on first hearing the term at a conference regarding care of

wounded warriors (at the first of the Smithsonian & Navy Medicine Institute Ethics Conference Series [S&NMIECS 2010]), I wondered if supplanting "wounded warrior" with "wounded," "ill," and "injured" would also emplace hierarchal taxonomies of harm that might exacerbate uneven outcomes for *dis*abled SMs. In other words, whether the newer terms might denote, valorize, and sustain differentiated levels of sacrifice, service, and worthiness; and subsequently, differentiated levels of recognition and access to resources.

In fact, comments shared with me by *dis*abled SMs and their providers, and voiced elsewhere (S&NMIECS 2010) indicated that injuries sustained by active duty SMs in non-combat conditions and harm caused by illness *are* considered differentially from those sustained in combat, even though members of all categories (wounded, ill, and injured) may consider themselves and be considered by others as having offered up[59] comparable service–but not necessarily comparable sacrifice–in the U.S. Armed Forces. At WRAMC and subsequently at WRNMMC I observed and was told by practitioners and patients that they use the designations "wounded," "ill," and "injured" explicitly to distinguish people from and among each other, and to establish, acknowledge, and sustain hierarchies of what they regard as degrees of service and sacrifice and the rewards that redound thereto; rewards such as recognition and access to resources.

*Dis*abled SMs' recovery and re-deployment or re-entry into civilian life are regarded by medical practitioners, therapists, patients, family members, and NMAs as shared objectives in rehabilitation facilities at MTFs (Chivers 2011; Reiber et al 2010). Care at clinics and activities that are offered and recommended to or required of wounded, ill, and injured SMs are geared

[59] Widespread SMs' usage of variations on the term "offer it up" were pointed out to me by a Navy Captain in August 2010 after I told her about my research. We were attending a conference about ethics in human subjects research (TSNRP post-award workshop, Baltimore 2010) in which she addressed integrity in military medical research compliance and reporting. She importuned me to pursue my work, but even more urgently, to pursue the use of this generative term. I agreed and told her I would consider it a discursive mechanism to look out for and unpack. See Appendix A, field note 680FN.

towards adaptation, training, and assimilation; yet their outcomes are uneven. This may result not only from individuals' broad range of harm, and unique recovery capabilities, but also from their varying capacity or willingness to participate in particular modes of rehabilitation (Messinger 2009 a,b; 2010). At the same time, while some modes of rehabilitation and various therapies offered to, prescribed for, and or required of *dis*abled SMs who have endured invisible damage may often be effective, they may also be inappropriate, ineffective, or absent–and are themselves often invisible, as in the case of drug and behavioral therapies (Tanielian and Jaycox 2008).

Working among *dis*abled SMs, care providers, families, and NMAs at WRAMC and then at WRNMMC, I observed that those whose *dis*abilities were manifestly corporeal and who were able and willing to adapt to prosthetic devices, assistive technologies, and athletic regimens of recovery appeared to be more successful in being recognized and being granted access to resources than those who were *in*visibly harmed and who might not easily, obviously, or successfully participate in rehabilitative interventions that rely on external technologies and physical regimens. In comparison to *dis*abled SMs whose corporeal recovery is palpable, *in*visibly wounded SMs may not be "seen" as *dis*abled, may subsequently not be regarded as deserving of or willing to undertake highly visible modes of rehabilitation; and may not be perceived by themselves or others as making progress or recovering successfully.

Contradictory Acknowledgements and Ellipses

While journalists and others may disseminate information about the wars we are waging, and some people may engage in debate regarding their worth and their operationalized nomenclatures, very few civilians seem familiar with or discomfited by the real human risks, costs, and consequences of war (Jaffe 2011; Maddow 2012; Minear 2010). Moreover, the spaces

in which the range of harmful human consequences of war are palpable are themselves delimited, at MTFs, for example. Furthermore, based on narratives of people within MTFs, the kinds and degrees of human harm and provision of care that are contained there–their scales–are difficult to apprehend, cope with, and justify. The stories expressed and discourses sustained at a MTF are complex and contradictory–and they may be difficult to successfully or consistently access or participate in, even for some SMs, family members, NMAs and care providers.[60]

Terms: Disability and Deservedness

I reviewed a focused body of literature and found explications of the work that conceptions of fitness, power, and social reproduction do; of the noteworthy loci where they may intersect; and at their dynamic intersection, how constructions of *dis*ability may appear and complicate notions of deservedness. Borrowing from formative work by Goffman (1959, 1963) and subsequent elaboration by CDS scholars (Adkins 2003; Bogdan and Taylor 1992; Davis 2010; Linton 2010; Schneider and Ingram 2005; Shuttleworth and Kasnitz 2001,2004; and Whyte and Ingstad 1995), by *dis*ability I mean designations of embodiment that are socially constructed and deployed to identify people who are differently abled. And, informed by the debate about recognition and redistribution between Butler (1997) and Fraser (1995, 1997) and continuing commentary on it by other scholars (Oswin 2008; Swanson 2005), I use deservedness to mean the condition of acquiring, or claiming, or being deemed eligible for social recognition and access to cultural, political, and economic as well as *im*material resources.

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[60] In spring 2012 a fellow pedestrian waited with me at the intersection that leads from the Medical Center Metro stop on the NCA's Red Line to the south gate of WRNMMC. The traffic signals at this intersection (both for pedestrians and for drivers of various vehicles) are routinely disregarded, and the street itself is very wide and was at that time in disrepair to the extent that it was difficult to traverse. As the "walk" signal flashed and we finally were able to make our way, dodging speeding vehicles running the light and having waited a long time for the 23 seconds we had to get across this bumpy, barrier-encumbered street, the fellow beside me asked in an exasperated tone, "How are earth are people in wheelchairs supposed to get across?" "They're not," I replied, "They're supposed to come here in ambulances, helicopters, shuttle buses, cars, and vans."

The DOD, VA, Social Security Administration (SSA), Department of Health and Human Services (DHHS) and Americans with Disabilities Act (ADA) define "disability" in similar ways. Within their legislative and policy language, "disability" means: Inability to conduct what are routinely regarded as major or "daily" life activities (DLAs),[61] such as caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working (DOD 2011; VA 2011; SSA 2011; DHHS 2011; ADA 2009).

With other social scientists, I posit *dis*ability as a relative term of categorization that depends on numerous sociocultural and spatiotemporal factors and contingencies, including perceptions and enculturated pre-conceptions of normalcy, fitness, and ability (Adkins 2003; Albrecht 1976; Davis 2010; Linton 2010; McRuer 2006, 2010). Notwithstanding my conviction that all people express or embody varying degrees of ability in a constellation of human capacities, by using the word "*dis*ability" within this document I mean altered ability, as perceived by self and others, to successfully manage what are broadly regarded (in context) as routine DLAs.

Recognition and Access to Resources

By "deservedness" I mean politico-economically condoned worthiness for gaining access to and utilization of various types of recompense; in turn, by "recognition" I mean overt apparent acknowledgement; by "access" I mean capacity to obtain; and by "resources" I mean assets such as financial benefits, attention, special passes and privileges, extended health care, employment

[61] Depending on our disciplines and stances, people say and use two terms for these tasks: Daily Life Activities, or DLAs; and Activities of Daily Living, or ADLs. I use the term and acronym employed in the Americans with Disabilities Act (ADA): DLAs. Please see Glossary for my brief discussion of the work that acronyms do.

opportunities, invitations, media such as newspapers, blogs, internet, big screen television, modes of transportation, badges, gear, and equipment.[62]

In addition, during my fieldwork and analysis I relied on and referred to CDA and CDS scholarship which reveals and insists that subjectivity and *dis*ability are always-in-formation. This work considers how rights and responsibilities are defined, understood, enacted, embodied, expressed, expected, measured, and conferred. These schema led me to scholars that study, theorize and problematize, and in some cases practically apply knowledge about, issues of structure and agency (Ahearn 2001; Keane 2003; Leitner et al. 2007; Pêcheux 1972); sovereignty (Agamben 1998; Hansen and Stepputat 2006; Mnembe 2003); risk, blame, and responsibility (Douglas 1994; Douglas and Wildavsky 1983; Hill and Irvine 1992; Kahan 2008, 2010; Kahan and Braman 2006; Ortner 2006); of neoliberalism (Duggan 2003; Leitner et al. 2007; Ong 2007); of citizenship (Leap 2004; Meekosha and Dowse 2007); service and value (Appadurai 1986); and subject formation[63] (Althusser 1971; Leap 2010:187-220).

Theoretical Framework for Research

Underlying Concepts

The scholars to whom I turned use various lenses to look at and complicate the ways in which ability is recognized, access is conferred, and subjects are empowered–or not. Their work helped me to understand how constructs of fitness, power, and social reproduction can emerge; and it indexed, or rather opened, a space for researching the lived experiences and discourses of *dis*abled SMs, families, NMAs and care givers in rehabilitation units at MTFs. These constructs

[62] My sense of "resources" was informed first by my literature review; second by the way subjects related them to me; and third by performances I observed.

[63] By using the term "subject formation" I am acknowledging and following scholars who examine how we come to understand ourselves within contexts, discourses, and ideologies; and the ways in which our understandings are dynamic; i.e., how and why they change (Althusser 1971; Leap N.d., 2004; A.T. Smith 2011): They examine subjection, subjectivity, and subject formation.

of fitness, power, and social reproduction animated my research approach: I operationalized "fitness" as perceived wholeness, ability, and regard as appropriately adapted or adaptable to a setting; "power" as structural, systemic, and agentive leverage that defines, acknowledges, and confers recognition and access to resources; and "social reproduction" as *im*material forces and relations that combine to inculcate, legitimate, and perpetuate lived experiences, subjectivities, conditions, and perceptions. To unpack mechanisms of recognition and redistribution, or access to resources at my field sites, I collected inter-subjective and inter-textual data (Chandler 2002:203-209) from, among, and around participants; and looked for signs and symbols that construed structure, agency, sovereignty, *dis*ability, subject formation, and deservedness.

My work showed that the relationship between *dis*ability and deservedness is dialectical– as Harvey describes, "always-in-(trans)formation, reflexive, contradictory, and unstable" (2010:11,12). The dynamic tension generated in this dialectical relationship and its *im*material resolution or irresolution affect people and their capacity to thrive equitably; so notions of *dis*ability and deservedness demand scrutiny.

Existing Knowledge about *Dis*ability, Civilian and Military

While considerable theoretical scholarship and knowledge exist in the fields of CDA and CDS regarding subject formation, my review of literature indicated that only a few anthropologists have applied this knowledge to military settings. In turn, much ethnographic research that has been conducted in military settings has focused on able-bodied individuals. Significantly, the very core of military service is founded on the fitness of its members. Military enlistment criteria include standards of mental and physical ability; and people who join the U.S. Armed Forces are regularly tested, measured, and judged against required levels of fitness and expected readiness (Bacon, Fontaine and Sandborne 2011; Sackett and Mavor 2006). The lived

experience of SMs who become *dis*abled is under-acknowledged and under-studied. Although numerous authors address *dis*ability and the social constructions of *dis*ability, the experience among formerly able-bodied people of becoming abruptly *dis*abled and undergoing self- and other-perceived changes in sociocultural constructions of their worthiness–or deservedness–appears to be under-acknowledged, under-studied, or misunderstood among civilian and military policy makers, health care providers, persons, and families.

To present, evaluate, and compare existing and missing explanations for the ways in which uneven outcomes may be agreed upon, enacted, and experienced by people who are affected by unexpected *dis*ability, either directly (*dis*ability to themselves) or indirectly (*dis*ability to their family member, patient, or charge) I reviewed a range of work that is founded on ethnography and qualitative research, including CDA and CDS scholarship. In these bodies of work some investigators have used textual data to examine and analyze the means by which subjectivity remains-in-formation, is enacted, and is perceived across time and in space among people who inter-connect with each other. I combined the knowledge embodied in these canons with my experience, practice, and participant observation to problematize interactions and perceptions of wounded, ill, and injured SMs, their families, NMAs, and care givers.

Much critical analysis and other literature about the military has been generated regarding recruitment and enlistment; experience in active duty; trauma, violence and abuse; and the effects of war on people, communities, nations, and humanity. However recent and current literature in social science does not comprehensively address the lived experiences of SMs' *dis*ablement and rehabilitation, nor the effects of their experiences among themselves, their families, providers, and communities. Anthropologists and military medical researchers can contribute to the literature by identifying the multivariable and complex lived experiences of

active duty SMs who become *dis*abled, and the sociocultural and politico-economic ramifications of their *dis*ablement and rehabilitation. These cultural phenomena may be under-recognized as SMs participate in treatment and rehabilitation and are either returned to active duty or re-enter civilian life.

I turned to scholars in disciplines other than anthropology who have conducted research aimed at understanding the compound multiple effects of being grievously *dis*abled in active duty. Because anthropologists seem to have largely neglected researching individuals' motivations for entering the military, I also turned to work on structure, agency, and subject formation. I wanted to consider subjective factors of enlistment and enrollment, and also to apprehend and deconstruct systemic influences on what people do–subjects' agency, or socioculturally mediated capacity to act in the world (Ahearn 2001:12)–and how they are viewed by themselves and others.

Discourses of Military Service, Social Reproduction, and Risk

I looked to work that has complicated and challenged naturalized discourses and knowledges (Althusser 1971:132) that uphold military service and heroism as prevailing politico-economic ideologies of the state and its agencies. Authors in this diverse canon examine how constructions of heroism and national service influence subjects to enlist, and some examine whether risks and costs of individual and communal pain, trauma, and suffering are masked in these constructions. These scholars' implicit focus on the mechanisms that influence able-bodied subjects to join the U.S. Armed Forces side-steps questions about how original perceptions of sacrifice and deservedness may change when SMs become *dis*abled. To extend their inquiries, in my research I asked if and how designations that hierarchize *dis*ablement may garble subjects' original notions and inherent expectations regarding sacrifice, service, worth, and reward.

I also looked to analytical scholarship that examines how, when, and in what form language, linguistic constructions, discourses, and texts emerge, are circulated, and gain consent (Gramsci 2005: 12,80, n.49). CDA scholars, for example, look at processes that mobilize texts to reify and generate loyalty to perceived conditions and instantiations of sexuality, gender, class, age, and ability (Davis 2010a,b,c; Fairclough 2003:123,124; Linton 2010:223-236; McRuer 2006:1-32, 199-208, 2010:383-392; Peterson 2010: 259,260; Rapp and Ginsberg 1991: 311-343, 2001: 533-556; Shuttleworth and Kasnitz 2001: 2-17). CDA's significance lies both in indexing the origins and reproduction of generative discursive mechanisms, and more pointedly, in the unintended, uneven, and perhaps unjust material and existential consequences that flow from them.

Because literature regarding structure, agency, and subject formation often indexes discourses and knowledges of risk, my review included work by scholars who critically research and theorize constructions and reproductions of responsibility, and who bring forward analyses of individual, environmental, politico-economic, techno-scientific, and sociocultural constructions, costs, and consequences of risk, choice, and blame (Appadurai 1986; Douglas 1994,1997; Douglas and Wildavsky 1982; Haidt 2012; Hill and Irvine 1992; Rose 2007a,b; Sackett and Mavor 2003). These scholars look at the intersecting roles of belief and knowledge in risk-assessment and choice-making, comparing the influences of enculturated beliefs with subjects' claims of seeking, acquiring, and processing information when making choices that involve them as individuals and as members of groups. Their scholarship aims to demystify the complicated work that is done before, during, and after the moment in which people evaluate risk and make choices. This bolstered my inquiry by helping me untangle the web of influences, mediations, threats, opportunities, aspirations, and demands that combine to induce some people

to enlist, and that prompt some *dis*abled SMs to seem to assume responsibility for their own injury and recovery, while others will not, do not, or can not.

Insights in work about "risk" shed light on contradictory notions of blame, guilt, post-traumatic stress, helplessness, depression, and anger as well as toughness, exhilaration, triumph, heroism, stubbornness, denial, success, and recovery that subjects at MTFs express in their life story narratives of *dis*ablement and rehabilitation.

Research Process

Observations, Considerations, Questions, and Application

I noticed that some SMs may appear to be excluded from widely-endorsed and -mediated rehabilitative regimens because of their *in*visible and "inadmissible" injuries; they may be tacitly constructed as ineligible for or may be excluded from the benefits that accrue to subjects who seem to be granted access on the basis of visible or "admissible" *dis*ablement. This observation led me to consider whether in a naturalized process at the site (a process that seems obvious and justified [Althusser 1971:172]), many subjects who interact at a MTF appear to co-construct, mutually acknowledge, and engage in or "consent to" (Gramsci 2005:12) discourses of *dis*ability and deservedness that appear "normal" while maintaining hierarchical forces and relations within a system of care (Fairclough 2003:24-28; Lancaster 2003:74; Warner 1999:57; Wool 2011:194,195). In turn, privileged SMs may be rewarded in ways that others are not; i.e., those subjects who are "able" to participate in the discourse reap its promised rewards; while those who are not asked or permitted to, may not. Some may be required to prove or negotiate their worth via documentation, performance, contestation, or display.

I examined some discourses of fitness, power, and social reproduction, and identified some texts whose analyses helped me to problematize the costs and consequences, or the

"condition," of military *dis*ablement and related *im*material expressions of deservedness. These texts' foci revealed both overlapping areas of research and also openings within and between analyses. Finding presence and absence of theory encouraged me to undertake ethnography of the discourses and lived experiences of *dis*abled SMs being rehabilitated at MTFs. My objective in critiquing existing theory and conducting new research was to reveal something significant about people in places; something we don't already know: How linkages between *dis*ability and deservedness are expressed, experienced, and managed.

I applied my cross-analysis of work to the complex realm of military rehabilitation, and found that unresolved issues of fitness, power, and social reproduction intersect at this site and at their intersection a productive struggle emerges in which notions of responsibility for *dis*ability and deservedness are in dialectical relationship. Military recruitment efforts and subsequent contractual negotiations may mystify the potential risks of joining the U.S. Armed Forces: In a hegemonic consenting process both the recruit and the state may consent to overlook the very real possibility of wounding, illness, and injury; and the shift in sovereignty that would ensue after a *dis*abling event. The disruptive forces and relations in this potent and potentially transformative space invited further inquiry about the ways in which subjects experience their struggles for recognition and access to resources before and after *dis*abling events; and how their lived experiences and shared institutional discourses may inform the calculus of assessing socio-cultural, corporeo-cognitive, and politico-economic limits, and functions that co-constitute conditions, costs, and consequences of contemporary military service and deployment.

Methodology

Overview and Oversight

To assay my hypothesis, at my sites I foregrounded, gathered, and examined texts that helped me understand the ways in which people there managed adventitious *dis*ability and how they subsequently decided, agreed, and acted on who deserved what kind of recognition, and who gained access to and utilization of what resources. I used ethnographic methodology including participant observation; field noting; recording of interviews; acquisition, description and photocopying of material culture; and gathering of pertinent media content. I transcribed, interpreted, and analyzed my study data using and adapting tenets and tools of CDA and CDS to discover the textual mechanisms that co-constitute how *dis*abled SMs in rehabilitation and affected others are perceived and treated by themselves and others.

In addition to academic oversight by my dissertation committee and academic mentors, my work was monitored and critiqued by two onsite affiliates: The onsite research Principal Investigator (PI), Dr. Meryia Throop; and onsite mentor Dr. Sara Breckenridge-Sproat, the Chief of Nursing Science and Clinical Inquiry (CNSCI) at WRAMC and WRNMMC who is now at Tripler Army Medical Center in Honolulu, HI (TAMC). Their support, oversight, and participation at the site helped me to conduct ethical and productive research, and to sharpen my methodological and analytical sophistication.

After promoting the study's aims and objectives to potential subjects, I screened volunteers for eligibility, obtained signed Informed Consent Forms (IFCs) from them, and scheduled interviews and follow-up meetings in locations identified by me and participants as accessible, confidential, private, and safe.

Finding Texts That Express Lived Experience

Using ethnographic methodology to collect qualitative data regarding respondents' perspectives, i.e., their sense of their own and others' position and agency within inter-textual phenomena, including within systems of care, I was able to explore and become informed about how subjects make sense of their own lived existence in rehabilitation, both individually and within systems of shared meaning. I considered their texts and contexts: The sensory, material, cognitive and inter-subjective complexes within and around them (Dahlberg, Drew and Nyström 2010: 46, 91). Guided by fieldwork and methods of CDA scholars I gathered, transcribed, and closely read diverse texts to identify expressions of positionality, subjectivity, and meaning in time and within space. Texts signify and are signified within systems of meaning, or interwoven orders of discourse, that are learned and reproduced among people who communicate intelligibly with each other, and who act on their inter-intelligibility (Fairclough 2003:21-25).

Because my data comprised multivariable texts, I used CDA to guide my collection, close reading, and deconstruction of words and other lexical components of expressed texts; and to unpack the significance of contextual semiotics, such as material culture, signs, and symbols. For texts using images, I identified perspectives and aspects of positionality such as gaze, location, and viewpoint; for voiced textual components I noted collocation, repetition, disfluency, silence, aphasia, and tone; for somatic and cognitive textual components I considered facial expression, gesture, posture, placement, visibility; and for corporeal, surgical, prosthetic, and assistive components I paid attention to usage, temporality, and morphology.

Following CDS scholars I also applied tools and tenets such as intellectual scrutiny, skepticism, imagining, and position-switching to identify centralized as compared to marginalized subjectivities and positionalities (Garland-Thompson 2011:603; McRuer 2006:172-198). By comparing linguistic usages across bundles of narrative excerpts that reflected and built

upon one another, I mapped transitions in subjectivity, agency, and positionality to co-locate respondents in relation to other subjects and objects within their contexts and along their mortal[64] journeys.

The relation of my study to other research is complementary and elaborative: It will strengthen and deepen scientific, institutional, familial, and individual understanding of becoming *dis*abled, and will provide significant data to military policy-makers and practitioners as well as to other researchers who are investigating military medical phenomena. More broadly, this study may enhance CDA, CDS, and social science scholarship by offering qualitative data that is both unique to an understudied military population and may also be generalizable to an under-acknowledged civilian population. Overall, this study will contribute to ongoing research that strengthens health care policy and practice by contributing new knowledge and productive applications within military and civilian systems of care.

Review of Chapters

Summary

In Chapter One: How People Experience Real and Imagined Boundaries I have discussed what prompted and informed my research, and how I conducted it. First, I noted that people at MTFs who care for, rehabilitate, and evaluate wounded, ill, and injured SMs, and SMs themselves, respond in multivariable ways to types of harm and levels of care and modes of rehabilitation. People at these sites often express admiration to each other when they have perceived "obvious" examples of human courage, prowess, and expertise co-enacted by patients

[64] I relied on Hill, who appears to reach back to Kant's 1765 "moral geography" (Elden and Mendietta 2011:8, 9, 149, 296) in order to plot her subject's Moral Axis, Moral Geography, and Moral Center (Hill 1995:97-145). In turn, Modan elaborates Hill to interweave a moral framework into her subjects' geographical territory (Modan 2007:90, 298); and Leap explores discursive constructions of moral geographies among his subjects (Leap 2009:202). I have extenuated these elaborations and looked to Agamben 1998, Arendt 1979, and Mbembe 2003 to offer a linked concept that pays homage to Kant, Hill, Modan, and Leap–and at the same time invokes my subjects' transitional cognition, corporeality, lived experience, and *un*certainty of death; i.e., I trace and refer to their MorTal Journeys.

and their providers. Yet what appears to be missing in these manifestations is recognition of people who can not or will not–or are not asked to–sign on to modes of rehabilitation that are privileged.[65]

I described why I conducted ethnography at two MTFs; i.e., to unpack the means by which people's perceptions of SMs' *dis*ability and participation in rehabilitation there corresponded with their constructions and designations of deservedness for recognition and access to resources. My introduction explains why I investigated the ways in which wounded, ill, and injured SMs and others regarded themselves or others as more or less deserving of recognition and reward for their work than SMs who seemed to have avoided *dis*ablement; whether these perceptions depended on the type of harm SMs sustained and the kind of rehabilitation in which they were selected to participate; and how subjects at MTFs used words, signs, symbols, surfaces, and spaces to enact, legitimate, and reproduce mechanisms of inclusion and exclusion among those whom they deemed or who deemed themselves as deserving–or not.

I also have described using critical analysis to examine how messages were composed and understood; to probe whether *dis*abled SMs' bodies were intelligible texts that people read even–or perhaps particularly–when they were visibly *dis*abled and obviously repaired; and whether by comparison SMs' cognition, psyches, and physiologies were unintelligible texts that people could not apprehend; and understand the extent to which textual intelligibility influenced constructions of deservedness. I looked at how linguistic elements were used, by which I mean how people wrote or inscribed, read or understood, and compared or struggled with texts, to find how some *dis*abled subjects were heralded while others were ignored; and how people justified

[65] By privileged modes I mean regimens in which practitioners and participants mutually and publicly express and herald "obvious" feats of corporeal achievement that signify successful recovery and that lead to broad recognition and access to resources; as featured for example, in Esquire magazine, January 2007, in which a "wounded" SM who is multiple amputee is pictured on the cover and his story told in an article entitled *The Meaning of Life* (Mockenhaupt 2007:76-106).

designations and enactments of deservedness, recognition, and access to resources, such as state-of-the-art extended care, awards, career training, and opportunities, and incremental benefits.

I pointed to how I noticed that in a tense, dynamic, and perhaps irreconcilable dialectical relationship, intangible and ambiguous corporeal and accoutremental texts of *dis*ablement and rehabilitation signaled, obscured, and disguised real *im*material experiences of deservedness. In the following chapters I elaborate my use of theory, my methods, the data I collected, how I analyzed them, and what I gleaned to be their significance; and I make recommendations regarding the applicability of my findings.

Chapter Two: Accounting for Fitness, Power, and Social Reproduction provides the literary sources I used to formulate my research design and data analysis. In it I review and critique select scholarship regarding structure, agency, subjectivity, *dis*ability, and deservedness. I call on the work of a cross-disciplinary group of theorists and applied social scientists who scrutinize texts, semiotics, and ideological apparatuses; and who offer conceptual frameworks gleaned from observing and listening to subjects at their sites. I look at the work that texts do, and why they constituted my research data.

In Chapter Three: Listening Up, I paint the picture of where I conducted my research and how I became positioned there, offering descriptions of the people and spaces I studied and the ways in which we worked together. I elaborate how I defined, collected, and analyzed data; and offer examples of my methods, instruments, and footing.

My Chapter Four: Knowledges, Tools, and Technē, provides details of the CDA I conducted. Finding, analyzing, and interpreting the location, meaning, and significance of the social and material culture that I observed and gathered, I distinguish institutional/military and rehabilitation/MTF orders of discourse, and other supporting, contesting or dis-identifying

discourses–and subjects (Pêcheux 1982:155-170) 19. Following Fairclough 2003, I report on the discourses that undergirded networks of social practices at the sites; point to textual genres, styles, and discourses in examples of text; and describe modalization, the hedges that offer and withdraw allegiance to established orders of discourse. I show the way these critical components index how "social events, social practices and social structures" (Fairclough 2003:23) are reproduced within systems of meaning.

In Chapter Five: What We Know Now that We Didn't Know Before I discuss my data's semioses and significations. I explain what I learned through my analyses, getting at what my findings attest, how their discovery builds on extant knowledge, and what significance it has currently and prospectively, within and beyond military settings. In that Chapter I also comment on unexpected findings that invite further research.

I lay out my research summary and recommendations for practical application that my research invites and supports in Chapter Six: Prāxis. Finally, in Afterward: Real and Imagined Boundaries, I offer some concluding thoughts and opening questions, asking the reader to engage with me in an imagined conversation about how we decide who deserves what.

A Final Note

My field sites are nexuses for multiple axes of living experience where military and civilian personnel care for, support, rehabilitate, and evaluate *dis*abled people who have been assigned there; and wounded, ill, and injured assignees participate in their own treatment and rehabilitation. My research offers insight into how some formerly able-bodied subjects and affected others were qualitatively affected by adventitious *dis*ablement, and how they subsequently gained recognition and access to resources or not. Data provided by participants permitted me to methodically deconstruct expressions and perceptions of relations and forces

within modes of rehabilitative care. I am grateful to have been given this knowledge: It is for use and application by the actual subjects of my research; for others like them; and for people who are associated with and interested in them and others like them, now and in the future. It is for us.

CHAPTER 2

DISCOURSES, ACCOUNTS, REFLECTIONS

Literature Review

Introduction to Review of Theory, Method, and Ethnography

In this chapter I provide a summary of some central issues and arguments regarding constructions of *dis*ability and deservedness, and of military service; and show where they intersect and correspond, the ways in which they invoke, constitute and animate discourses, and how they produce knowledges of fitness, power, and social reproduction. Reviewing theory, method, and ethnographies while gathering and considering texts at the site bolstered my capacity to locate mechanisms at work among people who were interacting in rehabilitation at a MTF; mechanisms that effected, or expressed, or co-constituted changes in sociocultural constructions of *dis*ability–and that imbricated deservedness.

Ethnography is a well-established immersive qualitative methodology that provides researchers with insights into everyday subjective experience by means of onsite participant observation, field-noting, interviews, transcription, collection of textual content, interpretation and analysis (Douglas 1966:111; Geertz 1973:19-21; Lutz 2001:7-9; Nadar 2011:211; Ochs and Schieffelin 2001:268-269; Oliffe 2005:395). My literature review bolstered my commitment to drawing on the theoretical perspectives of established qualitative researchers who use ethnographic methodology and critical analysis of authentic texts to gain greater understanding of peoples' lived experience within a space and during a time (Chatterji 1998:355; Hill 1995:98, 2005:159-162; Leap 2009:219,n.1; Messinger 2010a:281,2010b:150; Wool 2011:2, 224,225).

Text is situated language use that marks itself and its users' location within economic, social, cultural, and historical settings (Leap 2003:403). Texts include actual words in narratives

and life stories, as well as content in distributed media (Abu-Lughod 2008:1-3; Fairclough 2003:23-37; Johnstone 2008:20-22; Linde 1993:3; Silverstein and Urban 1996:1-3). Texts include things we say, read, write, hear, see, smell, move through,[66] and wear. They include objects, artifacts, and materials. And they are signified and apprehended within systems of meaning that are learned; and covertly and overtly reproduced among people (Bourdieu 2003:39; Chandler 2002:59; Decena 2008:354; Fairclough 2003:23-37; Pêcheux 1982:156; Vološinov 1973:22). These data are entry points for understanding peoples' points of view and the prevailing ideological constructs through which they are being recognized (Leap 2004:160n.14); they offer qualitative researchers the opportunity to glimpse and attempt to understand the lived experience of people from their own points of view and across terrains of experience and subjectivity that are always-in-formation (Leap N.d.:16-18, 2004:134-162).

Gathering texts provided by people in their own contexts enables researchers to understand peoples' senses of themselves within their lived experience (Dahlberg, Drew and Nyström 2002:18). By gathering textual data that both inscribed and circumscribed *dis*abled SMs and inter-related others' lived experience, I was able to learn how they were actually interpreting, making sense of, and coping with their unforeseen experiences and conditions, their lives forever changed.

While considerable theoretical scholarship exists in the fields of CDA and CDS regarding subject formation, my review of literature indicated that only a few anthropologists have applied this knowledge to military settings. In turn, much ethnographic research that has been conducted in military settings has focused on able-bodied individuals, and only some on amputees. Significantly, the very core of military service is founded on corporeal, cognitive, affective, and conative ability–or fitness–of its members. Military enlistment criteria include standards of

[66] Space is a kind of text (Chandler 2002: 110-114; Harvey 2000:116; Lefebrve 1991:26; Soja 1996:1).

mental and physical ability; and people who join the U.S. Armed Forces are regularly tested, measured, and judged against required levels of fitness. The lived experience of *dis*abled SMs, i.e., those who have become unfit by becoming wounded, ill, or injured; and their families and providers, is under-acknowledged and under-studied.[67]

Currently a space exists between work that examines and compares adventitious *dis*ability among civilians and among members of the military. Although authors of numerous journal articles, books, introductions, chapters, and editions of special issues of scholarly and other publications address *dis*ability and social constructions of *dis*ability, the experience among formerly able-bodied people of becoming *dis*abled and undergoing self-perceived and other-perceived changes in sociocultural constructions of their worthiness or deservedness may be under-acknowledged, under-studied, and misunderstood among public policy makers, health care providers, individuals, and families–especially (if ironically) in the very arena in which fitness is the core value: In the U.S. Armed Forces.

Many authors point out that *dis*ability may be lifelong, transitory, or adventitious; and that all humans experience kinds or phases of relative *dis*ability; for example because of illness, injury, age, discrimination, and incomprehension or discomfort in unfamiliar or challenging settings (Gordon and Rosenblum 2001:16; Hughes 2005:82; R.F. Murphy et al 1988:241,242). These constructions vary depending on contexts and perspectives, including in relation to identity, access, social policy, social justice, human rights, and social movements (Davis 2010c:304; Jensen 2005:35,58; Nicholson-Crotty and Meier 2005:241; Lindenbaum and Lock 1993:xi; Rapp and Ginsberg 2001: 534; A. Young 1993:116). The critical work of these analysts "decenters" beliefs about *dis*ability.

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[67] Garland-Thompson provocatively mobilizes the critical "feminist materialist disability concept *misfit*" to examine and "think through the lived identity and experience of disability as it is situated in place and time." While researching the "fitness" of wounded, ill, and injured SMs in rehabilitation, I respectfully kept "misfit-ness" in play (Garland-Thompson 2011:591).

Of the multiple (self-)perceived or imposed conditions that flow from constructions of *dis*ability, many CDS scholars index notions of deservedness, and some index able-bodiedness and *dis*abled-bodiedness across conceptual and *im*material continua of cognitive and corporeal wholeness, wellness, adaptability, and queerness (Bardounis 2010:448; McRuer 2010:383; Schneider and Ingram 2005:18,19; Sontag 1978:57). Others complicate ideas about eligibility, belonging, and fitness that emanate from notions of deservedness, or the recognition and access to redistribution of resources that are co-constituted by designations of "ability;" or, conversely, the stigma and marginalization that attach to people who are framed as "others" because of their perceived *dis*ability or impairment (L.M.C. Brown 2010;180,181; Goffman 1961:127; R. Murphy 1995:241).

In my inquiry about costs and consequences of *dis*ability designations, I have been edified by the debate about recognition and redistribution between Butler 1997 and Fraser 1995, 1997 in which the authors argued about the *im*material costs and consequences of marginalization or exclusion, and the awards and benefits of inclusion. Fraser indexed and extrapolated punitive sociocultural consequences endured or embodied by people who are marginalized; and Butler responded rigorously to insist that the effects of exclusion are primarily and significantly economic. Their argument remains productively unresolved and is dialectical. Subsequent scholars have elaborated but not settled the question of whether constructions of exclusion have primarily and profoundly economic or sociocultural consequences. Oswin accepts the implicit irresolution, regarding the effects as "both and;" i.e., as co-occurring (2006:665). Swanson goes further, criticizing Butler's and Fraser's positions as essentializing, and arguing that spheres of experience are neither separate nor in competition, but rather are co-constructed in hegemonic phenomenological processes; they are complex and over-determined

conditions of existence that are always-in-formation (2005:88). I attached these contending, unreconciled, and dynamic arguments about recognition and redistribution onto the juridical and political analyses of social policy, practices, and effects of entitlement such as those offered by Schneider and Ingram 2005, finding deservedness is the condition of acquiring, or claiming, or being deemed eligible for social recognition and access to cultural, political, and economic as well as *im*material resources.

To get at how people make decisions, and where power resides, I relied on theorists of structure and agency, turning for example to Ahearn 2001, who proffers agency as the capacity to act in the world, and who investigates numerous interpretations of that capacity: Who structures it? Who recognizes it? How is it seized, expressed, acknowledged? For her part, Ortner 2006 traces and historicizes vivid and vacillating explanations for action and responsibility, finding (with Giddens 1971) that the subject has power within structured conditions. Crumley 1987 looks to modern, conquering hierarchicalization and its downward-distribution and -scaled eviscerations of power, comparing and calling for flat heterarchies that would recuperate, de-structure, and equitably re-distribute power, returning agency to individuals, groups, and communities (1987:156,157). Foucault re-positions power as productive between and for the entities that send it back and forth, and parses the controlling work that it does both ways (1977:169). His re-inscription of structural, systemic, and agentive mechanisms of power is useful to me because in it he demands recognition and reassessment of the mutual benefits accrued by dominant and oppressed entities in exchanges of power that are always-in-formation.[68]

Keane 2003 goes to the heart of problematizing and objectifying agency itself, arguing for the reinstatement of ethnography, of the embodied encounter, and of foregrounding

[68] In fact, my data animated Foucault's formative critical concept.

contradictory and productive expressions, i.e., texts, semiotics, and narratives of authority as the dialectical loci of personal power (Keane 2003). Leone 2005 finds expressions of personal and resistant power embodied in material culture which he discovers; and Spivak complicates the agency of the post-colonial sub-altern, finding that when agency is identified it may be masqueraded as authentic, yet is an artifact of oppression–an embodiment disingenuously re-emplaced by the still dominant and oppressive projection of autonomous power onto the "other;" evident, or evidenced, but not integral, and certainly not homogeneous (1988:294,295).

I called on the work of a cross-disciplinary group of theorists and applied social scientists who offer conceptual frameworks gleaned from observation, consideration, and experience with people negotiating their own and others' subject positions. I examined central tenets of this scholarship to understand constructs and mechanisms at my site that appeared to destabilize and confound efforts of some people in rehabilitation to secure recognition and access to resources for themselves, for those they were supporting, or for whom they were providing care; while, at the same time, efforts of others were apparently readily defined (or, "identified"), recognized, and rewarded. Discovering and understanding what might account, explain, enable, or support these differences comprised my literature review efforts.

During my field work I applied cross-analysis of theory to locate and complicate issues of choice and of determination–of who deserves what, who decides, and on what basis–to the realm of military service and rehabilitation. I found that unresolved issues of fitness, power, and social reproduction[69] intersect at this site; and at their intersection a productive struggle emerges in which notions of service and responsibility are in a dynamic dialectical relationship. Looking at

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[69] I mobilized these three concepts to frame my research, and I use this phrase ("fitness, power, and social reproduction") throughout my dissertation. By *fitness* I mean perceived wholeness, ability, and (self-) regard as appropriately adapted or adaptable to a setting; by *power* I mean structural, systemic, and agentive leverage that defines, acknowledges, and confers recognition and access to resources; and by *social* re*production* I mean *im*material forces and relations that combine to inculcate and perpetuate lived experiences, subjectivities, conditions, and perceptions.

discourses of fitness, power, and social reproduction helped me to problematize the conditions, costs, and consequences of military *dis*ablement and correlated (or, co-related) experiences of deservedness. These overlapping areas of research and openings within and between analyses offer the basis for my argument that decisions about who deserves what are based on social and textual constructions (and apperceptions) of fitness that are always-in-formation; that people consent to these constructions; that these constructions are powerful and productive; and that their reproduction has under-acknowledged mortal consequences.

Among the texts that exist at my sites some are instantiations of material culture–posters for example, prosthetics, uniforms, and gear. Archeologists are anthropologists who gather and analyze material culture, reading social relations via "remains"; i.e., found texts that are landscapes, fauna and flora, artifacts, accessories, and manufactured objects and products. By spatio-temporally, historically, and geographically contextualizing material culture at their sites, archaeologists suppose the meanings and roles of found objects, locating their findings within social contexts and relevant political economies, and explicating their significance–then, now, and into the future. Some archaeology is political: Its practitioners analyze material culture to consider power and potential in human action and socioculture. In my literature review, I turned to Crumbley 1987; Hodder 1994; Leone 1984, 2005; A.T .Smith 2011; and Urban and Silverstein 1996 to consider material culture as a kind of text (many kinds of text), looking to their theories to understand how objects may hypostasize and bear witness to mechanisms of sovereignty, and how material culture mediates authorization and subjection in political spaces (A.T. Smith 2011:415).

Much of contemporary archaeology is devoted to finding and studying what humans have left behind in order to reveal social structures, social relations, and social change. The

archaeological record consists of material factors or material culture[70] which are evidentiary data and include remnants of things, remains, or artifacts: Objects such as tools, weapons, art, decorations, structures, assistive technologies, prosthetics, badges, uniforms, posters, and other "remains" of objects produced for use by people.

Marxist archaeology uses filters of materialism and historical-determinism to sift and sort data and to theorize and apply knowledge regarding social conditions, struggle, and change. Marx practiced and advocated the use of observation, analysis, interpretation, and explanation of human behaviors as documented and presented in human history–past and present. In his writings, he referred only briefly and tangentially to archeology (Trigger 2007:331[71]) while arguing that modes of production (of material) are determining factors in social relations. Marx's apprehensions and exhaustive writing about material determinism, modes of production (including forces and relations), commodification, fetishization, mystification, ideology, class struggle, the dialectic, alienation, and transformation continue to be dynamic levers for theorizing and complicating the ways in which sociocultural and politico-economic conditions change, and power shifts.

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[70] Interestingly, within military discourse(s) and anthropologies (and archaeologies) of war, *matériel* culture comprises a domain of knowledges: Matériel culture encompasses the material remains of conflict, from buildings and monuments to artifacts and militia, as well as human remains. In this domain, people study diversity in the material record of war and conflict, grapple with challenges of preserving, presenting, and interpreting it, and affirm the significant role matériel culture plays in contemporary society (Beck, Gray and Schofield 2002). Matériel, when used in English, means equipment and supplies; both in military (e.g., arms, supplies and equipment), and commercial supply chain management–as compared to "personnel" (*Random House* 2011).

[71] Trigger 2006 points to a passage in Marx's Capital: A Critique of Political Economy (New York, NY: The Modern Library, Random House 1906): "Relics of by-gone instruments of labor possess the same importance for the investigation of extinct economic forms of society, as do fossil bones for the determination of extinct species of animals. It is not the articles made, but how they are made, and by what instruments, that enables us to distinguish different economic epochs. Instruments of labor not only supply a standard of the degree of development to which human labor has attained but they are also indicators of the social conditions under which the labor is carried on" (Trigger 2006:331). In the same section, Trigger refers to the oft-quoted, subsequently provocative, and continuously productive passage from Contribution to the Critique of Political Economy (1859) in which Marx asserts: "In the social production that humans carry on, they enter into definite relations that are indispensable and independent of their will, relations of production which correspond to a definite stage of development of their material forces of production…the mode of production in material life determines the general character of the social, political, and intellectual processes of life. It is not the consciousness of humans that determines their existence; it is on the contrary their social existence that determines their consciousness" (Trigger 2006:331). Marx's notion of material determinism continues to fuel arguments about whether "structure" or "agency" accounts for human experience. Giddens and others posit "structuration" as explanatory (Giddens 1979; Ortner 2006). Interestingly, structuration itself is dialectical; and so the argument is sustained.

The controversy, applicability, and problematics of Marx's complicated ideas reflect and uphold one of the central tenets of his canon–that of the dialectic: The unremitting and continuously productive struggle between or among contradictions. Per Marx, contradiction is the ever-present, dynamic, and productive condition that always already exists between opposing forces,[72] and fluoresces in change. Contradictory relations are those social associations and connections that arise, exist, and are knowable in conflict or opposition with each other; they appear *ir*resolvable; and they include and express struggle. Conflict and contradiction inhere in social relations and their dynamic tensions are sources of change. Identification, acknowledgment, and study of contradiction contribute to understanding changes in social systems in the past, present, and into the future (Marx 1978a).

Materialism and historical-determinism notwithstanding, at my sites I studied material culture as text, while recognizing and privileging the notion that archaeological remains are made and left by knowledgeable social actors–or agents. By seeking evidence therein of social, political, and economic structures and conditions, I am using a dialectical approach, considering the underlying contradictions of social processes and modes of reproduction, and persons' attempts to resolve, or contend with, those contradictions (Shanks and Tilley 1992:137). Understood dialectically, social change emerges from dynamic interactions at various scales among contradictions in relations of reproduction that are structurally determined, social, historical, economic, and material (Patterson 2030:9-11). In this view, change occurring as the result and resolution of conflict between forces and relations, or modes of reproduction,

[72] Unlike Foucauldian theory in which power is seen as emanant and dynamically distributed within all systems, and in which (potential) resistance is viewed as a resident, always-already constituent of systems of power, Marxist theory reifies opposing forces and posits (or positions) their inevitable struggle(s)–even their *ir*resolution–as productive. While I look to Marxist interpretation to identify influences of modes of *re*production–their forces and relations–and to consider contradiction, alienation, and transformation; and my theoretical framework is held together by acknowledging contradiction as a motor of struggle and change, I also agree that power is productive, and that it flows, however *un*evenly, back and forth in every relationship. Since my analyses are undergirded by the work of theorists who critically examine and identify ideological apparatuses–their mechanisms, expressions, and effects–and theorists who followed and continue the recognition and redistribution debate launched by Butler and Fraser, I relied on dynamic contradiction–including this between Marx and Foucault for example–to animate my research.

including consequences of bio-medico-scientific and technological advances, leads to transformation in sociocultures. Dynamic tension, even conflict, between forces and relations of reproduction may be expressed by antagonism between factions or groups whose self-interests are respectively either threatened or advanced by these developments; and who may act in response (Marx 1978a; McGuire 2002; Patterson 2030).

Borrowing from Marxist archaeologies, I am agreeing that humans are shaped by and shape modes of reproduction; and that "modes" are forces and relations of reproduction that may enable people to transform their own conditions, and that underlie society, social order, and social change. Further, I am theorizing that forces of reproduction are expressed in and through discourses of rehabilitation, and that they include intentions, mechanisms, practices, tools, and technology; and, that within rehabilitation, relations of reproduction are expressed in and through practical divisions of labor and of effort. Forces and relations, or modes, of rehabilitation are workings or mechanisms that constitute and sustain power and control even as they may flow back and forth between and among their co-constituents.[73]

A.T. Smith 2011 has brought forward an argument that the systematic study of sovereignty via material culture is inchoate in contemporary archeology, and deserves to be recognized and "redistributed" (424). Invoking Agamben 1998, Mbembe 2001, and Hansen and Stepputat 2006, Smith ratifies notions of authorization and subjection and hitches these twin concepts onto how sovereignty is constituted and mediated in an array of places and practices, finding two emergent areas for critical inquiry: "(T)he practical regimes involved in reproducing the polity; and the material mediations of objects and landscapes in strategies of governance and experiences of subjection" (2011:416). His review and call to action correspond nicely with my

[73] Here I mobilize the multiple meanings of constituent: A component part or ingredient; a resident of a constituency, especially one entitled to vote; a person who appoints or authorizes another by power of attorney; and a word, phrase, or clause that forms a part of a larger linguistic (discursive) construction (*Random House* 2011).

impetus to include material culture in my data, and my sense that what is at stake in the negotiations at my sites among the people I am studying are at least in part questions of sovereignty–who and whose? Wherefrom and whereto? With what consequences?

When Smith exhorts us to study what politics do rather than what they are he conjures Abu-Lughod 1991, Das 2007, de Certeau 1980, and Leap 2004. He asserts the importance for ethnographers and archaeologists to consider not just the spectacular but also everyday practices, regimens, rituals, embodiments, and activities[74] in order to unpack how sovereignties are reproduced and undone (A.T. Smith 2011:419). Smith also traces alienation and points to archaeology's current move towards studying political associations (2011:422). What is germane for my research is Smith's location of sovereignty's remains in landscape, space and "spaces of exception" (*viz.* Agamben 1998 "state[s] of exception"), noting that garrisons, monuments, bodies, and material objects are "powerful" (2011:425); i.e., capable of authorization and subjection. In turn, the material culture at my sites is present not only to the observer but also through references in my respondents' stories, narratives, interview responses, and other texts. Smith's emphasis on the productivity of studying assemblages, to include structures, systems within structures, spaces, objects, and practices, bolsters my parallel commitment. Moreover, his conceptual centering of the polity and its practices parallels my own focus on people in rehabilitation and the spaces and processes they share (2011:426). My intention likewise is to productively foreground and utilize texts, including material culture, to account for banal lived experiences of authorization and subjection at my sites.

McGuire 2008 notes that when discovered, disclosed, and interpreted, knowledges about the role of material culture, including assemblages of tools and technology, may be practically applied to untangling naturalized mechanisms of *in*equity, and may even enable transformation

[74] Or as Bickford characterizes them, practices that, however powerful, are also "banal" (Bickford 2011:130).

(2008:33-37). His theory bolsters my consideration of SMs in rehabilitation and their inter-dependents as people who have been commoditized via training and deployment, subsequently alienated via corporeal and cognitive harm, and who currently are being transformed within a delimited time-space; i.e., in rehabilitation at a MTF. Respondents and the content of material culture express how orders of discourse manifest, and tournaments of value unfold (Appadurai 1986:21; Fairclough 2003:203,204,207; Williams 1977:165).

While qualitative research among civilian subject populations is routinely conducted by social scientists, particularly anthropologists and ethnographers, notwithstanding work by Messinger and Wool, most studies about SMs are conducted by scientists using quantitative methodologies (Moore et al 2011; Pope 2005:1180-1181,1184; Oliffe 2005:398). In turn, quantitative research about wounded, ill, and injured SMs often focuses on evaluation from the points of view of medical providers. Very little research that aggregates and analyzes qualitative data collected from the patient's perspective has been conducted with SMs who are participating in treatment and rehabilitation at MTFs. Moreover, most qualitative research regarding hospitals has focused on and collected data from service "providers" such as medical and therapeutic practitioners, rather than on service "consumers" (patients and their families) and has privileged the providers' points of view (Rankin 2003:64).

In order to enhance practitioner, patient, and family understandings of SMs' lived experience during rehabilitation, and to improve management of recovery and re-entry into civilian life or re-deployment into military active duty, some researchers have called for research that privileges the patient's point of view (Jennings et al 2005:178). Researchers who have probed aspects of treatment from patients' points of view have identified critical aspects of their subjects' experiences which vary from or are under-acknowledged by their providers (Chatterji

1998:374-379; Wikberg and Bondas 2010:54-59). Findings from their research have contributed to enhancements of patient care, including improved treatment modalities, facility design and operationalization, and more authentically informed or "enlightened" case management, safeguards for patient safety, and improved end-user satisfaction (Hovey et al 2011:667-669; Rankin 2003:64,65). Even in this terrain however, it appears that very little qualitative work has been done to probe the lived experience of SMs who have been wounded, become ill, or sustained injury during active duty and who, with support from their families and care providers, are being treated and rehabilitated at MTFs.

Accounting for Military Disablement

What is largely missing in these inquiries and contestations is anthropological research and analysis about people who are adventitiously *dis*abled during military active duty; and how their altered status affects their ability to be equitably recognized and have access to redistribution of resources (although see important critical work by non-anthropologists Gerber 2000; Jensen 2005; Moore 2004; Tanielian and Jaycox 2008; and Woolhandler 2007). For the most part, CDS scholars who complicate sociocultural constructions of *dis*ability and deservedness do so with regard to civilians (Albrecht 1976; Hershenson 2000; Shuttleworth and Kasnitz 2001), notwithstanding notable anthropological work done on physiatry and rehabilitation models among amputees at a military medical facility (Messinger 2008a,b; 2009a,b, 2010a,b, 2011; Wool 2009, 2010, 2011; Wool and Messinger 2012). And authors who examine sociocultural aspects of military recruitment and retention usually do so with respect to SMs who do not overtly require or demand rehabilitation (Asch, Kilbur and Klerman 1999; Asch, Heeter and Savych 2009; M Brown 2006; Guttman and Lutz 2010; Kleykamp 2005).

Much of the current work that does investigate the lived experiences of *dis*abled SMs emanates from the research, writing, photography, and postings of journalists and photographers, sociologists, humanitarians, medical practitioners, public health specialists, and political scientists (Bast 2010; Clark et al 2007; Erbes et al 2007; Gerber 2000; Goldstein 2009; Ketwig 2008; Minear 2010; Priest 2003; Priest and Hull 2007a,b,c; Woolhandler 2007); or it is expressed via media that include blog postings by SMs themselves (*Armor Down* 2012; *Caring Bridge* 2011; *Home Fires* 2011; *SemperMax* 2010; *Wounded Warrior Project* 2010). These accounts open a portal for anthropological ethnography that probes the socioculture and lived experience of wounded, ill, and injured SMs from their points of view across a territory (online social networking) that is geo-physically–and spatio-temporally–unbounded and therefore inclusive at a new scale.

Researchers who have contributed significant findings regarding outcomes of *dis*ablement for active duty SMs continue to call for additional multi-disciplinary, longitudinal, and mixed-methods research to identify and understand mechanisms of adjustment to *dis*ability, productive coping modalities, and improved quality of life (QOL) outcomes (Caravalho 2011:iii,32; Kennedy et al 2010:767,768; Kerstin et al 2006:487). In their quantitative study for example, Elliott et al found that goal instability is associated with poor adjustment to *dis*ability and is also linked with perceptions of social stigma, particularly when individuals rely on external resources to support their sense of self-coherence. Understanding the limitations of their instruments to provide practitioners with meaningful interventions, the researchers called for additional qualitative work to better understand the ways in which individuals invoke or construct or seek coping modalities (Elliott et al 2000:262,263).

Qualitative work that has been done within community and institutional systems of care has frequently been undertaken by medical anthropologists. Antelius 2007 for example, conducted participant observation, field-noting, and interviews in four community-care facilities among patients *dis*abled by trauma, and their providers. She collected, compared, and analyzed textual narratives within these settings to find that participants co-constructed new senses of "patient selves" that were productive within a horizon of hope in the present rather than in the future. Grounding her work in complex and inter-related textual expressions of lived experience helped Antelius to understand that an altered conception of hope could underpin successful coping modalities and enhanced perceptions of quality of life among *dis*abled patients and their community providers. She initiated a call for rehabilitative activity and communication among providers and patients that would focus on accomplishments in the moment rather than the future in order to re-make meaning and to foster a sense of hope that may be in-formation but is also palpably attached to the new self in the new condition in the new moment (Antelius 2007:338).

In his ethnographic work among amputees at a MTF, Messinger 2010a has shown the healing benefits of peers' and peer families' interactions and the practical importance of their unfettered engagement with the altered physical and social worlds that patients actually inhabit within multiple dimensions of their real lived experience (2010a:281). His work has come to the attention of policy-makers within the U.S. military healthcare system (MHS) and has generated additional calls for qualitative research among *dis*abled SMs (Caravalho 2011:28).

For their part, Reiber et al conducted a seminal study across DOD and VA scales to capture information regarding the success (or not) of a DOD Directive to restore amputees to their highest possible functional level in military and civilian sectors. In concert with a 2008 VA

evidence-based study, the researchers discovered that current practices are not adequately informed by participant patients' perspectives (Reiber et al 2010: 287).

Critical quantitative research among physiatric providers has been conducted by Weaver et al 2009 using survey instruments to measure medical and psychosocial issues, rehabilitation delays, therapy and vocational needs, social support, and discharge planning. They identified that SMs typically grapple with polytrauma, often presenting sequelae such as traumatic brain injury (TBI), post traumatic stress syndrome (PTSD), depression, and fractures. The researchers also noted that QOL is lower in the population that has endured recent *dis*ability as compared with subjects whose wounds, illnesses, or injuries are not recent. They found that from the point of view of providers, while support of family and friends is positively correlated with adjustment to *dis*ability, it may also complicate care management. Weaver et al surmise that patients' discretion, preferences, and leadership should be foregrounded and valorized in their own care and management processes–acknowledging at the same time that their study was underpowered by not including patients' perspectives (2009:517,518,520).

Kennedy et al 2011 derived critical quantitative data regarding the positive contribution of psychological "pre-rehabilitation appraisals" (2011:601) and their efficacy on coping strategies and functional independence in a longitudinal prospective study among *dis*abled civilian patients. They administered questionnaires to cohort members as they moved from admission to rehabilitation facilities, and after their discharges, to institutions or to home settings. The researchers indicated the need for a broader range of psychological measures of patients' points of view, noting that their study collected data exclusively via administered survey instruments, and was limited by its lack of ethnographic data.

In their 5-year multicenter study, Whiteneck et al 2011 used mixed quantitative and qualitative methods to examine therapy services received by civilian patients during the first year after their *dis*ablement. They investigated whether and in what ways reduced length of stay (LOS) policies were acting to shift the burden of ongoing care to families and communities. They concluded that when care is provided in a continuum, inpatient rehabilitation is "only the beginning," and that future studies should examine post-discharge lived experience in more detail, and from patient and family perspectives, including at-home (Whiteneck et al 2011:367).

The critical work that lies ahead for research among wounded, ill, and injured SMs, their families, and care providers at a MTF is to discover the kind of intimate subjective knowledge that is currently under-represented in *dis*ability and rehabilitation studies in civilian settings generally, and military settings in particular.

Among the numerous research studies that are being conducted at MTFs in the United States, most are quantitative with the exception of some qualitative and mixed methods work being done regarding efficacy of complementary alternative medicine (CAM) in rehabilitation; influence of psychosocial and alternative interventions in treatment of PTSD and TBI; the relationship of management of rehabilitation with perceptions of recovery and re-entry success outcomes; and the effect of structural mergers on patient safety and provision of best practices (Reb, Saum, Murphy, Breckenridge-Sproat 2012 N.p.; Jennings 2008; Messinger 2009a,b, 2010a,b; Moore et al 2011).

I reviewed a range of authoritative work to present, evaluate, and compare existing and missing explanations for the ways in which outcomes may be agreed upon, enacted, and experienced by people at MTFs who are affected by *dis*ability, either directly (*dis*ability to themselves) or indirectly (*dis*ability to their family member, patient, or charge). In planning my

theoretical and methodological approaches I also turned to scholars in disciplines other than anthropology who have conducted research aimed at understanding the compound multiple effects of being *dis*abled in active duty (Gerber 2000; Minear 2010; Nelson, Starkebaum and Reiber 2007; Tanielian and Jaycox 2008; Vasterling et al 2008; A. Young 1993). And because anthropologists seem to have largely neglected researching individuals' motivations for entering the military (as opposed to studying influences of advertising and other predatory mediations on enlistment, about which there is a range of scholarship [ACLU 2008; Asch et al 2009a,b,c; Pérez 2008; Turse 2009]) I also turned to work on structure, agency, and subject formation. I wanted to consider subjective factors of enlistment and enrollment, and also to apprehend and deconstruct systemic influences that seem to act on (potential) SMs' agency (Ahern 2001a,b; Ortner 2006).

In unique ways, Arendt 1998, Bacevich 2007, Clausewitz 1976, Herman 1999, Scarry 1985, and Sontag 1978 complicate and challenge naturalized discourses and inter-textual constructions, or knowledges, that uphold military service and heroism as prevailing politico-economic ideologies of the state and its agencies. These authors look at how constructions of heroism and national service influence subjects to enlist, and they examine whether risks and costs of individual and communal pain, trauma, and suffering are masked in these constructions– or whether overt mediations of risk and *dis*ablement act as incentives. However, these scholars' implicit focus on the mechanisms that influence able-bodied subjects to join the U.S. Armed Forces side-steps questions about how original perceptions of service, sacrifice, and deservedness may change when SMs *become dis*abled. To extend their inquiries, and to respond to comments and questions asked by people at my sites, in my ethnographic work I asked if and how designations that hierarchize *dis*ablement (i.e., "wounded, "ill," and "injured") may

complicate subjects' original notions and inherent expectations regarding service, worth, and reward.

Ethnographies of Military Recruitment, Reproduction, and Rehabilitation

When members of the U.S. Armed Forces are harmed many of them are assigned to MTFs where rehabilitation interventions are undertaken with the objective of returning them to service ("return-to-duty" [RTD]) or to civilian life (Chivers 2011:1; Dao, Carey and Frosch 2011:1; Goldstein 2009:72; Sheftick and Holzer 2007:1,2; U.S. Army website 2010; USHCVA 2007; Wain et al 2005:351-357; WWP 2010a,b). Surgeries, prosthetics, and therapies; drugs; CAM interventions; and support from care-givers and others can combine to enable some (but not other) wounded, ill, and injured SMs to re-claim their fitness for resumption of recognized military or civilian roles and responsibilities. Journalist Aliff has written about the demands and difficulties as well as the origins and ethics of such labors; and other journalists, documentary film makers, photo-journalists, autobiographers, and SMs have too (Aliff 2010:1,2; HBO 2007; Goldstein 2009; National Priorities Project [NPP] 2010, 2011; Woodruff and Woodruff 2007; and Wounded Warriors' Project [WWP)] 2008, 2010). They attest to the contradictions, challenges, acts of personal and professional courage, pressure, demands, models and technologies–the "knowledges" and troubled dynamics of inclusion and exclusion that erupt within these multivariable policies, processes, and practices.

Using quantitative and qualitative methodologies Tanielian and Jaycox 2008 look unflinchingly at the *un*expected socio-economic costs and consequences of contemporary military *dis*ablement, in particular, TBI. They find that misrecognizing the actual effects of diminishment or destruction of originally qualifying attributes such as cognition threatens economic and sociocultural bankruptcy for individuals, families, communities, and providers;

and the authors project serious structural and systematic disruptions to military recruitment and retention (436-440).

Some SMs are able or choose or are s/elected to "be rehabilitated" (see WWP 2010, 2011 publications and blogs; and *SemperFie* blog 2010, 2011). For others though, as numerous analysts and SMs report,[75] military "standard-of-care" rehabilitation practices and procedures do not restore their apparent fitness, neither as perceived by themselves nor by others; and this may lead to reduced recognition and access to resources, as well as inability to reclaim recognized roles and responsibilities–and benefits (Davenport 2009:1, 2010:1; Gariti et al 2009:1150, 1151; Pine 2011:1,2; Richardson et al 2007:681-683; Tanielian and Jaycox 2008:221-227; USHCVA 2007; Vasterling et al 2008: 356-358; Woolhandler 2007:6-8).

My position as an anthropologist participating in, observing, and grappling with unexpected and contradictory experiences at a MTF drew me to literature of other social scientists who have conducted research within contested field sites in the U.S. What I mean by "contested" sites are those that are portrayed in extremely differentiated and often antagonistic terms by people within and outside them; people familiar and unfamiliar with their sociocultural, politico-economic and spatio-temporal economies; people who have firm opinions one way or another about their legitimacy; threat to stability and social justice; and effect on people, communities, and nations. Among a number of authors, five have written work particularly pertinent to my research: Gusterson, an anthropologist who conducted research among scientists at a nuclear weapons laboratory (Gusterson 1998); Lutz, an anthropologist who conducted ethnographic research in a community surrounding a military base (Lutz 2001); Minear, a historian who conducted ethnography in collaboration with the Veterans' History Project at the American Folklife Center, U.S. Library of Congress, among SMs returning from Iraq and

[75] Please see APPENDIX A for select transcriptions of interviews with SMs, family members, and care providers.

Afghanistan (Minear 2010); Bickford, an anthropologist who conducted ethnography among former high-ranking East German military officers (Bickford 2011); and Messinger, a medical anthropologist who continues to conduct ethnography among amputees in rehabilitation, first at WRAMC and now at WRNMMC (Messinger 2009a,b; 2010a,b;2011; Wool and Messinger 2012). Their methods, analyses, engagement with vital dialectical contradictions, and continuous critical reflexivity regarding their own subject positions productively informed mine. In addition, raw, direct, and ongoing life-story narratives provided by colleagues and respondents at my site shaped and enriched the utility and productivity of my study as they perspicaciously challenged my assumptions, research questions, methods, interpretations, and findings. The authenticity and immediacy of their lived experiences compelled me to listen and observe more rigorously and to hone my reflexivity.

Gusterson is the scholar, anthropologist, and ethnographer whose fieldwork experience most resonated for me, and to whom I most often turned when challenged by irresolvable intellectual, emotional, and methodological contradictions at my site. Throughout his book about conducting research at a nuclear weapons laboratory, Gusterson discusses his perspectival movement back and forth between preconceptions and re-conceptions during two years of observing, interviewing, participating, and conversing with people at Lawrence Livermore National Laboratory in California. In his postscript, Gusterson notes "I came to Livermore in search of 'the truth' about nuclear weapons but left with two truths, one for each of the communities I had come to know through the strange practice we anthropologists call fieldwork" (Gusterson1998:234). During my own work at WRAMC and WRNMMC, I recognized Gusterson's description of fieldwork as "strange," not necessarily in its sense as unusual, extraordinary, curious, or odd; but rather in its connotation of being out of one's natural

environment, coming from outside one's own locality, outside of one's previous experience, "unfamiliar."[76] Furthermore, I identified with his research journey–initially seeking "the truth" about a community, and subsequently discovering more than one community and more than one truth, via ethnography, the attempt "to simultaneously achieve empathy with and distance from the diverse people (we) set out to understand" (Gusterson 1998:14).

Critical Discourse Analysis (CDA) and Critical Disabilities Studies (CDS)

Representative Range of Formative Work

Points of view vary across their respective epistemological and ontological horizons, yet much of CDA scholarship and CDS pose fundamental questions about eligibility, and offer insights that complicate tests for or measures of recognition and access to resources when these levers rely on ideas about fitness or ability. In turn these complications co-constitute provocative notions about the ways in which constructions of *dis*ability and deservedness are instrumentalized or mediated in human interaction. The sociocultural effects of these mediations have significance for people; they shape and determine the implementation, or absence, or co-option of socially just policies and practices that materially influence peoples' lived experience (Lindenbaum and Lock 1993:xi, referring to work by Young 1982; and Asad 1979).

CDA scholarship examines how, when, and in what form language, linguistic constructions, discourses, and texts emerge, are circulated, gain consent (Gramsci 2005:80n.49), and produce beneficial and detrimental *im*material effects. It finds and unpacks the hegemonic work that language does as a constitutive element of social life and practice (Fairclough 2003:203,204,207; Williams 1977:165). Furthermore, CDA looks at the processes that mobilize

[76] The derivation of the English word "strange" has relevance for (linguistic) anthropologists: From late 13thC it has meant "from elsewhere, foreign, unknown, unfamiliar," from Old French estrange (Fr. étrange) "foreign, alien;" in turn, from Latin extraneus "foreign, external," from extra "outside of." Its sense of "queer, surprising" is attested from late 14th C (*Random House* 2011).

texts to reify and generate loyalty not only to conditions and instantiations of sexuality, gender, class, age, ability, and national security for example; but also to their defense under perceived conditions and instantiations of contestation, or even assault (Hodges 2010:72,73). CDA's significance lies both in indexing the origins and reproduction of generative discursive mechanisms, and more pointedly in foregrounding the *un*intended, *un*even, and perhaps *un*just material and existential consequences that flow from them.

CDA's scrutiny of talk and text (Abu-Lughod and Lutz 1990:910) enables the study of meanings and perceptions. It is a way of investigating communications which constitute social action and of identifying patterns of signification and representation which constitute culture[77] among groups. The use of the term "critical" signifies analysis that focuses on exploring features of discourse that have become so obvious they either appear to be common, acceptable, and natural; for better or worse may not be noticed at all; and may be hegemonic or even predatory (Fairclough 2003:202; A.T. Smith 2006:61). Fairclough coined the term CDA to name his set of philosophical premises, theoretical methods, methodological guidelines, and specific techniques for linguistic analysis within a broader range of textual analysis (Jørgenson and Philips 2002:60). By adding the word "critical" to "discourse analysis" Fairclough was referring to analyzing social meaning-making within linguistic and textual events and discrete networks of knowledge, or discourses, and at the same time contesting naturalization in textual exchanges. Fairclough activated critical thinking in textual analysis: questioning practices, causes, and effects whose outcomes are *un*even and whose very components, the use of words for example, may mask strategic, even predatory, objectives (Fairclough 1993:205-209).

CD analysts believe that language is not powerful in and of itself, but is imbued with power as a result of who uses it, how it is used, and the context within which this usage takes

[77] Culture is expressed as or in dynamic, intelligible and replicable behaviors and expressions of beliefs.

place. Discourses do not merely reflect social practices but also constitute or construct them. This means that CD analysts must study texts and the specific complex of social practices in which they play a part. CDA requires paying attention to specific words, phrases, and locutions, and their relationship within sociocultural and spatio-temporal contexts. It refers to the analysis of written, heard, seen, smelled, touched, or spoken; i.e., sensed, texts in order to interpret the way that language functions. CDA scholarship offers a useful and productive toolkit of methods and analyses that link the textual and the social; and until recently it has largely been overlooked within medical research generally and within research regarding rehabilitation at MTFs in particular (J.L. Smith 2007:60,61).

CDS comprise an interdisciplinary subject area for scholars, activists, and advocates who are interested in *dis*ability, human interaction, and social justice (Adkins 2003:1-4,27,28; Shuttleworth and Kasnitz 2001:3-5; YUGPCDS 2011). These scholars have generated critical work that posits human *dis*ability as a sociocultural construction that is always-in-formation across continua of perceived ability and impairment (Baynton 2010:40,41; Cushing 2002:32,33; Joseph and Alex 1972725; Kaplan 1999:3,4; OHCHR 2011; USDJCRD 2000:33; Whyte and Ingstad 1995:25). CDS scholarship combines to create a fertile area of study that disrupts conventional–even "naturalized"–notions of subjectivity, ability, status, eligibility, and deservedness; and which also seeks redress through *prāxis*, or informed action in the world (McGuire 2008:3). CDS calls out, confronts, and may rectify *in*equitable policies and practices of recognition, and access to or redistribution of sociocultural, politico-juridical, economic, and material resources (Linton 2010:223).

Like critical race theorists, *dis*ability researchers who scrutinize inscriptions of stigma that have real costs and consequences for people also parse structural and systemic mechanisms

of normalization and marginalization to index workings of powerful forces and relations in the production, management, challenge, and resistance to shifting and intersectional paradigms of identity, inter-subjectivity, and self (Crenshaw 1996:360; Gerber 2000:29; Gordon and Rosenblum 2001:10; Kapferer 1979:130). Davis 2010 for example complicates sociocultural and politico-juridical markers of identity–including in his nuanced argument regarding the after-effects of passage of the Americans with Disabilities Act (ADA) in 1990–to challenge the utility, stability, and "internal coherence" of *dis*ability as a category (2010c:309). By contrast, Siebers 2010 pinpoints "(the) intersectional identity (of) complex embodiment" as the very construction that enables productive contestation of oppression, stigmatization, and potential erasure of the *dis*abled (329).

Some CDS scholars critically question existing public and private policies and practices relating to *dis*ability, and locate key debates in *dis*ability studies in contemporary contexts, including challenging how social justice and human rights issues relating to *dis*ability are interpreted and advanced. These authors acknowledge that pre-disposing enculturated notions about race, poverty, gender, sexuality, class, age, and ethnicity intersect with those of *dis*ability to complicate (and sometimes to valorize) *in*equitable or socially *un*just access to recognition and *re*distribution of resources. They reveal and problematize the conditions, ideologies, and politico-juridical economies that uphold such notions (Collins 1998:152,153; Frank 2000:3; Sidney 2005:133).

Numerous CDS scholars and activists aim to influence public policy towards social justice and human rights at individual (or personal), family, and community levels and to examine the harm done globally by war–the injury, impairment, and *dis*abling effects–to persons and communities; even to humans as a species (Farmer 1996:279; Singer and Hodge 2010:2).

And some CDS researchers apply qualitative and quantitative research skills in conducting research and ethnographic studies to build a body of knowledge that may influence or promote evidence-based practice for people with *dis*abilities among those that advocate for, collaborate with, and provide care for them (or us) in fields of healthcare, education, public policy, and law (Antelius 2007:325,338,339; Artiles 1998:34,35; Erbes et al 2007:359; Erikson et al 2001:42,49; Harlan and Robert 1998:28,29; Rodman and August 1995:599; and A.Young 1993:140-142).

Some scholars have productively complicated CDS by critiquing its elision of able-bodiedness's "invisibility" (McRuer 2006:2). McRuer notices and problematizes what he describes as "compulsory able-bodiedness," finding in this unstable sociocultural construction a productive parallel with other constructions of normalcy, including heterosexuality. He finds able-bodiedness to be the unstable imagined condition against which deviations or deviances such as *dis*abilities are not only measured, but more significantly, are reified. McRuer examines the efforts involved in maintaining constructions of compulsory able-bodiedness; notices their relocations within complex forces and relations of power; and comments on their disappearance; i.e., their naturalization and subsequent invisibility. Moreover he refocuses his cultural and economic analysis through a neoliberal capitalist lens, asserting that "neoliberalism and the condition of postmodernity, in fact, increasingly need able-bodied, heterosexual subjects who are visible and spectacularly tolerant of queer/disabled existences" (2006:2). By doing so McRuer points out that a neoliberal viewpoint relies on stigmatizing and celebrating "difference" in order to operationalize individual responsibility, to privatize services, and to thrust the burden of attaining and sustaining equality onto the individual–the individual whose embodied identity is composed and imagined as compared to a normative one. As McRuer notes and my data support, these discursive and politico-economic shifts paradoxically enable extension and reproduction of

*in*equitable practices and outcomes. They further complicate the work that constructions of normalcy and their subordinations of *dis*ability "do;" while excused, explained by, and understood through tenets of neoliberalism (2006:3).

McRuer's work dialectically invigorates my critical analysis of how some *dis*abled SMs are *re*cognized; i.e., they are "seen" and are "visible," as heroic embodiments of ideal citizenship when their modes of rehabilitation and recovery mimic compulsory able-bodiedness; while others may be misrecognized, disregarded and "disappeared" when their illnesses, injuries, and recoveries do not appear to uphold dominant ideologies. Herein lies a productive contradiction that underlies and complicates all of my findings: Based on what I observed, what people told me, what I gathered, and how I analyzed my data, harm and repair that are *visible* make the work of ideological apparatuses *invisible*. The centrality of this conundrum within a particular set of "social practices" valorizes researching the lived experience of those who endure and attempt to overcome visible and invisible wounds, illnesses, and injuries sustained during active duty in the U.S. Armed Forces. This rich area of inquiry (regarding visible and invisible wounds, illnesses and injuries) was explored in some depth by Tanelian and Jaycox 2008; it deserves further research.

Among other informative texts I turned to were those of Rapp and Ginsberg. In their review of the politics of reproduction, Rapp and Ginsberg focus on human reproduction, yet their deconstructive analysis refers to and mirrors other kinds of reproduction, notably social reproduction in its ideological sense as the continuity of social systems, and understandings of social and cultural renewal (Ginsberg and Rapp 1991:311). The ways in which Rapp and Ginsberg point to the shaping of discursive practices and biological constraints within political-economic history are theoretically and methodologically useful for my examination of the

practices, policies, and politics of military recruitment and rehabilitation. The authors look at forces and relations of power that constitute and resist hegemonic imperatives, and parse distributions and expressions of power by indexing scholarship that investigates the "mutual determination of … domains of productive and reproductive relations" (1991: 312-313). Their work supported my objective to locate the sources of and explanations for dynamic tension and instability at my site, helping me to reconsider the productivity of power and the tacit and overt conditions of consent that underlie, indeed construct, the dialectical relationship between patients and providers (and their agents) at MTFs.

Rapp and Ginsberg also examine the politics and distribution of social constructions of deservedness, analyzing how citizenship and ability (by extension for my inquiry, fitness) continue to be discursively con-figured and pointing to what they characterize as a (potential) shift in "disability consciousness" due to the expanding presence of embodied differences in postindustrial democracies (Rapp and Ginsberg 2001:534). Their inquiry includes a discussion about the ways in which increasing visibility and intensified cultural awareness of difference due to *dis*ability/ies are shaping and destabilizing contemporary debates, practices, and policies regarding recognition, choice, intervention, and access to resources–not only among healthcare providers but also individuals and families, or kin (2001:534,551). They argue here that contemporary constructions of *dis*ability are being actively re-inscribed (are in-formation) because of emergent technological and bio-medical interventions that problematize choice, (potentially) pitting agents and advocates of eugenics (in their example) against agents and advocates of diversity rights.

Rapp and Ginsberg frame a central and complex debate within their discussion of contradictory notions, mechanisms, and narratives (discourses) of kinship and reproduction, and

their mediations. They ask who decides what and how much is owed, or "due," and to whom, when embodied difference is detected and permitted, erased, or enhanced? They are talking about subjects who are perceived to aspire to normalcy or even supra-normalcy: subjects who wish to perceive themselves or to be perceived by others as embodying characteristics that are regarded or constructed as "better" than normal. In cases of corrective or elective ("plastic") surgery for example, or pre-natal surgery, or selective abortion, how is recognition measured? What is its currency? What access does it afford? Does the individual decide? Or the family? The state? Or another provider? Who is or are the agents? In their exploration, Rapp and Ginsberg fundamentally challenge naturalized notions of subjectivity, ability, status, eligibility and deservedness; and exhort redressing *in*equitable policies and practices of recognition and access to sociocultural, politico-juridical, economic, and material resources through ethnographically-founded analysis of "unnatural histories" (2001:552).

Rapp and Ginsberg also complicate the question of somatic alteration, which I reframe as central choices and sources of dynamic tension in military rehabilitation. They and numerous other scholars recast and complicate rehabilitative/restorative regimens, bio-medical technologies, and actual mechanical and electronic apparatuses such as prostheses and implants as potentially foisted on subjects by experts, chosen by subjects, or jointly agreed to by expert and subject. All the while, subjects and the somatechnics may remain-in-formation.

*Dis*abled SMs who are undergoing rehabilitation at MTFs face contests similar to those that Rapp and Ginsberg identify among their subjects: contests between what bio-medical technological and pharmaceutical interventions, or "socio-medical practices," they can or are willing to embody and what is demanded of them in order to be mainstreamed (Rapp and

Ginsberg 2001:540); or, as I argue, to be recognized, to reclaim access to resources, and in effect, to *un*intentionally participate in or to co-construct social reproduction.

In addition to their work regarding structure and agency, Rapp and Ginsberg also critically scrutinize modern, democratic, de-institutionalized (but not depoliticized) narratives of personhood, and of human value. At my site, the impetus of providers to return *dis*abled SMs to service or to productive civilian life is problematized by confusion about who is making the critical choices and who is controlling the discourses that will enable or forestall those outcomes.

Rapp and Ginsberg offer insights and theoretical means of unpacking normalized and hegemonic discourses of citizenship and of rights in order to methodically and methodologically retrieve and re-inscribe narratives of inclusion, re-attaching them back onto the subject (Rapp and Ginsberg 2001:545). And in her formative discussion of the cultural construction of childbirth, Rapp 1993 includes an elaboration of the historical contingency of science and scientific knowledges, framing them as discursive and interpretive processes that are always-in-negotiation within spheres of production and consumption (1993:63). This insight underpins her analysis of cultural constructions such as childbirth, and elsewhere *dis*ability, as sites of struggle for power, and therein locates inherent instability.

Rapp includes medical anthropology as a constructed and unstable field of critical inquiry (1993:59). Her elaboration contributes heuristically to my research about rehabilitation of wounded, ill, and injured SMs because it acts to re-cast the knowledge, interventions, and choice-making that transpire within an apparently *un*even terrain. These actions and reactions may be framed as discourses, and their claims and counter-claims may be interpreted as constantly-in-negotiation by all agents. Rapp's heuristic further helps my analysis by repositioning the agents, i.e., *dis*abled SMs, families, medical practitioners, and policy-makers,

as subjects of and subject to shifts in forces and relations of power that result in shifts in statuses for recognition and access to resources. Moreover, her acknowledgement that her respondents are the data sources for this analytical tool kit reactivates my commitment to ethnography, discourse analysis, and research regarding my subjects' life-worlds[78]–their lived existence in the world. Rapp says that the people who consented to be interviewed in her study "provided insightful comments on the force fields within which their own options and possibilities were inscribed" (1993:71).

What is overtly missing in Rapp and Ginsberg but which may be inferred as tacit in their argument is a rigorous discussion of how the neoliberal state and its modes of production and consumption mask and mystify predatory ideological influences (for insightful unpacking of neoliberal conditions see Duggan 2003a,b; Lancaster 2008; Leitner et al 2007; and for exegesis of masking and mystification see Leone 1987); and how state apparatuses (repressive apparatuses such as the Army; and ideological ones such as the family [Althusser 1971:142,143]) co-constitute notions or interpellations of unfettered individualism and choice.

This question is important to my research because in the late modern moment in the U.S., established neoliberal political-economic policies and practices continuously attempt to transfer responsibilities from the state to the individual–yet before, during, and after recruitment into the U.S. Armed Forces, which are structural entities of the DOD, which in turn is an agency of the state, the individual consents to voluntarily relinquish her autonomy and its attendant responsibilities. She formally waives her perceived self-sovereignty via a hegemonic exchange in which access to increased recognition and benefits are authorized, mediated, and granted by the

[78] Husserl, E. 1970. The Crisis of European Sciences and Transcendental Phenomenology. D. Carr, trans. Evanston, IL: North Western University Press.

state and legitimated not just institutionally but also by the body politic.[79] But this transference goes against neoliberal tendencies and so the question and resolution of who owes what to whom when SMs are *dis*abled is socioculturally confusing. This confusion may underlie the struggles that erupt at sites of military rehabilitation and beyond, in the forces and relations of family, community, and state spaces in which public and private responsibilities are blurred, benefits are in contention, and awards are unevenly distributed. Confusion about who owes what to whom is costly; and its costs as yet are uncalculated.

On the other hand, Rapp and Ginsberg's work helps to deconstruct ideologically emplaced or adopted embodiments by revealing the multiple influences, including evolving discursive practices and bio-medical technologies, that conspire to limit and permit[80] somatic alterations in the late modern moment while at the same time asking: Whose agency is at and in play? Their arguments are germane to my research because the authors and the arguments foreground critical questions regarding individual, familial, and social rights, responsibilities and obligations within a neoliberal political economy that valorizes choice, achievement, and perfectability (Rapp and Ginsberg 2001:540,541); or in my inquiry, "rehabilitation," i.e., institutional efforts to return *dis*abled SMs to their former capacity, standing, rank, rights, or privileges or to co-produce a facsimile of their former capacity.

CDS scholar Davis historicizes and critiques the construction and deployment of normalcy, positioning it as a hegemonic configuration and motor of cultural production that has been co-constituted by notions of progress, industrialization, and "ideological consolidation of the bourgeoisie" (Davis 2010a:17). Davis also problematizes the continued utility of identity

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[79] I use "body politic" in the same way as Arendt 1978; A.T. Smith 2011; Stepputat and Hansen 2006; and Mbembe 2003; i.e., to invoke the people and People who are citizens within geo-politically recognized entities, often "nations."

[80] See Steward 1955:36 for this productive dialectical usage, along with the author's reference to Forde 1949, "circumscribe and afford."

politicking, tracing and paying homage to its former productivity as a means to identify and contest dominant oppressive ideologies (privileges of race and gender for example, and of "ability"), but criticizing structuralist and post-structuralist over-theorizations that serve to distance "people" with "specific markings" from "humanity" with "unlimited" and "undelimiting" markings." Davis calls for a "dismodern" politics that can pinpoint and contest "disablement by (the) larger system of regulation and signification" (Davis 2010b:313). Here Davis gives a nod to the importance of acknowledging (bodily) difference, but notes that difference (as in his example of *dis*ability) is a uniting feature of personhood and subjectivity. This is an important distinction because my sense is that some of the *un*even outcomes (variously punitive and rewarding) that emerge among the people I studied in their settings are based on uncontested ideologies of hierarchical difference–of domination and subordination–and that, as in Davis, these ideologies need to be examined. The discursive exemplar at my site is the distinction made between "wounded," "ill," and "injured" SMs.

In the debate about how *dis*ability, stigma, difference, equality, and social justice unfold in late modernity, individual and collaborative work by Whyte and Ingstad 1995 has been influential and provocative in my cross-disciplinary analysis and scrutiny of the cultural significance of designations of *dis*ability. In the preface to their collection of essays about local and global constructions of *dis*ability, Whyte and Ingstad provide an instructive overview of the relationship of *dis*ability to culture, noting that in principle *dis*abled persons are regarded as being chronically incapacitated, eligible for rehabilitation but not curable[81] (1995:1-24). The authors unpack the categorization of "incapable of performing in culturally expected or required

[81] This dyadic "condition" productively parallels Agamben's description/depiction of *homo sacer*: One who is banned (or banished); and who may be killed (or left to die) but cannot be sacrificed (Agemben 1998:8).

ways" by complicating the ways and places[82] in which the expected performance is sited. They argue that notions of *dis*ability are contingent on exigencies of social interaction, community, identity, and cultural assumptions that underlie personhood; and that these contextual factors are geopolitically variable and cross-culturally unstable.

Whyte and Ingstad call into question the kinds of fixed classifications or taxonomies that are proffered and utilized by communities and organizations, and they affirm the relevance of actively considering identity and values *in situ*–without reactively resorting to or relying on privileged perspectives that may inhere in cultural relativism. They point out that in some cultural and geopolitical contexts, *dis*ability does not or cannot exist, and they warn of the expedient instrumentalization of *dis*ability as a categorical construct, unpacking the naturalized Euro American notion of and impetus for equality and individual rights; and problematizing the identification of difference. They note the inevitable contradiction inherent in a conception that attempts to both recognize and obliterate the significance of difference at individual and community levels.

This point is integral to Critical Race Theory (CRT) too. Just as there is dialectical tension at the intersection of ethnicity, class, age, gender and sexual identity, so too there is instability, contradiction, and potential transformation at the intersection of shared identity as a social being, and as an individual with unique *dis*abilities. CR theorists' arguments foregrounding struggles over recognition and access to rights and resources put in play the notion that strategic essentialism and "tests" of deservedness may be productive when intentionally deployed in juridical and legislative battles for recognition and redistribution.[83]As Stephen 2001

[82] As in Leap N.d., these sites may be both privileged *and* subordinate.

[83] But see also Davis' 2010a:xii-xiii contrasting argument above in which he critiques essentialization as unproductive–even deleterious.

notes in her work on complexes of identity, politico-economic contestations between the state and un- or under-recognized, but well-organized constituencies, affirm that to be productively operationalized, claims to recognition and access based on identity must be put forward strategically, either at the individual or community level. More pointedly, to be productively and appropriately deployed, these claims and stances must be understood as always-in-formation, depending on spatio-temporal conditions and situational objectives (Stephen 2001:8).

Oswin 2007 indexes strategic essentialism as well, but historicizes and problematizes its contested politicization; and drawing from an interview by others with Spivak, Oswin interrogates the co-option of identity in struggles for recognition and redistribution among re-organized coalitions of under-represented citizens; i.e., homosexual citizens whose juridical rights do not match their actual access to *im*material resources in South Africa's contemporary neoliberal landscape (2007:650).

CDS and CRT theorists' attention to strategic essentialism (and Davis' refutation) bear directly on my research because I am trying to untangle the mechanisms that underlie SMs' changing complexes of identity, including their autonomy and dependence, and the work these mechanisms do or don't do, or can or can't do. In their work, Whyte and Ingstad index and complicate the notion of individualism, adding critical commentary about culturally contingent readings of dependence (2005:11). If able-bodied subjects relinquish their corporeal and cognitive sovereignty during military enlistment; if they "offer up" their autonomy, individualism, and independence to the state, thereby both giving up and acquiring "identities;" and if the state subsequently remits some components of their identities back to SMs in rehabilitation, the arguments about strategic essentialism and its uses are significant. The state maintains partial sovereignty over the wounded, ill, or injured SM, who continues to be

understood as an active duty member of the Armed Forces; yet it requires her to assume responsibility for her own rehabilitative corporeal, cognitive, and psychological achievements, and rewards her success thereto. By default, the state penalizes those who can not or will not re-assert their own autonomy–who can not or will not reclaim their independence–by withdrawing, diluting, or diminishing rights of and access to recognition and redistribution. In order to prosper in rehabilitation, the SM is required to both abandon and retain essential elements of her identity and, left to her own devices, to call on or perform them strategically. This dialectical and alienating condition burdens the SM with irresolvable and mystified challenges regarding what elements of her identity are essential and which are intersectional. In addition it prompts me to describe the people among whom I conducted ethnography as "inter-dependents."

Whyte and Ingstad further note the emergence of rehabilitation in confluence with constructions of *dis*ability as a discourse and institutionalized business, and its commodification, or, as I view it "co-modification:" a mode of production and consumption in Western post-World War I political economies (Whyte and Ingstad 2005:9,10). These points are also elaborated by Arluke and Gritzer 1985 who carefully index the 20th-century materialization of rehabilitation as a scientific complex of interventions, technologies, and knowledges (i.e., *physiatry*), a state-sanctioned and tightly controlling source of public benefits, a site for the administration of social policy, and a locus for the display and interplay of market forces.

In her epilogue to an edited volume, Whyte takes up the importance of understanding the lived experience–the phenomenology–of the *dis*abled subject (Whyte 1995:277,279). Here she not only indexes the value of an interpretive stance that is centered in the subject's life-world, but also cautions against privileging text or discourse analysis, warning that narratives are made available or selected, or even constructed and positioned; and that they are not uniquely or

comprehensively descriptive of this or any experience. Whyte elaborates by invoking the potential for objectification or "Othering"–even erasure–of the subject that may reside in Foucauldian methodologies of discourse analysis, and refers to Abu-Lughod and Lutz's (1990) criticism of over-theorization in which they, and by default she, argue that relying on pre-determined structures[84] for getting at meaning may inadvertently remove or co-opt the subject (Whyte 1995:268). Whyte asks that the subject's own agency not be omitted from anthropological analysis so the researcher does not to fall into the trap of representing *dis*abled persons as "Others" (276, 277), deferring to Kleinman and Kleinman who define "the felt flow of inter-subjective transactions in local moral worlds…(as being) attentive to structures of relevance" (1991:279).

Whyte's invocation of this passage is somewhat contradictory in that it *un*intentionally invokes Williams' "structures of feeling" (the formative but not determining processes that shape experience [1977:128-135]), and repositions phenomenological research and discourse analysis as in dynamic tension with each other in apperceptions of real *im*material conditions. I think she means to valorize both in tandem with each other as co-productive methodologies in dialectical relationship with structural and *im*material conditions. She is cognizant, even concerned, that the use of discourse analysis on its own to understand the subjectivity of *dis*ablement may be epiphenomenal, thus putting the subject at a remove. Whyte uses this cautionary note to recall the central contradiction that she and Ingstad index and find productive, if challenging: The dualistic and contradictory stance, i.e., the dialectic, of seeing and denying difference while experiencing, observing, or analyzing it (Whyte and Ingstad 2005:19). As Crenshaw and other CR theorists also point out, Whyte observes in a recuperative note that it is at the intersection of *dis*ability, race, gender, ethnicity, age, and sexuality, at the nexus of changing discourses and

[84] Or, as I read them, routinized methodologies.

lived experience, that the transformative potential–the power–of contradictory practices, discourses, experiences, and *im*material conditions resides. She adds that the presence of this dialectic invites additional ethnographic fieldwork (Whyte 1995:283-284). What she does not adequately address or problematize is whether, or in what relative ways, structure or agency or another wellspring of influence or choice accounts for *un*even lived experiences and their texts.

Ingram and Schneider, along with Jenson, trace the modern history of entitlements to get at the social construction and politics of deservedness that were first assembled to recognize and exemplify veterans and then *dis*abled soldiers as worthy citizens (Ingram and Schneider 2005:33; Jensen 2005:53). And Albrecht positions the evolution of a complex of rehabilitative services, facilities, and deserving clients as a reluctant and unstable political and institutional response to unforeseen and unmanageable, even un-imaginable, advances in bio-medical technologies that continued to enhance survivability, alongside fierce challenges to long-standing contemporary American cultural denials of the social presence of *dis*abled persons. He notes the broad and destabilizing significance this discursive and industrial response has as it continues to exact a socialization process that is always-in-formation–pointing to the contrasting, challenged, and complex subjectivities of providers, policy-makers, and patients, especially with respect to adventitious[85] *dis*ablement (Albrecht1976:31). In doing so, he echoes observations noted above by numerous other scholars and researchers regarding constructions of *dis*ability.

Across multi-disciplinary fields, some others have investigated how embodied differences are detected and permitted, erased or enhanced, desired, projected, and taken up by subjects, as well as how they are recognized, rewarded, penalized, or overlooked. They have examined how objects such as prostheses, machines and equipment; additives such as steroids, vitamins or supplements; or processes such as cosmetic or elective surgery are utilized, adapted

[85] Unexpected, not original.

and justified in expressions of and reaction to real and imagined demands for access to a range of resources. Their scholarship, across demographic fields that are not bounded by civilian or military status, informs mine by offering work that broadly plumbs the corporeality and embodiment of fitness, using comparative phenomenologies of the lived experience of *un*intentional altered embodiment and alternative analytical "workings" of the subject and the subjects. Their texts (those of the authors and of the subjects) put on offer complexes of idealizations and materializations that complicate mechanisms and proveniences of structure and agency (Aizura 2009; Linder 2007; McRuer 2006; Mowlobacus 2010).

For example, Aizura 2009 cross-examines his own notions of what impels Thai transgendered subjects to s/elect "beautifying" surgical procedures, finding that whereas his original theoretical hypothesis essentialized the motivations for participating in these enactments as over-determined responses to racialized ideological notions of beauty circulating in a globalized economy, his ethnography and the texts he analyzed, including narratives, imagery, and spatio-temporal and bio-medical practices themselves, suggest rather more complex "choices" about recognition and (self-)distribution of somatechnical capital in late modernity (Aizura 2009:305,313,315 n.6). Among other revelations, his mindful and nuanced analysis exemplifies the importance of accounting for what actors actually say and what they actually do within systems and settings, and how these actions or enactments shape and are shaped by broad experience, or embodied knowledge, of and in the late modern social moment.

Linder also discusses bodily alteration. In his reflexive analysis (he includes a photo of himself, "flexing"), Linder provocatively and contradictorily indexes bodybuilding as a means to achieve exaggerated fitness that resists modern and alienating modes of production and consumption, positioning this enactment as an intentional and highly self-disciplined and

self-regulated corporeal, cognitive, and psychological stance against modern forces and relations that perpetuate narcissism, isolation, anxiety, and mindless consumption. He bases his interpretation on the emergent wellness and fulsome agency he observes and participates in at bodybuilding gyms, through magazines, and during competitions, and argues for academic reassessment of the significance of horizons of experience that have been traditionally "dismissed" as beneath the scholastic gaze–beneath academic regard (Linder 2007:452). This resonates in my work for several reasons: In the U.S. Armed Forces there is an abiding and overtly articulated requirement to be "fit;" SMs speak openly about being "lifetime athletes" who are members of "a fit fighting force;" rehabilitation regimens at MTFs emphasize–even demand–athleticism; and advanced prosthetics and other corporeal interventions "pushed" in military rehabilitation may result in exaggerated physical capacities. In addition, my position and participation as a contractor within a MTF has generated some related questions for myself and others, not only about my "ability" to remain critical, but also regarding the worthiness and ethics of my emplacement at the site itself. Linder's overt self-insertion, i.e., his emplacement and reflexive embodiment in the space he is investigating, serve as examples to me of the value of being in the community "we" study, of privileging existentialism over idealization, of being in the world.[86]

In his exegesis, Linder complicates notions of fitness, cross-indexing physiological and psychological, and self and others' assessments (2007:454). He draws in practices and regimens of exercise, nutrition, and display, including what he views as fruitful mediations via events and magazines, photography and film; even linking the production of big bodies with expressions of art and beauty that enable access to justice (Linder 2007:461). In this argument, personal agency is held up as the mechanism for overcoming structural barriers to self-realization and

[86] See Sartre 1965:255-275 for more about consciousness and being *in* and *of* the world itself.

concomitant fulfillment. Linder's stance superficially challenges my readings of *dis*ability and deservedness in which I have tentatively inferred, parallel to Aizura's original inference at his "site," that overweening athleticism and the rewards it accrues express an unexamined response to ideological interpellation. Yet Linder gets at a central question that emerged in my research, that is addressed but not resolved by Messinger (2009a,b), and that is reported by numerous subjects and journalists: Why do some *dis*abled SMs embrace and extol extreme athletic rehabilitative models while others will not take them on? And, why do some "rehabilitated" SMs wish to, agree to, or consent to RTD, whereas others resist, resent, and may even re-appropriate overt and tacit RTD mandates (Aliff 2010; Chivers 2011; Priest, Hull and deCille 2007a,b,c)?

In contrast to Linder, when Mowlobacus problematizes mechanisms of interpellation[87] he looks at controlling structural influences that are activated when self-identified gay men cyber-prowl; including a provocative and germane discussion about the ways in which bodies get re-organized and re-presented in order to be re-cognized within particular taxonomies of fitness (Mowlabocus 2010). Some of the "results" of these self-actuations resemble those that Linder presents–exaggerated physiognomies for example; however Mowlabocus' stance is quite different. He "worries" the implications of the expressions and performances he observes, participates in and comments on–asking by whom they are authorized, authenticated, limited, and permitted (Steward 1995:36).

Mowlabocus complicates who (or what) is wielding control over participants' varied and arbitrary representations of themselves, e.g., the same person may web-post numerous variations of himself[88] using numerous markings depending on the demarcations of the space in which he is

[87] By which I mean being hailed (Althusser 1971, Pêcheux 1982).

[88] Unlike elsewhere in discussion of my subjects, here I generalize *male* gender because men comprise the subject group Mowlobacus examines.

"performing." Mowlobacus posits that the very "virtual" physicality he is scrutinizing is an ironic communicative means to seek recognition and access because, although real people are producing and consuming the images, the images themselves are not authentically attached, except imaginatively, to the subjects in search of recognition. On their face, his ethnography, analysis and remarks parallel the before, during, and after aspects of research I did regarding *dis*abled SMs' experiences and the *im*material conditions and settings, i.e., the spaces, in which their inter-subjectivities, identities, and selves became re-organized and re-read. More integrally, Mowlabocus' scrutiny of what impels and supports, or what hails and who recognizes, the adoption of borrowed (not original) "parts and pieces" gets at the complications of bodily re-organization as represented by prosthetics, drugs, surgeries, and assistive technologies that are unevenly imposed on, welcomed, adopted, refused by, or denied to *dis*abled SMs in rehabilitation.[89]

Aizura 2009 recognizes subjectivity that works and re-works ideological interpellation (Pêcheux 1982:57). Linder's subjects intentionally re-form their physicality *in extremis* in order to overcome hegemonic expectations of production and consumption that reward "good" subjectivity while erasing individualism and self-expression. In Mowlabocus, the subject turns to multiple and virtually disembodied self-representations in response to the need to be recognized within over-determined structural categories and their overt and tacit taxonomies. The constructions of fitness invoked by authors who scrutinize body alteration are in high contrast, yet underlying their discussions are similar interrogations of powerful reorganizing mechanisms.

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[89] By re-appropriating Aizura's, Linder's, and Mowlabocus' arguments, and by reviewing them, I am reconsidering adventitiously *dis*abled persons rather than the adventitiously improved or enhanced persons these authors invoke. Their arguments strengthen one of mine: Attributes that circulate in discourses of military fitness are no longer intact in the *dis*abled SM, so apparently the state no longer considers her as wholly productive–she no longer embodies controlling ideological notions of fitness. Based on what respondents told me and what I observed, for *dis*abled SMs in rehabilitation this destabilization is productive and powerful; it flows back and forth and is always-in-formation (Foucault 1997:194).

These critical analyses encourage my inquiry into the *un*intentional refiguring of *dis*abled SMs' bodies (and minds and psyches); and the spatio-temporality of the policies, processes, and practices that undergird them.

Other Scholars Who Locate Subject Formation and Transformation

Other analyses complicate ideas about individual choice in the context of naturalization of forces and relations of power. If ideological processes and practices of state apparatuses such as the Army or the family mask or veil mechanisms of power, do subjects recognize that they are being hailed and interpellated? (Althusser 1971:139,140,172-175). These works show that by naturalizing defining conditions of *in*eligibility (by making them appear "obvious" no matter how unequal, mystified, or punitive they may be), ideologically underwritten and enacted policies, practices, and inter-subjectivities rationalize, recognize, and reward behaviors that bolster them(selves). This mutually-recognized and dominant rationalization, or hegemony (Gramsci 2005:12,13), encourages maintenance of the status quo and may intentionally garble comprehension of agency (who is making the decision when consent is required and provided?), rather than permitting informed acquiescence, re-appropriation, or resistance (Pêcheux 1982:157). In his elaboration of Althusserian subject-formation Pêcheux notes:

> … every discursive practice is inscribed in the contradictory-uneven-overdetermined complex of the discursive formations which characterize the ideological instance in given historical conditions…(and) every subject is constitutively held to be the responsible author of his acts, of his 'behavior' and of his 'utterances' in each practice in which he is inscribed as a subject and this by virtue of the determination of the complex of ideological formations (and, in particular, of discursive formations) in which he is interpellated as a 'responsible-subject.'
>
> – Pêcheux *The Subject Form of Discourse in the Subjective Appropriation of Scientific Knowledges and Political Practice*

That is, subjectivity is pre-constructed (is always-already-there); and yet, within it, ongoing recuperation-reproduction-reinscription of knowledges occurs. These knowledges are simultaneously signifiers and signifieds: They identify residual skills and expertise in the object; and they provide insight to the subject. As understandings, these knowledges co-reside in and co-construct subjects and subjectivities, by interpellating, recognizing, and hailing them–and by circumscribing their recognition and access to resources.

Pêcheux indicates that the interpretive relationship animated among agents produces "elementary ideological effects of identification-interpellation of subjects, imputation of responsibilities, and distribution of meanings." These meanings are triadically engaged: They are accepted by the "good" subject; resisted by the "bad" subject; and worked by the "dis-identifying" subject (Pêcheux 1982:158). The texts I gathered sketched the contours of always-in-formation subjectivities and outlined my understanding of participants' and my own engagement at the sites. Subjects used or were interpellated by dominant (or, institutional) orders of discourse in order to categorize themselves and others within taxonomies of corporeal, cognitive, and affective damage and the conditions thereto, e.g., in combat, because of illness, or by accident. They imputed their responsibilities to participate in modes of rehabilitation, and to be retained, or re-deployed, or to re-enter civilian life. And within this discursive system they participated in and distributed meanings–for example, agreeing on or resisting who deserves what degrees of recognition and access to resources. I found their texts to be reproductive variants of global, dominant usages that are re-negotiated and recuperated locally and are sometimes re-inscribed or resisted in unexpected, even unmanageable, ways. [90]

[90] I was also influenced by S. Hall 1980. He invokes another tripartite model for understanding subjectivities via text analysis: 1. dominant-hegemonic, or operating inside the dominant "global" code; 2. negotiated, or appropriating the "global" to adapt it to the "local" by incorporating or territorializing it; and 3. oppositional, contesting and altering the global code via de- and re-totalization (1980:175). These "positions" resonate with Pêcheux's "good," "bad," and "dis-identifying" subjectivities (1982:158); and with Fairclough's "dominant", "oppositional," and "marginal" meaning-making (2003:206).

Foregrounding these questions puts on offer contending forces and relations of measurement, assessment, and means-testing that circulate in spaces of rehabilitation at MTFs. When damage occurs to the qualifying corporeal, cognitive, and psychological attributes for military eligibility that are construed by the state and the recruit, mutually-contracted terms and conditions have also been adventitiously altered, so the state and the SM must re-calibrate their responsibilities and obligations in a multivalent evaluative and rehabilitative process. Notwithstanding the scholarship indexed here, these re-negotiations are not broadly mediated or socioculturally recognized. By delimiting forces and relations, or modes, of production and consumption of military rehabilitation within MTFs these corporeal, cognitive, psychological, and institutional re-organizing processes may be removed or alienated from the public sphere (Axelos 1976; Marx 1978; Ollman 1976; Sayers 2003; Thomas 2004). These modes may also distort subsequent re-consenting requirements to "enlist" in multiple specific therapeutic interventions and may in turn contribute to their disruptive and disturbing real effects.

