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12 **Labors of Love:**13 The Transformation of Care in the Non-Medical Attendant Program at Walter Reed  
14 Army Medical Center  
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Although members of the U.S. military may be primarily thought of in terms of their institutional roles (as soldiers and little else)<sup>1</sup> they are always also beloved kin, made as social selves through their ties to family and fraternity as well as through their coordinates within the institution of the U.S. military (MacLeish in press). A marine is still a husband, a soldier still a daughter.

When members of the military are injured, as in other contexts of injury and illness explored by anthropologists (Mol 2002, 2008; Patton 2010; Petryna 2002; Povinelli 2006), the regimes of subjectivity within which caring attention is offered, and the social relations it maintains, are always multiple, no single one having an exclusive claim on configurations of people and their respectively ailing and caring bodies. This article is about the intersection of these regimes. It explores what happens when aspects of the attention and care that come from the ties of kin,<sup>2</sup> are enfolded within the institution of the U.S. military within which both wartime injury and immediate postwar rehabilitation are circumscribed.

As military technologies both protect soldiers from, and expose them to, newly survivable kinds of injury (see MacLeish this volume), military medicine expands apace. But the military medical system in the United States finds itself underresourced to provide the new kinds care that it offers. This is especially true for resource intensive practices like the physical rehabilitation of grievously injured soldiers. In this context, the care that injured soldiers' families feel compelled to give out of their loving attachments takes on a new valance: It bolsters a clinical care regime in need of support and a military institution that recognizes and compensates this care along with the injuries and hardships that have necessitated it. Caring for injured soldiers thus enmeshes kin in the structure of clinical care, subjecting the care of kin to the logic of the clinic. In this article we explore the ways that one military treatment facility has—to various effects—structured this care of kin into an opaque and bureaucratized remediation of the unbalanced economy of resources and

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care that characterize not only the military medical system but also contemporary biomedicine, more generally.

Grounded in two different fieldwork experiences at Walter Reed Army Medical Center from 2006 to 2008 and 2007 to 2008, respectively,<sup>3</sup> we look at the U.S. Army's Non-Medical Attendant (NMA) program whereby an injured soldier's kin is given a per diem and travel expenses to come and help the soldier in their rehabilitation away from home at Walter Reed. To put it in deceptively simple terms, the NMA program brings together two kinds of care and two social regimes; those of a clinical program of rehabilitation and those of kin.

Living at the intersection of these regimes, in these grey zones of care where biomedical logics mix with the loving care of kin, is often fraught, as the labors of love come close to, and often cross into, a clinical domain. The burden and burnout associated with such grey zones of care especially have received increasing attention (Almberg et al. 1997; Klarić et al. 2010; Takai et al. 2009; Ybema et al. 2002). Our exploration sheds light on the ways that living in such grey zones—perhaps especially when they are so thoroughly institutionally encompassed—complicates and alters the relationships on which such care is based.<sup>4</sup> In large part because the coordinates of domesticity are rather particular in the setting of Walter Reed, the NMA program also allows us to augment work that focuses on the feminization of caregiving, a common feature of such labor that was notably weak at Walter Reed.

There is much important work that seeks to define the meaning and attendant responsibilities, obligations, and political possibilities attached to the notion of care (see, esp., Tronto 1993; for a very helpful recent overview, see Phillips 2007). For our purposes it is useful to hold on to care as a multivalent concept, the flexibility of which allows it to be deployed, both by us, and by those we worked with at Walter Reed, in multiple ways.

We make use of the many meanings of care to explore the blurring of the lines between the obligations and dependencies of kin and intuition and between institutionally supported care and compensated labor that are part of the NMA program itself. We ask how these blurred lines, and the ambiguities they entail, are embedded and configured within the functioning of the NMA program and what impacts these configurations have on family members and soldiers who are part of the NMA program.

We trace the complex impacts that the NMA program, its rules, and its vagaries, have on the relationships between injured soldier patients and caregiving family members, as well as on the family members themselves. We focus in particular on the tensions between the role of the NMA as understood from a clinical logic of rehabilitation and the meaning it has for those who fill it and whose care and concern are, rather, grounded in felt obligations of kinship and love.

In our various discussions with injured soldiers' family members, they described giving little thought to how they would get to Walter Reed when hearing their son or daughter, cousin or brother, husband or wife had been seriously hurt in Iraq or Afghanistan. They just note feeling compelled by their deep attachments to those for whom they care; being pulled to their side by love and pain. Once there, in many instances, these family members took up places in inpatient rooms and camped with their injured loved one even when other housing might be available for them at

3 Walter Reed or close by. They participated in new kinds of intimate activities with  
4 their loved ones, feeding, toileting, and bathing them and cleaning their wounds.  
5 They contributed their caring labor to helping these wounded loved ones begin the  
6 process of healing.

7 During this initial inpatient hospitalization, it becomes clear to kin the kind  
8 of temporal and residential commitments providing this care will entail and the  
9 pull that brought them to Walter Reed may keep them there for long stretches—  
10 often months on end for a year or more—as an NMA. As NMAs, these family  
11 members feel the pressures of their new role as they encounter new edges of their  
12 own dependence and independence, new weights of responsibility, and the various  
13 unyielding structures of military discipline. All of these pressures compound the  
14 push and pull of sociality of kin.

15 The presence of kin at Walter Reed is enabled and supported by the NMA  
16 program and newly arrived family members quickly come to call themselves, and  
17 be referred to by others as, “NMAs.” There is no single process through which  
18 family members are introduced to the program. Case managers or social workers  
19 who visit inpatients often introduce family members to the program. They may  
20 also learn of the program through conversations with their loved one’s unit liaison  
21 stationed at Walter Reed. Sometimes, a family member will find out about the fi-  
22 nancial support available through the NMA conversations with other NMAs who  
23 have been at Walter Reed longer and who have a wealth of experience to share.  
24 The existence of the NMA program is also mentioned in some (although not all)  
25 of the handbooks of information that are generally made available to family mem-  
26 bers, but none actually outline the duties of an NMA, the expectations clinicians  
27 have about what NMAs should and should not do, or the fact that if clinicians  
28 become exasperated with an NMA they can “fire” them if it is for the good of the  
29 patient.<sup>5</sup>

30 From the perspective of kin, the entitlements that come with an NMA  
31 allow them to enact the caring ties of kin at Walter Reed. They seen as institutionally  
32 provided entitlements of kin, rather than perquisites of a clinical program. This helps  
33 explain the anger and frustration kin expressed when clinicians were dissatisfied with  
34 the care they provided their own loved ones. But from the perspective of clinicians,  
35 the NMA program helps to fill the gap between the kind of intensive and long-term  
36 attention required by the sophisticated and complex programs of rehabilitation they  
37 offer, and the shortcomings in their own resources to provide that attention. From  
38 the perspective of clinicians, the job of the NMA is to supplement the clinical care  
39 that they can offer.

