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Jennifer Terry

WSQ: Women's Studies Quarterly, Volume 37, Numbers 1 & 2, Spring/Summer 2009, pp. 200-225 (Article)

Published by The Feminist Press
DOI: *https://doi.org/10.1353/wsq.0.0143*

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JENNIFER TERRY

Claudia Carreon has trouble remembering. The thirty-four-year-old native of Nogales, Mexico, was riding in a fuel convoy through Baghdad in June 2003 when it collided with an Iraqi truck. She was part of a U.S. Army National Guard transportation company, having enlisted in 2000 with hope of achieving U.S. citizenship and other benefits promised in exchange for her military service. Less than a month after the accident, she was demoted from the rank of Specialist to that of Private First Class for failure to follow an order.

Claudia suffers from memory loss and mild dissociation caused during an incident she cannot recall. The only physically obvious wounds she manifested at first were damaged knees; but then her memory problems surfaced when she was accused of disobeying orders. In fact, she simply forgot what she was told to do. Shortly thereafter, she was diagnosed with traumatic brain injury (TBI).

After being demoted and then diagnosed, Claudia was sent back to the United States to be treated at a new "polytrauma unit" at the Palo Alto Veterans Administration Hospital, one of four specialized clinics recently established at VA hospitals around the United States to deal with what is being called "the signature wound" of the ongoing wars in Iraq and Afghanistan.[1] As part of the therapy to restore her memory function, Claudia relies on a personal data assistant (PDA) as a memory prosthesis to remind her of important events from day to day. "Basically, this is my memory," she says, referring to her PDA. "It's just that my memory is not in my brain, it's in my hands" ("Doctors Scramble" 2006).

Claudia does not remember being pregnant and giving birth to her daughter in 2001. She relies on photographs of family members to remember who they are. Interviewed by various media outlets in late 2006, Carreon made the following comments: "To the best of my recollection, I have never been pregnant. I don't know what it is to be pregnant. I don't know

[*WSQ: Women's Studies Quarterly* 37: 1 & 2 (Spring/Summer 2009)]

what it is to give birth, and basically I don't know what it is to have a child. All that I know is that I have a baby. She is my daughter. She is two years old. I talk to her every day. She says, 'Mommy,' because she sees pictures of me, but I don't know. I don't know" ("Doctors Scramble" 2006). "I only know I am married because of my wedding band" ("Claudia Carreon" 2006). "The notes and the pictures, those are my memory. When I look back, that's how I can tell what's real" (Alaimo 2006).

Traumatic brain injury is estimated to account for a little over 19 percent of all injuries among U.S. soldiers in Iraq and Afghanistan (Tanielian and Jaycox 2008). A politically conservative newspaper, the *Washington Times*, reported in May 2007 that between January 2003 and March 2007, 2,130 military personnel were treated at the Defense and Veterans Brain Injury Center, a joint venture between the departments of defense and veterans affairs based at Walter Reed Army Medical Center in Washington, D.C. About 70 percent of these cases were classified as mild TBI (Lengell 2007). A 2008 study funded by the California Community Foundation and conducted as a joint project of the RAND Health Division and the RAND National Security Research Division, reported that, of the approximately 1.64 million U.S. troops deployed to support operations in Iraq and Afghanistan since October 2001, as many as 300,000 U.S. combat veterans (around 19.5 percent) have suffered at least one concussion, and many have been blasted several times (Tanielian and Jaycox 2008). Symptoms of TBI include diminished impulse control, decelerated cognitive processing, aphasia, coordination problems, memory loss, and social alienation. Clinicians note how difficult it is to discern these symptoms from those suffered by veterans with posttraumatic stress disorder, a syndrome that may emerge even among veterans who have not experienced direct violence but instead have been traumatized by the casualties and deaths of other soldiers in their units; by the psychological demands of being in stressful combat situations; or by the psychological damage caused by unrelenting and unprosecuted harassment, including, in the case of many women veterans, sexual assault by men in their units.

The 2008 RAND team, co-led by two women psychologists, Terri Tanielian and Lisa Jaycox, warned sympathetically of the dire costs, financially and socially, associated with TBI in particular. They noted that only slightly more than half the veterans receiving treatment for TBI received minimally adequate care. Moreover, the twenty-five-member research team stressed that treating the growing numbers of combat-related TBI patients represented a formidable cost to the nation: the estimated cost of treatment for

cases of mild TBI was between $27,000 and $33,000 per patient, and in cases of severe TBI, the amounts climbed to between $270,000 and $408,000 per patient. Many of these cases, whether mild or severe, were also accompanied by other injuries, suggesting that the overall costs of veterans' rehabilitation would be astronomical in the next few years. Based upon current rates of TBI, roughly twenty-seven hundred cases identified to date, estimates of the total one-year societal cost range from $591 million to $910 million.

An estimated 20 percent of U.S. military personnel injured with TBI are women. Their injuries are generally caused by the detonation of improvised explosive devices or by vehicular accidents. Dr. Harriet Zeiner, a neuropsychologist who oversees the treatment of U.S. Iraq war veterans in Ward 7-D of the Palo Alto VA polytrauma center, has become a leading expert in diagnosing and treating patients like Claudia Carreon. "Men tend to hate the loss of memory and the loss of information," Zeiner observes. "Women experience it as a change in their ability to relate. And that . . . is what I [mean] by the wound internally, *the wound in who you want to be in this life*" ("Doctors Scramble" 2006; my emphasis).

I will return to Claudia's situation again.

Drawing on the elegiac consideration of "woundscapes" by audio artist Gregory Whitehead and the claims of Michel Foucault concerning the power of life-administering and the acts of "letting die" practiced by biopower regimes, I am interested in examining what is being called the "signature wound" of asymmetric warfare (Whitehead 1986, 2000; Foucault 1978).[2] In what follows, I analyze the naming and treatment of the injury as a signature wound marking a particular converging history of technology, geopolitics, and biopolitics to show the ways in which medical techniques and violent warfare function in a relationship of mutual provocation, provoking one another in a manner that indicates the close ties between hygienic and military logics in modern U.S. empire building.[3] This analytical inquiry challenges the tendency in much of Western feminist scholarship and activism to assume an opposition between humanitarianism and militarism; by contrast, I assume that these two are deeply linked in modern logics of liberal democracies and Kantian cosmopolitanism.[4] The cases of wounded women such as Claudia Carreon are especially illuminating in support of these claims. As you will see, much of what follows is an open-ended inquiry, frequently punctuated by the articulation of rhetorical questions as well as by questions that call forth further research and writing. The inquiry will raise more questions than it answers. I say this to acknowledge the incomplete nature of the

project as it stands at this point; indeed, I will continue to develop the work further over the next few years. But this gesture of admission also allows me to work through an interrogatory mode in order to highlight ethical critique and to suggest new ways of marking the significance of injuries that occur to particular bodies, bodies that are situated in particularly perilous spaces, where biopolitics, geopolitics, and violent conflict converge.

