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Veteran Therapeutics: The Promise of Military Medicine and the Possibilities of Disability in the Post-9/11 United States

*This article draws on a decade of ethnographic work with injured U.S. soldiers and veterans to show the collateral effects of military medicine’s salvific promise. In tracing these effects through recent changes in amputation protocols and less spectacular conditions such as posttraumatic stress disorder, I show that the prevalent model of “veteran therapeutics,” which posits cure as the aim of post-war has perverse and cruel effects. Drawing on disability theory, I explore alternative ways to read the frictions that soldiers and veterans experience, stretched between the medical model of veteran therapeutics and an emergent sense that cure may be an impossible goal. Alternatively, the article turns to moments when veterans learn to live with disability, rather than living in anticipation of its end. Though small, such moments contain possibilities for a less cruel mode of inhabiting disability, offering incipient signs of what we might call a *crip art of failure*. [veterans, disability, biomedicine, United States]*

In addition to the well-worn truism that war may be bad for people but good for medicine, historians, anthropologists, and others have recently been unfolding the ways that war is not only the laboratory within which new advances in technology and medicine are discovered and tested, but the ways that the rehabilitative and reconstructive aspects of military medicine in particular have acquired a kind of salvific force (Howell 2014; Puar 2017; Terry 2017), redeeming what would otherwise be war’s insufferable waste (see Linker 2011). Much of this scholarship takes off from Foucault’s famous statement that in the age of biopolitics wars are waged in the name of vitality itself, for the well-being of the population rather than the protection of the sovereign. Not only is this logic central to the rise of so-called humanitarian war in the late 20th century (Fassin and Pandolfi 2010) it has also been a central feature of the U.S.-led post-9/11 wars.¹ But these recent wars show other forms of vitality are at stake as well. A perverse vitality is extracted from war through new medical knowledge and military technology and tactics that reduce death while increasing debility (Puar 2017), while simultaneously promising

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to erase the embodied traces of war violence that linger in sacralized soldier bodies and minds.

Here, I heed the caution of these arguments against an optimistic embrace of medicine's *promise*—its promise to the nation, and to soldiers and those who share their lives, that medicine can make good on the violence of war. Rather than allow the medical advances garnered in war to appear simply as a vital social good, I aim to situate the promise of military medicine in a fuller context and to attend to the ways that the logics and practices of medicine can cut many ways at once.

Drawing on a decade of ethnographic work with injured U.S. soldiers and veterans, I trace the ways their bodies and minds are configured as part of the rehabilitative promise of military medicine. But I also follow the clinical and social life of what I call “veteran therapeutics”—the cultural and clinical logic, informed by the curative imaginary of biomedicine (Clare 2017, 60–61) and the normative imperatives of rehabilitation (Stiker 1999) that healthy veterans are those who are cured, showing no pathological signs of their service.² I show that while soldiers and veterans are themselves often invested in such redemptive and normative possibilities, they are also surrounded by evidence of their collateral effects, uncertainties, and sometimes, failures—from iatrogenic conditions to the persistent prevalence of suicide. Thus, these attachments to the curative promise of medicine, attachments embedded in a broader moral and biopolitical landscape that devalues disabled lives and worlds, take on the cast of cruel optimism (Berlant 2011), sometimes producing new harm and usually stalling veterans in a protracted and disappointing present.

In doing this, I offer ethnography as a way to hold our thinking about the promise of medicine and imperatives of cure and rehabilitation accountable to the frictions of life as it unfolds in particular living bodies, in particular worlds. A central tenet of medical anthropology has, of course, long insisted on the relevance of “local moral worlds” (Kleinman 1992) to any understanding of medicine. But here, as part of the emergence of disability anthropology (Friedner 2015; Friedner and Zoanni 2018; Ginsburg and Rapp 2013; Ingstad and Reynolds Whyte 2007; Kasnitz and Shuttleworth 2001; see Bloom 2019) I supplement medical anthropology's imperative to understand situated suffering (e.g., Kleinman et al. 1997) with work in critical disability studies that asks us to consider the possibilities of other orientations to impairment and difference (Kafer 2013); the possibilities not of cure, but of disability itself (Clare 2017).

My aim is not to suggest that military medicine or rehabilitation are *wrong* but to ethnographically dislodge the fantasy of their promise. To do this, I move us across a range of ethnographic sites and moments—from soldiers at Walter Reed Army Medical Center who had just been catastrophically injured in Iraq and Afghanistan to more recent work with injured veterans in Texas and elsewhere who are many years past the end of their military service. By moving across these sites, we move from the more acute and more explicitly medicalized spaces of recovery to the broader world in which the imperatives of recovery continue to resonate.

Innovation and Iatrogenesis

Starting in the fall of 2007, I conducted a year of fieldwork based at Walter Reed, the U.S. military's flagship medical facility in the nation's capital, widely known

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3 for its treatment of combat injured soldiers (Wool 2015). When Walter Reed first
4 opened its doors in 1909, it was not to care for injured soldiers, but was a showpiece
5 of training, research, and cutting-edge techniques, a new site for American medical
6 innovation. When the United States entered WWI in 1917, it quickly became one of
7 four hospitals designated to care for soldiers as they began to be shipped home, newly
8 devastated by industrial warfare. It was then that the hospital began specializing in
9 prosthetics, joining its original purpose of medical innovation to the exigencies of
10 war. Through cutting-edge technology, and the early consolidation of rehabilitation
11 as a field of medical specialization, Walter Reed became the place where the moral
12 and political promise of military medicine would be publicly fulfilled: that injured
13 soldiers could be remade into socially reproductive men (Linker 2011). Throughout
14 the world wars, the promise of military medicine emerged not only as one proffered
15 solution to the “problem of the disabled veteran” (Kinder 2016), but as beneficial
16 for the nation, as it reaped the rewards of military medicine and technological
17 innovation, which have brought us everything from the use of the helicopter for
18 emergency medicine, to the use of DDT under the sign of public health (Conis 2017).
19 Injured soldier bodies could thus yield returns in the form of medical knowledge—
20 from prosthetics to plastic surgery to neurology—that could benefit the civilian
21 public and American medicine itself. Contemporary media heralded these “dual
22 purpose” innovations, with one 1943 headline in the *Washington Post* declaring:
23 “Walter Reed—Miracles for War—And Peace. Our Soldier Patients Benefit from
24 Hospital’s Research—And Civilians Too.”