40 So, while the NMA program supports and sustains the presence of kin, while it  
41 makes it possible for family to do what they feel compelled as family to do, it can  
42 also make life difficult. Until 2007, eligibility for the NMA program ran along lines  
43 familiar to readers of *American Kinship* (Schneider 1980) meaning that family was  
44 defined as linked to the servicemember by blood or law. After 2007, NMAs could  
45 be nonfamily members—most often girlfriends or boyfriends of servicemembers—  
46 but the policy had only ever been tentatively enforced and servicemembers often  
47 maneuvered around such regulations. But even now, nondependants are not enti-  
48 tled to the medical care or other benefits that military dependants receive, some-  
49 thing that makes living away from home—almost always out of state and away

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3 from whatever work, family, or school one had—even more challenging. Every  
4 30 days, NMAs must file paperwork to receive their entitlements. Although many  
5 service members have a few different family members acting as NMAs at various  
6 points in their time at Walter Reed, and NMAs sometimes take breaks to go home  
7 for a week or more, the bureaucratic requirements that accompany an NMA’s  
8 scheduling and movements can become increasingly frustrating to family members  
9 over the course of their loved one’s treatment, which frequently lasts well over  
10 a year.

11 Such institutional interventions are already part of life for soldier-patients—  
12 referred to in military parlance as “Wounded Warriors”—who remain active duty  
13 members of the military for the duration of their rehabilitation. Such practices  
14 may also be familiar, although no less frustrating, for NMAs who are also mili-  
15 tary spouses, children, or other “dependents” if they live in military communities  
16 where ordinary life enfold an array of such interventions. For kin who are not “de-  
17 pendants” and for those who are but who, like many spouses of National Guard  
18 or Reserves members, are not habituated to the ubiquity of the military’s rigid,  
19 explicit, and often byzantine institutional procedures, such measures proved disori-  
20 enting. For all the family members we spoke with, regardless of their familiarity  
21 with the quotidian monitoring and regulation of military life, the institutional inter-  
22 ventions associated with being an NMA were felt to complicate, rather than simply  
23 support, their ability to care for loved ones.


#### 24 25 Official Ambiguities of the NMA Program

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27 With its official sounding acronym and attendant paperwork, one might well expect  
28 the NMA program to be definitively laid out on paper, if not in practice. But the  
29 institutional policies that govern the NMA program are very difficult to pin down  
30 for anyone who should care, or need, to find them.

31 The features of the program that are most consistently mentioned in military  
32 health insurance information and in the National Defense Appropriations Acts  
33 (NDAA)—the federal documents that actually guarantee the funding on which the  
34 program is based—are the reimbursement for travel expenses and the availability of  
35 a per diem.<sup>6</sup> But even these details change from year to year and are often unclear  
36 at any one time. For example, the 2010 NDAA attaches these entitlements to a  
37 “qualified non-medical attendant” without reference to how such “qualifications”  
38 might be determined.<sup>7</sup>

39 And the duties associated with the NMA role are not specified in any of these  
40 policy documents. For example, the 2003 NDAA notes “the attending physician  
41 or surgeon and the commander or head of the military medical facility exercising  
42 control over the member determine that *the presence of such an attendant may*  
43 *contribute to the member’s health and welfare*” (Division A; Title VI; Subtitle C;  
44 Section 633). The kinds of “non medical attention” the Non Medical Attendant is  
45 expected to give remain unaddressed.

46 The various handbooks Walter Reed produces for injured service members and  
47 their families to provide information about life there during rehabilitation are  
48 equally ambiguous about the role of the NMA. The handbooks are written in  
49 English and some are directed at servicemembers, while others are written for

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3 family members. If intended readers were not literate in sh (which was the  
4 case with a substantial number of family members who **did** neither spoke nor read  
5 **in** English) there was no apparent alternative. Some handbooks were available on-  
6 line. Hard copies of others were available in the Soldier Family Assistance Center,  
7 especially since 2007.

8 Although the individual handbooks themselves are vague about the NMA pro-  
9 gram, the ambiguity about the status and responsibility of the NMAs themselves is  
10 ironically compounded by the proliferation of the different handbooks with differ-  
11 ent information none of which is distinguished as “the right one” for soldiers and  
12 kin to read. Amid the disorientation and distress that accompanied their arrival at  
13 Walter Reed, few people who had handbooks in their possession had read them  
14 from cover to cover, and they were apt to be swept away in the piles of paperwork  
15 and other things that quickly took up both space and attention.

16 For example, the 2007 *Walter Reed Warrior Transition Brigade Warrior Hand-*  
17 *book* written for “Wounded Warriors” who,<sup>8</sup> since 2007, have been organized into  
18 special military organizational units known as Warrior Transition Brigades,<sup>9</sup> men-  
19 tioned neither the NMA role nor the program. The 2008 version defined the NMA  
20 position by referring to the permissions and attendant rules and bureaucratic prac-  
21 tices (what are generically referred to as “orders” in military argot) which govern  
22 the role, primarily elaborating how to people acting as NMAs must file paperwork  
23 to get entitlements.

24 Unlike the insurance and federal policy documents, which tie the need for an  
25 NMA to the general “health and welfare” of the servicemember, the *Warrior Hand-*  
26 *book* states that the need for an NMA is assessed “based on how the Warrior can  
27 perform his activities of daily living (ADL)” and that “If a Family member is no  
28 longer able to care for their Warrior as a NMA, they are allowed to rotate duties  
29 to another Family member.”<sup>10</sup> Nowhere is this rather specialized term, *ADL*, ex-  
30 plained and nowhere are the expectations of the NMA and their “duties”—to do  
31 with ADL or otherwise—actually enumerated. Nowhere is it explained, for exam-  
32 ple, to the parents of an injured servicemember what it means to “care for”—or fail  
33 to care for—“their Warrior as an NMA.”

34 Adding to the ambiguity is the Walter Reed website, which links to both the 2007  
35 *Combined Hero Handbook* and also to yet another undated *Hero Handbook*.<sup>11</sup>  
36 The undated document contains no mention of the NMA role or program. The  
37 136-page 2007 *Combined Hero Handbook* does include a section on the NMA  
38 role, paying much needed attention to the particular ways in which becoming a  
39 “caregiver” for a spouse or a child can be physically and emotionally taxing and  
40 listing available resources. Yet, like the brief mention in the 2008 *Warrior Transition*  
41 *Brigade Handbook*, this 2007 section (which is notably titled *NMA Orders*) focuses  
42 on the bureaucratic practices required to become bureaucratically recognized as an  
43 NMA and the entitlements the status entails. Of the caregiving responsibilities of the  
44 NMA or their obligations vis-à-vis their injured servicemember, the section notes  
45 only that NMAs are there to “help with daily needs” of the soldier (p. 77) and  
46 should “check in with the Casualty Affairs Office if you are the NMA for a Soldier  
47 taking leave” (p. 78).

48 Although these various official versions of the program and its origins are silent on  
49 its role in the institutional landscape of the post-9/11 military, the current contours

of the U.S. military and the nature of its deployments are undeniably a key part of the story.

In their broader discussion of the costs of war in Iraq, Bilmes and Stiglitz (2008) note that health related costs are underestimated and make up a huge proportion of what they refer to as a “three trillion dollar war.” Bilmes and others have recently revised this figure upward to as much as \$4 trillion, a large portion of which is devoted to caring for veterans (Bilmes 2011). Compounding these financial burdens, the repeated deployments of service-members as well as higher survival rates and the resumption of rehabilitative care that was, during the Vietnam war, the responsibility of the Veteran’s Administration, rather than the military itself, has also put great strains on the military’s medical corp.<sup>12</sup> At Walter Reed, one explanation given by clinicians for the dependence on civilian physical and occupational therapists was that their military counterparts were deployed.

