Weary Warriors

Power, Knowledge, and
the Invisible Wounds of Soldiers

Pamela Moss and Michael J. Prince

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Preface

War, death or sickness did lay siege to it.
–William Shakespeare, *A Midsummer-Night's Dream.*

These are men whose minds the Dead have ravished.
–Wilfred Owen, *Mental Cases*

In *Weary Warriors* we examine psychologically wounded soldiers from conflicts spanning the American Civil War, through the two world wars, the war in Viet Nam, UN peacekeeping missions, Iraq, to the current war in Afghanistan. Our interest primarily is not with the question of why soldiers are stressed or how they become exhausted from a given war, nor is our interest to detail the specifics of individual weary soldiers emerging through a particular war in order to compare illness and combat experience. Our chief interest rather is with the questions of why and how claims of combat stress are regularly contested by psychiatric and military authorities, and how combatants themselves, individually and in various forms collectively, struggle for recognition, treatment, and support for war-related neuroses. Major questions we address are these: How do material bodies and bodily discourses of individual lives create weary warriors? How are psychological wounds and the emotional distress of military personnel taken up by different configurations of power and knowledge over time? How are distinctions between the well soldier and the ill soldier established and enacted? How do soldiers find support institutionally within and outside the military? And, after discharge into civilian life, where and how do veterans with ill bodies seek help and understanding?

We have written this book with three groups of people in mind. The first group is a group of scholars and students in military studies and the history of warfare, the sociology of health and illness, disability and

public policy studies, social and cultural geography, and the growing area of Foucault studies based prominently in history, philosophy, political science, and women's studies. We see that these students and scholars in these fields share an interest in psychiatry and trauma and in the subjectivity of embodied individuals in pain and distress. A second group is veterans themselves from both recent and distant battles as well as veterans' partners, other family members, and organizations representing veterans in advancing their claims to state organizations and medical institutions. A third group includes professionals: caregivers and health practitioners working with veterans dealing with posttraumatic stress disorder (PTSD) and other mental health issues as well as policy- and decision-makers in legislatures and executive departments of government that administer the programs and regulations that govern the lives of so many weary warriors.

While these people remained at the front of our minds as we wrote, we cannot claim that this book was written for them as readers. Indeed, it is the first group, scholars and students, which are most likely to read this book. And that is okay with us. Our overall goal is to show how a particular way of thinking—developed in dialogue with the works of Michel Foucault and of several poststructural feminists—breaks open what weary warriors are and how those warriors get constructed. Once we unsnarl the knots that have produced traumatized soldiers as ill in the way they are ill and reentangle lines of thinking that have been submerged or left out of the way we think about soldiers enduring deep emotional and psychological distress are thought, we can begin to act differently. By acting differently, we do not mean forcing traumatized soldiers into prewound lives or ensuring assimilation into existing social and cultural environments. We mean that weary warriors need to be taking up their place within society, at home, and in their lives without being marked with a ostracizing mental illness, while feeling alive and ready to engage in living every single day, and having ample and appropriate support to reduce suffering.

With such an array of interests, titling our project proved difficult. Following Judith A. Lyons (2007: 312), we recognize that the "term 'warrior' is controversial, often deemed politically incorrect [within civil society]. However, it is deliberately used … to highlight that the experience of war does change a person." Charles R. Figley and William P. Nash (2007b) employ the expression "war fighters" to designate those who served their country in battle through the armed forces as combatants. Noah Richler (2012) calls Canada a warrior nation as do, more critically, Ian McKay and Jamie Swift (2013). Trevor Greene and Debbie Greene (2012) refer to the warrior path for a soldier's journey of survival and healing following a

brain injury. Chris Linford (2013) employs the term "warrior rising" to describe his journey as a soldier from PTSD and back. Martin L. Cook (2004) talks about the moral warrior among U.S. soldiers faced with difficult choices to make. And Michael Ignatieff (1998: 112) writes of the warrior's honor in modern times as the notion of "war as a moral theatre in which are displayed manly virtues in public." As we will show in the following chapters, the extent to which war changes a person and whether such change is unique to wartime are subjects of longstanding and continuing debate. Our focus in this book is on the mental anguish and emotional wounds of combat exhaustion, war-related stress, operational trauma, and psychological disorders of military personnel engaged in both war operations and peacekeeping missions.

Similarly, we had difficulty in deciding what other terms to use to describe what it is that we were trying to capture. We use the term "soldier" interchangeably with "combatant," and both include the wide range of military combat personnel: sailor, pilot, gunner, and marine. For us, the word "soldier" denotes the one who fights on orders from state-based armed forces. We variously use terms such as "traumatized soldiers," "psychologically wounded soldiers," "soldiers enduring deep emotional distress during combat," and "the soldier with a ravished mind" to unsettle the notion that weary warriors suffer from the same illness in every war. Likewise, there is no corresponding link between our choice of descriptor in any passage and either a diagnostic category or a preference on our part to describe these invisible wounds. We chose to use "Viet Nam" instead of "Vietnam." "Vietnam," primarily in the U.S., sets up a state-centered view on the war. This particular view is manifest in the names of war neuroses themselves, as in "Vietnam Syndrome" and "Post-Vietnam Syndrome." We try to distance ourselves from this view and to write more from an international view without any disrespect to American weary warriors who served during that war. We also recognize that our use of "combat" itself is problematic. Although much of our work concerns the soldiers whose paths of weariness began on the battlefield, we appreciate that other active- and nonactive-duty military personnel can endure emotional trauma as an effect of war. We also acknowledge that the way in which we framed our interests guided us to historical sources that take up emotional trauma in the military as something affecting combat soldiers. The idea that it is not only soldiers in combat units that endure distress to the point of breakdown, but also noncombat soldiers, nurses, medics, and other active-duty personnel became more popular in the past twenty-five years or so. We attribute this shift in thinking in part to the way in which wars and armed military conflicts now take place.

Key to our argument is the idea that discourse and materiality are entailed within the other, and inseparable in the reality we experience. In keeping with our theoretical goal of providing an alternative understanding for the changing course of war neuroses over roughly the past one hundred years, one rooted in Michel Foucault's work and in feminist poststructural theory, we need to figure out how to refer to the discursive practices (report-writing, record-keeping, movie-making, policy-making) and materialized discourses (reports, records, movies, policy) that generate weary warriors. To this end, we conceptualize soldiers' ill bodies as the effects of the intra-action among ideas, notions, and a priori understandings of what ill bodies are and what they can do with the concrete bodies that have suffered some disruption to a biological, neurological, or physiological process *simultaneously.* Empirically, we focus on the interplay between the actual bodies of soldiers with war neuroses and the discursive constructs associated with being a soldier and being ill via diagnostic categories, regulating policies, masculinized gender roles, and popular cultural depictions. Throughout the book, we refer to a wide range of elements that fall within the realm of how we understand discourse and materiality to be connected. We sometimes use the terms "discursive-material" or "material-discursive" to describe something, as a text, a practice, or an effect. We sometimes use discourse and materiality as separate things, mostly with the purpose of conceptually highlighting one aspect of the text, practice, or effect—but we do so with the understanding that both are deeply implicated within the other.

In this book, we examine psychiatry, the military, and masculinity, and the ways in which these three come together to generate weary warriors. We understand that these are but three sets of relations, processes, and realms of influence that actually inform the way in which soldiers come to be ill. That we chose to focus only on these three does not negate the need to understand how other *dispositifs* (which is how we come to understand the three in chapter 1), other sets of power relations (such as capitalism, citizenship, or sexuality), and other realms of influence (such as private lives, nation-state politics, or pacifist ideologies) contribute to how it is weary warriors surface differently according to the place and time of the conflict, whose side the soldier fought on, and the wider, political, and economic outcomes of a particular conflict.

One way in which these ideas play out in the book is through our analysis. For example, our understanding of institutions as fluid and flexible entities feeds our interpretations of how weary warriors come to be. We see that military psychiatry is not a place of uniformity but one full of discrepancies and contradictions. Rather than claiming that the military is

a rigid, fixed structure, an image that is prominent when studying or reading about the military, we try to highlight military sites that are flexible and elastic to show how generative a set of practices can actually be.

Another way these ideas manifest is through the manner in which we include the voices of weary warriors. Voices appear in the book in the written words of veterans themselves in relation to memoirs, diaries, and poems; in the testimonies and transcripts of military courts or tribunals; in reports by military psychiatrists and health professionals; and in the anguished utterances of parents and partners as reported in media stories. The voices are heard in the shouts and screams of panicked fear and terrified anxiety. As well, voices of weary warriors are heard in their silences, whether a state of uncommunicativeness from combat shock, a general lifelessness resulting from extreme despair or trauma, or the quietness of meditative prayer.

These sensitivities—of the people we write for, the terms we use, the premises of our thinking, the analytical choices we make, and the voices we hear—frame the way we have taken up our project. Our objectives in writing this book have been to highlight how the conceptual categories of soldiers' neurotic bodies rooted in military psychiatry (as, e.g., shell shock, battle fatigue, PTSD, and operational stress injury [OSI]) as well as the physical expression of war neuroses located firmly in soldiers' ill bodies (as, e.g., irritable heart, paralysis, nerve strain, and flashback) shift over time in particular places and specific conflicts; to elaborate on the processes through which soldiers, military psychiatrists, and society more generally both reinforce and contest these categories and physical expressions of war neuroses; and to extend the critical thinking and understanding of the social practices that create, reinforce, and contest both the discourses about and the material existences of the ravished minds and troubled souls of weary warriors. Not simply the object of positivist knowledge, the burned out soldier's mind, body, and soul compose a battlefield of symptoms, varying diagnostic tools, rival treatment methods muddled by different mixes of care and coercion side by side with the contending imperatives of the armed forces, the creed of a practicing psychiatrist, and cultural constructs of masculinity. Our overall goal of the book is to generate a path through which to see this battlefield in a different way, one that offers an alternative theory that reads weary warriors as minds, bodies, and souls seeking some surety within a changeable set of power and knowledge relations.

Acknowledgments

War-related wounds to the body, mind, and soul of military personnel in historic and current times can hardly be ignored. Yet the cause, significance, and treatment of combat trauma remain hotly disputed after centuries of debate. Military psychiatry has been the predominant site where these disagreements play out, primarily because military psychiatrists are the first to see a soldier with combat trauma. Cultures, nation-states, and societies more generally shape the way in which traumatized soldiers are treated medically and socially, and supported financially, and are (not always) welcomed home. In this book we tease out some of the issues important in the ways in which soldiers and veterans become done in, disenchanted, and worn out—that is, how they become weary warriors.

Each of us brings a different set of interests to this project. Pamela Moss is trained in social and cultural geography, although she primarily works in interdisciplinary settings. Conceptually, her interests in experience, space, and power have led her to feminist theoretical frameworks that focus on women, resistance, and illness. She is most interested in those concepts that assist in teasing out the unremarkable, mundane acts people do that can challenge existing figurations of power and knowledge. Empirically, Pamela's research takes up discursive constructions and material practices of the subject, body, and self in various contexts—as in medical diagnostic practices, song lyrics, and her own experiences as an academic (Moss 2011, 2013a; Moss and Teghtsoonian 2008). Pamela's interest in traumatized soldiers arose from a conversation she had with an elderly man who had been a German prisoner of war (POW) held by Canadian soldiers during the Second World War.

Michael J. Prince is trained in political science, public administration, and policy analysis, and has conducted research in areas of welfare state programs and services for a range of groups, including persons with dis-

abilities and military personnel and veterans. Establishing veteran bene-
fits was an early milestone in the development of social security programs
in the United States, Canada, and other countries (Prince 2000, 2006, 2009;
Rice and Prince 2013). Core concepts and themes informing Michael's
work include the role of ideas and ideologies, interest and power relation-
ships, and the need to examine the actual workings of administrative and
policy processes of social practices along with material and symbolic re-
source allocation (Prince 2009; Rice and Prince 2013). Michael is the son of
a Second World War veteran who served overseas in the Royal Canadian
Air Force as a flying officer and wireless air gunner.

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over the past 120 years was crucial because, as the following pages argue,
no single relation of power and no single form of knowledge adequately
define the material-discursive realities and discursive-material expres-
sions surrounding any weary warrior.

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Introduction

Weary Warriors Walk among Us

Combat, Knowledge Circulation, and Naming Traumatized Soldiers

He who fights with monsters might take care lest he thereby
become a monster. And if you stare for long into the abyss,
the abyss gazes also into you.
—Frederich Nietzsche, *Beyond Good and Evil*

I was caught in an emotional mental battle that pitted what I now
considered the "real" world—genocide in Rwanda—and the "artificial"
world—the detachment and obtuseness of the rich and powerful.
—Lieutenant General Roméo Dallaire, *Shake Hands with the Devil*

Weary warriors are soldiers who have suffered deep emotional distress
during combat. Whether in reaction to the din of artillery fire, the stench
of a rotting corpse, or the glance of dead comrades after a short skirmish,
some soldiers, pushed beyond the edge of emotional constancy, break
with soldierly behavior. They rush the enemy, taking admonitions as ad-
miration, earning nicknames of madness. They run away into the cover
of trees, wandering for days, forgetting armed encounters. They weep,
poised to fire, incapable of pressing the trigger. They collapse, they break,
they fall to pieces—sometimes during combat, sometimes on leave, and
sometimes after the end of the war with a delay of weeks, months, or per-
haps even years. Yet soldiers survive these moments of seemingly endless
anguish, their minds ravished by the threat of death, their bodies dazed
and muted by the sight of the dead, and their souls vacant to make room
for the dying. They are gathered up by other soldiers, hailed as heroes and
returned to their regiments, condemned as cowards and court-martialed, or

evacuated to hospital with a case of nerves. The so-called heroes, stunned by their own actions, receive medals and other honors for their courageous acts, reinforcing the soldier's way of life in battle. Military courts sentence cowards to death or dishonorably discharge them, cutting them off from any future relationship with the military. Others, the ones who suffer shock, those who recoil from their own training to kill, and the ones who manifest mental illness, are either whisked away and treated as war casualties or regarded as returning veterans and left on their own to become civilians once again.

Weary warriors are not a product of modern warfare, having been recognized as early as Ancient Greece, in both Classical and Hellenistic Greek civilizations (Shay 1995; Tritle 2000). Weary warriors were noted as neither ordinary nor extraordinary, or even in need of "fixing"; they were generally viewed as a possible, though not an inevitable, result of soldiers engaging in warfare. One of the noblest warriors in Western Civilization, Achilles, seems to have suffered a mental breakdown demonstrated by his outrage at the death of Patroclus, his feeling dead inside, and his remorse at the betrayal by his leader Agamemnon (Shay 1991). Rather than a point of entry for one's own demise, the vulnerability of Achilles' heel could be read as the vulnerability of a soldier's mind, a soldier's body, and a soldier's soul. Herodotus ([440 BC] 2002: 117) tells a story of an Athenian soldier at the Battle of Marathon, Epizelus, going blind after being "opposed by a man a great stature in heavy armour, whose beard overshadowed his shield," a phantom who felled a close comrade by his side. A soldier's life during the first millennium C.E. was often sequestered from the rest of society, and what actually became popular within the rest of society were stories of heroism and images of grandeur, no doubt to feed the nation's need for honor, the soldier's need for chivalry, and society's need for manhood (see Braudy 2005). Descriptions of war veterans, though, continued to include images of soldiers suffering emotionally from the cruelties and atrocities of war, and perhaps even from war's absurdities in ways that were accepted and for the most part unremarked upon. Although anguish, guilt, and rage plagued veterans, these aspects of a veteran's persona were not cause for alarm. They were an expected part of a veteran's temperament.

Notwithstanding these sentiments, in 1688 a Swiss physician, Johannes Hofer, wrote about the unusual mental state of soldiers stationed away from home and called it *mal du pays* or *nostalgie* (homesickness or nostalgia) (Sedikides, Wildschut, and Baden 2004). Explanations of nostalgia over the years ranged from the struggle over demons and the vibrations of animal spirits in the fibers of the brain, to a change of barometric pressure causing a rush of blood downward, all resulting in the strong draw

to go home. While initially thought to affect only Swiss soldiers, it became clear that nostalgia was present among soldiers across nations. Over the next two centuries, nostalgia as a physiological disease of the brain became a popular explanation for soldiers' illnesses, particularly among the French military. The term was resurrected to describe soldiers' illness in the American Civil War (E. Dean 1997). Nostalgia and insanity were the two most common diseases for which Union soldiers were released by the Army. Discharged Union soldiers were sent home, to nonmilitary asylums, or remained in service and formed into Invalid Corps (later to become Veteran Reserve Corps) (Dean). In the defeated confederacy, soldiers had little support nationally, except for the National Asylum for Disabled Volunteer Soldiers that was accessed primarily in Union states for Union soldiers (Marten 2011). Such inadequate support and funding, as well as a culture of "resisting progress and preserving tradition," provided support for the soldiers' homes movement in the Southern states throughout the 1880s and 1890s (Rosenburg 2011). These homes were somewhat closed communities where veterans, especially those with nostalgia, did not have to engage with the outside world.

During the Great War of 1914–18, the numbers of soldiers wounded emotionally during combat dramatically increased on both sides of the trenches. Changes in the technologies of war fostered a wider range of potential wounds than previously encountered, especially emotional and psychological ones, including the deployment of units (with as few as ten soldiers thus intensifying the combat experience), the replacement of cannon fire (with indirect fire thus extending the time a soldier is actually engaged in warfare), and the introduction of trench and chemical warfare (thus bringing closer the possibility of death even in nonbattle times). Stories began to circulate among soldiers and civilians alike that the new mechanized weaponry was able to inflict undetectable brain damage through mortar fragments (Leese 2002). During lulls in a battle, perhaps as a temporary break in logistics or a short-lived negotiated truce, stretcher bearers picked up the bleeding while orderlies roamed the fields and trenches collecting soldiers who were wandering aimlessly among or cowering next to the dead. "Shell shock," as it came to be known, identified soldiers who had cracked or broken down under the emotional strain of combat. Even though early descriptions of these types of nervous breakdowns seemed always to include tremors and ceaseless twitching as identifying features of a soldier's illness, somewhat in line with the fitful fire of machine guns (Leese: 62), shell shock remained the descriptor of the soldier's ill body. Once at the field dressing station, these soldiers with additional symptoms of crying, muscle weakness, and paralysis were tagged and pulled from combat. The rapid increase in the numbers of weary

warriors was alarming in terms of both the severity and the cause of the trauma. Accounts of traumatic shock cases in the early part of the war set the tone for choice of treatment in the field following the advice of such physicians as Charles Myers, Herman Oppenheim, and Karl Boenhoffer (Lerner 2001; E. Jones, Fear, and Wessely 2007). Once away from the frontline, soldiers presenting with shock were given a couple of days rest, were transported to the nearest military hospital, or were evacuated to psychiatric hospitals back home.

The sheer numbers heightened awareness of the existence of weary warriors and caused concern in many quarters. For military leaders who were preoccupied by developing a strategic response to enemy aggression, soldiers breaking down in the field signaled the potential for mass hysteria and desertion, something untenable so early in a war. For politicians worried about waning support for the war, stories of prolonged illness communicated fear of the unknown among constituencies. For bureaucrats, concerned about financing the war, sick soldiers indicated financial strain in the form of future treatment and disability pensions. For military psychiatrists, torn between care for the patient and duty as an officer, soldiers in shell shock bespoke fundamental challenges to existing understandings of the impact terror and fear had on soldiers in combat, particularly in the face of modern warfare. Thus, the soldiers with physical manifestations of invisible mental wounds became a focal point of medical inquiry in the military, especially because only some soldiers were affected by combat. Discussion of the cause of mental breakdown in combat included hysterical, psychological, predisposition, and neurophysiological arguments, each with a different set of treatment protocols. Disagreement ensued over what constituted traumatic shock as opposed to malingering or cowardice. For the authors, the increased numbers, awareness, and discussion of weary warriors within and outside the military marked the emergence and collective recognition of the ill soldier. It appears that this conundrum has fuelled the dispersion of psychiatric knowledge during a century of struggle, with soldiers' ill bodies as battlefields.

Names for Soldiers' Ravished Minds

Shell shock, although void of its original, tactile meaning, is still one of the most recognizable names associated with the effects of the distress soldiers experience in and after combat. Over the past century soldiers' ravished minds have had numerous names. In the Great War, British soldiers' charts might have read "Shock," while German charts might have read *Kriegsneurotiker*, *Nervenschoken*, *Granatfernwirking*, or *Granatkontusion*, and

French charts possibly read *simulateur de création* or *simulateur de fixation* (Binneveld 1997: 95, 119, 141; Lerner 2003: 61). There were late-nineteenth-century names of irritable heart and nostalgia alongside new ones, often specific to experiences in the Great War: barbed-wire syndrome, battle dreams, brain fog, debility, effort syndrome, fatigue, hysterical disorder, irritable heart syndrome, lassitude, mental trouble, nerve strain, nerve shaken, nerve wrack, nervous breakdown, soldier's heart, traumatic hysteria, traumatic neurasthenia, war neurosis, and war psycho neurosis.[1] By the end of 1917, British military psychiatry had dispensed with shell shock as a diagnosis, opting instead for a more the general term NYD (N) (not yet diagnosed [nerves]) (Leese 2002: 56); their Allies followed suit. The imperial Russians tended to favor neuropsychiatric (NP) for all mental illness, with nervous exhaustion being but a small percentage of overall psychiatric illness (Wanke 2005).

By the Second World War military psychiatrists in all the Allied forces were forbidden to use shell shock and instructed to use the term "battle fatigue" in reference to the emotionally and psychologically wounded. Roughly equivalent for the same illness in other places at the same time were *NP* for the Soviets, *shinkeisuijaku* for the Japanese, and *Kriegsneurosen* for the Germans (Binneveld 1997; Lin 1989; Wanke 2003). In the United States, the term "battle fatigue" to designate the distress soldiers suffered during and after combat soon gave way to operational exhaustion among UN troops during the Korean War, and, only a few years later, battle exhaustion gained popularity among military psychiatrists during the American Vietnam War. By the 1980s throughout the West, in, for example, Belgium, Canada, France, Great Britain, the United States, and West Germany, "combat stress" was widely used as a term to depict the experience of a soldier who had endured emotional or psychological trauma in battle, while "delayed stress" emerged as a mark of Viet Nam veterans developing stress-related symptoms months and years after returning home. Names for war neuroses are again proliferating, much as in the first twenty-five years of the twentieth century, including, for example, "Gulf War Syndrome" (GWS), "postcombat disorder," "posttraumatic stress disorder (PTSD)," and, most recently, "operational stress injuries" (OSI).

Changes in the name of the sickness soldiers experience are not simply the result of bureaucratic orders, scientific discoveries, or popular psychology trends. They reflect shifting knowledge bases used to diagnose and treat emotional and psychological distress soldiers endure; they also deal directly with the concrete manifestation of bodily disruptions soldiers suffer. For example, in the latter half of the nineteenth century biomedicine was increasingly becoming the dominant knowledge base used to address issues of illness and disease in civil society (Foucault 1994), a context

that informed the development of military psychiatry. One of the more fascinating types of illness during this period was hysteria, a seemingly somatic illness on which neurologists, biologists, and psychologists were focusing attention. At the onset of the twentieth century, then, it is not surprising that military psychiatry as part of this wider medical knowledge base took a soldier's invisible wounds to be indicative of an emotional state beyond the breaking point of what a soldier can usually endure. It is also not surprising that they often treated the physical manifestations of the trauma—mutism, paralysis, blindness, and deafness—as hysterical, meaning in this instance psychosomatic. The psychologically wounded soldier, much like the hysterical woman, was a complex entity in need of explanation and of treatment. Tangible markers produced as evidence of the breakdown included disruptions in physiological (circulation, digestion), neurological (muscles, sensations), and cognitive (concentration, memory) processes. Military psychiatrists maintained that the subconscious mind was producing bodily sickness because soldiers repressed the horrors of the experience of war.

In contrast, by the 1990s psychiatry had become the key knowledge base governing diagnosis and treatment of any malady identified as having a psychological component, including the emotional distress experienced by combat soldiers. Symptoms associated with the emotional distress soldiers suffered in combat were less about a few soldiers not being able to withstand combat and more about the emotional and psychological transformation a soldier undergoes during deployment, something family members and society more generally would notice when a soldier returned home (see, e.g., Bedford 2002; Hart 2000; Sloane and Friedman 2008). Parallel to hysteria a century before, psychiatrists identified physiological, neurological, and cognitive disorders among distressed soldiers. However, rather than hysteria being the rubric around which to organize soldiers' ravished minds, psychiatrists ordered soldiers' bodies in terms of deep, long-lasting stress effects on systems and processes in the body, particularly the overactivation and sensitivity of the fight-or-flight response. Soldiers who have served on the frontline in recent wars no longer present with symptoms of neurosis—weeping, disorientation, fear, nightmares, amnesia, sensory disruption, and paralysis. Instead, soldiers present with symptoms of stress—disturbed sleep, outbursts of violent behavior, agitation, irritability, moodiness, pain, hypervigilance, anxiety, and short-term memory loss.

Over the past two decades, there has been an upsurge in interest in soldiers' ravished minds among medical historians, social scientists interested in psychiatric illness, and the general public (e.g., Babington 1997; Bouvard 2012; Carden-Coyne 2009; Hoge 2010; Kilshaw 2008; Tyquin

2006; Wheelwright 2001). Such interest has no doubt been buoyed by the increase in number of armed conflicts worldwide, the rise of national identity-based separatist wars, the global circulation of detailed descriptions and images of war, and the media coverage of war crimes trials. This renewed interest is evident in medical and political debates over the actual existence of syndromes associated with combat missions; in works written by veterans as to their personal symptoms and profound struggles, at times highly publicized; and in policy and program responses by military personnel and by federal governments to a new generation of weary warriors.[2] Roughly one in three American soldiers serving in Iraq and Afghanistan develop some degree of PTSD postcombat.[3] In addition, media reports indicate that between 22 and 52 percent of American soldiers injured in Iraq and Afghanistan suffer traumatic brain injury (TBI) that leads to depression and Alzheimer's-like conditions.[4] Popularity, though useful in drawing attention to the long-term damages of the effects of war, does not necessarily lead to nuanced explanations of the creation and proliferation of traumatized soldiers. Detailed contemporary accounts of the history of the diagnostic category of PTSD tend to claim that this particular war neurosis is an invention motivated by social and political agendas of physicians and/or sufferers, a timeless condition reformulated in the presence of better insight, or an illness imbued with social and cultural norms and mores (see, e.g., E. Jones et al. 2003; Summerfield 2001). Much of the recent history about soldiers' nervous disorders focus on the latter two explanations, thus relying on either the assumption that the changes in the name of the illness reflect more precisely the psychogenic origins of the illness, which in turn has a beneficial effect by routing out cowards and malingerers, or the somewhat neutral assessment that there are factors contributing to understanding nervous conditions that are not psychopathological (see, e.g., Figley and Nash 2007a; E. Jones and Wessely 2005a; Shephard 2000). It is even the case that soldiers, and families of soldiers, clamor for a psychiatric diagnosis, both in the sense of legitimating the tragic effects of war on individual soldiers and their families and of claiming full and partial veteran disability pensions (see Coleman 2006). The consistency with which these types of explanations have appeared, and subsequently reappeared, over the past century, intimate that the immediacy of governing needs (funding for the production of capable soldiers, health-care provision for mental illness, disability benefits for veterans, and psychiatric-based medical research) eclipses the need for other types of understandings of soldiers' psychological wounds, understandings located outside psychiatry and the military.

An understanding of weary warriors arising from critical thinking in social theory can provide insight into the contexts within which psychia-

try and the military exist and draw authority. We maintain, in contrast to the prevailing literatures about war neuroses, that this recent swelling of interest in war neuroses suggests a general unease about what psychiatry as science and the military can offer combat soldiers and veterans. Focusing on individual motivations for diagnosis serves the interest of only a few, especially those making out soldiers to be lazy malingerers and psychiatrists to be money-grubbers. Boring deeper into the psychology and physiology of combat trauma is useful, but limited. Unlike explanations of weary warriors that rest on the seemingly prima facie foundations such as the inevitability of psychological wounds, the physiology of the fight-or-flight reflex, or the breakdown of the morality of individual soldiers, critical social theory assists in untangling the sets of relations that have given rise to the emergence of traumatized soldiers. Critical social theorists show extensively that ideas, thoughts, and notions about illness, disease, and the practice of medicine have a considerable impact on the way in which illness is experienced and taken up more generally by society, including the diagnosis itself. Yet drawing attention to the socially constructed nature of illness, disease, and the practice of medicine is not enough. Examining how the specific pathways, through which knowledge about illness circulates, is important to generate credible explanations of the place war neurosis has on a soldier's ill body. This circulation of knowledge in itself is in need of explanation.

Circulation of Knowledge and Its Relationship with Power

In recent works about the history of war neuroses, none of the orientations draws attention to the sets of relations through which power is either exercised or deployed (Binneveld 1997; Holden 1998; E. Jones and Wessely 2005a). These works do not capture the mechanisms, as sets of social relations imbued with power, through which knowledge about war neuroses come to be used within psychiatry, the military, and wider society. There is nothing evolutionary about the terms used to describe emotionally tattered soldiers; that is, there has not been enhanced clarity over the mental distress combat soldiers experience. Rather, the changes in names for soldiers' ravished minds mirror changes in the ways knowledge about war neuroses come to describe the psychologically wounded soldier. By tracing shifts in the names of war neuroses over time and placing them in contexts wider than just the military or psychiatry, one can find reflections of specific configurations of power dispersed through various social relations that support the circulation of specific characterizations of war neuroses, including psychiatry, the military, and society more generally.[5]

Examination of these social relations, with both discursive and material aspects, shows how the exercise of power has profoundly shaped soldiers' experiences, psychiatry's conceptualizations, and society's depictions of psychological distress among combat soldiers.

Understandings of weary warriors as malingerers, as constitutionally weak, or even as an inevitable part of war, break apart when focusing attention on the deployment of power. In their place comes the idea of the designation of war neuroses as an effect of specific configurations in the exercise of power and the dispersion of knowledge. In these configurations of social relations, there is interdependency among those who get to say what truth is and what claims they use to support what they say. The control military psychiatrists have in designating who is ill and who is not illustrates how the exercise of power is inextricably wound within what counts as knowledge (Foucault 1980a).This notion of power/knowledge matters because it provides an alternative basis around which to organize the social practices that support conventional notions about combat soldiers and war neuroses.

In *Psychiatric Power* (2006: 202), Michel Foucault suggests "it was especially the child much more than the adult who provided the support for the diffusion of psychiatric power in the nineteenth century." Throughout the nineteenth century, with the increased merging of the school with the hospital as institutions of learning and health care, the child became the locus of the struggle by psychiatrists over that which constitutes normal. Following Foucault, we would like to suggest that it was soldiers in warfare (alongside other configurations, especially women in patriarchy, see Appignanesi 2007) who provided support for the diffusion of psychiatric power in the twentieth century.[6] Throughout the twentieth century the coupling of a particular type of masculinity, honed and then instilled by the military, via psychiatry, as institutions of war and mental health, the weary warrior became the site for the formation, application, and contestation of psychiatric forms of power/knowledge. Changes in names of soldiers' ravished minds, sometimes abrupt, through official military memoranda, and sometimes subtle, through the persistence of the use of shell shock as a descriptor of soldiers' shattered nerves in popular media, mark identifiable points in the shifting nature of competing understandings, explanations, and applications of psychiatric power/knowledge.

War neuroses generally and soldiers' ill bodies specifically have become the battleground on which the diffusion of psychiatric power plays out. As a major figure in the elaboration and exercise of psychiatric power/knowledge throughout the entire twentieth century, the weary warrior has roots in the practice of late-nineteenth-century psychiatry, especially in relation to soldiers, trauma victims, and women. Positioned promi-

nently in the late 1800s, psychiatry sought to offset the polarity of medical knowledge that explained madness in terms of either psychology or pathology, by making claims about the interdependency of the mind and the body (see Foucault 1988a). This particular knowledge base set the stage for the deployment of power through various sets of relations in the early twentieth century, feeding into treatment protocols for neurotic soldiers presenting with hysterical forms of bodily symptoms. As well, the forward psychiatry system set up in the Great War, adapted in the Second World War, and (seemingly) perfected in the Viet Nam War, informed the psychiatric power and knowledge configurations in the military over the last quarter of the century.

Examining the contexts within which the names of war neuroses shift, permits observation of various expressions of the diffusion of military and psychiatric power/knowledge. Contexts in which one is acutely aware of the exercise of psychiatric power can be effective in demonstrating how the organization of power both distorts the regularity of order in the institution, in the case of warfare the intersection of psychiatry and the military, and, at the same time, makes the institution function, in this case the institutionalization of military psychiatry (Foucault 2006: 15). For weary warriors, these contexts—field dressing stations, field hospitals, military hospitals, convalescent homes, asylums, and treatment centers—are usually the first institutions they encounter following emotional distress or a psychological breakdown in combat. With the advanced development of forward psychology strategies for treating war neuroses in tandem with the introduction of heavy screening for potential psychological breakdown in combat situations and later the intensification of realistic and reflex training for combat soldiers, the contexts within which psychiatric power is exercised spanned longer periods of time and included more people in the soldiers' lives. Scrutiny of contexts farther afield from the direct experience of combat trauma, including cultural media depicting soldiers and veterans in plays, novels, film, and television, can establish pieces of the pathways that texture and sustain the configuration of psychiatric power and knowledge at any given moment.

In each of these contexts, losing sight of the fleshed aspect of the weary warrior can only cause misunderstanding of what emotional distress and psychological wounds mean. Parallel to scrutinizing the contexts that reflect configurations of power/knowledge related to military psychiatry, the body needs attention in order to show more clearly the materialized aspects of the expressions of power. The body is the scene of both the expression of power, even in its most radically relational form, and the individual, in power's effects (Foucault 1988a, 1990a, 2006). For soldiers in the Great War, once the pall dropped over them in battle their bodies

were transformed into vessels of sickness, with fatigue, muscle weakness, constipation, uncontrollable weeping, nausea, and inconsolable fear. During the first two years of the Second World War, German soldiers did not collapse like soldiers in the Great War as military leaders expected; rather, they suffered terribly from stomach and intestinal problems, a phenomenon referred to by German psychiatrists as *Symptomsverschiebung* ([displacement of symptoms]; Binneveld 1997: 92). Military psychiatrists initially deemed the psychiatric services in place for American soldiers in Viet Nam a huge success because of the low rates of combat stress, between 2 and 5 percent of all combat troops. What military psychiatrists had not been prepared for, however, was the high incidence of "delayed stress" or "post–Vietnam syndrome" after return home (E. Jones and Wessely 2005a: 128–31).

Arguments and Themes

Our argument stems from the premise that the transition from shell shock to PTSD is not merely an extension of an understanding of weary warriors, enhanced by insight into war, nor a new or improved psychiatric explanation of soldiers' experience of war. To understand how weary warriors today walk among us, what needs attention is the organization of power, in particular military and psychiatric power, and of knowledge that psychiatry and the military tender. Organizations of power can be described by examining the contexts within which soldiers experience war neuroses, including the way in which their own bodies are part of setting the parameters for reckoning deep emotional distress as psychiatric illness. One part of the cultural context we feature in the analysis is masculinity. We treat masculinity as an important element in the generation of the weary warrior rather than as an explanation for emotional trauma and mental breakdowns.

Combatants and veterans we call weary warriors can be seen to be part of "the large, ill-defined, and confused family of 'abnormal individuals'" observed in recent centuries (Foucault 2004: 323). The soldier with a ravished mind appears as a psychiatric personage in the nineteenth century after the emergence of other types of abnormality. Indeed, it may be said that the weary warrior is a fourth figure in the modern domain of abnormalities coming after, then joining alongside, the dangerous individual or moral monster in penal matters; the undisciplined or incorrigible person to be confined and corrected; and the onanist or sexual deviant, to be supervised and educated. Like other categories of abnormal individuals, weary warriors are the subject of psychiatric techniques of identification

and diagnosis, therapeutic interventions and disciplinary treatments, and formal organizational arrangements—all of which involve relations of psychiatry, the military, and masculinity as well as their practices. Thus, we keep warriors in homage to the path through which they became weary.

Weary warriors have distinct origins and distinguishing systems of knowledge, comprising a contested interplay of psychiatry, the military, and norms of masculinity that manifest (or materialize) variously over time and space within a range of different social institutions, including the state and family. From the mid nineteenth century to today, the character of the agitated, exhausted, and shocked soldier has been the object of psychiatric and military gazes. Accordingly, we are interested in understanding how certain soldiers and veterans both bodily and textually are deemed by psychiatric and military systems to be traumatized, while others are not. In exploring the way authority features in the manufacturing of normal and abnormal military personnel, we engage in figuring out how war neuroses and combat stresses offer a site for an analysis of power relations in and around the psychiatric practices, armed forces, and societal customs of masculinity.

Our concern about how the psychological wounds of military personnel in combat have been conceptualized, labeled, and challenged during any given war and over time across conflicts and battles does not remain solely discursive; we want to be sensitive to the materiality of these discursive practices. We understand discourse to be deeply material, and materiality to be deeply discursive. In academic language, we refer to this as the ontological politics of ill soldiers. The reality of war trauma is not a fixed given, drawn from a general reality of war, but rather is a changeable entity that takes form in the context of cultural, historical, and material settings. These settings are similar to the settings soldiers emerge from and are returned to postconflict, and those that these soldiers have a hand in shaping as they make their way through their deployments. The politics of ontology is about who gets to determine what, when, and how weary warriors belong to the real. An officer presiding over the medical boarding process? A military psychiatrist at a field dressing station designating a soldier with combat stress? A government bureaucrat adjudicating an application for disability pension seven years postdeployment? A journalist covering an unjust war claiming that soldiers were automatons of an imperialist nation-state? A family reflecting the social norms of the day encouraging a veteran to seek support from the resource center? The ontological politics of weary warriors involve struggles over shaping what is real and could be or ought to be made more real or less real (Mol 1999)— that is, these politics involve struggles over how to define, fix, and support

soldiers' ill bodies. They also involve the conceptual tools professionals, family members, advocates, and academics use to disclose a particular reality of traumatized soldiers (Hekman 2010).

The arguments we put forward in this book differ from the works in the burgeoning literature about the emotional trauma of soldiers in three key respects. First, we do not accept the a priori notion that the discussion of war neuroses needs to be solely, or indeed primarily, located within the purview of military psychiatry. To date, much of the discussion of war neuroses has been located in, and mostly about, the field of military psychiatry. Our analysis focuses on the interplay between the configurations of social relations, or power/knowledge formations, within the expression of the science of psychiatry vis-à-vis military imperatives. Granted, much of the empirical data about war neuroses exist primarily in psychiatric military contexts. Still, there are other places to look for data that can demonstrate how knowledge about emotional distress among veterans circulates within psychiatry, within the military, and in society more generally. Scrutinizing the links and connections between these data and the formation of power/knowledge can lead to insights into the diffusion of psychiatric knowledge. As well, in contrast to other historical analyses, our analysis highlights the mechanisms through which psychiatric power shapes the ascription of diagnostic categories to soldiers' ill bodies via diagnosis and treatment, and creates cultural and social awareness about emotional and psychological distress among combat veterans in wider society.

