

Genital Injury in Modern Warfare: The Struggle for Intimacy Inside the Bio-power of the
Military Institution

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Introduction

Injury has forever existed as a fundamental feature of warfare and the current Global War On Terror (GWOT) is certainly no exception. However, since the aftermath of the Civil War, injury has commonly been perceived as a visible phenomenon that has shaped the way people have cared for and responded to injured veterans. The attention visible injuries received in the past, such as broken bones, amputated limbs, and physically scarred faces, still shape the way injury is perceived today, which renders more invisible injuries such as genital injuries obsolete. The invisibility of genital injuries is both unseen and unheard. These injuries are physically hidden from the public eye and are missing from public conversation. A purpose of this paper thus becomes addressing the severity of combat-induced genital trauma seen in modern warfare in order to put it into visible conversation. Genital trauma is not a new feature of military combat, but is rather dependent on the social construction of warfare over time. Modern warfare thrives off of scientific knowledge, which is changing the ways battles are fought through advanced technological weaponry. The technologies constructing modern warfare are also exposing soldier bodies to modern vulnerabilities of genital trauma. Cases of male veterans with genital injuries are significantly rising but it is uncertain how this translates into knowledge for how these genitally-injured men transition into the rehabilitation system at Walter Reed National Military Medical Center (WRNMMC). The masculine embodiments of a man's genitals raise questions on how genital injury psychologically impacts the male soldier body and the ways in which the military may be responding to the phenomenon. Although genital injuries have been becoming increasingly prevalent since the start of the GWOT in 2001, there is still a scarce body of literature supporting how these broken soldiers rehabilitate genital trauma, and in turn, this invisibility ultimately casts them to suffer in silence. I argue that the lack of both scientific and

social knowledge on genital injury is due to the bio-power manifested in the military institution, which is perpetuating this phenomenon into an invisible crisis. Ultimately, the paper will reveal how genital injury challenges the framework of bio-power within the military institution in an attempt to propose a novel model of rehabilitation centered on the intimacy of genital injury.

Methods

The purpose of this research is to address the severity of combat-induced genital trauma seen in modern warfare, with the foundation of the argument being built upon the examination of genital trauma's influence on the male soldier body. The focus is only on male soldiers rather than on both male and female soldiers, because although there is little literature on male soldiers suffering from genital injury, there is even less on females suffering from genital injury rendering it into a difficult topic to study even though cases do exist. There are three similar, yet distinct terms that are used throughout: genital trauma, genital injury, and genitourinary trauma/disease. Genital trauma describes the physical exposure a soldier experiences in combat. Genital injury characterizes the lived embodiment after the trauma. Lastly, genitourinary trauma/disease reflects the injury in a more medicalized fashion, highlighting how the VA categorizes it.

There are five key objectives that this paper is meant to achieve. The first is to reveal the prevalence of combat-induced genital trauma in combination with its scale of invisibility, or lack of knowledge, in order to justify its need for further attention. The second key aim is the inclusion of bio-power, or the power to control populations of people, and why it is important in relation to genital injury. For this paper, bio-power is specifically attached to the military system, and how it acts as the driving agent behind the military's production of knowledge. A

third significant objective is to flesh out and prioritize intimacy as a necessary virtue attached to genital injury, along with examining its role in relation to bio-power. The fourth objective is to locate problems within the current military rehabilitation system and propose a novel intervention strategy that includes genital injury. Lastly, the body of the research as a whole should create a multidimensional body of knowledge that is able to accurately capture what is at stake for a male soldier exposed to genital trauma.

Due to the challenges of gaining military or VA access, the research design consisted of primarily literature review alongside some personal ethnographic fieldwork. The literature review encompasses both quantitative and qualitative data on genital trauma and masculinity alongside a mix of theory and history describing power structures, military culture, and the military rehabilitation system. I also utilize several military and VA manuscripts in an attempt to analyze how these institutions perceive genital injury. I use this literature review as a method to further my understandings of how genital injury fits within the context of the military. The personal ethnographic fieldwork consisted of two interviews, whose names will remain anonymous, in the fall of 2014. Both interviewees signed a form of consent giving me permission to use their claims in my research. I use the literature review alongside my fieldwork in order to build a foundation of credibility in this field, which then allows my proposed intervention strategy to have more merit and reliability.

In order to justify researching genital injury, the paper will first address why this topic should be more visible in today's society, highlighting quantitative evidence on genitourinary rates of incidence taken from the Department of Veterans Affairs (VA) and the Dismounted Complex Blast Injury (DCBI) Task Force. I propose that the significant increase in genitourinary injuries is due to the social construction of modern warfare. The social

construction will reveal three devices, which I refer to as “vulnerable technologies,” which expose soldiers to genital trauma and leave the injured soldier facing a difficult rehabilitative process.

In order to understand the rehabilitative model within the military, the paper will delve into the theoretical roots and history of military rehabilitation and culture. This history will lay the foundation for how and why rehabilitation operates today, exposing the influence of bio-power in the forms of both science and technology. Because there are no specific guidelines for rehabilitating genital injury, the paper will analyze three military documents that reveal how military bio-power shapes the construction of genital injury knowledge, or lack thereof. This extends into a discussion involving personal ethnographic fieldwork to highlight the intimacies of genital injury knowledge at an individual level.

Although research on the psychological damage of genital trauma is still scarce, the paper will examine two qualitative studies and one ethnographic study that highlight the tight relationship between the phallus and masculinity. The purpose of these studies is to question what is at stake for the genitally injured male body and will transition into a theoretical review on the social construction of masculinity to then explain why men place such a strong phallogocentric emphasis on genital injury. In order to put this theory into context, the paper will then discuss genital injury in a medical setting. The patient/doctor narrative will be deconstructed in order to capture the intersection between sexuality, gender, and healthcare, exposing the challenges that accompany genital injury in the medical field.

Together, the mix of theory and reality should provide a sufficient framework for introducing a paradigm shift in military rehabilitation from one rooted in history and enforced by bio-power, onto a novel model that is better suited for veterans recovering from genital trauma.

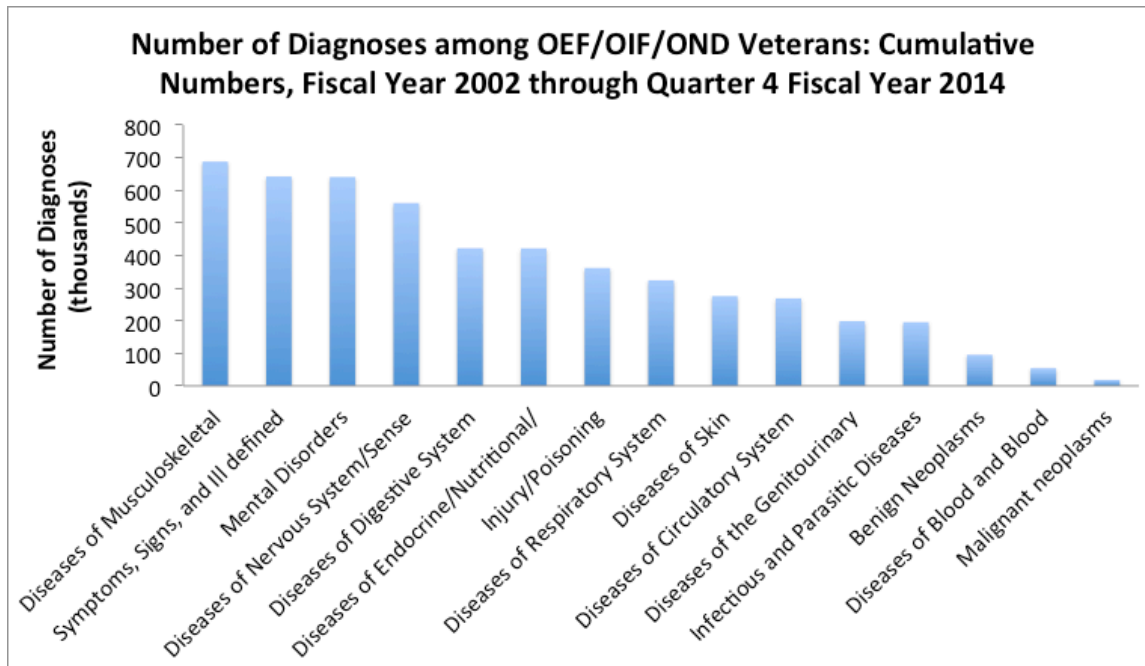
Finally the paper will conclude with a proposal for how social diagnostic technologies can act as epistemic resources for the facilitation of this novel rehabilitation model for genital injury.