25 Today, Walter Reed remains the prime site in which the redemptive possibility of
26 military medicine is seen to be given flesh. For example, the rehabilitative trajectory
27 of Sgt. Brendan Marrocco, the first surviving quadruple amputee of these wars who
28 spent nearly a decade at Walter Reed, was widely publicized. Marrocco was in a
29 vehicle hit by an EFP (explosively formed projectile) in Iraq in 2009. The following
30 year, he appeared photographed during a physical therapy session on the 4th of
31 July cover of the *New York Times*, the story celebrating his effort to “reclaim his
32 life” through rehabilitation. In 2013, Marrocco was at the center of another flurry
33 of media attention when he received a double arm transplant, attention that largely
34 portrayed the surgery as miraculous, despite the recognition that the function of the
35 transplanted arms would be limited.

36 During my fieldwork there in 2007–8, as throughout the wars, the majority
37 of such casualties had been blown up by improvised explosive devices (IEDs), a
38 single injuring event that results in multiple confounding conditions. The vectors
39 of force of an IED are sheered and shaped by the physical specificities of military
40 tactics and the battle space, by the kinds of armor the military constantly redesigns
41 to keep soldiers from dying, and by the responsiveness of battlefield medicine,
42 which finds new ways to intervene in the midst of these forces and keep soldiers
43 alive. Survival usually entailed some combination of confounding wounds including
44 burns, shrapnel, broken or shattered bones, traumatically amputated limbs, organ
45 damage, broken eardrums, along with traumatic brain injury (TBI) which has joined
46 post-traumatic stress disorder (PTSD) as the twin “signature injuries” of these wars
47 (see Terry 2009). The result is serious injury to multiple systems of the body—a
48 condition known as polytrauma, which many clinicians suggest should itself be
49 thought of as the signature of these wars.

Partly in reaction to the disastrously ill-equipped landscape of rehabilitation that faced casualties of the Vietnam war, Walter Reed had robust rehabilitation programs and a sophisticated amputee clinic (Messinger 2010), and soldiers could, in theory, stay for as long as was needed to stabilize their body in its new form. The decision about how long to stay involved complex negotiations between soldiers and clinicians, and between them and the family members who were paid to live with soldiers throughout their rehabilitation (Wool and Messinger 2012). The Army Medical Command continually updated its practices and facilities as the landscape of injuries became clearer and as their own research and experience suggested new best practices.

Nevertheless, this ongoing evolution led to significant transformations in a range of clinical practices, transformations that were cruelly optimistic, a salvific promise to make the wounded body better that also made it worse. Take the case of amputation and prosthetic use. At the start of the wars, standard treatment for catastrophically injured limbs was to amputate them clean, high, and early. That is, a mangled leg would be amputated at the lowest point that was still above the top of the injury and would ideally be sutured into a straight, neat, and compact residual limb that would heal into a standard shape. Amputations would be performed soon after injury, generally before transport to a tertiary hospital like Walter Reed.³ These practices were thought to lead to the best outcomes for prosthetic adoption, and amputation before transport was thought to be safer. However, after the first few years of the Iraq war, Army doctors drew on their rapidly accumulating experience of blast-injured limbs to effect a fairly radical transformation (Kellermann et al. 2017; Nessen et al. 2008).

First, it seemed that some limbs that appeared unsalvageable in the theater of war proved to be salvageable through reconstruction back at Walter Reed or other state-side military hospitals. Because amputation is clinically seen as a failure and limb salvage a better clinical outcome, now, supported by improvements in the management of hemorrhagic shock, soldiers may be transported half-way around the world with open fractures or wounds and still-mangled limbs held together with bandages, forceps, or other temporary measures in the hopes that those limbs might be reconstructed. This also meant that should amputation prove necessary, it now increasingly happens at a tertiary hospital like Walter Reed. Surgeons there have found that even in cases of amputation if they had more—even if more messy—muscle, bone, and skin to work with, they could create residual limbs that seemed to lead to better rehabilitation outcomes and prosthetic adoption. So, instead of early, high, and clean amputations, medics and doctors in the field as well as surgeons at home now work to preserve as much limb length as possible, with surgeons creating residual limbs that are more varied and irregular in shape. These changes, in turn, have fed into increased tele-communication between battlefield and state-side clinicians, and also more integration and collaboration between surgery and prosthetics, another factor that has further enhanced the success of prosthetic adoption.

This successful story of innovation has had a range of consequences. For one, it has led to a more iterative process of rehabilitation, where multiple reconstructive surgeries may be followed by physical therapy, which may be followed by revision surgery and further physical therapy and further revision and so on, all in the name of limb salvage. It has also led to increasing numbers of delayed amputations—i.e.,

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3 amputations that happen months after injury and after repeated surgeries and ex-
4 tensive physical therapy have been unable to achieve a satisfactory result (Helgeson
5 et al. 2010).