WOUNDSCAPES AND VULNEROLOGY

> *Vulnerology is the knowledge of wounds—how to interpret the wound such that each opening, or leak, or rupture, reveals new meaning. . . . It is impossible to think of a specific technology in separation from the damage it can do. . . . Working as a vulnerologist carries the same kind of stigma as a mortician—wounds after all represent dead subjective experience, dead experience that most people would prefer to suppress or forget. Wounds are the physical repositories for the memory of experience that most people would prefer to suppress or forget. The experience of receiving a wound is a shock and the connection between shock and amnesia is pretty well known. There is simply a massive individual and cultural resistance to recognizing the significance of wounds.*
>
> —Gregory Whitehead, Display Wounds (art piece)

Gregory Whitehead, in a 1986 audio art piece, *Display Wounds*, posits the method of vulnerology as the knowledge of wounds, and the vulnerologist as a stigmatized and abject producer of knowledge. Taking on the persona of the vulnerologist, the artist slows the audio track ever so slightly to enact a resistance to the speed he attributes to intensified levels of two phenomena: technologically enabled lethality and cultural amnesia. The effect of the auditory slowdown is nearly hypnotic. While delivering what seems to be a didactic lecture to an intimate audience not yet familiar with the field, Whitehead explains that vulnerology is a method for interpreting "the wound such that each opening, or leak, or rupture, reveals new meaning" (1986). The vulnerologist is a semiotician of wounds and a genealogist (in the Foucauldian sense of the term) of "woundscapes"—territories marked by injuries to bodies that index particular moments in the wounding capacities of technologies. Exhibiting the demeanor of a forensic surgeon offering evidence as would a physician-instructor in an anatomy lab, the vulnerologist performs a revealing incision followed by a careful suture, while proceeding with his

excursus on the significance of vulnerology: "It is impossible to think of a specific technology in separation from the damage it can do (1986)." Under these words we hear what seem to be the sounds of surgery: skin being cut, flayed, and then stitched up, interspersed by interludes of tango music.

A vulnerologist is working against a collective will to forget. S/he opposes an economy of forgetting that would otherwise take shape as an amnesia archive.[5] As Whitehead notes, "Wounds are the physical repositories for the memory of experience that most people would prefer to suppress or forget. The experience of receiving a wound is a shock and the connection between shock and amnesia is pretty well known. There is simply a massive individual and cultural resistance to recognizing the significance of wounds." (2000, 138)

Michel Foucault, in the last portion of *History of Sexuality*, volume 1 (1978), lays out what he means by biopower in a section called "Right of Death and Power over Life." Foucault is interested in noting the shifting logics that pertain to premodern modes of sovereign power as these give way to the modern form of biopower that he ties to liberal democracies of the West. Sovereign power was articulated, among other ways, in the exercise of the sovereign's right to take life or let live. The right of death, having undergone "a very profound transformation of these mechanisms of power" since the "classical age" of sovereign power's decline, in biopower regimes, works "to incite, reinforce, control, monitor, optimize, and organize forces under it: a power bent on generating forces, making them grow, and ordering them, rather than one dedicated to impeding them, making them submit, or destroying them" (136). The exigencies of "a life-administering power" align to a shift in the right of death, which "is now manifested as simply the reverse of the right of the social body to ensure, maintain, and develop its life" (137).

In this very passage, Foucault goes on to remark,

> Yet wars were never as bloody as they have been since the nineteenth century, and all things being equal, never before did regimes visit such holocausts on their own populations. . . . Wars are no longer waged in the name of the sovereign who must be defended; they are waged on behalf of the existence of everyone [society must be defended]; entire populations are mobilized for the sake of wholesale slaughter in the name of life necessity; massacres have become vital. It is as managers of life and survival, of bodies and the

> race, that so many regimes have been able to wage so many wars, causing so many men [*sic*] to be killed. . . . If genocide is indeed the dream of modern powers, this is not because of a recent return of the ancient right to kill; it is because power is situated and exercised at the level of life, the species, the race, and the large-scale phenomena of population. (137)

In his elaboration of the death drive of biopower regimes (regimes that compel life among some and let others die through procedures of life administration), Foucault distinguishes two modalities of interrelated development: the first, which he calls "anatomo-politics of the human body," centers on the body as a machine: "its disciplining, the optimization of its capabilities, the extortion of its forces, the parallel increase of its usefulness and its docility, its integration into systems of efficient and economic control." Anatomo-politics followed a logic of what Foucault refers to as "discipline." The second development followed a logic of regulatory controls, or what Foucault identifies as a "biopolitics of the population." Reproduction, birth rates, life expectancy rates, mortality rates—these are the matters of concern in the life-administering logics of biopower. "The disciplines of the body and the regulations of the population constituted the two poles around which the organization of power over life was deployed." Biopower "characterized a power whose highest function was perhaps no longer to kill, but to invest life through and through" (139).

Although Foucault said very little about their specific role, among the great players in this dramatic turn are physicians, and in particular military physicians, or physicians caring for the wounded in wartime. They are engaged in life-administering practices, working at odds against death to contend with "the naked question of survival" (137). The logics of biopower and the logics of modern warfare are evident in a historical tracing of the mutual provocations of medical responses to the intensifying lethality of modern weaponry and military tactics. And it is fitting that the signature wound of the current U.S. military occupation of Iraq is a case through which to trace some of this history, since the overall rates of literal survival from combat wounds are higher now than in the past few wars that the United States has fought, but the intensity of damage caused by new weapons and tactics is profound. More soldiers survive, and yet those surviving suffer multiple traumas—amputations, spinal cord injuries, massive brain injuries, infections—as a result of a number of improvements that increase the likeli-

hood of surviving death. What accounts for this outcome of lower death rates and higher levels of devastating suffering? How would a vulnerologist's tools of interpretation help to make sense of this state of affairs? And how should a vulnerologist account for the woundscape caused by the disavowed injuries and deaths of civilians in Iraq and Afghanistan, injuries and deaths that result from white phosphorous bombs, daisy cutter bombs, or cluster bombs dropped on densely populated locations in cities like Fallujah, Najaf, and Baghdad?[6]

SIGNATURE WOUNDS IN RECENT HISTORY

Each modern war has its signature injuries. Signature wounds result from the development of evolving kinds of weapons coupled with the elaboration of military strategy. Signature wounds give rise to innovations in medical knowledge, so in some respects we owe many advances in medical treatment to the bodily suffering wrought by war. Why, then, aren't the wounds caused by the myriad air-dropped detonating devices (daisy cutters, cluster bombs, white phosphorous bombs, and so on) elevated to the status of signature wounds in medical discourse spoken by U.S. physicians? Answer: the bodies suffering these wounds are those of the Other; they are abjected, and disavowed, wounds. Not that spectacularizing these wounds would allay the problem; to the contrary, the urge to "help" has rationalized many violent military adventures and is driven by a visual economy of the suffering of Others so that their bodies become the grounds for intervention and further "peacekeeping" militarist practices.