Our approach is akin to historical medical anthropology, feminist cultural geography, and critical social theory, and therefore signals how our work differs from military histories, especially official accounts, as well as most histories of clinical psychiatry that consider the incorporation of psychology and human sciences into military establishments and civil society. Although examples of the dispersion of psychiatric power/knowledge of war neuroses are readily available from the American Civil War and Russo-Japanese War through to contemporary UN peacekeeping missions and the Iraq War, we do not present a chronological report of assorted configurations. Rather, we concentrate on those configurations that sharply contrast the ideas about war neuroses (as expressed through the name), traumatized soldiers (with their ravished minds, ill bodies, and injured souls), and the social practices that support, reproduce, or challenge the ideas about both. Through the formulation of in-depth snapshots, we are able to bring into focus particular organizations of power in how soldiers suffer trauma and emotional distress. We maintain that this approach provides a fruitful avenue for insight into the assorted configurations of the social relations of power over time. These snapshots offer

an occasion to explore in more depth the exercise of power in particular power/knowledge configurations.

Second, we maintain that the dispersion of psychiatric power over the twentieth century took place on and through the psychologically wounded soldier. Much of the research about war neuroses focuses on cause, diagnosis, and treatment in theaters of war, with only scant attention paid to the psychologically traumatized soldiers themselves, and even less to their positioning within power/knowledge configurations. This research, too, tends to focus on the British and American experiences, which have been informed by the German and Russian experiences in the early twentieth century and by nonmilitary psychiatry more recently. Our analysis breaks this pattern.

We draw on multiple data sources in order to generate in-depth snapshots of time-specific and place-specific configurations of power/knowledge, and then juxtapose the data against other specific snapshots. Drenched with the specifics of a particular context, these data provide room to consider alternatives to conventional understandings of soldiers' psychological wounds and their emotional distress in battle and offer insights into the processes that construct war neuroses and create weary warriors. This approach *in format* supports our arguments about the shifts in understanding war neuroses over time and how this took place on the backs of the soldiers with invisible psychological wounds. Through these snapshots, we are able to situate soldiers' ill bodies institutionally, culturally, and experientially so as to clarify the mechanisms through which psychiatric power circulates and lays claim to knowledge about soldiers' ravished minds. We also integrate more fully the Canadian experience, drawing on Canadian medical journals, Canadian soldiers' autobiographies, Canadian military psychiatry documents, and various Canadian state policy and programs introduced to deal with soldiers' ill bodies.

Third, we hold that changes in configurations of power/knowledge take place gradually over long periods of time. We first identify two points in time, the mid nineteenth century and the early twenty-first century, and then frame our analysis around figuring out how understandings and arrangements changed over that time period. We note particular ideas, events, and practices throughout the time period that illustrate a shift in thinking, acting, and reacting to soldiers' psychological wounds. Much of the empirical work about war neuroses centers on military psychiatric developments in the Great War, the Second World War, and the American Vietnam War. The empirical data found in these works are extremely useful, primarily because of the sheer amount of information included in the detailed descriptions. The analyses matter less for us because they fail to come to terms with the gradualness of change in the social relations of power and the circulation of knowledge. By including empirical sources

outside these time periods, we can provide a more nuanced analysis of the shifts in thinking about psychologically wounded soldiers beyond simply that of a name change. The long period of time we analyze permits the identification of temporal and spatial patterns, comparative moments of the exercise or deployment of power, and changes in social and cultural attitudes toward war, soldiers, and illness.

Our approach is somewhat like Braidotti's (2012: 4) cartographic method: "a theoretically based and politically informed reading of the process of power relations [that] fulfills the function of providing both exegetical [explanatory] tools and creative theoretical alternatives." We apply this method to both the concepts we use to illustrate our arguments as well as to our analysis of the texts to show how conceptualizations of the traumatized soldier changed gradually over time. Rather than looking for the same illness time and time again, we strive to make theoretical and empirical space for the coexistence of continuities and disparities, control and collapse, discipline and disorder, and enabled and disabled selves to demonstrate just how distinct soldiers' ill bodies are and how fraught the change in thinking about psychological war wounds is in practice. Thus, we do not try to describe or explain the history of weary warriors in terms of a single theoretical perspective or universal narrative. Instead, in our poststructural approach to understanding weary warriors we examine multiple realities and manifold practices, consider resistance and dissonance, and move toward a more nuanced understanding of historically specific weary warriors.

We frame our thinking about psychiatry, the military, and masculinity in the first two chapters through a review of some poststructural and feminist theory as the basis for explaining the role of power and knowledge in the cause, onset, symptoms, and treatment of trauma in combat soldiers, as well as being ill and living with a war neurosis. The order of the following chapters (chapters 3–8) roughly coincides with the course a soldier's life might take after having developed or been diagnosed with a war neurosis: how soldiers would come to know about war neuroses, how the lives of soldiers suffering emotional distress in combat would be transformed by both psychiatry and the military, how the soldiers themselves would make sense of being ill with a war neurosis, what treatment traumatized soldiers would receive, how psychologically wounded soldiers would be seen socially and culturally, and how ill veterans' lives might be after leaving the military. In chapter 9 we revisit the framing of our arguments and reflect on the advantages and limitations of conceiving war neuroses as we have. Through our own reflections, we came to see that our cartographic approach mimics the weary warrior—that is, they are both a patchwork of sorts. Our approach embraces multiple sources from various time periods to challenge the idea that research needs to

have a unitary subject; uses conceptual and theoretical sensitivities that foreground flexibility in form and substance; and offers an alternative way to look at, understand, and engage with soldiers encountering combat trauma. Similarly, we argue, weary warriors are nonunitary subjects whose positions change, shift, fluctuate, and multiply in an assortment of situations. Weary warriors are somewhat like a patchwork in that even though they comprise disparate parts, there are still patterned, discernible individuals that hang together as wholes no matter how seemingly loose, fleeting, or fragile they may appear.

Notes

1. We compiled this partial list from a review of four medical journals from Canada, Great Britain, and the United States between 1914 and 1919, all of which had international elements that included drawing on information from non-English-speaking countries, most prominently Germany and Austria: *British Medical Journal, Canadian Medical Association Journal, Journal of the American Medical Association,* and *Lancet.*

2. For a debate over the existence of war trauma syndromes, see McHugh and Treisman (2007) and Summerfield (2001). For examples of struggles publicized and popularized through books and news media, see Dallaire (2003), Doucette (2008), and Finnegan (2008). For examples of think-tank publications that discuss the impact of invisible war trauma wounds, see Cesur, Sabia, and Tekin (2011); and Tanielian and Jaycox (2008).

3. Mainstream media reports suggest that one in three American soldiers serving in Iraq were diagnosed with at least one mental health problem, with PTSD being the most common diagnosis (Dao 2009). The report was based on a University of San Francisco study.

4. Of American veterans from the Afghanistan and Iraq wars treated by Veterans Affairs between 2001 and 2005, 31 percent were diagnosed with mental health and psychosocial problems, most commonly PTSD (Paddock 2007).

5. Moss (2013b) offers a detailed look at how the underlying psychiatric knowledge explaining mental breakdown in combat shifted from the individualist idea of a soldier's psychological flaws to the universalist claim that everyone has a breaking point. She argues that affect, in this case expressions of love, mediates the practice of military psychiatry via the military psychiatrists themselves. This analysis is an example of how to show the fluidity of the military and to trace how things other than military discipline and psychiatric protocol, for example, manage the generation of weary warriors.

6. Women throughout the twentieth century have been subject to similar effects of particular configurations of power and knowledge. We maintain that the arguments laid out here could usefully be applied to women throughout the twentieth century, especially in light of myalgic encephalopathy, which is known variously as a hysterical, psychosomatic, and a contested illness.

Chapter 1

Ravished Minds and Ill Bodies
Power, Embodiment, Dispositifs

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> For it is the psychologist's business to try to understand "the mechanism and power" of the individual, to know "what men can do and what they cannot do," and to learn how human conduct is governed.
> —Frederic C. Bartlett, *Psychology and the Soldier*

> Moreover, it is no accident that Freud, reflecting on the neuroses of war, should have discovered, as a counterweight for the life instinct, in which the old European optimism of the eighteenth century was still expressed, a death instinct, which introduced into psychology for the first time the power of the negative.
> —Michel Foucault, *Madness*

As part of our task to unravel the pathways through which power and knowledge circulate to produce ill soldiers and shape the way ill soldiers experience the trauma of breakdown in combat, we draw on poststructuralist and feminist thinking. Poststructural thinking calls into question fundamental, taken-for-granted concepts, such as power and knowledge, as well as the tangible acts and events shaping everyday life.[1] Poststructuralists invite reflection and critique as ways to engage the concepts used to make sense of the world and also the processes through which the world comes to be the way it is. They do so by not focusing always on the obvious, by taking up atypical lines of query, and by challenging conventional understandings of a phenomenon. Concepts arising from poststructuralists' attempts to rethink the world assist us in disentangling the sets of relations within and among discourses that shape how truth claims solidify and are subsequently circulated in specific encounters between, for example, soldiers and physicians.

In addition to drawing on poststructural arguments about power, knowledge, and discourse, we follow a number of feminist arguments. Contemporary feminist theory has a long-standing interest in exploring the intersection of gender, health, and medicine, especially in terms of how women have been treated over time by psychiatry as mad, hysterical, and depressed (Appignanesi 2007; Mitchell 1974; Oppenheim 1991; Showalter 1985). Women's bodies as differentiated from the normative male body in gendered discourses of science and knowledge became an obvious site for the investigation of power and how it circulates.[2] For feminists to take cultural phenomena, including illness, seriously, they also need to take into account political and economic contexts when trying to understand the material aspects of living, including the material aspects of the body.[3] Thus, within these feminist discussions, ill bodies—as more than just ailing biological entities and more than just products of failed idealizations of healthy bodies (Bendelow 2009; Birke 1999; Einstein and Shildrick 2009; Howson 2005; E. Martin 1995; Munch 2004; Ussher 1997, 2006)—make for a rich source of information to trace various pathways that power and knowledge have come to take.

In this chapter we frame our reading of the numerous and wide-ranging accounts of soldiers suffering deep emotional distress as a result of combat. We first discuss Michel Foucault's ideas about power, knowledge, and discourse so as to provide a vocabulary to articulate our tracings of the pathways through which weary warriors emerge as entities. We then engage with Foucault's more elaborate concept of the *dispositif* (or disciplinary apparatus) that captures to some extent the circulation of power and knowledge in the production of subjects. We next turn to a discussion of embodiment as a way feminists have conceptualized the link between discursive constructs and material realities of the body in response to tensions in Foucault's work. We close the chapter with our own concept of embodied apparatus to emphasize the discursive-material aspects of the life and experience of an ill combat soldier.

Power, Knowledge, and Discourse

Power, according to Foucault, is not located in any one place, structure, or authoritative figure; rather, power is produced "from one moment to the next, at every point, or rather in every relation from one point to another" (Foucault 1990a: 93). Because it is generated in each and every encounter, power is not something "acquired, seized or shared" (94); instead, it is recognized, exercised, and deployed, the effects of which we live through in the sense of facilitating some behaviors and restricting others. Thus, power

is everywhere not because it has a singular location (as in the general or the psychiatrist or in a military hospital for psychiatric cases) but because it emanates from each point through which power passes (an encounter between an officer and a soldier or between a psychiatrist and a patient). Because power originates in so many different places, its practice is not the same. Power can be both blatant, as in a violent act of destruction, and subtle, as in a hidden act the impact of which comes only later. There is coercion, manipulation, corruption, and malevolence as well as cooperation, persuasion, ethics, and benevolence. Never absolute in its deployment, power is always negotiable. Just as there is assertion, there is contestation; if there is subjugation, there is opposition; where there is oppression, there is resistance. The question to ask about the role of power in the emergence of the psychologically wounded soldier is not, " 'What is power and where does it come from?' but 'How is it practised?'" (Deleuze 1999: 71).

The notion of power as disciplinary pervades Foucault's body of work, especially in *Discipline and Punish* (Foucault 1979). Its omnipresence in the rituals of everyday life of modern times does not simply reflect some centralized power, but expresses that power in a *microphysics* through gestures, acts, mechanisms, and effects in a multitude of ways (26, 139). Discipline acts on bodies in specific ways, bringing into existence what Foucault called "docile bodies" (135–69), ones that could be "manipulated, shaped, [and] trained" to obey, respond, become skillful, and increase its force (136). Disciplinary power is subtle, pernicious, and sometimes unseen. Yet, as Foucault notes emphatically, because power arises in situ, at the point of encounter, there are inevitably circumstances mediating its effects, thus making the microphysics of power an uneven terrain. So, while more discipline increases the forces of the body enhancing utility as in screening soldiers for psychiatric illness, that same discipline erodes the same forces generating disobedience as in soldiers allegedly feigning illness.

Being both productive and relational, Foucault's notion of power is useful in understanding how certain sets of practices (psychiatry and the military) and groups of people (psychiatrists and officers) come to have an influence on subjugated bodies (psychologically wounded soldiers). Power is intricately woven into the production of knowledge, bodies, and subjectivities through what Foucault refers to as power/knowledge. Power/knowledge describes a specific coalescence of relations that link particular strategies of the deployment of power with a specific set of truth claims, as, for example, the relationship between a psychiatrist who is also a commissioned officer acts as the knowledgeable guide and a patient who is a soldier in active service then submits to treatment. By setting the parameters around what counts as knowledge, the circulation

of power/knowledge in various fields of study (biomedicine, neuropsychology) and in practice (diagnosis, military training) still holds sway in determining expectations and norms of behavior. Because power is rarely practiced *on* someone, the subject (as knower and the object as known) becomes the effect of the circulation of multiple, and competing, configurations of power/knowledge.

Power/knowledge is a valuable conceptual tool when looking closely at relatively large-scaled entities because it provides a way to both maintain an entity's shape and to acknowledge the fluidity of its boundaries. Thus, when thinking of psychiatry as a particular configuration of power/knowledge at a given time in a particular place, there is still plenty of conceptual space to access the battery of influences such as advances in neurology and brain science (at the turns of the twentieth and the twenty-first centuries), patient resistance to treatment (the anti-psychiatry movement in the last quarter of the twentieth century), society's pulse for acceptance of psychiatric knowledge (the mainstreaming of Freudian psychoanalysis in the mid twentieth century), and different psychiatric practices across the globe (psychotherapy, electrotherapy, and pharmacotherapy in American, British, Canadian, German, and Russian military practices). Similarly, when thinking about the military, masculinity as a specific configuration of power/knowledge circulating through and articulating with military practices at particular moments in time and space gives form to masculinized subjectivities as part of a soldier's identity.

The circulation of power, or what Foucault in his later work calls relations of force (Foucault 1990a: 92), is not uniform. Because power is productive, expressions of power are never identical (but can be similar), always local (but never localized), and inevitably unstable (though fixed enough to generate effects, known as power-effects). Because power is relational, what matters more than the notion of power itself are the *arrangements* of force relations and how they connect to one another. Tracing these connections, or articulation points, can show how specific bodies are effects of the circulation of power and knowledge. Foucault argued that subjects, too, like bodies, are effects of power and that subjectification, or the process of making subjects, is embroiled in the same productive and relational sets of power/knowledge (Foucault 1980a, 1988b, 1990a, 1990b). He characterized his body of work as "a history of the different modes by which, in our culture, human beings are made subjects" (Foucault 1982: 777). Similar to Foucault, the process of making soldiers enduring emotional breakdown in combat into a subject is part of our project. More specifically, we are interested in how soldiers traumatized by encounters in combat come to be subjects and to act in the web of power relations that comprise various configurations of power/knowledge.

These articulation points within particular power/knowledge configurations can be traced through various discourses of power and knowledge. Discourses can be best described in Foucault's work not as signs that produce meaning, but rather as "*practices* that systematically form the objects of which they speak" (Foucault 1972: 49; emphasis added). These practices form discursive structures that bring into recognition entities like psychiatry, the military, and masculinity. Through these discourses, both power and knowledge circulate; it is in their systematicity (via patterning, repetition) that a specific configuration of power/knowledge emerges and can be identified. The practices involve material acts that are themselves imbued with ideas, unarticulated notions, and opinions about ways of thinking and behaving that have effects on particular things. Recognizing discourse permits the analysis of similarities across texts, images, and stories that are effects and products of specific configurations of power/knowledge (S. Mills 1997). For example, discourses about illness, mental health, trauma, emotion, family, spirituality, combat, manhood, chivalry, and camaraderie shape how a soldier comes to express psychological wounds as a result of combat to a field medic, a commanding officer, a medical doctor who is a commanding office, or a military psychiatrist.

To understand more precisely the production of subjects and bodies as *effects* of power relations, Gore (1995) identified eight dimensions of power in Foucault's work: classification, distribution, exclusion, individualization, normalization, regulation, surveillance, and totalization.[4] Though all these dimensions are disciplinary in nature, each works differently in the production of subjects and bodies. For example, a PTSD diagnosis as both psychiatric knowledge and psychiatric practice is a type of classification that not only marks bodies as ill within particular circles of knowledge producers (such as military psychiatrists), but also invokes value-laden readings of that ill body (as in mentally disturbed veterans with tendencies toward violence). These dimensions often work together, such as a psychologically wounded soldier self-monitoring (as a type of surveillance) through psychotherapy while in treatment in a military hospital, who is also excluded from the general population for being ill. As well, the productive aspect of deployment of power generates innumerable configurations of relations organized around a particular concept, notion, or aggregation of knowledge like psychiatry, masculinity, and the military. By rethinking the notion of power as something not to be held or redistributed, but rather as something that is negotiated constantly, a contextualized space for action emerges rife with the potential for resistance. Resistance, however, is not always the easiest or most readily accessible response. Instead, resistance takes multiple forms—rejection, contestation, indifference, nonengagement, revolution—that join together over

time to reshape the configuration of power/knowledge itself. In the case of recruits, soldiers, and veterans who endure or have endured emotional distress as a result of combat, resistance may manifest itself in the simulation of illnesses, the self-affliction of actual harm, insubordination, desertion (or going AWOL), displays of perceived cowardice and lack of moral fiber (LMF), and legal challenges to adverse decisions regarding eligibility for disability benefits and/or related social services from the state.

With regard to the soldiers with traumatized psyches as a result of living through combat, an inquiry into the organization of multiple configurations of power/knowledge involved in producing soldiers' bodies and minds as ill can provide insights beyond those available in the literature about war neuroses, whether these are biological, culturalistic, naturalistic, therapeutic or militaristic.[5] Indeed, centering analysis on the organization of power/knowledge as it relates to war neuroses is the analytical method advocated by Foucault in *Psychiatric Power* (2006: 4; emphasis added): "Power does not belong to anyone or even to a group; there is only power because there is dispersion, relays, networks, reciprocal supports, differences of potential, discrepancies, etcetera. It is in this system of differences, *which have to be analyzed,* that power can start to function." Access to these relays, networks, supports, and discrepancies in an analysis of power/knowledge about war neuroses clearly arises from the ways that different configurations of power/knowledge overlap, entwine, and interact. Tracing articulation points between soldiering and masculinity or ill bodies and mental illness can assist us to figure out how shell shock was relatively accepted as an outcome of the Great War whereas delayed stress among American veterans of the Viet Nam War came to be devalued culturally.

Focusing on arrangements of power/knowledge and their articulation with one another does not preclude experience of illness or disciplinary power as something of analytical interest. These arrangements must be recognized as complex and multifaceted phenomena that can be both individual and collective (Moss and Dyck 2003: 58–60; J.W. Scott 1992). Refusing the naturalization of experience as the taken-for-granted base from which knowledge emanates permits alternative understandings of experience to emerge. Casting experience as generative somatically and discursively is a practical conceptual strategy that parallels the conception of power as productive and relational. Experience is at once both the act of interpretation of bodily sensations, emotions, events, and encounters, and in need of interpretation vis-à-vis the processes through which experience comes to be understood as experience (after J.W. Scott: 37). In this way, experience, deeply material and simultaneously socially constructed, is integral to, not determinant of, the production of subjects and bodies.

One way to ensure that experience is central to a reading of weary warriors is to take into account feminist understandings of the concept of embodiment.

Feminist Understandings of Embodiment

Conceptually feminist theorists have developed nuanced understandings of how bodies, knowledge, power, and discourse come together to produce subjects. The body itself became a site for feminist inquiry both because of its *biology,* with women's bodies being different from men's bodies, and because of its *meaning,* with women's bodies associated with emotions, caring, and social reproduction, and men's bodies associated with rational thought, provision, and economic production (Lloyd 1984; Shildrick and Price 1998). Indeed, women's bodies were central in the discussion of science as a privileged space for producing knowledge (Haraway 1988; E. Martin 1991). Power, always integral to feminism, became part of the discussion of *how* bodies were read, *how* they acted, and *how* they were treated in various settings (Bordo 1993; Currie and Raoul 1992; Ebert 1996; Ussher 1992). Informed by many different theoretical traditions, one concept, that of embodiment, captured feminists' theoretical attention as a way to address both the materiality and the social construction of bodies and their interaction with both power and knowledge (Davis 1997; Diprose 1994; Kitzinger 2007; McLaren 2002; Moss and Dyck 2003). Missing from the discussion about feminist embodiment is the weary warrior. We maintain that feminist notions of embodiment can contribute to understanding military psychology as masculinist spaces in the production of nervous shock as a widespread illness/condition among warriors through soldiers' bodies and the process of subjectification.

   Although initial feminist engagements with Foucault's ideas were negative, sometimes to the point of hostility (Alcoff 1990; Fraser 1985; Hartsock 1990), some feminists saw benefit in Foucault's thinking in terms of the overall feminist project.[6] Two key works—Elizabeth Grosz in *Volatile Bodies* (1994) and Rosi Braidotti in *Nomadic Subjects* (1994) influenced the ways in which feminists came to take up embodiment conceptually and empirically.[7] Grosz's account of subjectivity, particularly in the area of sexuality and gender, emerged out of a concern over how dualistic thinking frames the ways in which Western philosophy understands the body, especially dichotomous thinking that separates mind from body and locates corporeality singularly with one type of body (based on, e.g., sex, race, class, nationality, or gender). She meticulously lays out a model that undermines the flight to essentialism in biologic accounts of the body and to

relativism in social constructionist accounts. Her conceptual reorientation of the body as being neither—and simultaneously both—discursive and material has been incredibly influential in feminist accounts of the body. Her work cautions against taking the physical body for granted and using it to determine the subject, against presuming the body is a blank slate on which society writes the idyllic norm, and against containing concepts of the body in tightly woven frameworks. A notion of embodiment drawn from her corporeal feminism seeks to break apart the notion of a unified subject and provide an account of subjectivity that can accommodate both difference between bodies and the specificity of one body, a notion that could readily be applied to soldiers breaking down during combat particularly over time. Thinking of ill soldiers as having embodied subjectivities could assist in moving the debate about whether soldiers enduring pain from irritable heart in the latter half of the nineteenth century were suffering from shell shock, battle fatigue, or PTSD, toward a discussion of which discursive-material circumstances led to the various categorizations of, and interventions in, soldiers' ill bodies over time.

The fluidity of Grosz's idea of the body is echoed in Braidotti's work on subjectivity. Like Grosz, Braidotti focuses on the materiality of the body as a means through which to break the presumed neutrality of the subject common in Western configurations of subjectivity. Feminists have argued that the assertion to be neutral actually masks the presence of man, manhood, and masculinity as the norm against which all subjects are defined (see Lloyd 1984). For Braidotti, once the materiality of the body is taken into account alongside the idealized notion of what a woman is (i.e., once the body is embodied)—by having *worked through* the discursive and material sites that reduce woman to either her biology or her idyllic form—subjectivity can become nomadic and thus move from place to place, body to body. In other words, nomadic subjects are no longer pretied to particular bodies; nomadic subjects are fluid with permeable boundaries, on the move, and ready to incarnate through a different configuration of power relations. Yet, as she is quick to point out, severing a subject from the overarching collective sense of identity is never complete; it is a strategy that creates space for the emergence of more nomadic subjects.[8] Her understanding of embodied subjects stretches beyond sexual difference to include other significant markers of difference such as "race, culture, nationality, class, life-style preferences, and so on" (Braidotti 1994: 199). It is not too difficult to think of bodily material breakdowns as another significant marker of difference, a difference that matters considerably in the life of a soldier who suffers extreme distress as a result of engagement in battle. Freed from both discursive and corporeal harnesses that ensure stasis, nomadic subjects can be at once bound sharply to a configuration

of a specific materialized subject positioning (as a masculinized soldier suffering psychological breakdown in combat manifested as mutism), and then just as abruptly can detach from, rearrange, and slide into, or over time make a slow transition toward, a different configuration of materialized subject positioning (as a rehabilitated combat soldier prepared once again for battle).

Empirically, feminists interested in embodiment and illness have applied the ideas developed by Grosz and Braidotti and their engagement with Foucault, resulting in fascinating studies of social norms, networks of power, and the production of knowledge. Liz Eckermann (1997), for example, uses embodiment—as an effect of power/knowledge in the politics of truth—to highlight the (ironic) nexus between cultural values of beauty and medical treatment modalities. (For more on the politics of truth, see Foucault 1980c and 1997.) Instead of viewing self-starvation as part of a woman's quest for a beautiful body, Eckermann claims that the ideas about thin bodies in psychiatry vis-à-vis self-starvation are a result of local circulations of power/knowledge. Because of the constitutive nature of power/knowledge, women engaging in self-starvation acts are produced by prevalent beauty discourses and psychiatric categories as well as actively resisting widespread understandings of women's bodies in both realms. Thus, acts of self-starving challenge Western sensibilities, which in turn dismiss self-starvers as irrationally deviant (Eckermann 1997: 169). Ineke Klinge (1997) considers the production of osteoporotic bodies in biomedical discourses through intervention strategies in labs, clinics, and health policy. Her analysis shows the subtle ways in which a normal process of aging conflates with women's (potential) health status and then intertwines with health-care systems and the delivery of health care. She argues that in lieu of one biological body, there are in fact multiple bodies serving multiple, disciplining agendas, and that women's bodies through engagement with the health-care system become managed care sites. However, within these bodies there is room for women individually and collectively to resist disciplinary power and create their own stories about brittle bones, stories that may or may not jibe with the various bone stories on offer. Nelly Oudshoorn (1994), in her study of sex hormones, demonstrates how scientific knowledge informs, shapes, and produces natural bodies. Instead of clinging to the idea that sex hormones exist and define natural bodies, she maintains that it is through both the activities of scientists researching sex hormones and the decontextualization of scientific knowledge that sex hormones have become naturalized and associated primarily with women's bodies. With the recognition that power is relational and mobile, she is able to trace how the production of knowledge intimately relates to women's bodies *through* sex hormones.

These types of feminist analyses of embodiment have opened up the discussion of how bodily discourses and material bodies generate byzantine entities enmeshed in their own multifaceted contexts. Yet some feminists remain concerned that the materiality of everyday life has been eclipsed by the intense focus on discourse, text, and language (Alaimo and Hekman 2008). Karen Barad (2003) calls for a material turn in feminist theory and insists on moving the focus away from the representational toward performativity. She maintains that Niels Bohr's account of theoretical concepts not being ideational but physical arrangements provides a link between the conceptual and materiality that Foucault misses (Barad: 814–20). Although Barad concedes resonance between Bohr's apparatus and Foucault's discursive practices (those repetitive acts that people draw on to shape their own responses in certain situations), she argues that a focus on Bohr's understanding of apparatus as a set of open-ended practices that assume neither a bounded exteriority (a fixed set of acts) or a unified interiority (a fixed entity without its own diversity) will actually be closer to understanding how the discursive and the material are inseparable. Bodies, both human and nonhuman, then, in her account, are from the cellular level already discursive and material because of the dynamic intra-action of phenomena. Claiming nondeterminacy of discourse, materiality, and the fusion of the two permits a refinement of embodiment that can account not only for a snapshot of a path to the here and now, but also for an endless menu of possibilities for the next step. When soldiers suffering deep emotional distress as a result of combat are cast as embodied entities with discursive-material aspects, processes involving masculine normative expectations of being soldiers and soldiers' experiences of mental and body breakdowns, for example, highlight the infinite possible pathways through which these psychologically wounded soldiers come to be and how their choices get shaped for both immediate and future acts.

In contrast to centering the subject in the body as Barad does, Annemarie Mol (2002), in her ethnography of atherosclerosis, purposefully relocates her bodily notion of the subject in the various sets of relations within which individuals exist. She frames a discussion of subjects, subjectivity, and bodies in terms of two dichotomies: subjects and objects, and subjects as knowers and objects as known (44–50). She maintains that performance, as a concept to describe the identity garnered by the body and the self, though both idealized and material, carries with it a resonance with staging the subject (which then turns into an object), and an idea that success comes only at the end through hard work.[9] Instead, she chooses the verb "enact" to describe what subjects do, with no qualifiers so that the reader can give a fresh interpretation of what lies in her text (41–43). For Mol, coming to terms with pathology of the body alongside

the talk and medical interventions in the outpatient clinic reintegrates the subject and object, and the knower and the known. As she introduces the knowledge embedded in practice into the usual pattern of a physician's medical background and the patient's experience, she is able to show how the spreading of knowledge enacts objects through specific practices (50). One site of enactment for psychologically wounded soldiers is psychiatric practice with all the attendant knowledge embedded within the practice outside the relationship between the officer as psychiatrist and the soldier or officer as patient, including military codes of conduct (punishment for cowardice, medical boarding), medical protocols (on diagnosis, treatment, and understandings of mental illness), combat duty orders (about service and deployment), and individual oaths (conflict between healing the patient and winning a war).

These particular understandings of subjectivity, subjects, discourse, materiality, and bodies frame our feminist notion of embodiment. As a concept, embodiment needs to capture the tension between the specific materiality of *a* soldier's body in a particular place and the discourses and practices that constitute that same body historically and in the present (after Moss and Dyck 2001). For us, embodiment concerns lived-in spaces, generated through webs of power/knowledge, the effects of which are spun around, through, and with each other, where bodies engage in common tasks and routines as well as extraordinary acts and deeds. Because bodies are neither wholly discursive nor solely material, but are both profoundly discursive and intrinsically material, bodies as effects of power have draughty boundaries with undetermined courses of conduct. Much like bodies, these lived-in spaces are objects enacted through repetitive daily social practices that are already drenched in the inseparable discursive-material aspects of thoughts and deeds. Much like the lived-in spaces, force relations too are saturated with integral patterns of the discursive and the material. Conceptually, embodiment ravels together diverse, concrete practices embedded with (and within) specific configurations of power/knowledge that in turn hold a subject's subjectivity in place until the subject is nomadically incarnated elsewhere. As effects of power, bodies populate these spaces and engage in these practices as both materialized subjectivities and enacted subjects.

In relation to weary warriors, using embodiment to frame how an account of soldiers' ill bodies comes into being, how they are treated by the military including by military psychiatrists, and how soldiers heal from and live with ill bodies, entails detailing the sensorial, psychical, and emotional distress combat soldiers encounter during service and demonstrating how various psychiatric, masculine, and military discourses inscribe fleshed bodies with idealized notions of psychiatric illness, soldiering,

and manhood (c.f., Meyer 2009; Roper 2008). We argue that soldiers' ill bodies are enacted as *specific* discursive-material entities in these lived spaces relationally and recursively. *Relationally* various sets of social relationships and webs of power/knowledge (psychiatry, masculinity, and the military) both discipline soldiers' ill bodies and open up spaces of possibilities for action (suffering, learning, healing). *Recursively,* ongoing and repeated patterns of practices (in combat, through convalescence, with coping) and enactment of texts (diagnosis, treatment protocols, and social policy) assemble the contours of the present as much as the reading of the past and the shape of the future. To trace the relational and recursive pathways constituting soldiers' ill bodies with war neuroses, we need to integrate our notion of embodiment into Foucault's analysis of how the articulation of discourses within the power/knowledge configurations work in tandem with other elements in these social relations and practices that produce, as effects, both bodies and subjects. In other words, we need to integrate our notion of embodiment into Foucault's concept of *dispositifs,* or disciplinary apparatuses.

Toward Embodied Apparatuses

Psychiatric Power, a set of lectures Foucault gave at the Collège de France in 1973 and 1974, provides a more nuanced demonstration of the exercise of power through psychiatry as a specific configuration of power/knowledge in the nineteenth century. Foucault draws out the social practices of the psychiatrist within the asylum as well as the acts of those residing inside the asylum. He focuses on the recurrent engagements of the psychiatrist with the mad to show how the exercise of power manages bodies before curing them. The practice of asylum psychiatry entails the psychiatrist repeatedly telling a patient that he or she is ill until that patient embraces this notion as fact. Only when the patient accepts madness can therapeutic intervention begin. The psychiatrist in the asylum demands not only the management of illness, but also the management of all patients' needs as well as the deprivations generated as a result of not meeting these needs. This is but one example of the way in which psychiatric power is practiced in the asylum. Other practices include cold baths, laudanum, and cauterization prescribed on the basis of the etiology of illness (Foucault 2006: 180–81).

Yet it is not just these types of activities that define the asylum as a medical treatment center for the mad. The manner of the patient's initial encounter with the psychiatrist (Foucault 2006: 182), the organization of patients within the asylum according to symptom not disease process

(180), and the visible power a psychiatrist holds over other patients all contribute to the facilitation and reproduction of the potential for discipline by the psychiatrist. What makes the asylum a disciplinary medical space is the omnipresence of the doctor, literally and symbolically. This disciplinary space comes into being not through the content of the knowledge the psychiatrist holds, but through the supplementary power ceded to the psychiatrist because of the formalized medical stamp on that knowledge (184). Disciplinary practices organized as a regime manage and administer the lives of the mad to the point that the reality of the asylum is inevitable, the power of the psychiatrist is realized (173–75, 188). The asylum then is an *effect* of power at the scale of the institution and in the form of exile, and is arranged through the relationships between the subjugated patient's body and the knowledgeable psychiatrist's body (188–89).

Because repeated patterns of the exercise of disciplinary power, or what Foucault calls *discursive practices,* within a disciplinary space like the asylum shift and change according to new ideas, individual preferences, funding regulations, or devaluations of particular types of knowledge, the porous boundaries of power/knowledge are indeterminate and subject to both internal resistance or external influence. Thus, the notion of a dominant knowledgeable body enacting a specific stamp on a disciplinary space as an extension of the institution, such as the medical stamp on an asylum, has waned throughout the twentieth century. With the dissolution of the asylum through mental hygiene reform, the rise of private practice, and deinstitutionalization, psychiatrists' bodies are no longer panoptic institutions in and of themselves. Instead, their bodies effectuate the regulations of a professional association organized around a particular knowledge base. The same is true generally for physicians and surgeons. Even though their bodies represent the institution of medicine, and more specifically biomedicine, by way of hospitals and specialized clinics, the striking institutional practices as seen in the asylum no longer exist.

Foucault refers to both the arrangement of social practices of power within a specific configuration of power/knowledge and the mechanisms through which power is exercised as *dispositifs* or "disciplinary apparatuses" (Foucault 2006: 46–57, 63–87). He defines "apparatus" as "a thoroughly heterogeneous ensemble consisting of discourses, institutions, architectural forms, regulatory decisions, laws, administrative measures, scientific statements, philosophical, moral and philanthropic propositions—in short, the said as much as the unsaid. … The apparatus itself is the system of relations that can be established between these elements" (Foucault 1980b: 194). Apparatuses emerge within specific historical contexts and strategically function to address a societal need—as, for example,

the asylum acting as a repository of the mad and incorrigible children and the public school system addressing the need for socializing children who are under the legal working age. The continued existence of disciplinary apparatuses reflects the flexibility of the relations and patterning among the constitutive elements.

Because of the heterogeneity of any one apparatus, there inevitably is overlap between apparatuses, thus permitting psychiatry, for example, to "plug into a whole series of disciplinary regimes existing around it" (Foucault 2006: 222). Articulation of various disciplinary apparatuses reinforces existing power relations, with one apparatus using the disciplinary stamp of the other to support a host of different social practices. A diagnosis, for example, generated within the disciplinary apparatus of psychiatry often serves as a significant marker in other apparatuses, like the military, to make decisions about individual people. Diagnoses circulate through discourses among various disciplinary apparatuses as plugs, and administrative forms as manifestations of regulations act as the outlets. Commanding officers assess competency for soldiers to return to service according to the existence (or absence) of particular psychiatric diagnoses just as state officials rely on the same diagnoses to determine eligibility of veterans for disability benefits. Masculinity, too, matters in both the assessments of competency and determination of disability benefits. Though not always explicit in the forms themselves, the expectations of manly behavior contradict potential options—that is, lifetime public financial support for mental breakdown while serving the nation.

As an expression of power/knowledge within an apparatus, Foucault's elaboration of disciplinary power leaves more room for understanding the nuances of how power is exercised which, in turn, permits a more flexible view on the productive potential of power, particularly in terms of embodiment. An embodied apparatus does not have to be disciplinary. Because of the way in which force relations are productive and relational, power is both restrictive and liberating (or *potestas* and *potentia* after Braidotti 2002) at the same time. We seek to highlight the materiality of the social practices that produce the elements of an apparatus—indeed apparatuses—without dismissing the impact of discourse as a set of ideas, linguistic practices, and written texts that have regulatory effects. Embodiment is not the anthropomorphized description of the relationship between bodies and other phenomena, such as good citizens, well-trained soldiers, or cured neurotics. Rather, embodiment challenges us to think in terms of bodies being a mechanism of the deployment of power instead of being vessels to carry out a particular discourse or a venue through which an individual can internalize a set of ideas. At the same time, we wish to pull out the discursive aspects of deeply material relationships

between, for example, the state and the soldier, as in pay schedules, disability benefits, and danger pay, and between the body and identity, as in masculine ideals of virility and militaristic accounts of mental health. Just as discourse does not determine individuals' actions, the materiality of the body as ill does not create an undifferentiated subjectivity without social or cultural meaning. Maintaining the simultaneity of materiality and discourse allows the detailing of the relational and recursive aspects of soldiers' concrete actions as well as the organization and regulation of those actions in dealing with the experience of war.