Clinicians working at Walter Reed specifically pointed to these circumstances as necessitating the NMA program. For example, during a conversation about how to motivate patients who were skipping their physical and occupational therapy sessions, a senior physician explained that the responsibility for adherence had to be shifted to NMA family members because there were not sufficient “techs and other staff” to escort patients to appointments because of deployments.

What’s more, while the injuries that servicemembers sustain have always impacted them in ways that extend beyond the damage to their bodies, this is more true in the post-Vietnam era “All Volunteer Force.” Following from the U.S. military’s recruitment agenda that had to compensate for the end of the draft in 1973, servicemembers are now more likely to make careers out of their military service (Bacevich 2005; Bailey 2009) and families have been actively incorporated into military life and are now counted among the military’s “Total Force” (Chu et al. 2007).

### Managing Official Ambiguities and Emergent Meanings of NMA

The stakes of following rules and understanding orders in military life are high and there is an explicit emphasis on hierarchy and structure. Although scoffing or griping these rules is also equally part of military life, opaque rules put those subject to them in a difficult position (on the complexities of life in military communities, see Hawkins 2005; Lutz 2001; MacLeish in press). At Walter Reed, this culture encompasses not only servicemembers but also those spouses and children classed as their dependents and those who become subject to that set of rules and orders that govern NMAs.

To deal with this dilemma, people living at Walter Reed, not unlike those living in military communities more generally, become fluent in practices (knowing how) and tend not to bother with logics (knowing why). Servicemembers and NMAs learn what kinds of paperwork to file, to whom, and when. They learn a language of acronyms and entitlements, even though they may not know what an acronym stands for or why they are entitled to a certain benefit. One of the consequences of this necessarily pragmatic approach to navigating military protocol is that the identity categories they imply are tenuously thin: *Being* something (like an NMA or an entitled soldier) is flattened out into certain kinds of *doing* (filing paperwork and



following orders). This was readily apparent at Walter Reed, despite (or perhaps because of) the proliferation of documents that outline practices related to specifically medical benefits and entitlements.


For example, when Zoë Wool learned in a passing conversation that there was a payment servicemembers received if they received an amputation. She asked Jessie, the wife of a soldier whose leg—it was rapidly becoming clear—was likely unsalvageable, what the payment was. Jessie it was “TSGLI.” Wool asked Jessie what TSGLI was. Jessie said it was \$50,000. Laughing at the circular direction the conversation was taking, Wool asked her to explain what TSGLI was, where it came from. Jessie began her explanation by attempting to decode the acronym, but the words escaped her. Did the *L* stand for *Limb*? The *I* was definitely *Insurance*. Maybe *Amputation* was in there, but no, there was no *A*. Eventually, Jessie came back to the meaning that mattered in that moment: TSGLI is \$50,000 you get when you lose a leg. More specifically it is the \$50,000 she and her husband will get if he agrees to let his doctors amputate his mostly nonfunctional and painful left leg.



TSGLI is indeed explained in the *Combined Hero Handbook*, something she might have glanced at amid the other endless papers she managed. There was also a stack of pamphlets on the TSGLI payment that Jessie walked past every day; she showed no sign of noticing them. And, when considered from her perspective as loving kin, she didn’t need to know that TSGLI is an acronym for Traumatic Servicemembers Group Life Insurance, but that the payment itself is called the Traumatic Injury Protection Under Servicemembers’ Group Life Insurance or that the payments were created in 2005 under Section 1032 of the Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and Tsunami Relief, 2005. It would not have made her a more well equipped wife to know that it is the VA, rather than the U.S. Army, that pays out these benefits, or that they can range from \$20,000 to \$100,000. Jessie knew what she needed to about TSGLI, including how to get it should the time come.





As this example suggests, at Walter Reed, the most important kind of knowledge (knowledge about how to do) seemed to come most often not from the carefully composed and strategically placed pamphlets or copious handbooks, but through experience in conversation with peers. Wives tell other wives about what to do if they forget to extend NMA orders in time to get new ones before the current ones expired. Mothers tell brothers about how their entitlements differ from those extended to soldier’s dependants (i.e., their spouses and children). Chances are if the other family members asked didn’t know the answer, they’d be able to point you to the office, volunteer, or social worker who did. But the “official” status, history, and rationale of various programs—what their acronyms stand for, what the federal government had in mind by creating them—are often irrelevant, and sometimes inaccessible, to those they are meant to both govern and serve. The meaning of categories like NMA within which people become institutionally legible, and therefore entitled to benefits and subject to regulation, are, in this pragmatic stance, rather irrelevant to the negotiating of official ambiguities and knowing enough to make do.



In this context then, “NMA” isn’t taken on as an aspect of selfhood. It’s another acronym, another set of paperwork to file and keep track of, like TSGLI, BAH (Basic

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3 Allowance-Housing), TDY (Temporary Duty), ITO (Invitational Travel Order)  
4 and so many others that characterize military family life. Being an NMA is thus  
5 assimilated into the array of technical practices already in place for military mem-  
6 bers and their families and from their perspective it has little if anything to do with  
7 the mandate of the NMA in the eyes of doctors, case managers, therapists or others  
8 inside or outside the hospital.

9 In practice, the term *NMA* was used by those who it described and their injured  
10 loved ones to mean something like “person who lives with an injured soldier and  
11 helps them out.” The emergent (rather than officially documented) significance of  
12 being an NMA was that NMAs received a \$60 per diem and some travel expenses,  
13 that they stayed with the soldier in their room on base in either the Mologne House  
14 hotel, the communal, family oriented Fisher House, or small innlike Guest House,  
15 or off-post in a variety of free housing, and that they got a meal card  daily use  
16 in the on-post cafeterias.

17 In practice, those fulfilling the NMA role helped care for soldiers  by a wide range  
18 of necessary tasks that ranged from medical to social to bureaucratic. NMAs shared  
19 the large paperwork load that is such a big part of life at Walter Reed and in the  
20 military more generally. They often found themselves spending time at different  
21 finance offices, at the pharmacy, running mail related errands, attending meetings  
22 and formations to gather information among other tasks. One of the only practices  
23 that was explicitly understood to rest on the shoulders of an NMA was that they  
24 were to ensure that servicemembers did not spend the night alone. In 2007, this  
25 was a relatively new rule and various current and former managers of outpatient  
26 housing explained it as addressing the problem of accidental overdoses and drug  
27 and alcohol interaction  as well as potential suicides (on suicide rates in the U.S.  
28 Army and other forces, see Chiarelli 2010).

29 Those  who were acting as NMAs knew  were responsible for finding a  
30 replacement if they had to, or  to, leave, although according to at least one  
31 official account it was the soldier  who was “allowed to designate one person to  
32 stay and help with daily needs,”<sup>13</sup> in addition to doing much of the more mundane  
33 work of living together, like making plans, doing laundry, and keeping in touch  
34 with family and friends far away.

35 Although there were few practices explicitly tied to the NMA work, NMAs also  
36 functioned as caregivers in the more *medical* senses attached to the term attendant  
37 in other contexts. They would often take servicemembers to their various appoint-  
38 ments, which not infrequently meant pushing wheelchairs, and carrying medical  
39 equipment as well as paperwork and notebooks. They would remind soldiers to  
40 eat and take their meds and would help to change wound dressings, catheters, and  
41 colostomy bags, and had a hand in often literally and existentially messy tasks re-  
42 ferred to with the catchall phrase “activities of daily living” (ADL) in a context  
43 of ongoing biomedical intervention. But for kin acting as NMAs, these tasks were  
44 understood as one’s familial or fraternal obligation, rather than part of one’s duty  
45 as a per diem and travel expensed NMA, because it was out of this kind of loving  
46 care and  obligation that they’d been drawn to Walter Reed, and entitled to those  
47 subsidies  in the first place.

