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REMEMBERING AND RE-MEMBERING

Lived Experience of Military Service Members in Rehabilitation

Deborah A. Murphy

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Disclaimer: The views expressed in this chapter are the author's and do not reflect the official policy of the Department of Army, Navy, Air Force, Marines, Department of Defense, or any agency of the US government.

As an applied linguistic anthropologist, I conduct ethnography to study and understand local semiotics. At my field site I observe, collect, and interpret signs and symbols – elements of communicative behavior including texts of all kinds. "Text" is situated language use (language in its broadest sense) that marks itself and its users' location within economic, social, cultural, and historical settings (Leap 2003). Texts include actual words in narratives and life stories, content in distributed media (Chandler 2007; Fairclough 2003; Johnstone 2008); and things we say, read, write, hear, see, smell, move through, and wear. Even space is a kind of text (Soja 2003). Texts also include objects, artifacts, and materials (Leone 2005). They are signified and apprehended within systems of meaning that are learned; and are covertly and overtly reproduced among people (Bourdieu 2003; Decena 2008; Pêcheux 1982).

Textual data offer entry points for understanding points of view and the prevailing ideological and socio-cultural constructs through which people recognize themselves and are being recognized. They offer ethnographers the opportunity to glimpse and attempt to understand the lived experience of people across terrains of experience and subjectivity that are always-in-formation (Leap 2004). Texts signify and are signified within systems of meaning, or interwoven "orders of discourse" that are learned and reproduced among people who can communicate intelligibly with each other, and who act on their inter-intelligibility (Fairclough 2003). Gathering texts provided by people in their own contexts enables ethnographers to understand peoples' senses of themselves within their lived experience (Dahlberg, Drew, and Nyström 2002).

My field site is a military treatment facility (MTF). With the consent of study participants there, I probe how perceptions of ability (and disability) and perceptions

of deservedness are linked in the lived experience of patients, family members, non-medical attendants[1] (NMAs), and caregivers who are in rehabilitation – either being treated or providing or supporting treatment. With their help I study whether there is a felt link between disability and deservedness, how the linkage is sustained, and how it affects levels of recognition and access to resources. By "recognition" I mean being acknowledged, being addressed, being thanked, being saluted for example; and by deservedness I mean gaining access to such things as parking privileges, gifts, rewards, and privileged modes of communication including devices like tablets or smart phones. By collecting and analyzing textual data that both inscribe and circumscribe wounded, ill, and injured military Service Members' (SMs) and interrelated others' lived experience, I learn how research participants are actually interpreting, making sense of, and coping with their unforeseen experiences and conditions. For example, with permission, I listen to stories, study posters, announcements, and flyers, join in or observe activities, take notes, and examine material culture such as uniforms, medals, patches, and prosthetics.

My idea has been that studying the effects of adventitious alterations to "ability" in a structured and text-rich system like an MTF – a distilled space in which human socio-culture takes on an exaggerated and particular range of expression – will shed light on how it is that people decide on who deserves what, and how we subsequently confer or withhold recognition and access to resources. I hypothesize that while some material and immaterial results of being wounded, becoming ill, or being injured might be "obvious," some might be "unnoticed"; and that these differences in perception might account for differences in levels of recognition and access to resources, and their consequences (Althusser 1971; Lancaster 2003; McRuer 2006). In other words, in this space I can observe and hear about what happens when people are unexpectedly changed; how their subjectivities are affected; and in what ways and depending on whom, recognition and access to resources get re-calibrated. By gathering textual data and critically analyzing them, I get at the particular mechanisms governing practices and experiences at my site. My overall aim is to gain insights into aspects of lived experience that are significant to people's inclusion or exclusion at this site and beyond, how those aspects are constructed and reproduced, and the degrees of deservedness we accept or deny or negotiate when our own or others' subjectivities (and their embodiments) are unexpectedly altered.