As their name suggests, signature wounds require a semiotic analysis of the injury and its place in the history of technology. Such an analysis brings to light a matrix of dynamic elements: weapons, targets, physical locations, bodies, medical tactics, diagnostic terminologies, and histories. The wound is a kind of signification that can be read or interpreted to offer narrative accounts of histories of weaponry, of clashes over power, of bodily vulnerability, and of the elaboration of medical practices. In strange ways, plenty of medical knowledge results from bodily wounds inflicted in human conflict, indicating a mutual provocation of might and medicine that lays to waste the cherished idea that violent conflict and humanitarianism are mutually exclusive.

During the Napoleonic Wars of the early nineteenth century, the bayonet-mounted musket at the end of the infantryman's rifle resulted in a battlefield woundscape populated by bleeding soldiers and by medics who

devised the practice of triage for prioritizing the treatment of those who could be returned to the battlefield as quickly as possible. The essence of this procedure is still practiced in military and civilian medical facilities. Signature wounds give rise to signature medical techniques.

During the U.S. Civil War, when a modestly estimated six hundred thousand Americans died as a result of battle and disease, injuries caused by advances in artillery (both cannons and handheld guns) were signified by millions of amputations, deep wounds to the internal organs, and shock effects resulting from heavy bullets fired by scattershot muzzles. Neurologist Silas Weir Mitchell studied nerve injuries during the war from a hospital in Philadelphia. He drew on knowledge gained from war injuries to develop theories concerning the cause and treatment of "phantom limbs," an affliction suffered by amputees with war wounds that had led to gangrenous and other deadly infections and thus to amputation. An early generation of machine guns delivered multiple rounds of bullets, causing greater damage than single-round rifles. Many veterans suffered from surgical sepsis and a relative few were evacuated. The bloody war occasioned the development of many new surgical and sterilization techniques, which, in turn, were refined in the next iterations of major battle during the Spanish-American War and World War I.

The Spanish-American War introduced a new generation of magazine weapons that used white powder, replacing earlier single-shot black powder rifles, which would reveal their shooter's location in a cloud of black smoke. Teddy Roosevelt and the Rough Riders made use of the multiple-firing guns during their fight with Spanish forces in the Battle for San Juan Hill in Cuba. That war also involved the use of land and water mines, operated by electricity to detonate on contact or by mechanical or chemical means, using deadly nitroglycerin or dynamite. New and more deadly weapons inspired medical knowledge that would assist in the treatment of new wounds but also in the future development of weapons.

The Great War of 1914–18 operated at two major technospatial levels: war aviation and trench warfare. Both levels yielded an intensified woundscape in terms of sheer numbers of suffering soldiers and in the damage each new weapon system was capable of producing. Among the most notorious of the war's signature wounds was shell shock, believed by many medical experts to be caused by a pummeling of heavy artillery that left its afflicted with an array of symptoms, including fatigue, irritability, headaches, loss of concentration, nervousness, and even catatonia in some cases. Battles of attri-

tion carried out through volleys of blasting weaponry in the trenches of the Somme and in Verdun resulted in massive numbers of shell shock patients and soldiers whose bodies and faces were surgically reconstructed using plastic surgery techniques that have been incorporated by the now billion-dollar international industry of cosmetic surgery. As one commentator put it, "If Serbian terrorists had not assassinated Archduke Franz Ferdinand on a spring day in 1914, it is highly possible we might never have had a Pamela Anderson" (Kuczynski 2006, 61).

Modern industrially produced chemical weapons had their debut in World War I, when the German army first introduced mustard gas (yperite) in September 1917. This was the most lethal of the chemicals used during the war. Its brilliance as a lethal agent derived from its being nearly odorless and taking about twelve hours to take effect. The Germans needed only to add small quantities of this highly toxic gas to explosive shells lobbed at the enemy or at territory the enemy was predicted to traverse. People who came into contact with the gas suffered from both internal and external bleeding, bronchial damage, extreme nausea, and burning eyes and skin. A lethal dose of poisoning would usually result in a four- to five-week process of painful death.

World War II resulted in the deaths of an estimated 50 million people between 1939 and 1945. Nearly 1.1 million U.S. military personnel were wounded from the nation's entry into the war in 1941 until the surrender of the Japanese and the Germans in 1945. Alongside the planned deaths of incarcerated people in German concentration camps through the use of noxious substances such as Zyklon-B, a cyanide-based insecticide treated with a stabilizing agent to maximize its lethality in gas chamber mass poisonings, the war intensified weapons delivered by aerial bombardments that killed and maimed scores of people concentrated in metropolitan areas of London, Dresden, and Tokyo. The culmination of the war in the Pacific came following massive destruction wrought by the successive bombings of Hiroshima and Nagasaki, using newly devised nuclear bombs developed by leading scientists of the Manhattan Project. The victims' signature wounds consisted of skin incinerations and severe radiation toxicity. Hiroshima, a city of 400,000 people, lost between 70,000 and 100,000 with another 130,000 wounded, 43,500 of them severely. Within the month following the bombing, many manifested blood disorders consisting of lowered counts of white blood corpuscles, which led to heightened vulnerability to infection and high fever. Some, struggling to compensate for anemia and decreased white

blood cells, produced much higher than normal levels of both red and white blood cells, leading to infections in the chest cavity. Many developed keloid tumors while healing from severe burns. Nagasaki and Hiroshima, following the massively destructive atomic bombing sorties, became laboratories for studying the effects of radiation poisoning, the resulting knowledge of which is embedded in the science and practice of contemporary radiology (Lindee 1994; Serlin 2004, especially Chapter 2).

Chemical weaponry was central to the U.S. strategy in Vietnam, where napalm was used in flamethrowers and bombs to intensify the lethal effects of flammable liquids. Napalm was designed primarily to burn and adhere to materials. It was also used to induce suffocation by means of its ability to remove oxygen rapidly from the air and to generate large quantities of carbon monoxide. Its signature wounds were displayed on bodies (in the form of severe burns, skin discoloration, and disfigurement) and in landscapes (the substance was dropped from helicopters to clear landing zones). Another hallmark of the Vietnam War was the use of Agent Orange, a herbicidal defoliant that was one of several "rainbow herbicides" used by the U.S. military from 1961 to 1971. Agent Orange, produced commercially by Dow Chemical and Monsanto, was treated to release dioxins that are linked to specific types of cancer and to genetic defects.