The re-consenting process and experience are not unique to subjects of and in military rehabilitation. In my review of literature I studied and analyzed work regarding subject formation that indexed parallel re-enactments among other people within other spaces of negotiation for recognition and access. In order to understand how people perceive and engage, or are perceived and are engaged, in the changing conditions of their lives, some scholars scrutinize what humans say and what they do–spatially, temporally, corporeally, linguistically–and how these actions or enactments continue to shape their experience in the social moment. The visibility, intention, consequences, and success of human actions express agency, the socioculturally mediated capacity to act in the world (Ahearn 2001:112). Scholars who problematize human agency in the

social moment may also look at structural and systemic political[91] forces and relations to tease out what determines the ways in which subjects are regarded, or recognized, and how they regard and recognize themselves; and how the conditions of their recognition–their formation–are correlated with their ability to gain or regain access to sociocultural and material resources (Collins et al 2008; Hill and Irvine 1992; Lancaster 2003; Ortner1984, 1995, 2006).[92]

Leap uses ethnography and discourse analysis of life-story narratives to interrogate the structural and agentive dynamics of accepted and refused subject formation, finding that this condition is one of hegemonic engagement, is "always in formation," and is inextricably coupled with ideologies of embodiment and emplacement (Leap N.d.:18,19). Looking at pre- and post-Apartheid accounts by same-sex identified persons regarding access and denial of access to spaces of desire, Leap carefully parses consent of the state and of the individual. In a continuous if uneven and tension-ridden process, the state irregularly re-acknowledges or recognizes the individual, opportunistically manipulating his[93] legitimacy; while at the same time the individual refuses to accept–or may dis-identify with–the subjectivity arbitrarily imposed upon, partially conferred, or removed from him (Pêcheux 1982:163). Noting that juridical changes do not necessarily result in *im*material ones, Leap calls these muddled assignations of status (in his example to both subjects and locations) "privileged" and "subordinated," and finds they co-constitute a dynamic site of struggle and co-implicate notions of authority (Who is the author?), of authenticity, and of citizenship (Leap N.d.:1,2).

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[91] By "political" I mean to infer power and potential, as well as policy.

[92] In addition to Ahearn's detailed discussion about constructions and expressions of agency (2001:112), see CR theorist Crenshaw 1996 for a rigorous examination of complex and intersecting expressions of agency that are bound up in multiple re-inscriptions of identity (1996:357); and Duggan 2003 for the ways in which agency is politicized and inequitably re-inscribed under conditions of neo-liberalism (2003:15,16).

[93] I use this male-gendered term because Leap writes here about men who have sex with men.

Leap's work is significant to my research because it examines how the interpellated subject grapples with ideological demands and constraints. Leap's scrutiny informs my inquiry regarding the tense and irregular engagements of patients and care providers in the uneven terrain of military rehabilitation. Guided by Leap's analysis, in which he indexes critical insights of Althusser and Pêcheux regarding ideology and subject appropriation, I can reconsider *dis*abled SMs' subject formation: Some *dis*abled SMs accept their institutionally-imposed roles and responsibilities within discourses and technologies of rehabilitation (they are *good* subjects); some refuse to take them up (they are *bad*–or refused–subjects); and others "work" their subject form by partially adopting, parodying, "misunderstanding," or misrepresenting rehabilitation regimens (they are *dis-identifying* subjects). This analytical framework helps me to apperceive and re-evaluate my respondents' texts, narratives, positionings and positionalities–and the consequences thereto.

Invoking Habermas, Leap links the productive struggle he apprehends to the co-formation not only of subjectivities but also, and inherently, to the opening of spaces that are public spheres. Leap elaborates this notion of place, linking his subjects' embodiments and emplacements with the significant cultural messages and *im*material effects that were systemically mediated and imposed by Apartheid. This entry point enables a thoroughgoing examination of self-regulation in which Leap problematizes the very instruments that are utilized to denote and exploit "difference" and to justify hierarchies and domination, examining contradictory totalizing and identitarian constructions of appearances, distinctions, markings, and abilities. He finds that subjects can and do "refuse," and can and do construct themselves in response to shifting requirements, demands, and ideals (Leap N.d., 2004).

Similarly, dynamic and dialectical tensions that inhere in the struggle between these contradictory constructions show up at sites of rehabilitation and are expressed in multiple ways, some relatively benign and others mortal. Humor, parody, sarcasm, self-deprecation, over-achievement, under-recognition, apparent callousness; as well as suicide, drug abuse, depression, anger, withdrawal, dysfunction, apathy, failure to thrive, and other forms of abjection and self-inflicted or other-directed violence (or, in Leap, "refusal") may be evident among patients and care-providers. And co-occurring defensive strategies that practitioners deploy to maintain privacy and human subjects' protection may prevent transparency in and entry points to modes and sites of care. At the same time, access and exposure may result in families being disrupted; communities sundered; and policy-makers, case managers, therapists, and enlistees themselves vilified (Dao and Frosch 2010; Dao, Carey and Frosch 2011). Or, as noted by Messinger (2009a,b) and suggested to me by respondents, SMs who can not or will not sign on to institutionally-sanctioned rehabilitative regimens may simply be disregarded, ranked poorly in evaluations for further treatment, or discharged without adequate support systems in place. For their part, care-providers may feel overwhelmed, inadequate, thwarted by conflicting demands, and helpless (Pine 2011; Priest and Hull 2007a,b,c; Wilson 2012).

Leap's discussion of sources and constitutions of multiple subject positions, their "everyday geographies," and their spatio-temporal fragility goes directly to my search for understanding the ways in which notions of fitness, of power, and of social reproduction unfold at sites of rehabilitation (N.d.:19,20). And by imbricating his subjects' physical presence in desired spaces alongside their shifting place[94] in the national memory, Leap also offers a means for construing my site as real and imagined space in which subjects and their subjectivity are re-constituted (N.d.:43, 44). Although Leap's discussion focuses on the specific geo-political and

[94] For a complex and thoughtful exegesis of "place" in the national imaginary see also Anderson 2006.

spatio-temporal condition of self-identified same-sex males' refused subject formation in pre- and post-Apartheid Cape Town, he critically queries significant determining factors of subjectivity, pointing to constructions and mechanisms of structure, agency, differences in ability, deservedness, and claims that are in formation and actively in dispute; i.e., are in dialectical relationship to each other.

The heuristic of identifying and locating subject *mis*appropriation put forward by Leap as a productive evaluative tool is bolstered in Messinger's study of rehabilitation at a MTF, as the latter's ethnographic analysis turns on a related angle of inquiry (Messinger 2009a,b). Using ethnographic methodology, Messinger follows a few SMs who are amputees. Via participant observation, interviews, and collection of narratives from various therapeutic aspects and positions, he researches his subjects' lived experience in their courses of rehabilitation. Messinger finds that depending on their acceptance or refusal or *in*ability to participate in prescribed bio-medico-technologies and athletic models of rehabilitation, these subjects may enjoy, or be excluded from, or confuse their own and others' perceptions of the benefits that are owed and provided to themselves. In his argument, Messinger challenges practitioners to consider this working of the subject form, affirming that subject refusal may not necessarily be wholly intentional;[95] rather it may emerge from complex and under-recognized impositionings that have significant material impacts on SM amputees' ability or permission to reclaim access to resources and status as citizens; or for that matter, to recover "successfully." Messinger, like Leap, is interested in exigencies of difference, and looks to structural and agentive factors that mitigate for and against constituted subjects' full socio-political and juridical representation. He unpacks mechanisms that both construct and legitimate spatio-corporeal appearances, looking and listening for the presence and absence of both people and instruments of embodiment.

[95] When for example a prescribed prosthetic limb may be unconformable, not work very well, or be too heavy to wear.

Speaking to constructions of *dis*ability and rehabilitation policies, Meekosha and Dowse 1993 link notions of citizenship with imposed subjectivities that rest on constructions of "normalcy," interrogating similar juridical and politico-economic policies and practices that determine exclusion and situational inclusion, or belonging.[96] Meekosha and Dowse's subjects of interest are *dis*abled people organizing for access to rights of sociocultural, juridical, and politico-economic recognition and access to resources in Australia. Nonetheless, their work on national imaginings and discourses of who qualifies, i.e., who is recognized, as a citizen; and within which subject positions people are able to access resources and to be imbued with ideologically and socioculturally acceptable rights and responsibilities, parallels Leap's close reading of narratives of exclusion and refused subject formation in South Africa.

Work that Complicates Sovereignty

In analyses of productive and destructive forces and relations of power and of their modes and manifestations, some scholars consider the unstable locus in which corporeal, cognitive, and psychological sovereignty resides.[97] These considerations are germane because they open a space for debate about self-governance that is significant to my study of mechanisms of military recruitment and rehabilitation, and constructions of *dis*ability and deservedness. By enlisting (or, during enlistment), SMs give up their autonomy and are no longer independent; yet later, those active duty SMs who are wounded, ill, or injured are required or expected to reclaim aspects of their autonomy in order to participate in specific regimens and be successfully

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[96] And see Bérubé 2003; Blakey 1990; Hartsock 1984; Maurer 1996; Nagel 1998; and Peterson 2010 for instructive examinations of sociocultural and politico-economic constructions of citizenship and belonging, and their *un*intended costs and consequences; i.e., their trade-offs.

[97] By which I mean the power over life and death.

rehabilitated. [98] Their altered state is one in which they must take responsibility for re-assuming "normal" life; for some, after being subjected to near-death.

Agents' cognitive and corporeal capacities to act in the world are aspects of their individual power over themselves–their sovereignty. The construction or perception of innate or emanant human sovereignty appears as a defining if contradictory factor in the contemporary area of study referred to as "necropolitics" in which global, national, and local assemblages and re-territorializations of power are located and analyzed (Mbembe 2003). Agamben figures in this literature because he examines human *being*. Who he asks, has sovereignty over human corporeality and mortality, and under what *im*material conditions, and what socio-political and ethical constructions (Agamben1998)?

Agamben complicates Foucault's notions of bio-power and technologies of self (Foucault 2004), positing that whereas Foucault abruptly leaves totalization and individual choice as interrelated but opposing spatio-temporal and politic-economic explanations of human conditions, for Agamben totalizing structural forces and individual relations converge; that is they intersect in his unitary if dialectical theory of power, in which structure and agency are co-constituting and contradictory aspects of choice, "the voluntary servitude of individuals (coming) into contact with objective power" (Agamben1998:6). His argument reactivates similar debates among scholars of structure and agency such as Bourdieu 1977, Giddens 1979, and Ortner 1984 and then powerfully re-reads them through ontological and phenomenological lenses. In his examination of lived human experience, sovereignty, and potentiality, Agamben co-locates the individual's and the nation-state's struggles for existence within the context of war and violence. He elaborates Foucault's conception of bio-power to further complicate corporeal or "bio"-sovereignty in modern political economies, including the *im*position and experience of a

[98] Where "success" means to return-to-service or to re-enter civilian life.

seemingly contradictory yet very real dual condition of subjective individualism within a paradigm of totalizing structuralism. Agamben further examines the concomitant strategies, demands, and concessions of the tense negotiation that unfolds in arguments about just and unjust, or chosen and forced, participation in mortal performances of citizenship and nationality, including in war (Agamben 1998:2-7).

Considering aspects of self-sovereignty leads me to re-examine "obvious," "true," and "naturalized" conditions under and within which SMs, their peers, and supervising authorities labor; and offers a re-entry point to consider the struggles for recognition and access. In the U.S. Armed Forces, independent or individual self-expressive actions are not permissible while SMs are in uniform or on duty. Such actions are both overtly and tacitly suppressed by rituals, routines, dress, and gear that are central to military conduct and lived experience, including in training, testing, exercises, measurement, rehabilitation, and return-to-service policies and practices. These forces and relations of power continuously reassert their sovereign dominion to negate the agent's own bio-power. This persistent re-assignment of sovereign control over the SM's mortality and *dis*ability to thrive controls, disciplines, and punishes (Foucault 1977). And it may be that the state of extreme *dis*ability that befalls some SMs can be compared to being stripped bare of faculties and of resources, rights, and responsibilities (Agamben1998:7). I further explore my findings regarding the notion of being stripped bare, and of being repaired, and recovering in Chapters Four and Five. These themes are central to critiques of military recruitment and rehabilitation, and to unpacking schema of power and social reproduction; furthermore, they lead inexorably to complex and interrelated examinations of the experience and utilization of harm in war, which is both inflicted and experienced by SMs.[99]

[99] Interrogative territory that also includes research about post traumatic stress, pain, torture, rescue, rehabilitation, healing, and social justice.

Reflections on "Subject" Recruitment

My engagement as a participant observer and researcher at a MTF emplaced and enabled me to witness ongoing negotiations regarding recognition and access to resources among *dis*abled SMs and the people who support and provide for their rehabilitation within a shared terrain of policies and practices that circumscribe their care. To help me understand how these negotiations may perdure, and what may constitute and sustain their contradictions and dynamic tensions, I also turned to scholarship that studies, theorizes, and problematizes how rights and responsibilities are understood, adopted, claimed, conferred, appropriated, contested, and removed; and the rewards, costs, and consequences of these enactments. Trying to understand where choices to enlist in the Armed Forces come from; how choices are made and honored with regard to rehabilitation of *dis*abled SMs; and what and who are accounting for and attending to *un*even outcomes for the people I studied motivated and directed my inquiry, informed my review, and influenced my understanding and responses.

Military recruiters reach out to enlist male and female SMs based on their own and their potential candidates' refracted notions of fitness, eligibility, and worthiness of commitment to national service (Astore 2008; Bacevich 2007; GoArmy.com 2010; Minear 2010). This process complicates who defines, ascribes, and embodies these notional attributes, suggesting that dynamic contradictions may underlie popular conceptions and enactments of enlistment criteria and their ownership. Within this complex, various arguments index classic debates about whether structure or agency accounts for decisions people make, pointing to shifting ideas about subjects and subjectivities; and de-centering some ideas about what motivates or influences enlistment. Astore 2008 and Bacevich 2007 are critical and self-critical, finding that critiques regarding fairness in who enlists often elide or devalue individual choice or intention. Bacevich in particular honors and wrestles with the mortal significance of individual differences in

apprehending what constitutes national service; what sacrifice means and to whom; who decides; and what may be the consequences of enlistment (2007:19).

Examining Eligibility and Fitness

Other scholars explore actual enlistment and resistance statistics and narrative texts to problematize embodiments, expressions, and rejections of eligibility and fitness criteria that result in active constructions of being chosen, choosing, or refusing to enlist or to remain enlisted. For example, Kleykamp 2005 contests some notions about who enlists and why, finding fault with popular explanations which insist that "lower- or working-class" recruits enlist because they have few or no other choices. She finds that "middle-class" youths' desire to enter college, and familiarity with military life through family and community experience are more influential levers of enlistment than socio-economic barriers to success (Kleykamp 2005:15). Other researchers who have asked SMs "What prompted you to enlist?" have found that within personal narratives, complex ideations about duty, service, and worth that are offered as motivating factors are not simply attributable to the influence of powerful structural and systemic mediations such as advertising but are also firmly put forward as expressions of the individual's choice to be tested, measured, and recognized; as a familiar extension of the work that kith and kin do and have done; and to fulfill family and community expectations (Cohen 1998:3; NRC 2003, 2004; Simons 1998; USAAC 2006). On the other hand, some veterans' organizations, resistors, and refused subjects broadly mediate their experiences and concerns about predatory, destructive, and fetishizing modes and discourses of fitness for service and ideologies of service (Bacevich 2007, 2009; IVAW 2010; VVAW 2010, 2011).

Bacon et al acknowledge the ways in which pre-determined attributes are mediated; more specifically noting that the attributes themselves and the subsequent lifetime measurements and

testing that work to secure the attributes and the enlistees are actually unstable–they are always-in-formation and subject to change (Bacon et al 2011:1). Policy documents of the American Civil Liberties Union (ACLU), R.J. Moore and Pérez, also comment on the instability of mediated military attributes of eligibility and fitness for service, critically linking this *un*intentional instability to predatory and arbitrary tactics of recruitment that flex when enlistment goals are not met, and may be turned against enlistees during training, deployment, and retention (ACLU 2008:21,22; R.J. Moore 2004:185; Pérez 2008:128).

Some scholars scrutinize the means by which SMs themselves are continuously tested, recognized, rewarded, and retained, or punished and discharged, by their superiors. Various analysts comment on the numerous institutionalized U.S. Armed Forces' rituals and routines that incorporate arrays of subjects, texts, and semiotics in displays, performances, and tasks. These semioses utilize uniforms, gear, badges, pins, patches, songs, marches, pronouncements, orders, salutes, exercises, athletic feats, stances, gestures, responses to commands, and chants; and they require comprehension of and response to orders, physical preparedness, and ability (or capacity to act). These processes are noted by researchers across numerous fields, including Bourdieu who discusses sociologically significant instruments of denoting and enacting distinction and status (Bourdieu 1984:259); Calefato, who problematizes the *mis*appropriation of military clothing and gear (Calefato 2005:151-153); Chandler (2002) and Joseph (1986) who acknowledge the power of uniforms to convey hierarchy, rank, and responsibility; by my own observation and participation in the reproduction of roles, responsibilities, and relationships via semiotics in military promotion and retirement performances; and by U.S. Army policy documents that clearly and specifically denote military corporeal, cognitive, and psychological standards and assessment tools (USAP 2005, 2010).

Each of these mediations continuously invokes and naturalizes overt and tacit assumptions of and requirements for able-bodiedness and able-mindedness. For thoughtful and incisive related analytical commentary on the power of the unspoken, I relied on Decena who locates and reveals hegemonic tacitness, tacit subjectivity, and, more particularly, *sujetar,*[100] as productive if *in*direct means of sustaining and containing conflicting, potentially disruptive, and multivalent roles and responsibilities within formal and informal relationships; of preventing them from being moved, getting disordered, or "falling" (Decena 2008:340,354,355).

Summary of Literature Review

Some social science scholars, researchers, and ethnographers have posited, described, and analyzed sociocultural constructions of *dis*ability and of deservedness. Others have critically analyzed and commented on mechanisms of military recruitment and retention. Some few have conducted ethnographic work that problematizes physiatric models, practices, and outcomes for recovery in rehabilitation units at MTFs. Researchers who have studied *dis*abled veterans' care after their discharge from active duty (their "aftercare") within political economies of public health and federal administration of social policy have found and sometimes contested *un*even delivery of services and outcomes for patients at their sites (Woolhandler 2007:14). Yet very little anthropological research has been conducted regarding the lived experience of wounded, ill, and injured SMs in rehabilitation–the life-worlds of active duty members of the U.S. Armed Forces whose ability to conduct their duties has been adventitiously altered within their scope of

[100] Decena introduces his use of this concept: "In Spanish grammar, the "sujeto tacito" (tacit subject) is the subject that is not spoken but can be ascertained through the conjugation of the verb used in a sentence. For example, instead of saying "*I* go to school," in Spanish one might say "Voy a la escuela" without using the *Yo* (I). Since the conjugation *voy* (I go) leaves no doubt who is speaking, whoever hears this sentence knows that the subject is built into the action expressed through the verb… (here Decena makes a useful footnoted detour to justify his use of a grammatical concept, and to acknowledge a productive criticism by Dinshaw)…Using this grammatical principle as a metaphor to explain how my informants (*sic*) interpret how others view their lives, the *sujeto tacito* suggests that coming out may sometimes be redundant. In other words, coming out can be a verbal declaration of something that is already understood or assumed–tacit–in an exchange. What is tacit is neither secret nor silent." (Decena 2008:340).

responsibilities; who are being and may continue to be rehabilitated; and whose cognition, corporeality, and well-being have been changed, along with that of their families and care providers.

Literature I have commented on here indexes and problematizes constructions of *dis*ability and deservedness that are in dialectical tension. It includes work that spans a focused range of intellectual and ethnographic inquiry across interrelated fields. Thinking about theory and method within these fields, I discovered and examined focal areas of interest with regard to recognition and access to resources. In this body of literature, explications of and for fitness, power, and social reproduction emerged and intersected in noteworthy ways and at their intersection constructions of *dis*ability appeared. They constitute a complex locus for identifying mechanisms of recognition and redistribution of resources that are based on unstable notions of deservedness. Within this fraught locus, foundational ideas about who deserves what, who is responsible for what, and who decides, are in competition.

By unpacking some mechanisms of recognition and redistribution in literature that examines structure, agency, power, sovereignty, *dis*ability, subject formation, and deservedness I found a space opening for further research into the lived experiences and discourses of *dis*abled SMs, including their recovery and re-integration. These apprehensions, insights, and observations helped me to identify and interpret a number of conditions at my site that were puzzling; among them, issues of *un*even recognition and access to resources among *dis*abled SMs, their families and care providers who were participating together in spaces of rehabilitation.

CHAPTER 3

LISTENING UP

Getting to the Site and the Subject(s)

> well uh its uh its uh a **mixture** of uh of uh my perception is↓ that there is a **mixture** of uh what shall I say **perceptions**↓ so for example if something is is uh obvious↑ like a physical↑ wound↑ then there's **no reservation at all** … but when you get to psychological illnesses↓ um uh I I I there is a a a a fair number of people who uh say that they're too easy to **fake** and and these people↓ um … and uh and uh um you know I have um **mixed feelings** about that↓ because on the one hand … uh it justifies that these guys aren't faking it but on the other hand↓ why do we need **physical evidence**↑ you know↑ ►someone reports what's going on and it **seems to me** it should be sufficient↑
>
> – Participant 030

Introduction

In this chapter I describe my methods, explaining my research steps and showing how and why I created and closely read verbatim transcriptions of interviews, field notes, and content from material culture. I offer a chronotope[101] of my methodology, which included securing Scientific Review Committee (SRC) and Institutional Review Board (IRB) approvals, describing my participant observation, field noting, recruiting potential participants, screening for eligibility, informed consenting, protecting confidentiality, interviewing, verbatim transcribing, coding, data storage, and textual analysis. To frame my methodology I drew on Fairclough 2003, who advocates using ethnography and CDA. He notes that using CDA on its own may be an incomplete means of understanding how people live within their systems of meaning; and he

[101] Following Ganser, Pühringer, and Rheindorf, here I borrow Bakhtin's concept of the chronotope to theoretically and methodologically focus on a "construction of space and time in and through texts that were never unmediated or 'natural;' rather were always already ideological, historically specific and constitutive of 'genres'" (A. Ganser, and J. Pühringer, M. Rheindorf 2006:1)–in my example, the *genre* of "human research subjects." In The Dialogic Imagination Bakhtin borrows from Kant and references Einstein, using the term chronotype (literally meaning "space-time") to express the inseparability of space and time in a fused, carefully thought-out, concrete whole artistic genre: "a formally constitutive category and form of immediate reality that determines the image of man in literature" (Bakhtin 1981:84,85;n.1,2).

particularly recommends using CDA and critical ethnography together, to get at "how discourse figures as an element in their way of living" (2003:210).[102]

In this chapter I indicate how and where I found texts, and within them, genres, styles, and discourses: the linguistic elements of "networks of social practices" that Fairclough refers to as comprising orders of discourse (2003:24). In addition, I discuss how I identified modalizations: how authors offer and withdraw commitments to the institutional order of discourse at a MTF–a discourse that includes organizing principles for construction and maintenance of linkages between *dis*ability and deservedness. Using aspects of these linguistic features, I posit respondents' positions as central, oppositional, or marginal within the institutional order of discourse (Fairclough 2003:206); positions that align with Pêcheux's good, bad, and dis-identifying subjectivities (Pêcheux 1982:157), and that invoke Leap's subjectivity-in-formation, including refused subject formation (Leap N.d.:4,30).My review of how I got to the sites and the subject(s), i.e., my methodology, functions as an entry-point for justifying my description of data analysis in Chapter Four.

Since my focus was on *dis*ability, I also applied CDS insights to sift[103] my collection, analysis, and interpretation of data. Using this methodological frame, I looked for evidence of how orders of deservedness are sustained in rehabilitation discourses, the ways in which people manage them, and what the con-sequences are for SMs, their families, NMAs, care providers–and, by extension, for policy-makers, practitioners, and people elsewhere. By considering the work that genres, styles, and discourses were doing in texts, and by thinking about what was being normalized or marginalized I found that there is a "felt" linkage between *dis*ability and

[102] Fairclough credits Chouliaraki 1995; Pojular 1997; and Rogers 'forthcoming' (2003:210).

[103] i.e., to examine minutely and discriminate or distinguish between normative and marginal expressions, performances, and claims (*Random House* 2011).

deservedness, that the linkage is expressed in multivalent ways, and that depending on the provenience of SMs' harm and the modes of their rehabilitation, recognition and access to resources are variably conferred/attained, withheld/unavailable, or doled/wrested

Methodological Foundation

Ethnography: Participant Observation, Field-Noting, and Interviewing

Ethnography provides the researcher with respondents' perspectives in context–their sense of their own and others' position and agency within inter-textual phenomena, including within power relationships. At two MTFs I observed, participated in, and co-enacted inter-subjective activities to gather authentic qualitative data that described experiences from the perspectives of persons in their contexts.[104] My research subjects' authentic voices and actions within their contexts expressed their lived experience to me; and, to the degree possible, I identified and put at a remove my own naturalized assumptions and ways of perceiving by considering and contrasting mine and others' with theirs; and by examining not only things with which I was unfamiliar, but also those things which seemed most obvious, most familiar, most natural: Making the familiar strange and the strange familiar (Chandler 2002:211,212).[105]

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[104] Including my own.

[105] Chandler runs this oft-used phrase to ground in his classic work Semiotics: The Basics, 1st edition, noting, "We cannot step outside our signifying systems. Semioticians seek to distance themselves from dominant codes by strategies aimed at denaturalization. The notion of 'making the familiar strange, and the strange familiar' is now a recurrent feature of artistic and photographic manifestos and of creative 'brainstorming' sessions in many fields. The phrase itself has been attributed to the German poet Novalis (1772-1801, aka Friedrich von Hardenberg), who declared that the essence of romanticism was 'to make the familiar strange, and the strange familiar.' The concept is found amongst other Romantic theorists such as Wordsworth and Coleridge. The notion is also closely associated with Surrealism and with Brechtian 'alienation.' However, its adoption by semioticians probably owes most to Russian Formalist criticism (Lemon & Reis 1965). Victor Shklovsky argued in 1916 that the key function of art was estrangement, defamiliarization or 'making strange' (ostranenie)–i.e., renewing our perception of everyday things and events which are so familiar that our perception of them has become routinized (Hawkes 1977:62-67). Russian Formalism was a key influence on the development of semiotics in Eastern Europe, and the legacy of 'making the familiar strange' is an important one for semiotics. However, as Simon Watney notes, the strategy of defamiliarization is itself, of course, ideological and has been associated with the notion that the tactic of surprise may serve to banish 'distortions' so that we may 'objectively' perceive 'reality' (Watney 1982:173-4). Clearly the strategy of 'making the familiar strange' needs to be coupled with an awareness that whilst we may be able to bypass one set of conventions we may never escape the framing of experience by convention" (Chandler 2002:211,212).

Using this methodological approach for several years, I searched for evidence of the ways in which sociocultural mechanisms of inclusion and exclusion might be doing their work. My belief that there is "nothing outside the text" directed my attention to semiotics. By considering whole contexts and the sensory, material, cognitive, spatial, temporal, and inter-subjective signifying systems within and around them, I explored and became aware of how people made sense of their own lived experience, both individually and within systems of shared meaning.

Via participant observation and conversations, my ethnography included listening to and noting expressions of subjects' self-perceptions and lived experiences in spaces and over time(s); recording and transcribing life stories, narratives, and semi-structured interviews; making field notes; gathering and photocopying content and material culture; and probing my study participants' expressed readings of interrelated texts. To monitor my interpretive stance, in some cases I co-validated data by sharing and reviewing transcriptions and notations with respondents to insure that I had listened well and noted words authentically; or to check that what I noticed included viewpoints and interpretations other than my own.[106]

Ethnographic research methods have some history of use in medical settings, for example in examining and refining practices. Issues that arise when undertaking ethnography in clinical settings include establishing research roles, gaining access to particular individuals, recording data, and conducting research ethically (Pope 2005:1180,1182,1187). In co-related settings such as clinics, waiting areas, eating facilities, passageways, and units (i.e., hospital "wards"); and among participants who interact within a circumscribed space and time such as a MTF, ethnographic methods of participant observation, interviewing, and collecting documentary material may enable collection and examination of data that express lived experience. At the same time, because a MTF is a military medical setting, multivalent vulnerabilities and

[106] Please see some examples of transcriptions and field notes in Appendix A.

challenges abound for researchers and respondents. Beyond the strictures that apply at a military base regarding access to information, spaces, and people, subjects of interest are often stressed, over-protective[107] or over-protected; over-researched or over-looked; and wounded, ill, and injured. And a conceptual barrier exists: People in military and medical settings, together and separately, create and sustain "scientific" discourses that valorize measurements, numbers, and other quantitative data. The necessity for collecting and analyzing qualitative data may be viewed as suspect, or even bogus.

For these reasons, at WRAMC and WRNMMC I was methodical in planning and conducting my research, and spent much of my time familiarizing myself: becoming well-acquainted and conversant among and about the spaces and people where or with whom I conducted research and the "bodies" that oversaw my work; and making myself and my methods "obvious."

Sometimes in my fieldwork, people asked me to explain more fully what I was after, and I talked to them about my belief that the ways we view ourselves and others rely on perceptions that may change and in turn may affect how we interact with each other. Perceptions change for various reasons, and are influenced by *im*material, sociocultural, politico-economic, discursive, ideological, and spatio-temporal shifts. I explained that gathering narratives provided by people in their own contexts would help me to understand their senses of themselves and their lived experiences, and would offer me the opportunity to locate and compare perceptions and subjectivities-in-transition due to adventitious *dis*ablement to themselves or to someone they were supporting or caring for. Being at this field site using ethnographic methods I would be able to find sources, examples, and references regarding perceptions of *dis*ability and degrees of deservedness from people who were experiencing them.

[107] Some NCMs for example (611FN).

I told people who were interested that I wanted to learn about the lived experience of people at the site–from their points of view and across terrains of experience and subjectivity that are always-in-formation (Leap N.d.:2,3). I explained my interest in how people regard themselves and others, their senses of themselves in contexts, and my belief in the productivity of discursive formations–texts, narratives, and discourses co-authored and recognized by people at the site–and of forces and relations prevailing on and through them. Thinking about how subjectivities rest on interpellation and recognition is important to my research because it helps me to map the contours of power relations, and to locate "blocking"–the precise management and planning of actors' positions in order to produce a performance that makes sense.[108]

Asking people to talk to me, listening to their stories, and taking in other kinds of texts comprised my data collection. While some people who met me were skeptical, and in a few cases even dismissive of my fieldwork objectives, for the most part, echoing Gusterson's experience, almost everyone I approached was open, even eager, to talk with me; and many mentioned they were glad that someone was interested in hearing their stories and in doing the work we might undertake (Gusterson 1998:36). On the other hand, as I note below, not everyone who was receptive agreed to participate in my study for the record.

Those who did participate were very generous; and some respondents directed me to unexpected areas, resources, people, and policies that would inform and enlighten my research. For example, a CAM [109] practitioner suggested I spend time at a reflecting pool behind WRAMC's Mologne House, a hotel-like residence for recovering SMs and their family members

[108] The English verb "block" can also mean to shape or mold or stretch using an object or mechanical process; to obstruct someone or something via obstacles; to stop passage of impulses in nerves; to group together to allow intelligibility in a single operation; or to hinder the actions of another, especially legitimately (*Random House* 2011). The theatrical "bloc(k)ing" process I refer to here has a conceptual relationship to the historical "bloc" that Gramsci identifies as "forming and reforming" to influence social and ideological processes and to procure consent. Because the bloc forms as a response *to* and an instrument *of* struggle, even as it dominates, it is hegemonic (Gramsci 1971:60-61,418).

[109] Complementary Alternative Medicine; e.g., employing yoga, Reiki massage, Qigong, or acupuncture practices in healing regimens.

or NMAs, to get a different view of *dis*abled SMs and their families, including children and companions, at that controversial location;[110] and a patient encouraged me to go to a particular coffee shop off base where many *dis*abled SMs and their families or companions routinely gathered. Over a period of months a self-identified "injured"[111] SM showed me his stitches, pointing to them, stroking them, and telling me how they represented his progress; and indeed they seemed to as they changed in size and prominence, migrated, and finally disappeared, leaving telltale scars which then became the subject's subject–one of his texts. His scars themselves were both revealed and hidden depending on whether he wore the fittings that attached his prostheses to his stumps,[112] or removed his prostheses, and whether he wore shorts.[113]

An officer with whom I worked frequently reminded me to read *Doonesbury*,[114] (as did a professor and mentor at American University). "You need to do that!" my WRNMMC colleague

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[110] In 2007 The Washington Post newspaper published a series of articles by investigative journalists Dana Priest and Anne Hull, and photojournalist Michel de Cille, revealing and condemning conditions at WRAMC. Several of the articles focused on Mologne House and two other facilities on base in which *dis*abled SMs, their families and non-medical attendees were gravely neglected during their rehabilitation. In 2008 the Post was awarded the Pulitzer Prize for Public Service for the reporting (Priest, Hull and de Cille 2007a,b,c).

[111] Participant 080 told me he was harmed while in active duty–NOT in combat rather, in an accident. His leg was crushed when a truck rolled over him.

[112] As abrupt as this term may sound, it is the term used by practitioners (including prosthetologists) and patients for the anterior section of a limb left intact and "flapped" (or covered with skin flaps or grafts) after amputation.

[113] A therapist in the Military Advanced Treatment Center (MATC) at WRAMC explained to me, "Amputees run 'hot' until their bodies adjust to their new mass; that's why they wear shorts, even in cold weather." I also observed that many active-duty SMs routinely wear regulation T-shirts and shorts; this reflects and aligns with their self-identification as life-time athletes, and their requirements for frequent "PT" training and testing.

[114] Since September 1968, except for a 22-month hiatus from January 1983 to October 1984, cartoonist Garry Trudeau's Doonesbury strip, chronicling over 40 characters who were originally connected through a small group of college undergraduates, has been published in various newspapers and books, nationally and internationally. Since 2004 Trudeau has featured story lines regarding military SMs, including disabled soldiers and their experiences at Walter Reed Army Medical Center (WRAMC) in Washington DC. See http://www.doonesbury.com

[115] I am quoting my colleague from field notes, and with her permission. In a subsequent e mail exchange I asked Trudeau "how he does it." He said he supposes he does it the way I do, by listening to people (personal e mail communication September 2012).

said repeatedly. [115] Or, "Did you see it yesterday? I don't know how Trudeau gets the access and I don't know how he knows all this stuff, but he nails it every time. He gets the people right, the talk, even the (clinical) units and bed numbers!"

Reflexivity–thinking critically about roles and relationships, about ethics and responsibilities, and one's own position–is a central part of ethnography; hence some remarks about my preparation and preparedness. During fieldwork, my central activities included gaining access, building trust, establishing familiarity, and being persistent. Because my sites are military bases and medical facilities, their combined status made them ideal for my research; however, being able to be there also required unusual preparation and a kind of personal readiness that I had not anticipated. I was required to undergo and regularly renew or update various security and background checks, certifications, immunizations, training,[116] and sequentially deeper background checks.[117] My site administrators also required that I undergo intra- and internet, e mail usage, and workplace security training and certifications; to adopt, use, and comprehend frequent changes in system access codes; and to retain knowledge of appropriate responses to safety threats.

As a civilian, this kind of training was unfamiliar and at first rather alarming to me; however, I soon became used to ongoing re-certification demands, onsite security inspections,

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[116] Human subjects research and Health Insurance Portability and Accountability Act (HIPAA) certification for example; ethics and workplace harassment training; finger-printing; American Heart Association Basic Life Support training (BLS); as well as local emergency response training.

[117] To be cleared to work at our new location in Bethesda, in July 2011 I completed a security check that took six weeks and required me to complete 40 pages of personal information, including listing everywhere I had travelled internationally during the last decade and the names and contact information for everyone with whom I made contact while overseas. Canada and Mexico did not "count." As a naturalized citizen (I was born in Canada), I was also required to provide documentation of my path to U.S. citizenship, including coming up with some materials and information I had not seen or read since my naturalization in July of 1984. An employee of the former* Immigration and Naturalization Service (INS) retrieved the information I needed, most critically a particular number I could not find, that he easily accessed on his computer. Rather than saying the number out loud, he swung his screen so that I could read it, and urged me to "write this down somewhere" (I did).
*In 2030 most INS functions were transferred from the Department of Justice to the newly created Department of Homeland Security (DHS). INS falls within U.S. Citizenship and Immigration Services (USCIS), one of the three agencies that comprise DHS. The others are U.S. Immigration and Customs Enforcement (USICE), and U.S. Customs and Border Protection (USCBP).

and various signs and symbols of real and imagined danger; as when, for example, an unusual[118] 5.0 earthquake roiled in August of 2011 at the newly merged Bethesda, Maryland site (WRNMMC) where emergency routines were still being tested. Later, fire, terrorist, and baby-kidnapping drills and real emergencies erupted; clearance requirements abruptly changed; walk-through compliance audits were conducted; security gate clearance practices were altered; and access to various systems routinely expired and required re-certification.

While I had anticipated and been prepared to obtain IRB-approval for my own human subjects research, I was not well-prepared for ongoing, repetitive, time-consuming, and often obtuse requirements for myself. However, over three years, this dynamic complex of demanding requirements richly if "adventitiously" enhanced my fieldwork: It meant that I met and interacted with multivariable people, learned diverse jargons, became familiar with and to people I would not otherwise have met–and became trusted and trusting.[119] I had been qualified as a linguistic anthropologist–now I was qualified to be in wards, clinics, barracks, mess halls, ceremonies, offices, classrooms, mandatory formations,[120] on grounds and in facilities across the campuses of two MTFs; and encouraged and allowed to listen to and consider the implications of peoples' narratives and performances there, as well as the content of various forms of material culture (signs for example).

Prior to subject enrollment and later during interviews, I used my judgment to determine the level of potential participants' comprehension of the consent form, the overall study purpose, and the voluntary nature of the study. As I have been taught by medical researchers and

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[118] i.e., unusual for the Mid-Atlantic area of the U.S.

[119] At such junctures (which were frequent) I spent time in self-reflection (reflexivity), and turned to work by other anthropologists regarding identification with one's research subjects, ethical conduct of research, agency, cultural relativism, and "epistemological estrangement and intimacy" (Keane 2003:225, 243).

[120] Mandatory weekly meetings in which announcements are made to all members of a brigade; sometimes unscheduled formations are held to announce unexpected events and mitigations.

practitioners onsite, if a participant demonstrated severely diminished capacity, i.e. required re-orientation to person, place, or time during the consent or interview, I deemed the potential participant either ineligible to consent or ineligible to continue, and destroyed all data associated with him or her. My lack of formal healthcare training had disturbed some members of the SRC and IRB at my site, so prior to their approving my protocol, I was required to build-in and follow these additional steps:

- Affiliate my study with an onsite PI who was a medical practitioner
- Sit in on consenting and screening activities being conducted by medically qualified researchers prior to conducting my own interviews
- Take Basic Life Support (BLS) classes offered by the American Heart Association and become certified
- Familiarize myself with the locations, personnel, and contact information for the hospital emergency room, Wounded Warrior Transition Unit and Clinic, (WTU and WTC), Emergency Department, Fire Station, and Base Security

Oversight of Methods at the Site and in the Moment

In addition to academic review by my dissertation committee members[121] and by an academic outside reader,[122] my work was monitored and critiqued by two onsite affiliates in the Centers for Nursing Science and Clinical Inquiry (CNSCI),[123] first at WRAMC and then at

[121] Committee Members: Dr. William Leap (Chair), and Dr. Daniel O. Sayers at the American University in Washington, D.C.; Dr. Janice Agazio, at The Catholic University in Washington, D.C.; and Dr. David Peterson, at The University of Nebraska in Omaha, NE. Dr, Agazio is a retired Army Lieutenant Colonel.

[122] Dr. Bonnie Jennings, at Emory University, Atlanta, GA. Dr. Jennings is a retired Army Colonel.

[123] Within the WRNMMC Department of Research Programs (DRP).

WRNMMC: Dr. Meryia Throop, Deputy Chief; and Dr. Sara Breckenridge-Sproat, Chief.[124] Dr. Throop acted as the "onsite" Principal Investigator (PI) for my research. She is an active-duty Army officer and nurse scientist who has served on IRBs and SRCs at two major MTFs. Collaboration in my study was one in a series of Dr. Throop's efforts to identify, measure, apprehend, qualify, and quantify costs and consequences of SMs' exposures to numerous kinds of risk, to generate awareness among policy-makers and practitioners, and to determine appropriate, accessible, and beneficial means of protection. Dr. Throop's and Dr. Breckenridge-Sproat's support, oversight, and participation at the site helped me to conduct ethical and productive research and sharpened my methodological and analytical sophistication.

To carry out human subjects' research I acquired IRB approvals from WRNMMC and The American University (AU) where I was a graduate student in linguistic anthropology. Following advice from AU's IRB,[125] I first submitted a detailed research protocol to WRNMMC's IRB. The plan included my objectives, timeline, consent forms, and interview guides for each of the several kinds of respondents I was seeking, recruitment flyer, proposed subject population and field locations, data collection methods, a description of how I would insure confidentiality, and bio-sketches of my Dissertation Committee members. I orally defended the proposal twice at WRNMMC; first to its SRC and then to its IRB. Members of both boards requested extensive modifications and additional review cycles.

After I received IRB approval from WRNMMC, I submitted the entire approved research protocol for review by AU's IRB. After submitting a minor modification to AUs board (a

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[124] Dr. Breckenridge-Sproat is now Deputy Chief of Nursing at Tripler Army Medical Center in Honolulu, HA (TAMC); and Dr. Throop is currently Deputy Chief of the Armed Forces Center for Nursing Science and Clinical Inquiry (AFCNSCI) in Kandahar, Afghanistan.

[125] WRNMMC is not only a joint-force military base, it is also a hospital. Its SRC and IRB approval processes are more complicated than AU's IRB approval process because WRNMMC requires review and approval of consent forms and research conduct under strictures of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). For that reason I acquired site approval first, then academic approval.

modification I had to have approved first as a protocol amendment by WRNMMC's IRB), I received AU's IRB approval. I also received IRBs approvals from WRNMMC and Uniformed Services University of the Health Sciences, Rockville, MD (USUHS) to use de-linked qualitative data I had gathered as an Associate Investigator in 2010-2011 in an approved and funded study [126] assessing the feasibility of offering Qigong classes to wounded, ill, and injured SMs, and measuring the efficacy of Qigong practice in moderating participants' self-identified pain, insomnia, and stress symptomatology.

Because some proposed study participants would be civilians (family members, NMAs, and care providers); and because I might interview civilians offsite, both AU's and WRNMMC's IRBs required that I use an AU Informed Consent Form (ICF) for non-WRNMMC healthcare beneficiaries. The inability of WRNMMCs IRB to provide human subjects protection for non-beneficiaries and civilians at first posed a barrier to obtaining that IRB's approval. However, when Dr. Throop suggested using either consent form, as necessary, each oversight entity was satisfied. This tactic was considered particularly innovative by the WRNMMC IRB, and was strongly supported. A number of WRNMMC IRB members mentioned its utility for my and future studies because the Board had often been unable to approve studies in which non-military beneficiaries such as girl- and boyfriends, best friends, or relatives might participate (and whose data might be rich and significant), often by virtue of *un*planned snowball sampling.

Data Sources and Collection

My sources included narratives, images, objects, spaces, events, and passages, including passages of time. All of these were wellsprings of texts that co-constituted intersecting discourses, practices, and lived experiences. To find and collect this textual data, I relied on

[126] The study, "Feasibility of Offering Qigong to Wounded Warriors in Transition," was funded by TriService Nursing Research Program, Rockville, MD (TSNRP).

ethnographic methods, including participant observation; field noting; recording of interviews; field-noted descriptions, and copies or photographs[127] of material culture. Sometimes I obtained an example of an object itself, such as a military magazine; newspaper; announcement; handbook of regulations; dictionary of acronyms; anthology of appropriate wording for military letters, presentations, and reviews; and a coin.[128]

In addition to conversational, narrative, and life-story texts, the qualitative data that I collected also included content from signs, posters, flyers, blogs and announcements; observations and descriptions of postures and gestures, uniforms, gear, badges, and medals; exercises, equipment, rooms and facilities; ramps, stairs, elevators, tunnels, and other access ways; scars, skin grafts, tattoos,[129] stitches, and other body alterations; and prosthetics and other assistive tools and technologies. I reviewed and analyzed my range of textual data as I collected them, including my field notes and memos, to continuously locate key words and themes, to see the relationships between and among components, and to extract meaning. I reviewed some narrative data with participants when recordings and transcriptions were completed and when subjects were available and interested.

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[127] I chose to request permission for photographing, copying, and field-noting material culture and not for photographing *people* for four reasons: 1. to conform to IRB and Public Affairs Office (PAO) strictures at my sites regarding capturing and publishing images; 2. because overt photography can induce its own "demand" effects and become a kind of methodological artifact unto itself (Adair 1984; Orne 1973); 3. because covert photography would have been (and is) neither permitted nor ethical; and, 4. because photography might have compromised human subjects' confidentiality.

[128] At the end of many formal and informal military ceremonies, senior officers pass coins to junior officers and enlisted SMs. The coins are passed from palm to palm, in a handshake. This is difficult to perceive for the outsider, yet for insiders the acknowledgement of respect and congratulations is profound. I observed the coin exchange many times–probably more than I am aware of because at first I did not recognize what had transpired; for example, I realized coins had been passed to honorees at promotion and retirement ceremonies, awards events, and once, in the gymnasium at WRNMMC, from the current Chairman of the Joint Chiefs of Staff to 5 SMs in wheelchairs. The senior officer walked between a phalanx of SMs as he exited the gym after making a speech, and paused briefly 5 times to bend and shake their hands. As I knew by then and so was able to perceive, with each handshake the General passed a coin to honor the SMs' sacrifice and service, the topic he had just addressed in a Town Hall presentation to Wounded, Ill, and Injured SMs and their families and NMAs. Each time, the General nodded very subtly over his right shoulder to his aide who re-supplied him (in a kind of modified handshake) with a single coin. I knew this because the act had been explained and described to me when I asked about collections of coins I noticed in SM' offices, quarters, or barracks. Coins can be inscribed for particular events or accomplishments, or may be generic, as in a Commander's coin (430FN, 258FN).

[129] While description and analysis of the breadth of data available at a MTF–or at any facility or institution in which thousands of people interact–is well beyond the scope of this dissertation, the vast array at a MTF beckons additional research.

In my effort to engage 48 study participants I intentionally talked to between 75 and 100 potential subjects (I had IRB approval to approach 200 people, and perhaps in one way or another I did), and placed IRB-approved flyers, "welcome" letters, and contact card handouts at numerous MTF locations. Inclusion criteria and my contact information were clearly provided in all recruitment materials, as well as a brief overview of the research's local IRB-approved objectives and methods, and the required local IRB stamp of approval with date.[130] I also wore a button identifying my study, and I identified myself as a researcher and anthropologist; asked people for referrals; and used a small amount of snowball sampling to contact additional subjects known by volunteers or others to be interested in participating. They were contacted either by me or by the volunteering participant, and we explained the study's purpose and methods in detail to each referred potential participant.

I also presented my study *to* and requested participation or referrals *from* several groups of Nurse Case Managers (NCMs); members of two Wounded Warrior Brigades (WTBs); several physicians; a number of therapists; and a group of NMAs at their weekly meeting. During and each of these presentations people waxed enthusiastically about helping me to connect with participants; however, later, very few of them did. This experience was familiar to me because of other recruitment efforts I engaged in for approved studies at my sites; the Qigong study for example. Securing research participants is notoriously difficult at a MTF. When asked why, a number of people told me subjects there are over-researched, vulnerable, stressed, and pre-occupied (254FN). One of the most compelling answers though, and my own perception, turned on a simple structural explanation: People in the military are in constant transition; not only patients and their families, but also providers. SMs' are subject to Permanent Change(s) of

[130] Please see Recruitment Materials in Appendix B.

Station (in their vernacular, they are "PCSd") every 2 to 3 years. This means that committing to projects may be simply impractical.

When individuals showed interest in participating, I explained the study's purpose and methods and we scheduled eligibility screening, consenting, and interviewing either in person, or by phone. Every participant who agreed to be recorded while being interviewed, whether military or civilian,[131] read and signed ICFs, and military participants being treated at WRNMMC also signed Health Insurance Portability and Accountability Act of 1996 (HIPAA) authorization forms. We spent time together in advance talking about the kinds of questions I would ask them in the interview we were planning together; agreeing on a date; and confirming an accessible location in which they felt safe, private, and comfortable. After potential participants had agreed to all the conditions for moving forward as study subjects, I provided them with a copy of their signed documents, and re-iterated their freedom to withdraw consent at any time.

In addition, as recommended by research colleagues at my site,[132] I encouraged participants' understanding of the consent process by being patient and not rushing the consent process; using 8th grade level English language[133] in the consent documentation; requesting consent only at a time when the potential participant was not obviously distressed or in pain; and encouraging participants' family members or friends to be present during consenting procedures. I was not required to obtain consent from family members or friends who were sitting in on screening, consenting, or interview meetings because I did not acquire or use any information

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[131] Some NMAs, friends and family members were neither members of the military nor military beneficiaries.

[132] And required by the IRB.

[133] At WRNMMC, the IRB measures consent form readability using was the Flesch–Kincaid Grade Level scale, which assigns a score on the basis of the minimal grade level required to read and understand English text in the U.S. The range is 0-12, reflecting "grade level." The test was originally developed under contract for use in the U.S. Navy (Kincaid et al 1975: 8-75).

about them. When, in an audiotape, a voice was heard other than the participant's, I did not include or allude to that ambient data, beyond field-noting that another person had been present.

To screen potential participants I talked to or met with people who indicated interest in participating. We talked about their status, the study's aims and methods, and consenting procedures. I explained that potential respondents who were not military beneficiaries would be protected by AU's IRB Informed Consent and Confidentiality protocols; and that military beneficiaries would be protected by WNMMC's, included HIPAA protections.

Of the people who indicated they were interested in participating several were not eligible to do so under the requirements I had submitted and had approved; for example, some did not speak English well enough to understand my objectives or to converse easily with me (nor did I speak their first language fluently); a few others decided not to for their own stated and unstated reasons;[134] some were too agitated or ill or ill at ease to converse easily; and several didn't show up for the screening talk.

Among those I found eligible and who agreed to consent, several people did not show up for the consenting meeting; i.e., from the 57 people who originally expressed interest in being in the study, 39 people finally participated in field-noted talks (16), or recorded interviews (23). In Table 3.1 below I show who formally consented to participate in my study; i.e., respondents who agreed that I could record or write detailed field notes of our interviews and conversations, and who signed consent forms and HIPAA Waivers (I did not collect any Personally Identifying Information [PII]; or Personal Health Information [PHI]): 16 active duty SMs, 5 family members, 1 NMA, and 17 care providers. I also show the ranks (where applicable) and genders

[134] Reasons stated to me included: "Huh. OK well, never mind;" "I don't think I feel comfortable;" "I don't know how long I'll be here;" I'm leaving next week;" "I can't control my schedule so it would be hard for me to do an interview;" "Maybe my daughter won't want me to, I'll get back to you;" "Oh I thought you were talking about something else;" "My husband was injured in Vietnam so it's too long ago."

TABLE 3.1: Participants													
Participants		Active Duty SM				FAM	NMA	CARE PROVIDER					
39		16				5	1	17					
		Officer	8	Enlisted	8								
Male	18	Male	4	Male	7			RN	DNP	MD	NCM	Thrp't	
Female	21	Female	4	Female	1			1	4	3	5	4	
MIL /x-MIL	25	Abbreviations: MIL–Military, x-MIL–former Military, RN–Registered Nurse, DNP–Doctorate in Nursing Practice, MD–Medical Doctor, NCM–Nurse Case Manager, Thrp't–herapist (occupational, speech and audiology, physical, and social work)											
CIV	14												

of my respondents, and their statues (civilian, military, ex-military). The family members who participated were parents, and spouses or partners. Of the care providers who participated, 1 was a Registered Nurse (RN), 4 were Doctors of Nursing Practice (DNPs) 3 were Medical Doctors (MDs), 5 were Nurse Case Managers (NCMs), and 4 were therapists (occupational, speech and audiology, physical, and social work).

After eligibility screening and informed consenting, I interviewed or conversed with participants and made a few follow-up calls to clarify particular comments. I received 3 emails from participants who wanted me to have their additional thoughts. All of the interviews took place in locations that study participants had identified as comfortable for them; for example we met in a private office or conference room onsite; on a bench in a garden; at an onsite eating facility; and offsite at a coffee shop. Telephone interviews were conducted using a preferred participant contact number and time; and made from an onsite private office with the door closed, or from my home office. Although several potential participants requested that we conduct their interviews via Skype, Facebook or e mail exchanges, I did not agree to because Voice over Internet Protocols (VOIP), online social networks, and Internet Service Provider networks (ISPs) are not secure.

Although I planned to use a digital- and tape-recorder at the same time to insure against data loss during recorded in-person or telephone interviews, I ended up using 2 digital recorders. In three cases the first one lost power, and twice I successfully switched to the back-up recorder (transcriptions 090 and 100); and although we were interrupted, our interview continued. The first time this happened (transcription 080) I was not aware that the recorder had stopped, although participant 080 told me afterwards that he had heard a warning beep. When I moved to turn off the recorder I saw that it had stopped, and asked the participant how long he thought we had been talking without being recorded. He estimated 3 or 4 minutes. We talked about what he had just said, and I field-noted the remarks I remembered from the end of our interview.

I developed 2 questionnaires; one for SMs; and one for family members, NMAs and care providers.[135] Although each guideline had many of the same questions, they varied because one group of participants was supporting or caring for a wounded, ill, or injured SM; and the other group was SMs themselves. I structured the interview questions as open-ended inquiries to allow subjects to express themselves, coupled with probes to elicit detailed descriptions and to insure that I gathered a minimum of information I needed; for example the participant's response to my question about being *dis*abled, as noted in the example below, in Table 3.2 where I show a span of questions and answers from a recorded interview to illustrate how I probed for respondents' answers to my central question about *dis*ability; and also to offer an example of a typical interview pathway–by which I mean the kind of verbal volley that occurred when I asked a question, the respondent answered, I asked for more detail or clarification and the respondent agreed (or not). I ask if the respondent considers himself to be *dis*abled. He hesitates a little, and I probe for more comments. By doing this, together we get at deeper ideas of how the respondent regards himself I relation to the appellation "*dis*abled." This brief exchange offers a rich

[135] See Interview Guides in Appendix B.

grouping of the respondent's dynamic ideas about the word *dis*ability: He begins his response cautiously, saying "I dunno about disabled." When I begin to probe he first says "it's a rightful term," that "don't offend me;" and after another probe becomes more objective, describing *dis*ability generally and how it may apply to others, saying "you don't have to be you don't have to have gone through a physical trauma to be disable."

TABLE 3.2: Example interview question, probes, and responses		
Interviewee	Question	Response
080b SM Self-Identified as "Injured"	Wow … do you think of yourself as disabled or when you hear the word disabled does that connect with you?	*Ss hh* sn- I am limited … … … I dunno about disabled I am limited I mean there's certain things that I can't do and there's certain things that I might not be able t' do as faaast … but I could still do it or I could still like I said just give it a shot
	Follow-up question, Probe 1	Response 1
	Yeah … you know the reason I ask is that the word disability is used a lot in the military right? Disability benefits disability all kinds of different disability stuff assessments when people retire or leave the service whatever	I mean it's it's a rightful term
	Follow-up question, Probe 2	Response 2
	Q: It's a what term?	It's a right term it's not a wrong term it don't offend me it is what it is I am what I am *hh* I mean you can't
	Follow-up comment, Probe 3	Response 3
	It's interesting though	I mean you don't have to be you don't have to have gone through a physical trauma to be disable … that's why they got cases of PTSD and TBI … *hh* you know there's u- even if you lose an eyesight you become disabled because even if you start losing your eyesight without fully losing it you you start becomin' disable because now it takes you longer it t- you exstrain yourself more to see so I mean it's a rightful term uh it's not wrong *hh* to be offended by it is j'st ignorance
	Follow-up comment Probe 4	Response 4
	Yeah yeah thanks that's interesting because uh depending on where you hear it or who says it or how it's applied it means lots a different things so your answer saying um I might be limited in some ways that's very interesting to me 'cause that makes a lotta sense to me	'N if I I hear you know it's like … … you know … to be … grotesque in in a sorta way you y'know you fuckin' disabled guy e- e- that I might take offense to but if I hear eh you disabled guy I'm like OK I am disabled you know what I'm saying you know it is it's how it's put in the context or where is it put what words is used that's like if I hear you know you fuckin' cripple ok you know I'm crippled it's no big deal

When I probe the last time in this section, the respondent uses more emotional, personal words: "it's how it's put in the context or where is it put what words is used that's like if I hear you know you fuckin' cripple ok you know I'm crippled it's no big deal." Later in this interview the respondent disavowed his *dis*ability, characterizing himself as an athlete, cyclist, and extreme sports competitor (080).

Because there are no research protocols or widely-recognized standardized tests to determine the ability of SMs with PTSD, depression, or TBI to provide informed consent, I did not exclude potential participants with these self-identified symptoms. Bolstered by language in extant IRB-approved protocols at my site, knowledges within the nursing science research group with whom I was affiliated at WRNMMC, and my prior ethnographic work there consenting and interviewing human research subjects, I purposively assumed that potential participants could provide informed consent when they had been advised of the nature and aims of my study and were able to say them back to me. After all, inclusion of subjects who have been affected by various visible and invisible wounds, illnesses, and injuries was central to my research. In addition, I was not permitted to (nor did I want to) access their medical records and so would not know (or be interested in) their psychological or cognitive diagnoses. In fact many respondents and potential respondents talked to me, unprompted, about their self-identified PTSD and TBI.[136] I did exclude people under 18 years of age, people who could not speak English, and people who could not say back my study aims and demands after I explained them using simple terms.

I collected a limited amount of individual demographic data[137] to describe and quantify the characteristics of interviewees; i.e., their name, age, gender, cell phone number (to facilitate

[136] As included in transcriptions of interviews with respondents 222-I and 228-I for example, not included in Appendix A.

[137] See the IRB-approved Demographic Data Form and Interview Guides in Appendix B.

texting[138] while setting up interviews), military rank if applicable, and e mail address. I collected this data to verify and describe the characteristics of the sample for future confirmability, generalizability, study replication, and comparison with other research. I de-linked personally identifying data by:

- Making the top of the form in which consented participants noted the limited set of personal data a separate tear-off section
- Removing that section from the data form and attaching it to the signed ICF
- Assigning and using participant numbers rather than names
- Removing all names (including names of locations) from transcriptions
- Securely archiving the master code that linked participants' names with their participant study numbers

I had been working onsite as an Associate Investigator (AI) in several other studies prior to beginning my own approved dissertation research, so I was keenly aware of wounded, ill, and injured SMs' and associated others' potentially complex and demanding physical, psychological, and cognitive burdens; and I knew that these may be exacerbated by participation in studies or by varying levels of intensity in interest from others, including researchers like me, care providers, family, friends, and officers. Subjects I recruited may have been multiply vulnerable because of their membership in the Armed Forces, their injuries, and their concerns about confidentiality and potential repercussions, or punishment for speaking honestly about their experiences and perceptions of their own conditions. Their mere participation in research such as that which I conducted, and my interest in them, may have been stressful or associated with stigma by respondents and others.

[138] i.e., cell (tele)phone texting of messages, not issuing of additional "texts".

Because I am aware of this potential subject burden complex, in the informed consenting process I identified mechanisms to protect respondents' confidentiality and pledged to use them; and more significantly, I clearly emphasized subject's right to withdraw, quit, or refuse to participate at any time, without ramifications. In addition, I would have notified care-providers such as NCMs if a participant had expressed destabilizing effects of trauma; and would have escorted a participant to the emergency department should his or her behavior become threatening to him- or herself or to others. Although I remained conscious of these steps I was not required to take them. In fact, many of my respondents expressed their pleasure in talking about their experiences and perceptions, and offered to talk again.[139]

To ensure that I would recognize and acknowledge SMs' and other research participants' subject burdens in the moment, I remained very sensitive to emergent signs and signals of discomfort or resistance among the people with whom I interacted while gathering data, discussing content, and speculating on data significance. For example, I tried to consistently meet expressions of fatigue, weariness, irritation, concern, anger, confusion, sadness, distress, or worthlessness with respect, empathy, and calmness. When I sensed discomfort I asked respondents to freely express their concerns rather than my making assumptions about their condition. For example, before our interview, respondent 100 emphasized that s/he did not want anyone to know s/he was participating. During our recorded interview, when s/he explained her/his initial view of psychologically injured or ill SMs, s/he started to speak nervously, to the extent that s/he whispered (which I indicated in the transcription by using #10 font and italics; see lines 0005, 0009). We paused; s/he then laughed and assured me s/he was comfortable. Note that in transcription excerpt that follows, and in additional examples in the next chapters, I

[139] I am aware that their expressions of enjoyment may have masked concern or discomfort. For this research, as in all the ethnography I conduct, I relied on what respondents say and what they do rather than speculating about their unexpressed thoughts or emotions; while at the same time staying very aware of their demeanors–which are texts.

number the excerpted lines starting with 0001, rather than using the line numbers from the extended full transcriptions. I do so in order to contain the texts, and to make my comments and referrals simple and clear.

Example 3.1

100*v2* [140] Self-Identified Care Giver, 181 words out of 8677 in the transcription

0001 No there's been um … several people who after I'm speaking with them it's quite
0002 obvious the um … … tsk ... the uh injury … and … you know I had one guy going hh
0003 ho man they're gonna take my gun you know they might not take my gun so there so
0004 how did I mean he is completely focused he wants to get better he wants to get back
0005 on deck and um I w's just looking at him like oh my god you have a gun you know I mean I [R]

0006 Oh ok ... you OK? [Q]

0007 … … … … w's … oh heh heh heh … …
0008 And so um it'ssss … most most people are positive though I hh I think … I mentioned
0009 this last week that I did have one guy who was polite and rude at the same time and just
0010 told me he just wasn't interested in what I had to say say and he said I came here because
0011 I wanna know what's going on with me and then walked out the door heh heh [R]

I was prepared to ask if the person being interviewed would like to terminate the interview or participation in the study itself; and was prepared to destroy notes or erase recordings that were underway, and if requested would have done so in the presence of the study participant. I emphasized the confidentiality of our encounter, offering the interviewee the choice of discontinuing the activity in the moment or of dropping out of the study, both without recriminations. Both the site PI and I were committed to seeking immediate help should a study participant signal the need for assistance

In anticipation of possible psycho-social risk during recruitment, eligibility screening, consenting and interviewing, I told potential participants that they would be referred to a case

[140] As I note in the introduction to Appendix A, I created three versions of my verbatim transcriptions: In the first (*v1*) I captured all the words, and added prefixes "Q" for questioner and "R" for respondent to each section. In the second version (*v2*) I added lines numbers in the left-hand margin and appended [Q] and [R] to each section. In version three (*v3*), I "marked" linguistic features using **bold** type for emphases;↑ and ↓ for rising and falling tones of voice; and ►for repeated phrases and notable comments. Excerpt 3.3 is from *v2* of the interview numbered "100."

worker, primary care provider, or chaplain at WRNMMC if they felt the need to discuss their reactions or if they voiced any mental or emotional distress; and I emphasized that we would stop interviews if affected participants displayed or expressed distress. Additionally, I noted to potential participants that they held the right to report to a representative of WRNMMC's Responsible Conduct of Research Studies (RCRS) department or IRB whatever they might believe to be intrusive or threatening research procedures; and I included RCRS and IRB contact information on the participants' copy of their signed informed consent document. In the eligibility screening phase prior to consenting, some potential participants did specifically express these concerns to me and we agreed that they were not eligible by dint of their anxiousness. They did not accept the risk (although others did) that expressing opinions or feelings regarding their experience might provoke undue embarrassment, psychological stress, stigmatization, invasion of privacy–or punishment.

My sites were military bases, my subjects were either members of the military or were closely associated with the military, and several members of my collaborating team (the onsite PI, one dissertation committee member, and military mentors for example) are active duty or retired members of the U.S. Armed Forces. I needed to be vigilant about real or imagined coercion during recruitment for my study, so I used two forestalling and intersecting mechanisms: Recruitment was conducted only by me or by the onsite PI;[141] and when present during recruiting, screening, consenting, or interviews, the PI appeared in civilian garb.[142]

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[141] Who is an active duty Lieutenant Colonel in the Army, as well as a Doctor of Nursing Practice (DNP) and research scientist.

[142] This tactic is acceptable to the WRNMMC IRB, although people with whom I worked and conducted research, including participants, broadly understood that identities are not necessarily concealed by wearing civilian clothing. Indeed the PI and I were familiar to many of the people we approached. Changing clothing to obviate coercion is a good example of semiosis–signaling (sending and receiving) particular meaning ("I am not trying to coerce you") by means of texts, in this case alternate garments.

I tried to approach people in non-threatening ways; and among people who were interested, I frequently talked about being able to discontinue participation in the study at any time. I told SM participants and their significant others that I would not discuss individual participation or refusal with base commanders, department chiefs, officers, or unit directors–or anyone else for that matter. And I was sure to inform everyone who had given us permission to recruit and who managed the recruiting spaces and interacted in them, about the objectives and aims of the research, and emphasized that potential participants did not have to respond to any questions that they did not wish to answer.

In my proposal and plan I anticipated that benefits of participation in the study would be absent or minimal for subjects. I offered no monetary incentives or gifts for participation.[143] On the other hand, research study participants have been reported to benefit by being able to freely discuss their experiences in a non-judgmental setting, by being seen as representatives of others like them, and by contributing knowledge that may help themselves or others like them (Taylor et al 2010:348). When I screened people who were interested in participating we talked about the fact that while they would not receive direct measurable personal benefit from participating in this study, the knowledge that might be gained with their help would be used to apprehend the as-yet under-recognized experiences of people who are affected by adventitious *dis*ablement in general, and at the same time, the experiences of *dis*abled SMs, care providers, families and NMAs undergoing or providing rehabilitation at a MTF. And, as we often speculated together prior to participating in interviews and sometimes confirmed together afterwards, simply sharing stories might prove to be beneficial for each of us–comforting, relieving, assuaging, or even enjoyable.

To ensure respondents' confidentiality, I transcribed all the recordings myself, and archived transcriptions, consent forms, and master coding list in a protected folder on my

[143] Nor did participation incur any tangible costs to my study subjects–except with respect to giving time.

computer; and hardcopy in a locked cabinet. I do not refer to any of my respondents by name nor comment about them with other respondents or associates not involved in the study. I thanked all my respondents in person and in writing (by means of Thank You notes, not e mails). Now from time to time, when I greet research respondents we do not refer to our work together at all.[144]

I entered field notes by hand into notebooks during participant observations, conversations, and interviews; and while considering texts in time and space. I transcribed these notes too, coded them with numbers, and numbered each line for reference. These transcribed notes are also archived into a protected folder on my computer and my handwritten notebooks are locked in a cabinet.

After recording interviews with respondents I transcribed our conversations verbatim, numbered the lines, and appended [Q] for Questioner and [R] for Respondent. I labeled the transcriptions using the actual participant number and converting it to a transposed number to help protect confidentiality when quoted in the manuscript. I identified the type of respondent, the number of words in the interview, the recorder I used, the number of the recording, and its length in minutes and seconds. I added the setting, the respondent's civilian or military status and gender, date, and the time of day (TOD).

I used *hh* to indicate sharp intake of breath, **bold** to indicate speaker's emphasis, and ↓ for falling and ↑ for rising tone. I added … for short pause; … … for medium pause; and … … … for long pause. In a second step, after additional readings and "listenings," I added ► to flag words or phrases that illuminated notable or shared themes, and they appear in the versions below, as indicated by *v3*. In the transcription excerpt below, Example 3.2, I have labeled the transcription and noted its version (*v3*); noted the interviewee's de-linked number (060);

[144] While this can be socially awkward, non-acknowledgement is an important aspect of protecting respondents' confidentiality and we adhere to it.

captured the number of words in the excerpt compared to the number in the transcription; numbered the lines; and indicated intakes of breath, emphasis, tone, pauses, and notable phrases:

Example 3.2

060*v3* Wounded Service Member, 131 words out of 7906 in the transcription

0001 my very↓ one of my **first thoughts** and after it was after everything got sorted y- like after
0002 we looked around in the truck↓ and we got pulled out of the kill zone↓ and all that kinda
0003 stuff after those things↓ I remember thinking uh … will this be enough to get me a **purple**
0004 **heart**↑ because I really wanted a **purple heart**↑ I wanted I wanted that purple heart↑
0005 because ►I wanted to be **recognized**↑ as someone who had been in **combat**↑ and I wanted
0006 to have a **medal**↑ which was clearly a **signifier** of that↓ and the purple hearts are very
0007 recognized↑ it's probably the third of the fi- top five medals receiving from war↓ and you
0008 really get you really get some uh some uh attention↓ so … [R]

I also transcribed content from signs, podcasts from events at other sites, documentary films, posters, and blog postings that directly informed my research; for example in the excerpt 3.3 below, I show field notes (FN) I made after watching a documentary about the family member of an injured SM. I watched the film a number of times, and transcribed sections of the narration.

Example 3.3

610*v3*FN Field notes after watching a documentary film

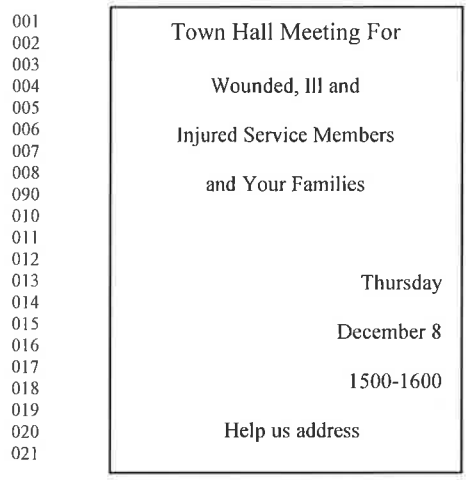
0001 Several months after the Wounded Warrior Care conference at the Smithsonian, I watched
0002 an online documentary about the female panelist Ivonne Thomas and her *dis*abled spouse.
0003 In it the narrator said, "**This** isn't what people think of when they think of **injured**
0004 **soldiers**↓. Five or ten years ago people weren't surviving these kinds of **injuries**↓. When
0005 there are **two wars** going on, being a military wife takes a certain kind of toughness↓.
0006 ►But nothing could prepare her for this↓" (Nyier 2010:2).

The next excerpt is a simple transcription of the verbal contents of a series of posters whose texts changed over a period of several months. In the first poster (Version 1, 2011), both "Wounded, Ill, and Injured" and "Wounded Warrior" appeared. In the second (Version 2, 2012),

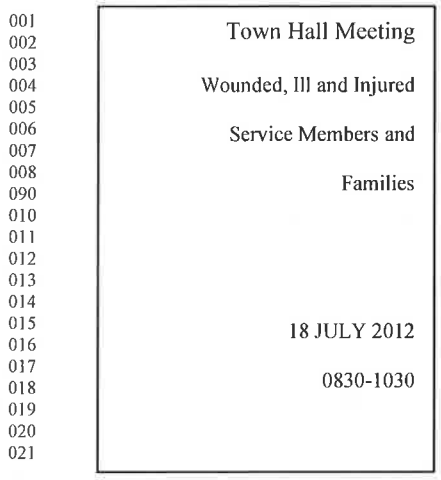
"Wounded Warrior" had dis-appeared. I placed the transcribed text as it appeared in the original sources, and numbered the lines:

Example 3.4

Example of poster verbiage in Town Hall meeting Posters, December 2011 (1) and July 2012 (2)



Version 1, 2011



Version 2, 2012

The next example (3.5) is an excerpt from one of my transcriptions of a blog posting and the comments that followed in an online conversation among SMs about service, sacrifice, smoke,[145] and heroism. All of these words appeared frequently in the texts that I gathered, and so this conversation was important to capture, parse, review, and consider. In this exchange on *HomeFires.com*,[146] a soldier comments on his reasons for joining the Army and bloggers

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[145] I noted the use of "smoke" in a number of texts. One was in a story related to me by a self-identified invisibly "wounded" SM. Reference to this story appears in Appendix A, Field Note 120, line 0017. The SM related this story prior to listening to or answering any of my questions. I recall it this way: A Service member who self-identified as "Invisibly Wounded" recounted the story of a ghost town in Pennsylvania that he wants to visit when he leaves rehabilitation at WRNMMC. He said a coal mine ignited under the town and no one noticed for years. When people finally realized the ground was getting hot, and saw plumes of **smoke**, they decided to drill holes to see what was going on. The holes provided air that fueled the underground fires. No one could figure out how to stop the fires, and the **smoke** increased until the town was finally evacuated. The Service member ended his story saying there was no way to staunch the fires, and that they will burn for 300 years. The respondent's choice to tell me this story about SMOKE SIGNALS appeared to me a as metaphor for the socioculture in which we currently find ourselves, vis a vis unseen wars and their effects.

[146] *Home Fires* features the writing of men and women who have returned from wartime service in the United States military. The project originated in 2007 with a series of personal accounts from five veterans of the Iraq war on their return to American life. It now includes dispatches from veterans of wars past and present (http://opinionator.blogs.nytimes.com/category/home-fires/).

comment back. Because this is a transcription of written content, I did not indicate [Q] and [R], nor sharp intakes of breath, emphases, falling or rising tones, nor pauses. I numbered the lines, and added ► to flag words or phrases that illuminated notable or shared themes:

Example 3.5

Home Fires September 9, 2011, 7:30 pm
►Smoke Signals
By JAKE SIEGEL
http://opinionator.blogs.nytimes.com/category/home-fires/

0001 ►Not long after 9/11 I joined the army and later spent 15 months in Iraq. Soon, I'll
0002 leave Afghanistan on one of the last military rotations before the projected
0003 withdrawal of United 003 States in 2014. ►This story of mine and the thousands
0004 others will be 13 years old by the time that war is over.
0005 It's been 10 years of thinking and fighting, of wrestling with Salafists and war
0006 profiteers and my own mercenary ego, which had seen in violence and war not only
0007 a ►means of service and sacrifice but also the chance for grandeur, the force of
0008 history breathed into my own small story.
0009 Now for the anniversary of that inaugural Moment When History Began we
0010 remember it in private and public—sometimes with prayer or ceremony and
0011 sometimes with theme-park anniversary discounts for first responders and soldiers
0012 and ►platitudes about honoring heroes. It's harder now to separate what is solemn
0013 from what is kitsch. But in the beginning, ►inside the smoke at ground zero, I
0014 could see the connections.

Sept. 12, 2011 at 3:49 p.m. 10 Comments

0015 I want to thank both Siegel brothers for their contribution, written and lived. You
0016 have provided a welcomed and thoughtful ►respite from this weekend. Again,
0017 thank you, ►you are appreciated.

0018 Hello Harry, I enjoyed reading your brother's piece -- though "enjoyed" is probably
0019 inappropriate. I like the intimacy of his narrative. The problem for with these stories
0020 and photos is that they bring me right back to The Moment. The emotions get as
0021 visceral as they were on that day. We want to recollect but are averse to it all at
0022 once. ►I choose to avert the gaze, so to speak. Perhaps that's how it is for many
0023 readers. ►Your brother is a hero, for sure - a smart and articulate one at that! God
0024 bless him.

Verbatim transcription requires close attention to texts; i.e., listening and re-listening, reading and re-reading, and mindfully pondering elements. The transcriber listens, witnesses,

interprets, and reproduces utterances verbatim. At the same time, she creates meta-texts: Objects of analysis that are both self-referential and epiphenomenal; i.e., the transcriptions themselves. To guard against the distance these meta-texts threatened, I frequently reached back[147] to my original sources, people, and material culture.

Analysis

Data Analysis

Peoples' perceptions and descriptions of their own experiences are of core value to those who seek to identify and understand agentive and structural levers of social *in*justice. To figure out how self- and others' perceptions of *dis*ability correspond with their constructions, designations, and experiences of deservedness I chose to gather and analyze texts of a particular group of people who are interconnected in an extreme condition: at a MTF. I focused on texts because they are signifying verbal, visual, and tangible[148] components of systems in which meaning is tacitly and overtly shared among and between people. Using CDA and insights from CDS I transformed textual information into accessible and productive knowledge.

By using the methods, tools, and practice noted here I ensured the rigor of my data collection, the informed consent and voluntary participation of my respondents, the authenticity of their texts, the contextualization of the data, the transparency and replicability of my methods, the scholarly undergirding of my analysis, and the utility of my findings for adventitiously

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[147] I use this term understanding that in military discourse "Reach-Back" means providing "operational warfighting units–battalions and brigades–the opportunity to reach outside of their traditional avenues of information flow and use national intelligence community assets to gather information to fill 'gaps' in tactical intelligence" (Radzikowski 2008:24). After 2004 when DOD "reached out" to social scientists to join brigades as cultural experts in Iraq (and eventually later Afghanistan), some concerned anthropologists objected to the fact that ethnographic findings sought by DOD regarding who could be identified as enemies by mapping structural ties and hierarchies within tribal social networks–or "human terrain systems" would be spawned specifically for Reach-Back, and would put uniformed and non-consenting human subjects at risk (NCA 2008).

[148] And are also, arguably, fungible; i.e., exchangeable or replaceable, in whole or in part, for another of like nature or kind (*Random House* 2011).

*dis*abled subjects and those who are interested in or engaged with the people, policies and practices that co-construct and uphold notions of *dis*ability and deservedness.

Using ethnographic methodology to collect qualitative data I was able to explore and become informed about how SMs and others make sense of their own lived existence in treatment and rehabilitation, both individually and within systems of shared meaning, i.e., orders of discourse. I considered their texts and contexts: The sensory, material, cognitive and inter-subjective complexes within and around them (Dahlberg, Drew and Nyström 2010: 46, 91); and the network of discursive practices within which they were located; the relationship of semioses to other elements; their discourses; the institutional order of discourse, and the textual and inter-textual structures, systems, and actions they co-constituted and upheld. In other words, following Fairclough 2003, I looked for how linkages between *dis*ability and deservedness are rooted in the way social life is organized at a MTF, considered dynamic tension that erupts in tournaments of value there (Appadurai 1986), and pondered what makes obstacles to resolution of this tension more or less *in*tractable (Fairclough 2003:209).

Following insights of CDS scholars I also applied data-sifting methods such as intellectual scrutiny, skepticism, imagining, and position-switching to identify centralized as compared to marginalized (or even, outcast) subjectivities and positionalities (Garland-Thompson 2011:603; McRuer 2006:172-198).

Having worked at WRAMC and WRNMMC for some time, I had already considered the space we were in as a kind of theater whose texts, or props, signified meaning inter- and intratextually (Chandler 2002:201; Goffman 1983:149-151[149]; Kristeva 1980:68; Johnstone 2008:164-68). The extreme *dis*ablement and increased numbers of SMs being treated at my field

[149] Goffman says "embedding."

sites,[150] their mortal interconnection with family members, NMAs, and caregivers; and in particular, the widely varied performances of recognition and access to resources that I was observing and which seemed to depend on types of *dis*ablement and modes of rehabilitation, prompted me to ask if people "naturally" (Lancaster 2030:72,73) rely on semiotic textuality to decide who deserves what at these military medical facilities–and elsewhere.

I wondered if implicit references to familiar texts (their *inter*textuality) and the relationships between them (their *intra*textuality), enable people to tacitly agree on notions and enactments of fitness, power, and social reproduction within specific systems of meaning. And, I wondered, if these notions and enactments were being signified in this space, and their reproduction was affecting how benefits are awarded or withdrawn, or how worthiness was apprehended, how were these constructions being tacitly negotiated and understood in order to "structure and sustain hierarchical social relations" (Decena 2008:340)?

In other words, I became interested in understanding whether texts that might be construed by myself and others as denoting or constructing perceptions of fitness, power, and social reproduction at these sites were indeed expressing, supporting, or constructing a link between notions of *dis*ability and notions of deservedness.[151] I committed to using tenets of CDA to locate the genres, styles, and discourses that were constructing and sustaining meaning at the site via texts. In addition, I applied insights of CDS scholars to challenge my own interpretations.

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[150] Because of combat "surges" in Iraq and Afghanistan; for example, in spring 2010 a Marine amputee predicted to me (at the MATC clinic) that "we'll be real busy in here by August ma'am". When I asked why, he mentioned the upcoming surge in Kandahar City in Afghanistan. "And it'll be all Marines ma'am. That's what we do." Sure enough by September the number of amputees returning from Afghanistan to the MATC clinic had itself "surged" (Murphy, field notes 2010). Much later a colleague noted that summer is a "busy time for the enemy," and that casualties always mount in the summer (when the combat zone is in the Northern Hemisphere). Since 2003, annual resurgences of activity by Iraqi and Afghan resistance occur in "the fighting season," as noted by various military and civilian speakers, authors, analysts, and journalists (Flintoff 2011).

[151] By deservedness I mean worthiness for recognition and access to material, cultural, social, economic, political and technological resources.

When analyzing my data I worked from the point of view that everything disclosed is intentional, is significant, has shared meaning, and can be revelatory when dis-covered; i.e., can illuminate subjectivities within modes, or forces and relations, of power. Everything that can be observed, heard, seen, sensed, or otherwise provided by subjects, and material culture within their contexts, provides textual instantiations of subjectivities-in-formation. Close reading and consideration of textual elements within narratives provided by subjects of research and their contexts helped me to understand their senses of themselves and their lived experience, and offered me the opportunity to discover, locate, and compare perceptions of "being" and of "subjectivity" (in the Althusserian sense [1971:171], and as used by Leap N.d.:2; Pêcheux 1982:157; A.T .Smith 2011:417). By doing so I found sources, examples, and references to *un*just and *un*even outcomes from people who were experiencing them; and I was able to glimpse and attempted to empathize with the lived experience of my research participants–from their points of view.

Combining ethnography with use of CDA tools of analysis and considerations from CDS, I unpacked the texts that comprise my data. I looked for genres, styles, and discourses, and examples of modalization so I could understand the dialectical and semantic interweaving of the actions, representations, identifications, and claims/counterclaims that enabled intelligibility and maintenance of the MTF's order of discourse, the "particular combinations or configurations of genres, discourse and styles which constitute the discoursal aspect of a (network of) social practices" which Peterson elaborates (2010:259, citing Fairclough 2003:220). I agree that genres, styles, and discourses govern coding and reproduction of institutional "goals, principles, and practices" (Fairclough 2003:220) among the people I was studying.

Genres, Styles, Discourses, Modalization, and Deixis

Genres are actional and include the ways subjects and objects convey representations of lived experience–in interviews for example, or blog postings, or documentary films. Styles are identificatory and comprise the ways that subjects and objects signal alignment and identity with each other and with ideological apparatuses. Styles are influenced by sociocultures and are contingent, for example styles may show up as differences in word choice, emphasis, and detail when an SM describes her recruitment, or "enrollment," experience to a researcher for example, and how she may describe the same period of her life to military buddies. Or, by extension. how she may tell the her recruitment story during a period of "fit" active duty, and how she may relate it later as a veteran who has been "separated" because of a *dis*abling illness. Discourses are representational, conveying particular ways of representing lived experience within particular space-times; as in the discourse of rehabilitation. Discourses flex and are flexible; they remain-in-formation, and may compete against each other, as civilian and military discourses may for example, in representations of military "service," or military "work."

To illustrate how I discerned, located, and critically analyzed these linguistic features, I offer two examples below; one in which I pinpoint genre, style, and discourse; and the other in which I comment on modalization, understanding that neither these features nor the excerpts themselves can be "isolated" so much as "pointed to," and that because they co-constitute intelligible communication cannot be considered as standing alone or apart from other texts.

The first example (3.6) is an excerpt from the transcription of a family member's interview (070*v2*). I mark it as "*v3*" to note that I have added diacritical marks to note breath, emphases, tone, and pauses; and ► to flag significance utterings, based on close re-readings and -listenings, and in comparison with other texts. I [Q] do not "mark" my own utterances. The

narrator [R] had identified her partner as a "wounded" SM, and in this section was responding to my question [Q] about the use of "wounded warrior" compared to the use of "wounded, ill, and injured" SM:

Example 3.6

070*v3* Family Member, 87 of 8692 words in the transcription

I asked:

0001Do you think he (meaning her family member who is her partner), do you and he hear, or I
0002 guess you can only speak for yourself, but do you hear that phrase 'wounded ill and
0003 injured'? or do you hear 'wounded warrior'? or do you hear both? [Q][152]

She replied:

0004 Umm … like I'm **sure**↑ that I mean he **might** hear wounded ill and inured at work↓ but
0005 like like ►I'm↑ part of the wounded↓ I'm basically part of the wounded warrior network↓
0006 there um there was a lot of like … **merchandise** associated with the wounded warriors
0007 you know at un- at (*name of university*)↓ and um um you know the ►**a lotta the T shirts**
0008 and stuff like that↑ would have um … **wounded warrior** like associated like associated
0009 stuff on them↑ at Walter Reed↓ … [R]

By thinking about the author's actual words, and our context, I establish the genre (in this excerpt) as "situated" interview; i.e., a semi-formal exchange between questioner and respondent that is tied to the MTF's network of social practices; a time-space in which actors express themselves with regard to their ensembles–both their sartorial and performance ensembles. In this case, the author is using words that make sense to me in our shared space, and in reference to herself and her partner. These words and their usage are generic features. We had had several discussions prior to the recorded interview, and here she alludes to both the university she attended (0007) and to Walter Reed (0009), after having said the words "wounded warrior" and "network" (0005). I mangled the question, and created confusion about who is "you" (please see

[152] I hope I am not alone in cringing when I listen to and transcribe my own conversation or interviewer questions. The way I ask this question, presented here verbatim, is an iconic example of halting speech and confounding deixis: Who is "*you*"? When the respondent answers she courteously extends the confusion regarding who is "you" by beginning to speak for her partner, then switching to speaking for herself.

n.45 below); in turn, the respondent complied with my direction, and mixed deictics, starting with reference to the "subject" by using the pronoun "he" (0004), switching to "I" (0005) changing to "merchandise" (0006) and "stuff" (0008), and ending with "them" (0009).

To designate the excerpt's style I looked for words that the author uses when she expresses who she is; and how, with whom, or with what she identifies. The author aligned herself with Wounded Warriors, and consumers of Wounded Warrior material culture ("merchandise"0006, "T-shirts" 0007, and "stuff" line 0008). She used the phrase "I'm a part of" in 0005, followed it in the same line with "I'm basically part of the wounded warrior network," and then in line 0006 merged herself with merchandise–with material culture–that identifies members of the wounded warriors' network. The most compelling feature of style in this excerpt is the author's construction of an overt "association" crescendo. She said "**merchandise** associated with the wounded warriors" (0006), emphasizing merchandise first, followed by wounded warrior; then re-organized her point with a notable emphatic repetition: "**wounded warrior** like associated like associated stuff," in which wounded warrior becomes foregrounded (0008). This excerpt's style is one of solidarity; it aligns with the military ideological apparatus, and relies structurally on nouns that establish the author less as an individual than as a working part of a producing and consuming group: network, merchandise, T-shirt, and stuff (the author said "stuff" twice in an 87-word comment).

To get at the discourse being co-constructed and sustained in this excerpt I looked for words and terms that conveyed particular ways of representing lived experience. I found "I'm sure" and "I mean" (0004), "I'm part," and, "I'm basically part" (0005); then, "you know," "you know" (0006, 0007). From these features I derived the discourse as being representational of the obviousness of military service, the well-entrenched feeling of being part of the military family,

the certainty of *dis*ablement, and the roles that some SMs and their families play in managing damage: Some identify as Wounded Warriors, creating and vigorously maintaining a network, and fueling the network through work, consumption, display–and reporting. This discourse is centrally located within the MTF order of discourse (focused on rehabilitation), and also within the institutional/military order of discourse. It is neither oppositional nor marginal; it resonates with the central hum of the dominant governing (global) order of discourse, and within that, more locally, with the MTF order of discourse–the discourse of rehabilitation.

Modalizations show how, where, when, and what authors commit to or deny within overlapping, even competing, discursive representations. Modalization is relational and dynamic; it is a linguistic means of aligning with, maintaining, and continuously co-constructing a discourse; resisting, denying or undoing a discourse; or hedging, switching, persuading, seeking agreement, or contra-dicting a discourse. Modalization may include evaluations and demands; indices of mood, opinion and speculation; hedges; and feints. Some clusters of modalizations do all of this work.

For example, in the excerpt below, the author variably extends and withdraws claims; contra-dicts; supports, and questions the MTF order of discourse.[153] This 266-word excerpt is culled from an interview of 5953 words from participant 020 [R]. In this excerpt, most of the bridging interviewer comments [Q] are "missing." I offer this excerpt to index how and where I found examples of modalization, and what I derived when I found this feature using CD analytical tools. It is in "*v3*" style, with "marks."

After I asked 020 whether she regarded her patients as *dis*abled, she averred and noted that most of the people she works with are amputees, many of whom have only one leg. She also

[153] i.e., the dominant discourse purporting that rehabilitation restores wounded, ill, and injured SMs to their former status and rank, or may even elevate them beyond their prior selves; by means of the athletic model of rehabilitation for example.

commented on SMs with brain injury in an immediate elaboration to her categorization of who among her patients are "disabled:"

Example 3.7

020*v3* Care Provider, 44 words out of 5953 in transcription

0001So they're they're missing **one leg** um↓ so they have uh a physical **disability**↓ they're
0002 unable to um … well they uh ►they don't **have two** legs like **most** of us↑ *hh* do um so that
0003 makes them disabled↓ but **also** those who have uh [R]

0004 **traumatic brain injury**↓ also I think of course that's also a disability↓ [R]

When I asked her,

0005 Can you tell me some ways you think of the people you work with as capable? [Q]

She replied,

0006 Well I think ►**outside** of their physical disability↓ which pretty much it's it's no longer a
0007 physical disability↓ because ►they **have** new **legs**↑
0008 I **really** I uh really um think ►they're capable of heh heh whatever it was that they were
0009 doing before
0010 Uh umm yeah↑ they're uh to me they ►they have **no** impairments ►apart from uh if they
0011 have traumatic brain injury of course↓ or ptsd↓ but in terms of other issues↑ uh I think they
0012 are ►**capable** still of performing those those functions↑
0013 Well uh I **think** ►they **share** my uh my my thinking in that ►b- beyond their physical
0014 impairment↓ which is uh
0015 No longer an impairment↑
0016 They are able to function … ►fully um apart from their their injury↓

0017 *Hhhh* I *hh* I uh **honestly think** ►there's nothing lacking in that within that group↓ um they
0018 seem to be **happy**↑ so … I'm n- I'm don't think within this setting they're lacking for
0019 anything↑ [R]

I picked this example because in it the author provided almost all of the many features of modalization, in a compact response to a question about a complicated issue: an issue that itself is unresolved, in-formation, shifting, and dialectical. Who is *dis*abled? What do we base our viewpoint on? How do characterize our viewpoint to others? To ourselves? Locating modalizing words and terms helps the analyst to learn what moods, or opinions, or preferences are being

expressed in texts; what relationships are being expressed, considered, and re-considered. The ways and places in which modalization functions as a dynamic textual feature provide clues about the author's intent and position, and are especially compelling when they evince dynamic tensions and animate dialectical relationships. Efforts made in these areas of struggle help to locate central (or oppositional, or marginal) ideological and practical management of lived experience.

In this text example, the author contra-dicted herself, and imagined that "they" share her opinion–yet her opinion is itself unclear. 020 started her response with a formula: They're missing one leg therefore they have a physical *dis*ability (0001). Then she struggled to justify her conclusion: Well they don't have two legs "like most of us" so that makes them disabled (0002). Here is a clear modalization–they aren't like us so "that makes them" *dis*abled. "Doesn't it?" isn't overtly stated, yet hangs, tacitly implied. To help herself move past this temporary confusion the respondent made another assertion about *dis*ability: that people with brain injury "of course" have a *dis*ability (0004). Yet she started this declaration with "I think" followed by "of course"–parrying her stated thought. In this short excerpt she used the word *think* or *thinking* 6 times, pairing her usage with persuasive words such as "*Hhhh* I *hh* I uh **honestly think"** (0017), followed by the hedging word "seem" (0018). Repeatedly, the author offered a comment and then withdrew or contra-dicted it. For example she said "outside of their physical disability which pretty much it's it's no longer a physical disability because they have new legs!" (0006, 0007), followed almost immediately by "they have no impairments" (0010). She surmised that they think like she does, and beyond their physical impairment "which is uh no longer an impairment they are able to function fully um apart from their injury" (0013-0016).

In this excerpt, the author hedges, committing to, and withdrawing from point(s) of view. Finding examples of modalization like these is important because examples of this linguistic feature (modalization) index the tension between and among points of view (even within one individual), and show how stances vary, are contingent, and may be *un*intentionally misrepresented. In turn, "seeing" evidence for these dialectical relationships (between and among competing discourses for example, or between and among competing people in tournaments of value) helps to bring the dynamic contours of lived experience into focus.

In addition to the striking modalizations that appear in this textual excerpt, I am also following 020's use of the words "missing," "outside," "beyond," "before," and "apart." Later in the interview she volubly expressed concern that once her patients have "left" the MTF they will face barriers and challenges that do not exist "inside." As I re-read and re-listened to the all of the interviews, I was struck by respondents' repeated uses of these words, plus "loss," "lost," "left," "out there," and "in here." I returned to each transcript and flagged such repeated or notable usages with ►.

Text analysis often leads the researcher to another rich aspect of discourse: the shifting, complex, and confounding use of pronouns and co-related words that act on behalf of names. In addition to showing where and how authors vouchsafe action (genre), express identity (style), represent themselves (discourse), and make commitments (modalization), noting and interpreting the ways in which authors use pronouns may help the analyst understand otherwise inchoate ideological and practical aspects of lived experience. For example in the excerpt that opens this chapter (and I present here below in Example 3.8) the author's use of pronouns is notable. During this interview we had been discussing visible and invisible damage, and I probed whether the respondent perceived a link between *dis*ability and deservedness. The respondent said,

Example 3.8

030*v3* Care Provider, 139 words out 7144 in transcription

0001 well uh it's uh its uh a **mixture** of uh of uh my perception is↓ that there is a **mixture** of uh
0002 what shall I say **perceptions**↓ so for example if something is is uh obvious↑ like a
0003 physical↑ wound↑ then there's **no reservation at all** … but when you get to psychological
0004 illnesses↓ um uh I I I there is a a a a fair number of people who uh say that they're too easy
0005 to **fake** and and these people↓ um … and uh and uh um you know I have um **mixed**
0006 **feelings** about that↓ because on the one hand … uh it justifies that these guys aren't faking
0007 it but on the other hand↓ why do we need **physical evidence**↑ you know↑ ►someone
0008 reports what's going on and it **seems to me** it should be sufficient↑ [R]

Within a response of only 139 words out of the 7144 in this transcription, the respondent uses a wide array of pronouns and words that stand in for names or nouns. To highlight their use, the weight of the usages, I underlined the pronouns, and the co-related terms "number," "people," and "guys." I noted the particular number of times 030 uses each of the pronouns I am interested in, and offer that "count" in Table 3.3 in order to show how the speaker is "weighting" people as compared to processes and institutional workings. These differences in numbers of usages (for kinds and relationships of subjects and agents) point to how the speaker is identifying sources and flows of power.

TABLE 3.3: Relative weight of pronoun usage

Pronoun or Correlate	# Times Said
Who, something, what, someone, my, number, they, that, guys, we	1
People, these	2
You	3
I	5
It, it's	6

These multiple, shifting uses of pronouns and other stand-in words for names/nouns are significant because they index the instability of the perception 030 is trying to describe–

including his own and others (where others may be institutions). Finding instability is important because it may point to an area of confusion, resistance, or struggle that might otherwise go "unnoticed" and subsequently be tacitly accepted, naturalized, or considered "obvious."[154]

In lines 0001, 0006, 0007, and 0008 the speaker employs "it" or "it's" and in line 0006, "that," without specifically mentioning what he is referring to; i.e., he uses "false diectics" (Penelope 1990:130-133). The speaker's use of false diectics allows him to vaguely refer to a topic that the listener may not know about, understand, or agree with, but that the author assumes "is" understood. Penelope explains (1990:130,131),

> False deixis occurs when it, this or that have no identifiable reference…in the context in which they occur…Speakers and writers use deictics to trick us into supplying information from our own assumptions, beliefs, and misinformation…. In such phrases, *it* refers vaguely to something both speaker and hearer believe they already understand.
>
> – Penelope *Speaking Freely: Undoing the Lies of the Father's Tongue*

While I do not believe that 030 was trying to trick me, his usages are metonymic for the garbling of agency that I am interested in sourcing in the discourses I am examining: the *un*intentional con-founding and con-fusing of who is responsible for what, who decides, and what the con-sequences are of those "decisions." Although in this chapter I do not extend my examination of pronouns, I note that English language speakers use many pronouns and co-related words; and based on my ethnography, in military discourses multiple additional words[155] stand-in for the subjects to which they refer. Table 3.4 below lists of regularly deployed English

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[154] As in other areas of my research, this observation is dialectical in itself because I am affirming that things "unnoticed" are "obvious." See Althusser 1971, Duggan 2003, Lancaster 2003, McRuer 2006, and Warner 1999, 2002 for productive discussions of obviousness, normalization, and naturalizatio.; and for tacitness and '*subtejar*' see Decena 2008.

[155] As well as acronyms, please see Glossary.

pronouns, and some examples of military "stand-in" words; i.e., words that replace or refer to proper nouns, and names of people and organizations:

TABLE 3.4: English pronouns	
Subjective	I, you, she, he, it, we, you, they
Objective	me, you, her, him, it, us, you, them
Possessive	mine, yours, hers, his, its, ours, theirs
Demonstrative	this, these, that, those
Interrogative	who, whom, which, what
Relative	whoever, whomever, whichever, whatever
Indefinite	all, any, none, some, another, anybody, anyone, anything, each, everybody, everything, few, many, nobody, one, several, somebody, someone
Reflexive	myself, yourself, herself, himself, itself, ourselves, yourselves, themselves
Intensive	myself, yourself, herself, himself, itself, ourselves, yourselves, themselves
OTHER NAMES FOR PEOPLE IN THE MILITARY	
	buddies, friends, family, members, guys, brothers, sisters, sir, ma'am
OTHER NAMES FOR ENTITIES IN THE MILITARY	
	the company, the force, the branch

Texts are endlessly "analyzable." I made multiple versions of transcriptions, and "multiply" analyzed them. The table below (3.5) identifies some of the other lenses through which I viewed my data, and the order in which those "views" occurred. No matter how many times one parses texts, surprises always appear, patterns get detected, and relationships become obvious; so using several different kinds of analysis is a good way to honor and mine texts. Although I used a number of methods to derive meaning, my primarly analytical tool was CDA. Detailed discussion about the numerous ways I considered each of the texts I documented is not germane to this Chapter because here I am focused on the productivity of using CDA; on the other hand, I intend this reference as a reminder of three things: first, that multiple readings and variable considerations of texts generate depth in insights; second, that carefully considered insights lead to significant findings which may not be readiluy apparenet; and third, that one must always return to the text, in context:

TABLE: 3.5 Other analytical steps			
	ACTION	CONTENT TYPE	RESPONSE
Step One	Participate and Observe	Semioses	Note interactions, spaces, conversations, signs, announcements, celebrations, salutes, uniforms, assistive technologies, prosthetics, exercises, scars, stitches
Step Two	Interview *person* Photograph, field note or photocopy *object*	Narration, story, conversation Image Copy	Record, field note, sketch, transcribe verbatim
Step Three	Transcribe	Words, ellipses, sounds, gestures, spacing, images	Code subject identity, number lines, identify emphases, pauses, and tone of voice
Step Four	Mark	Transcription of words and sounds, ellipses	Insert additional diacritical marks, font changes, and symbols to further penetrate usages
Step Five	Identify and Entitle Narrative Segments and Establish Narrative Arc	Marked transcription	Separate paragraphs noting type and "moral" of narrative segment
Step Six	Parse Exemplary Segments	Segments of marked transcription	Number text fragments, emphasizing repetitions, and idiosyncratic dysfluencies
Step Seven	Plot	Words placed into tables identifying Voice and Subject Position	Map repetitions, pronouns, disfluencies, tone, hesitations, location
Step Eight	Deduce Subject Position: Good, Bad, Disidentifying	Plotted words	Locate acceptance, resistance and "working" of dominant ideology

A Note About My Data Collection and Analysis

My research methodology was circumscribed by issues of access and of approval (including approval from DOD Public Affairs Office [PAO] that I was required to secure prior to publishing my dissertation). Limitations of my methods include the small number of people who agreed to be interviewed (some agreed to being recorded, others did not), and the narrow range of data that I analyzed. I conducted my research between 2009 and 2012, and in my dissertation have made allusions to numerous sociocultural and politico-economic influences on myself, my subjects, and my sites. I have captured and analyzed only a small amount of data that I gathered

from "outside" my sites–texts from the 2010 Smithsonian Conference on Wounded Warriors for example; and commentary from several blogs. On the other hand, during that time, critical DOD, VA, DHHS, and State Department policy changes occurred under the Obama Administration; and re-emphases, or re-directs, in media reporting of SMs, their families, NMAs and care providers occurred in online and print newspapers and magazines, broadcast radio and television, cable television and satellite radio, blogs, Twitter, Facebook, billboards, and podcasts that influenced SMs' deployment, health care, benefits assessments, restrictions based on gender, visibility, and status. For example, I have alluded only tangentially to the historic change that DOD authorized in 2011 to begin awarding Purple Heart medals to SMs who were injured by PTSD and TBI during combat; and to the overturning of "Don't Ask Don't Tell" legislation (DADT). These multivalent changes in contemporary U.S. history need to be further researched to understand their influences on linkages between *dis*ability and deservedness for people in the Armed Forces, and inter-dependents' access to recognition and resources during rehabilitation at a MTF. In addition, the data I did collect is rich with significance and "deserves" to be further plumbed.

Summary of Methodology

Finding Texts and Examining their Linguistic Features

Locating examples of textual genre, style, discourse, modalization, and deixis helped me understand how subjects stage their texts to be intelligible and how this staging locates actors and directs how they take, assign, or evade responsibility. Staging organizes discursive consciousness, indexes communicative competence, and signals communicative intelligibility at the site and in the moment. CDA, and the important insights that *CDS* brings to discourse analysis, helped me to find textual features that deepened my comprehension of my data's inter-

textual and -subjective significance, and to access the knowledge about relations, forces, and *im*material effects that are always-in-formation within systems of power[156] both for the actual subjects of my research; for others like them; and for people who interested in them, now and in the future. In addition, CDA (and CDS) helped me to problematize my own and other mediated structural or normative assumptions, and to develop actionable recommendations that may support or challenge existing policy and practices with regard to just outcomes for *dis*abled SMs and other people who are self-identified as *dis*abled and for whom uneven access to recognition and access may occur.

By using ethnographic methods and textual analysis in a qualitative study, I looked for examples of how *dis*abled subjects and those with whom they interacted at a MTF accepted, enacted, legitimated, and reproduced mechanisms of inclusion and exclusion. I examined spatio-temporal, linguistic, and semiotic factors of interaction and experience and found that in sometimes *un*expected ways, *dis*abled SMs' types of *dis*ablement and modes of rehabilitation profoundly influenced their own and others' notions about their worthiness or deservedness, and that these complicated perceptions affected their recognition and access to resources in the moment and beyond. To index and support my research findings, in Chapter Four I discuss my data and analysis in more detail, using extended examples of text and lengthier notations. I have explained my methods above, so that people can understand what I did, and perhaps themselves more consciously and routinely identify *un*even conventions by which we designate or accept designations of worthiness. Understanding the methods I employed may help other people to point out and explain texts that complicate, confound, or perpetuate perceptions of fitness, power, and social reproduction and that link *dis*ability and deservedness; for example, the sign in the MATC clinic (please see depiction of sign, Chapter 1, page 1).

[156] Arguably, all systems are systems of power.