48 And servicemembers did not make claims on family members based on their  
49 “NMA duties.” They would however make claims based on their familial and



social ties, in the same way they would in other circumstances. For example James, a double amputee, asked his wife Erin to bring his wheelchair when she came to meet him at the bar one night. One could conceivably split these two activities—the bringing of the wheelchair and the going out for drinks—into two different realms of sociality, the first held together by NMA duties and the second with ties of kin. But these practices weren’t split, and neither Erin nor James made any distinction between them. Erin brought the wheelchair because her husband asked and needed her to. When she, on occasion, expressed frustration with having to shuttle the empty wheelchair to him, she couched her complaints in the context of her care and concern for James as her husband. Because James would usually need Erin to get the chair at the end of a day walking on his prosthetics, Erin would note that he sometimes pushes himself too much using his prosthetics, which would cause him pain and sometimes blisters that would, in turn, make him upset and unable to use his prosthetics for a time. Although this also impacted his ability to fully participate in his rehabilitation regiment, when Erin talked about these moments, she talked about how James is as a person who she knew and loved—how hard he pushes himself, how he can be reckless with his own body, how that can impact their domestic life as a young married couple with a young child. Her attention and concern for him intersected with, but was not grounded in, the requirements of his rehabilitation program or the mandates of his doctors and therapists. She was obligated to shuttle the empty wheelchair around under the ties of their relationship, regardless of her duty as an NMA. Erin expressed her obligation as one grounded “wifely” duties and care. Although such a task overlaps with the ADLs clinicians expected her, as an NMA, to provide, to Erin bringing the wheelchair was rather disconnected from the doctors who had somewhere said her presence would contribute to James’ “health and welfare” or the army bureaucrats who, month after month for over a year, signed the paperwork that granted her the NMA entitlements. To her, these tasks and these entitlements were equally, and independently, features that were contained within her loving attachments to her husband.

The NMA program thus draws on distinctions—between medical and nonmedical attention, between wages and entitlements, and between institutional and familial or fraternal obligation—which it simultaneously conflates. At Walter Reed ADLs include not just things like eating and bathing, but also more explicitly medical needs like dressing wounds, monitoring infections, and keeping sutures clean and dry as well as the activities like filing paperwork and learning the bureaucratic ropes, which might not, in the usual sense, be considered activities of living, or even “activities” at all. Assisting with ADLs thus includes a degree of medical treatment despite both the *non* in Non-Medical Attendant and the original idea behind the NDAA amendments that created the program, which were targeted at bringing family to the side of injured servicemembers and improving their overall “health and welfare” rather than their precarious bodies.

#### Regimes of Work and Care

On the one hand, and from the perspective of those occupying the NMA role, the labor they do and the money they receive are entailments of the care that makes and maintains the sociality of kin. On the other hand, and from the perspective of

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3 clinicians and the compensatory logic of the NMA program, which is necessitated  
4 by current war borne institutional inadequacies, this labor and money are entail-  
5 ments of an institutionally circumscribed and surveillable caregiving role; something  
6 that comes very close to employment. Although the money provided to NMAs is  
7 technically a per diem and not a wage, it is rather unlike most military per dia or  
8 entitlements, which are intended to defray temporary living expenses accrued when  
9 servicemembers, with or without their families, receive travel orders requiring them  
10 to live in a more expensive place. But NMAs live with soldiers and have no accom-  
11 modation expenses of their own. Unlike other subsidies, the (never clearly stated)  
12 logic of the NMA per diem is to supplement wages lost when someone (who is  
13 not a member of the military) leaves their job to become an NMA. Thus, although  
14 the program is enabled by the recognition of the labor of love and care that net-  
15 works of kin entail, it is practically inseparable from institutionally circumscribed  
16 work.

17 This intimacy between the life and labor of kin ties and of waged work recalls the  
18 fact that, far from being a private unit beyond the reach of the state, the family has  
19 always been foundational to it. Feminist analyses have long made the case that the  
20 informal labor of home and family enables more official and explicitly organized  
21 and recognized forms of work and networks of association (Benston 1969; Dalla  
22 Costa 1972; Morton 1971). Although labor in these analyses focuses on “women’s  
23 work” and mothering, it reflects the understanding that the (re)productive work  
24 that constitutes home and family is fundamental to the (re)productive work that  
25 constitutes capitalist society. The NMA program represents an interesting twist on  
26 such situations, not only because the culmination of recovery for most servicemem-  
27 bers at Walter Reed is not their simple reentry into the productive work force but  
28 also because they will continue to receive a percentage of their wage as disability  
29 compensation and may be prohibited from working full time.<sup>14</sup>

30 Its also important to note that while the balance of NMAs are, in our experience,  
31 women—especially the mothers and wives of servicemembers—there is a very large  
32 minority of men who also fill this role—especially brothers, fathers, and occasionally  
33 the husbands of service members. And the practicalities of living far from home and  
34 the stresses of life at Walter Reed often mean that a servicemember may have a  
35 number of family members, men and women, who fill the NMA roll for varying  
36 stretches of time throughout the rehabilitation process. What’s more, given the  
37 cafeterias, meal cards, and easy fast food and the fact that most outpatients with  
38 NMAs live in a room at the on-post Mologne House hotel without a kitchen or  
39 much space to “tidy up,” domesticity at Walter Reed and the NMA’s place in it can  
40 just as easily resemble a bachelor pad as a loose approximation of a heteronormative  
41 household. For these and other reasons, the NMA category at Walter Reed is not  
42 clearly gendered in the overt way other caregiving roles may be (on nursing, see  
43 Malka 2007).

44 Furthermore, although the NMA program does recognize certain family config-  
45 urations as governable units of a particular population, its officially encoded ambi-  
46 guity also complicates a straightforward biopolitical reading. This is compounded  
47 by the fact that soldiers have other explicit contracts to the military and are subject  
48 to various biopolitical interventions that give them a rather different relationship  
49 to the state than the members of the sometimes-rotating roster of family members

who become NMAs. Because of this institutional context, servicemembers and their NMA kin don't quite form a coherent operable unit in the way that the Foucauldian reproductive family does in the eyes of the state (Foucault 1990:133–159). Thus, we argue that the NMA program, in its policy based and more emergent meanings as well as the labor it involves, sits awkwardly between these approaches to understanding the vectors of social force that may regulate bodily care in other social settings.

This slipperiness of the NMA program is because of, at least in part, the fact that it formalizes a relationship between the care of kin and the work of caregiving in a way that radically alters this very distinction. Unlike *perruque*, those practices of grafting labor, which, as de Certeau notes (1988:24–31), trickily exploit the spaces of official work to perform personal tasks that are useless to it, the NMA program makes existing labors of care and relationships that such labor maintains and is based on, legible within (although never reducible to) a new logic of use. In a historical moment marked by the retreat of the state from the provisioning of military health care both in the United States (Glantz 2009; Howell and Wool 2011) and increasingly in Europe (Lutz 2007), the NMA program represents an interesting twist. The state, in this case in the guise of the U.S. Army, does not provide all the care that their own Medical systems of rehabilitation specify as necessary. But they do enable and expect family members to step in where their institutional resources stop. But this compensation and the attendant expectations of what constitutes care that are attached to it subject the care of kin to the logic of the clinic.