A difficulty in employing the concept of an apparatus is the sweeping way such a widely encompassing concept disconnects subjects from historical processes. Our notion of embodiment provides a framework for noting the specificity of the relationships within an apparatus as well as recognizing the existence of multiple possibilities arising within each configuration of power/knowledge. When thinking in terms of embodied subjectivities, manifestations of distress can be unique to an individual soldier while at the same time being part of a collective outbreak of a group of soldiers at a particular time. As the soldier is not isolated from the same web of processes that the treating psychiatrist is caught up in, the effects of the interaction between the two contribute to the constitution of both the soldier and the psychiatrist as subjects, as well as to the tone of the relationship itself. Something similar could be said of the sets of relations within which the soldier and psychiatrist are positioned, in that these power relations contribute to the framing of the patterns of the relationships of the elements in the apparatus. Thus, the effects of the multiple interactions of relations of power are generating subjects as soldiers, as psychiatrists, or as veterans; so, too, are the material-discursive manifestations of those force relations, such as the architecture of the exhaustion unit, the cultural depictions of traumatized soldiers, and the organization of resistance movements both inside and outside the war theater.

Foucault gets beyond the discursive trap of claiming that processes are socially constructed by reaching into the organization of power relations and their material effects. Yet there is little doubt that thinking in terms of disciplinary apparatuses deflects the analytical focal point away from an individual, body, or subject, toward an analysis of relationships among complex entities, like institutions, professional practices, and discourse of ideal bodies. Keeping the analysis of extreme psychological distress at such a scale cannot capture the subtleties of what actually happens to soldiers during a breakdown in battle, the experience of the breakdown, and the life-changing effects of having broken down in combat. Embodiment, however, refocuses the analysis onto the weary warrior without having to rely on experience as an unmediated event or on the material body as the

only surface on which to inscribe discourse. Broken embodiments frame the way in which weary warriors come to populate these disciplinary apparatuses. Thus, following weary warriors through these apparatuses as they engage the relays, networks, supports, and discrepancies of difference, we come to see the embodied and nomadic aspects of weary warriors as they endeavor to maintain the boundaries of their minds, bodies, and souls.

Tracing Conceptual Paths

Historically psychiatry as a field of study casts a wide net. The mind, the brain, the body, the emotion, the heart, and the soul all come under the psychiatric gaze. The power deployed via psychiatric practice within the military actively enacts illness through the minds, bodies, and souls of soldiers who contend with the effects of combat. Their bodies break emotionally, physically, and psychically, and it is psychiatrists and related mental health professionals who attempt to fix that which is broken. The relational and recursive patterning of military psychiatric practices are the points at which illness becomes shell shock, battle fatigue, or an OSI. These names attached to individual bodies and printed in texts contain embodiments, but not necessarily the embodiments they intend to contain.

In this chapter we have traced our own conceptual path that frames our understanding of the ways in which power and the body figure into the organization of knowledge. In the following chapters, we hold in tension the discursive aspects alongside the material manifestations of the lived-in spaces of weary warriors. Weary warriors are not born, they are made. One of the things that we emphasize is the discursive-material character of not only the relations and interactions weary warriors engage, but also the bodies themselves. The goal of our analysis is to critically explore multiple expressions of embodiment with both individual soldiers and groups of soldiers in order to describe some of the various ways in which mobile fragments of subjects break and come to constitute the weary warrior. To bring specificity to weary warriors, we need to look more closely at ideas of weary warriors that are more conventional. We turn to this task in the next chapter.

Notes

1. The field of poststructural thinking is incredibly wide. We draw primarily on the poststructuralist work of Michel Foucault, and to a lesser extent on the

works of Gilles Deleuze (1990, 1999) and Gilles Deleuze and Félix Guattari (1987).

2. Such philosophers as Fox Keller (1985), Haraway (1989), and Harding (1986) set up the critique of science from feminist perspectives.

3. Three collected volumes of material feminism pieces that show a range of views on materiality from a feminist perspective are Alaimo and Hekman (2008), Delphy (1984), and Hennessy and Ingraham (1997). Material feminism draws on critical theory for some of the thinking about wider structural processes. See Calhoun (1995), Durham and Kellner (2006), Fraser (1989), Held (1980), J. Martin (1973), Miklitsch (2006) and Zoller and Dutta (2008) for general understandings and contemporary applications of the critical theory that inform our framing, including the area of health.

4. Although identified to assist in figuring out how children were disciplined in a classroom, the classification system is still useful for understanding how power is practiced in different settings.

5. See Cantor (2005); Foa, Keane, and Friedman (2000); E. Jones and Wessely (2005a); and Tanielian and Jaycox (2008).

6. With regard to the body, see McLaren (2002) and Sawicki (1991).

7. *Nomadic Subjects* is now in its second edition (Braidotti 2011).

8. This is the case for subjectivities either as effects of power or as categories of positioning to which a subject is attached. A collective subjecthood is still needed for grounding politics.

9. She draws on Goffman's (1959) notion that people perform and present their self in everyday life (Mol 2002: 34–35) and Butler's (1990) notion that people engage in performativity wherein identity is not given but practiced (Mol: 37–39). This referencing by Mol of Goffman's work fits nicely with Foucault's own acknowledgement of Goffman's work on asylums and the social situation of mental patients and other inmates.

Chapter 2

Unsettling Notions

War Neuroses, Soldiering,
and Broken Embodiments

———◆———

> Without the neurotic the mind of man would be stationary. The war may
> teach those who have not already learned the lesson by what slightly
> graded steps the normal differs from what we call the abnormal.
> —Montague David Eder, *War-Shock*

> Over the years, combat psychiatry has evolved from a barely
> recognized entity to a sophisticated science with ramifications in
> every area of military planning. Beginning with the Civil War,
> each subsequent conflict has led to a refinement of treatment
> techniques and has added progressively to our understanding and
> conceptualization of man's ability to deal with the stresses of combat.
> —Peter Bourne, "Military Psychiatry and
> the Viet Nam War in Perspective"

Soldiers subject themselves and their bodies to a whirlwind of activity
when seeking assistance for something that somehow feels broken, or not
quite right. Medical interventions begin once a soldier presents to a physi-
cian, by choice or sometimes without volition, with bodily sensations that
get worked up as symptoms once they are transcribed onto the physician's
notepad. Diagnosis as a practice begins with physicians seeking physi-
cal causes for the manifestation of symptoms first and diagnosing war
neurosis only when there is no physiological etiology. Once a physician
ascribes a specific war neurosis—irritable heart syndrome, battle fatigue,
or mild TBI (mTBI)—as a category of illness, a psychiatrist then prescribes
treatment as a collection of modalities that for many turn into regiments
that structure the organization of daily living. Psychiatry, the military,
and masculinity each play a role in the constitution of ill soldiers and war

neuroses and together set the stage with a specific cast of characters and a script for living as a weary warrior. All three are complex ensembles of values, power relations, and social practices and each can be identified as a separate entity with its own internal structures, practices, and processes that strive to sustain and reproduce in relation to each other; that is, each is a specific configuration of power/knowledge.

The weary warrior is a unique entry point into an inquiry of these ensembles, for it is through psychiatry, the military, and masculinity that the psychologically wounded soldier comes into focus and is disclosed as a subject (Hekman 2010). In its early years of existence, psychiatry as a medical practice focused solely on madness and insanity, leaving neurologists to deal with illness associated with nerves as the visceral parts of bodies. Over the twentieth century, psychiatry extended its purview, taking over the mental (or nonbodily) side of nervous conditions and expanded to include a host of illnesses and disorders related to the mind.[1] Against a backdrop of an ascending dominance of medicine as the way to treat ill bodies, psychiatrists became part of the standing military—that is, psychiatrists were integrated into military service rather than as civilians in service to soldiers, and psychiatry as both a science and a practice became subject to military rules, conventions, and imperatives. Over time, as mental health settled into one aspect of the overall health of the individual soldier, psychiatry, psychiatrists, and psychiatric thinking became more integrated into recruitment efforts, training protocols, and structures of command. Commonly held beliefs about what it means to be a man were part and parcel to the joining of psychiatry and the military, especially as played out through being ill as a result of deep emotional distress during combat. Although hard-and-fast rules do not govern all aspects of masculinity, there are ideas and notions that weeping, cowardice, and breakdowns are not manly, and that stolidity, courage, and control are.

Information about trauma, neuroses, soldiering, citizenship, treatment, disability benefits, and tactical training is useful in order to explore to what extent particular ideas organize possible activities psychiatrists and soldiers engage in. Yet it is not just the ideas we focus on; from information on the same topics, we also examine the arrangement of the mechanisms used for the exercise of power (force relations) as constitutive of the lives of ill soldiers. We can trace palpable effects of psychiatry, the military, and masculinity on traumatized soldiers, including ongoing emotional distress, intensity of symptoms, limited economic opportunities for veterans, and material acts of violence done to veterans in the name of psychiatric treatment.

In this chapter, we make our way through literatures about the use of culture in psychiatry, the military and its practices, and a range of dif-

ferent types of masculinities. We pick at the use of culture as a means to explain illness and psychiatry, and explore some of the ways that culture figures into our own framing. We take up conventional theories of the military and contrast them with oppositional descriptions of power as a way of rereading the military. We also critically engage with the notion of masculinity in a way to trouble stereotypical ideas about men without dismissing them as significant in defining what it means to be a soldier in the military.

Renegotiating the Link between War Neuroses and Culture

One of the difficulties in studying illness, whether at the scale of the individual body or of society, is how to account for differences across cultures. Manifestations of symptoms associated with war neuroses vary from place to place and time to time, nervous exhaustion bringing on epilepsy among Russian soldiers in the Russo-Japanese war, gastrointestinal problems among German soldiers in the initial years of Nazi Germany's advance across Europe, and low rates of battlefield nervous breakdown among American soldiers in Viet Nam in the early 1960s (Binneveld 1997: 97; Shephard 2000: 340; Wanke 2005: 18, 24). Differences could partially be attributed to the way in which psychiatry was being practiced in these particular places. In Russia, military psychiatry focused on the neurological aspects of mental disease producing a materialist bias far exceeding the type of psychiatry being practiced elsewhere at the time. After the Second World War, German psychiatrists maintained that they had put into practice the lessons learned from the Great War, and thus used military discipline to halt the creation of neurotic soldiers in combat. For American soldiers, the increase in the number of psychiatrists serving in Viet Nam, the twelve-month service rotation, and a general state of high morale were credited as having kept low rates of combat fatigue in the early years of the war.[2]

A limitation in the existing literature on war neuroses is the consistent use of culture, in various guises, as an *explanation* for differences in the manifestation of neurotic symptoms among soldiers and veterans. There is no place other than in analyses of hysteria that culture stands out as the root cause of illness. In the formidable sea of writing about women's hysteria, Elaine Showalter's body of work is the most recognized and popular contemporary scholarship on the topic.[3] Her interpretations of the work of Jean-Martin Charcot, Josef Breuer, and Sigmund Freud form the basis of a feminist critique of hysteria based on two premises: that hysteria is a cultural construct arising out of women's social circumstances, and

that women even in hysterical states can speak for themselves. In France, Charcot (1987) legitimated hysteria as a range of bodily manifestations of psychological distress, which for him was in part hereditary and in part psychological. Although maintaining that hysteria was predominantly a female condition, Charcot argued against hysteria being solely a female problem; the causes of hysteria, however, differed for males and females.[4] In Austria, Josef Breuer and Sigmund Freud ([1905] 1997) introduced, and for the most part developed, psychoanalysis through famous case studies, including those of Anna O. and Dora.[5] Their work on theorizing the unconscious through "talk therapy" solidified the link between hysteria and sex by making the singular cause of hysteria a psychological conflict over a sexually traumatic incident (Freud [1905] 1997).[6] Freud attempted to outline a theory on male hysteria to a professional audience of psychoanalysts who were simply not interested (Showalter 1993: 290). That hysteria was primarily attached to women's bodies changed drastically at the onset of the Great War with soldiers presenting with what doctors at field hospitals saw as hysterical neuroses. Even though psychiatry on the whole recognized male hysteria, it was not a popular diagnosis, not the least of which because hysteria implied an effeminate way of being and seemed to be linked to homosexuality and sexual impotence (Showalter 1985: 171–73). This movement from women's hysteria to warrior's neuroses waned once the war ended, with military psychiatry severing men's war trauma from women's maladies.

Showalter maintains that ideas about hysteria as an illness made great strides in Charcot's and Breuer and Freud's times, if for nothing else because of the break with the biologically deterministic role of women's reproductive system (which had been the prevailing medical view before Charcot). Her criticism of this work lies with the dismissal of other social circumstances that lead to hysteria and further reinforce the restrictive pillar of sexual repression, thus providing welcomed cultural support to a patriarchal society. Showalter maintains that after the end of the Great War women knew better than men about shell shock because they knew how powerlessness can lead to pathology (Showalter 1985: 190). She also argues that the soldiers and military psychiatrists, even the most sensitive ones, were so firmly ensconced in patriarchal culture that they could not see the true meaning of hysteria.

What is problematic with Showalter's focus on culture to explain the manifestation of war neuroses is that by using socially constructed cultural concepts that organize bodies (patriarchy) as causes for other socially constructed cultural concepts that describe the experiences of bodies (hysteria), she fails to identify a material basis to hold the concepts in place. Showalter repeats the same weakness when she applies the same

argument she developed for understanding war neuroses among male hysterics to Gulf War Syndrome (GWS), which she calls a contemporary collective expression of hysteria, some seventy-five years later (Showalter 1998: 133–43). Even though GWS arose in a different era from the era in which shell shock arose, among different social and cultural circumstances, Showalter reiterates that soldiers presenting with somatic illness can only be a response to a collective cultural narrative that renders material differences in the bodies of ill soldiers as mere physical expressions of emotional trauma—that is, Gulf War veterans clamoring for the recognition of GWS are the same as the male hysterics from the Great War. Yet in contrast to mutism and other forms of paralysis indicative of male hysteria among soldiers during the Great War, GWS veterans present with skin rashes, headaches, fatigue, burning semen, anxiety, respiratory ailments, and birth defects in their children born after the war.[7] Bodily differences do not count in her analysis. Her grip on culture remains tight, and as a result she reinforces the need for the power of psychiatry as a medical configuration of power/knowledge to silence soldiers' stories of their own ill bodies that link deleterious effects of their bodies to toxic vaccinations and depleted uranium, and that ends up bolstering the moralistic imperative that these suffering soldiers would be better off with a psychotherapist and not another medical test.

In contrast to Showalter's use of culture as an explanation for the widespread onset of bodily symptoms, the practice of military psychiatry during wartime uses culture to explain differences in dealing with soldiers presenting with symptoms associated with war neuroses. Culture can be used to explain differences at a very fine scale, such as the professional practices among a group of military psychiatrists. In Britain during the Great War military psychiatrists were apt to describe war neuroses differently depending on the rank of their patients, a practice that led to variations in treatments offered. Officers suffering traumatic neuroses and treated at Craiglockhart Hospital near Edinburgh had recorded in their medical notes vaguer descriptions of symptoms than the rank-and-file soldiers treated at Maghull Hospital near Liverpool—fatigue, depression, lapse of memory versus loss of speech and hearing, paralysis, fits, and hysterical gaits (Leese 2002: 85–102, 103–20). At Craiglockhart, psychotherapy or the talking cure was the favored choice of treatment; at Maghull, electroshock therapy was more prevalent (Leese). Culture also can refer to the organization of military practices in the treatment of traumatized soldiers. In Nazi Germany, the low rates of mental breakdown among combat soldiers in the latter part of the 1939–45 war have been explained in terms of extreme military discipline—that is, the execution of an estimated 15,000 young men in the last two years of the war who had

cried, showed cowardice, tried to leave the battle, or broken down in any other way (Shephard 2000: 305).

These various uses of culture to explain particular aspects of the psychologically wounded soldier tend toward being culturalistic explanations of individuals. Culturalistic explanations use an aspect of culture as the direct *causal* link for a particular action (a specific diagnosis used by a group of physicians at a particular hospital; low rates of mental breakdown being the result of military disciplinary policy), a symptom (mutism among the rank and file because they are unable to speak against their leaders; an issue civilians are grappling with being introduced into military contexts, such as sexual repression being sublimated or irrational fear of toxins causing rashes), or a treatment (materialist bias in Russian psychiatry focus on organic processes, psychotherapy preferred by Western psychiatrists).

Determining a causal link between some aspect of culture and onset of war neurosis is not always straightforward. Culture, when invoked as explanation, glosses over complex processes of the constitution of the materiality of meaning. Edgar Jones and Simon Wessely (2005a: 192) claim that by drawing on Clifford Geertz's (1973) definition of culture as "systems of meaning" as "learned patterns of behavior and thought," "functional disorders are prone to its effects in terms of symptom identification, labeling, explanation and treatment." Besides oversimplifying Geertz' notion of culture, they set up a direct link between culture (as a set of learned behaviors) and the malfunctioning of soldiers' bodies. Rather than exploring the learned patterns of behavior and thought within military psychiatry, they identify the psychiatrist as the medium through which a set of nonmedical ideas enter into the clinical encounter that the individual psychiatrist as clinician then acts on in some manner. For instance, they claim that disordered action of the heart did not "go away" and was actually reintroduced after the Great War as "effort syndrome" by cardiologist Sir Thomas Lewis of Mount Vernon Hospital. They argue that in lieu of his organic rationale for disordered action of the heart in his early work, Lewis (1920) chose a psychogenic diagnosis for effort syndrome in 1940 because psychiatry—as a cultural practice, not as an effect of power— "eclipsed" organic models for understanding soldiers' irritable hearts (E. Jones and Wessely 2005a: 194).[8]

Edgar Jones and Simon Wessely (2005a) go even farther with their claims about how war neuroses are linked to culture, and use it to explain how diagnosis relates to the incidence of illness. They maintain, "it remains conventional wisdom that as psychological *enlightenment* spread during the twentieth century, psychiatric models for unexplained symptoms gained ascendancy over more *intellectually suspect* organic claims"

and that "[t]he former popularity of the [hysteria] diagnosis was a cultural phenomenon, which may be unrelated to *real* changes in the incidence of hysteria" (196; emphasis added). They relegate the medical practice of diagnosis to the cultural sphere and hysteria to the realm of mental illness, while at the same time claiming that hysteria is a psychiatric disorder without organic genesis. They support their argument by showing how nonulcer dyspepsia prevalent during the Second World War among British troops and the exposure to toxins for soldiers during the Gulf War were effects of popular health concerns among civilians being transported into war theaters (198–99). They argue that contemporary fears of gastrointestinal illness among urban dwellers during the Second World War, and later the impact of phosphates, pesticides, vaccinations, and radiation in everyday understandings of the body and the environment during the 1990s influenced the ways in which soldiers presented symptoms and came to tell their stories of illness.[9] They conclude that these illnesses were merely conversion disorders. What is significant in all these claims that Jones and Wessely make is the use of culture as an authoritative justification for the wielding of psychological explanations of soldiers' ill bodies.

Culture can also be called upon to explain individuals themselves, especially in terms of a set of collectively held cultural values inscribed onto the body. Masculine notions of soldiering, for example, though multifaceted, generally include some form of camaraderie and loyalty among themselves and fellow soldiers, chivalry toward the vulnerable, obedience to authority and nation, bravery in battle, and fitness of the body—in short, the honorable warrior (Ignatieff 1998). Such masculine values of soldiering usually exclude any and all moral and physical weakness, except for wounds resulting from acts of bravery. As an ideal, these notions shape the context within how soldiers come to understand themselves as soldiers. With regard to illness, a general understanding of a set of cultural values as part of masculinity and as part of the military can explain the general tenor of how illness is integrated into soldiers' identities. However, culture in this sense cannot explain either the individual or the collective body (the antebellum, Victorian, or Jazz Age body in the United States, or the Biedermeier, Weimar, or Nazi body in Germany) or the specificity of a symptom (paralysis, memory loss, diarrhea, flashbacks, or outbursts of violence). Arguments based on culturalistic premises also support naturalistic framings of bodies. In further discussion of the impact of culture in the ascription of diagnostic categories on soldiers' ill bodies, for example, Jones and Wessely conceptualize culture as an entity separate from the military practice of medicine and psychiatry and come to the naturalistic conclusion that "war syndromes are one more phase in the continually evolving picture of man's [*sic*] reaction to adversity" (208). Undoubtedly,

these types of explanations tend to reduce individuals to strands of form-less thoughts, positioned as mere points in a wider trajectory of history.

Works that draw on culture to explain aspects of the ascription of a war neurosis onto a soldier's body are even more problematic when claims rest on the assumption that psychiatry and the military either are outside culture or should be immune to the effect of cultural values and practices. Psychiatry over the past century has increasingly dealt with the biologi-cal basis of mental illness, with brain science being given more credence, respectability, and authority to explain the mind. However, even though psychiatry is a discourse about biological and physiological processes, it remains a body of knowledge that is sustained by practices regulated by a professional body, and as such is (a) influenced by other discourses and bodies of knowledge and (b) not anchored in any way to the mind as a physical entity. Moving toward a more science-based psychiatry, free from cultural values, further reinforces a naturalistic view of illness based on culturalistic practices. Thus, when Jones and Wessely (2005b) claim that war syndromes should be categorized as medically unexplained symp-toms, they are actually pulling all soldiers' bodily sensations into a psy-chiatric discourse that endorses one particular way of understanding the body and the mind—in biological and physiological terms.

Breaking away from a culturalistic grounding in accounts of situating war neuroses entails renegotiating the link between illness and the process of creating weary warriors. So, in lieu of unscrambling the influences af-fecting symptoms, diagnoses, and treatments of psychologically wounded soldiers in cultural terms, one could focus instead on how weary warriors come to be—both conceptually and in practice. Claiming culture as some-thing needing explanation rather than invoking it to explain war neuroses takes seriously the notion that weary warriors are not culturally specific. Illness is not determined by culture, nor is it merely influenced by cultural values. Accepting that illness is not simply a breakdown, malfunction, or defect in or of the body means looking farther afield at how bodies de-velop, sustain, and live with illness within and across various cultures. If illness itself is something that cannot exist outside multiple sets of social relations, then tracing the articulation points of culture and the ill bodies of soldiers with ravished minds can show how cultural explanations are *effects* of the circulation of power and knowledge.

Soldiering as an Institution

By engaging theoretically and empirically with military institutions, we maintain that there is both more and less to military institutions than

meets the conventional gaze, especially with regard to what constitutes soldiering. We are drawn to question the model of military establishments depicted by most of the literature over the past century or so as a set of stable, formal structures that wield sovereign power. The actual functions and lived effects of the military in the arena of military psychiatry for emotionally traumatized soldiers—rather than only, and simply, the official claims and institutional-centric portrayals of military establishments—are significant. We reject the conception of soldiers as static machines, instilled with a set of national and civic values, trained to obey orders, and invoked as needed to sustain the state, as too one-dimensional, and instead probe for additional effects and multiple meanings of both the military and soldiers.[10] Similarly, we reject the assumed self-evident solidity of the military, and prefer to look for unstable identities, changeable social practices, and fluctuating relationships.[11] By looking at fluidity and diversity within military establishments, we are not rejecting the realities of state coercion, formal authority, and prescribed hierarchy. Rather, we are building on and engaging with these highly visible actualities because we are interested in identifying processes and techniques that constitute soldiers in relation to often contending domains of psychiatric knowledge and in relation to particular historical periods and cultural settings, technological innovations, and military contexts.

The idea that the military is a human machine rests on a history of organizational studies and social theories that include bureaucratic rationalization and domination, classical leadership and management studies, a scientific view of war and systems analysis for military operations (with constructing scenarios and applying game theories), official war histories, and new public management, especially in our contemporary age of neoliberalism (Becker 1998; Morgan 1997; P. Smith 2008). The machine imagery is longstanding in the social and natural sciences, an image that "works best when the social world acts in a very repetitive way," or when those in control desire an environment or organization to operate in a systematic and predictable manner (Becker: 40). The emphasis, with this mechanistic imagery, is on a system organized around hierarchies and formal positions, around a legal-rational administration in which behavior is rule-based, and around a narrative tradition that highlights leaders and downplays the rank-and-file. This emphasis is especially apparent in military history.

Five dimensions characterize the machine-like nature of the military. First, in recent centuries the need for a close alignment between the nation-state and sovereign power has led to the institutionalization of coercive powers. Historically, in empires and kingdoms, militaries were tied to "the consolidation of power by national monarchs who felt the need for

permanent military forces to protect their dominions and to support their rule" (Huntington 1957: 21). In more contemporary times, militaries are integral to the modern state that, as Max Weber argues in his definition of the state, is "a compulsory organization with a territorial base [where] the use of force is regarded as legitimate only so far as it is either permitted by the state or prescribed by it" (M. Weber [1922] 1968: 56). The modern military is thus inextricably linked to the legitimate coercion of the state; military force is lawful force. Morris Janowitz (1960) elaborates on this fundamental dimension: "The unique character of the military establishment derives from the requirement that its members are specialists in making use of violence and mass destruction" (200). As an institution for the exercise of state-sanctioned force, the military must "maintain combat readiness [and be] prepared to fight effectively and immediately" (201).

Second, modern militaries are professional militaries, a phenomenon with origins in the Prussian army of the early 1800s (Huntington 1957), if not earlier. John Keegan (1976: 63) writes of post-Renaissance armies, "from the seventeenth century onwards, it is Roman military practices—drills, discipline, uniformity of dress—and Roman military ideas—of intellectual leadership, automatic valour, unquestioning obedience, self-abnegation, loyalty to the unit—which are dominant in the European soldier's world." A new and conspicuous branch of knowledge regarding warfare and militaries, symbolized by the work of Carl von Clausewitz in the 1830s, articulated a scientific view to war and combat, prioritizing the professional status of the military. Alongside the emergence of the officer corps and military education was the conscription of men, producing a shift from "the temporary citizen, soldier, sailor, and aviator [to] professional armed forces" (Janowitz 1960: 204).

Third, military institutions are elaborate bureaucracies; they are large, complex systems of interrelated branches and divisions with an overall functional *unity* of command. With formal structures organized on the hierarchical principle that higher-rank officers supervise and order lower-rank officers and enlisted men, militaries contain elaborate regimes of rules that determine the roles, statuses, and actions of all personnel. In comparison to other formal organizations in contemporary societies, the military has a high degree of differentiation in functions and of stratification in positions and formal status. Structures are real, in this understanding, entailing controls and constraints, with a primacy over the actions and choices of the actors who populate military structures. Military establishments also have a high degree of expected conformity to the norms and values of the armed forces. Even more than bureaucracies, *militaries are institutions*. Institutions, as theorized in organizational sociology, are a more developed form of complex organizations in society by "develop[ing] an

inner logic and direction of their own" encouraging a well-defined identity and recognition as a special depository of cherished social values and exercising considerable autonomy (Perrow 1986: 176).

Fourth, military institutions spawn cultural systems with their own configurations of practices and rituals, histories and critical events, heroes and villains. More-particular sets of beliefs and values—military subcultures—are recognized to operate, and are officially encouraged to persist within the navy, army, air force, marines, merchant sea, and special forces branches. As mini-societies, they contain their own personnel, courts, police, rules, housing, health care, and education services. They constitute a symbolic universe of distinctive values, beliefs, vocabularies, ideologies, and outlooks on the world (English 2004; Freeman 1948; Huntington 1957; Janowitz 1960; Jenkins 2004; Spindler 1948); this universe is also known as a total institution that is relatively closed and disciplinary in nature. Erving Goffman (1961), from a less structural viewpoint than the ones elaborating the bureaucratization of the military, coined the term "total institution" to describe organizations in which the everyday spheres of work, sleep, and play occur in the same place, with the same coparticipants, and under the same authority and staff surveillance. Goffman suggests that military academies and induction centers, naval ships and air bases, army barracks, concentration camps and POW camps, as well as military hospitals and treatment centers resemble total institutions in the way in which they organize everyday life.

Fifth, the relationship between the military and civil society is fraught with tension. As Samuel Huntington (1957: viii) expresses it, "the formal, structural position of military institutions in the government [raises the issue of] objective civilian control" over this system of force and authority. If the prime intended beneficiaries of military organizations are the citizenry, then "the crucial problem posed … is the development of democratic mechanisms whereby they can be externally controlled by the public" (Blau and Scott 1962: 42). At the height of the Cold War, alongside the alarm over the military-industrial complex, the military's relationship with civil society came under heavy scrutiny with much attention given to the existence of a separate political system within a state. More recently, even with the declared end of the Cold War in 1989, issues of civil-military relations remain a serious issue for military leaders and scholars across nations (Charters and Wilson 1996).

These five dimensions sum up most social science literature on military, focusing on institutional distinctiveness, internal cohesion and discipline, and the apparent stabilities of command structures and functional continuities in actions over time. Yet our refusal to view soldiers and the military as static entities forces us to turn to competing understandings that

emphasize fluidity, porosity, aberrations, and multiplicities, like those in Foucault's concept of power/knowledge. Even so, Foucault himself was not immune from the tendency to assume these dimensions in his references to the military in his own work.

On many occasions, Foucault wrote or spoke about the military far more like a structural functionalist than one might expect, describing the military as a set of coherent hierarchical arrangements of force relations, together with a discursive logic of strategies, commands, and tactics, built on a juridical notion of power tied closely to national sovereignty, and to civil and international law (Foucault 2003). From this perspective, military institutions are constitutional systems of domination, organizations of right and might, repressive powers with single centers of legitimacy and control, with "the professional and technical prerogatives of a carefully defined and controlled military apparatus" (Foucault: 267). Recruits are selected, trained, and disciplined to be capable, dedicated, and obedient within highly formalized, rigidly hierarchical, and explicitly nationalistic structures in order to produce strong identifications to the unit and overall institution through feelings of camaraderie, duty, and patriotism.

Foucault argued that most studies of institutions focus on the overall structures and the people who rule them or on the ideologies developed to legitimate their existence, activities, and resource claims. He preferred, however, a third approach, investigating "the techniques, the practices that give concrete form" to the institution and the political rationality embedded in the strategies and processes of a given institution, whether an asylum, hospital, or prison (Foucault 2000b: 410). But he did not identify the military as a social institution in need of investigation. In other work, Foucault (2007) offered analytic guidelines for studying major social institutions. Institutions as such were not the prime focus of analysis for Foucault; instead he conceived them as mechanisms of conduct and effects of power. He recommended going behind the institution and seeking, in a wider perspective, what he called a technology of extrainstitutional power; querying the internal function officially expected to be performed and, instead, examining the actual functions linked to external factors; and detaching the relations of power from a given object and examining those power relations from "the perspective of the constitution of fields, domains, and objects of knowledge" (Foucault 2007: 118). Likewise, we do not endeavor to write a history of the military, psychiatry, nor how masculinity fits into either; rather, we attempt to unravel regimes of discursive and material practices concerning the ill bodies of soldiers as constituted in the military through psychiatry; both these institutions are embedded within and informed by various understandings of masculinity.

During what turned out to be the final decade of his life (1975–84), Foucault turned his research attention to matters of war, struggle, and the army.[12] As the intermediary between war and civil society, Foucault (2003: 159, 163) saw military institutions as having general effects on the whole society through developments in medicine and teaching clinics and, in regards to "the distribution of weapons, the nature of weapons, fighting techniques, the recruitment and payment of soldiers, [and] the taxes earmarked for the army," as having implications for "the economy, taxation, religion, beliefs, [and] education." He wrote also about the "military dream of society," an ideal type of discipline that emerged in the 1700s, with "its fundamental reference … to the meticulously subordinated cogs of a machine … to permanent coercions, to indefinitely progressive forms of training, and to automatic docility" (Foucault 1979: 169). In a view of history undoubtedly influenced by Machiavelli, Hobbes, and Nietzsche, Foucault stated, "Humanity does not gradually progress from combat to combat until it finally arrives at universal reciprocity, where the rule of law finally replaces warfare; humanity installs each of its violences in a system of rules and thus proceeds from domination to domination" (Foucault 1977: 151). Here Foucault is making a claim, one with deterministic overtones, that a persistent militarism exists supported by the ongoing militarization of culture, economics, and politics in our age (Cowen 2005; Enloe 1983, 2000, 2007; Shigematsu and Camacho 2010a).

This deterministic approach appears in Foucault's general tendency to describe the military in mechanistic images and in terms of sovereign versus disciplinary power. While Foucault called for analyzing the tangible functioning of institutions and acknowledged that technologies of discipline never quite work out as planned, he repeatedly refers to armies and military institutions as "a manifestation of force, … the physical, material and awesome force of the sovereign, … [and as] a precise system of command" (Foucault 2000c: 232) . In comparison with other institutional fields of action he examined—asylums, sexuality, and prisons are clear examples—Foucault never saw the military as an institution in and of itself with people and processes or an entity in need of analysis. For Foucault, the military as an institution is a "crystallization of diverse programs, technologies, practices, mechanisms and strategies" (232) that in turn "inform individual behavior" (232) and "act as grids for the perception and evaluation of things" (232). Foucault's threefold types of power—sovereignty, disciplinary, and governmentality—were not broadly employed in understanding militaries or the military as an institution. There is a surprising reliance on the legal and constitutional powers of the body politic as repressive and negative (Wickham 2006) and, to some extent too, a reliance on disciplinary power as subjection. With a heavy emphasis on

official practices and systems of authoritative discipline, bodies then were produced as static and monolithic. In this way, the military as an institution works to "produce permanent and solid effects that can perfectly well be understood in terms of their rationality. … This is what gives the resulting apparatus its solidity and suppleness" (Foucault 2000d: 23). And so is the case with soldiers. Yet apparatuses are fluid entities formed through various articulations of force relations and informed through both material processes and competing discourses that produce only the appearance of being solid and supple.

In a similar fashion, Foucault habitually depicted soldiers in mechanistic terms as docile bodies. He emphasized macrostructures and top-down power relations rather than the relational approach to the microphysics of power elaborated on in his other writings.[13] Docile bodies are subjected and practiced entities, with increased aptitude and utility along with increased submission and domination. The docile body is subjected to various techniques of control designed to transform the human body (gestures, behaviors, and self-awareness) to instill certain qualities and skills, and above all what we may call productive obedience for use within machineries of power, such as schools, factories, hospitals, and, of course, armies. In a military context, docile bodies are produced through processes of recruitment and screening, basic training, socialization and indoctrination, exercises and drills, plus other practices, all the while under close surveillance. The soldier is "a sort of machine with many parts, moving in relation to one another, in relation to arrive at a configuration and to obtain a specific result" (Foucault 1979: 135). Being both an object and target of power soldiers are produced to be compliant bodies as well as practical bodies. From training, marching drills, and command structures of militaries comes the "body-weapon, body-tool, body-machine complex" (153).

In a careful assessment of the docile body thesis from a feminist perspective, Monique Deveaux (1994) identifies as pitfalls the reductionist and static conception of the subject and power. She writes, "Foucault's extreme reluctance to attribute explicit agency to subjects in this early account of power results in a portrayal of individuals as passive bodies, constituted by power and immobilized in a society of discipline. Significantly, this analysis gives way, in Foucault's later works, to a more complex understanding of power as a field of relationships between free subjects" (228). Basically, Foucault failed to take his own evolution in thinking on power and the body, and apply it to the military and to soldiers. In addition, the distinction between the body and the soul or psyche, which Foucault proposed in some of his works, remained underdeveloped and certainly never applied to military contexts.[14] The promise of Foucault's approach to the military, though unfulfilled, is worth undertaking along analytical

lines of poststructural inquiry for examining soldiers suffering distress in or after combat. We do not try to describe or explain war neuroses, ill soldiers, and broken bodies in terms of a single universal narrative. Instead, in our poststructural approach to the military and weary warriors, we examine multiple practices, consider resistance, and move away from an institutional-centric view, just as Foucault counseled. We go beyond Foucault's work by tracing specific points in the military of how ill bodies of traumatized soldiers are produced, processes that challenge the conventional images of the military as stable, closed, and formal systems. In the later years of his work, Foucault wrote about people as living, thinking beings, ideas suggestive of soldiers as active, self-reflective subjects. And while Foucault tended to present military establishments as purposefully coherent and systematic organizations, he also advised students in his lectures that such structures mask confrontations and subjugate knowledge; that is, structures stifle awareness and understanding from those below, those at lower ranks in an organization, and those deemed unqualified by leaders or experts to speak with credibility on particular issues. For us, the idea of subjugated knowledges masked by seemingly fixed structures fit the experiences of shocked soldiers, traumatized veterans, fatigued pilots, exhausted troops, and their emotional struggles in combat and memories of battles. For us, it is crucial to imagine the individual soldier or veteran not as a docile body that is solely the effect of disciplinary mechanisms, particularly ones in the military, but rather as an embodied self constituted by material and discursive forces within a given power/knowledge configuration.

Ravished Minds and Broken Bodies

Scholars and researchers interested in war neuroses tend to address psychological wounds either through medicalized understandings of the mind—that is, via psychiatry and psychology—or through the context within which a war neurosis as a set of unsettling bodily sensations is experienced—that is, the military. Even if indeed primary, psychiatry and the military are not the only ensembles of discourses, materialities, and practices that shape soldiers' experiences of psychological wounds. Masculinity, too, has a dramatic impact on the ways in which weary warriors express illness and engage with psychiatry in the military, and beyond to other social institutions, to seek medical advice. Weak, sick, and ailing bodies contradict the masculine ideal of soldiers' bodies being strong, healthy, and energetic, and set up ill bodies as unreliable, gutless, and fallible, not worthy of being soldiers, not worthy of being men.[15] Women,

too, are subjected to these masculine ideals. Because military training in most Western countries rests on specific ideas of manhood as tough, virile, and honorable, for example, ill bodies by definition cannot be soldiers (Goldstein 2001; Huebner 2008). A soldier becoming ill after suffering deep emotional stress during combat questions the very constitution of a warrior.[16] Such readings of the discursive links between masculinity and soldiers' ill bodies cannot account for deviations, contestations, and transformations of relations and practices within psychiatry, the military, and masculinity itself. The challenge becomes one of recognizing masculinity as part of the constitution of a warrior without using it, or its breakdown, to explain the existence of weary warriors in the military.

Studies of men have coalesced into a field of study over the past thirty years or so. The field itself has shifted toward understanding masculinity rather than focusing on men. Key to understanding men's studies is the concept of masculinity that has undergone various conceptual shifts over time. Most prominently, masculinity has been conceptualized in three different ways: as a patterned hegemony, a cultural ideology, and a gendered performance (see Reeser 2010; Whitehead 2002).

Robert Connell, for example, suggests four general patterns of masculinity in Western society: hegemony, complicity, subordination, and marginalization (1995: 77–81).[17] Connell's model casts men and masculinity as social constructs, with a hierarchical organization of multiple ways of being a man and producing the identity of man. The dominant conception of masculinity, the hegemonic one, is at the top of the hierarchy and describes the organization of gender relations as the support of a patriarchy that subordinates women. The latter patterns exist in relation to the hegemonic pattern within any given context; each pattern serves to maintain the hegemony of one particular type of masculinity. Men may choose to do their gender in a way to make them appear normal (complicity), while gay and bisexual masculinities are marginalized and nonwhite masculinities subordinated. In effect, the classification structure could be applied anywhere when there are various masculinities subordinate to a dominant masculinity; it is only when manhood, manliness, and men are attributed specific characteristics that specific masculinities emerge. In a Western hegemonic masculinity, men's identities are valued over women's, white identities over nonwhite, heterosexual identities over homosexual and transsexual, aggressive identities over passive, and able bodies over bodies that are impaired. The idea of a hegemonic masculinity means that heterosexual aggressive white men are advantaged, even when not all men and women engage in practices of hegemonic masculinity, because a hegemonic masculinity entails men's subjugation of women, nonwhites, nonheterosexuals, and passive identities.