TABLE 3.6: Key to methods and analysis, textual markings	
Notation (examples)	Meaning
[Q]	Questioner
[R]	Respondent
021	Respondent Code Number and Transcription Number
021*v2*	Transcription Number with Flags
SM, FAM, NMA, CP	Respondent Type
5789	Number of Words in Transcript
SONY or OLYMPUS	Which Recorder
13	Recording #
59:43	Length of Interview
10:30 a.m 10:30 p.m.	Time of Day
Office	Setting
M, F	Gender
CIV, MIL	Status
hh	Sharp Intake of Breath
BOLD	Emphasis
↑ ↓	Rising and Falling Tone
… , … … , … … …	Short Pause, Medium Pause, Long Pause
►	Notable Comment or Word
METHODS	
Type	Features
Ethnography	Participant Observation, Field Noting, Interviewing, Collecting of Texts, Downloading, Transcribing, Interpreting, Analyzing
CDA	Critical Discourse Analysis
CDS	Critical Disabilities Studies
Genres	Actional
Styles	Identificatory
Discourse	Representational
Modalization	Relational and Evaluative
Pronouns	Diectics and agency
Order of Discourse	Particular combinations of genres, styles, discourse that constitute the discoursal aspect of networks of social practices
Finding	Knowledge gained *via* identification of repeated discoursal themes in Data

CHAPTER 4

KNOWLEDGES, TOOLS, AND TECHNĒ

Data and Analysis

Subjects and Objects Matter

In this chapter I describe in detail some of the data I collected and annotated, and analyze them–discussing their semiotics, including linguistic features; identifying shared themes that animated new discourses; and pointing to how my data collection and analysis answered, or altered, or even countered my original research questions:

1. Do military Service members, family members, non-medical attendants, and care-providers interacting in care and rehabilitation at a Military Treatment Facility experience linkages between notions of *dis*ability and notions of deservedness?
2. In what ways are these experiences consequential?
3. How are linkages between *dis*ability and deservedness at this site constructed, expressed and sustained?

I refer to the data I gathered from subjects and objects of my ethnography in representative excerpts and brief descriptions of the texts within their contexts; and account for the shared themes I detected when I reviewed and considered my data *in toto*. In Chapter Three I showed the ways in which the data appeared,[157] and pointed to where I looked for evidence regarding how respondents accepted, resisted, and worked tenets of the MTF's order of discourse: a discourse of rehabilitation. Using CDA, I pinpointed expressions of genres (and generic features), styles, discourses, modalization, and uses of pronouns; and I indicated that some tenets of the MTF discourse have become so obvious that they appear to be common,

[157] Because I sought to identify mechanisms that are present and may or may not be visible (although they make an appearance) I use the word "appear" advisedly, relying on the reader to consider its immanent and extrinsic connotations at the same time.

acceptable, and natural. For better or worse, these features may not be noticed or noted at all and they may cover-up sources of *in*equity; or, sources of renewal.

My original questions about how apparatuses of fitness, power, and social reproduction are sustained at my sites, and the ways in which taxonomies of harm there contribute to linking kinds of *dis*ability and modes of rehabilitation with degrees of deservedness were answered in ways that led me to understand some things I had not anticipated and will plumb in this chapter. For example, a MTF appears to be a spatio-temporal locus for re-attaching missing things, for locating things that were lost, and for recuperating adventitiously wounded, ill, and injured bodies, psyches, memories, and ideals. In addition, my data and analysis show that aspects of the structural, ideological, and practical MTF technē[158] act on SMs, their family members, NMAs, and care-providers, and also the people who work, visit, photograph, sketch, film, report on, interact with, and interview people there.

In my data collection and analysis, I looked to archeology, choosing to consider the provenience of social and material culture at my site as one of the means of understanding how fitness, power, and social reproduction are co-constituted and expressed there, and if their dialectical tensions fluoresce in change. The research questions I was exploring rested on participants' perceptions and realizations of the provenience of various harms to SMs, and subsequent modes of treatment and rehabilitation. Where was the SM harmed (corporeally, cognitively, geo-physically)? What modes of care and rehabilitation were being experienced (athletic, pharmaceutical, prosthetic, alternative)? And were origins of harm and axes of rehabilitation linked with degrees of recognition and access to resources?

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[158] Technē: Greek τέχνη A "making" that produces something; also an art, a skill, or a method (*Random House* 2011). In Chapter One, p.6, n12, I referred to advanced prosthetology in which human bodies are repaired using sophisticated replacement parts, borrowing the term *soma-technics* from scholars who examine the effects that technologies, technēs and techniques have on embodiment, subjectivity and sociality. Soma-technical scholars critically examine forces and relations at work between the body (soma), and the various technologies, technēs, and techniques (technics) that shape it.

My sites are military-bio-medical-rehabilitative complexes in which tools and technology are abundant and comprise much of the material culture I observed, gathered, noted, and analyzed. The assemblages I analyzed included gear, uniforms, prostheses, equipment, and assistive technologies. At the same time these sites are arenas in which intense activity occurs between and among multivariable people who are inter-dependent. Their practices and interactions, including therapeutic authorization and subjection, constitute technē (Heath and Menelay 2008). In using the term I am borrowing a concept keep in play notions of "making" that produce something; an art, a skill, and a method; practical reason, craft, and technique (Axelos 1976:9,63); practice, individualized, and structured action (Foucault 1985:62); as well as intentional re-crafting of self and selves (Boellstorff 2011:59). By using technē I gesture towards the combined effort–the labor–undertaken by inter-dependents to make, make whole, or re-make. Heidegger notes, "In technē, through art and handcraft, man participate(s) in conjunction with other contributing elements–with 'matter,' 'aspect,' and 'circumscribing bounds'–in the bringing forth of a thing into being" (1977:xxiv).

I reviewed and considered texts, including material culture, in their entireties and within their contexts. I studied texts as fragments that combine and "correspond," and are commissioned, delegated, and deployed as assemblages that authorize and bear witness to subjection. These texts were narrated, performed, displayed, posted, and circulated; and were also made and became available to me under, or perhaps within, a sovereign aegis: The state of care and rehabilitation at a MTF, a protective and protected space and time of recovery.

Based on my data analysis, which I develop below, I interpreted inter-dependents' participation in rehabilitation as a kind of collaborative restitution of things lost: corporeal, cognitive, ideological, and idealistic. I also learned that the remains of and recuperation from

damage are comparatively more powerful when they are apparent,[159] and when their provenience is intelligible; i.e., when their manifestations, origins, and expressions are perceptible. In contrast, those things and conditions that are not apparent, such as depression, brain damage, or disease, are more difficult to apperceive and assess;[160] yet their effects on gaining recognition and access to resources, or not, are profoundly felt.

My respondents resisted or re-organized my presentation of the very mechanisms I was attempting to discover. Through their accounts they told me that linkages between *dis*ability and deservedness were not necessarily disempowering levers of *in*justice, but rather were overtly acknowledged and rigorously upheld means of reattaching and re-inscribing things that are destroyed, lost, and missing; not only limbs, skin, and balance for example, or the ability to remember names of family members, but also structures, ranks, and supra-normative values of service, sacrifice, and selflessness. Moreover, they told me that they are not *dis*abled.

Based on analysis of my data, not only are subjectivities at a MTF always-in-formation, so are the mortal journeys along which participants rehabilitate and attempt to recover aspects of their former rank, status, and standing. In diverse and uneven ways, by simply being there, "inter-dependents" co-constitute, co-acknowledge, and co-sustain vicissitudes and vagaries of corporeal, cognitive, affective, conative,[161] and ideological harm and recuperation. Those who do not are elsewhere: at VA or community facilities, at home or homeless, employed or interning at

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[159] As pointed out by Messinger (2008b:109), please see Cacciapaglia, H, and K. Beauchamp, G. Howells 2004:181 for the effect of visible disability on subjects' willingness to interact.

[160] I learned (and was instructed) that assessments reached within the twin evaluation processes of Medical Evaluation Board-*ing* [MEBs] and Physical Evaluation Board-*ing* [PEBs]) figure centrally in the military discourse of *dis*ability. In these formal processes, determinations regarding fitness for active duty and "percents" of *dis*ability are ascribed and sub-sequently accepted, rejected, or appealed by SMs who are being retired (or "separated"). Their statuses and percents are linked to payments.

[161] The part of mental life having to do with striving, including desire and volition (*Random House* 2011).

a federal agency, in administrative or analytical "desk" positions in the military, or re-deployed down range.[162] Rehabilitation at a MTF is a space-time, a discourse, and a therapeutic "spell."

While I was conducting research I observed that people, stories, spaces, images, objects, and phenomena were being produced, expressed, performed, and responded to via inter- and intratexts that re-inscribed authorization and subjection (Hansen and Stepputat 2006: 295-315; A.T. Smith 2011:415-432) in a discursive complex of "making whole." To explain the provenience of my impressions, I point to themes that were salient[163] in the data that I gathered and that I discovered when I paid attention to repeated and shared words, terms, and allusions. Narrative excerpts below are extracted from originary verbatim transcriptions that I have de-linked to protect participant identities.[164] Here I describe where I detected themes, and moreover, what they appeared to be. My aim is to engage the reader in understanding how I identified themes that co-responded to undergird my research findings, how I erected a framework to parse their significance, and what bolstered my subsequent recommendations.

Deriving Meaning(s)

Sources and their Significance

I looked for themes among my data so that I could identify, compare, and evaluate shared or contradictory aspects of my respondents' accounts of their lived experiences, and thereby extract some kind of significance to address and inform my research questions; to foreground and examine mechanisms or "authorizations" at work that were shaping my respondents' subjections; and ultimately to shed light on similar mechanisms elsewhere, even everywhere. My

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[162] When SMs refer to being "down range" they told me they mean "while deployed" and "while in combat training." The etymology of this expression deserves further research.

[163] In military parlance, "a salient" is a projection of the forward line into enemy-led territory (*Random House* 2011).

[164] Several transcriptions of interviews I conducted may be found in Appendix A, along with some of my field notes.

operative supposition was that shared meaning resides among diverse textual assemblages, and is not just embedded in narratives or stories, but actively constitutes them. These meanings and interpretations arise from and are comprised of signs and symbols, or semiotics. By semiotics I mean signs and signals that create, convey, and confirm meaning–and co-constitute or represent reality within sign-systems where senders and receivers "read," extract, shape, and share mutually intelligible meanings. They do so via texts, contexts, and content that are co-occurring, co-constituted by each other, accessible to each other–and that remain-in-formation. Subjects are interpellated by ideological and repressive state apparatuses, lingua of interpellation are textual; and there is nothing outside either ideology (Vološinov 1973:21), or text (Derrida 1974:58).

Through data collection and analysis, social science researchers can look for and find signs and symbols in human interaction that produce effects on people, and examine how these signs and symbols, or significations, work in social practice–what they signal, how they are received and sent back, and how this dialectical flow supports, resists, or renegotiates dominant ideologies (S. Hall 1980:175). By locating and describing these sociocultural mechanisms, researchers can help others to do the same, thereby collaborating in examining practices which may be taken for granted and some of whose effects may prevent socially just outcomes in human endeavors.

To find productive[165] significations I searched for the locations and provenience of recurring usages, terms, words, and emphases among my data, always relying for direction and validation on authentic texts I gathered and observed in the passages where my respondents and I worked and mingled together, or that were provided by research participants in interviews and conversations. I looked at textual features whose presence (or absence) indicated subjects' and

[165] By using the word "productive" I mean to imply producing or having the power or potential to produce; in this research, the power to produce effects on people.

objects' positions in relationship to the MTF order of discourse; and whose components co-constituted "sub" discourses. This led me to apprehend a hierarchy of discourse at the sites: The dominating, stable, "global" discourse (institutional/military) at the "top;" the "local" discourse (MTF) shifting beneath it; and numerous "subjective" dynamic discourses at the base--some affirming, some contesting, and some re-negotiating the governing discourses.

To get at the linguistic features that govern coding and reproduction of institutional goals, principles, and practices among the people I was studying, I applied CDA to my data, and added diacritical markings to linguistic elements of the texts I collected and transcribed to help me draw out and emphasize lexical relationships that might not otherwise have appeared and that I used to make my claims: That subjects at my site managed and interpreted their lived experience by means of signs and symbols, including words, within systems of meaning which co-constituted and upheld a local order of discourse that is authorized by the military/institutional order of discourse. The MTF order of discourse rests, however *un*easily, on suborders of shared themes which constitute new discourses; and the data and the things to which these data refer within these networks of meaning are always-already in dialectical tension; they are always-in-formation.

When researchers study cultural and linguistic human dynamics we find varying levels or layers of information that we hope to convert to knowledge. Some of the work we do is quasi-journalistic; for example, when we report things we observe and that people tell us. However, it is our aim that critical thinking about these observations and reports, curiosity, simple persistence, and co-operation from our respondents will lead us to more and more nuanced understandings of human interactions and to insights regarding the structural, systemic, and agentive mechanisms that underlie *un*even or *in*equitable outcomes at our sites. In turn, we hope

that our deepened or deepening understandings will lead us in generating knowledge about something we did not know or notice or understand before; knowledge that will be pertinent and applicable to emancipation or another expression of social justice for people we are interested in–and others.

In this process, "obvious" elements are evident first–the quasi-journalistic questions and answers; the activities, images, gestures, words, subjects, and objects that we readily observe and with whom we participate. In turn, the data and the obvious elements lead to other questions and answers, more indirect signs and symbols, more esoteric findings. When we researchers find these–when, with the help of our respondents, we get to this level or these layers–we are truly discovering, and we are often surprised.

Respondents and Responses: "Respondence"

Below, using examples of texts and showing how I analyzed them, I offer the sequence of discoveries that led me to themes, findings (which I take up in more detail in Chapter Five), and recommendations (which I offer in Chapter Six). I analyzed all my data in the same way, moving from noting what was being reported, to locating and describing particular linguistic features, to considering these features' meaning with regard to the author's position in the MTF order of discourse, to flagging resonant themes, to considering themes as discourses-in-formation, and then to drawing out the significance of my findings.

I asked participants whether there is a link between *dis*ability and deservedness. Based on my data, the answer is "Yes." The link is obvious, and is expressed, justified, or challenged depending on the respondent's stance or the material culture's authority. The subjects I interviewed were able to respond to this question once I contextualized it, meaning once I used examples that had been provided to me by SMs and others regarding their meanings of

"recognition" and "access to resources."[166] In the example below (040*v2*, lines 0001-0060) I have retained my questions and remarks; i.e., in the sections followed by [Q]. In the respondent passages, followed by [R], I have indicated emphasis, rising and falling tone of voice, sharp intake of breath, and commonly expressed elements, following the convention I described in Chapter Three. To illustrate examples of themes that resonated in many data, I have underlined words that this respondent used to confirm her perceptions that there is an obvious link between *dis*ability and deservedness:

Example 4.1

040*v3* Care Provider, 479 words out of 4599 in the transcription

0001 Thank you I do have a list of questions that I could read but i- I'd love to
0002 just get a sense from you do you *hhhh*- have any response when I say that
0003 original idea that original question in your experience do you know of a
0004 link between how the s- Service member was injured and or be- became
0005 wounded or became ill and then h- how that person was able to access both
0006 resources and by that I mean maybe things like maybe parking privileges
0007 or gear or attention or um membership or invitations to participate in things
0008 um and also … recognition and those things are kinda linked the resources
0009 being tangible things the parking privileges for example and the recognition
0010 being somewhat less tangible and I wonder of you could talk to me a little
0011 bit about the thoughts you have about this subject [Q]

0012 I think uh it's ►**huge**↑ right from the start↑ like when we get the aerovac
0013 list patients are identified as battle or non-battle↓ [R]

0014 Mm [Q]

0015 And ►battle-injured patients um are typically coded as severe↑which means
0016 their families either meet them in Germany↑ or here [R]

0017 Uh oh [Q]

0018 If it's a non-battle injury↓your families get **notified** but they may or may
0019 **not** [R]

[166] In my first presentations and opening conversations with listeners, including members of WRNMMC SRC and IRB, people asked me what I meant by "recognition" and "access to resources," so I asked them back: What does it mean to you? They gave me examples which I then parlayed in my interviews and field-noted conversations.

0020 Mmm [Q]

0021 ►Be brought here to see them↓ [R]

0022 Mm [Q]

0023 So you can have somebody↑ ►coming from **theater** with say a medical
0024 problem↓ rule out leukemia↓ and they're twenty-six years old↓ and they
0025 arrive very sick↓ and there's no family and there's a lot↑ of
0026 miscommunication non-clarity [R]

0027 Mmm [Q]

0028 About how and when that family is able to [R]

0029 Oh wow [Q]

0030 To come↓ [R]

0031 Wow [Q]

0032 So it's a very high-anxiety time with these ►young kids with **illness**↓ [R]

0033 Illness yes thank you [Q]

0034 ►Illness as opposed to **wounded** and the patients and honestly it's almost
0035 across the board it doesn't matter if it's if they're diagnosed with a cancer if
0036 they're diagnosed with ↑[R]

0037 Hmm [Q]

0038 A stroke↑ if they you know what**ever** heh if it's a **medical problem**↓ their
0039 family is **not brought ►here** once their family finally does arrive↓ which
0040 usually takes I dunno two to five **days**↓ [R]

0041 Mmm [Q]

0042 Once the family's ►**here**↑ ►there's a lotta discrepancy in terms of where
0043 they get **housed**↓ [R]

0044 Mm [Q]

0045 So if a if a wounded warrior wife↑ arrives with two children↑ during there's
0046 a social worker there it's all arranged↑ their **liaison** assigned↑ they have
0047 housing↑ [R]

0048 Great example [Q]

0049 Whatever it is↓ [R]

0050 Yu- [Q]

0051 If there's a **sick** person here↓ … and they're on orders↓ they can be put into
0052 a **hotel** which may sound OK but somebody has to **do** that↑ [R]

0053 Hmm [Q]

0054 It doesn't have the same a- [R]

0055 Hmm [Q]

0056 ►Automatic **switch** that a wounded warrior↑ has and then once **here**↓ the
0057 family members may … or may not↑ have access to the same **kinds of**
0058 **things** that the wounded warrior families do … so↓ [R]

0059 So [Q]

0060 ►Right from the beginning it's **very different**↓ [R]

I have consistently found that when a respondent has a chance to talk, she will tell a story; and even sections of interviews have complete stories, with introductions, orientations, evaluations, and codas (Hill 1995:96-147). For example, in this first section of our interview, comprising 479 words out of 4599 in the entire transcription, in answer to my opening question about differences in access the respondent's first comment is, "I think uh it's huge right from the start," and her last, "Right from the beginning it's very different." When I transcribed and analyzed my data I looked for such narrative arcs. And, after hearing and reading stated responses, and noting their resonant themes, I looked for each text's genre, style, discourse, modalization, and use of pronouns so that I could think about how the respondent's words indexed her positioning with respect to the MTF order of discourse i.e., central (good subject), oppositional (bad subject), or marginal (dis-identfying subject). Understanding positioning

helped me figure out how subjects managed their lived experience and whether their ability to access recognition and access to resources (i.e., their deservedness) was being supported, foiled, or interrupted in some way. Depending on these discoveries, I was able to sort out significance regarding lived experience, and generate policy and practice recommendations.

Returning to the excerpt from my interview with 040, I probed the text to find that the genre is an interview, with generic features of a pro-active professional account; the style aligns with unrecognized needs of under-served (undeserved?) ill SMs; and the discourse is advocatory, representing patients' experience. The modalizations in this excerpt are consistently pro-active, affirming resistance to the MTF's order of discourse and re-presenting a competing discourse. Although the author makes some contradictory claims, i.e., "I think," (0012) and "honestly," (0034) followed by "I dunno," (0040) for the most part she is supplying evidence for a point of view, and carefully if passionately (using many emphases) building her case. When she becomes very firm in building her case she backs off slightly and briefly, saying "I dunno" (0012), "whatever" (0038), "whatever it is" (0049), and "a lotta" (0042) in contrast to her many articulate, informed, professional direct usages as noted in support of the genre. She switches back to her professional discursive uses and critique when she says, "Automatic switch that a wounded warrior has and then once here the family members may … or may not have access to the same kinds of things that the wounded warrior families do …" (0056-0058) as a closing argument; then finishes emphatically with "Right from the beginning it's very different" (0060), echoing the firm opinion she expressed at the beginning of this excerpt: "I think uh it's huge right from the start" (0012).

In Table 4.1 below, I show key words and terms from this excerpt and their locations; and I group linguistic elements to show how they informed my ascription of genre, style, and

discourse. Some words or phrases work hard–bolstering my identification of genre, style, and discourse; for example, the ways and places in which this respondent repeats her use of the words "illness" and "sick" leads me to consider her commentary as knowledgeable, strategic, and genuinely interested in surfacing and examining uneven outcomes for differently harmed SMs (and their family members); i.e., differences between wounded, ill, and injured. I have used **bold** face to draw attention to where and how often 040 says "illness" or "sick:"

TABLE 4.1: CDA of 040 Excerpt lines 0001-0060		
Linguistic Feature	Evidence (words and terms)	Lines #s
Genre: Interview Generic Features: Professional/Pro-active		
In this recorded interview, between a Questioner [Q] and a Respondent [R], 040 uses professional words that indicate her insider knowledge. She also asserts herself, is firm, and pro-active.	I think, we, aerovac	0012
	Patients, identifying, battle, non-battle	0013
	Battle-wounded patients, coded	0015
	Germany, here, families	0016
	Non-battle, notified	0018
	Coming from theater	0023
	Problem, leukemia	0024
	Sick	0025, 0051
	Illness	0026
	Diagnosed	0035, 0036
	Stroke, medical problem	0038
	Housed	0043
	Wounded warrior, wounded warrior wife, children	0045, 0056, 0058
	Social worker, arranged, liaison, assigned	0046
	Housing	0047
	Hotel	0052
	Access, family, family members	0057
Style: Aligned with under-represented SMs		
040 signals her alignment with under-represented patients by expressing herself as an empathizer with insights regarding their and their family members' experiences.	Huge	0012
	May or may not	0018
	Twenty-six years old	0024
	Arrive very **sick**, no family	0025
	High-anxiety time, young kids with **illness**	0032
	Illness as opposed to wounded	0034
	Usually takes I dunno two to five days	0032
	Lotta discrepancy	0042
	They can be put into a hotel	0051, 0052
	Doesn't have the same	0054

	May or may not have access to the same kinds of things that wounded warriors do	01057, 0058
	Right from the beginning it's very different	0060
Discourse: Advocatory		
The respondent is a care giver who is clear in her observations and evaluations regarding uneven recognition and access among SMs who have been wounded or become ill (she does not mention "injured"). Her words, and the examples she points out, indicate that she is advocating for equal treatment	So it's a very high-anxiety time with these young kids with **illness illness** as opposed to wounded and the patients and honestly it's almost across the board it doesn't matter if it's if they're diagnosed with a cancer if they're diagnosed with a stroke if they you know what ever heh if it's a medical problem their family is not brought here once their family finally does arrive which usually takes I dunno two to five days once the family's here there's a lotta discrepancy in terms of where they get housed	0042, 0043
Modalization: Resistant, Consistent, Evidence-Based, Passionate, and Moderately Negotiative		
040 hedges slightly when she makes some of her assertions; yet returns to her reportage. For example she uses "I think" AND "So you can have;" "honestly" AND "whatever" before concluding by re-asserting, "Right from the beginning it's very different."	I think	0012
	So you can have	0024
	Honestly it's across the board	0034
	Whatever	0038
	I dunno (note change in articulateness)	0040
	There's a lotta discrepancy (note change in articulateness)	0042
	Automatic switch	0056

040's use of pronouns supports her position as an advocate; in other words she emphasizes and dwells on ill SMs, using "they" or "their" 13 times; and the system, processes, practices, and outcomes–the situation–that she is objecting to, using "it" or "it's" 9 times. In Table 4.2 I list the pronouns she uses, and count them, to support my interpretation of her interest in and commitment to discussing SMs and the "system." She downplays herself and me (using "you" or "your" only once each, and "I" only 3 times); and continuously focuses on the subject and subjects under discussion, using "it," "it's," "they," and "their," 13 times.

TABLE 4.2: Example of 040's pronoun usage	
Pronoun or Correlate	# Times Said
We, kids, you, person, things	1
Your, somebody	2
I	3
Their	4
Family, families	8
It, it's	9
They, their	13

Next, I point to **emphases** in this excerpt: Time after time in reviewing transcriptions I have noted that speakers' emphasized words offer a précis of their story; and that even within sections, emphases are telling. 040 emphasizes these words (in sequence): **huge, severe, notified, not, theater, very sick, illness, wounded, medical problem, not brought here, here, housed, liaison, sick, switch, kinds of things, different.** These words are important to the author. They have been emphasized; and their import to the CD analyst is that these key words are resonant with meaning, certainly to "an" individual, and perhaps to many people. In their emphasis and sequence they tell a condensed version of the story.

Finally, I show flagged remarks (using ►) to note comments that resonate across many texts, and to indicate how I noticed them. In aggregate, flagged comments presented "themes" shared among respondents. For example, all of my respondents attested knowing of or experiencing a relationship between *dis*ability and deservedness; however, all of them also resisted or "worked" my assumption that they viewed themselves or the person they were caring for as *dis*abled. I return to that finding and to my use of flagged comments below, in my discussion of "themes." The flagged comments in this excerpt were the same as or similar to

many made by other care providers, and their resonance informed my finding that those "professionals" who care for wounded, ill, and injured SMs appear to express themselves as more observant of and concerned about discrepancies in levels of recognition and access to resources than SMs, their family members, and NMAs. Care givers' texts and the features of their texts were consistently "marginal" with respect to the rehabilitation/MTF order of discourse; in other words, their expressions "worked" or "worked at re-negotiating" practices in which they were actors. In this excerpt, I flagged the following comments:

- ▶ huge right from the start
- ▶ battle-injured patients um are typically coded as severe
- ▶ coming from theater with say a medical problem
- ▶ young kids with illness
- ▶ illness as opposed to wounded
- ▶ here
- ▶ whatever heh if it's a medical problem
- ▶ there's a lotta discrepancy in terms of where they get housed
- ▶ somebody has to do that
- ▶ Automatic switch that a wounded warrior has
- ▶ Right from the beginning it's very different

Based on my analysis of this data, including establishing its genre, generic features, style, discourse, modalization, use of pronouns, emphases, and resonant words and phrases, the author's position is marginal vis-à-vis the MTF order of discourse: She works at a MTF and is well-versed in its discourse; however, she objects to the under-recognition of SMs who are "ill" (or sick), and of their family members who may or may not get access to them quickly, may or may not get housing onsite, and may or may not get infrastructural support–compared to family members of "wounded" SMs. She succinctly and passionately lists and describes *in*equitable outcomes that befall SMs who are "ill" as compared to SMs who are "wounded." I ask her elsewhere in the interview about how she comprehends the word or designation "*dis*abled:"

> thinking about disability in a completely different way and
> uh so it's quite a all-encompassing kind of word and depending
> on where you hear it and who uses it people may or may not
> resist the idea of calling someone disabled … and I wonder
> if you have any thoughts about that [Q]

and she says,

> I'm I'm not sure how to respond to that I d- like I think
> PTSD is a good example people PTSD the rating has changed
> to thirty percent … [R]

While she first avers that she cannot respond, she is able to respond, and does immediately, using a measurement ("thirty percent") to illustrate her point. She is a firm and concerned care provider, equipped with institutional knowledge, tools, and technē, who is identifying and questioning *in*equities in designations and outcomes.

In another similar response a physician said she "got it" (meaning the "link" I was asking about), and related an example. I recreated her comments in field notes (because this was not a recorded interview I did not add coding for emphasis, or tone of voice), underlining the resonant terms and words regarding the link between kinds of *dis*ability and deservedness, and flagging notable usages, i.e., comments or words that recurred among diverse data:

> Example 4.2
>
> 430FN Care Provider
>
> 0001 Oh I get it. You mean like my patient who was aerovac'd to WRNMMC
> 0002 from (*area of combat*) with (*terminal illness*) and was pissed that after
> 0003 twenty years of active duty she didn't get the same goodies as the Wounded
> 0004 Warriors? ►Like big screen TVs, and video games? And ►visits by big
> 0005 wigs? She was ►so pissed she put together a group of other terminally ill
> 0006 patients and they fought for their special stuff and they got it before she
> 0007 died

Here, the flagged phrases are:

> ►Like big screen TVs, and video games
> ►visits by big wigs

► so pissed she put together a group of other terminally ill patients and
► they fought for their special stuff and they got it before she died

What is important about capturing "common" or shared comments after multiple readings is that their resonance grows, and becomes more significant and compelling when the analyst sees or hears them repeatedly from multiple sources. Therein lie areas of concern that subjects (or authors, or agents) have posited; not ideas the researcher brings to her interpretation, but things said by respondents. As the researcher surfaces these comments, patterns become evident, themes coalesce, and a pathway to research findings appears. When confused, or overwhelmed, or stymied, the linguistic anthropologist "returns" to what the person said. To keep "said things" in play I flagged notable comments, and considered them with special interest. In all the data I collected, themes echoed in one way or another. As I moved through my analysis annotating, flagging, and pondering, several themes became salient. Before discussing these shared themes below, I return to where and how I found them.

My second research question was "How is this link consequential?" Respondents replied or indicated that linking kinds of harm with kinds of deservedness results in differential levels of recognition and access to resources; and furthermore, that these results are obvious, notable, and in competition. Depending on their stances, respondents and the content of material culture vouchsafed the differences as fair or unfair, and indicated that they are conveyed as understandable or not by means of circumscribed and predictable sovereign policies and practices that make sense in the MTF order of discourse.

For example, a Marine[167] who self-identified as a having lost both legs in combat, participated on a panel discussing the effect of emergent active designations "Wounded," "Ill," and "Injured," as contrasted to the extant term "Wounded Warrior" (S&NMIECS 2010). Because

[167] He was introduced as a Marine, he was in uniform, and he self-identified as a Marine, even exclaiming the Marines exhortation "ooorah" at the end of his comments.

I transcribed this text from a podcast,[168] I have marked it with the conventions I discuss in Chapter Three, and have added underlines to indicate words that index the consequences I am researching. The panelist asserted,

Example 4.3

613FN Service Member

0001**Yes**↑ I want to be known as '**wounded**.'↑ **Not** as 'injured.'↓ I **want** people
0002 to **recognize right away**↑ that I lost my legs↑ while fighting for
0003 freedom, that **I got blown up**↑ down range. I served my **country**↑ and
0004 **gave my limbs**.↑ Two of my buddies **died**. That's **not the same** as a
0005 training accident.↑ That's **not the same** as getting sick.↑ I made a
0006 different kind of **sacrifice**↑ and I am proud of it.

The panelist I am quoting emphatically differentiated himself from other SMs because, he said, he had lost 2 limbs in combat (his legs were immediately detached from his body in an explosion, not surgically amputated); and this differentiation was important to him.

In a different field-noted conversation, a care provider who had worked at WRAMC for nineteen years (but not at WRNMMC) was sarcastic when I asked her about the consequences of linking *dis*ability with deservedness. She had asserted that there is a link between kinds of *dis*ability and kinds of recognition; then indicated that SMs who are "ill" still get very little attention.[169] She said after 2003, when OIF began, "Amputees got sexy" (140FN).

In another text (a recorded interview), a family member commented that her wounded partner had an advantage over buddies who had been invisibly injured. She told me that he had been the sole survivor of an IED explosion, and that although his legs had been "shattered" he was not an amputee. She also said he has PTSD and TBI, and that because he could walk, and work, and had been re-deployed, others had assumed he was grappling with illness rather than

[168] I attended the event and did not take notes adequate for quotation, so I listened to it later and transcribed some panelists' remarks. The event was public, the website is public, and the podcast is available publicly at: http://nmvaa.org/nmi/media/category.php?cat=healthcare

[169] She also said that some celebrity visitors to WRAMC consistently spent time with SMs who were ill.

combat wounds. In this section the respondent talks to me about how knowledge of his physical injuries helped her partner get the attention and advancement he was seeking: An officer recognized him, was familiar with his medical history, and started advocating for him. In addition to the markings I have described in Chapter Three, here I have underlined words that point to the consequences I have asked about:

Example 4.4

070*v3* Family Member, 290 words out of 8692 in the transcription

0001 Well yeah yeah just really **intense process**↑ just a **very intense** process↓ *hh*
0002 uh and so then for him to **deploy**↑ and um again like you know be him
0003 being massively **massively** affected at his job both in terms of training
0004 younger me- younger or lower ranking members of the service *hh* or um
0006 you know just in giving him you know him getting acts of heroism and
0007 valor↑ whatever↓ um - for **him to deploy** again↑ and then come back to
0008 another MED boarding↑ was ultra discouraging↓ but at this point um
0009 at some uh at some time **a captain** like he had worked with before uh
0010 **recognized him**↑ and started really advocating for him↑**really strongly** *hh*
0011 um again by accessing his medical history↑ and you know that his
0012 injuries↓ like I think part of it is that like the **thing that keeps tripping**
0013 **people up** isn't his TBI↑ ►it's **mostly** that his legs were um were
0014 shattered↓

0015 Um yeah↑ and I think if it was **just the TBI**↓ I think that people would be
0016 less sort of enthusiastic about helping him↓ but because um or if it was **just**
0017 **the** TBI↑ or **just the** PTSD↓ *hh* um but because it's like a … like a **legit** …
0018 like **physical injury**↑ that you know he's like he's **you can look** at his leg↑
0019 and see scars or medical history or MED boards or X-rays as opposed to
0020 something like PT- PTSD↓ or you know more about therapy you know or
0021 TBI↓ where ►people don't really understand it↓ *hh* um I think that that has
0022 been a really big↑ help *hh*

This respondent was firm that once someone with authority remembered her partner's physical damage (0009), and by implication may also have tacitly recognized his "successful" recovery, the officer wielded some power that moved the SM towards rewards he had been unable to access before because he did not "look" damaged; rather, others assumed his damage was *in*visible (0016-0018), incomprehensible (0020), and therefore not as worthy (0011, 0012,

0016, 0017). The genre is an interview, and the generic features are those of "reportage."[170] The style is aligned with the rehabilitation/MTF order of discourse and the institutional/military order of discourse. The author's discourse represents her and (by proxy) her partner as members who negotiate their way through a familiar system and who seek and display manifestations of their membership (in another section of our interview, which I noted in Chapter Three, the respondent discusses merchandise, stuff, and T-shirts that celebrate Wounded Warriors). Her position is central to the MTF order of discourse.

I also asked respondents to tell me about how the link between *dis*ability and deservedness is sustained. All of them gave me examples of the link being expressed by means of words, exchanges of objects, ceremonies, acquisition of gear, and visibility. For example, when I asked 100 to describe how particular kinds of "ill" patients were recognized, compared to patients at the MATC–the "amputee" clinic–she said (missing lines numbers indicate spaces for questioner's comments which I do not include in this excerpt):

> Example 4.5
>
> 00*v3* Care Provider, 339 out of 8644 words
>
> 0001 *Hh* um … *hh* … … … … maybe on a a much smaller … **level**↑ … um …
>
> 0002 you know↓ ... um you would ►see maybe **an amputee**↑ the- they're a lot
> 0003 ►more **visible** um sorta draws more of **the heartstrings** when you see a uh
> 0004 young person without a limb↓ or several limbs↓ *hhh hhh* um f- for the
> 0005 program **I work in**↑ they just get discharged↓ and sent home↓
>
> 0006 now there's **another** program↑ where they **actually have**↑ a graduation …
> 0007 and they **have** a graduation um actually in **my** clinic
>
> 0008 And they **invite people** to come to the graduation↑ so they go through this
> 0009 whole program so they► there is recognition *hh* um we **don't do that**↓
> 0010 because I think everybody leaves might not leave at the **same time**↓ um ssso
> 0011► it's a different **type** of program↓ it would be nice if everybody came↓ …
> 0012 **you know** people who came at point **A**↑ will all leave at point **B**↑ but that's

[170] By which I mean a recounting, or report.

0013 **not always the case**↓ and *hh* um it's a usually a **smaller group** um a
0014 smaller group of people↑ so I think to do **you know** a little graduation or
0015 ceremony↓ is not um↓ the the clinicians are **all overworked**↑ and to throw
0016 in a you know a **juice and cake**↑ **party** a couple of times a week is just just
0017 **not** that they would **not** that anybody would↓ … **not** like it↓ ►I just **don't**
0018 think there's *hh* there's time↓

0019 So I I I do y- wanna y- e- was **your question** I'm thinking **you know** if let's
0020 say ►an amputee↑ **you know** they take you know they get fitted for their
0021 **prosthetic**↑ they um **calluses build up**↑ everything's **ready**↑ and they take

0022 their first couple of st- I mean I mean↑►you know there's **people**
0023 **cheering**↑ *hh* um **I don't think** they do that with↓ … (*kind of illness*) **you**
0024 **know**↓ so it it's just I went out in the community and I didn' punch
0025 somebody at Walmart↑ **you know YAY**↑ let's get some cake↑ [R]

To easily locate the words and phrases 100 used to directly answer my question, I underlined them in this excerpt. The respondent identifies a way in which recognition is different depending on the kind of *dis*ability and the mode of rehabilitation: a graduation event (0011). Before doing that though she emphasizes that, "you know ... um you would see maybe an amputee the- they're a lot more visible um sorta draws more of the heartstrings when you see a uh young person without a limb or several limbs" (0002, 0003)–directly, emotionally, intimately seeking accord (from the questioner), and offering to share an assumption regarding how amputees are viewed. Ironically, she makes this plea within a discussion of uneven outcomes and consequences for variously harmed and rehabilitated SMs.

The respondent then explains the ways in which it would be difficult to have a graduation event for *her* patients: everybody may not leave at the same time (0010); it's a smaller group (0013); the clinicians are all overworked (0015); and there's not enough time (0017). In her next move however, she ponders my question and shifts her commentary towards a more thoughtful observation, saying "I'm thinking" (0019), and then describes what happens when amputees improve, and how their advances in recovery are celebrated. At first her tone is upbeat: "you

know if let's say an amputee you know they take you know they get fitted for their prosthetic they um calluses build up everything's ready and they take their first couple of st- I mean I mean you know there's people cheering" (0019-0022). By comparison, she gives a downbeat example of what the corresponding advance in recovery would mean for *her* patients: "*hh* um I don't think they do that with … (*kind of illness*);" punctuated by ironic, even sarcastic, imaginary responses: "you know so it it's just I went out in the community and I didn' punch somebody at Walmart you know YAY let's get some cake" (05023-0025).

When we spoke I sensed wistfulness in her voice (not easily transcribed); and when I re-read her transcription or re-listen to her interview, I am struck each time by the *sound* of her disappointment (for herself? Or her patients?)

The text's *genre* is narrative; the author is telling me a story and using real and imagined scenarios to illustrate her points. The *style* is slightly off-alignment with the MTF order of discourse; her identification wobbles as she recounts her perceptions (this excerpt is from the transcription I refer to in Chapter Three in which the respondent whispered when she was uncomfortable). For example in line 0017 she says "I just don't think;" in line 0019 she says "I'm thinking;" and then towards the end of this section in line 0023 says "I don't think" again. In the same phrase she distances herself (although she *is* one of the clinicians among the group she is discussing) by saying "*hh* um I don't think they do that with … (*kind of illness*) you know" (0023).

The discourse in this excerpt represents and reproduces real contradictions in the MTF order of discourse. I find 100's discourse *weakly resistant* in a way that reminds me of Scott's "weapons of the weak," such as gossip, and false deference (Scott 1985). While 100 is not being "false," her switches in tone, from reporting with some conviction (0006,0007), to being wistful

(0011-0018), to joking (0025) for example; her interweaving of real and imagined scenarios–in fewer than 350 words–and her irrepressible appeal to the listener (she says "you know" 9 times) –thread her narrative with uncertainty.

This excerpt is replete with modalizations. The author hedges, suggests, proffers and withdraws opinions, and frequently attempts to pull in, persuade, amuse, reach agreement with, or surprise the questioner. In Table 4.3 I list examples of words and phrases that denote modalization(s); for example the speaker often attempt , or offers, or seeks to include the interviewer by saying "you know:"

TABLE 4.3: Modalization in 100 excerpt

Modalization: Seeking accord, drawing on heartstrings, and irony; hedging.	You know	0002, 0012, 0014, 0016, 0019, 0020, 0022, 0023
	You would see maybe	0002
	When you see	0003
	It would be nice if	0011
	I just don't think	0017, 0018
	I'm thinking	0019
	There's people cheering	0022
	I don't think	0023
	You know YAY	0025

This highly modalized commentary contributes to my sense that the *discourse* wobbles towards and away from, or perhaps spins unevenly within, the MTF order of discourse. The respondent works at the "heart" of the enterprise, as a clinician caring for and rehabilitating injured and ill SMs (who are invisibly harmed), and helping to manage their interactions with family members and NMAs (and other care providers for that matter). At the same time her attention appears to be focused on what might be for her patients compared to what appears to be for visibly wounded SMs; and on what the questioner already "knows."

In contrast to 040 in example 4.1, in this example, 100 focuses on SMs other than the ones she cares for; and from a highly personalized point of view appeals repeatedly to the questioner to agree with her as she struggles to maintain her position at the center of the MTF order of discourse. In Table 4.4 I isolate and count this respondent's use of pronouns and correlates of pronouns; i.e., words that stand in for nouns and names. Her tentativeness shows up readily in her 59 such uses, and the weight she places on "you know" (9), "I," (13) and "they" (13). Her mingling of "I" references includes a performance of "I" as an ill patient (0024), further complicating and obscuring who is speaking for whom and about what.

TABLE 4.4: Example of 100's pronoun usage	
Pronoun or Correlate	# Times Said
My, us ('s), person, we, everybody, anybody, everything	1
People	2
You, your	3
It, it's	4
You know	9
They, their, I	13

I also point to **emphases** in this excerpt because they offer a précis of 100's story: she emphasizes these words (in sequence): **level, an amputee, visible, the heartstrings, I work in, another, actually have, have, my, invite people, don't do that, same time, type, you know, A, B, not always the case, smaller group, you know, all overworked, juice and cake party, not, not, not, don't, your question, you know, you know, prosthetic, calluses build up, ready, people cheering, I don't think, you know, you know, YAY.** These words are important to the author: They have been emphasized. Emphases' import to the CD analyst in this and all other accounts is that these are the critical feelings, concepts, impressions, or events the author is

expressing. When I "read" these emphasized words as a sentence, I hear 100's comments condensed, as follows: "Level an amputee visible the heartstrings I work in another actually have have my invite people don't do that same time type you know A B not always the case smaller group you know all overworked juice and cake party not not not don't your question you know you know prosthetic calluses build up ready people cheering, I don't think you know you know YAY." This reading tells the story of a care giver struggling with inequity, yet not finding a stance or an opinion that would de-center or marginalize herself. Her answers to my questions form an unresolved ongoing conversation and fraught commentary. In this particular *respondence,* 100's emphasized words confirm that she is unsettled, unsure, and weakly resistant to the practices in which she is currently engaged. I find her at the *center* of the MTF order of discourse, drifting to the margin. She is a good subject who has doubts.

I flagged the following comments in this excerpt to isolate themes I will return to in my comprehensive analysis, and to indicate some sources of findings:

> ► see maybe an amputee
> ► they're a lot more visible
> ► there is recognition
> ► it's a different type of program
> ► I just don't
> ► an amputee you know they take you know they get fitted for their prosthetic they um calluses build up everything's ready and they take their first couple of st-
> ► you know there's people cheering

I interpreted these and other respondent remarks regarding how the link between *dis*ability and deservedness is sustained to mean that the link they perceived to exist–and described in some detail– is dynamically and semiotically sustained, within tournaments of value (Appadurai 1986:21).

My sense of "tournament" was informed by the performances of competition that respondences invoked; for example, "wounded warriors" themselves and others told me that they

were more prominent, more recognized, had more access, and were being reported on[171] more frequently and more broadly than ill or injured SMs. As respondent 090 said,

> Example 4.6
>
> 090*v3* Care Provider, 33 out of 1659 words in the transcription
>
> 0001 W- w- a couple of uh↓ it's pretty much a **common understanding**↑ … 'n'
> 0002 perception that↓ ► the **wounded warriors**↑ meaning the wounded in OIF↓
> 0003 are entitled to the **highest priority** of care [R]

My own participant observation supported respondents' examples of wounded SMs being valorized more than those who had been injured, and much more than those who were ill. Celebrities, politicians, journalists, entertainers, documentary film makers, and even illustrators (Kino 2012:1), never mind researchers, regularly visited the "Wounded Warrior" clinics, the "Wounded Warrior Café," the "Wounded Warrior" nursing unit, and the MATC at WRNMMC (and had done so before at WRAMC and NNMC). Two caregivers (140FN and 150FN) remarked that very few people visit or have their photographs taken with ill, or injured patients and caretakers; nor do very many visitors sign photos of themselves with ill or injured SMs. I knew that such photos are not framed and displayed in the dialysis units, for example, cancer wards, pulmonary clinics, or psychiatric wards. Dozens, perhaps hundreds, of framed pieces on walls at WRNMMC that do feature stories, testimonials, photos, and newspaper articles about patients who have been visibly injured and visibly repaired are displayed in areas that are devoted to "wounded" patients.

In addition, 2 of the respondents whose interviews I recorded (100, 200), noted that members of charitable organizations and other groups frequently descend on "amputees"[172] in

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[171] In a variety of print and online media.

[172] References to "amputees" always invite questions, stated or unstated, regarding the provenience of the wounds that led to subjects' limb loss. As my data showed, when people refer to an "amputee" at a MTF they are usually referring to an SM who

various spaces at WRNMMC, and had before at WRAMC and NNMC, to distribute gifts, handshakes, hugs when feasible, and salutary comments–usually, "Thank you for your service." My fieldwork confirmed that this particular expression of gratitude is often heard being made spontaneously, even self-consciously, in hallways, outdoor walk ways, cafés, and other common spaces within the sites; and is used almost exclusively to those who are *visibly* wounded and *visibly* being repaired (using prosthetics for example; or specialized bicycles; or Segueways®). By contrast, outside the site on the metro, buses, sidewalks, parades, ceremonies, grocery stores, and other shared spaces, this expression of gratitude is frequently made by "strangers" to *any* people in uniform. Based on my observations and what people related to me, my sense is that within the MTF's circumscribed spatio-temporality ("inside"), visibly wounded and self-identified "wounded warrior" SMs are "thanked" while those who are ill and injured are not; whereas "outside," in unbounded space-time, anyone in uniform is thanked. The semiotics of "the uniform" being worn, among those who are not in uniform (in the public sphere), seem to invoke a mixture of guilt and gratitude that some people are unable to suppress, and it erupts in an uninvited act of "noticing" and making obeisance.[173] Whereas, inside a MTF (which is both a military hospital and a military base), the semiotics of "wearing" rehabilitative *tools and technologies* invoke a similar and more focused feeling among a more select group of "viewers" towards a more select group of "people being viewed."[174]

I learned that some SMs appreciate this kind of remark ("thank you for your service"), on- or offsite, while most do not because of the attention it draws to them individually, the

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was "wounded" rather than someone who lost a limb because of diabetes or a training accident. This further corroborates the value of examining the ways in which attention is skewed, and more importantly, how this process is naturalized.

[173] And from time to time, as I witnessed, making accusations or demanding explanations regarding DOD policy from people in uniform.

[174] The impetus to "view" and to "display" wounded SMs is a topic that deserves more research. Sontag discusses the effect on viewers of "war" (and pornographic) photography. For some viewers extreme damage fuels an incentive to end war; for others, to join the military; and for others the scenes become banal and unaffecting (Sontag 2006:17).

vagueness of the intent, and the murkiness of the response that is expected in return. Several respondents in all my categories noted that "thank you for your service" is an annoying and difficult comment to respond to (258FN, 253FN, 614FN). As one person said (based on my field notes I am reproducing her comments), "On whose behalf am I answering? My own? My units's? My (branch of) service? How I am I supposed to answer? It's embarrassing" (258FN).

Perceptions, Consequences, and Sustainment of Links between Disability and Deservedness

Throughout my ethnography, and in each of my research encounters, I worked at getting answers to my research questions, and for the most part I was successful. Respondents did identify a link between *dis*ability and deservedness; they did express and describe felt consequences; and they did note ways this link and these consequences are sustained–they gave me examples. Moreover, they *dis*avowed *dis*ability; and did so with much frequency and forbearance, via repeated corrections, refutations, and re-definitions of my usage of the word "*dis*ability," including by people whose role it is to make *dis*ability assessments, and by respondents who pushed back and self-identified as "not *dis*abled," yet repeatedly returned to the designation–with the inferred understanding that they were negotiating a *dis*ability *process* as compared to reimagining themselves as a *dis*abled person.

In one way or another, all of the data I gathered included linguistic or textual features that rebuffed, denied, or resisted *dis*ability as a self-description of wounded, ill, and/or injured SMs. This ironic realization made itself apparent to me after I constructed and presented *dis*ability to respondents, overlaid it onto material culture at the site, or used it to filter and sort early ideas about research findings.[175] Repeatedly I was misunderstood, or corrected. As a result, I decided

[175] Interestingly, when I presented papers about my research at the Society for Disabilities Studies (SDS) in 2012, and the Society for Applied Anthropology (SfAA) in 2010 and 2011, some audience members did not accept my construction of wounded, ill, and injured military Service members as *dis*abled either.

that Identification and Disavowal among wounded, ill and injured SMs and supportive others at a MTF is an important dialectical theme that supports a burgeoning discourse; and that *dis*avowal of *dis*ability is an important finding. I return to Shared Themes below, and to findings in Chapter Five.

I view this disavowal as a kind of ironic resistance: At the same time that respondents and material culture disavowed SMs' "*dis*ability" and "*dis*abilities," their texts also shored up links between *dis*ability and deservedness; and, I used the term because of incessant references to *dis*ability by people at my sites! People I interviewed disavowed their own or their charge's *dis*ability repeatedly and this surprised me because for three years, on a daily basis, people at my sites talked about *dis*ability–endlessly. What I learned from my respondents and material culture at the sites is that within or as a constitutive principle of MTF's system of meaning (its order of discourse), *dis*ability is "read" through semiotics that have specific meaning "here," or "inside," and not "there," or "outside." At a MTF, *dis*ability is a process, not a condition or identity.

My range of textual data containing linguistic features disavowing *dis*ability includes transcribed verbatim interview contents, field noted conversations, and participant observations, For example, a young woman pushed an SM who is a double amputee in a wheelchair away from a meeting in the gym. The monthly meeting they were leaving was billed variously over time as a "Town Hall for Wounded Warriors;" a "Town Hall for Wounded Warriors, Wounded, Ill and Injured Service Members, Families and Non-Medical Attendants;" and most recently (August 2012) as a "Town Hall for Wounded, Ill and Injured, Families and NMAs."[176] The amputee, his female companion, a research colleague, and I spoke for a few minutes about the Town Hall meeting and the topics that had been raised, which were mostly issues about parking,

[176] See my "map" of this sign and its changes in content in Chapter 3, page 132.

accessibility, and very young children's needs.[177] When I asked them if they experience a link between this SM's *dis*ability and the deservedness he garners, they glanced at each other, laughed, and responded, switching my use of *dis*ability to the word they preferred. "I don't think of myself as handicapped," said the SM. "We call him handi-capable!" exclaimed the woman (640FN).

I relate this episode to illustrate two things: one, to show one of the ways that my assumption was rebuffed; and two, to indicate the rapidity with which some people switched my word (*dis*ability/*dis*abled) to another word or expression (handicapped). In her recorded interview (see excerpt below in Example 4.7), 070 discussed in some detail how SMs and those that support them use terms that refer to body parts and medical diagnoses rather than using the encompassing (and for them inappropriate, even meaningless) designation "*dis*abled." In a part of our conversation 070 talked specifically about how SMs refer to themselves and others, not as *dis*abled persons, but as SMs who have things: a "bad knee" in this example (4.7, line 0005); or PTSD, TBI, or hearing loss (in lines 0024, 0025 in example 4.8 below):

Example 4.7

070*v3* Family Member, 86 out of 8696 words

0001 Um … like I don't think he would↓ … I don't think he's **ever said** anything
0002 like **disabled** um↓ or anything like that↑ *hh* and even when … he's **talked**
0003 about other soldiers who are you know↓ in … er … who are going to be
0004 MED boarded out↑ or who are **wounded**↑ I think he'll say like their specific
0005 injury↑ or he'll be like↓ oh I have a bad **knee** or whatever↓ like I don't think
0006 he would he would say that somebody is **disabled**↑

In the encounter outside the Town Hall meeting (640FN), the family member (or NMA) and the SM switched my word "*dis*abled" first to their "reading;" i.e., "handicapped;" and then to their expression "handi-capable." On the surface this seems to be a pro-active, cheery, high-

[177] When family members come to a MTF and stay there in support of their wounded, ill or injured SM, some of them are very young children, even babies.

functioning kind of management of serious adventitious damage. Yet the couple's use of the word "handi" in their linguistic construction not only immediately re-directs the listener to a part of the body the SM can still use (a part that is "capable," his hand), it also acts synechdochally to represent the person's power and potential via "the hand." This re-appropriation (by the respondents) also speaks to the interest and intent in the MTF's order of discourse to assign problems to parts (even brains) rather than to whole persons. Messinger writes about the issues this elision presents for "successful" recovery: For some people in rehabilitation it means their recovery can never be successful because the person has not been rehabilitated (perhaps not even "recognized"); rather, the symptom has (Messinger 2009a:16-18,b:1-5;2010a:281-303).

Another ethnographic observation tangentially gets at the same kind of phenomenological disavowal. An SM who was facially disfigured and using two prosthetic limbs held a door open for me one day when I was exiting the "Wounded Warrior Café" in Building 62. "Go ahead ma'am," he said impatiently as I hesitated to push through, struggling with a pile of take-out containers and feeling self-conscious about his complex *dis*ablement and what I perceived to be my contrasting able-bodiedness. Then I noticed his T-shirt; it said, "I had a blast." The meaning of this encounter rests not only on the mordant humor of the T-shirt's phrase,[178] but more importantly on another kind of re-direct that occurs among people and as an example of a constitutive mechanism of the MTF order of discourse: The observer is re-directed to an event (or ceremony, or exercise, or use of tools and technology) rather than being able to linger in discomfort, concern, or even horror. This effect "ably" serves to enable people to manage their inter-dependence at a complex site in which mortality has primacy in every aspect of co-conduct.

[178] The use of humor in medical technē is beyond the scope of this document; nonetheless it appears, and re-appears, and re-appears again in many discourses at a MTF, and is a constituent "part" of the order of discourse itself–not necessarily in the "governing" institutional/military order of discourse but certainly in the "managing" MTF order of discourse, and in the many suborders of discourse that are always-in-formation at such a site and among its population of patients, families, and care-givers.

More importantly, the effect of a T-shirt like this is to naturalize corporeal, and sometimes cognitive, damage; and to build a kind of "brand of brothers."[179]

I field-noted another example of discursive re-directing, in material culture: In a hallway of the "Wounded Warrior Unit" on the 4th floor of WRNMMC hospital there is a very elaborate large framed piece which displays a handwritten testimonial from a former patient, surrounded by photos of a U.S. president shaking his hand, military medals, engraved commendations, commemorative coins, badges, and pins. The testimonial reads in part, "All ye who enter here, understand. This is a place of joy and of laughter. If you are looking for people who are in bad shape, or sad, or hopeless, go somewhere else." Among other messages of disavowal, this one disavows *dis*abling authorization and subjection; yet it emanates from the hospital unit in which the most seriously harmed patients are being cared for. My sense is that this complicated semiotic emblem does many kinds of work, at varying levels: On its "surface" it displays recognition and access to resources of the highest "order"–from the U.S. President and various high-ranking military service members; and disavows *dis*ability. At the same time it signals that this level of deservedness is relatively exclusive; and comes at great cost.

Returning to direct examples of disavowal of *dis*ability, I recount this episode: When I defended my research proposal to a regulatory Board at WRNMMC, a Board member asked me to explain my terminology. "Disabled? Disabled? What do you mean disabled?" she asked, then declared, "I don't hear that word used here" (420FN). This was remarkable to me because much of the conversation among SMs (so-called "able," and so-called "*dis*abled") at a military facility concerns *dis*ability assessments, benefits, measurements, and processes. For example people who retire are "out-processed." During that period (which may take weeks, even months) their *dis*abilities are assessed so that their retirement payments can be adjusted "fairly." So-called

[179] See family member 070's comments in Chapter 3, Example 3.6 regarding merchandise, stuff, things and T-shirts.

"able," and so-called "*dis*abled" SMs have the opportunity to contest their "*dis*ability assessments."*Dis*abilities range from eczema, to broken vertebrae, to loss of limbs, or brain damage. So the topic is endlessly present, while the "identification" as a *dis*abled person is not. In the case I note here (420FN), the person speaking was a clinician who self-identified as having worked at WRAMC and WRNMMC for many years. It seems unlikely that she had not heard the word "*dis*ability" used at these sites. Yet within the MTF order of discourse, this is not a permissible or intelligible identity; and so, for some constituents, is neither acknowledge-able, nor comprehensible. In this exchange my use was contested as provocative.

I explored the *dis*avowal I encountered, asking many people to talk to me about it. In a telephone interview, a self-identified family member of a "wounded" SM responded to my comment that many people I had spoken to rebuked my characterization of them (or someone they were supporting) as "*dis*abled." Her answer was interesting to me because she spent most of her words talking about another family member,[180] her dad. In fact it was not clear to me in many instances whether she was talking to or about her dad, or her partner. She had met her partner in the amputee clinic at WRAMC (they later married). Because she was voluble and enthusiastic it was not easy for me to stop her and ask for clarifications, nor at the time did I want to stop her very detailed and impassioned responses. And, since we were on the phone it was more difficult to signal "slow down." In any case, she said,

> Example 4.8
>
> 070*v2* Family Member, 364 words out of 8696
>
> 0001 Yeah in the military that's true like it's not a it's not a word that I think of
> 0002 and it's interesting for me because um because my dad is disabled um so
> 0003 like that whole sort of like so to me then I'm like OK I'm like keep your

[180] To help me understand how family members manage adventitious disability, I also interviewed civilian respondents who had no connection with the military and were themselves differently abled, or had a *dis*abled family member; or as in the case of respondent 050, 2 adventitiously *dis*abled relatives (Appendix A).

0004 ratings and that's not bad or anything you know like that just means that
0005 …you know like there's particular services and particular like not
0006 entitlements but particular ... things that he has access to and he has
0007 access to and he needs to have access to and advocates for so with my dad
0008 for example one way like one way like when we um flew to Europe a
0009 couple of years ago after I graduated from (*graduate program*) and he I
0010 had never mentioned to the travel agent that he was disabled and um when
0011 we got onto the to the plane there was this whole scramble because he is
0012 visibly disabled um … and I mean he's not in a … … wheelchair but like if
0013 you looked at him[181] you'd be oh like it's basically when he was like in a
0014 plane accident a couple of years ago and one of his legs is now shorter than
0015 the other and he has to wear like sort of a brace an' it sorta looks like he has
0016 a club foot … but if you look at him you can see like see like that that older
0017 gentleman right there is disabled um so was a scramble to like figure out
0018 seating and this that and the other thing and um you know so anyways when
0019 I hear that word disability or disabled I don't think … like I don't
0020 necessarily assume that it describes the body you know But it does … it is
0021 the kind of language you need to use to get access to different kinds of civil
0022 services whereas in the military I know like I never heard I never seen
0023 anyone said like persons who were specifically disabled but they will
0024 say like they have a specific thing like they have a TBI or they have a a
0025 PTSD or they have they're hard of hearing [R]

There is a trove of data in this text that I analyzed in the way I discussed in Chapter Three, using CDA to locate and identify "telling" linguistic features. For example, I identify the genre as an interview and its generic features as amounting to an exegesis; i.e., 070 explicated meeting and marrying a self-identified "wounded" SM; the style as aligned with both the dominant institutional/military order of discourse and with the MTF order of discourse; the discourse as presenting a relationship of courage within a field of harm, adaptation, and recovery; the modalization, as authoritative, making and sticking with claims; and the respondent's use of pronouns as indicative of her membership in a group. I view her position as central to the MTF order of discourse.

In the discussion here, I am focused on this respondent's treatment of "*dis*ability." With respect to embracing or disavowing the idea of being *dis*abled, this respondent did both. When

[181] See 070's use of "look at" here and in line 0016, and compare to her comment about "language" in 0021.

talking about herself and her wounded SM husband she disavowed his *dis*ability and that of his buddies, and couched her remarks about *dis*ability in the military in explanations of how she and he negotiate structures, processes, and systems. When she talked about her dad though she switched to a civilian discourse of *dis*ability in which adventitious *dis*ability, and age, are surprising and difficult to deal with by those who are not expecting them (including her dad? including herself?).

The words she does use when speaking of "not" being *dis*abled in the military were:

> 0001 Yeah in the military that's true like it's not a it's not a word that I think of
> 0002 services whereas in the military I know like I never heard I never seen
> 0003 anyone said like persons who were specifically disabled but they will
> 0004 say like they have a specific thing like they have a TBI or they have a a
> 0005 PTSD or they have they're hard of hearing

Whether she speaking of her partner or her dad (or both) is unclear as she continues to move back and forth throughout this interview excerpt, adeptly discussing civilian and military understandings of "*dis*ability" and characterizing them differently, especially emphasizing that in the civilian world she knows that *dis*ability "is the kind of <u>language</u> you need to use to get access to different kinds of civil services" (0021) "whereas in the military I know like I never heard I never seen anyone <u>said</u> like persons who were specifically disabled" (0023). She notes that in the civilian world (her dad's world),

> 0015 the other and he has to wear like sort of a brace an' it sorta looks like he has
> 0016 a club foot … but if you look at him you can see like see like that that older
> 0017 gentleman right there is disabled um so was a scramble to like figure out
> 0018 seating and this that and the other thing and um you know so anyways when
> 0019 I hear that word disability or disabled I don't think … like I don't
> 0020 necessarily assume that it describes the body you know But it does … it is
> 0021 the kind of language you need to use to get access to different kinds of civil
> 0022 services whereas in the military I know like I never heard I never seen
> 0023 anyone said like persons who were specifically disabled but they will
> 0024 say like they have a specific thing like they have a TBI or they have a a
> 0025 PTSD or they have they're hard of hearing [R]

yet continues by pointing out that in the military, by contrast, people refer to areas of the body that have been affected when referring to *dis*abled persons (0024, 0025). This leads me to consider the discursive disciplines she brings to living in both worlds: One (outside the MTF) in which *dis*ability does not describe the body you know; and the other (inside the MTF) in which descriptions of areas of the body you know are the *specific* means of eliding references to *dis*abled personhood. In the civilian world your *dis*abled body is not all of you. In the military world, the part of your body that is *dis*abled (or missing) is you–yet you are not *dis*abled, one of your body parts is. This insight readily aligns the author with the discourse of rehabilitation in the military in which advanced prosthetology, interventions, and therapies replace, or repair, or remodel body parts to make people whole.

In one of her last remarks 070 urged me to consider "infrastructural" aspects of designations of *dis*ability in the military. She said. "Actually one last thing *hh* um I think that when you're thinking about resources you go- you may wanna sort of add a note for yourself about whether or not they're infrastructural resources or like one time offs ..." The (infra) structural aspect was pointed out to me by a number of people. For example, I met with a physician and retired military SM after he was referred to me by an NCM who said we should meet to discuss my research. He pulled out a few printed flow charts, diagrams, and lists of acronyms to help me understand that "*dis*ability" is not applicable to wounded, ill and injured SMs' corporeality, cognition, or affectivity. Rather, he explained, "*dis*ability" is a process of claims, evaluations, adjudications, and appeals–all of which lead to decisions regarding separation benefits; and occasionally, to altered fitness reports that accompany return-to-duty orders and define where SMs can continue to serve.[182]

[182] I interviewed a lawyer in the VA claim appeals division and she echoed this viewpoint.

In another series of interviews, a self-identified "Injured" SM spoke with me at length about his experiences. Below I present short sections from his first and second interviews. The speaker's use of the word "barely" reminded me of another use of the word "bare;" i.e., Agamben 1998 in his discussion of the subject as a refugee, prisoner of war, or enslaved person in the State of Exception, stripped *bare*. The SM's usage of the same word ignited my interest in viewing a MTF as a dialectical state of exception in which subjects who *have been* stripped bare experience the re-placement of missing corporeal, cognitive, accoutremental and sartorial parts via re*habili*tation. In addition, this speaker's use of the word "well" is ironic and revelatory as he describes himself changing from a couch potato, to an active-duty soldier, to an injured SM, and then to a competitive athlete and candidate for return-to-duty.

In our interview, the speaker talked about "mom" staying with him as his NMA; about getting an apartment; about gaining self-respect, physical agility, motivation, and energy after his injury by means of his therapy. He says before he lost his leg he was a couch potato and now he's a competitive athlete; before he lost his leg he couldn't swim, now he swims every day. In this narrative the speaker describes himself as doing better now than he did before he lost his leg in a training accident, which was a truck "rollover." His remarks moved me along in my thinking about service, sacrifice, self-worth, and rehabilitation; as well as governance, or sovereignty. Who is in charge? By looking for expressions of agency I traced the ways my respondents were experiencing shifts in who was determining what. Respondent 080 provided much rich text in the two interviews I conducted with him (a,b). In analyzing the following sections, I am interested in locating features that describe his management of decisions:

Example 4.9

080a,*v3* Injured Service Member, 343 out of 9326 in transcriptions "a" and "b"

0001 Well barely me↓ **mine** was just rollover in and I got my foot crushed so there was no added
0002 no aadddded↓ … I mean I bumped my **shoulder** my left shoulder but besides that it did not
0003 it hasn't been wasn't much of a … like **some** of the guys↓ … uh … here they got a double
0004 amputation they got a triple amputation or got a a quad where they **got no hands**↑ and all
0005 that or they got shrapnel somehow↑ they're trying to repair **that** I dunno↓ somehow they're
0006 tryin to repair that you got uh … nerve damage they tryin to test repair that stuff … ah … I
0007 guess you
0008 could say uh ... I … one of the **less** injured I … um as far as healing↑ I'm already heal …

080b,*v3* Injured SM

0009 I don' do PT or uh er OT anymore[183]… but what I **do** see is the uh prosthetic- the
0010 prostheses personnel becaaause as I got recently picked up cycling again↑ and since I b'en
0011cycling I lost about twenty pounds an' uh my uh hh my residual limb *hh* shrunk a little bit
0012 so I hadda re-socket it 'n'
0013 then I had shrunk a little more so uh I might be ch-↓ I might be goin' to another socket 'n'
0014 tried a few legs see which is better↑ 'cause I gotta **diversity** of uh legs I got uh I got one for
0015 running one for swimmin' hh I got one that uses spec- one that uses specifically for …
0016 cycling I w's using another one but they di- like a participant in an event the uh Bataan
0017 Death March an' I used a leg trying to be trying to get back **as a matter of fact** I do more
0018 physical things now that (*sic*) I used to when **I- before** I got hurt … yeah because before I
0019 was work … might go to gym f'n hour on my own … but … I'm not pretty good at it↓ but I
0020 do it↑

The author self-identifies as "injured" when asked about the terms-of-art whose effects I am interested in understanding. He contrasts actions of "me," "mine," and "I" (0001) with things that "they" or "the guys" got (0003-0005). Although I asked him about himself, he foregrounds SMs and providers, and combines them into one "they" (0006). He self-identifies as "less injured," (0008) reiterating his relatively low degree of injury and comparing himself to others who have suffered more (even after I point out that he is missing most of one leg). In the entire version of the transcription, when asked if he considers himself "*dis*abled," 080 speaks at length about his renewal through rehabilitation, his increased level of activity using various prostheses, the new sports he has taken up including competitive cycling, the mischief he gets into because

[183] Physical Therapy (PT); Occupational Therapy (OT).

he is too active, and his excitement about his "RTD": he will Return to Duty as an active member of the Army, and will continue to serve.

In this excerpt, when referring to people more severely wounded than he, the speaker uses "some of the guys," and "they." His intention switches abruptly at "somehow," (0005) as he considers what is happening at and in the MTF. He ponders, saying "somehow" twice; his use of "they" and "that" indexes the rehabilitative complex and the MTF order of discourse: "they're tryin to repair that," "they're tryin to test repair that" (0004-0006). Whether he is referring to others or himself is muddled, seemingly clear at 0001, 0002, then unclear again after "I dunno" (0005). By line 0006 the speaker seems to have switched to musings about his own "stuff." This is followed by the modalization "I guess you could say" that draws in the listener for agreement (0006, 0007). The respondent introduces his own phase of "healing" (0008). Right after listing what he has *gained* (he "picks up cycling again" 0010), he makes a reference to *loss* (of weight, 0011) for which he claims some agency: "as I got recently picked up cycling again" (0010). It is followed though by a very brief shift in agency–he reports that his residual limb "shrunk a little bit"–he didn't do it, it happened (0011).

Respondent 080 refers to "legs" quite differently than the caregiver who said "they have new legs!" (020). Here the respondent is clear that his legs are objects, that he has many of them, that they are for different uses. He says he has a few legs; one for running, one for swimming, one specifically for cycling (0014-0016). *These* are tools for him and he uses *them*. He expresses his own agency again (0011,0012), claiming responsibility for rectifying, or at least dealing with, the con-sequences of his residual limb shrinking: "I hadda re-socket it," he says, and "I had shrunk."

In lines 0016, 0017 the speaker describes the reaction of a different "they" (not some of the more seriously wounded SMs). Here he tells the ironic tale of being admonished for participating in an arduous activity against the proscriptions of his care givers–*they* are the "they" here; i.e., care givers who objected ("di- like" I understood in the moment as "didn't like") to his participation in the Armed Forces Bataan Death March. Annually, the combined U.S. Armed Forces holds a "Bataan Death March" in which a limited number of qualifying "able-bodied" and "disabled" SMs are permitted to participate. According to the website www.bataanmarch.com " 'The Bataan Memorial Death March' is a challenging march through the high desert terrain of White Sands Missile Range, conducted in honor of the heroic service members who defended the Philippine Islands during World War II, sacrificing their freedom, health and, in many cases, their very lives."

The speaker explains in 0017-0019 why he went against *their* advice and participated in a grueling event under extreme conditions, using one of his "diversity of legs." This is an example he offers of the effort he continues to make "trying to be trying to get back" (0017). In this series of fragments the respondent is establishing to the listener that he is trying to get back to a stage or phase or condition that he never had before. He states as matter of fact (0017, 0018) that he is more active now than he was before he was injured. This type of assertion was puzzling to me until I re-considered it as a signal of reclamation and transformation that locates combined efforts to recover a state and memory of normalcy, able-bodiedness, and fitness. In this recovery effort the injured (or wounded, or ill) self (and inter-dependents) project forward a new, changed self (How I will manage? or, This is the way I will manage) and backward (How did I manage before?), based on the present (How am I managing now?). Moreover, assertions such as 080's that he is more active now than he was before he was injured, affirm the presence in the MTF

disorder of discourse of the multiple benefits of the (extreme) sports model of rehabilitation introduced in 2007 at WRAMC, whose mixed consequences Messinger examines (2009, 2010). This respondent is at the center of the MTF discourse; he is a good subject.

The differential degree of recognition and access to resources that I observed among those who elected or were selected to participate in a sports mode of rehabilitation ignited the research I am now reporting. Indeed, the respondent completes this section by admitting "I'm not pretty good at it but I do it" (0019-0020), in which "it" refers to the complex of individual and group identification, rehabilitation, technology, extreme exercise, derring (or daring) do, and recovery that this SM has so energetically described and is individually embodying; see the speaker's use of "on my own" (0019).

Another SM, who self-identified as "wounded," talked to me about *dis*ability:

Example 4.10

060b,*v3* Wounded Service Member, 564 words out of a total of 7905

0001 I don't I I I↓ … … um I dunno↓I don't really I don't consider myself disabled um↓ I
0002 consider myself … … … … … … ooo uuhh … like I I I I consider↓… … … … I I
0003 consider what I what I've experienced to be **traumatic stress** not↑ post↑ traumatic↑ stress↑
0004 most most things that are that are put together by kind of the civilian **rear echelon**
0005 administrative kind of stuff ↓I think has more to do with with them↑ than it does the people
0006 that are **actually going through it** and part of that is it's just gotta be such a **bitch** to deal↑
0007 with all this stuff↑ and the fact that **now** heh I think it was half er the number of people
0008 asking for disability's quadrupled I think disability I think has a lot to do with↓ … … …
0009 **see** disability in my mind is a lot like↑ um … tsk is a lot like your **travel voucher**↑ so when
0010 you go on active-duty as a reservist or when you do when you do any active-duty when you
0011 do anything **anything** y'know Un- Uncle Sam asks you to do you get to fill out a travel
0012 voucher which basically … um gives you an opportunity to recoup some of the **expense**
0013 that you paid to do Uncle Sam's bidding↑ so you get a certain **allotment**↑so uh you get like
0014 a certain amount of **money**↑ for your laundry you get a certain amount for ATM fees↑ you
0015 get a certain amount for gas and so uh↓ what you **do** is↑ you try to **optimize** the amount of
0016 money you get back so whether you did any of this stuff or not↑ you still try to get **as**
0017 **much as** you can↑ um because you don't wanna you don't want to **short-change** your
0018 opportunity so you're a- it's all about you wanna **optimize your opportunity**↑ so you
0019 wanna get get the best you can out of that situation

[break here to eliminate lengthy repetitive examples]

0020 so I think now from a what I've heard from people who've just got back from Afghanistan↑
0021 anybody who's been in any kind of **anybody** who's got a combat action badge↑ means that
0022 they've seen combat and **anybody** that's seen combat automatically is checked as PT as
0023 now as post traumatic stress↑ so anybody who has post traumatic stress now **automatically**
0024 tsk no er if you've been in if you have a Purple Heart↑ I think you're **automatically**
0025 checked as post traumatic stress↓ and then you're **automatically** eligible for disability↓ so
0026 what you do is you wanna **optimize** that payment disability↑ disability's not a I think I'm
0027 disabled↓ it's disability is how much I can get

[break here to eliminate lengthy repetitive examples]

0028 so how much disability are you getting disability in that context has **nothing** to do with
0029 physical injury↑ it's not
0030 how much I↑ think **I'm** disabled it's how much I can get **you**↑ to think I'm disabled↓ so I
0031 can get **as much money as I can** that's what disability means↓ but I think there are a lotta
0032 people that don't that **don't give shit** an' an' wanna get their disa- disability↓ even though
0033 they may not intrinsically **think** they're disabled they wanna get disability because they
0034 feel like they're owed it↓ or they deserve it↓

For many co-participants (including myself) being interviewed is both easy and challenging. In this excerpt for example, the speaker had waxed confidently about many aspects of his lived experience as a recruit, an enlisted SM, a soldier in training and in combat who was subsequently wounded, decorated, and separated. The respondent had trouble though when I asked "Do you consider yourself *dis*abled?" First he found it hard to get his footing (0001). His fitful and very personalized effort was resolved temporarily when he found a perch but not before pausing to recount his ongoing *dis*tress (0003). Having established himself as stressed, 060 was able then to describe his view of where the idea of *dis*ability comes from (if not exactly calling out the MTF order of discourse, at least pointing to it: "rear echelon administrative kind of stuff" [0004,0005]) and why it is *con*founding (0004-0007). After using "I" fifteen times, and "myself" once, 060 switches the subjects (and objects) of his commentary to "things" (0004) and then to "stuff" (0005), and contrasts "them" (0005) with "the people that are actually going

through it" (0006)–where "it" apparently refers to an administrative process he will explain. This *set* creates a *topology* in which the form bends while the meaning–the content–remains intact.

In these excerpts, the respondent, who has self-identified in each of our many conversations as a "wounded" SM, talks at length, several times, about "others" who identify as *dis*abled although he does not. In his extended narrative he returns frequently to his main story about getting a Purple Heart; [184] for example in this excerpt:

Example 4.11

060a,*v3* Wounded Service Member, 131 words out of 7905

0001 my very↓ one of my **first thoughts** and after it was after everything got sorted y- like after
0002 we looked around in the truck↓ and we got pulled out of the kill zone↓ and all that kinda
0003 stuff after those things↓ I remember thinking uh … will this be enough to get me a **purple**
0004 **heart**↑ because I really wanted a **purple heart**↑ I wanted I wanted that purple heart↑
0005 because ► I wanted to be **recognized**↑ as someone who had been in **combat**↑ and I wanted
0006 to have a **medal**↑ which was clearly a **signifier** of that↓ and the purple hearts are very
0007 recognized↑ it's probably the third of the fi- top five medals receiving from war↓ and you
0008 really get you really get some uh some uh attention↓ so …

His comments are contradictory and productive as he struggles with his stated goal to have been wounded and get recognition, and his disdain for others who make similar if *un*equal claims. The speaker performs a dialectical lexical act, simultaneously protesting and affirming what he believes, thinks, contests, and avers about *dis*ability; throughout the interview (knowing what topic I am researching) he argues about what *dis*ability means. "Being" a self-identified "wounded" SM who is no longer in the military, and who disavows his own *dis*ability seems uncomfortable to him–in our long interview he hesitates repeatedly when answering my question "Do you consider yourself *dis*abled?" and resorts to a long complicated string of metaphors to explain how to think about *dis*ability in the military. This move serves to distance himself from

[184] Until recently, and for almost 200 years, the Purple Heart has been a medal and form of recognition that exclusively awards Army SMs who have been visibly wounded in combat. In 2011, after intense advocacy and lobbying from Wounded, Ill, and Injured SMs' family members among others, by act of Congress the Purple Heart is now also awarded to victims of PTSD and TBI sustained in or attributed to harm in combat.

*dis*ability and also to put *me* at a remove from him and his lived experience by posing metaphor after metaphor with which I cannot easily identify (starting at 0009). The speaker combines civilian and military terms and examples, and uses "you" almost exclusively for many minutes. I am unclear whether he means "me," the interviewer, or "you,"–the other, the institution, the order of discourse, the imagined audience; [185] or, simply, entities other than him.

The section is so lengthy that I have left out a great deal of commentary in which the SM makes identical rhetorical moves, stubbornly clinging to his use of "you" in a painstaking extended explanation of how to think about what *dis*ability means in the military. Ironically he captures exactly what I hear from many other sources–all of them very different from him in most ways (except for their shared experience with rehabilitation at a MTF): that I have been approaching my research using an idea of *dis*ability that does not "fit" with the idea of *dis*ability held by members of the military, their family members, care givers and NMAs. The way I am using the term does not belong, neither in the global institutional military order of discourse, nor in the local MTF order of discourse; nor, apparently, in the multiple discourses animated by people at the MTF. Because of this mis-fit, my usage is unintelligible, or at least unacceptable–in some cases, disturbing, even insulting (420FN).

When I realized and accepted that I was relying on an unacceptable construction[186] I changed how I asked my questions; from then on respondents were more comfortable and even more voluble talking about how they perceive themselves with respect to ideas about *dis*ability. In this interview, under some pressure from the respondent, I re-framed my question, turning our conversation from whether the respondent considers himself to be *dis*abled into a conversation

[185] He knows I am conducting research whose findings will be disseminated.

[186] Perhaps I was co-opted by demands regarding intelligibilitywithin the order of discourse. In any case, my original usage had erected a barrier, and I was willing to deconstruct it.

about how I hear the word "*dis*ability" all the time at the site and am interested in how respondents use and understand it. He seems more comfortable, and comes up with a trenchant observation in example 4.10:

0032 people that don't that **don't give shit** an' an' wanna get their disa- disability↓ even though
0033 they may not intrinsically **think** they're disabled they wanna get disability because they
0034 feel like they're owed it↓ or they deserve it↓

The speaker conducts mini evaluative speculations which help him *dis*tance himself from "the people that are actually going through it who go through these things," and from "them." He is establishing a firmer position in "the fact that now" (4.10 line 0007) that will help him and the listener to clearly differentiate him from others who claim to be or are assessed as *dis*abled. The speaker is positioning himself outside, as an oppositional, or bad subject, despite his awards, his pride, and the kindness he experienced when cared for after being wounded in combat. He is doing so by disparaging the claim that would recompense his sacrifice, as he explains.

In the passage, deixis switches abruptly a number of times as the speaker tries to sort out whether *dis*ability is a thought (something in *his* mind), or a thing: "*your* travel voucher" (0009). The respondent knows that I am a civilian, and this may explain why the modalization in his extended metaphor gets complicated (0009-0019). As this respondent struggles to continue to disclaim his own *dis*ability he must mobilize example after example that pertain to military experience because these examples are from his own lived experience, and are part of the MTF order of discourse that enables sense-making for its subjects (and not for the researcher). The examples he uses provide a rationale he may be striving to create in order to sort out his own relationship to *dis*ability while framing it so that a civilian may understand–a particular challenge when that civilian seems to have framed *dis*ability in a way that is unintelligible to an SM (or ex-SM). In any case, the linguistic features index a struggle. "(Y)our travel voucher" is *con*fusing–

whose voucher and whose travel? Travel where? There are repetitions of "when you do" (0009-0011) that confuse who is doing what, and to whom, and that synecdochically index bigger mis-apprehensions of *dis*ability (in military and civilian sectors).

The respondent's exposition makes sense within the institutional/military order of discourse; i.e., where actions in response to orders (Uncle Sam's bidding [0013]) are measured, ranked, vouchered, and compensated–or "allotted" (0013). The speaker is an "ex" Army member; this may help explain why he *also* uses wording from a neoliberal order of discourse in which the onus to thrive is on the individual. In an extended passage here (0008-0019) the respondent uses valorizing words that are monetary; i.e., "voucher," "recoup," "expense," "bidding," "allotment," "amount of money," "fees," and "short-change." Elsewhere in the interview this participant uses monetizing descriptives to "account" for his Purple Heart as a kind of "currency." These words work hard to account for *dis*ability as part of a barter system in which payments are made to offset expenses, and corresponds with the "administrative kind of stuff" (0005) that the speaker purports is conducted by the "civilian rear echelon" (0004) in an awkward pass-off of responsibility for "stress" from the military to the civilian sector.

He also says "optimize," "opportunity," "recoup," "you get," "you try," "you still try" forcing me to think about *con*fusion of governance, or sovereignty, that I now suspect underlies much of the dynamic tension at MTFs and which I propose as a factor of struggle in authorization and subjection. Notions and acceptances of who is responsible for which aspects of rehabilitation and recovery are always-already-in-conflict and are also *con*fusing.

Here lies a tricky move–using meaning-making from a military order of discourse to recast responsibility for the process of military *dis*ability as *up for barter* in a marketplace. This passage helped me *re*consider modes of *re*production–forces and relations–as well as co-

moditization. The repeated use of the word "optimize" and variants such as "you try to optimize," and "opportunity," even when he says "your opportunity," may denote dialectical struggle in the SM's ongoing attempt to come to terms with what he has lost (or expended) and what he has gained (or been allotted). These are payments; he is describing a rationale for being re-paid, even while disavowing his own *dis*ability and thence, his own means of being monetarily recompensed.

Within this exhaustive commentary regarding the process (and discourses) of *dis*ability and how they remain-in-formation, the narrator relates the notion that being *assessed* as *dis*abled can be actively *devaluing*. He includes news he has heard that "anybody" (he repeats this word 4 times [0021,0023,0024]) who has seen combat is now "automatically checked" as having PTSD, and so is "automatically eligible" for *dis*ability (he uses "automatically" 4 times too [0022-0025]). Understanding this calculus, he advises that unlike him, i.e., "me," "myself," or "I;" what "you" want to do is get as much as "you" can (0026, 0027). These uses demonstrate the vicissitudes of diexis; i.e., how some pronouns (you, I, it) can be deployed to confuse or mask or deny agency. In this passage, it is difficult to know to whom the speaker is referring.

Finally the respondent emphatically lays out his reification of *dis*ability in market terms: as a process of persuasion within a system of exchange; not a condition of corporeal, cognitive or adventitious alteration to fitness. He says "*dis*ability has nothing to do with physical injury" (0028, 0029). The narrator sets up the scenario in which "I" (the SM) can get "you" (the administrator) to think "I'm" *dis*abled; and by how much (0030, 0031). This *accords* with the descriptions I gathered from other military personnel, policy documents, and other respondents. Participant 060 finishes his exegesis of military *dis*ability by distinguishing between himself and a "lotta people" (0031, 0032): "They" who don't give a shit and do make these claims, unlike he,

who does not claim to be *dis*abled nor would make *dis*ability claims. What is significant in the respondent's final remark in this section is that he tentatively assigns deservedness to people who claim *dis*ability: *Dis*ability is both their claim and something "they" are *owed*, IF they choose to claim "it." He concludes by saying "Even though they may not intrinsically think they are *dis*abled they wanna get *dis*ability because they feel they're owed it or they deserve it" (0032-0034).

This section is significant because it reveals the confusion that is inherent in the institutional military order of discourse regarding who owes what to whom; while at the same time complicating SMs' *dis*avowal of *dis*ability. According to this respondent, it depends. The *dis*ability discourse is in flux: it is in-formation. His position is oppositional to the MTF order of discourse; he is a bad subject.

In the last example of data analysis I use a section from an interview that I referred to in Chapter 3[187] in my discussion of methodology and modalization. I re-consider it here because I want to point specifically to "data" and "analysis" regarding disavowal of *dis*ability; and to exemplify the value of re-reading and re-listening to texts in order to continue to find entry points for analysis. As Leap explains, textual details amplify voices, and their contexts "position those voices within systems of reference and meaning which are socially, not just personally, constructed" (2003:403-04). In this interview, I asked 020, "…in what ways do you think of the people that you work with as being disabled?" Her reply follows:

Example 4.12

020*v3* Care Provider, 266 words out of 5953 in transcription

0001So they're they're missing **one leg** um↓ so they have uh a physical **disability**↓ they're

[187] Transcription Excerpt 3.7, in Chapter 3, page 142.

0002 unable to um … well they uh ►they don't **have two** legs like **most** of us↑ *hh* do um so that
0003 makes them disabled↓ but **also** those who have uh [R]

0004 **traumatic brain injury**↓ also I think of course that's also a disability↓ [R]

Then I asked her, "Can you tell me some ways you think of the people you work with as capable?" She replied,
0006 Well I think ►**outside** of their physical disability↓ which pretty much it's it's no longer a
0007 physical disability↓ … because ►they **have** new **legs**↑
0008 I **really** I uh really um think ►they're capable of heh heh whatever it was that they were
0009 doing before
0010 Uh umm yeah↑ they're uh to me they ►they have **no** impairments ►apart from uh if they
0011 have traumatic brain injury of course↓ or ptsd↓ but in terms of other issues↑ uh I think they
0012 are ►**capable** still of performing those those functions↑ [R]
0013 Well uh I **think** ►they **share** my uh my my thinking in that ►b- beyond their physical
0014 impairment↓ which is uh
0015 No longer an impairment↑ [R]
0016 They are able to function … ►fully um apart from their their injury↓ [R]

When I asked "…can you think of any kinda kinds of recognition that your patients or the people that you work with might not be getting?" she said,

0017 *Hhhh* I *hh* I uh **honestly think** ►there's nothing lacking in that within that group↓ um they
0018 seem to be **happy**↑ so … I'm n- I'm don't think within this setting they're lacking for
0019 anything↑ [R]

The care giver respondent disavows "*dis*abled" as an accurate or useful description of wounded and injured SMs in her care. When I ask her about whether her patients are "wounded," "ill," or "injured," she remarks that they are all wounded because they all suffered harm in combat that resulted in amputations. She adds that a few might be injured. Although she notes that many of her patients have TBI or PTSD, or both, as a therapist in the MATC where amputees are rehabilitated, she does not describe herself as someone who "cares for" SMs who are "ill." Note that the speaker always uses "they" or them, not a name, nor a case description, nor any other personal designations or pronouns, or "labels"–only "they." This remove enables and enacts liminality and objectification: People in her care at a MTF are not individuals. I posit

that by this usage the narrator repositions her patients as bodies transitioning within a state of exception.

020's repetition of deictic "it's" (0006), [188] enables a linguistic huddle as she appears to wait for an internal "signal" for her next linguistic move: "Well I think outside of their physical disability which pretty much it's it's no longer a physical disability … because they have new legs" (0006,0007). This observation contra-dicts her opening one: Well they uh they don't have two legs like most of us *hh* do um so that makes them disabled" (0001,0002).

The narrator positions herself as distinguished from her patients, stating repeatedly "I" and "me" to refer to herself and her stance, as distinct from her patients'. By using *it's it's* in line 0006 the speaker *con*fuses "their (having a) physical disability" with their "no longer (having) a physical disability;" and pauses to reflect on her own *con*fusion. This example typifies repeated usages throughout my data in which the people about whom the speaker is commenting, including the speaker him or herself, the conditions, the time-space, and the observation are unclear, undifferentiated, and difficult to express; i.e., they are in-formation.

As I described in Chapter Three, this section is powerfully modalized; the speaker speaks FOR her patients, going so far as to make the remarkable suggestion that "they" share her "thinking" (0129) In this usage "thinking" acts as code for the MTF's order of discourse, which represents and reproduces the ideological stance; i.e., that because of rehabilitation and advanced prosthetology, "Wounded," and some "Injured," SMs can function fully–perhaps even more fully than prior to their disablement: They are re-fit.[189]

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[188] And extraordinarily insightful, if *un*intentional, "whatever it was" (0008).

[189] Note that in this discursive twist, the MTF order of discourse elides the "before" of its population of wounded, ill and injured patients; a before of fitness (Peterson 2012, personal communication).

The people the speaker is alluding to have complex *dis*abling corporeal, cognitive and even affective "harms," some of which she names; yet the speaker asserts that "they seem to be happy" (0010). "Their physical impairment" (0013, 0014) is followed by an immediate self-rebuff (0015,0016):

0013 Well uh I **think** ►they **share** my uh my my thinking in that ►b- beyond <u>their physical</u>
0014 <u>impairment↓ which is uh</u>
0015 <u>No longer an impairment↑</u>
0016 They are able to function … ►fully um apart from their their injury↓

This contra-diction establishes the speaker as a "good" subject, someone at the center of the MTF order of discourse; whose subjectivity corresponds with the dominant interpellating ideology; an ideology which positions rehabilitated SMs as fit–even super-fit–and whose interpellated subjects scramble[190] to re-attach parts that have been lost, detached, or blown a-part; and who collaborate to resume their ranks and roles as well as bodies, minds, emotions, and embodiments. The speaker says once they have been rehabilitated and re-fit, "there's nothing lacking in that within that group," (0017); and, "I don't think[191] within this setting they're lacking for anything" (0018). In turn, the qualification that "apart from their injury" there's "nothing lacking" serves as a recursive *re*iteration of the central argument disavowing *dis*ability. In 0017 the speaker finally uses a term other than "they," (she says, "that group") to identify the people in her care–summing up and summoning multiple criss-crossing themes; stumbling, and hesitating while struggling to maintain her argument, her stance, and her *dis*tance. While she may be keeping her distance from her patients, she is positioned centrally in the MTF order of discourse. She is a good subject.

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[190] See the use of "scramble" above in 070's comments about her *dis*abled father getting onto a plane and surprising the attendants in Example 4.8, lines 0011, 0017, Chapter 4, pages 185,186.

[191] While the analytical exercise is beyond the scope of this document, it is always attractive to problematize what people mean when they start the expression of an opinion with "I don't think."

This respondent also uses "outside," (0006) "apart from," (0010, 0016) "beyond," (0013) and "within," (0013, 0018). I noticed these words in many of my data, and believe they are metonyms for the circumscription of the rehabilitative time-space in which this respondent works (the MTF), beyond which ("outside," "out there") is the rest of the world; and for most, the rest of the subjects' lives.

Discourses-in-Formation

Irrepressible Shared Themes: Disavowal of Disability

I discovered shared themes in respondences; words used over and over again in diverse texts; words such as those I note above: "outside," "apart from," "beyond," and "within," for example. Tracing linguistic features of the texts I had collected led me to this discovery. Below I identify themes that cohered in my data when I analyzed these irrepressible features, and locate some of their sources. I posit (or "position") the shared themes I detected as dialectical, and have entitled them as binaries, even though I understand that human experience and perceptions exist in constellations of (mental and physical) existence, not along lines or across spectra.

Subjects at my site provided complex responses to the many questions I asked them, and I observed complicated events, ceremonies, and activities. Throughout my field work I received mixed messages about "being" *dis*abled, as I have discussed above. This was the most dominant shared theme that I detected, no doubt because asking people if they considered themselves, were considered by others, or considered others in their care as "*dis*abled" was central to my research and was the topic we engaged. In discussions that ensued, as I have shown above, respondents disavowed *dis*ability while at the same time identifying with making claims for *dis*ability (070, 080). Even the respondent who talked early in his second interview about potentially being regarded as a "fuckin' cripple" (080b, Table 3.3, Chapter Three, p. 19) because of his loss of a

leg and use of various prosthetic legs ended up talking about being an extreme athlete; about participating in competitive cycling; about no longer being a couch potato; about marching in the Bataan Death March (example 4.9, lines 0016, 0017). At the same time, respondents described being a member, being in a military family, having a role, re-attaching themselves to a role, and rank, and responsibilities. I bundled evidence of these shared textual elements theme into the binary theme of Disavowal/Identification.

Inside/Outside

I was also struck many times by the frequency with which respondents used words referring to inside and outside–or these words themselves. I noted above in Example 4.12 that 020 used these words in her interview: "outside," "apart from," "beyond," and "within." [192] She also said,

> Example 4.13
>
> 020*v2* Care Provider, 41 words out of 5445 in transcription
>
> 0001 They pretty much have to adapt to the outside
> 0002 Not to how it is here where the inside pretty much adapted
> 0003 to them so uh I think it's … more accommodating in here
> 0004 whereas outside it's it is what it is

I began to listen for similar uses, and found them, abundantly. This discovery prompted me to think about such repeated uses and to sort them into a shared theme: via recurring textual constructions of an "in here" (within and among people in the discursive rehabilitative complex) and an "out there" (a place, time, and condition beyond the circumference of the MTF), respondents clearly generated a discourse about Inside/Outside. Inter-dependents experience and reported a palpable sense of their space-time "in here," "inside," or "here" as a place that is for

[192] Her use of "apart from" kindled my interest in associating other words with what actually transpires at a MTF; for example, "apart" invoked "a part," and body "parts."

better or for worse familiar and comforting, if not comfortable. They compared it to an unbounded space "out there," or "outside" that is, for better or for worse, unfamiliar, uncomfortable, and discomfiting. For example, when he talked about his evacuation to a hospital 060 said:

Example 4.14

060b,*v2* Wounded Service Member, 102 words out of 7906 in transcription

0001 It was kinda this super kind super gentle super supportive … and it
0002 was just a … it turned into t' being a pr- a pretty kinda almost like
0003 a special experience because it was uh it was a place that only that
0004 only the injured get to see and um … inside that place was just was
0005 just it was just a really **kind** en- that's w's just the place where you
0006 just waited aaaan' um you just waited and um … … it was in the
0007 Green Zone and um … an' I was in the back bunk back here
(*showing a photograph*)

Loss/Recovery

Encouraged by finding repeated uses of words that referred to inside and outside, I looked for other such intertexts. In the data I found that authors repeatedly used words and other semioses to indicate losses and recoveries, things lost and missing; kindnesses and healing found; acquisition and loss of gear, conditions, uniforms, prognoses, prosthetics, and gifts; as well as losing and regaining status, rank, and originating ideals. For example, when 060 talked about being blown up by an IED and then flown by helicopter to the nearest Forward Operating Base (FOB) he stressed the kindness and attention "he got:"

Example 4.15

060b,*v2* Wounded Service Member,102 words out of 7609 in transcription

0001 so then we get back to the base we get back to the base just the
0002 amount of attention and the amount of attention and kindness I got …
0003 the guys on the helicopter were all so awesome just so kind and and
0004 so helpful and everything and it was so it was so strange because in
0005 the military there's nothing the military's not a place for kindness and a

0006 place for compassion it's a place for suck it up get it done move on but the
0007 IEDs were messing people up so bad that the the type of support was just
0008 unbelievable

Others talked about gaining things and losing things; for example 080 said,

Example 4.16

080b, *v2* Injured Service Member, 97 words out of 9326 in transcription

0001 Hyuh no I mean I have *hh* like I said many privileges that I got wid it but …
0002 … *hh* … uuhhh … if there was a way for me to get my leg back … … I
0003 would definitely give it all up … the only thing I would not wanna lose is
0004 what I learned with this experience … … I would be glad to get my leg back
0005 but I don't ever wanna lose the uh you know what I learned from it … …
0006 yeah it *hh*

Some care providers talked about loss and recovery, losing and finding. Others referred to permanent losses. For example, someone who cared for "ill" SMs said:

Example 4.17

100*v2* Care Provider, 173 words out of 8677 in transcription

0001 No I just … no I think just the same that disability it just goes back
0002 they'll give somebody a crutch to fall back on and not work mentally
0003and um I I really um am very passionate about (*kind of illness*) because
0004 *hh* it *tsk* … you really don't have much I mean you can not to at all
0005 minimize this but you can lose a leg and still have your faculties and
0006 after all the rehab you know have a job
0007 You know ok life but the fact is *hh* you know you can talk on the phone
0008 you can interact with people you can go to parties visit with family um
0009 somebody who has (*kind of illness*) sometimes a bunch of times people
0010 are scared of them um they don't know how to interact with other people
0011 and therefore they can't get things done I mean you lose so much more you
0012 lose a lot more you lose y'know support work companionship 'cause people
0013 don't understand and then it spirals

030 sent me an e mail after our interview in which he said,

Example 4.18

030*v1* Care Provider, 182 words of out 386 in e mail

R: In terms of your study, I imagine it's harder for someone like (*name of SM*)

who was injured in training than someone with a visible combat injury like a missing limb. No one would accuse the amputee of "...trying to get out of stuff." What I find striking is the intense loyalty and love these brothers and sisters in arms have for one another. It's so powerful and I can only imagine how sad they become when they are forced by injuries to leave their pals. Several years ago I met a guy who had both legs blown off. His unit was still out and I saw him in his wheelchair every day. He was struggling very hard to get enough command over his prosthetic legs to be able to stand when the guys returned from the battle zone. He succeeded; they swarmed around him when they got off the buses. As the days went by when I saw him he was back in the wheelchair, but he was so proud of himself for standing and saluting the others when they returned.

Another care provider talked about lack of knowledge among civilians regarding wounded, ill, and injured SMs:

Example 4.19

010*v1* Care Provider, 65 words out of 5445 in transcription

R: these preconceived notions of um these men and women that have you know lost their limbs 'n been injured maybe disfigured and things that that people aren't going to be as accepting of them or um that maybe that they themselves the injured think that you know maybe they're aren't good enough er that they're not going to be treated the same as everyone else

010 also spoke about SMs *leave* to *find* a job:

Example 4.20

010*v1* Care Provider, 104 words out of 5445 in transcription

R: You know how um they're getting out of the military they wanna go on an' either go back to school or find a job um some of 'em'll stay in the military but I think the majority say they're starting their med boards they wanna get out they think this is a sign er you know or they've kind of done their duty you know heh
Yeah it is yeeeaaaah you know I just try to be supportive you know because I can't say I blame them I mean they have just risked life and limb and lost limb and almost their lives

030 referred to gaining and losing status:

Example 4.21

030*v1* Care Provide,r 269 words out of 7098 words in transcription

R: Well they um they're more um units in which people who are wounded get get special treatment ummm uh it's a it's a double-edged sword on the one hand it's really good that they're that they're putting resources into these people who gave so much *hh* on the other hand uuummm these people are taken out of their normal units in one case I was at a base um … of Army Rangers *hh* … and uh and … some of the guys had the prestige of when they were when they were doing airborne kind of activities they stuff they wore they have a special beret or something like that with a unique color which identified them as one of those *hh* heavy-duty warriors But when they got into the wounded warrior unit they lost the beret and they they felt like you know they were really um being demoted one guy he said he said to me I went from a hero to a zero

Yeah they get really uh some of them get really depressed and lost I mean lots of them have made the military their or have intended the military to make the military their career So it makes a big difference for the rest of their uh rest of their lives I mean the rest of their their working lives while they stay in the military … makes a big difference to them and some of them were depressed I mean apart from being depressed by their injuries which is reasonable to expect also *hh* they're depressed because they were lowered in status

040 talked about present and future loss:

Example 4.22

040*v1* Care Provider, 37 out of 4797 words in transcription

R: And you know a number of these young men no longer can have children They've lost testicles they've had penile damage Damage so even issues of um you know sort of very **identity**-related You know physical injuries

080 talked about losing and finding:

Example 4.23

080b,*v1* Injured Service Member, 204 words out of 9326 in transcription

R: But once I accepted … how m- the rest of my life is gonna be … you know missing a part of my limb an' you know you have to use prosthetic and all that stuff and before it was a bother for me to put on but you know what I remember that when I was deployed took off your boots go to sleep you get up in the morning you wanna go to the baffroom you hadda put on

> your boots you hadda everywhere you go you hadda put on your boots put it on take it off put it on everywhere you go and one's didn't matter then so you know I equated that from that prostheses to that you it's like before I used to put on the boot to go out to the baffrom it's the same thing it's just like a longer heavier boot Yeah I hadda find a way to understanding and accept it better Not I just did it on my own I had to *hh hh* you could go through as much counseling as you want ... but if you don't find a way to understand it it doesn't matter you're never gonna understand it

And a self-identified wounded SM who had extensive internal damage talked to me several times and volunteered to be a respondent. He did not agree to being recorded when we spoke so I field-noted our conversation, which included this note:

> Example 4.24
>
> 120FN Wounded Service Member Field notes
>
> Describes amputees respectfully and with consideration and also notes that they have their limbs removed then get prosthetics and rehabilitation and they move on whereas he faces much more surgery, pain and recovery challenges

Service/Sacrifice

I found other shared dialectical themes that enriched my understanding of my respondents' lived experience at a MTF, experiences they expressed and performed in new discourses that were "always-in-formation." When she talked about some wounded SMs returning to duty, participant 010 invoked service and sacrifice. She said,

> Example 4.25
>
> 010*v1* Care Provider, 73 words out of 5445 words in transcription
>
> R: like um … unit in (*name of another military installation*)? So some of the amputees can go back there and still remain in active duty um one of the guys that I know just recently did that and um then you know one of their colleagues said uh you know er one of their fellow service men said you know he's one of the lucky ones he's getting to go back to duty

When another care provider talked about members of service organizations bestowing gifts on her patients, she described their reactions:

Example 4.26

020*v1* Care Provider, 104 words out of 5953 words in transcription

R: Um I think that they you know they really enjoy it I think that they it's funny 'cause a lotta times they think they were just doing their job and if it didn't happen to them they'd rather it happened to them because if it didn't happen to them it woulda happened to another member of their team *hh* and so you know so I think they really appreciate it they're really thankful sometimes they joke that it's deserving because of everything they've sacrificed but I think for the most part they're very thankful you know and really appreciative of appreciative of the support

020 also talked to me about how SMs are regarded:

Example 4.27

020*v1* Care Provider, 65 words out of 5953 words in transcription

R: Yeah sure uh huh they're uh they're seems to be a positive attitude out there f- you know based on the the people I interact with
Regarding their service they always talk about you know there guys are defending the country country and they uh uh they they sacrificed themselves you know for their country and they uh
And it's always in a positive light

In one of the many interviews I conducted with 060 he talked about his interactions with other wounded, ill or injured SMs, saying,

Example 4.28

060*v1* Wounded Service Member, 150 words out of 7906 words in transcription

R: … … … well it makes me wounded warriors makes me think about the guys without legs and who are visibly visibly chaaanged uh um and I think I think what the visible changes … I think … the way I feel when I see a wounded warrior … is … my um my knee jerk feeling is kind of uh um shame and an' sadness because uh it's such a clear signifier of the … price that that someone else has paaaid Uhhhmm now that uh that sensation that feeling is is kind of rendered neutral by the fact that I too uh experienced And uh and uh sacrificed uh for Uncle Sam …

but that leads me to think that part of what a visible wound a a very visible wound does is it kind of makes people feel a sense of um … uhm shame or Sadness

Individual/Group

People at my sites often referred to the difference between being regarded as a member of a group, such as an "able-bodied" active-duty SM, and being an individual who was undergoing rehabilitation, evaluation, and assessment. One respondent who self-identified as an "invisibly wounded" SM described in some detail his experience of "now" (wounded and in rehabilitation) being considered an "individual," whereas before he considered himself to be, and was always addressed as, a member of a group. In my field notes I wrote:

Example 4.29

120FN

Says that people are <u>part of a group</u> in the military until they get injured, then they are <u>individuals</u> Thinking of or dealing with people as <u>individuals</u> is very different for military people

When a therapist talked about the way her wounded patients were treated in passageways at WRNMMC she noted, (using the word "campus" for the site):

Example 4.30

010*v1* Care Provider, 45 words out of 5445 words in transcription

R: You're walking with them on campus you'll see plain clothes I assume retired military <u>individuals</u> coming up to them and talking
Chatting with them as if the- they know them
Maybe they they're <u>in some group together</u> Yeah!
So they they get treated very well

And a psychiatrist commented on the same structurally-determined and process-driven distinction, suggesting that I pay attention to how it can be detected, and where it springs from. He also said (as in 120FN), that once people are wounded, ill, or injured and are being treated

and rehabilitated, they become individuals and that the transition from training and working with a group, to being "treated" as an individual, is challenging, especially for those who are returned from deployment (370FN).