Significance

Since 2011, the VA has been releasing quarterly reports on the almost two million eligible veterans who have served in Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), or Operation New Dawn (OND). According to the latest VA Health Care Utilization Report, which contains data from October 1, 2001 to September 30, 2014, 198,513 veterans have reported some type of disease of the genitourinary system, constituting 17.6% of the total number of diagnoses among OEF/OIF/OND veterans (Epidemiology Program 2014).

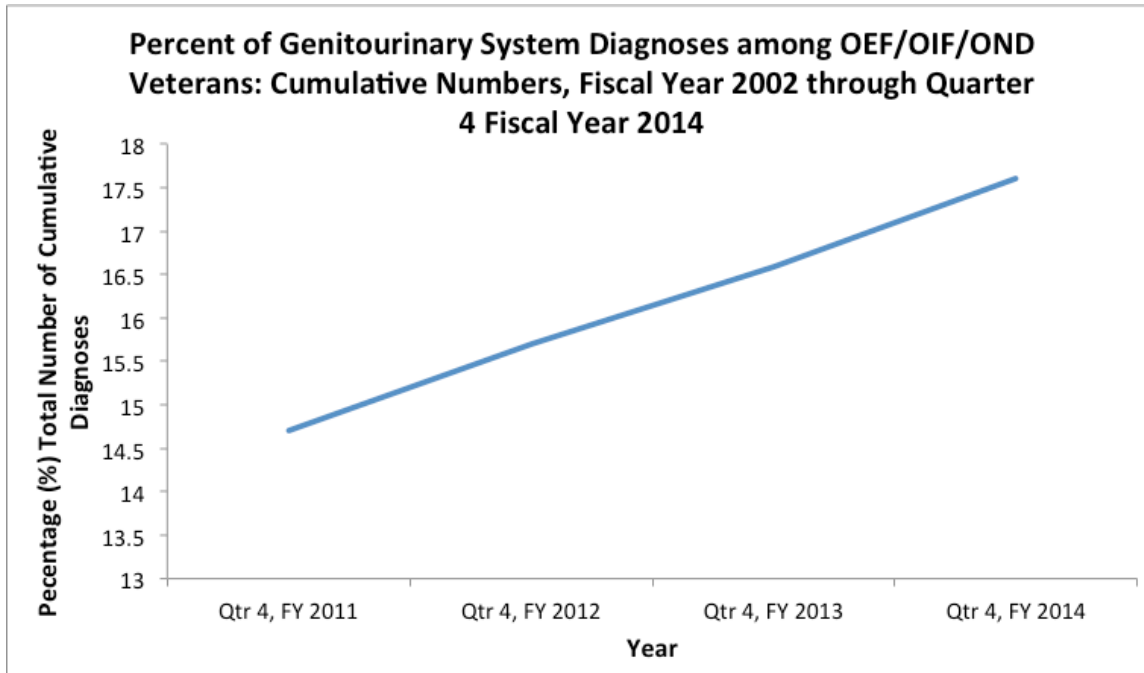
This data can be visualized below.

Figure 1



Data obtained from VA Health Care Utilization Report

Figure 2



Data obtained from VA Health Care Utilization Report

Unfortunately this report does not take into account how many of these veterans accessed the VA multiple times and in different years, and thus significantly overestimates the total burden.

However, looking at Figure 2, there is a linear trend upward in percent of genitourinary system diagnoses, which helps visualize the prevalence increase of this war alone.

A more accurate method of classifying the prevalence of genitourinary injury is to look within the Joint Theatre Trauma Registry (JTTR) created by the DCBI Task Force that tracks actual incidences of genitourinary trauma. From 2005-2010, this database has recorded 1,525 genitourinary injuries that have occurred in both OEF and OIF. In 2010, the DCBI Task Force recorded a historic high of 12.7% of all battlefield injuries being that of the genitourinary system, a 350% increase from the prior baseline seen in past conflicts (Carvalho 2011). To put this into perspective, the Civil War documented a total of 1,497 genitourinary injuries, accounting for only 0.61% of all battlefield traumas, while the historical average is somewhere between 2-5%

(Han et al. 2013). This comparison is significant for two reasons. First, it objectively supports the claim that the number of genitourinary cases as a percentage of total battlefield injuries seen in modern warfare constitute a significantly higher portion of those in similar cases reported in past conflicts. Second, this implies that genital trauma isn't a new phenomenon but has indeed been documented in wars past. The latter is interesting because it suggests that medical experts and VA policy makers should be well aware of genitourinary injury treatment options today.

However, polytrauma, defined as “the occurrence of injuries to more than one body system,” is becoming a common occurrence in modern warfare and is challenging this linear knowledge-treatment relationship (DoD, Warrior Transition Leader 2011). Genitourinary injuries are currently being classified as a Dismounted Complex Blast Injury (DCBI) by the DCBI Task Force because 90% of genitourinary injuries are not isolated, but rather accompany other debilitating injuries such as major lower limb amputations and other extremities (Carvalho 2011). This complicates treatment options and often leaves genitourinary injuries as subsequent issues to the more prioritized life-threatening injuries such as limb amputations, which can therefore result in delayed treatment and future fertility or hormonal problems. Needless to say, the striking 350% increase of genitourinary injury prevalence rates today suggests that there is an external force responsible for this change, and that this injury may be a product of its social context. Thus, I propose that there are three scientific devices, which I refer to as vulnerable technologies, which are the primary causes of increased genitourinary injury prevalence today.

The Social Construction of Genital Injury through “Vulnerable Technologies”

Warfare doesn't exist in a vacuum as a timeless object, but it is rather a man-made phenomenon, which creates a changing body of knowledge throughout time. Although genital injuries may have been prevalent in previous conflicts, new forces of warfare are generating new classifications of genital injury today, such as dismantled complex blast injury or polytrauma. The study of genital injury today is different than the study of genital injury in the past and thus must be understood as a product of its social context. For this reason, I will take on a social constructionist approach, adopted from Ian Hacking, that treats genital injury as the product of the interaction between conscious and knowledgeable agents (Hacking 2000). In other words, the episteme of genital injury should be understood through the contextual factors in modern warfare and not just as a biological phenomenon. Thus, I propose that there are three primary forms of scientific knowledge and technology, which I refer to as “vulnerable technologies,” that cause the type of combat-induced genital injury today.

Traditionally, combat weaponry consisted of rifles or other firearms that produced single projectiles and a high prevalence of gunshot wounds. This most likely justifies why less than 1% of battlefield injuries were documented as genitourinary during the Civil War and why historically on average genitourinary constituted 2-5% of total injuries. Now, however, U.S. soldiers being deployed in Iraq or Afghanistan are facing a new type of enemy weapon called an improvised explosive device (IED). This new type of weapon technology projects pieces of shrapnel, consisting of glass or metal fragments, at 2,000 feet/second from the ground upward once detonated, and now accounts for almost two-thirds of all genital injuries (Han et al. 2013). IEDs are hidden in the ground and can be disguised to resemble unthreatening objects, which allows them to appear invisible to the soldier. Unlike in previous wars where a human body was

responsible for operating weapons, IEDs used throughout the GWOT don't require the consciousness of human thought. IEDs are indifferent to who they impact, rendering them into "thing-killing" devices (MacLeish 2013). However, what separates IEDs from other explosive devices such as landmines? Although both are activated without human consciousness, an IED targets human bodies, whereas landmines are built and intended to target large machines. Thus IEDs are designed for pure human violence and terror, rendering them into severe public health threats. The scientific, invisible, and "thing-killing" embodiments of IEDs combine to form a type of vulnerable technology. For both soldiers on foot or in a vehicle, the impact from the blast targets the lower half of the body, leaving a soldier's genitals extremely vulnerable to severe physical trauma.