In contrast to Connell's conceptualization of masculinity as a patterned hegemony, John MacInnes (1998) favors understanding masculinity as a cultural ideology, or a system of thinking about behavior (and of behaviors themselves) that serve the interests of a dominant group. This use of ideology emerged to describe the hegemony of one class over another, which, as Sara Mills puts it in *Discourse* (1997: 30), entailed one class being "duped into using conceptual systems which were not in their own interests." MacInnes argues that the notion of masculinity emerged as a process of socialization at the advent of modernity in order to maintain inequalities between men and women. Rather than being built on biological claims about men being superior to women, claims that were popular at the time, masculinity as a cultural ideology could eschew sexual difference as the basis for which to differentiate women and men in society and could rely on the social constructed nature of gender to support the subordination of women, reproduce the sexual division of labor, and sustain men's privilege in society.[18] Like Connell's use of hegemony in understanding various forms of masculinity, MacInnes also relies on a model of dominance to explain how masculinity retains value and privilege at the expense of women.

Distinguished from being either a patterned hegemony or an ideology is the notion of masculinity as a gendered performance. As Judith Butler (1990) argues, gender identity, including masculinity, is a cultural construct invoked to maintain heterosexual desire by defining what is feminine and what is masculine. Individuals *perform* gender in accordance with what is culturally accepted to be indicative of what women and men do and how they are to act as women and as men. Because masculinity when performed is a social construction that does not rely on biology as the basis for manhood nor on ideology as the glue that holds identity in place, the focus of masculinity is more on the doing, rather than the being, of manhood.

These views of masculinity are readily apparent when looking at the military, especially in terms of training. Following Connell, if the practice of training warriors in the military were organized around a set of values that sustain an idealized form of masculinity, then the threat of the feminine and the homosexual would become central in the maintenance of that hegemony. Reinforcement of masculine qualities in training techniques takes place through routine humiliation tactics, such as a drill sergeant calling recruits ladies, girls, fags, and homos, names that serve to emasculate recruits; and group sanctioning practices, such as the threat of rape or rape itself, for those whose behavior is somehow out of synch with the others, in attempts to force peers to adhere to the (for the most part unwritten) warrior code. These techniques are also used with

female recruits (Francke 1997). In tandem with MacInnes (1998), if masculinity were conceived as a cultural ideology, it is easy to see how training recruits by invoking hypermasculine values parallels the creation of nationalist ideologies through the identification of military heroes, both of which sustain masculinity culturally as something needing to privilege men in settings even beyond the military (see Dawson 1994). Butler's idea of masculinity as a gendered performance is apparent in the training song, "This is my rifle, this is my gun; this is for fighting, this is for fun," with the recruits holding their rifles in one hand, and grabbing their crotches with the other.[19] Through these types of repetitive acts, soldiers are set up to perform their military identities in specific ways.

Yet all these conceptual frameworks for masculinity preserve the relatively tight links between men and masculinity and between women and femininity by framing masculinity in opposition to femininity, and men's identities in opposition to women's. This is even the case with performativity, whereby performative acts assume empirical bodies. Studies juxtaposing women with masculinity and men with femininity expose how concrete bodies are presumed to be a certain way. As soldiers, women's bodies are a rich site for exploring the presumed links between masculinity and male bodies because women are not expected to be located in male institutions like the military. Annica Kronsall (2005) looked at Swedish women in the military to sort through how a hegemonic masculinity actually works. She argues that the norms of the institution appear more clearly through the comportment of female officers when wanting to be seen as a member of the military rather than as a woman. As well, the toning down of sexualized language and the ridding of the armed forces of pornography, both of which challenge the militarized link between sex and violence, reveal how the very presence of women in the military alters how the hegemony of masculinity works. Kronsall's argument supports the idea that hegemony is a process that is never complete, is subject to resistance, and is flexible in the production of masculinities in the military.

These conceptualizations of masculinity also tend to keep out other types of discourses that effect complex identities. For example, the militarization of masculinity describes the process through which notions, ideals, and expectations of men's behaviors generally are linked to globalization, war, and the military, particularly in the context of nation-building and national identity. Cynthia Enloe examines militarized masculinities in her work on globalization and international relations (Enloe 2004, 2007). She argues that masculine ideals have to include the delineation of feminine ideals and that the national identities of men and women are judged by these ideals. In her extended example of Serbian militias, militarized versions of masculinities, when embedded within the context of nation-

building, cast women as mothers-of-soldiering-sons, as making maternal sacrifices for the sake of the nation (Enloe: 106–9). While the idealization of (younger) women as Serb soldiers in service of the Serb nation contradicts mothers-of-soldiering-sons, Enloe maintains that the mothering ideal is stronger and therefore takes up a more prominent positioning of defining femininity.

Even though the conceptualizations of masculinity variously as a patterned hegemony, an ideology, and a gendered performance attempt to separate bodies from concepts, the conflation between bodies and concepts is reproduced in empirical studies about masculinity in the military. In both Kronsall's and Enloe's works, women as part of a militaristic understanding of the world are inserted into a male institution, both literally and symbolically, to draw out how a hegemonic masculinity works on the ground. But both interpretations of women's bodies in these settings remain tied to expectations of how men's bodies look and behave. Women change their comportment when called upon to be an officer to a normative demeanor, one closely resembling that of a male officer. The idea of integrating women as mothers-of-soldiering-men as integral to the reproduction of the nation keeps women's bodies out of masculinity and aligns them firmly as a definition of femininity. In addition to the strength of this definition of femininity that Enloe notes, the woman as soldier threatens the definition of masculinity in that there is too much overlap between possible acts and expectations of men's and women's behaviors.

This conflation of concepts and bodies is further enhanced when layered with culturalistic understandings of soldiers suffering mental breakdown or nervous exhaustion in battle. Although scholars, particularly feminists, have sought to highlight the gendered nature of the structures of the military, militarization, and globalization, less attention has been paid to the link between traumatic stress issues and masculinity. Two exceptions are Sandra Whitworth's (2008) examination of masculinity and PTSD and Susie Kilshaw's (2009) anthropological reading of GWS. Whitworth argues that the presence of war neuroses lays bare the foundation upon which militarized masculinities are based. Through a gendered analysis, she explores the rites, myths, and training that constitute the recruit as a warrior, and argues that because of the differential rates of PTSD among women and nonwhite men, PTSD appears to stem from cultural norms rather than combat per se. She makes the case that for men, PTSD arises from the failure to live up to the standards of the military's expectations of manhood; for women, from experiences of sexual assault and abuse; and for nonwhite men, from being assigned to dangerous duties and high risk activities. Then she reasons that because the masculinity activated in the military is a type of hypermasculinity, *all* aspects of femininity, indeed

all aspects of the other including homosexual and nonwhite identities, must be excised from the psyche in order for masculinity to take hold and sustain itself among those in the military. It is only when the feminine emerges through, for example, PTSD, that the fragility of what constitutes the military's idea of masculinity is disclosed. Though on the surface compelling, the argument falls prey to the same pitfalls of culturalistic claims; that is, using culture in the form of the cultural norms of a militarized masculinity to explain onset of a war neurosis.

Kilshaw's (2009) account of GWS echoes the culturalistic claims made by Whitworth as well as those made by Elaine Showalter, Edgar Jones, and Simon Wessely. Kilshaw refuses the construction of GWS as a result of toxic poisoning of depleted uranium or long-lasting reactions of vaccinations, and characterizes GWS as a collective bodily expression of communal war experiences, experiences that threaten a warrior's sense of masculinity.[20] She identifies several types of threats to masculinity, ranging physically from lack of fitness to infertility, impotence, and burning semen syndrome; culturally from the practice of men serving alongside women to the acquisition by men of women's diseases; and emotionally from shame over being ill as a noncombatant to anxiety over being househusbands after the war. She argues that the acute juxtaposition of detesting the feminine during training and then enduring seemingly feminine bodily sensations once a warrior, such as fatigue, weakness, and emotions, causes a general anxiety over a warrior's gendered identity, which serves to ensconce the idea of a threatened masculinity even further as a cause of illness. Muddled in this jumble of threats are wider cultural practices that influence the ways in which veterans make sense of their illness, including medical classifications of somatic syndromes as medically unexplained physical symptoms and general angst over health. Kilshaw agrees that GWS, like other new illness movements, tends to illustrate at an extreme scale a more generalized theme of risk society, that of being worried over threats to health.[21] Relying on culture, including the threat of masculinity, to explain GWS as a warrior's illness reinforces the bifurcated understanding of war neuroses—that is, instead of being understood as organic illness, war neuroses are expressions of cultural anxieties and beliefs and reduced to being understood and subsequently treated psychologically.

Within most frameworks about masculinity, militarism, and war neuroses, as Whitworth's and Kilshaw's works illustrate, soldiers crystallize within a military that seeks to keep masculinity in the soldier and the soldier in a masculine institution. Yet masculinity as a concept is more complex and as a practice works in more subtle ways than simply a dogmatic military code prescribing manhood and defining manliness among warriors. There is agreement that there is no singular masculinity pro-

moted in the military (see Agostino 1998; Belkin 2012; M. Brown 2012; Connell 2000; Highgate and Hopton 2005). Studying the deep distress soldiers experience during and after combat poses conceptual barriers when trying to understand how masculinity—as a material discourse that sets up expectations for behavior and as a practice that reinforces ideas about manhood—shapes the task of soldiering as well as appropriate means through which soldiers express illness. Categorizations of fixed and semifixed identities for men, historically specific cultural ideologies of masculinity, and ideas of gendered performances have given way to more subtle understandings of how men's subjectivities are constituted through changing notions of manliness over the life course and from context to context.

Connell (2002) values the subsequent work by others that have introduced flexibility and fluidity into the concept of masculinity. These works have enriched understandings of how men's lives as men come to unfold, by identifying multiple types of masculinity, both conceptually and empirically, that have complex relationships with one another in tolerance and tension. Yet studies of men's fleshed bodies have not kept pace with the extensive theorizations, partly because of the way in which masculinity entered into academic debates: via discussions about identity, ideology, and performativity (Edwards 2006: 151ff). The scene has been slowly changing. Stephen Whitehead (2002) reintroduces the male body as something that is a product of both genes and ideas, and of both expectations and acts, rendering the body as both a discursive and a material construct. Judith Halberstam (1998), in *Female Masculinities*, undermines the presumed link between masculinity and manhood with men's bodies and offers a more open reading of what constitutes gender. Todd W. Reeser (2010) follows up on Halberstam's notion of stripping masculinity of its inherent link to men and challenges people to think about how complicated masculinity as a concept actually is, how visible it becomes when one does not assume that it resides only with men, and how unstable the practices of masculinity are in everyday life. Aaron Belkin (2012) shows how militarized masculinities are falsely unitary, and routinely engage the unmasculine to firm up a fictitious masculine norm.

There is little doubt that the onset of a collection of bodily sensations that military psychiatrists frame as a war neurosis compromise the masculinities the military have on offer to warriors and pave the way for soldiers' ravished minds and ill bodies to be key sites in the feminization of military bodies. But explaining the onset of symptoms as a breakdown of coherence in a warrior's sense of identity fails to account for the more flexible notions of masculinities and the ways in which other sets of relations may be psychiatrized, militarized, or masculinized in different ways.

Tracing various articulations of the sets of force relations and the associated practices within psychiatry and the military as part of an embodied account of an apparatus that produces soldiers with ill bodies as subjects could show how masculinity informs the way weary warriors experience illness, engage in treatment, and live as veterans.

Toward Broken Embodiments

In challenging and amending some of Foucault's ideas with his own conceptual apparatus, we are not rejecting the role of hierarchy, the place of sovereign state power, or the effects of disciplinary mechanisms. Rather, we critically investigate their contingencies and disjunctures and consider various forms of resistance and struggles in military contexts over the ill bodies of soldiers. In addition, we do not readily accept the thesis that after the Cold War militaries shifted from a modern to postmodern form of organization (Gilroy and Williams 2006; Janowitz 1976; Moskos, Williams, and Segal 2000). In this view, "the postmodern military is said to be less tied to nation-states, increasingly 'androgynous,' and more fluid and permeable with civilian society" (Shigematsu and Camacho 2010b: xxvii). To be sure, transformations have taken place in western militaries, such as the shift from conscription to all-volunteer forces in many countries in recent decades (Gilroy and Williams), yet scholars who have interrogated this notion of postmodern military suggest that "heteronormative and racialized relations of power" persist in contemporary militaries (Cowen 2005; Shigematsu and Camacho 2010b).

Throughout the remaining chapters, we present our analysis by generating in-depth snapshots and pulling out bits and pieces of overarching narratives located in psychiatry, the military, and masculinity. Through these snapshots, we *place* war neuroses in and on soldiers' ill bodies and demonstrate some of the effects of this placement. We show how the authority of psychiatric knowledge guides the initial diagnosis of a war neurosis and shapes the range of options for treatment in specific time periods. We also pay close attention to how masculinity as an effect of power shapes the maintenance and contestation of particular configurations of psychiatric knowledge and popular cultural norms, especially in the sense of how particular forms of manhood dovetail with military practices. To guide our analysis we introduce complementary theoretical concepts that elaborate our main argument as laid out here about embodiment as a lived fusion of discourse and materiality, and embodied apparatuses as arrangements of mechanisms used for the diffusion of power/knowledge. Embodied diagnosis highlights the body and its descriptors as a dynamic

interaction between discourse and materiality, and takes embodiment more seriously than merely an avatar of a familiar idea. Contested illness pulls together our ideas about power relations and ill bodies as cultural constructs. It refers to illness that is "dismissed as illegitimate—framed as 'difficult,' psychosomatic, or even non-existent—by researchers, health practitioners, and policy-makers operating within conventional paradigms of [power/]knowledge" (Moss and Teghtsoonian 2008: 7).

As we sift through various military psychiatric as well as nonmilitary settings that address soldiers' ill bodies, we show how specific environments provide space to both reinforce and contest discourses and social practices about war neuroses, sometimes even at the same time. As well, we identify processes that soldiers diagnosed with a war neurosis engage in that reproduce and challenge prevalent notions of what it is to be ill as a result of trauma from combat as both a diagnosable psychiatric entity and an illness not recognized as legitimate by the military. These processes comprise specific discursive and material practices, including entitlement to health-care benefits, claims for social welfare, clinical presentation of symptoms, and policy formulation. Engaging ideas about resistance and activist acts among soldiers and veterans to claim and reclaim their bodies as ill or disabled, especially in terms of collective identities, is a significant component of understanding the effects of war neuroses.

Notes

1. The *Diagnostic and Statistical Manual of Mental Disorders (DSM)* has been the standard for psychiatric diagnoses from its first publication in 1952. Since that time, the DSM has expanded in its four subsequent editions to include not only major mental illness such as psychoses, schizophrenia, and phobias, but also learning disabilities, personality disorders, environmental and psychosocial factors, and acute medical conditions, with special attention to children under eighteen years old. Critiques of the DSM focus on the pervasiveness of mental illness categories describing things having to do with the mind, the creation of diagnoses that transform everyday life activities into mental illness, and the authority of psychiatry to determine mental illness. For a discussion of these issues, see Loughran (2012). In the context of diagnosing depression, see Horwitz and Wakefield (2007). See also the thoughtful review of their works by R. Williams (2009).
2. Although this number never exceeded twenty (Shephard 2000: 343).
3. Showalter's most significant works on hysteria are from 1985, 1990, 1993, and 1998. Other recent interesting feminist analyses of women's hysteria include Mazzoni (1996) and Appignanesi (2007). Other feminist takes on mental illness more generally can be found in Fee (2000).

4. Even so, Charcot created a spectacle of the hysterical women he was treating at the Salpêtrière in Paris by parading them through his Tuesday night lectures and featuring their images in photographs as part of his physiognomic records. See Charcot (1987) and Didi-Huberman (2003). See also Showalter (1985: 147–54 and 1993: 315). See also the discussion in Lerner (2003: 22–27) about Charcot's interest in traumatic neurosis and English physician John Eric Erichsen's interest in Railway Spine, and their link to the wider discussions about hysterical conditions in the 1870s and as precursors to contemporary diagnoses of PTSD.

5. The case study of Anna O. was included in this volume. The case study of Dora was published later by Freud, and gives a stricter interpretation of hysterical neurosis in Sigmund Freud ([1905] 1997). Dora's name was Ida Bauer.

6. "Talk therapy" was a phrase coined by Anna O. [Bertha Pappenheim] for the psychoanalytic process between the therapist and the patient. For details, see Breuer and Freud ([1895] 1974).

7. Symptoms associated with GWS are designated in a variety of places. Kilshaw (2008: 229–30 [appendix]) presents a collection of the symptoms soldiers in the United Kingdom reported that were drawn from Gulf War veterans' associations.

8. Although E. Jones and Wessely (2005a: 194) note that perhaps the hypothesized organic reasons for disordered action of the heart could have been proven incorrect, it is clear that they understand the trajectory of Lewis' effort syndrome to be one with a psychological cause and not an organic one.

9. See Kroll-Smith and Kelly (2008: 304–22) for a discussion of general understandings of the interactions among bodies and, in, and with the natural environment.

10. The idea that bodies are subject to the exercise of disciplinary power to the point of docility was developed by Foucault in *Discipline and Punish* (1979: 135–69). In this perspective, the body becomes a cog in a machine that can be moved from place to place, from task to task. Our critique, based on Foucault's own arguments in *Discipline and Punish* as well as his later works on sexuality, challenges this idea. The critique does so by undermining the intensity of docility by reintegrating a relational notion of power into a reading of the military. For more details on power and its circulation, see chapter 1.

11. Teresa Iacobelli (2007) examines the seemingly random pattern of executions in the Great War among Canadian soldiers on trial for desertion. She queries how military justice and discipline work in a military where only 25 of 222 guilty verdicts led to execution. She maintains that this high number of pardons challenges the generalized notion of the military as an absolute, closed institution and that military justice was accomplished in different ways during wartime (see also Iacobelli 2013).

12. In a self-admitted fascination with the ideas of Clausewitz on war, Foucault was curious to explore if war provided a valid analysis of power relations, of making sense of modern societies, and of understanding historical processes. He wondered "if military institutions and the practices that surround them … are … the nucleus of political institutions" (Foucault 2003: 47). When ad-

dressing the political significance of military institutions, however, he reiterated a structural functionalist approach, remarking that national militaries "obviously make it possible to win victories [and] they also make it possible to articulate society as a whole" (158).

13. For an in-depth inquiry into Foucault's preoccupation with war, force, and power, see Hanssen (2000), chapter 3.

14. For discussions of soul and psyche in Foucault's work, see *Discipline and Punish* (1979: 29–30), *The Care of the Self* (1988b: 133–44), *The Government of Self and Others* (2010: 303–6, 352–74), and throughout both *The Hermeneutics of the Subject* (2001) and *The Courage of Truth* (2011a).

15. Elaborating the ideas about gender and sex in a peacekeeping military, Kronsall (2012) argues that the feminine excised in acts of war as aggression, dominance, and might reemerges and must be embraced in order to develop peaceful relationships among combative nations. Her work challenges the static notion that normative masculine dimensions of a soldier's identity must dominate.

16. Some psychodynamic approaches to the explanation of weary warriors would point to this fundamental contradiction as the source of a war neurosis. For example, see Kudler, Blank, and Krupnik (2000: 176–98).

17. Robert W. Connell also publishes under R.W. Connell and Raewyn Connell.

18. Though controversial among gender theorists, MacInnes' ideas about masculinity are important because they foreground the problematic nature of using cultural arguments to explain social relations. See Howson's (1998) review of MacInnes's *The End of Masculinity* for a short assessment of the controversial nature of MacInnes's arguments. See also Duff's review in *Journal of Sociology* (1999: 388–89).

19. The example of the training song comes from William Arkin and Lynne R. Dobrofsky (1978).

20. See Wheelwright's (2001) account of the construction of GWS through the efforts of key people including Gulf War veterans, researchers, doctors, and press agents. See Lehr (2010) for a rationale to counter the material (toxic) causes of GWS.

21. Kilshaw (2008: 214–15) cites new illness movements as those where the sufferer becomes the expert and where the sufferer and advocates "maintain an unfaltering conviction as to [the illness'] nature."

Chapter 3

Classifying Bodies
through Diagnosis

Knowledges, Locations,
and Categorical Enclosures

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Classificatory thought gives itself an essential space, which it proceeds
to efface at each moment. Disease exists only in that space, since
that space constitutes it as nature; and yet it always appears rather
out of phase in relations to that space, because it is manifested in
a real patient, beneath the observing eye of a forearmed doctor.
—Michel Foucault, *Birth of the Clinic*

Another problem is if a soldier purposefully misattributes symptoms
of PTSD to MTBI [mTBI]. Unfortunately, mental health problems
are still stigmatized in the military, more so than brain injury. Soldiers
may be concerned that seeking care for mental health problems will
impede career advancement or ability to obtain a security clearance. …
Thus, soldiers may knowingly assign PTSD-related symptoms and
emotional distress to the more acceptable MTBI [mTBI].
–Karyn Dale Jones, Tabitha Young, and Monica Leppma,
"Mild Traumatic Brain Injury and Posttraumatic Stress Disorder"

We now begin following the arc of how soldiers become weary warriors,
both in the sense of individual bodies breaking down under the pressures
and acts of war and as a group of people having witnessed, endured,
and perhaps engaged in inhumane acts. We begin with a discussion of
diagnosis, a process through which bodies become marked with a specific
category that carries with it a set of meanings generated in many spaces,
including the battlefield. In classifying bodies as well as groups of sol-
diers, psychiatry and the military work together to seek clarity in what
they are facing or having to deal with. Soldiers have minimal input into

how they are classified; when they attempt to make changes, there can be harsh repercussions.

Over the course of his writings, Foucault distinguished a number of techniques in the deployment of power that work toward subjugating bodies and controlling populations. Foucault used the term "biopower" to describe life power—desire, agency, and resistance—and power over life—increased management, organization, and control by institutions over bodies, including groups of people, individual persons, biological processes, and genetic constitutions. Using the body as an entry point, Foucault argued that the various elements within an apparatus articulate with forces, desires, multiplicities, and other bodies to come together to produce human subjects (Foucault 1980d: 74). The politics arising from the exercise of biopower are organized around either the human body as an effect of power (anatomopolitics), or the human species for social control or enhanced productivity (biopolitics). An anatomopolitics highlights the disciplinary nature of a specific technique of power and a biopolitics emphasizes the regulatory effects of the exercise of power.

What does this mean for us in undertaking an embodied study of soldiers enduring the effects of deep emotional distress of combat and war? Mapping an anatomopolitics might focus on the practices a soldier engages in as a recruit, active soldier, or veteran to identify, mitigate, or recover from the effects of stress, fatigue, or trauma. For example, a male Canadian soldier deployed in Afghanistan might recognize the onset of a nervous collapse in a member of his combat unit because he was trained to observe restlessness, outbursts of anger, and erratic behavior as signs of emotional difficulty among his intimate peers. An interesting research question for cultural theorists would be: How does a soldier negotiate his own masculinity under such pressure for performance and responsibility, in light of his own potential breakdown. In contrast, a biopolitics of weary warriors might focus on specific mechanisms through which power is deployed in order to generate a particular type of soldier through the regulation of behavior. For example, third location decompression (TLD) centers set up and reinforce expectations of what life is to be like postdeployment. Key in the formal aspects of decompression is a series of seminars and lectures on what symptoms of operational stress to look for in daily life. An interesting research question for social scientists would be, How do soldiers come to incorporate self-monitoring of their behavior on an ongoing basis and then act on difficulties when they arise?

Instead of using biopower as an entrée into how power/knowledge circulates within and between our understandings of apparatuses as embodied, we prefer something less abstract that allows us to figure out some of the pathways that permit the emergence of neurotic and traumatized sol-

diers both discursively and materially. We draw on empirical descriptions of the exercise of power, whether disciplinary or regulatory. Jennifer Gore (1995) identified eight distinct ways that Foucault described power being exercised and even found each technique present in the elementary-level classroom. The eight techniques are surveillance, normalization, exclusion, distribution, classification, individualization, totalization, and regulation.[1] Though not inclusive of all the ways power can be exercised, it is useful to think about the exercise of power along these lines for at least two reasons. First, we are able to provide texture to some of the practices that materialize the ideals shaping psychiatry, defining the military, and signaling masculinity. Second, we are able to cut into the graininess of the texture to trace points of connection that can show *how* power produces ill soldiers. Some of our analysis tends toward an anatomopolitics, while other parts appear to build on a wider biopolitics. We develop neither a hybrid of the two nor a full multiscale analysis. Our goal is to not rest too long on any one type of analysis of power so as to demonstrate *how* practices of power generate effects.

Given our interest in the subtleties of how simple techniques of power matter, it makes sense for us to focus across many of the techniques rather than on just one. Much has been written about these techniques of power, especially surveillance and the panopticon, about normalization and the adherence to social norms, about classification and psychiatric diagnoses, and about regulation and the conduct of conduct.[2] Although we refer to some of these techniques throughout the book, in this chapter we want to direct our analysis primarily toward classification.

Classification is the systematic practice of ordering that is based on a set of agreed-upon sorting principles. Although systematic, classification is not smooth in practice; there is debate, disruption, and discord alongside consensus, coalescence, and congruence. This is certainly the case with diagnosis. Diagnosis is one of those practices that already hold within them competing configurations of power/knowledge. Although differentiated primarily on the basis of disease etiology, other sets of values inform the practice of diagnosis, such as the military need for mentally sound soldiers for combat as well as the idea that men with nervous conditions are sissies. Yet because of the authority a diagnostic category holds outside diagnosis as a psychiatric practice, the effects for soldiers and veterans are not a matter of origin, expediency, or appraisal. Rather, the effects of diagnostic power matter with regard to pension, social status, employment opportunities, and general well-being.

In this chapter, we focus not only on the *effects* of classification as a technique of power—that is, soldiers categorized as neurotic through the designation of psychiatric wounds, but also on the jumble of power/

knowledge relations that give rise to the *exercise* of classification, as, for example, academic debates over disease etiology, lines of command, and expectations of manhood. We pull out the discursive-material elements of classification as a technique of power in order to highlight how discursive practices of naming and labeling feed into the reading of bodily sensations, and vice versa. We then narrate accounts of diagnostic categories across time periods as they have been taken up in particular spaces of military psychiatric practice in a number of wars. We tell these stories through the conceptual framework we set out in chapters 1 and 2.

Classification as a Process of Embodiment

To be sure, for those who have endured deep emotional distress or psychological stress as a result of combat, making sense of the intense experience of breakdown brings with it countless benefits; some of the most desirable of these are inner peace, relief from pain, and freedom from fear. How a traumatized soldier goes about making sense of the breakdown of the psyche and the body in the context of the repugnance of war is both circumscribed and constituted by the ways in which psychiatry plugs into the military. Tracing the connection between the two via the many elements of the *dispositif* (apparatus) entails identifying practices that facilitate the establishment of a general coherence for the collective understanding of battle trauma. Medical practice in psychiatry in the last quarter of the nineteenth century and first two decades of the twentieth century centered on translating clinical observations into a classification system of mental disease and was beginning to make etiological inroads by sorting symptoms through the pathology of anatomy (Foucault 1994). The preoccupation with ordering generated a set of protocols designed for psychiatrists as medical physicians to sort through the bodily sensations and behaviors of psychologically wounded soldiers. This classificatory thought in diseases of the mind of the traumatized soldier set similarity as the trajectory of a disease and difference as a contraindication, a premise that underlay most branches of psychiatry at that time. Yet this classificatory thought also set as a standard a general ordering of psychiatric knowledge that held within it the thinking, the nature, and the scope of the medical gaze under military circumstances. Although initially intended perhaps to be a tightly ordered, Linnaeus-like naming system, diagnosis in practice ran into bodies that simply did not fit the categories in existence, especially the bodies among the droves of soldiers breaking down in combat in Europe in 1914 and early 1915. The use of the knowledge going into classification systems, inclusive of its congruence and discord,

resulted in field and hospital decisions that created uncertain boundaries in the ascription of a diagnosis, in the rationales for breakdown, and in the options for continued service. These *fluid* diagnostic practices early in the twentieth century generated spaces where the soldiers did not belong; they were not necessarily mentally ill, but neither were they of sound mind. And, given their embodied status and the circumstances surrounding the onset of their distress, they had little choice as to what they were going to do about it.[3]

The liminal spaces soldiers are positioned to take up are generated by the practice of diagnosis as it unfolds in the battlefield (following Mendelson 2009). Once located in a space that already holds within it codes of illness (a physician's training, the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*), triage protocols) and effects of the exercise of power in shaping the situation (e.g., casualty evacuation paths, frontline orders, state policies), soldiers, particularly combat troops, have little agency once wounded (Lee 2009). The liminal spaces generated by the medical understandings of ill bodies were vital in enacting weary warriors. The idea that the psychologically wounded warrior could be part of the constitutive process of psychiatric wounds was anathema to practicing physicians and psychiatrists when war neuroses were first conceived as an object of psychiatric inquiry. They were integrated into existing frameworks and *differentiated* with the empirical description of *war* neuroses in contrast to *peacetime* neuroses. Soldiers were little more than bodies to observe for the advancement of knowing more about hysteria and neuroses, bodies to scrutinize for cowardice or malingering, or bodies to fix for carrying out militaristic goals through honor and duty. As part of our tracing, what if we reread a soldier's agency back into the classification system of war neuroses by psychiatrists? Integrating the idea that the wounded warrior is active materially and discursively as part of the constitution of the categories of war neuroses undermines the premises that were central to defining war neuroses initially as an object worth investigating. Making the claim that the constitutive interaction among ill bodies and knowledges informing ill bodies that shapes choice, acts, and arcs of experience plays out through the agency of psychologically wounded soldiers, military psychiatrists, and the bodies of both turns classificatory thought about war neuroses into a cultural record that holds within it exemplars of particular scientific practices.[4] Introducing agency is not just a matter of giving soldiers choice; rather, agency is a complex process that is constituted, enabled, and circumscribed by matter and discourse at the same time.

Andrew Pickering's idea of a performative paradigm for science fits nicely here and helps tease out some of the complexities of dealing with the agential aspects of multiple elements of an ensemble. Pickering fol-

lows Foucault's ideas about scientific knowledge in that knowledge is not revealed or representative of a world external to the language used to articulate that world; rather, scientific knowledge is the doing of things, the practice itself. He conceptualizes practice in two senses, both of them part of science: as an act around which all that follows is organized, and as "specific, repeatable sequences of activities on which scientists rely in their daily work" (Pickering 1995: 4); the second sense is the cultural aspect of knowledge formation. Protocols and methods organize scientific practice just as observing, measuring, counting, and conceptualizing compose the doing of science. Through the introduction of agency—both human and nonhuman—Pickering comes to understand science as less representational and more performative. Through what he calls a "dance of agency" between resistance and accommodation among human and nonhuman elements, he combines a deep materialism with the social and cultural aspects of scientific practice. As agents in scientific practice, both humans and nonhumans (rivers, clouds, molecules, and compounds) act and do things. Their doing is neither completely by choice nor determined by something outside the act; agency is already integrally part of the constitutive elements comprising what he calls the "mangle" (Pickering 1995: 23). By conceptualizing science as a mangle of practice, he is better able to understand the *doing* of science as complex, unpredictable, and fluctuating performances. His performative image of science can be "regarded as a field of powers, capacities, and performances, situated in machinic captures of material agency" (Pickering 1995: 7).[5]

As a way to negotiate military psychiatry as a mangle of practice, Pickering's ideas about scientific practice can facilitate a critical reading by refocusing the military psychiatric gaze away from classifying broken down soldiers toward the production of weary warriors. In other words, rather than being set up to fix the broken pieces clogging a war machine, military psychiatrists engage in practices that address *how* war itself is constitutive of soldiers' psyches. Poring over the diagnostic categories created specifically to capture what happened with someone who was "blown up by a shell" (Malloch 1915: 1038) or someone "getting their bell rung" (K. Jones, Young, and Leppma 2010: 372) with no visible injury can show an alternative view of the plight of weary warriors. Although looking at the classification of war neuroses in this way cannot clarify definitively what is "wrong" with a soldier or how neuroses develop within and among soldiers (not that these are even desirable goals), it can bring to light other parts of the mangle that Pickering talks about. Recall that Annemarie Mol (2002) also understands science to be made up of practices that consist of organized protocols (such as diagnostic criteria for screening recruits for nervous disorders) and repeatable acts (such as MRIs for ruling out

organic brain disease or damage in soldiers presenting with neurotic sensations) that sustain and reproduce a particular power/knowledge configuration (that of a masculinized military psychiatry, for instance).[6] Rather than using the verb "perform" and the noun "performance," we, like Mol (2002: 41), use the verb "enact" and the noun "enactment" to highlight a *generative* ontology that values disruption, suspension, and perturbation alongside resemblance, resonance, and reverberation.[7] Tracing some of the classificatory thinking that has gone into understanding war neuroses over time can show some of the ways psychiatric practice in the military has enacted weary warriors.

Enacting weary warriors through military psychiatric practice is more than tying a tag onto the toe of a weeping warrior who is lying on a stretcher in the desert of southern Iraq, awaiting evacuation by transport helicopter. Enactment entails the weaving together of the assumptions, values, and practice norms emerging from the specific ontologies around which power/knowledge configurations are organized. Embodied enactments are at the crux of our critical reading. The ontologies that both Pickering and Mol use are generative and embodied—embodied in a way that takes as central the idea that both human and nonhuman elements are both deeply material and deeply discursive at the same time. Both are reminiscent of Karen Barad's (2003: 814) understanding of agential realism, expressed as a relational ontology inclusive of matter and meaning that is both intra- and interactive. Classificatory thought about war neuroses confines disease and illness, and subsequently ill bodies of soldiers, to a disembodied category that only comes to be embodied once ascribed to a living being. In contrast, an embodied understanding and critical reading of diagnosis in psychiatric practice in the military includes acknowledgment of the material-discursive constitution of body parts, bodies (as assemblages of body parts), and the intra- and interaction of the body and the body parts. As well, the production of knowledge about psychic trauma wounds in the military utilizes highly discursive means via abstract categories to talk about neurological processes of broken bodies. Repeated patterns of similar symptoms define diagnosis as a taxonomic practice. Yet, as Pickering notes, "we live in the thick of things, in a symmetric, decentered process of the becoming of the human and the non-human. But this is veiled from us by a particular tactic of dualist detachment and domination that is backed up and intensified … by science as our certified way of knowing" (Pickering 2008: 8). One is intrinsically wound up in the psychiatric knowledge of the day, one that is informed both by discourse and materiality, matter and meaning (Barad 2007). This is no less the case now than it was when Jean-Martin Charcot was parading hysterics on stage for both entertainment and prestige (Charcot 1987),

when Sigmund Freud gave up dissecting eels and worms and began a psychiatric practice at Berggasse 19 in Vienna, or when Charles S. Myers (1915) wrote about what he called shell shock near the beginning of the Great War.

What was significant at the time when war neuroses became central to the circulation of power/knowledge as part of psychiatry was the debate over soma and psyche, matter and the abstract, the body and mind. What is significant to military psychiatrists now as interest in war neuroses is on the rise is the move toward dissolving the seemingly rigid classifications of the body and the mind. In the midst of deconstructing classificatory thought as a social practice of power that subjugates marginalized and historically oppressed groups of people and individuals, feminists are revisiting theories that discount the fusion of mind and body in order to excavate insights into the materiality of disciplinary discourse. Elizabeth A. Wilson (2004b) argues that much can be learned about the relationship between the body and the mind by reengaging with neuroscientific theories that have been heavily criticized, particularly by feminists, for being biologically reductionist and deterministic. She offers a set of claims that open up discussion about the role materiality plays in movement, affect, illness, and knowledge claims. Wilson arrives at her argument from close readings of Sigmund Freud's theory for treating hysterical pains, Simon LeVay's proposition that functioning of the hypothalamus determines sexual orientation, Paul MacLean's proposition that the limbic system mediates emotional responses, Peter Kramer's kindling model of pharmaceuticals in treatment of depression, Charles Darwin's study of blushing lizards, and Oliver Sacks' inquiry into lytico-bodig disease.

Two of Wilson's points—that medical interventions into biological functioning are normalizing acts (à la Griggers 1997) and that evolutionary theory itself is based on divergence of species rather than the reproduction of similarity—provide insight into how we can make sense of the production of weary warriors. First, medical intervention on the battlefield and in the military is necessarily circumscribed by the need to fix bodies that are broken, return them to a normative state of fitness, and stave off onset or recurrence of cases of nerves. Once psychological soundness became part of the nomenclature for defining a fit warrior, military psychiatrists became more intrinsic to the military as an institution and part of defining military imperatives. And just as the ideal masculinity in the military must close off and keep out femininity and homosexuality to maintain its own discursive boundaries, the ideal military psychiatric practice must close off and contain sickness and mental illness to maintain its discursive boundaries, boundaries that are continually being assailed by the military's own practices—that is, combat, service, training, and

treatment—that generate weary warriors. Psychiatry in the military is in the business of producing normal soldiers, and psychiatric practice supports this normalization process by classifying ill bodies as neurotic ones.

Second, the concept of divergence, on which theories of species development evolved, has often been overlooked in favor of the application and popularization of the modernist scientific notion of sameness that supports the goals of regularity, efficiency, and prediction. With these goals at the forefront of decision-making within the military, disciplinary power deployed through the military as an institution models relationships and bodies (normalization) wherein one soldier could possibly stand in for the whole of the army symbolically (in recruitment posters [individualization]) and substantively (as in the chief commander in state negotiations over military action [totalization]).[8] Ensconced in these principles, military psychiatrists base their practice on systematically differentiating neurotic warriors from normatively healthy ones who are free of mental illness (classification).

By reorienting our inquiry toward divergence rather than similarity, we are able to intervene into the production of acts and explanations and follow cracks, account for anomalies, and implicate ruptures in the thinking about psychologically wounded soldiers. The question is not really about becoming more precise in capturing what a war neurosis is, its etiology, or its manifestation of psychosomatic symptoms, which is what much of the medical literature on war neuroses is about (see chapter 2). For us the question is, How do the diagnostic categories arising out of classificatory thought resonate or break with the power/knowledge configurations in play at the time of their generation? And, How does an embodied reading of war neuroses open up alternative understandings of psychologically wounded soldiers? In order to access and partially trace these oscillations in meaning and breaches in words and ideas, in the rest of the chapter we focus on the *practice* of diagnosis, the patterning of grouping bodily sensations into symptoms forming categories as well as the activities military psychiatrists rely on to conduct their work. The reverberations and discontinuities we write about are located at multiple scales within this intra- and interaction constitutive of material-discursive bodies. We hope to give a sense of the variation among the ensemble of elements that compose an embodied apparatus.