In an interview with an NCM who helped conduct assessments as part of the MEB and PEB processes that many respondents referred to when they corrected my use of the word "*dis*ability," the respondent said, "When you're injured in the military you really understand the difference between being treating as an individual and as a group (member)" (090). Another respondent explained that when people get injured they're on their own, they're individuals, they're not treated the way they were when they were in the group and a lot of them want to get back to the group and they can't (Example 4.31, 130b).

Sovereignty/Mortality

Agamben 1998 and other scholars of necropolitics, or the power over life and death, influenced my impressions of working with people at a MTF (Arendt 1979, 1998; Foucault 1995; Hansen and Stepputat 2006; Mbembe 2003). The felt power over life and death that pulses through a military base and hospital is ever-present. Alongside the transfer of sovereignty that occurs when people enlist or enroll in the military, all decisions about training, posting, deployment, ranking, assessments, and benefits are made by others for SMs who are co-called able-bodied and are bound in groups of others "like" them. When SMs are wounded, become ill, or are injured, weighty life and death decisions are made regarding their rescue, evacuation, triage, modes of treatment, rehabilitation, and re-entry or discharge. At the same time, responsibility for recuperation shifts to them as unique individuals. They and their families are in a tentative vulnerable position. Care and benefits are promised to active duty SMs unless and until they are deemed no longer fit to serve (are "unfit"). When family members and NMAs

move into barracks to support wounded, ill, and injured SMs they may or may not adapt easily to a military environment; their presence is both encouraged and discouraged, depending on numerous factors, including the prestige that is attached to their SM's kind of *dis*ability and mode of rehabilitation (090, 120FN). They and associated inter-dependents at a MTF are managing mortal issues under the aegis of the institutional military order of discourse (which some family members understand and identify with and others don't); [193] and within the rehabilitation/MTF order of discourse in which signals regarding who is responsible for what may be garbled.

My identification of the theme Sovereignty/Mortality was validated by many elements like these two from very different textual sources. The first is an excerpt from a field-noted conversation in which a retired officer who had been recalled to serve as an NCM in the Wounded Warrior Brigade explained to me the effect of SMs being required to re-embrace their own sovereignty after having separating from the military:

> Example 4.31
>
> 130bFN Nurse Case Manager
>
> (*Name of respondent*) said that when guys and women too tell him they want out he always says don't rush it. Don't make that decision yet. They get out, he said, they go home and their friends from high school are unemployed and living with their parents. Then they want back in and they call him and there's nothing he can do.

In the next example, a documentary film maker describes her work with a family member whose injured SM spouse had been suffering for several years from profound irreversible effects of Spinal Cord Injury (SCI) and TBI. The film-maker said,

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[193] In addition to which some are military beneficiaries and others are not, which complicates who gets paid for what, who pays for what, how much sacrifice is required by those who leave their homes to live at a MTF and care for someone there, how long people can stay (Messinger and Wool 2012).

Example 4.32

> This isn't what people think of when they think of injured soldiers. Five or ten years ago people weren't surviving these kinds of injuries. When there are two wars going on, being a military wife takes a certain kind of toughness. But nothing could prepare (a military wife) for this.
>
> – Abdou *Far From Home, Injured Vet is Never Alone*

Nascent Discourses

I found shared themes in my data, and labeled the prominent ones (that is, those most often invoked) as "binaries" to exaggerate their dialectical tensions. More significantly though, I believe these "themes" co-constitute active formations of disparate discourses,[194] some supporting (at the center, or "good"), some opposing (from outside, or "bad"), and some *re*negotiating (at the margins, or dis-identifying with) the MTF order of discourse. In fact my sense now is that the MTF order of discourse itself cannot exist without these constitutive shifting, animated, dynamic and contradictory (i.e., dialectical) suborders, or nascent discourses.

Conclusion

In this chapter I have presented exemplary portions of narrative data that I collected, annotated, and analyzed; and I have pointed to my use of tenets of CDA to detect significant findings, including the effects of authorizing orders of discourse on subjectivity. I have identified shared themes and noted their relevance in answering and even countering my research questions. I found evidence that prompted additional questions and evidence that complicated how participants in rehabilitation at a MTF construct and describe their lived experience, and what comprises their practical knowledges, tools, and technē. I have plumbed some of the data I collected, annotating "semiotic signposts" to show where I located critical textual usages, and

[194] My thanks to Dr. David Peterson who pointed me in this direction (2012 personal communication).

briefly explaining their salience. Those exemplars of data, and the means by which I critically analyzed them, indicated where and how I found evidence that led me to my findings.

There is a generative relationship between my data, my analyses, and my identification of "found" themes: Understanding what I dis-covered amounts to important knowledge for policy-makers, providers, patients, families, and communities. Knowing some of the sociocultural mechanisms that what underlie *un*even outcomes and erect barriers to social justice informs those who can do something to mitigate them. For this reason, I have offered details of my data analysis, and before concluding, I have presented a discussion of shared themes.

The course of my ethnographic research altered my own stance; this means that in the next chapters I re-present and re-evaluate my research questions. I had assumed that I could apply a socioculturally constructed notion of "*dis*ability" onto a group of people; and that "they" might "stand in for"[195] other people. I was mistaken on both accounts; i.e., I mistook the ways in which my assumptions would align with or provide a portal for inquiry into my respondents' lived experience and with the material culture that shape and reflect their experience. My mis-apprehensions were not profound or fixed; they remained-in-formation and were influenced as they should have been[196] by what I discovered. In unexpected ways, my questions were warmly received and my inquiry broadly supported; while at the same time, I realigned my assumptions based on what my respondents told me and what material culture at the site refracted about *dis*ability, deservedness, and lived experiences at a MTF.

I survey my findings in Chapter Five and explore the ways in which these understandings re-present SMs, family members, NMAs and care-providers not as subjects who are arbitrarily,

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[195] By which I mean a person who substitutes for or represents another actor. As has occurred throughout my inquiry about disability and deservedness among members of the military, I have encountered, contemplated and used (or not) words that are *un*intentional double entendres; e.g., the words "member" and "dismember"–and the phrase I reference here, "stand in."

[196] Research aims to build on existing knowledge to find new knowledge–expected and unexpected.

mortally and unwillingly–even unwittingly–interconnected, but rather as agents who intentionally and productively co- and re-constitute ideals upon which they rely to make sense of and negotiate their worlds: Ideals that shape the meaning of their lives and deaths; and thereby express their varied subjectivities. In Chapter Six I provide my sense of the data's significance and make recommendations regarding their applicability, or *prāxis*.

CHAPTER 5

WHAT WE KNOW NOW THAT WE DIDN'T KNOW BEFORE

Findings and Significance

Introduction: Locating my Findings

My findings are significant to understanding structural and agentive mechanisms that result in uneven distribution of resources among people whose abilities change. These resources include visibility and recognition; and access to privileges, and to privilege. Knowledge I gained at my research sites is both unique to military settings and may also apply elsewhere. In this chapter I elucidate my findings and point to the ways in which their knowledges may be significant to MTF patients and their families; to people who care about and for them; to military and civilian health care policy-makers, practitioners, and patients; and to people in general. To put my findings into play I point to some of their sources and draw some conclusions about their significance; and I locate my findings within 3 nested[197] discourses: the institutional/military order of discourse; the MTF order of discourse; and the "nascent" order of discourse among inter-dependents in rehabilitation at a MTF.

To discern findings and assess their significance I started with readily gleaned observations and answers to my research questions, and from there moved to deeper analysis, digging for less "apparent" meaning. Answers to my research questions led me to a complex of additional questions-and-answers in which I identified more findings, including shared themes that constitute discourses-in-formation. These nascent discourses are hierarchically nested within

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[197] I intentionally choose to describe the discourses at work at a MTF as being both nested and constituting a "hierarchy." My choice to point out a "hierarchy" denotes the over-determination I am discussing–the structural influence that is felt and described in lived experience at a MTF. The orders of discourse I am discussing are also "nested;" i.e., they reside among each other, in horizontal layers, intertwined, and transecting. Indeed, my respondents and their data reflected nested and hierarchical (self-) positionings; their content is dialectical insofar as it is both horizontal and vertical. Perhaps another way to conceive of these power relationships is within a spiral or helix; in any case I regard the matrix of relationships I observed as constituting nested and hierarchical orders of discourse, and have chosen to depict them "vertically" in Table 5.1.

the MTF system of meaning–its order of discourse. In turn, the MTF order of discourse is hierarchically nested within (and governed by) the institutional/military order of discourse, which is governed by (is "beneath') the concept "Order of Discourse." For the most part, my findings are located within the MTF order of discourse at the same time that they are governed from "above" by the institutional/military order of discourse; and affected from "below" by nascent orders of discourse.

My examination of nested discourses led me to understand that to sustain their systems of meaning, orders of discourse in the military and at a MTF (and perhaps everywhere) rely on constituent discourses. For example, the institutional/military discourse relies on the "family order of discourse," and on MTF orders of discourses. In turn, the MTF discourse relies on sub-discourses that remain-in-formation to couch themes of lived experience that are dynamic and dialectical. The orders of discourse I am discussing are hierarchical and govern social practices at different scales and with different degrees of stability: Global (very stable, even rigid); local/group (plastic, topological, somewhat flexible); and individual or personal (dynamic, unstable). Each order sustains the one it is governed by, in a productive relationship. Table 5.1 shows how I locate or "map" the orders of discourse I found, and their animating dominant themes. At the top are the overall findings that a) discourses rely on each other to continue to exist and have meaning; and b) that *dis*ability is a socioculturally and structurally contingent construction that governs practices: it constitutes a discourse in itself. Below these overarching findings are components of the institutional/military order of discourse that governs two orders "below" it: the rehabilitation/MTF order of discourse; and nascent orders of discourse which irrupt in and are animated by shared experience.

TABLE 5.1: Location of findings					
Orders of Discourse					
Discourses Rely on Each Other			*Dis*ability is Socioculturally and Structurally Contingent		
Institutional/Military Order of Discourse					
Military Lives are Different		*Dis*ability is a Process		Members of the Military are also Family Members	
MTF Order of Discourse					
Perceptions of *Dis*ability are Linked with Degrees of Deservedness	The Link between *Dis*ability and Deservedness has Felt Consequences	Texts Sustain the Link between *Dis*ability and Deservedness	Visibly Harmed SMs are More Recognized and Have Greater Access	Rehabilitation is Space-Time of Recovery	A MTF is a State of Exception
Nascent Orders Of Discourse					
Loss/ Recovery	Identification/ Disavowal	Inside/ Outside	Service/ Sacrifice	Individual/ Group	Sovereignty/ Mortality

Sourcing My Findings

In Chapter Four, following Faircloughian tenets, I pointed to linguistic features that are elements of the MTF order of discourse: the system of meaning and linguistic network of social practices that co-constitute and sustain care and rehabilitation within the circumscribed space-time of the MTF. Their genres, styles, and discourses co-constitute the MTF order of discourse in complex dialectical relationships which are influenced by performances of lived experience. Genres are the means by which subjects convey representations of their lived experience; via talk or in interviews for example; news reports; posters; announcements; films; or ceremonies. Genres are discursive ways of acting and interacting in the course of sociocultural events; they are "actional," and they have "generic features" that differentiate them from each other. In an

interview for example (an interview is a genre), a respondent may tell a story, report an event, establish expertise, or request support–or may do all of these things.

Styles are the unintentional ways that subjects and objects signal alignment and identity with each other and with ideological apparatuses, using various textual, linguistic, and gestural extextualizations. In my data, stylistic elements include semioses, among which are lexical choices (e.g., words, pauses, dysfluencies, ellipses, repetitions); direction of gaze; gestures and salutes; choices of clothing; displays of stitches and scars; choices among and uses of prosthetics and assistive technologies; medals; uniforms; and gear. Styles are "identificatory."

Discourses are ways of representing lived experience within particular worlds or space-times–at a MTF for example. Discourses may flex and be flexible; they remain-in-formation, and are dialectical. Discourses may compete against and co-opt each other. They respond, however slowly or quickly,[198] to ideological, social, and politico-economic fluctuations, and are "representational."

In addition to genres, styles, and discourses, I scrutinized my data to note and analyze modalization, use of pronouns, emphasis, and repetition. Modalization refers to the stance authors take with respect to the representations they are commenting on or referring to. Signs of modalization are hedges, claims, refutations, contradictions, commitments, and doubts. Authors' uses of pronouns indicate their interpretations or representations of agency: Who did what? Who decided? Within texts, attribution of agency is often fleeting, contradictory, false (Penelope 1990:130-138), or muddled. By contrast, emphases are *un*intentional signals to the listener, reader, or viewer that "this is what my story is about." While emphases may seem contradictory, when noted and isolated, and left in their original sequences, emphases track the "moral" of the

[198] i.e., they are temporally contingent; and their temporal dimensions vary. For example, global orders of discourse flex very slowly--even imperceptibly across space-times; whereas nascent orders of discourse are palpably flexible and responsive.

story the text (or author) is telling. Table 5.2 shows my findings in order of their "appearance" their "availability:"

TABLE 5.2: Appearance of findings			
MANIFEST: These findings were readily apparent and sustain evident notions and practices	1a	Perceptions of *Dis*ability are Linked with Degrees of Deservedness	These findings form and inform the institutional/military order of discourse; they are "obvious" and largely justified or explained by the mutual promise made between SMs and "forces."[199] These conditions of experience are lived and performed within the rehabilitation/MTF order of discourse.
	1b	The Link between *Dis*ability and Deservedness has Felt Consequences	
	1c	Texts Sustain the Link between *Dis*ability and Deservedness	
	2	Visibly Harmed SMs are More Recognized and Have Greater Access	
	3	*Dis*ability is a Process not an Identity	
	4	Military Lives are Different	
ACCESSIBLE: These findings required more analysis, and constitute shared themes	5a	Loss/Recovery	These shared themes in the MTF order of discourse constitute discourses-in-formation; i.e., nascent discourses that are not obvious yet are irrepressibly expressed in texts and whose discovery yields individual and group "(self-)recognition."
	5b	Identification/Disavowal	
	5c	Inside/Outside	
	5d	Service/Sacrifice	
	5e	Individual/Group	
	5f	Sovereignty/Mortality	
RECONDITE These findings were deeply embedded	6	Rehabilitation is Space-Time of *Re*covery	These are findings regarding naturalized aspects of inter-dependents' lived experience that co-constitute an existential and ideological period of liminality and potential transformation.
	7	A MTF is a State of Exception	

Noting repetitions is useful within single texts and across texts that animate discourses. By tracking repetitions the analyst can detect individual and group themes, and decide whether their presence constitutes the workings of a sub-order of discourse: a nascent discourse. For example, "loss," "lost," and "missing," and references to "loss," such as graphic images of silhouettes without features, appeared repeatedly across my collection of texts. So did references to "finding," "getting," "gaining," and "found;" in descriptions of self-transformation for

[199] By forces I mean to infer Branches of the Armed Forces, and other forces; such as tacit and overt personal and institutional "promises."

example, and in graphic images of iconic people in maps, or at locations. Their multivalent repetitions signaled a shared theme that was present often enough that I recast it as a discourse-in-formation, i.e., a nascent discourse, that I named "Loss/Recovery."

Some findings from my research were easy to detect; other less so. Some demanded numerous re-considerations and repeated analyses. In Table 5.2 I organize my findings in order of their "appearance," and allude to their "availability" by using the categories Manifest, Accessible, and Recondite. In doing so I am indexing a chain of detection and revelation.

Detecting and Identifying Findings, 1-4

My analysis yielded deepening[200] insights. First, I found that there is a link between perceptions of *dis*ability and ideas about deservedness; the link has consequences; and the link is sustained semiotically. The data show that the link is vouchsafed by respondents and text authors as "obvious;" and it is justified, challenged, or "worked" depending on the respondent's stance. Inter-dependent people in treatment and rehabilitation at a MTF do proclaim,[201] suffer, enjoy, confer, contest, and *un*intentionally enact links between *dis*ability and deservedness. Whether or not they identify themselves or their charge as "*dis*abled," (a finding I take up below), the people and material culture that I studied comprehend and valorize altered levels of fitness differentially depending on proveniences of harm; how the harm manifests (corporeally, cognitively, affectively–and often co-morbidly);[202] and the mode of rehabilitation that is being experienced. Distinctions between kinds and proveniences of harm are upheld and sustained by resident subjects and objects, i.e., by people and by material culture whose texts identify how and where

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[200] And, as I describe above regarding orders of discourse, my findings were also nested, hierarchical–and "spiralled," or helical.

[201] By which I mean indicate, denounce, and extol.

[202] The signature condition of current wounded, ill, and injured active-duty SMs and of contemporary "warfare" is *co-morbidity* in which multiple syndromes, disorders, diseases, and damage co-exist; for example PTSD may co-exist with TBI, limb loss, depression, and anxiety (Tanelian and Jaycox 2008:178, 193-196).

SMs were hurt (corporeally, cognitively, and geo-physically); and they valorize the ways in which they are being cared for and rehabilitated. Those who are most prominent are "wounded" SMs and their inter-dependents. Those who are ill, or have been injured, those who care for them, and their treatment regimens, are less frequently featured, viewed, or displayed.

This finding is significant in several ways. Beyond showing that the "Wounded, Ill and Injured" taxonomy of harm is obvious, that it describes a hierarchy of worth, and that it is discursively and practically upheld, my data also show that depending on their stances, people at MTFs accept, resist, and "work" the experiences they endure within this actualized taxonomy and that their consequent outcomes for "successful" recovery are *im*materially affected by their positions within the hierarchy of harm, treatment, and rehabilitation. Even within the "state of exception" that a MTF represents (and whose naming I justify below), some SMs are mediated as more equal than others. And people at my sites knowingly accept, confer, or contest correspondingly *un*even levels of recognition and access to resources. These enactments are real, are intelligible, and have consequences within and beyond well-defined shared systems of meaning; i.e., beyond the institutional order of discourse and the MTF itself.

T-shirts offer one of the most accessible vehicles for understanding particular messages that have shared meaning, such as the "obvious" understanding that SMs wounded in combat, and especially amputees, are at the "top" of the taxonomy of harm. Printed or embroidered T-shirts are worn by many SMs, family members, and NMAs at WRNMMC. Their messages vary. The most mordant are worn by self-identified "Wounded" SMs (the most "visible" of whom are amputees); for example, an SM in a wheelchair wore a T-shirt that "said:" Combat Wounded Marine: Some assembly required. A self-identified family member of a wounded SM told me about the T-shirt she liked the best (in excerpts I have underlined "telling" words and phrases):

Example 5.1

110*v2* Family Member, 26 words out of 8692 in the transcription

0001 … like I remember there was this one where there was like a star
0002 … but the star had crutches and a band aid on it [R]

At a MTF, *un*even levels of recognition and access to resources are obvious, they signal embodiments of power, and they are semiotically reproduced. Their obviousness and acceptance appear to rely on military socio-acculturation, in which competing ranks, degrees of sacrifice, and probability of harm construe terms of membership. When I interviewed a care provider who had worked at both WRAMC and WRNMMC, she described her perception of the link (0001), the consequences (0003), and the sustaining elements (0005):

Example 5.2

040v*2* Care Provider, 64 words out of 4797 in the transcription

0001 I think uh it's huge right from the start like when we get the aerovac
0002 list patients are identified as battle or non-battle and battle-injured
0003 patients um are typically coded as severe which means their families
0004 either meet them in Germany or here if it's a non-battle injury your
0005 families get notified but they may or may not be brought here to see them
[R]

By applying CDA to her interview transcription[203] I discerned the generic features of her responses in our interview as pro-active, professional, and accountable. I found her style aligns with *un*recognized needs of under-served ill SMs; and that her discourse is advocatory, representing patients' experience, and seeking changes. Her modalizations in our interview were consistent and pro-active, featuring commitments to change, and concern about *in*equities. She affirmed resistance to the MTF's order of discourse, and re-presented a competing discourse. Because she is a practiced clinician in this setting and is advocating for change based on her knowledges, despite her critical stance I do not view her as oppositional/outside the MTF order

[203] I analyze her transcript in more detail in Chapter 4.

of discourse (or, as a "bad subject"). She is at the margin, productively negotiating the MTF order of discourse. She is a dis-identifying subject.

An NCM made the link I asked about, the consequences, and the sustainment (or social reproduction) very plain when she said to me:

Example 5.3

090*v1* Care Provider, 14 words out of 3605 in the transcription

R: At Walter Reed the wounded warriors are entitled to the highest priority of care

A therapist who worked with ill patients answered my question by saying,

Example 5.4

030*v2* Care Provider, 60 words out of 7098 in the transcription

0121 and the other thing is that I don't see wounded warriors they are in a
0122 unique category because they have their own services and when you're
0123 in that category you have your own uh your own uh … psychological
0124 support services and your own y y your own unit in fact so I don't see those
0125 guys apart from that [R]

Many signs, posters, flyers, and announcements supported a link between *dis*ability and deservedness. One prominent sign in the lobby of the recreation facility said simply,

Example 5.5

Wounded Warriors First

Another sign identifies a large restaurant and eating area in a building that houses and supports wounded, ill, and injured SMs and their family members and NMAs, as well as brigade leaders, NCMs, administrators, maintenance personnel, care givers, recruiters for research projects, commercial vendors at booths and tables, entertainers, and many visitors. Although anyone can be there (and usually, "anyone" is), the sign says:

Example 5.6

Wounded Warrior Café

The fact that the sign privileges a single group is uncontested; in fact the space it signals is heralded as identifying a locus for those who are being served at the MTF, and guests are frequently taken there to "see" or mingle or eat with *visibly wounded* SMs and their family members, NMAs, and care providers. In turn, my data showed that visibly wounded SMs are usually understood to be amputees. What is significant about this chain of apprehensions (those who are being served are wounded warriors, wounded warriors are visible, visible SMs are amputees) misrepresents the population of SMs that has been harmed since 2001: Between 2001 and 2010, 400,000 U.S. SMs have been medically evacuated from Iraq or Afghanistan due to PTSD, depression, TBI, or a combination of these conditions; 49,000 SMs have been medically evacuated because of non-combat related injury, illness, or self-inflicted wounds; and 2000 SMs were medically evacuated because of severe damage to or loss of limbs or digits (all of these SMs had immediate or subsequent amputations) (Fischer 2010; Magda et al 2012; Tanelian and Jaycox 2008). Despite the fact that 2.25% of SMs deployed to OIF and OEF are now amputees, my data analysis showed that as a group and individually, those who have lost limbs are iconic for and are mediated as those who have served and sacrificed and are now being rehabilitated.

At various clinics and events at WRAMC and WRNMMC, representatives of some organizations promoted membership and gave branded gear, event tickets, and invitations to wounded SMs, and sometimes to their family members as well, and not to those who have been injured or are ill. A respondent talked about this, and succinctly explained how she understood the link, the consequences, and the sustainment:

Example 5.7

020*v2* Care Provider, 47 words out of 5953 in the transcription

0001 One of my patients he was invited to participate in some like sports
0002 event and when the um organization found out he was not an amputee
0003 er a wounded warrior they told him he couldn't come and they didn't
0004 let him go they took back his tickets

I had also noticed that many organizations dedicated to supporting SMs and their families valorize wounded SMs above injured, and infrequently make references or overtures to SMs who are ill. Two people I interviewed together in an unrecorded field-noted conversation pointed this out too, and remarked on some celebrities or visitors who by contrast, do distribute their attention equally (0016, 0017, below in Example 5.8), visiting ill patients in units (i.e., wards) and eating facilities. My field notes of our conversation read in part,

Example 5.8

140FN, 150FN

0001 (*Name of participants*) both talked about high visibility, select
0002 attention, and celebrity visits for WWs[204]
0003 They get gear, stuff, gifts, donations (requested and not) events,
0004 invites, special participation–not available to injured and not offered
0006 to ill Donations are often undirected–and may be unwanted, unnecessary
0007 May take truckloads to transport all the "stuff" away when SMs are
0008 discharged
0009 Talked about "ill" not really "appearing" at all–they were very sensitive
0010 to and aware of the low visibility and absence of "ill" in discussions and
0011 acknowledgement of those who have served and sacrificed
0012 Said that infrastructural, systemic, and cultural conditions are all factors
0013 of "success" or "failure" in recovery
0014 Often people do not know that they can be more visible; or, that their
0015 visibility is overshadowing equally deserving others
0016 Mentioned some celebrities or visitors who do distribute their attention
0017 equally

These two respondents are articulate, practiced care providers who were eager to participate in my research after a colleague mentioned my area of interest. One of them said that

[204] Wounded Warriors.

success or failure in recovery is governed by multiple infrastructural, systemic, and cultural conditions (0012). Unprompted (but cognizant of my research interests) one said that "ill" patients don't "appear," and have "low visibility" (0009); her companion countered that those who have high visibility may be "overshadowing equally deserving others" (0014, 0015). Their remarks stand outside the MTF order of discourse (and they do too; neither currently works at a MTF); their discourse was oppositional; yet my field notes show that they concluded our conversation by commenting,

Example 5.9

140FN, 150FN

0018 What is the point of doing research about these subjects?
0019 To acknowledge others' experience
0020 To educate participants at every level

In turn I characterize their position with respect to the MTF order of discourse as productively oppositional/outside. They are "slightly" bad subjects. What is significant about their viewpoints is that they have had "insider" status, and now have "outsider" status; yet their insights and commitment to rectifying *un*even outcomes traverse both fields. Although each of them has been "outside" for several years, their observations remain incisive. Merely speaking about, listening to, field-noting, and analyzing their concerns adds authority to my findings.

For their part, SMs also recognized and talked about the link, the consequences, and the sustaining semiotics. One respondent talked about the first thing he thought of after realizing he had been wounded in combat:

Example 5.10

060b, *v2* Wounded Service Member, 58 words out of 7906 in transcription
0001 will this be enough to get me a purple heart because I really wanted a
0002 purple heart I wanted I wanted that purple heart because I wanted to be
0003 recognized as someone who had been in combat and I wanted to have

0004 a medal which was clearly a signifier of that and the purple hearts are
0005 very recognized [R]

An injured SM who had had a leg amputated after a training accident at a domestic posting told me,

Example 5.11

080*v2* Injured Service Member, 44 words out of 9326 in transcription

0001 they're trying to repair that I dunno somehow they're tryin to repair that you
0002 got uh … nerve damage they tryin to test repair that stuff … ah … I guess
0003 you could say uh ... I … one of the less injured [R]

SMs' testimonies further authorize my findings. They recognize and speak of the taxonomy of harm in which they figure, extracting differentiated degrees of recognition and access to resources (i.e., deservedness) from the realm of theory, and embodying them in lived experience.

When I asked a physical therapist about words she hears that describe SMs in rehabilitation, she said when she hears the word "wounded" she thinks of amputees, and she indicated that as far as she knew injured and ill patients get little attention, whereas for amputees:

Example 5.12

020*v2* Care Provider, 130 words out of 5953 in transcription

0001Yes so um *tsk* there's always news crews media around we've had
0002 I think like I said before we've had the history channel discovery
0003 channel you know if there's any filming the work outs they're doing
0004 their rehabilitation process um they get lots of gifts heh heh t-shirts
0005 electronics you know ipods ipads new cell phones they get taken on
0006 lots of trips um lots of thank you's lots of thank you cards un you
0007 know you know even monetary they're monetarily compensated and
0008 awarded and there's obviously the awards ceremony they're thanked for
0009 their service um their bravery and they oftentimes given medals and you
0010 know a lot of big wigs from Washington come in you know shake hands
0011 and make an appearance so heh heh yeah [R]

Another respondent mentioned that,

Example 5.12

010*v2* Care Provider, 11 words out of 5445 in transcription

0001 The wounded warriors get all sorts of gear and special equipment [R]

and another,

Example 5.12

040*v2* Care Provider, 10 words out of 4797 in transcription

0001 Patients who were injured in-country just don't get the same treatment [R]

Here follows a last example supporting "manifest" findings: One of the "mom" NMAs got really angry because her son was sent to barracks less desirably equipped and located than the "Wounded Warrior" barracks when a new group of SMs arrived by helicopter, were admitted to the facility for care and rehabilitation, and moved into premier barracks. Three different respondents told me about this story: A male NCM who had been in the military for 28 years and who told me this story as an example of family members not understanding what "has to" happen at a MTF in order to manage patient flows and distributions of care (130b); a female civilian NCM who told me that the transfer was a familiar example of how wounded, ill, and injured SMs get treated differently, and the effects on them and their family members (090); and the mom herself who said it was unfair that her "injured" son who had been living in the same room for many months at a prime housing facility while he was undergoing rehabilitation was being pushed out to a less desirable (i.e., less accessible, less prominently located, older, with no separate kitchens) housing facility to make room for an incoming "Wounded Warrior."

The texts that these respondents provided (a conversation field-noted with permission; a recorded interview; and a chat in a lobby by way of a referral) led me to position the authors in

relationship to the MTF order of discourse in this way: the military NCM is at the center/supporting; the civilian NCM is at the margin/negotiating; and the family member (the SMs' mother) who was not a military beneficiary, is oppositional/outside the MTF discourse. I base these assertions on my analysis of the genres, styles, and discourses of the respondents' texts. I offer an analytical assessment of one version:

The military NCM (032a) presented a case to illustrate how some family members have difficulty understanding the rules at a MTF. We met in his office and he was in unifrom. I know him, and we talked a little about his family, his imminent retirement, and his career in the military. Based on my field notes, when he provided the example of the mom who got mad he talked about:

Example 5.13

130b FN Care Provider

0001 NMAs are paid $2000.00/mnth
0002 Often they don't want to leave!
0003 Family members who are not military beneficiaries themselves don't
0004 understand what has to happen as new groups of patients arrive
0005 Recently wounded warriors have precedence over injured SMs who have
0006 been at WRNMMC for awhile

His discursive genre was an intrerview with the generic features of a briefing. He established his credentials by referring to his many years of active-duty service, his earning of an advanced degree, and the number of cases he was managing. He illustrated his comments about *dis*ability and deservedness using particular examples from his experience at a MTF, and dwelled on what people think they deserve, using examples of complicated *dis*ability assessments (including percentages for particular *dis*abilities), and the appeals process. He wondered aloud if some SMs with impaired cognition may have been "prior," meaning, in the institutional/military discourse, "already ill when they joined the Army." He punctuated his comments with figures

(0001). His style was aligned with the institutional/military order of discourse. He was wearing an Army Combat Uniform (ACUs,[205] the everyday dress of active-duty Army SMs at WRNMMC), and he allotted 30 minutes to our conversation. His discourse represented the MTF order of discourse (0005,0006). Because I was field-noting I did not capture our conversation verbatim and so have not analyzed in detail his modalization (except to note his opinion that "family members who are not benefiricaires don't understand what has to happen" [0005, 0006]), use of pronouns, emphases, or noteworthy quotes. Nonetheless I can estblish his position at the center/supporting the MTF order of discourse. He is a good subject.

The female civilian NCM related the story differently:

Example 5.14

090*v2* Care Provider, 523 words out of 3605 in transcription

0001 W- w- a couple of uh it's pretty much a common understanding 'n'
0002 perception that the wounded warriors meaning the wounded in OIF
0003 Yeah [Q]
0004 Are entitled to the highest priority of care … *hh* … I say that because
0005 I take care of both wounded in combat and in country ... this country
0006 for instance I have one patient who was wounded in (*name of domestic*
0007 *station*) *hh* and he is not considered as u- entitled to the same
0008 expeditious care as someone who's an OIF OEF veteran *hh* … … and
0009 in fact we just had an uh a uh an in pertaining to him because he is not
0010 an OIF OEF veteran we are trying to make not me but um the people
0011 that control the beds in (*name of barracks*) need to make room [R]

0012 Hmph [Q]

0013 For in-patients that are going out-patient [R]
0014 And because he's not an OIF OEF veteran even though he's sssstill
0015 on crutches and has an upcoming knee surgery he's gonna have a
0016 knee replacement they're moving him to (*name of another barracks*) [R]

0017 That's a different uh a different [Q]

0018 Yeah it's a little bit further away from the hospital [R]

[205] Army Combat Uniform, often called by civilians (but not by SMs) "fatigues" and "camouflage."

0019 Yeah would you say it has less prestige more prestige same prestige [Q]

0020 I think that I would say it's it it's uh um not as nice it doesn't have
0021 a kitchen in it
0022 Um … he's got an NMA which is a non-medical attendant and she will
0023 either be in the room next door or in the room across the hall I'm not
0024 sure I know which
0025 But t- the mother herself was quite undone [R]

0026 Oh [Q]

0027 She's not happy about it because she perceives a disparity of care she
0028 perceives that her son who is just equally injured *hh* as a military
0029 service member should be entitled to the same quality of care as the OIF
0030 OEF soldier or marine
0031 Service member who was injured in Iraq [R]

0032 Mm that's precisely the cond- [Q]

0033 But [R]

0034 -ition I'm interested in [Q]

0035 Right [R]

0036 Because it's um … … tsk … because it's so [Q]

0037 I will give you her name if you like so you could speak with her [R]

0038 Yeah I'd love to speak with her 'cause I do have permission
0039 and uh interest in talking with NMAs and uh family members [Q]

0040 Right so that [R]

0041 So [Q]

0042 Would be that is something that she's actually verbalized to me that [R]

0043 OK [Q]

0044 She's quite upset about [R]

0045 Ok well with her permission and your permission I'd love to talk to
0046 her er listen to her [Q]

0047 Right an' I was not sure that him being injured in the United States had
0048 anything do with him being moved *hh* but I heard from um one of the
0049 (*member of particular branch of service*) in um control here that that is
0050 exactly true that that was part of the rationale behind the move for him so
0051 it's well known within the hospital that the OIF OEF veterans get enhanced
0052 access to care above everybody [R]

0053 Ok [Q]

0054 They get first priority [R]

In this rendition of the story I am discussing, the genre of the text is an interview and its generic features amount to an appeal. The respondent's style aligns her with the SM's mother; and her discourse represents her position as functionary of the MTF order of discourse. While pointing out and describing the elements of others' struggle over the kind of preferences we are discussing, her style positions her at the center, supporting the workings of the rehabilitation /MTF system, telling a detailed story and reporting on systemic and structural *im*material effects, and proposing degrees of worthiness.

The mom herself spoke very briefly after I had been referred to her; we exchanged just a few comments in passing. Although she didn't present herself as "mad," she noted that moving her son wasn't right.

This triadic[206] story neatly represents how stances influence positions. It supports my primary research finding; i.e., that at a MTF, a link between *dis*ability and deservedness is perceived and experienced by subjects there; the link redounds to consequences which are felt and can be described (even from disparate points of view); and the link is sustained by ideological and semiotic mechanisms in the MTF order of discourse (medals, gear, gifts; or, no kitchen, farther distance from the hospital, an "undone" mother[207]) This finding is signficant to

[206] By which I mean told from 3 points of view.

[207] The NCM described the mother as "undone." I did not observe her to be nor did she self-identify as "undone."

managing adventitious *dis*ability at various scales: personal, communal, local, and global. My finding shows that people know, and experience, and can recount *un*even sociocultural, and politico-economic outcomes.

Data analysis pointed me to a second finding: in the MTF order of discourse, those who are visibly wounded, ill, or injured are more recognized, and are able to gain greater access to resources than those whose harms are invisible, or even less visible. Degrees of visibility of harm and obviousness of modes of rehabilitation have a reciprocal relationship with levels of subject visibility, and with recognition and access to resources. Amputees have the highest visibility with respect to their prestige and also their harm has the highest visibility: they have visible parts missing and visible parts attached. This finding is ironic because visible harm leads directly to more visibility, without indexing degree of harm or representing percent of wounded, ill, and injured SMs; and it is significant because of its Althusserian obviousness In other words, this finding attests the idea that what is obvious is right and true (Althusser 1971:171).

Among the texts that I considered were Segueways and adaptive sports cycles distributed to and used by some SMs who have lost limbs. People, including visiting dignitaries and celebrities–and researchers–greet these somatechnical usages with interest and curiosity in contrast to their lack of obvious or enthusiastic attention paid to SMs who walk using canes, crutches, or medical and non-medical personal assistants. SMs who use service or therapy animals are also warmly greeted, engaged in conversations, and encouraged on- and off-post; and those who use visible prosthetic limbs are noticed by other people in multiple ways, including words and gestures of praise and encouragement; mediated invitations to join groups and activities (by "mediated" I mean narrowly- and broadly-cast announcements and overtures); inclusion by film and documentary-makers in producing and distributing media content;

greetings by visiting celebrities, dignitaries, politicians, medical providers, researchers, and even illustrators (Kino 2012:1).

SMs who look "fine" yet must use smart phones or other handheld devices to remind themselves and others of their contact information, including phone numbers, where they are living, e mail addresses, family member names, and appointment schedules, are not noticed by others, or may be dis-regarded or dis-appear, and so become invisible.

Because ill inpatients are set apart in units, and ill out-patients attend specifically designated clinics, SMs who are "ill" are not visible to most "others." When noticed, they may appear un-well; however their presence is ephemeral. A clinician related her observation that ill and injured patients in clinic waiting areas were bypassed when "wounded warriors" were moved ahead and "seen" more promptly (420FN).

At a clinic I talked with an SM who is an amputee, as he described having dinner the night before with then President Obama. The SM mentioned that they were seated together for several hours and conversed avidly, and that the event was well-attended, filmed, and partly broadcast. As he spoke, I noticed that among the small group of *in*visibly wounded, ill, or injured SMs who were also listening, several joked that they had not been invited to attend the dinner.

A self-identified wounded SM who looked intact, met with me and his NCM to talk about my research questions. With their permissions I field-noted our conversation, and based on my notes he said,

> Example 5.15
>
> 120FN Self-Identified Invisibly Wounded Service Member
>
> 0001 When people assume he's fine he tells them about what happened
> 0002 to him. He asked me, "I look fine, right?" then explained that
> 0003 his pelvis is wrecked, his hips are a mess, and his rectum and
> 0004 bladder are destroyed. He said he was 22 years old and has a

0005 colostomy. He's had 15 surgeries and has to have more. He's in
0006 constant pain. His bladder can't be fixed; it leaks all the time.
0007 He told me wounded warriors get whatever they need or ask for
0008 or demand, but no one understands the condition he's in because he
0009 looks fine. He asked me, "I look fine right?" then said "I'm invisibly
0010 wounded right?" He continued by saying that once he tells people
0011 what's going on with him he gets respect. He said he had to explain
0012 because otherwise "they just don't get it" He said that was because
0013 "they don't see anything the matter with me." He told me that he
0014 respects them and once he sets them straight, then they respect him

A clinician who had recently joined a clinic devoted to a particular illness agreed to be a respondent. When I asked about how she had adapted to working at a MTF she said,

Example 5.16

100*v2* Care Provider, 93 words out of 8677 in transcription
0001 I was a little scared of but now now that I know it I'm a lot more um
0002 ... … …
0003 you know I know what these people … go through I have some more insight
0004 of what their life is going to be like um … and they're uh y'know and um …
0005 their sacrifice is it's invisible it's um their sacrifice and uh everything … is
0006 just harder for them and it's gonna be even more harder because people
0007 don't see … what their um their challenge
0008 is and so [R]

A respondent e mailed me shortly after our interview. He remarked on visibility:

Example 5.17

030 e mail Care Provider

R: I'm on an overseas assignment and just read an article in today's (July 9, 2012) *Stars and* 0002 *Stripes* which I thought would interest you. It's on the front page. Here's a quote from the article, by Sgt. Justin Rajotte (who had injured his back while training): "You get the title 'broken' and once you get that title, it's hard to convince people that (the injury) is actual, that it's real and that you're not trying to get out of stuff." It's also available on line at http://www.stripes.com/news/warrior-transition-unit-s-role-changes-with-times-1.182445 In terms of your study, I imagine it's harder for someone like Sgt. Rajotte who was injured in training than someone with a visible combat injury like a missing limb. No one would accuse the amputee of "…trying to get out of stuff."

Another respondent clarified what she meant by different kinds of attention accorded to variously harmed patients. She said that visibly wounded SMs get a lot of media attention. When I asked her to explain she continued,

Example 5.18

020*v2* Care Provider, 27 words out of 5953 in transcription

0001 Yes so um tsk there's always news crews media around we've
0002 had I think like I said before we've had the history channel
0003 discovery channel you know [R]

This care giver talked extensively about visible and invisible harm, and mentioned amputees as the most obvious of the visibly wounded. She continued by remarking,[208]

Example 5.19

020*v2* Care Provider, 27 words out of 5953 in transcription

0001 When you're walking with them [amputees] on campus you'll see
0002 plain clothes I assume retired military individuals coming up to them
0003 and talking … chatting with them as if they know them … maybe
0004 they're in the same group together [R]

Another respondent remarked on the obvious differences in how visibly and invisibly harmed SMs were recognized and gained access to resources, relating the following example:

Example 5.20

010*v2* Care Provider, 63 words out of 5445 in transcription

0001 I remember one individual [amputee] saying he got ... cash … and a brand
0002 new gun … (*and*) special clothing … (*and*) a nice trip.
0003 They (*amputees*) get the iPad and the um iPod.
0004 So (*at the Wounded Warrior Café*) there's free entertainment you'll see all
0005 these different companies coming in presenting products and offering you
0006 know having different offerings for them (amputees) [R]

[208] Please note that in each text excerpt I start line numbers with 0001 (versus using the lines numbers from the entire transcription) to simplify reading, referencing, and intelligibility in this document.

I found that inter-dependents' participation in rehabilitation is a kind of collaborative restitution of things lost: corporeal, cognitive, ideological and idealistic. The remains of and recuperation from damage are comparatively more powerful when they are apparent,[209] and when their provenience is intelligible; i.e., when their manifestations, origins, and expressions are perceptible. In contrast, those things and conditions that are not apparent, such as depression, brain damage, or disease, are more difficult to apprehend (and to assess[210]). Many data elements supported my finding that the link maintained between kinds of *dis*ability and degrees of deservedness is dynamic and semiotic, that it is witnessed, lived and sustained by means of words, exchanges of objects, ceremonies, acquisition of gear, and magnitudes of *in*visibility. As 100 expressed it in 0006, 0007 (above, in example 5.16), these findings are significant with respect to the challenges for those who are invisibly wounded, not just at the MTF, but later, outside: "it's gonna be even more harder."

This finding is significant within and beyond the MTF order of discourse because it speaks to one of the ways we decide *who* deserves *what*. Apparently, people who are missing parts, and have had parts attached (and sometimes re-attached) are more deserving of recognition and access to resources than others who appear "whole." This finding applies widely to people everywhere. Its multivalent obviousness deserves more research. If at a MTF we decide *who* deserves *what* based on who is missing what, and why, then we probably do so elsewhere, and by extension, everywhere. If the provenience of harm, plus the obviousness of harm, plus the technological sophistication of the mitigations of that harm (advanced prosthetics for example; or

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[209] As pointed out by Messinger (2008b:109), please see Cacciapaglia, H, Beauchamp K, and Howells, G. 2004:181 for the effect of visible *dis*ability on subjects' willingness to interact.

[210] I learned (and was instructed) that assessments reached within the twin evaluation processes of Medical Evaluation Board-*ing* [MEBs] and Physical Evaluation Board-*ing* [PEBs]) figure centrally in the military discourse of disability. In these formal processes, determinations regarding fitness for active-duty and "percents" of disability are conferred and sub-sequently accepted, rejected, or appealed by SMs who are being retired (or "separated"). Their statuses and percents are linked to payments.

participation in sports model of rehabilitation) redound to more enhanced deservedness, we may be privileging a small group at the cost of erasing a large one.

My third finding is that within the institutional/military order of discourse,[211] *dis*ability is understood to be a process of being assessed and making claims (252FN); and that neither so-called able-bodied and able-minded SMs, nor those who are in treatment and rehabilitation, nor their inter-dependents, identify themselves or their charges as *dis*abled. Medical anthropologist Messinger 2010 points this out with respect to military amputees who refused prosthetics and did not identify as *dis*abled at WRAMC.[212] Messinger acknowledges Kurzman 2003 who writes about civilians who refuse prosthetics and do not identify as *dis*abled (Messinger 2010a:283); as well as Frank 2000, who conducted ethnography of a woman who was born with no limbs and throughout her life has refused both a "*dis*abled" subjectivity and use of prosthetics (Messinger 2008b:110).

I read critical accounts about and explanations of *dis*abled subject refusal (Adkins 2003; Bérubé; 2003; Cushing 2003; Davis 2010c; Frank 2000; Ingstad and Whyte 1995; Linton 2010; McRuer 2006; Meekosha and Dowse 1997; Mockenhaupt 2007 Rapp and Ginsberg 2001). Even so, my supposition was that formerly able-bodied SMs who became wounded, ill, or injured, their inter-dependents, and the content of material culture at my sites would express subjectivities of *dis*ability. After all, I was not focused only amputees at a MTF who use or refuse prosthetics; in fact, my research questions were anchored in the discourse of distinction between wounded, ill, and injured, and visibly and invisibly harmed SMs–and, at my sites the

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[211] I am locating this finding within the institutional/military order of discourse (which governs the MTF order of discourse) because virtually everyone I talked and listened to at WRAMC and WRNMMC discussed *dis*ability frequently, no matter their condition, or the occasion.

[212] Interestingly, 2 of my respondents talked, unbidden, about Messinger's subject, an SM who is an amputee. My respondents pointed out that his refusal to use a prosthetic was complicated: It did not fit well, it was heavy, and the patient did not accept the somatechnic intervention that had been imposed on him. He was not ready to adopt "it" and the new embodiment "it" connoted–even though in other respects he was compliant (Messinger 2010b; 140/150FN).

word "*dis*ability" appeared centrally and repeatedly in many texts. However, when I asked respondents about considering themselves or their charges as *dis*abled they disavowed the identity.

For example, a self-identified wounded SM talked to me about his experience being blown up in an explosion during combat, being hurt, having surgery, and being rehabilitated at a MTF. I asked if he hears or thinks about the term "wounded, ill, and injured," and he said:

> Example 5.21
>
> 060b, *v2* Wounded Service Member, 166 words out of 7906 in transcription
>
> 0001 Yeah but th- ill and injured I don't wounded makes me
> 0002 think of combat ill and injured makes me think of … s- somebody's
> 0003 ill or somebody's injured [R]
>
> Then I asked him if he thinks of himself as *dis*abled:
>
> 0004 I don't I I I … … um I dunno I don't really I don't consider
> 0005 myself disabled um I consider my self … … … … … … ooo
> 0006 uuhh … like I I I I consider … … … … I I consider what I what
> 0007 I've experienced to be traumatic stress not POST traumatic stress
> 0008 … … but when it comes to disability … disability has in my mind I
> 0009 would then … …. … this little piece on my dd 214 that says I'm
> 0010 getting a disability payment an' that I think … … for me has a kind
> 0011 of feeling behind it that that seems … uh ... strangely enough
> 0012 dishonest heh heh hh heh heh [R]

In this interview, right after the respondent talks about "wounded" meaning hurt in combat (0001, 0002), I ask him (who has self-identified as wounded in combat) if he considers himself *dis*abled. After some hesitation he says he does not consider himself *dis*abled (0004), and shifts his description of himself to "traumatically stressed" (0007), which signals a side-step and an appropriation of "ill."[213] Here, towards the beginning of our 48-minute interview, the author disavows *dis*ability as a self-identity and explains that in the military, *dis*ability is a

[213] By which I mean this respondent switches the discussion to illness even though he has self-identified as wounded in combat.

process of making claims; whereas at the end of the interview he also proposes that there *is* a link between *dis*ability and deservedness. In that "coda" (Hill 1995) 060 says,

> But I think there are a lotta people that don't that don't give shit an' an' wanna get their disa- disability even though they may not intrinsically think they're disabled they wanna get disability because they feel like they're owed it or they deserve it.
>
> – 060b

This modalization is significant to my analysis because it signals the SM's discomfort with the question, the identity, and the process. I positioned him as oppositional to the MTF order of discourse; outside. He is a bad subject.

I asked a self-identified injured SM the same question:

> Example 5.22
>
> 080a,*v2* Injured SM, 58 words out of 9326 in the transcription
>
> 0001 … do you think of yourself as disabled or when you hear
> 0002 the word disabled does that connect with you? [Q]
>
> 0003 *Ss hh* sn- I am limited … … … I dunno about disabled I am
> 0004 limited I mean there's certain things that I can't do and
> 0005 there's certain things that I might not be able t' do as faaast …
> 0006 but I could still do it or I could still like I said just give it a shot [R]

My data showed that for structural, systemic, and ideological reasons, in the military/institutional and MTF orders of discourse, the way "*dis*ability" is used does not align with civilian expressions of adventitious *dis*ablement, neither in aspects of the adventitious event (accident, physical damage) or condition (diagnosis of cancer for example; depression; or a painful back), treatment, rehabilitation, recovery, and return-to-duty; nor regarding re-entry with altered abilities into a civilian community.[214] This finding is significant because it challenges the

[214] Some of my respondents were civilians who have themselves, or have family members who have, been adventitiously "*dis*abled."

ways in which people construct (and in these disavowals, de-construct,) *dis*ability; moreover, disavowal of *dis*ability by respondents in this research reflects the extraordinary power that networks of social practice; i.e., of orders of discourse, have on how people view themselves and others in variable contexts. This finding underscores and advances CDS' contention that *dis*ability is a sociocultural and contingent construction. My respondents were making sense to each other (and themselves) within a MTF whose rehabilitation order of discourse is governed by an institutional/military order of discourse. These nested systems of meaning do not permit members to identify as *dis*abled. Membership in the military, even its terms (the "promise"), relies on SMs' fitness, or their re-fitting.

Because the meaning of *dis*ability is parlayed differently in military and civilian discourses, SMs who are adventitiously *dis*abled and the people with whom they interact at a MTF can only partially represent or "stand in" for other people and their experiences in other places. In originally making an assumption that so-called "*dis*abled" people or actors in a particular place might substitute for or represent so-called "*dis*abled" actors in any place, I had discounted the power and particularity of forces and relations in context.

Based on what I found in my data, one of the reasons that *dis*ability is understood differently in the military is structural: *Dis*ability is a *process* of claims. The other reason is ideological, and is correlated: The harm, rescue, rehabilitation, and modes of recovery with which SMs and their inter-dependents are grappling are implied as potential outcomes of their original military enlistment or enrollment compact. This compact animates SMs' extreme and banal activities, makes them meaningful *in situ*; and alters (even co-opts) the idea of adventitious *dis*ability that is widely held elsewhere; i.e., that altered ability to conduct DLAs connotes "dis" ability (ADA 1990). In the institutional/military order of discourse, abilities (and their

embodiments, i.e., SMs) that have been altered are rehabilitated, re-fit, or removed; and are eligible to make claims, i.e., to receive bene-fits.

For many people who are enlisted or commissioned into the U.S. Armed Forces, the risk of being wounded, becoming ill, or sustaining injury is neither masked nor mystified; it is both implied and specified as a motivating factor of and for their enlistment, and is offered up as a potential payment-in-kind for the life-long rewards and benefits they receive or will receive.[215] The inherent risk of being harmed comprises SMs' and their families' "sacrifice" and may in some cases be understood to signify their "service;" for example, when SMs lose limbs.[216] The mutual promise, i.e., between military "forces" and SMs, and by overt extension their family members,[217] is invoked constantly by means of semioses–words, salutes, exercises, ceremonies, chants, claims, tools, and technology–and constant usage of the word *dis*ability. The visibility and audibility of these invocations–their obviousness, both in interpellating[218] and in sensorial terms–correlates with subsequent recognition and access to resources that variously embodied SMs attain, or refuse, or "work" as good, bad, and dis-identifying subjects.

An injured SM who had one leg amputated talked to me about the likelihood that he would be re-deployed:

Example 5.23

080b,*v2* Injured Service Member, 321 words out of 9326 in transcription

0001 Well yeah like I said the the sports thing I'm doin' it's
0002 just a way of testing myself you know a way of pushing
0003 myself … deployment just part of the job it it's kinda like you

[215] A physician with whom I met stressed this to me; he used the word "promise" several times in our 30-minute conversation.

[216] Many respondents used the term "gave life and limb" to describe or qualify the service and sacrifice they understood to have been offered up by SMs under discussion–including themselves; e.g., see 020's transcription in Appendix A..

[217] I mean that family members are also inducted into the military family. They say so.

[218] By which I am referring to Althusserian "recognition" and "hailing" (1971:172,173).

0004 go to school for a degree right? … … annnn' after awhile
0005 you wanna work in that degree you wanna put that degree
0006 that you get to wanna earn your livin' doing that what you what
0007 you learned same thing in the military in the infantry I
0008 mean what's the point of learning how to shoot learn and
0009 communicate how to fight or whatever if you're never gonna do it
0010 Yeah that isn't so as I'm saying if I'm understand the military
0011 I understand that there's a possibility that I might get deployed
0012 again so I'm OK wid it I mean *hh* it's like a firefighter that
0013 decides I'm ownna be a firefighter blah blah blah blah blah … and
0014 not expect to ever get burned? if it doesn't happen … it's good
0015 I mean but not assume that he'll ever get burned? Or police
0016 officer that says I'll never get shot? I'm like … what were you
0017 thinking living it? You got so many things out there I would
0018 it's just foolish I'm not gonna lie to myself I'm not gonna
0019 create an imaginary world that I'm … then find out I'm like oh
0020 yeah yeah yeah yeah you're deploying next month … then
0021 have all these issues that it coulda been avoided by admitting
0022 the truth from the beginning
0023 Well you gotta accept reality … … and the minute you accept
0024 reality is the minute you start
0023 dealing wid it and you find ways
0025 to deal wid it … because otherwise like I said you end up
0024 with
0026 frustrations [R]

I found that the generic features in this respondent's interview reveal it to be a reflexive commentary; he comments on his and others' choices (firefighters 0012, police officer 0015, 0016), the risks he faces, the dangers he signed on to, and the work that his membership requires and that he is ready to undertake. Although he lost a leg, he now has many legs (see detailed analysis of 060's transcriptions in Chapter Four). He was fit, now he is re-fitted. His style is aligned with the institutional/military order of discourse: disciplined, resigned–insofar as he has signed over or given his allegiance to his force–and "trained." His own discourse represents the dialectical military ideology of subjection and authorization: the respondent is rigorously trained, and tested; he is prepared to return-to-duty after setbacks; never to leave anyone behind (including himself); and to continuously maintain his ability to provide service and sacrifice to

his force, and by extension his family. He is at the center/supporting the MTF order of discourse, and is overtly governed by the institutional/military order of discourse. He is a (very) good subject.

I found a consistent message that those who are in the military "family" believe that military lives are "different." My (and others') research found that SMs self-select[219] and are rigorously trained and tested to be fit, to return[220]-to-duty after setbacks, never to leave anyone behind, and to continuously maintain their ability to provide service and sacrifice to their force, their families, their communities, and their nation–as 060 has explained. Through intense physical, mental, and psychological training, SMs form strong bonds and identify within a military "family." Their senses of themselves, or subjectivities, are based on their fitness, resilience, and readiness to protect "the nation" and to fight "the enemy." Their family members are trained, too, and their subjectivities also become bound up in their SMs' identities: They too join the military family. In turn, individuals, organizations, and communities may herald SMs' and their families' sacrifice, and readiness, and celebrate their patriotism and heroism.

When we conducted an interview together, I asked 090 (who is a civilian) to talk to me about whether she perceives a link between *dis*ability and deservedness. She responded by talking about her family (I provide my question first, in lines 0001-0006):

Example 5.24

090*v2* Care Provider, 57 words out of 3605 in transcription

0001 And we had already talked informally about what I'm
0002 interested in I'm interested in hearing about your point of view

---

[219] While some people who are not members of the military forces or are no longer active-duty may disagree, SMs and family members with whom I worked at a MTF told me that they voluntarily joined the Armed Forces for numerous reasons, primarily because they chose to.

[220] I noticed that the word "return" is used frequently in the military order of discourse. For example, when (dead) bodies of uniformed personnel are shipped back to the United States from abroad, their journey, arrival and ceremonial acknowledgements (at Andrews Air Force Base in Maryland for example) are referred to (are "mediated") as "return services."

0003 uh about the differences between the kinds of recognition people get
0004 and the kinds of access to resources they get depending on how they
0005 were wounded ill or injured an' um I wondered if you had any thoughts
0006 or comments about it [Q]

0007 *Hh* well argh argh … first of all … tsk my family's a military family
0008 my husband is just recently retired after thirty years my daughter is
0009 active-duty right now in the active duty Army [R]
0010 I have lots of uh I mean military is part of … the military culture's
0011 just part of my family [R]

Many of my respondents and much material culture that I examined clearly expressed that being in the military is being in a family, that "military lives are different," that "just being in the military is *dis*abling," and that when SMs and their families join the Armed Forces they are "forever changed." While these assertions may seem contradictory; i.e., that for members of the military family, *dis*ability is understood as a process, that it is also understood to be an inherent risk of membership, that just being in the military is *dis*abling, and (as I describe below) wounded, ill and injured SMs do not identify as *dis*abled, within the institutional/military and MTF orders of discourse, these ideological elements co-exist and make sense. This finding is significant because it demonstrates that the internal "logics" and knowledges within systems of meaning and networks of social practice may be impenetrable to outsiders. When this is evident, their mechanisms beckon research.

While my original notion that my findings would apply to civilians is not "wrong," I found that because of particular contingent meaning-making factors in the MTF order of discourse, my research findings may not apply directly to civilians who do self-identify as adventitiously *dis*abled; whereas, they do elucidate ways in which people decide who deserves what, and they support that visibility of difference is extraordinarily powerful, for better and for worse. My research findings contribute specifically to understanding the experience of

rehabilitation for SMs and their inter-dependents at a MTF; and more broadly to unpacking, challenging, and influencing how people decide who deserves what.

Detecting and Identifying Findings 5a-5f

I also found that multivariable texts at the sites reflect and refract shared themes of lived experience at a MTF. Particular shared words and phrases or images contained, referred to, borrowed, transposed, and re-emplaced (entextualized) linguistic features, and appeared irrepressibly. These versatile elements appeared to constitute, promote, and uphold the "end" of making and sustaining meaning for their rapporteurs. They index aspects of lived experience at a MTF that are dialectical, dynamic, and irreconcilable; i.e., they are discourses-in-formation. I grouped them into binaries, the first of which is Loss/Recovery.

This collection of line fragments is culled from 4 respondents' transcriptions and I list them to show the kind of use I am after:

Examples 5.25

060 Wounded SM

price that that someone else has paid
when you lose a body part
lost their legs or arms
by the tone of the words was missing something there was like
this piece that wasn't there anymore an' he sounded he sounded
diminished

030 Care Provider

when they got into the wounded warrior unit they lost the beret
I mean apart from um being depressed by their injuries which is
reasonable to expect also they're depressed because they were lowered
in status and so um … he was really despondent about it and uh I'm
sure he wasn't the only I mean to lose something that you're so proud
of I mean first to earn the badge or the emblem or the beret is a great
uh uh everybody takes great pride in that they wear those things prid-
proudly and to lose it it's really a demotion it is a demotion I mean no

matter how anybody puts it I mean uh even though people say well it's not you know it just shows your activities but it's a a it's a demotion they probably won't re-achieve some of them with more serious injuries

080 Injured SM

See if we could do it you know we just got recovering
Ride 2 Recovery

010 Care Provider

there's attachments for their prosthetics

050 Family Member

they're attached to a socket
lost her leg above the knee
she lost her leg after surgery
lost complete use of his arm on his left side
she had a recovery period
her other remaining one

At a MTF, everyone who is wounded, ill, or injured has lost something: health, status, a body part, memory, family members, buddies. And those who care for and rehabilitate SMs are collaborating at recovery. The theme is eminent, yet so naturalized that until the analyst ponders texts methodically and considers linguist features and elements in detail it may not "occur." As soon as I focused on finding words and images that reflected Loss and Recovery–they were "there." Because of their omnipresence, and the ("obvious") eminence of the theme itself at a facility devoted to replacing, re-fitting, and restoring people, I (theoretically) elevated this "theme" to a discourse-in-formation that upholds the MTF order of discourse; not a new discourse, but one that that is dynamic, unstable, and contradictory. The significance of this finding is two-fold: first, it indexes lived experience of everyone at a MTF; and second it demonstrates that words are emblems.

When SMs and others corrected my deployment and underlying sociocultural construction of the word "*dis*ability," I found they were also brushing up against another shared theme: Identification/Disavowal. The next story was related by the ex-active-duty Army soldier who had been treated and rehabilitated at a MTF, and who self-identified as "wounded" and also as "not *dis*abled."

Example 5.26

060b,*v2* Wounded Service Member, 68 words out of 7908 in the transcription

0001 Oh yes so anyway so my buddy told me he's like you've got a
0002 purple heart you've got uh you c- you can go but you can get
0003 you can go and get disability you should you should apply
0004 for disability … and when he said that I I didn't want to do it and
0005 I won't do it because I I don't think I'm disabled [R]

Even within this short excerpt, the respondent struggles with Identification and Disavowal, alternating between embracing and rejecting his own and another SM's identities as "*dis*abled." Until 2011, Purple Hearts were granted only to SMs injured in combat.[221] This respondent was deployed and wounded in 2003, and earned a Purple Heart. Even so, he, like others who spoke to me about "not being *dis*abled" disavows his altered ability. His genre is an interview whose generic features construct an argumentative explanation in narrative form. In his 48-minute interview (this is excerpted from the second of 2 interviews, "a" and "b") 060 tells many stories to illustrate his points of view, and tells me before and afterwards that he has enjoyed talking to me. His military jargon ("buddy," in line 0001, and "you can go and get disability you should you should apply for disability" in line 0003), pitches his style in this short section towards identification with the ideological apparatus that constructs and sustains the MTF, yet he resists how he recognizes himself and is being recognized by another (via earning a Purple Heart), arguing about being subjected to the dominant discourse. On the basis of this

[221] And by default, only to men.

excerpt, his discourse represents him as oppositional/outside the MTF discourse, the realm in which the identity he has sacrificed so much for, i.e., a wounded SM awarded with a distinguished medal, is privileged. Moreover he is even resisting the very distinction he has made elsewhere in his interview–that *dis*ability is NOT an identity, it is a process. How can *dis*ability have nothing to do with, and everything to do with a Purple Heart? Only in the contradictory relationship of a Faircloughian order of discourse: a way of representing lived experience within a particular space-time; a way that flexes and is flexible, that remains-in-formation, and is dialectical. This SM is responding to his own ideological, social, and politico-economic fluctuations, and sharing in the construction of a critical discourse.

What is significant about finding a discourse of Identification/Disavowal among wounded, ill and injured SMs, their families, NMAs and care providers, is that it uncovers a central struggle between how we view ourselves (and are viewed), depending on spatio-temporal factors. This nascent discourse speaks broadly to the difficulty of accounting for thousands, if not hundreds of thousands of SMs (some of whom move on to VA or community care facilities, or to home) who are both claiming and not claiming to be *dis*abled. The finding also speaks to the difficulty of assessing and doling benefits; and appealing and justifying assessments–all of which activities require massive federal and state commitments to provide adequate resources.[222]

Another theme I identified is "Inside /Outside." My data contained innumerable direct and implied references to this binary; recurring textual constructions of an "in here," within and

[222] I met with a lawyer who adjudicates Veterans Administration benefits. S/he noted that because of Veterans Opportunity to Work to Hire Heroes Act of 2011 (VOW), including mandatory training for VETS with respect to claiming benefits, 500,000 new claims will be processed in 2012; discussed VA's burgeoning needs for resources, people and money because of increase in demand from an expanded pool of informed people with claims; discussed how claims can be appealed regionally (VA); nationally (VA); then beyond VA to Regional Court, Circuit Court and Supreme Court; and that claims can be denied and appealed, and often are.

among people in the discursive rehabilitative complex; and an "out there"–a place, time, and condition beyond the circumference of the MTF. One respondent said,

Example 5.27

010*v2* Care Provider, 148 words out of 5445 in the transcription

0001 So uh I think it's … more accommodating in here whereas outside
0002 it's it is what it is there is there are not that many accommodations
0003 beyond what is expected … (w)ell just as an aside that's one of my
0004 concerns um for the uh for the guys because they are so accommodated
0005 in this environment my concern for them when they leave this setting
0006 and go back to their homes their families and because they're so used
0007 to to this kind of environment and you out there it's totally different
0008I think they would have adjustment problems and issues um…but
0009 f- for the most part I'm just concerned that that when they go out there
0010 it's not going to be as inviting yeah…(s)o honestly I suspect the
0011 question of disability becomes clearer once they're out of the hospital
0012 when they're in the world and trying to function [R]

Another respondent referenced being Inside /Outside. In this section he talked to me about someone who was "in" some aspects and areas of the military yet "outside" others:

Example 5.28

030*v2* Care Provider, 131 words out of 7098

0001 as veterans and uh a lot of these guys are choosing to stay in …
0002 they get good services um but uh its really limited their their units
0003 are uh insulated I mean there's a guy I work with in uh one of my
0004 units he's a civilian guy recently retired military and he had been a
0005special forces guy and uh he know he knew he would be a great
0006 counselor for these guys and uh he wasn't uh he wasn't allowed to
0007 talk to these guys because because he wasn't you know you know
0008 part of their contingency but I know he would have been ideal because
0009 he'd been in special forces for years and knew you know a lot of the
0010 classified stuff a that these guys were doing

The author speaks about dialectical aspects of being both In and Out. In this passage, words describe action taken or not ("choosing to stay in" [0001]); of representations ("their units are isolated" [0002, 0003]); and of identification ("because he wasn't part of their contingency"

[0007, 0008]). This respondent may struggle, yet he does not "worry" or "work" the central tenets of the ideological apparatus that construct and sustain the MTF order of discourse; nor does he resist or refuse how he is being interpellated–how he recognizes himself in relationship to his conditions of experience. On the contrary he recognizes himself and inter-dependent others as subjects of the dominant authorizing discourse; in other words he is central/supporting the MTF order of discourse.

Linguistic and ideological juxtapositions like these, and the components that make up my arbitrarily constructed binary may be "interesting;" what makes them finding significant is that the theme Inside/Outside is dynamic, adaptable (being inside and outside, and going inside and outside; being required to be inside, or not being permitted to be inside), and representational. It is a discourse-in-formation: generative, productive, and contradictory. Its dynamic tension may or may not resolve, yet its very energy fuels the MTF order of discourse. When discourses flex and respond, as this one does, it is doing some kind of successful work; in this case, providing a means to make sense of contradictory systemic and phenomenological aspects of lived experience within the institutional/military and rehabilitation/MTF orders of discourse.

One of the most central internal binaries of the institutional/military and MTF orders of discourses features an endlessly reflexive and ideological commentary about Service/Sacrifice. This multivalent "topic" acts to call and justify military membership, and its benefits and costs. In virtually all forms of text I observed or collected in my data, service and sacrifice are invoked, from the "thank you for your service" transactions that I alluded to in Chapter Four, to the ceremonies that occur at such places as Dover Air Force base when dead SMs are "returned." What impressed me when I analyzed my data was that this 'binary theme" is a daily dynamic conversation that is animated by people at the site and in the moment. For example, SMs are

referred to among themselves and interdependent as "service" members, and they and their family members talk incessantly about "sacrificing," not necessarily their lives or their limbs (they do that too), but also their personal time, their family stability (SMs are re-posted every 2-3 years), their physical well-being due to arduous training and exercises, and their "lives." Much conversation includes talk and text about what people "will do" after they retire, after they "leave," after they have "served" their contracted commitment. This discourse is dialectical, personal, dynamic, and seemingly unstable; yet its very presence appears to act as a continuous binding mechanism, persuading and assuring some continuity in individuals' identity with respect to shared aspects of their group membership. In addition, at an individual level this discourse includes ways to explain and understand what appear to outsiders to be irreconcilable performances of duty. For example, as I noted in my review of data and analysis, when she talked about some wounded SMs returning to duty, a care provider invoked service and sacrifice, saying,

> Example 5.29
>
> 010*v2* Care Provider, 70 words out of 5445 in transcription
>
> 0001 like um … unit in (*name of military base*)? So some of the
> 0002 amputees can go back there and still remain in active duty um
> 0003 one of the guys that I know just recently did that and um then
> 0004you know one of their colleagues said uh you know er one of their
> 0005 fellow service men said you know he's one of the lucky ones
> 0006 he's getting to go back to duty [R]

When I asked another care provider about how her family and friends regard or describe her work and her patients, she responded by talking about references to SMs' sacrifice and service:

Example 5.30

020*v2* Care Provider, 43 words out of 5953 in transcription

0001 Regarding their service they (family members and friends)
0002 always talk about you know there guys are defending the country
0003 country and they uh uh they they sacrificed themselves you know
0004 for their country and they uh and it's always in a positive light

Like other "obvious" aspects of the orders of discourse I am interested in unpacking, comments about service and sacrifice seem "natural" in a military environment. Yet the unexpected ways in which they are deployed at a MTF are significant; i.e., they are used by SMs and their inter-dependents to explain otherwise irreconcilable "sets" and "points" in their topology of membership. While discursivity in the governing orders of discourse appears to remain stable, underneath, at the level of lived experience (compared to doctrine), service and sacrifice are difficult to manage; their effects are unstable. By constructing a discourse, i.e., by "forming" one, people animate means of managing daily difficulties, via exchanges and expressions of shared thematic concerns. This is significant because the Service/Sacrifice discourse, and others like it, enact, identify, and represent real conditions of experience that continuously and dynamically support, contest, and negotiate structural tenets of the institutional/military order of discourse itself. Absent awareness and examination of discourses like this one, structures may be rigidly over-determined, or covertly undermined–for better and for worse.

Many elements contributed to my designation of another shared theme: Individual/Group. One exemplar is from the transcript of an interview with an administrator who conducted assessments as part of the MEB and PEB processes that many respondents referred to when they corrected my use of the word "*dis*ability," moving my understanding from a socio-culturally constructed identity to a process. She said, "When you're injured in the military you really

understand the difference between being treated as an individual and as a group (member)." Another respondent explained, "What happens when people get injured is that now they're on their own, they're individuals, they're not treated the way they were when they were in the group and a lot of them want to get back to the group and they can't."

A wounded SM told me in a field-noted conversation that,

> 120FN
>
> 0001 People are part of a group in the military until they get injured,
> 0002 then they are individuals
> 0003 Thinking of or dealing with people as individuals is very different
> 0004 for military system/people

The significance of this binary goes to the heart of what it means to join the military as a so-called able-bodied individual, then to join a group (in fact, to join many groups at different scales), to join the extended military family, abdicate some self-sovereignty–some individualism and responsibilities that redound thereto–in order to receive particular kinds of support, even benefits; and then, when adventitiously harmed, to become dis-jointed, to leave the group(s), to be required to re-embrace aspects of self-governance that were not required when the SM was part of a group. In addition, many of my respondents described themselves or their charges as wanting to be re-deployed, and to get back into their groups, i.e., their military units. [223]

My identification of the theme "Sovereignty/Mortality" was prompted by considering elements from different textual sources: A retired Army officer who had been recalled to serve as an NCM explained that when guys and women too tell him they want out he always say don't rush it. Don't make that decision yet. They get out, they go home, and their friends from high school are unemployed and living with their parents. Then they want back in and they call him and there's nothing he can do (130bFN). His comments, and others, continuously pointed me

[223] Not their hospital or rehabilitation units.

towards the fact that when positioned "inside" the institutional/military and MTF orders of discourse, SMs' mortality is governed by them: by means of action, identification, and representation. They may be deployed, lose "life or limb," become wounded, ill or injured; yet their sovereign discourses and the systems of meaning that enliven them also circumscribe their lives and deaths: to differing degrees (depending on rank, status, and naturalized privileges) they are provisioned.[224]

Another sort of text led me to find the nascent discourse Sovereignty/Mortality: It appeared among references to family, military service, and sacrifice in sources such as a documentary film about Ivonne Thompson, the wife of an SM who has been injured (not "wounded"). In the film Ms. Thompson says, "I never in a million years ever even fathomed this being an outcome of him going over there. He wasn't like he was supposed to be. He's forever changed." [225] Lives and deaths of family members are imbricated in military service too. This finding is significant because it peels back the layers (or laminations) of structural and agentive responsibility that bind to each other within orders of discourse.[226]

Detecting and Identifying Findings 6 and 7

I gleaned two more findings, both extracted from understandings of data I culled during participant observation: First, at a MTF rehabilitative sojourns are undertaken and endured

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[224] Although not to the extent that many civilians might assume, according to a retired Army Colonel who commented on my finding (Jennings, personal communication, 2012). She indicated that there are many "costs" to SMs that are under-recognized; i.e., that widely are assumed by civilians (and even some potential SMs) to be "paid for."

[225] Ivonne Thompson, military wife of Injured SM, panelist at Navy Smithsonian Conference on Wounded Warrior Care 2010, blogger, activist, and subject of the documentary *Far From Home, Injured Vet is Never Alone*, produced and directed by Abdu Neiyer, 2010.

[226] Hill identifies "laminations of voices" and a "moral geography" when she explores conflicting ways of speaking and contradictory ideologies that are distributed across a complex of voices through which respondents construct their stories These laminations express distinct layered voices in a shifting moral geography; they speak alternatively about confidence, heroism, learning, ambivalence, subjectivity, and "trouble;" and they articulate an emergent sense of the centered self, and of mortality (1995:96-147). When layered together, laminations combine to reveal "essence"—a composite, multiply refracting self. I appropriate her concept, adding letter "t" to present these "geographies" as mortal.

within a sovereign space-time that has real and imagined boundaries; by which I mean that real harms are managed there (or not), while imagined[227] levels of and links between *dis*ability and deservedness are also parlayed. SMs' and their inter-dependents' mortal journeys begin long before wounds, illness, and injury are sustained or treated, and last beyond treatment and rehabilitation. Nevertheless, it is at a MTF that previously so-called able-bodied and able-minded SMs interact with others in order to restore themselves to their former rank, status, and "standing." A MTF is more than a place in which wounded, ill, and injured SMs are cared for. It is a space-time in which things lost and missing are re-attached; a state of transition and liminality in which consociates "re-member" and rehabilitate people and ideals. In these circumscribed spatio-temporalities, sovereignty which was abdicated by "able-bodied" SMs in their period of incorporation; i.e., enlistment or enrollment, is re-claimed by or thrust back upon them during their liminal period of recovery, and efforts at re-incorporation (van Gennep 1906:21; Turner 1969:94). In treatment and rehabilitation, inter-dependents work at re-attaching and re-inscribing corporeal, cognitive, and affective notions and embodiments of service, sacrifice, and patriotism. Outcomes are *un*even in these space-times and among these inter-dependents. Despite (or perhaps because of) the "obvious" taxonomy of deservedness that respondents attested to, for those who can not, or will not, or are not selected to be recognized, recalled, and re-membered according to the tenets of the rehabilitative/MTF order of discourse, there may be unexpected, unnoticed, or unacceptable outcomes within their shared space-time.

My last finding is that a MTF is a state of exception; a counter-fit of the state of exception that Agamben and others scholars of necropolitics discuss (Agamben 1998:9). *contra*

[227] By using "imagined" I am suggesting "imaged" and "imagine-ed," and indexing ideological conditions of existence, real and imagined. According to Althusser, "Ideology represents the imaginary relationship of individuals to their real conditions of existence" (1971:162). This relationship is imaginary in the sense that ideology does not refer to the physical conditions of life, but to the psychosocial states, relationships, and perceptions that are formed through ideas.

Agamben, a MTF is not a refuge for banished subjects who have been stripped bare, nor a zone in which they are suspended from the very trappings that define human-ness (1998:5-12). Rather, a MTF is a state of exception in which humans who to some extent have been stripped bare and dis-membered (either literally or figuratively, or both by virtue of wounding, illness, or injury) are re-incorporated. In this space-time, harms are re-dressed; people and things interact to recover that which is lost or missing; and transformations may occur. SMs, family members, NMAs, and care givers interact to repair, heal, and assuage; while at the same time, co-constituting understandings that are shaped by ideology and that express enactments of power within, outside, or at the margins of orders of discourse. These enactments of power are expressed semiotically through somatechnical skills, knowledges, and technē. They convey productive hierarchical forces and relations of power within a taxonomy of harm and of correspondence: obvious for those who are "wounded;" obscured for those who are "ill;" and glancing for those who are "injured." Correspondences (or, co-respondences) involve actions, spaces, and things such as designations, clinics, and gear. They are texts that represent signifying components of authorization and subjection, and are signs of allegiance to belief systems in which real and imagined recovery may occur.

Summary of Findings and their Significance

Discussion

> Meaning cannot (and does not wish to) change physical, material and other phenomena; it cannot act as a material force. And it does not need to do this: it itself is stronger that any force, it changes the total contextual meaning of an event and reality without changing its actual (existential) composition one iota; everything remains as it was but it acquires a completely different contextual meaning (the semantic transformation of existence). Each word of a text is transformed in a new context.
>
> – Bakhtin *Speech Genres & Other Late Essays*

What people say and what they do is meaningful. Without understanding the implications of meanings, politics–by which I mean the power and potential that acts on and through people in particular political economies–may be discounted; therefore, assessing and assigning significance of findings is productive. This discussion has plumbed the "semantic transformation of existence" that occurs among texts in particular contexts. Table 5.3 lists my findings and indexes their significance. When I asked people if they perceive, experience, enact, or detect a relationship between the way people become *dis*abled and how they then gain recognition and access to resources they said yes. They also corroborated that there are consequences to such relationships, and that some people benefit on account of, or at the expense of, others. My respondents provided examples of the ways in which the link between *dis*ability and deservedness is expressed, felt, and sustained; and their examples led me to construct a matrix of co-constituting discourses in which:

1. Semiotics express and attest that compared to invisibly harmed SMs, visibly harmed SMs are recognized more and have greater access to resources such as parking privileges, tickets to events, gear, commendations and celebrity.
2. In the institutional/military and rehabilitation/MTF orders of discourse, *dis*ability is a process of making and appealing claims, and of being assessed and recompensed. It is not an identity or condition.
3. In the institutional/military and rehabilitation/MTF orders of discourse, members believe that they and their lives are different from those of non-members, in particular, civilians. When people join the military they join a multi-scalar family, and so do their family members.

4. At a MTF texts of all kinds express discourses-in-formation. In a productive relationship, nascent discourses co-constitute the orders of discourse that govern them. They are dynamic, contradictory, and dialectical. These discourses reflect shared themes of concern, interest, and struggle. They are: Loss/Recovery; Identification/Disavowal; Inside/outside; Service/Sacrifice; Individual/Group; and Sovereignty/Mortality.
5. During rehabilitation, inter-dependent people collaborate to enact recovery from harm. Things that are missing are re-attached, replaced, or repaired. People are re-membered. Rehabilitation is a liminal space-time in which participants attempt to restore wholeness, health, and ideals.
6. A MTF is a state of exception in which wounded, ill, and injured subjects who have been stripped bare are redressed.

Understanding how some people manage their lived experience, and what their lived experience entails, may provide means to mitigate *un*even outcomes, including *in*visibility and *in*audibility. To do that (to understand), researchers must pay attention to and think about what people say and what they do, in context–and what they can not do or can not say, yet which may be indexed via texts. Findings can be extracted from data via analysis, and their significance discerned by means of critical thinking. Significant findings may be reshaped into recommendations and applied to policy and practice in networks of social interaction.

In Table 5.3 below, I show my "order of findings," précis their significance, and index their implications.

TABLE 5.3: Significance of findings			
Significance	Finding		Implications
These findings indicate that people at a MTF know and can describe their conditions of existence and they recognize inequity.	1a	Perceptions of *Dis*ability are Linked with Degrees of Deservedness	Some people get more recognition and access to resources than others and the reasons must be examined so that enactments of deservedness are equitable.
	1b	The Link between *Dis*ability and Deservedness has Felt Consequences	
	1c	Texts Sustain the Link between *Dis*ability and Deservedness	
	2	Visibly Harmed SMs are More Recognized and Have Greater Access	
	3	*Dis*ability is a Process not an Identity	
	4	Military Lives are Different	
These findings show that performances and responses to conditions of existence are productive.	5a	Loss/Recovery	Shared experiences foment dynamic tension, and may be productive when expressed, acknowledged and valorized. When they are mutually intelligible, they combine to construct new orders of discourse.
	5b	Identification/Disavowal	
	5c	Inside/Outside	
	5d	Service/Sacrifice	
	5e	Individual/Group	
	5f	Sovereignty/Mortality	
These findings index the MTF as spell of recovery and transformation.	6	Rehabilitation is Space-Time of Recovery	"Dis-membered" people in rehabilitation are suspended together between states of prior incorporation and future re-incorporation
	7	A MTF is a State of Exception	

Conclusion

> What is the point of doing research about these subjects?[228]
> To acknowledge others' experience
> To educate participants at every level
>
> – FN140/150

In this chapter I have used excerpts of data and ascribed their sources to draw out and discuss my research findings, and to consider their significance. Each of the people I observed and listened to, the respondents who talked to me, and the material culture I studied presented

[228] In our discussion the repsiondents and I spoke about subjects meaning "people in a study," and subjects meaning the "topics of *dis*ability and deservedness."

many of the same issues, themes, and struggles. Whereas some supported the "system" of policies and practices within which they interacted as "good" subjects, some "bad" subjects resisted or refused systemic and structural permissions and limitations thrust upon them; and some dis-identifying subjects "worked" them through misuse, refusal, parody, or advocacy. All used similar phrases, terms, allusions, examples, and expressions. On the surface this may "seem obvious;" after all, they are all connected with or are themselves wounded, ill, or injured SMs being cared for and rehabilitated at a MTF. Indeed, the impetus for my inquiry and analysis at a MTF was fueled by that very "obviousness" and potential naturalization of *in*equitable links between perceptions of *dis*ability and perceptions of deservedness. On the other hand, my findings are not obvious. By listening and reading closely I discerned textual markers that convey ideologies of fitness, power, and social reproduction; trace their effects; and to discover elements that express and comprise acceptance, disregard, and rejection of *un*even outcomes.

I found that in the taxonomy of harm labeled "wounded, ill, and injured," ill and injured SMs are widely held to deserve less; their lesser status is naturalized and has become obvious within the orders of discourse at my sites. The obviousness of differentiations in worthiness is obviousness that "we cannot *fail to recognize* and before which we have the inevitable and natural reaction of crying out loud (aloud or in the 'still, small voice of conscience'): 'that's obvious! That's right! That's true!'" (Althusser 1971:172; emphasis in original). In other words, among people at a MTF, conditions of shared existence are ideologically and discursively instilled and sustained. Finding and noticing constitutive elements may help to mitigate *un*even outcomes, including attention, successful recovery, and support for people whose abilities have been unexpectedly altered in combat, because of disease, by accident–or for unknown reasons.

In Chapter 6 I recommend ways of putting these significant findings into practice, and consider what that may mean for various people: Those who are at the center of systems of care and orders of discourse that are co-constituted as MTFs; those who are outside; those who are at the margins; and those anywhere who have been affected by adventitious *dis*ablement and whose recognition and access to resources–their deservedness–are at stake.

CHAPTER 6

PRĀXIS

Summary and Recommendations

Overview

To gain a better understanding of whether there is link between constructions of *dis*ability and constructions of deservedness, between August 2009 and September 2012 I conducted ethnography at two MTFs in the National Capital Area: WRAMC (since closed), and WRNMMC. In these spaces, people collaborate to treat and rehabilitate wounded, ill, and injured SMs: members of the military who were once perceived as "fit" or "able," and whose fitness or ability was adventitiously altered during active duty. These sites offered loci for studying what occurs when perceptions of humans' abilities are unexpectedly altered, and their consequent "deservedness" for recognition and access to resources changes. My findings are significant to understanding structural and agentive mechanisms that result in *un*even distribution of resources among people whose abilities change. These resources include visibility and recognition; and access to privileges, and to privilege. Knowledge I gained at these sites is both unique to military settings, and may also apply elsewhere.

Changes to SMs' abilities have various etiologies;[229] they may be eventuated in combat, by accident, because of disease, or due to training and requirements for physical and cognitive "readiness" (or, causes of *dis*ability may not be traceable). The designations "wounded," "ill," and "injured" are discursive components of a rhetorical strategy that has been devised and applied by agents and agencies of the U.S. Federal Government, namely people within DOD and

[229] As with "effects," "causes" of adventitious *dis*ability are variously explained, experienced, understood, diagnosed, expressed, reported and performed; they are dynamic, always-in-(trans)formation–and may be dialectical; i.e., contradictory, unstable, and reflexive. During my research I remained interested in how people responded to "received" and "sent" signals of etiologies of harm; and how their responses reflected ideological stances and conditions.

VA, to acknowledge all active duty SMs who have been harmed, in contrast to privileging those harmed in combat, or "Wounded Warriors." While "wounded" continues to refer to being hurt while in combat, "ill" means being harmed by disease, and "injured" means being hurt during active duty but not in combat, in a training accident for example. The harms that befall active-duty SMs are understood by them to be risks of enlistment, enrollment, or commissioning,[230] and are among the factors that comprise notions of service and sacrifice.

To unpack mechanisms of recognition and access to resources,[231] at my field sites I collected inter-subjective and inter-textual data (Chandler 2002:203-209) from, among, and around participants; and looked for signs and symbols that construed structure, agency, sovereignty, *dis*ability, subject formation, and deservedness. I foregrounded, gathered, and examined texts that helped me understand the ways in which people there managed adventitious *dis*ability and how they subsequently decided, agreed, and acted on who deserved what kind of recognition, and who gained access to and utilization of what resources. I used ethnographic methodology and analyzed my study data using and adapting tenets and tools of CDA and CDS to discover the textual mechanisms that co-constitute how *dis*abled SMs in rehabilitation and affected others are perceived and treated by themselves and others.

By gathering textual data and critically analyzing them I dis-covered discursive mechanisms governing practices and experiences at my sites, and gained insights into aspects of lived experience that are significant to people's inclusion or exclusion, and the degrees of deservedness being accepted, or denied, or negotiated at these sites–and potentially beyond them. I asked people to talk about their lived experience as someone who had been unexpectedly

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[230] "Enlisted" SMs are enlisted (and are designated by "E" ranks); officers enroll and are commissioned (and are designated by "O" ranks).

[231] My sense of "access to resources" is informed by other scholars' explications of "redistribution;" e.g., Butler 1997; Fraser 1997a,b, 2000; Oswin 2006; Swanson 2005.

harmed and was now being treated and rehabilitated, or someone who was caring for such a person; and I field-noted, collected, and annotated events and material culture at the sites. When respondents indicated that they did perceive a link, I asked them to talk to me about how they experienced that link and its consequences; and how they "felt" that the link was expressed and sustained. I studied components of material culture to discern the same linkages and expressions.

Believing that textual usages are governed by and co-constitute orders of discourse, I applied CDA to interpret my data; and I used insights from CDS to help me reflect on and challenge my positionings and interpretations of constructions of *dis*ability and deservedness. My analysis focused on identifying Faircloughian components of genre, style, and discourse[232] within texts to understand the relationship of my data and my respondents (i.e., my research "respondences") to orders of discourse that I perceived as governing their lived experience: the (global) institutional/military order of discourse; the (local) rehabilitation/MTF order of discourse; and the (personal and communal) nascent orders of discourse that were in formation.

Via critical analysis of my data, and following Althusser 1971, Pêcheux 1982, Fairclough 2003, and McRuer 2006, I located my respondents' positions as "central," "outside," or "marginal" with respect to orders of discourse governing sociocultural, medico-interventional, and discursive practices within their space-time. These Faircloughian positions align with Pêcheux's[233] "good," "bad," and "dis-identifying" subjectivities (1982:156), and reflect McRuer's Crip theory in which dominant and marginal corpo-realities correspond to construct,

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[232] I analyzed other discursive components such as repetition, emphasis, and voice (i.e., heteroglossia) as informed by Bakhtin 1981, 1986; and Hill 1995, 2005. I also considered the ideological work that texts do, following Vološinov: "Every sign, as we know, is a construct between socially organized persons in the process of their interaction. Therefore, *the forms of signs are conditioned above all by the social organization of the participants involved and also by the immediate conditions of their interaction.* When these forms change, so does the sign. And it should be one of the tasks of the study of ideologies to trace this social life of the verbal sign. Only so approached can the *problem of the relationship between the sign and existence* find its concrete expression; only then will the process of the causal shaping of the sign by existence stand out as a process of genuine existence-to-sign transit, of genuine dialectical refraction of existence in the sign" (Volosinov 1973:21, *emphasis in original*).

[233] As well as Leap 2009:202; Modan 2007:90, 298; and Muñoz 1997:11,12.

decenter, re-inscribe, and contest normativity (2006:149). These posit-ings, or theoretical positionings, informed my understanding of how interpellating influences acted on and were enacted by subjects at my sites–how people experienced and reproduced subjection and authorization, and how they recognized themselves and others within systems of meaning, even as their subjectivities (and objectivities) remained-in-formation.

Using ethnography and CDA I confirmed that participants in rehabilitation at a MTF experience differentiated levels of deservedness within a taxonomy of harm; and I dis-covered unexpected findings regarding discourses-in-formation. My analysis shows that there are links between how people perceive altered levels of fitness, their provenience, and their mitigations or "modes of rehabilitation" and how they then agree to accept, confer, or negotiate co-responding levels of recognition and access to resources. These enactments are intelligible within shared systems of meaning, or orders of discourse. They signal embodiments of power, and are themselves powerful.

I also found that subjectivities and discourses of fitness, power, and social reproduction are dialectical. They always-in-formation, are contradictory and dynamic, and articulate struggle that may result in transformation. Perceptions of *dis*ability are linked with degrees of deservedness and these links have material consequences. Visibly harmed SMs who are being visibly rehabilitated,[234] and their family members and NMAs get more recognition and access to resources than invisibly harmed and invisibly rehabilitated SMs. I also found that in the over-determined and hierarchically structured institutional/military order of discourse, "subjects" understand and express *dis*ability as a process, not an identity; i.e., within their orders of discourse, wounded, ill, and injured SMs and those military beneficiaries or caregivers

[234] That is, can be "seen" to be in rehabilitation–because of their visible prosthetics for example, or accompaniment by service animals, or use of assistive technologies.

supporting them did not identify them as having been "able" and now being "disable"–they identified them(selves) with having been fit and now seeking bene-fit(s).

My research helped me to "hear" that people in the military view themselves and their lives as different from civilians', and identify as belonging, i.e., as being subjected and authorized, in more than one family within a familial hierarchy. My analysis also reflected that the multi-tiered military family and its rewards and requirements (to change postings or PCS[235] every 2-3 years for example; or to be deployed) supersede personal family demands. I found too that SMs identify as and strive to maintain their statuses as lifetime athletes within the orders of discourse that govern practices and subjects at my sites and beyond;[236] that "wounded" signals "amputee;" and that amputees are more visible, more recognized, and have better access to a broader range of resources than other wounded, ill, and injured SMs.[237]

In my data, I found repeated shared themes whose discursive scopes I cast within binaries; i.e., Loss/Recovery, Identification/Disavowal, Inside/Outside, Service/Sacrifice, Individual/Group, and Sovereignty/Mortality. These dialectical discourses-in-formation underlie and co-constitute the rehabilitation/MTF order of discourse, which in turn sustains the institutional/military order of discourse in the hierarchy of governing discourses at my site.[238] The dynamism, contradiction, and "struggle" that repeated invocations of these binaries evoked

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[235] PCS is the acronym (used as a noun, verb, and adjective) within the institutional/military order of discourse to stand for "Permanent Change of Station;" and refers to the process, activity, and condition of being moved, by order, to another location.

[236] Some of my respondents were civilians, and I interviewed some respondents offsite, in civilian settings.

[237] This is significant because since 2001, 2000 Service members have undergone amputations or have lost limbs and digits at the site of their injury; while 49,000 have become ill or contracted a *dis*abling disease; and 400,000 have PTSD, or TBI, or both; yet amputees are iconic of military "service" and "sacrifice" and the recognition and access to resources (including mediation in the public sphere) that redound thereto.

[238] I intentionally choose to describe the discourses at work at a MTF as constituting a "hierarchy." My usage denotes the over-determination I am describing–the structural rigidity and influence that is "felt" and described in lived experience at a MTF. The orders of discourse I am discussing are also "nested;" i.e., they reside among each other, in horizontal layers, intertwined and overlapping at numerous "margins." Indeed, my respondents and their data reflected nested *and* hierarchical (self-)positionings; their content is dialectical insofar as it is both horizontal and vertical; and is dynamic, contradictory, and unstable.

led me to find the MTF as a liminal space-time of re-covery: Re-covery of things lost, detached, and missing–not just limbs and aspects of cognition, but also ideals; a spatio-temporality in which dis-membered people are re-membered.

After Pêcheux, I positioned inter-dependents' collaboration in re-covery as a kind of struggle in which good "speaking subject(s)" may tentatively "turn against" the dominant ideology, expressing "distantiation, doubt, interrogation, challenge, revolt…and (who may experience) separation" (1982:157). Pêcheux's trope of separation signals van Gennep's rites of passage schema, in which there are dynamic phases in life: Subjects move periodically (and, in my research, adventitiously) from stable "incorporated" conditions, through conditions which separate, marginalize, and finally re-stabilize them. Resting foundationally and notionally on the experience of crossing a *limen* or threshold, van Gennep calls these three dynamic phases[239] pre-liminal or separated; liminal, or transitioning; and post-liminal, or incorporated (1960:21). Among my data I found numerous textual elements that support sociocultural and material perceptions and interpellations of "members"[240] being separated, experiencing transition, and being re-incorporated–corporeally, cognitively, and ideologically.

My sense of the MTF as a liminal space-time of re-covery was further informed by Turner 1969, who accepted van Gennep's central trope of threshold or limen, and elaborated the condition of liminality, a condition "betwixt and between" (1969:95). Liminal beings, continues Turner,

> (h)ave no status, property, insignia, secular clothing indicting rank or role, or position in a kinship system—in short, nothing that may distinguish them from their fellow neophytes or initiands. Their behavior is normally

239 Of separation, marginalization, and re-stabilization.

240 As, members separated from families and military forces or branches; people dis-membered–corporeally, cognitively and affectively; and, dialectically, as people both re-membered and separated.

> passive or humble; they must obey their instructors implicitly, and accept arbitrary punishment without complaint. It is as though they are being reduced or ground down to a uniform condition to be fashioned anew and endowed with additional powers to enable them to cope with their new station in life. Among themselves, neophytes tend to develop an intense comradeship and egalitarianism. Secular distinctions of rank and status disappear or are homogenized.
>
> – Turner *The Ritual Process*

At my betwixt and between sites, and among my respondents, former (military and civilian) roles are suspended[241] in an intense collaborative effort to restore–to rehabilitate–beings: To fashion them anew, and enable them to cope with their new stations in life. However, my data analysis pointed to the MTF as a liminal space in which inter-dependents confer and are conferred with a kind of problematized community spirit, solidarity, and togetherness; i.e., a variation of Turner's concept of *communitas.* Per Turner, this modality of "egalitarian social relationship" emerges in periods of liminality as "an unstructured or rudimentarily structured and relatively undifferentiated *comitatus*, community or even communion of equal individuals who submit together to the general authority of the ritual elders" (1969:96). By contrast, and in a dialectical process, at my structured sites, inter-dependents achieved and expressed a sense of differentiated *comitatus* that showed up in their textual usages and designations of degrees of deservedness; some agreeing with tenets of the dominant orders of discourse, some disagreeing, and some negotiating them. In other words, the liminality of the MTF is complicated.

My data, my sense of the MTF as a complicated liminal spatio-temporality, and my reading of Agamben and other scholars of necropolitics[242] further led me to consider the MTF as

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[241] By which I mean, SMs and those who "support" them are at the same time and in the same space, altered and detached from what have been regarded as daily life activities (DLAs). For civilian and military care givers, the suspension occurs within the spatio-temporalities of asymmetric warfare, advanced military medical interventions, and unprecedented co-morbidities.

[242] Scholarship regarding the relationship of sovereignty and power over life and death (Agamben 1998:24,25; Hansen and Stepputat 2001:2, 2006:297; Mbembe 2003:11-13,26; Rose 2007a:2; A. T. Smith 2011:419).

a "counter" state of exception; a discursive and experiential condition and threshold in which human beings that have been to some extent stripped bare and separated (Agamben 1998:8),[243] and the provenience and consequences of their harms, are re-dressed. In this state, wherein care and treatment are vivified by wounded, ill, and injured SMs as well as those who support them, the power over life and death is manifest and manifested, via texts.

Situation of My Research Findings and Recommendations

Constructions of adventitious *dis*ability (and of deservedness) are discursive, sociocultural, and environmental; the effects of these constructions are *un*even and poorly understood; and they require further research. The lack of mutual knowledge and understanding between civilian and military cultures is divisive and costly at personal, familial, community, and national scales. Understanding the lived experience of military active duty, including adventitious *dis*ablement, is important to bridging the gap between civilian and military cultures; and acquiring knowledge about the real and lasting effects of becoming wounded, ill, or injured while in active duty is critical to managing costs and consequences cross widening politico-economic, juridical, bio-medical, and sociocultural geographies in military and civilian terrains.

Since September 11, 2001, approximately 2000 active-duty SMs have become amputees; while upwards of 400,000 have PTSD or TBI or both; and about 49,000 SMs have become ill because of disease, or have been injured in accidents (Fischer 2010; Magda et al 2012; Tanelian and Jaycox 2008). The extent of SMs' wounds, illnesses, and injuries, and the effects on their families and communities, are challenging the ability of DOD, VA, and civilian health-care

[243] Agamben explores the question of language and bare life, noting, "The question 'In what way does the living being have language?' corresponds exactly to the question 'In what way does bare life dwell in the *polis*?" He continues, "The living being has *logos* by taking away and conserving its own voice in it, even as it dwells in the *polis* by letting its own life be excluded, as an exception, within it. Politics therefore appears as the truly fundamental structure of Western metaphysics insofar as it occupies the threshold on which the relationship between the living being and the logos is realized. In the politicization of 'bare life'–the metaphysical task par excellence–the humanity of living man is decided" (1998:8; emphasis in original).

systems to respond effectively. Signature wounds of contemporary war, particularly combat wounds that result in multiple amputations and corporeal reconstructions, are more broadly mediated and may be stimulating more apparently effective interventions, e.g., advanced somatechnics and prosthetology, sophisticated reconstructions, and transplants, than SMs' illnesses, diseases, and accidents; notwithstanding recent attention to rising rates of suicide across all military forces and among enlisted and officer SMs who are both deployed and stationed domestically.[244]

*Dis*abled SMs are categorized within a taxonomy that is invoked to distinguish and hierarchize degrees of sacrifice and proveniences of harm. In many texts that refer to SMs whose fitness has been adventitiously altered in an array of ways, "Wounded," "Ill," and "Injured," (usually linked together as "wounded, ill, and injured") have become terms-of-art and of categorization that are replacing the designation "Wounded Warrior." In addition, care and rehabilitation, as well as highly visible mediations, appear to be triaged[245] so that SMs most likely to be re-enabled to represent the original ideals of service and sacrifice are foregrounded[246] against others who apparently can not, or do not, or will not be successfully, obviously, and comprehensibly refitted, or regain power, or be able to socioculturally and corporeo-cognitively reproduce their ranks, roles, responsibilities, and service.

I located central/supporting (good), outside/opposing (bad) and marginal/negotiating (dis-identifying) subjectivities for at least some of the people who interacted at my research site in

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[244] As of this writing (August 2012) more active-duty members of the United States Army are killed daily by suicide than by wounds sustained in combat (Rosenberg 2012:7).

[245] I am borrowing the word "triage" to index intentional and con-sequential allocation of resources. The word is a noun and a verb, meaning: In a hospital, the principle or practice of sorting emergency patients into categories of priority for treatment; the principle or practice of sorting casualties in battle or disaster into categories of priority for treatment; the principle or practice of allocating limited resources, as of food or foreign aid, on a basis of expediency rather than according to moral principles of the needs of the recipients (*Random House* 2011).

[246] By which I mean are featured in media and at events.

order to discover the presence and "felt" effects of ideological mechanisms within institutional/military and MTF orders of discourse. I paid attention to how and where respondents "said" they had incorporated and reincorporated themselves–or, how they didn't. In some cases this included literal re-incorporation of subjects who acquired and learned to use, or taught someone else how to use, prosthetics–these are "good" subjects of rehabilitation. Others refused or could not participate in reincorporation–these are "bad" subjects; i.e., SMs, family members, NMAs, or care providers who can not, or do not, or will not sign on to regimens that signal "worthy of recognition," or "worthy of gaining access to resources." In other cases, subjects' reincorporation was transitional, incomplete, or refused; these are "dis-identifying" subjects for whom "normal" care and rehabilitation regimens are not easily adopted, identified, communicated, or supported. These are people who do not converse easily or even intelligibly within the MTF order of discourse.

The fact that neither the active duty SMs who participated in my research, nor their family members, NMAs, or care givers identify themselves or their wounded, ill, and injured inter-dependents as *dis*abled conjured the work of McRuer who argues in Crip Theory that ideological and sociocultural constructions of normativity enable *dis*ability, queerness, marginalized subjectivities, and otherness (McRuer 2006). McRuer examines the efforts involved in maintaining constructions of compulsory able-bodiedness; notices their relocations within complex forces and relations of power; and comments on their disappearance; i.e., their naturalization and subsequent invisibility (2006:2,33,34,383). And elsewhere, McRuer invokes Halperin to point out that *dis*ability is a position–not an identity (McRuer 2010:385).[247]

[247] Bell 2010 invokes Hall 1992:229 to make the same point; i.e., "(A)s Stuart Hall has explained, 'cultural identity is not an essence but a positioning' " (Bell 2010:378).

In their variously expressed contestations of my labeling (i.e., my calling their altered subjectivities "*dis*abled"), study participants specifically resisted being identified by what McRuer describes as reified deviations, even deviances, from the unstable imagined "condition" of normalcy, i.e., "compulsory able-bodiedness" (2010:383), to align themselves with a normal "process" (claiming *dis*ability benefits) rather than an "ab"normal condition (being *dis*abled). In tandem with the vigorous disavowal I am describing, participants also explained or justified why it is that some wounded, ill, and injured (particularly "wounded") SMs are recognized: They are "seen" as heroic embodiments of ideal citizenship when their modes of rehabilitation and recovery mimic compulsory able-bodiedness; when they "appear" to be able (able to walk, to compete, to think, to emote, to remember). By contrast, when their illnesses, injuries, and recoveries do not appear to uphold dominant ideologies, those who do not "appear able" (or look and act whole) are misrecognized, disregarded, even "disappeared." Indeed, harm and repair that are *visible* make the work of ideological apparatuses *invisible*.

In the U.S. across the last decades of the 20thC and through the first decades of the 21stC there continue to be calls from social and political scientists, journalists, healthcare practitioners and public policy makers to bridge the gap between civilian and military cultures[248]–or at least to forge mutual understandings of them–in order to foster collaboration in areas such as individual and community health care and wellness; access to education; employment opportunities; *dis*ability rights; husbandry of federal, state, and regional resources, including spending on weapon systems' development, procurement, export, and utilization; and revisiting objectives for national defense and offense (Cohen 1998:1; Kusiak 2008:75; Maddow 2011;204; Gromke and

[248] And a parallel effort is occurring between DOD and VA policy-makers and administrators to accomplish some commensurate goals, primarily to reduce systemic duplication and obfuscation, and to streamline the transition for SMs from DOD to VA systems of care and facilities. This massive effort involves a tricky unification of disparate orders of discourses, including the meaning (and experience of) of claiming, assessing, and recompensing *dis*ability.