6 In many ways, these evolutions fulfill the redemptive promise of military
7 medicine—fewer amputations, better functional outcomes even for those who do
8 have them, and new medical knowledge that extends beyond the battlefield, as
9 more and more civilians also opt for “previously unthinkable” delayed amputations
10 (Okeowo 2012). But if vitality—both a preservation and a flourishing of life—is
11 seen as one outcome of such innovations, this vitality is not quite so straightfor-
12 ward. The new iterative picture of rehabilitation and amputation produces very
13 specific and protracted kinds of pain—these, too, are result of medical innovation
14 and the widespread faith in medicine’s salvific potential. These are collateral effects
15 of veteran therapeutics.

16 When I met James in the Fall of 2007, he had already been at Walter Reed for a
17 few months and had had one leg amputated above the knee. His wife, Erin, and their
18 almost one-year-old daughter were living with him at Walter Reed. James tilted his
19 slim and slouchy body back in his bright magenta titanium wheelchair, balancing
20 in a wheelie as he told me about how exactly the doctors reconstructed his leg. He
21 explained it wouldn’t always be so noticeable that they had remade his shin out of
22 what used to be his calf.⁴

23 Despite efforts at physical therapy and narcotic medications, the pain in his
24 reconstructed leg had been getting worse, and he’d become unable to continue
25 practicing with his prosthesis. He stopped going to most of his physical therapy
26 appointments. The stump of his other leg began to swell, not being trained into
27 submission by the pressure of the prosthetic socket and the binding “shrinker”
28 sleeve worn with it. Prosthetic use also desensitizes the residual limb, as the limb
29 accommodates the hard surface of the socket.

30 The occasions when James did venture out on foot with his cane and prosthetic
31 leg rather than his wheelchair left him exhausted and in pain, but he hid it behind
32 the conspicuous display of the very prosthetics that hurt him (see Messinger 2009).
33 Always wearing shorts when we ventured out, James’s pain becomes invisible behind
34 the biotechnical promise of his prosthetic, allowing him to be read not as disabled,
35 but as “hyperprosthetized” (Mitchell and Snyder 2015, 57).

36 Shortly after New Year 2008, James had another surgery, this time to reset his
37 ankle, which the doctors thought might make his leg more functional. They were
38 wrong. A few months after that, he underwent a delayed amputation. His second
39 leg is now gone below the knee. By the summer, he was learning to walk on two
40 prosthetic legs, but usually goes without them, using his wheelchair instead. He is
41 getting better at moving around without the chair too—finding ways to scoot and
42 crawl along the floor (though he often prefers it, such alter mobility is not part of
43 the normative picture of rehabilitation and not something included in the practices
44 of veteran therapeutics). As we sit smoking outside, he tells me he’s waiting for
45 another surgery, this time to remove “HO,” or heterotopic ossification: new bone
46 that grows at the site of injury and can bore painfully into the flesh.

47 Heterotopic ossification is relatively uncommon in the civilian amputee popula-
48 tion but is estimated to occur in more than half of soldier amputees injured in Iraq
49 and Afghanistan. Its commonness is in part a marker of the material specificities

of these wars: It is more likely to occur when a limb has been injured in a blast. But it is also a consequence of the innovations in surgical practice discussed above: HO is more likely to occur when the amputation site is within the zone of injury, a consequence of the shift toward surgical salvage and the preservation of limb length (Alfieri et al. 2012; Nessen et al. 2008; Potter et al. 2007). The prevalence of HO, the intense pain that it causes, the surgical revision it requires, the fact that James will undergo yet another procedure in which his flesh will be opened and his bone will be sawed and his skin will be stitched, another procedure from which his body will have to heal before he can restart the painful effort to walk on prosthetic legs that he would rather not use—all this is *also* what the fulfillment of military medicine's promise feels like as it is routed through James's body.

Of course, there are other examples in which soldiers choose not to undergo amputation but to continue with the iterative cycle of reconstruction and recovery and revision. But both in those cases and others in which soldiers may opt for delayed amputation, soldiers themselves evince a faith in the promise of military medicine, which has already been so cruel. In fact, while most soldiers who undergo delayed amputation generally have less pain and more limb function than they did before, at least one study suggests delayed amputation may lead to negative mental health outcomes in part because soldiers have unrealistic expectations for the results (Helgeson et al. 2010).

Tracing the implications of the moral fable of innovation, of the redemptive promise of military medicine, as it is routed through the body of a particular injured soldier—James—reveals its painful contractions. Most notably, that while medicine can increase the vitality of war—the measure of life and health that war is said to yield—the specific trajectory of that vitality can be perverse—newly salvageable limbs can wrack the body with pain; delayed amputations can yield less neurological pain, but more mental distress; the imperative to preserve limb length can lead to better function, but also the unruly and painful growth of bone and a protracted and iterative process of medical stabilization that can stretch on for years. Perhaps it is worth noting that Sgt. Marrocco, the first surviving quadruple amputee of the post 9-/11 wars who was injured in 2009 and received a “miraculous” double arm transplant in 2013, lived at Walter Reed not only for that four years, but for at least another five years of rehabilitation after that, totaling nearly a decade of treatment that included multiple reconstructive surgeries for both his upper and lower limbs as well as his face.

One lesson here is that the growth of vitality is not without its pains, and ethnography will not allow us understand such vitality as an obvious or straightforward good. At the same time, we learn a seemingly contrary lesson: that the redemptive promise of medicine, and the imperative of veteran therapeutics for soldiers to *recover*, be cured, erase the legacies of war's violence through enactments of normative or extra-normative capacity remain compelling, not only for medicine but also for soldiers.