Although IEDs may be the most direct vulnerable technology responsible for genitourinary injuries today, their impact is partially dependent on a soldier's armor. Modern body armor consists of a Kevlar vest and helmet that primarily covers the upper body and head. Because the war in Iraq and Afghanistan is mainly being fought on the ground, the design of body armor centers on giving soldiers mobility with their legs and so most of the armor covers the upper torso. A Kevlar groin protector called a "skirt" was administered in 2004, but was often not worn and was deemed useless to the force of IEDs (Paquette et al. 2007). Some soldiers chose to not wear the skirt, not because it impacted agility, but because they found it emasculating (Wool 2014). However, since the advent of the "skirt," two models of ballistic underwear was introduced in 2011, which provide better protection from penetrating fragments. A small study found that there was a 72% chance of exposure to genital trauma without ballistic underwear compared to a 38% chance with the ballistic underwear (Williams et al. 2013). Although ballistic underwear is a significant improvement in preventing physical vulnerability,

the existence and advancement of genital armor alone leaves the soldier emotionally vulnerable to genital trauma. The label, “skirt,” was emasculating not only because it feminized the soldier, but also because it reproduced the fear the genital trauma exists. As military technology advances, “it encapsulates [the soldier] in the nervous tension between the phantasmagoric technological empowerment of the body and the felt vulnerability that technologized ‘invincibility’ only intensifies” (MacLeish et al. 2013). Body armor allows these soldiers to be put continuously in harms way, and with improvements in ballistic underwear, it perpetuates the existence of genital trauma and renders it a natural feature of warfare. Thus the technological advancement of modern armor becomes a vulnerable technology because it facilitates the existence of genital injury as an ontological object.

Lastly, the third vulnerable technology responsible for the significant increase in genitourinary injury is the advancement of medical knowledge and technology. In past wars, it wasn’t unusual for soldiers to die from battlefield injuries due to the inefficiency of life-saving technologies. However, in 2010, it was reported that there was an overall survivability rate of 88% from IEDs, due to doctors being able to successfully conduct life-saving operations (Han et al. 2013). This great survivability rate is only partially reflective on improved medical technologies because it is also due to the improvements of battlefield responsiveness. There are also now specialized units called Forward Surgical Teams, which are medics that provide immediate life-saving surgery on the battlefield (Williams et al. 2013). Thus when acting together, medical technologies and quick responsiveness of care contribute to the high survivability rates of trauma. Although the majority of soldiers impacted from an IED blast are surviving, they are doing so at the expense of incurring one form of injury or another. Advancements in medical technology now leave the soldier vulnerable to an injury he may not

have survived from in the past. Most notably, the soldier becomes vulnerable to surviving an IED blast with a genital injury. Like body armor, this vulnerable technology is meant to sustain human life, but does so at the cost of allowing genital injuries to exist.

All three vulnerable technologies create the foundation for understanding why genital injury exists today, but also suggest that there is even a greater force at work. The scientific knowledge behind these technologies is changing the soldier experience, a knowledge ultimately derived from the “body politic”. As defined by Nancy Scheper-Hughes and Margaret M. Lock, the body politic is an instrument of social and political control over individual bodies (Scheper-Hughes and Lock 1987). Each vulnerable technology exists as a product of the body politic operating at the institutional level of the military. Although IED blasts, modern armor, and improved medicine may physically cause and sustain genital injuries, they only do so because the body politic of the military normalizes warfare. The soldier is socially constructed to conform to the needs of military order, putting the body onto the battlefield and into harms way. The fact these soldiers experience genital trauma within the boundaries of the military institution is significant because it raises questions as to how this type of injury intersects with the social and cultural embodiments of an American soldier. Thus it is crucial to understand the historical and cultural features of the military, which ultimately shape how both the injured male self and the military institution perceive the intersection of masculinity and genital injury today.

Theoretical Roots and Historical Constructions of Military Rehabilitation and Culture

The quantitative data and technological forces behind genital injury discussed thus far constitute it as an acceptable epistemic phenomenon, an object that has the potential to produce knowledge. However, its existence alone does not translate into intelligible knowledge without understanding what genital injury means within the context of the military institution. With this in mind, the epistemology of genital injury requires a framework that includes theories of power within the military, social and cultural constructions of the male soldier, and historical constructions of rehabilitation. The purpose of providing this mixture of theory and history is to introduce how the bio-power manifested within military institution shapes the rehabilitation model of injured soldiers. The underlying goal is to begin the conversation that the current model doesn't support the intimate structure that genital injury rehabilitation ultimately requires in order to be successful at an individual level.

Looking at the power of disciplinary structure within the military institution from a theoretical standpoint is of paramount importance to understanding how medical rehabilitation in the military is shaped today. Adopting French philosopher Michele Foucault's theories on power structures, the military is built on disciplining and controlling soldier bodies. For Foucault, the power of discipline dissociates power from the individual body and lends it to the institution as a whole (Foucault 1977). For the military, this translates into using discipline to objectify the soldier body into discrete parts so that bodies can be mechanically controlled into collective movements that ultimately constitute a superior force than that of the elementary forces that compose it. Discipline makes individuals the body of knowledge but this then renders them into objects and instruments of its greater exercise, which Foucault refers to as "docile bodies". The

soldier is defined as a subordinate of a greater system, which only requires the soldier to be a mechanical object rather than as a subjective human being.

Thus, it can be said that the military institution is using bio-power to discipline the soldier body into a machine for the greater good of the institution. Bio-power objectifies the human soldier as a replaceable body that can easily be interchanged into or out of the power-governing system. Bio-power is different than the body politic because it is exerting its control over populations of people, rather than an individual body. This distinction is significant because disciplining populations of people necessitates the regulation of sexuality and gender as well (Scheper-Hughes and Lock 1987). Bio-power finds a niche within the military because the military is built off of the strict construction of the masculine male soldier. However, the military's bio-power model operates through populations of able-bodied soldiers, failing to adequately care for those suffering from injury. If bio-power is built off the power to govern populations of people, then it creates a rehabilitation model centered on objectivity and standardization, ultimately detaching itself from the intimacies of patient knowledge.

Although bio-power may shape how the rehabilitation model treats injured bodies, it is also crucial to understand the military institution as a product of scientific, social, and political constructions that change across American history. Beginning in the early nineteenth century, constructions of a male soldier were predicated on physical efficiency and masculine competency. Entry into the military relied on diagnostic technologies that consisted of a criteria combining able-bodiness and male beauty. The ideal soldier was to embody both superior physique and superior morale (Serlin 2003). Thus, the stigmas that are attached to the ideal soldier today stem from these diagnostic technologies that didn't just provide criteria for the normal image of a soldier, but also implied what certain characteristics weren't deemed

acceptable as normal. Technologies didn't just create embodiments of the ideal soldier, but also reproduced images of what constituted an acceptable disabled soldier.

After the Civil War, the injuries that piled up were mainly visible injuries such as missing limbs and amputation stumps. Material evidence of physical wounds reproduced disability as a visible phenomenon that soldiers could become proud of. Instead of diagnostic technologies creating normal images of soldiers, technologies of photography became the form of science that constructed embodiments of the ideal injured soldier. Photography enabled the "cultural distinction between 'tragically' disabled and the congenitally 'deformed'" (Serlin 2003). This dichotomy between injured veterans and congenitally disabled was ultimately predicated on the visibility of masculine injuries, and continued to exist into WWI. Photographers made sure to capture the heterosexual behavior of injured soldiers in order to preserve their masculinity.

War challenges the socially constructed American soldier, manifested on masculine virtues, because it exposes the soldier to physical weakness in the form of disability. The Civil War left thousands of visibly injured veterans and cost the U.S. government millions of dollars at the expense of the veteran pension system. Although the institutional burden of these injured veteran bodies was significantly damaging to the country's economy, the country was suffering more from the impact it had on sexuality and masculinity in America (Linker 2011). Soldiers, the pinnacle of masculinity, were praised for their autonomy and pride but yet pensions, a symbol of weakness and dependence, challenged their strong character. Public confidence in both the U.S. military and country was diminishing as people watched injured veterans, who symbolized the strength of the nation, waste away on the support of the government. The military needed a solution that could restore masculinity and once again bring the male soldier to embody the ideal American virtues.

Knowing that the nation could not afford another pension system disaster, the invention of military rehabilitation was built after WWI as an instrument for both cultivating masculinity and transforming the disabled soldier into an independent wage-earning man. Again, images of veteran amputees attempted to represent them as artifacts of popular culture, capturing hard facial expressions, smoking cigarettes, or even in some cases, the pinup girls painted on prosthetic limbs (Serlin 2002). Through the technology of photography, injured veterans came to constitute a different category of disability, one that transformed them into a “supercrip.” Their affiliation with the military allowed the perception to exist that these injured men could overcome physical disability and then could go on to achieve vocational success (Linker 2011). American culture fed off the image of the masculine soldier and post-WWI America needed the injured veteran to prove he could retain his normative status as a heterosexual masculine body so that physically capable bodies could perform labor and drive industrial capitalism. The quintessential goal of capitalism exemplifies bio-power at work, but also captures the important role of gender. Heteronormative imageries of masculinity became a critical manipulative device for obtaining desired outcomes at the institutional level across America.