Feaver 2001:1-41; Szayna et al 2007:1). And it is likely that these calls have lasted through centuries of dynamic tension between civilian and military worlds of experience elsewhere (*viz* Clausewitz 1984:605).

The alleged cultural divide is lopsided because while SMs are always-already former, dormant, or eventual civilians, the reverse does not apply; in other words, all surviving military personnel were once or will again be separated from the military, for various reasons; i.e., too young to enlist or enroll or be commissioned, retired, or discharged for example; and will ultimately participate in civilian life, out of uniform, and without active-duty status (Sackett and Mavor 2003:135). Yet most civilians will not become members of any of the uniformed[249] services in the U.S.: Currently fewer than one percent of the U.S. population (approximately three million people) are active duty military SMs.

At the same time though, as some CDS scholars point out, all people who are not currently self-identified as *dis*abled, have been or will be *dis*abled either permanently *or* temporarily, via disorientation, disease, accidents, age, incarceration, addiction, and other conditions that disqualify us from able-minded and -bodied status–at least according to the way many of us in the U.S. currently construct *dis*ability (Gordon and Rosenblum 2001:16; McRuer 2010:388). A great deal of work has been and is being done regarding *dis*ability among civilians, some of it exploring effects among families, providers, and communities. Alongside that work, ethnography about *dis*abled military SMs can contribute knowledge between and among overlapping groups of so called able-bodied and *dis*abled civilians and members of the military.

[249] The United States Uniformed Services included the Public Health Service (PHS) as well as the Armed Forces: Army, Navy, Marines, Air Force, National Guard, Coast Guard and Reserves for each of the Armed Forces. Members of the U.S. Public Health Service wear uniforms that are very similar in most respects to those of members of the U.S. Navy. PHS is part of the Uniformed Services and not part of the Armed Forces.

By identifying the multivariable and complex lived experiences of active-duty SMs who become *dis*abled and the sociocultural and politico-economic ramifications of their *dis*ablement and rehabilitation, mutually incomprehensible sociocultural phenomena may be better understood–both by civilians about some military SMs, by military SMs about some civilians, and by so-called able-bodied and -minded people[250] anywhere (by which I mean to imply, "everywhere") about so-called *dis*abled people.

In addition, although a tremendous amount of work has been dedicated to critiquing the U.S. military, militarization, and militarism, there is little written work that provides ethnographic detail about the lived experience of active duty wounded, ill, and injured SMs in rehabilitation, notwithstanding notable work by Benedict 2007; Messinger 2008, 2009, 2010, 2011; Wool 2011; and Wool and Messinger 2012. Of the ethnographic work that does exist, much is photojournalistic, graphic, and filmic (Priest, Hull and deCille 2007a,b,c; HBO 2007; Goldstein 2009,2010; Trudeau 2007, 2012). Wounded, ill, and injured SMs and their environs deserve more scrutiny.

These points are germane to my summary and recommendations because:

1. Constructions of adventitious *dis*ability are sociocultural as well as environmental; and the effects of these constructions are *un*even, under-recognized, and poorly understood; they require research.
2. The lack of mutual knowledge and understanding between civilian and military cultures is divisive at personal, community, institutional, and national scales.

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[250] Or, *CA*–"Currently Able-Bodied;" an acronym and phrase that have arisen in *dis*abilities discourse to problematize the longer- standing term and acronym *TAB*–Temporarily Able-Bodied. From the points of view of many *dis*abilities activists, TAB glosses intellectual and invisible *dis*ability, may be perceived as a threat by the listener (or message recipient), and may also be counter-productive insofar as it connotes aging (for example) as a disabling (Edison, Laurie Toby and Debbie Notkin 2010). Following CRT, I choose to err on the side of including such things as aging in the realm of "*dis*ability" because of the sociocultural and politico-economic lived con-sequences that may redound to those who are viewed as less able, and therefore less deserving, due to age.

3. Understanding the lived experience of military active duty, including adventitious *dis*ablement, is important to bridging the gap in understanding between civilian and military cultures; members of the military are *people* who are the same and different from civilians, and vice versa.
4. Knowledge about the real and lasting effects of becoming wounded, ill, or injured while in active duty is critical to managing costs and consequences across widening politico-economic, juridical, and bio-medical geographies in military and civilian terrains.

Many of my respondents and data pointed out that in the military, *dis*ability is a process, not a condition. These respondences located inscriptions of *dis*ability within a "global" institutional/military order of discourse, and more locally within the rehabilitation/MTF order of discourse, and led me to consider the productive power of the structural forces and the agentive responses at my sites: the ideological factors that co-constitute and may even determine real and imagined lived experience. According to Althusser, "Ideology represents the imaginary relationship of individuals to their real conditions of existence" (1971:162). This relationship is imaginary in the sense that ideology does not refer to the physical conditions of life, but to the psychosocial states, relationships, and perceptions that are formed through ideas. Ideology refers not to how people are actually geo-physically situated in society, but how they experience their real and imagined situatedness. Althusser's notion of interpellation illustrates how ideology maintains power among people: Ideological frameworks interpellate, or call out to individuals who, in a productive process, may naturalize and rationalize their situations no matter how *un*equal or disenfranchised they may "actually" be. [251] Ideology naturalizes and justifies people's

[251] Cameron 2005 provides a relevant example of interpellation in her discussion of gender and language ideologies, arguing that readers who indulge in self-help books do so not to actually improve their lives, but "for the pleasure of 'recognizing'

beliefs and behaviors; this rationalization encourages maintenance, rather disruption, decentering, or re-inscription of the dominant discourse.

Building on Althusser, Pêcheux focuses on discourse, arguing that "the problem of discursive practice necessarily leads on to the problem of the effect of the complex of discursive formations on the subject-form" (1982:155). Subjects at my site responded variously to the discursive formations imposed on them by what Pêcheux describes as "interdiscourse," [252] the "external determination of (their) subjective interiority" (Pêcheux 1982:157). Within ideological and discursive frameworks, "good" or centrally-positioned subjects respond positively to interpellation and do not question their perceived existence in the world; "bad" or outcast subjects question, challenge, or merely refuse to answer the "hails" of ideology; and dis-identifying or marginalized subjects problematize or re-negotiate the ways in which they are being "recognized." The successful interplay of ideology, structure, and identity is contingent upon "good" subjectivity; and indeed, based on what respondents told me and what I observed, those who are being cared for and rehabilitated at MTFs have "self"-selected as SMs (during prior to and during their enlistment or commissioning); and during active duty are living out experiences that are not wholly unexpected, and in turn may be mediated as examples of heroism, sacrifice, and service–depending on their provenience, forces and relations of rehabilitation, and visibility.

Agents, Agency, and Agencies

The very people I was positing or positioning as *dis*abled refuted this "subjection." Via data analysis, including listening, I discerned an identitarian and rhetorical strategy that

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themselves. They said that the texts helped them to understand themselves better, and that far from being inspired by this to change themselves, they usually felt 'reassured' that their own ways of acting were normal, even if they were also problematic" (2005:464).

[252] And Fairclough characterizes as orders of discourse (2003:26).

differentiates *dis*ability from *dis*abled. SM respondents did not self-identify as *dis*abled despite their constant use of the word "*dis*ability" at the sites. Critical analysis of texts at the MTFs where I conducted research revised my understanding of altered corporeal, cognitive, and affective embodiments among SMs who were harmed. For example, someone who had lost both legs in combat was not *dis*abled, he or she poses (and is posed) as "Wounded;" someone who had TBI because of repeated exposures to concussing blasts, is posed as "Ill;" and someone who had been grievously hurt while training–perhaps losing an eye, or an arm, or part of a brain, is posed as "Injured." None of these subjectivities allowed for self-identity as "*dis*abled." On the other hand, within the institutional/military order of discourse, linguistic elements featuring words and terms such as "disability claims" and "assessments for disability benefits" milled and swirled constantly, comprising much of the conversation and activity among so-called able-bodied and so-called dis-able-bodied SMs, administrators, care givers, family members, and NMAs.

Across their experience, so-called *dis*abled SMs have statuses as both active duty and veteran members of the Armed Forces. In the U.S., SMs who officially receive some kind of treatment are processed and cared for under the auspices of two federal agencies: The DOD and the VA. The distinction is notable because the mandates, budgets, and administration of these two federal agencies are unique and separate–although they may sometimes overlap at a patient or client scales; and they are frequently, confusingly, and sometimes disruptively conflated in public discourse. The texts I reviewed are distinguished within their own contexts, the sites of my respondents' lived experience; at MTFs which are in military bases overseen by the DOD. Noting this distinction may serve to bring into focus who is offering what to whom, who is to be

condemned or commended (or, indeed, "co-mended"), and what needs to be done in order to address *in*equities that are expressed in lived experience at these sites.

Depending on the stance of the analyst, the underlying objectives of and for rehabilitation may be differently determined and activated by DOD as compared to VA.[253] At MTFs, direction and objectives for rehabilitating[254] *dis*abled active duty members of the Armed Forces (for example whether to return them to Service; to place them within other federal agencies, or internships; to direct them towards employment beyond the military; or to medically retire them),[255] are factors in the choice of rehabilitative models that are assigned to and undertaken by wounded, ill, and injured SMs. By contrast, choice-of-care modalities for Veterans who are being cared for at VA facilities involve strategies for sustaining maximum long-term health and welfare in organizations, institutions, communities of care, and home.

Therapeutic services offered at hospitals, clinics, and rehabilitation facilities that are not part of the DOD or VA systems may also treat *dis*abled SMs; there is a gap in the literature comparing *dis*abled SMs' lived experience "inside" MTFs and VA facilities, and their experiences at "outside" facilities. And, some *dis*abled SMs get no treatment at all or discontinue treatment, either because of assessments that do not sanction or allow them; because of their own or their family's or advocate's refusal; because of their own incapacity; because they and their wounds, illnesses, and injuries are neglected or unacknowledged; because they are isolated and

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253 The widespread and often unrecognized confusion about the difference between the DOD and the VA is not probed here except to identify an opportunity for research by anthropologists and others; and, to offer a general description of responsibility for care of active duty *dis*abled SMs. The DOD is broadly responsible for the care, treatment, and transitioning of active duty and retired members of the Armed Forces and their families, or, military beneficiaries; whereas the VA is a system-of-care that is broadly responsible for *Veterans*, persons who are former members and not career members of the Armed Forces, including *dis*abled, medically-discharged, and separated members of the Armed Forces, and not their families. The DOD provides care and treatment for active duty and retired career SMs and their families at military medical facilities–MTFs. At dedicated Veterans' facilities including offices and hospitals, the VA provides care for Veterans including short-, medium- and long-term health care, job assistance, educational support through the GI Bill, and home loans (U.S. Department of Defense 2010; U.S. Department of Veterans Affairs 2010; KaiserEdu.org 2010).

254 Or, as might be considered here, the "telos of rehabilitation."

255 I use the passive construction here advisedly, meaning to keep in play the central question of who does what to whom.

cannot attend treatment programs; or because the system simply fails them through neglect, denial, incompetence, undependability, or *un*intentional punitiveness (Woolhandler 2007:1-26).

Theory and Application

I aimed to prompt insights into aspects of lived experience that are significant to people's inclusion or exclusion, and to degrees of deservedness we accept or deny–at my research sites and beyond. My findings may signal ways in which all of us everywhere can reconsider how we link notions of altered and reconstituted abilities with notions of deservedness; and how we can bridge the sociocultural, politico-economic, and ideological divide between our military and civilian worlds; worlds in which people, families, and communities share responsibility, risk, and consequences. *Re*consideration of how *dis*ability and deservedness may be linked, and efforts to acknowledge shared human experience, even in different sociocultures, require application of findings into practice; and in my summary I am recommending this application.

Many critical thinkers focus on interpreting what humans do, under what conditions, and for what reasons, in order to understand what we are, what we contend, and what we have the potential to be (Axelos 1976; Bernstein 1971; Marx 1988). The study of humans' practical activities in the social moment, through methodologies that may incorporate ethnography, participant observation, and various modes of analysis, continues to grip and engage historians, philosophers, sociologists, and anthropologists (de Certeau 1984; Ong 1991; Roberts 2006). By understanding or at least interpreting human actions and their *un*intended consequences in the past and present, and forecasting "subsequences," social scientists offer insights into mechanisms of cultural formation, systematicization, stability, conflict, change, and emancipation that can influence human potential in the present and into the future. These insights probe and identify aspects of lived human experience: its emplacements, differences and similitudes, structures and

courses of power, and struggle. In turn, application of these interpretations and understandings–these new knowledges–may foster social justice (J. Collins et al 2008; Boellstorff 2005; Collier and Maurer 1997).

Some critical theorists have used material culture and its provenience to identify previously elided or disregarded evidence of human agency and to enact collaborative action in the world (Blakey1990; Conkey and Gero 1997; Duke and Saitta 1998; Leone 2005; Sayers 2003, 2006). Others have been able to identify and deconstruct systemic juridical, political, and sociocultural inequities, erasures, and marginalizations in their studies of what people can or can not or refuse to do, and the real material and experiential consequences of those *in*actions. In collaboration with community members, their insights have provided knowledge and tools that might otherwise have been elusive, impenetrable, or *un*intentionally suppressed. This *prāxis*, or informed knowledge in action (McGuire 2008:33,34) has enabled claims and actuation of social justice (Crenshaw 1996; Gotanda 1996; Harrison 1998; Hill Collins 1998; Leap 2003, 2004, 2008, 2009).

Whereas Marx identified "praxis" as the defining work or action of humans in political economies, today many critical anthropologists who annotate human actions and their consequences combine theory and practice to enact *prāxis*, or informed action in the world–among communities and thus, within political economies–in the recuperation of individual or community presence, and in pursuit of human and civil rights (Marx 1978d; McGuire 2008; Orser 2007; Sayers 2006). These rights include achievement of equal recognition, equal access to resources, and equal conference of worth and deservedness. While attaining these rights may appear to be an "obvious" goal, at some scales, for example within orders of discourse and lived

experiences at two MTFs, this goal and those who deserve attainment of these rights may be seen or viewed *in*equitably.

Ironically, "visibly" wounded SMs, who comprise 2.25 percent of SMs who were medically evacuated from OEF, OIF, and OND between 2001 and 2010, represent the most obvious effects of a continuous war effort that is not otherwise "seen" by most Americans. My research showed that when attention is drawn to wars' effects, through encounters with and images of visibly wounded people and the soma-technics of their rehabilitation, viewers' consciences may be assuaged or challenged, ideals may be recovered or contested, and service and sacrifice may be hypostatized. At considerable cost and with lifelong consequences, that which has been *un*intentionally overlooked (in this case, contemporary war and its effects) is re-packaged and re-presented; the original compact regarding service and rewards is repaired; and the productivity and worthiness of SMs who adopt and adapt to athletic models of rehabilitation are re-membered. By contrast, I found that the *in*visibility of some bodies whose wounds, illnesses, or injuries are at a remove, unapparent, or unintelligible, may not draw "attention" to other consequences of active duty military membership and service; i.e., disease, chronic pain, accidents, internal damage to organs and tissues, depression, loss of memory or impaired cognition, or suicidal ideation. Rehabilitative regimens and remediations for these "existentialities" and their exigencies may be under-recognized, overlooked, or disregarded; and their deservedness comparatively less valorized, even unredeemed.

To act on the information I have collected and the knowledge my data have provided, rather than looking to or at how policies, practices, and people "appear," those who care about rectifying instantiations of fitness, power, social reproduction, and *un*even outcomes should demand authentic accounts of lived experience; accounts that mark actual effects of policies and

practices on people–otherwise, at the same time that people are being cared for and may heal, the real causes and effects of their *dis*ablement, their subjection and authorization, may not be examined nor understood, nor challenged, nor mitigated. To some extent, application of my findings may also help bridge the gap between military and civilian sociocultures and political economies. To act on this potential, people who suspect, denigrate, or misapprehend alternative sociocultures must learn firsthand about them. This action also entails demanding authentic accounts of lived experience; i.e., observing, acknowledging, and listening to actual people–and privileging what they say and do– rather than relying on preconceptions or appearances.

Significance of My Work

Personal, Local, and Global Texts

My research findings have significance for the people with whom I worked and where my work transpired:[256] people at a DOD facility, joined in mutually constituting efforts to recover and to be healed in a rehabilitative space-time. In my data I found evidence of discourses-in-formation, including in shared expressions recounting steps along mortal journeys. Respondents' corporeal, cognitive, and affective trajectories were conveyed "elementally" within their descriptions and reflections about their lived experience, or in material culture, by means of expressions and performances of and about SMs, family members', NMAs' and care givers' lived experiences. In turn, these elements constituted moves, turns, switchbacks, arrows, hesitations, motility, positions, stances, and transformations within a space-time and along particular mortal pathways, both at individual and group scales.

Among the repeated themes, the nascent discourse of Sovereignty/Mortality led me to consider a question-and-answer dialectic so "naturalized" that it had not occurred until I

[256] Here I am consciously using the word transpire in its original meaning: To reveal or become known (*Random House* 2011).

analyzed my texts: What is a Military Treatment Facility?[257] Originally, I posited a MTF as a discursive complex: A state apparatus; a productive and powerful discipline relying on prescribed sets of skills and knowledges; a division of labor within a political economy; and a mode (formed by forces and relations) of *re*production. I found that a MTF is a state of exception as well as a liminal and transitional space-time, in which people and things interact to recover (or as I find, re-cover) that which is lost or missing.

At a MTF, persons and ideals that were torn-apart, harmed, or spoiled (Goffman 1964) are now being pulled back and reincorporated. In order to restore wounded, ill, and injured SMs to their former rank and status, or a facsimile of it, inter-dependents work to reattach lost attributes: body parts, memory, cognitive ability, organs including skin, physiological, bio-chemical and psychological balance, health, well-being, ability, access, legitimacy, justification, and service. In turn, rather than being barred or banned (Agamben 1998), people at a MTF are tendered; i.e., presented, viewed, filmed, studied, researched, recorded, and reported. Select coverage of their words, postures, assistive technologies, exercises, and recovery efforts mediate the very re-fitting that must occur in order to overcome corporeal, cognitive, and notional results of war; results that are perceived as real (literal), and imagined (metaphoric), depending on stances, viewpoints, predilections, actions, zones, deployments, and *lived experience*. Personal, familial, institutional, and community recoveries are uneven: variously successful, variously mediated, variously noticed, and variously experienced.

At these sites, texts co-constitute skills and knowledges and generate discourses; and tacit understandings are shaped by ideology. Subjects and objects at two MTFs conveyed productive hierarchical relations of power within a taxonomy of harm and of care; their knowledges were expressed semiotically, involving actions, spaces, and things, such as designations, eating

[257] This process vividly confirmed that what is tacit is neither secret nor silent (Decena 2008:340).

facilities, and assistive technologies. These texts constitute signifying components of authorization and subjection and signs of allegiance to belief systems.

Qualitative data at a MTF support the finding that there are links between how people perceive altered levels of fitness and how they agree to accept, confer, or experience corresponding levels of recognition and access to resources; these enactments are intelligible within shared systems of meaning, or nested orders of discourse; they signal embodiments of power and are powerful; and they are semiotically reproduced. To substantiate these claims, I critically analyzed texts where evidence of these findings resided; and I did so for each subsequent claim, and with each of several discourses-in-formation that I discerned in my data; i.e., nascent discourses such as Loss/Recovery. In addition, I pointed out places in which I surfaced evidence of contradiction, struggle, and transformation.

Order of Findings

In Table 6.1 below I show my order of findings; and annotate their significance. The first group of findings, 1a-4, was "manifest" insofar as each was readily evident and vouchsafed as "obvious" by respondents and material culture at my sites. The second group, 5a-f, was "accessible;" i.e, by applying CDA I was able to get at these findings and their meanings. The third group of findings was "recondite," by which I mean that these were profound, difficult to detect and locate–even abstruse. I am indexing and differentiating the degrees of difficulty in my "dis-covery" to do two things: First to mimic the journey of discovery that comprises research; i.e., a journey whose efforts lead to unexpected (even adventitious) answers and questions; and second, to complicate the "order of findings" itself. As I found in my analysis,[258] hierarchies (and, "tables") are productive and counterproductive: They reveal and mask structure and

[258] And as many others have noted, *viz* Agamben 1998:6; Bourdieu 2003:39; Chandler 2002:59; Decena 2008:354; Fairclough 2003:23-37; Pêcheux 1982:156; Vološinov 1973:22.

agency. In other words, neither people, nor data, nor respondences are themselves hierarchical; yet, depending on analytical objectives, experiential and ideological contexts, and tacit knowledges, their contents may construe hierarchies and be harnessed to reveal dominance and suppression (even oppression). To wit, I present my findings in "order:"

TABLE 6.1: Order of findings		
MANIFEST These findings indicate that people at a MTF know and can describe their conditions of existence.	1a	Perceptions of *Dis*ability are Linked with Degrees of Deservedness
	1b	The Link between *Dis*ability and Deservedness has Felt Consequences
	1c	Texts Sustain the Link between *Dis*ability and Deservedness
	2	Visibly Harmed SMs are More Recognized and Have Greater Access
	3	*Dis*ability is a Process not an Identity
	4	Military Lives are Different
ACCESSIBLE These findings indicate that discourses irrupt in the form of dynamic reflections, performances, and responses to conditions of existence.	5a	Loss/Recovery
	5b	Identification/Disavowal
	5c	Inside/Outside
	5d	Service/Sacrifice
	5e	Individual/Group
	5f	Sovereignty/Mortality
RECONDITE These findings indicate that a MTF is a potentially transformative liminality.	6	Rehabilitation is Space-Time of Recovery
	7	A MTF is a State of Exception

For Further Inquiry and Action

In comparison to *dis*abled SMs whose corporeal recovery is palpable, *in*visibly wounded SMs may not be "seen" as equally harmed, nor regarded as deserving of or willing to undertake highly visible modes of rehabilitation; and they may not be perceived as making progress or recovering successfully. Having conducted my research, I now wonder whether hierarchized

wounded, ill, and injured embodiments of *recipients* of harm infer that *agents of harm* are hierarchized too. In Table 6.2 below I show a tentative taxonomy of "valorization of harm," and posit a future arena for research; an arena I did not enter and now recommend be explored further: Does harm sustained in combat ("wounded") reify a productive presence of "the enemy" while distancing the SM from responsibility for her own harm? Does disease or illness ("ill") connote unseen, unintelligible, and even unbelievable vectors of harm–or conditions of *un*acceptable vulnerability?[259] And do accidents ("injured") conjure misfortune, laziness, or *un*intentional disregard of risk? This is a question-and-answer complex about structure, agency, ideology, and lived experience whose findings might also lead to productive recalibrations of how we decide and act on who deserves what. In other words, does the "way" an active duty SM became wounded, ill, or injured also connote differentiated degrees of service, sacrifice, and worthiness? And if so, do these ideological differentiations apply to people "beyond" an MTF?

TABLE 6.2: Resonsibility for harm

Kind of Harm	Responsible Agent	Role of Recipient	Prestige
Wound in Combat	The Enemy	Physically Attacked While Fighting: Not at Fault?	HIGH?
Illness Acquired During Active Duty	Virus, Bacteria, Depression, Rape, "Risky" Behavior (e.g., unsafe sex)	Physiologically or Immunologically Vulnerable: At Fault?	LOW?
Injury Acquired During Active Duty	Accident, Arduous Training, Competition or Event, "Risky" Behavior (e.g., riding a motorcycle)	Physically Harmed or Worn Down: At Fault?	MEDIUM?

[259] Feldman has written provocatively about unseen and perhaps imagined vectors of harm (in "transgressive circulation"), including viruses that may be construed as enemy invaders; e.g. Mad Cow Disease, Severe Acute Respiratory Syndrome (SARS), even HIV/AIDS (Feldman 2004:18).

Conclusion

Each of the transcription examples I provided and analyzed in Chapters 4 and 5 is unique. *In toto*, they comprise excerpts from 23 recorded interviews I co-conducted, and 16 field-noted conversations–all of which were offered by people both like and unlike each other. Yet despite their differences in age, gender, rank, responsibilities, relationships, locations, severity of harm, disposition and dispossessions, plans for re-entry or return-to-duty, elements in each of their narratives were recursive, refractive, and reiterative. For example each talked about or referred to loss, each disavowed *dis*ability as a subjectivity, and each pondered and compared their statuses as individuals compared to members of groups. I asked them all about their lived experience and they answered. They told me they were glad to be heard; and they were generous, detailed, personal, and impassioned. The details respondents shared were dialectical–within each narrative and across my collection. The people I listened to accepted, resisted, and "worked" their shifting subject positions as they navigated their shared space-time; and as they and their inter-dependents collaborated in recovery.

Accepting the fundaments of my subjects' varied and at the same time shared lived experiences was challenging because of my own predilections, biases, ignorance, and in retrospect, mis-understandings regarding SMs' management of individual and group risk, service, and militarization. However, by returning over and over again to the data, and honoring their integrity, I learned about lived experience at my site, and was able to perceive authorization and subjection which remained-in-formation for all of us.

I found that during rehabilitation at a MTF, social and material culture manifest links between kinds of harm and the levels of recognition and access to resources that wounded, ill, and injured SMs attain. I also found that linkages between *dis*ability and deservedness are

intelligible; i.e., they can be and are read and recounted. I found that visible harm and tangible modes of rehabilitation confer higher status than those that are invisible; and that the institutional/military order of discourse governs and sustains the MTF's discursive positioning of *dis*ability as a process not an identity. I found people in the military regard themselves as being part of a family, and that they believe their lives are different from civilians'. I found that SMs and their inter-dependents relate shared themes of lived experience that undergird orders of discourse. And, I found that rehabilitation is a space-time, and a MTF is a state of exception.

Various texts and writing engage the rehabilitation of *dis*abled SMs in contrasting and contradictory ways. Some publications, websites, and blogs may use the narratives of *dis*ablement and rehabilitation as tools for recruitment, to generate and fund support for "Wounded Warriors," or to reach out to individuals who are interested in or have a connection with SMs who have been harmed. Various media may feature stories and images of (so-called able-bodied and *dis*abled) celebrities and champions of military rehabilitation, and participant subjects, who have overcome inconceivable assaults on their corporeal and psychological integrity, or who have enabled others to do so, and who have often adopted or adapted to extreme sports model interventions (Messinger 2009 a,b; 2010 a,b; Vogel 2012). At the same time, others may judge military rehabilitation policies, practices, and expectations to be unfair, even punitive; and may recount the potentially lifelong *in*ability for wounded, ill, and injured SMs to regain their status as functioning members of either civilian or military life; or, of their being forced to redeploy or return to active-duty after having been seriously wounded, become seriously ill, or been seriously injured and too rapidly rehabilitated and released (Aliff 2010:1,2).

From some participants' points of view, being forced to return-to-duty (RTD) in the field abridges their ability to thrive. Yet for others, being "able" to enact their full membership as

active duty SMs after being wounded, becoming ill, or being injured fulfils their commitment to military and national service, and upholds the mutual contract or "promise" made on enlistment or enrollment, in which to some extent sovereignty is foresworn in exchange for status, rank, and benefits. Based on my research, RTD may restore some SMs' sense of purpose. They may characterize rehabilitative policies, practices, and experiences as ecumenical and life-saving; their rehabilitation teams humane, heroic, and transforming; and their outcomes motivating, honorable, and life-affirming. Those who cannot RTD may be relieved (in both senses of the word), angered, or discouraged. These reactions vary. By contrast, all the SMs I listened to agreed that *dis*ability as a process not a corporeo-cognitive or affective identity. In one way or another they all expressed their movement from "fit" towards "bene-fit"–not from "able" to "dis-able." This shared viewpoint may have evidenced their coherence (by which I mean intelligibility and consistency) within shared orders of discourse; and may "deserve" further research to get at the extent to which their (self-)identifications are structurally imposed and required, rather than being agentively "felt."

In any case, for various reasons, some people enlist in, enroll, or are commissioned into the Armed Forces. Their exposure to risk is "obvious," yet remote; it may be modified by interpellating ideological apparatuses that both subjugate and authorize SMs, their family members, NMAs, and potential care givers. Notions of being recognized for service and sacrifice are central to the exchange that occurs when SMs renounce their individuality for group membership; when they train; and when they are deployed. On the other hand, when their fitness is altered unexpectedly[260] by being wounded, becoming ill, or sustaining injury, SMs become

[260] As it must be "seen" and "seem," since ideals of life-long athletic fitness are intrinsic to recruitment, enlistment, and membership and therefore not overtly "expected," even though their real risks may be tacitly understood and accepted.

dis-aggregated from their groups, and are sent to MTFs to be re-assembled, to recover, and to be re-grouped with collaborating and tiered inter-dependents.

Folklore of the Future

Respondent 030 told me "what people report is true;" in addition, what they experience is notable and consequential. When similar people in similar circumstances have widely varying outcomes in their ability to prosper, despite the similar promise they made and that was made to them, levers of *in*equity are worth excavating and examining. By identifying structural, systemic, and ideological mechanisms of *in*equity we can begin and sustain the work of forestalling *in*justice. By accepting my findings as real, policy-makers, providers, and patients may be able to actually challenge, mitigate, and rectify *in*equitable treatment, thereby forestalling aspects of *un*even recovery outcomes such as feelings and experiences of exclusion, worthlessness, ineffectivity, depression–or anger, bitterness, and hostility. If we actively and intentionally regard SMs who are incommensurably harmed as persons equally deserving of recognition and access to resources we may be able to prevent divisive and perilous mortal[261] threats and consequences to them and their families and communities, and to other people who have been wounded, become ill, and been injured; i.e., people anywhere whose abilities have been adventitiously altered.

Dissemination, consideration, and application of my findings may strengthen and deepen scientific, institutional, familial, and individual understanding of being harmed, and provide heretofore under-acknowledged data to military policy-makers and practitioners as well as to other researchers who are investigating military medical phenomena. More broadly, this study offers qualitative data that are both unique to an understudied military population and may also

[261] N.B. "Mortal" means "having to do with life and death," and "human" (*Random House* 2011).

be applicable to under-acknowledged civilians. What I learned will not prevent people from joining military Service or Forces; nor should I presume it to. On the other hand, consideration of my findings may enable wounded, ill, and injured people and their inter-dependents in MTFs' political economies to gain enhanced recognition and access to resources, and to view and treat each other equitably. For civilians whose abilities have been adventitiously altered, these insights may provide evidence that will activate demands for equal "regard."

The people with whom I worked and studied were diverse. In turn the data I collected from them and within their spaces expressed congruence and non-congruence. During my extended period of participant observation I noticed many contradictions at the site and in the moment, so disparity in my textual data was not a surprise; it matched and validated dynamic tensions that were generative and productive and that continued to infuse and energize my research. My work shows that the relationship between *dis*ability and deservedness is dialectical; and that mere presences, presentations, and performances of people at my site were also dialectical: always-in-transformation, reflexive, contradictory, and unstable. The dynamic tension generated in these dialectical relationships and their *ir*resolution showed up in their corroborating, contradictory, and particular–even peculiar–data. Yet at the same time, central themes emerged, some expected, some surprising, all remarkable. They co-constitute an order of discourses-in-formation within a system of significance that is hierarchical, taxonomic, and power-ful.

Enactments of fitness, forces and relations of power, and reproduction continue to be sanctioned and to unfold at WRNMMC (and had done so formerly at WRAMC); these shared meanings are being tacitly negotiated and understood in order to "structure and sustain hierarchical social relations" (Decena 2008:340); and at the same time to restructure and regain–

to recover–lost ability, lost limbs, lost wellness, lost subjectivities, and lost ideals. My respondents' texts at their sites described or laid out a contextual terrain in which tacit understandings of service and sacrifice make sense, and so do taxonomies of harm, and hierarchies of deservedness. In other words, interactions of participants at a MTF embody the "common sense" Gramsci describes (1971:326, n.5):

> Common sense is not something rigid and immobile, but is continually transforming itself, enriching itself with scientific ideas and with philosophical opinions which have entered ordinary life. 'Common sense' is the folklore of philosophy, and is always half-way between folklore properly speaking and the philosophy, science, and economics of the specialists. Common sense creates folklore of the future, that is as a relatively rigid phase of popular knowledge at a given place and time.
>
> – Gramsci *Selections from the Prison Notebooks*

A Final Note Regarding My Research

I conclude Chapter Six with thanks to participants who provided insights regarding their lived experience, and to IRB regulators at AU and WRNMMC who enabled me to conduct research in a space that is foreign, perhaps frightening, sometimes vilified, and certainly strange to many civilians. Members of the military, like members of organizations and communities elsewhere, are people. What people say and do and endure deserve scrutiny because their acts and lived experiences are consequential: individually, and among groups in families, communities, institutions, organizations, and nations.

My research participants provided data and permitted me to methodically deconstruct their expressions and perceptions of relations and forces within modes of rehabilitative care. I am grateful to have been given their knowledge: It is for use and application by the actual subjects of my research; for others like them; and for people who are associated with and interested in them and others like them, now and in the future. It is for us.

CHAPTER 7

DISABILITY AND DESERVEDNESS

Real and Imagined Boundaries

How do we decide who deserves what?

People with whom I conducted research at Walter Reed variously decried and upheld the ways in which kinds of harm and modes of rehabilitation construct and reproduce ideas about deservedness. While they did not validate my original use of the word disability, they did acknowledge and proffer differentiated degrees of harm and of recognition and access to resources that they or their charges experienced. Beyond trying to explain or disclaim the complicated and arcane military evaluation system used to measure and compensate harm sustained during active duty, most of my respondents also clearly articulated their positions with regard to their own or their charges' wounds, illnesses and injuries: Care providers tended to object to the uneven ways in which SMs were regarded based on their perceived disability and its provenience; SMs themselves tended to accept and uphold the taxonomy of harm and of reward indexed by the term "wounded, ill, and injured;" and family members I listened to (and non medical attendants) pointed to inequities that they framed as systemic and structural rather than personal.

At the same time as they worked together *geo-physically* in recovery, people with whom I conducted research also appeared overall to negotiate the sovereign space in which we interacted with a kind of *metaphysical intentionality*; i.e., with phenomenological pertinence and consciousness in their references to existent and nonexistent subjects and objects.[262] At any rate, they were able to talk about their experiences with insight and in detail.

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[262] *Random House* 2011

Other researchers have noted the positive effect of qualitative research on some of those "subjects" who participate: People like to tell their stories, and they like to be listened to. I can report the positive influence my research had on me–it expanded my empathy, as an ethnographer and as a person. In examining how we determine who deserves what, I found complexes of over-determination in which unjust and inequitable outcomes befell people, while at the same time finding actors helping each other, for better or for worse, to recover.

As I complete my current research I ask myself and the reader: In what ways do we decide who deserves what? How do we help each other gain equitable access to recognition and resources? And how are we helping ourselves and others recover after more than a decade of combat in Iraq and Afghanistan?

APPENDIX A

TRANSCRIPTIONS and FIELD NOTES

Explanatory Note

After recording interviews with respondents I transcribed our conversations verbatim, using prefix [Q] for Questioner and [R] for Respondent. I labeled the transcriptions using the actual participant number and converting it to a transposed number to help protect confidentiality when quoted in the manuscript. I identified the type of respondent, the number of words in the interview, the recorder I used, the number of the recording, and its length in minutes and seconds. I added the setting, the respondent's civilian or military status and gender, date and the time of day (TOD). This was the first transcription version, or *v1*.

In a second version of each transcription, i.e., *v2*, I numbered each of the lines; and appended [Q] for Questioner and [R] for Respondent.

In a third verison, i.e., *v3*, I "marked" the transcription, using *hh* to indicate sharp intake of breath, **bold** to indicate speaker's emphasis, ↓ for falling and ↑ for rising tone, … for short pause; … … for medium pause; and … … … for long pause. In a second step, after additional readings and "listenings," I added ► to flag words or phrases that illuminated notable or shared themes, and they appear in the final versions.

The 10 transcriptions in Appendix A include examples of Version 1 (*v1*), verbatim with no marks, and prefixes Q and R; and Version 2 (*v2*), with numbered lines and appended Q and R. I do not include marked transcriptions (*v3*) in this Appendix.

010*v2*

Care Giver	5445 words		Olympus recording #06 29:49 min	
Setting	Rank	Gender	Date	TOD
Private office	CIV	Female	10 APR 2012	0900-1000

0001 So it's April the 10th and I'm … interviewing participant #001 for disability and
0002 deservedness … and uh … participant #001 were you comfortable with the consent form
0003 that you signed? [Q]

0004 I am uh huh [R]

0005 Thank you any questions about it? [Q]

0006 No no questions [R]

0007 Thank you … I may read everything so I don't forget to ask you particular questions [Q]

0008 Sure [R]

0009 Thanks … but what you say is important and there aren't any right or wrong answers …
0010 and I may ask you to repeat some things so I'm sure I understand what you mean … … …
0011 where do you hear or do you hear the words … wounded warrior? [Q]
0012 I hear the words wounded warrior um on the campus of uh the Walter Reed hospital hh and
0013 also in the news on television yeah [R]

0014 'K … and when you hear that term what does it mean to you? Can you think of some [Q]

0015 Uh it means to me someone who is wounded in battle on the on the battlefield … oh um
0016 yup [R]

0017 OK … have you heard the term wounded ill and injured those three words together? [Q]

0018 Nooo [R]

0019 OK … … is this the first time you've heard that phrase? [Q]

0020 Yes together [R]

0021 OK when I say that phrase does it have any meaning to you? [Q]

0022 Um it … it actually broadens um my my understanding of um wounded … um because you
0023 You mentioned ill? in there [R]

0024Uh huh [Q]

0025 And I uh I always heard of wounded and injured [R]

0026 Hmm [Q]

0027 But not ill in there [R]

0028 OK what does ill suggest to you? [Q]

0029 Ill suggests to me that umm wounded is more than uh uh a physical um ... hh disability that
0030 It can also include those who are not physically uh injured [R]

0031 OK thanks [Q]

0032 But but are uh are still active military [R]

0033 OK … thanks what do you think injured means what does injured mean to you when you
0034 Hear the phrase? [Q]

0035 When I hear that phrase injured it … it uhhmm brings to *hhh* mind more of a physical um
0036 … I don't want to r- um repeat the word injury [R]

0037 No no that's fine whatever comes to you head [Q]

0038 But uh more of a a physical harm physical harm um arising from uh um an incident? [R]

0039 OK … *hh* when you're talking with family members or friends or they're talking with you
0040 … … how do they refer to the people that you work with here? [Q]

0041 Hh well they refer to them as the wounded warriors it's um always wounded warriors um
[R]

0042 Hmmm [Q]

0043 Even … in the clinics [R]

0044 Hmm [Q]

0045 Its wounded warriors … talking with other co-workers wounded warriors yeah [R]

0046 OK and how about family or friends do they ever refer to th- the people that you work with
0047 here? [Q]

0048 Uh no family or friends and friends they're refer to uh these individuals as uh wounded
0049 military it's never wounded warriors [R]

0050 Hmm [Q]

0051 It's more wounded military [R]

0052 Mmm … is that something you've already noticed or you're just thinking about it now? [R]
0053 I'm thinking about it now! but yeah that's addressing that they never say wounded warriors
0054 and actually when they do say that they tend to ask me what's that?! and then I have to say
0055 explain the guys who actually have actual injuries like amputations they are the wounded
0056 warriors [R]

0057 Oh that's really interesting [Q]

0058 Yeah [R]

0059 Thank you [Q]

0060 Mmm hmm [R]

0061 What kinds of medical issues are the people that you work with being treated for? [Q]
0062 Uh most of them are being treated for uh ptsd that's post traumatic disorder uh stress
0063 disorder uuuhhhmmm …. …. *tsk* traumatic brain injury [R]

0064 Mmmm [Q]

0065 And of course um physical um impairment from amputation yeah so they are receiving uh

0066 rehabilitation [R]

0067 OK [Q]

0068 Treatment [R]

0069 Um OK if you think of a few of people that you work with do you know since when
0070 they've been cared for? Do you have any sense of how long [Q]

0071 Uh most of them hum seem to [R]

0072 They've been in rehabilitation? [Q]

0073 Be cared for in the past let's see at most two years? but most recently within the past year
[R]

0074 OK [Q]

0075 Yeah [R]

0076 Alright … … when you think about the people you're working with how do you describe them when you talk with family members or friends or when you're thinking in your own mind or even colleagues … do you have a term for them? [Q]

0077 Actually I do now realize that I do make um *hh* a d- what's the word I'm looking for

0078 Actually [R]

0079 Hmm [Q]

0080 There's a difference actually in my communication with colleagues as opposed to family
0081 and friends [R]

0082 Uh huh [Q]

0083 When I'm talking with colleagues I'll say the wounded warriors ss uhm but when I'm
0084 talking with family and friends outside of this setting I refer to theeeem as uhm the guys
0085 who are who uh had the amputations [R]

0086 Huh OK OK thanks [Q]

0087 Because then they they tend to understand I'm saying [R]

0088 They understand it better [Q]

0089 Than wounded warriors [R]

0090 Yeah they understand it better [Q]

0091 Yeah [R]

0092 That kinda references back to what you were saying a [Q]

0093 Mmm [R]

0094 Minute ago [Q]

0095 Yeah [R]

0096 When I say the word disability what does that mean to you what comes into your mind
0097 when I say that? [Q]

0098 For disability that means that the person is unable to carry out normal functions of uh
0099 everyday living such as walking um taking care of themselves uh bathing on their own [R]

0100 Uh huh [Q]

0102 Changing their clothes getting uh to and from [R]

0103 Uh huh [Q]

0104 Work and anywhere they have to go without assistance? I mean uh with assistance that they
0105 They need to have assistance [R]

0106 Huh uh huh [Q]

0107 Assistance to do uh uh oh those things [R]

0108 OK … … in what ways do you think o- of the people that you work with as being disabled [Q]

0109 Well they have um in- for my for my study they actually are unilateral below the knee
0110 amputations [R]

0111 Mmm [Q]

0112 So they're they're missing one leg um so they have uh a physical disability they're unable
0113 to um … well they uh they don't have two legs like most of us hh do um so that makes
0114 them disabled but also those who have uh [R]

0115Mm [Q]

0116 Traumatic brain injury also I think of course that's also a disability [R]

0117 OK can you tell me some ways in which you think of the people you work with as capable [Q]

0118 Well I think outside of their physical disability which pretty much it's it's no longer a
0019 physical disability because they have new legs! [R]

0120 Mmmm [Q]

0121 I really I uh really um think they're capable of heh heh whatever it was that they were
0122 doing before [R]

0123 Huh mm [Q]

0124 Uh umm yeah they're uh to me they they have no impairments apart from uh if they have
0125 traumatic brain injury of course or ptsd but in terms of other issues uh I think they are
0126 capable still of performing those those functions [R]

0127 Thank you … … how do you … do you notice how other people talk about patients' or
0128 people you work with disabilities or capabilities any thoughts about how other people
0129 comment on or talk about or refer to? [Q]

0130 Well uh I think they share my uh my my thinking in that b- beyond their physical

0131 impairment which is uh [R]

0132 Mmm [Q]

0133 No longer an impairment [R]

0134 Mm [Q]

0135 They are able to function … fully um apart from their their injury [R]

0136 OK [Q]

0137 Mmm [R]

0138 Thank you I wanna talk now a little bit about recognition [Q]

0139 Uh huh [R]

0140 And by that I mean um people paying attention to or acknowledging *tsk* uh can you tell me
0141 about recognition that you see the people that you're working with tha- that they get … can
0142 you see any forms of recognition that they get the group may get or individuals may get
0143 And [Q]

0144 Su- [R]

0145 And if you can OK can tell me about it [Q]

0146 Sure umph go ahead well sure uh since I work closely with the amputees and we have a
0147 very good relationship with our study participants sometimes we would have lunch with
0148 them [R]

0149 Hmm [Q]

0150 Umm they would talk about getting well uh going on on these hunting trips [R]

0151 Hmm [R]

0152 Ski trips that uh uh that's paid for for uh through some organization or within the military I
0153 guess they have funding for [R]

0154 Hmmph [Q]

0155 Those expeditions aaand one individual um I remember him saying that he got ... I think
0156 four thousand dollars cash? And he's gonna use that towards getting a new truck? [R]

0157 Hmm [Q]

0158 He also got a brand new gun [R]

0159 Huh hmph [Q]

0160 For hunting yeeess and uh they had special special clothing that they use for the hunt? [R]

0161 Hmm [Q]

0162 So th- they actually were given it at the end? and they were a- they they stayed at this
0163 wonderful cabin where they met with retired older you know really retired um *tsk* members
0164 of the military [R]

0165 Oh huh [Q]

0166 So it was more of a um nice trip [R]

0167 Yeah [Q]

0168And um compensation also [Q]

0169 Huh and uh um these are related to you by someone you were working with by several that
0170 you were working with or some of the people you were working with that they related
0171 these [Q]

0172 Yes [R]

0173 To you [Q]

0174 Yes they related that and they seem to be going lots of ski trips lately [R]

0175 Oh that's nice [Q]

0176 For instance last week one of the guys had to cancel me because he had to go on a ski trip
[R]

0177 Really? [Q]

0178 With the other guys so uh [R]

0179 Huh [Q]

0180 So uh they uh they leave for spring break and they they went skiing I think in Utah I thin- I
0181 think that they uh that they went uh so uh they they enjoy perks- and I think also hh when
0182 you're walking with them on campus you'll see plain clothes I assume retired [R]

0183 Mmm [Q]

0184 Military individuals coming up to them and talking [R]

0185 Hm [Q]

0186 Chatting with them as if the- they know them [R]

0187 Hm [Q]

0188 Maybe they they're in some group together [R]

0189 Hm [Q]

0190 Yeah! [R]

0191 Hm [Q]

0192 So they they get treated very well [R]

0193 And so as we're thinking about this together d- do you that's … unique … … tell me about
0194 who gets that attention tell me a little bit more so let's go back a bit [Q]

0195 OK [R]

0196 The person the people who have talked to you about this kind of thing and that you've

0197 noticed [Q]

0198 Uh huh [R]

0199 Can we go back to whether we would h- how they [Q]

0200 H- [R]

0201 Are injured [Q]

0202 They they were th- the amputees um *hh* had uh unilateral bi- uh below the knee
0203 amputations but even the ones their friends who are bi-laterals but have of course of course
0204 have um prothese prostheses they they als- are also able to inco- to enjoy those um those

0205 gifts so I think it has to do with those h- having the physical injury … yeah um from battle [R]

0206 It's uh very interesting to think about i- all those different activities [Q]

0207 Yeah! [R]

0208 And all the older retired people [Q]

0209 Coming in [R]

0210 Yeah [Q]

0211 Yes spending time with them [R]

0212 Yeah … can you think of any kinda kinds of recognition that your patients or the people
0213 that you work with might not be getting? [Q]

0214 Nnn [R]

0215 It's kinda it's sorta a funny question 'cause how can you talk about something [Q]

0216 Right [R]

0217 That is not happening [Q]

0218 Right [R]

0219 As we're thinking about this anything strike you or occur to you? [Q]

0220 *Hhhh* I *hh* I uh honestly think there's nothing lacking in that within that group um they
0221 seem to be happy and I say that because I made a comment to one of my co-workers
0222 regarding you know these guys' you know are protected on campus everything is catered to
0223 them but out there in society is not like that [R]

0224 Mmm [Q]

0225 They pretty much have to adapt to the outside [R]

0226 Mmm [Q]

0227 Not to how it is here where the inside pretty much adapted to them [R]

0228 Mm mm [Q]

0229 So … I'm n- I'm don't think within this setting they're lacking for anything [R]

0230 Hmm great comment [Q]

0231 Yeah [R]

0232 Thank you [Q]

0233 Mm hmm [R]

0234 So my next question I think you've kind of covered it but I'm gonna just go over it with
0235 you in case it makes you think of something else [Q]

0236 Umm hmm [R]

0237 The resources your patients have access to … um special privileges or special attention [Q]

0238 Uh huh [R]

0239 We touched on that a little [Q]

0240 Uh huh [R]

0241 Training or employment opportunities? [Q]

0242 Uh huh [R]

0243 How about things like special equipment … dvd players or big screen TVs … [Q]

0244 Oh yeeesss uuumm hh I know for the for the um the i- they get iPods I've heard of um
0245 iPads [R]

0246 Hmm [Q]

0247 And uh also no *tsk* that has to do with other things but uh in terms of electronics [R]

0248 Hmm [Q]

0249 I know the uh they get th uh the iPad and the um … the iPod [R]

0250 Hm [Q]

0251 Yeah [R]

0252 Huh [Q]

0253 iPods and iPads yes [R]

0254 How about things like parking privileges you already mentioned attention from people [Q]

0255 Uh huh [R]

0256 Training or employment opportunities inclusion in social activities [Q]

0257 Uh in [R]

0258 Any other thoughts? [Q]

0259 Um … I know uh um with regard to training they actually uh um they go through if if they
0260 they choose to they get to go through an internship program? [R]

0261 Hmm [Q]

0262 And uh um eventually they may move out into contracting if they're going to be leaving
0263 the military … or even if even if they're staying within the military hh there's a pretty good
0264 pipeline between them ending their treatment and going back into active military duty?
0265 where maybe they have a desk position but but it's ac- [R]

0266 Hmm [Q]

0267 -tive military duty um *hh* and their qu- um they're I can tell that they're happy about that
[R]

0268 Hmmph mm [Q]

0269 'Cause they express yeah I'm doing an internship 'n that's uh uh I probably may end up at
0270 the defense department [R]

0271 Hmm [Q]

0272 Or I may go back out in the field uh you know not in the uh field more oh uh you know but
0273 more of a uh uh a desk [R]

0274 Hmm [Q]

0275 Operations type [R]

0276 Mmm [Q]

0277 Or I may go back [R]

0278That's a great example [Q]

0279 To work [R]

0280 Thank you [Q]

0281 Uh huh [R]

0282 Any other thoughts about recognition that service members … you're aware of get here or
0283 elsewhere [R]

0284 Well I uh I know uh um … at the wounded warrior café they actually have lots of um live

0285 enter- [R]

0286 Hmm [Q]

0287 -tainment [R]

0288 Hmm [Q]

0289 And that's where the guys go to have their lunch … they sign the voucher and they have

0290 their lunch right there [R]

0291 Good point yeah [Q]

0292 So there's uh free entertainment you'll see uh all these different companies coming in um
0293 presenting products and um offering you know having different offerings for them [R]
0294 OK thanks these are great examples [R]

0295 Uh hmm [Q]

0296 As we're talking um I'm gonna ask this question in a couple of ways a couple of times [Q]

0297 Umm hmm [R]

0298 And I'm sorta coming back to it [Q]

0299Umm hmm [R]

0300 'Cause it's not an easy one anything you can think of that they don't get here or elsewhere
0301 and uh actually you touched on that when you talked about [Q]

0302 Uh huh [R]

0303 The inside versus the outside [Q]

0304 Right [R]

0305 Not versus but as compared to [Q]

0306 Uh huh [R]

0307 Can you talk a little bit more about that that the kinds of recognition or access to resources
0308 that may be available here and not elsewhere? Or different from elsewhere? Can y- [Q]
0309Well elsewhere um in terms of um accommodation for instance here for instance at the
0310 warrior café you can th- the tables are adjustable [R]

0311 Mmm [Q]

0312 They're adjustable [R]

0313 Hmm great example [Q]

0314 They're adjustable and on the outside that would be hard to find! [R]

0315 Uh huh [Q]

0316 Even the uh th- the way the sidewalks are made it's made for wheelchair and it's also made

0317 y- you know they have these um groves uh in the sidewalk? [R]

0318 Uh huh [Q]

0319 And it's also made for made for [R]

0320 Uh huh [Q]

0321 Wheelchair so I think I think uh on the outside while you know you know the curb is is
0322 lowered for th- for those who have a disability in walking um … I … uh … overall it- it's
0323 you see it more here [R]

0324 Uh huh [Q]

0325 Than you would see you know more accommodations on the outside and for instance that

0326 you know like I said and the uh uh café and [R]

0327 *Hh* [Q]

0328 Tables are uh uh adjustable [R]

0329 Huh [Q]

0330 There are you know wide spaces in [R]

0331 Uh huh [Q]

0332 In between and I noticed outside I've noticed that if you were at a restaurant even a regular
0333 person with a with a regular disability comes in they have to move stuff [R]

0334 Uh huh [Q]

0335 Out so it uh seems like an inconvenience whereas here you know people will you know

0336 help out 'n 'n um it's already there you know [R]

0337 Yeah [Q]

0338 There's there's you know the wide space so you know you're able to maneuver um in the
0339 restaurant well the café but also um … it's just more accommodating [R]

0340 Yeah [Q]

0341 For them [R]

0342 Yeah yes [Q]

0343 The- they have a special line just for them at the café [R]

0344 Yes [Q]

0345 That's not available on the outside [R]

0346 Very good example [Q]

0347So uh I think it's … more accommodating in here whereas outside it's it is what it is [R]

0348 Hmmph [Q]

0349 There is there are not that many accommodations beyond what is expected … um you
0350 know f'instance if you have uh a certain um number of parking spots you know outside [R]

0351 Hmmph [Q]

0352 A certain amount has to be able has to be just for the disabled whereas here [R]

0353 Mmm [Q]

0354 They have more of that [R]

0355 Yeah [Q]

0356 There may be two [R]

0357 Yeah [Q]

0358 Parking spots [R]

0359Yeah yeah [Q]

0360 But uh here [R]

0361 Yeah [Q]

0362 Here it's you know it's very accommodating [R]

0363Yeah good point [Q]

0364 Yeah [R]

0365 When people outside of this facility and we're getting close to the end I appreciate all of

0366 this time thank you [Q]

0367 Uh huh [R]

0368 Outside of this facility talk to you how do they talk about … the people here the people
0369 here's military service do people talk to you about that do people ever comment about …
0370 how … refer to military service er uh the people that you work with [Q]

0371 Yeah sure uh huh they're uh they're seems to be a positive attitude out there f- you know
0372 based on the the people I interact with [R]

0373 Huh [Q]

0374 Regarding their service they always talk about you know there guys are defending the

0375 country [R]

0376 Mm [Q]

0377 Country and they uh uh they they sacrificed themselves you know for their country and
0378 they uh [R]

0379 Mm [Q]

0380 And it's always in a positive light [R]

0381 Hmm [Q]

0382 And even when I'm with friends and and they see guys who clearly are are military out
0383 there uhm out there in uh you know in in society it um there's a certain reverence? [R]

0384 Hmm [Q]

0385 Reverence toward toward them? [R]

0386 Hmmm [Q]

0387 So over all I think i- it's a positive um [R]

0388 Mmm [Q]

0389 Attitude yeah [R]

0390 Mmm do you sense any differences when people are thinking or talking or commenting
0391 about people who are wounded ill or injured? [Q]

0392 Oh sure uh the when they're thinking about military wounded or ill or injured it's always
0393 The physical? [R]

0394 Mm [Q]

0395 Um disability? you know the guys who have amputations who lost their legs or arms hh um
0396 the guys who um and actually even though people are aware on for the most part about ptsd
[R]

0397 Uh huh [Q]

0398 Or tbi [R]

0399 Uh huh [Q]

0400 They really don't focus on that [R]

0401 Mm [Q]

0402 When- they're focusing on the physical [R]

0403 Mm [Q]

0404 Uh injury … and that's what I'm just saying this I think that's why people seem to be seem
0405 to view ptsd and tbi more s- uh subjectively [R]

0406 Mm [Q]

0407 And negatively? [R]

0409 Mm [Q]

0410 Um more than the uh [R]

0411 Mm [Q]

0412 The physical injury [R]

0413 That's really interesting thank you [Q]

0414 Mm hmm [R]

0415 Uuuum what's it like for you to be working with people who do not seem to be wounded ill
0416 or injured you're working with them and they don't appear to be wounded ill or injured …
0417 can [Q]

0418 Mm [R]

0419 Comment on that at all? And you have in that in some senses you have you've talked about

0420 ptsd And you've talked about tbi does does is that different for you? [Q]

0421 Uh hh do you mean in the military setting? [R]

0422 Uh yeah [Q]

0423 Or just overall [R]

0424 Well actually I wanted to know about both [Q]

0425 Uh and s- [R]

0426 And you have touched on both a little [Q]

0427 *Hh* [R]

0428 Bit and I just wanna come back to it [Q]

0429 Sure I think umm … …. *hh* I'm sorry can you repeat the question I I [R]

0430 It's a funny question! Heh heh [Q]

0431 Heh heh [R]

0432 I may re-word this question! [Q]

0433 Ha ha ha [R]

0434 E what's it like for you when you're [Q]

0435 Ha ha ha [R]

0436 Uh … [Q]

0437 Uh huh [R]

0438 Uh in different settings to be around [Q]

0439 Uh huh [R]

0440 People … … … uuuummm whooooo you know what I will have to re-word this question.
0441 I'm thinking about [Q]

0442 Mmmm [R]

0443 Your own feelings and I'm thinking about when you're around family members and you [Q]
0444 Uh huh [R]

0445 Talked about that or friends I'm thinking about when you work with staff or cadre or in
0446 different settings like you said Building 62 [Q]

0447 Uh huh [R]

0448 I'm just interested in uh how that is for you with uh with people who are woun- people with amputations as you've noted [Q]

0449 Uh huh [R]

0450 Um how does that feel does it feel different for you in different settings? [Q]

0451 Oh ye- yes and I guess I can compare it to working with the guys here and then working as
0452 a nurse in a hospital [R]

0453 Oh yeah that's interesting yeah [Q]

0454 A regular hospital and because I work with cancer patients outside of here [R]

0455 Huh [Q]

0456 And uh I have have to say even though cancer is to me the worst thing to happen in the
0457 world um you have and I guess it's the culture here also you have more of you have more
0458 you're more of aware of what you're doing and it's serious [R]

0459 Hmmm [Q]

0460 You're working with the wounded warriors [R]

0461 Mmm [Q]

0462 So I'm uh always u- extra careful of how I I project myself [R]

0463 Hmm [Q]

0464 What I might say hh and when I'm in a the oncology unit I'm just doing nursing and these
0465 people of course they have cancer [R]

0466 Oh that's a very interesting comparison [Q]

0467 Yeah yet you still have that compassion for the patient [R]

0468 Mmm [Q]

0469 But *tsk* but i- you don't have to mind yourself around [R]

0470 Mmm [Q]

0471 And be careful about what you say because they're ill you know the- they're there for
0472 treatment [R]

0473 Uh huh [Q]

0474 And of course you're respectful of the patients but uh hh I feel like the- there you you have

0475 to just be aware [R]

0476 Hmm [Q]

0477 *Hh* of you of your of your behavior what you say and your attitude [R]

0478 Hmm [Q]

0479 Around uh – the pa- the subjects in the in my project here [R]

0480 Mmm [Q]

0481 Hhh compared to the patients I'm seeing at the hospital [R]

0482 That's really interesting [Q]

0483 Yeah uh huh [R]

0484 Huh [Q]

0485 It's uh totally different you have to be very careful with how you say see how you project
0486 yourself and sometimes I find myself being very mechanical here [R]

0487 That's really interesting [Q]

0488 Whereas I'm just being fluid when I'm at the hospital [R]

0489 Yeah [Q]

0490 You know I do do this I do that and even if the patients may be dying I'm still you know
0491 working with them and you know but here it's like you know uh huh don't do these go- be
0492 careful and uh make sure and yeah [R]

0493 And you had already noticed that working here had you noticed that already or you're just
0494 thinking about it now [Q]
0495 Well um it's just coming out because I'm talking about it but um more like a like a self-
0496 reflection where I feel like I'm now realizing this but uh yeah I'm I'm uh very careful more
0497 careful I should say and it's not even as hands-on as what I do do at the hospital [R]
0498 Yes this is quite interesting isn't it? Just as you say it yeah [Q]
0499 Concentration you have to look for that values and call the doctor and whereas here you
0500 know you're just seeing the guys doing the testing and you know questionnaire and uh yeah
[R]

0501 What would you what would you attribute that to as we talk about it together? [Q]
0502 I think i- it could be due to the fact that … that this is my first major encounter working in a
0503 military um institution but I think also um because of the way and and I'm just doing my
0504 own subjective description of how they're put on a pedestal here you have to make sure
0505 that you're not getting anybody upset and so it seems like there is more of a spotlight on
0506 you you're working with them then when you're working with when I'm working with a
0507 cancer patient at the hospital! [R]

0508 That's fascinating very insightful good for you wow OK last one tell me a bit about what
0509 you expect for the people that you're working with when they leave here again you you
0510 kinda connected that in your earlier comments but i- if you think about some particular
0511 people that you're working with and you sort of project ahead what do you expect for
0512 them? [Q]

0513 Well just as an aside that's one of my concerns um for the uh for for these guys because
0514 they are so accommodated in this environment my concern for them when they leave this
0515 setting and go back to their homes their families and because they're so used to to this type
0516 of environment and you out there it's totally different I think they would have adjustment
0517 problems and issues um … and it um I think it can be more detrimental to them? than you
0518 know some people you know it- it's good to have they're back in into society so they're
0519 able to adapt 'n' and you know try to move on with their lives I think that because of the
0520 level of comfort they have here I don't think it's gonna be easy to adapt to a new because
0521 of their own disability a new environment um since they are here so I'm um just concerned
0522 I I always say (*inaudible*) to them here I'm really concerned about when they go out there
0523 how are they going to adjust? You know some of them I I have seen that they have
0524 successfully done so there was one one particular individual I am thinking about now and
0525 he went to college outside of the military then he he joined the military after college and
0526 then had uh the amputation injury and he's one of those who had the internship and now
0527 he he lives offcampus and he lives in an apartment and he has a job at the defense
0528 department so he made a very good adjustment an' you could see that since he was here [R]

0529 Really [Q]

0530 Because he was always working out he he made all his appointments he was very rigid and
0531 very strict about himself you know … very respectf- I mean they're all respectful like that
0532 truly but in terms of falling through with an appointments now he ne- he never had to re-
0533 schedule with us [R]

0534 Really [Q]

0535 I mean you know they can't get out so they scratch all these I'm not coming um so you you
0536 can actually see or realize this but that who is able to make uh a good transition based on
0537 how [R]

0538That's really interesting [Q]

0539 They are here so I'm just concerned about because most of those guys this guy was like a
0540 you know our model subject but f- for the most part I'm just concerned that that when they
0541 go out there it's not going to be as inviting yeah [R]

0542 Uh when you think about somebody like that was his family or a non-medical attendant

0543 involved did you meet any of his family or um [Q]

0544 Well we met his mom um after he finished the study but he said she she was here initially
0545 for the first few months because he delayed a lot to go back home he can have you know
0546 you know you've been here and I know you thought you know you were going to lose me
0547 and so you know you get to fuss for a few months but after that you need to go back home
0548 'cause he's from Connecticut and um so I thi- he w- he was very independent yeah [R]

0549 Do you think that's connected with his outcome? [Q]

0550 I think so I think so there's one other person I'm thinking of he has a friend who is his

0551 what's it called? [R]

0552 Non-medical attendant NMA [Q]

0553 Non-medical attendant NMA and uh they had been trying to cut him off because he's been
0554 here for t- for too long as an NMA and he was was pretty much appealing it and um
0555 appealing it for having his NMA stay any longer and he's always complaining about you
0556 know oh the guys who are married they make more I mean he was single and um you know
0557 so I- he was I know he might have a hard may have a hard time … adjusting um yeah [R]
0558 Yeah that's quite a difference isn't it yeah [Q]

0559 Yeah [R]

0560 The N- the NMA that you're talking about he's been here a long time? [Q]

0561 Long time it's his friend from high school he's just hanging out with him all this time [R]

0562 OK he was here for a long period he came to the end of his period but um … the patient
0563 was able to appeal that uh decision [Q]

0564 Right [R]

0565 And then the NMA can stay longer [Q]

0566 Can stay longer [R]

0567 Interesting … well … anything else you wanna talk about think about say? [Q]

0568 No I I think we've touched on all of it a little bit um it's just interesting that um I always
0569 think about this you're doing a study on this so that's good [R]

0570 Well thank you for participating it really helps [Q]

0571 Sure thank you [R]

0572 I'm going to turn off the recorder in a minute but I just wanted to make sure to let you
0573 know that if you have any additional thoughts or questions for me there's my card and now
0574 I'll turn off the recorder [Q]

020*v2*

Care Provider	5953 words			Olympus #07 35:23 min
Setting	Rank	Gender	Date	TOD
Private office, door closed	CIV	Female	10 APR 2012	0900-1000

0001 Thank you so it's uh April tenth with participant number two for the disability and
0002 deservedness study … and we've um reviewed the consent form *tsk* and … I'm gonna ask
0003 some questions I may read so I don't forget anything [Q]

0004 That's fine yeah heh heh [R]

0005 Thank you and everything you say is important and interesting it doesn't there's not

0006 right or wrong [Q]

0007 OK heh heh [R]

0008 And I might ask you to repeat some things to be sure I hear them and also I may go back

0009 to some things [Q]

0010 OK [R]

0011 So some of the questions may sound repetitive and that's on purpose [Q]

0012 'K [R]

0013 Can you tell me where you hear the words wounded warrior [Q]

0014 *Tsk* uuum mostly on campus in the physical therapy uum *tsk* a lot on the television in the
0015 media um y'know newspapers news channels *hh* discovery channel history channel heh
0016 heh uuum *tsk* yeah I think that probably covers it heh heh where I hear the most [R]

0017 Thank you thank you and what does that term say to you what do you think about when
0018 you hear it or read it or see it what does it mean to you [Q]

0019 *Tsk* um I always think about somebody that's been injured in battle so during and a lot
0020 of times you do think of amputees [R]

0021 OK thank you have you heard the term wounded ill and injured or those three words
0022 together have you heard anyone say that or have you noticed that anywhere [Q]

0023 *Tsk* most of the time I I'll hear wounded and injured … I … don't usually usually ill isn't
0024 you know um connected into those two terms or with those two terms [R]

0025 OK and when you we talked a little bit about wounded when you hear wounded or injured
0026 uh what does it make you think about anything you wanna add? [Q]

0027 *Tsk* um usually I think of um veterans coming back from you know Afghanistan and Iraq
0028 that have been um basically that have been injured by an explosive IED explosive device
[R]

0029 OK now that we're talking about it does ill mean anything to you? [Q]

0030 *Tsk* yes so when I think of somebody that's ill I think of you know chronic diseases um
cancer things like that yeah heh [R]

0031 OK good thank you how do your family members or friends refer to the people that you

0032 work with here [Q]

0033 *Tsk* um usually … … probably because I have specified that they're wounded warriors
0034 they're called wounded warriors *hh* sometimes amputees because I think a lot of the
0035 amputees here fall under that term … um … *tsk* soldiers veterans military personnel [R]

0036 OK thank you … what kinds of medical issues are your are the people that you're working

0037 with being treated for [Q]

0038 I mostly work with um … the soldiers that are coming back from Iraq and Afghanistan that
0039 um *tsk* that are amputees so for our study purposes you know we're working with amputees
0040 um down in the physical therapy [R]

0041 OK and uh when you think of some of the people you're working with can you give me an
0042 idea of how long they've been here? Do you have any idea about that? [Q]

0043 *Tsk* yeah um most of them anywhere from a few months to a year or so … uh usually
0044 around a year maybe a little bit plus they've been rehabilitated and are moving on or a lot
0045 of times getting out of the military heh … takes I think it takes about nine months for them
0046 to finish their med boards and then a lot of them once they're injured come in and start
0047 their med boards right away wanna get out [R]

0048 And they talk to you about that? [Q]

0049 Uh huh yeah so [R]

0050 Does that sound like a uh it connects with uh the work they're doing in rehabilitation at all?
[Q]

0051 *Tsk* I think they uh [R]

0052 Do they talk to you about it? how does it come up [Q]

0053 I think uh a lotta times… it's probably my curiosity me asking what are you going to do
0054 after this when you get out sometimes they start talking about internships that they're
0055 gonna do or looking or a job or going back to school just in normal conversation
0056 throughout their rehab um and a lotta times they sa- they say you know they'll bring it up
0057 you know how um they're getting out of the military they wanna go on an' either go back
0058 to school or find a job um some of 'em 'll stay in the military but I think the majority say
0059 they're starting their med boards they wanna get out they think this is a sign er you know
0060 or they've kind of done their duty you know heh [R]

0061That's very interesting when they talk to you about it do you have any thoughts about it or
0062 how do you feel about those conversations [Q]

0063 Yeah it is yeeeaaaah you know I just try to be supportive you know because I can't say I
0064 blame them I mean they have just risked life and limb and list limb and almost their lives
0065 sometimes so I think they have soooome um *tsk* sometimes I think they have some negative
0066 feelings towards you know the military at this point they don't one of the guys was actually
0067 getting married and he said he wasn't going to wear his uniform he was going to wear a tux
0068 he had had you know he was just devastate about what happened to him and he had you
0069 know really negative feelings towards the military at that point *hh* so um [R]

0070 That example helps thank you [Q]

0071 Yeah no problem yes like I'm kinda I empathize with them I can understand where they're
0072 coming from and actually I am I'm really a little bit surprised when they say they say they
0073 wanna stay in … but I think that that's really you know very commendable uh obviously
0074 you know I think they all are very like um brave and I just think I wouldn't blame them for
0075 wanting to get out and I think the majority of what I've seen is most of them after they're
0076 injured want to um you know get out of the military you know they feel like they've done
0077 their duty to their country you know you know they want to get out they want to move on
[R]

0078 And the few people that wanna stay in how does that come up? the same way? [Q]
0079 Yeah um the same way usually if they're finished their therapy you know or they're kind of
0080 making progress in their therapy they're starting to either do internships or they're you
0081 know basically we end up talking about oh you're finished with therapy what are you going
0082 to do now? And sometimes they'll say or they're they're actually leaving they're getting
0083 deployed and they're going back to wherever you know they've been stationed or um their
0084 like um … unit in Camp Lejeune? So some of the amputees can go back there and still
0085 remain in active duty um one of the guys that I know just recently did that and um then you
0086 know one of their colleagues said uh you know er one of their fellow service men said you
0087 know he's one of the lucky ones he's getting to go back to duty [R]

0088 Really [Q]

0089 Yeah so it's so crazy because there are so many different opinions and they're on and you
0090 now it's a broad spectrum and they're both you know extremes [R]

0091 Yes those those examples are very different from each other [Q]
0092 Yes yes yeah exactly most of the time you know they're finished 'n you say what are you
0093 going to do now and they say I think I wanna stay in I think I have noticed the a couple of
0094 guys that say they wanna stay in are um more longer-term they they're older they've been
0095 in the military longer I think that you know they've made that commitment the younger
0096 guys usually are the ones that say you know I think I'm ready to get out heh heh heh heh
[R]

0097 Thank you that's very interesting when you talk about the people you're working with here
0098 when you're talking to family or friends about the people you're working with here how do
0099 you refer to them or describe them [Q]

0100 Um usually I'll say um since we're doing our research subjects sometimes I'll sat patients
0101 participants the guys heh heh um you know the soldiers service men a lotta times wounded
0102 warriors because that's a term that everybody kinda seems to have coined you know as
0103 kind of to uh to describe the the guys that I am working with the amputees [R]

0104 If you talk to family members here or NMAs non-medical attendants … w- would you say
0105 the same? Would you use the same terminology? [Q]
0106 *Hh* no I think actually usually typically I'll refer to them by their first name yeah heh heh
0107 you know to make a connection with uh with the NMAs and the family members um
0108 sometimes if we're talking about in general you know service members I used to refer to
0109everyone as soldiers but I was told *hh* they're not depending on what branch that they're
0110 not … that they're not all concerned soldiers so I don't heh heh heh [R]

0111 Heh heh heh [Q]

0112 I try not to say that any longer heh heh heh [R]

0113 That's a great example too I'm gonna switch here a little bit now and ask you when I say
0114 disability what does that mean to you [Q]

0115 Uh think that they're many facets of disability uuum you know physical disability
0116psychological disability mental um disability um probably most people in this uh setting
0117 most people would think disabled or wounded veterans so physical disabilities [R]

0118 OK and um … how do you think of your patients wh- or um people you work with in what
0119 ways do you think of them as disabled? Any words or thoughts come to your mind? [Q]

0120 Yeah you know it's uh it's surprising because it's it's what I live that's why I love what
0121 I'm doing it's so rewarding I don't necessarily think of them as being very disabled yeah
0122 they get to um in down in physical therapy wonderful therapists wonderful equipment and
0123 they're taught to do pretty much everything they once did before they were injured so um

initially you know at first they may have some trouble um getting around like they used to er um even the simplest tasks are probably a lot harder for them but usually by the time they have finished through their entire rehabilitation process they're very functional you know they' re functioning they're happy they're resilient and they're able to do you know mostly what they want to do they ski if if they want to you know there's attachments for their prosthetics you know snowboard skateboard you know walk run so and ah um even you know even you know upper body upper body you know they have attachments so they can lift things they're different ones for different skills so there's one for more finer motor and one for lifting heavier objects so I don't really think of them as being very disabled especially you know towards the uh end of their rehabilitation [R]

Yeah yeah that's really interesting thank you it's funny because the next question was gonna be how do you think of them as capable and you just said it heh heh heh [Q]

Heh heh heh [R]

So thank you how do other people talk about y- the people you work with about their disabilities do you have a sense of that? [Q]

Hh yeah a lot of people um seem to think that they're greatly disabled and that you know it's such a sad thing um e- and you know what I'm doing and who I'm working with it's just so sad these young men and what's happened to them *hh* but I try to tell people it's not they're so resilient they're in great spirits the values that we work the participants that we work with I mean they're in great spirits a lot of them make full recoveries um get back to doing to what they used to do maybe even learning new skills so you know so I think that it it it's seen as um I dunno you know lots seen as very dramatic you know it's seen as life-changing and it is I'm sure very life-changing you know but just very debilitating which it's not necessarily [R]

Mm mm thank you can you talk to me a little bit about the kinds of recognition that you see the people you work with getting ways that you see that they get recognized [Q]
Yes so um *tsk* there's always news crews media around we've had I think like I said before we've had the history channel discovery channel you know if there's any filming the work outs they're doing their rehabilitation process um they get lots of gifts heh heh t-shirts electronics you know ipods ipads new cell phones they get taken on lots of trips um lots of thank you's lots of thank you cards un you know you know even monetary they're monetarily compensated and awarded and there's obviously the awards ceremony they're thanked for their service um their bravery and they oftentimes given medals and you know a lot of big wigs from Washington come in you know shake hands and make an appearance so heh heh yeah [R]

who do they get thank you notes from? [Q]

Tsk um anyone from um local school kids to um thank you items like local churches 'n things 'll donate quilts and um and crafts that they've made um a lot of them come from

0162 kids um sometimes organizations you know charitable organizations will send over thank
0163 you notes [R]

0164 Hmmm what kind of impact does that have on the service members? [Q]

0165 Um I think that they you know they really enjoy it I think that they its funny 'cause a lotta
0166 times they think they were just doing their job and if it didn't happen to them they'd rather
0167 it happened to them because if it didn't happen to them it woulda happened to another
0168 member of their team *hh* and so you know so I think they really appreciate it they're really
0169 thankful sometimes they joke that it's deserving because of everything they've sacrificed
0170 but I think for the most part they're very thankful you know and really appreciative of
0171 appreciative of the support [R]

0172 When you say sometimes they say it's deserving c- can you tell me about that kind of
0173 reaction? [Q]

0174 Sure yeah um you know they'll talk about how they get … um you know because they're
0175 injured they get a certain amount back from the government and things like but you know
0176 and they say that I'd rather have my leg than the thirty thousand dollars or or whatever I'm
0177 getting [R]

0178 I see what you mean I see what you mean [Q]

0179 You know so they kinda get heh heh heh [R]

0180 And sometimes that happens when they're getting the thank you's?
0181 It came up when you

0182 were commenting on that [Q]

0183 *Tsk* yeah no I'm moreso I'm thinking of the um uh like um possessions you know the the
0184 gifts not the thank you's but I think moreso when its kinda like the compensatory item you
0185 know items like the- they get a grant a for a car they get money for their injuries *hh* and
0186 those types of things you know they said they'd rather have their leg than you know have
0187 that heh heh but but they're happy that they're getting it heh heh heh [R]

0188 No I got it heh thank you is there anything that occurs to you about that they don't get
0189 anything and that's a that's a hard question because [Q]

0190 It is [R]

0191 It's hard to think of things that you don't see or you don't think about [Q]

0192 Yeah it is [R]

0193 Anything you think they don't get? [Q]

0194 *Tsk* uuuum *hh* you know sometimes they've complained about um certain things like um
0195 living situation um some um complain like this single guys say that they don't get as much
0196 of a excuse me living stipend as the married or that they don't get um as much
0197 consideration you know they had to um like their NMAs may not be there as long because
0198 you know one like guy had his buddy there you know his NMA and he's like you know
0199 they're trying to send him home months earlier than someone that might have his wife
0200 'cause you know it's normal to see a man and his wife together but you know th- they see
0201 me and my buddy you know and think they're just playing around heh heh so uh that kind
0202 of thing and he said even when he was in the service he was more higher ranked as uh but
0203 because he was single he would have to you know get up early because it snows he was
0204 stationed in New York he'd have to get up early earlier than low- ranking you know his
0205 more low-ranking team mates er you know um comrades heh heh and that he would end up
0206 having to like shovel the snow while they slept in because they you know had a wife and
0207 family so you know that kind of thing you know money sometimes depending on how
0208 injured they are or when they came in you know they'll say one guy got something they
0209 didn't get like a new phone or an ipad um sometimes they feel like they're not getting the
0210 support they deserve as far as you know when they're trying to you know um trying to
0211 contact you know people about *hh* uh their med boards or things that they need you know
0212 um *tsk* I can't remember the exact example but there was someone that was really having
0213 issues with *hh* um you know getting with someone who he was trying to get in touch with
0214 and needed information on something and he felt like the person was very rude treated
0215 them you know very badly you know didn't help him like you know he should have been
0216 helped so sometimes I think you know they they don't think they- they're getting *hh* the
0217 support they deserve for you know the things that they need [R]
0218 And do do you say that it's when they're single is that what you 'r referring to or does it
0219 vary [Q]

0220 I think it varies because the single guys feel that way but then this guy in particular was
0221 married but his wife is active duty er no his wife is former military and so you know she
0222 came in an' helped but still and it didn't seem to make much of a difference you know this
0223 person who was supposed to be helping him with something I'm sorry I can't remember the
0224 exact example of what this person was supposed to be helping him with wasn't very helpful
0225 wasn't very concerned wasn't uh you know I guess efficient uh um so he was he was very
0226 upset about that because he was you know I'm here he's a double amputee 'n yeah you
0227 know he's yeah I feel like I just deserve better [R]

0228 Did he think did he have a theory as to why that was happening? [Q]

0229 *Hh* um no uh well he said actually he said she was even kind of like she asked him if he
0230 had TBI if he didn't understand yeah was rude about it yeah said you do need to have
0231 someone here to help someone you know to to facilitate this meeting and that's the end of
0232 this conversation [R]

0233 Didn't make it better for him [Q]

0234 No so kinda that made it worse so you know uh I- don't you know I mean he thinks I guess
0235 he didn't understand it really at all yeah he thought maybe she was just being just yeah
0236 when she brought up the TBI 'n that was kind of like you know prejudicial er you know
[R]

0237 Hmmph that's a great example thank you so wh- d- the next question I was going to ask
0238 you was the resources your par- your pa- *tsk* oh the people that you work with have access
0239 to the resources like I was going to ask you about some of the things you already
0240 mentioned special privileges special attention training and opportunities special equipment
0241 you mentioned dvd players big screen tvs parking privileges attention from people training
0242 employment inclusion in social activities um I'm thinking of these as resources that they
0243 can get that they have access to and you mentioned a couple of them already any others you
0244 can think of that they have access to? [Q]

0245 Um they always have special privileges where they get to go on trips you know and take
0246 some time off from their pt a lotta the times they because you know right now they're job
0247 is physical therapy so if they don't go to physical therapy there's consequences so
0248 sometimes they take off to go on these trips um although a lot of times its physical so um
0249 they'll get to go scuba diving in Cancun but you know every day they're out there
0250 swimming so they're still you know somewhat rehabilitative uuuumm *tsk* yeah training and
0251 employment they have special resources that help them obtain internships and jobs um you
0252 know as they're as being rehabilitated an' towards the end and after they're finished with
0253 physical therapy um *tsk* parking privileges hh uh that's you know that's a concern that's
0254 like with you know a thing that everybody here on campus I know one of the guys said that
0255 he couldn't find any parking you know 'n he parked in one of the spots that said reserved
0256 for special visitor or something along those those lines and some woman yelled out to him
0257 so who are you what special visitor are you and he said well I'm a veteran of Afghanistan
0258 yeah and I'm wounded warrior who are you heh heh heh and they just stayed there and
0259 you now he's injured he's a he's um a bilateral above-the-knee amputee it's hard for him to
0260 get from a to b and it's hard for him to get to physical therapy he needs to be able to park
0261 close to physical therapy *hh* and certain things like he had a large van and uh because it
0262 was wheelchair accessible and he would you know take up a good amount a space 'n you
0263 know someone left a message on his windshield saying like you know great job a-hole
0264 taking up two spaces er something heh heh heh so they don't hardly have on this campus
0265 necessarily have special parking privileges heh heh it's been a little bit of a problem [R]

0266 Sounds like it heh [Q]

0267 But you know they've changed that the garage so it used to be that uh the America garage I
0268 think it's now uh only really reserved for patients used to be other people were coming in
0269 and parking now they've tightened up security 'n make sure it's just patient parking so heh
0270 I think they're trying to help with that [R]

0271 Good examples any other kinds of recognition that's other service members get here or
0272 elsewhere can you think of anything that you we've covered a lot so um let's think a little
0273 about [Q]

0274 Yeah heh I'm just thinking maybe on Veterans Day restaurants an' places like that'll you
0275 know give special deals and discounts um I dunno I'm [R]

0276 That's fine what I was going to say next is let's think about elsewhere let's we've talked
0277 about here do yu have any thoughts about um recognition um or access to resources that the
0278 people that you work with may or may not get when they're not here when they're
0279 elsewhere do you have any thoughts about that? [Q]

0280 Oh yeah I think if they weren't on uh a military establishment there's a lot of things that
0281 they wouldn't get you know a typical hospital you know a lotta times *hh* you know you
0282 don't get chances to go on trips go on excursions you don't get any kind of you know
0283 monetary uh compensation for anything that you've done that's like good in your life you
0284 know um I guess you know you wouldn't get the same kind of treatment that you would
0285 here you know you wouldn't get any kind of special treatment um *tsk* same thing I think as
0286 far as out in the real world there's a lot of you know ex military veterans that maybe before
0287 OEF OIF um are probably jobless like the rest of us you know that are struggling in this
0288 economy or you know struggling to find future employment *tsk* and they don't don't
0289 necessarily have the resources um that these guys here on base have and I think because the
0290 guys here are wounded an- and you know are in this establishment they are probably 0279
0291 considered um first you know for jobs that are uh you know connected to this establishment
0292 you know the DOD DISA you know places like that you know because of the connections
0293where if they were elsewhere 'n you know and they didn't know someone or *hh* they may
0294 they may not have those opportunities awarded to them [R]

0295 Yeah that's a good that's interesting what does DISA mean? [Q]

0296 *Hh* um the uh Defense Intelligence System something it's it's it's like uh basically like um
0297 *tsk* um like IT agency intelligence but um like working for like the defense agency same
0298 thing with like DIA defense intelligence agency I think DIDA's a branch of that but it's
0299 like uh intelligence the uh um systems analysts that work for them [R]

0300 OK thank you when you hear people talk outside of this facility how do they talk about uh
0301 the people here with respect to their military service any thoughts about how people you
0302 hear or people say to you or uh wh- not here but outside of here [Q]

0303 *Hh* outside? Um you know I think that um everyone seems to be very grateful you know or
0304 the service that um these you know young military personnel have given um seem to think
0305 that this is a wonderful establishment u- um yeh I think that they're very I think grateful
0306 towards you now the military personnel that have you know risked risked their lives and
0307 their limbs you know for um in order to um you know um I guess you know promote a
0308 better uh a uh I guess a better a more peaceful environment you know an' uh uphold our
0309 rights you know and and um you know our freedom and our safety so that's kinda seems to
0310 be what people really talk about and associate with Walter Reed [R]

Thank you that's very helpful um any thoughts about how people talk about uh the patients' disabilities that we haven't already talked about? Do you hear people talk about it er [Q]

Yeah one thing is I feel like um like my fiancée er my husband's grandmother was saying you know these poor guys it just breaks my heart and you know like they're really not that sad they're not that sad pitiful guys you know they're probably you wondering and saying you know nobody will marry me now which I think is a funny old ideal to have and I think that people are going to … uh… um you know have these preconceived notions of um these men and women that have you know lost their limbs 'n been injured maybe disfigured and things that that people aren't going to be as accepting of them or um that maybe that they themselves the injured think that you know maybe they're aren't good enough er that they're not going to be treated the same as everyone else I y- er I don't necessarily think that's the case but I have heard a lot of people worry about once they leave here Walter Reed y'know and they're not being coddled and you know here it's the norm people here a majority of people here on campus are injured in some way there's you know a lot of amputees a lot of things you'll see here that's kind of the norm and I think we become you know maybe desensitized but then when they go out ''n you know back to Arkansas wherever they're from and there's people not used to seeing you know amputees walking around with probably prosthetics on you worry about how they are going to be perceived how people are going to receive them an' um you know I guess if they're going to be able to function you know in in that environment 'n' you know back when they're in their you know in their home environment and also you know you worry about the veterans from the Vietnam war there's a lotta veterans that came back were forgotten about an' I've heard people say I hope it's not the same situation all over again you know these young men you know twenty years later aren't getting the care they need then aren't getting the resources they need then you know suffering from psychological trouble and you know substance abuses you know psychological disorder substance abuse the things that you're seeing with the Vietnam vets homeless homeless you know they're homeless money problems you know lack of jobs 'n' just lack of resources in general for them … so [R]

Well thank you that's really helpful you do you feel when you're here like uh when y- a- a- uh I'm sure you have felt differently during the time that you've been here but f you could just give me some thoughts about what you feel like when you're at the Galley or in Building 62 or subway or Dunkin' Donuts at the Post Office I just have a list of different places [Q]

Other places yeah [R]

Can you just tell me a little about and you already have so like I said some of these are repetitive but I- I wanna get a sense of um how it is that you feel about being in these different spaces with people who are [Q]

Yeah I think there's a um … a sense of I mean you kinda feel like you know this is a military establishment it's you know we've talked about you know like kind of a totally different environment buy you kinda get pulled into that you feel like you're a part of it you

know a part of this part of this military world I feel like I'm fortunate to be working here you know a I feel like there's a lot of resources you know a lot of you know very intelligent um very caring you know practitioners um some of the best in the world researchers doctors nurses you know rehabilitation staff physical therapists you know I think it's like I feel like you know I'm I'm happy to be a part of it you know I feel like I'm kind of a part *hh* a small part of the bigger whole and uh I feel very fortunate like I said and I mean hopefully I feel like I'm I would like to I feel like to be making a difference [R]

Fascinating thank you when you hear uh this is somewhat different but I was just thinking about the guy who was having such issues getting the stuff he needed how how does that feel when you hear about that? [Q]

Yeah that's frustrating I think that's really frustrating it's upsetting i- it makes me angry it kinda makes me you know I don't just feel I just I think I empathize with him I feel his anger and its kinda sad that somebody you know could you know act that way towards somebody who you know most of us would consider a hero you know think of everything he's risked you know for your safety and your wellbeing and for this country an' the cause and for you and then not only to be not helpful but insult him and his awareness and his intelligence and so that's frustrating and you know you want you wish that I could do something to help him and then the physical therapist I work with she kinda verbalized feeling the same way an' um but I think he went back and went over kinda went back to his company commanding officer and made a kinda made a big deal about it an' said I'm not gonna deal with deal with this department any longer an' if I need anything I'll deal with I'll go through you an' [R]

My next question you already touched on what do you expect for your patients when they leave here? Let's go back to that just for a sec when you think about the people you're working with what do you expect for them when they leave what do you think about? [Q]

Hh I expect for them um you know for the most part to maybe be really able to um *tsk* do all the activities you know that that they um were able to do before hand or after hand you know heh heh after that I guess rehabilitation afterwards so … in … an' um part of just me bein' on the physical therapy and being involved … excuse me as far as with our study what I hope is that you know we've been able to make a difference in … you know um if they're part of our experimental group you know helping them maintain er hopefully we're reaching our our outcome measures so we're helping them to maintain *hh* you know um their goals to help maintain (*inaudible*) and functional ability and you know help decrease pain an' even if they're in the control I'm hoping that maybe we've made a difference to their um throughout you know being somewhat so- you know being part of their support group an' you know bein' there throughout their recovery process *hh* yeah [R]

OK thank you anything else you wanna mention? [Q]

Hh I don't think so heh heh heh I could um I 'm very wordy so I've been talking to you a

lot [R]

0391 heh heh it's OK well thank you if you do oh I forgot my card I've got at my desk and I will
0392 give it to you but if you do think of anything later that you thought you would like to add
0393 just let me know you know where to find me [Q]
0394 OK great [R]

0395 I'm gonna turn this off now [Q]

030*v2*

Care Provider	7098 words	Olympus recording #__		
Setting	Rank	Gender	Date	TOD
Private office, door closed	CIV	Male		1600-1700
Telephone Interview				

Dialing phone, phone ringing

0001 Hellooo [R]

0002 Oh (*respondent's name)* hi it's (*interviewer's name*) how are you? [Q]

0003 I'm fine thank you how are you? [R]

0004 This is so nice of you to spend a few minutes with me on the phone I really appreciate it [Q]

0005 Well I'm uh glad to do it … glad to help [R]

0006 I wondered if uh um if you had uh tried to send me back the consent form? [Q]

0007 I faxed it in yesterday [R]

0008 Oh OK yeeeeaaah I did get three bl- [Q]

0009 You shoulda gotten it [R]

0010 Blank pages and I wondered if maybe they went in the fax machine at your end upside
0011 down but [Q]

0012 Uch I dunno but [R]

0013 But [Q]

0014 I I guess I'll try again [R]

0015Uh OK yeah or um I can send you a stamped self-addressed envelope [Q]

0016 OK [R]

0017As long as you're comfortable to b- [Q]

0018 Yeah yeah I do consent and and I certainly I do consent and I mighta I might have put it in
0019 backwards 'cause I sent all three sheets [R]

0020 OK thanks thanks very much for [Q]

0021 Uh [R]

0022 I figured that's pretty much what it was heh [Q]

0023 Yeah [R]

0024 Uh OK heh good… um what I'm doing is talking to people er well really listening to

0025 people [Q]

0026 Uh huh [R]

0027 Talk to me about their impressions of uh uh the link between disability and deservedness
0028 with respect to how um tk disabled Service members are both rehabilitated and then either
0029 gain access to recognition and resources or not or something in between depending on their
0030 uh uh kind of injury and uh the rehabilitation they may or may not participate in and [Q]
0031 The what that they may or may not participate in? [R]

0032 The kind of rehabilitation? [Q]

0033 OK uh huh [R]

0034 In other words uh for some people it's a sorta a sports model for other people its
0035 pharmaceutical regimens [Q]

0036 Uh huh [R]

0037 For some others it's it's uh lots of different kinds of therapies or rehabilitation hh and um
0038 based on anecdotal stuff and just my own observations and st- stuff people have talked to
0039 me about it seems like it's… rather uneven and then recently there's … over the last
0040 couple years there's the terms wounded ill and injured have become more popularly used
[Q]

0041 Uh huh [R]

0042 More visible so it's really an interesting area for meeee to do a little digging in and I uh I'd
0043 love to hear a little bit about your point of view I'm so intrigued about the work that you do
0044 and maybe we could start there [Q]

0045 OK well lemme uh start by em clarifying the work that I do [R]

0046 Yeah [Q]

0047 Uh I uh for the past f-f- five years or so a- at least five years um I go out uh twice a year for
0048 two months at a time and I live on military bases [R]

0049 Wow [Q]

0050 And I've done this uh I just got back a few months ago from uh Okinawa where I was on a
0051 uh Marine Corps base [R]

0052 Oh wow [Q]

0053 Working with Marines and now I'm leaving for uh uh on May 29th to be on a Royal Air
0054 Force base to work with uh U.S. Air Force uh [R]

0055 Wow [Q]

0056 Uh people and uh it it I've done this all over the world and so hh and so uh m- my I'm not
0057 part of the uh organization I'm an outsider [R]

0058 Uh huh [Q]

0059 Obviously I'm a civilian I'm an outsider [R]

0060 OK [Q]

0061 And I'm uh I'm employed by a civilian company which has a contract with the Department

0062 of Defense [R]

0063 OK [Q]

0064 And the uh the uh unique uh aspect of my particular program is that people can come to me
0065 without generating any records I don't- a big selling point is that I don't keep any written
0066 records [R]
0067 Hmph [Q]

0068 I don't [R]

0069 Hmm [Q]

0070 So that when I when I do briefings to talk about the program I always say that it's career
0071 friendly security clearance friendly and special operations friendly because nobody finds
0072 out about it [R]

0073 Oh awesome [Q]

0074 Yeah now now the the limitations are *hh* are that is the constraints on that are are I have a
0075 duty to warn that is I must I must breech confidentiality and I tell 'em this before they
0076 come talk to me hh if they're in any danger of hurting themselves or somebody else what
0077 they call in the military duty to warn issues [R]

0078 Yes yes we se- we see the same thing yes [Q]

0079 Yeah so I so I ca- I can't I'm not the guy uh and I'm a- and I tell them if you want to speak
0080 to someone in utter confidentiality I can refer you to them of course there are chaplains but
0081 there are also people who are categorized as restricted reporters … are you familiar with
0082 that category? [R]

0083 No no that's new to me [Q]

0084 OK what that is is for example uh people that ha- that are uh um victims' advocates for
0085 sexual assault and things like that hh um sometimes in the in the past well women have said
0086 to me that I you know I I was abused by my husband an' I an' I reported it and he lost a
0087 stripe and I'm never gonna do that again [R]

0088 Hmph [Q]

0089 So a lotta people who were reluctant to report … uh for that reason they they uh created
0090 restricted reporters and these are people to whom you can go and get services hh but you
0091 don't generate a a report up the chain of command [R]

0092 Oh OK [Q]

0093 Now they keep the case open I believe for a year I could be wrong about that and during
0094 that year for example if he re-offends and you say I'm sicka this guy I'm gonna turn him in
[R]

0095 Uh huh [Q]

0096 Uh then you can the- they keep the record then they do a regular report [R]

0097 OK [Q]

0098 So uh with the restricted report you have a choice of whether to make it confidential or not
0099… in any case I'm not a restricted reporter so [R]

0100 OK [Q]

0101 I can't talk to people about any kind of abuse issues [R]

0102 OK [Q]

0103 The other thing is that I am because I go in and out every two months I'm *hh* theoretically
0104 … uh … and contractually uh supposed to be just dealing with uh with uh just issues that
0105 don't require long-term treatment that is real serious things things like ptsd for example [R]

0106 OK [Q]

0107 But in actuality I deal with everybody [R]

0108 Mm hmm [Q]

0109 Because uhm in the regular services very often there's' uh uh a long wait … sometimes
0110 three four five weeks' wait before you can see an official counselor so sometimes actually
0111 the uh regular standard services call me and say can you see this guy we're gonna see 'm
[R]

0112 Ohh [Q]

0113 Got ptsd or whatever he's got [R]

0114 Hmm [Q]

0115 and we know you're not the guy that's supposed to see 'm but would you see him so the
0116 fact is that I see everybody [R]

0117 Wow [Q]

0118 And the other thing is that I don't see wounded warriors who are in a unique category
0119 'cause they have their own services and when you're in that category you have your uh
0120 own services own uh uh psychological support services and yer own yer own they uh uh
0121 they have their own units in fact [R]

0122 Right [Q]

0123 So I don't see those guys … apart from but I I do see people that have been in the waar
0124 people that have had experiences that they will neeevvvveeerrr forget people that have had
0125 experiences that that they feel like they can't tell anybody about [R]

0126 Mmm [Q]

0127 Because they they so ashamed of it [R]

0128 Mmm [Q]

0129 I mean one guy was telling me this Marine he had uh shot a uh shot and killed a seven-
0130 year-old boy so he said to me I can't tell my wife [R]

0131 Mmm [Q]

0132 'Cause she'll think I'm a I'm monster they've got a five-year-old boy [R]

0133 Mmm [Q]

0134 So he goes home to Chicago and he takes the kid to the park hh and the guy happens to be
0135 Puerto Rican so th- his son is dark-skinned and so uh uh the kid looks like th guy he shot
0136 and he's he's just freaking [R]
0137 Mmm [Q]

0138 Out laying in the grass calling his wife hh [R]

0139 Oh [Q]

0140 Come and get me she has no idea what's going on [R]

0141 Uh hmm wow [Q]

0142 So anyway that's just to give y- [R]

0143 Wow [Q]

0144 An overview [R]

0145 Yeah [Q]

0146 Of the things I've been doing for the past five years [R]

0147 Wow mm what got you started? [Q]

0148 You know I was atta a a uh just by coincidence I was atta dinner with somebody and uh uh
0149 there was a bunch of people there I didn't know and one guy was talking about this
0150 program hh and I thought … how do I get into that? [R]
0151 Hmmm [Q]

0152 And I asked I just pursued it from there [R]

0153 Wonderful so are you a psychologist? [Q]

0154 No I'm a marriage and family therapist [R]

0155 Oh cool [Q]

0156 So it's a masters-level license in California [R]

0157 Yeah [Q]

0158 In California you can get you can get a uh a uh a social worker or a uh or a marriage family
0159 therapist with lance- with Masters degree [R]

0160 Yes perhaps that's the connection that when I was introduced to you I was introduced

0161 through (*name of colleague*) [Q]

0162 Yeah yeah [R]

0163 Y- yeah awesome [Q]

0164 Yes yeah [R]

0165 Um um w- in your purview um do you get the sense of whether uh there is a link between
0166 how people perceive disabilities whether they be visible or invisible and the recognition
0167 that people get based on those perceptions? [Q]

0168 *Hh* well uh it's it's a a miiiixture of uh um my perception is that there's a mixture of uh

0169 what shall I say … of perceptions [R]

0170 Uh huh [Q]

0171 S- so for example if something is uh if something is obvious like like a physical wound
0172 then there's no reservation at all but when you get psychological illnesses … um i- i-
0173 there's a- a- a fair number of people who who say that they're too easy to fake [R]

0174 Hmm [Q]

0175 And and these people um u u I think they support the idea of psychological illnesses like
0176 PTSD for example but uh … they feel like um it's not re- it's not enough it's not rig-
0177 rigorously enough uh scrutinized and that lots of people are uh lying about it and and just
0178 getting a lifetime of benefits [R]

0179 Mmm [Q]

0180 So there's that uh perception as well as that says yeah these guys are injured whether you
0181 see it or not you know they certainly deserve help um this maybe I'm sure you've seen
0182 these articles that uh that people um in your neighborhood as a matter of fact that are
0183 saying that there are physical wounds brain things that can be detected in PTSD [R]
0184 Yes [Q]

0185 And uh you know I have mixed feelings about that on the one hand uh it justifies that these
0186 guys aren't faking it but on the other hand why do we need physical evidence evidence you
0187 know someone reports what's going on [R]

0188 Yes good point yep [Q]

0189 I mean it should be sufficient [R]

0190 Yes good point the very fact that we can u- perhaps identify in some um way actually is the
0191 very liability [Q]

0192 Yeah [R]

0193 'Cause why should we yeah [Q]

0194 Yeah [R]

0195 Yeah do you do you end up listening to or speaking with or meeting with people who are ill
0196 uhm sick? Uhm w- what I mean by that is um cancer liver disease kidney [Q]
0197 Um No um I haven't in general no [R]

0198 OK [Q]

0199 In general no I see families as well as uh the uh military folks either with the active-duty
0200 person or without [R]

0201 And have you heard that term I was mentioning? Wounded ill and injured? Does that come
0202 across your [Q]

0203 Uhhhm I hear wounded warriors more than I hear anything [R]

0204 OK and then th- when you hear that I I know you mentioned it a few minutes ago and I am
0205 familiar with the units that you are that you talked about but uh w- what does it represent
0206 to you? When you think about wounded warriors and wounded warrior units what is that
0207 about [Q]

0208 Well they um they're more um units in which people who are wounded get get special
0209 treatment ummm uh it's a it's a double-edged sword on the one hand it's really good that
0210 they're that they're putting resources into these people who gave so much hh on the other
0211 and uuummm these people are taken out of their normal units in one case I was at a base
0212 m … of Army Rangers hh … and uh and … some of the guys had the prestige of when
0213 they were when they were doing airborne kind of activities they stuff they wore they have
0214 a special beret or something like that with a unique color which identified them as one of
0215 those hh heavy-duty warriors [R]

0216 m [Q]

0217 But when they got into the wounded warrior unit they lost the beret [R]

0218 Mmmm [Q]

0219 And they they felt like you know they were really um being dem- [R]

0220 Hmmmph [Q]

0221 -Moted one guy he said he said to me I went from a hero to a zero [R]

0222 Reeeeaaally that's interesting [Q]

0223 Yuueaah [R]

0224 Wow [Q]

0225 You know like it wasn't fair b- [R]

0226 Yueah [Q]

0227 But the other part of the argument is that those berets are for guys that are jumpin' out of
0228 airplanes an' an' doing [R]

0229 Yeah [Q]

0230 All this you know Ranger stuff [R]

0231 Yeah [Q]

0232 And these guys due to their injuries were no longer doin' it however they had earned those
0233 berets you know you have to take tests 'n 'n and be y'know rated a certain way to get those
0234 things and they felt like they didn't do anything hh to lose it except except get wounded [R]

0235 Yes [Q]

0236 Y'know through no fault of their own you know and now they didn't they didn't have the

0237 prestige [R]

0238 Hhph [Q]

0239 They had before so they were depressed about that [R]

0240 That's the very area I'm interested in actually it's uh as the subjectivity changes the reason
0241 I'm really interested in this population is that the very idea of uh being in the military in
0242 any of the military forces is that you're able or you're fit and that um that's measured and

0243 tested and observed and recognized and rewarded as you suggest and so my interest is in hh
0244 what happens when that goes away for one reason or another … *hh* … the example you
0245 provided is a good one … *hh* what happens to the person's sense of themselves and uh [Q]

0246 Yes [R]

0247 And and the uh um that's very interesting that you brought that up because that's the uh
0248 precisely the kind of thing that I'm interested in what are the mechanisms at work there [Q]
0249 Yeah they get really uh some of them get really depressed and lost I mean lots of them
0250 have made the military their or have intended the military to make the military their career
[R]

0251 Uh huh [Q]

0252 So it makes a big difference for the rest of their uh rest of their lives I mean the rest of their
0253 their working lives while they stay in the military … makes a big difference to them and
0254 some of them were depressed I mean apart from being depressed by their injuries which is
0255 reasonable to expect also hh they're depressed because they were lowered in status [R]
0256 Yes and when whe we s- when I hear you say lowered in status can you tell me more about
0257 that is that actual or perceived? [Q]

0258 Well it's perceived but what uh else is there? I mean [R]

0259 Yes [Q]

0260 I mean I think it is [R]

0261 Heh heh [Q]

0262 It's wholly a perception y'know the- they put on a different color hat they see what they're
0263 wearing they're proud to be still in the military these guys could get out hh and get
0264 disability benefits as uh veterans and lot of these guys are choosing to stay in [R]

0265 Hm [Q]

0266 And they get good services um but it's really unlimited their units are um um insulated I
0267 mean there's a guy I worked with in um one of my units he was a civilian guy retired
0268 military and he had been a Special Forces guy aand he knew hh he would be a great
0269 counselor to these guys and he wasn't they were he wasn't allowed to talk to these guys
0270 because he wasn't part of their [R]

0271 Hmmph hmmph [Q]

0272 You know contingency but I thought he would have been ideal because he been in Special
0273 Forces for a lotta years and knew just you know a lotta the classified stuff that these guys
0274 these guys were doing [R]