By studying corporeal, cognitive, and conative changes and their consequences in a space and time devoted to managing adventitious change, i.e. at an MTF, my projects address large questions about the body, identity, and disability; while at the same time indexing – or pointing to – how ideas and ideology centered on "fitness" (and unfitness) are applied; i.e. their real effects in lived experience. The existentialities that I track, the mechanisms that construct and sustain them, and the evidence I find and document regarding the tacitness of these processes may be useful in theory and in practice – for social scientists, care providers, and researchers. By connecting theoretical questions and propositions regarding subjectivity with actual lived experience of alterations in self and others' perceptions of worth to recommendations for change(s) in practice and policy, in of applied theoretical anthropology

Context

In the United States of America under the auspices of two federal and the Veterans Administration care, treatment, and transitioning o Forces and their families, or military that is largely responsible for "vet members of the Armed Forces, incl medically discharged, or separated fi

The DOD provides care, treatm short-, medium- and long-term he support, home loans, and insurance and hospitals (DODI 2009; VA 2(bilitation centers, MTFs are charge all branches of military service so they are also charged with providi the uniformed services, which inc Armed Forces (Army, Navy, Mar and Reserves).

Objectives for care and rehabilit active duty in their respective forc within other federal agencies in int towards employment beyond the n influence the choice of treatment n wounded, ill, and injured SMs. I facilities involves strategies for susta institutions or communities of ca mandates, budgets, and administrat separate – although they may som they are frequently, confusingly, discourse.

While therapeutic services for w offered at hospitals, clinics, and reh or VA systems, there is a gap in inside MTFs and VA facilities with wounded, ill, or injured SMs get either because of assessments that because of their own or their fam further treatment; because they are or because the US health care

change(s) in practice and policy, my ethnography at an MTF provides an example of applied theoretical anthropology.

Context

In the United States of America (US), SMs who receive health care are treated under the auspices of two federal agencies: The Department of Defense (DOD), and the Veterans Administration (VA). 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 largely responsible for "veterans," persons who are former and not career members of the Armed Forces, including those who have been designated as disabled, medically discharged, or separated from the Armed Forces; and not their families.

The DOD provides care, treatment, and rehabilitation at MTFs; the VA provides short-, medium- and long-term health care, hospice care, job assistance, educational support, home loans, and insurance at dedicated veterans' facilities including offices and hospitals (DODI 2009; VA 2011). Beyond functioning as hospitals and rehabilitation centers, MTFs are charged with maintaining the health of personnel from all branches of military service so that they can carry out their military missions; they are also charged with providing clinical settings for health care trainees across the uniformed services, which include the Public Health Service, as well as the Armed Forces (Army, Navy, Marines, Air Force, National Guard, Coast Guard, and Reserves).

Objectives for care and rehabilitation at MTFs include whether to return SMs to active duty in their respective forces, including being re-deployed; to place them within other federal agencies in internships or on a permanent basis; to direct them towards employment beyond the military; or to medically retire them. These factors influence the choice of treatment modalities that are assigned to and undertaken by wounded, ill, and injured SMs. By contrast, choice-of-care for veterans at VA facilities involves strategies for sustaining maximum long-term health and welfare in institutions or communities of care, within neighborhoods, and at home. The mandates, budgets, and administration of these two federal agencies are unique and separate – although they may sometimes overlap at patient or "client" scales; and they are frequently, confusingly, and sometimes disruptively conflated in public discourse.

While therapeutic services for wounded, ill, or injured SMs and veterans are also offered at hospitals, clinics, and rehabilitation facilities that are not part of the DOD or VA systems, there is a gap in the literature comparing SMs' lived experience inside MTFs and VA facilities with their experiences at outside facilities. And some wounded, ill, or injured SMs get no treatment at all or discontinue treatment, either because of assessments that do not acknowledge, sanction, or allow them; because of their own or their family's or advocate's inability to secure or support further treatment; because they are isolated and cannot attend treatment programs; or because the US health care system writ large simply fails them through

oversight, denial, incompetence, undependability, or neglect (Benedict 2009; Woolhandler 2007).