War Neuroses and the Great War

The story of war neuroses begins in medias res. Lengthy and detailed descriptions of surviving warriors' emotional and mental ailments existed

well before psychiatry emerged as a scientific knowledge formation. In the Trojan wars, the deep emotional distress of combat brought on Achilles' rage at the death of his most honored friend and warrior, Hector, and Ajax's killing spree of sheep before taking his own life (Tritle 2000). Alexander the Great's murder of one of his own officers and long-time friend, Cleitus the Black, in a focused outburst of anger was no doubt influenced by Alexander's increased excessive consumption of alcohol during the years of Greek war campaigns (Tritle 2003). Gaius Marius' intrusive thoughts about war, acts of mass violence, traumatic nightmares, insomnia, and heavy drinking (alcohol abuse) can all be sorted into the classification of PTSD (Birmes et al. 2010). However it was the struggle between psychiatry and neurology for dominance of understanding the mind that the case of war neuroses emerged as an entity worth investigating.

In the latter half of the nineteenth century, as psychiatry was emerging as a coherent knowledge formation, hysteria and neurasthenia occupied a premier place in the debates of the time. The origin of the onset of hysterical symptoms (diagnosed predominantly in women) and neurasthenic symptoms (predominantly in men) were not sorted by diagnostic category; the discussions about etiology were parallel within each category. Organization of classificatory thought in these debates was around whether war neuroses were physical (somatic) or psychological (psychical). There were at least four distinct conceptualizations in the debates over etiology of war neuroses at the turn of the twentieth century, ranging from the imaginary to a firm organic basis to a mental disease. (1) A group of psychiatrists who had been trained as neurologists conceptualized hysteria as originating in the relationship between the psychiatrist and the patient (following French psychiatrists Jean-Martin Charcot and Joseph Babinski). (2) Emergent psychoanalysts (e.g., Sigmund Freud, Karl Abraham, Ernest Jones, and Ernst Simmel) from German-speaking countries and Great Britain, many of whom trained as neurologists, and psychiatrists finding psychotherapy useful in treatment (e.g., William H.R. Rivers, William McDougall, Charles S. Myers) claimed that war neuroses were either solely or mostly psychical in origin, with varying somatic effects. (3) A mixed group of neurologists and forensic psychiatrists claimed neuroses emerged from a combination of physical and psychological influences (e.g., German scientists Hermann Oppenheim, Alfred Goldscheider, Gustav Aschaffenburg). (4) A group of neurologists primarily claimed war neuroses arose strictly from the physical part of the body (e.g., Austro-Hungarian scientist Arthur von Sarbo). Among these four conceptualizations there is some overlap, most of it arising from a similar notion of a material body.

A predominant, almost stereotypical, image of the soldier's neurotic body was one of an emotionally weak, feminine, exhausted, cowardly, and immature body that was highly suggestible, withdrawn, and often times

silent or unable to speak clearly. There was a notion that the soldier was trapped, lost in an abyss. And, if not either psychotic or psychopathic, then the nervous soldier was probably simulating weakness to get out of doing a soldier's duty (malingerer). Locating the discussion of the emotional breakdown of military personnel in peacetime debates over hysteria and neurasthenia set up the study of nervousness solely in the medical and scientific camps. These debates tend to dismiss the specific case of a soldier's arc of experience and to displace the horrors of war into the vicissitudes of daily living. This image of the soldier's body informed the break from the physical aspects of the dual line of argument—both psychic and somatic—whereby the psychological took over as primary etiological influence. A key shift in this break is Adolf Strümpell's argument about neuroses of covetousness that arose secondarily from desire, especially with regard to securing compensation for injury (Ferenczi 1921).

Changes in warfare technology in the last decades of the nineteenth century and the first decades of the twentieth century that included enhanced artillery and larger mortar shells, higher-accuracy rifles, long trenches delineating the frontline, and aerial combat seem to have had an impact on the type of wounds soldiers were presenting with during the Great War. Sorting through such wounds was an empirical challenge not just to the military, but also to those practicing psychiatry. Psychiatrists, pressed into military service, faced a never ending stream of nervous soldiers. Psychiatric diagnosis as a practice set up ill bodies as the place to play out on a mass scale what had been thought about for some years. In the field, empirical observations tended toward specific differentiations of bodily processes supported diagnostic categories that described bodies, whereas the academic psychiatrists located in the hospitals away from the frontline tended toward finding similarities among bodies and identifying trends in groups of symptoms. Thus, competing names for what seemed to capture nervous breakdown in combat emerged, organized around how a specific physician *read* the ill body. For example, the terms "commotional syndrome," "shell shock–wounded," and "*Granatschock*" highlight symptoms associated with a blow to the head; "pension neurosis" and "compensation hysteria," a perceived desire to live off the state; and "effort syndrome" and "cowardice," a value system running contrary to the masculine ideal of a good and honorable soldier. See table 3.1 for a partial list of the names assigned to soldiers' ill bodies as a result of combat-related breakdown.

This empirical challenge for psychiatrists serving in the military, however, did not negate or even mitigate the drive toward locating the source of breakdown, even as the war wore on. The categories assigned preserved the existence of war neuroses as an illness safely ensconced in psychiatric classificatory thought. Diagnostic practices—both in the field and in the hospital—enacted war neuroses as a collective designation of soldiers

Table 3.1. Diagnostic Categories of Hysterical, Neurotic, and Traumatic Illness among Military Service Personnel and Medical, Colloquial, and Operational Names Describing the Bodies and Minds of Combat Troops Enduring Deep Emotional Distress or Psychological Wounds

Acute Battle Neurosis	Acute Stress Disorder	Acute Stress Reaction
Acute Stress Syndrome	Aeroasthenia	Aeroneurosis
Anxiety Neuroses	Arctic Stare	Aviator's Neurasthenia
Aviator's Stomach	Barbed Wire Disease	Battlebrain
Battle Exhaustion	Battle Fatigue	Battle Hypnosis
Battle Reaction	Battle Shock	Battlefield Brain
Bengal Head	Brain Fag	Cardia-Neurosis
Cerebral Blast Concussion	Chronic-Fatigue	Combat Exhaustion
Combat Fatigue	Combat Stress Reaction	Commotional Syndrome
Compensation Hysteria	Cowardice	DaCosta's Syndrome
Debility	Delayed Stress	Delusory Psychosis
Disabled Soldiers	Disordered Action of the Heart	Disturbed Action of the Heart
Effort Syndrome	Extreme Exhaustion	Fatigue
Flying Stress	Functional Dyspepsia	Functional Nervous Disease
Gastric Neurosis	God Only Knows	Goldbricking
Granatschock	Gross Stress Reaction	Gulf War Syndrome
Hysteria	Hysterotraumatism	Irritable Heart
Kriegsneurosesn	Malingering	Mental Breakdown Arising from Shock
Mental Disturbances	Mentally War Wounded	Mild Traumatic Brain Injury
Nerve-Shaken Soldiers	Nerve-Shattered Soldiers	Nerve-Strained Soldiers
Nervous and Mental Shock	Nervous Breakdown	Nervous Exhaustion
Neurasthenia	Neurasthenic Insanities	Neurasthenic Prisoner
Neurocirculatory Asthenia	Neuroses of Covetousness	*Névrose de Guerre*
Nostalgia	*Nostalgie*	Not Yet Diagnosed (Nerves)
Obusite	Old Sergeant Syndrome	Operational Stress Injury
Operational Stress	Pension Neurosis	Pilot Fatigue
Pithiatism	Polytrauma	Postoperational Strain
Posttraumatic Headache	Posttraumatic Stress Disorder	Posttraumatic Stress Reaction
Posttraumatic Shock	Post–Vietnam Syndrome	Psychic Trauma
Psycho-Neuroses	*Schreckneurosen*	*Scrimshanking*
Shell Shock	Shell Shock–Sickness, Nervous Shock, Nerves	Shell Shock–Wound, Concussion
Soldier's Heart	Staleness	Traumatic Brain Injury
Traumatic Neurasthenia	Traumatic Neuroses	Traumatic Shock
Tropical Neurasthenia	Vietnam Syndrome	War-Hysteria
War Neuroses	War Psychoses	War Shock
War-Strain		

who were weak-willed, damaged, and emotionally predisposed to debility.[9] Whether the source was designated as an overprotective mother, an absent father, or unresolved sexual tension, bodies still had uneven gaits, deafness, nightmares, mutism, and anxiety. Psychiatrists enacted war neurotics through their meticulous observations and bodily examinations of individual troops, working under the assumption that if there were no identifiable underlying organic process causing illness, then the illness had to lie in a cracked, fractured, or broken psyche.

Elizabeth Wilson (2004a) helps break apart this assumption and reintroduces an embodied way of understanding the bounded connection among body parts and organic processes. She argues, "conversion hysteria does not point to what is *beyond* the organic body. On the contrary, it directs us right back into the heart of organic matter; hysteria is one particular mode of biological writing. If this seems to render hysteria prosaic, is this not because we have known biology only in its most inert forms?" (78; emphasis in original). Assumptions informing the knowledge used to make sense of ill bodies—or, in terms of practice, the psychiatrist's reading of the ill body—shape the way in which bodily (biological) sensations (such as pain) and acts (such a deafness) get worked up into symptoms. Sets of symptoms can then be included in a category that ostensibly captures an organic process of disease or describes a psychiatric condition. This transformation of bodily sensations and acts into symptoms is a crucial mechanism in accounting for an ill soldier because the mechanism short-circuits the agency of the body and the soldier. Cancellation of bodily agency affects the way a body enacts its trauma, stress, or shock, and thus glosses over the differences of that which cannot be readily accounted for—such as nervous disorders among combat soldiers—rendering them less textured and able to fit into multiple categories at the same time. Such displacement in diagnostic practice, of course, is supported by the articulation of other apparatuses and discourses, as, for example, nerve-stricken soldiers are cowards and sissies. What Wilson's ideas mean for war neuroses and weary warriors is that the body as an agent in its own constitution can be brought back into the center of diagnostic practice in military psychiatry. This move makes hysteria—as diagnosed in the Great War—actually only one way of seeing how trauma is etched onto a body. But it is not the only way to understand weary warriors.

Posttraumatic Stress Disorder

Of the thirteen different diagnostic categories reported in the five-week period from 1 January to 9 February 1945, in 2nd Canadian Exhaustion

Unit's operating near Ravenna, Italy (Canadian Exhaustion Unit [CEU] #2 Quarterly Report, April 1945), a diagnosis of one case stands out: post-traumatic syndrome (table 3.2).

This rupture—relocating the cause of nervous breakdown from sensitive or unstable psyches to an external stimulus that could cause a break in any psyche—reflects wider social and cultural processes. And although the diagnostic category did not stick or become dominant until more than a quarter of a century later, its presence reflects the oscillation between the various dichotomies on offer at the time (that persist even now) to place weary warriors into an illness schema—difference/similarity, psychogenic/somatogenic, internal/external, and permanent/transient.

As a diagnostic category of mental illness, PTSD did not appear formally until 1980 with the publication of the *Diagnostic and Statistical Manual of Mental Disorders*, 3rd ed. (*DSM-III*; American Psychiatric Association [APA] 1980). Richard J. McNally (2004) recounts some of the conceptual problems with the category of PTSD. Inclusion of PTSD in the 1980 version of the *DSM* was fraught with controversy over whether it was a medical disease or a social construct of a medical disease. McNally notes that PTSD is unique in the *DSM* in 1980 because it is a phenomenon that has

Table 3.2. Neuropsychiatric Casualties Admitted to the #2 Canadian Exhaustion Unit, 1 January to 9 February 1945

Psychoneuroses (Anxiety State, Anxiety Hysteria, Hysteria, Reactive Depression, Psychoneuroses Unspecified)	85
Psychopathic Personality–Inadequate Type	52
Mixed States (Psychopathic Personality with Anxiety State, Anxiety Hysteria, Schizoid Type, etc.)	31
Mental Retardation	1
Schizoid Personality	5
Psychosis	1
Chronic Alcoholism	6
Epilepsy (Suspect)	1
Posttraumatic Syndrome	*1*
Concussion	2
Narcolepsy	1
NYD (N) (Not Yet Diagnosed [Nerves])	29
NAD (Nerves) (Not Able to Diagnose [Nerves])	19
TOTAL	234

Source: CEU #2, Quarterly Report, April 1945 (our emphasis).

within its definition an external cause for the disorder. The precedent for including an external cause for disease was the inclusion of gross stress reaction in the 1952 *DSM-I* (APA 1952), which legitimated—medically and psychiatrically—psychological wounds for soldiers. In the most recently revised version (APA 1994), PTSD can be either from an external stressor *or* an emotional reaction to an event, making PTSD a category with *both* an internal and an external cause. The present definition according to *DSM-IV* (APA 1994) of PTSD involves exposure to a traumatic stressor of fear, helplessness, or horror either through personal experience, witnessing an event, or learning about the death or injury of a loved one that causes a set of characteristic effects that are persistent and medium to long term, including mood swings, violent outbursts, nightmares, increased state of arousal, hypervigilance, intrusive thoughts, psychic numbing or emotional anesthesia, trigger avoidance, feelings of guilt, failure and lack of a future, anxiety, reduced ability to express a range of emotions, persistent reliving of traumatic event (both asleep and awake), and social withdrawal. PTSD can be acute, chronic, or with delayed onset. And PTSD is not restricted to combat situations.

The circumstances within which the identification of posttraumatic syndrome potential surfaced as a rupture in the Second World War permitted and even facilitated movement of trauma into and across a range of influences; such influences include the gaze of military psychiatry, increasing interest in trauma in civilian psychiatry, and modifications in the structure of the medical corps in the military.[10] Rather than scrutinizing the etiological differences within and between hysteria and neurasthenia, military psychiatrists shifted their focus to understanding psychiatric wounds specifically relating to military operations. This shift gathered steam during the Second World War with the delineation of "pilot fatigue" and "old sergeant syndrome," reflecting the specific tasks soldiers carried out; or "tropical neurasthenia" and "arctic stare," reflecting the physical environmental context within which soldiers undertook their duties. Use of fatigue, exhaustion, and stress as concepts to capture what was going on psychically with soldiers' ill bodies made empirical sense as the intensity and frequency of battles and armed conflict increased. Use of the terms "operational" and "combat" as descriptors for the type of fatigue, exhaustion, and stress soldiers were enduring reflects the psychiatric gaze on military operations rather than the ill bodies outside the military, which had been the departure point for psychiatric engagement during the Great War.

During the Second World War, trauma became an organizing concept around which to place ideas about fright, fear, and psychological injury, especially in clinical social work and clinical psychology, but also in civil-

ian psychiatry. So, while the military psychiatrists were negotiating the influential roles that internal and external factors play in nerve cases, and were valuing the impact of the harsh physical and psychological conditions soldiers fought in (M. Jones and Lewis 1941), civilian psychiatrists were focusing on trauma as an element useful in understanding psychiatric conditions. They began making claims that everyone had a breaking point, trauma takes a toll on everyone, and the breakdown is just a matter of when it will take place (R. Greene 1976: 429).

These ideas seeped into the practice of psychiatrists on the ground in the Second World War and supported the shift of the military psychiatric gaze. But the shift was not smooth, nor merely in competition with one other viewpoint. Indeed, psychiatrists in the military were engaged in a number of debates with competing moral, medical, and military claims while being commensurate with the patriotic and nationalist loyalties. Wilder Penfield, a surgeon representing Canada on an American, British, and Canadian three-week mission to the Soviet Union in 1943, reported on the surgical practices of the Soviet forces (Penfield 1943) in an article in the *Canadian Medical Association Journal.* Concluding his article, he identified the surgical advances of the Soviets, including the use of sulfonamides for wound treatment, blood and blood substitutes for bleeding and shock, and development of surgical specialists (Penfield: 461). His sixth point strayed from surgery and into psychiatry: "[I]mproved treatment of neuroses. Psychoneurosis is rare in the Soviet Union for they have an ample supply of its specific antidote, *i.e.* high morale. This they do not need to import from abroad" (461). Roy R. Grinker, an American Air Force psychiatrist, responded to Penfield in a letter to the editor (Grinker 1944). In addition to commenting about the inappropriateness of a surgeon making claims about psychiatry, Grinker expressed concern about the move toward denying the existence of neuroses. He wrote, "anyone can crack" under the strain of war, and high morale "defined as stern military discipline, a hatred of the enemy, and a courage instilled by an ideal" does not combat neuroses (379).

A similar exchange took place between W. Ronald D. Fairbairne (1943) and John Mackwood (1943) in the *British Medical Journal.* Fairbairne stated that from a national standpoint and for military efficiency, instead of psychotherapy, neurotic soldiers needed evangelism; the preaching of faith and the exercise of pastoral care (Fairbairne: 186). Mackwood responded, maintaining that morale defined in terms of evangelism does not combat war neuroses and that this slip into ethics and morals will not well serve distressed soldiers returning to civil life: "It is a psychiatric problem now, and will be after the fighting has ceased" (Mackwood: 396). American gen-

eral George Smith Patton epitomized this patriotic nationalist approach to dealing with war neurotics in his infamous slap of Private Charles Herman Kuhl in 1943 in the 15th Evacuation Hospital, Nicosia, Italy. Criticized for his act by military brass, he was ordered to apologize publically in front of the media and personally to Private Kuhl. Yet Patton's views did not change. Just after the incident, Patton issued a directive forbidding "battle fatigue"—not the expression of that term, but the experience of battle fatigue itself (Axelrod 2009: 116–17).[11]

After the Second World War, psychiatry became a more formalized part of most Western militaries. Rather than pressing psychiatrists into service during wartime, military medical training included the training of psychiatrists in both clinical and operational applications. For example, the American experience in the Second World War with insufficient training in neuropsychiatry, nationwide shortage of psychiatrists, and lack of *military* psychiatric training, paved the way for the establishment of schools for military psychiatry (Menninger 1966). The School of Military Neuropsychiatry began running stateside 20 December 1942 as a four-week course open to medical officers with at least one year's training in psychiatry (55). The School expanded and moved to Mason General Hospital, Long Island, New York, and by December 1943 a twelve-week course for any medical officer served as core neuropsychiatric training (56). In total, 1,000 medical officers were trained between December 1942 and December 1945 (56). Overseas training, usually only a week's duration, was done in Europe and in the South Pacific (59–61). The School laid the groundwork for continued training in neuropsychiatry within the American military, which guaranteed attention to war neuroses. What that attention turned out to be has varied over the past seven decades—from focused training to reduce breakdown in combat (exemplified by the low percentage of psychiatric casualties in the initial years of American war in Viet Nam) to lack of experience in understanding postdeployment stress reactions to trauma among veterans of the Viet Nam, Gulf, Afghanistan, and Iraq Wars.

These three factors—the gaze of military psychiatry, increasing interest in trauma in civilian psychiatry, and modifications in the structure of the medical corps in the military—assisted in the shift from seeing the deep emotional distress of combat troops as internal to the individual and manifest as hysteria or a neurosis toward considering each and every soldier as a potential psychiatric patient.[12] This expansive shift in diagnosis, located in a mass of old practices and new ideas in the Second World War, brought mass change much later, including a rewriting of etiology, a new relationship between soma and psyche, and a reinforcement of similarity as the organizing tool for differentiating psychologically ill bodies.

Weary warriors clearly are not a new phenomenon, but it is not as simple as exposing traumatic reaction as an acultural, achronic, and aspatial entity as some psychiatrists and psychologists studying trauma would claim (after E. Jones and Wessely 2005a).[13] Rather, it is a matter of nestling the psychiatric scrutiny of ill bodies in particular organizations of classificatory thought—that is, figuring out its placement in the mangle. For example, Viet Nam War veterans welcomed PTSD as a diagnosis because a diagnosis would mean legitimacy, legitimacy would mean treatment, and treatment would mean relief (see Scurfield 2004). Refusal of the label of PTSD by some contemporary veterans may be linked to the concept of emasculation given the hypermasculine culture in which young men are firmly ensconced. However, the popularity of PTSD in the past decade has risen considerably through national defense initiatives and awareness campaigns in Canada, Great Britain, and the United States, as well as through United States–based reports of the seemingly shocking numbers of 25 to 38 percent of troops serving in Iraq and Afghanistan being diagnosed with PTSD or suffering from psychological problems upon return (Arthur, MacDermid, and Kiley 2007; Tanielian and Jaycox 2008). These numbers are not higher, or lower, than the numbers of war neurotics in the Great War, exhausted troops during the Second World War, delayed stress among Viet Nam veterans, and PTSD sufferers from United Nations peace operations. But there is increasing public recognition that the prevalence of trauma among veterans of the Iraq and Afghanistan wars is indeed higher than in earlier wars.

This move toward locating the weary warrior in a category that not only applies to every potential soldier, but also to potentially everyone in civil society, marks the psychologically wounded soldier as "normal" under extreme conditions (at the frontline) yet "pathological" under noncombat traumatic conditions (at home). Through the practice of classification, the soldier is cast yet again into a liminal state where the pathological is normalized and the normal is pathologized. The weariness of the warrior fluctuates according to context.

What worth, then, does a diagnostic category have that can include so much and be grasped for multiple groups of people with varying reactions to trauma? Over a decade ago Derek Summerfield (2001) called into question the utility of PTSD as a diagnosis. He maintains that the classificatory power of PTSD has stretched beyond its limits and that the use of the category needs to be reevaluated given the wide usage *outside* clinical settings. Like Allan Young (1995, 2004), Summerfield points out that PTSD is not a timeless entity that is being discovered by multiple generations. It is a set of "practices, technologies, and narratives" that serve the interests of associated groups, as, for example, people, institutions, and moral arguments

(Summerfield: 97). His rationale for challenging the category rests on his claim that "society confers on doctors the power to award disease status" to people and that using ineffective or outmoded categories conflates normality and pathology (Summerfield: 98). Critics of Summerfield point out that the dismissal of suffering, the usefulness of ascribing a diagnosis to assist people with moving on in their lives, and the lack of recognition of PTSD as a disease render his argument unpersuasive (Rapid Responses 2001). The engagement with Summerfield's argument resurrects long-standing debates over organic disease versus psychiatric condition; external events and internal predispositions; existence or nonexistence of physiological malfunctioning; and the dismissal of using social theory to engage debate about medical psychiatric issues. When Summerfield responded to some of his critics, he reiterated his central argument: "As a category post-traumatic stress disorder can support some weight, and I am saying that we should debate how much this is, but it cannot support the tower block that has been erected on it" (Summerfield: 1301).

We would categorize both Summerfield and his critics as being overly simplistic in their understanding of the impact society and culture has on the notion of disease itself as well as individual diseases and illnesses. Then again, we agree that his argument about the conflation of normal and the pathological is an important point; as is his observation about the parameters of the category being subject to revision. We argue that the category of PTSD enacts weary warriors through the practice of comparison in science, medicine, and psychiatry within the military, and that the most powerful comparative practice is between what constitutes the normal warrior and what constitutes the pathological warrior.[14] There is a danger in normalizing the effects of war on individual soldiers, just as it is dangerous to pathologize each breakdown in combat. Over the past 150 years or so, the oscillation between the two poles has been reflected in classificatory thought that in turn has served various interests—military, social, cultural, economic, state—at given points in time. Perhaps most importantly, the rupture toward externalizing etiology in congruence with civilian psychiatry produces everyone as a potential psychiatric patient.

Shell Shock and Traumatic Brain Injury

Classificatory thought necessarily brings with it a different set of tools for thinking about neurotic soldiers. This can be demonstrated by troubling the reliance on etiology as the basis for differentiating bodily processes that have in some sense gone awry. One well-trodden path might be to

locate unobservable wounds in the unseeable psyche, while a less-trod-den path might be to locate psychiatric wounds (hysterical mutism, hys-terical deafness) in something else unseeable—that is, within unseeable bodily wounds. Because classificatory thought depends on some form of observation, enhanced observational practices, such as computed tomography scanning (CT scans) and magnetic resonance imaging (MRI), bring more body parts into view. Once observable, classification of psychiatric wounds could be better differentiated between that which is psychic and that which is somatic. With this kind of information yet another path might be apropos—that is, revisiting categories of illness and applying insights of scientific observational practice to the categorization process. Enacting weary warriors from this angle reconfigures the connection and articulation among the elements of the apparatuses so that resonance and rupture exist simultaneously, letting us see different types of weary war-riors. Reading the diagnostic categories of shell shock and TBI side by side can provide insight into how the machinations of apparatuses via the plugging of one apparatus into another apparatus work.

Shell shock was an empirical description of first impressions of what was happening on the battlefield with the onset of symptoms. Initial de-scriptions of what was referred to as shell shock rested on the assump-tion that behavioral disturbances could arise from unobservable damage from blows to the brain and to the senses. Charles S. Myers described the similarities among three patients he attended to at the Duchess of West-minster's War Hospital in Le Touquet, France, in late 1914 and early 1915 (Myers 1915) (see table 3.3).

Myers' case notes follow each soldier's journey from the moment the shell burst, through the dressing station, to the hospital. He meticulously observes, measures, and records the changes in the sensations of the three soldiers, their bowel movements, and their memories of the events. He pieces together the event seemingly causing the emotional and bodily distress through memories, other soldiers' accounts of the same incidents at the hospital, and hypnosis. Case 2 recalls,

> I remember the journey in the train here distinctly. There were continual of-fers of tea, cocoa, sweets, and cigarettes. They wouldn't let us sleep for these things. I had a bad headache all the way down from the trenches. I did not bother much about my sight, as I thought it was imaginary. It wasn't until I got rid of the pain in my stomach which I came in with that I began to find my sight wouldn't let me read. (Myers 1915: 318).

Myers ends his comparative description with a statement that positioned him outside the dominant thinking of the period:

> Comment on these cases seems superfluous. They appear to constitute a definite class among others arising from the effects of shell shock. The shells

Table 3.3. Similarities among Three Shell Shock Cases Described by Charles S. Myers

	Case 1	Case 2	Case 3
Cause	Shells bursting about him when hooked by barbed wire.	Shell blowing trench in.	Shell blew him off a wall.
	Preceded by period of sleeplessness.	As in Case 1	?
Vision	Amblyopia [lazy eye]. Reduced visual fields.	As in Case 1.	As in Case 1.
Hearing	Slightly affected for a brief time.	Not affected.	As in Case 2.
Smell	Reduced acuity.	Total anosmia [impaired olfactory senses].	Unilateral anosmia and parosmia [natural odor not sensed].
Taste	Almost absent.	Reduced acuity.	As in Case 2.
Other Sensations	Not affected.	As in Case 1.	As in Case 1.
Volition Movements	Not affected.	As in Case 1.	As in Case 1.
Defaecation	Bowels not opened for five days after shock.	As in Case 1.	As in Case 1.
Micturition	Urine not passed for 48 hours.	Not affected.	As in Case 2.
Memory	Apparently slightly affected.	Distant amnesia.	As in Case 2.
Result after Treatment	Gradual improvement with rest and suggestion.	As in Case 1, supplemented by hypnosis.	As in Case 1.

Source: Adapted from Myers (1915: 316).

in question appear to have burst with considerable noise, scattering much dust, but this was not attended by the production of odour. It is therefore difficult to understand why hearing should be (practically) unaffected, and the dissociated "complex" be confined to the senses of sight, smell, and taste (and to memory). The close relation of these cases to those of "hysteria" appears fairly certain. (Myers 1915: 320)

Reflecting on the relationship among shell shock, hysteria, and neurasthenia, in 1919 Frederick W. Mott wrote,

There is no doubt that this term [shell shock] was an unfortunate one, and led to a considerable amount of misconception. It was a very natural conclu-

sion, at first, that men who had been exposed to the unprecedented stress of bombardment should suffer from *commotio cerebri.* But a great many men who have been returned from suffering from *shell shock* would have been more appropriately designated as *shell shy.* (Mott 1919a: 439; emphasis in original)

Mott's shift from an external etiology to an emotional one, with close links between emotional breakdown and cowardice, makes sense given what had happened in the interim: hysteria and neurasthenia as the categories for understanding neuroses dominated the knowledge and the practices in forward psychiatry within the opposing militaries, with French and German psychiatrists and psychiatric debate leading the way. What is most interesting about Mott's observations about shell shock is what he concedes after making such a statement:

> It is extremely difficult to differentiate commotional shock from emotional shock, for both may be attended by a state of unconsciousness followed by hysterical or neurasthenic symptoms. Still, there is no doubt about it, men do suffer from commotional disturbance of the brain without any signs of injury on the body, and that they are the subjects of organic changes, due to the forces generated by the detonation of high explosives, especially when they are in enclosed places, such as dug-outs or narrow trenches. (Mott 1919a: 439)

Two things here that diverge from the usual understanding of war neuroses in the Great War as arising from a break in the psyche are worth noting. One, the body appears to react to commotion and emotion in the same way. Two, the body appears to change organically as a result of being near explosions. The difficulty in distinguishing etiology, especially close to the front, makes the practice of diagnosis more intensely reliant on classificatory thought. And the classificatory thought of nerve cases throughout most of the war was either hysteria or neurasthenia. Mott notes as proof of what he calls true shell shock as altered cerebral-spinal fluid (collected through lumbar punctures and which contains blood and albumin) and minute hemorrhages in various parts of the body.[15] Unfortunately for soldiers, these leakages were not readily observable, manifested as nervous symptoms, and often came on later as other types of illness or disease. As a result, soldiers themselves are pushed into a diagnostic category that brings with it a battery of subsequent practices in, for example, the realm of psychiatry in terms of treatment, the military in terms of status, wider cultural trends in terms of acceptance or rejection of feminized veterans, and society in terms of pensions and postdeployment support.

A surge of diagnoses of TBI and mTBI in the twenty-first-century war in Afghanistan and the war in Iraq among soldiers in the West rekindled interest in shell shock. According to the World Health Organization (WHO),

TBI is a certain external cause of intracranial injury that can be either focal or diffuse (WHO 2011). Intracranial injury consists of the brain colliding against the skull, which may result in bruising, lacerated tissue, hemorrhage, or other organ damage. Diagnosis of TBI among soldiers entails a collection of symptoms including a history of a blow to the head, possible loss of consciousness (from a few minutes to several hours), concentration problems, memory loss, sensory disruption, sleeping difficulties, headache, and mood changes. For mTBI the symptoms are the same as in TBI, but with less intensity, fewer incidents, and slighter effects. Associated conditions, such as blast lung (when explosions go off in confined spaces), cerebral blast concussion (brain damage from a blow to the head that was caused by an explosion), and postconcussion syndrome (a set of symptoms lasting longer than the usual effects of a blow to the head) emphasize the material damage that a detonation of an aerial bomb, artillery shell, mine, grenade, or any other explosive device (including improvised explosive devices [IEDs]) can do to a body. Access to this damage comes through a set of symptoms mostly related with mental damage, nervousness, memory loss, behavioral changes, and depression. Cognitive impairment, partly because cognition is now more systematically accounted for through measurement, has recently been recognized as a symptom of combat. But only since about 2005 have the American military and other Western militaries acknowledged the impact TBI and mTBI has had on soldiers serving in Iraq and Afghanistan (see Jetly and Heber 2011).

Just as shell shock was the so-called signature wound of the Great War, TBI has flourished as the signature wound of the recent Western wars in Iraq and Afghanistan. Controversies over hysteria and neurasthenia with Myers' initial understanding of shell shock mirror the debate over the diagnostic categories of PTSD and TBI. The two categories are similar in symptomatology (unconscious for a period of time with post-injury amnesia) and etiology (a blow to the head). There is also resonance in the idea that outside of definitive evidence, the possibility of neurosis from shells blowing up (Myers 1915, 1916) and neurosis of brain damage from a blast injury (Thompson, Scott, and Dubinsky 2001) need consideration. The differences between the two—presumably in terms of rejection and acceptance in the dance of agency—reflect the context within which the idea informing the classification (categorization) took place. Shell shock as a category—both in its popular and diagnostic forms—had to contend with the growing influence of psychiatry as part of medical science centered on debates between differentiating war and peace neuroses and distinguishing hysteria and neurasthenia.[16] In contrast, TBI already has a solid footing outside military psychiatry and is positioned vis-à-vis the external etiological categories of injury-based postconcussion syndrome and

psychiatric-based PTSD. Like PTSD, TBI can potentially happen to anyone and is not confined to combat situations. This current debate reflects the persistence of both psychic- and material-based understandings of illness that tie the distress to a soldier's nervous system to either an internal (the mind) or external (an explosion) source to explain invisible wounds.

Cultural understandings, values, norms, and mores play a role in the constitution and ascription of diagnostic categories. Making tangible nationalist ideologies is a strategy that can then be politically mobilized in support of what is becoming a less popular war. On the one hand, the recent rise of diagnoses of TBI in lieu of PTSD coincides with increased domestic dissatisfaction with American troops in Iraq and Afghanistan. Battlefield medicine in twenty-first-century wars indicate high incidence of overlap between TBI and PTSD with neurological damage from blows to the head resulting in complex psychological reactions and pathophysiological disruptions because of the ways in which the effects of the injuries and disorders are described in the medical literature. Blaming IEDs for the breakdown of a soldier can maintain an individual's masculinity by keeping cowardice out of and honor in a soldier's identity.[17] This kind of explanation holds intact the ideal soldier that can only be undermined by sneaky opponents who do not follow the rules of combat. The message mobilized is that it is not the case that the nervous soldier is brain-addled, weak-willed, or a psychic casualty of an honorable war. There is a physical cause to soldiers' behavioral problems and the devious enemy is the source, and we need to hold our ground against the tricky bastards. Even if a soldier cries every now and again, it is justified.

On the other hand, there was no parallel cultural understanding to support the diagnostic category of shell shock. No social role existed that nervous soldiers could easily and securely occupy. The droves of soldiers breaking down could not easily be reconfigured into a politically supportive message. Mobilization of a wide reaching message that proclaimed the human toll of such wounds was popularized through the writings of war poets and novelists, including Siegfried Sassoon, Owen Wilson, Robert Graves, Erich Maria Remarque, and Ernest Hemingway. Limited public accounts of the devastating effects of the war on so many young men were available during the war and were often hidden as a way to keep up the morale on the home front.

Myers' descriptions of the three cases of shell shock in 1915 parallel these descriptions of TBI as a diagnostic category—injury from an explosion, a blow to the head, or being blown into another object. Rebecca J. Anderson (2008) makes the argument that Myers was more accurate than he or his colleagues gave him credit for—he identified the psychosocial complexities of TBI in the battlefield in 1914, and classified them appro-

priately. She maintains that the brain does not change: it has merely taken nearly a century to track the neurological damage caused by a blast, damage that can be extreme, persistent, or even delayed (216). Because of the advance in technology in emergency trauma medicine in the battlefield and in body armor, soldiers with head injuries and posttraumatic stress are surviving and living long enough for military psychiatrists to be able to track long-lasting effects. The change that Anderson talks about—located in the structural organization of military psychiatric practice—is change external to the body. But Anderson's claim renders the body itself without agency, insinuates that bodies act and react the same now as in 1915, and casts the brain and associated neurological and physiological systems as independent of the blast injury. This is not quite the case. The practices of the Great War and the wars in the twenty-first century differ, and the categories (generated by classificatory thought) enact weary warriors differently and enclose them in tightly woven diagnostic categories.

The unqualified pursuit, acceptance, and belief that the invisible wound is located solely and entirely within the material realm refuses the deep material-discursive character of the constitution of the body, including human and nonhuman agency. Just as the categorical denial of material influences in psychiatric conditions (popularized in the practice of Joseph Babinski) that eventually subsumed shell shock into hysteria and neurasthenia, the repudiation of psychical influence or stress reaction in TBI closes off the inter- and intra-action of body parts, including the brain. Neither conceptualization successfully blends the psyche and soma together as co-constitutive forces; underlying both is the assumption that the two are separate entities. An embodied reading challenges this assumption and casts body parts as agential, not inert, and that the understanding brought into existence by discourse that already holds within it the materiality of that which it enacts. Elizabeth Wilson's observation that hysteria is not beyond the organic body informs our reading of shell shock and TBI. We see both as resting on a particular reading of the biological body. By opening up that reading of the body and the categories used to read that body, a different understanding of weary warriors can emerge.

Naturalistic readings of the body limit the way in which one can see a body. TBI may describe a body partially, just as PTSD and shell shock do; the categories expose only part of the mangle of practice. And it is these practices that enact weary warriors. But if we are to take seriously the notion of agency as part of embodiment, then the process through which classification enacts a soldier's ill body needs to be embodied. Pamela Moss (2008) shows how a category can become understood as embodied, at least partially. She analyzes four contemporary definitions of myalgic encephalomyelitis competing for dominance among clinical physicians,

research scientists, and activist groups. She argues, "what seems to be happening over a relatively short period of time is a mutual constitution of both diagnostic categories and ill bodies, simultaneously being discursive and material, existing in those lived (imagined and real) spaces of everyday life" (174). Although not part of her discussion, she points toward the agential characteristics of the engagement of ill bodies with diagnostic categories and the human agents that generated them. The categories of shell shock, TBI, and others attempting to capture what goes on with combat soldiers need to be reread so as to enact weary warriors and their bodies as embodied entities that are active agents in effecting the constitution of injuries, bodily sensations, and ill bodies. We maintain that the debate over whether it is the breakdown of the psyche that affects the body or the breakdown of the body that affects the psyche is not helpful. If psychiatry, and medical science more widely, insist on relying on classificatory thought (and they do and will because it is effective), then they need to generate categories (with protocols for treatment) that usefully and effectively cast the psyche and soma as co-constitutive. These categories need to be based on changing bodies, categories and bodies that are porous, shifting, fluid, and agentic.

Combat Stress Reaction and Operational Stress Injuries

By the beginning of the twenty-first century, classificatory thought had consolidated the efforts of patient groups, military psychiatrists, and civilian psychiatrists interested in the broken psyches of ill soldiers by locating the key classificatory categories outside the medical world. This move was facilitated by military psychiatry's embrace of the universal claims of post-traumatic stress and TBI. The deepening tension between soldiers' and their families' experiences of combat-related illness, military imperatives of maintaining mentally sound soldiers, and military psychiatric practice has been ameliorated and a new category generated. The ongoing plugging of one apparatus into the other—psychiatry and the military—has enacted a host of diagnosable illnesses associated directly with military service. The military classification of soldiers' ill bodies in the Canadian Forces, OSI, includes all combat-related stress and trauma injuries. The umbrella term is defined as "any persistent psychological difficulty resulting from operational duties performed by a CF [Canadian Forces] member" (Canadian Parliament 2007: 1). With this new classification, the military effectively returns debate over the etiology of broken bodies and ravished minds to psychiatry and contains the rupture of the seemingly endless ways individual bodies can break down when placed into situ-

ations that have soldiers enduring long periods of inordinate stress. By creating a nonmedicalized category of illness, the military can once again engage in the business of creating normal soldiers, even though between a quarter and a third of all troops will endure some psychological illness after serving in combat situations. Classifying soldiers under a nonmedical umbrella permits psychiatry to engage in psychiatric practices such as debating etiology and designing treatment protocols.