Veteran Therapeutics

While amputations remain the iconic signifier of the disabled veteran, they actually account for a vanishingly small proportion of the overall injuries, with only about

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3 1,800 amputees throughout the entirety of the wars thus far. Let me sketch a more
4 accurate picture.

5 At the VA, the most common ailments for post-9/11 veterans are injuries to
6 the joints and connective tissue—chronic problems that often come with chronic
7 pain and reflect the intensity of routine wear and tear during deployments in which
8 soldiers regularly ride around over bumpy terrain in massive vehicles wearing 60, 80,
9 or 100 lb of armor and gear. This is closely followed by mental and behavioral health
10 diagnoses, particularly PTSD—diagnosed in about 20% of veterans (Tanielian and
11 Jaycox 2008)—depression and anxiety. Somewhere between 11% and 20% of all
12 service members deployed post-9/11 have sustained a TBI (Lindquist et al. 2017).
13 In addition to these, there are a slew of other afflictions arising from the varied
14 exposures that have been routine parts of post-9/11 deployments—everything from
15 sleep disorders and addiction to respiratory illnesses and cancers connected to toxic
16 military exposures. Never far from this picture is that fact that veterans are also at
17 increased risk for suicide. Though the widely circulated figure of 22 veteran suicides
18 per day has proved to be misleading (MacLeish 2019), recent VA research finds
19 that, compared to age-adjusted civilians, risk for suicide is 19% higher among male
20 veterans and more than 100% higher among female veterans.

21 This brief sketch should offer some sense of the complex picture, a picture not
22 evoked by the term “disabled veteran” or the clean and prosthetically enhanced
23 body of the iconic amputee. Whatever we call them, these veterans are likely to
24 have multiple afflictions and multiple service-connected diagnoses that are often
25 made legible though a veteran’s VA disability rating, a percentage based on an
26 immensely complex rating system calculated in part through compounding (rather
27 than additive) percentages of functional limitation. Dale, for example, had been a
28 firefighter EMT before he joined the National Guard. He ended up serving as a
29 medic at one of the largest U.S. bases in Iraq. Now in his mid-30s, Dale has a 30%
30 disability rating for a combination of PTSD, tinnitus, and chronic back pain. He
31 is also trying to get a determination of service connection for knee injuries and for
32 chronic sinus problems he connects to exposure to burn pit smoke, which might raise
33 his rating another 10%–20%. Jane is a veteran now in her early 40s with a 70%
34 disability rating for chronic stomach and eye problems, depression, and sometimes
35 incapacitating pain in her ankles and back, all of which stem from injuries during
36 her service. Jason has a disability rating of 100% from a severe penetrating TBI he
37 sustained in 2005.

38 In the nearly two decades of these wars, there has been a remarkable flourishing
39 of options through which veterans can and do seek repair. There are writing retreats
40 and self-help training, sweat lodges, and Christian evangelical healing. There are
41 bariatric pressure chambers that promise to cure PTSD. There is acupuncture, yoga,
42 art therapy, and EMDR. In stark contrast to the system of medical care available to
43 civilians, there are thousands of organizations that have cropped up to offer these
44 services to veterans for free or at low cost, and though care within the VA remains
45 highly pharmaceuticalized, complementary and alternative approaches are increas-
46 ingly available within the VA system itself, where all care for service connected
47 conditions is provided for free.

48 But even across that varied ecology of care, I have been struck by the prevalence
49 of a medical model of veteran disability. By “medical model,” I mean to evoke both

the classic distinctions between lived experience and biomedical knowledge articulated in medical anthropology—e.g., Arthur Kleinman’s (1988) distinction between illness and disease or Margret Lock’s work in the space between situated and supposedly universal biologies (2001, 1995)—and also to evoke the “medical model of disability” articulated within disability studies, which names and aims to denaturalize the biomedically inflected understanding that being disabled results exclusively from individual impairment and should be corrected by expert intervention into the body or mind (Shakespeare and Watson 2001; Taylor 2017). Alloyed to the old ideas that health is the absence of disease and that a good subject of such a condition should want to be cured, this hybrid sense of medical logics of functional difference and medical cure are what undergird contemporary “veteran therapeutics,” a model of veteran health and wellbeing that invests in the promise of recovery, the return to a state of normalcy—of non-disability, reflecting the underlying premise that “disability in the United States is often viewed as an unredeemable difference” (Kafer 2013, 74).⁵

There are many reasons for the prevalence of this medical model of veteran therapeutics. Certainly it has to do with the wider setting of the United States, where—despite this era of anti-vaxxers and “alternative facts”—biomedical authority retains a solid grip on social understandings of health, and the body and its processes are highly biomedicalized—something we see in everything from the astoundingly high rates of prescription drug use (Dumit 2012), to the problem of “too much medicine” (Kaufman 2015) late in life, to the comparatively high rate of caesarian sections (Davis-Floyd and Cheyney 2019). These features of U.S. health care are bound to a medical and pharmaceutical industrial complex in which health, indeed the promissory logic of cure, has been transformed into a space of capital extraction (Dumit 2012; Kaufman 2015; Petryna et al. 2006). The VA is certainly part of this, if one that is comparatively unburdened by insurance limitations.

This broader U.S. logic of biomedicalized care is amplified and takes on a new moral weight in the context of veteran therapeutics because of the long entanglement of war and medicine as companionate forms of institutional expertise and the deep embedding of the nationally redemptive promise of military medicine in cultural orientations to, and normative aspirations for, disabled veterans. It is a key part of American “attachments to war” (Terry 2017). In the Vietnam era, the failures of this military medicine’s redemptive promise were spectacularly displayed. The shadow of that era haunts the post-9/11 moment in myriad ways, including a kind of doubling down on both the biologization of the harms of war and the investment in biomedical redemption. For example, while the biologization of mental distress may have officially announced its return to the scene with the revolution of the DSM III in 1980 (Mayes and Horwitz 2005), when the diagnosis of PTSD first appeared as a remedy for Vietnam veterans (Scott 1990; Young 1995), the contemporary biologization of PTSD is particularly “passionate” (Young and Breslau 2007), sending clinicians and researchers hunting for biomarkers in brightly illuminated fMRI images of soldiers’ brains.