Noting these distinctions may serve to bring into focus who is offering what to whom (and where), who is to be condemned or commended (or, indeed, "co-mended"), and what can or may need to be done in order to address inequities that may be expressed in lived experience among SMs and veterans at various health care sites. In turn, just as advances in military health care offer critical knowledge for care of civilians – locally, nationally, and globally – knowledge regarding uneven rehabilitation outcomes at an MTF may also offer insights with broader application.

My Field Site

Walter Reed National Military Medical Center is an MTF that was formed in 2011 when Naval National Medical Center in Bethesda, MD and Walter Reed Army Medical Center in Washington, D.C. merged in Bethesda. The restructuring that prompted their merger was part of a series of federally mandated military base closures and realignments (DOD 2005). While the scope of medico-therapeutic care offered at the merged location is broad, and its patient population diverse (including family members and beneficiaries), its focus and renown are in the care and treatment of active duty male and female SMs from four branches of the Armed Forces (Army, Navy, Air Force, and Marines) whose fitness for duty has been adventitiously, i.e. unexpectedly, altered by wounds, illnesses, or injuries.

At Walter Reed I collaborate in writing research grant proposals, securing funding, conducting ethnographic research to understand the lived experience of people whose abilities have been adventitiously altered, and applying knowledge to practice and policy. As in many kinds of work, administrative work takes up a third of my time, and training and security requirements for working at a military facility occupy a number of hours of every month; yet I am able to work with researchers, investigators, and participants at least half of each day. Co-investigators who collaborate in my research include military and civilian health care practitioners across a spectrum of specialties. Some of the studies we have collaborated in have probed the ethics of conducting research among people who have been harmed and are undergoing rehabilitation; the effect on wounded, ill, and injured SMs of practicing Qigong (a meditative movement practice); and the challenges of inculcating a culture of inquiry (seeking out and using evidence-based practices) in nursing units.

To gain entrée to my field site and the world of my research participants, I first became a research assistant in a DOD-sponsored mixed-methods (qualitative and quantitative) study being conducted at Walter Reed in D.C., working as a contractor for a military medical research foundation that was administering the study's granted funds. I disclosed to my colleagues that I was an applied linguistic anthropologist planning to submit my own research protocols to the Walter Reed Institutional Review Board (IRB). I consented potential participants, conducted interviews, administered surveys, and aggregated and managed data.

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My role blossomed into being a research study coordinator in the Center for Nursing Science and Clinical Inquiry at Walter Reed in D.C., and after July 2011, in the Department of Research Programs in Bethesda. I wrote grant proposals, managed submissions in the local online tracking system, responded to administrative requirements, defended proposals to the IRB, and become certified as an onsite human subjects researcher. My Walter Reed colleagues supported my research goals and lines of ethnographic inquiry, and asked me to become an Associate Investigator in a number of their studies. In that role I collaborate in data collection, interpretation, analysis, and dissemination (presenting study findings). When I was ready to submit my own proposal for approval and oversight, I secured the support of senior military colleagues who were credentialed at Walter Reed, who became Principal Investigators for my studies, as is required at military facilities. Since then I have continued to collaborate with military and civilian teams of researchers who are conducting research at Walter Reed and collaborating institutions; for example, in a study about the physiologic effect of training service animals, with investigators at the Uniformed Services University of Health Sciences; a study of the relationship of autonomic regulation, gene expression, and mind–body practice with researchers at Harvard University and Mount Sinai Beth Israel Medical Center; and a study of the healing influence of art therapy with teams at Drexel University, PA. Now, as a research program manager at a brain injury clinical research institute at Walter Reed, I also work with investigative and technology teams to capture, codify, archive, and disseminate data, via the Federal Interagency Traumatic Brain Injury Research (FITBIR) registry, housed at the National Institutes of Health (NIH) in Bethesda.

Other anthropologists have conducted work at Walter Reed; for example, medical anthropologist Seth Messinger (2010) has shown (among other findings) the healing benefits of peers' and peer families' interactions with SMs in rehabilitation, and the importance of engaging with and acknowledging the altered physical and social worlds that patients actually inhabit. Messinger's work has come to the attention of policy makers within the US military health care system and has generated calls for further qualitative research among wounded, ill, and injured SMs (Caravalho 2011).