### The Tension of Regimes of Love and Work

As we suggest, the various implicit and opaque understandings of the meaning of being a good NMA and the ambiguous relationship between NMA labor qua NMA labor and the very same labor that is felt to be the kin making labor of love and care, created many problems for those involved. This is perhaps most acute when kin see their activities as being supportive of the servicemember even if they run counter to the needs or expectations of clinicians, who see them as NMAs. They find no easy route out of this dilemma, because in accepting their per diem, kin also become NMAs and can be evaluated as good or bad NMAs in a way that is quite different than being evaluated as a good or bad wife or father, girlfriend or brother.

#### *Caring Kin, Careless NMA*

Henry was a noncommissioned officer in the U.S. Army Reserve (see Messinger 2009 for a more detailed discussion). He was deployed to Iraq in 2006 and after a mere four days he was injured. He had been assigned to travel to a village with his commander and the commander of the unit they were replacing. An explosive device detonated killing everyone in the vehicle except Henry. He lost an arm below the elbow and some fingers on his intact hand. At Walter Reed, first his brother and then his cousin served as Henry's NMA and both of them were seen as problems by clinicians.

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2  
3 In the occupational therapy clinic, where Henry was largely treated, there was  
4 a certain amount of frustration with both his NMAs. “These guys don’t get it,”  
5 explained an occupational therapist, “they have to understand that they’re here  
6 to do more than play video games. They are supposed to get [the patient] to the  
7 hospital and encourage him when he’s here. Instead they come in late, leave early,  
8 and his brother just sleeps.”

9 From the perspective of this therapist who views the relationship between Henry  
10 and his brother or between Henry and his cousin through the clinical logic of  
11 rehabilitation, neither NMA “get it” that part of their “job” was to make sure that  
12 Henry came to therapy and participated fully and compliantly. Henry, however,  
13 viewed their job as NMAs differently. He was very frustrated with U.S. Army,  
14 blaming his commanders for his injuries, feeling frustrated with what he saw as  
15 the limitations to the prosthetic technology he had received, and feeling disfigured  
16 and stigmatized by his physical injuries. In Henry’s view his brother, and then his  
17 cousin, were there to help him in other ways; to keep him company, to be a link to  
18 his home.

19 Because they did not fulfill the clinical needs associated with the NMA role Henry  
20 was counseled about his own responsibility for his brother and cousin. When the  
21 situation did not improve Henry’s brother was informed that he would no longer  
22 be receiving a per diem and was encouraged to accept an air ticket home. Henry’s  
23 cousin replaced him, the situation repeated itself, and he, too, was invited to leave.  
24 The clinicians’ view of Henry as only minimally compliant led to further problems.  
25 A few months after his cousin’s departure, Henry explained that he’d been given the  
26 option of staying in rehab and being assigned a job or leaving the rehab program. He  
27 opted to leave, which meant ending his rehab and accelerating his medical retirement  
28 from the military.  
29  
30

31 *Supporting Kin versus Supporting the Clinic*

32 Sometimes, however, NMAs do “get it” and still provide support that the clinicians  
33 see as counterproductive. One soldier, whose fiancée served as his NMA, spent  
34 several months dealing with an infection in his stump that precluded him from  
35 using a prosthetic. He would come to the physical therapy clinic fairly regularly to  
36 work on core abdominal strengthening exercises and other activities he was cleared  
37 to do, but he was also frequently late to his appointments or just sat chatting with  
38 his fiancée. His physical therapist expressed sympathy about his frustration, but also  
39 was annoyed that his fiancée did not try to motivate him more. “She should try to  
40 push him, otherwise what’s she doing here?” The fiancée took an alternative view:  
41 “I know he should probably do more work here, but how strong does his gut need  
42 to be? I mean when he can walk, he’ll work his ass off, but now he’s upset, and  
43 how will it help if I nag him too?” Her prediction was borne out. In the weeks after  
44 the infection in her fiancé’s stump was identified and cleared and the patient very  
45 quickly went from walking with crutches, to walking unassisted to running. Beyond  
46 this, her situation is emblematic of the ambiguous situation that family members  
47 and NMAs more generally find themselves in between the needs of clinicians and  
48 their loved ones (Chatterjee 1998; Taylor 2008).  
49

Clinicians evaluate family and loved ones based on a couple of domains: how family members behave to and around their injured servicemember; and how much they perceive NMAs supporting the clinical program at Walter Reed based on the programs own aims and logic.

On the first issue clinicians can be quite critical about families and others including predicting the quality of relationships that they only provisionally know. For instance occupational and physical therapists would often evaluate the longevity of a relationship according to where the partner sat while the servicemember was an inpatient. One therapist noted:

If you walk into a patient room and his wife or girlfriend or whatever is sitting by the bed, holding his hand, talks to the docs or to us or whatever you can pretty much guess that they'll get through this, but if she's sitting by herself away from the patient then you can bet it's on its way out.

In one case clinicians discussed how the wife of one particular inpatient was being disengaged. But they weren't cognizant of the complex family dynamics between her, her injured husband, and his mother, who was also staying at Walter Reed. As she put it:

His mom never got along with me, she didn't like that we got married just before he [deployed]. Plus we're all trapped over at the [residential building] and when we get here she puts herself next to him like she's the queen. She gets real mad if we ask to be alone and starts crying, so now I don't even ask. I just sit there and we'll see what happens when [he] gets discharged from here.

Her physical proximity to the soldier and her apparent disengagement was inextricable from the space taken up by his mother and the particular and unsettled configuration of family that all of them labored within. But this configuration and labor was not apparent to clinicians and fell outside the logic of the clinical program (on other tensions between the logic of this clinic and the experiences of servicemember patients, see Messinger 2010).

But things are not necessarily more clear when the issues involved do fall within the purview of the clinic and its logic, which is oriented toward moving the patient through the rehabilitation program and to which the love and care of kin and the dynamics of families are incidental. For instance one critically injured patient had a parent NMA who was a physician as well. The surgical team included this NMA on their email communications regarding various clinical options for his care. But another patient whose mother NMA was a nurse and who positioned herself as a skeptical advocate was seen as the source of irksome demands, even though she had also once correctly identified the possibility of a fungal infection as one of the ongoing problems her son faced.

#### *Being Subject to the NMA Program*

In addition to being evaluated by clinicians according to the logic of the clinic, becoming and NMA entails becoming subject to other dimensions of military logic

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2  
3 and practice. NMAs are encouraged and expected to attend morning formation, a  
4 key practice of inculcating military bodily discipline, with soldiers. To get their per  
5 diem and other entitlements, NMAs must resubmit their paperwork to the military  
6 every month and receive official status and documentation, which are referred to  
7 in both talk and text as “orders.” To take trips or return home with soldiers,  
8 NMAs must get new orders, which requires more paperwork and much waiting  
9 as requests are checked and must pass through many hands and offices as they  
10 are run up the various bureaucratic chains of command to receive the signature of  
11 a servicemember’s commanding officer or the decision, diagnosis, or opinion of a  
12 particular clinician. Some clinicians have quietly told NMAs (like Jason’s parents  
13 who we discuss further below) that they should keep the NMA formally as one  
14 individual but switch off. Jason’s parents switched every couple of weeks or so.  
15 One reason they avoided any scrutiny was because of the relatively loose policy on  
16 visitors as well as the fact that Jason was regarded by clinicians as a responsible  
17 patient, if not always a pleasant one.