0275 Yes … yes interesting uh when they uh uh when that changes for them e- uh do they
0276 articulate that in ways that you're familiar with? Or that you've experienced or is [Q]
0277 Well uh uh as I say- um in general I don't talk to those guys but the one guy I spoke to said
0278 I went from a hero to a zero [R]

0279 Yeah good point [Q]

0280 And so uh um he was really y- y- despondent about it and uh I'm y'know I'm sure he
0281 wasn't the only one I mean to lose something that you're so proud of it to first [R]

0282 Yes [Q]

0283 To first to earn the uh the badge or the emblem or the beret is a great honor everybody
0284 takes great pride in that they wear their pride proudly [R]

0285 Yes [Q]

0286 And uh to lose it it's really uh a demotion [R]

0287 Yes I see your point [Q]

0288 It is a demotion you know no matter how anybody puts people say you know well it's not you know it just it sho- shows your activity but it's a it's a demotion something they really worked hard for and wanted [R]

0289 Right right and perhaps cannot cannot re-achieve [Q]

0290 Right [R]

0291 Would you agree? [Q]

0292 And they probably cannot re-achieve some of them with more serious injuries [R]

0293 Yeah [Q]

0294 The other thing is that there's some people you know I mean I read about one guy do you
0295 ever read the Stars and Stripes? [R]

0296 Yes from time to time [Q]

0297 Um hmmm it's online by the way its stripes . com so you c- you c'n see it online [R]

0297 OK thanks [Q]

0299 I mean I read about one guy who I think had uh had an amputation and he had a prosthetic
0300 and he actually went back into combat it was he was so determined to get back into his unit
[R]

0301 Hmph [Q]

0302 Sort of unusual but they let him in even though he had a prosthetic arm or a leg or
0303 something [R]

0304 Yeah yeah it's remarkable I have read a little bit about that yes it is remarkable [Q]

0305 Yeah I mean these guys are so proud hh and they wanna do what they've been doing and
0306 they get wounded and uh in general are excluded [R]

0307 Yes yes good point do you u- do you have um do y- do you work with some of the families
0308 or the family members or do you generally just see the Service members [Q]

0309 No I work with the family members as well sometimes I do couples and family counseling
0310 and sometimes *hhh* I work with the families when the guys are down range which is what
0311 the guys call their when they're you know w- in the combat zone they call it down range
0312 when the guys are down range I work with the families that are back on the base and
0313 sometimes when the guys come back I work with families 'cause uh in lots of cases they
0314 have um uh relationship problems [R]

0315 Mmm mmm [Q]

0316 As you might expect [R]

0317 Right [Q

0318 I mean I mean these guys are out in a war zone where they adapt certain behaviors for
0319 for their survival which are totally inappropriate when they come home [R]

0320 Yes [Q]

0321 Rr mm that's a recipe for disaster [R]

0322 Yes [Q]

0323 Disaster in general [R]

0324 Yes [Q]

0325 Although lots of people have figured out how to deal with it [R]

0326 Yes it's interesting some some figure it out and others don't and it's interesting to think
0327 about [Q]

0328 Yes [R]

0329 What the differences are [Q]

0330 Yeah [R]

0331 Betw- between those two kinda conditions [Q]

0332 Y- [R]

0333 Or or between [Q]

0334 That's interesting I mean I I mean I dunno sometimes I feel like the older people are more
0335 able to deal with it the ones that have had their relationships for longer [R]

0336 Hmm [Q]

0337 A lotta young people got married because they were enlisting an' uuuhhh it was the only
0338 way they could bring girlfriends with them and hh in many cases the um one guy used the
0339 term starter marriage but y'know [R]
0340 Hmmph [Q]

0341 It wasn't all that well thought out it seems like in some cases [R]

0342 Wow that's interesting … do you see any women? [Q]

0343 Oh yes I see women who are active-duty and I see women who are spouses in some cases
0344 in general its it's the men who are down range and the women that are home but there are
0345 women that are that are down range and the men are at home [R]

0346 Yeah [Q]

0347 And that's really interesting too [R]

0348 Yeah it's q- it's for me there's an interesting sert of dialectic or two sides of one coin with
0349 respect to service *hh* we really can't I mean sif we say that someone who's lost limbs have
0350 they given more? is that service worth more? is it the same? It' a really sort of a tricky to
0351 even talk about or think about 'cause it's so hard to imagine comparing suffering
0352 comparing [Q]

0353 Right [R]

0354 Um sacrifice sacrifice and service and yet some of the Service members I've talked to or
0355 listened to um are pretty firm about their feeling that there should be a hierarchy of whooo
0356 got hurt in combat who is uh amputee who's y'know I mean some of them rely on that and
0357 then others j'st debunk it and say I- one woman had 26 years of active duty service and
0358 died of stage four liver cancer she was pretty mad when she was here at Walter Reed that
0359 she wasn't accorded the kind of uuuhhh acclaim or recognition that others were because
0360 she wasn't in that as you pointed out wounded warrior brigade she wan't in a the wounded
0361 warrior unit she was in a cancer ward and um so i- it's it was very interesting to think about
0362 k- ho do we even compare levels of service or levels of sacrifice? [Q]

0363 Riiight well and you know y'know in our in our civilian systems we have the same

0364 hierarchy I mean you know when people do lawsuits I mean an arm is worth this much [R]

0365 Yup [Q]

0366 A leg is worth that much [R]

0367 Yup [Q]

0368 If it's your right hand you get more than if it's your left hand I mean w- we have that art-
0369 that hierarchy even in our legal system [R]

0370 Yes good point and in a way i- i- it's originally I got started along this path for a couple of
0371 reasons but one of them was that one of the people at my university to whom I was turning
0372 t- for some help with funding um actually said to me Oh you can't suggest that losing uh
0373 that that tbi or ptsd is as much a sacrifice as losing a leg and that really stopped me in my
0374 tracks heh heh heh because I mean which would you rather lose not that you can choose not
0375 that you want to compare but the idea of not being able to think straight or remember your
0376 kids names it seems like a pretty big thing to give up [Q]

0377 Yeah uh I agree I don't see how you can uh make the difference b- because uh [R]

0378 Yu [Q]

0379 You know i- i- it I mean I can imagine a life of torture when I see I mean the guy I spoke to
0380 that I that I told you about that had killed the kid [R]

0381 Uh huh [Q]

0382 I mean he couldn't sleep [R]

0383 Mmmph [Q]

0384 He w's terribly tortured I mean it wasn't obvious I mean this guy is ba- I mean I said
0385 where's your dog tag it's in this coffin [R]

0386 Mphfff [Q]

0387 His friend got killed right next to him I mean he [R]

0388 Mph [Q]

0389 I mean he got blown up woke up in the hospital with a concussion the next day hh he w- he
0390 walks around all night he can't sleep he's picked up by the military police [R]

0391 Hmmph [Q]

0392 *Hh* and they wanna tell him test him for alcohol and breathalyzer and all that an' he's you
0393 know he's oh he's got n- n- nothing goin' on like that and they're what are you doing
0394 walking around at four a.m. he says I can't sleep [R]

0395 Wow hmph [Q]

0396 And so I'm not sayin' that it's mm b- beeetttter or worse to have that condition compared
0397 to losing an arm or a leg I w- I wouldn't wanna make I don't know how you can make that
0398 kind of decision [R]

0399 I I yup yup I [Q]

0400 I mean this guy's is suffering and he will suffer fer … hh … for a really long time [R]

0401 Yu [Q]

0402 For maybe his whole life [R]

0403 Yu [Q]

0404 He said I can't I ca't tell my wife [R]

0405 Wow [Q]

0406 I can't ell anybody except you you're the only guy outside of my unit that I've ever told
0407 this [R]

0408 Wow [Q]

0409 To [R]

0410 Amazing wow uh your point in your e mail was something I've heard as well which is that
0411 um … just being in the military is disabling [Q]

0412 *Hh* well also yeah and uh and uh yeah that specific uh that uh in general but I mean
0413 specifically I spoke to one of the doctors and I said some of these guys are wounded and
0414 she said these guys are all wounded [R]

0415 Wow [Q]

0416 These guys are walking up and down these uh mountains with uh a hundred twenty pounds
0417 of stuff on 'em [R]

0418 Hmph [Q]

0419 I mean I mean including their all their weapons and all their armor and all that protective
0420 gear and all their provisions they uh hh walking up and down these mountains in
0421 sometimes you know really brutal cold winters [R]

0422 Umf [Q]

0423 With a hundred and twenty pounds on them well you know I'm a backpacker I go out with
0424 forty-five pounds and I wanna cry [R]

0425 Yeah yeah [Q]

0426 You know and I wanna cry [R]

0427 Yeah [Q]

0428 And these guys are ar- now I realize now I that they're twenty-five years old but still but
0429 she said they've all they've all got injuries to their joints you know their backs and things
0430 like that regardless of whatever happened in the war just walkin' up and down like that
0431 injured all of them [R]

0432 Yes w- would you say that pertains to psychological issues as well? [Q]

0433 … You mean that they're all inured psychologically? [R]

0434 Yeeaaah I mean without being too broad-brushy without being [Q]

0435 Well I think i- I I wouldn't necessarily say that because um there's a lotta support troops
0436 that uh that don't get into the combat … areas there's a lotta of people inside the wire
0437 inside the green zone [R]

0438 Mmm [Q]

0439 For example I I spoke with one guy he was a lieutenant commander in the Navy and he was
0440 d- uh a physician and an' an' an anesthetist [R]

0441 Hmm [Q]

0442 And so so he was there with his wife fer er marital problems 'mn he was saying yeah I was
0443 down range and everything and she said whadda ya talking about man? You were playing
0444 GI Joe and you were in the hospital and you were in the green zone [R]

0445 Hmm [Q]

0446 And you were perfectly safe [R]

0447 Hmph [Q]

0448 OK I wasn't in the combat zone but uh I really was in a bad neighborhood and and the truth
0449 is they are still lobbing rockets in [R]

0450 Hmph [Q]

0451 And they still are in an element of danger hh b- but its hard to see that he would be as
0452 injured as compared to someone [R]

0453 Mmm [Q]

0454 Who actually saw people killed [R]

0455 Hmmm [Q]

0456 Or maimed [R]

0457 Good example yep very good example uh- [Q]

0458 So not everybody is equally touched by it [R]

0459 Yes yes and as you've pointed out a few minutes ago some people want to just get back i-
0460 into combat get b- back into active-duty aaand be down range and [Q]

0461 Right [R]

0462 Yeah [Q]

0463 I met a guy actually he was sent back because he was shot in the head and survived [R]

0464 Umph [Q]

0465 And um … I saw 'im 'cause he came in for marital uh uh issues with his wife and he was
0466 really sad that he couldn't get back to his unit he wasn't allowed to go to return to his unit
[R]

0467 Wow [Q]

0468 He was really sad about that [R]

0469 Amazing [Q]

0470 And these guys have got such loyalty to their unit to [R]

0471 Yes [Q]

0472 I mean the guy uh uh again I mean the guy who I had told you about who had killed the uh
0473 boy hh um he told me that he can't sleep at home and his wife can't figure it out and that he
0474 said he feels much safer outta one of these forward operating bases in the middle of you
0475 know uh great danger [R]

0476 Wow [Q]

0477 Because he knew there was somebody sitting up with [R]

0478 Wow [Q]

0479 A rifle protecting him [R]

0480 Isn't that remarkable [Q]

0481 And he said he could sleep like a baby there and he's home in Chicago and he can't sleep
0482 in his house [R]

0483 Wooow [Q]

0484 Yeah it was pretty shooocking [R]

0485 It is shocking [Q]

0486 Yeah [R]

0487 What do you do to keep yourself steady? [Q]

0488 Well (*name of interviewer*) uh ehh i- sometimes it's really i- it's really hard when I'm over
0489 there when I'm back here it's a lot easier but when I'm over there I mean I recall hhhh um
0490 y- in Okinawa I w's uh a s- supporting uh about six different uh Marine Corps bases so I w-
[R]

0491 Wow [Q]

0492 I was actually located I the middle of the island where I could easily get to all these other
0493 bases 'cause rather than living on the base an' I recall sometimes just weeping going from
0494 one base to the next [R]
0495 Wow [Q]

0496 It was holy crap I can't believe what's [R]

0497 Oh my [Q]

0498 You know what that guy went through and what I just heard [R]

0499 Oh my [Q]

0500 'N of course I've got to pull myself together and go on and see the next guy [R]

0501 Wow [Q]

0502 So it's but when I come home you mean how do I personally keep myself together when I
0503 come home I usually go to a hot springs for a few days [R]

0504 N [Q]

0505 And just chill when I'm overseas I I do Tai Chi every day I've been doing that fer a really
0506 long time I do [R]

0507 Hey [Q]

0508 I do that in the morning 'm 'n an' I play guitar at night [R]

0509 Oh [Q]

0510 You know even briefly 'cause I'm really tired [R]

0511 Yup [Q]

0512 Tha- that seems to to help me even out [R]

0513 Wow awesome … your point was really interesting too about th- the hierarchies in the
0514 civilian world because one of the threads of the work that I'm doing is also the fact that
0515 anything that happens in the population I'm looking at is also it's people so it happens
0516 elsewhere too it happens in a different way perhaps it's it's more diluted 'r perhaps it's less
0517 extreme or more disaggregated but I- I- I'm really interested in the point you made about
0518 how we w- uh decide on percents of mm disability assessments [Q]

0519 Oh yeah [R]

0520 Yeah in the civilian world as well there are hierarchies about who deserves what … uh [Q]
0521 Yeah right and then I start thinking about a- umm about professional sports [R]

0522 Yeah [Q]

0523 Where people get concussions and tbi and things like that and that's emerging now as a
0524 new uh related issue [R]

0525 Yes yes good point [Q]

0526 These guys who get suicidal and they wacky too [R]

0527 Yes that's a good point … absolutely [Q]

0528 So that's [R]

0529 And [Q]

0530 Just comin' out now [R]

0531 D'y- do you have um … d- did you have a familiarity with the military before you became
0532 involved as a um a contractor and as a therapist did you have do you have family members
0533 or were you in the military yourself? [Q]

0534 Well uh my brother was in the Army for four years my uncle was in the Army in the
0535 Second World War and I was actually sent to uh um University of Michigan to study uh
0536 Naval architecture and Marine engineering 'n that w's all paid for by the U.S. Navy [R]

0537 Oh for pete's sake [Q]

0538 And I worked for the Navy as a civilian naval architect marine engineer … uuummmm …
0539 y'know ages ago you know [R]

0540 Hmmph … wow how was that experience for you was it interesting? [Q]

0541 It was real interesting it wasn't you know it wasn't the profession that I I realized that I- I
0542 wanted to to do I mean hh I was a kid in the uh you know Bronx New York hh 'n here was
0543 some guy fr- from the Brooklyn Navy Yard an' saying all these things we're offering
0544 scholarships and it's a work study program and all these things hh an' an' you can go to
0545 University of Michigan and for me it was an opportunity [R]

0546 Mmm [Q]

0547 To do that and I realized after awhile I realized it really wasn't what I wanted to do [R]

0548 Di- [Q]

0549 Anyway I did it for about six years [R]

0550 B- [Q]

0551 So that was my civilian contact with the military [R]

0552 Oh that's fascinating wow do you stay in touch with your brother? [Q]

0553 My brother died a few years ago actually he died in a veterans' home awhile so he w's had
0554 treat treatments in the VA home in California [R]

0555 He has my sympathies I'm sorry [Q]

0556 well thank you but uh uh that was uh several years ago and I thought he had wonderful
0557 treatment and I w's I was real envious of the level of care he was getting in uh in uh
0558 Yountville California [R]

0559 Huh [Q]

0560 They've got this gorgeous VA home it's not just like a building in a uh in acity it was like
0561 it's probably got five hundred to a thousand acres around it [R]

0562 Wow amazing [Q]

0563 It's gorgeo- it w's sold to the state for one dollar in like like you know two- [R]

0564 Uh [Q]

0565 Thousand or something like that you know as a present to use as a VA home [R]

0566 Wow there's so little I know about VA and as I learned more I am quite astounded a- a-
0567 well … one thing is that it's very hard for many uh many civilians to understand the
0568 difference between DOD and VA a- and they're quite different [Q]
0569 R: Right [R]

0570 Um but also so the the sort of uuuhhh prejudice against VA as a being big bureaucratic
0571 mess a- and yet when I talk to people or listen to people or connect with people many of
0572 them have stories like the one you've just … alluded to uh about great care and and
0573 amazing facilities and [Q]

0574 It was amazing let me say that uh aas soon as he weeent in they gave him a room first of all
0575 when you go into this place in Yountville first of all the- they uh uh have uh a nine-hole
0576 golf course on it [R]

0577 Hmmph [Q]

0578 They've got bowling alleys on it y- you get two a room when you first get there and um
0579 and it's got air conditioning and cable tv [R]

0580 Hmph [Q]

0581 And they've got a a mess hall where you go to and all that and after about- if you have uh
0582 uh a spouse you can get a a room with your spouse you get a private room hhh and if
0583 you're there for five or six years you can get your own room as well hh uuumm … they've
0584 got all kinds … they've got a hospital a full hospital right … on … the … site … right
0585 there [R]

0586 Huh [Q]

0587 Right there [R]

0588 Huh [Q]

0589 With a helicopter air lift you know facilities [R]

0590 Wow [Q]

0591 And all that stuff and so it's fantastic it's just a gorgeous fantastic place [R]

0592 How fascinating … were you surprised? [Q]

0593 I was really surprised heh heh [R]

0594 Heh heh heh [Q]

0595 I was really surprised and delighted [R]

0596 Yeah [Q]

0597 You know [R]

0598 Uh huh [Q]

0599 It was like a uh the best care he could have had gotten [R]

0600 Wow [Q]

0601 Oh and they have three levels just to give you a little more uh they have three levels of care
0602 you go in and you part of the general population and you walk over to the mess hall and
0603 you eat and things like that hhh um the second level of care when you need more care he
0604 went through all three levels before he died hh second level there is they'll bring you your
0605 meals [R]

0606 Hmph [Q]

0607 They'll bring them to your room hh and the third level of care is more like a nursing home
0608 type of thing [R]

0609 Hmm [Q]

0610 Where they they just take complete care of you [R]

0611 Mmm [Q]

0612 You know like in a uh uh an assisted living kind of facility

0613 Wow [Q]

0614 So I was really impressed and for no charge whatsoever an' uh he was a veteran I mean he
0615 was a regular veteran you know he wasn't heroic he wasn't a career man or anything like
0616 that he put in uh three or four years when he joined and um tk he got great service [R]

0617 Was he deployed? [Q]

0618 He was uh well he was in the fifties and he was uh deployed to uh to uh Germany [R]

0619 OK OK [Q]

0620 Actually but he wasn't in combat [R]

0621 OK uh interest- [Q]

0622 But he had full benefits [R]

0623 Ing … wonderful [Q]

0624 Yeah [R]

0625 That's a good story [Q]

0626 Yeah [R]

0627 I appreciate these insights thank you very much [Q]

0628 You're welcome (*name of interviewer*) I'm um happy to help out in any way that I can and
0629 um if there are further things uh you wanna talk about I'm glad to talk to you about this
0630 stuff [R]
0631 Thank you I probably will follow up because I've just recently started interviewing people
0632 because I've just recently received formal approval to do so [Q]

0633 h huh [R]

0634 So um as I listen to people I uh new questions are formulated and then uh sometimes I
0635 wanna get back to people just to be sure I understood a direction they were going or p'raps
0636 something that I might not have thought about in the moment so- [Q]

0637 Uh huh [R]

0638 I would love to think that I could reach out again [Q]

0639 I'd be glad to talk to you but I'll be going overseas but uh uh I'm still on my e mail that
0640 you have an' I'm on Skype too so we c'n talk on the phone if we can arrange you know the
0641 right times with time zone differences and all that [R]

0642 Fabulous thank you so much I sure wish you safe travels [Q]

0643 Thank you [R]

0644 And uh yes yes let's do that let's stay in touch it- it's a a [Q]

0645 OK OK and if ya wanna do you have my address to send me the uh [R]

0646 No [Q]

0647 So lemme give you my address [R]

0648 Thank you [Q]

0649 (*interviewee address details*) [R]

0650 Yup [Q]

0651 You gotta pencil? [R]

0652 Yes [Q]

0653 (*address details*) [R]

0654 OK [Q]

0655 (*address details*) [R]

0656 OK [Q]

0657 (*address details*) [R]

0658 Great (*interviewer's relative*) lives in (*address details*) [Q]

0659 Great what what part? [R]

0660 You know what? I'm not sure (*interviewer's relative*) just moved to a a street called uh uh
0661 (*address details*) uh (*address details*) em an' I think it's near the (*address details*) I'm not
0662 sure [Q]

0663 I live in (*address details*) myself but I don't know where (*address details*) is [R]

0664 Well well- [Q]

0665 I think I have an idea of w- where it might be [R]

0666 Well I think I think [Q]

0667 I think I might have an idea of where (*address details*) is I do live in (*address details*)
0668 which is a great neighborhood [R]

0669 It sure is it's fabulous well thank you very much [Q]

0670 You're welcome (*name of interviewer*) and best of luck with your project [R]

0671 Thanks a lot and I I will stay in touch [Q]

0672 Thank you [R]

0673 OK good night [Q]

0674 Bye bye [R]

030F/U e mail
0001 I'm on an overseas assignment and just read an article in today's (July 9, 2012) *Stars and*
0002 *Stripes* which I thought would interest you. It's on the front page. Here's a quote from the
0003 article, by Sgt. Justin Rajotte (who had injured his back while training): "You get the title
0004 'broken' and once you get that title, it's hard to convince people that [the injury] is actual,
0005 that it's real and that you're not trying to get out of stuff." It's also available on line at
0006 http://www.stripes.com/news/warrior-transition-unit-s-role-changes-with-times-1.182445
0007 In terms of your study, I imagine it's harder for someone like Sgt. Rajotte who was injured
0008 in training than someone with a visible combat injury like a missing limb. No one would
0009 accuse the amputee of "…trying to get out of stuff." What I find striking is the intense
0010 loyalty and love these brothers and sisters in arms have for one another. It's so powerful
0011and I can only imagine how sad they become when they are forced by injuries to leave their
0012 pals. Several years ago I met a guy who had both legs blown off. His unit was still out and I
0013 saw him in his wheelchair every day. He was struggling very hard to get enough command
0014 over his prosthetic legs to be able to stand when the guys returned from the battle zone. He

0015 succeeded; they swarmed around him when they got off the buses. As the days went by
0016 when I saw him he was back in the wheelchair, but he was so proud of himself for standing
0017and saluting the others when they returned.
0018 This time around I'm working with a U.S. Air Force squadron who aren't as directly
0019 involved with face to face combat as the marines and soldiers I've worked with and I
0020 haven't encountered the injured population that you are studying, so I don't know how
0021 much help I can give you. I respect very much what you're doing and I'm quite interested in
0022 the issues you're studying; I'll be happy to talk to you if you'd like. The best time for me to
0023 chat will be after the first week in August. I fly out on July 29 and it usually takes me
0024 around a week before I can speak in full sentences! Just let me know what you think.

040*v2* Care Provider	4797 words	Olympus recording #11/21 30:10		
Setting	Rank	Gender	Date	TOD
Private office, door closed	CIV	Female	04 MAY 14	0900-1000

0001 OK and you are participant number four today is May the 14th and we're here to talk about
0002 your experience as a **care**giver and your ideas about the link … between how people are
0003 wounded are ill and become injured and the kinds of recognition and access to resources
0004 that they achieve or don't achieve I'm interviewing pa- er um care providers patients
0005 family members and non-medical attendants and uh in our conversation today you're a care
0006 provider is that right? [Q]

0007 Correct [R]

0008 Thank you I do have a **list** of questions that I could read but i- I'd love to just get a sense
0009 from you do you hhhh- have any response when I say that original idea that original
0010 question in your experience do you know of a link between how the s- Service member was
0011 injured and or be- became wounded or became ill and then h- how that person was able to
0012 access both resources and by that I mean maybe things like maybe parking privileges or
0013 gear or attention or um membership or invitations to participate in things um and also …
0014 recognition and those things are kinda linked the resources being tangible things the
0015 parking privileges for example and the recognition being somewhat less tangible and I
0016 wonder of you could talk to me a little bit about the thoughts you have about this subject
[Q]

0017 I think uh it's **huge** right from the start like when we get the aerovac list patients are
0018 identified as battle or non-battle [R]

0019 Mm [Q]

0020 And battle-injured patients um are typically coded as severe which means their families
0021 either meet them in Germany or here [R]

0022 Uh oh [Q]

0023 If it's a non-battle injury your families get **notified** but they may or may **not** [R]

0024 Mmm [Q]

0025 Be brought here to see them [R]

0026 Mm [Q]

0027 So you can have somebody coming from **theater** with say a medical problem rule out
0028 leukemia and they're twenty-six years old and they arrive very sick and there's no family
0029 and there's a lot of miscommunication non-clarity [R]

0030 Mmm [Q]

0031 About how and when that family is able to [R]

0032 Oh wow [Q]

0034 To come [R]

0035 Wow [Q]

0036 So it's a very high-anxiety time with these young kids with **illness** [R]

0037 Illness yes thank you [Q]

0038 Illness as opposed to wounded and the patients and honestly it's almost across the board it
0039 doesn't matter if it's if they're diagnosed with a cancer if they're diagnosed with [R]

0040 Hmm [Q]

0041 A stroke if they you know what **ever** heh if it's a **medical problem** their family is **not**
0042 **brought here** once their family finally does arrive which usually takes I dunno two to five
0043 **days** [R]

0044 Mmm [Q]

0045 Once the family is **here** then there's a lotta discrepancy in terms of where they get **housed**
[R]

0046 Mm [Q]

0047 So if a if a wounded warrior wife arrives with two children during there's a social worker
0048 there it's all arranged their **liaison** assigned they have housing [R]

0049 Great example [Q]

0050 Whatever it is [R]

0051 Yu [Q]

0052 If there's a **sick** person here [R]

0053 Hmm [Q]

0054 And they're on orders they can be out into a **hotel** which 0053 may sound OK but somebody has to **do** that [R]

0055 Hmm [Q]

0056 It doesn't have the same a- [R]

0057 Hmm [Q]

0058 Automatic **switch** that a wounded warrior has and then once **here** the family members may or may not have access to the same **kinds** of things that the wounded warrior families do … so [R]

0059 So [Q]

0060 Right from the beginning it's very different [R]

0061 Thank you and it sounds as though right from the beginning you recognized the question as
0062 soon as I started to ask you the question and that's a- interesting to me thank you the um
0063 term wounded warrior has been used for years and another term has emerged wounded ill
0064 and injured and I wonder if you can speak a little bit about your familiarity with those two
0065 terms? Have you do you have a sense of wounded ill and injured being used? [Q]

0066 I I don't have a sense of injured wounded as different [R]

0067 OK … the um in some of the um it's not formal policy but in some of the um posters and
0068 presentations even in a panel I attended a panel of Service members family members um
0069 the entire day was focused on this was at the Smithsonian was focused on the difference
0070 between wounded ill and injured uh as compared to wounded warrior and people **explained**
0071 that what they meant was wounded was injured in combat ill is sick as you suggest
0072 leukemia cancer something else injured means I was hurt but I it wasn't in combat [Q]

0073 Owwwhhh OK [R]

0074 S- [Q]

0075 So it was an injury in theater [R]

0076 Yes [Q]

0077 But not a combat wound [R]

0078 Yes I I right an accident an active-duty talking about people who are active-duty so it sounds like that means you haven't heard that term much [Q]
0079 N- no well I didn't understand that to be the distinction I am aware that there are patients
0080 that come in and I see them anyway when they first come and do an evaluation uum … …
0081 the w- the difference between the **wounded** and the **injured** [R]

0082 Mmm [Q]

0083 Depending on the severity of injury [R]

0084 Mm [Q]

0085 May not be that distinct in terms of the issue I was thinking about [R]

0086 Mm good point [Q]

0087 Like a **severely injured** soldier's family might be here [R]

0088 OK [Q]

0089 As soon as they arrive [R]

0090 OK OK thank you [Q]

0091 If it's an injury or if it's wound they almost never hear of it's ill [R]

0092 Th- a- uh even I should ask even if the illness is very severe? [Q]

0093 Correct [R]

0094 OK thank you thank you um how long have you been working with … Service members
0095 either at Walter Reed here or Walter Reed Georgia Avenue [Q]

0096 Four years [R]

0097 Four years [Q]

0098 Four years [R]

0099 And what kind of work were you doing before that? [Q]

0100 The previous job I had I worked with a private practice a (*kind of healthcare*) private practice [R]

0101 OK … um so we could spend probably spend three days talking about all that because I am
0102 sure there are tremendous similarities and differences uh I am interested though in whether
0103 um the kinds of recognition that people get here how they differ differ from or are the same
0104 as the kinds of recognition people get elsewhere when they're wounded ill or injured
0105 particularly I think I'll focus on the wounded part right now? Uh meaning what we just
0106 talked about … do you have a sense of the recognition people get depending on their
0107 wounds in **this** environment? [Q]

0108 *hhh* … … Humph not I'm not sure I do here I think it was more distinct actually over at
0109 Georgia Avenue I mean clearly that was the identified injury amputee uum and while the
0110 amputees still **come** here I don't I don't hear that there's also a tremendous n- neurology
0111 practice here [R]

0112 Hmmm [Q]

0113 TBI [R]

0114 Uh huh [Q]

0115 Neuro surgery [R]

0116 Uh huh [Q]

0117 So … … w … I guess that I don't **hear** the amputee population as emphasized as was over
0118 there [R]

0119 Mmm [Q]

0120 Um [R]

0121 That's really interesting uh and uh coming back to what you were saying because Walter
0122 Reed DC was a was a highly visible [Q]

0123 Uh huh [R]

0124 Was that what you meant? [Q]

0125 Uh huh [R]

0126 A um well-known care facility military treatment facility for amputees? [Q]

0127 Correct and this still **is** … it just you don't **hear** it [R]

0128 Hmmm [Q]

0129 At least **I** haven't [R]

0130 W- [Q]

0131 Yet heard it in the same light [R]

0132 Mmm [Q]

0133 And that and that may not be a **bad** thing because you know these TBI patients are severely
0134 injured and um … and yeah you've got really severe abdominal wounds that are also
0135 coming so I don't hear the subtle and I'm not sure it was um it was **not** so subtle I think at
0136 Walter Reed [R]

0137 Hmmm [Q]

0138 It is more subtle here [R]

0139 That's very interesting thank you I wonder what accounts for that? well you've explained
0140 some of that but there are many **kinds** of specialized care here um … … do you think that
0141 accounts for it the experience you just said? You just mentioned? [Q]
0142 You know I'm not sure I think the the fourth fl- you know there's more uh flexibility
0143 **between** the floors here so that the **entire** fourth floor can house you know **various** kinds
0144 of injuries [R]

0145 Hmm [Q]

0146 Whereas on Sixteenth Street fifty-seven pretty much was the amputee unit [R]

0147 Mmm [Q]

0148 Fifty-eight would get TBIs [R]

0149 Hmmm [Q]

0150 But … overflow of um amputees and then fifty er sixty-five and sixty-eight would be more
mixed [R]

0151 Mmm [Q]

0152 Surgical units sooo if an amputee ended up in say in one of the sixties they would really
0153 they would make an effort to eventually get them to the fifty-seven [R]

0154 Mmm [Q]

0155 Er the fifty-eighth floor with the idea that there was more here it's almost like the entire
0156 fourth floor it's not a really an effort to keep amputees on four east or four center [R]

0157 Oh OK OK [Q]

0158 If that makes sense and so it's sort of more diverse um … [R]

0159 Huh [Q]

0160 And I I suspect that I'm not the best person to answer it because part when you're asking
0161 for acknowledgement of um … it used to be very obvious like when a VIP came to visit
0162 Sixteenth Street or Georgia Avenue typically they would see fifty-seven fifty-eight even
0163 though you had wounded warriors on sixty-eight and sixty-five [R]

0164 Yeah yeah [Q]

0165 The **focus** was always fifty-seven fifty-eight [R]

0166 Yeah [Q]

0167 And maybe the I- [R]

0168 Really good example [Q]

0169 But **here** they **do** cover the entire fourth floor [R]

0170 Mmm [Q]

0171 So there's better recognition of **all** the wounds [R]

0172 Hmmm [Q]

0173 **All** the injuries [R]

0174 Very interesting that's really interesting [Q]

0175 And it may be that it's just you know to some degree just geography [R]

0176 Yes which comes first I guess is always the question I I am so interested in your way of
0177 explaining it in terms of actual units and floors and so there is a different geographic
0178 geophysical component in what you're talking about [Q]

0179 Right right [R]

0180 And part of the work I'm trying to do is to think about space [Q]

0181 Uh huh uh huh [R]

0182 Think about the effect that space has on people people and behaviors [Q]

0183 Uh huh [R]

0184 Ways that we perceive things and so your examples were **really good** because you're
0185 talking about different kinds of spaaaaces in which people are treated cared for [Q]
0186 Uh huh uh huh [R]

0187 And how they transition between and **among** those spaces … and it's quite different here
0188 it's quite different here from what it was at Walter Reed at the **other** Walter Reed yeah
0189 thank you that's really interesting do you think of when I say the word disability what do
0190 you think of? [Q]

0191 … … since working with the military my **thought** about disability is **significantly** different

0192 heh heh [R]

0193 Heh heh [Q]

0194 I mean **here** you see single double triple quadruple amputees [R]

0195 Yup [Q]

0196 Aaand people with uh severed spinal cords C-six C-seven and brain damage [R]

0197 Yup [Q]

0198 That will never be repaired [R]

0199 Yeah [Q]

0200 It's it's really a **skewed** vision [R]

0201 Yeah [Q]

0202 Of h- of severity I think [R]
0203 Yeah of severity yeah right it's an interesting field site for me because um the idea of …
0204 one of the criteria s- a criterion for being in the armed forces is being able-bodied being fit
[Q]

0205 Mmm [R]

0206 And being measured and tested over and over again and the measurements and tests are
0207 reflected in lots of ways medals or promotions or events or ceremonies so it's interesting to
0208 me to think about what happens when that **changes** when it's adventitious [Q]

0209 Mmm [R]

0210 Disability as compared with not that you can really compare suffering but some disabilities
0211 are genetic and these are not these are unexpected **profound** changes in many cases so I
0212 can u- really respond to what you're saying I can really it **resonates** for me maybe because
0213 I'm also a civilian coming from a different world and um so the word disability … takes on
0214 a rather different [Q]

0215 Mmm mmm mmm mmm [R]

0216 Meaning it's used a lot here…by people when they're speaking about assessments when
0217 they're speaking about different kinds of things and when I…presented my topic to IRB I
0218 was asked why are you using that word? … which surprised me becaaause it's used a **lot** in
0219 the military...because it has when people **retire** when people it's used a lot by both
0220 apparently able-bodied people and u- obviously disable-bodied people and everybody in
0221 between…and so when you have I shouldn't be talking so much heh heh but I wonder if
0222 you have any other thoughts about disability any other thoughts about disability as a word
0223 that used a lot but when we say it out loud people…might be surprised that we're using
0224 that word … does that ring any bells for you? [Q]

0223 *Hhh* ... … uuum well [R]

0224 Hmm [Q]

0225 I- it's interesting because I think on the in-patient side when we're working when I work
with the acutely injured patients and their families they're still in the phase of trying to integrate
[R]

0226 Hmmm [Q]

0227 All the bad news … … you know it's really hard for them to [R]

0228 Yup [Q]

0229 Siphon out any good news [R]

0230 Yeah [Q]

0231 Other than I can say my son or husband's alive [R]

0232 Yeah [Q]

0233 Because it seems like in the first couple a weeks they hear a lot of a lot of different
0234 evaluations … um … but I do think there are injuries that don't sort of qualify under the
0235 idea initially like [R]

0236 Mmm [Q]

0237 I'm on a committee now that's looking at sexual injuries genital and um and [R]

0238 Mmm mmm [Q]

0239 And you know a number of these young men no longer can have children [R]

0240 Mmmm [Q]

0241 They've lost testicles they've had penile damage [R]

0242 Yeah [Q]

0243 Damage so even issues of um you know sort of very **identity**-related [R]

0244 Mmm [Q]

0245 You know physical injuries [R]

0246 Yup [Q]

0247 The impact of that does not come out I don't think fully I don't think until they're almost
0248 ready to be discharged [R]

0249 Oh interesting wow [Q]

0250 Yeah because they're so physically impaired [R]

0251 Yup [Q]

0252 In many waaays [R]

0253 Yeah [Q]

0254 That their inability to have a sexual relationship doesn't come up [R]

0255 Yeah yeah [Q]

0256 Until they're further waaay down the line [R]

0257 Yeah [Q]

0258 And ready for discharge getting ready for passes and [R]

0259 Yeah [Q]

0260 Then it's a question … so honestly I suspect that that question of disability becomes clear-
0261 er once they're out of the hospital [R]

0262 Mmm [Q]

0263 When they're really in the **world** and trying to **function** [R]

0264 Yeah yeah that's another thing that I was going to ask you about thank you for bringing it
0265 up so as we project fooorward how does our sense of those for whom we're caring how do
0266 we project what's going to happen an' there can be some concrete ways that we do
0267 someone's going back home someone's going to VA someone's going to be deployed but
0268 your point is really good about the … uh … continuing change with respect to identity and
0269 the uh emergence of the uh ideas about oneself when th- that happens it doesn't happen at
0270 this stage it happens with this or this stage and that's a good example … [Q]

0271 Well and I also think that the reverse is true like there have been some really very severely
0272 brain-injured patients that have come through … that initially excuse me everybody goes
0273 like oh my god [R]

0274 Hmmm [Q]

0275 You know Glascow (?) scales of three? What's gonna happen? What's their future? You
0276 know at what point do you talk to the family about withdrawing care [R]

0277 Mmm [Q]

0278 Or hospice you know it's a huge issue [R]

0279 Yeah [Q]

0280 And y- you just never **know** heh I mean as much as you think you know you know you just
0281 never know so they're one guy whose significantly improved [R]

0282 Wow [Q]

0283 When first arrived had a gcs (?) of I think three or four? Uuum who probably'll never ever
0284 get even to a ten but this quality of life issue i- a- eha- what happens? [R]

0285 Yeah [Q]

0286 And it's amazing that he's **improved** [R]

0287 Yeah [Q]

0288 But will he ever will he ever **function**?

0289 Yeah [Q]

0290 … you know ... how do we how do we intervene with a family on that? [R]

0291 Yeah [Q]

0292 Over the **long haul** [R]

0293 Over the long haul yeah yeah that's a good question and it starts to make a word like
0294 disability tricky because it's [Q]

0295 Yu! [R]

0296 Because it's multi-dimensional [Q]

0297 Oh yeah heh heh well there's even a study that's going on that I have periodically reviewed
0298 um an u- they use what's called the severity of illness sc- uh sc- scale [R]

0299 Hmmm [Q]

0300 Aaand it's a study on the impact of severity of illness of the patient on children … I'm
0301 prett- that may not be accurate wording but I'm pretty sure that's the concept aaaand um
0302 and so **I** will review over after the researcher looks **I** will double check the chart to make
0303 sure all the medical issues are scaled and rated [R]
0304 Mmm [Q]

0305 Well the rating scale itself treats an amputation in a certain category as a five [R]

0306 Ah [Q]

0307 But if you've got **four amputations** [R]

0308 *Hhhh* [Q]

0309 … there's no way to change that **score** and that's heh to me that was like the biggest eye-
0310 opener there is the injuries that we're **seeing** you know the level of disability [R]

0311 Yeah [Q]

0312 We've got a severe head injury coming in at a five [R]

0313 Mmm [Q]

0314 What about the amputees that even a double amputee or or even a single amputee comes
0315 through you're like ho don't worry you're going to be great it's no big deal [R]

0316 *Hhh* it's amazing [Q]

0317 How do you [R]

0318 It's amazing [Q]

0319 How do you get through that? So you know my head is so different from when I first got
0320 here [R]

0321 Yeah [Q]

0322 But the you even look at the tools and severity of illness I think there's five categories that
0323 they assess you now five physiological [R]

0324 Mm [Q]

0325 Systems that they asses well if you've got a severe TBI and you're you know have lost
0326 three limbs ffff you know and have abdominal wound [R]

0327 Mmm [Q]

0328 And have and you know you lost both testicles [R]

0329 Yeah [Q]

0330 You know you're a five in each one but does that really **describe** what the heck is
0331 happening? [R]

0332 Yeah very good example wow [Q]

0333 I don't think we can even **measure** the severity of the illness that we see [R]

0334 Yeah [Q]

0335 Or injury let me put it that we see [R]

0336 Yeah yeah thank you when I've uh uh spent time with people who are retiring and they're
0337 talking about **assessments** [Q]

0338 Hmm hmm [R]

0339 The disability the use of the word disability is quite different … uh eh it's used in the same
0340 sort of **functional** way in a conversation yet what they're referring to in some cases is a-

0341 again this is apparently able-bodied able-minded person is retiring and they're talking
0342 about their disabilities .. based on their service er um there **are** um there are things that
0343 people identify and then they get linked with benefits or um … a**ssess**ments and for me that
0344 was interesting it changed my understanding of the breadth or sert of the constellation of …
0345 **points** of disability it's not so much a continuum it's not so much a linear thing [Q]

0346 Um hum [R]

0347 Sort of disabled or not disabled as you suggest it gets quite complex and for people who are
0348 apparently able-bodied able-minded they may have a someone was telling me about a
0349 some other stuff that she needed to have **recognized** and that it would have things attached
0350 to it uh and those were disabilities and so i- uh that's what stopped **me** because I was
0351 thinking about disability in a completely different way and uh so it's quite a all-
0352 encompassing kind of word and depending on where you hear it and who uses it people
0353 may or may not resist the idea of calling someone disabled … and I wonder if you have any
0354 thoughts about that h- h- I'm talking away as though you're interviewing me heh any
0355 thoughts about how [Q]

0356 Um [R]

0357 People use it [Q]

0358 I'm I'm not sure how to respond to that I d- like I think PTSD is a go example people
0359 PTSD the rating has changed to thirty percent … disabled so heh heh when you're using
0360 able-bodied at the time that I see most of the patients as in-patients [R]

0361 Yes [Q]

0362 You know [R]

0363 Yes yes [Q]

0364 You've got this very horrible complex [R]

0365 Yes [Q]

0366 Question of how … how are they going to be in the future so maybe a year down the road
0367 all their surgeries are done they've been in physical therapy you know you have a better
0368 chance of sort of assessing you know how are they adjusting how are they functioning all
0369 those things … *hh* … but I do think there's a **retirement mentality** of uuuhhhmm of
0370 people then shifting gears [R]

0371 Huh [Q]

0372 To [R]

0373 Uh huh [Q]

0374 To what do I get? After giving twenty years of my life [R]

0375 Yeah [Q]

0376 Or thirty or whatever [R]

0377 Yeah yeah [Q]

0378 Uuuumm so I **do** think you know some people that I've let's say p- patients that I've seen
0379 as wounded warriors I think that's one set but I've **also** seen … w- uh um … distressed [R]

0380 Mmm [Q]

0381 **Staff** returning from theater [R]

0382 Oh good example [Q]

0383 I see them as out-patients aaand a majority of them coming in the majority will say don't
0384 try giving me a PTSD don't try givin' me you know they're very resistant for the most part
[R]

0385 Hmm [Q]

0386 To being diagnosed [R]

0387 Mmm [Q]

0388 Buuut there are a **few** that will come in and say give me what a computer would say [R]
0389 *Hh* [Q]

0390 'Cause they're getting out [R]

0391 Yeah [Q]

0392 Now that percentage is really small but what really threw **me** as a new clinician and not get
0393 what that was [R]

0394 Yeah yeah [Q]

0395 What that was about [R]

0396 Thank you that's kinda what I was talking about [Q]

0397 You know it's easier for me to see it now … … um … you know and once in awhile like a
0398 less severely ill a less severely wounded [R]

0399 Mmm [Q]

0400 Patient … … may really push for instance [R]

0401 Mm [Q]

0402 Push ta stay in the hospital longer not to be discharged because there's a financial benefit
0403 for them to be in longer [R]

0404 Mmmm [Q]

0405 You certainly don't see that with the severely disabled because they're gonna be here
0406 whether they want to or not [R]

0407 Yeah yeah good point yeah and as with many other things it's **people** so whether it's in the
0408 military or civilian [Q]

0409 Right right [R]

0410 There's a percent that you're gonna look and say hm hmm [Q]

0411 What's to be gained here? [R]

0412 I'm almost finished thank you for all this time do you think of your patients have you ever

0413 thought of your patients as disabled? Has that ever … [Q]

0414 Well u- for me with the in-patients .. uumm well that I would have to say that's changed
0415 over time when I first came here it was … I was blown away by the injuries [R]

0416 Yeah [Q]

0417 Like couldn't foresee what it was gonna be like [R]

0418 Yeah [Q]

0419 And then after my first **year** and I had seen some of those in-patients as out patients [R]

0420 Mmm [Q]

0421 And seen them on campus [R]

0422 Mmm [Q]

0424 And seen them start running aaand [R]

0425 Mmm [Q]

0426 Or hear back from them that they're doing great you know that they've had injuries and
0427 healed you know [R]

0428 Yeah [Q]

0429 And that they've adjusted it became more and more incredible source of amazement [R]

0430 Yeah yeah yes [Q]

0431 How do they do that? [R]

0432 Yes yes I share that [Q]

0433 How do they do that? [R]

0434 I was so inspired by your talk when you mentioned that 'cause that's a very **powerful** thing
0435 for me or us to [Q]

0436 Uh huh [R]

0437 Experience [Q]

0438 Uh huh [R]

0439 Seeing that happen almost beyond being able to articulate for me [Q]

0440 Right right [R]

0441 An' I'm glad I'm uh interested that you mentioned um … you might hear back from
0442 somebody because that might be somebody who couldn't remember your name couldn't
0443 really figure out why he or she was in the hospital [Q]

0444 Uh huh [R]

0445 Then a year or two later sending an e mail saying you know it's Mother's Day and we're
0446 going out later or whatever it is so that touches on the people who aren't necessarily
0447 visibly … disabled [Q]

0448 Uh huh [R]

0449 And yet have made huge steps or progress or changes or ad- that's a great word adjustment
0450 so thank you for that [Q]

0451 Yeah I think the most fun at least over on Sixteenth Street it hasn't happened as much here
0452 because I suspect again this geography is very different *hh* you know [R]

0453 Hmmm [Q]

0454 The hospital uhhm the hospital was smaller on sixteenth street the [R]

0455 Yeah [Q]

0456 From my perspective more overlap with discharged patients [R]

0457 Um hmm [Q]

0458 I don't routinely run into patients as much anymore [R]

0459 Yes [Q]

0460 It's like in-patients are here outpatients are over there and it's just not quite [R]

0461 Yeah [Q]

0462 The same environment but u- um it was always fun like sometimes you know being in
0463 psychiatry people did not want to reveal a lot when they were in-patients about [R]

0464 Yes [Q]

0465 History or you know whatever they just wanted to get identified they didn't want one more
0466 problem identified a [R]

0467 Right [Q]

0468 And they just wanted to get well and get out buuut afterwards when I would run into them
0469 like in the hallway they they would start talking maybe the wife might start to talk [R]

0470 Huh [Q]

0471 You know there was this seeeense of continuity [R]

0472 Yeah [Q]

0473 That uh that at least so far I haven't experienced in the same way here [R]

0474 I think the space spatial component is [Q]

0475 Yeah [R]

0476 Major it's simply the fact that there are well much there are 88 buildings at least or ninety
0477 buildings we had a lot of buildings at Walter Reed but the scale of the buildings was all
0478 quite similar and the scale of the buildings here it's a very different scale with respect to the
0479 height and some other things so it's quite interesting so it's it's practical it's geographic it's
0480 geo-physical it's spatial it's also practical with respect to practices are different unit-based
0481 not policy so much as just um uh how I do things and who I [Q]

0482 Uh huh [R]

0483 And where I send people or where I keep people and I have experienced the same thing I
0484 miss that [Q]

0485 **Yeah** oh yeah [R]

0486 Seeing people yeah well thank you I really do appreciate it [Q]

0487 Welcome [R]

0488 I'm going to turn this off now [Q]

050*v2*

Family member	6129 words		Olympus recording #12/21 30:30	
Setting	Rank	Gender	Date	TOD
Bakery, at a table outside	CIV	Female	29 MAY 12	1700-1800

0001 It's uh May the 29th May the 29th? Yeah [Q]

0002 Yes that's correct Tuesday May the 29th [R]

0003 Thank you [Q]

0004 You're welcome [R]

0005 You are participant … five … thank you and um [Q]

0006 No problem [R]

0007 And um I'm glad we could meet today because I wanted to hear a little bit more about your
0008 per**spec**tive [Q]

0009 Uh huh [R]

0010 Having a family member who became … disabled [Q]

0011 OK I have two [R]

0012 Actually you have two [Q]

0013 I do hmmph [R]

0014 OK hold on hold on one sec while I get I want to be sure I ask you about particular things
0015 we can talk about things but [Q]

0016 OK [R]

0017 But um I want to be sure that I um [Q]

0018 Absolutely [R]

0019 Want to be sure I don't forget some things that are uh important for me later that I'll be
0020 darn it what I'm doing now is I'm pulling out an interview guide and that's really for me
0021 but you're welcome to look at it [Q]

0022 OK oh no problem [R]

0023 If there **are** things that I … get interested in following up about and you can think about
0024 this [Q]

0025 OK [R]

0026 Uh let me know of it's OK toooo uh call either you back or set up another brief meeting
[Q]

0027 OK [R]

0028 Absolutely [Q]

0029 OK [R]

0030 So let's start with what you were just saying you have two family members who are
0031 disabled [Q]

0032 I dooooo actually my aunt lost her leg above the knee um because of medical malpractice
0033 … um it was kind of an accident where it was she was just not closely monitored and her
0034 leg actually died [R]

0035 Oh uh [Q]

0036 After surgery [R]

0037 Oh uh [Q]

0038 So she lost her leg after surgery [R]

0039 At what age? [Q]

0040 She was probablyyy fifty-three when it happened and then my brother-in-law uh was in a
0041 bad motor cycle accident last spring and he lost his leg also above the knee and he lost
0042 complete use of his arm on his left side [R]

0043 Really [Q]

0044 Uh hmm [R]

0045 I didn't know that part [Q]

0046 Uh huh his arm and his leg [R]

0047 Oh wow his arm and his leg and he still has his arm it's intact but he can't use it? [Q]

0048 The nerves have actually been severed *hh* [R]

0049 Oh [Q]

0050 In his arm so he can't he has no longer functionality of it anymore so [R]

0051 OK well let's talk about both of those uh um re- uh family members [Q]

0052 Uh huh [R]

0053 It's interesting that they both lost legs and one is a [Q]

0054 It is [R]

0055 A family member by **birth** and one is a family member by **marriage** [Q]

0056 Uh huh it **iss** it is [R]

0057 Uh huh [Q]

0058 And it's nice because they've actually been able to encourage each other [R]

0059 They they know each other? [Q]

0060 Um we in- when my aunt found out that my bother-in-law had was losing his leg she was
0061 with us the night he was in the accident she reached out to him and offered to kind of help
0062 him support him … … through um … him in the process of learning to walk again getting
0063 legs getting fitted with insurance so [R]

0064 Wonderful wow [Q]

0065 She considers herself his adopted aunt so so it's been great they have a very good
0066 relationship now [R]

0067 How long was she in the hospital? [Q]

0068 She was in the hospital probably about eight weeks [R]

0069 Mmm [Q]

0070 She had to go to rehabilitation after she had one surgery I believe it was two we- er it was
0071 probably about probably ten days and then they actually had to remove her leg [R]

0072 Hmmph [Q]

0073 And then sheee had a recovery period and then she went to a rehabilitation hospital [R]

0074 And was that in the community where she lived? er [Q]

0075 Yes [R]

0076 How long … was she an in-patient there? [Q]

0077 Uuuum in-patient? [R]

0078 Yeah like actually in the rehabilitation facility did she go on a daily basis or was she
0079 staying there [Q]

0080 She actually stayed there [R]

0081 She stayed then OK uh huh and was she referred there by her um physicians at the
0082 hospital? [Q]

0083 Yes [R]

0084 Yes [Q]

0085 It was easy for her it was easier for her … because she had a hard time walking especially
0086 after losing [R]

0087 Hmmm mmm [Q]

0088 And her and her leg didn't have her other remaining one didn't have much strength so it
0089 was very hard for her to get up and go to the bathroom you know the small things so it
0090 actually made it easier on her to be at the re- the rehabilitation hospital [R]

0091 Yeah and were there lots of other people there with limb loss? Or who [Q]

0092 Yes yes a lot [R]

0093 An- and [Q]

0094 But [R]

0095 Your impression is how did that how did that go for her that experience? [Q]

0096 Um she found that af- that her her I guess fellow patients that had lost limbs also had a
0097 really hard time coping with it … she found a lot of them were very negative [R]

0098 Hmmmmff [Q]

0099 And had very negative views but she u- and she used that experience to try to develop her
0100 own positive attitude and focus on what she **could** do versus what she **couldn't** do [R]

0101 Does that come naturally to her a postitive attitude? [Q]

0102 Yes she's a very optimistic person but uh she found it difficult she found that a lot of
0103 people had uh anger issues with losing their limbs [R]

0104 Hmm [Q]

0105 And that they felt disappointed or upset [R]

0106 Um hmm [Q]

0107 But I wonder if that's just because that's the initial period when you've uh **lost** something
[R]

0108 Do you have any sense of whether those people that sheee observed as being negative do
0109 you have any sense of whether their attitudes changed? Or you don't know? did she stay in
0110 touch? er [Q]

0111 I think- she does actually she does [R]

0112 Huh [Q]

0113 I think some of them have changed over time and some haven't [R]

0114 Yeah different ages? Different kinds of [Q]

0115 Different ages different e- um amputations some uh there were several members who lost
0116 both their legs [R]

0117 Hmm [Q]

0118 And they were actually able to turn their attitude around and kind of focus more on the on
0119 the positive things and and you know really take back their lives [R]

0120 I see hmmm [Q]

0121 Then they started a community with tango dancing and roller skating [R]

0122 Really [Q]

0123 Yes all of these new things to e- to encourage each other to try and [R]

0124 Do you think she took up some new things after her recovery er during her recovery [Q]

0125 I think it's still been hard on her she's been able to stay positive but in terms of taking on
0126 new projects or you know getting more into the d- dancing li- like she used to [R]

0127 Hmmm [Q]

0128 Or horseback riding she hasn't been able to do that yet though so we're encouraging her
0129 and she making steps [R]

0130 Yeah [Q]

0131 Little by little [R]

0132 Is she a um paternal or maternal relative to you? [Q]

0133 She is a paternal relative [R]

0134 OK so is it your father's sister? [Q]

0135 No it is the wife of my father's brother [R]

0136 Oh for pete's sake OK OK huh [Q]

0137 Yes [R]

0138 OK huh and how did the family react? How did you react? How was it for everyone around
0139 her? [Q]

0140 Well we were very sad to see her lose her limb but we were very amazed by her attitude
0141 and that she was kind of able to move on and keep going an' … she decided not to let it get
0142 her down [R]

0143 Hmph [Q]

0144 And she went back to work after she got out of rehabilitation an' it w's it was very very
0145 impressive it's hard to see her still struggle with small things … though … so ... we would
0146 love to see her at a point where she has a little bit mo- more mobility [R]

0147 How long ago did this happen do you think? [Q]

0148 Two years [R]

0149 Two years OK so relatively recently does she have a prosthetic leg? [Q]

0150 Yes she does she has a C-leg [R]

0151 A C-leg [Q]

0152 Yes yes amazing [R]

0153 Can you describe that? [Q]

0154 Uuuum it has a computerized knee which is really fascinating because it can actually adjust
0155 to surfaces [R]

0156 I guess uh yeah you mentioned that I think yeah is that what the C stands for? [Q]

0157 Yes computerized heh heh [R]

0158 Huh [Q]

0159 But its uh I think it checks your gait [R]

0160 Uh huh [Q]

0161 And how you're walking? sixty times … a second [R]

0162 Wow oh wow [Q]

0163 And so it's very very it's very fascinating and very state-of-the-art previously she haaaad
0164 one version below which it it was type of titanium leg but it didn't have the computerized
0165 knee and it's amaaaazing the difference it makes [R]

0166 Really [Q]

0167 It does … especially when it comes to steps and inclines [R]

0168 Oh [Q]

0169 Which are very challenging if you're an above-the-knee amputee? Because it takes so
0170 much energy to move [R]

0171 Mmm [Q]

0172 To actually move to try to move your prosthetic [R]

0173 Wow [Q]

0175 So it was it was great it was great to be able to see her go downstairs without having to
0176 focus on how to keep her knee straight to bend so [R]

0177 Ummm [Q]

0178 Her heel or the toe to bend so it kind of freed her mind to not focus on you know heel toe
0179 heel toe while she was walking [R]

0180 Oh how fascinating [Q]

0181 It is it really … it made such a huge difference for her even her perception of having a
0182 prosthetic [R]

0183 Hmm oh that's interesting uh [Q]

0184 Yes [R]

0185 So it eased her did it ease her heh I'm answering instead of asking you to so what
0186 differences did it make to her what can you think about [Q]

0187 Uh umm I think it made her feel less disabled though she felt more confident [R]

0188 Hmm mmm [Q]

0189 Um ... like she walked with less of a limp [R]

0190 Mmm [Q]

0191 And um people didn't recognize it immediately as a prosthetic and it's true [R]

0192 Hmmm [Q]

0193 And it's true my brother-in-law had the same experience going [R]

0194 Oh that's [Q]

0195 He went over to a C-leg as well [R]

0196 Oh did he? [Q]

0197 Uh huh [R]

0198 With her encouragement? Or just coincidentally? [Q]

0199 They had kind of talked about it C-leg is I guess it's recommended now for people who are
0200 I think who have active life-styles and he's trying to be more active he rides bicycles he
0201 swims every day he's quite athletic [R]

0202 Oh and he's younger than she? [Q]

0203 He is thirty-four [R]

0204 Huh [Q]

0205 So he's pretty young [R]

0206 Yeah [Q]

0207 But it uh it made a very big difference because he really can walk without a limp [R]

0208 Wow that's amazing [Q]

0209 Yes it's really really amazing [R]

0210 And how was his attitude at the beginning? [Q]

0211 He accepted it hh not he I de- he didn't necessarily have he also he had a brain injury a
0212 very bad brain injury [R]

0213 Huh hummmph [Q]

0214 Though with his accident but um he was able to kind of accept it that it was a fact and he
0215 was alive and this is kind of what was going to happen so he and his family have tried to
0216 make adjustments in their life to make things easier on him he's also kind of gotten back
0217 into his routine [R]

0218 Hmph [Q]

0219 Which is very interesting 'cause his home is split on to three levels [R]
0220 Oh my goodness [Q]

0221 Yes … and … he makes it up all of those three flights of stairs

0222 Wow that's amazing [Q]

0223 But the C-leg made a very big difference because he could actually go downstairs without
0224 having to keep that knee straight [R]

0225 Hmmm [Q]

0226 And worrying about it locking or bending to get downstairs [R]

0227 Do you think you may not know this but um [Q]

0228 Uh huh? [R]

0229 Did he heee consider changing where he lives at the beginning because of that formidable
0230 challenge? [Q]

0231 *Hhh* they had talked about it and part of the reason was they also needed more space they

0232 have quite they have six children? [R]

0233 Oh! [Q]

0234 Yes heh he heh but when they actually started working with the insurance company the
0235 insurance company recommended that they build a new home [R]

0236 Oh [Q]

0237 To make it a little bit easier for him because hh they believe on a day he might need an
0238 elevator and even though he's young now [R]

0239 Uh huh [Q]

0240 But they say as you get older if you have a prosthetic it gets less and less easy to walk [R]

0241 Oh uh huh OK do you have any sense of how his children reacted and adapted? [Q]

0242 They have really gotten used to him having a prosthetic it I'm uh except for the youngest
0243 who it's very very hard on him [R]

0244 Huh huh [Q]

0245 Still [R]

0246 And how old is the youngest? [Q]

0247 Um or not the youngest he was the youngest last time I visited heh heh heh [R]

0248 Heh heh heh [Q]

0249 Not last time I saw them uh when they were at my wedding he is four he was two when the
0250 accident happened and uh they think he has a hard time kind of ff understanding what
0251 really happened because their father who was there all the time he was away for three
0252 months in rehabilitation … which was really hard on all the children [R]

0253 And do you think his uh progress uuuhh … let's talk a little bit about his progress he, he

0254 has an amputated limb [Q]

0255 Uh huh [R]

0256 He has uh a limb left that's he can't use and he has brain damage or had brain damage [Q]

0257 Yes [R]

0258 And were those paraaallllell tracks of recovery or were those [Q]

0259 Some he's recovered quicker than others um he's adapted to losing his losing his leg as
0260 well as he's learning to function with only one arm but he still has a hard time with
0261 memory and uh uh and colors [R]

0262 Colors? [Q]

0263 Yes colors! [R]

0264 Interesting huh [Q]

0265 His perception of color [R]

0266 Really [Q]

0267 Uh hum anything that's brightly colored is very upsetting [R]

0268 Upsetting? [Q]

0269 Uh hum so that's part they had to actually go through the whole house and change the
0270 colors [R]

0271 Some kind of um ... stimulation that's too much [Q]

0272 Yeeess it was too much [R]

0273 Well how about things like remembering his children's' names [Q]

0274 He struggled with that probably for the first month and a half his wife was pregnant when
0275 he was in an accident she was [R]

0276 Hmmm [Q]

0277 Abooooout seven and a half or eight months pregnant and he um kept forgetting she was
0278 pregnant [R]

0279 OK … … wow [Q]

0280… And so he did improve by uh about two months after the accident he kind of could
0281 remember [R]

0282 Hmmm and did he have therapy cognitive therapy as well? [Q]

0283 He did and i- it had he still continues to and it does help and [R]

0284 Huh [Q]

0285 I see uh I think I I I spoke with him and he's fluent in three languages so he can actually
0286 switch very very easily [R]

0287 Oh still huh [Q]

0288 He's he forgets minor details and he might repeat himself several times [R]

0289 Hmm [Q]

0290 But in terms of he still can sp- switch between three languages pretty easily which is very
0291 impressive [R]

0292 That is very impressive it's impressive **any**way [Q]

0293Heh heh it's impressive anyway [R]

0294 After a after a brain injury and [Q]

0295 Brain injury [R]

0296 Serious physical injury and serious cognitive injury it's even **more** impressive [Q]

0297 It is it is [R]

0298 Wow [Q]

0299 It is but he can still switch between languages [R]

0300 Huh [Q]

0301 Which makes me think that maybe er e- it's getting better? [R]

0302 Um [Q]

0303 But I know his family has concerns [R]

0304 Yeah and remind me you may have just said this but remind me you knew him before the
0305 accident? [Q]

0306 I did [R]

0307 You did [Q]

0308 Uh hmmm even though they're far away we try to Skype ... often [R]

0309 Oh oh nice [Q]

0310 And um especially now since he's home and he's not working we can kind of catch him a
0311 little bit easier so [R]

0312 How that going? Not working is that [Q]

0313 It's hard it's a different society so … they're in they're in where it's more common to have
0314 a woman stay at home and a husband work so now with both parents home it's just a l- it's
0315 just different [R]
0316 Hmmm [Q]

0317 I think it kind of breaks their mind set of how they perceive the family [R]

0318 Uh huh yeah [Q]

0319 Of i- a husband is more a provider and where a wife is [R]

0320 Yeah [Q]

0321 Is more of a stay-at-home mom [R]

0322 Hmmm [Q]

0323 So it's very it's different on them [R]

0324 Yes I bet it is yeah and I wonder if um … if that changes ... well let's think about this does
0325 that change planning for uh the uh typical er uh the expected scenario wife at home
0326 husband at work [Q]
0327 Uh huh [R]

0328 Now though husband is home [Q]

0329 Uh huh [R]

0330 Husband and father and partner is home uh is uh do y- is uh do you know if they uh if the
0331 partner his wife feels like she needs or wants to be out [Q]

0332 That is **not** accepted heh heh heh [R]

0333 OK [Q]

0334 Heh heh in the area that they live in so for now they're both just raising their children [R]

0335 OK well that's a big job [Q]

0336 It is a [R]

0337 That's a really big job [Q]

0338 For six children yes [R]

0339And it's a treat for kids to have both parents at home [Q]

0340 It is they both uh he still has the one thing that has kind of remained is that he sleeps quite
0341 often [R]

0342 Huh [Q]

0343 Though he needs to sleep about four hours during the day [R]

0344 Really [Q]

0345 'N take a nap and then he can kind of recover but [R]

0346 Hmmm [Q]

0347 Otherwise he has a very short temper [R]

0348 Hmmm [Q]

0349 And sharp mood swings [R]

0350 Hmmm and f- linked with fatigue with fatigue perhaps [Q]

0351 Uh huh it mi- it might be [R]

0352 If sleep helps [Q]

0353 It might be [R]

0354 Interesting [Q]

0355 They say it's a side effect of his brain injury [R]

0356 Hmm OK and when you uh see him uh when you- how did your relationship with him
0357 change or not …when he went through such profound changes himself [Q]
0358 He was more willing to reach out and talk to us after he had his accident because he knew
0359 that we were already comfortable with my aunt who had lost a limb [R]

0360 Huh [Q]

0361 And that he was kind of curious how we related to her an' he wanted to tell us about what
0362 his experience was hhh it was uh he's the first amputee I believe [R]

0363 Hmmm [Q]

0364 In my husband's family so I think a lot of their my husband's family is still learning about
0365 some of the challenges [R]

0366 Mmmm [Q]

0367 That comes with amputations and we already had an idea because of my aunt [R]

0368 Huh hmm wow [Q]

0369 So I think he felt more comfortable with discussing through [R]

0370 It's pretty interesting isn't it [Q]

0371 It is it is [R]

0372 It's such a co-incidence seems like an odd word but it [Q]

0373 It is unusual [R]

0374 Odd pairing of circumstances [Q]

0375 It is [R]

0376 Through uh through uh marriage [Q]

0377 Exactly [R]

0378 Yeah [Q]

0379 It's kind of interesting but he would get very excited and uh call us around midnight his
0380 time to show us his leg and hospital room [R]

0381 Huh [Q]

0382 And um what progress he'd made [R]

0383 Really [Q]

0384 It was he was very excited about it [R]

0385 Oh that's fascinating [Q]

0386 It was [R]

0387 And uh does that mean that he that he … knew that there were people that could understand
0388 in a different way? I mean that seems unusually uh umm sharing it seems unusually uh um
0389 communicative to me [Q]

0390 Hyh yes I think he was he knew that we could appreciate it in a different light *hh* because I
0391 think that uh his family is still focusing on the negative aspects [R]

0392 Hmmm [Q]

0393 Of his in- injury? [R]

0394 Hmm [Q]

0394 And they had hoped he would make progress? [R]

0395 Mmm [Q]

0396 And so we try to remind them his progress already is very remarkable [R]

0397 Remarkable yes [Q]

0398 To walk without a limp [R]

0399 Unbelievable [Q]

0400 And being in an accident like that [R]

0401 Hmmph [Q]

0402 Just a year ago [R]

0403 Mmm unbelievable [Q]

0404 Is pretty remarkable [R]

0405 Yeah and is his his [Q]

0406 We try to remind them that you know he actually is doing very very well [R]

0407 Good point [Q]

0408 I know and so you- I think their perception is a little different because he's the first person

0409 they've known who's gone through such an accident like this [R]

0410 Hmmm [Q]

0411 Yes I guess so I think they had hoped that things would kind of go back to normal very

0412 quickly [R]

0413 Mmm [Q]

0414 And that's possible … but you know not i- you'll have to change your definition of normal

[R]

0415 Yeah there you go [Q]

0416 Exactly [R]

0417 The new normal [Q]

0418 Exactly [R]

0419 Yeah and so they're adapting [Q]

0420 Yeees [R]

0421 And in a way this almost sounds as though they're adapting more slowly than he [Q]

0422 Yes heh heh I think that's part of the challenge he faces with his family [R]

0423 Yes [Q]

0424 But they are adapting a bit more slowly than he is [R]

0425 Yes and do you think that if I said the word disabled to any of those people that we're
0426 talking about or to you or that matter [Q]

0427 Uh huh [R]

0428 That would sound like it fits or it doesn't fit [Q]

0429 *hhh* … I don't think hhh either my brother-in-law or my aunt would really perceive
0430 themself as disabled … … I uh I their just … they b- believe that they have the capacity to
0431 function as we do [R]

0432 Hmm hmm [Q]

0433 And they don't feel like especially my aunt she doesn't feel like it j- defines who she is [R]

0434 Hmm mmm [Q]

0435 Um I think the C-leg though also really helped with that when she she was working with
0436 when she was working with her prosthetic I watched her struggle with it for about a year
0437 and hh it was different it was what you think of when you think of a conventional
0438 prosthetic [R]

0439 Uh huh [Q]

0440 It was just a just a knee [R]

0441 Uh huh [Q]

0442 That would it looks almost like a piece of pipe [R]

0443 Hmmm [Q]

0444 There attached to a socket and you would have to I think it was you would hit the toe to
0445 bend the knee [R]

0446 Hmmm [Q]

0447 And hit the heel to walk [R]

0448 Hmm mmm [Q]

0449 But when she was when she wore it uh she could only think of that function [R]

0450 Yeah yeah [Q]

0451 And we too so uh having a new [R]

0452 That makes sense [Q]

0453 Leg really opened her mind to not have to to think constantly about it while she was
0454 walking [R]

0455 Fascinating 'n [Q]

0456 I really think it helped her a lot [R]

0457 Yeah the technology c- component I mean the care component [Q]

0458 It does [R]

0459 The … uh … all kinds of things are important here [Q]

0460 Uh huh [R]

0461 And significant [Q]

0462 It is [R]

0463 But the idea that uh tech- technical advancement technological advancement could make
0464 such a huge difference I know it's obvious but it's [Q]

0465 Uh hh [R]

0466 Sort of amazing too at the same time [Q]

0467 It is amazing but i- it really did improve it really improved her quality of life [R]

0468 Her quality of life [Q]

0469 It did before she wo- before she hated her prosthetic [R]

0470 Hmm [Q]

0471 She would **not** put it on if we were around her for the weekend she would just prefer to be
0472 in a wheel chair [R]

0473 Really [Q]

0474 Than wear it because she just really didn't like it she really hated it [R]

0475 Wow [Q]

0476 Um when she got her new C-leg she never minded to put it on in the morning and walk [R]

0477 Hmmph [Q]

0478 Or … [R]

0479 Huh [Q]

0480 She would show us how well she was doing [R]

0481 Awesome [Q]

0482 Walking up ramps or stairs or downstairs it was really impressive [R]

0483 Huh how's her other leg doing? [Q]

0484 *Hhh* uh she actually had to have replacement knee surgery

0485 Oh wow [Q]

0486 Yeah huh I know two months ago [R]

0487 Wow um she's taken on a lot in the last couple of years [Q]

0488 She has taken on quite a bit [R]

0489 Wow yueah [Q]

0490 And unfortunately there was a complication with that as well [R]

0491 Ahh [Q]

0492 So she was completely … uh unable to walk [R]

0493 Oh oh my [Q]

0494 For two months [R]

0495 And now? [Q]

0496 She's uh she's sloooowly getting back into where she can walk a little bit at a time and now
0497 she's really sore but uh it's been a challenge [R]

0498 Mmm [Q]

0499 For her [R]

0500 Do you spend time with her at all? [Q]

0501 Yes … I I I usually I try to go out to see them at least once a month [R]

0502 Oh [Q]

0503 And last year I was out probably two at least twenty-two twenty-four times [R]

0504 Oh really! Oh wow [Q]

0505 Yes! Yes [R]

0506 Good for you! I'm sure that makes a big difference to her to both of you [Q]

0507 Heh! My uncle says it makes a really big difference because she'll make an effort to wear
0508 her prosthetic for us and show us how well she's doing so [R]

0509 That's great [Q]

0510 So we like to to be here with her to try to encourage her to try new things and [R]

0511 Good [Q]

0512 You know walk a little bit with uuuussss and sit outside so [R]

0513 Awsome [Q]

0514 I think if we moti- or I'll I'll take her grocery shopping with me so [R]

0515 Does she have any kind of cognitive involvement in her episode? [Q]

0516 No [R]

0517 No [Q]

0518 She didn't have any [R]

0519 No [Q]

0520 Just my brother-in-law [R]

0521 And how's he doing now? [Q]

0522 Tk he's doing better hh he still haaas he still has moments heh heh … though so … but they
0523 I think they're getting better with time *hh* I wonder sometimes if it's just he doesn't feel
0524 under**stood** entirely? [R]

0525 Hmm [Q]

0526 A little? Because it is … I could see how it would be frustrating to feel like you're making
0527 so much progress and not have others around you notice … how remarkable it really is [R]

0528 Hmmm … yes … yes let's think more about that that's interesting so it would be
0529 frustrating or could be frustrating [Q]

0530 I could see that it would be it could be frustrating [R]

0531 Yeah huh yeah [Q]

0532 Though he does plan a lot of activities to get kind of out of the house and involved with
0533 other amputees in the area? [R]

0534 Hmmm hmmm oh really [Q]

0535 Uh huh u huh [R]

0536 Hmm [Q]

0537 He enjoys it especially swimming I think that's his favorite [R]

0538 Hmmm … what you've brought up makes me think about an interesting kind of dialectical
0539 relationship the private and the public [Q]

0540 Uh huh [R]

0541 The idea that he is going through an experience on his own and he's yet going through an
0542 experience with others [Q]

0543 Uh huh it is [R]

0544 Uhhh … and so some of the i- some of what he's going through and I'm **absolutely** making
0545 this up [Q]

0546 Uh huh [R]

0547 But from what you're saying it makes me [Q]

0548 Uh huh [R]

0549 Think about that interesting uh dynamic tension between what [Q]

0550 It is [R]

0551 Others perceive and what he perceives 'n [Q]

0552 Uh huh [R]

0553 Some of it's the same and some of it's different [Q]

0554 It is it is interesting one thing my uh aunt said I think when she went into public she felt
0555 more she felt disabled [R]

0556 Mmmmph [Q]

0557 Even though she may not feel like that in private [R]

0558 Mmmm [Q]

0559 I think that she felt like people perceived her as being disabled and it made her feel almost
0560 a little worse about herself? [R]

0561 Mmm hmmm [Q]

0562 In some contexts so I remember when we went to the grocery store one day she was doing
0563 very well she was walking with her C-leg and we bring a chair just in case she gets tired
0564 'cause she was just learning how to walk with it and I was kinda I was walking behind her
0565 and uh with her wheelchair she decided to sit down for a little bit and I pushed her towards
0566 the cashier and the man in front of her turned and said oh can I help you with your
0567 groceries I like to do one good deed [R]

0568 Owwhh [Q]

0569 For the day and that really upset her heh because [R]

0570 Yeah [Q]

0571 He didn't … she's uh she's fine hueh heh heh [R]

0572 Yeauuhhh that's a really good example yeah it's a really good example of something we've
0573 been touching on which is that [Q]

0574 Uh huh [R]

0575 The well what other people perceive and what you perceive what the person perceives and
0576 what others perceive because in her mind and again I'm uh this is conjecture but she's
0577 doing well she's making progress [Q]

0578 Mm [R]

0579 She's [Q]

0580 Uh huh [R]

0581 Maybe not quite as comfortable outside as inside but still she's doing **fine** [Q]

0582 Uh huh [R]
0583 And then someone thinking they're doing something wonderful notices comments an' sorta
0584 in a pat- in a patronizing way [Q]

0585 Exactly [R]

0586 Perhaps … making I mean I shouldn't be putting words in **your** mouth [Q]
0587 No but that's exactly what's happening 'n that would n- and that is the kind of
0588 circumstance that makes her feel less comfortable with who she is [R]

0589 And I wonder about things like and you may not know this but I wonder if things like
0590 parking signs or uh various kinds of signs that say uh handicapped this or [Q]

0591 Uh huh [R]

0592 Or something something something I wonder if that gets read in a different way depending
0593 on who she's with or what space she's in [Q]

0594 Hyhh I think it can be they don't seem to bother her as much and actually there's a
0595 movement now where it has taken the handicapped logo? And changed the uh wheel into
0596 the half of a heart [R]

0597 How nice [Q]

0598 To show that you're proud of your disability [R]

0599 Nice [Q]

0600 So she has a lot of those stickers and things [R]

0601 Nice [Q]

0602 Around the side of her car so [R]

0603 Nice [Q]

0604 Everyone knows that she's really proud of who she is and it's only at moments like whe-
0605 when we were at the grocery store that it [R]

0606 Yes [Q]

0607 That it really impacts her a little bit [R]

0608 Yeah that reminds me of coupled that I listened to who were who I talked to briefly [Q]
0609 Uh huh [R]

0610 Briefly after a town hall at Walter Reed uh a young man who was a double amputee above

0611 the knee [Q]

0612 Oh wow [R]

0613 And his partner a woman pushing his wheelchair and they stopped and chatted for a few
0614 minutes and um they were referring to someone who in a conversation said handicapped
0615 and they both started to laugh their heads off they were [Q]

0616 Uh huh [R]

0617 Were really into the conversation they said it's when someone uses the word handicapped
0618 in the moment [Q]

0619 Uh huh [R]

0620 And they said we call it handi capable [Q]

0621 Heh heh heh [R]

0622 And they thought it was highly amusing and it sounds like that logo you were talking about [Q]

0623 Heh heh heh [R]

0624 And it puts a spin on it that is highly empowering [Q]

0625 It does exactly that is especially what m- and my aunt has been influencing my brother-in-
0626 law to kind of … feel good but my brother-in-law re**fuses** to use a wheelchair [R]

0627 Oh really [Q]

0628… He will wear his prosthetic from the time he wakes up in the morning until the time he
0629 goes to bed at night because he just refuses to sit in a wheelchair [R]

0630 Hmmph [Q]

0631 And that makes him feel more um I th- I think that makes him feel more disabled [R]

0632 Hmm [Q]

0633 So he stands on his feet all day he gets out in the yard he does gardening [R]

0634 Mmmphff [Q]

0635 He even manages to wear clogs [R]

0636 Heh heh! [Q]

0637 With a prosthetic [R]

0638 Remarkable [Q]

0639 Which is very very impressive [R]

0640 It is it's remarkable [Q]

0641 It is [R]

0642 So let's speak a little bit about and we're almost done thank you so much [Q]

0643 Oh no problem [R]

0644 Let's think a little bit about the wheelchair that's really interesting any thoughts about what
0645 that would be so different for him? [Q]

0646 I think you know before his accident he l- he was a very active person he was never really

0647 sitting down he was handy [R]

0648 Huh [Q]

0649 Love to fix everything around the house and I think just having to sit [R]

0650 Ah [Q]

0651 Was just h- he it was just did not sit well with him [R]

0652 Mmm [Q]

0653 I wonder I I think it made him feel a little um useless [R]

0654 Mmm [Q]

0655 In some ways because he was just so active before [R]

0656 Mmmm thank you for that insight [Q]

0657 It is it is interesting watching him kind of go through this process [R]

0658 Yeah and um just wanna finish up with a question I have right in from of me [Q]

0659 Uh huh [R]

0660 What does what dies disability mean to you? The word [Q]

0661 Hmmm that's a difficult one I think to me it means impaired in a way but a lot of people
0662 who you would see 'n are disabled uh I don- it's hard to say that they really whether I
0663 would perceive them to be disabled because it does seem to have a negative connotation
[R]

0664 Uh hmmm thank you [Q]

0665 To it I'm sorry if it's a bit (*inaudible*) answer [R]

0666 Oh no that's fine I'm interested in what comes into your mind [Q]

0667 It's hard especially actually I probably would have said physically impaired [R]

0668 Hmmm [Q]

0669 You know before having my brother-in-law 'n my aunt both become amputees it 'n that has

0670 changed my perspective over time [R]

0671 Yes [Q]

0672 Because uh i- I know that I seem them and I know that they c'n really do almost everything
0673 I could do and it may be in some cases better so I dunno disabled doesn't it's a strange
0674 word [R]

0675 Yeah thank you any other thoughts? That you wanna share with me? [Q]

0676 Mmmmmm? Uh nope [R]

0677 You would be OK if I contacted you because there might be something that well I'm going
0678 to transcribe this [Q]
0679 OK [R]

0680 And leave out any personally indentifying information that we might be unaware of and if

0681 in that process [Q]

0682 OK [R]

0683 I come across something that strikes me as needing more um comment [Q]

0684 Uh huh [R]

0685 It's OK if I call you back? [Q]

0686 Absolutely [R]

0687 Or thank you thank you [Q]

0688 Oh no problem [R]

0689 I'll turn this off now [Q]

060*v1*

Service member	7906 words		Olympus recording #013	48:25
Setting	Rank	Gender	Date	TOD
Coffee shop at a table Inside	Ret'd CPL	Male		0900-1000

Q: OK so you're participant six oh oh six … … … thank you

R: OK

Q: An' um we had talked in the past about … *tsk* being hurt when … you're a service member it's kind of my area of interest but I o- I'm open to anything you wanna talk about primarily I'm interested in the … … link between disability and deservedness er depending on the kind of harm people undergo and the kind of rehabilitation or treatment the undergo is there a perception either by them or by others that they get a different kind of recognition or access to resources that's that's the question I'm looking at I'm interested in your perspective from your point of view … and the thing I'm thinking about when I think about recognition is you know greetings and visibility and … uuum status and then access to resources I'm thinking about things like better treatment parking privileges internet big screen TVs access to resources and I know that now you're not active-duty right

R: Right

Q: But that doesn't really matter I'm interested in your point of view because you were … very much involved in all aspects of what I'm talking about and you still are

R: Well uh the very first thing that comes to mind is uckk uckk the night I got injured … in um in Iraq December 31st 2006 *hh* my uh my initial thoughts with the moment after the IED blew up right next to the the driver's side door of the humvee I was driving uuh umm I immediately felt searing pain in my pinky and in my right thigh
Q: Hmmm

R: And uh um I w's I immediately wondered if that was the full extent of the injuries so I checked my **body** kind of with my own awareness I looked down I felt down around my feet 'n' my ankles and I felt sweat in my lower back and I wondered if it was blood and then I remembered um I remembered feeling that the deep throbbing sensation in my groin that kinda showed up a little bit uh later and th- and uh and I remember the throbbing sensation in my groin wasn't wasn't **terrible** but it was significant I w's having a hard time breathing but it wasn't debilitating I could move around I could kind of talk in kind of a I was kinda choked up a little bit but I could talk and um I remember thinking immediately whether the- the minor injury on my pinky or the burn on my thigh would be significant enough to get me a **purple heart** it was my very one of my first thoughts and after it was after everything got sorted y- like after we looked around in the truck and we got pulled out of the kill zone and all that kinda stuff after those things I remember thinking uh … will this be enough to get me a **purple heart** because I really wanted a **purple heart** I wanted I wanted that purple heart because I wanted to be **recognized** as someone who had been in **combat** and I wanted to have a **medal** which was clearly a **signifier** of that and the purple hearts are very recognized it's probably the third of the fi- top five medals receiving from war and you really get you really get some uh some uh attention so … I 'member in the car ride er not the car ride but in the humvee ride back to the base … I remember saying to the doc 'cause I didn't at the time I didn't think the the impact to the groin was was that significant but I remember I remember telling telling the doc hey wrap my hand up make it look really really **bad** so I can get a purple heart 'cause I was I was just kind of like no one died no one had any severe injuries so I was I was just **elated** so we were making jokes in the truck and all that kind of stuff so then we get back to the base we get back to the base just the amount of **attention** and the amount of **attention** and **kindness** I got from people the Colonel showed up and was like and you know 'cause at that point when the doc started back at FOB Loyalty when the head doc started checking me out

Q: Back at what?

R: FOB Loyalty Forward Operating Base Loyalty um he s- he was checking out my groin and what he found from the blunt force trauma was a laceration and a significant amount of swelling in a an important part of my g- genitalia and um that swelling caused him to be concerned and on- he then had me medivac'd to the main hospital but I remember thinking you know it didn't seem like that big of a **deal** until he said you can still have children with only one testicle and I was like cha sha OK but is there any way I can keep them **both** heh heh heh heh and he said oh well you know we're going to get you checked out we're going a get you squared away and so like and so you know I just kinda gave up trying to worry about it and just kind of let the elation of **not being dead** kind of overwhelm me and I remember the colonel came and he's like you know be brave and everybody was sooo just sooo **kind** and so supportive and then uh they put me on the helicopter and uhm ... you I had the the guys on the helicopter were all **so awesome** just so kind and and so helpful and everything and it was so it was so strange because in the military there's nothing the military's not a place for kindness and a place for compassion it's a place for suck it up get it done move on but the IEDs were messing people up **so bad** that the the type of support was just **unbelievable** so after the helicopter ride I got off the helicopter they rushed me into the into the emergency room where there were fifty doctors just waiting to help and then when they realized that it wasn't that **big of a deal** I mean everybody didn't need to be there … they then uh just t- the necessary people stayed and *snf* by that point it was New Year's

Eve so … um the rest of the people kind of uuhhhmm ner- there 'ere three people working on me just ultrasounding and making sure everything was OK taking pictures and things *hhh* and um by the end of that night they they through the imagery of the ultrasound they were able to sh- to show conclusively that the **damage done** to my uh uh testicle was not um did not um warrant its **removal** or um would have any **long-term impact** so then I was sent to the waiting area to um wait for my ride to come get me in 'bout and I think that was about two days and th- that was the most surreal part of the whole experience because … … … it wa- it wa- it was **the kindest** … the most … I mean you w- wouldn't you wouldn't **imagine** but these guys from the **colonels** to the **officers** to the people in the chow hall to theee t- the other guys Marines the uh uh Army guys infantry **didn't matter** I mean these guys were soooo frickin' nice to each other it was **crazy**

Q: Nice to each other

R: Oh god it was you wouldn't believe it hey *(first name)* hey *(last name)*- I'm goin' a get some dip or I'm goin' to the the chow hall you need anything? You want anything to eat? I got it man don't even worry about it Colonels coming in hey you guys you guys need anything you just let me know anything you need wh- we got gotch you we gotch you uuumm hey we're goin' to do this you wanna come er hey how ya feelin' um just the niiiiicest people you ever ever come across I mean it was just such **kindness** and it was so … it was very surreal it was strange that people were just so I mean it wa'n't strange you know it made **sense** but it was just … it was **not** n- not the normal military

Q: Ummm

R: It was kinda this super kind super gentle super supportive … and it was just a … it turned into t' being a pr- a pretty kinda almost like a **special experience** because it was uh it was a **place** that only that **only the injured get to see** and um … inside that place was just

Q: Hmmm

R: Was just it was just a really **kind** en-

Q: Whoa you're showing me a picture whoa

R: And it that's I mean there was nothin' more to it

Q: Wow

R: Than that and I mean it kinda it was just

Q: That's the place you were in

R: That's w's just the place where you just waited aaaan' um you just waited and um … … it was in the Green Zone and um … an' I was in the back bunk back here
Q: Hmmph

R: Right back there

Q: Wow

R: And uh then I remember the next well 'cause what was crazy was that the day **before** … a guy guys from our company the driver got killed in an IED attack and then the day AFTER a guy in our company got killed by an IED attack both were **drivers** both were hit by IEDs that hit the **driver's** side that w's three days in a row I was the only driver that got hit with an IED on the driver's side that didn't get killed that wasn't killed uh um s' I mean that's that's showing you these right

Q: Yeah a picture of a picture of the damage to the truck right?

R: Yu- and you've heard the you've heard the sound of the video right? Here you may want this you can kinda' hear … … … … you can kinda hear the sound of my voice
Q: Really

R: Well you c'n I- I recognize **I** hear it uuumm *(audio from video) "uhhh we got we got uh one casualty with uh-"*

Q: How did you happen to record it?

R: I had my camera out right away when I found out that no one was **killed** and that I was relatively OK I I immediately took my camera out an' took those two pictures and
Q: Mmm

R: And started trying to take video but this is the … … … *(audio from video) "we got right and hey this guy is uh small injuries to the face uh we got one casualty with uh followed by lacerations just to the face lacerations to the face-"* and that was uh that was only uh

Q: Was that the medic?

R: That was **me** yeah that was my voice

Q: That was you

R: And you can't uh uh **I** can hear it but I don't know if you could hear it I could hear the uh like when you get hit in the groin you get this uuuggggghhkkk and you know kinda talk like this *(squeaky voice)*
Q: Mmmmm mmmm

R: And it kinda hurts you know like that you know the-

Q: Kinda clenching

R: Yeah uh huh and hear it in my voice

Q: And so you had a camera with you

R: Yeah I hadda camera was right on my side all the time I mean I got hundreds of pictures

Q: Well I know you have pictures and it hadn't occurred to me till today to ask you ho- why that was so heh heh when you talked about everybody being nice first I was thinking you mean the health care providers but you meant eeevvvrybody

R: Everybody

Q: Colonels **everybody**

R: Colonels generals **everybody** Marines were nice to Army Army were nice to **Marines** uuuuhhhhmmm

Q: Was it only in that space you just showed me? When you were inside that space?

R: Well uh inside that space it w's like it was like a this magic bubble

Q: Hmmph

R: Inside that space you could do **noootthhhiiinnnggg** wrong I mean you were you had *hh* you had the support of **every**body

Q: Hmmmph

R: Top to bottom so even the head even head people were were kind an' uh it was surreal it was a it was *ssshh* it w's a it was a **weeeeird** experience

Q: Mmm

R: It was I mean it was seeing … it would be like seeing a fierce evil draaagon that blows fire all

the time

Q: Heh!

R: Come back to the **castle** and curl up next to

Q: Hmph!

R: You and place the **fire-breathing mouth** on your **knee** and just calmly sit and rest the

Q: Hmmm

R: That's how **different** the behavior was

Q: Quite an image that's very

R: Yu-

Q: Striking when you said the word head it made me think about uh did you get examined for uh head injury if it was bl- blunt trauma that caused damage elsewhere were you also s- uhh

R: No uuhhmm

Q: Scoped or scaped where um

R: No they'd and I think it in two thousand and six the the traumatic brain injury stuff was not as **big** of a **deal** and I guess I wasn't or wasn't they weren't their awareness of that injury was not as **strong** as it was later on and then it I wasn't complaining of any

Q: Mmm

R: Headaches or anything like that

Q: Mmm mmmm

R: Uuuhhhm … so

Q: So when you left that space and when you got back home um can you talk about your perceptions of the difference between or maybe just wounded ill and injured is a term that's starting to be used a lot more it it used to be it used to be wounded warriors which would sort of point to a particular kind of wound in combat and now there's a mo- a move really or a lots of people have been placed wounded ill and injured wounded meaning in combat ill meaning sick in any way physiologically psychologically and injured meaning you got hurt but not in combat does that ring any bells for you? does that sound familiar? Does that make you think about anything in particular?

R: … … … well it makes me wounded warriors makes me think about the guys without **legs** and who are visibly **visibly chaaanged** uh um and I think I think what the **visible changes** … I think … the way I feel when I see a wounded warrior … is … my um my knee jerk feeling is kind of uh um shame and an'

Q: Hmmm

R: Sadness because uh it's such a clear signifier of the … price that that someone else has paaaid

Q: Hm

R: Uhhhmm now that uh that sensation that feeling is is kind of rendered **neutral** by the fact that I too uh experienced
Q: Hmm

R: And uh and uh sacrificed uh for Uncle **Sam** … but that leads me to think that part of what a visible wound a a very visible wound **does** is it kind of makes people **feel** a sense of um … uhm shame or

Q: Hmmm

R: Sadness

Q: Mmmm

R: Or um uh kind of a **weird** feeling and that weird feeling kind of motivates a type of **kindness**

Q: Mmm

R: That is that is made is made more significant by the **weirdness** that they feel when they **see** it

Q: Mmm

R: And so I think what happens when you know someone says you know for example I was in the VA the other day on Thursday doing my my guided meditation class and there was a **guy** in there who w's in Iraq but he w's in the **Navy** an' I remember he just looked feeble and shaky and he didn't he didn't **look** wounded he just he just looked messed up in some way form or fashion and I didn't **feel** any kind of … I felt more **pity** for him uh just kinda like uh kind of like a like a my uh my f- my first my honest first thought was … he was n the Navy what k- what the hell did

Q: Hmmph

R: Did the **Navy** do in Iraq? An' that's just part of the military kind of *hhh* kind of competition

kind of thing

Q: Mmm

R: The Army always makes fun of the Navy and the Marines the Marines for being jar heads and meat heads and the they um and then the Marines make fun of us for being wimps and pussies

Q: Heh heh heh

R: And then 'round and 'round everybody makes fun of the Air Force

Q: heh heh heh

R: And 'around and around it goes but I remember seeing that kid an' uh he was clearly messed up in some form or fashion an' but it didn't look like he was messed up in a in a kinda a **wounded warrior kind of way**

Q: Hmm mmm

R: See I think what the wounded warriors like the guys that have the prosthetics

Q: Uh huh

R: And things like that like the one arm you know y-y- you look at a a twenty-five year old kid

with a

Q: Mmm

R: With one arm an' you're clearly like whoa that's that's the price of **war**

Q: Hmmm

R: Uhhmm so it's in your **face** and it's constant so that there's that that uh **guilt** and shame and kind of you know tha- those feelings really uuhhh they're one end of a spectrum I think

Q: Yeah

R: Because they're so far on on one end

Q: Yeah

R: They they you feel that other end of the spectrum too so I think that's what that does and then … nah I remember I saw **another** guy from the VA uuhhhmm who looked **fiiiine** I mean he looked he looked fine like me you know he looked probably like me you know not a problem no visible problem

Q: Mmmm

R: But when we were talking 'bout sleep an' I explained what I call white light- what I call white nights an' I explained

Q: Hmmm

R: It like uh uh like a train uh well I could give give you a good visual but like a train … um moving past you at the super super super fast your thoughts just keep picking up faster and faster and faster

Q: Mmmm

R: Faster 'n' 'round 'n' 'round 'n'n 'round 'n' 'round

Q: Mmm

R: The the m- more you try an' go to sleep the more the faster they go an' the fast they go 'n'

Q: mm

R: And they can mmmrrrmmmm mmmmrrrmmm nnnrrruu nrrrruuuu

Q: Mmm

R: And the you're just like FUCK

Q: Yeah

R: Uhm so I kinda of explained it like **that** using hand gestures and later he said ... to his **dad** he said that was the best example of what I'm experiencing I've ever heard and told 'im about *(name of interviewee's blog)* 'n maybe he reads the blog I dunno but he was he was he was in a **blue hospital outfit** so he clearly was having some serious issues and I- I bet a lot of those stem from not being able to **sleep** so uh um … that not being able to **sleep** thing I mean that's a hard one

Q: Yeah

R: I mean that's a hard one it's hard to notice you know but it's also hard to deal for the individual going **through** it because when you see you see par- when you see the guy with you know one arm so you're like well he **clearly** has something to be

R: To be uh uh not sleeping well about but um part of my biggest problem wi- with dealing with uh **transition** was the frustration of not being able to sleep an' tryin' to figure out how that was **possible**

Q: Mmm

R: And so there's a little bit of shame associated with that too because you're like I mean y'know what's th- what's the matter here so *hh*

Q: Hmmm

R: That's a that's a big deal so that's uh an interesting issue

Q: Uh huh

R: To uh kinda think about

Q: So you r- you've come across a lotta people who have variousssss uhhh damage

R: Yeah

Q: Yeah and uh are they active-duty or uh not active-duty

R: Right

Q: Or is it mostly people who are out of the service now

R: Uhhhmmm most of the people I've interacted with are … er most of the people I've intera- I've interacted with who are **out** are out and the people that I do interact with who are **in** still in one guy in particular um two guys in particular um uhh … I think they're uh I think they h- they have issues that are **pulling** at them that are

Q: Hmm

R: **Sucking** energy from them b- but they're they're trying to be the hard chargers that we're trained to be and just keep driving on

Q: Hmmm mmmm and when you think about it do those c'n do is the do those categories wounded ill and injured make sense to you or are do they seem false or phony do they seem forced do they seem natural do they make sense?

R: Wounded makes sense ill doesn't work for me uuhmm injured … … makes me think of football

Q: Hmm

R: Like one of the things our coaches used to ask us in football are are you hurt or injured?

Q: Hmm

R: And um … if you were **hurt** you could keep playing if you were **injured** you'd have to come out of the game

Q: Oh very interesting

R: Maybe it was the other way around

Q: But still it was a category

R: Yeah but th- ill and injured I don't wounded makes me think of combat ill and injured makes me think of … s- somebody's ill or somebody's injured

Q: Hmm but what about the word disabled does that how does that resonate for you does it makes sense to you? is it associated with any of the things we're thinking about?

R: I don't I I I … … um I dunno I don't really I don't consider myself **disabled** um I consider my self … … … … … … ooo uuhh … like I I I I consider … … … … I I consider what I what I've experienced to be traumatic **stress** not POST traumatic stress

Q: Mmm

R: But **traumatic stress**

Q: Mmm

R: And so … because I've **experienced traumatic stress** I think it's eeeasier for me to … experience **traumatic stress** from other things 'cause I know what traumatic stress looks like

Q: Mmm

R: I know it's like I'm more susceptible to it now

Q: Mmm

R: And because I'm more susceptible to traumatic stress on **one** end of the spectrum I'm more susceptible to **other** things on the the light end of the spectrum so y'know it's just two sides of a coin

Q: Hmmm

R: I don't think you can ever look at one in isolation

Q: Right… I agree

R: So … so I mean I- I think I think most all t- the terms that are brought up by by uh the civilian doctors and officers in the **rear** are designed for um political and uhhhh uhhh administrative purposes uhm so mostly they're designed for paperwork

Q: Mmm

R: Uh and money so uh

Q: Mmm

R: Most most things that are that are put together by kind of the civilian rear echelon administrative kind of stuff I think has more to do with with **them** than it does the people that are actually going **through** it and part of that is it's just gotta be such a bitch to deal with all this stuff and the fact that now heh I think it was half er the number of people asking for **disability**'s quadrupled

Q: Yeah

R: Er it's the highest it's ever been or something like that

Q: Yeah I saw that or a piece about that in the paper this morning … the reason I ask is because ev- I think about the word disability in a way in lots of ways and um when I uh bring it up in a military context people kinda look at me like whaada ya talking about and then when I say well you guys talk about it all the time 'cause you talk about assessments all the time whether you consider yourself able-bodied or able-bodied but as you plan to retire or leave or whatever there's a lot of conversation about disability … uh degrees of right?

R: Yeah oh

Q: Exactly what you just mentioned administrative money paperwork so I'm I'm it's interesting to me that that when I say it and it comes out of my mouth it's like whadda ya mean where but if we turn it around and say the way you just described it it's linked with assessments it's linked with this and that then it's a familiar term so as with all words heh heh it actually it depends on the context

R: Yup

Q: It depends on who says it

R: Yup

Q: And so I- I frequently get a little push back of why are you talking about disabled people oh you're talking about disability benefits or not … assessments let's just call it assessments so it's a very interesting and complicated … area because in my experience people both identify and dis-identify with it

R: Uh huh

Q: And I think what you said is very interesting that in your mind in your experience disability is associated with administration that is it's associated with paperwork associated with managing things… and not necessarily

R: I think disability I think has a lot to do with … … … see disability in my mind is a lot like um … *tsk* is a lot like your travel voucher so when you go on active-duty as a reservist or when you do when you do any active-duty when you do anything anything y'know Un- Uncle Sam asks you to do you get to fill out a travel voucher which basically … um gives you an opportunity to **recoup** some of the **expense** that you **paid** to do Uncle Sam's bidding so you get a certain allotment so uh you get like a certain amount of money for your laundry you get a certain amount for ATM fees you get a certain amount for **gas** and so uh what you do is you try to **optimize** the amount of **money** you get back so whether you did any of this stuff or not you still **try to get** as much as you **can** um because you don't wanna you don't want to sort-change your opportunity so you're a- it's all about you wanna optimize your opportunity so you wanna get get the best you can out of that situation that's actually the same way with ammo allotment so when you go to a firing range you go you ask for a certain amount of ammo now if you don't need that

amount? If you don't actually use all that ammo up or need all of it you **never** turn that ammo in because if you turn that ammo in you won't get the **same amount** of ammo the next time so you always try to **maximize** your your recoup so disability now uh I think because because the administrators and the uh the uh the um the instead of the **tip** of the spear the the uh uh the **shaft** of the spear uh as the shaft of the spear's trying to figure out how t' how to **deal** with all these people coming from the tip of the spear they've tried to cover their bases by kinda doing kinda blanket **stuff** so I think now from a what I've heard from people who've just got back from Afghanistan anybody who's been in any kind of anybody who's got a combat action badge means that they've seen combat and anybody that's seen combat automatically is checked as PT as now as post traumatic stress so anybody who has post traumatic stress now automatically *tsk* no er if you've been in if you have a purple heart I think you're automatically checked as post traumatic stress and then you're automatically eligible for disability so what you do is you wanna optimize that payment disability disability's not a I think I'm disabled it's disability is how much I can **get** so it's like travel voucher how much can I get from a travel voucher I didn't use any laundry but I can get that laundry? gimme that laundry so how much disability are you getting disability in that context has **nothing** to do with physical injury it's not how much I think I'm disabled it's how much I can get **you** to think I'm disabled so I can get as much **money** as I can that's what disability means

Q: Do you think that's um uh unique to the military? Or do you think that's a human behavior characteristic elsewhere

R: I think it's it's across the board when you're doing something … … that you're not wholly passionate about the cause for … so … …. like I know a lot of people who work for the government because working for the government gives you a lotta opportunities an' uh helps you you know with good benefits and all that kind of other stuff but also they don't give a fuck about what they're doing they do it because that's their **job** so the- they're not necessarily passionate about their job they do it anyway I mean if you're not passionate about your job you know it's just some big bureaucratic monster that's an' then you see that the people who contract you out are making two hundred thousand dollars a year for **you** but they're only paying you a hundred and thirty thousand 'n so you see that they're getting this and then you see politicians are doin' this an' that and then you see also that kind of stuff and then you see heh heh the fact that the government can create trillions of dollars out of thin air and it's like hell I might as well **get mine** so I think it's the same kinda thing in the military people because it's such a huge entity and because the fight the f- the fight has such kind of … … not necessarily concrete reasons behind it and the fact that you're just you're mostly just fighting for your buddies and for the people next to you and for um … your team you're not necessarily fighting for the greater good of democracy or to end all tyranny um so in that sense you go aw shit I mean I'm I'm I'm … givin' all this time here so I'm gonna take every advantage I can to get what I want er to get what I I'm gonna get what I **can**

Q: What I can yeah yeah *(name)* I'll take you name out of this when I transcribe it sorry do you think that your attitude changed because it seems to me that you w- that you were passionate about the work you were doing as an active-duty soldier and you stayed passionate about it sound passionate about it so what you're describing I recognize I understand I think you're describing it really well

R: Um hmm

Q: But I wonder if you could talk to me about that level of passion

R: Well my experience in the military had a lot more to do with I think unm the first thought that popped into my head was destiny so I never thought er really associated my behavior with helping the cause of America I associated my behavior in was as a matter of my own integrity so … my behavior in war and in Iraq was predicated on my own understanding of being a good man for the sake of being a good man so uh … … … so that I mean that's why I behaved the way I behaved but I also it seems a buddy of mine and I we call it bothing it so when you both something you c- you can you blend in by doing what people around you are doing and speaking in the way people around you are speaking *hh* but you also have you also have this kind of internal resource that you you recognize as your as your core something that that you kind of hold kind of apart from that so I made sure that I blended perfectly with the people around me and I did not only that I excelled but at the same time I also was able to um maintain my sense of integrity because I was just able to recognize the the I was able to both it … and so uh … uuuuhhh … … shit … ask me that question again

Q: I was interested in when you used the word passion- where it's absent or where it's present

R: Oh yes so anyway so my buddy told me he's like you've got a purple heart you've got uh you c- you can go but you can get you can go and get disability you should you should apply for disability … and when he said that I I didn't want to do it and I won't do it because I I don't think I'm disabled

Q: Oh that's interesting yeah

R: Ao I mean when it comes to uh when it comes to money for traveling and taking advantage of all that kinda stuff I have no problem … I have no problem talking every fee I could get from the government not a problem in the world and my opinion the ul- ultimate ultimately the people who are telling the military what to do don't give a flying fuck about the individuals in the military not in any way shape or form they can't they can't they try they act like they do they go and they give medals and they shake hands and they say nice shit but in order to be a leader at that level I do think that you can you can you can be able to do … ere r be able to uh care for each individual and still be effective so with regards to that I have no problem talking as much advantage of the government with regards to pay and for travel vouchers and things like that as I can … but when it comes to disability … disability has in my mind I would then … …. … this little piece on my dddt 214 that says I'm getting a disability payment an' that I think … … for me has a kind of feeling behind it that that seems … uh .. strangely enough dishonest heh heh hh heh heh

Q: Well I was keeping track o what you were saying and that doesn't align with what you were saying that's not how you self-identify that's not you don't claim that not to the government nor to yourself yeah yeah and your distinction between disability as a thing that you get and disability as a thing that you are is key

R: Yeah yeah yeah

Q: So if you aren't __ you don't want to get I mean they're linked

R: Yup

Q: I think but ___

R: But I think there are a lotta people that don't that don't give shit an' an' wanna get their disa- disability even though they may not intrinsically think they're disabled ? They wanna get disability because they feel like they're owed it or they deserve it

Q: Yeah yeah

R: I'm mean that's that's fine I mean uh an' I think see I think … … I think when you when you when you lose a body part it changes your identity uh how you identify yourself and i- it's totally __ um and I think I think if you didn't have … y'know too uh y'know too good of an identity to begin with then you came in and you're still feel the feel the kinda way you felt before an' you don't have a strong sense of integrity er go with whatever what ver way the wind blows so if y'r if you're expecting your life to be made better by someone else um… … an' I think I think it's easier to just take disability and be like oh whatever I don't care it doesn't that's not going to have a negative impact on me or or maybe you do feel like you've given your you given your all to the military and you feel like you got nothing out of it like … you've got all this pain you've got this suffering and you you're you're things aren't the way you'd hoped they'd be and … you feel that you do deserve it so there might be there might be people like that … … .. but I mean I mean I I heard my voice I heard his voice the buddy I talked to h- hs- he sounded different after his second deployment he still had the same kinda he still used the same words by the tone of the words was missing something there was like this piece that wasn't there anymore an' he sounded he sounded diminished … … I mean I I felt bad

Q: And he was apparently not wounded ill or injured?