Framework

Because my work is based in the belief that notions of ability (and disability) are socio-culturally constructed and environmentally influenced, I requested permission and have been able to conduct research in a space where being "fit," becoming "unfit," and being rehabilitated are overtly understood, acknowledged, and enacted; i.e. at an MTF. People in this setting offer a geography of marked subjectivities; a space in which I can listen to, observe, participate with, and interview people who expressly acknowledge themselves and consociates by rank, ability, readiness, and resiliency. They mark themselves and others, notice changes, make claims, and enact measures within a highly structured system; a system in which signs and symbols

abound and are associated with changes – for better and for worse – in status, and subsequently in ideas about deservedness. The people with whom I work are providers, administrators, coordinators, or recipients of care, and whether they have grasped my role as an anthropologist or not, they say they support my ethnography because they share my interest in understanding the lived experience of SMs whose perceived fitness has been unexpectedly altered, and the under-recognized consequences of having been wounded, become ill, or been injured. At the same time, consociates at Walter Reed are cognizant of and usually expressive about the place and system in which we work: a military base and hospital. The very semiotics I am interested in tracking are central to our varied roles in this space and time; signs and symbols at a military treatment facility are not just prominent; they are essential to identifying – even codifying – and managing change(s) in rank, status, ability, recognition, and access to resources.

Socio-cultural constructions of deservedness may attach eligibility for recognition to facsimiles of able-bodiedness (McRuer 2006). Based on what other researchers and ethnographers have posited, what I observe and collect, what respondents tell me, and what my analysis reveals, it seems that semiotics of posture, gait, uniforms, salutes, medals, and even prosthetics and assistive technologies that mimic able-bodiedness may actively mediate messaging that rewards particular kinds of harm and modes of rehabilitation; in other words, privileged valuations rest on visible and intelligible expressions of corporeal re-integration, such as being able to walk upright. Thus a chain of membership, dis-membership, and re-membering appears to connect particular people, and not others. Some SMs appear or claim to be excluded from widely endorsed and mediated rehabilitative regimens because of their invisible, unintelligible, and "inadmissible" injuries; and they are tacitly constructed as ineligible for, or may be excluded from, the benefits that accrue to others who are granted access on the basis of their visible or "admissible" harm. In addition, when SMs are harmed, they disavow self-identifying as "disabled," distinguishing themselves from others using nomenclature that hierarchizes harm; i.e. as "wounded," "ill," and "injured," the terms-of-art that are replacing the phrase "Wounded Warriors" in many texts.

After September 11, 2001, many US military communications began to include the term "Wounded Warrior," in a rhetorical strategy to reflect the warrior ethos and spirit of wounded soldiers (Krull and Haugseth 2012; Pincus 2012; USAPS 2008; WWP 2011). For a number of years the term "Wounded Warrior" was used in numerous texts to denote people from any of the Armed Forces who had been grievously harmed in combat and were undergoing rehabilitation at MTFs. Based on my data collection and analysis, this term also came to connote "amputee." By 2010 however, in response to patients and their advocates who regarded "Wounded Warrior" as an exclusive term that referred to only a segment of those who had been harmed during active duty, many people and mediated texts began to refer to SMs whose fitness has been adventitiously altered in an array of ways as "wounded," "ill," and "injured"; referring respectively to people who have been harmed in combat, people who have been harmed by disease, and people who have been harmed in, or by, accident(s) (S&NMIECS 2010).