However, the construction of rehabilitation wasn’t just political, but also shaped by social and cultural perceptions of normalcy at the time. The goal of the rehabilitation institution was to manufacture an able-bodied man out of a disabled body, using social constructions of gender and sexuality of the time to make this into a reality (Linker 2011). In order to maintain the masculine embodiments of its institution, the U.S. military needed to ensure the disabled soldier retained his heteronormative status through propaganda, portraying disabled soldiers as brave and courageous, even after suffering injury on the battlefield (Serlin 2003). Gender and sexuality became targets for exploiting the power and strength of the nation. Even though a veteran may

have been injured, he was still a man, and thus symbolized strength, vigor, and physical potency. Rehabilitation after WWI centered on fixing the image of the broken American soldier through norms of masculinity, shaping how disability and injury came to be socially constructed.

Eventually, images of injured veterans as masculine figures in post-WWI America enabled the growth of prosthetic limbs in the rehabilitation setting because there was a need to make amputees look like able-bodied citizens (Linker 2011). Prosthesis became a cultural weapon for defending soldiers' masculinity, further separating disabled soldiers from those congenitally disabled. The congenitally disabled existed far before the veteran amputee but yet the latter was responsible for the advent of rehabilitation and prosthesis development, which raises concerns about the prioritization of injury at the institutional level. Military bio-power is concerned with maintaining masculine and disciplined bodies, and due to the social construction of the male soldier, it elevates injured soldiers to this supercrip status. The military couldn't afford the risk of having physical injury emasculate their symbol of manhood, which enabled the mobilization of the onset of rehabilitation technology as a means to preserve the heteronormative notions of masculinity in post-WWI America. However, prosthetic manufacturing became a business rather than a service, stripping disabled soldiers of their individuality and identity. The standardization of artificial limbs reflected the institutional embodiment of bio-power instead of the patient-based goal of individual rehabilitation. It became material proof of industrial capitalism, using visible injury on veteran amputees as fuel for its engine. Prosthetic limbs made injury visible and perpetuated visibility as a key constituent of injury. Ultimately, the military institution objectified the disabled soldier into a broken machine in need of fixing, so that it could maintain its lucrative image of power and masculinity.

From the Civil War to the aftermath of WWI, the image of the American soldier played a crucial bio-political role in shaping ideas about gender, sexuality, disability, and masculinity. While bio-power normalized the disabled soldier to embody visible injuries, it also rendered injuries invisible to the naked eye as unimportant to the bio-political concerns of capitalism. The history of military rehabilitation displays how injuries are prioritized based off the goals of the institution, rather than the goals of the individual. History also reveals the impact of science and technology on the construction of masculinity. This history becomes important because it helps explain the operation of military rehabilitation today.

Scientific knowledge and technology still serve as fundamental features at Walter Reed, which is most evident in the military's strong emphasis on utilizing prosthetic limbs as the most appropriate ways to shape "normal" clinical outcomes of rehabilitation. These normal outcomes refer to the normative forms of productive masculinity that have been shaping rehabilitation since the aftermath of WWI (Wool 2014). The rehabilitation model at Walter Reed remains predicated on the notion of restoring patients to a level of physical functioning based on the pursuit of standardized and repeated clinical outcomes. This model medicalizes masculinity as to represent the return of physical strength, neglecting the invisible sexual or emotional aspects of masculinity. These invisible embodiments of masculinity lack both the objectivity of scientific knowledge and the visibility of prosthetic limb technology. The military treats prosthetic limbs as a privilege that offers the best clinical outcomes because of the lucrative promise both technology and science embody (Messinger 2012). Walter Reed thrives off of prosthetic technology and scientific knowledge because it is objective and allows bio-power to operate at maximum efficiency. Rehabilitation prioritizes the medicalized outcome over the

patient outcome because its highest concern is the function of the system as a whole, rather than the individual parts or bodies that it is composed of.

Today, the military's reliance on modern science for objective outcomes is perhaps best seen in erectile dysfunction (ED) drug spending. The VA spent \$71.7 million on these drugs in 2012, an increase of \$27.1 million seen in 2006 (Bray 2013). Similar to prosthetic limbs, the objectivity of ED drugs reduces patients to their body parts and allows physicians to standardize care centered on returning the patient body back to its pre-injury state. In this regard, ED drugs are just another example of how bio-power marginalizes whole bodies and perpetuates acceptable norms of rehabilitation experiences. For soldiers suffering from ED, drugs like Viagra become just another type of military prosthetic; one that is rooted in the capitalism of bio-power. Although ED drugs are most commonly prescribed to soldiers suffering from post-traumatic stress disorder (PTSD), the military also perceives them as adequate solutions for soldiers suffering from genital injury (Bray 2013). The fact that the military prioritizes the use of science and technology as a prosthetic means to fixing an injury, whether it may be invisible or not, is concerning because it is dehumanizing to the injured veterans that require much more attention than the return of physical strength treatment.

The science behind drugs and prosthetic limbs medicalizes injury into a procedure of returning the body back to normal physical functioning of the pre-injury state. The medicalization renders the body into parts, similar to how bio-power uses discipline and order to render bodies into cogs of a greater system. However, genital injuries are complex and require a rehabilitation model different than the scientifically objective one currently in place. The uncertainty of how genital injury fits into the military model of rehabilitation raises questions on how military medicine is currently attempting to treat this issue.

Bureaucratic Representations of Genital Injury in the Military

Rehabilitation isn't solely a bodily process, but also is both highly bureaucratic and institutionalized. Although the VA is releasing genitourinary injury prevalence rates to the public, this doesn't necessarily translate into the steps the VA is taking to care for this specific cohort of injured veterans. Furthermore, because genital injury is a phenomenon confined to the illusive constructs of the military institution, it is difficult to obtain actual knowledge on the rehabilitative protocols involved. While the invisibility of explicit genital injury rehabilitative protocols remains at large, it doesn't necessary rule out other methods of obtaining this information. By analyzing representations of genital injury in three political documents, Artiss Symposium 2012 manuscript, Warrior Transition Leader: Medical Rehabilitation Handbook, and the Traumatic Servicemember Group Life Insurance (TSGLI) Schedule of Losses, issued by either the VA or Department of Defense, I demonstrate an alternative method of revealing how the military currently perceives genital injury. The purpose here is to not only reconstruct the epistemology of genital injury into a more visible phenomenon, but also to suggest how the representations of genital injury, or lack there of, ultimately reflect attitudes of bio-power embedded within the military institution.

The Artiss Symposium is an annual conference series hosted by the VA, and in 2012, the topic was "Evaluation and Treatment of Genital Injuries in Combat Warriors." Besides the facts and issues of concern brought up by the keynote speakers, all of which being VA psychiatrists, the language they use is particularly significant. Even though the psychiatrists are advocating for better rehabilitation outcomes for genitally injured veterans by focusing less on biomedical practices and more on holistic medicine, they are unconsciously contradicting themselves by using scientific language. They say things such as, "It is of no value to you or your patient to

make an observation that no one can repeat. If someone cannot repeat it, it cannot be followed, it cannot be measured, and we cannot help the patient with that observation” (Wain et al. 2012). It seems as if these physicians are placing a ton of value on validity and reliability through methods of measurement. This goal-oriented and cumulative process resembles Thomas Kuhn’s definition of “normal science,” which constitutes daily scientific activity based off of a repeating pattern (Kuhn 1996). However Kuhn was not arguing for the continuation of “normal science,” but rather the sudden revolutionary change that occurs from questioning theory. The physicians that are attempting to measure psychological outcomes of genital injury are too concerned with standard metrics of disease. In this way, they are medicalizing genital injury into the exact biomedical object in which they are supposedly arguing against. Although they are making progress by looking at measurements of intimacy rather than of physical erectile functioning, a revolution in genital injury discourse will not occur until concerns over reliability and measuring are exchanged for concerns that are less scientific and instead more holistic and individualized.