So, what effects does veteran therapeutics have as it shapes disabled veterans’ own understandings of their lives and futures? With a few notable exceptions, the veterans I’ve worked with in recent years continue to pursue cures for their conditions—for PTSD, chronic pain, for neurological symptoms related to toxic

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3 exposures—with varying degrees of optimism. But as time stretches on and symp-
4 toms remain, many simultaneously develop a kind of emergent understanding of
5 their conditions as parts of them they have to learn to live with. That is, on the
6 whole, veterans have a sense that their conditions must be lived with, rather than
7 cured, while simultaneously turning to curative treatments—a contradiction that
8 arises from the friction between the promise of military medicine and the ongoing
9 experiences of pain and debility that ripple out through veterans’ bodies, lives, and
10 worlds.

11 This contradiction was especially evident at a retreat for injured veterans I at-
12 tended in 2013. Put on by the non-profit organization “Help for America’s Heroes,”
13 the aim of the weeklong event was to get injured veterans “on the road to recovery.”
14 They had selected 100 veterans—all but two were men—who they identified as “the
15 most severely injured” out of the more than 300 who had applied. They brought
16 them, and their families—almost all wives and many with children in tow—to a
17 family-friendly luxury resort for a week of workshops, inspirational talks, well-
18 ness and job fairs, and VA assistance. Central to the retreat were a group of peer
19 leaders—other injured veterans who had previously benefited from the organization
20 who acted as both facilitators and role models for the new veterans in attendance.
21 Each day featured a morning session in the resort’s massive ballroom. We sat at
22 large round tables with our plates of buffet breakfast listening to speakers and then
23 to each other as the microphone was passed around the room.

24 While some of the events were canned (but no less effective) motivational speeches
25 that emphasized the individual veteran’s ability to overcome their struggles with the
26 help of their family and perhaps God, a morning panel of team leaders evinced
27 more candor. Each team leader told their story, most focusing on finding sources of
28 support and strength. They encouraged the other veterans present to seek help, to
29 never give up, to keep fighting and walking the road to recovery. But there was a
30 darker counter tone to the note of optimism in these stories, a tone amplified as the
31 panel took questions and comments from the rest of the veterans. As the microphone
32 circulated through the room, veterans and their caregiving wives voiced despera-
33 tion, frustration, exhaustion, anger, and despair. Wives with secondary PTSD who
34 spent years trying to get their husbands help from the VA and repeatedly had claims
35 deferred or denied; veterans who were drowning in debt, who were isolated and
36 exhausted and didn’t know how to go on. And in response, alongside the exhorta-
37 tions to keep going and the affirmations that things would be different because now
38 they had the organization on their side, some team leaders acknowledged that even
39 for them—the role models of recovery up there on the dais—the war was not over,
40 every day was a struggle, each morning you have to get up and make it through the
41 day all over again. The message that emerged was that each veteran had to struggle
42 to get better—to “walk the road to recovery”—but also that recovery was further
43 along than anyone there had traveled, that perhaps none of them would ever reach
44 it.

45 The Sisyphean echoes of such an effort are especially appropriate, given the way
46 that suicide was considered (see Camus 1991), as it often is in discourse about
47 veterans, as the alternative to recovery. Many veterans talked of their intimacy
48 with suicide, some had attempted it, others had given it serious thought (and con-
49 tinued to do so). One spoke of driving his car at high speed into a brick wall.

Another simply said that if his mother hadn't dropped everything to help him, he wouldn't be alive. Another—a well-known motivational speaker and Vietnam veteran—described pulling out what he had hoped was his breathing tube while undergoing months of skin grafts after a phosphorous grenade went off in his hand. The result was a painfully constrained vision of possible future trajectories: Either you walk the road to recovery—though it may be long and hard and not ultimately get you to its promised destination—or you succumb to your despair. Vitality here is crude and all or nothing.

Elsewhere, I've thought about the way that heteronormative couplehood is figured as the social form that is supposed to secure life against this threat—transforming intimacy into a technology of suicide prevention (Wool 2019). But here, I want to focus on this mortal imperative to recover, and on the consequences of a medical model of veteran therapeutics in a situation where the contours or even the meaning of “recovery” are not so straightforward and a state of “being recovered” seems more the exception than the rule. I want to show both the orientation of cruel, sometimes flagging, optimism that characterizes this situation, as well as the ways this situation might contain an inchoate sense of an option other than recovery or failure, even as this sense is overwhelmed by the fantasy of recovery.

Perhaps the only speaker at the retreat who voiced an alternative to the painfully constrained horizon of possibility—the binary of recovery or mortal failure—was a team leader named Kenny, a former Marine who still had a bullet lodged at the base of his skull a decade after being shot through the jaw in Iraq. Doctors had opted to leave the bullet in place, given the risks of surgery. They anticipated it would calcify, that Kenny's own bone would stabilize it, minimizing the risk to his brain, nerves, and spinal cord posed by the possibility of it shifting positions. But 10 years later, that hadn't happened. Kenny lived with a range of neurological problems from pain to aphasia caused by the bullet impinging on his nerves. And he also lived, as he put it, a fraction of an inch away from death. In Kenny's reckoning, there was no cure to pursue, no incremental progress, only life and death. His message to other injured veterans was not about the road to recovery, but about making the most of each moment.