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Theoretical Stance

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While the genesis of these terms lay in an attempt to be inclusive of all active-duty SMs who have been harmed, as often – or perhaps always – happens, unexpected consequences unfolded, pivoting on a dynamic struggle between structure and agency (Ahearn 2001). I have found that as a result of, or in response to, this more recent rhetorical strategy, SMs who have suffered harm are categorized (by themselves and others) within an animated taxonomy that uses "wounded," "ill," and "injured" to distinguish provenances of harm, degrees of sacrifice and service, and levels of deservedness. By provenances I mean sources of harm: where and how harm occurs and is found – not just corporeo-cognitively, but also geo-physically, as in a combat zone for example; technologically, as in a truck rollover, or via an Improvised Explosive Device; and bio-medically, as in psychological health disorders, cancer, heart disease, or diabetes.

Theoretical Stance

To identify semiotic mechanisms at work in the terrain of an MTF, I use analytical and methodological tools plumbed from Critical Disabilities Studies (CDS) that examine constructions of fitness, power, and socio-cultural reproduction (Adkins 2003; Davis 2010; Ingstad and Whyte 1995; Lindenbaum and Lock 1993; Rapp and Ginsburg 2001; Shuttleworth and Kasnitz 2001). In these catchments, researchers problematize notions of disability and deservedness, positioning fitness and unfitness, and eligibility and ineligibility as textually and socially constructed notions that maintain forces and relations of power via normalization and naturalization. By "normalization" I am referring to foundational work done by critical scholars of stigma in which being (or claiming to be) normal is associated with and co-constitutes inclusion; and by "naturalization" I mean the process by which practices that are broadly condoned become so "obvious" that they also become unnoticed, are tacitly understood, and may remain unexamined (Ablon 1981; Althusser 1971; Brown 2010; Decena 2008; Fairclough 2003; Goffman 1959, 1963; Pêcheux 1982). Identifying, examining, and elucidating how normalization and naturalization occur among people within a space enables reflection, contestation, and equilibration. By expressing and examining usage of the apparently inclusive term "wounded, ill and injured," my respondents and I illuminate unanticipated yet powerful exclusionary work that its operationalization may be doing.

Critical Discourse Analysis (CDA), whose analytical method examines how, when, and in what form language, linguistic constructions, discourses, and texts emerge, are circulated, and gain consent (Fairclough 2003) also informed my scrutiny. CDA looks at processes that mobilize texts, which in turn reify and generate loyalty to perceived conditions and instantiations of sexuality, gender, class, age, and ability.

CDA's scrutiny of talk and text (Abu-Lughod and Lutz 1990) enables the study of meanings and perceptions. 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 place. Discourses do not merely

reflect social practices but also constitute or construct them. CDA requires paying attention to specific words, phrases, and locutions, and their relationship within socio-cultural and spatio-temporal contexts. CDA scholarship offers a useful and productive toolkit of methods and analyses that link the textual and the social; and that has been somewhat overlooked within medical research generally, and within research regarding rehabilitation at MTFs in particular (Smith 2007). Its significance for my work lies both in indexing the origins and reproduction of generative discursive mechanisms; and more pointedly, in the (usually) unintended, uneven, and perhaps unjust material and existential consequences that flow from them. Based on what people tell me and what I observe during the course of my ongoing research, orders of deservedness at MTFs are sustained in discourses among SMs, their families, NMAs, and care providers; and these discourses have palpable consequences that are expressed, reflected, experienced, and upheld in spatio-temporal interactions (Howarth and Stavrakakis 2002).

Although points of view vary across their respective epistemological and ontological horizons, most CDA and CDS scholarship poses fundamental questions about eligibility, and offers insights that complicate tests for or measures of recognition and access to resources when these devices rely on ideas about fitness or ability. In turn these questions complicate notions about the ways in which constructions of ability and deservedness are instrumentalized or mediated in human interaction. The socio-cultural 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 influence peoples' lived experience (Lindenbaum and Lock 1993).

In the last two decades' move towards patient-centered medicine within and outside the military, the burden of selecting, adhering to, and sustaining appropriate treatment and recovery regimens increasingly falls to individuals, families, and communities (IOM 2012; PPACA 2010). Underlying this shift in responsibility may be the assumption that patients have the recognition and access to resources that they need to make informed decisions about their own health management. This assumption may obviate the lived experience of people who are not considered eligible to receive and use privileged tools and technologies. Examining and deconstructing uneven if normalized aspects of lived experience among a group of people who are deemed as having been altered by wounds, illnesses, or injuries may help patients, health care providers, and policy makers identify and critically evaluate incommensurable recoveries (or un-recoveries). In turn, thresholds of "eligibility" may be re-examined, and unexpected consequences may be forecast, mitigated, or forestalled.