18 Even getting mail, one of the most banal of daily activities that might seem  
19 to fall below the radar of military discipline, was a militarized activity. If injured  
20 servicemember outpatients wanted their NMA to be able to pick up their mail, they  
21 had to go in person, regardless of their physical condition, to the outdoor mail kiosk,  
22 which was only open a few hours a day and wait in line for as much as 45 minutes  
23 in the middle of a day full of often-exhausting appointments and often exacerbated  
24 by the effects of various pain and other medications, to show their ID and fill out  
25 the necessary paperwork to be kept on file. A new NMA meant another trip. Only  
26 then would a father, for example, be able to pick up his son’s letters, magazines, or  
27 mail ordered goods.

28 But those acting as NMAs appreciate the complexities of the situation, aware of  
29 both the positive and negative aspects of the system and institution of which they  
30 have become a part. At times, they resent aspects of the militarization of their lives,  
31 but find few opportunities to express this, in part because they are grateful toward  
32 the medical center for treating their loved one and because they are absorbed into  
33 an explicit ethos about the military as a kind of extended family. For example, one  
34 mother of a young soldier who lost both of legs above the knee in Iraq, talked about  
35 feeling uncomfortable on the post. No one in her family had experience serving in  
36 the professional U.S. military (her grandfather had served in World War II), and she  
37 felt constrained by all the administrative rules.

38  
39 It’s hard for me to know how I feel about this. I’m so concerned with just  
40 getting [my son] better, up and walking and everything that I kind of let the  
41 rest of it fade into the background. But yeah, sometimes it bothers me. Like,  
42 it’s a stupid thing, but I hate having to show my I.D. when we drive back  
43 onto the post. Or I hate asking for permission for things like travel  
44 arrangements, or the announcements and the formations. But, if these things  
45 are part of getting him home to me, then it’s fine.

46  
47 What makes the constraints of the NMA role bearable to her is her maternal  
48 sense of care for, and obligation to, her injured son. The burden of “these things” is  
49 born by her care for her son, which makes them worth the trouble. The logic of the



3 clinical rehabilitation programs, military bureaucracy, and government obligation  
4 bump up against the needs, knowledge, and labor of kin that pull family into  
5 militarized work. Dimensions of that militarized work are allowed to fade into the  
6 background as people make the care of kin front and center.

7 As NMAs, kin thus negotiate the fraught terrain of multiple expectations and  
8 obligations, which are rooted in divergent understandings of a soldier's needs. Al-  
9 though clinicians may have clear understandings of those needs based on partic-  
10 ular medical meanings of rehabilitation and the logic of the clinic, our conversa-  
11 tions with NMAs show that their understandings of these needs exceed such neat  
12 models. They know, perhaps more profoundly and intimately than even the array of  
13 doctors and therapists working on various parts of a servicemember's rehabilita-  
14 tive care, that medically framed issues located primarily in the body are inseparable  
15 from others that encompass servicemembers' emergent senses of their new selves and  
16 bodies, extending out into social and family life. NMAs, given both their intimate  
17 knowledge of this array of needs and other desires, may be in a unique position  
18 to understand the way these needs articulate with each other; something that is  
19 often invisible or irrelevant to the priorities and logics of the clinic and its official  
20 structures.

21 Manny was an enlisted U.S. Army soldier in his mid-twenties who had suffered  
22 serious injuries to both his abdomen and left leg from a roadside bomb while serving  
23 in Iraq. His mother Marisol, had been with him as his NMA for over a year and,  
24 when he was unable to, she had regularly changed his catheter and likely permanent  
25 colostomy bag, which were required because of his injuries. Marisol was deeply  
26 concerned about whether or not these injuries would cause lasting damage to his  
27 penis. Because she helped him with his catheter and also, initially, with bathing,  
28 she saw that there were no superficial signs that might suggest a problem. But her  
29 concern was specifically whether he would be able to achieve an erection so he could  
30 masturbate and have intercourse because she considered these to be integral to his  
31 experience of masculinity and youth. Although she was very comfortable discussing  
32 her concerns with Wool, she was reluctant to bring them up with Manny, thinking  
33 that he wouldn't want to talk to her, his mother, about such things. Her concern  
34 was compounded by the fact that she spoke no English and thus had very limited  
35 access to information about her own son's condition or the expectations of clinicians  
36 beyond what he was willing to disclose. Although she was Manny's NMA in the  
37 emergent sense of the term used by servicemembers and families, she could not  
38 help him with the endless bureaucratic activity that fell to other NMAs, nor could  
39 she—as a “good NMA” should—monitor and insist on his adherence to a clinical  
40 program the composition and rules of which she had no access to. Yet Marisol's  
41 specific concern about the functionality of her son's penis, which she could see  
42 “looked okay” was a product of her labor on his body and those rather *medical*  
43 activities like catheterizing that were inevitably part of daily living at Walter Reed  
44 and that were also considered part of NMA labor. Yet this concern was also, perhaps  
45 more so, born out of her motherly care for Manny and his future as a particular  
46 kind of man, and a particular kind of contributor to their network of kin and its  
47 possible future generations. Her sense of the limits of her ability to help him was  
48 also conditioned by their mother-son relationship and their shared understanding  
49 of the place of sexuality in family life, an issue that servicemembers and NMAs said

only came up in clinical encounters if they raised it (which they were sometimes uncomfortable doing) and that was often addressed with prescriptions of Viagra or Cialis and little else.

Such concerns overlap with, but also exceed, the clinical logic of rehabilitative care and the roles of NMA and Wounded Warrior. They are addressed to complex understandings of family, intimacy, and masculinity. And so while clinicians may see kin as “bad NMAs” or may be unaware of the kind of work that they in fact do (as was the case for Marisol), clinical logics are often both ignorant of and insufficient to the concerns kin have for their loved ones because those logics leave untouched the questions of self and social attachment that are being renegotiated at Walter Reed.

### A Plurality of Cares

Although officially part of the logic of the clinic, the NMA program unfolds within the context of injury, rehabilitation, and unstable and uncertain bodily and familial futures characterized by profound changes that cross cut the various forms of relatedness and aspects of care that tie soldiers and others together as kin. The program doesn’t simply add another obligation to an already existing relationship nor does it simply commodify the care of kin. It draws on ties that are constantly in flux, and weighs them down in a moment in which they are already particularly worn. NMAs and servicemembers appreciate the supplements of compensation, but they are not in themselves enough to buoy the many burdens or fortify the strain.

Given the increased rates of injury survival and the sheer number of injuries, concerns about so-called caregiver burnout are increasing among clinicians and researchers. Caregiver burnout is the process by which individuals, such as NMAs, become overwhelmed by the needs of their ill or injured loved one (or patient-clinicians report becoming burned out as well) and become exhausted and disengaged. Research on this has tended to be done on family members providing support to chronically ill individuals (Ybema et al. 2002) or to those to provide care to individuals with dementia disorders (Almberg et al. 1997). Many NMAs reported frustrations with their servicemember as well as feeling exhaustion and frustration themselves.