Although the 2012 Artiss Symposium raises awareness of the significance of genital injuries seen in modern warfare, it does not necessarily mean other military discourses are doing the same. The Warrior Transition Leader: Medical Rehabilitation Handbook, issued by the Department of Defense in 2013, and edited by Rory A. Cooper, Col Paul F. Pasquina, and Ron Drach, is a dense packet intended to provide knowledge for families on the rehabilitation process of their fallen soldiers moving forward. Issued in 2013, it could be assumed that this 256-page handbook would include information regarding the rehabilitation of a soldier recovering from genital trauma, but that assumption is mistaken. By looking at the index, it is clear that nowhere to be found are the words genital, genitourinary trauma, or even urologist. Looking at chapter 6 of the manuscript, “Definitions, Descriptions, and Complications of War-Related Injuries and

Illnesses,” this chapter promises to expose the type of injuries soldiers are experiencing today. The last injury listed is polytrauma, which was defined earlier by the DCBI Task Force as “the occurrence of injuries to more than one body system.” This is the only time anything remotely close to genital injury is mentioned, and it is referred to only as the “renal/urinary tract.” The authors’ even use the term “invisible” to describe some injuries part of polytrauma such as TBI and PTSD, but never genital trauma. It is almost too obvious how little the military institution stresses the importance of genital injury in its rehabilitation system, never even mentioning the word “genital” once. Even more concerning is the lack of other sexual words such as fertility and intimacy, both of which are only mentioned once in the entire handbook. Not all soldiers face genital injuries, but it can be assumed that all soldiers take pride in their phallogentric self and thus care about the ability to have intimate sexual experiences even if they don’t show it. The military needs to recognize how sexually vulnerable injured soldiers are on the inside and need to incorporate information on sexual health in rehabilitation handbooks. In a time, where the prevalence of genital injury is at a historic high the fact these terms remain absent in a manuscript published in 2013 is unacceptable.

Not only does this handbook disregard genital injury as a worthy type of injury, but it also reflects certain aspects of the military’s embodiment of bio-power. This is best seen in chapter 8, “Assistive Technology, Accessibility, and Universal Design,” which is the longest chapter in the handbook, reaching forty pages, and thus suggests this chapter is of utter importance to the goals of the institution. The chapter is rich with pictures, many of which are prosthetic limbs. However, most of these images of technology are depicted so that they are isolated from the human body. The fact that these prostheses are seen as separate from the human body is significant because it reflects Foucaultian constructs of bio-power, which treat

soldiers as objects with replaceable parts, no longer acting as human beings, but rather as machines subjected to the power and discipline of the military institution. This rehabilitation manuscript is perpetuating the idea that only technology can be assistive and provide access, leaving no place for the episteme of patient knowledge in the model. These are also all technologies that assist the injured soldier in performing vocational tasks, ranging from auditory and visual assistive technologies to prosthetic arms and legs. The emphasis on returning the injured veteran body to the workforce is a concept rooted in the initial design of rehabilitation in America. However, due to the institution's detachment from individual human bodies, the military is blind to this outdated vocational model of rehabilitation. Thus, under the bio-power of the military institution, it becomes extremely challenging for an injured veteran to re-create his own identity.

Besides these two military resources, The Traumatic Servicemember Group Life Insurance (TSGLI) Schedule of Losses, issued by Federal Register of the Department of Veterans Affairs, is another military resource ripe with invisible attitudes of genital injury. This document makes official the introduction of genitourinary loss compensation into the TSGLI Schedule of Losses in 2012, but the actual compensation breakdown is what I am focused on, rather than the bill itself (VA 2012). The "Schedule of Losses" categorizes the payment amount each soldier receives for his respectable injury. Most significantly, it is interesting to see how genitourinary losses rank in regards to other losses such as facial reconstruction or phalange damage. To be more specific, this VA document reveals that the anatomical loss of the penis receives equal compensation (\$50,000) to that of one, not two, lips. Moreover, surgery to correct the jaw allocates \$75,000 and amputation of a single thumb is allocated \$50,000. There is a common theme here. Visible injuries on the face or of phalanges receive either the same or more

than that of an invisible injury such as the anatomical loss of the penis. This document also explicitly says that total payment received may not exceed \$100,000. This is also significant because the majority of genital injuries are not isolated, and soldiers who experience genitourinary loss experience lower limb amputations as well, which would most likely well-exceed the \$100,000 ceiling, forcing injured veterans to pay out-of-pocket.

Besides the monetary disparities, the language used in the TSGLI chart is further concerning because of how it medicalizes genital injury. Most significantly, the term, “Losses,” puts a genital injury in the same category as a facial burn or a phalange amputation. By doing so, the VA ultimately renders the phallogocentric embodiment of genitals invisible. It also dehumanizes the injured soldier into equating body parts with cash, quantifying worthiness in terms of compensation. By equating body parts into cash with no concern for how each body part may contribute different meanings to the individual human a whole, is yet another example of how bio-power operates within the military institution.

Lastly, this chart doesn’t take into consideration the embodiments of genital flesh past the aesthetic level. The penis and testicles embody fertility and the capability of having children and starting a family. Although it is important that this TSGLI chart targets aesthetic reconstruction, it fails to include other compensatory benefits that go beyond the physical flesh of injury. The TSGLI chart, or VA attitudes in general, neglect the fact that genital injury challenges the power to generate new life. Currently, in vitro fertilization is only offered to veterans that fall under the most severe category of injury, leaving the majority of genitally-injured soldiers paying out-of-pocket at an average cost of \$10,000-\$15,000 per in vitro fertilization cycle (Han et al. 2013). The lack of fertility benefits highlights the attitude of the military towards injury: that visible

injury demands prioritized attention because of how social and cultural norms of sexuality and gender are shaped by visual perceptions of people in America.

Among all three of these military documents, language, or the lack thereof, seems to be a significant theme in understanding how the military perceives genital injury. It is also concerning to see the amount of disconnect between different military discourses on the subject of genital injury, most notably between the conference on genital injuries in 2012 and the military rehabilitation handbook published a year later in 2013. Together, these military discourses suggest that veterans suffering from genital injuries are not being properly cared for or are not being shown the amount of deserving attention this type of injury so drastically needs. Furthermore, it raises questions on how the injured soldier body actually lives and responds to the knowledge of a genital injury under the institution's bio-power model of rehabilitation.

Personal Ethnography on the topic of Genital Injury

In November of 2014, I gained access to speak to a naval pilot, Soldier X, and a VA psychiatrist, Doctor Y, to discuss modern military life and genital injury. Although neither interviewee had been exposed to genital trauma or its treatment, I knew that discussing my research with someone inside the military institution would give me a deeper perspective into genital injury phenomena. I did initially expect both Soldier X and Doctor Y to have some knowledge on the injury. However, to my slight surprise, I found that both interviewees lacked any real knowledge on the prevalence of genital injury occurring in OEF, OIF, and OND. I quickly realized that the purpose of these two interviews was no longer to gain objective knowledge on genital injury, but it was rather to interpret their subjective responses to genital injury as an embodied phenomenon.

Aware of Doctor Y's affiliation with the VA, I initially assumed that he should at least be aware of veterans returning from war with genital injury. I was excited to finally discuss this injury with a professional, but I quickly realized my assumptions of his knowledge capacity were far from correct. He confessed to me that he doesn't hear about genital trauma or injury and initially asked me if there are any soldiers experiencing this type of exposure. I quickly responded by informing him about the 350% increase in prevalence rates from the baseline seen in past conflicts. Judging by the apparent look of surprise on his face, I could sense he was somewhat embarrassed. His rebuttal as to why he was unaware was that physicians often tend to the more visible problems out there. I asked him why he thought the public doesn't hear about genital injury and, with a sincere sense of humility, he said, "the public doesn't know about it because most of the doctors working with the VA don't know about it." The humility I could sense was comforting because it implied a sense of professional equilibrium in the room. He respected the objective facts of my research and it made my findings seem more meaningful. His lack of knowledge also left him feeling more vulnerable in the intimate space of the conversation. This intimate space is significant in the episteme of genital injury because there is nowhere to hide from the truth. This space exposed Doctor Y's vulnerability to knowledge and allowed me to leave with a lasting impression.

Unlike the discussion with Doctor Y, the topic of genital injury didn't operate as smoothly with Soldier X. Being aware of the sensitive nature of genital injury, I made sure to first gain the trust of Soldier X by having a harmless conversation about his experience as a naval pilot. It wasn't until the very end of our discussion that I brought up the topic of genital injury, and immediately after I could sense he was no longer comfortable. It was as if I was now speaking a foreign language. "Genital trauma?" He asked cautiously, wishing his ears had

mistaken him. I proceeded to inform him on some of the facts I had uncovered in my research. Not only had he never heard of such trauma, but also naively claimed there isn't any difference between a soldier blowing his leg off and a soldier being exposed to genital trauma. Initially, I thought this attitude was due to his position as a pilot, not being exposed to threats of IEDs on the ground. However, after some more probing, he claimed that any piece of major information is incorporated into every service of military training. Because genital injury wasn't in his training, it thus didn't exist as an ontological phenomenon. To him, the idea of genital trauma was ridiculous, but both his blunt responses and lack of knowledge suggest that just the very topic of genital injury can make people vulnerable. As a masculine soldier, Soldier X has been socially constructed to avoid talking about sensitive sexual health issues and it was very evident in my conversation with him. It appears as if the vulnerability doesn't solely lie in the physical exposure of combat, but also the intimate space of conversation. Again, it isn't the knowledge Soldier X has, but it is rather the knowledge he doesn't have that offers a further understanding into the episteme of genital injury as an embodied phenomena.