In these and many other modern military adventures, wounding and medical treatment have provoked one another in profound ways. Medical knowledge, in other words, has been used to create weapons and, in turn, to generate new forms of diagnosis, treatment, and rehabilitation. This is a point that Talal Asad has made in the context of his larger analysis of the neo-Orientalist discourses that surround and underpin much of the rhetoric of George W. Bush and his administration that seeks to legitimate extreme tactics of preemptive war and of secret "extraordinary rendition." Through these policies, suspected "terrorists" are killed or tortured, and the suicide bomber is constructed as an especially deranged type, particularly terrible "not simply because he killed innocents or was prepared to die . . . or simply because he killed himself . . . but because he killed himself in order to kill innocents" (Asad 2007, 40). I encourage interested readers to read Asad's brilliant analysis of the construction of the suicide bomber for its illumination of the parallel points of and divergences between putatively (morally and politically) opposite agents of violent conflict: the allegedly deranged Islamic terrorist and the so called properly trained citizen-soldier of liberal nation-states such as the United States. But here I will concern myself briefly with

an ancillary passage of Asad's text in which he discusses the seventeenth-century foundation of liberalism and liberal states and the latter's characteristic claim to a monopoly on the legitimate use of force and violence.

To closely paraphrase Asad, liberalism of the Lockean type has its origins in the violent politics of the Renaissance, wherein liberty and warfare were bound together. Gradually, the state acquired exclusive power to wage war externally and to impose punishments internally. Under this arrangement, the morally autonomous individual has the right to choose his or her own life, and the sovereign state has the right to use violence in defense of the conditions of the good life. This arrangement is not only that of the founding of liberal states, but also the ongoing maintenance of them. Violence founds the law and is therefore embedded in the very concept of liberty that lies at the heart of liberal doctrine. The right to kill is given to the state and the state then authorizes the kind of killing that will be legitimate (war, self-defense, protection of the community). Hence, the doctrine of preemptive war is underpinned by a liberal logic of protecting the community from an immanent attack (Asad 2007, 58–59).

Asad moves on to consider "another, less dramatic aspect of modern state violence . . . that informs liberal politics." I quote him at length, in support of my argument and the evidence I have provided so far to support it:

> The mobilization of individuals within and by the sovereign democratic state and the care devoted to its population have been at the heart of the liberal conception of the good life. And a guarantee of that life is the citizen-soldier who is prepared to kill and die for it, yet whose health, longevity, and general physical well-being are objects of the democratic state's solicitude. Taken together, these well-known facts hint at something unique about the violence intrinsic to modern liberty. This has to do partly with advanced technologies for death dealing. The fact that modern warfare has given birth to numerous inventions is well known. These include improved techniques for destruction, of course, but also for the restoration of human life. Important developments in surgery, psychiatry, and psychology, as well as in nursing and hospital administration, are famously connected with the demands and consequences of modern war. . . . It is as though advances in the surgeon's healing art, on the one hand, and the production of ever more ingenious ways of wounding and maiming, on the other, were locked in an endless

> game of mutual provocation, of death and of life, which rich and technically advanced liberal states can play with endless variation.[7] (60–62)

Now, in the context of what George W. Bush has referred to as the "global war on terror," we are promised new directions in medical research and innovation that are provoked by traumatic brain injuries and polytraumas, the wounds declared as signatures of this conflict. Among the innovations are new physical and psychological therapies to help sufferers regain speech, memory, and the ability to read and to perform logical reasoning, as well as learn how to walk and otherwise move, assisted by prosthetic limbs. New battery-operated portable fusion pumps are being developed to block peripheral nerve activities as a form of anesthesia. These pumps are connected to catheters that are implanted along affected nerves and provide a steady infusion of local anesthetic to block pain from wounds so it does not reach a soldier's arms or legs. These new devices are likely to be adapted to non-combat-related injuries as a general practice in the area of anesthesia. And a whole new generation of prostheses and other supports, including robotic legs and arms, skin and tissue grafts and scaffolding, and computational memory devices, are being developed and manufactured to compensate for polytraumatic injuries.[8] These are but a few of the products of recent woundings.

What we are witnessing is another chapter in the history of modernity, a history in which medical science is fundamentally bound up with wounding as a modus operandi for developing innovations and perfecting new techniques. A humanitarian rationale is frequently offered as an antidote or a properly ethical response to massive wounding emblematized in the development of new medical techniques, as Gregory Whitehead's vulnerologist laments, noted earlier. This mutually provoking relationship between wounding and healing underscores the evidence of a relationship not so much of intentional dependency between militarism and medical science, but of mutual provocations that are highly mediated through cultural narratives. What are these cultural narratives? What can we learn from the reading position of "vulnerologist" about the mutually implicated (and provoking) domains of medical science and militarism at this particular juncture of history? How can we avoid the production of an "amnesia archive"? These are some of the questions that arise from interrogating the conditions under which a woman like Claudia Carreon loses her memory.

WOMEN, HUMANITARIANISM, AND EMPIRE BUILDING

Returning now to thinking about Claudia's condition, it is interesting to note how she has been described by the neurological physicians who have cared for her. Dr. Harriet Zeiner, you will recall, mentioned that women veterans who sustain a "closed head injury"—those whose injury is not visible on the surface of the body—tend to confront particular challenges in the treatment process. Claudia could not remember that she was married, or that she had been pregnant, or that she had given birth to a daughter a few years before her injury. While many of Zeiner's male patients experience the loss of memory as a debilitating relinquishing of control over information, Zeiner diagnoses her female patients to have experienced what she refers to as a wound that causes an acute problem of relating to one's history and to others, or in Zeiner's words, a "wound in who you want to be in this life."

The doctor's commentary reflects some of the dominant ideological tropes, or figures, through which women have been linked historically to nationalism, modern imperialism, and war and, most significantly, maternalism—as in "mothers of the nation." Claudia's incapacity to remember being a mother is cited as a sign of the profundity of her injury. The concepts of the nation as mother to be guarded and protected and the mother, in turn, as the figure for nurturing and reproducing the nation have a long history in Western political thought. But in addition to this, a common symptom of women veterans recovering from trauma is their inability to "read sexual cues" or to respond discriminately to sexual advances. While the U.S. military continues to fall far short of adequate prevention and prosecution of acts of rape and severe sexual harassment perpetrated on women soldiers by their male peers and those ranking above them, the issue of women's inherent erotic appeal has been cited as a reason to keep women out of the military, or at least combat, where they are said to function as a seductive distraction that threatens to undermine the male warrior's focus on male bonding and carrying out the tasks of destroying the enemy (essential features of the "warrior culture," produced through "unit cohesion"—the fraternity of the "band of brothers") (Hillman 2007).