The strange temporality of his injury was part of what led him to posit a different way of reckoning time—a presentism that eschewed any future horizon formed largely by the fact that the moment of his injury was almost absurdly extended—the bullet that entered him in the flash of a muzzle hadn't yet been stilled 10 years on. He pointed out an ironic fact—one he explained to me he'd simply come to accept—that if he got into a car accident, say, or fell off a ladder, or otherwise sustained a serious head injury, he might end up being killed by that bullet. Flaunting the logic of veteran therapeutics, in one account of his story, Kenny says, “Recovery is a funny word. You recover from some things. But some things only get worse.”

Kenny's almost Zen approach revealed the promise of veteran therapeutics as a false one. But his skepticism about recovery and cure is by far the exception across the landscape of veteran therapeutics. Take, for example, PTSD. Sometime around 2010, the VA began to approach PTSD as curable by default, rather than chronic or lifelong. The VA's own meta analyses indicate that 53% of people who receive effective treatment will no longer meet the criteria for PTSD diagnosis (<https://www.ptsd.va.gov/>), a figure that does not in itself warrant the VA's

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3 optimistic approach. When I once expressed my skepticism about this optimism to
4 a colleague who works at a large VA, she did not share it. She told me that PTSD
5 *is* curable, and it should be understood that way. Treatment can be effective, and
6 veterans should know that. It may seem hard to argue with that logic. Isn't not
7 having PTSD better than having it? Shouldn't we encourage diagnosed veterans to
8 work their way into that slim majority who no longer meet the criteria?

9 My effort here is certainly not to argue against treatment, but we would do
10 well to remember that efforts at treatment do not have to be the same thing as an
11 imperative to cure. I want to note that such an imperative, however well intentioned
12 and however evidence based, can have perverse consequences—perhaps especially
13 (though not exclusively) for the 47% who find themselves still over the diagnostic
14 threshold. From a public health or clinical perspective, it may make good sense to
15 adopt a disease model and shout from the rooftops that PTSD *is* curable, while
16 still knowing that it may or may not be curable in any given case. But as work on
17 the violence of care reminds us (e.g., Garcia 2010; Mulla 2014), anthropologists
18 must think twice about the seemingly unimpeachable logic of saving lives, especially
19 when that biopolitical imperative entails not caring in any particular way about the
20 particular people living them (Stevenson 2014). What is ethnographically striking to
21 me about the seemingly unimpeachable exhortations to veteran cure and recovery is
22 the way that veteran therapeutics forms a normative expectation of what life in the
23 aftermath of injury should look like, and that veterans must find ways to actually
24 live these lives spread across the optimism of its curative logic and the emergent
25 awareness that, for so many in their worlds, as Kenny says: Some things get better.
26 Some things get worse.

27 If Kenny's orientation to recovery helps dislodge the fantasy of veteran therapeu-
28 tics' optimistic promise, the case of Bianca and Alejandro illustrates the difficulty of
29 living disability while being simultaneously invested in, and disappointed by, that
30 promise. Bianca is a veteran in her 30s and a social worker at a veterans' service
31 organization in Texas. She is also the primary support for her husband, Alejan-
32 dro, who is also a veteran. Alejandro has an 80% disability rating for an array
33 of service-connected diagnoses. Primary among them are PTSD and depression, to
34 which are added asthma and a slew of chronic musculoskeletal conditions. I inter-
35 viewed Bianca in 2017 about her own experiences as a soldier and veteran, as well
36 as her experiences as a caregiver to Alejandro, who, seven years after the end of his
37 service was far from cured. He almost never slept through the night, periodically
38 going into their sons' bedroom to make sure they hadn't died in their sleep. Some
39 days, he would fall asleep for 24 hours straight. He still had trouble with crowds
40 and preferred not to leave the house. He couldn't manage his own care and only in
41 the past couple of months had he been able to get himself to some of his doctors'
42 appointments without Bianca's escort.

43 Alejandro had been a fuel truck driver in Afghanistan while Bianca had been
44 stationed state-side working with a psychological operations unit. He survived his
45 first deployment, but one of his closest buddies was killed while taking one of
46 Alejandro's shifts, and he was undone by his sense of grief and guilt as well as by
47 the toll of his serial exposure to death.

48 In her account, the years since Alejandro's deployment unfolded as a trajectory
49 of ups and downs. First, Alejandro got a job driving trucks for Dr. Pepper. He

struggled, and began drinking, but managed to keep his job until after their second son was born. Then he got fired. He got another job as a security guard, but his anxiety was relentless, and his drinking got so bad that he ended up in the ER. Things got better, and then the drinking got worse. He ended up in the hospital again. Bianca counts this as one of his many “bottom of the barrel moments.” This time he was admitted to the ICU for a week with severe acidosis (acidic blood) and pancreatitis so severe doctors considered removing his pancreas. As a result, he developed diabetes. At the time of our interview, Bianca said that things were looking up. Alejandro had been in weekly psychotherapy for 10 months and had started traveling to his sessions on his own. He’d started taking the initiative to call his psychiatrist when he seemed to need an adjustment in his medications. That summer, with Bianca’s extensive preparation, help from his psychiatrist, and extra doses of anxiety medication, he’d even flown by himself to California to visit a buddy he served with in Afghanistan.