So while the \$60 per diem might replace the pay of a full time minimum wage job, such a supplement is not sufficient support for caregivers. One mother NMA owned a beauty salon in her Midwestern home state and was trying to raise money to pay her employees. She had always calculated their wages based on the total number of clients the salon brought in, a number dramatically reduced by her absence. She was faced with the decision of firing her employees or perhaps shutting down the salon even though she received a per diem and had a bit more money coming in from a church fundraiser back home.

And NMAs give up much more than just income. This same mother was painfully aware of the strain her absence put on her daughter, who was back home in high school, and on her husband who had become, in effect, a single father. Sitting outside, knitting and sipping coffee from a travel mug donated by a support organization, she explained that you never think about your son coming home injured. You think about the fact that they might not come home at all, but never this. In

3 every way possible, she had felt unprepared. The longer her son's recovery process,  
4 the more challenges she faced, the clearer the wide ranging effects of his injury and  
5 her absence became, and the further they rippled out from her own life. Her business  
6 and her family were at risk of becoming casualties too.




7 In another case Jason's mother, Sarah, was deeply saddened by how bitter and  
8 angry he had become. Jason had been a promising high school athlete and had  
9 hoped to use this as a way to pay for college. However, after graduation he had  
10 joined the U.S. Army. He was in Afghanistan when he was struck by the explosion  
11 of a rocket propelled grenade, which led to the amputation of one of his arms  
12 at the shoulder. One evening Messenger had seen Sarah sitting outside the PT clinic  
13 weeping. She explained that she was very frustrated and upset by her son, Jason,  
14 who was easily angered and verbally cruel to her. This was no secret in the program;  
15 members of the clinical team had observed Jason's anger and frustration about the  
16 loss of his arm and the end of both his military service and any opportunity to play  
17 certain sports. In a conversation with Messenger, Sarah vented about sadness. At  
18 one point, to Messenger's surprise, she blurts out, "If I never see another disabled  
19 vet again I'll be happy!" She apologized, but explained that so much attention "is  
20 put on the vets, and sure—they are the ones who got hurt, but we got hurt too and  
21 everyone expects us to just smile and not care what we have to do or what is said  
22 to us."

23 This conversation took place in 2007, after the scandal over housing and bureau-  
24 cracy at Walter Reed had cost several highly placed officials their positions. In the  
25 aftermath of the scandal several changes were instituted to help both servicemem-  
26 bers and their families, including changes to the regulations and units overseeing  
27 patients on the post as well as the development of Soldier Family Assistance Centers  
28 (SFACs) which were designed to help families with the burdens associated with  
29 being an NMA. However certain realities of military life made some problems un-  
30 avoidable. Certainly one source of these feelings comes from the claustrophobia of  
31 living conditions at Walter Reed. Most outpatients shared a hotel room with their  
32 NMA for months at a time. These were standard rooms with two queen-sized beds,  
33 a couple of chairs, a dresser with a television, and a desk with a computer. Soldiers  
34 and their kin must fit their lives into these spaces, along with medical equipment  
35 like wheelchairs, prosthetic limbs, crutches and also the abundance of donations  
36 and purchases that endlessly accumulate, from quilts to computers. One mother  
37 said "after living like this, on top of one another, it's no surprise that we have  
38 arguments."  
39




#### 40 *The Compounding Burdens of Support in the NMA Program*

42 In addition to this dimension of the logistics of the NMA program, which added  
43 to the strains family members already felt in the aftermath of their loved ones'  
44 injuries, there were bureaucratic dimensions of the program, which exacerbated  
45 them further. For instance the problems between Sarah and her son Jason were  
46 causing family strains and problems between Sarah and her husband. On top of this  
47 Sarah's husband, who split the time with Jason, had health care needs of his own  
48 that could only be met in his hometown. The irony that Sarah's husband needed  
49 healthcare, which he could not receive in a medical center, was not lost on the

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2  
3 clinicians. But they were powerless to help him because neither of Jason’s parents  
4 were his dependents. If Jason had been married his spouse and NMA would have  
5 been entitled to health care and to certain kinds of clinical support for the experience  
6 of frustration. But parents were excluded from this.

7 So while the NMA program offered certain kinds of supports for caring kin whose  
8 affections could be seconded to supplement inadequate institutional care, there were  
9 many different kinds of bonds and many different  of caring labor needed to  
10 maintain them that the NMA program simply didn’t, and couldn’t address. Sarah’s  
11 husband could not access medical service and this exacerbated her sadness and  
12 frustration over her son, his condition, the way he treats her, and the things, as she  
13 says, “we [i.e., we kin, we NMAs] *have to do*.” Although Marisol couldn’t ensure  
14 Manny’s compliance with rehabilitation and keeping paperwork in order, nor other  
15 tasks that fell to NMAs and were important to clinicians and to the military, she also  
16 lived with Manny in one small room, helped him with the maintenance of his  and  
17 devices, and went to ESL courses that Walter Reed began offering  in  
18 recognition of the predicament of NMAs like her. Like in the case of Jonathan and  
19 his parents, Manny’s own compliance with his rehabilitation program allowed for a  
20 helpful exploitation of the NMA program’s ambiguity so that his mother Marisol, as  
21 a non-English speaker perhaps an “unqualified” NMA, to remain and to contribute  
22 a good deal of caring labor. Yet, at the same time, like Sara’s husband, Marisol  
23 could not access health services at Walter Reed and concerned about being past due  
24 for her annual well-woman checkup, which was very important to her given her  
25 own family history of cancer.

26 And there was labor that Marisol performed that went unrecognized within the  
27 NMA program even as it improved the health and well being of servicemembers  
28 and even though it was only because she was Manny’s NMA that she was able  
29 to do this labor. In the kitchen of the communal on-post Fisher House, which  
30 accommodated 19 soldiers and their families, Marisol also often made dinner for  
31 Manny and other soldiers and family members who were living there. The Fisher  
32 House’s communal kitchen, living room, dining room, and patio spaces offered  
33 opportunities for servicemembers and family members alike to support each other  
34 in such clinically extracurricular ways. And although they were extraneous to the  
35 clinical logic of the NMA program, they were vital to the lives that soldiers and  
36 their kin lead at Walter Reed and in this way helped sustain the presence of NMAs.

37 Living in close quarters during a moment that was intensely difficult, painful,  
38 and uncertain for everyone exacerbated the tensions that existed within relationships  
39 and families and sometimes also between servicemember families who  drawn  
40 from a wide cross section of the population, from the rural Midwestern, to the  
41 exurban Northeast, to the suburban South. But it was also often through interactions  
42 that cross-cut these distinctions, grounded in the common experiences of being so  
43 dramatic  grown and drawn together by the violence of a war that was a guiding  
44 force of  that people would work to navigate not only the NMA program but  
45 also about other features of life at Walter Reed. For example, Marisol spent hours in  
46 the Fisher House’s communal spaces helping to look after infants and toddlers while  
47 their soldier and NMA parents were indisposed or in need of a break, especially  
48 in the evenings after the children had been picked up from the Child Development  
49 Center (i.e., daycare). And it was also often in these informal spaces that people

would **leant** of other ways to manage the stresses of life at Walter Reed, like the fact that—unlike the situation for medical care—children could be looked after during business hours at the CDC regardless of their dependant status.