But Claudia is not a mother within the classical construction of maternalist nationalism. She is, an immigrant-cum-citizen-soldier, a member of what is being called a "new fighting force." Claudia entered the U.S. Army at a particular time in its history: a time when the military leadership had decided, after reflecting on what went wrong during the Vietnam War, that it was better to have an "all volunteer" (or "professional") military, rather

than to enforce a policy of mandatory conscription. The decision came after those in command concluded that the mandatory draft of young men not only had contributed to inefficiency and financial expense in executing the war in Vietnam, since many draftees lacked the aptitude and motivation to fight, but also had fueled the antiwar movement. Instead of imposing a mandatory draft, the Pentagon decided that it would enhance its recruitment efforts to attract willing participants to its ranks, starting in the late 1970s. This included opening the doors to more women, particularly in the air force and the army. The leaders believed that the logic of allowing individuals the choice to join the military, coupled with enforcing standards of recruitment, would make the military more cost-effective and, ideologically, more palatable. While during the Vietnam War, women constituted less than 2 percent of military personnel, now the figure is around 16 percent (Hillman 2007).

Women's participation in the military has changed through a variety of factors. First, technological advancements now make many military tasks reliant less on pure physical strength and more on technical precision and knowledge. Second, military leaders saw an opportunity to raise the standards of performance among recruits by reaching out to women. Without women, the U.S. military would have suffered not only a shortage of personnel in the postdraft era, but also a striking drop in educational levels and test scores of new recruits.[9] Third, outside consultants urged the military to recruit more women because they would be cheaper. Fourth, the percentage of African American women who enlisted in the military has increased substantially, reaching 39 percent of the female army personnel on active duty in 2004, the year following the U.S. invasion of Iraq.

However, women, regardless of their ethnicities, are officially excluded from 15–20 percent of military positions, including those classified as combat ground positions (combat aviation is open to women, but its positions are overwhelmingly occupied by male pilots). Official assignment to a combat position comes with supplemental pay and carries a greater likelihood of promotion and commendation. Since women cannot hold these positions, they are locked out of the main channels of upward mobility: money and rank. Most women are concentrated in health care and administrative assignments. An increasing number are assigned to logistical operations tasks, such as delivering fuel and supplies from one location to another. Given the nature of military occupations such as those in Afghanistan and Iraq, a larger number of troops and supplies are necessary for carrying out the ground missions. This means that, while they may not be recognized or compensated

for combat activities, women assigned to medical tasks and to transporting supplies are among the growing number of injured and killed as violent conflict occurs along the roads and in the concentrated population centers, where female soldiers do their work.

Claudia and women like her make up a special subset of male and female military recruits in the all-volunteer army. She is one of thousands who have joined the ranks as a condition for acquiring U.S. citizenship. Most who pursue this avenue are concentrated in the lower ranks of the military, or those ranks that are open to individuals who have not yet acquired a college education. They have limited upward mobility and are among those most likely to be deployed to zones of conflict. It should be noted, however, that immigrant citizen-soldiers perform important symbolic work in the hegemonic production of twenty-first-century American nationalism as "multicultural." Their stories are mobilized in selective forms of U.S. inclusion, to produce an image of the United States as a place to turn to for promising opportunities and for patriotic belonging, even in the midst of the imposition of severe restrictions on immigration into the nation. Vowing to give one's life to fight for the nation is held up as an ideal mode of acquiring citizenship; most other motivations are overshadowed by such a dramatic and self-sacrificial image.[10]

In the midst of all of this, political scientist Julie Mertus (2004), in her recent book on human rights and U.S. foreign policy, notes that significant changes in U.S. military operations encompass human rights to a greater degree than do the activities of many civilian branches of the U.S. government, at least in principle, if not in consistent practice. Mertus recognizes that the traditional "warrior role" that traditionally has been inculcated in new recruits to the military is being modified by an increasing focus on developing "peacekeeping" practices. The two roles—warrior and peacekeeper—are in many ways incompatible, Mertus argues, and yet the U.S. military has attempted to combine them to carry out peace enforcement operations of the sort that the United States conducted in Kosovo in the 1990s. Peace enforcement operations involve a soldier's ability to negotiate with warring groups and to ensure security with the use of force being only one (and often not the most effective) tool in the arsenal of practices. Mertus suggests that one of the ways the military is adapting to its new role as peace enforcer is to cultivate negotiation skills among the new kinds of people who are being recruited to the U.S. military: namely women and people of color, including those of "foreign descent." The logic here is that these previously

excluded people will bring new skills of understanding, empathy, reason, and deliberation to the complex situation of military occupation and counterinsurgency campaigns. Management and mediation skills, not simply the skills required to kill the enemy, are being emphasized. Whether this faith in new kinds of soldiers is warranted is an open question, as I see it. The awful atrocities carried out by female soldiers at Abu Ghraib prison certainly is reason to abandon the faith that simply being a woman makes one less susceptible to becoming a war criminal under circumstances that encourage the brutal treatment of detained people. But it is, indeed, interesting to consider how the U.S. military is *re*deploying a rhetoric of humanitarianism, akin to sentimentalism, to support its imperial adventures—a rhetoric familiar to those who have studied every U.S. war since at least the Spanish-American War—and is now featuring women soldiers as important emblems of this humanitarianism, which, in the case of the invasion and occupation of Iraq, is proclaimed as a sign of the liberation of women in the United States, as compared with the alleged enslavement of women in majority-Islamic countries. And this, of course, is another way in which the politics and history of humanitarianism and militarism are intertwined.

American studies scholar Amy Kaplan (2002) reminds us in her powerful text *The Anarchy of Empire in the Making of U.S. Culture* that humanitarian claims have been at the forefront of all modern American military excursions, claims that have been mobilized to rationalize the seizing of territory and resources from Native Americans; from Native Hawaiians; from peoples living in Cuba, Puerto Rico, the Philippines, Korea, Vietnam, and now Iraq. Humanitarian salvation, Kaplan notes, has been a powerful ideological mechanism for justifying U.S. empire to the masses in the United States. A rationale of liberating others—of bringing democracy to allegedly backward cultures—and particularly claims of liberating women: these are fundamental ideological mystifications burying wounds and deaths that continue to haunt the United States.