My ethnography at an MTF continues to show that unless asked and listened to, consociates in rehabilitation at an MTF may not notice or question aspects of their lived experience that could or should be managed differently. My research respondents frequently note (and my ethnographic data express) that civilian and military lives are "different," and that active duty and veteran status are different too; nonetheless, calls and support for bridging gaps between these cultures are burgeoning, including with respect to health care (Cohen 1998; FPCMHC 2012; Gronke and Feaver 2001; Mad USHCVA 2007). An MTF repres space for ethnographic inquiry al broadly, may address and offer in cerns, including linkage between c between members of the military

Methodology

Research across the Military Hea clinicians, social scientists (includir 2008; Engel et al. 2014; Finley 2(over 1,000 active protocols were phases – scientific, administrative, federal strictures regarding human erally considered vulnerable subje human protection guidelines exist 2014; DODI 2011). Many studie civilian investigators and particip national, and even global scales. and practice – and affect civilian

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Gronke and Feaver 2001; Maddow 2012; PRC 2011; Szayna et al. 2007; USHCVA 2007). An MTF represents an unexpected yet appropriate and complex space for ethnographic inquiry about health care policy and practice; and more broadly, may address and offer insightful solutions for contemporary social concerns, including linkage between disability and deservedness, and misunderstanding between members of the military and civilians regarding equity.

Methodology

Research across the Military Health System (MHS) is conducted by a range of clinicians, social scientists (including anthropologists), therapists, and others (Barton 2008; Engel et al. 2014; Finley 2011; Gariti et al. 2009); in 2014 at Walter Reed over 1,000 active protocols were underway. Each of them was reviewed in three phases – scientific, administrative, and ethical – then approved and overseen under federal strictures regarding human protection. Because military personnel are generally considered vulnerable subjects due to the potential for their coercion, unique human protection guidelines exist for studies being conducted at DOD sites (CITI 2014; DODI 2011). Many studies at MTFs are multi-sited, including military and civilian investigators and participants; and are being conducted at local, regional, national, and even global scales. Their findings influence military medical policy and practice – and affect civilian medical care as well (Moskowitz 2013).

To conduct ethnographic research at Walter Reed, I submit proposals for review and approval in an online tracking system; and solicit letters of support from clinicians and administrators who consider the practical impact of the work I am planning, and permit access to spaces and people over whom they have responsibility. Once study protocols are approved and acknowledged, I recruit potential participants by typical ethnographic means, such as word of mouth, introductions by key influencers, flyers, and by identifying myself and my study aims to people with whom I have permission to mingle – for example, in clinics, eating spaces, recreation facilities, internal hallways, and pass-throughs; outside in gardens; or at events. In addition to the several badges I am required to wear every day at Walter Reed, when recruiting potential subjects I often wear a badge that is associated with the particular study underway, including the study's name and IRB approval number.

In order to receive IRB approval and letters of support I provide details about the people I seek to enroll, eligibility and exclusion criteria, the justification for their particular participation, the questions I will ask; the ways in which I will strive to ensure equal representation in sexuality, gender, class, age, and ability; and how my encounters will be empathetic and respectful. This discussion leads to and promotes interest in and support for the work I conduct: questions that anthropologists ask, and the ethnography we conduct, are persistently fascinating to ourselves and others because we are truly invested in listening to peoples' stories. At Walter Reed, my interest in how people regard themselves and are regarded by others after unexpected changes in their abilities consistently elicits more curiosity, support, and participation than disinterest or resistance. Other researchers have noted that

qualitative research study participants report benefit from 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). When I screen people who are interested in participating, we talk about the fact that while they may not receive direct measurable personal benefit from participating in the study, the knowledge gained with their help will be used to comprehend experiences of wounded, ill, and injured SMs, care providers, families, and NMAs who are undergoing, supporting, or providing rehabilitation; and may positively impact military and civilian health care policy, practice, and patient experience.