After analyzing the two sets of field notes, it seems as if the invisibility of genital injury and the intimacy of dialogue emerged has two major themes. The fact the VA Artiss Symposium conference series, composed of mainly psychiatrists, discussed genital injury in 2012 and that VA psychiatrist Doctor Y is unaware of the phenomenon in 2014 implies that genital injury research isn't being sufficiently translated into policy. It suggests that research on genital injury isn't prioritized enough to be communicated to every sector at the institutional level of the VA. On the other hand, the invisibility at the service member level, as seen with Soldier X, suggests that soldiers aren't comfortable discussing such a sensitive subject. Their socially constructed masculinity, which prevents notions concerning the fear of disabled

masculinity, makes the soldier feel vulnerable when discussing genital injury. The sexual connotations behind the male genitalia are not considered masculine features and thus the American soldier is constructed without the ability to discuss such sensitive and intimate issues. The emotional vulnerability attached to simply discussing genital injury suggests that there is much more at stake than just the biological implications of the physical injury. It alludes to the understanding of genital injury as an embodied phenomenon that challenges social and cultural constructions of American masculinity.

The Impact of Genital Injury on Masculinity

As soon as a soldier wakes up from an IED explosion, often the first thing he asks about isn't whether he has suffered brain trauma or if he still has all his limbs, but rather if his genitals are still all there. Soldiers often ask not to save them if their "junk" gets blown off (Bray 2013), or even sign "do-not-resuscitate pacts" if they lose their genitals, and worst of all, "some guys said they'd rather be dead" than to know they have to live with a genital injury (Wool 2014). From these responses, it seems as if there is more at stake than just the mere loss of genital flesh. There is another hidden component to genital injury that is different than other non-fatal combat injuries. For veterans living with genital injuries, one of the biggest fears they face is abandonment. Often these veterans ask the question, "who will want to be with me now?" (Wain et al. 2012). They ask these questions because of the implications genital injury has on a heteronormative relationship. One woman of a genitally-injured veteran was quoted saying, "I'm never going to forget you. I'm never not going to be your friend. I just can't be your spouse anymore" (Wain et al. 2012). These anecdotes suggest that the impact of genital injury

extends outside of the injured body and into intimate attachments of life. It raises the stakes of genital injury and implies that the costs of genital injury go far beyond the physical loss of flesh.

Qualitative research on the impact of genital trauma or genitourinary surgery is scarce but nonetheless still exists. Looking at a study conducted by Bullen et al. 2010, “Looking Past the Obvious: Experiences of Altered Masculinity in Penile Cancer,” the research team interviewed nine men, the majority of whom were married, that had received surgery to treat their penile cancer. The researchers were primarily interested in how these men initially coped with knowing that treatment meant the amputation of their penis. Through a set of survey questions, they found that these men were most concerned with the ability to have penetrative ejaculatory sex, maintain intimate relationships, and experience fatherhood. One patient was reported saying, “I think that if it was before I had children...I would have been totally devastated, totally devastated” (Bullen et al. 2010). This suggests there is much more at stake than the aesthetically visible consequences of penile amputation or genital injury. These men are more concerned with missing out on having children and starting a family, and suggests that ideas of intimacy, fertility, and fatherhood are all truly important to a man’s identity.

In a separate study conducted by Lucas et al. 2013, “The Impact of Genital Trauma on Wounded Servicemen: Qualitative Study” the primary objective was studying thirteen British soldiers that were exposed to genital trauma. The median age of these men was twenty-six and only four of them were married. The research team was primarily dedicated to asking questions on how genital injury impacts a loving relationship, such as “Are you currently within a relationship? How many children do you have and how old are they? Have your injuries affected your ability to have a normal sexual relationship?” (Lucas et al. 2013). These questions suggest that the consequences of genital injury aren’t restricted to the individual body but also

extend into the body's social relationships. The study concluded that these genitally-injured veterans placed a stronger emphasis on their genital injuries than their other co-morbidities because of the importance they attribute to the phallus in relation to heteronormative intimate attachments.

Although both Bullen et al. 2010 and Lucas et al. 2013 differ in regard to civilians suffering from penile cancer surgery rather than soldiers suffering from genital trauma, it nonetheless highlights the significant attention towards concerns about intimacy and fertility. The emphasis both physicians and patients place on relationships and children also suggests that this phenomenon has implications about the loss of future and how this episteme is to be defined. These studies suggest that even the most masculine men can be concerned with notions of love and attachment, which don't usually have a place in the socially constructed ideal figure of a soldier. It raises questions on how important phallogentric ideologies are when defining masculinity.

An ethnographic study on traumatic injury, "Attachments of Life: Intimacy, Genital Injury, and the Flesh of US Soldier Bodies" conducted by Zoe Wool between 2007 and 2008 at Walter Reed, offers an anthropological perspective on how trauma suffered in modern warfare impacts a soldier's masculinity. Like the Bullen et al. 2010 and Lucas et al. 2013 studies, the loss of masculinity was at stake for these injured veterans. However, unlike these two studies, Wool is more concerned with the remaking of life at Walter Reed through its sexual and intimate attachments inside the walls of the rehabilitation institution. Instead of focusing on genital injury, she is more concerned with the importance of genitals and heteronormative sexual behavior in military rehabilitation. She reports one veteran saying that, "the first thing he wanted to do when he saw Erin was have sex, begging her to close the door and get into the hospital bed

with him.” Wool says this “was a common enough story at Walter Reed,” for soldiers who do not necessarily suffer from a genital injury (Wool 2014). Her ethnography exposes the importance of penetrative sex and feelings of attachment in the rehabilitation process. It suggests how injured veterans no longer view rehabilitation as a one-dimensional process centered on regaining physical strength, but rather on sustaining intimate relationships with those that they love. However, according to Wool’s assessment, this implies that genital injury challenges this intimate model of rehabilitation, because it may prevent veterans from engaging in heteronormative sexual behavior such as penetrative sex. Nonetheless, this ethnography and the two former qualitative studies raise similar questions that center on masculinity and why the phallogocentric implications behind genital injury seem to be of utmost importance to men.

There is a theme surrounding the phallogocentric implications of genital injury and this is ultimately due to the social construction of masculinity. At a young age, boys learn through social observations, interactions, and language, and how gender roles and stereotypes come to construct the normal male identity. They learn that to be a man in society, you ought to embody self-dependence, strength, and success. As boys grow older, they learn that manhood is tied to their penis and sexual competency is associated with masculinity. According to Mitchel Tepper, the social construction of masculinity is what makes an acquired disability so difficult to cope with because of its impact on male sexuality (Tepper et al. 1999). Soldiers experiencing genital trauma fall into this classification of acquired disability. Being born as a biologically able-bodied male, these men have lived their entire lives under society’s classification of normal men and have taken advantage of their phallus as a type of sexual embodiment of power. This is what makes an acquired disability so hard to cope with because these once able-bodied and sexually functioning men knew what it was like to hold this power.

Genital injury challenges social constructions of the able-bodied man because of how strongly the preservation of genitals is intertwined with sexual competency. Essentially, the problem for these injured veterans becomes how normal constructions of male sexuality are based off phallogentric ideologies, which render impotence and alternative forms of sexual expression into forms of disability. This confliction between constructions of phallogentric thought and disability create a term coined by Thomas Shakespeare, “disabled masculinity” (Shakespeare 1999). For the male soldier, genital injury is accompanied with this feeling of disabled masculinity because they are consumed by this narrow notion of heteronormative male sexuality that focuses on erectile function. They can’t divorce this thought from their head because it has been socially constructed in their mind throughout their lives. They are then faced with a dilemma of disabled masculinity that is not only restricted to the individual body but extends into the social experiences of their every day life (Shuttleworth et al 2012). People have been socially constructed to perceive the American soldier as a symbol for physical strength or able-bodiedness. People have also been socially constructed to perceive American manhood in a heteronormative fashion that stresses the normal function of a man’s phallus. For a veteran living with genital injury, the social dilemma of disabled masculinity is overcoming the notion that the phallus is the only means by which to carry out socially constructed notions of manhood that stress the importance of heterosexual relationships and starting a family. He now must build a new phallogentric identity that challenges normal constructions of both the American soldier and masculinity in order to socially reintegrate into society.