Bianca says she is focused on curing his PTSD. She tells Alejandro: “Listen, get this PTSD under control in 10 years because right now we’re looking at the 10-year mark waving at us.” Thinking of veterans with whom she works who have been in the same precarious state for 20 years or more, she says “How about we nip this in the bud in 10 years? That’s *my* goal.” But with each of these ambitions—each gesture of faith in veteran therapeutics—she hedges. She says his alcoholism is “probably the best it’s been in many years.” And then adds, “But it’s still, I don’t wanna say it’s a problem, but it’s still there.” She finds beer cans in the garbage or the remains of last night’s drink in a glass in the living room. She says: “There was a time when he did completely cut it out, but then it slowly was, ‘Oh lemme have one beer,’ and then ‘Lemme have another beer.’”

Her goal is to get rid of his PTSD in 10 years. “But,” she said, “I don’t know. We got another three years to find out.” Right now, he’s getting better, “on an increase” she says. “But yeah, there could potentially be another 40 years.” Reflecting on the seven years since he left the Army, Bianca said:

There were times that I thought “Yeah he is getting better and maybe we will see the end” and then he regresses. And then we’re back up again. [Now] I feel like we’re on an incline, and like maybe there is an end. But I really don’t know. I really don’t know, and I really don’t know if he will completely regress again and bottom out again.

As she puts together her account of Alejandro’s trajectory, again and again and again the tension surfaces between the trajectory she wants—the road to recovery that, while perhaps bumpy, at least leads toward the horizon of cure—and the experience of waxing and waning, ups and downs, of not one but many bottom-of-the-barrel moments. And as much as Bianca wants to give an account of the telos of recovery, the last seven years tell a different story. Bianca is certainly invested in curing Alejandro. For years, she has made appointments and taken him to them, kept an eye on his medications, initiated psychotherapy, all in the hopes that one day none of that will be necessary. But she also says that she can’t force Alejandro to get better, and she knows, thanks in no small part to her experience as a social worker, there is only so much she can do.

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3 This makes her rather unlike most of the wives at the “Help for America’s
4 Heroes” retreat who told story after story of burning themselves out while chasing
5 down the next treatment at the VA or Teresa, the wife of a soldier with lung disease
6 caused by burn pit smoke who reads every piece of relevant clinical literature she
7 can get her hands on and takes her husband criss-crossing the country trying out
8 new treatment options and enrolling in studies. While Bianca is invested in moving
9 toward cure, she finds ways to live with Alejandro’s disability at the same time as
10 she lives in anticipation of its end. She is understanding about his sleeplessness and
11 doesn’t expect him to keep regular hours. He spends most of the day on social media,
12 but Bianca knows that much of that is his way of being with others—particularly
13 the guys from his unit—and she doesn’t mind. Though she longs for a cure in the
14 future, she also attends to the realities of the present.
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16 Notes toward a Conclusion: The Possibilities of Disability 17

18 The virtual hegemony of veteran therapeutics constrains the ways that disabled
19 veterans inhabit their worlds. Where evidence of the failure of military medicine to
20 fulfill its redemptive promise is everywhere and consistently bound up with suicide;
21 where hope for cures in the future both exhaust and animate life in the present, it
22 can feel nearly impossible but also necessary to maintain an investment in recovery,
23 and it is exceedingly difficult to imagine, never mind inhabit, other possibilities,
24 other visions of vitality that are not so normative, and not so bound to a zero sum
25 game of life and death.

26 One space that opens up such possibilities comes from disability itself. In critical
27 disability work, the imperative to cure has long been criticized for what many see
28 as its eugenic or genocidal edge—an assertion that we would each and all be better
29 off if disability and disabled people did not exist. But, not unlike the many scholars
30 who may both offer critical readings of medicalization and also note the social and
31 cultural value of diagnosis (Cohen 2006; Hacking 1986; Murphy 2006), this critique
32 of cure has recently been nuanced from within the disability world—particularly
33 from people living with chronic pain who experience disability as both a valued
34 identity and font of critical thought and politics *and* as a source of distress that
35 could be permanently ameliorated by medical cure (Price 2015). Others point out
36 the complexities of valuing disability in contexts where impairments are produced
37 through the legacies of colonialism and its ongoing violences (Livingston 2005;
38 Puar 2017), environmental injustice (Taylor 2017), or racist structures of carceral
39 violence (Ben-Moshe et al. 2014). This leads to what disability writer and activist
40 Eli Clare calls “grappling with cure.” Clare (2017) draws on his own lifetime and
41 long disability history of often violent encounters with the promise of cure while
42 taking seriously the arguments of friends in disability community who long for cure.
43 Rather than resolving the tensions, Clare maintains them, tracing the consequences
44 of curative logics and practices both for better and for worse. Cure may be part
45 of a horizon of justice at the same time that many within disability movements
46 also experience disability as a source of value containing new social and political
47 possibilities centered on interdependence and anti-normativity, not something to be
48 tolerated but something to be desired (Kafer 2013; McRuer and Wilkerson 2003;
49 Sins Invalid 2019).

While this position of “desiring disability” (Kafer 2013) need not be opposed to many kinds of therapeutic intervention, it *is* antithetical to the idea of disability as unredeemable that underlies the heroic virtue of salvific medicine, which is so central to veteran therapeutics. Not surprisingly, it is not a common perspective in the worlds of disabled veterans. In fact, there is virtually no traffic between the worlds of disabled veterans and the worlds of the critical disability community in the United States. And while I have referred to disabled veterans, this is not an emic category. Veterans almost never refer to themselves as disabled and when they do, it is almost exclusively used in relation to one’s disability rating. As one veteran with a 70% rating said “I don’t think of myself as disabled. I’m differently abled.” A classic discursive distinction that acknowledges difference while rendering disability abject. And yet, in nascent and not fully articulated ways, like in Bianca’s willingness to live with Alejandro’s disability while still anticipating its end, I have encountered incipient elements of the possibilities of disability.