All of this activity helps sustain and improve the lives of servicemembers at Walter Reed and contributes in ways more or less diffuse to the programs of rehabilitation, which are, from the clinical perspective, its focus and the official reason for the NMA program. But it is less easy to determine which of these forms of activity are “officially” NMA work. What aspects, for example, of Marisol’s caring labor, from looking after others’ kids to maintaining her son’s colostomy bag, is or is not “part of the NMA program.” Marisol “failed” to help Manny with his paperwork when they both went home to visit Manny’s sibling. All living together on West Coast, but this is not a failure in her ability care for . . . . And even though Manny’s injuries did not impact his limbs and no longer **effect** his ability to prepare his own meals, Marisol does indeed contribute to his “health and welfare” when she fills the communal kitchen with the nostalgic smells of her beef empanadas. Marisol’s cooking might well be understood as “women’s work” and it is also supported by the care of her eldest daughter who looks after her youngest son back on the West Coast while she misses her mammogram and lives in a modest room with her adult soldier son. But, in a way that recalls Kittay’s work on the multiplicities of dependency that are part of loving labor (Kittay 1999), Marisol’s labors are also acts of care supported both by the per diem she receives from the U.S. military and from the flexibility of the NMA program that Manny’s own diligence—which is also supported by a whole array of social networks between soldiers and kin that arise in Walter Reed’s common spaces—allows them both to exploit.

#### Discussion and Conclusion

For the people we worked with and who we’ve written of here, love and its obligations have physical effects, pulling them across the country, sometimes across oceans, and motivating the work of their hands on the bodies of those whose pain and need they feel.

We have showed how the work of care motivated by these ties of kin is supported by the NMA program. But we have also showed the ways that the NMA program makes this work, and the caring kin who perform it, subject to a clinical logic of rehabilitation, which is sometimes invisible, sometimes irrelevant, and sometimes antagonistic to the logic of care within which it is offered by the family and friends of war-injured servicemembers.

The tensions between these regimes of rehabilitative work and loving care are exacerbated by the slipperiness of the NMA category, and it’s opacity to those who fill it. We have showed how some particularities of military life—community members ability to pragmatically navigate byzantine bureaucracy, the requirement to become a subject of orders—sustain this opacity. Extending work that explores the impacts of caregiving on family members in the grey zones of care where the labors of love mix with the work of medically managing life, we have traced the tensions between these regimes of love and work. We have argued that, beyond understanding the impact of a new role that is added to the relationship between caregiver and injured kin, we should approach life in these gray zones as suffused

2  
3 with all the uncertainty, precarity, and intensity that comes along with serious  
4 injury or illness and attempt to understand the multiple ways that such gray zones  
5 compound and transform social attachments and the senses of self they help fashion.

6 We have showed how, in the particular gray zone of Walter Reed, the ill-defined  
7 role of the NMA is constantly negotiated between the caregiver and the person  
8 for whom they care and also the clinical, administrative, and more strictly military  
9 entities on the post. It is shaped by many feelings of love and labors of care, and  
10 also by the banalities of military life and the institutional exigencies of current U.S.  
11 military priorities and engagements, which produce particular kinds of survivable  
12 injuries requiring long-term rehabilitation that must make use of the care of kin as  
13 supplementary labor. As we have shown, these forces draw the NMA into different  
14 and clashing regimes of legibility and accountability. On the one hand, the NMA's  
15 kinship is the prerequisite of their continued presence. This kinship is full of specific  
16 histories of intimacy and its limits and expectations around various displays of  
17 affect, affection, proximity, and sexuality. On the other hand, as NMAs, kin become  
18 accountable to a variety of authorities at Walter Reed all of whom are in a position  
19 to evaluate the NMA's efforts and those evaluations may discount or distort the few  
20 bits of those intimate histories that clinicians perceive. This awkward intersecting of  
21 logics, roles, and priorities not only affects servicemembers' rehabilitation but also,  
22 inevitably, the totality of their lives and the closest relationships within which they  
23 are being reconfigured. As part of this process, as we have shown, the emotional  
24 and kinship-driven commitments, which recruited the family member to the side  
25 of their loved one undergo a transformation as the work of the NMA becomes a  
26 fungible element of the clinical rehabilitation program.

## 27 28 29 Notes

30  
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34 University of Toronto, Scarborough.

35  
36 1. For ease of reading, we use the term *soldier* inclusively and interchangeably with  
37 *servicemember*.

38 2. We use the term *kin* throughout the article to identify the category of people who  
39 serve as NMAs, not because they are necessarily related to a servicemember by blood or  
40 law, but, evoking "fictive" kinship and mindful of broader notions of relatedness that are  
41 grounded in "kin-ness" but arise out of various critiques of kinship proper (Carsten 2000;  
42 Franklin and McKinnon 2002; Schneider 1984), to suggest the close, *caring* (and, usu.,  
43 long-lasting) qualities of the relationships that, in practice, are what made people "eligible"  
44 to act as NMAs.

45 3. Zoë Wool conducted fieldwork between 2007 and 2008 based primarily at one of the  
46 on-post housing facilities for soldiers and their family members. Seth Messinger conducted  
47 fieldwork in the U.S. Armed Forces Amputee Patient Care Program at Walter Reed between  
48 2006 and 2008. Between 2001 and the periods of our respective fieldwork, well over 30,000  
49 U.S. servicemembers had been injured as a result of the ongoing conflicts in Afghanistan  
and Iraq. Over 1,000 have lost a major limb or limbs. Many of these patients have been  
treated at Walter Reed Army Medical Center.



4. For a poignant exploration of such concerns in a context with less institutional enrollment, see Kleinman 2010.

5. We are not arguing here that the “problem” with the NMA program can be “solved” by clarifying the clinical expectations of the NMA or formalizing the procedures through which a family member becomes a bona fide, entitlement-receiving NMA. The frustrations and tensions we document here are a function of family caregiving especially in this military medical context, not of the implementation of a particular program.

6. For an example from TRICARE see <http://www.tricare.mil/Factsheets/viewfactsheet.cfm?id=181>, accessed January 26, 2010; for an example from the 2005 NDAA 37 U.S.C. § 411h(c)(2).

7. Title VI, Subtitle C, Section 633. See [http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111\\_cong\\_reports&docid=f:hr288.111.pdf](http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_reports&docid=f:hr288.111.pdf), accessed April 6, 2010.

8. See <http://www.wramc.army.mil/WarriorsInTransition/handbooks/WITHHandbook.pdf>, accessed March 28, 2010.

9. At other military medical facilities and in most media reports about them, Warrior Transition Brigades are known as Warrior Transition Units or WTUs.

10. See <http://www.wramc.army.mil/WarriorsInTransition/handbooks/WarriorTransitionBrigadeWarriorHandbook.pdf>, accessed March 28, 2010.

11. See <http://www.wramc.army.mil/WarriorsInTransition/handbooks/WalterReedHeroHandbook.pdf>, accessed March 28, 2010. *Hero* in this context also refers to injured servicemembers.

12. For broader health-related ramifications of this current context, see Howell and Wool 2011.

13. *Combined Hero Handbook*, 77.

14. For an illuminating historical contrast of these dimensions of the rehabilitation of injured soldiers at Walter Reed during World War I, see Linker 2011.

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