Kaplan analyzes the popularity of coming-of-age stories, in the genre of historical romance, that were best sellers during the Spanish-American War. This conflict began in 1898, when the United States went to war with Spain in the name of liberating Spanish colonies from the tyranny of the Spanish Crown. These historical romances hark back to the period of the American Revolution a century earlier and, in formulaic predictability, feature white male protagonists whose characteristic bravery and spirit of independence propelled them to fight for the nation's independence against the royal

antagonists of the European dynasties. In his quest for independence, the male hero's honor was emblematized by his ability to save and protect white women from myriad dangers, including those posed by the rugged wilderness of the frontier. In Kaplan's analysis, the frontier provided the ground for dramatizing white masculine bravery, pronounced in heroic gestures of taming the elements for the purposes of eventual domestication to ensure the protection of women and children. When the western territorial frontier of the United States was finally seized, the U.S. government, and the capital interests supporting it, reached across the seas to eventually build an empire in the South Pacific and Caribbean. But the government did so with a kind of remote control, mobilizing a rhetoric of benevolence and chivalry that disguised acts of subjugating others and appropriating their resources. In other words, the chivalrous sentimentality of the historical romance genre worked to support a geopolitics and biopolitics of gender, race, and empire. Saving the damsel in distress allegorized U.S. foreign policy to make the subjects of empire into feminized and infantilized subjects, as weak and dependent and therefore in need of protection from afar —the proverbial "white man's burden" (A. Kaplan 2002, 92–120).

In a chapter on Manifest Domesticity, Kaplan analyzes how the nineteenth-century doctrine of separate spheres for men and women, which defined the public world of commerce and politics as appropriate for men while cloyingly "elevating" women's role to that of the lady of the household, was implicated in the imperial expansion of the United States, which led it to dominate the western frontier and eventually well beyond. She argues that the categories of domestic and foreign and of private and public were deeply dependent upon one another in the fulfillment of Manifest Destiny. Kaplan's readings of popular nineteenth-century white women's writing bring to light how the doctrine of separate spheres was deployed in the service of American empire, whereby white women domesticated the frontiers of the empire and guarded the borders of both the home and the nation from the threat of "foreign invasion." The "empire of the mother" was a crucial development in mid-nineteenth-century middle-class culture, at a time when the United States was violently expanding its control across the continent. A cult of true domesticity infused the dominant gender, race, and sexual ideologies of this tumultuous time, situating Anglo men as fitting frontiersmen forging westward and their female counterparts as taming the men's passions by providing a stable haven, bounded and orderly and civilized by means of the caring and nurturing sensibilities of the mother-wife.

But such a stable image of middle-class gender relations is a potent fiction, Kaplan argues, one that functions to obscure the specific ways that westward expansion included middle-class women as "civilizers" in their special roles as "refined" women. Indeed, it wasn't only their husbands and children these women would be taming. It would be the so-called savages, the beasts, and the wild lands that, within the discourse of domesticity, would benefit from the lady's loving but stern hand. In popular literature, the violence of westward expansion was itself obscured by means of drawing highly idealized female figures whose "touch" was described as gentle but also resolute, in the spirit of benevolent missionary work (whose own violent history was constantly being "forgotten"). The dual meaning of "domestic"—referring to the home, but also, in foreign policy parlance, the nation—had substantial consequences then and now. In the nineteenth-century chapter of U.S. imperialism, to promote the idea of the enclosed nation as home, a foreigner or a group of foreigners is named and, often, regarded as inferior or demonized within. "Domestication," "domesticity": these came to be signifiers for measuring whether a foreigner or a savage had been adequately tamed. Both represent processes that are reiterated in nineteenth-century popular writings, and we can observe the legacies of this discourse in our current moment.

Kaplan stresses the dynamic nature of domestication; it is anything but static. Domestic discourse "was deployed to negotiate the borders of an expanding empire and divided nation" (divided by severe racism that was supported by the massive industry of chattel slavery and by antagonisms between white settlers and annexed indigenous peoples). But the rhetoric, rather than stabilizing the representation of the nation, heightened the conflictual and contingent nature of the boundary between the domestic and the foreign, "a boundary that broke down around questions of the racial identity of the nation as home." Domestic discourse performed a double movement: "to expand female influence beyond the home and the nation, and simultaneously to contract women's sphere to that of policing domestic boundaries against the threat of foreignness" (A. Kaplan 2002, 23–24).

This longer history makes me wonder how best to understand the depiction of the wounded in popular accounts of the Iraq war's woundscape. We learn about Claudia Carreon as an injured woman, a wounded U.S. soldier, a disabled veteran, a Latina, a foreigner who recently became an American citizen, a forgetful mother, a confused patient, the carrier of a signature wound in a "global war on terror." What do representations of her in

popular media accounts of the "global war on terror" allegorize? We could also ask, What do academic deconstructions of her representation allegorize? I am wondering, for example, how the genre of the historical romance and how the discourse of Manifest Domesticity compare with the narratives and representations emerging now, in the twenty-first-century U.S. imperial expansion, which entails the recruitment of women, especially women of color, into the U.S. military. What genres of fiction and journalism are popular now and how do they relate to the current wars in Afghanistan and Iraq? How is heroism configured in popular narratives, including documentary films about the wars? What ideal spectators do these narratives construct or configure? Waiting wives of soldiers? Caregiving mothers who aid their injured children, both men and women? Since the discourse of the contemporary Pentagon is attentive to honoring "the men and women in uniform," what do we make of this inclusion, in light of the nineteenth- and early twentieth-century expansions? What do the bodies of injured women soldiers signify in media accounts of them?

THE POLITICAL ECONOMY OF VITALITY

Nikolas Rose (2006), in his recent book, *The Politics of Life Itself*, follows in the path of Foucault in examining the contingent history and future of what Rose calls a "politics of vitality." Rose argues that, compared with earlier points in modern history, the twenty-first century's version of vital politics is no longer delimited by the poles of illness and health, nor is it focused on eliminating pathology to protect the future of the nation. "Rather," he notes, "it is concerned with our growing capacities to control, manage, engineer, reshape, and moderate the very vital capacities of human beings as living creatures" (3). This implies a particular kind of subjection, or what Rose and others refer to as "biological citizenship," a form of governmentality through which individuals are expected to manage their own affairs and to secure their own futures (Rose and Novas 2003). Moreover, this subjection occurs in the context of a reorganization of the powers of the state and a decline in the state's responsibilities for the management of human health and reproduction. Private corporations and professional groups govern the possibilities for how the consumer/patient may act in relation to her or his health management, and money matters. "Biocapital" and "biovalue" bring together the demands of shareholder value with those of human value, and they do so on a remarkably unequal field of operation. The "somatic ethics" of our time are deeply interwoven with the spirit of biocapitalism, according

"a particular moral virtue to the search for profit through the management of life" (Rose 2006, 8).