R: Uhhh no I think he did receive a purple heart I don't know exactly what it was for … but he was in somethin'

Q: You know it's interesting when you said when you lose an arm and I was thinking about what you started talking we talked about gaining a purple heart so it's interesting about gaining and losing an' what you give and what you get and that's a part of all human life but in the uh extreme condition of what you're talking about it takes on a kinda … … … uh intensity you give and you get an' … … I think that's partly what you were alluding to depending on how you self-identify you uh expect to get or you expect to give in very different ways depending on who you are does that makes sense?

R: Sure

Q: Does that sound like part of what you were saying? OK thank you we're almost I'm almost through with questions but I did want to ask you … if you could talk to me about the kind of recognition you get

R: … … uh mm … … well uh having the purple heart is a trump card um … … hh … uh I w's I w's drunk at a *(name of team)* game and we'd finally won a game we'd just beaten the *(name of team)* and these these two guys were *(name of losing team)*'s fans and um they were saying something about Air Force an' I w's like the Air Force?! And so then they started talkin' shit to me an' so I I I hadn' mentioned that I w's in the military 'n' they were sayin' somethin' and I w's I w's like oh really? and then so then I I responded by taking out my Army ID throwing it down on the table an' I w's like is this not enough? An' I threw down my purple art- my purple heart membership for life card and they both just shut up an' they were both just like oooph and they looked like they went from they went from being two stallions to being you know to being little bunny rabbits and they were kinda like lookin' around and then this one guy who was watching all this at first talking about um __ and then he saw the purple heart card and he immediately switched direction, stopped paying attention to th' other two guys came over and gave me a hug

Q: Really

R: I remember another time heh heh uh I w's at a bar un u- talkin' to this girl 'n' she was telln' me about how her dad was a Marine and __ all that kinda stuff and then I w's like oh well uh you know uh I was in the military sh' w's like oh really and then I showed her my purple heart card and she started crying and she wanted my phone number and we even went on a date an' um and there's I gave my MOM my purple heart medal she j'st lost it uuuuhhhmm I get I get more I get more respect from people online when they find out I have a purple heart and y- it's- it's immediate it's immediate credibility it's a type of a- well it's a type of authority really because … one of the things about authority that y' gotta remember is that authority's gotta be recognized by other people authority is like **money** I mean if you really look at it a dollar bill's just a piece of paper but because other people recognize it as valuable you c'n use it now because other people recognize it for while it's valuable they can say well I defer to him because he has a purple heart but if they were just saying I defer to him 'cause he has something that you don't recognize then you're like aw shit I can't identify I can't identify myself as identifying with that because I don't identify that as valuable so then you know any way but it goes 'round 'n' 'round so that definitely has has significance… uuhhmm I don't I don't bring it up as much now … … I don't really bring it up to anybody really well let's see that's not true we were in uh we were in New York city the other day an' I didn't have my military ID but I had my purple heart life c- life membership card an' theee Museum of Modern Art gave my wife an' I two tickets for free that w's um fifty dollars uuuhhhmmm

Q: Huh wow that's exactly what I'm interested in hearing about I mean all the things that you're saying it's your point about the value being recognized because I was going to ask you that what happens on the civilian side as well I mean you gave me some examples of people who would recognize stuff within the military mentality or experience and you just related an example in th- on the civilian side in the civilian … … … space how did you feel when you got the tickets?

R: Uhhh I felt realy really good especially because it made my wife so happy to have something like that heh heh but no the purple heart w's definitely I see uh I see the uh the uh purple heart as social capital … … …

Q: Thank you and the last question is can you uh think of any or talk about any recognition that **don't** get

R: … . … … … … … … … … I dunno … uuhhhhmmmm … … … … … … … … … nah not anything of any event

Q: No that's fine it's sometimes it's not easy to answer a question about something that you don't um just using the word don't sometimes do- it's sorta asking a question that is talk to me about something that isn't … s' … sometimes there are things that that seem to be linked with other things … … and so sometimes people have a sense of not getting kinds of recognition that others get and that's sounds like that j'st doesn't resonate ffor you … fair

R: Well I mean the times that I've brought it out I mean there have been a couple a times I've I've brought out the purple heart as 'n' those are things those are things that are kind of contrary to my understanding of how to how to be a gentleman and uh the football experience I've … I've had a lotta shit and regret over that experience I w's being an asshole um then the uh the other w- with that girl using it there m- that was me taking advantage of the situation uh for my ego's sake bo- both both those times were all about ego … but my my dad taught me a lesson with going to Harvard Law School h's I's when I found out he went to Harvard law I said Dad did you used to uh you know tell people that you went to Harvard Law school to y'know to figure that helps you get girls and well well son I never told anybody Why? y'know no Harvard shirts license plates an' shit why? he said it's much more valuable when when other people when people finds out from others hh s … and so that h's that was always … influenced me so any anything that I have or any kind of special accolades that I have I I don't I try not to I try not to let me ego get behind t 'n' 'n' 'n' uh shout it from the rooftops because that's very fleeting that's the real value comes from when someone else says so I mean uh I mean even that to me you talk about you wan' talk about … certain contexts just being in the military will get you all kinds of accolades so … much less being injured just being in the military that gives you __ on Twitter I get uh every week some uh someone says uh Tweets me dun't know me from Adam Tweets me says thank you for your service … … …

Q: Thank you thank you for your conversation

R: Uh huh

Q: Goin' a going to turn it off now

070*v1*

Family Member	8692 words		Olympus recording #21 45:40 min	
Setting	Rank	Gender	Date	TOD
Private office Telephone interview	CIV	Female		1600-1700

Q: May I please speak to *(name of respondent)*

R: Hey is this *(name of interviewer)*

Q: Yeah

R: How are you doing today

Q: I'm fine how are you

R: I'm doing OK

Q: Sounds like your life is very busy

R: *Hh* yeah it is pretty busy

Q: Heh heh … so you're PCS-ing

R: Umm … we're ... sorta kinda um because of um (*name of partner*)'s injuries we're actually changing MOSs um 'cause he used to be in the infantry *hhh* aaand um … he's moving to an intelligence analyst position

Q: Oh awesome good for him

R: So … yeah so we were planning on staying here for another three to three to four years um but in order um to do that position change he has to go to school for four months and then um we're actually gonna be re-stationed at Fort Hood after that

Q: Oh wow

R: Yeah because and because um because it's only a four month school like it's a four month school in Arizona *tsk* family can't go with him which is good because I already started um a position at University of Hawaii Minoa

Q: Oh oh wow

R: Um yeah but um yeah so in January so we're PCSing now but it's like a weird kinda timeline because um

Q: Yeah

R: I guess normally *hh* we would be PCSing closer to actually going to Fort Hood *hh* which is uhm in January

Q: Yeah

R: Like mid-January um as opposed to now where it's like August

Q: Yeah yeah

R: You know um so yeah so we're trying to get him together to go to school *hh* um and *hh* also trying to like take care of the majority of um ... stuff that's associated with PCSing uh um

Q: Yikes

R: Before I'll have to do it by myself

Q: Yikes … that's a lot

R: Yeah it's a little bit busy and for the first time I'm teaching for the first time at a non you know like (*name of former school*) campus um 'cause I've only ever taught at schools that I was going to you know

Q: Ohhh that's different yeah

R: So yeah so um it's yeah just a little bit busy

Q: Yeah I'll say have you started the teaching yet?

R: No we don't start until the twentieth I believe

Q: OK

R: Um .. and uh you know some of it's like kinda weird because um you know the deadlines for stuff like I keep asking things like it's the same deadline as (*name of former school*)

Q: Yeah

R: Um so I actually thought I would have until mid-July to pick books but it's definitely like *hh* too late to pick books now for the class

Q: Oh heh heh

R: Which is fine um 'cause um for my class at (*name of former school*) I mostly just used articles or whatever *hh* um I just had like um recommended textbooks

Q: Yeah

R: That people could like sorta get on their own um but I just felt *hh* like kind of a jerk so I was like oh man

Q: Oh heh heh

R: And I can't pick books

Q: Oh heh heh

R: Dang it

Q: Oh rats that's all right that's OK so tell me

R: What's working

Q: So tell me again where you're teaching I didn't hear

R: Oh I'm teaching African American studies um

Q: OK

R: I was hoping to teach uh … a technology course um ... but unfortunately they didn't have an opening for that and I mean the thing is that they actually … know um it's an adjunct position so the main reason that I'm taking it is I'm hoping to flip that entire paycheck towards swipe card debt

Q: Oh

R: That I got when I was an undergrad myself um … and um … so yeah so an' I also wanted to start building up my CV early so I have a teaching history

Q: Uh huh

R: Outside of um the university

Q: Oh really

R: Outside of (*name of former school*)

Q: Huh

R: Um … but uh unfortunately *hh* I mean it's uh in some ways it's good as Dr. (*name of professor*) pointed out um it's important to document that you can each other things

Q: Oh well there you go

R: Other than in your subject area

Q: Yeah

R: Yeah so so it's not like the worst thing ever um yeah so

Q: Oh no yeah I'm it's it's and li- life is what happens while we're making other plans right

R: Exactly exactly and *hh* um the other thing I'm doing is that I'm working at a coffee shop near here

Q: Oh you are

R: Oh yeah

Q: Huh … wow

R: Yeah yeah it's pretty *hh* it's pretty nice um the girls are very uh they're very amused because um you know like there's that stereotype that you're gonna have like a certain writer or academic you know working at a coffee shop so they're pretty tickled *hh* that they actually do

Q: Hah ha! You're funny that's funny

R: Heh heh

Q: Heh heh how anthropological that's great

R: Heh heh

Q: Heh heh I love it … so which school are you at which where where are you teaching

R: Um I'm teaching at University of (*name of location*) which is in (*name of city*)

Q: Oh OK yeah

R: Uh huh

Q: Whoa now tha- that's uh prestigious

R: … yeah I mean it's um ah it's it's pretty cool it's uh um you know I'd rather be in Maryland um … you know and I- we were hoping that we could get stationed in Maryland because you know one of our goals was (*name of partner*) going for *hh* the um intelligence analyst MOS was for him to um … you know like they have a pretty active intelligence analyst community in the DC Maryland area ... um so … but *hh* you know it is what it is

Q: Yeah

R: And Fort Hood is um … is not a bad place to be stationed from what we understand

Q: Oh good

R: Um yeah it's uh it's supposed to be a really young post uh because it's one of the largest military installations … um … you know in the U.S.

Q: Yeah it might be the largest

R: Yeah it's pretty huge

Q: Yeah

R: It's pretty huge

Q: Well that sounds good that sounds good have you ever lived in Texas

R: Huh no I don't but I have an aunt who lives in Texas

Q: Ok ok

R: Uh uhm … so I'm gonna *hh* reach out to her at some point 'cause she

Q: Mmm

R: Actually used to work at a university there

Q: Oh wow

R: Um yeah so um so you know just to see what's up

Q: Yeah wow well you're very good to take some time with me on the phone today thanks a lot

R: No worries no worries

Q: I appreciate it yeah I'm doing a study here at Walter Reed and I uh in Bethesda I think I told you a little bit about it awh- when we had coffee awhile ago ... I did get I got IRB clearance

R: Yay

Q: You are so nice to go yay … heh heh heh I got it at

R: Heh heh heh

Q: AU and at Walter Reed an' um I think I sent you consents and if you're comfortable with the AU one … ... um … that would be good uh please let me know

R: OK … can you re-send me those

Q: Yup yeah I sure can and then the other thing is if uh if *tsk* I don't know if we can do this because you don't have the consent uh right now but I would like to record our conversation if you're comfortable and if you're not I'll just take field notes … or

R: Oh yeah we can do it

Q: Or can we

R: We can record it that's fine

Q: Ok thanks

R: I'll um just post date when I sign the consent form I'll just post date it

Q: Well thank you and then I'll be sure that I don't say your name or your uh partner's name … while we're talking 'cause it's completely anonymous and I'm really just trying to get a feeling for the experience that people have when they are … uh family members of someone who's uh wounded ill or injured

R: Uh huh

Q: And uh the different participant groups thank you I'm just going off just gonna turn on the tape just hang on thank you so you're participant number nine thanks for being on the phone this afternoon and my participant groups are family members service members themselves non medical attendants and care givers and uh who are associated with uh wounded i- ill and injured service members in other words they're either the service member themselves or they're in a support role of some kind and um what I'm interested in is uh hearing about people's experience of how their levels of recognition and access to resources are influenced by how their injuries were uh uh *tsk* were sustained uh and so

R: Uh huh

Q: Just uh we can be really simple and informal about this I don't want to necessarily go through a list of formal questions I just wanted to kinda get a sense from you *hh* about whether you perceive or have experienced that uh based on your *tsk* wounded ill or injured service member's *hh tsk* uuuhh um disabling harm whether there's because of the way it happened or how it happened or the results whether there's a difference between the kind of recognition he or she gets and what others get

R: I would say so um … um … (*name of partner*) um oh sorry about that

Q: Oh it's ok I'll take it out I'll take it out

R: Um my partner was injured in combat as part of uh a stencil (?) seven in uh I wanna say two thousand seven

Q: Ok

R: Um in January *hh* um I guess you probably are gonna probably wanna not say the name because since there were only seven people uh who died that's pretty indicative of

Q: That's fine

R: Of who he is or er whatever but anyways

Q: Ok

R: Um a lot of people actually thought he had died as well and so we'll have um

Q: Ok

R: These moments where … right when he was um coming back from leave uh from his last deployment somebody recognized him and they were saying it was like they had seen a ghost

Q: Oh wow

R: Um … um yeah because um *hhh* just because of the extent of his injuries

Q: Hmm

R: You know very …like no one was expecting him to … survive and if they did they expe- they weren't expecting him to like be upright and walking and still in the infantry

Q: Wow

R: Um …so um I think that … just because it was such a dramatic he was like one of the big big uh uh um … sort of … sort of attacks on __ U.S. military personnel in Iraq that year I think because of that a lot of people do recognize sort of his name or sort of put it together with other stuff that he's done or seen um … I think that's there's just like *hh* this really big push to be helpful … you know

Q: To be helpful

R: Uhhmm yeah to be helpful or to um *hh* to like for example this whole things with the MOS changing *hh* … um … really a big part of that is because of um … you know the kind of um the kind of um … you know the kind of very visible um … sort of sort of incident that it was because it what basically happened with that *hh* he's been up he's been up for MED boarding I wanna say three times now two or three times *hh* and uh the first time um … you know they were really pushing for him to get out uh er and it was really stressful and this that and the other

and it was just really you know like he felt really dramatic uh not dramatic but uh distressed and it was really dramatic b- in part because um I think that it was the first time for him that he had to really think about the military as sort of this machine that churns out bodies you know … um … so he was just it was really very hurtful and … uh less than awesome experience thing and you know in part because he was one of the few infantry men to got through Walter Reed who was assigned to the infantry like that was you know like they ended up having to like create a whole new set of paper work for himself and um a couple of other people who were just really gung ho about it returning to active duty service after being at Walter Reed

Q: Wow that's experiment that's extraordinary

R: Well yeah yeah just really intense process just a very intense process *hh* uh and so then for him to deploy and um again like you know be him being massively massively affected at his job both in terms of training younger me- younger or lower ranking members of the service *hh* or um you know just in giving him you know getting acts of heroism and valor whatever um for him to deploy again and then come back to another MED boarding was ultra discouraging but at this point um at some uh at some time a captain like he had worked with before uh recognized him and started really advocating for him really strongly *hh* um again by accessing his prior service record and you know that his injuries like I think part of it is that like the thing that keeps tripping people up isn't his TBI it's mostly that his legs were um were shattered

Q: Oh ok

R: Um yeah and I think if it was just the TBI I think that people would less sort of enthusiastic about helping him but because um or of it was just the TBI or just the PTSD *hh* um but because it's like a … like a legit … like physical injury that you know he's like he's you can look at his leg and see scars or medical history or MED boards or X-rays as opposed to something like PT-PTSD or you know more about therapy you know or TBI where people don't really understand it *hh* um I think that that has been a really big help *hh* I mean in some ways this is also kind of frustrating because

Q: That's really interesting

R: Because you'll have since he looks really young you'll have people … be … um … I don't want to say jealous but sort of … dismissive of the extent of his injuries um so there's been a couple of times so far where you know where he's had you know some fall ins with um … the … some sergeant majors out here where they've had you know you know like they've been really … working for a reason to sort of punish him

Q: Aggh

R: To slap his wrist for something

Q: Really

R: And it's been interesting because some of that has been sort of related to me because I was in school in (*name of state*) um … they really want your spouse to be like in the same state as you

Q: OK

R: So that's at some point that became kind of a problem and you know this whole thing uuhhm but yeah so anyways um yeah I'm sure there's a lot of other soldiers that he's worked with or um … that you know that um you know that my friends know or that my friends are married to

Q: Uh huh

R: And they won't like they won't be like be being encouraged to change MOSs or be retained you know like once

Q: Oh

R: Like guy er one person who I know um … his wife was saying say that you know that basically the Army was just gonna cut 'em off you know 'cause part of the effect of his TBI is like epilepsy or whatever like he's been having seizures uuhhhmm and

Q: Wow

R: And they're just like … you know … here's your disability check like … you know like get on out

Q: Wow … that's dramatic yeah

R: Yeah it is pretty dramatic

Q: Yeah I'm I'mso interested in everything that you've said an' I wanna go back for a sec' to what you said about a a new kind of realization a- about the uh uh about the military and then u- based on the fact that he was fighting to b- stay in

R: Uh huh

Q: Yeah that's really interesting it's it's kind of mysterious to st- to me it was at the beginning before I started this work and before I started at Beth- at Walter Reed in Washington and then here in Bethesda *hh* and it's it'suh I've learned so much a- about a little bit of that if you know what I mean learn a lot about a little

R: Yeah

Q: So if you don't mind if we can just go back there for a minute ... uh tell me about that again he wanted to stay in and it was hard to convince other people that that was the right thing to do for h- I mean other people in the military

R: Yeah other people in the military um OK so basically uh um …he's a really great guy um but … he … well when he was in high school he wasn't a successful high school student um in part because of family circumstances um but also just in part because I think h- you know now you know since I'm an educator myself like … we've talked a little bit about you know his dyslexia uh and his ADHD

Q: Huh huh

R: And um based on what he was describing you know about his *hh* educational track when he was in high school and middle school *hh* um… I think he was diagnosed with both of those but I don't think he was actually receiving treatment

Q: Ok

R: Um so high school was a real struggle for him uuumm *hh* and he ended up working *hh* you know a variety of odd jobs and the kind of jobs where um he probably would make not an awesome living but like … a steady like blue collar living

Q: Yeah

R: Um if he wanted to stay with those um in his home town … but then ____ happened and he ended up enlisting uuhhhmmm you know which was a goal that he had when he was younger but you know he sorta clanched(?) that patriotism into overdrive and he joined umand you know he just fell into this life where you know where there's a lot of tradition which I think resonates with him umthere's a lotta history which resonates for him aand uh not camaraderie but … uh there's a … like a sorta respect between service members that I think just … like really really speaks to him …um and I think beyond you know sorta that sorta that aspect of military culture um I think that sometimes he's … you know a little nervous about uh about what it would be like um … if he wasn't in the military like what if he hadda get a job

Q: Yeah

R: You know he's got he's never gone to college he's you know um … … he's not he's not he's not he's most of his skills now are related to boats or … you know being in the infantry and that was actually *hh* one you know of the really scary things about getting MED boarded because um I kept being like OK like you know I can earn a __ income like if I wasn't in graduate school I could go into the private sector and you know make a comfortable income to support both of us you know more than likely you know not sure since it's been awhile since I've tried to do that *hh* but you know when I was working in DC I was pulling in like forty thousand fifty thousand a year you know

Q: Yeah

R: Um … but he looked at what I'm doing now and I looked at what he's making now and how he's making more than his parents made and how he's making more than my parents made at the same age

Q: Mmm

R: And gets really… … legitimately nervous about whether or not he'd be able to pull in the same salary if he wasn't in the Army but I think there's this sort of lifestyle thing and this identity think that's a really really big part of it too … but underlying it there's just sort of … this anxiety about whether or not he'd he'd be able to ... have access to the same kind of dignity

Q: Oh wow yeah yeah

R: Or yeah respect yeah I mean 'cause like I mean

Q: That's re-

R: He doesn't want to be like he's said more than once he doesn't want to work at Walmart you know and he doesn't want to go back to the same kind of job that he worked

Q: Yeah

R: You know … when he you know was in high school or middle school you know

Q: Yup that uh it's a really good way to uh uh explain it to me thank you and actually it's amazing it resonates for me I uh there's so much about the atmosphere in which I work that I really appreciate and it has it's it's nothing like what you're talking about but it's just a little bit of the same culture of courtesy and respect and structure and all kinds of things that I didn't realize I would value so much

R: Uh huh

Q: And um it's been really … eye-opening to me to see how umvalorized that can be- become for for myself so I c- so by extension I- it's it's it starts to make sense that … you wouldn't want to leave you wouldn't want to leave if

R: Uh huh

Q: If you've committed to being a service member … yeah *hh* and so when he was very grievously injured there was um the obvious quote unquote idea that well now it's time to move on 'n' he pushed back he and you pushed back is that right

R: … yeah he pushed back and honestly um …a lotta that I basically met him a yea- about a year maybe about four months into his recovery process

Q: Huh

R: Um because you know I was like you know I lived near Walter Reed and um um you know yeah so that was how he and I met we're both from the same area both from Massachusetts but um

Q: Oh that's wild

R: But um yeah we didn't just know each other we just didn't know each other in high school so *hh* we now have this running joke where we probably met each other a couple of times because he'll mention places and locations and I'll go like I was probably at that party

Q: Wow oh that's amazing

R: … um yeah so by the time I met him um he'd already been through a couple of surgeries and um … you know … when at the time was really ambivalent about leaving … the Army … um but because of his own dedication to physical therapy and um … … and sort of stubbornness I guess um he …fully recovered you know after the explosion they were not sure he was he was gonna walk again

Q: It's unbelievable (*name of family member*) wow

R: Yeah … so it was um it was a very long … and even now his back his back is at times messed up and and his legs are still really sore um so it's one of those things where you know I think there's just this constant tension between *hh* you know him wanting to be in the infantry and wanting to be remain physically active and you know to remain in thatreally long history in the Army and being aware that you know sometimes your role has to change

Q: Yeah yeah

R: And um I think part of what made sort of his pushing against this this this drive to leave … um is because you know I so this is my read of it the Army and the Armed Forces don't care about you recovering to your peak physical condition *hh* they care about whether or not you can go back into the service so I think one of the reasons why he … encountered such a push back is because Water Reed is structured so that you know if you're damaged enough physically that you go to Walter Reed they don't want you to come back … you know because you're not fit you're probably not gonna be fit for active duty

Q: Yeah

R: *Hh* uuhhm … so I think part of the reason he was pushing back as hard as he did is that because he lucked in to having some really fantastic doctors and nurses who um you know really worked with him and got him to this point where the body that you see and the body that he lives in doesn't always pardon me match doesn't always match the body that you see described in his MEB profile

Q: Wow yeah

R: Um and I mean that doesn't mean that his MEB profile is wrong I mean he can tell when it's going to rain because of you know the extent of theinjuries to his legs

Q: Wow

R: You know his back is unfortunately messed up and this that and the other but I think I think that there was uh … sort of that tension like his own understanding of what he is capable of physically doing um … and … um you know this cantankerous attitude and you know if you're telling me I can't do then I really really really want to do it

Q: Heh heh

R: You know

Q: Yeah I cou- wow it's amazing it's it's just extraordinary …uh do you think he do you and he hear or I guess you can only speak for yourself but do you hear that phrase wounded ill and injured or do you hear wounded warrior or do you hear both

R: Um we hear wounded warrior

Q: Ok

R: Umm … like I'm sure that I mean he might hear wounded ill and inured at work but like like I'm part of the wounded I'm basically part of the wounded warrior network there um there was a lot of like …merchandise associated with the wounded warriors you know at un- at University of (*name of state*) and um um you know the a lotta the T shirts and stuff like that would have um … wounded warrior like associated like associated stuff on them at Walter Reed … like I remember

Q: Yeah yeah

R: There was this one where there as like a star … but the star had crutches and a band aid on it

Q: Oh wow

R: Yeah because it was yeah it was like a wounded warrior T shirt

Q: Wow … that's good … yeah so that that resonates for you more than the wounded ill and injured

R: Yeah I would say so

Q: Yeah it's interesting because when I- want I the *tsk* terminology or the sorta discursive thing that's happening is the wounded warrior prevailed and then wounded ill and inured started to be used and they're being used in the at the same time and in the same places and now depending on the space like is it a poster is it a gathering is it an announcement it depen- is it a clinic depending on where you are wounded warrior … is there or not there or they're both there so it's really interesting for the linguistic point of view that in interested in to sort of see how these … *tsk* words change and then how they're associated with other things or are they … so that's the kind of what I'm looking at and I ha-

R: Yeah I mean yeah I mean I think um I mean I'm even thinking now and I spend spend a lot on I spend a lot well not a whole lot but I have spent some time on salsas (?) um and um mostly they use wounded warriors I think I don't thinking I've actually heard um actually heard what it wounded ill and injured um outside of like … the hospital

Q: Yeah yeah ok do you ever … hear the word disability o- and when you hear it how do you hear it what's the context

R: I will I will use it um the reason I use is that um … I think that um … … you know like I just been tryin' a … …gradually introduce the idea to (*partner's name*) that um at some point he's going to be he's going to have invisible disabilities um … both because um the kind of injuries that he sustained are eventually going to lead to chronic pain condition … uhm … but I mean part of that is just because of my education level

Q: Yeah

R: Um … like I don't think he would … I don't think he's ever said anything like disabled um or anything like that *hh* and even when … he's talked about other soldiers who are you know in … er … who are going to be MED boarded out or who are wounded I think he'll say like their specific injury or he'll be like oh I have a bad knee or whatever like I don't think he would he would say that somebody is disabled

Q: Yeah … thank you

R: Hm um but I do think it's interesting like if you're looking at the linguistics of it I do think it's interesting how it works the body part of it you know um almost like there's

Q: Mm

R: Almost like that almost like there's like almost there's an idea that the soldiers is shamming or faking and the __ __

Q: Yeah yeah well that's a g- did you say the body part

R: Huh

Q: Go back to what you said did you say the body part … is that what

R: Yeah the body part like somebody 'll have like a bad knee

Q: Yeah yeah yeah yeah gotcha

R: Or like a bad leg … er you know whatever

Q: Yeah yeah it is really interesting isn't it it's so um it's so linked with all these corporeal um signifiers … so much of the recognition and c- other things that happen around that ... uh the

injuries are so *tsk* I mean it seems obvious but it is amazing to think about how it's so body oriented you have special insights about that because of your own work and your own interests it's amazing but um …I keep being struck over and over again by things that are very obvious but of course when things are very obvious that's when they're interesting because are they what makes them obvious um and an' um here it's sort of its sort of really nested idea of obviousness because when people are visibly injured it's obvious and other obvious things happen but if you think about sort of quote unquote obviousness or n- things that get naturalized it gets pretty complicated pretty fast so I'm interested in what you just said I'm really interested that rather than saying I think this is what you just said in part rather than saying disabled or blah blah that someone might say yeah he has a bad leg or she has

R: Or a bad back

Q: Yeah lost her arm or whatever that's really interesting what got me …puzzled for awhile was that people really pushed back when I used the word when I talked to people when I've used the word disability disabled people have said to me that idea I have of disability is so completely different from the military where in the military disability is about assessments and claims and benefits and retirement

R: Right

Q: And all that kind of stuff so it's not a condition so much it's mot a description of a *tsk* of a firmness the way I think of it at least socio-cultural construction heh of you know a constellation of abilities on the other hand it's and idea about how you are able to uhm get linked with … … uhm benefits and assessments and evalu-

R: Yeah in the military that's true like it's not a it's not a word that I think of and it's interesting for me because um because my dad is disabled

Q: Huh

R: Um so like that whole set of like so to me when I'm like OK I'm like keeping my __ and __ and that's not bad or anything you know like that just means that …you know like there's particular services and particular like not entitlements but particular ... things that he has access to and he has access to and that he needs to have access to and advocates for so with my dad for example on way like one way like when we um flew to Europe a couple of years go after I graduated from my masters program um and he I had never mentioned to the travel agent that he was disabled and um when we got onto the to the plane there was this whole scramble because he is visibly disabled um … and I mean he's not in a wheelchair but like if you looked at him you'd be oh like it's basically when he was like in a plane accident a couple of years ago and one of his legs is now shorter than the other and he has to wear like sort of a __ an' it sorta looks like he has a club foot … but if you look at him you can see like __ like that that older gentleman right there is disabled um so was a scramble to like figure out seating and this that and the other thing and um you know so anyways when I hear that word disability or disabled I don't think … like I don't necessarily assume that it describes the body you know

Q: Yeah yeah

R: But it does … it is the kind of language you need to use to get access to different kinds of civil services

Q: Yes isn't it interesting

R: Whereas in the military I know like I never heard I never seen anyone said like persons who were specifically disabled but they will say like they have a specific thing like they have a TBI or they have aa PTSD

Q: Yup yup

R: Or they have they're hard of hearing

Q: Yup

R: You know or whatever um but some of those will just get dismissed the same lines oh well they're main street (?) so of course they have TBI of course they're hard of hearing

Q: Yeah very good

R: And then and that huh

Q: Yeah yeah I so understand what you're saying it's just amazing yeah uh huh

R: Uh huh

Q: And if if if the word does come up it's because I'm retiring and I need to be working on my disability

R: Right

Q: And it might be someone who otherwise we would think of quote unquote as you know able-bodied or able-minded or whatever it is whatever the idea about something is *hh* the person is retiring so they have to work now in their out-processing they have to work for months of um evaluations and assessments with respect to the things that happened while they were active duty for twenty or thirty years and- how many of those things can be associated with their service and so it's a completely different spin uh … not spin even it's a completely different understanding and it's been very enlightening to me 'cause I am interested in the social construction of quote unquote disability *hh* and um it's sort of like what are you talking about ma'am heh heh what are you on about

R: Heh heh

Q: It's uh been extraordinary and an' very helpful actually really helpful … ... yeah

R: Heh heh

Q: Yeah well thank you it's been really rea- wonderful to connect and I appreciate it do you have any other thoughts for me a- as we think about how perceptions of u- w- wounds illnesses and injuries connected with recognition and access to resources I mean you were sooo it's been so helpful and you've said so much I just I don't know if there's anything else you wanna say

R: Actually one last thing *hh* um I think that when you're thinking about resources you go- you may wanna sort of add a note for yourself about whether or not they're infrastructural resources or like one time offs … 'cause like (*name of service member*) every now and then at church (?) that one of the guys he sees 'cause he saved um a couple of people er he saved two other soldiers during the um you know one of the incidents that he was in you know in Iraq um they all like put together money and so they're like buy supplies for him you know

Q: Hmph

R: Like night vision goggles like I think of one then another time it was you know like small bits of equipment such as it's an ongoing relationship they kinda have

Q: Mmm

R: Um and it's um really nice but it's also you can not necessarily reply on …you know

Q: Mmm oh yeah

R: Um … and stuff like being able to go through a MED board and like get guaranteed support or whatever like that so that's really different

Q: Yes yes

R: Some of those are really hard to access because like no one will explain to you *hh* how to do either

Q: Yes good point well my sense my sense of resources has changed a lot also as I've been doing the work because you are bringing me just as you have reallyuh different spin on what resources are for example one um *tsk* doctor that I um listened to me talked to about first she was really saying I don't understand what you're doing and when I tried to explain it better she said ah I get it she's an oncologist and she' said ah like my patient who was aerovac'd from overseas from Iraq had been in the service for a long time stage four … um cancer I don't remember what kind of cancer doesn't matter and she realiz- and she didn't have a big screen TV or video games and it really pissed her off 'cause she said the wounded warriors got big screen TVs and video games and she wanted them and she said oh you mean that kind of resources ok ok yeah heh yeah and so she advocated with some other patients uh and she got her big screen TV and her video games and so …my sense of resources you're quite right is it infrastructural is it um being able to go on a kayaking trip is it… being invited to participate in something that someone else isn't invited to

is it parking some in person was saying you know when you talk about resources really my big issue is uh I don't have parking privileges and I should have parking privileges so it's really interes- it's been really interesting its very plastic you know it's very it goes all over the place and it's I love your idea of the infrastructural versus the one one time offs because *hh* another service provider was telling me about um you know sometimes groups come into the MATC clinic and *hh* uh give gifts or do something or er or pass people at Mologne House this used to happen all the time at Walter Reed when I would be there and people would like from some charitable group would come in and bestow gifts on everybody and is that access to resources what is that is that is that recognition and you know a year has gone by and this provider was telling me that in her world when I said the word that's what she thought she thought oh you mean like the gifts they get from the church organizations that come in and give them gifts and I was like yeah well ok yeah maybe so it's been really amazing to hear about how people … think about resources and I like your idea about the infrastructural and because those are so um hard to um define and so frustrating and so um um difficult to nav- navigate

R: Yeah especially because sometimes they rely on systems that … … … they're not all updated around the same tine

Q: Heh heh well put heh heh heh heh I've just been through that all week about my CAC card and my um tsk ID badge which are expiring in a couple of weeks and its going to take me a couple of weeks just to get it … done

R: Exactly exactly and like with ours we um we've been trying to get a cost of living allotment which isn't associated with like (*name of service member*) being disabled it's just associated with the service and you know some parts of it require a marriage certificate some explicitly don't require a marriage certificate but they want the minimum number of paper work um … … … and yeah crazy __ (?)

Q: Wow that's amazing (*name of family member*) you know when we bring anthropological lenses to this it's like wow

R: Heh heh

Q: It's like wow in some spaces you're like wow and in other spaces you're like an' we know this but it's so like dramatic

R: Exactly

Q: Like don't show me this piece of paper in that space because I don't wanna see it I don't need to see it and it's just gonna make my life more difficult or where's that piece of paper because I have to see it

R: Yeah you're right

Q: Amazing

R: Yeah if you need any more help let me know um

Q: This has been awesome

R: Yeah I normally swap off between doing openings or doing closings at the coffee shop every other week

Q: Oh

R: So if I can't be with you uuhhm *hh* in the day my time then like one week I prob'ly be able t'do like in the day my time … the week after

Q: Ok cool oh that's very cool

R: And if you need anything else you can just let me know

Q: Thanks a lot now I don't know whether you've gone through this experience sometimes but I really felt urgent at the beginning like I got my IRB clearance and I w's like god man I got- but now I'm just relaxing you it's that people are available when they're available and it's been wonderful people have been so generous I would like to follow up 'cause you've hit on some really important things I want to ponder and come back and ask you a little bit about and so yeah

R: No worries but what you could do that would be really helpful to me I actually need to submit my IRB soon for my dissertation

Q: OK

R: So uh if you could send e a copy of yours that would be awesome

Q: Oh sure of course that would be my pleasure …uh I

R: Thank you so much I'd really appreciate it

Q: Oh yeah and I could send you some other stuff too and it might take me a couple days but there's um stuff that went along with it that was really instructive about uh … making it work making it finally get approved yeah 'cause yeah here's there's a review there's a scientific review committee as well

R: Uh huh

Q: And they I h- I went through that as well I went through that process and in that process I um I learned a lot about how to rephrase what I was trying to do so um yeah I'd be happy to where are you gonna do your fieldwork

R: Uuhhm I'm basically gonna try to do a lot of it digitally we don't I have an ongoing relationship with um a belly dancer here in DC so I was hoping to get some of my answers on the there phone I feel like I might need to *hh* bribe people you know not bribe 'em but offer

Q: Heh heh thank them

R: Offering an inducement yeah just so no one's there like … specifically invite others

Q: Yeah yeah well you know it's interesting we I just one of my research colleagues and I are going through a process with another study about what uh level of quote unquote incentive we could um offer and we have come up with something uh that is gonna be IRB-approved we have early signals it's gonna be fine and we this is not the kind of thing that you're talking about but it's in the realm we're gonna do a coffee mug with the study logo on it and we're gonna do a five dollar gift certificate that's redeemable on post and um

R: Mm

Q: Yeah and w- she did a lot of research and went to to a um actually went to a workshop in which the- the whole thing it was a special interest group about coercion and influence and all the things that we have to be careful about in research

R: Yeah exactly

Q: Yeah but she came away feeling really excited and liberated about what we could do and so even a small token in fact in one of the studies we're doing that's come up over and over and over again we're doing a study about we're doing a study with people who have been in research studies because it's a vulnerable population right in fact you could argue that it's a multiply vulnerable population they uh uh abdicated sovereignty they've done all kinds of things people in the service I mean and she's in the service

R: Uh

Q: Uh uh and then if you're in and then and then and then should you be considered a multiply vulnerable subject and are you in fact off b- off b- bounds outta bounds

R: Right

Q: So we're looking at this an' um we're

R: Hmm hmm

Q: And we're wondering and the answer we believe is no because you don't you know we can't make decisions for other people if you wanna talk to us talk to us

R: B-

Q: One of the things that keeps coming up is people keep saying they really loved being in research when they were thanked and they were thanked either verbally or with a pen or even just something w-

R: Yeah

Q: Yeah it does make a difference you know stuff material culture it it does make a difference I think do you know there's

R: Well what I w's thinkin' of doing was um sending like um an actual thank you card because this is the thing that's associated with a particular belly dance studio um what I'd like to do is I'd like to send a thank you card *hh* with a little gift certificate in it *hh* but then I'm like well I'm not supposed to know their addresses

Q: Oh yeah

R: But you know something like that I don't know I hafta

Q: Something like

R: I actually haven't written an IRB before

Q: Ok ok

R: I'm just really sitting and looking at it heh heh

Q: Yeah uh huh yeah I like

R: What do I do now

Q: I think I can help and here's an idea for you tsk we came across the same kinda thing it's like it has to be confidential so blah blah blah so what we're doing now is we're gonna put up a website address to show the results the findings the thank you's the all kinds of stuff so any participant who has access I mean you have to be careful about that you can't assume that everybody has access nor can everybody understand *hh* what they're viewing online or even see it for that matter but for those who can *hh* we're going to provide a link to show where the research went what people participated what we found an' and that's based on some participants saying I wish I knew what had happened … I wish I knew where all my words went

R: Huh heh

Q: So it might it might be that you can do something that accessible to people anonymously but that also thanks them … I'm not re- I'm not really helping you

R: Yeah

Q: At the moment but maybe I can send some stuff that will help

R: Yeah yeah

Q: Ok wonderful you know I'm thinking about a colleague at American who did some interesting work she was a couple of years ahead of me and I can't think of her name right now but I I she might have some stuff that's interesting to you because of the way she conducted here study and the people with whom she conducted the study so let me think about that a little bit more but in any case I will send you some stuff

R: Fabulous thank you so much I really appreciate it

Q: Thank you and I'm so thrilled to hear about the … uhm … without sounding too post-enlightenment the progress I'm so excited to hear about what you and your partner are doing it's just awesome it's complicated and it's awesome awesome wow

R: Yeah he's… that's a pretty good way of describing him

Q: Heh heh heh heh that's great to hear that's great to hear

R: Heh heh heh heh

Q: Thank you so much have a f-

R: Sure you have a nice day ok call if you need anything

Q: I'll do it thanks (*name of family member*) bye

R: Bye

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Setting	Rank	Gender	Date	TOD
Private office, door closed	SGT	Male	25 Jun 12	1400-1500

Q: OK so you're participant number eight … I'm gonna to ask you some questions and … just talk it's uh the twenty-fifth of June and what you say is important to me and I'm just gonna try to listen and and I might ask I might repeat some questions and I might refer to this so I don't forget anything … … so do you have any questions about the consent form that you signed

R: *Hsss* nope

Q: Okay … where when you hear wounded warrior where do you hear that where are you when you hear the words wounded warrior

R: Wadda mean where?

Q: Well uh when you think about when you hear that or read that … or when it that comes into your consciousness … where are you are you …. does it ring any bells for you the term wounded warrior like where do you see it er who says it or

R: Weee … it's become a general term so it doesn't it doesn't **bother** me

Q: And do you j'st sorta hear it around or uh

R: Yeah

Q: Yeah … OK what does it mean to you wh … does it mean anything to you? what does it suggest to you?

R: *Hh* … soldier that got hurt

Q: OK do you ever hear the term wounded ill and injured

R: Yeah that's what they changed it into now because it's not only not on- w- not only about wounded guys I mean there're guys *hh* that durin' their service get I dunno they get I mean they don't have to be in the combat zone they might they might develop cancer or certain other issues so uh who knows

Q:Yeah actually that's what I was going to ask next is like what diff- what does- what difference between those words … anything else you wanna add?

R: Nnnope

Q: So what would ill mean to you
R: Ill … … … … I dunno it ever could hit with me I mean it's just so uhh mm like I said it's not a matter of bein' just physically … hurt it's a matter *hh* even though you have *hh* some physical issues *hh* it could be psychological it could beee … physical due to a v- something viral so uhh

Q: OK thank you how about injured … that mean anything?

R: Injured e- er I think it's more a a physical traumatic event you know say like in my case like a rollover

Q: Yeah

R: Like my foot got smashed and eventually g- got amputated many guys here they went through IEDs er an' what have you and then they got s-s-severe traumatic situation an' they lost what they lost

Q: When you say rollover I think I know what you mean but can you tell me what you mean by rollover? Whe- when you got hurt

R: You know when a vehicle gets in an accident it just rolls over pretty much that

Q: Were you in the vehicle

R: Yeah uh huh

Q: Er yeah wow OK … … … *tsk* so you just said that that meant that your foot got crushed right? yup and then later it g- complications come and that's why they had to

R: So much uh tissue *hh* damage that uh they couldn't *hh hh* that was in- the blood flow g- was interrupted permanently and certain parts of my foot were startin' to die so first they amputated a few toes then I hadda infection they amputated towards the ankle … … had another infection and then finally they amputated towards the uh uh the calf

Q: Wow was that here? Or uh

R: Uh e- per se *hh* it was actually in the in the old Walter Reed

Q: Oh yeah yeah that's where we met

R: Uh huh

Q: Yeah so u- how long were you there? … having all that happen I mean … like under care

R: Well I got there in uh September twenty-ten so I been there since

Q: Oh yeah? You came over with us in the … big merger

R: Yeah!

Q: … … … how did that affect your commute? Or have you been living on post?

R: Uh no as a matter of fac' 'fore we even move' I was granted um an apartment by the uh Yellow Ribbon Foundation which … I mean they pay everything … an' it was … in uh (*name of neighborhood*) which w's kinda far from the old Walter Reed but due to the transfer it was convenient to this to th' Bethesda location so I w's like when they offered me I w's like perfect only five minutes away I don' even have to worry about it

Q: Oh that's fantastic how did they find you?

R: Uhh as a matter of fac' my mother was my NMA at the time … an' I needed a little bit extra room … 'cause I was starting to get better 'n' requirements were I'm a grown man *hh ss* I 'st need a little more privacy so … I asked *(name of nurse case manager)* he's one of the nurse case managers that works over there at the uh uh physical therapy section an' um … he contacted the the uh Yellow Ribbon Foundation 'n' they aksed him a few questions and they found me they

told me it would take 'bout two three months but you know when I asked I was preparing for it so I was like yeah ... at this point I'm goin' a be this I'm goin' a be that 'n' so ... it worked out

Q: So you were well prepared for what they asked you

R: Yeah I I I they sa- be w- wit- what they aksed me was more based on capabilities

Q: Mmmm like your own capabilities

R: So they could match me to the apartment you know I uh the- so they goin' a get an apartment that needs an elevator if it's on another floor what's that goin' a do stairs it had stairs and all that or does he need special baffroom 'n' things you know that's that's what they were asking … 'n'… I was pretty much ahead I go I go up stairs and all that stuff on my own so … it w's… uh it was pretty easy all was a matter of waiting for uh uh apartment to be uh uh to become uh … free 'n' get clean 'n' after that that was it

Q: That is awesome I don't think I knew that

R: Yeah

Q: So you lived in there before the uh merger

R: T' as a matter of fact yeah in … May last year that's when I I got my apartment

Q: Cool … you know that makes me think of a question … when um up until then you'd been living on post right … so then you moved to an apartment ... h- wh- what was that experience like? Being off-post and still being in rehabilitation or still recovering or getting different … um … prostheses 'cause I know you've had a few

R: *Hh* … uhh … I mean uh … 't first I was in uh you know in the uhh Mologne House … had one room it was just was just like bein' in a hotel 't w's one room talked to squad leader *hh* they got me uh two small rooms in the build- building eleven … … which uh two was two small two small rooms linked with a baffroom you 'n' for more privacy that's when I went to there so uh it wasn't really by that time I already had my car I already had gone to uh gone to Kentucky to get my car an' I drove my car over here 'n' I was already doin' drivin' 'n all that stuff so I I did I didn't I was already considering what was comin' *hh* I w's preparin' for what I was gonna need I mean I went to get the car I was drivin' the car so I was getting' … whe- when I went in change it was just a matter of going up one stairs and as it was over there in Walter Reed I was goin' up stairs I mean not fast but sometimes the elevator would break down so I have to an' not to mention the room they gave me was uh like the elevator was here an' a hundred meters away an' so I still hadda walk … it was no biggie

Q: That's amazing then how about um well I'm gonna get myself all distracted it's all so interesting I was gonna say how was it uh for you living in uh an apartment and just being uh off-post umm in a in a group of people that isn't necessarily uh service members or undergoing rehabilitation how did that go?

R: W- … I mean … I know a few of my neighbors 'cause I see 'em an' I say hi a few of 'em has stopped and we have conversated but I don't really interact with them but I'll tell you one thing though was is the good thing about it is i- when I get to the apartment 'n' I'm done wid having appointments during the day i- it it's like I'm off … a sort of er like uh when you live on post you done with your appointments but you're still on base an' you're like it feels like you're still at work in a sorta way even though you're you're in your room or what what have you i- that's why uh

Q: Uh yeah that makes sense … so uh is your mom still here?

R: No no no no she uh after the first year I sent her back to New York … I was feelin' a whole lot better I could do a few things for myself so I was like

Q: Heh heh good

R: An' my my NMA orders ... *hh* ... they were allot- we consider you better a lot- much better so we gonna cut you're your uh eligibility for NMA

Q: Oh really

R: Yeah an' I told my mom BYE MOM I GUESS IT'S TIME FOR YOU TO GO

Q: Heh heh heh did you think it was a uh a good timing? Like were you or uh to early

R: Yeah 'cause I w's I w's uh already thinking about it but um like OK but I was like OK an' my mom was havin' fun as as I progressed she was doin' less and less and she was just chillin' it an' eventually I'm like … … I'm like OK … … she she she didn't wanna go she was like

Q: She didn't wanna go

R: Yeah like 'cause it was just so easy to take care of me … after awhile

Q: Good good did uh any of your other family visit?

R: My dad my sister they came my sister had come and stayed wid us for a little bit uh… … … a few friends came over … … … *hh* 'n' that's pretty much all

Q: 'S good enough good enough … so now um … are you still being treated for your leg? Er you still have to do stuff?

R: I um as far as healing I'm already heal … I don' do PT or uh er OT anymore ... but what I do see is the uh prosthetic- the prostheses personnel becaaause as I got recently picked up cycling again and since I b'en cycling I lost about twenty pounds an' uh my uh *hh* my residual limb *hh* i- i- shrunk a little bit so I hadda re-socket it 'n' then I have shrunk a little more so uh I might be ch- I might be goin' to another socket 'n' tried a few legs … see which is better 'cause I gotta

diversity of uh legs I got uh I got one for running one for swimmin' *hh* I got one that uses spec- one that uses specifically for uh … cycling I w's using another one but they di- like a participant in an event the uh Bataan Death March an' I used a leg

Q: *Hh* wow

R: *Hh* yeah so there's a few things that I … that's the only care I uh receive oh yeah 'n' then well I'm undergoin' sleep study

Q: Oh yeah?

R: They say I snore at night but I don' hear myself so uh I don't believe it

Q: No you're asleep heh heh heh sounds like you're pretty active sounds like you're doing a lot of different … things

R: Trying to be trying to get back as a matter of fact I do more physical things now than I used to when I- before I got hurt … yeah because before it was work … might go to gym f'n hour on my own … but…

Q: That's quite a transition

R: Oh yeah

Q: I mean you just named like five or six different activities cycling swimming I didn't know you were a swimmer it's uh

R: I'm not pretty good at it but I do it

Q: 'S awright 's awright

R: Yeah

Q: Wow the cycling sounds like … awesome

R: Oh yeah it's pretty fun I just recently I bought a bike

Q: Oh you did?

R: A bike a bicycle yeah well I bought one the first last year it almost gave me a heart attack when I paid fifteen hun'ed dollars f'r everything … … but then I bought a bike like a month ago … …. *hh* … … 'nnnnn' way before I would never h' paid that amount of money for a bicycle but … an' I ended up I paid four thousan' dolla's so uh …

Q: Times change

R: Yeah … uh … I got into it more I got dedicated myself more to c- cycling 'n' like I said it helped me lost I lost already twenty pounds so I'm liiiike …

Q: That's fantastic

R: I'm hopin' I could lose another twenty an' be where I need to be as far as weight goes

Q: Who got you connected with the cycling how did that happen? How did it first how did you first get interested in the cycling

R: Uhh *hh* … … iiiiit initially started when I did um … *hh (name of therapist)* from uh from the (*name of a clinic*) he he if you know ea- 'n' *(name of another therapist*) they're like there's a soldier ride an' they asked me if I wanna participate and I'm I dunno what is that an' I w's just a few months into my care I was still goin' to uh P- uh physical therapy an' all that stuff an' *hh* I did a soldier ride an' I an' I rode an upright actually me an' uh this guy name uh uh a guy named *(name of fellow patient)* we was doin' swimmin' he's a friend now a- and we got offered the same thing so we decided t' do it an' I remember we pissed off *(name of nurse case manager)* doin' that ride because that was our first time on a bikes an' all of that and we j'st wanted to go

Q: Heh heh and it pissed him off?

R: Yeah because we wanted to test ourselffs we was hungry for testing ourselffs see if we could do it you know we just got recovering and just i- just the fact that you got on a bike was __ t' see how much you could do it *hh* so he's like you guys need to slow down an' I'm like dude why? but you gotta a lotta a guys on that you got I'm gonna say like I'm not hurt like I don't go I mean right now until I look back into um number of guys pull it because it was a ride it wasn't a race it was a matter of everyone riding along with each other

Q: Risky
R: But you know like I said we we we did it and we was hungry for it to test ourselves so

Q: The two of you went off on your own?

R: Nah we were wid a group but what happened is that we w's we w's running we w's actually tryin' a drive fast that we had other guys and we pushed 'em and they w's they were starting to pick up 'n the people that were don' the handcrank for th' first time or what have it they fell all way over back behind and we w's j'st goin' and goin' *hh* and I w's tryin' to keep up wid the group an' alla that

Q: And you liked it?

R: Yeah yeah that was fun and that's when I bought my first bike that's when I spent that fifteen hunr- the fifteen hundred but I uh I hu actually did it more because after that I c- I participated in a mini triathalon that uh w' was done in Texas by the (*name of a center of care*) yeah 'n I aksed 'em for a bike so I could practice wiff and *(name of therapist*) came to me in a bad way he say well you should asked an' I say I did ask I didn't just walk in there a grab somethin' I don't do

that it's not my thing I mean *hh* finally got permission well do it but he came 'n probably says you already f- you already messed up dude so and I was sayin' you know what I not gonna be asked I got the money so that's when I bought the bike and this one? You know there's a lotta organizations out there that help you … u- … acquire competitive equipment 'n' stuff like that but the thing is that you wait you gotta wait for dem when dere ready and dey gotta do a whole ceremony presentation that's where I wanna get this other bike on my I own so I w's like … I wanna ride when I wanna ride and I uh have conditions on how when or where what should I because these organizations they be like well you gotta ride at least three times mm a year you gotta participate in three types of things whatev' events and I'm like now I'm because I bought it myself I'm open if I feel like participating I participate if not I don't I don't I don't owe them s- I don't owe then nothin'

Q: With that kind of thing do you have to qualify in some way do you hafta

R: Naw it's just 'cause you're a wounded warrior you automatically qualify in that sense but like I said there's conditions to it grant it that what they get you it's pretty nice very competitive equipment buuut *hh* I'm like what happen if I choose I decide a do it but something else I can't do it den fallin' back on my word and I hate doin' that if I said I'm gonna do something I'm like do it there's circunstances that leads me not bein' able to do it I would do it

Q: So how did you figure out what you wanted di- like did you research on the bike or did you work with a salesman or something it it sounds like a a very specialized bike

R: Uuuuh i- it is uh uh a racing bike and it's not top o' the line but it's pretty good *hh* there's a few upgrades that I could do to it a' improve it *hh* uuuuuhh when I started this year when I started riding wid ride to recovery that group that rides out of buildin' fifty

Q: Ride to recovery I wanna write that down ride to recovery building fifty

R: Actually it's more like that it's Ride 2 Recovery

Q: Oh Ride 2 Recovery thanks so you started with them

R: Yeah I started with them uhh *hh* actually what happened is … the warrior games came along an' I actually did it this year participating in air rifle shooting 'n an- uuuhh h air pistol shooting an' uh I participated in the thirty k uh cycling

Q: Were you always such as athlete

R: Na dat's what I'm sayini' Uuh dat's de thing before I got hurt I woulda never done nothin' like this why I could be chillin' at home why I need to participate *hh* but … I did it more just to test myself just to push myself

Q: It sounds like it

R: To have a reason to push myself 'cause *hh* I'm one a those persons to get home and lay and I wanna like I c'n just sit down and vegetate a little bit

Q: When you first biked what leg were you using like how did you figure out how to ride on just your basic leg did it go OK er

R: Well y- you consider the prosthetic mimics a foot it an' I used to ride a bicycle when I was younger just for fun with my cousins and my friends like I didn't think it w's nothin' … so I I knew the basics of it oh er like I said that's when we did that ride I w's just hungry to go fast and becasue w's like it was the first time on an upright 'n there was also a road bike 'n it was one a those specialized bikes so I w's j'st goin' 'n goin' 'n goin' so it was just a matter of learning how to … how to time the prosthetic leg it's just like still now you know the new leg that I have it has first I did the regular pedals clinging pedals ... and I put it wid the clips 'nnn I j'st recently upgraded to clipless … *hh* which iron- ironically iiiiis *hh* you got normal pedal *hh* a clip is dat bucket looking thing wid the strap and den clipless those things that you actually clip onto the pedal itself just that uh that previous one it was called a clip so since you don't use that mechanism it's called clipless

Q: But is still has a

R: Yeah yeah you

Q: Does it have a release if you fall

R: Yeah it is a matter of ankle release if you twist your leg so I usually release my my uh goo- leg first then I step off then I twist my other leg to get off it

Q: Wow that's amazing all that has happened in a short period of time it seems

R: Well I I'm learning i- i- it's still a learning … still a learning process … …
Q: When your family members talk to you or refer to you do they do you think they say wounded ill and injured or do you think they say wounded warrior or do you think they say or er whadda they say I mean do they say *(name)* do they say your name which I'll take out of the transcript

R: That's it … they refer for me as me

Q: Yeah

R: I mean I'm the one who clowns around

Q: No kidding *heh heh* no kidding you've always got a twinkle in your eye so even when you're looking at me dead serious you got that twinkle I know somethin's comin'

R: It's like uh uh … I went to ~~Peru~~ for New Year's ss hh an' I w's goin' we was in a small town 'n you got people you know that that are combat vets over there from whatever discrepancy

prove dey have wid other countries or whatever … 'n *hh* there was a guy that was missin' … a leeeg .. he was walking wid crutches he was missing his leg a- above his knee *hh* an' I saw him and I was like before my cousin saw him and I was like look at that monkey he's makin' fun a me … he's mocking me he's like wha who who who you know they got angry like he w's like who's makin' fun you know they don't understand what I been through but an' like what they saw was a guy that was worse than me and they say HEY they just looked at me and they say whatever man an' you got no sense … I keep doin' it like that 'n eventually they got it they got into it they saw somebody else and they went yeah he's makin' funna you and they said yeah let's go k- kick his butt 'n yeah ahh

Q: When you're walkin' around outside post do people stop you or talk to you or ask you about about stuff because they see your prosthetic leg

R: It's n- it's more it's not towards what happened *hh* unless I'm in uniform or what have it *ss* some sorta identify that I'm in the military an' granted they know I w's in da military *ss* 'n w's like they just see the prosthetic 'n *hh* they curious 'bout the prosthetic and then it's what happened and then eventually they asked me what happens but then it's more like like with this leg the "I walk" the bottom "I walk" they ask me which is what's this is what's that big thing in the back 'n I tell 'em it's a battery and then I explain to 'em what it does and then they're like Oh if I'm wearing the other one a de other ones they're like oh what's that for and I'm like you you know 'cause people have an idea of it but they don't know e- exactly i- it's just like anything you know that you know you have an idea about … what foods are good for you *hh* but unless you actually dedicate yourself to uh er a trained method of dieting or whatever you really don' know what's good really good for you or WHY it's good for you

Q: Yes until you get into it and study it and start to ask questions 'n

R: In terms of like NOW to know all the differences

Q: Sounds like there's a difference in price
R: There's definitely a difference in price you know you go to uh you go to uh Target or whatever you buy a bicycle it's two hun'd dollars … 'n you think it's expensive 'n you carry it an' it's heavy an' all that but you know like it's you know I'm not gon' a be carryin' it I gonna be ridin' it so you don't carry it and then eventually you go to uh a higher level bicycles an' uh next think you know it's like there's a whole lotta lighter an' the price goes up higher an' see I was lookin' at buyin' another bike but I ain't gonna buy it anytime soon it's about fourteen thousand dollars and I don't have fourteen thousand dollars to buy it

Q: *HHHH* serious – a bike I didn't know that

R: ProSpecs (?) buut

Q: Wow I had no idea you could get a small car for that

R: It's you could get a full size car for that fourteen thousand dollars and still have some for two years' insurance second hand yeah when I paid off this bike I paid pff the four thousand dollars I

was like you know I coulda bought a car for this ... jeez I ultimately would benefit more from the uh bicy- I know that that's why I'm buyin' it I'm like BUT I still I coulda bought a car with this

Q: Yeah DUH it does go through your mind yeah

R: Yeah I coulda as a matter of fact could used that money I coulda bought a car in ~~Peru~~ as a matter of fact when I go over there I have a car that I could drive my car over there but it- it's better because I do I do need that bicycle just to get the cardio in and for what I'm doing an'

Q: Oh yeah and you're enjoying it and you're learning this whole other thing that you never did before I mean you might have ridden a bicycle but you didn't do it this way

R: Yeah I never

Q: Wow do you think of yourself as disabled or when you hear the word disabled does that connect with you?

R: *Ss hh* sn- I am limited … … … I dunno about disabled I am limited I mean there's certain things that I can't do and there's certain things that I might not be able t' do as faaast … but I could still do it or I could still like I said just give it a shot

Q: Yeah … you know the reason I ask is that the word disability is used a lot in the military right? Disability benefits disability all kinds of different disability stuff assessments when people retire or leave the service whatever

R: I mean it's it's a rightful term

Q: It's a what term?

R: It's a right term it's not a wrong term it don't offend me it is what it is I am what I am *hh* I mean you can't

Q: It's interesting though

R: I mean you don't have to be you don't have to have gone through a physical trauma to be disable … that's why they got cases of PTSD and TBI … *hh* you know there's u- even if you lose an eyesight you become disabled because even if you start losing your eyesight without fully losing it you you start becomin' disable because now it takes you longer it t- you exstrain yourself more to see so I mean it's a rightful term uh it's not wrong *hh* to be offended by it is j'st ignorance

Q: Yeah yeah thanks that's interesting because uh depending on where you hear it or who says it or how it's applied it means lots a different things so your answer saying um I might be limited in some ways that's very interesting to me 'cause that makes a lotta sense to me

R: 'N if I I hear you know it's like … … you know … to be … grotesque in in a sorta way you y'know you fuckin' disabled guy e- e- that I might take offense to but if I hear eh you disabled guy I'm like OK I am disabled you know what I'm saying you know it is it's how it's put in the context or where is it put what words is used that's like if I hear you know you fuckin' cripple ok you know I'm crippled it's no big deal

Q: Yeah the context that's interesting yeah yeah

R: Yeah it's how the message delivers not …

Q: Yeah yeah you know when we first started talking today you were talking about how you were pursuing your claim with uh the uh

R: The social security

Q: Yeah yeah yeah is that a disability claim or just a

R: It is but i- it's uh form what it's lookin' it's gonna be for a closed period disability claim 'cause since I'm going back to work uh I'm RTD and I'm going back to duty

Q: Oh you are

R: Uh huh … I w's gonna … an' they said I'm only gonna get back as far as a year goes which and I'm happy wid dat because still like I said I'm tryin' a build a house in ~~Peru~~ I got the land so I wanna y- it's money I could put into building and *hh* money goes different over there

Q: I'll say

R: Uh fourteen thousand dollars I *hh* … or whatever they give me I could use I could at least build the whole one floor like in here I could only prob'bly build a bedroom
Q: So uh a year from now you'll return to duty you mean

R: Naw in a few months

Q: Oh a few months

R: At the most in two months ... the sooner in two weeks

Q: Really? wow now is that something you apply for or are you

R: Uh huh otherwise my uh I woulda been uh medically retired from the military I went through the whole board process they foun- they got they gave me the findings and once my finding was there you do your final PO and you're like no I don't agree or they give you several options they don't give you all the possible options but they give you so you find yoooou pick uh you find the best suiting for what you wanna do an' I did n' I'm like I I I agree wit yer findings *hh* but I don't

agree wit me not bein' fit for duty so p- with dat I submitted my my uh COAD package my application for

Q: What's that

R: COAD Continued Active Duty you got COAD and COAR

Q: Continued Active Duty and…

R: Active Reserve

Q: Oh OK

R: That's for reserve or National Guard members

Q: You're doing the Active Duty

R: Uh huh

Q: Well congratulations did you have to fight for it?

R: S- n- not much of a fight it's you know you gotta uh follow the normal bureaucracy the normal they gotta they gotta see what you can do and what you cannot do an' uh

Q: Mmmm

R: Annn' they gotta see what limitations you have I mean they could if they found a use for you it's understandable if they find a use for you they's if not you know they're like oh you know you can't

Q: Yeah so does that mean you could be deployed
R: I could be deployed *hh*

Q: How do you feel about that?

R: No problem never had an issue wid it … never been afraid of death .. naw don't mean don't mean I'd try to commit suicide … I'm just not afraid of the idea

Q: No I understand the difference

R: I- it's just the normal thing being deployed I know I mean if I go out there I know that if I get deployed I might not be in the firing line like I know I'd like to be some one's like I'll go over there an' be in a somewhere in a big ol' base

Q: So I'm interested to hear you say this 'cause um it sounds like it's funny 'cause it sounds like you're doing some sports and stuff now that you didn't do before but that your feeling about being deployed is the same … I mean do you agree? That's interesting

R: Yeah

Q: Uh huh OK i- that ma- it's interesting 'cause some things change and some things don't change

R: Well yeah like I said the the sports thing I'm doin' it's just a way of testing myself you know a way of pushing myself … deployment just part of the job it it's kinda like you go to school for a degree right? … … annnn' after awhile you wanna work in that degree you wanna put that degree that you get to wanna earn your livin' doing that what you what you learned same thing in the miltary in the infantry I mean what's the point of learning how to shoot learn and communicate how to fight or whatever if you're never gonna do it

Q: You make a good point

R: Here's it's like here's I might as well get out the military

Q: Yeah but that's not the decision you made

R: Yeah that isn't so as I'm saying if I'm understand the military I understand that there's a possibility that I might get deployed again so I'm OK wid it I mean *hh* it's like a firefighter that decides I'm ownna be a firefighter blah blah blah blah blah … and not expect to ever get burned? if it doesn't happen … it's good I mean but not assume that he'll ever get burned? Or police officer that says I'll never get shot? I'm like … what were you thinking living it? You got so many things out there I would it's just foolish I'm not gonna lie to myself I'm not gonna create an imaginary world that I'm … then find out I'm like oh yeah yeah yeah yeah you're deploying next month … then have all these issues that it coulda been avoided by admitting the truth from the beginning

Q: It's interesting I I don't know if that's … common or uncommon makes sense when you say it makes sense with who you are I mean

R: Well you gotta accept reality … … and the minute you accept reality is the minute you start dealing wid it and you find ways to deal wid it … because otherwise like I said you end up with frustrations

Q: Well everything that you say always com- always reminds me that you are well-prepared right? You're well-prepared … I'm saying this I'm thinking about this because even in the uh different kinds of things you're talking about you were prepared to persist with your claim you were prepared t- um the various things that you've mentioned you were prepared for uh uh testing yourself you so what you're saying to me now makes sense along with everything else because you're talking about if you're gonna train for something

R: *Hh* that's a another reason why it's I intend to participate in next year's warrior games I participate this year … an' I went in with what they offer me .. but I realized in order to participate in it I need to put out a little more so that's why I star- picked up cycling doing the whatever whatever but I'm tryin' a' I'm looking to get a air rifle I ownna start shooting as of now so when next year I compete again for it I'm more accustomed to the weapons system and the positions and to the rating the gradings that it goes to it that's why I like I told a lotta the guys whether win or lose last year doesn't matter

Q: Right

R: It left me hungry for victory but it didn't matter it was like a recon process *hh* it was me learning what it is that a competition is about now next year that I go I'm actually gonna go for that competit- I might get my heart broken or I might not but if I lose all I know is that I shoulda trained a little harder or I shoulda put on a little more for the __

Q: For the next year what does what are the activities you have to do in that there's shooting there's

R: Well there is multiple events … I'm only going for shooting and I ownaa try to do bow *hh* and I'm ownaa add that to it and I'm doing a cycling again … *tsk* last year or I mean this year I was dead last so I'm not letting that happen me t' me again

Q: Ok well thank you just the last couple of questions can you talk to me about … uhm recognition that you get or recognition that you don't get do you ever have a sense of that you've talked about some of that already

R: Recognition that I get

Q: Yeah any ideas or examples or expectations or

R: Oh

Q: Surprises

R: You know for the things that I do just the ability t' start something 'n' completing it is the recognition that I look for … now added things like I like I did the Bataan Death March a few months back which is twenty six point two miles in over there in the desert it's a walk

Q: And you have stuff with you yes you have to carry stuff

R: Uuuuuh you *hh* this is several categories we enter in the uh civilian without weight … buuut I mean I hadda c- water bottles and all this stuff that I was carrying to drink … … iiit *hh* I did it and I w's to admit towards the end I w's just going along and I'm like and this is what I was thinking at the moment I w's like who the fuck in their right mind volunteers to walk through a desert for twenty six point two miles

Q: Heh heh

R: And I w's like oh no my dumb ass does it

Q: I was just going to say someone like you

R: And I was like and I was like towards the end and I was and I was tired and I was burnin' and I was you're almost towards the end don't quit now I mean I was and due to the walk I was just tearing up … because I was like I wanted to stop I was pushing myself so it felt good when it finished it it I won' it just like I said i- I had that reward that I was looking for that I was able to do it

Q: Yeah

R: And that's another thing b- like I said before if you woulda aksed me you wanna do it I'd be like no I wouldna walked it when I had two good legs but now I'm doin' it

Q: That's amazing what a ya how do ya what do ya how do you explain it d- when you think about that

R: *Hh* it's like I said it's all about me wanting to test myself I don't care to prove myself to nobody it's about my I'm testing myself

Q: And before you lost your leg or part of your leg um you might not have done some of these incredible challenges and now you do that's a that's a change how do you explain that

R: Well it's like a it's a … when with the doctors I when they told me they couldn't save my leg … and I become very … angry at that word can't

Q: Huh

R: It's uh I hate that word I learned I learned to hate that word can't sooo just the idea that I can't do a walk or I can't do a race *hh* it just pushes me through it

Q: Did you have that uh that dislike of the word can't before you got that news

R: No because I used to use it as an excuse to quit

Q: Oh that's really interesting

R: The uh not it's just like now there's no there's no room for can't you try you try and you try if you fail you fail but you keep on trying at least you failed at trying

Q: Wow

R: So that's what I do

Q: Amazing growth I mean just extraordinary to me wow *hh* see you always have these good insights remember I told you that last year you have a lotta you do a lot of thinking … … what about resources is the last question the resources that you have access to are there are some that you feel like you get access to special privileges training and equipment employment opportunities um is there anything that it's kind of a funny question to ask like is there anything that you don't get like some access to some kinda resources … you've given me some good examples about the ~~Yellow Ribbon Fund~~

R: There is many organizations that are willing to work with disabled with disabled veterans … uuuhhh I have access to them … … to a certain point I do have priority to other points I don't because y'know I'm only missin' part of my leg compared to other people that have other type of disabilities an' all that and granted because of the kinda injury I had *hh* the kind of injury that I went through it's totally I'm also got things that guys with worse injuries that I had like in my case ... I could return to duty stay in the military if I choose to which I did and I'm getting the chance to do dat … if I'm not I coulda chosen to go to school start an internship which I did start an internship but I could do an internship and apply in another job … but it's just that's the thing though that it's the military if it gets an opportunity it doesn't … the way the military mentality goes going back to work with them y-I will now be treated … like a handicapped or I will not be if I'm granted special favors it wouldn't be that many it would be very limited as compared to you know you in a civilian sector *hh* oh let 'im do it because he's this oh no way 'cause you you going no because them you lose that … desire to fight

Q: Hmmph

R: And I'm um I've always been a firm believer that you deserve what you earn and if it's given to me I don't I don't deserve it

Q: Hmm you know it's interesting 'cause as you're talking about this and very insightful comments and a lot of I can tell that you do a lot of thinking about stuff um … your desire to return to duty was that sustained throughout or you you had to you had to work on that in your own head as you were recovering as you w- were able to cycle or swim 'n do all this stuff from the very beginning of your treatment or your recovery or your injury for that matter do you think there was a transition in your thinking about I wanna go back or did you always feel like you wanted to go back

R: No there was a transition definitely from when I first got hurt you know through that part dat you think everything's over … and den physical therapist is um *(name of therapist)* came in and said you wanna start physical therapy and I w's like oh man I just had surgery and so he said yeah but we need to get you on your feet back quick

Q: Hmmph

R: And you get back on that horse and I'm like what horse I ain't no cowboy me being my smart ass self

Q: Why am I not surprised heh heh heh

R: So heh heh I tol' I tol' we got there and you know I was a little bummed out about my leg and all that stuff … and I was like man what am I gonna do and blah blah blah blah blah blah but then I'm in there and I saw guys with worse injuries double amputee triple amputee missin'

Q: Whew

R: Two legs one arm … they're missin' many other parts or *hh* they also got psychological issues and stuff like that an so many things and I'm like you know what and I w's like I better count my blessin's .. yes I missin' that but I need to do dat

Q: Wow

R: And somethin' I w's told then while I was healing I was like I'm not gonna push myself much … and they were like no you need to and I'm like no I am not until I know I'm fully healed until I know that scar I mean the only thing that's left there's scar and there's nothin' healin' in there I'm not gonna push myself an' I did that … *hh* and that period is gone and so now

Q: Ok

R: But once I accepted … how m- the rest of my life is gonna be … you know missing a part of my limb an' you know you have to use prosthetic and all that stuff and before it was a bother for me to put on but you know what I remember that when I was deployed took off your boots go to sleep you get up in the morning you wanna go to the baffroom you hadda put on your boots you hadda everywhere you go you hadda put on your boots put it on take it off put it on everywhere you go and one's didn't matter then so you know I equated that from that prostheses to that you it's like before I used to put on the boot to go out to the baffrom it's the same thing it's just like a longer heavier boot

Q: Very practical
R: Yeah I hadda find a way to understanding and accept it better

Q: Did you get help with that or did you figure that out on your own

R: Not I just did it on my own I had to *hh hh* you could go through as much counseling as you want .. but if you don't find a way to understand it it doesn't matter you're never gonna understand it

Q: Yeah

R: You always gonna be angry about it you always gonna deny it I mean there's days that … you know like last this weekend *hh* my feet was hot we was fishin' 'n' my left foot was hot so I took off and I put my foot in the water I would say man I wish I could do it instead of having the sensation of hot foot in my … buut I mean there's times like you get frustrated with certain

activities but it's not the point that *hh hh* it changes my mood or anything I mean well it is what it is

Q: How could you tell in the healing process that's what so interesting you gave yourself time to heal before you pushed yourself how could you tell when it was time to start pushing

R: How?

Q: Yeah

R: *Hh hh* I I I'm pretty observant in many things I like to observe a lotta things I like to think situations and areas and all a that I saw guys that have similar worse or whatever and they were pushing their self … and after they were heal or say they were consider heal had more surgery for situations like bone growth or what have it 'n' I was like that just a set back there's no point on it so that's why I said how did I know because once it closed once it 'cause it had closed it looked like it was closed but I guess there was a pocket of pus in there that hasn't fully closed I I e- eventually I opened it

Q: Really

R: Yeah they it was fully closed everybody thought I am and it felt like a callous and one day I picked into it and it opened and a little pus came out of it and I said what the heck is this

Q: Is that right wow

R: *Hh* so once that area was closed 'n' there was no doubt in my mind that's when I started to push myself slowly that's when I started doin' uh i- i- picked up the cycling picked up *hh hh* swimmin' I was doin' the swimmin' before this because it was because it has no impact on my leg *hh hh*

Q: Mm did you used to swim before
R: Eennhh recreationally go to the pool jump in there I went to ~~Peru~~ 'n' *hh* we uh uh for New Year's 'n' uh we went to the pool my cousins and all a that … 'n' my whole family's like are you going to be able to jump in the pool? And I'm like what not?

Q: That's awesome

R: Right now they never seen me swim they know before I left I like to go to the pool and all a that 'n' I like to be as as a matter of fact every time I travel from vacation it w's like everybody's the pools' over there because I love to be in the pool I w's like I say I wasn't like a professional swimmer but I loved messing around in the pool wit you havin' fun in it … and we went there *hh* and I took off my leg and hopped off a the chair all the way over to the edge of the pool and jumped in there and everybody was like .. shocked and then I came out the other way and they were like what and they were like and then I swum a few laps and they were like oh you can really do and my family my family from ~~Peru~~ they were really shocked they were at first worried about it

Q: Yeah

R: I had m- I had one a my little cousins he was about ten years old *hh* and he was over he constantly asked me will you able to do it can you do it and I was all around I was like why not *hh* …until they saw it they believed it *hh*

Q: Awesome that's a great story anything else you wanna tell me about or talk about or think about together

R: Hyuh no I mean I have *hh* like I said many privileges that I got wid it but … … *hh* … uuhhh … if there was a way for me to get my leg back … .. I would definitely give it all up … the only thing I would not wanna lose is what I learned with this experience … … I would be glad to get my leg back but I don't ever wanna lose the uh you know what I learned from it … … yeah it *hh*

Q: A lot you learned a lot you've been teaching yourself a lot you've been observing it sounds to me like you're thinking about yourself in different phases …

R: Uh huh

Q: Yeah and when we talked about recognition you talked to me about self-recognition like you were gonna get through that march and that was gonna be the recognition oh by the way did anybody do anything nice when you finished the … Bataan

R: Oh yeah yeah yeah … I got um Army achievement medal for it an' they're talking about uh they put me in for an Army commendation medal for the warrior games … I mean I'm glad because there's things that are put in uh in for my promotion points get promoted to the next rank but still it's uh just that fact that I did it dat I was dere that I achieved the purpose that I set the goals that I set myself I mean I tol' 'em I was heart-broken with the shooting

[Battery ran out – check field notes regarding last comments]

090*v1*

Care Provider	3605 words		Olympus recording #015 19:54	
Setting	Rank	Gender	Date	TOD
Conference room, door closed	CIV	Female	10 JUL 2012	1000-1100

R: Here we go testing one two three July the tenth

Q: Thank you ma'am thank you ma'am I'll find out later how you did that well as you know I didn't bring a formal interview because I thought we'd just chat as you know

R: Put the index fifteen fifteen so you'll be able to find it again

Q: Thank you fifteen fifteen and you're participant number nine

R: Yup that's right that's

Q: Thank you participant number nine and it's uh um I guess it's July the tenth

R: Uh huh

Q: Ok so thanks and you're a care provider

R: Uh huh

Q: And we had already talked informally about what I'm interested in I'm interested in hearing about your point of view uh about the differences between the kinds of recognition people get and the kinds of access to resources they get depending on how they were wounded ill or injured an um I wondered if you had any thoughts or comments about it

R: *Hh* well argh argh … first of all … tsk my family's a military family my husband is just recently retired after thirty years my daughter is active-duty right now in the active duty Army

Q: Really where's she stationed

R: (*name of station*)

Q: Good for her

R: Yeah she's a (*name of role*) officer

Q: Wow

R: Thirty years old young girl

Q: Wow such an accomplishment

R: Uh huh and then I have two first cousins one is retired Navy pilot and the other one is still active-duty Air Force pilot now he's a he's a general in charge of that Nevada National I think Air National Guard

Q: Wow they're such prestigious posts

R: 'N' now uh huh and my husband's father he's well he's passed away but he's retired Air Force pilot um my dad was in the navy so

Q: Yeah

R: I have lots of uh I mean military is part of … the military culture's just part of my family

Q: Yeah and many Forces

R: Yeah 'n' my husband's two brothers were also uh one's retired Army uh artillery officer and the other one's j'st was uh spent four years in the in the uh in the Army

Q: Wow

R: Ss … so I have a special love in my heart for … this this concept of service … t- to this country and … I think I watched it come full circle

Q: Mm

R: I grew up amo- I was a teenager in the Vietnam war … and I graduated from high school in nineteen seventy ... and the Vietnam I think you did as well I think we're close to the same age

Q: I think a long time ago _____

R: And in the Vietnam war which is a very unpopular war *hh* it was just the opposite we looked down at the poor young service members as to what was wrong with them because we felt like we were conscientious objectors

Q: Yeah uh huh why would they do that

R: Why would they become what we call baby-killers my husband was one of those baby-killers his family was strong military family his father was retired Air Force in fact his father was actually an Air Force bomber during the Vietnam war so he didn' he didn' have a problem with his conscience

Q: Heh heh

R: Heh heh he thought he was doin' the right thing and I guess

Q: Uh huh
R: That's my husband's family that's their mentality uh so my husband took a four year scholarship he went to college and paid his time back but he had to go through the tsk um criticism ridicule in the college campus for his participation in ROTC *hh* and then we also saw the Vietnam veterans come back .. from the war uh with what we now know as PTSD but at that time we didn' identify it as anything other than *hh* man he is *f*'d up heh heh

Q: Heh heh hand gesture

R: Yes heh he I do I did have a boyfriend when I was in high school his name was (*name of boyfriend*) and (*first name of boyfriend*) went off to the Vietnam war *hh* and … right before I guess maybe months before he was scheduled to come back he got shot it was Easter Sunday in his tent and he got shot *hh* an' he lived but he came home tsk and I remember (*first name of*

boyfriend) came home and sat around 'r joined part of our family wh- what we did at the time ss you know I'm still in high school ssso we used to watch the Mickey Mouse show

Q: Yeah

R: Four thirty in the afternoon so he's sitting in the living room with me and my … four or five brothers

Q: Oh wow

R: An' uh … he had his arm around me we were sittin' on the sofa and a clock struck probably four thirty or five o'clock the cuckoo clock tsk

Q: Heh heh

R: (*first name of boyfriend*) jumped off the sofa and hit the ground … and we just looked at him a' that's up with that

Q: Oh oh oh

R: We just didn't have a clue

Q: Yeah … why would you th-

R: No an' an' (*first name of boyfriend*) wound up a m- a few months later leaving the city he grew up in which was (*name of city*) where we're from

Q: Huh

R: And I never saw him again never heard from him again he like jus' couldn't handle what was going on there was no treatment for him … an' no one understood what was going on (*first name of boyfriend*) was a different and he wanted to come back and resume his life with all of his friends um of which were working really hard to dodge the draft

Q: Ha ha ha quite a contrast

R: Right yup so

Q: Fascinating oh wow yeah we didn't know then my son who I was mentioning a few minutes ago his dad my first husband also was in Vietnam in the Navy and got wounded

R: Wow where did he get wounded

Q: He was on a ship in the Mecong Delta an' he kinda took some shrapnel

R: What year was that

Q: Well I'm not really sure I can pinpoint the year

R: 'Cause I think the war ended around seventy-two

Q: Yeah … yeah an' he w's we met when I moved to (*name of city*) we met uh which would have been nineteen seventy three

R: Mm mm

Q: And um

R: So what type of benefits w- did he entitled to er what type of care did he get as a wounded warrior

Q: Well he um he I now know didn't adjust well after coming home and he sorta denied his involve- not denied but turned away from his involvement in the military left uumm I'm not exactly sure what the term is but separated himself his was ok he was treated medically and he was ok he wasn't uh disabled it didn't seeeeem he was disabled enough to not be able to move on with his life but he was profoundly mentally affected

R: Uh huh

Q: I realize now and uh um he does get tre- he goes to VA a wonderful VA in (*name of city*) … and uh has and uh has had great medical care there but um I'm not sure about those details 'cause he didn't talk about them

R: That's right

Q: Didn't talk about it at all yeah and it came together later for me ... because of my interest now

R: D'you ever do you think subconsciously you were trying to help help to understand his experience too?
Q: I think so yeah so the kinds of recognition that people get I'm wondering what do they what do they depend on and it's not true of all life but in the military it's so um it's such um extraordinary examples of um human service

R: Mm hmm

Q: Human suffering

R: Courage

Q: It's s- it seems to me that it would help if I could understand from people like you who provide care and have such a wonderful perspective um if you could link with u- help me link kinds of recognition and access to resources with kinds of *hh* injuries and the reason I'm asking

in this way is because of the recent use of the term wounded ill and injured *hh* and because I have had people service members tell me that it's important to them

R: Can I use your book to take notes

Q: Of course

R: 'Cause I have a lot of experience with that particular wounded ill and injure

Q: Yeah it's seems important to s- many service members and *hh* … to have it understood how they acquired their injury in combat

R: Ok

Q: With illness or

R: W- w- a couple of uh it's pretty much a common understanding … 'n' perception that the wounded warriors meaning the wounded in OIF

Q: Yeah

R: Are entitled to the highest priority of care … *hh* … I say that because I take care of both wounded in combat and in country .. this country for instance I have one patient who was wounded in (*name of domestic station*) *hh* and he is not considered as u- entitled to the same expeditious care as someone who's an OIF OEF veteran *hh* … … and in fact we just had an uh a uh an in pertaining to him because he is not an OIF OEF veteran we are trying to make not me but um the people that control the beds in building sixty-two need to make room

Q: Hmph

R: For in-patients that are going out-patient

Q: Ok
R: And because he's not an OIF OEF veteran even though he's sssstill on crutches and has an upcoming knee surgery he's gonna have a knee replacement they're moving him to building fifty

Q: Hmm

R: *Hh* … …

Q: That's a different uh a different

R: Yeah it's a little bit further away from the hospital

Q: Yeah would you say it has less prestige more prestige same prestige

R: I think that I would say it's it it's uh um not as nice it doesn't have a kitchen in it

Q: Hmm

R: Um … he's got an NMA which is a non-medical attendant and she will either be in the room next door or in the room across the hall I'm not sure I know which

Q: OK uh huh

R: But t- the mother herself was quite undone

Q: Oh

R: She's not happy about it because she perceives a disparity of care she perceives that her son who is just equally injured *hh* as a military service member should be entitled to the same quality of care as the OIF OEF soldier or marine

Q: Uh huh

R: Service member who was injured in Iraq

Q: Mm that's precisely the cond-

R: But

Q: -ition I'm interested in

R: Right

Q: Because it's um … … tsk … because it's so

R: I will give you her name if you like so you could speak with her

Q: I'd love to speak with her

R: Yeah

Q: 'Cause I do have permission and uh interest in talking with NMAs and uh family members

R: Right so that

Q: So

R: Would be that is something that she's actually verbalized to me that

Q: OK

R: She's quite upset about

Q: Ok well with her permission and your permission I'd love to talk to her er listen to her

R: Right an' I was not sure that him being injured in the United States had anything do with him being moved *hh* but I heard from um one of the Marines in um control here that that is exactly true that that was part of the rationale behind the move for him so it's well known within the hospital that the OIF OEF veterans get enhanced access to care above everybody

Q: Ok

R: They get first priority

Q: Ok

R: The other thing that I and I know that's true tsk the other thing that I haven't known for a fact but that I have heard is that veterans that say for instance I I have a wounded warrior who's lost both of his legs in Iraq

Q: Uh huh

R: Say he needs to have more prosthetics ... and it's going to be a very difficult to get those through the VA services so if he decides he wants to come here *hh* he still has to wait he's put sort of

Q: Hmm

R: … even though he's wounded OIF OEF they still have to put him in a queue behind the newly wounded

Q: Oh is it because of when he got wounded?

R: No it's because they'd take care of him he's had his first set of prosthetics

Q: Oh

R: And now we have to take care of this new crop of wounded warriors

Q: Ok ok that's interesting because that's a differentiation among a group of um wounded warriors

R: Uh huh

Q: Who may get uh um the best care

R: Right

Q: And yet he's in the uh uh he has to wait

R: They're telling him you're still entit- for instance as a new TriCare beneficiary new prosthetics are not a covered benefit

Q: Oh ah

R: So once he's retired he cannot get his new prosthetics as a TriCare prime beneficiary

Q: Oh ok

R: He can only go to the VA to get a new set of prosthetics and if he happens to be too far from the closest VA that has those prosthetics … or his VA his local VA you know doesn't provide those and he decides I wanna he's gonna fly back to Washington DC and hang out here then he can get himself a new set of prosthetics but then he still has to wait

Q: I see an' i- does that apply to people who are retired or discharged not active-duty? Is he active-duty?

R: These are all retired in other words y- you're active-duty while you're here aaaall the patients that are here are active-duty but they all receive their medic- they all go thro- not all but most of them go through the medical board *hh* they get their findings

Q: Uh huh

R: And then they get separated … they get a DD 214

Q: Ok

R: And once they get their DD214 they're considered veterans and so s- so

Q: So he would be a veteran

R: Once he's retired yeah

Q: A- and he can come back to Walter Reed?

R: Um hmm Walter Reed will still take him back

Q: Does he go through a process of permissions in order to do that does he have to make an application?

R: No he just has to contact the providers here and ask for their help

Q: Oh ok

R: But because he's a TriCare beneficiary he still has TriCare prime he can come back

Q: Oh ok

R: TriCare prime will not authorize prosthetics in the civilian market

Q: Oh

R: But they will allow him to come here and get then

Q: And VA would be considered civilian?

R: D- uh VA is an entity in and of itself

Q: And I'm learning so much about that

R: Yeah

Q: And there is a common misappr- misunderstanding of how very different the two entities are

R: Right you have your military treatment facility or MTF and that's governed by that's governed by … the deputy surgeons the surgeon general uh i- in Congress and then you have the VAs the veterans administration that's totally run by I guess there's a general Shinseki who's in charge in this moment in time

Q: Mmm

R: It's also a federal program

Q: Mmm

R: *Hh* so i- so it's governed at that level

Q: Mm

R: And so that pot o' money is also been allocated now the civilian market they'll there'll be things like Johns Hopkins

Q: OK

R: Mayo Clinic

Q: Oh ok yeah *hh* so in this case hhhe's um retired and uh so he still a TriCare beneficiary so he can come back to an MTF like this he can get in a waiting line or er in a waiting list on a waiting list

R: Right

Q: For er uh enhanced prosthetics or better prosthetics

R: Right all military retirees can go back to a military treatment facility for care

Q: Ok yeah that makes sense alright very good and do you have any comments about people who may have uuh um maybe ill psychologically physiologically does that is that a whole uh u- subset of care that you have a uh p- access to that you work with?

R: I work with almost I would venture to say … … without a doubt it's very difficult for a wounded service member to not have PTSD

Q: Mm

R: … PTSD is a … a reaction to a very stressful situation … where you seem to focus on it I'm sure you know what PTSD is ok um … … … … there are some instances where patients for instance that were injured for the first time never had previous combat experience don't have PTSD because when they got injured they were given morphine … which prevents the … … … solidifying of their memories so by the time they get back to the country they've had this is in the case of … … bi-lateral amputees right now they give them morphine right away to take the pain away

Q: Mm

R: They generally give it to them almost as soon as they're injured the medics give it to them on the battlefield they come and they have morphine

Q: Mm

R: Uh mm … … *hh* ... so
Q: That's an interesting connection so if they can't remember

R: They can't remember so they don't experience it

Q: Wow what about what about people who appear able bodied I mean they may be able bodied but they are

R: We have lots of them

Q: Yup

R: In fact I take care of two

Q: Oh do you

R: Uh huh

Q: And do they have the same um levels of recognition and access to resources or s it quite different

R: They definitely do however … … they themselves will restrict that access because they will say

Q: Hmm

R: I don't want that stigma I don't want that on my record I am a Marine … I'm not weeeeak

Q: Mmm

R: I'm not subject to PTSD

Q: Mmm

R: But I can honestly say in my heart of hearts that this particular MTF *hh* and almost every other one I've worked at offers … quick thorough compassionate non-judgmental mental health care

Q: Awesome

R: Into the patients but the patients f- mentally health psychiatric services is all self-referral

Q: Mmmmm ok

R: I cannot make my patient go to a psychiatrist as I can in other services for instance if I think my patient has a fractured knee

Q: Yup

R: Or a fractured leg I can say ok john I'm making an appointment for with with orthopedic an' I want you to go and he'll say ok

Q: Yup

R: I'm not allowed to do that in mental health they have to seek it out and want to go

Q: Oh really

R: So the services are there if they want it but I also there are some patients that refuse to acknowledge that they have that 'cause they see it as a weakness

Q: Mm

R: Some see it as I want a high security job and if I have

Q: Mm

R: PTSD on my record I'm not going to be eligible for a particular job

Q: Yeah uh huh how about TBI

R: TBI is an interesting thing because I don't know that we've studied it enough I don't know if we know that much about it some th- the medical people here at Walter Reed will tell you *hh* that uh after about a year and a half they're about as good as they're gonna get

Q: Mm

R: And they never get worse but I have had patients tell me that they do get worse

Q: Hmm

R: But they do get worse people in TBI department 'll say well they might be worse yut that's not from TBI that might be from lack of sleep might be from PTSD

Q: Hmm

R: But not from a physical traumatic brain injury

Q: Hmm how fascinating so it's quite complex and not well understood yet

R: I think so

Q: Yeah you may know that I was in the Qigong study last year
R: Yeeees

Q: And people were people expressed benefit right away and uhm a couple of participants expressed benefits so we were pleased to hear that and so that uh uh a pilot study and so we're just compiling the results now but uhm it's a fascinating and very complex subject or condition

R: Relaxation in response have you heard of that

[batteries ran out recorder shut of CHECK FIELD NOTES]

100*v1*

Care Provider	8677 words		Olympus recording #016 02:38 and SONY recording #01/03 49:45	
Setting	Rank	Gender	Date	TOD
Office, door closed	LCDR	Female	11 JUL 12	1000-1100

Q: You're participant number ten did I say that? and it's the eleventh of July and what I'm trying to understand better is the experience of diff- of lots of different people who are here associated in one way or another with rehabilitation whether it's a care provider service member family member or nma and broad categories of al those people and get an idea of um their perception your perception or ideas or experience of how people get recognized and achieve access to resources depending on their kind of wound illness or injury and what got me started on this path and then I'll shut up is that um there was a term wounded warrior that was being used all the time and then it kinda changed and it was wounded warrior and at the same time it was wounded ill and injured and now wounded ill and injured seems to be kind of replacing wounded warrior a lot and I was here working and observing and thinking about things it seemed like depending on the category people would either be recognized or not and uh and so I wanted to find out how other people felt about that so that's why I asked you to participate so thank you

R: Thank you

Q: First of all um … … there's not there's no right or wron

R: K

Q: I'm gonna *tsk* … glance here so I don't so I'm sure I don't forget anything… aaand do you ever here the term aside from what I just said wounded warrior

R: Uh huh

Q: And if you do where do you hear that or see that

R: *Hhh* uhm I see it mostly in the mail hospital um not necessarily in the clinic that I work

Q: OK

R: Uh huh

Q: And when you when you see or hear that or think about that what does it say to you what does it make you think about

R: *Hhh* uhm hhh when I hear wounded warrior I mostly think of the physical … injuries uh not necessarily psychological … or invisible wounds heh heh

Q: Thank you OK anything else anything you want to add to that

R: No uh just pretty much uh working here I'm able to see the physical wounded warrior so um

Q: So we're talking about … wounded warriors and it's participant ten … switched recorders because this one pooped out … *snf* um so we're talking about the fact that you do … … let's go back one sec … when you think about wounded warrior you would you would mostly see or be aware of it or see it in the hospital but not necessarily in the clinic

R: Yes yes in the clinic that I work and uh *hh* um you know when I think of you know when somebody says wounded warrior I uh automatically think of uh amputees er you know some physical injury that impacts … their life either they're s- currently in a wheel chair using proste- um prosthetics of different type

Q: Uh huh uh and uh did you have you noticed the term or heard the term wounded ill and injured? has that crossed yer … s-

R: Uhh no only just talking with you

Q: OK

R: Did I hear that term

Q: OK and when I say that when I put those words together er ea- each of er any of those words does it what does it make you think about?

R: Well the ill the ill part uh makes me think about the invisible wounds the the the uh the behaviors and mental issues that come with being in war so i- um it's a little bit more a little bit more comprehensive uh uh description um for uh the warriors 'cause uh just because they … physically uh you could see they're wounded they could also *hh* be wounded mentally

Q: Yeah

R: As well but you know you see the physical you treat that first

Q: Yeah

R: And uh

Q: So most of the people that you work with are they … tell me about the people you work with

R: *hh* Uhm everybody who comes through my clinic has to have had a um … *tsk* … mild TBI

Q: OK

R: Or concussion

Q: OK

R: And has had problems stemming … from that either with um ... memory…

Q: Mm

R: Sleep

Q: Mm

R: Pain headaches irritability *hh* uh um there are some people who have a co-morbid … a lot of them co-morbid PTSD

Q: Hmm

R: With that

Q: 'N 'kay *tsk* … um so if I say wounded … what does that … suggest to you I'm going to break them down to each word

R: Ok

Q: And just sort of think of that together

R: To me wou- wounded even though I work in heh heh heh in that environment *hh* … wounded … to me automatically I would think of a *ss* a physical wound first uhm then I would think … mental second just by the word

Q: Yeah yeah it's interesting 'cause even at the beginning when we started chatting you were already thinking about visible and invisible so you have a breadth of knowledge that you're bringing to this … … I'm sensing ... yeah so uh if when we talk about ill some of these are little repetitive

R: Uh huh

Q: But I just want to be sure we kinda cover stuff

R: Uh huh

Q: When you think of ill

R: Ill um

Q: When you think of ill or you hear ill what do you

R: I hear ill I I … y'know I not that I think when I think of wounded physical and I think that's short-term not that it's short-term any long way think of ill illness … seems more long-term to me

Q: Mmm

R: And to me that brings in *hh* the whole mental health aspect of being ill

Q: Uh huh

R: And that is a long uh just as long if not longer journey

Q: Yeah

R: For recovery

Q: Yeah yeah … how about injured what does that suggest does anything come to mind?

R: I think that uh I think that injured is a nice uh um blends the two … 'cause you could be physic- you know you could be

Q: Yeah

R: 'Cause you could be injured either physically er er psychologically *hh* injured so I I would actually equally think of those two uh equally together with that term

Q: OK … when you're talking to friends or family ... or people outside this facility or they're talking to you … can you think about how they refer to the people you take care of or see

R: *hhh* uhhm with those words or

Q: No just uh just backing up or stepping back a little bit thinking of about how do people describe or how you describe to other people the the group that you look after

R: Well for my particular group I say … that they have um u- injury to the brain

Q: Mm

R: And they're having problems um and they come to this specialty clinic *hh* um and then I I tell them about the symptoms that they may have and the co-morbidities that they may have and their perception *hh* is oh my god that's such a hard job oh my gosh you're doing such great such great work how could you do that every day and my response is they're just people ah HEH HEH HEH HEH HEH

Q: Ah! So anthropological ooohhh

R: And and um you know I'll be honest when I wh- I was not exposed to this uh um *tsk* uh population in my practice before *hh* so coming here I was a little intimidated *hh* uuhhm just because uh the g- you know these guys *hh* they're trained they're trained to kill they're big and they're irritable aaand they have a brain injury an' you're like *hhh*

Q: Heh heh heh

R: And you're like hmm a lotta red flags here heh heh heh

Q: Heh heh heh

R: Heh heh heh I don't know if I wanna be over there

Q: Heh heh heh

R: But um y'know e- you e- you just get used to the population so uh but yeah I think if I explain it to people they're like oh my gosh *hh ss* it's a great cause I'm happy to be there um and um I'd say most of all the people who come in are very grateful

Q: Mm

R: To be in the program *hh* um but as I as I'm there longer … … y'know I don't t- i- u- u- *hh* I don't see uh uh I hope this is- so very un pc I don't feel *hh* as I'm there longer and I understand the population more … I just I feel the same way as I feel when I worked with the schizophrenics or I worked with the people with bi-polar or the child psych people you know I just kind of kind of all of a sudden they start to you know go ok this is what they're dealing with and I understand it a lot more

Q: Hmm hmm that's interesting

R: I mean they are they are a very special group um … and um but also the people that um the people with schizophrenia were a very special group too so um *hh*

Q: You've touched on something really central to my experience as well … I go back and forth almost on an hourly basis at least daily doing the same thing you've just said

R: Uh huh

Q: It's people … they're special … people are special

R: Uh huh

Q: There are special people everywhere

R: Uh huh

Q: It's interesting

R: Uh huh y- I mean I hope that didn't come out as a negative

Q: No no

R: Thing but I

Q: No no not at all

R: I mean I just just being there and uh you know getting that's a p- like I said that's a population I've never experienced before and *hh* um I was s- scared I was really scared um and then once I started talking to these people I'm like uh they're just nice regular people and they want to get better just like the people with schizophrenia

Q: Yeah

R: They just wanna get better so

Q: Thank you it's just such a personal experience I have had as well I continue to have and actually it's one of the reasons I wanted to be here because we feel as though it's very different that some aspects of the military are very different and some aspects of the military are very different

R: Yeah

Q: And some aspects of the experience are the same because it's people

R: Uh huh

Q: So that's amazing that you said that

R: Hmm

Q: That's threaded throughout all my experience here the last three years wow I I just was thinking too as we were talking about injured because your population and u- many of the people here are actually uh uh self-identified or diagnosed as traumatic brain injury I just realized that word of course comes up all the time with a specific diagnosis or a set of issues for damage

R: Mmm
Q: Yeah so that so that y- y- yeah … that connects with uh with some of the people you're talking about very specifically… … … let's see … hh when I say the word disability what does that what does that connect with do you hear that word here or do you think about that word here

R: *Hh* uh um ... I think … … y'know I think that you know I think that word I don't think that word that word's used very much and I think it has a *hh* a little bit of a negative connotation to it *hh* um y'know I would … … *hh* m- mostly say if somebody's at least in my clinic if somebody is really struggling … um I might say they have they have some challenges mentally *hh* but um um I w- disabled *hh* um mentally disabled I w- I just think is just t- uh i- i- uh it just m- i- i- i- that word makes me think well they're mentally disabled then they're excused from … taking y'know from their behaviors where um

Q: Hmm

R: Where I ju- you know in this setting p- people can have challenges but … I I just think that word can be used as an excuse

Q: Hmm

R: So I don't like that word and most of the people don't want to be excused they they wanna work to their best potential *hh* um .. e'en with the the ph- physical the physical wounds … I … I don't think I would ever … say that er er characterize anybody as disabled … even if it was quite obvious heh heh heh that they're missing all their limbs it just *hh* it just doesn't *hh* it just seems like it's maybe outdated and negative term to me

Q: Huh that's fascinating

R: Not that I not that I don't I- I disapprove of that term that just for me it's just

Q: It's very interesting

R: I don't I just don't li- maybe it's because I work in mental health I want people I don't want people to fall back on well I have a brain injury and therefore I can have an excuse for my behavior because I have a like no you'll be actually probably waaay more capable of doing way more you just have to do it a little differently to get through the day but uh but but we don't we don't really… people who come through our clinic usually *hh* are very driven to get better or work better sooo uh um that word we don't hear that much in the clinic and um I tend to stay away from it

Q: Huh that's really interesting it uh it's um … I I don't want to put words in your mouth but it's like a label it's kind of a label is it?

R: Yeah yeah um I would say it's a labeling word er ho- I mean I don't know if it's true for anyone else but it's that way

Q: Well I think it's true for a lot of other people yeah I think it is and sometimes people perceive that and sometimes people don't so it sounds like you have some insights *hh* that uh you're bringing with you for lots of reasons perhaps because of your training perhaps because of your innate ability to s- think about things but um … the fact that you can describe your discomfort with that word is really nice thank you I appreciate it

R: Uh huh

Q: … my next question is uh in wh- in what ways u- i- this question was sorta in what ways do you think of your patients as disabled and we talked about you really don't

R: no

Q: You wouldn't like to use that

R: No

Q: And so then I wonder in what ways do you think of your patients as capable?