This movement from one type of classification to another was incremental, attenuated one particular idea about the source of deep emotional distress, and resolved competing mandates. Incremental changes led by field practices were not just administrative declarations, but also descriptions of the activities (practices) of combat troops. For example, official British policy at the onset of the Second World War attempted to curb misunderstandings of combat-related breakdowns and designated that "Not Yet Diagnosed (Nervous)" was to be used as preliminary diagnosis in the field, never shell shock (Binneveld 1997). Although the term NYD(N) persisted, military medical personnel and military psychiatrists used other terms to capture soldiers' broken psyches as bodily sensations: functional dyspepsia, gastric neurosis, disordered action of the heart, or effort syndrome (van Nostrand 1943, part I). By the middle of 1943, the term "exhaustion" had become preferred by American, British, and Canadian militaries. Military psychiatrists began detailing the bodies of ill soldiers in ways that integrated the activities (practices) of war with bodily sensations. For American troops in North Africa during the Second World War, studies showed that there was a disproportionately higher rate of psychiatric wounds the longer soldiers engaged in combat (Grinker and Spiegel 1963). As well, fear and anxiety rose as campaigns dragged on, just as psychological breakdown was more likely when a soldier was physically tired (Hanson 1949). For German troops, rather than war neuroses there were many more organic diseases, especially gastric maladies, at the beginning of the war. Rather than demobilizing ill soldiers, the German military created battalions of soldiers with specific health problems, as, for example, Magenbattalion for those with stomach problems and Ohrenbattalion for those with hearing problems (after Ford 2000). But by the end of the war, there was a documented dramatic increase in the number of cases of war neuroses and in German accounts of military psychiatry. This phenomenon was referred to as *Symptomsvershiebung,* a displacement of symptoms (Binneveld 1997: 92).

After the Second World War, various phrasings and descriptions of "combat fatigue," "operational stress," and the more general "combat stress reaction" emphasized the relationship between the broken body and its military context. This partial demedicalization of the categoriza-

tion of broken psyches permitted soldiers' bodies themselves to be agents of change. Soldiers' illness did not fall within a disease category; their illness was context-dependent. Classificatory thought in this sense moved away from the management of disease types toward the management of broken soldiers.

As an extension of the thesis that everyone has a breaking point, first explored during the Second World War, etiology of the neurotic patient lost its central importance and took a back seat to the acceptance of anyone being a psychiatric patient. The attenuation of one particular characteristic of psychiatric wounds—potentiality—carries with it universalizing tendencies that render the practices designed to prevent breakdown, such as screening, less significant than tendencies that emphasize training for particular situations. As a response to the successes and failures of forward psychiatry in the Second World War, over the following two decades most militaries focused on how to train soldiers to deal with combat situations so that they would not break down. The American military used Skinnerian operant and Pavlovian classical training techniques to get recruits to shoot more readily and become more aggressive in battle (see Grossman 2009). Training for military medical personnel included some psychiatric training for all physicians and the introduction of clinical psychology into the armed forces through the permanent assignment of psychologists to American veteran hospitals (Kennedy and McNeil 2006).

These types of efforts resulted in the apparent success of American troops in Viet Nam with low psychiatric wounds in the first months and years of the war. Yet delayed onset of stress and trauma became an issue among American Viet Nam War veterans. Throughout the 1970s and 1980s the intensification of the medicalization of war wounds was accompanied by the medicalization of society more generally (Illych 1975; Conrad and Schneider 1980). With a rise in the demand for psychiatric services for emotional distress among veterans and the move toward diagnosing mental illness and PTSD, the pendulum swung back—away from context-dependent understandings of war neuroses toward debate over the existence of war mental disorders and trauma etiology.

Reworking the tension between competing mandates facilitates movement of classificatory thought. The pronouncement of OSI by the Canadian Forces marks another swing of the pendulum. Articulation of psychiatry and the military transforms the way elements within the military connect, just as the military provides a venue through which to display the applications of psychiatric practice and the flow of psychiatric power. As the military absorbed psychiatry, a new version was created, one that ameliorated tension between competing mandates, such as between healing psyches of broken soldiers and sending them to the frontline. Military psychiatrists are trained in military academies and specific ranks for military psychia-

trists in the medical services branch of various militaries. In some aspects there is no longer an articulation, but rather an amalgamation, even an integration. For a weary warrior, this conversion means that a soldier's incapacity due to breakdown—for every soldier has the potential to break down—is normalized back into the military and routinized into operations planning.

OSI characterizes the trend in contemporary approaches to diagnosing neurotic combat troops. The generation of this category sidesteps some of the stagnating tendencies in medicine generally and psychiatry specifically—that of pathologizing normality. Alongside the increased importance of military psychiatrists in prevention and treatment of illness rather than in determining etiology, this retreat into a nonmedicalized category for soldiers' ravished minds opens up new articulations between psychiatry and the military. The classification of a range of mental illnesses and diseases a weary warrior might potentially encounter as a militarized entity instead of medical category generates a different set of practices. For example, surveillance as a central pillar in identifying and treating OSIs counters the burial of traumatized combat soldiers within the institution, which might have been the case fifty years before. In addition to a soldier's own self-surveillance, family members, friends, and civilian general physicians are also trained to be sensitive to emergent symptoms of OSI. This extension of surveillance widens the purview of a militarized psychiatric power that transfers responsibility of maintaining a sound mind and body of veterans to the veterans themselves and to their social networks.

From Broken-down Bodies to Weary Warriors

The military war service patient is not just a combatant with symptoms, nor only a soldier of specific rank, role, and field placement based on combat experience. The military patient is an embodied individual with a life and lived experience prior to the war as a person at a certain age with a specific personal material history, including job training, education, and social status, that may also include a propensity to illness, a history of nervousness, a complex set of familial relationships, and unresolved emotional issues. Use of these embodied elements to classify soldiers with ill bodies does not translate into an embodied practice for diagnosis; rather, classification as a deployment of power in the mangle of practice strips away the relational and generative ontology on which embodiment rests and reinserts a supernal designation of illness based on the normative and totalizing scientific concepts of similarity and sameness.

Military psychiatric practices through which weary warriors get enacted are both time-specific and place-specific. Classification as a practice

is itself fraught with tensions, arising out of other types of knowledge-
making practices (for example, etiology debates), and power relations (for
example, the military need for troops at the front). Once inscribed with
a category, classified as a broken soldier with shell shock, PTSD, or blast
injury, the soldier emerges as a weary warrior who is left to forge a path
through the effects of being psychically wounded; some of those effects do
not manifest until after leaving the military when the soldier begins hav-
ing flashbacks, seeks employment, or even applies for life insurance.

The lessons about hysteria and neurotics from the experiences of the
Great War were partially eclipsed by fatigue and stress for soldiers *after*
returning to civilian life. Wrapped up in the economic well-being, and the
patriotic success of having thoroughly defeated fascism, Allied soldiers
returned home after the Second World War to a different society than the
one they had left. The Great Depression had eased in part because of the
growth gained in the production of military goods in the primary and
secondary economic sectors. A postwar housing boom made home own-
ership available to the average income worker. New roles opened up for
men with the expansion of economic roles for women. Social mores and
cultural norms were in a sea of change. Many returning veterans felt more
kinship with their buddies from war than with their families of origin,
making daily life tortuous for many.

Classification as a technique of power normalizes weary warriors as
part of military operations. Military psychiatrists over time have been
integrated into the protocols of the military and therefore are part and
parcel to the psychological management of soldiers—both as individual
bodies and as a group. Normalization, of course, is not free of the tensions
constitutive of the production of weary warriors through classification.
Although soldiers' agency exists within these classificatory processes as
an expression of psychiatric *and* military power, there is little expression
of individual agency in the moment when soldiers break. Soldiers ren-
dered helpless while ensconced in a tightly woven hierarchy are in a dif-
ficult place: there is no way out except to accept assistance and follow
protocol. Yet each particular instant where elements articulate with one
another generates the potential for a different or alternative configuration
to emerge. And what emerges is this wide variation of weary warriors,
whose various dimensions we examine in the following chapters.

Notes

1. Foucault provides many details throughout all his writings as to how disci-
    plinary power works. His descriptions were nuanced at the micro level such

that when teasing out his illustrations, Gore was able to distinguish these eight different techniques. The irony that Gore's typology itself is a practice of classification does not elude her or us. We are very much aware that our own analysis reproduces the same masculinized knowledge relations that we critique in this book.

2. For a fine overview of the ways in which Foucault's work has been taken up in the area of surveillance, normalization, and regulation, see the collection of Foucault's essays and contemporary works edited by Crampton and Eldon (2007). On regulation and governmentality, an important field of study that draws on Foucault's ideas about regulation, see Miller and Rose (2008) and Rose (2007). On diagnosis, see Skene (2002).

3. These circumstances changed somewhat by the end of the twentieth century. With much higher incidences of delayed onset, as opposed to onset on the battlefield or in active service, there is more choice and agency among active duty or peacetime personnel as well as veterans to undergo diagnosis or to seek medical advice and treatment for broken bodies and psyches.

4. By the term "arcs of experience" we mean differentiated assemblages of acts shaped by choice and restrictions that meld together (in memory, in observation, or in movement) that capture a set of events. By the term "event" we mean that which subsists and inheres between things and propositions as an "incorporeal, complex, and irreducible entity, at the surface of things" (Deleuze 1990: 19) that is neither located in "'deep' bodies [or] 'lofty' ideas" (132).

5. By the term "machinic" he means those liminal practices accomplished by machines that are neither human nor nonhuman (Pickering 1995: 7).

6. A set of "standards of physical examination during those mobilizations for which selective service is planned" is included as Appendix B, Mobilization Regulations Pertaining to Mental and Nervous Diseases and Neurological Disorders, in a U.S. Army Medical Department publication (R.S. Anderson et al. 1966: 775–7). The United States War Department created a protocol for physicians examining recruits for induction into the armed forces to be used during mass mobilization during the early part of 1942. Three categories—unconditional acceptance, may be accepted, and unconditional rejection—provided guidelines for the physician to determine fitness for the corps. The tolerance for nervous disorders was set along the lines of four descriptive categories constituting what the War Department considered to be "normal": "normal nervous system; who appear to have normal understanding, whose speech can be understood, who have no definite signs of organic disease in the brain, spinal cord, or peripheral nerves, and who are otherwise mentally and physically fit; hysterical paralysis or hysterical stigmata and local muscular spasms which do not cause mental or physical defects disqualifying for general military service; muscular tremors of moderate degree" (775). Leeway in the may be accepted category differs only in intensity of the "normal" recruit, except for the addition of drug addiction, especially opium derivatives (775). Reasons for unconditional rejection included 17 conditions: "insanity, epilepsy, idiocy, imbecility, chronic alcoholism, stuttering or stammering to such

a degree that the registrant is unable to express himself clearly or to repeat commands or to demand the countersign, constitutional psychopathic state, chronic essential chorea, tabes (locomotor ataxis), cerebrospinal syphilis, multiple sclerosis, paraplegia or hemiplegia, syringomyelia, muscular atrophies and dystrophies which are obviously disqualifying, hysterical paralysis or hysterical stigmata so serious that these defects are disqualifying for military service, neuritis or neuralgia which is not temporary in character and which has progressed to such a degree as to prevent the registrant from following a useful vocation in civil life, and brain tumors" (775).

7. Meaning of "perform" and "performance" is either in a Goffman (1959) or a Butler (1990) sense.

8. A good example of the symbolic is the American recruitment poster designed by J.M. Flagg, distributed in 1917. The poster had a picture of a white-haired man, clad in a star-banded top hat, pointing his finger directly at the viewer. Underneath the picture was the slogan, "I Want You" on the first line, "For U.S. Army" on the second line, and "Nearest Recruiting Station" on the third line. The viewer was imagined to be a young heterosexual man with a strong physical physique. The recruits, of course, were much more varied in their appearance, physicality, and sexuality.

9. A paternalistic tone accompanied the imposition of a "new" (to the soldier) knowledge about broken bodies that had not until this time been popularized. Barker (1993) takes up the issue of agency in the fictional character of Billy in his *Regeneration* trilogy. See chapter 5 for more discussion about agency and the link to subjectivity.

10. We address the uneven integration of veterans into civilian life in chapters 4, 5, and 8.

11. Charles Kuhl had been suffering from malaria at the time of the incident. Later, when interviewed after the film *Patton* was released, Kuhl said that the general was "pretty well worn out … I think he was suffering a little battle fatigue himself" (quoted in Axelrod 2009: 116).

12. In support of this general argument, Moss (2013b) traces specific accounts of how record-keeping and report-writing among military psychiatrists contributed to this shift through practices of love.

13. See the collection of essays on PTSD by Rosen (2004) for a discussion of a range of views on the nature of traumatic stress.

14. In chapter 5 we illustrate some of the conceptions of weary warriors in the context of the formation of subjectivity.

15. The designation on the toe tag of true shell shock would be "shell shock–W."

16. Shell shock was (and still is to a certain extent) a common term used to describe a soldier's psychological response to the vicissitudes of war. E. Jones, Fear, and Wessely (2007) argue that such terms persist even in light of *no* scientific or medical proof. The use of the word "shell" in the vernacular goes beyond the need for "proof," and is part of a collective (cultural) understanding of how to make sense of weary warriors.

17. This debate is reflected in the popular international television series, *Downton Abbey* (2011). William (Thomas Howes), one of the footmen serving as bat-

man to Matthew Crawley (Dan Stevens) the heir of the estate, is wounded on the battlefield by a shell explosion while protecting Matthew (*Downton Abbey* 2011, 2.5). Rather than William being written with shell shock as a psychic breakdown, William is written with shell shock as a physiological breakdown. Much like mTBI, shell shock–W maintains the effects of soldiering as honorable and nothing to be ashamed of. Focusing on the external source of the wound keeps effeminate illness out and a normalized masculinity in place; William dies a hero rather than (ma)lingering as a neurotic.

Chapter 4

Managing Illness through Power

Regulation, Resistance, and Truth Games

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In the ham fisted grip of military authority, it seemed, psychiatric expertise
could become a most effective divining rod for emotional authenticity.
—Josephine C. Bresnahan, "Dangers in Paradise"

[I]ndividuals … are in a position to both submit to and exercise this
power. They are never the inert or consenting targets of power; they are
always its relays. In other words, power passes through individuals.
—Michel Foucault, *Society Must Be Defended*

History tells us there are ill soldiers both falsely and truly. The questions
thus arise, Who decides the authenticity and reality of a warrior's ail-
ments? Is it a military doctor, nurse, or psychiatrist? Is it a senior officer,
military court, or review tribunal? Is it the individual's own body in con-
junction with one or more of these other actors? And what do military
authorities do about false claims and deviant actions by individuals in the
armed forces? We are interested in the issue of the truthfulness of illness
or abnormality in combatants with regard to how power and knowledge
generate weary warriors. In examining the management of the ill soldier,
our focus is not so much on this management as a therapeutic phenom-
enon of medical care, but rather as a configuration of various forms of
authority and ways of knowing. "Whenever an individual could not fol-
low … the discipline of … the army," Foucault remarked, "then the Psy-
function stepped in" (2006: 86). To be sure, multiple kinds of power and
knowledge are institutionalized within the realms of psychiatry and the
military as well as in the power relationships of institutional force and
constraints, medical surveillance, rehabilitation, and capacity building.

Managing the ill soldier commonly occurs through the exercise of coercive power via military laws, policies on national security, and the sheer force of the state in the form of incarceration, punitive sanctions, and ultimately execution. Since the late nineteenth century the application of psychiatric ideas and practices to psychically stressed soldiers has led to formulations of the normal warrior and the warrior who is unwell. We look at particular circumstances and episodes in modern warfare in which psychiatry and the military not only complement or substitute for one another as relations of power and knowledge, as Foucault suggested, but also collide and struggle over how to manage the individual soldier. Not just a fact of modern warfare and contemporary societies, the psychologically ill soldier is also an effect of the relations of power and knowledge in and among military establishments, psychiatric practices, and cultural norms, especially norms that pertain to ideas of masculinity and morality.

We contend that managing combat illness comprises practices of "regimes of truth" or "truth games" (Foucault 2003, 2008; Weir 2008) that are entangled with issues of courage and cowardice, duty and irresponsibility, and morale and discipline. These practices and processes invest relations of power and knowledge into, onto, and through the bodies of individual solders. We understand these truth games conceptually in terms of resistance and regulation at both personal and collective levels of soldiers in the armed forces. The field of managing the ill soldier includes self-inflicted wounds and desertion as well as conceptions of malingering, fatigue, cowardice, and LMF, among other effects of combat. These phenomena emerge at various times in conflicts as problems for military campaigns—strategically and scientifically—and become objects of knowledge and domains of regulatory interventions.

Regulatory techniques for the management of ill soldiers target the bodies of soldiers in two ways: at the general body of military personnel (biopolitics) and at the individual body of the soldier or veteran (anatomopolitics). Regulatory methods for military personnel, some of which are discussed in other chapters, are concerned with screening and recruitment, training and discipline, propaganda and censorship, and are all aimed at forging a collective identity, building a fighting spirit, and maintaining morale among the armed forces and civilians alike (Foucault 2004; Matsumura 2004). Regulatory techniques directed at the body of individual soldiers and veterans who may be psychologically ill or unwell in other ways include containment, separation from other troops, medical surveillance, denial, rehabilitation, redeployment, and discharge (Bresnahan 1999). In more extreme circumstances, techniques of regulation for ill soldiers include court-martial, incarceration, denouncement and stigmatization, and military execution (Babington 1983; Brandon 1996; Corns

and Hughes-Wilson 2001; Godefry 1998; Iacobelli 2013; E. Jones 2006; Lilly 1996; Oram 2004). Regulatory techniques often manage the general body of military personnel and individual soldiers at the same time. For example, regulating individual soldiers who are ill avoids the spread of fear, panic, and aimlessness among troops more generally. By punishing specific individuals, the military sets an example to all troops of the consequences of insubordinate behaviors (which often includes illness). As well, swift redeployment of emotionally traumatized soldiers demonstrates that a case of the nerves is no way out. As we know, management is management, not control. Thus, we also have an interest in mapping out specific types of resistance by soldiers in practice as a part of military power and in relation to psychiatric power.

In this chapter we explore how truth gets worked up in military psychiatric practices and how this truth then is used in other parts of the military. We couple Foucault's understanding of power and resistance with our own understanding of embodiment so that we can make sense of how weary warriors are enacted through what we consider to be a flexible military. We detail two types of war trauma that straddle the boundedness of psychiatry and military as apparatuses. A critical look at both types of trauma—LMF and deviant soldiers—indicates how the apparatuses articulate with one another quite differently from how they plugged into one another in the case of diagnosis in military psychiatric practice.

Power and Resistance

We are interested in applying Foucault's conception of resistance, which has received notable attention in social theory and political analysis (Feder 2011; Heller 1996; Hequembourg and Arditi 1999; C. Mills 2000, 2003; Pickett 1996; J. Reid 2006), but *not* in applying that conception to military organizations or to weary warriors. As we noted in chapter 1, the military is an institutional domain that Foucault did not examine in any great detail in his body of work, despite his fascination with the conception of war for analyzing power. Nor did he apply in a concrete manner the idea of resistance within the military, probably because he tended to portray the army as a tightly ordered disciplinary apparatus that produces docile bodies. The figure of the soldier that appears in Foucault's work is of the productive machine. Nonetheless, we begin by recalling Foucault's statement, "Where there is power, there is resistance" (1990a: 95).[1] He saw points of resistance to be present everywhere in networks of power relations, playing various roles as "adversary, target, support, or handle" in these relationships. Resistance was typically "a reaction or rebound" by

individuals or by groups against the exercise of dominating power. As an example of "the microphysics of power," resistance entails the local tactics and specific practices by those on whom the power is directed and at the outreaches of overriding power structures. From the viewpoint of managing hierarchical interests, resistance threatens organizational integrity by "fracturing unities" that, Foucault postulated, would trigger "effective regroupings" by authorities to prevent the proliferation and the regularization of resistive acts (96).

Various theorists have usefully identified further elements of a Foucauldian notion of resistance. For Brent Pickett (1996:461), these elements are that resistance "is non-hierarchical, concerned with memory and the body, and the negation of power, while still potentially affirmative of something else." While a Foucauldian approach does not include normative reasons for explaining or justifying resistance, it does include "the possibility of resistance leading to new forms of subjectivity" (464). Julian Reid (2006: xi) writes that "life itself, in its subjection to governance, can and does resist, subvert, escape and defy the imposition of modes of governance which seek to remove it of those very capacities for resistance." Amy Hequembourg and Jorge Arditi (1999: 665) offer the insight that "resistance is not one thing [but] is a multiplicity of different things depending on the strategy implemented." Catherine Mills (2000: 265) notes how Foucault suggested that "resistance and the subject who resists are fundamentally implicated within the relations of power they oppose." Drawing on both Butler's and Foucault's work on resistance, Mills adds that resistance "also carries with it the danger of the subject's own dissolution" (272) or death, putting the subject at risk from the efficacy of an authority striking back at the resister. As Mills expresses it, "while power will survive this encounter, the subject who resists may not," given the inequality in force relations (272). At times, though, the exercise of retaliation toward the resister may be reversible, at least in some partial fashion.

Building on this line of analysis, we suggest that resistance is implicated with power in the domain of fighting operations and of managing illness among combatants. Accompanying the power of force relations within a military establishment is the resistance of some of its own soldiers at local and specific sites by means of multiple tactics. Where there is the exercise of power by an army in militaristic or psychiatric ways, there is the possibility of resistance by some of its troops. Such resistance takes a number of forms, including malingering or simulation, self-inflicted wounds, desertion, cowardice, fragging, or failure to carry out one's duty.[2] Understandably, these sorts of resistance are construed as challenges to the hierarchical nature of power, especially in an authoritarian system like a military. Such acts of resistance are a calculation, an intentional choice

with the objective of disengagement from the military mission at hand, an escape from immediate dangers.

At the same time, acts of resistance provoke countermeasures by military authorities, ranging from disciplinary power mechanisms such as warnings through an array of punishments to the definitive exercise of sovereign power as the right to take life by military execution. In a military context, especially in times of armed conflict, resistance as insubordination is a core threat to discipline, order, victory, and survival. Acts of resistance are intrinsically dangerous, disreputable by military standards, and highly controversial acts. We present empirical material to illustrate that sanction by the state and military on resistant or deviant soldiers can and has been reversible in the short term and, in certain cases, several decades later.

The resistance of soldiers connects with subjectivity through processes of agency and (re)subjectification. As Pickett (1996) explains, "there is always at least some resistance to the imposition of any particular form of subjectivity, and thus resistance is concomitant with the process of subjectification" (458). He adds, "The practice of resistance is directly linked to the practice of self-creation. Refusing what we are" (464). Hequembourg and Arditi (1999: 665) agree: "resistance indeed implies the existence of a subject, at least partially autonomous, who actively opposes the structure of domination." Soldiers accused of desertion or LMF, or in self-inflicting wounds are examples of subjectification by which soldiers are constituted as cowards rather than resisters.

Acts of resistance by soldiers relate to Foucault's concept of technologies of the self: soldiers deploying techniques in specific times and places to act on their own bodies to become subjects that materially are or nominally appear to be injured, ill, or shocked. So-called malingerers and simulators enact an individually contrived subjectivity, engaging in public performances that present them as overly docile, unpredictable, and nonproductive as military personnel. Soldiers who inflict wounds on themselves are consciously reshaping their bodies, reconstructing themselves as subjects by producing a defect or pathology. Margaret A. McLaren (2002: 110) argues that resistance offers an alternative configuration of power/knowledge that does not always take hold in the ways that those resisting might want. At the very least, however, resistance reignites the pathways through which power is deployed. Rather than grand ruptures or mutinous rebellions among soldiers, within the military "one is dealing with more mobile points of resistance, producing cleavages in a society [in the military] that shift about, fracturing unities and effecting regroupings, furrowing across individuals themselves, cutting them up and remolding them, marking off irreducible regions in them, in their bodies and minds"

(Foucault 1990a: 96). Although not speaking about resistance among soldiers, Foucault describes the way that resistance works within apparatuses such as psychiatry and the military: "Just as the network of power relations ends by forming a dense web that passes through apparatuses and institutions, without being exactly localized in them, so too the swarm of points of resistance traverses social stratifications and individual unities" (96).

Malingerers and Their Practices of Simulating Illness

As an issue in the military generally and especially during warfare, malingering is an old and enduring concern. It has a clinical literature that dates back at least 175 years (Ballingall 1855; Gavin 1838), with particular attention to the American Civil War (D. Anderson and Anderson 1984; Chipley 1865; E. Dean 1991; Freemon 1993), around the time of the Great War (Hurst 1918; Rennie 1911; F. Weber 1918; Yealland 1918), the Second World War (Bresnahan 1999; Brussel and Hitch 1943; French 1996; N. Lewis and Engle 1954), the Viet Nam War (Lynn and Belza 1984; D. Smith and Frueh 1996), and contemporary armed conflicts (Bélanger and Aiken 2012; Nies and Sweet 1994). This literature, not surprisingly, derives from the standpoint of military officers, psychiatrists, neurologists, psychologists, and medical doctors—in other words, those in positions of authority who are concerned about understanding, detecting, managing, and punishing acts of malingering in the armed forces.[3]

In lectures on psychiatric power and his other works on madness, Foucault commented on the issue of malingering or simulation, but generally downplayed the power-effects of such conduct. When "someone who is not mad could pretend to be mad," Foucault (2006) writes, this "simulation does not really call psychiatric power into question [for the reason that it is not] an essential limit, boundary, or defect of psychiatric practice and psychiatric power, because, after all, this happens in other realms of knowledge, and in medicine in particular." He continues, "We can always deceive a doctor by getting him to believe that we have this or that illness or symptom—*anyone who has done military service knows this*—and medical practice is not thereby called into question" (Foucault 2006: 135; emphasis added). Foucault suggests that the deception of doctors is a fairly common and straightforward occurrence, even in military contexts. In our view, however, looking at the history of weary warriors shows that malingering or simulation has posed, and still does pose, significant challenges to psychiatry and the military as embodied apparatuses. In the domain of military psychiatry and in medicine more generally, the question of whether

a neurotic or hysterical soldier is really suffering from a war-related neurosis (read: is pretending to be ill) has been a striking and persistent issue since the nineteenth century.

Discursively, a multiplicity of judgmental terms has emerged around this phenomenon of malingering and simulation. These include "faker, goldbrick, scrimshanker, racketeer, sick bay commando, shirker and slacker" (Carroll 2003: 732). Still other terms that the soldier faces as a result of malingering are "coward," "deceiver," "fraud," "lead-swinger," "liar," "pseudo-PTSD," "sham invalid," and "symptom exaggerator." These are harsh, derogatory terms with the intended effect of stigmatizing the actions and (publicly) shaming the individuals accused. Perhaps the only exception, the only positive context, relates to malingering by POWs: "Amongst prisoners of war simulation of disease for purposes of reparation tends, of course, to be regarded as fair play and as rather creditable than discreditable, if it is successful" (F. Weber 1918: 8).

This complex of discourse indicates that real or suspected deception is a direct struggle against psychiatric practice, military medical staff, and military commanders. The presentation of false symptoms or illness remains contested within medicine, military establishments, and veteran bureaucracies in welfare states. Malingering is an object of research and theorizing by historians, clinicians, and policy-makers and is part of power/knowledge configurations in relation to *who* possesses the truth about a soldier's health status. "The combination of simulated with genuine signs or symptoms is often especially difficult to detect" (F. Weber 1918: 168). Whether real or imagined, detected or undiscovered, malingering in the military illustrates the prospect of resistance in power relationships as the efforts, at least by some individuals, at various points in time in specific spaces (battlefield, trauma unit, convalescent hospital) to resist authority, to avoid the grip of military surveillance, to evade the duty of active service or redeployment to the lines, and to resist practices and knowledge associated with medicine. Malingering as a form of resistance brings with it other stigmatizing forces by disparaging malingerers as effeminate, challenging the masculine ideal of the fighting soldier.[4] In the U.S. armed services during the Second World War, one way "to deal with fear of combat involved defining military manhood in relation to certain definitions of womanhood," thus characterizing them "as a bunch of whiny women" (Bresnahan 1999: 42).

Over the past few centuries, psychiatry and other branches of medicine have had a good deal to say about malingering in the military (and in other domains of life) in classifying types of malingering, identifying the causes and motives, and devising and administering methods for detecting feigned illnesses by soldiers. Much has been written on how to detect

simulated symptoms, how to avoid warning the patient that any suspicions were held of his claims, and how to elicit honest responses to tests and examinations. Typologies of malingering over time became more detailed and tactics for unmasking malingerers changed with developments in medical technologies, forensic science, computerized record keeping, and cultural attitudes. During the American Civil War, doctors in both the Northern and Southern military forces diagnosed ailing soldiers as either suffering from a physical illness, such as irritable heart, or simulating symptoms to avoid military duty (Freemon 1993). In the early decades of the twentieth century, various classifications with more elaborate types of malingering were developed by physicians who referred to malingering as "mythomania" and the simulation of disease as "pathomimia." Forms of malingering sorted by health specialists came to include feigned insanity or mental disease and "false claims of depression and suicidal behavior … or other legitimate psychiatric disorders" (Carroll 2003: 735); assumed fits, including epilepsy; pretended or grossly exaggerated defects of back pain, hearing, vision, or speech; voluntary starvation; spurious pyrexia, enuresis, hemoptysis, sleepwalking disorder, or artificial hernia; simulated cases of chronic venereal disease; and pseudo-PTSD or factitious PTSD.

An early classification informed by initial work on psychoanalysis distinguished between neuromimesis (the unconscious mimicry of disease) and hysterical malingering (the awareness and more or less voluntary imitation of disease, or conscious shamming) (F. Weber 1911). Other specialists similarly distinguished between involuntary malingering ("the exaggeration of symptoms and prolongation of incapacities") and pure, true, or voluntary malingering (purposeful simulation and deception) that, in the experience of one neurologist during the Great War, was "very rare in the British and French armies" (Hurst 1918: 28). In 1915 the Neurological Society of Paris debated the issue of the simulation or exaggeration of symptoms in nervously wounded soldiers. The classification of malingering adopted set out the following categories (Roussy and Lhermitte 1917): assumed malingering—produced by such actions as taking picric acid to produce jaundice, or tobacco to produce conjunctivitis; invented malingering—creating or copying a disorder so as "to excite attention, commiseration and pity," "the form most commonly observed in the army"; exaggerated malingering—"an amplification of the symptoms caused by some real objective lesion, either neuropathic or organic"; and "prolonged malingering—the willful persistence in a pathological attitude or a symptom associated with some definite lesion, after the latter is healed or obviously improved" (xxxi–xxxii).[5]

Underlying these categories of malingering, a range of causes were acknowledged. Reflecting on the American Civil War, an army surgeon

suggested that the motives behind soldiers feigning insanity were self-preservation; to gain charity, public relief, and shelter; and "to excite public interest and curiosity and to obtain notoriety" (Chipley 1865: 6). A physician in the Royal Army Medical Corps in the early years of the twentieth century described the etiology of simulation in terms of wishing to secure exemption from military service altogether, feeling nostalgia and homesickness, avoiding exposure to new dangers at the front, evading an unpleasant duty, circumventing the consequences of misconduct, and hoping for a pension or other financial compensation for supposed injuries (Pollock 1910). Other explanations on how and why the exaggeration of symptoms may occur centered on clinical settings and practices: the patient's need for sympathy induced by emotional disturbances, the effect of repeated examinations by medical staff in intensifying the patient's subjective sensations, and the effect of suggestions by family members or colleagues in intensifying or prolonging the symptoms (Rennie 1911). This range of motives and factors is comparable to those identified by clinicians in the early years of the twenty-first century to understand malingering in today's militaries (Carroll 2003; Geraerts et al. 2009).

From the perspective of authority positions in psychiatry and the military, possibilities of clinical deception and malingering have produced several techniques for exposing contrived physical or psychiatric symptoms and determining the *true* status of the soldier. We have identified five technologies of truth.

1. Tribulation. This is a set of mechanisms that are tests or ordeals. As critical examinations more than clinical evaluations, these trials of hardship are conducted under often dramatic and severe circumstances designed to find out the presence or absence of a condition. In the American Civil War, methods used by army surgeons and officers on suspected malingerers included threats, floggings, water-therapies, whirling-chairs, and chloroform (D. Anderson and Anderson 1984; Chipley 1865). Carroll (2003: 734), a forensic psychiatrist, observes, "tactics to unmask malingering were used that would not be allowed today. For example, a man who was suspected of faking blindness was taken to the edge of the river and told to walk forward. He promptly fell into the river. Another man who claimed he could not straighten his back was placed in a large cask of water. The cask was filled, and he was given a choice of either straightening his back or drowning. He subsequently was able to stand up straight. Firing a pistol near the ear was a method used to expose feigned deafness."

2. Clinical Evaluation. Through the use of initial assessment and successively extensive examinations, CT and MRI scans, medical workups,

and therapeutic interviews, the medical gaze and psychoanalytical ear are at play. Practitioners generally believe that most simulated symptoms and feigned activities will be recognized at this stage of malingering management, although they acknowledge that probably not all inventive simulators will be detected nor all simulated symptoms unambiguously distinguished from actual conditions.

3. Continual Observation (Surveillance). Carefully watching the soldier or veteran on a regular and at times unobtrusive basis over a prolonged period—at a field hospital, rehabilitation facility, outpatient clinic, or alcohol and detoxification unit, among other sites—offers opportunities to establish the veracity of the diagnosis and symptoms, or to determine that the presentation of clinical signs is missing, inconsistently manifested, or wildly exaggerated (Roussy and Lhermitte 1917; Yealland 1918). "Occasionally an unskilled malingerer may be detected flagrante delicto. … The appropriate treatment for a paraplegic man, who is discovered walking in the ward when he thinks he is alone and unseen, is to send him to the military authorities for punishment" (Hurst 1918: 28).

4. Verification of Records. A standard technique for determining the validity of claims is through collecting and confirming information about the soldier. This includes such methods as contacting relatives and reviewing family history, obtaining any previous medical records, and ascertaining military details that, in the United States for example, can be obtained through national service records and the national POW register. This gathered body of evidence may then be compared against patient-supplied information to confirm or challenge the truth claims of the ill soldier.

5. Confession by Person or Body. A confession, in this context, is not about a soldier admitting to a disorder but rather about a soldier owning up to shamming ill health. Confessing is a multifaceted phenomenon, a process with various dimensions: whether the confession is voluntary or forced (as under tribulations), conducted in the presence of medical or military personnel, judged as credible or fanciful, deemed to be punishable or not, and communicated by bodily signs and/or spoken words. In the military, confessions do not seem to be a major technique for producing truth about maladies or malingerers. Writings by psychiatrists, neurologists, and other types of physicians suggest that confessions of simulating disorders are an uncommon occurrence and not always straightforward, depending in part on whether the traumatic experience is a recent or distant event. An admission of guilt of malingering is not necessarily a true statement: "a confession is by itself no sure indication of simulation [of insanity]. A genuine psychotic may try to achieve

early release from certification by asserting that he has simulated" (At-kin 1951: 385). "Very rarely a malingerer confesses that he is shamming [convulsions or hysteria], but a confession should only be accepted if it is not forced from a man and it fits with the facts. … Such cases should be sent back to duty at once, but without punishment" (Hurst 1918: 28).

As well as by an admission through speech, a confession of ma-lingering can come from the body itself through the presentation of dubious movements or other corporeal signs. As an American military publication for the Second World War warned troops, "the malingerer posing before a psychiatrist as a nervous-breakdown case will almost invariably meet with an unpleasant surprise. It is difficult to escape detection for the simple reason that a man cannot fake the dilation of the pupils in his eyes. This dilation, which can't be faked, accompanies the symptom of extreme jumpiness, which sometimes can" (Bresnahan 1999: 203). Here the body speaks the truth, disclosing to medical and psychiatric experts the true state of a soldier's health. Malingering, therefore, involves a double betrayal: the first, the act to conceal one's actual conditions; the second, discursive and bodily actions that reveal that actuality.

Malingering as a practice by some soldiers makes what does not ex-ist to be something that does seem real. Such practices function within a truth game or regime of truth that Foucault (2008: 18) describes as "the articulation of a particular type of discourse and a set of practices … that … legislate on these practices in terms of true and false." Certainly in the military and in a combat context, a regime of truth is not a neutral space nor is it simply consensual, especially when both self-reporting and medi-cal diagnoses of symptoms are involved. Indeed, "truth is a thing of this world: it is produced only by virtue of multiple forms of constraint. And it induces regular effects of power" (Foucault 1980c: 131), through, for ex-ample, technologies of self. Different participants may all express versions of a psychiatric discourse of (materialized) symptoms and treatments and of a military discourse of (materialized) service, combat, and fatigue. Yet through these discourses there operates particular perspectives of this or that soldier in this or that situation.

Initial truth claims of a soldier or veteran generate a sequence of re-sponses and actions by medical and military personnel. Claims of identities and one's psychiatric conditions—expressed psychical and physiological conditions—become subject to a determination of what is true and what is false. Consider this dramatic report of several cases of factitious PTSD at a Veterans Health Administration medical center:

> A growing number of young men have reported an array of symptoms that suggest a diagnosis of posttraumatic stress disorder. Five such men, all claiming to be Viet Nam veterans, were treated at a VA medical center; three said they were former prisoners of war. In fact, none had been prisoners of war, four had never been in Viet Nam, and two had never been in the military. Instead, all five suffered factitious disorders. (Sparr and Pankratz 1983: 1016)

The health specialists who authored this report conclude,

> Guilt or indifference about our treatment of Viet Nam veterans should not prevent clinical objectivity and reasonable confrontation of a patient's fabricated histories and factitious symptoms. It is not necessary to be suspicious of everyone, but a brief military history should be taken on all veterans to look for service-related stressors. (Sparr and Pankratz 1983: 1019)

Signs of a problem of truth include exaggerated complaints disproportionate to the material results, contradictions in the documentary record of the soldier, numerous discrepancies in their life story and family history, and the apprehension by health specialists of ulterior motives by patients, such as seeking to gain financial benefits or free services (Carroll 2003; Sparr and Pankratz 1983). Military and medical authorities deploy various techniques (discussed above) to investigate and judge the claims, to assess the problematic signs, and then to establish a dominant discourse of truth using powers of sovereignty and psychiatry.