Given the projected costs of treating traumatic brain injury in a growing number of veterans, it is not difficult to imagine how the mentality of biocapital will operate. A part of the longer history of medicine and violent conflict that I haven't mentioned yet, and will only mention in brief here, is the recurrent use of poor and working-class people as subjects of medical study and experimentation, usually rationalized as necessary for the advancement of medical knowledge. Money matters here, obviously. There is very little said, at least in the circles of state power, about the ethical responsibilities the United States may bear in providing support for Iraqi and Afghan casualties of war. What will become of them in the vastly unequal field of global biocapital? What will become of people in Claudia's situation, especially given the formidable costs of medical insurance and the obstacles that impede a decent quality of care? Who will pay for treatment and what will motivate them to pay? Whose bodies will be conscripted in the service of research and new technological development? What biocapital interests are at play in the development of novel medical techniques? And what narratives will be developed to rationalize these?

CONCLUDING THOUGHTS

Inderpal Grewal, in her trenchant analysis of race, gender, and citizenship after 9/11, reminds us that "the powers of freedom . . . [that] produce modes of governmentality, are undertaken not simply by the sovereign right to kill, but also through the legal right to save. . . . It is the interrelation between the sovereign right to kill and the humanitarian right to rescue that constitutes modes of modern power, whether by states or other institutions of power" (2003, 537). Grewal is informed by Foucault's theorizing of governmentality, a neologism Foucault used to signify that, in Thomas Lemke's words, "it is not possible to study the technologies of power without an analysis of the political rationalities ["mentalité"] underpinning them" (2000, 2). Grewal references a range of nonstate institutions of power, from religious missions to nongovernmental activist organizations to contemporary consumer markets, to emphasize the interrelations between governmentalist techniques of moral reform, health and hygiene campaigns, educational development, consumer advertising, peer security surveillance, and many other modes that are instrumental in the formation of new classes of dominating and dominated subjects.

When reviewing the history of such interrelations as they are manifested in colonized locales, Grewal succinctly observes "saving" involved destroying (Grewal 2003, 537). Knowledges supplanted other knowledges. Some who were subjects of reform missions also became subject to other types of reform under the sign of a new nationalism. Grewal is constantly attentive to the emergence of new subjectivities, new manifestations of nationalism, new effects of governmentality, new forms of regulation; her effort is to trace the dynamic pressures and generative repositionings of governmentalist practices. For this reason, she argues for paying attention to everyday aspects of social life, including consuming practices and, moreover, the discourses of choice and freedom that circulate through them. Although consuming practices may seem unrelated to the powers of the state, Grewal notes that "forms of self-regulation cannot be dissociated from forms of state power through which some regulatory mechanisms become more powerful than others" (2003, 538). "Choice" operates as a regulatory mechanism, counterposed against a threatening specter of "unfreedom" or the loss of choice. In a slightly different fashion, "saving" or "rescuing" are also regulatory mechanisms. They too draw on an ideal of freedom and an anxiety about unfreedom that has given rise to an unfortunately large number of impositions, if not always outright atrocities.

What is expected of Claudia Carreon? Where is she located in what Nikolas Rose (2006) refers to as "citizenship projects" of our moment in history? How is her biological status linked to her legal status as a subject and object of empire? What is her "choice"? What does her story, presented to American television audiences, who are urged to "support our troops," indicate about the political economy of vitality during a particularly virulent chapter of anti-immigrant sentiment that has been sweeping the United States? How does Claudia's condition call forth a feminist critique of humanitarianism as it has functioned instrumentally to promote the expansion of U.S. empire? How could such a critique address the haunting effects that emanate from the all-too-common belief that humanitarianism and militarism are fundamental opposites? These are questions that can be raised using a vulnerological method.

I have tried to show how a historically informed semiotic analysis of signature wounds may work to illustrate the symbiotic relationship between war-making and humanitarianism, and between biopolitics and geopolitics. Such an analysis seeks to note how the political economy of vitality today plays out not only in the wounding and treatment of a woman such as

Claudia Carreon, but also in the cultural narratives that bring her to our attention. My aim has been to make it clear that we cannot afford to assume that war, imperialism, and humanitarianism belong to different moral orders. If we assume so, the consequence is a deadly and protracted condition of cultural amnesia.

JENNIFER TERRY is an associate professor of women's studies at the University of California, Irvine. She is the author of *An American Obsession: Science, Medicine, and Homosexuality in Modern Society* (1999); coeditor of *Processed Lives: Gender and Technology in Everyday Life*, with Melodie Calvert (1997); coeditor of *Deviant Bodies: Critical Perspectives on Science and Difference in Popular Culture*, with Jacqueline Urla (1995); and author of "Killer Entertainments," in *Vectors: A Journal of Culture and Technology in a Dynamic Vernacular* (Fall 2007, http://www.vectorsjournal.org/index.php?page=7&projectId=86).

NOTES

1. Polytrauma care is for patients who have sustained multiple injuries that are life threatening and manifested in some form of physical, cognitive, psychological, or psychosocial impairment and functional disability. Common examples are head injuries, visual or hearing impairments, amputations, burns, and bone fractures. The other VA polytrauma units are located in Tampa, Florida; Minneapolis, Minnesota; and Richmond, Virginia.

2. The terms "signature wound" and "signature injury" are commonly featured in recent discourse about casualties experienced by U.S. soldiers battling in Iraq and Afghanistan. Indeed, besides Dr. Harriet Zeiner's using the terms, the 2008 RAND study, mentioned above, referred to TBI as one of the "signature wounds" of the Iraq and Afghanistan wars. The increasingly common usage of these terms suggests an interesting move toward marking wars through a historiography of wounds; that is, as a means through which to construct a history of armed combat that foregrounds the wounding capacities of new weapons systems and the damage they can do. While the terms have been used lately by physicians, psychologists, and journalists reporting on the war, their growing prominence may well have an impact on the subdiscipline of military history that has tended to focus on specific "events" (battles, military campaigns, wars) of battles or on the biographies of significant military leaders and the tactics they carried out.