In other words, as many anthropologists and ethnographers do, I seek approval for asking people to talk to me, for recording or noting their narratives, participating in or observing their activities, and collecting examples of material culture – objects – at my research site. To gather these data, I ask people in various spaces such as clinic waiting rooms, eating spaces, or events like Town Halls to share stories, or direct me to others who might. I provide my contact info and a flyer or postcard about the study, and inform them of its purposes and potential significance. I request that we conduct confidential interviews in spaces they may recommend that are secure, private, and comfortable in which I will record their comments (and mine). And, I ask people to point me to objects and media that they encounter, create, notice, react to, or wish for.

Findings

Since September 11, 2001, approximately 2,000 active duty SMs have become amputees; while upwards of 400,000 have been diagnosed as having comorbidities of Post-Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), and Psychological Health issues (PH), and about 49,000 have become ill because of disease or have been injured in accidents (Fischer 2010; Magda et al. 2012; Tanielian and Jaycox 2008). I found that visibility of harm and recovery's attributes (such as missing limbs and prosthetics) appears to be linked with the degree of attention wounded, ill, and injured SMs receive; indeed, visibility and invisibility of harm endured in military service is the subject of much scholarship (Tanielian and Jaycox 2008). What may be under-examined are linkages between provenances (i.e. origins and sites) of harm, obvious and unobvious modes of rehabilitation, and subsequent levels of recognition and access to resources. My examinations reveal that differences in "membership" experiences may result from actions that valorize fitness and re-fitting as key elements of eligibility for recognition and access to resources; and consequences of cognitive, psychological, and physiological "unfitness" may include experiences of "dis-membering," including misallocation of particular modes of rehabilitation, and inappropriate assumptions about being able to return to duty.

SMs who have obviously been corporeally dismembered (i.e. have lost limbs or digits), may more readily experience re-membership during and after rehabilitation. Based on my research, people who are harmed in combat are regarded (and may regard themselves) as more deserv
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Discussion

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regard themselves) as more deserving of recognition and access to resources than those who are harmed in accidents or by disease. Furthermore, visibly harmed SMs who are being visibly rehabilitated and whose harm originated in combat get more recognition and access to resources than SMs who are invisibly harmed; i.e. those whose harm (be it by accident, or by disease) originated during training or routine (non-combat) active duty and who are being invisibly rehabilitated (using drug regimens for example, or chemotherapy, or complementary alternative interventions such as acupuncture or meditation). My data indicate that SMs who are visibly harmed and understood to have been wounded in combat are selected to sign on to techno-scientific and athletic models of rehabilitation and appear to be recognized and rewarded in ways that others are not. Respondents inform me of kinds of recognition and access to resources, and I also observe mechanisms of inclusion and exclusion. For example, I notice (and study participants tell me) that people who use prosthetics, state-of-the-art transportation devices (such as Segways®), or service animals receive a lot of attention and praise; while some others who self-identify as having improved their ability to remember names and dates, or reduced their consumption of drugs, or are attaining better scores in cognitive measurements, are unnoticed – even disregarded.

Discussion

While qualitative research among civilian subject populations is routinely conducted by social scientists, particularly anthropologists and ethnographers, most studies about SMs have been conducted by scientists using quantitative methodologies (Moore et al. 2011; Oliffe 2005; Pope 2005). In turn, quantitative research about wounded, ill, and injured SMs often focuses on evaluation from the points of view of medical providers. Relatively little work 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 in general 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 some has privileged providers' points of view (Jennings et al. 2007; Rankin 2003).