Constructing Cowardice: Lack of Moral Fiber

As a diagnosis and a discourse, LMF is situated within its own history, truth claims, and relations of power/knowledge. During the Second World War, refusal to fly in combat or training missions, when constructed as something other than for psychological reasons of a neurosis, emotional stress, or physical fatigue, was designated by the Royal Air Force (RAF) and the Royal Canadian Air Force as a flaw in the individual's integrity, an illness of his soul.[6] This policy constructed categories of soldiers as the psychologically normal and the morally fit aircrew in contrast to the psychologically abnormal and the morally deficient. Aircrew members officially labeled LMF or a waverer were deemed to have lost confidence in their own abilities; their commanding officers and probably their fellow crew members also lost confidence in them. The history of LMF is an example of a multiple and layered knowledge on managing soldiers' ill bodies. Official information is almost absent, with little mention in histories of the RAF medical services and with records and files destroyed

or missing. Similarly, memoirs of air commanders or histories of bomber commands tend to take an uncritical view of LMF (E. Jones 2006). The actual experiences of aircrew are largely forgotten and only occasionally reported (Trainer 1994), although a modest academic literature has appeared decades after the war, written mainly by historians (Brandon 1996; English 1995, 1996; E. Jones; McCarthy 1984).

LMF policy processes and techniques involved administrative action by the RAF, a particular normalization of flying and combat stress, and the segregation and investigation of aircrew designated as LMF. As an operational policy, LMF was formally adopted by the RAF in April 1940, officially altered somewhat in July 1943, and officially ended in late 1945, although E. Jones (2006) offers documentary evidence that indicates the policy was practiced in the RAF into the late 1950s. The concept of LMF was not a psychiatric diagnosis but military judgment *acting like a psychiatric diagnosis.* LMF was an administrative term deployed within the senior ranks of the RAF command (Brandon 1996; E. Jones). "In the prewar period [of the 1930s] planners made little provision for psychiatric casualties among aircrews, mistakenly assuming that a highly selected, volunteer service would be virtually immune from psychological breakdown" (E. Jones 2006: 449). A core assumption underpinning the LMF policy was that men volunteering to be aircrew would not withdraw their consent to fly and go into combat missions (Brandon 1996: 124). Another officially held belief was that LMF, however it might be understood, was contagious and could rapidly spread throughout a crew, squadron, or entire base if not addressed by means of the removal and segregation of those aircrew designated as LMF or not yet diagnosed (Balfour 1973; Brandon 1996).[7] The LMF policy rested on the sovereign rights of the British state and the RAF as a branch of the armed forces, the latter of which defined the norms of LMF as the lack of self-control, personal fortitude, and courage. The RAF was the moral authority, developing an explicit policy and implicit cultural code within it, which expected aircrew to perform their duties steadfastly and without faltering. Those members of aircrew with LMF were seen as posing a clear threat to the morale and fighting capacity of comrades, endangering others and the general operations. Such norms intended to discipline the individual member as well as to regularize the aircrew and squadron alike.

Power-effects of the LMF policy encompassed the assertion and exercise of military authority, a control over and containment of what could be considered psychiatric in nature, and the disgrace and degradation of aircrew unwilling or unable to continue flying operations. The RAF's LMF policy was an executive action by senior commanders involving scrutiny by officers for its enforcement and the imposition of severe penalties as disciplin-

ary measures, such as the demotion of officers and others to lowest ranks, expulsion from the air force, and assignment to other military duties or civilian work. The very design and implementation of the LMF policy was meant to limit the role of psychiatrists and of physician medical officers as well as the application of psychiatric and psychoanalytic techniques in deciding why a crew member was unwilling to fly again. According to Brandon (1996: 127), "it is estimated that over 30 percent of all LMF cases were disposed of purely by executive action, without involving any specialist medical referral." Statements at the time by medical staff involved in treating cases of anxiety neuroses and lack of confidence among RAF aircrews indicate that "physicians were called upon to modify their diagnoses and treatment to conform to military requirements" (English 1995: 26). Conflicting opinions between military staff and medical staff over the validity of the LMF designation indicate interplay between regulation and resistance in managing flying combat stress and fatigue. In 1944 and 1945 there was some easing in the punishments imposed under the LMF policy—a de-disciplinarization or relaxation of military authority—and somewhat more recognition of the stress and strains from repeated flying in dangerous operations—a medicalization and psychiatrization of sorts (E. Jones 2006: 450, 456).

Stigmatization was most certainly an intended effect of the LMF policy. The label of LMF was a mark of personal shame and a technique of control used by the British air force to manage pilots. The aims were "to deter aircrew from reporting sick without due cause or simply refusing to fly"; to minimize the withdrawal rate from bomber missions; to contain fear, reinforce discipline, and maintain morale "among flying personnel." The belief of RAF commanders was that "a measure of stigma is needed to prevent both conscious and unconscious resort to psychological disorders as an exit from situations of personal danger" (E. Jones 2006: 455–56). What made LMF so stigmatizing was a combination of the administrative diagnosis, discourse, and degradations inscribed onto the aircrew. Breakdown by an aircrew member labeled as LMF was by definition due to nonmedical factors. The fault then lay with the individual, not the combat or the number of missions or the cumulative strain and shock of experiencing the loss of comrades. The individual was characterized as lacking confidence and fortitude; he was weak, jittery, and of bad stock.

Based on Freudian psychoanalytic ideas, RAF psychiatric doctrine explained that the breakdown of an aviator was due to character defects and an individual's predisposition to collapse or failure (English 1995). Under the LMF policy, the difference between aircrew who were medically ill and those who were not had severe consequences. Penalties for being LMF were harsh, producing a discredited subject: the immediate removal

of flying badges while under investigation, reduction in rank and loss of privileges, discharge from the air force with no financial compensation, and reassignment to the army, to work in mines or other civilian labor. The U.S. Army Air Force, when based in Britain in the Second World War, pursued a less stigmatizing approach to dealing with aerial combat stress, employing the concept of operational fatigue rather than LMF or a type of neurosis; in contrast to RAF practice, American commanders did not remove the flying badges of personnel unable or seemingly unwilling to fly in combat (Brandon 1996: 128: E. Jones 2006: 440).

Reassessing Deviant Soldiers

At the end of the Second World War, British Army Headquarters produced a "Report on 'Soldiers under Sentences' for Such Offences as Desertion, Cowardice, Mutiny, etc., Whose Case Have Been Reviewed in British Second Army" (Moll 1945). A fascinating account of the interplay of psychiatric and military practices during wartime conditions, the report concerns 596 soldiers who were serving sentences of three years for penal servitude for military-related offenses committed in June, July, and August of 1944, following the invasion of Normandy. Most had therefore seen a number of months of active service before they were charged and most had given themselves up. In an eight-week period from November 1944 to January 1945, these men were interviewed by a reviewing board (the British Second Army Reviewing of Sentences Board) made up of the deputy adjutant, quartermaster general, and assistant adjutant general of the Second Army along with one psychiatrist. The Board had the authority to suspend sentences on these soldiers whom it considered "worthy and would acquit themselves well. Each was warned of the serious consequences should he again commit a similar offence" (2).

The role of the psychiatrist and psychiatric knowledge emerged from evidence in court records and interviews by the Board with the convicted soldiers. "Those men, who at the interview were not impressive or showed signs of nervous instability, mental dullness or complained about their nerves etc., were subjected to a detailed psychiatric examination before a final decision was made with regard to future disposal. Similarly, if the Court Proceedings contained any reference to such disabilities, then a psychiatric examination was carried out" (Moll 1945: 2). Of the 596 cases reviewed, 204, or about one-third, were referred for psychiatric assessments. Of these 204 cases, most were transferred to auxiliary employment within the military; about one-quarter returned to full duty, a dozen were admitted to psychiatric hospitals for treatment, two were deemed to be

conscientious objectors and transferred to the army medical corps, and one was discharged from the service.

On the consequence of imprisonment, the Board observed both punitive and corrective effects: "The three months in prison had acted on many, not only as a deterrent to further crime, but as a 'rest-cure' or 'rehabilitation'" (Moll 1945: 4). Moreover the three months in prison "had given them ample time and opportunity to reflect hard and fully realize what a terrible mistake they had made" (4). As a general comment about the prisoners, the Board reported, "The great majority of prisoners were good personality types, only too anxious to be given the opportunity to redeem their characters. They were completely and utterly ashamed of their failure" (5). Thirteen soldiers from the cases before the Board were kept in prison because they are an "incorrigible type of man" (7).

> The real "bad eggs" or incorrigible types were weeded out, segregated and further punishment administered. For this group, fortunately extremely small number, Board members felt that harsh and rigorous treatment was the only alternative. Even some of these, after a further period of imprisonment, appeared to have had their warped outlook modified and eventually became reasonable soldiers. For the remainder we had no alternative but to retain them in prison, but who knows, they were probably just made of poor clay which could not be moulded, no matter how hard one tried! (Moll 1945: 14)[8]

The Board concluded that the majority of deserters in these cases were not true cowards. Most offenses were not believed to be premeditated but rather happened at the spur of the moment when the soldier was under great stress. Immaturity and peer pressure were other identifying factors: "Very often it was a case of a younger soldier led astray by an older man of low morale" (Moll 1945: 10). Some prisoners explained their behavior in terms of lack of training after being transferred to infantry from another arm of the service. The Board noted, "although one was careful not to show it, one felt that perhaps there had been too little preparation for a change to an active combat role" (11). Furthermore, the Board observed that certain types of these prisoners were war-weary individuals: "At this stage of the war there are many combatant soldiers, of good previous personality and attitude with good records, whose length of action in different theatres is considerable and who have reached the end of their resources to deal with battle stress" (12). The Board therefore accepted that many of these individuals had a "reduced capacity to adjust to further battle stress. Such cases needed, not further punishment, but considerate treatment for their past service" (12). With the aid of psychiatric assessments in some cases and the imperative to find additional troops for the frontline, the military went some way to normalizing these acts of devi-

ance by soldiers through identifying mitigating factors, admitting to some gaps in official practices, and recognizing the role of external influences on the soldiers sentenced. That most soldiers had done some active service, served some prison time and were now ashamed were also significant considerations by the Board in concluding that most of these offenders were good personality types. "Courage and cowardice are held to be psychological imponderables whose measurement and promotion still await final decision. The dividing line between real fear of external dangers and neurotic anxiety is extremely fine" (10).

From the cases reviewed, 435 soldiers were returned to full duty, many of them back to the frontline. Of these 435 soldiers, 37 received psychiatric assessments. What happened to these deviant soldiers—including soldiers with psychological wounds—who were offered a second chance to be warriors? Approximately 70 percent or 306 of those returned to duty were a success: 287 were reported as giving a satisfactory or greater service as a soldier, 17 were wounded in action and 2 were killed in action. Another 94, or 22 percent, were deemed to be a failure in that they were reported as unsatisfactory soldiers or convicted again, refused to go forward, went absent without leave, or wounded themselves as a way to get out of combat (self-inflicted wounding). A small group was examined by a psychiatrist and either downgraded, transferred, or admitted to a hospital. In explaining the 70 percent success rate of the redeployed soldiers, the Board wrote, "These were good personality types who for various reasons had failed once, realized their shortcomings, were given the chance to prove their worth and not again let the side down. The obvious neurotics, psychopaths, misfits, dullards etc., were spotted and directed into employment within the limits of their capabilities. The percentage of 'real bad eggs' has been small. This has been a tonic and serves to emphasize what has always been the case—the British soldier is by nature neither a coward nor a malingerer" (Moll 1945: 5). Between January and May 1945, when the war in Europe ended, the British Second Army Reviewing of Sentences Board returned an additional 372 soldiers to full duty at the frontline.

The Board's report to the Army underscored the importance of psychiatric knowledge and comparable forms of expertise in such proceedings, recommending that "there should be available to the board data of a scientific nature in the form of intelligence and aptitude tests, personality pointers etc. Thus, when a board was convened, it would have available, not only reports from the Prison Commandant, Prison Visitor [an experienced soldier who would talk to each prisoner], Padre, Welfare authorities and Educational Branch, but also a comprehensive technical assessment of each soldier" (Moll 1945: 3). Underlying this claim was the belief that "with this additional information, more accurate disposal rec-

ommendations will be possible" (14). Psychiatric knowledge could then assist military authority in determining which soldiers ought to have an opportunity to redeem themselves through redeployment to the battle lines, which soldiers needed care, and which ones were just plain bad.

On Whose Authority?

In modern times of warfare, the detection and naming of illness, cowardice, desertion, fear, malingering, LMF, and self-inflicted wounds are all implicated in relations of psychiatric and military power. The bodies of weary warriors are places of regulative acts and resistive actions. At some time or another, soldiers may grumble about their mission, question the judgment of their commanders, or complain about their situation. Such expressions of discontent regularly take place in private or safe quarters, outside the view of officers. Some soldiers, however, openly resist in the immediate or imminent presence of military commanders, including military psychiatrists. Simulating serious symptoms of fatigue, emotional trauma, or war neuroses or inflicting wounds on one's own body are forceful and public acts of resistance (J.C. Scott 1990). These acts of resistance operate at the confluence of psychiatric and military power and practices of knowledge. Such acts indicate a nuanced and complex set of power or force relations in the authoritarian structure of the military hierarchy, pointing to a microphysics of power where assertions are not unidirectional, and an exercise of power challenges military authority.

Even in military systems, individual members, as subject positions, "are not the exclusive 'property' of the dominant ensemble of power relations" (Heller 1996: 99), whether those power relations are the formal chains of command or the health sciences of the body and mind. Regulation and resistance both involve a capacity to create and recreate personal and social realities within relations of power of life and death. The review of incarcerated soldiers from the British Second Army under sentences for such offenses as desertion and cowardice near the end of the Second World War in Europe, illustrates that "the mechanisms of power that a group uses to control other groups are always potentially *reversible*" (Heller 1996: 101; emphasis in original). In this instance, senior levels of authority attempted to control a group of deviant soldiers for larger strategic reasons—that is, the need for troops at the frontline. Deviant soldiers, committing offenses against sovereign authority, were found guilty of serious breaches of military law. Yet when needed for other purposes, they were reassessed as objects of psychiatric and military objects of knowledge and given a second chance at redemption through continued service. This was a case

of military tribunals making and then unmaking soldiers as criminal sub-
jects. It also was a case of "a truth that can be deployed … from its combat
position, from the perspective of the sought-for victory" (Foucault 2003:
52).

Forms of resistance examined here reveal a connection between resis-
tance to power and soldiers' relationships to their own selves, their own
bodies, and their own souls. Malingering, simulation, and self-inflicted
wounding, as acts of resistance by soldiers, represent tactics for redefining
the boundedness of one's own subjectivity, from being subject to the risks
of combat and the dangers of the frontline, to becoming a subject who
presents as sick or injured and thus unable to be a warrior. If found out by
military authorities, the malingerer—in all-out efforts to appear abnormal
or unfit for regular duties—forfeits the positioning of the traumatized
individual, grounded in psychiatric knowledge, for another, the exposed
and disgraced faker, grounded in military norms and general morality.
Such acts of resistance are taken by soldiers who face only a field of impos-
sibilities, of intolerable conditions, of unthinkable horrors. Their actions
are local tactics, calculated ruses attempting to alter relations of military
force and to assert, in some measure, the primacy of their relationship to
their own self, their own reputation, or their own family. From the per-
spective of military authorities (and the nation-state officials authorizing
the military), these acts of resistance are not practices of freedom, but
rather are grave threats to their comrades, to the wider military mission,
and to a nation-state's basic interests. If anything, such resistance by sol-
diers is framed as ultimately a threat to the freedoms of civilian popula-
tions and thus is met by an array of responses of control by the military
and sanctioned by the nation-state.

The primary purposes of managing and regulating responses by the
military include minimizing panic or fear among troops, punishing resis-
tance and thus deterring further acts of insubordination, and maintaining
morale among the troops. The preparatory mechanisms through which
the military accomplishes its purposes are the enhancement of the combat
and operational readiness of soldiers, both individually and collectively,
and the maintenance of a military ethos as a set of regularized and ex-
pected norms for the manner of conduct. Inventions by the military, and
in some cases the nation-state, relate to the production of specific subject
positions or types of identities, such as how a number of aircrew in Brit-
ish bomber command in the Second World War were labeled as LMF
individuals. With the LMF policy, an argument can be made that the RAF
produced cowardice as a byproduct of official assumptions, administra-
tive definitions, and limitations on psychiatric practices.

The relation between truth claims and varied modes of resistance and power exercised by and through soldiers pulls together our understanding of the ways in which psychiatric and military power relations feed into one another. From the viewpoint of psychiatry and military psychiatrists, malingering and the question of truth among fatigued soldiers is established through tests of tribulation, clinical examinations, repeated observations, verification of personal and official records, and, at times, confessions by soldiers or their bodies. With respect to malingering, there is a simulation of gestures, movements, and behaviors all with the aim of producing an image of the recruit or soldier as someone who is suffering deep emotional distress. Through the power of false discourses and contrived material practices, the individual is manufacturing a factitious persona and subjectivity. With respect to self-inflicted wounds, the soldier is actually producing bodily impairments as an altered corporeal reality in hopes of giving up the frontline job as a combat troop. As an obvious example of an embodied truth, self-inflicting a wound is constructed as an abnormal and questionably ethical act that has a falsity behind the reality. The LMF policy disclosed aviators who refused to fly, whereas our analysis discloses a discourse of truth based partly on a specific hierarchy of social class and set of historical beliefs about masculinity. It must be remembered that LMF was created by senior officers and backed by both sovereign and disciplinary forms of power. The power-effects generated by this truth regime involve stigma, condemnation, and the disgrace of psychologically wounded flight crew members. Truth, resistance, and subjectivity are all bound up with complicated and contextualized relations of power.

Notes

1. Some of the terms related to resistance that Foucault used in his writings are "contestation," "perpetual agitation," "transgression," "struggle," "rebellion," "insurrection," "ruse," "opposition," and "interruption" (Hequembourg and Arditi 1999; Pickett 1996; J. J. Reid 2006).

2. The word "fragging" comes from a fragment of a grenade, and means killing a commanding officer by someone in the unit. Although popularized during the Viet Nam War, fragging was present throughout the twentieth century as a type of resistance among soldiers.

3. There is a deep-rooted literature on malingering, dating from about the 1870s, that deals with the simulation of disease or illnesses, both physical and mental, in relation to accident and life insurance and railway and tramway accidents; and to the establishment of state-sanctioned workers' compensation

systems, initially in Germany, and then spreading to other industrial countries in the late nineteenth through the twentieth century. For an entry point into this literature, see Caplan (1998), and Herbert and Sageman (2004).

4. The feminine is not only attributed to the soldier, but also to the type of care offered to the soldier. An article, "War Psychiatry," published in the *British Medical Journal* (June 16, 1916), identifies femininity—the women's touch in the care of wounded soldiers—as a contributing factor to malingering. Thus, "Simulators had a wholesome dread of the army doctor, but in these centers his visits were made at too long intervals. Infirmaries and lady volunteers were also responsible for much exaggeration by the wounded. Their very devotion tended to encourage morbid sentimentality in the men" (25).

5. Picric acid is a yellow-tinged explosive.

6. We are using the word "soul" in a way that is similar to Foucault (2001) and Rose (1999). That is, the soul is that which is ontologically distinct from the mind and the body. Although we have not developed the idea in any depth, we would maintain that it is a discursive-material entity.

7. Brandon (1996: 127) outlines the following official beliefs about the LMF policy: "1. Courage equated with character, and that it was possible to identify and select those with the 'right stuff.' 2. LMF was a dangerously contagious state. 3. The maintenance of morale depended on early identification and removal of 'waverers'. 4. Disposal of those unwilling to continue operational flying was not a medical decision. 5. Unless rigorous measures were taken, the operational efficiency of Bomber Command would be compromised."

8. Compare this remark to one by Foucault (1979: 135) in his discussion of docile bodies and soldiers: "By the late eighteenth century, the soldier has become something that can be made; out of a formless clay, an inapt body, the machine can be constructed." The British Army report cited here metaphorically suggests otherwise; that the clay of men is not a neutral material that can be manipulated any which way but rather varies in its own qualities and thus deviates in innate potentialities and limitations.

Chapter 5

Cultural Accounts of the Soldier as Subject

Folds, Disclosures, and Enactments

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> To be worn out is to be renewed.
> —Lao-tzu, *The Way of Lao-tzu*

> Evaluating fundamental questions of health in large populations
> is always extraordinarily difficult, but is particularly so after
> traumatic and complex wartime events. Nevertheless, unless these
> difficult questions are answered, we risk repeated occurrences
> of unexplained symptoms among veterans after each war.
> —Kenneth C. Hyams, F. Stephen Wignall, and Robert Roswell,
> "War Syndromes and Their Evaluation"

Mary Fissell (1991) argues that, in England, the patient's narrative disappeared as a medicine dominated by competing private practices giving way to a medicine centralized in a hospital setting. In the early part of the eighteenth century, medicine was part of popular culture and (mostly elite) individuals used a wide range of concepts to describe ill bodies and had access to an even wider range of remedies. Because of their lack of control over the "production and consumption" (93) of the circulation of such knowledge, physicians had to fit both their diagnoses and their recommendations for treatment to specific individuals. Once medicine was relocated to the hospital, with standard training and treatment practices, patients' narratives were replaced by observation and classification. Clinical observations turned into clinically defined protocols that began the practice of defining illness through observable symptomatology. The practices associated with the clinic set the trajectory of figuring out what was wrong with a body and how to treat it, which is still the norm today.

The shift, of course, was not quick, smooth, or orderly; hospital medicine emerged slowly over a long period of time with multiple impediments that served to erode patients' narratives, particularly around generating a diagnostic and therapeutic knowledge outside a patient's own understanding (105).

Fissell's arguments dovetail nicely with Foucault's (2006) understanding of psychiatric power—with the rise of both the psychiatrist in the asylum and psychiatry as a science and a practice that takes on "the power to define, control, and correct what is abnormal" (221). Foucault wrote about the production of the psychiatric subject through both exclusion and classification. Foucault's work *Madness* (2011b), originally published in 1954, lays out the intellectual issues he was dealing with while thinking about psychiatric illness vis-à-vis Freudian psychoanalysis. In 1962 he published a revised edition of *Madness* to articulate how dramatically his ideas had changed. In this version, the range of techniques of power—though not named as such—are evident in his descriptions of the constitution of mental illness. While not teased out, the kernel of the idea of how the exercise of disciplinary power excludes, classifies, individualizes, and regulates bodies is present. For example, Foucault's discussion of cultural definitions of illness by Emile Durkheim and Ruth Benedict shows how disciplinary power works in terms of scientific applications of knowledge (via statistical analysis and deviation from the norm à la Emilie Durkheim) and of cultural possibilities (via relegating people with mental illness into particular cultural positions à la Ruth Benedict) (Foucault 2011b: 99–105).

For Foucault (2011b), the *practice* of psychology excludes mad bodies by interning them in asylums; the *science* of psychology classifies mental illness to further subjugate bodies. Through exclusion and classification, the relationship between psychology and madness relies on

> a disequilibrium so fundamental [that the relationship itself] render[s] vain any attempt to treat the whole of madness, the essence and nature of madness, in terms of psychology. The very notion of "mental illness" is the expression of an attempt doomed from the outset. What is called "mental illness" is simply *alienated madness,* alienated in the psychology that it has itself made possible. (Foucault 2011b: 125; emphasis in original)

Madness was an early piece in Foucault's body of work. In it he laid out the architecture of his later arguments in *Madness and Civilization* (1988a). In *Madness and Civilization,* Foucault points out that as disease became more aligned with the organic, the experience of unreason was relegated to the psychological. Psychoanalysis did not emerge as a science to access the truth of madness; rather, it emerged as a way to mask the experience of unreason and to keep it in the realm of the medical. By the end of the nineteenth century, clinical observations recorded so meticulously

by trained physicians, neurologists, and psychiatrists steeped in elite and exclusionary scientific knowledge began trumping the bodily sensations of individuals and any other experience of illness.

Much like psychoanalysis, military psychiatry tries to mask the experience of unreason in order to keep it tightly bound within the realm not only of the medical, but also of the military. In the Second World War, for example, military psychiatrists conceptualized combat breakdown as an experience of unreason, both spatially and temporally. The idea that, given an extreme set of circumstances, anyone could break down reoriented the military psychiatric gaze to all combat soldiers rather than just the ones that were marked—formally and informally—as potentially weak. Soldiers diagnosed with battle exhaustion were treated close to the front and either were returned to battle quickly, usually within seventy-two hours, or were evacuated for more extensive treatment at a hospital, usually one designated for mental illness. Once released from medical care, soldiers were considered safe (but not cured) and were returned to duty or discharged to society. The increased reliance by the military on small group cohesion to maintain morale among combat troops (a social psychology approach) supported the quick turnaround among exhausted troops. Compounding breakdown recovery was the sudden separation from the soldier's squad after a battle. Treatment for exhaustion relied on psychotherapeutic practice, mostly in groups. Psychiatrists exploited the deep ties formed among troops based on trust, loyalty, and cooperation at the organizational level of squad or patrol and used a combination of guilt and honor to convince soldiers to return to their unit. This arrangement kept unreason firmly circumscribed within the military medical corps group while delimiting how long the unreason could be considered an illness.

Lessons from the Great War showed that nervous breakdowns in combat could result in high war pensions. After the Second World War postdeployment psychiatric disability was not officially linked to combat experience. Rather, the onset of mental illness after the war was causally linked to constitutional predispositions and social factors existing prior to the war. Civilian and military psychiatrists began taking war-time psychological wounds of soldiers seriously only after the end of the American Viet Nam War—not in terms of exhaustion, but in terms of trauma. More recently, enhanced medical training for advanced trauma care and forward surgical teams nearer to the battlefield increased chances of survival for a far greater proportion of soldiers wounded in combat than ever before.[1] Compared to psychological training for recruits that has delayed the onset of breakdown, forward medicine streamlined over the twentieth century is even more proximate, immediate, and expedient. The spatial

and temporal limitations so important in the Second World War for managing combat breakdown among troops have now been fragmented into an anywhere, anytime strategy for determining the unreason of a soldier.

In this chapter we negotiate the tension between the soldier's ill body and the way it gets talked about. Many discourses come to inform what counts as war neuroses, and use medicine and psychiatry as bases from which to circulate (assumed) knowledge about weary warriors. These identities are deployed through various mechanisms of the state, society, and economy to support or contest wider social policies, political agendas, cultural understandings, and individual behaviors. Our primary interest here is with the constitution of the weary warrior as a subject through cultural forms. We first lay out arguments about subjectivity and show how they fit into our wider arguments in other parts of the book. We demonstrate the fit by locating the generation of the weary warrior in a positive ontology and within various sets of practice—psychiatric power, military activities, and masculinist culture. We then present a series of cultural sites through which weary warriors have been generated—fiction, autobiography, and film.

Situating Subjectivity through Folds

Straddling the edge of the psychic and the organic, soldiers presenting with symptoms of nervous breakdown in and after combat have little to go on to describe their bodily sensations, let alone to describe what led them to feel a certain way. Soldiers and veterans work up their bodily sensations into categories that physicians can understand—for example, angry outbursts, anxiety, blurred vision, deafness, depression, despondence, headache, memory loss, moodiness, mutism, pain all over, paralysis, sleeplessness, stuttering, trouble finding words, inability to concentrate, weeping, and withdrawal from friends and family. It could have been a blast, some movement, darkness, and then waking up in a hospital. It could have been a summer celebration, with champagne, a vague sense of foreboding, and then waking up shivering underneath a picnic table. It could have been another blackout to numb the recurring nightmares, a violent act, and then seeking out help from the local veterans' association. Much like seeking out a language to convey feelings and bodily sensations, soldiers search for recognizable scripts to ground themselves in order to reestablish stability and fixity in a life that has been shattered.

Yet the preconfigured identities available to soldiers are not necessarily useful or effective in either dealing with their recent transformation or facilitating healing. In the context of invisible war wounds, after an

intense psychological wounding one's sense of self is practically erased. All notions of the self the soldier occupied—courageous, strong, and invincible, all part of being hypermasculine—must be rethought in light of the identities available for war neurotics and fatigued soldiers, characterized as weak, cowards, and merely shells of the masculine forms they once were. Even in the relatively progressive twenty-first century, when there is a general acknowledgment in the military and among civilians that anyone could break down in the face of war atrocities, when mental illness is apparently less stigmatized than ever before, and when soldiers can access resources to assist in treating emotional breakdowns, there is still the scepter of failure, worthlessness, dishonor, and femininity hanging over the soldier's head.

How does one go about rereading the weary warrior so that more possibilities appear to soldiers and veterans? No doubt the task of reestablishing a suitable identity without basing it on a sense of failure is gargantuan, especially given the limitations of engagement in such a task just after combat, just after diagnosis. And even before any identity can provide a script into which a soldier or veteran can walk, a portrait of a subject with crisper brushstrokes has to be imagined. The enactment of such a subject can counter the bounded, incongruous image of a war neurotic, fatigued soldier, or a soldier with mTBI. Subjects emerge that can distinguish specific historical periods as in the Greek subject via sexuality in ancient Greece (Foucault 1990b), the modern subject emerging as universally human (Latour 1993), or a postmodern subject arising from late capitalism (Jameson 1984). Rather than focus on a subject of an epoch, we want to trace various enactments of weary warriors in specific time periods that sometimes run counter, sometimes reinforce, and sometimes shatter the weary warrior as subject. The first step toward our goal is coming up with a way to see how subjectivity comes into being. Once we provide a critical account of how subjectivities emerge, we can reread the broken embodiments of weary warriors as subjects in critical, less-distressing, and more-compassionate ways.

In his critique of Foucault's body of work, Gilles Deleuze (1999) lays out a way of understanding subjectivity within a positive ontology. Deleuze describes a process through which subjectivities are created through the "fold." Subjectification involves four folds: the material part of self (organic, physiological, biological), the relation between forces (among human and nonhuman), the relation of truth to being and vice versa (power, knowledge), and the outside itself (institutions, ascriptions, acts). Through these four folds, a subject emerges that is not reducible to any one fold. Rather, at each and every moment a new subject forms, one that holds momentarily the effect of the variable depth, speed, and intensity of each

folding and its relationship to the others. There is no subject other than that which emerges through folding and unfolding, mixing and matching, variation and difference.

Foucault's overall project of drawing attention to the *conditions* of the emergence of the subject via power and knowledge sets the stage for the claim that "the conditions are never more general than the conditioned element, and gain their value from the particular historical status. The conditions are therefore not 'apodictic' but problematic. Given certain conditions, they do not vary historically; but they do vary *with* history" (Deleuze 1999: 114; emphasis in original). Variation and difference are already implicated in the folds that include the outside in the interior of the individual. Instead of a direct link between cause and effect, there is more of a Markov chain shaping and informing the emergence of an individual subject.[2]

What sorts of things happen in these folds which can produce a subjectivity that meshes with what we understand to be a weary warrior? How do patterns emerge that permit us to talk about a weary warrior? Annemarie Mol (2002) provides insight into these two questions in her ethnography of the practices that enact atherosclerosis. She attempts to unlace the tight binding of the subject to individual humans and to being active knowers. She locates her arguments in the discussion over dualistic ideas of the subject as human and the object as nature, as well as the active knowing subject with the passive object that is known. To break the binary of human/nature, Mol collapses the distinction between the doer and the deed, and argues that the deed itself constitutes the doer—one does not exist without the other. "Enact" as a verb comprises this idea, which applies to both subjects (humans) and objects (nonhumans). Thus, both war neuroses and weary warriors are enacted through diagnostic and treatment practices. Such practices include the presentation of a soldier at a dressing station with amnesia, a tale of a bomb exploding nearby, and a vague memory of unconsciousness. Then, after some time interval, the enactment continues through acquisition of a disability pension based on psychiatric illness, newspaper articles about the rising suicide rate of war veterans (see Alvarez 2009; Wilhelm 2011), and a movie depicting the psychological stress with which a bomb defuser lives (*The Hurt Locker* 2008).

Mol (2002) also challenges the idea that the subject is the knower and the object is the known. She argues that a foundational aspect of medicine clings to Marie-François-Xavier Bichat's pathology in that the subject as knower where the patient presents an informed narrative, for example, was eclipsed by the physician becoming the knower by making the cadaver the object known.[3] This switch supported the exaltation of the physician's knowledge at the expense of the patient as a knower and facilitated the rise of clinical observation as the golden standard for medical diagnosis

(see Fissell 1991; Foucault 1994). In modern medicine, the patient has been grafted back onto the material body through the reintroduction of a series of codified behaviors of individuals through the psychosocial dimensions of health. Yet the inclusion of psychosocial dimensions of an individual into medicine is but one way to go about reintroducing the subject back into medicine. Such an introduction reinforces medicine as the knower and the patient as the known. To break this patterning, Mol suggests a strategy to call into question the fundamental arrangement of medicine itself. That is, she argues that social critics need to focus on the knowledge generated in the *practice* of medicine.[4]

Susan Hekman (2010) provides insight into one tension that arises when thinking about how subjects can come into being. She argues that for a subject to emerge one has to take on an identity. An identity is something on offer within a society that an individual takes up and walks with. Without a distinctive identity that one can slip into, one's ontological status is erased: one ceases to be. She refocuses her question away from how a subjectivity is constituted toward the question, "what are the options for subjects who are denied identity and hence an ontology?" (95). In other words, what happens when an identity exists outside the range of acceptable identities, such as a war neurotic, traumatized soldier, or weary warrior? Hekman partially addresses her question by conceptualizing the subject along the lines of Andrew Pickering's mangle, arguing that

> Subjects are constituted through the intra-action of discourse, genetically coded bodies, social norms, technology, science, and many other factors. No single factor is causal; all are constitutive. And, as the postpositivist realists argue, the identities that subjects inhabit are real; they have material consequences. But I have argued that these identities are not real in the sense of objectively right or true. Reality is disclosed through our concepts and, most importantly, through my understanding of which subject position I inhabit. The reality this subject position discloses is my reality; other subject positions disclose a different reality. What avoids relativism in this formulation is not that I can declare that one subject position provides a truer picture of reality, but that I can compare the material consequences of the different disclosures. Some subject positions entail privilege, others deny subjects a viable life. These are real differences that can and should be the basis of social critique. (Hekman 2010: 107)

For Hekman (2010), variation and difference reside in the reality disclosed by a specific subject positioning. Social critique involves mapping out the material consequences of any one disclosure, such as a weary warrior, from multiple subject positionings (that are embedded in the mangle of the subject) via diagnosis, via policy, via culture, via … et cetera.

But what subject are we talking about? Which subject positionings matter in a study of weary warriors? Are they the ones that can situate sol-

diers' deep emotional distress in combat? Is it only the bounded entity of a soldier with nervous exhaustion? Is it the traumatized individual that has a formal diagnosis of PTSD? Or is it the bodily sensations themselves, so carefully wrapped up in something called symptoms? In an innovative writing project, Annemarie Mol (2008) queries the situations that authors use to write subjects and works through how subjectivities can be thought. She uses eating an apple as a way to tease out some of the usual poststructural aspects of subjectivity, as well as some uncommon aspects. She supports the argument that subjectivities are situated (temporally and spatially), decentered, and relational. In her descriptions, she draws out materialities invoked by thinking about eating an apple:

> Let's leave Braeburns out of this, but, let me tell you, I don't like Granny Smiths. In the late 1970s and early 1980s we (my political friends and myself) invested a lot in disliking Granny Smiths. At the time they were always imported from Chile, and thus stained with the blood spilled by Pinochet and his men. Once Pinochet had gone, it turned out to be difficult to re-educate my taste.... It should be possible, but so far I have not succeeded. Yes, I can eat a Granny Smith apple: bite, chew, swallow, gone. But it does not give me pleasure.... For how to separate us out to begin with, the apple and me? One moment this may be possible: here is the apple, there am I. But a little later (bite, chew, swallow) I have become (made out of) apple; while the apple is (a part of) me. Transubstantiation.... A person cannot train the internal linings of her bowels in a way that begins to resemble the training of her muscles. I may eat many apples, but I will never master which of their sugars, minerals, vitamins, fibres are absorbed; and which others I discard. (Mol 2008: 29, 30; emphasis in original)

These passages point toward the complexities of how subjects—ones that can be human or nonhuman, as, for example, a weary warrior, an ill body, a set of bodily sensations, or an entity that captures all of them—intermingle with one another. They also show how one might think about the inter- and intra-activity that goes on in the constitution of a subject. Though we do not use novel exemplars, we still are trying to invoke a different way to think, see, and thus enact weary warriors. We seek to challenge explanations of shell shock, battle exhaustion, combat fatigue, PTSD, and TBI, for example, that rely on culture as the differentiating factor in onset or expression of severe reactions to combat stress; that conceive breakdown in combat as a timeless organic process; and that locate psychiatric wounds and mental breakdown in the relationship between the patient and psychiatrist, in the personal circumstances of an individual's history, or in each and every one of us.

For us, the subjectivities associated with weary warriors, including those beyond the individual, can be traced along a particular fold, can be disclosed via a particular subject positioning, or can be enacted through a

specific set of practices. Such a multiplicity of tracings disclose sundry sets of implications, some of which support stability and fixity, some of which generate disorder and permeability, some of which affect the circumstances of daily life, some of which indicate discursive shifts. For example, just as war neuroses were new to psychiatry at the turn of the twentieth century, psychiatry as a scientific and medical system of organizing thought was new to war neuroses. The clash of these configurations of power/knowledge enfolded the shell-shocked soldier and generated a (relatively) new subject. Just as psychiatry as subject solidified claims to truth about shell shock, the material bodies of soldiers were subjugated, and sent back to the front or subjected to treatment that often depended on class background—upper- and middle-class officers received psychotherapy, and working-class ordinary soldiers underwent harsher treatment regimes.

The new subject of the shell-shocked soldier posed problems for the emerging welfare states in Australia, Europe, and North America because of the cost of pensions for disabled veterans. There were no prewritten scripts for soldiers once discharged. Veterans of the Great War were thrown back into civilian life where their families, friends, and communities had to deal with their wounds, their discontents, and their outbursts of violence.[5] After the discursive splash they made both in psychiatry and in the media as shelled shocked soldiers, they were left in large part to generate their own scripts, negotiate constraints, and move toward fixed, more comfortable, identities.