3. I am relying on the critical interventions made by feminist scholars who are generally associated with feminist transnational studies, an approach that pays attention to the inequalities and differences that arise from the new forms of globalization and from older histories of colonialism and racism; it emphasizes a world of connections and differences rather than of similarities and comparisons. Particularly useful are the key concepts of "transnational connectivities" and "transnational disjunctures," offered by Inderpal Grewal (2005). Tracing transnational connectivities provides a method for analyzing the production of subjects and identities in their specific but not geographically

fixed contexts. Thus, communication across (and mediation between) epistemological boundaries and geographical borders becomes important to track. As Grewal puts it in a chapter on new identities enabled by cosmopolitan and diasporic flows among South Asians in America, "Subjects were constituted within uneven and heterogeneous transnational processes" (37). I seek to extend this concept to my analysis of the uneven and heterogenous production and circulation of images of violent conflict associated with hegemonic narrations of "the global war on terror." My approach here also draws on other nonuniversalizing feminist interventions in feminist theory, including important postcolonial theorizing of the relational politics of location (Rich 2002; Mohanty 1987); on critical projects in diaspora studies, area studies, and studies of immigration (Brah 1996; Lowe 1996; Shohat 2002); and on critical theorizing of tourism and travel and of discrepant cosmopolitanisms and the gendered, raced, sexualized, and classed cosmopolitics of global feminisms (C. Kaplan 1997, 2001).

4. I am not claiming that physicians are responsible for this dynamic of mutual provocation, nor am I arguing that all modern medical knowledge derives from scenes of war. Instead, I am interested in drawing attention to the vast discursive and material connections between acts of wounding and acts of healing that implicate all kinds of authorities and subjects. I seek, in this inquiry, to address a broad audience with the question of *why* these domains—modern medical practice and the military—are so deeply interconnected and what this tells us about key foundational principles upon which liberal democracies are based.

5. I am borrowing here also from Lisa Lowe, who, in her consideration of how new world modernity, global intimacies, modern humanism, and a racialized division of labor are intertwined, emphasizes a concern for the archive. More specifically, she warns of how an economy of affirmation and forgetting is linked to the politics of our lack of certain knowledges. Among such knowledges is that of knowing how the humanist archive naturalizes itself and "forgets" the conditions of its own making. As Lowe puts it, what we think to be gender and race are traces of modern human forgetting. "They reside within and are constitutive of the modern narrative of freedom but are neither fully determined nor exhausted by its ends. They are reminders of the formalism of affirmation and forgetting" (2006, 206). For my purposes here, the oxymoronic term "amnesia archive" captures some of what Lowe is referencing: an institutionalized silence or invisibility brought into being by discursive moves that create a space for remembering that is constituted on very significant acts of forgetting. What the vulnerologist seeks to re-member are the somatic and semiotic traces of violence in order to stop the madness of escalating lethality. S/he exercises a hermeneutic maneuver to read back from the wound to the many forces that caused it and that continue to occlude a collective memory of the conditions that made the wound possible.

6. White phosphorous bombs act in a similar fashion to napalm: when a bomb of this sort explodes on impact, the chemical phosphorous bursts into flames, taking the form of burning flakes which cause extreme burns to the skin and tissue of any living creature in its vicinity. If ingested, it is generally fatal. In the first years of the U.S. invasion of Iraq, the Pentagon denied using white phosphorous in weapons but, by November 2005, admitted to using it to produce smoke in order to obscure the vision of enemy combat-

ants, a use that is not technically illegal under the Chemical Weapons Convention. Daisy cutter bombs are equipped with "daisy cutter" fuses, long probes attached to the bomb's nose that cause the bomb to detonate if it touches any solid object. The purpose is to maximize the blast damage on the surface of the target. Because a daisy cutter fuse will detonate the bomb prior to hitting the ground, it is capable of inflicting far more damage to a larger area than bombs using conventional fuses. Daisy cutters, like "weed wackers" are often used to clear brush or to create landing areas for helicopters. It is not a precision weapon, but is used to clear large territories. Obviously its impact is generally fatal when aimed at population centers. Cluster bombs are weapons dropped from the air or launched from the ground that eject multiple submunitions. They are generally intended to kill enemies; destroy vehicles, buildings, or infrastructure; or disperse leaflets. Often unexploded bomblets are left behind after a strike; cases of civilians, particularly children, finding these bomblets years later and being injured or killed by them have been reported in recent years in Vietnam, Kosovo, Lebanon, Iraq, and Afghanistan.

7. Asad also cites military historian John Keegan in support of his argument here. Keegan writes, "Weapons have never been kind to human flesh, but the directing principle behind their design has usually not been that of maximizing the pain and damage they can cause. Before the invention of explosives, the limits of muscle power in itself constrained their hurtfulness; but even for some time thereafter, moral inhibitions, fuelled by a sense of the unfairness of adding mechanical and chemical increments to man's power to hurt his brother, served to restrain deliberate barbarities of design. Some of these inhibitions—against the use of poison gas and explosive bullets—were codified and given international force by the Hague Convention of 1899; but the rise of 'thing-killing' as opposed to man-killing weapons—heavy artillery is an example—which by their side-effects inflicted gross suffering and disfigurement, invalidated these restraints. As a result restraints were cast to the winds, and it is now a desired effect of many man-killing weapons that they inflict wounds as terrible and terrifying as possible. The claymore mine, for instance, is filled with metal cubes . . . , the cluster bomb with jagged metal fragments, in both cases because that shape of projectile tears and fractures more extensively that a smooth-bodied one. The HEAT and HESH rounds fired by anti-tank guns are designed to fill the interior of armoured vehicles with showers of metal splinters or streams of molten metal, so disabling the tank by disabling its crew. And napalm, disliked for ethical reasons even by many tough minded soldiers, contains an ingredient which increases the adhesion of the burning petrol to human skin surfaces. Military surgeons, so successful over the past century in resuscitating wounded soldiers and repairing wounds of growing severity, have thus now to meet a challenge of wounding agents deliberately conceived to defeat their skills" (Asad 2007, 62, quoting Keegan 1978, 329–30).

8. For an example of these developments, see the work of artist David Hanson, who is at the Institute for Interactive Arts and Engineering at University of Texas, Dallas. A graduate of Brown University and Rhode Island School of Design, Hanson has worked on prosthetic and robotic devices that could be used in the rehabilitation therapy of combat veterans, including in the reconstruction of skin, using artificial tissue to remedy severe burn scars. For more on his work, see http://www.hansonrobotics.com/humans.html and http://iiae.utdallas.edu/projects/index.html.

9. The Gates Commission of 1970 recommended that the mandatory draft be discontinued, but it ignored women altogether while noting that the military involved more bureaucratic tasks and fewer ground forces. When the commission recommended higher standards for recruitment, the numbers and quality of male volunteers fell and the Department of Defense scrambled to recruit women. From 1974 to 1976, 88 percent of the women who joined the army were high school graduates, compared with 52 percent of the men. By 1984, 92 percent of military women had high school diplomas, compared with only 70 percent of male soldiers (Hillman 2007).

10. It should be noted that signing up to serve in the military does not guarantee citizenship immediately. The promise often takes a while to come through. Indeed, as many of the publicized obituaries of men and women serving in the current U.S. military indicate, citizenship is often granted posthumously.

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