Devin was a radio operator who deployed to Iraq in 2005 as part of a Quick Reaction Force that went out with every convoy, calling in air support and relaying coordinates. He left the military in 2010, married his boyfriend, Stephen, finished a BSc and began applying to programs in physical therapy. And then, one day in 2015, he fell asleep and couldn’t be roused for three days. “Not dosing on the couch,” he clarified, for me, it was “a deep, unwakable sleep.” This marked what Devin and Stephen called the “bright line” of before and after. Suddenly, Devin was wracked with pain that was aggravated by the lightest touch. He had trouble speaking, his thinking was slow. They started going to doctors and saw specialists in orthopedics, rheumatology, neurology, nephrology, and psychiatry. Stephen joked that they saw every specialty except OB/GYN. By the end of the year, Devin had been diagnosed with fibromyalgia, chronic fatigue syndrome, and irritable bowel syndrome, all connected to his exposure to burn pit smoke in Iraq, as well as TBI and PTSD. They filed a disability claim and he received a rating of 100% “complete and total,” meaning the VA does not expect his condition to improve.

Nonetheless, in the first years after the onset of his symptoms, Devin and Stephen continued to pursue more specialists in the hopes of more effective treatments. But the search for a cure was exhausting them and exacerbating Devin’s symptoms. Stephen said: “We went through that . . . obsessing, that’s a good word, obsessing over cure. How to make him back to what he was. But,” he realized, “that’s not gonna happen.” Devin said:

I feel that we have to learn how to function within the parameters, because I’ve seen in all of the research and reading that I’ve done, that they’re two different types of people. There are the type of people who were just normal people who got chronic fatigue syndrome [. . .] and then there were people who led extraordinary lives. They went skydiving, mountain climbing, and all this kind of other stuff. They got chronic fatigue syndrome and then they wound up trying to fight against it and they wound up in hospital beds and not doing very well, wheelchairs, because you can’t fight against it. Well, I’m in that second class.

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3 He says fighting for a cure, or even to regain lost capacities—like the running
4 he used to do to manage his stress—makes things worse. So, instead, Devin and
5 Stephen adjust, accommodate, function within the parameters.

6 As they learn to live with Devin’s disability, they have benefited from it in myriad
7 ways. They give more concerted attention to their own relationship, getting up at
8 5 am to have breakfast together every day and take advantage of the only reliably
9 good hours Devin has. They have weekly wine and cheese nights together on the
10 balcony of their house. They’ve started a monthly game night with other couples
11 they’ve met through a group for veterans with TBI. Stephen, who earned a law
12 degree in 2006, became certified as a Veteran Service Officer and passed the bar in
13 2017 so he could help other veterans file disability claims and advocate for their
14 needs. Not unlike the “accidental activism” of parents of disabled kids that Rayna
15 Rapp and Faye Ginsberg have written about (2011), Stephen has also advocated
16 for and won procedural changes within the VA that have improved care. Devin has
17 started painting. They always wanted to adopt a kid, and because of the parameters
18 of Devin’s capacity, they decided to try and adopt an older kid, the kind of kid
19 who would otherwise be less likely to be placed. About a year after I met them,
20 and after a carefully scaffolded transition process, they welcomed a nine-year-old
21 son, Jacob, who came to them out of a precarious family situation in another
22 state.

23 Devin and Stephen have grappled with cure in their own way, moving from
24 obsession to accommodation. And while Devin still goes to weekly psychotherapy
25 and acupuncture and still has a pharmacopeia of 26 different prescription drugs and
26 supplements, they are feeling their way out of the imperatives of veteran therapeutics
27 and its cruel optimism into otherwise modes of vitality made possible by yielding to
28 disability, finding their way into something like a crip art of failure (see Halberstam
29 2011). They are learning to inhabit a space that may not manifest the kinds of success
30 that counts as miraculous, that may not allow medicine to redeem the violences of
31 war, but that, at the very least, allows them room to maneuver beyond the confines
32 of the road to recovery and does not abandon the present for the sake of the future.
33 This is a space of ambivalence, a space where medicine and disability coexist in the
34 absence of an imperative to cure. A space where vitality may be uncoupled from
35 the things that count as good clinical outcomes—and thus a space where we might
36 collectively think differently about the relationship between war and medicine and
37 about the possibilities of life with disability after war.

38 39 40 41 Notes

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48 VA’s War Related Illness and Injury Study Center.
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3 1. For example, that United States ought to invade and occupy Afghanistan for
4 the sake of Afghan women (Abu-Lughod 2002), Iraq for the sake of its people,
5 or that it should engage in drone warfare in Waziristan for the well-being of the
6 American population (Gusterson 2019).

7 2. In dubbing this “veteran therapeutics,” I’m drawing on a perhaps unlikely
8 source—Eric Plemons’s (2017) work on facial feminization surgery in the United
9 States and what he calls “trans therapeutics”—a vision of transgender well-being
10 that is bound to the promise of medical (in his case, surgical) fixes.

11 3. In the military continuum of care, such specialized hospitals are known as
12 “echelon five” facilities, the top tier in a system that also includes battalion aid
13 stations (combat medics, forward surgical teams (tent hospitals near combat opera-
14 tions), combat support hospitals (large in-country hospitals), and definitive care
15 (full-service military hospitals away from combat operations).

16 4. All names of people and organizations are pseudonyms, with the exception
17 of public figures.

18 5. *Out of the Crucible* (Kellermann et al. 2017), an Army medical text book
19 consolidating “lessons learned” from over a decade of war, describes the benefits
20 of early and aggressive rehabilitation for combat amputees by noting: “Rather
21 than communicate to the warfighter that he or she is permanently ‘disabled,’ early
22 rehab signals the military’s commitment to help them recover to their maximum
23 potential.”
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