R: … oh well I think uh … the ones that ... well there's … a handful … of people whose lives are gonna a struggle and it'll pro'bly be a struggle for the rest of their life but … tha- that handful of people keeps trying and trying and tryin though somehow there's something in the back of your head going I don' think … you know the better days if they're coming they're faaar down the road but *hh* um … uh- you know I think the people most of the people who come are are very capable um they wanna learn they wanna understand what happened to them *hh* um and they're classes where they they're taught that you know after this brain injury … … e- you're not going to be able to do things the way you did I mean uh uh you let them know all their intelligence is still there *hh* uh um an example is like uh if you had ten years of piano lessons your ten years' of piano lessons heh heh are still there *hhh* it's just um … um mostly um … they're um the energy that it takes to do things um is much greater so you get much more tired so uh so once they understand that … um then I I they they um I think that's a a that's a big hurdle for them to get the that you know I'm the same person I'm just can't I can do everything I used to do *hh* I just have to do it a little differently you know maybe at a different pace

Q: Yeah

R: Maybe I can't do everything in one day maybe I'll have to do it in two days things like that so *hh*

Q: Accessing it might be different take longer help like get prompts in different ways

R: Yeah you know the stickies you're not gonna remember when you go out the door take your keys take this da da da I mean you know *hh* you just becomes second nature make myself a note 'cause I'm gonna forget an' so an' uh so I think a *hh* lot of them are very capable um coming in there are you know there have been *hhhh* you know less than I could count in one hand *hh* a couple of people who've come in who just haven't y- they've had other problems like s- substance abuse or alcohol problems and th- they uh uh have been sober and then they get here an' uh they just you know that that actual part wasn't was not dealt with appropriately before they got here so you know they

Q: Good point

R: You know they um you know it's frustrating because all the resources that they use here if they're drunk or using drugs I mean you know it's just a big waste uh if they're able to get better and come back great but it's you know sometimes they're just not ready or haven't been off long enough to make a big change

Q: Yeah yeah

R: And come here so

Q: Special class of stressors um do you think the people that you work with … are recognized … how do you think they're recognized how do you think they're recognized? And by recognition I mean well visibility but also privileges or access to um internships or uh um awards or uh greetings or parking privileges

R: You mean the patients?

Q: Yeah yeah an- I don't want to out ideas in your head but what I wanna get at is t- t- I'm asking you to talk to me about think about together … um these your patients are … working on issues of brain injury

R: Uh huh

Q: Uh they may or may not be visibly wounded is that right?

R: Right right mostly there aren't any uh physical

Q: OK and so uhm how do they get do people recognize that they're struggling with issues or people just assume they're fine

R: While they're in

Q: We- just uh your sense of while they're ether in the clinic or in and out of the clinic or just sorta your global idea about it

R: Well I think that they people people in the clinic I mean you could tell um um most people could tell who the patients are *hh* in the clinic not it's it's set up in a way but you you could tell who the people are coming in uuhhhm … *tsk* … I think out they do community trips where um … they take people out to maybe to breakfast or lunch and see how they act as a group and see how they interact with … the public … and um so … I think from what I've heard the public is is fine you know they're like ok 'cause you know where we live there's tons of military *hh* um but I think the soldiers have a harder time going out um an' interacting uh with the public so

Q: Do you think the- their struggles are struggles is an emotional word I guess but do you think the work that they're doing to get better do you think the effort they put into it is recognized in the same ways that we might recognize other efforts

R: *Hh* um … *hh* … … … … … … maybe on a a much smaller … level … um … you know ... um you would see maybe an amputee the- they're a lot more visible um sorta draws more of the heartstrings when you see a uh young person without a limb or several limbs *hhh hhh* um f- for the program I work in they just get discharged and sent home now there's another program where they actually have a graduation … and they have a graduation um actually in my clinic

Q: Really

R: And they invite people to come to the graduation so they go through this whole program so they there is recognition *hh* um we don't do that because I think everybody leaves might not leave at the same time um ssso it's a different type of program it would be nice if everybody came … you know people who came at point A will all leave at point B but that's not always the case and *hh* um it's a usually a smaller group um a smaller group of people so I think to do you know a little graduation or ceremony is not um the the clinicians are all overworked and to

Q: Heh heh

R: Throw in a you know a juice and cake party a couple of times a week is just just not that they would not that anybody would … not like it I just don't think there's *hh* there's time

Q: Yeah

R: So I I I do y- wanna y- e- was your question I'm thinking you know if let's say an amputee you know they take you know they get fitted for their prosthetic they um calluses build up everything's ready and they take their first couple of st- I mean I mean you know there's people cheering *hh* um I don't think they do that with … mental health you know so it it's just I went out in the community and I didn' punch somebody at Walmart you know YAY let's get some cake

Q: Right

R: You I I don't think people I mean that is a big …

Q: That's a great example

R: I mean it's a it's a that's a huge huge thing *hh* but … you know I don't think anybody's gonna celebrate that you didn't punch anybody out at Walmart heh heh heh so … so

Q: That's a great example it's a great example it's a milestone for the person the clinician is thrilled

R: Uh huh

Q: Er pleased whatever the person's reporting it back

R: Yeah uh huh

Q: The person's happy … recognizing it as a milestone and yet how many other people would get how big that was

R: Y- yeah right right

Q: That's a great example thank you ... um … … … … does it ever … seem as though there's a whole and I think you just touched on it really that there is a whole other set of things that happen … depending on visibility

R: Yeah

Q: Yeah OK I think we've covered that in some detail thank you … … um … … *tsk* … you've been so … helpful that I'm skipping over some things thank you … tell me a little about what you expect for your patients when they leave here

R: Well um y'know I'm not traditionally who you might should be interviewing but … … what I understand … that they do is that they when they leave they're given a discharge plan for their home duty station um with all the recommendations from all the disciplines *hh* um … an' um hopes that they'll follow up ... uhm because most of the people there are some people who are getting out of the military who were there … 'cause f- my from what I understood he wanted to stay in the military but you know maybe I I am

Q: Heh heh

R: Uh uh y'know maybe I am I- do- uh anyway

Q: Well we might come back to that

R: Uh yeah but uh … I don't know what why that happens er … how that happens but they go home with a plan and there's somebody who calls up *hh* um I know that one of the people who has been calling there's some people who just don't answer the phone y'know they just don't want to be bothered um but there's several … but the majority of them follow up I I don't I don't know how they're doing I just know that they touch base

Q: Well that's fine so uh when we're thinking about it have they been medically discharged or they're still active duty or and they're stationed somewhere else and they're following up

R: Yeah they're they're um they're stationed somewhere else

Q: OK

R: And um then they they get followed up … … … th- there are some people who … … they they're I know of a few people where they got discharged they went to their home duty station and they were ready to get deployed again uh there are some people ... who … go home the- I think they hope to stay in the military I don't think they would ever be … deployed I mean I hope they would not be deployed and uh there are some people who go home and retire so

Q: Yeah

R: I'm not uh … quite sure … … why they're in the program but th- you know there's decisions made

Q: Fair enough

R: I don't know I don't know

Q: No no that's great and and uh you reminded me that it's a multi-disciplinary approach that there are people with various different kinds of skills um and approaches and knowledge from various fields of care

R: Uh huh

Q: Uh for a period of time

R: Uh huh

Q: And so when you think about when you were talking about the recommendations they're recommendations from various uh

R: Disciplines

Q: Yeah uh disciplines yeah thank you

R: Yeah there's lots of um yeah no it's pretty um it's a comprehensive evaluation

Q: It's an interesting question I you know when I hear people talk to me about wanting to stay in or wanting to leave or wanting to retire or wanting to stay active duty or wanting to get deployed *hh* it varies tremendously and some of it's mysterious to me … I I don't get it but y'know people are individuals um I don't get it both ways heh heh or all ways it's uh always unique

R: Uh huh

Q: That is um but I'm wondering what you think I think you touched on it … that is some people seem very um uh firm that they want to stay in the military and they'd like to be deployed

R: Uh huh

Q: And some people are very firm that they don't want to stay in the military and some peo- and then there's of course everything in between

R: Uh huh

Q: And um … my my f- when I first started working here it always surprised me that anyone who'd been … injured let's say … damaged hurt would would then shy away but I am so wrong

R: Uh uh

Q: I wonder if you can comment on that

R: No there's been um … several people who after I'm speaking with them it's quite obvious the um … … *tsk* ... the uh injury … and … you know I had one guy going *hh* ho man they're gonna take my gun you know they might not take my gun so there so how did I mean he is completely focused he wants to get better he wants to get back on deck and um I w's just looking at him like *oh my god you have a gun* you know I mean I w's oh heh heh heh so uh *hh hh* yeah there yeah where I work there are really there isn't anybody … who is negative saying yeah when I'm finished here I'm gettin' out or I'm here to get my medical board I'm outta here it's not it's not like that the the few people who I have come across who are getting out *hh* I think they're getting out because they have twenty something years

Q: Oh ok

R: And so um it'ssss … most most people are positive though I *hh* I think … I mentioned this *last week* that I did have one guy who was polite and rude at the same time and just told me he just wasn't interested in what I had to say say and he said I came here because I wanna know what's going on with me and then walked out the door heh heh

Q: Heh he heh

R: So I think that person was the exception

Q: Heh heh I w's just gonna say

R: I think he was the exception

Q: in a way that example shows how … he is the exception

R: Yeah he really is

Q: 'Cause it really stuck out

R: Yeah

Q: Stuck in your mind

R: Yeah it's so heh heh heh

Q: Yeah heh heh heh and remind me that it's not all men [27:20]

R: *Hh* yes I have interacted with two women although there are other women there *hh* um tsk and um the women are great ah uh I mean women I think in general making a gross generalization under

Q: This is your opportunity

R: Researchers are all __ I mean women are inquisitive they ask more questions they're more comfortable

Q: Ah

R: I think they're more comfortable with asking questions and saying I don't know this explain it to me and just more talkative to get the conversation going to get more things out so um with those two female uh soldiers I've interacted with its been uh its been uh a a very interesting you just get a lotta you just get a lotta information and understanding

Q: Yeah

R: About their uh I mean their the- when I talk to the men most I'd say ninety percent of them don't really talk about their injury in particular when I 'm talking to them

Q: Mmm

R: Um but uh the women they'll tell me about their injury and exactly what happened and exactly their prob- and

Q: That's completely different

R: Yeah it's completely uh uh you know they're happy to disclose … any an' all

Q: Huh huh that's very different when I uh when I worked on a study last year we're just finishing it now of um *tsk* introducing Qigong to wounded ill and injured when I did the exit interviews the women's interviews would be thirty pages long and the men's interviews would be three pages long

R: Yeah so uh i- same thing heh heh heh

Q: Heh heh heh yeah and as with lots of stuff in the Armed Forces they're probably a lot fewer women however they show up am I right i- in your practice …

R: Yeah

Q: They're there just in smaller numbers

R: Um uh the women are much smaller numbers s- I I since I've been there … … I think I've only known t- two two I've interacted with but there have been others so I would say *hh* probably under ten way under ten

Q: And t- to be in your program does the does the uh service member have to have been OEF OIF or is it anyyyyy

R: *Hh* ... *hh* … I I I … … … hm I believe … yeaaah? Yes *hh* now uhm we've had people with injuries that um … may have not happened while deployed but they were deployed … I think those are exceptions uuhh so but yeah uh pretty much but i- i- you know it could change in the future since those missions are winding down so

Q: Yes that's interesting we had the same kinda criteria uumm for the Qig- I'm thinking about it again that is s- we started with had to be OIF u- OEF and then we said after awhile we amended the research because we realized there were some people who were very interested and they were in the warrior wounded warrior brigade wounded warrior unit were i- wounded ill or injured were interested n participating in the program so we amended it to say … have been deployed at some point but not necessarily those two uh … those two particular areas … so that sounds … I don't know if it's the same but it's making me think of the same the same thing … *hh* … um .. any thoughts about uneven outcomes based on how people are perceived not how they really are but how others perceive them either because the patients tell you that or because you observe them

R: … … … uh um … hh … I think it's just very hard to gauge mental health um especially in this population where they're just trained to keep moving forward so um … … … h- I … like with the the ph- the physical you could see you don't have to know the person or know person's personality … *hh* .. um when I worked at the other hospital I would go get coffee every day and I would see the same people and after a couple a years meaning they were there for years *hh* you know after awhile a person's you know walking with their prosthetic and so you see it now I dunno I dunno anything about this person other than what I see at the coffee shop so I'm like wow that person's doing great

Q: Yup

R: Um I don't know if I would necessarily see that with a someone with mental health uh brain injury problems um … … yeah

Q: It's interesting isn't it? I think about that too because I have the same experience I notice and I get excited about someone's quote unquote progress 'cause it's obvious and then I think hmm I wonder what ever happened to so and so who couldn't remember her kids' names

R: Uh hh

Q: And how would I know that how would I recognize that unless she told me

R: Right

Q: So it's really different

R: Yeah

Q: What drew you to this work?

R: *Hhh* uh th- heh oh you mean this

Q: Heh heh heh heh

R: Heh heh heh heh you mean

Q: Depending on what this means I'm thinking about you bring some special insights you have experience working with mental health issues um and now you're at a site where it's particular group of people all of whom are individuals we agreed on that and I'm interested … in what

R: Well actually this started um ... a long time ago when this center was kind of a a thought and *hh* I was over at the old hospital and um one of the founders there called me up 'cause my CV went in somewhere and he said wow this is you're exactly what we're looking for you have this background and this background and this background *hh* um would you be interested in working and I said weeelll I would be uuhhh however I … w- y'know ahem ahem I got into this thing ahem and I needed to take a job within a certain amount of time uh s- six months uhm and the person said uh well we're not ready to hire for another year year and a half … I said ok well uh um an'way I took another position got into this thing and um it was on the other side of the hospital heh heh and um actually when I was there a c- a colleague of mine said oh there's this place … … um across the street that's opening up and they have interviews and I want to interview for this position *hh* and I said oh my gosh that's the one that I

Q: Oh oh oh

R: That's for me and I wanted ok good luck 'cause s- this person's prior military and ... y'know I'm … not and so … um she went over and then uh they needed another person like me and so um she was able to um help coordinate I applied um *tsk* and uh got an interview over here and and so um i- to w- also for this *hh* is a promotion from where I was so

Q: Nice because you seem passionate about your work you seem interested in the details you seem

R: Well it's it's ver- it's something I didn't know

Q: Most people

R: I was a little scared of but now now that I know it I'm a lot more um ... … …you know I know what these people … go through I have some more insight of what their life is going to be like um … and they're uh y'know and um … their sacrifice is it's invisible it's um their sacrifice and uh everything … is just harder for them and it's gonna be even more harder because people don't see … what their um their challenge

Q: Yeah yeah

R: Is and so

Q: So it's um … it's a great place to be to be in order to help with that

R: Uh huh and I I'm much more knowledgeable about it so when people do ask me *hh* I'm armed with information so

Q: That's great that's great and I often wonder about see if you ever think about this everything about being in the Armed Forces is um predicated on able bodiedness and readiness mental readiness cognitive awareness um affective um appropriate affectivity and then for some people that changes abruptly well that might not be abruptly but it changes over time

R: Uh huh uh huh

Q: But often it's abruptly and I'm so interested … in … your thoughts about that because what a dramatic change for the person for the family for friends for com- c- colleagues for buddies

R: Uh huh uh huh

Q: what an abrupt change going from trained measured tested to … not … the same any thoughts about that does that come up do people talk

R: Yeah well what happens is that a lot of um people who have these mild injuries um uh they're tested *hh* and the tests that they have show that they're fine

Q: Hmm

R: And um … but the thing is when um *hh* you know if I'm sitting on the beach and someone else with a brain injury is sitting on a beach we look exactly the same *hh* um but … if there's any stress … that's where the energy of the other person it it just takes so much more energy so they can do it

Q: Mm mm

R: It's just y'know it's like if if you if you go to work … … I go to work I go home take the dog walk the dog er whatever I do um and then you know go to bed at ten o'clock .. the person with brain injury go to work come home eat and go to bed

Q: Wow

R: 'Cause that's they've already expended that that energy so there's no energy left for families

Q: Oh

R: For walking the dog for the kids or doing homework it's just *hh* not there so I think that's how it impacts and I think that people just need to be able to understand that that's the injury it's they just don't have the energy mm to do things like that and what they

Q: Yeah

R: What they need to do is figure out what how to um … manage their energy

Q: Mm

R: So the people who need it won't get their attention alone everybody gets … a little bit if attention

Q: Yeah

R: It's not gonna be the same but at least they'll get so- something

Q: And I guess that sounds as though that's something that they have to learn as the um new limit er not limit but um new way fo being

R: Uh huh

Q: That's something they have to learn about perhaps not even be discouraged about but say well that's how I am now and so what I do is this

R: Uh huh

Q: Or what I don't do is this

R: Yeah

Q: And it must take some uh practice

R: Yeah yeah

Q: And guidance

R: Yeah

Q: Um do people talk to you or the other that thing that comes up frequently for me and others talk to me about it is the surprise people have that it happened to them that they didn't d- they kne- of course it's dangerous of course you are serving and you know you're making a huge commitment *hh* and yet it's a surprise and when I've asked some people they've said that's because any of the many people are young and young people never think they're going to get injured or they're gonna get wounded but that isn't a consistent answer and I wonder if you can speak to that or if that comes up at all for you

R: Um … … … … no no it really doesn't come up even with some others studies I do there are other things um people coming from the outside … and they talk about their experiences but they never say I never thought it would

Q: Oh

R: Happen

Q: Oh thank you I can I wonder why that is do you think that's um … common for people in the f- for people in the Armed Forces

R: … well I think all … … … a gross generalization y'know one one of the enlisted guys um … y'know … they're risk-takers you know maybe they play sports they've already had a couple of concussions um maybe they've gotten into so- a couple of some fights or something I mean the- they're not … u- y'know the ones ready to go to engineering school or anything like that so I think they're a little bit more … of the risk-taker type … and uh

Q: So the physical part and sorta the idea of *tsk* of uh … suffering something is not necessarily something shocking to them 'cause used to … they're used to the idea of not risk or uh um danger perhaps

R: Yeah I think

Q: I don't want to put words in your mouth

R: No I think you know you see all these motorcycles you know lined up and uh ... *hh* … … y'know … I think that they're uh they've had prob'ly risky behaviors but they've gotten through them so *hh* so it just adds to their … um … being invincible and more ____ I don't know heh heh heh

Q: Hmph so you don't hear what I was just saying what I was asking about you don't hear about you don't hear people saying I never thought this would happen to me this is so unfair

R: No I not in the population I I work

Q: That's fascinating really interesting I I'm really responding throughout our conversation that uh uh thinking about um … understanding this population differently as you get used to them and then you can understand them better and they're not so intimidating and they're people and they're um a- a- again I really resp- I I really res- that really resonates for me because I ha- have had the same experience feeling very intimidated *hh* feeling as though I needed to be careful about everything I was doing then it really changed

R: Yeah

Q: It has changed so much so much

R: Yeah yeah

Q: So I appreciate that ... any other thoughts about … disability and deservedness that's sorta what I'm looking at

R: … … … … … no I don't think so _____

Q: No no it's interesting it's interesting that you uh that you really articulated well that the word disability is just not really not appropriate in this uh setting in this context

R: Uh hh

Q: It's just not appropriate and I I I'm interested in that um and then the deservedness side uh we talked a little bit about it we talked about um because of visibility and invisibility or because of

R: Mm mm

Q: Being able to appreciate changes or not it really

R: Mm mm

Q: Is different depending on the kind of wound illness or injury that someone might have and I just wondered if you have any other thoughts about that

R: No I just … no I think just the same that disability it just goes back they'll give somebody a crutch to fall back on and not work mentally and um I I really um am very passionate about mental health because *hh* it *tsk* … you really don't have much I mean you can not to at all minimize this but you can lose a leg and still have your faculties and after all the rehab you know have a job

Q: Yup

R: Pretty much live an ok

Q: Yup

R: You know ok life but the fact is *hh* you know you can talk on the phone you can interact with people you can go to parties visit with family um somebody who has mental health issues sometimes a bunch of times people are scared of them um they don't know how to interact with other people and therefore they can't get things done I mean I think it just it really has much more of an impact it's uh but I don't think y- uh y- I don't think you know I still I I I've worked in this field for so long that I I I tend to forget … … where society … is still with mental health and I I I would completely

Q: Good point

R: Clueless because uh I I just thought everyone was on my page and then I was like oh oh clearly not hmph

Q: Heh heh

R: Um but I think you know that people with brain injuries or ... um mental health diagnoses I mean there are a percent of just ___ of just difficult to deal with but they still are they start are *hh* they look at at least that their acts as one and their their injuries *hh* more as … … you just you know they look at it as well you know you don't have a strong enough will to beat this

Q: Yes yes

R: Like you know how people think uh uh and um try to say well imagine you broke your leg *hh* and then imagine you know somebody came with a sledgehammer and broke your leg

Q: *Hhs hhs hhs*

R: Are you just gonna say ok will that back you don't have enough will to get that bone back in place it's just you know

Q: Yeah see that's exactly I think that's exactly the kind of thing I wanted to uh think about together yeah

R: Yeah

Q: 'Cause uh uh my sense is uh very parallel to what you're talking about

R: Mm

Q: We might acknowledge it we might say oh yeah yeah I acknowledge that some people have mental health issues but when you think about how we … behave

R: Uh huh

Q: It's really different from what we say we say we recognize mental health is very important we say this we say that but you're right people are afraid of other people or they do get put off or they *hh* shun people or they stigmatize people

R: Uh huh

Q: Who look fine but they act weird or they don't remember stuff

R: Yeah

Q: So then you think oh well they're just stupid and you leave them alone or whatever

R: Yeah yeah

Q: And it's remarkable because it's central and you're quite right you can't compare suffering at the same time we need perhaps to think more about the way you think which is you know this is

… really important stuff this is really important stuff 'cause without your mental health you … have issues that you have to deal with all the time

R: I mean you lose so much more you lose a lot more you lose y'know support work companionship 'cause people don't understand and then it spirals

Q: Yeah and in some senses perhaps *hh* um … other kinds of support … I m- access to resources recognition

R: Uh huh

Q: Um … financial support

R: Uh huh

Q: Job opportunities internships it seems from what people have told me and what I've observed the reason I'm doing this work

R: Uh huh

Q: And getting support for it internally I'm so pleased is that un … it is really different the kinds of support you do or you don't get 'cause it looks like one person's trying and the other person's not trying or one person's hurt and the other person's not hurt and if when we talk about it together any of us we we would say oh no that's not really how I feel and yet it's kind of how we act

R: Yeah

Q: So it's really critical work to do *hh* and I'm so interested too that you're the people you work with … uhm are there because they really want to recover they really want to work at um recovery whi- prob'ly most people do but … it's interesting that uh just like in all military experience some things are so the same and some things are so different

R: Uh hmm

Q: So that it it's still people and they're still trying to recover and they're in a special place in order to t- to get the best kinda help they can to do the that

R: Uh huh

Q: So it's um it's pretty exciting

R: Yeah

Q: So it's um it's pretty exciting

R: Yeah

Q: I really appreciate it well thank you

R: Mm

Q: I will turn this off

Field Notes

During the course of my research I made hundreds of field notes; below are 40 that I refer to in my duisertation. I have numbered each line for reference.

13bFN
July 2012
0001 NMAs–paid $2000.00/mnth
0002 Often don't want to leave
0003 Branches treat W,I,Is differently–some try to get them "out" faster
0004 'Specially tough are the Reservists and National Guard who are called up and then can't be
0005 reactivated so are dismissed into civilian life and may have lost their jobs
0006 Bipolar got 100% and lost leg got 40%
0007 Based on capacity to work, to be hired
0008 So it "makes sense" because bipolar cannot be hired as easily if at all
0009 But it sucks because it seems unfair
0010 Mental conditions considered to be prior to enlistment and re-surface or surface due to or
0011 During active duty. NCMs and Nurses may regard them skeptically

020FN
May 2012
0001 After interview FC mentioned that several family members were/are in the military and that
0002 accounts for her/his positive attitude regarding matters and members of the military. Used
0003 the word "sad" a few times to relate the opposite of what her/his view is re: condition of
0004 wounded.

120FN
June 2012
0001 Met for one hour in NCM's office
0002 Self-identified Marine, severely internally wounded, 22 years old
0003 15 surgeries
0004 3 weeks induced coma
0005 Aerovac'd from Landstuhl
0006 15 months at Bethesda
0007 Invisibly wounded–bladder, hips, pelvis, rectum, colostomy, faces more surgery
0008 Glad to be alive
0009 Does not self-identify as disabled

0010 Believes those who rescued him (saved him) are more deserving than he
0011 Faces lack of understanding about the degree of his injuries and notes that WWs get
0012 Whatever they need or ask for or demand whereas others do not
0013 When people assume he's fine he tells them his story and they gain mutual respect
0014 Used the word *respect* many times
0015 Loves history wants to be a history teacher
0016 Recounted story of a ghost town in PA that he will visit (PA is where he's from). Story
0017 about a coal mine igniting and no one noticing for several years, then plumes of smoke
0018 noticed, then holes drilled to "see" what was going on. Holes provided additional new
0019 "fuel" (air/oxygen) and fire was re-nourished and sustained; town was evacuated; no way
0020 To staunch the fire; will burn for 300 years.
0021 Counseled friend who was injured stateside and who is participating in self-destructive
0022 behaviors; told buddy that he is as worthy as any one
0023 Counseled younger brother about not knowing the extent of what can or does happen
0024 Considers death as what "shoulda" not "coulda" happened to him – repeated
0025 Talks about Kasmir (sp) who was believed to be dead, then told he'd have to have his legs
0026 amputated and now is walking
0027 Describes amputees respectfully and with consideration and also notes that they have their
0028 limbs removed then get prosthetics and rehabilitation and they move on whereas he faces
0029 much more surgery, pain and recovery challenges
0030 Mentioned v*isible* and *invisible*
0031 Mentioned deservedness–"deserves" "deserved"
0032 Mother support
0033 No family in military (except grands)
0034 Everyone needs to re-think, re-consider
0035 People are part of a group in the military until they get injured, then they are individuals
0036 Thinking of or dealing with people as individuals is very different for military
0037 system/people
0038 Said Suck It Up many many times
0039 Wanted to re-deploy, now does not want to
0040 Re-considered because recovery has been long and difficult and he can no longer do what
0041 he was able to do before – and his squad is dispersed and or "out"
0042 Does consider himself disabled insofar as he cannot do daily activities
0043 Noted differences in force attitudes and NCM agreed – Army does not treat people the
0044 same, Army is less forgiving? Marines much more supportive
0045 We all talked about people moving on and how that's hard
0046 Talked about not "seeing" what happens when you push Ws and Is into areovacuation –
0047 then when at Bethesda you "see" what has happened what is happening – the extent
0048 Talked about miracles and uneven outcomes here (Bethesda)

140FN, 150FN
August 2012
0001 Civilian social workers who managed "Wounded Warriors," family members, and NMAs
0002 at WRAMC between 199_ and 200_
0003 Site: Coffee shop off site
0004 Arranged by: Meryia ran into them at a Metro stop in the summer, described our study,

renewed contacts, and asked if they would talk to us about their perceptions of the relationship between D&D at an MTF. We corresponded by email over the course of a few months and set up an initial meet and greet. They continue to work as social workers and care giving agents at another Federal Agency. They coordinate and manage care for family members who have been involved in disaters
We conversed for two hours at a coffee shop
Shared thoughts and observations regarding Disability and Deservedness
(*Name of participant*) characterized "wounded" –especially and perhaps exclusively, amputees–as having been 'sexy' for awhile
(*Name of participants*) both talked about high visibility, select attention, and celebrity visits for WWs
They get gear, stuff, gifts, donations (requested and not) events, invites, special participation–not available to injured and not offered to ill
Donations are often undirected–and may be unwanted, unnecessary
May take truckloads to transport all the "stuff" away when SMs are discharged
Talked about titanium jaw people – not visibly wounded and injured
Talked about "ill" not really "appearing" at all–they were very sensitive to and cognizant of the low visibility of presence of "ill" in discussions and acknowledgement of those who have served and sacrificed.
Talked about an example of a teacher or parent who wanted to bring children to "see" visibly and grievously wounded SMs to dissuade them from enlisting–familiar to DM.
Under-values life and experience of SM ("zoo animal"), and does not necessarily dissuade.
Role of NMAs and family members
Invited to be her –yet not necessarily supported in expected ways
(Infra)structural, systemic, and cultural conditions are all factors of "success" or "failure" in recovery
Talked about someone who had not used a prosthetic (arm) because it was uncomfortable (even non-functional) and whose recovery was regarded as less successful (Messinger writes about this)
Talked about a Michael Moore film from 2004 that unfairly positioned and described wounded participants–some of whom had not given consent to be included and whose roles and subjectivities were distorted
We all talked about Dawn Halfaker and her upper extremity loss, recovery and adaptation
Talked about the inordinate attention, gear, space and visibility that (highly visible WW) got we did not talk about her battle buddy who continues to go virtually unmentioned in all accounts
Upper extremity loss more difficult to adapt to, especially for women, than lower extremity loss
Guys always have gadgets
They talked about a checklist they have developed for another constituency of family members who are asked to come to sites where people have been wounded injured–and killed
What to expect
What will and will not be included or supported
People vary–some try to take advantage, others do not (reimbursement for example)

0048 Talked about Congressionally mandated change in coverage, post 2004–from KIA family
0049 gets no benefits to KIA family gets benefits
0050 Gave many poignant and funny examples of the extremes people go to, the advantages,
0051 benefits and support some have and others do not
0052 Framed observations within context
0053 Often people do not know that they can be more visible; or, that their visibility is
0054 overshadowing equally deserving others
0055 Mentioned some celebrities and/or visitors who do distribute their attention equally
0056 What is the point of doing research about this subjects (and its subjects)?
0057 To acknowledge others' experience
0058 To educate participants at every level
0059 To help manage expectations
0060 To re-frame what is possible
0070To listen to people who are grateful to be heard

251FN
February 2011
0001 (*Name of ex-military curent contractor*) and I stood silent as we watched the promotion
0002 ceremony of a disabled Marine, a double-amputee in dress uniform, being acknowledged
0003 for heroism, accepting his new ribbons, saluting and taking his pledge while seated in a
0004 wheelchair, surrounded by buddies, family, officers, and onlookers. We were in the lobby
0005 of a residential building at a military treatment facility (MTF); a hotel for recovering
0006 patients, family members, and non-medical attendees (NMAs). Although we did not know
0007 each other, (*name of ex-militarycurrent contractor)* began to speak to me as the ceremony
0008 ended, and he continued for 40 minutes. "I'm ex-Army" he began. "My whole family is
0009 military. Uncles, cousins, my dad. I know about this. I've been deployed. I know what it's
0010 like. But it still shakes me up. This kid is 22 maybe, 24. He had no idea. Kids don't
0011 understand the risks. No one understands the risks. My whole family is in the military and
0012 we don't even understand the risk."

252aFN
May 2010
0001 "It's funny" said an officer during her retirement ceremony. She had just turned 39. "I
0002 joined up because I saw an ad on TV showing soldiers zip-lining across a deep gulley and I
0003 wanted to do that too. But during training I cried every night. I wrote a letter to my mom
0004 every day telling her I wanted to come home. I'd never been away from home before.
0005 When I got to basic I wanted to go home. I wished I'd never left. But now that I'm retiring
0006 I dunno. It's funny. I had the best career I could have imagined. I loved it. I got
0007 opportunities and experiences I could never have got anywhere else. The Army is my home
0008 now. I still don't want to leave home–but now it's the Army I don't want to leave. Go
0009 figure huh?" Her mother joined her on stage at the end of the ceremony."I just wanted y'all
0010 to know" she said. "I still have all those letters. In fact I have them right here." She held up
0011 stacks of letters, bound with ribbons. "Welcome back home honey. We're still here.".

252bFN
Septmeber 2010

0001 Later the officer and I sat together while she was waiting for some out-processing
0002 paperwork. "Just being in the Army is disabling" she offered without prompting. "I mean
0003 I've got lots of conditions. Lots of percents. I'm going through this out-processing. It's taking
0004 months. I have to go back and forth with the company and the VA to get my ratings. I'm
0005 fighting for everything I can get. Like my eczema." Many people with whom I worked and
0006 some of whom I interviewed referred to their division of the Armed Forces as "the
0007 Company". I asked her about this usage. She said she meant 'the Army' when she said 'the
0008 Company.'

254aFN
January 2012
Nurse on 4C WRNMMC (WW unit)
0001 Well you know I'm from the civilian side so I see the difference I mean ha ha in the
0002 military we just do whatever we get these guys you know these guys come every Friday
0003 and every Sunday and we just do whatever they're in the military you know so thay have
0004 much worse stuff going on than civilians with the same kinds of stuff I mean all the dirt
0005 from over there all that bad stuff we have to do whatever and we just kinda say well you're
0006 in the military so whatever we're gonna try this and do that and there is a big benefit to the
0007 civilians later but on the civilian side you know there's all this stuff we have to be much
0008 more careful and there are all these you they we have to treat them differently with more
0009 safeguards and rules and protection but here in the military we do whatever and we have to
0010 because they have so much stuff and we do what we can. I have so much to say about this
0011 and I have written about this and I have an journal article coming out in Nursing Health and
0012 I really want to do more with this research I want to do more research even though I don't
0013 know where I'll get the time whatever with two kids but ha ha I really want to write about
0014 this and do research and get my work out there there is so much to talk about

430aFN
March 2012
0001 "Now I sort of see what you mean" said a medical specialist. "I had a patient who was
0002 active-duty for 27 years. She was aerovac'd from Iraq when docs there realized she had colon
0003 cancer. Stage 4. She came here to the oncology ward. And she got very pissed when she saw
0004 that wounded warriors were getting attention and special stuff that she did not have access to.
0005 It made her mad. So she rounded up some other patients who were sick and they pushed hard
0006 for the same kind of goodies. And they got 'em–at least some, before she died here. They
0007 got some big screen TVs in their ward. And some DVDs."

430bFN
July 2011
0001 A colleague and I submitted a research proposal to the Institutional Review Board (IRB) at
0002 Walter Reed Army Medical Center in Washington DC (WRAMC) in July of 2011, just
0003 weeks before the base was to close and merge with National Naval Medical Center
0004 (NNMC) in Bethesda MD as a result of congressionally mandated Base Realignment and
0005 Closing legislation (BRAC) that had passed in 2005. The merger would form the largest
0006 MTF in the world: Walter Reed National Military Medical Center (WRNMMC). Before

0007 being appraised and approved by the IRB and Human Use Committee (HUC), our proposal
0008 needed to be evaluated by the Scientific Review Committee (SRC).
0009 The SRC Chair required some changes to the proposal in which we had articulated our plan
0010 to study the lived experience of wounded warriors who are in rehabilitation and who have
0011 participated in research. We used the term wounded warrior advisedly because of its
0012 prominence in military settings as the broad descriptor of members of the armed forces
0013 who have been disabled since 9/11. We were aiming to probe the ethics and effects of
0014 conducting research on multiply vulnerable human subjects, i.e., people who have
0015 renounced their autonomy by joining the military, who are ranked, who are solicited by
0016 people who may have authority over them, and who are disabled.
0017 "What about active-duty service members who have been disabled by cancer?" the SRC
0018 Chair asked in her written response. "Or HIV/AIDS? Why are you not including them?
0019 Arguably they've made the same sacrifice as service members injured in combat. And
0020 many have participated in research. Before I release this protocol to the IRB and HUC you
0021 need to change your subject population" she wrote, "to include wounded, ill, and injured."
0022 We did, and the study was approved in September 2011.

480FN
April 2012
0001 Informal interview at a coffee shop
0002 40s, Caucasian female
0003 Has worked at VA for 6 years
0004 "always was a government person" "always planned to work for the government"
0005 "always says 'thank you for your service' to military personnel not because I believe they
0006 want to hear it - because that's how I feel" "Applied for many government jobs after
0007 graduating from law school and got a position at VA" in (claims and adjudication?)"
0008 current office/department
0009 Cheerful, energetic, passionate, about her work
0010 Referred me to a non-profit in Baltimore that treats and transitions addicted vets – McVets?
0011 Mentioned several times that the facility is like military barracks. Spare, rule-driven, tough,
0012 success measures central. Kicks people out who relapse. Promotes people who succeed to
0013 next level, i.e., private bed not bunks. Hard to get into. Mirrors military – structured, rule-
0014 bound, hard to get into and stay in, has concrete measures of success and rewards for
0015 achievement.
0016 She and her leadership classmates were unaware of this detox and training facility and its
0017 mission. They were introduced to graduates who had acquired jobs and overcome their
0018 addictions.
0019 Lawyer who adjudicates Veterans Administration Benefits
0020 Studied constitutional law at George Washington (or Georgetown?)
0021 Graduated 2012 among 80 people in VA leadership course
0020 Self-identifies as a patriot
0021 Does not have family members in the military (except deceased grandfather)
0022 Points out the differences between WWII Vets and Vietnam Vets wrt claims
0023 WWII claim late and little are understated and downplay their Service, Vietnam Vets claim
0024 much more, earlier and express entitlement even bitterness

0025 Because of VOW legislation, including mandatory training for VETS with respect to
0026 claiming benefits, 500,000 new claims will be processed
0027 Emphasized "choice," and "individual choice" when discussing enlistment.
0028 Dismissed politely and energetically the idea of air quotes/scare quotes around the
0029 expression voluntary force
0030 Was receptive and supportive of research and offered to be a backstop, sounding board,
0031 person to continue to talk to and run ideas by
0032 Agreed with and discussed VAs burgeoning needs (resources, people and money) and
0033 demand (expanded pool of informed people with claims)
0034 Discussed how claims can be appealed regionally (VA); nationally (VA); then beyond VA
0035 to Regional Court, Circuit Court and Supreme Court
0036 Noted that claims can be denied and appealed and often are; few move beyond VA
0037 jurisdictions, fewer move beyond regional civilian courts to circuit courts or Supreme
0038 Court
0039 Maryland Center for Veterans 41o-576-9626. 301 High Street Baltimore
0040 No "soft landing" for service members who are no longer active-duty
0041 Friend who talks about difficulty of transition and who seeks to help
0042 Service members feel "different," when in unstructured spaces/conditions very challenged
0043 Structure, frame, very important; talked about joy/passion of taking pictures when traveling
0044 and how that enables her to understand where she is and what's there. Her husband bought
0045 her a very very nice camera–she emphasized how nice it is–that has transformed her
0046 travel experience. She took 1000s of pictures while traveling to (name of country)
0047 VOW Act–with respect to employment for vets, august of 2012 will be enacted (?)
0048 Mandatory TAPs participation for exiting vets
0049 Only 30% currently take TAPs
0050 Mandatory extensive training to learn how to file claims

490aFN
May 2009
0001 When (*name of speaker*) asked her audience in the spiritual center at AU how many people
0002 knew someone in the armed forces, only one person raised his hand. (*Name of speaker*)
0003 asked him if he wanted to comment and he did: He explained that he had joined one of the
0004 forces because he wanted to, because he was attracted to the benefits and that he was
0005 neither poor nor ignorant nor duped – and furthermore that he was still glad he had joined.
0006 (*Name of speaker*) made a big deal about how when she speaks at private universities no
0007 one knows anybody in the military and when she speaks at community colleges everyone
0008 does.
0009 Her point is sophistic. The group in attendance at AU that evening were primarily Anthro
0010 students–they were self-selected anti-war, anti-militarization, and anti-militarism listeners.
0011 The fact that they indicated they didn't know anyone in the military is bogus since there are
0012 students at AU in the military–even in the Anthro Dept.
0013 So her point was false–it made a false correlation; but no one argued. Several people
0014 indicated to me that they were surprised–even disappointed–that I didn't argue with the
0015 person who spoke out. There was nothing to argue about. He was recounting his lived
0016 experience from his perspective. That was not respected.

0017 More than that, she indicated that the fellow who was a member of the military forces was
0018 wrong about his own experience.

490bFN
May 2009
0001 I lingered to talk to the speaker. "Thanks for your remarks" I started, wanting to ask her
0002 more about her response to the audience and the military service member. She interrupted
0003 me and headed away. "What are you doing about militarization?" she said shortly. "How
0004 are you making a difference?" She was gone before I could reply.

520FN
July 2012
0001 On the phone an active-duty female SM on medical leave and at school for her PhD
0002 describes herself as a wounded warrior who was in the warrior transition unit then says
0003 "well no, I'm injured, not wounded"

540FN
February 2012
0001 Today in a presentation at WRNMMC WW's were described as "the most deserving of all
0002 patients."

550FN
July 2010
0001 During his interview the participant explained, "I'm not a wounded warrior ma'am. I just lost
0002 my leg when I got run over by a truck." "Where were you when that happened?" I asked.
0003 "Down range. In Iraq" he replied. "So how do you describe yourself now?" I continued.
0004 "What do you mean?" he asked, "How do I describe what?" "Your status" I said. "Oh. I
0005 guess I'm uh well I guess I'm injured kinda. But it's not bad. I just lost my leg. A lotta other
0006 guys lost a lot more than me." The participant stroked his leg where his stump and prosthetic
0007 leg socket were joined. He was using a new leg and when I asked about it he said, "Oh pretty
0008 good ma'am. It fits pretty good. Better than the last one. You know, you get used to it."
0009 What next?" I asked. "Just tryin' to get home ma'am. Just tryin' to get outta here."

560FN
October 2011
0001 I had my hands full leaving Building 62 where I got lunch to go at the Warrior Café. An
0002 amputee held the door open for me. He was balancing nicely. On the back of his T-shirt I
0003 read a single printed sentence: I HAD A BLAST. "Nice shirt," I said. "Thanks ma'am." he
0004 replied as he followed me out.

570FN
May 2010
0001 "So what are you up to?" a senior officer asked me while I was sitting in the lobby of one of
0002 the wounded warrior barracks reaching out to potential Qigon research participants. He was
0003 wearing the Army Combat Uniform (ACU) so only by noting a small emblem was I able to
0004 discern his rank. I started to talk to him about my research. He interrupted. "You know

0005 ma'am" he said, shaking his head. "It's hard to say. A lotta these guys–and gals too–they
0006 may seem
0007 pretty beat up but it's hard to say. I know 'cause I do *dis*ability I interview these folks and
0008 some of them have a pretty good story. They come into my office like they're all beat up.
0009 And they have a lot on their minds, a lot to say. Then after they leave I look outside and I see
0010 them walking just fine. So I dunno. It's hard to tell. It's kinda getting to me actually," he
0011 continued. "I can't tell any more. I can't tell who deserves what. I feel like I'm going nuts. I
0012 feel like I need help 'cause I can't figure it out anymore. And that bothers me. I'm starting to
0013 feel *dis*abled myself. I can't sleep properly. It's starting to get to me."

590FN
April 2010
0001 At a Smithsonian & Navy conference in Washington DC about "Wounded Warrior Care" a
0002 Marine who is a double amputee participated in the afternoon panel. The panelists
0003 discussed their lived experiences of becoming *dis*abled while serving as active-duty
0004 members of the military, or of caring for an active-duty member of the military who had
0005 been *dis*abled. The Marine was in dress uniform, walking on prosthetic legs and using two
0006 canes. He wore many medals, including the Purple Heart. The moderator asked all the
0007 panelists to recount their individual stories. After telling his story of being blown up while
0008 in combat, being aware of losing his legs, and being aerovac'd to Germany and then to the
0009 United States, the Marine insisted on the importance of maintaining distinctions between
0010 "wounded," "ill," and "injured" SMs so that those like him who had been *dis*abled in
0011 combat would be recognized appropriately. He said he was angry that *dis*abled SMs who
0012 had become ill or injured might be lumped together with Wounded Warriors, and might
0013 then be accorded the same degree of respect, reward, and recognition without regard to
0014 their actual sacrifice.

600FN
April 2010
0001 On the same panel, a woman described her experience as the spouse of a military service
0002 member (SM) who was deployed shortly after their wedding, and who returned after a few
0003 months having sustained totally *dis*abling brain and spine injuries that rendered him unable
0004 to move, to speak, or (apparently) to comprehend his surroundings. "I never in a million
0005 years ever even fathomed this being an outcome of him going over there. He wasn't like he
0006 was supposed to be. He's *forever changed.*" Her use of this phrase struck me because in
0007 many conversations with able and *dis*able(d) SMs I had heard them say, when describing
0008 their experience being in the military: "Being in the military means being 'forever
0009 changed.'"

610FN
September 2010
0001 Several months after the Wounded Warrior Care cCnference at the Smithsonian, I watched
0002 an online documentary about the female panelist and her *dis*abled spouse. In it the narrator
0003 said, "This isn't what people think of when they think of injured soldiers. Five or ten years
0004 ago people weren't surviving these kinds of injuries. When there are two wars going on,

0005 being a military wife takes a certain kind of toughness. But nothing could prepare her for
0006 this." (Nyier 2010:2).

611FN
June 2012
0001 Met with Ms. (*name*) NCM for SMs and beneficiaries Division Head via CDR (*name of*
0002 commander) to discuss requirements for presenting an in-service to Nurse Case Managers
0003 at their Staff meeting June __, 2012.
0004 CDR (*name of commander*) had invited me to speak and had cc'd Ms. (*name*) and told me
0005 she would be the POC while the CDR was TDY. Ms. (*name*) was cc'd on the mailed
0006 invitation. I tried 4 times to connect with her to find out where, how many people, and how
0007 long?
0008 She was not there when we had agreed to meet and I left a note, and some materials,
0009 including a card.
0010 When I came back 30 minutes later she was peremptory. Uninterested, negative, abrupt.
0011 (*name*) said: "Is this yours too?" holding up our Researching Research flyer.
0012 "I wish you had been doing this earlier in the war when we needed it … in 2006 when we
0013 had some good data."
0014 I told her we are conducting many studies.
0015 She asked me what I wanted from our meeting. I thanked her for meeting with me and
0016 indicated that I needed to know the number of people, the amount of time I would have,
0017 and the location.
0018 She seemed impatient and gestured broadly in the air with her arm to identify the location–
0019 "you know the conference room … over there." On this floor, I asked her? She frowned
0020 and said impatiently "Yes, this floor."
0021 "What are we supposed to do?" she asked "Are we supposed to find patients for you?"
0020 "Well," I said, "You can help us yes, by referring us to people, by encouraging people to
0021 talk to us. By letting us know who we can talk to."
0022 Someone interrupted us and apologized and said she could come back.
0023 Ms. (*name*) looked at me impatiently. "Are we done?" she said abruptly.
0024 "Sure," I said, and left…
0025 Blocking access? Angry that we're reaching out? Not enough forewarning? Unwelcome
0026 pressure to accommodate me?
0027 Defensive? Overwhelmed? Irritated by research? Irritated by inappropriate research?
0028 Reminder of blocking that occurred when we tried to get access to this population 2 years
0029 ago via NCMs. Do they want us to be unable to listen? To ask? Do they not want us to
0030 hear?

620FN
March 2012
0001 "I've been working here since 2003 and I've never heard those terms 'wounded,' 'ill,' and
0002 'injured.' All we ever say around here is Wounded Warriors. That's what we're used to,
0003 that's what we've been taught to say, and that's what we say" commented a member of the
0004 (*oversight*) Board who was critiquing my research proposal before it could be released to
0005 the (*oversight*) Board at WRNMMC. "Why would we start to use those terms now?
0006 What's the point?"

630FN
July 2012
0001 Towards the end of my fieldwork, a poster appeared on easels stationed throughout Walter
0002 Reed National Military Medical Center (WRNMMC): "WE NEED YOU!" it read. "Town
0003 Hall Meeting For Wounded, Ill, and Injured Service Members and Your Families. Help us
0004 address important issues that affect YOU, our Wounded Warriors, and your families, at
0006 WRNMMC and the NSA Compound. Building 17 Gymnasium."

640FN
July 2012
0001 I talked to a couple after a Town Hall Meeting "For Wounded, Ill, and Injured
0002 Service Members and Your Families." The woman pushing a double amputee in a
0003 wheelchair said, "He's not handicapped." The man twisted backwards, beamed up at her
0004 and said, "Nah, it's HANDI CAPABLE!" They both laughed.

650FN
November 2010
0001 During the promotion ceremony of a Marine double-amputee I stood quietly with a staff
0002 member in the lobby at one of the "wounded warrior" residences at Walter Reed. While I
0003 had often seen him, I hadn't met him or talked to him prior to that day. Although neither of
0004 us was formally included in the ceremony, we both stood up and fell silent as the SM was
0005 honored for his service and sacrifice. As always happened during my fieldwork I was
0006 fraught with conflicting feelings and was privately struggling with why I was standing,
0007 why I was silent, why I was deeply moved. The staff member next to me broke our silence,
0008 saying quietly, "You know I'm ex-military. My whole family. Brothers, two uncles, my
0009 dad. I was in for twenty years. Retired in '08. And I still don't get it. I don't get why people
0010 join up. Look at this guy. No legs. Lots of medals. New rank. No legs. You know? Don't
0011 they get the risk? Why don't they understand how dangerous it is? Why don't they get it?
0012 Look as this guy."

670FN
April 2010
0001 "Hi there" said an officer visiting our research cell. "I hear you're completing your PhD.
0002 What are you researching?" I explained my interest in *dis*abled military service-members,
0003 in deservedness, and rehabilitation, and subjectivities. He listened patiently without saying
0004 anything. I continued, trying to make a connection that would prompt a response. "I
0005 worked in corporate marketing for a few decades. I sold my soul and I'm trying to see how
0006 much it will cost to buy it back" I joked. He looked at me impassively."Thank you for your
0007 service" he said. Later I learned that he serves at the Pentagon as a military health-care
0008 policy advisor. I saw him periodlically throughout the three years I conducted research and
0009 he always asked me about how it was going, what I was finding, and how I thought it was
0010 significant.

680FN
August 2010
0001 After the conclusion of a two-day workshop about federal grant administration, one of the
0002 guest speakers and I were sitting in the lobby of the conference center waiting for our
0003 shuttle buses. This speaker is a Navy captain and researcher, and she had addressed ethics,
0004 integrity and compliance in reporting. She had illustrated her remarks with very funny
0005 anecdotes about the vicissitudes of her own research reporting and the many unnerving
0006 times she had had to report deviations, adverse events, and non-compliance. We chatted for
0007 a few moments and she asked me about my work. I talked briefly, and she sat quietly. Then
0008 she asked me "What's the most popular saying in the Armed Forces?" "Hmm" I replied,
0009 "Not sure. Is it HOOOAAAHHH?" "No," she said. "It's 'Offer it Up'. Remember that. I
0010 think you'll do fine with your research."

700FN
May 2010
0001 Whenever anyone is asked to think about whether designations of wounded ill and injured
0002 are linked recognition and access to resources (i.e., deservedness) THEY INITIALLY
0003 RESPOND SKEPTICALLY AND THEN BEGIN TO TELL STORIES.
0004 Stories of patients who are ill, who have HIV/AIDS and who are neglected, unconsidered
0005 Clinician who related stories about ill and injured patients in clinic waiting rooms who
0006 were bypassed as "wounded (warriors)" where moved ahead in line–seen faster, earlier.
0007 Quadruple amputee at MATC who described his dinner with President Obama.
0008 Soldiers using prosthetics whose progress ins notable obvious and heralded while others
0009 who's wounds are invisible are not noticed–at Qigong class, in waiting area of MATC, on
0010 sidewalks, driveways, pass-throughs, eating facilities, after Town Halls
0011 On the other hand, reviewer at WRNMMC who pushed back when plan for LE for
0012 Research participants did not specifically include or allow for "ill" in recruitment and
0013 eligibility planning–and again, questioned researcher's plan for recruitment and eligibility
0014 screening for Dis and Deserve protocol
0015 (*Particular study*) participant who said he wasn't really wounded–he only got run over by a
0016 truck and lost his leg. "Not nearly the sacrifice of other soldiers who have been wounded in
0017 combat."
0017Marine at Smithsonian/Navy conference who insisted on maintaining distinctions between
0018 WIIs so that those (like him) who had been injured in combat would be recognized
0019 appropriately. He was defensive–even angry–that wounded Service members might be
0020 lumped together and even more angered by the idea that they all might be accorded the
0021 same degree of respect, reward and/or recognition.
0022 I wonder if the average college student is any less a dupe than the average military enlistee.

710FN
September 2010
0001 The amputees and other gravely wounded warriors wait for their appointments at MATC in
0002 a room that has a big big-screen TV showing breaking news of deadly marketplace
0003 explosions in Afghanistan (or?) Iraq. They sit in various states of ability watching their
0004 "brothers in arms" engaged in mortal hostilities.

720FN
April 2010
0001 When she sees that I am frustrated or anxious LTC (*name*) asks, "Did you still have your
0002 helmut? Did you have a place to pee? Did anybody die?" When I respond she says, "Well
0003 then, move on."

730FN
August 2010
0001 An active-duty Army nurse who has been furloughed from bedside care because of her
0002 PTSD joins our team as a support person. We find ways to keep her busy, and she is asked
0003 to accompany me to the MATC clinic to recruit potential participants for the (*name of*
0004 *study*). She has her ACUs on. Within a few minutes of getting set up at the table in the
0005 clinic she says "I can't take it here. I can't see these wounded warriors. I can't work with
0006 patients anymore because I can't take it. I can't sleep. I keep seeing them. I worked in the
0007 burn unit and I can't get them out of my head. We lost some and I keep seeing them. I was
0008 deployed in Iraq and my nerves are gone. I take sleep medicine and it doesn't help. I have
0009 PTSD. I sleep just a few hours every night. I can't sleep. This is wrong. We have to stop
0010 this somehow." She notices a warrior she had cared for in the burn unit some months prior
0011 and goes to him. He is in a reclining wheelchair and she crouches down so she can speak in
0012 his ear. He recognizes her and is very happy to see her, to talk to her, to listen to her. She
0013 tells him how happy she is to see him, how great he looks, how much he has improved.
0014 Then she urges him to sign up for (*particular intervention*) because it will help him with
0015 pain, and sleep problems, and stress. She comes back to the table and says "I can't stay. I
0016 need to go. This is wrong. We have to stop this somehow. You know the patients all have
0017 pysch teams, and the families do too. Well now we have to have them– the nurses have to
0018 have psych teams too."

750FN
July 2010
0001 I told (*name of Colonel*) that I had looked up the recent congressional testimony of (*name*
0002 *of retired Army Major*)'s husband, a much-decorated senior Colonel who is advises the
0003 Armed Forces regarding TBI, PSTD and suicide. "(*Name of Colonel's husband)* has
0004 presented testimony to Congress too" said (*name of Colonel*). "You should look him up." I
0005 did. (*Name of Colonel's husband)* was the Surgeon General of the Army National Reserve
0006 and now serves at the Pentagon as a military health-care policy advisor.

760FN
August 2012
0001 In the summer of 2012 I was writing the closing chapters of my dissertation and reading
0002 Andy Bickford's book, *Fallen Elites*. One morning while riding on the DC Metro Red
0003 Line I was completing a passage in Dr. Bickford's book about *doublespeak* when we got to
0004 Medical Center, my field site stop. In the passage Bickford refers to Carol Cohn's seminal
0005 article about doublespeak among nuclear scientists. I flipped to the reference section to see
0006 which source he was referring to: an edited volume by Scheper-Hughes and Bourgois
0007 1987(2004).

0008 I folded the corner of the page, and left the metro car. As I started up the escalator I heard a
0009 Metro system broadcast: "Due to the National Capital Area Metro Transit Improvement
0010 Plan, the following Metro system elevators are in rehabilitation;" a long list was then
0011 announced.
0012 Improvement? Plan? System? Rehabilitation?
0013 Perfect.

770FN
April 2010
0001 A few days before, in the same location, an apparently able-bodied soldier dressed in the
0002 Army Combat Uniform (ACU) asked me to write something down for him. "I have trouble
0003 remembering" he said. "I can't write anymore so I forget things." He showed me his
0004 Blackberry. "I have this," he continued, "But it's hard for me to understand what it says.
0005 Could you just write down that telephone number for me please? I don't want to forget it."
0006 I said sure, and told him my name. "Deb," he repeated. "I don't remember my name so
0007 well, so here's a card that says it." I read his name "OK (*his name*)," I responded. "I'll
0008 write down the number that's on that poster. Keep this paper and ask someone to help you
0009 read the number later." "Thanks" said (*his name*), and he left. Later I saw him walking in a
0010 hallway on post near Burger King. I said hi but he didn't seem to recognize me and did not
0011 reply.

780FN
September 2010
0001 "I've gained nearly forty pounds" said an SM quietly when we talked in the waiting room
0002 of a clinic for patients in the warrior transition unit (WTU) at an MTF. He had had his
0003 pelvis, hips and legs amputated and was using a wheelchair. He wore a baseball cap and
0004 kept his face lowered under the brim. "When I got here I was nearly dead. I weighed less
0005 than 80 pounds. I used to weigh 175. Everybody thought I wouldn't make it. But I did. I'm
0006 here. I don't talk too much about it. But everyone's surprised. Me too."

790FN
April 2010
0001 While I was sitting in the reception area of an amputee clinic at an MTF a young quadruple
0002 amputee wheeled in, and started talking about having dinner with the President the night
0003 before. "I was sitting beside him," he said. "He talked to me like a regular guy. When he
0004 found out I was from Hawaii we had a lot to talk about."

800FN
June 2010
0001 For a year I recruited wounded warriors to participate in Qigong classes as part of my
0002 responsibility coordinating a feasibility study that was approved and conducted at
0003 WRAMC. The study's primary objective was to see if it would be practicable to enroll
0004 members of the warrior transition brigade (WTB) into ten weeks of classes in Qigong, a
0005 mind-body practice that is the basis for Tai Chi and many martial arts and a complementary
0006 alternative medicine (CAM) recovery intervention. The secondary objective of the study

0007 was to see if the practice of Qigong would positively affect wounded warriors' self-
0008 identified sleep, somatic, and stress symptoms.
0009 As part of my job I conducted exit interviews with participants. To remind them to set up
0010 appointments with me I visited classes from time to time at the end of the 50-minute
0011 sessions. I wanted to be sure that the participants knew me and would respond when I
0012 called or texted them. At the end of one class I noticed that a participant who had been
0013 having trouble with his prosthetic leg when I first met him seemed much more comfortable
0014 and was walking well. "Wow ___" I said. "You're walking really well. How's it going?"
0015 "Much better ma'am" he replied. "This leg fits better and it's going pretty well."
0016 "Awesome" I answered enthusiastically.
0017 Out of the corner of my eye I saw another participant gazing at us as we spoke; an
0018 apparently able-bodied person who was eligible for enrollment in this Qigong class because
0019 of self-identified and diagnosed traumatic brain injury (TBI) and post traumatic stress
0020 disorder (PTSD). My attention had not been drawn to this person because there was no
0021 apparent change, no signal of improvement, nothing visible that had caught my eye and
0022 attracted my attention.

810FN
July 2010
0001 In the lobby of a residential building for patients in rehabilitation at an MTF, and their
0002 families and NMAs, a very young-looking woman pushed an equally young-looking
0003 disabled man in a wheelchair while she carried a toddler, a diaper bag, and a military
0004 backpack. She spoke to the man from behind as she wheeled him into the dining room. He
0005 did not respond to her. When I greeted her she did not respond to me.

APPENDIX B

INTERVIEW GUIDES, INFORMED CONSENT DOCUMENTS, RECRUITMENT MATERIALS, AND DEMOGRAPHIC DATA SHEET FOR MILITARY BENEFICIARIES

IRB-APPROVED INTERVIEW GUIDE 1

For family Member or Non-Medical Attendant who is supporting a Wounded, Ill or Injured Service Member being treated at Walter Reed National Military Medical Center in Bethesda, MD

Script

I'm Deb. I'm a civilian anthropologist conducting research about your experience as a family member or non-medical attendant at Walter Reed. I'm interested in understanding two things: Whether you think about your Service member as being wounded, ill, or injured; and how you experience him/her getting recognition and access to resources. By resources I mean things like attention from others, parking privileges, special accessories or equipment, special accommodations and the like.

[OR

I'm Meryia. I'm a nurse conducting research about your experience as a family member or non-medical attendant at Walter Reed. I'm interested in understanding two things: Whether you think about your Service member as being wounded, ill, or injured; and how you experience him/her getting recognition and access to resources. By resources I mean things like attention from others, parking privileges, special accessories or appliances, special accommodations and the like.

I'll ask you some questions and listen to your answers. There aren't any right or wrong answers, and you can quit at anytime.

I'm going to record our conversation so I don't forget anything - OK with you?

IF SUBJECT SAYS YES, CONTINUE.

IF SUBJECT SAYS NO: OK, I won't record our conversation. OK if I make notes then?

IF YES, SHOW PAD AND PEN

Thanks.

START 2 TAPES (digital primary, and analog back-up)

This is Deb with participant # _____. It's (date _____ and time _____).

What you say is important to me. I will ask some questions and listen to your answers.

I may ask you to repeat some things so I'm sure I understand what you mean. And I'm going to read the questions so I don't forget to ask any.

1. First, do you have any questions about the consent form that you signed?

2. Where do you hear the words "wounded warrior"?
    a. Can you tell me a little more about that?
        i. What does the term wounded warrior mean to you?
            1. Can you tell me a little more about that?

3. Where do you hear the words "wounded, ill and injured" together?
    a. Can you tell me a little more about that?
        i. What do those different words mean to you?
            1. What does wounded mean to you?
            2. What does ill mean to you?
            3. What does injured mean to you?

4. How do your family members or friends refer to your Service member?
    a. If they say wounded warrior what do you think they mean?
    b. If they say wounded, ill or injured what do you think they mean?

5. What kinds of medical issues your Service member being treated for?
    a. Since when?

6. When you think about your Service member being here, how do you describe him/her?
    a. When you talk to family members or friends, how do you describe your Service member?
    b. When you talk to other family members or non-medical attendants, how do you describe your Service member?

7. What does disability mean to you?

8. In what ways do you think of your Service member as disabled?

   [OR:
   a. In what ways do you think of your Service member as capable?

9. How do other people talk about your Service member's disabilities?

10. Tell me about recognition you see your Service member getting?

11. Tell me about recognition you don't see your Service member getting?

12. Tell me about the resources your Service member has access to?
    a. Like special privileges, or special attention?
    b. Or training or employment opportunities?
    c. Or special equipment or things like DVD players or big screen TVs?
    d. Like parking privileges, attention from people, training or employment opportunities, inclusion in social activities?

13. Tell me about recognition other Service members get here or elsewhere?

14. Tell me about recognition other Service members don't get here or elsewhere?

15. What are some other resources you can think of?
    a. That your Service member does have access to?
    b. That your Service member does not have access to?

16. When people outside of this facility talk to you, how do they talk about your Service member's military service?
    a. Tell me what that means to you?

17. When people outside of this facility talk to you, how do they talk about your Service member's disabilities?

18. Describe what it's like for you to be around people who do not seem to be wounded, ill or injured?

a. When you're around family members for example?
b. Staff?
c. Cadre?
    i. At the galley for example?
    ii. At building 62 for example?
    iii. At Subway or Dunkin' Donuts?
    iv. At the post office?
    v. At the credit Union?
    vi. At Main Street?

19. Tell me a little about what you expect for your Service member when he/she leaves here?
    a. How do you know that?
        i. Who told you that?

20. Do you want to tell me anything else?
    a. About how your Service member gets recognized?
    b. About how your Service member gets access to different kinds of resources?

21. Do you want to tell me anything else about being a family member (or non-medical attendant) here?

OK – that is all the questions I have. If you think of something later, call me or e mail me and tell me more.

Thanks for your time today.

You can call me back if you think of something else. My number is 301-400-1245.

[OR: Meryia

My number is 301-400-1237]

Anything else you want to say?

OK, I'm turning off both recorders now.

RESEARCHER–TURN OFF RECORDERS

OR

I'm finished taking notes now.

RESEARCHER–PUT PEN DOWN.

OK. Here's my number again, 301-400-1245 and thanks again for sharing your experiences.

Here's my card.

OR (if on telephone)

OK Here's my number again, 301-400-1245 and thanks a lot for sharing your experience.

You can call me back if you think of something else. My number is 301-400-1245.

Anything else you want to say?

OK, I'm turning off both recorders now.

RESEARCHER–TURN OFF RECORDERS

OR

I'm finished taking notes now.

RESEARCHER–PUT PEN DOWN.

OK. Here's my number again, 301-400-1245 and thanks again for sharing your experiences.

Here's my card.

OR (if on telephone)

OK Here's my number again, 301-400-1245 and thanks a lot for sharing your experience.

FIELD NOTES: Upon completion of interview, RESEARCHER will pause and reflect on interview and complete field notes observations about non-verbal expressions, such as participant gestures, voice (tone), facial expression, and posture. If possible, RESEARCHER will note preliminary observations about word choices, pauses, hesitancies, emphasis and/or repetition of words, and use of pronouns. These observations may be easier to make after the transcription is completed, and has been reviewed, reflected on, and mapped.

IRB-APPROVED INTERVIEW GUIDE 2

For Care Provider who is supporting a Wounded, Ill or Injured Service Member being treated at Walter Reed National Military Medical Center in Bethesda, MD

Script

I'm Deb. I'm a civilian anthropologist conducting research about your experience as a caregiver at Walter Reed. I'm interested in understanding two things: Whether you think about the Service members you care for as being wounded, ill, or injured; and how you experience them getting recognition and access to resources. By resources I mean things like attention from others, parking privileges, special accessories or equipment, special accommodations and the like.

[OR

I'm Meryia. I'm a nurse conducting research about your experience as a caregiver at Walter Reed. I'm interested in understanding two things: Whether you think about the Service members you care for as being wounded, ill, or injured; and how you experience them getting recognition and access to resources. By resources I mean things like attention from others, parking privileges, special accessories or equipment, special accommodations and the like.

I'll ask you some questions and listen to your answers. There aren't any right or wrong answers, and you can quit at anytime.

I'm going to record our conversation so I don't forget anything - OK with you?

IF SUBJECT SAYS YES, CONTINUE.

IF SUBJECT SAYS NO: OK, I won't record our conversation. OK if I make notes then?

IF YES, SHOW PAD AND PEN

Thanks.

START 2 TAPES (digital primary, and analog back-up)

This is Deb with participant # _____. It's (date _____ and time _____).

What you say is important to me. I will ask some questions and listen to your answers.

I may ask you to repeat some things so I'm sure I understand what you mean. And I'm going to read the questions so I don't forget to ask any.

1. First, do you have any questions about the consent form that you signed?

2. Where do you hear the words "wounded warrior"?
    a. Can you tell me a little more about that?
        i. What does the term wounded warrior mean to you?
            1. Can you tell me a little more about that?
            1.

3. Where do you hear the words "wounded, ill and injured" together?
    a. Can you tell me a little more about that?
        i. What do those different words mean to you?
            1. What does wounded mean to you?
            2. What does ill mean to you?
            3. What does injured mean to you?

4. How do your family members or friends refer to the people you take care of?
    a. If they say wounded warrior what do you think they mean?
    b. If they say wounded, ill or injured what do you think they mean?

5. What kinds of medical issues are your patients being treated for?
    a. Since when?

6. When you think about your patients being here, how do you describe them?
    a. When you talk to family members or friends, how do you describe your patients?
    b. When you talk to other family members or non-medical attendants, how do you describe your patients?
    2.

7. What does disability mean to you?

8. In what ways do you think of your patients as disabled?

    [OR:
    a. In what ways do you think of your patients as capable?

9. How do other people talk about your patients' disabilities?

10. Tell me about recognition you see your patients getting?

11. Tell me about recognition you don't see your patients getting?

12. Tell me about the resources your patients have access to?
    a. Like special privileges, or special attention?
    b. Or training or employment opportunities?
    c. Or special equipment or things like DVD players or big screen TVs?
    d. Like parking privileges, attention from people, training or employment opportunities, inclusion in social activities?

13. Tell me about recognition other Service members get here or elsewhere?

14. Tell me about recognition other Service members don't get here or elsewhere?

15. What are some other resources you can think of?
    a. That your patients do have access to?
    b. That your patients don't have access to?

16. When people outside of this facility talk to you, how do they talk about your patients' military service?
    a. Tell me what that means to you?

17. When people outside of this facility talk to you, how do they talk about your patients' disabilities?
    3.

18. Describe what it's like for you to be around people who do not seem to be wounded, ill or injured?
    a. When you're around family members for example?
    b. Staff?
    c. Cadre?
        i. At the galley for example?
        ii. At building 62 for example?
        iii. At Subway or Dunkin' Donuts?
        iv. At the post office?
        v. At the credit Union?
        vi. At Main Street?

19. Tell me a little about what you expect for your patients when they leave here?
    a. How do you know that?
        i. Who told you that?

20. Do you want to tell me anything else?

a. About how your patients gets recognized?
b. About how your patients gets access to different kinds of resources?

4.

21. Do you want to tell me anything else about being a caregiver here?

OK – that is all the questions I have. If you think of something later, call me or e mail me and tell me more.

Thanks for your time today.

You can call me back if you think of something else. My number is 301-400-1245.

[OR: Meryia

My number is 301-400-1237]

OK, I'm turning off both recorders now.

RESEARCHER–TURN OFF RECORDERS

OR

I'm finished taking notes now.

RESEARCHER–PUT PEN DOWN

OK. Here's my number again, 301-400-1245 and thanks again for sharing your experiences.

Here's my card.

OR (if on telephone)

OK Here's my number again, 301-400-1245 and thanks a lot for sharing your experience.

FIELD NOTES: Upon completion of interview, RESEARCHER will pause and reflect on interview and complete field notes observations about non-verbal expressions, such as participant gestures, voice (tone), facial expression, and posture. If possible, RESEARCHER will note preliminary observations about word choices, pauses, hesitancies, emphasis and/or repetition of words, and use of pronouns. These observations may be easier to make after the transcription is completed, and has been reviewed, reflected on, and mapped.

IRB-APPROVED INTERVIEW GUIDE 3

For Wounded, Ill, or Injured Military Service Member being treated at Walter Reed National Military Medical Center in Bethesda, Maryland

Script

I'm Deb. I'm a civilian anthropologist conducting research about your experience as a service member (or non-medical attendant) at Walter Reed. I'm interested in understanding two things: Whether you think about your Service member as being wounded, ill, or injured; and how you experience him/her getting recognition and access to resources. By resources I mean things like attention from others, parking privileges, special accessories or equipment, special accommodations and the like.

[OR

I'm Meryia. I'm a nurse conducting research about your experience as a service member at Walter Reed. I'm interested in understanding two things: Whether you think about your Service member as being wounded, ill, or injured; and how you experience him/her getting recognition and access to resources. By resources I mean things like attention from others, parking privileges, special accessories or appliances, special accommodations and the like.

I'll ask you some questions and listen to your answers. There aren't any right or wrong answers, and you can quit at anytime.

I'm going to record our conversation so I don't forget anything - OK with you?

IF SUBJECT SAYS YES, CONTINUE.

IF SUBJECT SAYS NO: OK, I won't record our conversation. OK if I make notes then?

IF YES, SHOW PAD AND PEN

Thanks.

START 2 TAPES (digital primary, and analog back-up)

This is Deb with participant # _____. It's (date _____ and time _____).

What you say is important to me. I will ask some questions and listen to your answers.

I may ask you to repeat some things so I'm sure I understand what you mean. And I'm going to read the questions so I don't forget to ask any.

1. First, do you have any questions about the consent form that you signed?

2. Where do you hear the words "wounded warrior"?
    a. Can you tell me a little more about that?
        i. What does the term wounded warrior mean to you?
            1. Can you tell me a little more about that?

3. Where do you hear the words "wounded, ill and injured" together?
    a. Can you tell me a little more about that?
        i. What do those different words mean to you?
            1. What does wounded mean to you?
            2. What does ill mean to you?
            3. What does injured mean to you?

4. What kinds of medical issues are you being treated for?
    a. Since when?

5. How do you refer to yourself since you were hurt or became ill?

6. How do your family members or friends refer to you?
    a. If they say wounded warrior what do you think they mean?
    b. If they say wounded, ill or injured what do you think they mean?

7. When you think about being here, how do you describe yourself?
    a. When you talk to family members or friends, how do you describe yourself?
    b. When you talk to other family members or non-medical attendants, how do you describe yourself?

8. What does disability mean to you?

9. In what ways do you think of yourself as disabled?

    [OR:

    In what ways do you think of yourself as capable?

10. How do other people talk about your disabilities?

11. Tell me about recognition you get?

12. Tell me about recognition you don't get?

13. Tell me about recognition other Service members get here or elsewhere?

14. Tell me about recognition other Service members don't get here or elsewhere?

15. Tell me about the resources you have access to?
    a. Like special privileges, or special attention?
    b. Or training or employment opportunities?
    c. Or special equipment or things like DVD players or big screen TVs?
    d. Like parking privileges, attention from people, training or employment opportunities, inclusion in social activities?

16. What are some other resources you can think of?
    a. That you have access to?
    b. That you don't have access to?

17. When people outside of this facility talk to you, how do they talk about your military service?
    a. What does that means to you?

18. When people outside of this facility talk to you, how do they talk about your disabilities?
    a. What does that means to you?

19. Describe what it's like for you to be around people who do not seem to be wounded, ill or injured?
    a. When you're around family members for example?
    b. Staff?
    c. Cadre?
        i. At the galley for example?
        ii. At Building 62 for example?
        iii. At Subway or Dunkin' Donuts?
        iv. At the post office?
        v. At the credit Union?
        vi. At Main Street?

20. Tell me a little about what you expect for yourself when you leave here?
    a. How do you know that?
        i. Who told you that?

21. Do you want to tell me anything else?
    a. About how you get recognized?
    b. About how you get access to different kinds of resources?

22. Do you want to tell me anything else about being cared for here?

OK – that is all the questions I have. If you think of something later, call me or e mail me and tell me more.

Thanks for your time today.

You can call me back if you think of something else. My number is 301-400-1245.

[OR: Meryia

My number is 301-400-1237]

Anything else you want to say?

OK, I'm turning off both recorders now.

RESEARCHER–TURN OFF RECORDERS

OR

I'm finished taking notes now.

RESEARCHER–PUT PEN DOWN.

OK. Here's my number again, 301-400-1245 and thanks again for sharing your experiences.

Here's my card.

OR (if on telephone)

OK Here's my number again, 301-400-1245 and thanks a lot for sharing your experience.

FIELD NOTES: Upon completion of interview, RESEARCHER will pause and reflect on interview and complete field notes observations about non-verbal expressions, such as participant gestures, voice (tone), facial expression, and posture. If possible, RESEARCHER will note preliminary observations about word choices, pauses, hesitancies, emphasis and/or repetition of words, and use of pronouns. These observations may be easier to make after the transcription is completed, and has been reviewed, reflected on, and mapped.

IRB-APPROVED CONSENT FORM WRNMMC
WALTER REED NATIONAL MILITARY MEDICAL CENTER
BETHESDA, MARYLAND

This consent form is valid only if it contains the IRB stamped date

Consent for Voluntary Participation in a Non-Clinical Research Study

Study site: X WRNMMC, __ MGMC, __USUHS

1. INTRODUCTION OF THE STUDY

You are being asked to be in a research study entitled, Disability and Deservedness: The Lived Experience of Wounded, Ill, And Injured Members of The U.S. Armed Forces at a Military Medical Facility".

You are being asked to participate in this research study because you are a Wounded, Injured, or Ill military service member, family member, non-medical attendee or care-provider being cared for or offering care in rehabilitation clinics and facilities at Walter Reed National Military Medical Center, Bethesda MD. Your participation is voluntary. Refusal to participate will not result in any punishment or loss of benefits to which you are otherwise permitted. Please read the information below, and ask questions about anything you do not understand, before deciding whether to take part in the study.

2. PURPOSE OF THE STUDY

The purpose of this study is to understand what it is like to be a Wounded, Injured, or Ill military service member, family member, non-medical attendee or care-provider being cared for or offering care in rehabilitation. This research seeks to understand your experience in your own words. Ultimately we want to understand how different kinds of disability and different kinds of rehabilitation may affect how you get recognition and access to resources.

You will receive no direct benefits for participating in this research; however some studies have shown that people who participate in research may report a sense of benefit because their participation may help others like them; or because being listened to is beneficial.

3. PROCEDURES TO BE FOLLOWED

If you agree to be a part of this study, you will be asked to take part in a recorded interview. In the interview, you will be asked about your experiences as a Wounded, Injured, or Ill military service member, family member, non-medical attendee or care-provider being cared for or offering care in rehabilitation clinics and facilities at Walter Reed National Military Medical Center, Bethesda MD.

The interview is a confidential in-person individual session with only you. We expect it will take between 20 and 40 minutes. The interview will be recorded by audiotape and will be

fully transcribed. By that we mean we'll send the recording to a service which will note what we have said and provide us with a written transcript of our interview. Nothing identifying you personally will be included in the transcription.

You may be contacted after the first interview to be asked to clarify a comment or to describe an experience in greater detail. This second contact, if required, would last less than 10 minutes and we would usually do it over the phone 3-9 months after the initial interview.

Information that you provide will help us to prepare reports and briefings that will be presented to Department of Defense leaders, at military, scientific and academic conferences, and in scientific and lay literatures. You will not be identified in any report or presentation. Quotes from the interview might be used in publications or presentations, but you will not be able to be identified.

4. NUMBER OF PEOPLE THAT WILL TAKE PART IN THIS STUDY

48 subjects are expected to take part in this study.

5. AMOUNT OF TIME FOR YOU TO COMPLETE THE STUDY

You will be part of this study for the time it takes to participate in the interview, which will be 20-40 minutes, and then possibly during a second contact for clarification (usually by phone 3-9 months after the first interview and lasting about 10 minutes.

6. ELIGIBILITY AND PAYMENT FOR BEING IN THIS STUDY

You will not receive any payment for being in this study.

7. POSSIBLE RISKS OR DISCOMFORTS FROM BEING IN THIS STUDY

There are no anticipated individual health or injury risks associated with this study. There are no anticipated risks to psychological health, although some subjects may find discussion of experiences during their rehabilitation, or the rehabilitation of another person to be stressful. No clinical services are provided in this study.

If something in this research makes you uncomfortable or upset, you can stop taking part in the study at any time without loss of benefits, repercussions, or recriminations; and you may contact individuals on the Scientific Review Committee, Institutional Review Board, Human use Committee, and Responsible Conduct of Research Studies, to report your discomfort. On this consent form there are contact numbers for these groups. If the researcher notes that you are distressed or anxious, you can be referred to your Nurse Case Manager, or to a local provider for help. Contact numbers for Nurse Case Managers and local providers are on this consent form.

If you are an active-duty service member, divulgence of any illegal activities or sensitive information, such as drug use, is required to be reported to your Commanding Officer, which may affect your military career.

8. POSSIBLE BENEFITS FROM BEING IN THIS STUDY

You may benefit from this study because you will have a chance to talk about what it is like to be a Wounded, Injured, or Ill military service member, family member, non-medical attendee or care-provider being cared for or offering care in rehabilitation clinics and facilities. Although the results of this study may not help you personally, they may help others like you and may assist nurses, doctors, and military leaders to know what it is like to become disabled and to receive rehabilitation therapy at a military medical facility, or to be someone who is a family member, non-medical attendee, or care provider who is supporting a disabled service member in rehabilitation at a military medical facility.

9. WHAT IS MY ALTERNATIVE TREATMENT?

None.

10. CONFIDENTIALITY/PRIVACY AND HOW YOUR IDENTITY AND YOUR RESEARCH RECORDS WILL BE MAINTAINED

The Associate Investigator will keep your research records. These records may be looked at by staff from the Responsible Conduct of Research Service, the Institutional Review Board (IRB) from the Walter Reed National Military Medical Center, Bethesda MD and other government agencies as part of their duties. These duties include making sure that the research participants are protected. Confidentiality of your records will be protected to the extent possible under existing regulations and laws but can not be guaranteed. Your name will not appear in any published paper or presentation related to this study.

This research study meets the confidentiality requirements of the Health Insurance Portability and Accountability Act (HIPAA). A HIPAA Authorization form for this study will be provided to you separately, and you will be asked to sign that form.

11. CONDITIONS WHICH MAY LEAD TO YOUR PARTICIPATION IN THIS STUDY BEING STOPPED WITHOUT YOUR CONSENT

The researcher may stop you from taking part in this study if it is unsafe or dangerous to you or if you lose your right to receive medical care at military hospitals.

12. IF YOU DECIDE TO STOP TAKING PART IN THIS STUDY; AND THE INSTRUCTIONS FOR STOPPING EARLY

You have the right to withdraw from this study at any time. If you decide to stop taking part in this study, you should tell the Associate Investigator as soon as possible; by leaving this study at any time, you do not risk losing your right to medical care. Contact informaiton for the Associate Investigator is provided on this form.

13. COMPENSATION TO YOU IF YOU ARE INJURED AND LIMITS TO YOUR MEDICAL CARE

You will not receive any compensation (payment) if you are injured as a direct result of being in this study. You should understand that this is not a waiver or release of your legal rights. You should discuss this issue thoroughly with the Associate Investigator before you enroll in this study.

Medical care is limited to the care normally allowed for Department of Defense health care beneficiaries (patients eligible for care at military hospitals and clinics). Necessary medical care does not include in-home care or nursing home care.

14. CONTACT FOR QUESTIONS OR PROBLEMS

You can talk to the Associate Investigator, Deb Murphy, at (301) 400-1245, about any questions or concerns you have about the study.

For questions about your rights or concerns while taking part in this study, call a representative of the Scientific Review Committee, Institutional Review Board, Responsible Conduct of Research Studies, or Human Use committee (groups of people who review how the research is conducted in order to protect your rights) at (301) 295-6512.

SIGNATURE OF RESEARCH PARTICIPANT OR LEGAL RESPRESENTATIVE

You have read (or someone has read to you) the information in this consent form. You have been given a chance to ask questions and all of your questions have been answered to your satisfaction.

BY SIGNING THIS CONSENT FORM, YOU FREELY AGREE TO TAKE PART IN THE RESEARCH IT DESCRIBES.

_____ _____

Participant's Signature Date

_____

Participant's Printed Name

OR

_____

Legal, Authorized Representative's Signature

_____

Legal, Authorized Representative's Printed Name Date

SIGNATURE OF INVESTIGATOR

You have explained the research to the participant, or his/her legal representative, and answered all of his/her questions. You believe that the volunteer subject understands the information described in this document and freely consents to participate.

Investigator's Signature Date (must be the same as the participant's)

Investigator's Printed Name

SIGNATURE OF WITNESS

Your signature as witness is intended to attest that the information in the consent document and any other information was explained to and apparently understood by the participant, or the participant's legal representative, that questions and concerns were addressed and that informed consent was freely given.

Witness' Signature Date (must be the same as the participant's)

Witness' Printed Name

Version – NNMC Non-Clinical CF 30 Jul 10 (SG)

PRIVACY ACT STATEMENT

Authority. 5 USC 301

Purpose. Medical research information will be collected to enhance basic medical knowledge, or to develop tests, procedures, and equipment to improve the diagnosis, treatment, or prevention of illness, injury or performance impairment.

Use. Medical research information will be used for statistical analysis and reports by the Department of the Navy and Defense, and other U.S. Government agencies, provided this use is compatible with the purpose for which the information was collected. The Chief, Bureau of Medicine and Surgery may grant use of the information to non-Government agencies or individuals in accordance with the provisions of the Freedom of Information Act.

Disclosure. All information contained in this consent statement derived from the experimental described herein will be retained permanently at the National Naval Medical Center, Bethesda, Maryland and salient portions thereof may be entered into my health record. I voluntarily agree

to its disclosure to agencies or individuals identified in the preceding paragraph and I have been informed that failure to agree to such disclosure may negate the purpose for which the experiment was conducted.

Participant's Signature	Date
Investigator's Signature	Date
Witness' Signature	Date

AMERICAN UNIVERSITY
Identification of Investigators & Purpose of Study

You are being asked to participate in a research study conducted by Deborah Murphy from American University. The purpose of this study is to gain understanding of the lived experience of members of the U.S. Armed Forces who have been wounded, ill or injured and are being rehabilitated at Walter Reed National Military Medical Center in Bethesda MD, or at another Medical Treatment Facility or base; and of the people who are providing care to them or supporting them in other ways. This study will contribute to the student's completion of her PhD in anthropology.

Research procedures

Should you decide to participate in this research study, you will be asked to sign this consent form once all your questions have been answered to your satisfaction. For eligible and consenting participants this study consists of an interview that will be administered in a confidential location that is accessible to and comfortable for you. You will be asked to provide answers to a series of questions related to your experience. With your permission, this interview will be audio recorded, and the interviewer, who is Deborah Murphy, may also take notes.

Time Required

Participation in this study will require 20-40 minutes of your time; and the interviewer may follow-up by telephone, using a number that you prefer, or in person for 5-10 minutes to confirm details of your interview.

Risks

The investigator does not perceive more than minimal risks from your involvement in this study.

Benefits

There are no potential individual benefits from participation in this study; however the knowledge the researcher gains by hearing about and considering your experience may help others like you, now and in the future.

Confidentiality

Your participation in this study will be confidential. Any information or impressions you convey will be confidential and will be de-linked from your personal identity by assigning you a code number, by not using your name, by not discussing you personally as a participant, and by securing all information your provide in double-locked cabinets, and digital files and secured databases that can be accessed by Deborah Murphy only. The results of this study will also be de-linked from you and your identity and any personal information that may be obtained by your participation in the course of screening, consenting, interviewing and follow-up.

The study results of this research will become part of Deborah Murphy's PhD Dissertation and may also be presented in published papers, panels, and at professional conferences. The results of this project will be coded in such a way that the respondent's identity will not be attached to the final form of this study.

The researcher retains the right to use and publish non-identifiable data. While individual responses are confidential, aggregate data will be presented representing averages or generalizations about the responses as a whole. Any individual quotes that are used will be de-linked from your personal identity. All data will be stored in a secure location accessible only to

the researcher. Upon completion of the study, all information that matches up individual respondents with their answers, including audio digital and tape recordings, will be destroyed.

Participation & Withdrawal

Your participation is entirely voluntary. You are free to choose not to participate. Should you choose to participate, you can withdraw at any time without consequences of any kind. You may also refuse to answer any individual question without consequences.

Questions about the Study

If you have questions or concerns during the time of your participation in this study, or after its completion or you would like to receive a copy of the final aggregate results of this study, please contact:

Researcher's Name: Deborah Murphy
Department: Anthropology
Institution: American University
Telephone: (973) 978-9029
E mail address: dmurphy3388@verizon.net

Advisor's Name: Dr. William Leap
Department: Anthropology
Institution: American University
Telephone: (202) 885-1830
Email Address: wlm@amercian.edu

Questions about Your Rights as a Research Subject

Dr. David Haaga
Chair, Institutional Review Board
American University
(202) 885-1718
dhaaga@american.edu

Matt Zembrzuski
IRB Coordinator
American University
(202) 885-3447
irb@american.edu

Giving of Consent

I have read this consent form and I understand what is being requested of me as a participant in this study. I freely consent to participate. I have been given satisfactory answers to my questions. The investigator provided me with a copy of this form. I certify that I am at least 18 years of age.

☐ I give consent to be audio taped during my interview. _____ (initials)

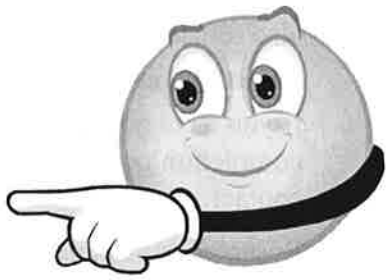
_____
Name of Participant (Printed)

_____ _____
Name of Participant (Signed) Date

_____ _____
Name of Researcher (Signed) Date

IRB-APPROVED RECRUITMENT MATERIALS
RECRUITMENT FLYER

I WANT YOU TO TALK TO ME



If you are a Wounded Warrior, a family member, NMA, or caregiver

If you are caring for, treating, or supporting a Wounded Warrior

You may be eligible for this study

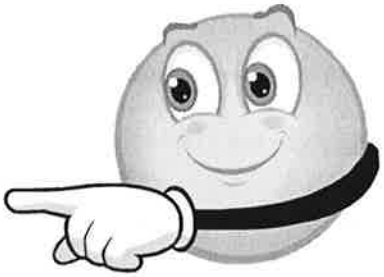
Stories about your experiences will help improve care and recovery for you and others like you – now and in the future. Everything you share will be confidential and secure.

Deb Murphy
Anthropologist
Call me: 310-400-1245 or e mail me: deborah.murphy@med.navy.mil

Disability and Deservedness Study WRNMMC IRB-Approved Protocol # 369924-3

Deb Murphy 301-400-1245
Deborah.murphy@med.navy.mil
Disability and Deservedness Study

Dear Potential Research Study Participant,



WELCOME .

We're glad you're interested in our Research Study, entitled Disability and Deservedness: The Lived Experience of Wounded, Ill, and Injured Service Members,
Caregivers, and Families at a Military Treatment Facility.

If you are a Wounded, Ill, or Injured service member at WRNMMC; or if you are caring for, treating, or supporting a Wounded, Ill, or Injured service member at WRNMMC, we hope you will participate in our Disability and Deservedness research study. We are interested in understanding the kind of recognition you are receiving and how you get access to resources.

Although no direct benefits are guaranteed, stories about your experiences may help improve care and recovery for you and others like you – now and in the future. And you may enjoy sharing your story.

Participation consists of being informed of your rights, signing a consent, being confidentially interviewed in person for 20-40 minutes, and possibly being confidentially interviewed a second time by phone for 10-minutes. Your identity and any personal information about you will not be included in the study findings. Everything you share will be confidential and secure.

We want to hear from you - please join our study!

Thank you.
Meryia Throop, Principal Investigator
Deb Murphy, Associate Investigator
The Center for Nursing Science and Clincal Inquiry (CNSCI), Bldg 17
Call us at 310-400-1242 or e mail us at
meryia.throop@med.navy.mil
deborah.murphy@med.navy.mil

IRB-APPROVED DEMOGRAPHIC DATA SHEET FOR MILITARY BENEFICIARIES

Data Collection Form

This section will be removed from the data below in order to de-identify you as a participant

Contact Information:

Name: _____

Email _____

Phone Number(s): Cell_____
Other_____

Preferred time to be contacted: _____

Section will be detached here at dotted line

.....

.....

Answer the questions you are comfortable answering. Your answers will be used to gather some demographic data about study participants and will be de-linked from your identity (above)

Background Information:

1. How old are you? _____
5.

2. What is your gender? (circle answer)
    a. Male
    b. Female
    c. Other

3. What is your current relationship status?
    a. Living with a partner
    b. Living with friends
    c. Living with family
    d. Single
    e. Married
    f. Separated
    g. Divorced
    h. Widowed
    i. Other

4. What is your completed education level?
    a. Some high school
    b. High school diploma or GED
    c. Technical or vocational school
    d. Associate degree
    e. Baccalaureate degree
    f. Master's degree
    g. Doctorate

5. If military, what is your current rank? _____ N/A

6. If military, what is your Military Occupational Specialty? _____ N/A

7. Please circle the item that best describes your career field:
    a. Operations or Operational Support
    b. Operations or Service Support
    c. Don't know
    d. Retired military
    e. Other
    f. Civilian (please indicate current career field)_____

8. Number of years in the military? _____ N/A

9. Family members in the military? Y N

10. Friends in the military? Y N

11. Have you been cared for previously at a hospital or treatment facility? (please circle) Y N

12. How long ago were you wounded, injured, or became ill? _____ years N/A

13. When did you arrive at WRAMC, or WRNMMC? _____ N/A

14. When did you leave WRAMC, or WRNMMC? _____ N/A

15. Where do (or did) you live while you are (or were) being cared for, treated, or rehabilitated? (please circle)
    a. On post
    b. In an apartment nearby
    c. At home
    d. Inpatient in hospital
    e. Other
    f. N/A

While in rehabilitation, are you being (or were you) supported by a family member? Y N N/A

16. While in rehabilitation, are you being (or were you) supported by a non-military attendant (NMA)? Y N N/A

17. Where does (or did) that person live?
    a. On post
    b. In an apartment nearby
    c. At home
    d. Other
    e. N/A

APPENDIX C

DOD APPROVED WOUNDED, ILL, AND INJURED

DEFINITIONS

30 April 2011
http://www.ncopromotionboard.com/army-promotion-questions/index.html

1. CATASTROPHIC INJURY/ILLNESS. A permanent, severely disabling injury, disorder, or disease that compromises the ability to
carry out the activities of daily living to such a degree that a Service Member or Veteran (SM/V) requires personal or mechanical
assistance to leave home or bed, or requires constant supervision to avoid physical harm to self or others.

2. COMBAT RELATED DISABILITY. A disability that has been determined by DoD as being attributable to an injury for which the
member was awarded the Purple Heart; or was incurred (as determined under criteria prescribed by the Secretary of Defense):
- As a direct result of armed conflict
- While engaged in hazardous service
- In the performance of duty under conditions simulating war
- Through an instrumentality of war

3. COMBAT RELATED WOUNDED WARRIOR. A term referring to the entire population of WII SM/Vs who incurred a wound, illness, or injury for which the member was awarded the Purple Heart or whose wound, illness, or injury was incurred:
- As a direct result of armed conflict or
- While engaged in hazardous service or
- In the performance of duty under conditions simulating war, or
- Through an instrumentality of war

4. COMMITTED DESIGNEE. Any person legally designated by the SM/V (or, if the SM/V is unable, by other legal authority, such as a court or the Military Department) who provides support, deemed necessary by medical authority, to the seriously injured or ill
SM/V following the occurrence of wound or injury or onset of illness, to his/her recovery. These might include parents, siblings, fiancées, other family members, or close friends. Committed Designees must demonstrate his/her commitment to serving in that role by incurring financial expense(s) or loss(es) (e.g. taking a leave of absence from work to support the member, making an unplanned move to the member's location of treatment, providing no-cost room and board to the member during or after recovery, providing caregiver services to the member).

5. COMPENSABLE COMBAT RELATED DISABILITY. A disability that is compensable

under the laws administered by the Secretary of Veterans Affairs that has been determined by DoD as being attributable to an injury for which the member was awarded the Purple Heart or was incurred (as determined under criteria prescribed by the Secretary of Defense):
- As a direct result of armed conflict
- While engaged in hazardous service
- In the performance of duty under conditions simulating war
- Through an instrumentality of war.

6. COMPREHENSIVE RECOVERY PLAN. The Recovery Plan is a patient-centered "life map" with identified goals from recovery and rehabilitation to community reintegration developed from a comprehensive needs assessment which identifies the recovering SM's and family's personal and professional needs and goals, and the services and resources needed to achieve them through specific activities in those key areas which were reviewed during the assessment.

7. DISABILITY EVALUATION SYSTEM. A system or process of the US Government for evaluating the nature and extent of disabilities affecting members of the Armed Forces; it includes medical/psychological evaluations; physical evaluations; counseling of members; and mechanisms for the final disposition of disability determinations.

8. ELIGIBLE FAMILY MEMBER. The term eligible family member, with respect to a recovering service member under the provisions of the Wounded Warrior Act, means the member's spouse; a child of the member (including stepchildren, adopted children, and illegitimate children); the member's parent or person in loco parentis to the member; or a sibling of the member who is on invitational travel orders or serving as a non-medical attendee while caring for the recovering service member for more than 45 days during a one year period. The term eligible family member, with respect to the provision of medical care at military medical facilities under the provisions of the Wounded Warrior Act, means a family member of a recovering service member who is not otherwise eligible for medical care at a military medical treatment facility and meets one of the following three conditions:
(1) is on invitational travel orders while caring for the service member;
(2) is a non-medical attendee caring for the service member; or
(3) is receiving per diem payments from the Department of Defense while caring for the service member.

9. FEDERAL INDIVIDUAL RECOVERY PLAN (FIRP). The FIRP is created with input from the SM/V's multidisciplinary health care team, the SM/V, and their family or caregiver. The FIRP tracks care, management and transition through recovery, rehabilitation, and reintegration. For each of these care phases, goals are identified, responsibilities are assigned and timelines arecreated. The Federal Recovery Coordinator works with existing resources, DoD and VA personnel, as well as other federal, state and private entities, to implement the FIRP.

10. FEDERAL RECOVERY COORDINATOR (FRC). FRCs are assigned to severely wounded, ill, and injured SM/Vs. Stationed at Military Treatment Facilities and VA Medical Centers, they serve as the ultimate point of contact for severely injured, ill, or wounded SMs and their families for ensuring that the SM/V's clinical and non-clinical needs are met. The

FRCs are responsible for initiating and maintaining the FIRP. FRCs ensure that:
- the right clinical and non-clinical case managers are engaged at the right time to achieve SM/V's goals.
- the SM or family is never alone in meeting access challenges or managing system barriers.
- systemic barriers to care and services are resolved at both the individual and the system level.

11. INCAPACITATING ILLNESS OR INJURY. The casualty status of a person whose illness or injury requires hospitalization but medical authority does not classify as very seriously ill or injured or seriously ill or injured and the illness or injury makes the person physically or mentally unable to communicate.

12. INJURED. Injured means suffering from any intentional or unintentional physical trauma, psychological trauma, distress, or damage to the body resulting from acute or chronic exposure to thermal, mechanical, or electrical energy; or to toxic, biological, or chemical agents; or from the absence of such essentials as heat or oxygen.

13. MAJOR LIFE ACTIVITIES. (Major life activities are currently defined in CFR 199.2b and PL 109-13, Section 1032 as "Breathing, cognition, hearing, seeing, and age appropriate ability essential to bathing, dressing, eating, grooming, speaking, stair use, toilet use, transferring and walking." The following proposed definition must not be used until required legislative changes have been made.)
(Proposed definition). Major life activities include the following:
a) basic daily living skills (e.g., eating, bathing, dressing)
b) instrumental living skills (e.g., maintaining a household, managing money, getting around the community, taking prescribed
medication), and
c) functioning in social, family, and vocational/educational contexts

14. MEDICAL CARE CASE MANAGEMENT. Medical care (clinical) case management is a collaborative process under the population health continuum which assesses, advocates, plans, implements, coordinates, monitors, and evaluates options and services required to meet an individual's health needs through communication and available resources to promote quality, cost-effective outcomes. Health is defined by the World Health Organization as: "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

15, MEDICAL TREATMENT. Medical treatment is any medical practice(s) or procedure(s) (that is not investigational) performed by health care/medical professionals on a wounded, ill, or injured Service member/veteran for the purposes of health-preservation/restoration.

16. MENTAL DISORDER. (Mental disorder is currently defined in CFR 199.2b as "For the purposes of the payment of CHAMPUS benefits, a mental disorder is a nervous or mental condition that involves a clinically significant behavioral or psychological syndrome or pattern that is associated with a painful symptom, such as distress, and that impairs a patient's ability to function in one or more major life activities. Additionally, the mental disorder must be one of those conditions listed in the DSM-III." The following proposeddefinition must not be

used until required legislative changes have been made.) MENTAL DISORDER (Proposed definition). A mental disorder that is represented by one of the diagnoses listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) by the American Psychiatric Association. Note that "V codes" represent situations that are not mental disorders. Unless otherwise specified, the terms psychological disorder and behavioral disorder have the same meaning as mental disorder.

17. MENTAL HEALTH STATUS. A person's overall emotional and psychological condition (American Heritage Dictionary, 2008, definition #3), characterized by the absence of or presence of psychological condition or disorder, with or without the need of medication.

18. NON-MEDICAL ATTENDEE. A designated individual or someone with a personal relationship to a WII SM/V who helps take care of the member or veteran, and whose presence may contribute to the SM/V's health and welfare, as determined by the attending physician or surgeon and commander or head of the military medical facility exercising control over the member.

19. NON-MEDICAL CARE MANAGER. The Non-Medical Care Manager will ensure the recovering service member and family get all the non-medical support they need. The NDAA defines their role as:
- Communicating with the service member and with the SM's family or other individuals designated by the service member
regarding non-medical matters that arise during the care, recovery, and transition of the service member
- Assisting with oversight of the service member's welfare and quality of life
- Assisting the service member in resolving problems involving financial, administrative, personnel, transitional, and other
matters that arise during the care, recovery, and transition of the service member.

20. NOT SERIOUSLY ILL OR INJURED. The casualty status of a person whose illness or injury requires medical attention may or may not require hospitalization, and medical authority classifies as less severe than Seriously Injured or Ill.

21. OUTPATIENT. Use of a health care facility for diagnosis or treatment without being admitted to a hospital or other authorized institution as an inpatient. Sometimes called a day patient. In-out [ambulatory] surgery. Surgery performed in the outpatient department of a hospital or other institutional provider, in a physician's office or the office of another individual professional provider, in a clinic, or in a "freestanding" ambulatory surgical center which does not involve a formal inpatient admission for a period of 24 hours or more. - 32 CFR 199.2(b)

22. RECOVERY CARE. All activity involved in the management, treatment, transition, and rehabilitation of the WII SM/V toward reintegration.

23. RECOVERY CARE COORDINATOR. An individual assigned by the government to recovering SMs whose duties shall include overseeing and assisting the SM as they process through the entire spectrum of care, management, transition, and rehabilitation

services available from the Federal Government, including services provided by the DoD, the VA, the Department of Labor, and the Social Security Administration.

24. RECOVERING SERVICE MEMBER. (Recovering Service Member is currently defined in NDAA 2008 as "The term "recovering service member" means a member of the Armed Forces including a member of the National Guard or a Reserve, who is undergoing medical treatment, recuperation, or therapy and is in an outpatient status while recovering from a serious injury or illness related to the member's military service. The following proposed definition must not be used until required legislative changes have been made.)

RECOVERING SERVICE MEMBER (Proposed Definition). Recovering Service member is a term used for a member of the Uniformed Services who is undergoing medical treatment, recuperation, or therapy and is in an inpatient or outpatient status, who incurred or aggravated a serious illness or injury in the line of duty, and may be assigned to a temporary disability retirement or permanent disability retirement list due to the disability evaluation system proceedings.

25. RECUPERATION. Recuperation is the healing of an individual following wound, injury or illness.

26. REHABILITATION. The process of enabling achievement and maintenance of optimal physical, sensory, intellectual, psychological, occupational, and/or social functional levels

27. REINTEGRATION. Reintegration consists of educational events, referrals, and proactive outreach activities for all military personnel including the National Guard and Reserve Component members, the WII SMs and retired members of the Uniformed Services, their families, and associated community members to enable access to services supporting their transition from the deployment cycle to routine civilian life or return to military duty, from medical care to rehabilitation, and sustainment through other meaningful employment activities.

28. SERIOUS ILLNESS OR INJURY (NDAA 2008). (Serious Illness or Injury is currently defined in NDAA 2008 as "The term "serious illness or injury" in the case of a member of the Armed Forces, including a member of the National Guard or Reserves, means an injury or illness incurred by the member in the line of duty on active duty in the Armed Forces that may render the member medically unfit to perform the duties of the member's office, grade, rank or rating." The following proposed definition must not be used until required legislative changes have been made.)
SERIOUS ILLNESS OR INJURY (Proposed Definition). The term "serious illness or injury" in the case of a member of the Armed Forces, including a member of the National Guard or Reserves, means an injury or illness incurred by the member in the line of duty in the Armed Forces that may render the member medically unfit to perform the duties of the member's office, grade, rank or rating.

29. SERIOUSLY ILL OR INJURED. The casualty status of a person who has: an injury; a physiological or psychological disease or condition; or a mental disorder that requires medical attention and medical authority declares that the condition is life-threatening or life-altering,

and/or that death is possible, but not likely within 72 hours. This may include Post Traumatic Stress Disorder and associated conditions as deemed by medical authority to be life-threatening or life-altering and/or that death is possible but not likely within 72 hours. NOTE: A casualty status is assigned at a specific point in time and could be changed.

30. TRANSITION. In the context of leaving military service, this term is defined as follows: For Active Duty members, it includes discharge, separation or retirement. For Reserve and Guard members, it includes being released from Active or Reserve duty as well as discharge, separation or retirement. The release may or may not be for medical reasons. It includes the assimilation back into a civilian way of life.

31. VERY SERIOUSLY ILL OR INJURED. The casualty status of a person whose illness or injury is such that a medical authority declares it more likely than not that death will occur within 72 hours.

32. WOUNDED. A SM/V who has incurred an injury as a result of an attack or other use of force against the US, US forces, or other designated persons or property. It also includes force used directly to preclude or impede the mission and/or duties of US forces, including the recovery of US personnel or vital US Government property. It also includes a person who was injured mistakenly or accidentally by friendly forces actively engaged with the enemy, who are directing fire at a hostile force or what is thought to be a hostile force.

33. WOUNDED WARRIOR. A term in popular use typically referring to the entire population of wounded, ill, and injured SM/Vs.

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