Medicalization of Gender and Sexuality within the Patient-Doctor Narrative

Defining the medicalization of genital injury is significant because the approach the physician proceeds with is strongly influential for the injured soldier's outcome. In past wars, the physician has primarily dealt with limb amputations and facial reconstruction, injuries that are visible to the naked eye. Today, however, the doctor faces a tremendous task in responding to genital trauma and treating invisible under-researched injuries. Understanding the injury begins with addressing what parts of the genitalia are affected by an IED blast. A study by Han et al. 2013 show that the scrotum, testis, bladder, kidney, ureter, and urethra all can be damaged, with the scrotum accumulating the highest percentage, 22-29 percent of total genital injuries. This doesn't include possible hormonal deficiencies or infertility problems that are common side effects of genital injury and can take years to become finally exposed. Dr. Rodney Davis, a urology professor at Vanderbilt University, says the wide spectrum is due the dynamic role of the soldier in combat. For a soldier on foot, the blast from an IED can send pieces of penetrating shrapnel directly into the penis or scrotum, whereas for those in a vehicle, the soldier is more likely to damage his kidney from the bounce of the vehicle (Woodward et al. 2010). When doctors handle soldiers that have just been blown up by an IED blast, their priority lies in saving the injured soldier's life, and this is why a genital injury is usually addressed with less priority. Even before the injured soldier reaches the surgeon, techniques such as using appropriate tourniquets can be used to stop hemorrhagic bleeding, but this method doesn't work when addressing genital trauma (Williams et al. 2013). In today's technologically and scientifically advanced world, it is easy to medicalize injured bodies into objects, amputating a limb and replacing it with a prosthetic is just one fairly standard example. The body becomes reproducible in this way and allows treatments to become universal and routine. However, the

medicalization of injury doesn't transfer knowledge in a linear fashion when treating a genital injury. Beth Kosiak, the associate executive director of health policy at the American Urology Association, asserts that the big underlying issue is that there isn't a true procedure for treating all of these urinary tract problems because there doesn't exist a body of literature on it (Woodward et al. 2010). The lack of knowledge challenges normal constructions of biomedicine and opens a new dimension of defining genital injury as an embodied phenomenon.

It is significant to understand that genital injury is not constricted to just the military institution, but is also prevalent in the civilian community. So then the question becomes why are doctors having so much trouble handling these new soldier cases? The answer is because there is a tremendous difference between combat-related urological trauma and civilian trauma. Civilian urological trauma can be repaired in most cases because there isn't nearly as much fragment penetration as there is in trauma induced by an IED blast (Williams et al. 2013). In combat, IEDs generate considerable force on impact, while civilian urological trauma most often stems from fall and motor vehicle accidents. Even gunshot wounds in the civilian setting are considerably less damaging because of the low-velocity nature of the bullet compared to the 2,000 feet per second nature of an IED. The technology of trauma thus becomes an important ingredient in the construction of genital injuries.

The sexuality and gender of genital injury creates a space of discomfort where both the patient and the doctor don't know how to act or don't know what to say. Genital injuries carry a sexual connotation that makes it a sensitive subject in the doctor-patient setting. The patient may be reluctant to discuss sexual dysfunction because of embarrassment or the physician may have a fear of offending the patient or causing discomfort (Wain et al. 2012). This embarrassment or fear exists because of how genital injury challenges the social and cultural constructions of

masculinity. Genital injury embodies a sexual language that is perceived to be feminine or queer. Sexual language thus becomes one of the barriers to overcome in facilitating a quicker path to recovery. In addition to sexual language, the socially constructed phallogentric self also contributes to discomfort in the clinical environment. Dr. Davis cared for a wounded soldier suffering from both limb amputations and genital trauma and noted how devastating it was to see a soldier attempt to reintegrate back into civilian life, asking questions such as, “He was a young unmarried male, where does he go from there?” (Woodward et al. 2010). Dr. Davis’s emphasis on this soldier being single and the uncertainty of finding intimacy suggests that the rehabilitation of genital injury concerns much more than the return of physical strength. At stake is the disabled phallogentric self, which indicates that treatment should devote its time and effort here.

It is concerning that both sides of the doctor-patient relationship lack the proper sexual healthcare knowledge because it can lead to delayed treatment and severe health consequences. Literature suggests that early therapy is important and therapy in the first four months of the injury occurrence is paramount for preventing long-term issues such as sexual dysfunction and infertility (Wain et al. 2012). Again penetrative sex and the ability to start a family are two strong embodiments of masculinity and suggest that medical efforts should target the injured phallogentric self. Currently, the lack of knowledge on rehabilitating this identity is due to the invisibility of sexual healthcare inside the military institution. Sexuality is misunderstood as an integral rehabilitation feature, which constructs genital injury into an invisible feature of warfare. It leads to a lack of coordinated care, which can create barriers to proper treatment. Understanding how the veteran perceives his genital injury and the importance of sexual

healthcare knowledge in the patient-doctor setting are two crucial elements that can ensure progress in this field.

The queerness of genital injury in the clinical setting is important because it can be expanded to apply to other soldiers suffering from a disability that challenges their sexuality. Veterans suffering from post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), amputations, and other complex injuries are vulnerable to tertiary sexual dysfunctions that appear not from physical trauma, but rather from the psychological and social aspects of sexual health (Tepper 2014). These veterans are suffering from the queerness of their injury because they no longer feel as if they can engage in intimate heteronormative behavior due to changes in their self-image. Furthermore, these severely injured veterans rehabilitate in a system that lacks appropriate protocol for sexual education. Currently, the U.S. President's Commission on Care for America's Returning Wounded Warriors: Serve, Support, Simplify (The Dole-Shalala Report), a doctrine that provides a multidimensional approach to treating veterans with serious combat injuries, fails to include a discussion on sexual healthcare (Tepper 2014). This lack of inclusion prevents VA physicians from setting clinical guidelines that emphasize the power of intimacy in rehabilitating complex injuries.

Paradigm Shift Towards a Feminist Model of Genital Injury Care

Although genital injury challenges a man's phallogocentric self, masculine identity, and normal heterosexual behaviors, this phenomenon also has the potential to embody much more than just the loss of self-virtues. Instead of genital injury being seen through the one-dimensional lens of masculinity, it should rather take on a more dynamic perspective that considers the other end of the gender spectrum. Genital injury shouldn't only be understood by

the masculine embodiments of a male soldier, but also by the feminine implications of the injured phallogentric self. Feminine, in this regard, doesn't refer to the virtues of female biology, but rather the antithesis of sexual heteronormative embodiments. However, this is in stark contrast with the military constructed definition of masculinity, which prides heterosexual competence and power, and therefore poses a threat to the embodiments of military culture. Thus, the feminine implications of the injured phallogentric self must refer more towards feelings of queerness and disability (Serlin 2003). In this case, queer and disability shouldn't be seen in their literal sense, but rather as categories that act against cultural norms of society. This clash of gender ideologies creates a symmetric relationship between masculinity and femininity; a balance of knowledge that empowers genital injury to be better understood as a lived and embodied phenomenon. It suggests that the understanding of genital injury as an epistemic object requires both masculine and feminine theories of understanding.

This brings into conversation feminist theory, which I will define through Donna Haraway's feminist politics. Haraway, a distinguished scholar of feminist studies, argues against scientific objectivity as a mode of knowledge because it takes a detached observer stance, usually one that is rooted in masculine empiricism. Instead, her vision is one of both feminist objectivity, which is more concerned with limited location rather than universality, and "situated knowledges", which is the idea that there is no truth and all knowledge is partial. Together these construct feminist science, which decries the masculine lens of scientific objectivity in favor of situated knowledges that stem from subjective partiality (Haraway 1988). The virtues of feminist science argue for the view from a body, which is constantly positioning and situating, and thus cannot rely on absolute truth from the view from above or nowhere. More simply put,

science's objectivity is founded on universal truth and it pushes away the lived experience from the perspective of the human body.