Beyond their utility in challenging health care policies and practices for wounded, ill, and injured SMs, my ethnographic research findings may be significant to social justice advocacy for people elsewhere who are unintentionally relegated as undeserving – people who may be excluded or "dis-membered" by naturalized mechanisms of recognition and redistribution. Indeed those who are excluded may not only be dis-membered from their original affiliation as fit members of a specific group within a specific force: they also may not be "re-membered" in the same ways – or at all.

My data show that people at my site and in my studies are galvanized by having their stories heard, by co-identifying multivariate texts that convey powerful normalized messages, and by thinking about their own subjectivities differently. As an

anthropologist at an MTF I can gather stories and observe practices in a space that expressly relies on signs and symbols, from a point of view that differs from those of SMs, their family members, care providers, and NMAs. Where my colleagues "see" routine practices, and implement or respond to naturalized policies, my interest in and training as an ethnographer, permit me to see the same data, i.e. the texts that we use and are surrounded by at Walter Reed, differently. In turn, by means of ethnography, study participants and colleagues are able to "see" themselves and their subjectivities – their lived experience – differently too.

Furthermore, my ethnography at an MTF helps us to understand that rehabilitation of wounded, ill, and injured SMs includes more than attending to their corporeal, cognitive, and affective recovery: Walter Reed is more than an MTF. It is also a medical refuge and a state of exception; a space-time in which harms are redressed and things lost and missing are reattached – not just limbs or cognition, but also attributes of membership. At this site consociates jointly work to re-member and rehabilitate both people and ideals such as sacrifice and service. As we solicit, contribute, share, and examine texts together, participants and colleagues find and note to me the remarkable and unremarkable, noticed and unnoticed ways in which their own and others' lived experiences differ and are changed when their fitness for duty is unexpectedly altered, their recovery regimens conferred, and their routines re-established depending on their status as wounded, ill, or injured. Together we find that the site, the source, and the visibility of the harm they have endured, and how their treatments plans are molded, may or may not engender marks of membership and equitable levels of recognition and access to resources.

The invisibility of some bodies whose wounds, illnesses, or injuries are unapparent or unintelligible may not draw "attention" to other consequences of active-duty military membership and service; e.g. 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. This is important to understand, as contemporary warfare, advanced modes of rehabilitation and re-integration, and the presence of militarization are felt in communities worldwide (Açiksöz 2012; Ben-Ari 2004; Gusterson 2007; Lutz 2009; Meekosha and Dowse 1997; Nordstrom 2004; Price 2008). In other words, the visible and invisible effects of war, and naturalized meanings of sacrifice and service continue to penetrate all walks and ways of life – socio-culturally, politico-economically, and with respect to health care. Wounds, illnesses, and injuries of war and military service affect SMs and civilians worldwide. The lived experience of rehabilitation at an MTF may differ to some extent from that of veterans and perhaps more so from civilians; yet I find that the span of disregard or erasure for those who cannot be "re-membered" for one reason or another, may be broadly under-recognized.

My ethnography at an MTF provides an example of applied theoretical anthropology. With the generous support of colleagues and research respondents, my participation and observation, interviews and surveys, data collection, and analyses demonstrate that constructions of as environmental; that the effects understood; and that they require The lack of mutual knowledge a cultures is divisive and costly at p Understanding the lived experienc is important to bridging the gap b the military are people who are versa. Garnering knowledge about ill, or injured – no matter the sou consequences across widening pc geographies in military and civilia

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demonstrate that constructions of ability and "dis"ability are socio-cultural as well as environmental; that the effects of these constructions are uneven and poorly understood; and that they require further research (Schneider and Ingram 2005). 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 rehabilitation, 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. Garnering knowledge about the real and lasting effects of becoming wounded, ill, or injured – no matter the source or visibility – is critical to managing costs and consequences across widening politico-economic, bio-medical, and socio-cultural geographies in military and civilian terrains.

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Note

1 Non-medical attendant (NMA) is a designation used within the US Armed Forces to signify a designated caregiver. Wounded, ill, and injured 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 caregivers. By means of ethnography at Walter Reed in Washington D.C., Wool and Messinger (2011) capture trenchant aspects of NMAs' lived experience.

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