Feminist science is significant in the epistemology of genital injury because it concentrates on the situated knowledges of the patient experience, which military bio-power doesn't seem to account for. For veteran soldiers suffering from a genital injury, too often are they placed under the lens of bio-power and objectified into a replaceable body by medical technologies, which don't take into account the bodily notions of sexuality and self-worth that are attached to the phallus. Cultural constructions of the military assume that because the U.S. soldier embodies a heightened sense of masculinity, injury can be overcome through physical perseverance and determination. However, overcoming a genital injury is not as linear of a process because it challenges the masculine identity of the military. In this regard, genital injury becomes an anomaly in the military rehabilitation model because the pain is invisible and associated with feminine embodiments. In the words of Thomas Kuhn, this anomaly should trigger a "paradigm shift" in how the rehabilitation system functions in relation to genital injury. The paradigm shift should essentially be seen as a shift from a masculine model centered on physical strength to a more feminist model centered on maintaining intimate relationships. This novel feminist model challenges the bio-power of the military because it is based on the individuality of the soldier's lived experience. Thus I am proposing that the rehabilitation of genital injury should take on a more feminist science approach that digs deep into the episteme of subjective patient knowledge rather than the universality of scientific objective knowledge in order to appropriately sustain a genitally-injured soldier's overall well-being.

However, to claim that feminist science can function as a mode of rehabilitation is contradicting. Rehabilitation has attachments to the military, masculinity and scientific

objectivity, constructing it as an anti-feminist virtue. The rehabilitation of genital injury simply doesn't align with feminist science for this reason. However, the embodiments of genital injury do fit the framework of feminist science. The problem is then the category of rehabilitation, and therefore the solution lies within the gender-disrupting aspects of genital injury discussed earlier: categories of queer and disability. Categories, or language, influence perceptions of knowledge, but also have the power to create new knowledge. Thus the clash between feminist science and rehabilitation can be solved through applying a queer or disability definition to rehabilitation: care. Care is softer and more intimate, disconnecting itself from masculine virtues of the military. In order for this to succeed at the institutional level, military language must switch from the rehabilitation of genital injury to genital injury care. Now, through the power of language, the ideals of feminist science can rightfully co-exist with military genital injury.

Social Diagnostic Technologies as Tools for Future Knowledge under Feminist Model of Military Care

Rosemarie Garland-Thomson, a feminist and disabilities studies activist, concerns herself with the cultural and material observations disability offers to the world. In her "Case for Conserving Disability," she places a strong emphasis on understanding disability as a narrative resource so that it can then act as an epistemic resource. She argues that bodily experiences construct our social reality and shape our understanding of the world (Garland-Thomson 2012). Using this same model, I want to propose how genital injuries can be seen as an epistemic resource through social narratives. However, I want to categorize social narrative into a form of diagnostic technology, a term in which Allan Young used to create the historical formation of post-traumatic stress disorder in his book, *The Harmony of Illusions: Inventing Post-Traumatic*

Stress Disorder (Young 1995). In this way, I propose that these social diagnostic technologies can redefine how genital injury is perceived with the intention of both creating a possible foundation for a feminist model of military care centered on genital injury and utilizing genital injury as an epistemic resource that brings feminism into the military and VA. Utilizing three pieces of literature that have already been cited in this paper so far (Tepper 1999, Messinger 2012, and Wool 2014), alongside a recent headline in the news, I will demonstrate how social diagnostic technologies act as methodological tools for providing the reader or audience with a heightened sense of the phenomenological understandings that underlie injury in all four cases.

In Mitchell Tepper's, "Letting Go of Restrictive Notions of Manhood: Male Sexuality, Disability and Chronic Illness," he provides an autoethnography on his personal experience living with an acquired disability. In doing so, Tepper allows the reader to become more intimate with his disability experience and how it influenced his masculinity. This intimacy isn't only important in this embodied sense, but also can be used as a tool for understanding disability as a social experience. The intimacy of autoethnography fits neatly into the proposed feminist model of care for genital injury because knowledge is being produced from the lived experience of the individual rather than the detached viewpoint of the bio-politically influenced medical professional. It carries the potential to serve as a method capable of spreading the knowledge of how veterans are personally adjusting to life with a genital injury. This makes autoethnographies useful because they can provide further insight into the best modes of care and future directions for other veterans living with genital injury.

In Seth Messinger's account of Lieutenant Robert Sanderson in "Getting Past the Accident: Explosive Devices, Limb Loss, and Refashioning a Life in a Military Medical Center," the reader is also able to become more intimate with Sanderson's personal experience of

rehabilitation in Walter Reed through Messinger's method of ethnography. More importantly, it brings to the surface how Sanderson challenged the military model of rehabilitation through a sense of self-fashioning. Sanderson resisted the institutional goals that emphasized the return of physical efficacy, and instead set out to create his own post-injury identity by attaching new meanings to his injuries that were specific to his body and self. The self-fashioning exhibited by Sanderson can be seen as a Do-It-Yourself (DIY) form of social diagnostic technology for veterans recovering from genital injury. Because genital injury doesn't fit the masculine mold of the military model of rehabilitation, veterans suffering from this injury need to adapt a form of self-fashioning that is consistent with their identity, not the identity of the institution. This type of social diagnostic technology gives genital injury a place in military care because it brings to the surface that there is much more at stake than the return of physical functioning. The subjective driven approach from the self-fashioning of the veterans to constructing meaningful knowledge fits in well with feminist science and thus should serve as a fundamental feature in defining genital injury care.

Zoe Wool's ethnography, described earlier in the paper, captures the reality of intimacy and heteronormative sexuality that is becoming a crucial feature of Walter Reed. It uses ethnography as a social diagnostic technology to render the bureaucratic walls of Walter Reed transparent so that rehabilitation is understood as a more social and sexual phenomenon. However, Wool's conclusions implicitly highlight the challenges of genital injury in a rehabilitation setting. It seems as if veterans with single and double limb amputations place an extreme importance on the ability to engage in penetrative sex because it is the only method to maintain or enter into an intimate relationship now that their self-image is altered. These men are relying on the power of their phallus to preserve this heteronormative behavior they so badly

desire. It further alludes to the daunting reality of living with a genital injury and the uncertainty behind how these men are recovering. It suggests that veterans living with genital injury, who may be unable to have penetrative sex, need to discover new meanings attached to preserving intimacy. Again, what is at stake is how these veterans strongly equate a genital injury to that of a phallic injury of the self. Through her ethnography, Wool uncovers subjective knowledge that reveals what truly matters to injured veterans, and thus exemplifies the potential power ethnographies are capable of in developing further knowledge on genital injury.

Finally, as recent as December of 2014, a major milestone occurred in the quest for illuminating genital injury as a lived phenomenon. The Bob Woodruff Foundation presented the “Intimacy After Injury” conference in December of 2014 that targeted the issue of injured veterans’ sexual health. This was the first ever public forum on this issue and marks a tremendous leap forward in genital injury education. A keynote speaker was Dr. Mitchell Tepper who advocated for interventions targeting issues of intimacy and attachment rather than those that center on physical and genital function (Poppe 2014). Both his words and the overall message of the conference suggest that genital injuries and sexual health are different than other combat-related injuries, and thus deserve different treatment strategies that target issues of gender and sexuality, rather than physical functioning. The conference acts as a social diagnostic technology because of its ability to congregate a population of people into an intimate space so that everyone in attendance can experience the same force of social awareness. Public forums, like “Intimacy After Injury” conference, highlight the importance of social knowledge because they put sensitive issues into conversation. This is significant because it provides a basis for lobbying efforts to include genital injury as a priority in the military and VA, which can lead to increased funding into research and eventually translate into better care.

The methodologies of autoethnography, self-fashioning, ethnography, and public forums can all be considered social diagnostic technologies because they reproduce social narrative history in a phenomenological fashion. They embody intimate details of both life and space similar to intimacy embodied within genital injury. These social diagnostic technologies also allow genital injury to act as an epistemic resource that introduces femininity into the military. The intimacies of veteran knowledge reveal that these men embody much more than just masculinity and discipline, opening up the military as an institution to be more representative as a space that embraces sexuality and gender. This is significant because it can then facilitate the acceptance of a feminist model of care into the VA. The knowledge on genital injury suggests that the features of feminist science provide a better approach to addressing the needs of veterans recovering from genital injury than the approach currently being undertaken by the military rehabilitation system. This paper shows that the return of physical functioning is not a priority for veterans living with genital injury and that attention needs to shift towards the impact on the phallogocentric self. The first step towards integrating feminist science into genital injury care begins with social diagnostic technologies acting as epistemic resources at the community level, with injured veterans sharing their experiences to others, constructing genital injury into a more social phenomenon. The goal then becomes capturing the attention of leaders in this field, such as Dr. Mitchell Tepper, who are capable of translating this intimate knowledge into policy reforms at the institutional level. Ultimately, feminist science through social diagnostic technologies can provide alternative forms of knowledge that help ensure that veterans suffering from genital injury understand that they are not alone and no longer have to suffer in silence.

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