Subjectivities, as we have argued before, are one of the many elements in apparatuses. Strategies connect elements that then support and are supported by various types of knowledge (Foucault 1980b: 196). In this sense apparatuses are indeed strategic. Military psychiatry as an apparatus congeals around a strategic purpose—that of dealing with groups of soldiers who are burdensome to the military because of their inability to be productive, who are mobilized as deficient through discourses of masculinity, and who justify the existence of psychiatrists in the military as well as the integration of psychiatry into military operations. Together, the practices arising from these strategic connections generate subject positionings for soldiers with nervous exhaustion to take up. These are not bodies that are ill necessarily in conventional ways—organically, orthopedically, or functionally. They are embodied subject positionings for the psychologically wounded, that in turn disclose a certain set of truths, realities, and knowledge that are themselves effects of power/knowledge. We are not saying that each individual engages in practices that intentionally support or purposefully thwart the generation of a collective subject positioning of a soldier enduring deep emotional distress as a result of combat. Rather, military psychiatric practices and those associated with them, such as

general physicians, with awareness of war trauma come with sets of rules that regulate how the psychiatrist engages with the patient. And it is these practices that collectively generate a space that circumscribes a soldier traumatized by war while at the same time projecting a fixed identity of the shell-shocked soldier, the war neurotic, the soldier with PTSD, and the soldier with mTBI. Resistance to these subject positionings is as, if not more, numerous as the popularized subject positionings. For example, American veterans and veteran groups of the Viet Nam War were instrumental in getting PTSD into the *DSM-III* (APA 1980). Indeed, the military designation of OSIs as the encompassing term for all sorts of psychiatric wounds and the scientific distinction between PTSD and mTBI counter the major trends in generating weary warriors as subjects. We maintain, however, that most individual and collective resistance is buried in the lives of those soldiers enduring deep emotional stress in and after combat who may already be dead, whose stories are salvageable from historical texts, and in the lives of those who walk among us whose stories are still emerging as they try to establish some footing in the everyday. For us, the subjectivities associated with weary warriors, including those beyond the individual, can be traced along a particular fold, can be disclosed via a particular subject positioning, or can be enacted through a specific set of practices.

One way to access and then trace subjectivities and the processes and practices through which subjectivities emerge is by critically reading texts written by, about, and for soldiers. These texts include an array of material and discursive practice-based enactments, as well as subject-making activities that soldiers and others engage in. Gleaning subjects from a variety of texts brings into focus the multiplicity—both in number and magnitude—of subjectivities available and taken up by psychiatrically wounded soldiers and veterans. Refusing singular understandings of soldiers and veterans who have endured deep emotional distress in and after combat permits a more robust appreciation of the myriad of connections among the elements of various apparatuses and their links to soldiers and veterans. Thinking in terms of folds, disclosures, and enactments facilitates the appearance of different understandings of the subject, subject positionings, and subjectivities that involve soldiers' and veterans' resistance to and accommodation of their multiple framings (after Pickering 1995). We now turn to critical readings of a number of cultural sources that work toward generating specific subjectivities associated with weary warriors. We trace folds, we disclose materialities via subject positionings, and we show how specific practices enact particular subjects. We have chosen these works purposefully for they illustrate our arguments by texturing the claims we make.

Un/Masking Un/Reason through Fiction

Pat Barker's novel *Regeneration* affords a rationale for rejecting the irrationality of war: "a society that devours its own young deserves no automatic or unquestionable allegiance" (Barker 1997, 249).[6] She questions why it is that a normal reaction to war is considered to be abnormal. Her message plays out in a series of relationships among war neurotics sent to Craiglockhart Hospital near Edinburgh for recovery, and the psychiatrists enlisted to cure them. She deftly weaves together invented characters and historical figures in order to comb through the complexity of what constitutes a war neurosis. The novel opens with Siegfried Sassoon's declaration against military authority that the war was being prolonged unnecessarily and that he, on behalf of other soldiers being sacrificed and those being treated unjustly, protests the war and refuses to return. Sassoon maintains that he was neither a pacifist nor insane when he made his claim that he was finished with the war (see Sassoon 1930). The tension between reason and unreason plays out through Barker's primary character, Dr. William H.R. Rivers, an anthropologist and psychotherapist drafted into the British Army Medical Corps to serve as a psychiatrist. She uses his reflections to provide a more nuanced reading of war neurotics from the Great War. Throughout the novel, Barker sets up different scenarios through which the context of the emergence of psychiatry as an influential field of science informs the characters' actions, reflections, and tensions. For example, she writes,

> As soon as he started work at the hospital he became busy and, as [Dr.] Head had predicted, fascinated by the difference in severity of breakdown between the different branches of the RFC [Royal Flying Corps] [see Armstrong 1936]. Pilots, though they did indeed break down, did so less frequently and usually less severely than the men who manned observation balloons. They, floating helplessly above the battlefields, unable either to avoid attack or to defend themselves effectively against it, showed the highest incidence of breakdown of any service. Even including infantry officers. This reinforced Rivers' view that it was prolonged strain, immobility and helplessness that did the damage, and not the sudden shocks or bizarre horrors that the patients themselves were inclined to point to as the explanation for their condition. That would help to account for the greater prevalence of anxiety neuroses and hysterical disorders in women in peacetime, since their relatively more confined lives gave them fewer opportunities of reacting to stress in active and constructive ways. Any explanation of war neurosis must account for the fact that this apparently intensely masculine life of war and danger and hardship produced in men the same disorders that women suffered from in peace. (Barker 1997, 222)

Although not necessarily accurate in most interpretations of Rivers' own views and practices through his publications, Barker captures the milieu

in which Rivers as a practicing military psychiatrist made sense of the nervous breakdowns among the various branches of the military involved in the Great War. Injuries of the mind are neither feminized nor cast as rituals of emasculation; rather, she writes into the subjecthood of the soldier a sympathetic place to alight when laden with helplessness and inaction as markers of long stretches of danger. Why not a neurosis? After all, women at peace were often hysterical and neurotic when languishing in a society that afforded them few paths and scripts that could move them away from their social morasses. As well, Barker compares Rivers' psychotherapeutic approach to Lewis Yealland's shock and persuasion approach (see Adrian and Yealland 1917) to contrast the debate within psychiatry about whether neurosis arose from weakness in character or was a result of the war. She writes that, for Rivers, "[psycho]therapy was a test, not only of the genuineness of the individual's symptoms, but also of the validity of the demands the war was making on him" (Barker 1997, 115).

Barker also provides insights into how a psychiatrist constructs the practice of psychiatry. For example, she writes about how Rivers must demythologize each individual patient's actions and memories. Rather than thinking of Jonah and the whale, Rivers needs to assist the patient in living with the memory of his head in a dead soldier's belly (Barker 1997, 173). Healing may actually go on even if in not the intended direction (242). She also permits the soldiers to generate spaces where they can actually be soldiers. She writes about them not talking about what went on in France to the women at home, less to protect the women and more because soldiers need the women's "ignorance to hide in" (216). Being part of the military also meant living in temporally bounded places, where soldiers could be dashing, jolly, patriotic, and honorable off the battlefield, away from the frontline, in order, no doubt, to survive.

Barker's work emphasizes—by her detailed account of Rivers' work in psychotherapy—both the conditions that constitute truth claims about the mind in psychiatry as an emerging science and the outside, not as a place, but as an external force, in this case specifically the war, in which individuals engage as a way to eventuate (come to) themselves as subjects (Deleuze 1999: 104; Lambert 2002: 26). Barker illustrates something important in our arguments: that the multiplicity of subjectivities comes into existence through specific practices; subjects are enacted. Barker's work is illustrative of practices that enact subjects through cultural representations. Her work does double duty: not only does she offer a nuanced reading of the shell-shocked soldier, but she also creates a space for veterans surviving the Gulf War to be something other than the weak-willed malingerers that can only complain of a life shattered by unseen forces. Her work was first published in 1991 when much of the discussion of the day

focused on external events possibly causing an organic malady among veterans of the Gulf War, such as exposure to uranium and viral infection from inoculations. Barker puts back into discursive play the notion that if indeed something external caused nervous breakdown among soldiers, then the external event did not have to be something unseen and surreptitious. The external event could actually be the war. And it is through the war that the veteran with GWS came into being. Those soldiers in service during the Gulf War did not always break down as a result of combat; rather, the "prolonged strain, immobility and helplessness" (Barker 1997, 222) positioned soldiers to take up a subjectivity that held within it a reasonable account of their unreasonable experience.

Tim Carlson, a Canadian playwright and director based in Vancouver, British Columbia, also uses a cultural medium to suggest alternative subjectivities for soldiers enduring deep emotional distress in combat. He is writing in the post-2001 world of the War on Terror, the USA Patriot Act of 2001, and Operation Enduring Freedom, an era entailing enhanced surveillance, heightened suspicion, and erosion of civil liberties. His play *Omniscience* (2007), set in the not-so-distant future, focuses on Warren Atwell, a documentary film editor working on a film about an urban war in which Warren's life-partner, Anna Larson, fought; she is now recovering from traumatic stress. His employer's director of wellness, Beth DeCarlo, is being investigated by George Ellis, from the state, for her involvement in Warren's disappearance and Anna's recovery. Carlson deftly entwines into the play Orwellian notions of surveillance, as, for example, searching for clear rooms and reveling in the idea that they exist (62), speaking in public places like the subway platform only when the sound is distorted by the passing trains (92–93), and twisting routine circumstances in interviews that support conspiracy with a veteran-led terrorist group (72, 94). Indeed, the entire state project—which Warren is documenting, within which Beth is facilitating health, in which George is investigating possible resisters, and for which Anna fought—is about installing a government commensurate with the interests of the many (read: few), aptly named the Reconfiguration. The story takes place in the era of postconflict renewal, where one area of the city, SouthWestFive, has just been cleansed (21). The goal of individual soldiers returning to civilian life is "to configure transition toward a positive future" (21), and Beth's role is to assist Warren and Anna to "reconfigure your life for wellness" (17).

Lieutenant Anna Larson is not the main character. It is only *through* her that the story unfolds. She joined the forces not because she would die for the cause, but because she wanted an education and a career. She served under extreme conditions cleansing SouthWestFive and became debilitated after involvement in a friendly-fire incident. Part of her reintegration

(transition toward a positive future) includes decompression therapy on an island outside the city and taking a long list of medications (Carlson 2007, 17, 44, 56). Anna's general demeanor throughout the play is either angry or withdrawn. Her symptoms of disorientation and hallucinations are symptoms acknowledged by Beth and George (38), and Beth describes the typical traumatic stress victim as wanting to hide (53). She acts paranoid (31), has seizures (48), and is drug-dependent (60–61, 67–68). When she has a voice to talk about herself she calls herself a "ghost soldier" (29), yells out "I'm the mental case. That's my role" (81), and taunts Warren about his interest in her being the "crazy vet segment" in his documentary (42). The circumstances under which Anna mistakenly fired on her own soldiers are played out in one of her flashbacks (50). Eventually, Anna tells Beth about the incident that Anna pinpoints as the beginning of the breakdown when, three weeks into her tour, she kills a soldier because he begs her to (89–90). She sent in a "bird" (drone) and through the "third eye of a dead man" she "fired a rocket in" (89, 90).

Carlson (2007) sets up a disturbing view of a surveillance society, a view that theater goers could see is not that far-fetched. Through the character of Warren, who acts suspiciously and is paranoid as a result of the repressive measures of the Reconfiguration, Carlson is able to hint that traumatic stress is part of a wider society—omniscience is the precursor of a traumatic stress. While Carlson is interested in forcing contemporary society to face the potential consequences of intense surveillance and infringement of privacy seeds now being sown, we are interested in his depiction of Anna as the metaphor for a society racing toward stress from trauma. The depiction of the character of Anna reinforces popular understandings of soldiers coming home to Australia, Europe, and North America from the twenty-first century wars in Iraq and Afghanistan. Carlson utilizes a fixed identity—that of a combat soldier with anger, flashbacks, hallucinations, medications, paranoia, and social withdrawal—to explore the travails of a repressive society. He chooses a woman for that identity, one usually reserved for male veterans, perhaps as a device to play up the shock of seeing a woman acting out traumatic stress from war, or perhaps to sharpen the idea of trauma as the weak-willed, submissive citizen of repression. His choice works well, given that women can easily be seen as emotional, as hysterical, and, in what is described often enough in the play, as insane. As a subject, Anna is rigid, though docile: there is no room for her to be something other than what society wants her to be. In a failing society, those who fit survive, and those who do not fit die. Anna, full in her ill body, survives as the living wounded for trying to escape *who* she is; Warren dies for trying to escape *as* he is. What Carlson brings to bear in this stringent framing is the notion that Anna's response is actu-

ally far more reasonable a reaction to the wrenching pangs of horror than the unreason of war. Yet what he does for weary warriors is to corral their potential subjectivities, cram them into one expression, and use it to show the ills of society.

Making Sense of Experience through Autobiography

In addition to novels and plays, autobiographies and autobiographical writings are useful sites to survey the contours of subjectivities enacted through the practice of writing as well as disclosed given the particular subject positioning taken up by the writer. War memoirs are a genre unto themselves (Harari 2007), with a large subset of those written by weary warriors as a strategy to deal with the experience of war and distress. Some autobiographers write shockingly candid versions of war, destruction, and death (e.g., Jünger [1920] 2003; Sassoon 1930; Tamayama and Nunneley 2000), while others embed their experiences in wider versions of their lives (e.g., Richardson 2005; Scurfield 2004), an amalgam of experiences shaping who they are (e.g., Doucette 2008; Swofford 2003), or poignant messages directed at society writ large (e.g., Graves [1929] 1995; Kovic 1976; Moore and Galloway 1992, 2008; Navarro 2008). Still others are brought under scrutiny for their permeable boundaries between truth and fiction, authenticity and imagination, and truth-correspondence and fabrication (e.g., Sajer 1971). When tracing subjectivities of soldiers with psychiatric wounds through autobiographies and autobiographical writings, the subjectivities captured are not necessarily the ones intended to be marked, nor are they the ones that resonate with popularized understandings of weary warriors as subjects. Subjectivities, as Mol (2008) suggests, are situated, relational, and decentered. Accordingly, an exploration of subjectivities can come in various forms.

Lieutenant General Roméo Dallaire is the highest-ranking military officer who has come out and publicly talked about his psychiatric struggles with flashbacks, depression, and suicidal thoughts. His autobiography, *Shake Hands with the Devil: The Failure of Humanity in Rwanda* (2003), is his story of the United Nations Assistance Mission for Rwanda (UNAMIR) in 1993–94. His autobiography begins much like any other, with stories of his childhood in east-end Montréal, the eldest of three and son of an army sergeant and his war bride from Holland. He writes about his formative moments, his wife and family, and his training in the Canadian Forces. Unlike many autobiographies of weary warriors that cover postwar experiences of dealing with war trauma, the bulk of Dallaire's story is about his deployment in Rwanda. In August 1993 Dallaire went on a fact-find-

ing mission to Rwanda to assess whether a peace-keeping mission needed to be sent to the country. Three months later he was head of UNAMIR, a mission charged with working with the interim government in support of the Arusha Peace Agreement. In April 1994 a one hundred–day civil war broke out, and by the end well over 500,000 Tutsi were dead.[7] Dallaire left Rwanda 20 August 1994, feeling as if he had failed. His story is an indictment of a world that closed its eyes and turned its back to slaughter, hate, and evil. As his account of the mission unfolds, the clarity of his understanding of the toll that witnessing genocide takes on soldiers deployed to observe and offer assistance begins to emerge. Strewn over the pages are accounts of a plethora of acts that Dallaire sees as transgressions of humanity. His deep Christian faith set the parameters of his engagement with the genocide going on around him, something he dedicated himself to avert (64) but could not stop or even slow down, and something for which he felt "deeply responsible" (1).

Because he did not organize his story around onset, treatment, or living a life with PTSD, we scrutinized the text for his descriptions of his body and of illness. Woven into his narrative is an account of the onset of traumatic stress and of his reactions to what psychiatry refers to as PTSD (see also Prince 2006). There were organized events to release tension collectively (Dallaire 2003, 134); there were accounts of dreams to provide insight into the politics of the key players in Rwanda (261); and there were efforts to allay the underlying fear of loved ones who lived on pins and needles waiting the phone call, visit, or television report of the death of UN soldiers (273–74). He recounts an iniquity of the effect of this tension, witnessed by a close aide and a UN soldier from Bangladesh, where hundreds of Tutsi were dead and dying in a church, an event that marked for him the beginning of the "wholesale massacre" (279–80). There are quips and brief asides describing bodily sensations that could be worked up into symptoms of PTSD: falling objects startling him when dropped to the floor (325), outbursts of anger (334–35, 494, 499, 500), zombie-like hollowed eyes with blank stares (454), claustrophobia (499, 504), emotional intensity accompanied by emotional repression (458, 462, 491), disturbing dreams (467), and "adolescent" acts pointing out the absurdity of the war (480). In a short passage where he describes the state of fatigue that some soldiers were in, he clearly articulates the tension he faces as a soldier when he weighs the health of his staff against his own operational imperative:

> I had a mission headquarters staff of fewer than thirty officers, with varying levels of skills and knowledge, trying to keep a multitude of operational tasks moving: I had made a vow that UNAMIR would never be the stumbling block to peace and stability in Rwanda, and the staff worked themselves ragged to fulfill that promise. I had not allowed my principal staff any leave time, with only a few exceptions, since the start of the war. A couple of

> people had become zombies, blank and unresponsive, and we'd had to send them home. Others were over-irritable and would become very emotional over conditions that we had been living with for some time. It was as if a line had been crossed and they began to interpret everything as if they were Rwandan, wholly identifying with the victims. Once they started inhabiting the horror they could not handle any serious new work. We started to send them off to Nairobi on the Hercules for a couple of days' rest. Their fatigue was a recognized medical state. After seeing a doctor in Nairobi, they would move to a hotel room and then wash, sleep, eat and somehow attempt to relax. Since there was no budget to handle the walking wounded, such bouts of rest and recuperation were at the expense of the injured person. (Dallaire 2003, 484)

Because of his position as a commander, Dallaire no doubt considered himself at least partially responsible for the walking wounded, which probably fuelled the recognition of his own condition that he vowed to get help at some point (488, 501, 505, 509).

Throughout the book, in his descriptions of traumatic stress, Dallaire describes situations, reactions, and bodily sensations that psychiatry would consider to be symptoms of PTSD. He described what could be considered a flashback, but does not use the word "flashback." He writes about reliving the deep emotional distress. After having been briefed of recent atrocities in the Goma area (near Zaire, present-day Democratic Republic of the Congo), Dallaire (2003) writes,

> I listened to the report without moving a muscle. It wasn't shock any more at the horrific descriptions. Instead I now entered a sort of trance state when I heard such information; I'd heard so much of it over the past two weeks that it simply seemed to pile up in my mind. No reaction any more. No tears, no vomit, no apparent disgust. Just more cords of wood piling up waiting to be sawed into pieces in my mind. Much later, back in Canada, I was taking a vacation with my wife and children, driving down a narrow road on the way to the beach. Road workers had cut a lot of trees down on either side of the road and piled the branches up to be picked up later. The cut trees had turned brown, and the sawn ends of the trunks, white and of a fair size, were staked facing the road. Without being able to stop myself, I described to my wife in great detail a trip I had had to make to the RPF [Rwandan Patriotic Front] zone, where the route had taken me through the middle of a village. The sides of the road were littered with piles upon piles of Rwandan bodies drying in the sun, white bones jutting out. I was so sorry that my children had no choice but to listen to me. When we got to the beach, my kids swam and Beth read a book while I sat for more than two hours reliving the events reawakened in my mind. What terrible vulnerability we have all had to live with since Rwanda. (Dallaire 2003: 314–15)

Dallaire takes up his emotional distress and reoccupies his broken embodiment with a new understanding of who he might become as part of who he is. In this passage, he follows the subjective fold of his material body, activated by external factors that then highlight for him the deep de-

spair he lived through and would now live through again. Instead of using words that inscribe him with the diagnosis of PTSD, he attempts to write his own subjectivity, not as one of someone ill, mad, or insane. Rather, he writes himself as a subject that has been part of an unspeakable inhumanity, who simply acts rationally to irrationality. He sidesteps psychiatry as medicine to unmask unreason, to show how anyone could break under such extreme distress. In effect, he naturalizes such a reaction, and normalizes what psychiatry has determined to be symptoms of PTSD.

In several such instances Dallaire explains his actions in rational terms against an irrational background. He writes about his own short-tempered responses to UN personnel who refused to listen to his plea for help, but does not refer to it as irritability (Dallaire 2003, 402–3). He tells about uncommon, valorous acts in dangerous situations, but does not refer to these acts as emotional numbness or feelings of detachment (405). He recounts dreams, some of them recurrent, of dead bodies, incidents he has been involved in, and images of cruelty, but does not call them nightmares (414, 467). His story, a disclosure of his subject positioning as one of the walking wounded who survived the genocide as a witness, works to naturalize what psychiatry understands as PTSD. His social and political standing as a high-ranking military officer in the global community reinforces the legitimacy of his version of truth claims within the power/knowledge configuration of war and psychiatric illness. Did Dallaire intend to put on display a subjectivity that challenged the conventional subjectivity of a weary warrior? No, we do not think so. We consider that his objective was to reassert the human condition as something fragile and not to be taken for granted. Through his acts, through his practices, through telling his story, he enacted a variant of the common subjectivity for the weary warrior, one that takes authority away from psychiatry and places a soldier's reactions to war trauma squarely within reason, a rational being. Dallaire enacts the weary warrior as a natural, logical reaction to the inanities of inhumanity. Naturalizing these particular reactions to deep emotional distress to war trauma does not make traumatic stress reactions inevitable—it is stories like Dallaire's that legitimize them. To generate this counternarrative, he draws on and recenters Christian values of mercy, compassion, and forgiveness, and invokes a pastoral knowledge of power.

Living Neurosis through Film Noir

Film, too, can be a site where weary warriors are made into subjects. War films construct returning veterans into many different subjects (Early 2003), some of which complement, contradict, or negate each other. Re-

turning war veterans are cast as heroes, poseurs, and anti-heroes (*The Best Years of Our Lives* 1946; *Cutter's Way* 1981; *Le Retour de Martin Guerre* 1982; *Taxi Driver* 1976); they serve as social symbols (*The Big Chill* 1983; *Dances with Wolves* 1990; *The Legend of Bagger Vance* 2000); they are motivated by guilt and revenge (*Lethal Weapon* 1987; *Rio Lobo* 1970; *The Searchers* 1956), act as comic sidekicks (*The Big Lebowski* 1998; *Meet the Parents* 2000), and encounter existential dilemmas (*The Man in the Grey Flannel Suit* 1956; *The Seventh Seal* 1957). These depictions, sometimes layered alongside contemporary social issues (e.g., the drug wars of Harlem in *Gordon's War* [1970]), sometimes centered on the disturbed psychological aspects of a troubled life (e.g., *The Long Night* 1947), and sometimes focused on the tribulations of war veterans transitioning to civilian life (e.g., *Till the End of Time* 1946), rely on some image of war veterans being damaged psychologically in some way.

Yet it is the genre of film noir that details many of the subjectivities wider society has to offer weary warriors. There are the walking wounded with ravished minds, symbols of postwar ennui (e.g., *Macao* 1952), castaways in their own homes and jobs (e.g., *Thieves' Highway* 1949), and foils against which war heroes emerge (e.g., *Brute Force* 1947). The structure of each film noir lays out the terrain that veterans travel postdeployment. Characters live in moody (rainy, stormy) and often uncomfortable (excessive heat) urban environments where the bad guys are ensconced in pristine rural settings (ranches, mountains). These films feature men negotiating the blurry lines of right and wrong and women as either their redeemers or their Achilles' heels. The plot guides the main character along a path of self-understanding where he finds himself in a do-or-die situation and is forced to determine—for a final time—his place in the world, which is often death. Indeed, film noir as a genre is an exemplar of exhaustion, trauma, and shock. The terrain mapped is not the terrain of a masculine hero as a confident, honorable, and grounded veteran; nor is it the terrain of the displaced war veteran having difficulty reintegrating into home life, family, and intimate relationships, finding a job, or securing a pension. More accurately, it is the path of a weary warrior, one fatigued from the grind of the war and disenchanted by the acts witnessed and his own complicity in them. No other genre does what film noir does: show what happens to individuals and the social connections these individuals have when war produces broken embodiments and shattered subjectivities. Film noir as a genre—including those films without characters as war veterans or direct links to the military or soldiers—calls into question what a society does after the supposed defeat of evil.

Each film takes one configuration of a neurotic syndrome, disorder, illness, or condition to feed into a larger argument about something else,

whether it is placelessness as in *Macao* (1952), time and personal trans-formation as in *Somewhere in the Night* (1946), anti-fascism as in *The Fallen Sparrow* (1943), or anti-Semitism as in *Crossfire* (1947). Even when there are no soldiers' bodies searching for redemption, transitioning to civilian life, or reliving the atrocities of war, places themselves undergo similar transformations. For example, in *The Third Man* (1949), postwar Vienna as a city, culture, and society is caught up in the throes of finding a place in a world that is just emerging from a devastating struggle while having to deal with foreign occupation as punishment, guilt from bowing down to a dictator, and the threat of being controlled economically by black mar-keteers. Vienna is damaged, but continues to exist, regenerated over and over again by trajectories set from its far and recent past, as well as by the characters that inhabit its heights, litter its streets, and scurry through its sewers.

Discourses of heroism pervade much of film noir, but it is not always the ideal hero that is circulating. While not quite the anti-hero that emerges in French and American cinema in the 1970s (after the Indochina and Viet Nam Wars), there are elements of undermining oneself, being driven by guilt, and eclipsing the significance of what happened during the war by foregrounding relationships with the other soldiers. The sense of survival sometimes governs the discourse of heroism and serves as the catalyst for weariness, as played out in *Key Largo* (1948). Major Frank McCloud (played by Humphrey Bogart) visits the family of one of the men who served with him during the Italian campaign. McCloud has no people to go home to, and has been kicking around for a few years with no goals in mind. He lands in Key Largo at a busy time: the sheriff is trying to bring two young Seminole brothers back to jail to serve thirty-day sentences, a Milwaukee boss and his gang have taken over the hotel, and a hurricane is on the way. McCloud spars with Rocco (Edward G. Robinson) through-out the storm—their pasts are visited not through flashbacks (which is a common technique used in film noir) but through dialogue about their character and the specific acts they engage in.[8] They of course have com-peting renditions of masculinity: Rocco humiliates women, pistol whips men, sacrifices innocent people, and cheats, double-crosses, and kills his enemies, while McCloud negotiates a tension between a desired cynicism ("All I care about is me and mine") and an imminent heroism ("Your head says one thing and your life says something else"). For McCloud, one place is as good as any other to make a home. The sense is that he worked through *survivor's guilt* and feelings of *helplessness,* and that he is *willing to trust again.* Once he has resolved these tensions (around the fold of the outside itself), he can come home—even if it is someone else's home—be-cause he can come home as the transformed (and refolded) war veteran.

Battle exhaustion has been depicted in a variety of ways in film noir, resulting in multiple enactments of weary warriors on film. The nuanced understanding of how emotions and actions come together with veterans with psychiatric wounds in the character of Frank McCloud contrasts starkly with the heavy-handed, nearly stereotypical view of the weary warrior in *The Blue Dahlia* (1946). Johnny Morrison (played by Alan Ladd), a lieutenant commander and military hero, with two members of his crew, George Copeland (Hugh Beaumont) and Buzz Wenchak (William Bendix), returns home only to find out his wife, Helen (Doris Dowling), is having an affair with Eddie Harwood (Howard Da Silva), the gangster owner of a night club called the Blue Dahlia. When he finds out that she was responsible for their son's death by car accident because of her drinking, he pulls a gun, throws it down, and storms out. The next morning, Helen turns up murdered. During the search for the murderer, a strong sense of *displacement* hangs in the air—no one seems to know where anyone is and everyone is looking for someone (something) else. A foggy ennui pours into each pause in dialogue and encloses each movement. As the search drones on, the hope for a peaceful denouement remains out of sight. Buzz, wounded in the war by shrapnel, has a plate in his head (making visible psychiatric wounds permits more legitimacy). *Loud sounds* and music set off excruciating headaches. He is *unable to concentrate*, *forgets* where he is, is *preoccupied with insignificant issues*, *bothered by repetitive acts,* and becomes *aggressive* at the drop of a hat. As an effect of battle exhaustion, Buzz's actions throughout the movie tell a story of the invisibly wounded combat veteran: they do not fit in, commonplace things are enemies, and society needs to take care of them. The *suspicion* of Helen's murder falls on Buzz. As Joyce picks at a blue dahlia, Buzz confesses to the murder evocative of what we today would understand as a flashback. However, Johnny, enacted as Buzz's leader and protector, the militarized hero, and all-around good guy, comes in and saves Buzz from war fatigue and those unexpected things (suspicion, exclusion) associated with it.

Conceptualizations of fatigue differ, depending on one's subject positioning, just as psychiatric wounds disclose different realities. In *The Stranger* (1946), the war veteran in this film is a Nazi—Franz Kindler (played by Orson Welles), the fictional mastermind of the Holocaust. Mr. Wilson (Edward G. Robinson) is the War Crimes Commission officer. In order to track Kindler, he releases another war criminal, Konrad Meinike (Kostantin Shayne), knowing that Meinike would lead him to Kindler. Meinike finds Kindler posing as Charles Rankin, a school teacher in a small New England town, engaged to be married to Mary Longstreet (Loretta Young). Once Rankin/Kindler realizes that Meinike has been broken by his experiences in the war and can no longer be trusted for the cause,

Rankin follows him, kills him, and buries him in the woods behind his home. Battle exhaustion plays out through Meinike, characterized as a *weak* link, living in a state of *nervous breakdown,* seeking forgiveness for his past deeds through religion. We call the expression of this particular set of bodily sensations a "breakdown" in the sense of battle exhaustion; moralists might call his fanatical conversion to Christianity as compensation for his guilt. During the Second World War, Allied military psychiatry was in the midst of a shift from explaining war neuroses as a result of something inherent in soldiers themselves toward understanding war neuroses as something that could happen to anyone. German military psychiatric explanations for battle exhaustion primarily linked *weakness* and *cowardice* to a lack of strong leadership. So, once Meinike was captured, he had no leader to follow and suffered a breakdown.

What is interesting about this film is that the German veteran actually has wheedled his way into a quiet, commonplace life in small town America relatively easily in comparison to American veterans in other films. Rankin, too, could be read as having symptoms related to battle exhaustion, but, because he is a Nazi, we see Rankin as a menace, pathological liar, and supreme manipulator. Evil is the illness, not something brought on by experiences of war. Discursively, anti-fascism outflanks battle exhaustion; unlike in other film noir with combat veterans, these men remain enemies and both Kindler and Meinike die.

Some of the main characters in film noir deal directly with their battle exhaustion rather than have it inform the way in which they take up their postwar lives. Usually war fatigue impedes the transition to civilian life and forces the veteran to search for a place to belong and an identity to slip into. *Somewhere in the Night* (1946) opens in a field dressing station with a soldier whose face and head are fully bandaged after he has fallen on a grenade. In a voiceover, the audience and the soldier understand that this is "something that happens to you. You forget who you are or where you belong." His identification papers mark him as George Taylor (played by John Hodiak), but the name does not feel right to him. Something is amiss. Clues to his true identity (if there is such a thing) initiate a hunt for a man named Larry Cravat and a missing two million dollars. The pursuit of Cravat drags him through criminal hangouts and thug life along the California coast. Christy Smith (Nancy Guild) as a new love, Mel Phillips (Richard Conte) as a nice bar owner, and Donald Kendall (Lloyd Nolan) as a police lieutenant, assist him in his journey. Although Taylor never truly remembers, he comes to understand who he was and who he is, and they are two very different people—the folds seem all messed up. George came home, but not to the person he was before; that man is gone and so is the woman he loved. Now there is a new home with a new

woman, situations and identities he can slide right into. Although a man of questionable moral fiber before the war, Taylor is saved by a textured sense of the concepts he used to disclose his new life: his notion of heroism. Battle exhaustion permitted him to complete the *transformation* he made upon enlisting in the service. He is more like Frank McCloud than Buzz Wenchak; through his *amnesia* from the *head wound,* he purges and cleanses himself in his preparation for a new life.

Unlike George Taylor, veterans in film noir do not always want to deal head-on with battle exhaustion, unless forced to. In *The Chase* (1946), Chuck Scott (played by Robert Cummings) returns a wallet to its owner, gangster Eddie Roman (Steve Cochran). Upon arrival, Eddie's sidekick, Gino (Peter Lorre) finds a job for Chuck as a chauffeur and issues him a uniform. Chuck becomes primary driver for Eddie's wife, Lorna (Michèle Morgan). Together, he and Lorna eventually concoct a plan to flee to Cuba so that Lorna can be free of Eddie's tyranny, and Chuck can be her savior. The plan goes off without a hitch, but in Cuba Eddie tracks them down. Just when Chuck is going to die … he wakes up, and cannot remember much of the last few days. He runs out of the house directly to the naval hospital to treat his battle exhaustion. The commander (Jack Holt) reassures Chuck that everything is okay, that *shock cases* often have *black outs,* and that *anxiety neuroses* prevent him from *remembering things clearly.* Once things settle down, the commander reassures Chuck that he will remember why he was where he was and what the uniform means. The commander treats Chuck as he would have in the field—that is, with reassurance, abreaction, and with the expectation that he would return to what was bothering him. But, in a flash, Chuck remembers and is off again running away to Cuba with a gangster's wife.

Parallel to the plot in *The Blue Dahlia* (1946), the veteran with battled exhaustion is the murder suspect in *Crossfire* (1947). The movie opens with a murder. Shadows and low camera angles prevent the viewer from seeing who is murdered or who the murderer is. Homicide detective Captain Finlay (played by Robert Young) runs the investigation of the murder of Joseph Samuels (Sam Levene). Sergeant Peter Keeley (Robert Mitchum), the prime suspect's best friend, runs an investigation of his own. The story unfolds in a series of flashbacks from different viewpoints. The prime suspect, Corporal Arthur Mitchell (George Cooper), is described by his army buddies as someone who is not tough, an artist, and the type of man who needs a wife. In a conversation with Finlay, Keeley says that he himself has killed men "where you get a medal for it," but Mitchell could not kill anyone, even there. Suspicion falls on Mitchell because on the night of the murder, he is described as being in a *strange mood, unfocussed, intoxicated, jittery, depressed,* and *unable to remember* what has happened. In this film,

battle fatigue is worked up as something "natural" and almost expected among men who are soft with artistic temperaments. The point is not that soldiers returning home after having been *displaced* for four years bring with them the trauma and activities of war, and then act unscrupulously; rather, the point is that veterans are being asked to return to a society that has only a few available slots for veterans, all of which are full of problems that entangle the veteran in a new, disillusioned world, including anti-Semitism, greed, violence, and fear.

Temporal Resonance

Critically reading cultural texts provides insight into the ways that society views the psychological, emotional, and spiritual wounds of soldiers. The artistic and creative depictions reviewed here work to undermine the masculine norm of the fighting soldier without invoking the negation of manhood (read: woman) as the key element in challenging the notion of war. The effects of these texts support the idea that there is some resonance in the types of war neuroses among weary warriors from different wars. That is, even though the specifics of the trauma vary, the cultural enactments are similar. Pat Barker's novels were published at the same time that British veterans of the Gulf War were lobbying for disability pensions. GWS was, and still is, a hotly contested illness, particularly because of the role the environment played in its etiological discussions, hearkening back to the days of contestation over the spraying of Agent Orange by the American military (P. Brown et al. 2012). The idea that the illness was all in one's head was popular among physicians, psychiatrists, journalists, and the public in general. Soldiers suffering from a combination of what was considered to be largely physiological symptoms, such as burning semen, cognitive impairment, loss of muscle coordination, and fatigue, were cast as a group as malingerers, whiners, and fakers. Tim Carlson's work, too, focuses attention on the vicissitudes of shifting from the war to the domestic front living with the shock of war, and how some bodies get lost in that transition.

Just as we are taking up the nomadism of the weary warrior as subject, autobiographies by weary warriors themselves indicate that becoming ill is but one pathway through which they become who they are as a subject at any given moment. In other words, each soldier's own specificity is much more complex than what we could ever call into evidence as a demonstration of the complexity of subjectivity. Their folds are manifold. Their stories tell us much about how their own sense of self transforms, sometimes with a slow reconfiguration of a variety of influences and sometimes

in a flash. Film noir was the signature genre of a generation of youth called on to fight a war that was beyond what had ever been imagined. These post–Second World War filmmakers as visual artists set as their task the weaving of cultural moments into a tapestry of real life. As part of capturing these youth, filmmakers used depictions of emotionally distressed warriors and psychologically wounded soldiers to draw attention to the social ills ushered in because of the war.
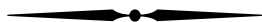
Notes

1. For the American case of over 90 percent survival rate, see Gawande 2004.
2. We use the term "Markov chain" to highlight the contingency of the interaction of variables with which individual subjectivities emerge. Andrei Andreivish Markov (1856–1922) was a mathematician who described the movement of one state to another through a set of random variables in terms of independence. Although we are not claiming the past and future of weary warriors are independent of the present, we are drawing attention to the present as part of a set of circumstances that are considered to have their own individual histories and futures. It is the contingent constitutive nature of these interactions that is significant in the emergence of a subject. But it is somewhat random which variables are enacted; that is, subjects cannot be predicted, nor always traced.
3. Bichat was an anatomist and physiologist. His works, though few in number, were influential in the emergence of the field of pathology. He studied through post mortems how particular bodily organs functioned and how disease processes altered organs. He died at the early age of thirty.
4. In fact, she argues that philosophy, too, needs to focus on the exemplary situations in written texts so as to cultivate the words and images they invoke (Mol 2008).
5. Tyquin (2006) does a fine job in detailing the long-term effects of shell-shocked soldiers in Australia, well into the 1930s.
6. Page number references refer to the Quality Paperback Book Club publication of the three novels in one volume (Barker 1997).
7. On the discussion of calculating the death toll, see Verpoorten 2005.
8. One use of flashback brings attention to the idea that someone or something survived, even though it may not have been the main character.

Chapter 6

Fixing Soldiers

The Treatment of Bodies, Minds, and Souls

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The object of these pages is a practical one. It is to collate and present in a convenient form the information which may be useful to those who are engaged in the treatment of soldiers and civilians—by heat and cold in baths, by electricity and radiation, by massage, mechanical apparatus, exercises and medical gymnastics, as well as by medicinal waters and climate in British health-resorts.
—R. Fortescue Fox, *Physical Remedies for Disabled Soldiers*

The invention of the "group," the conception of "social" or "human" relations as key determinants of individual conduct, were the most consistent lesson of the psychological and psychiatric experience of war.
—Nikolas Rose, *Governing the Soul*

During the Great War, faradization (electroshock therapy) was one of the methods for treating the psychoneuroses of soldiers, an application by physicians of strong electrical currents to different body parts of a weary warrior. As described at the time by a professor in the faculty of medicine in Paris,

> The patient lies absolutely naked on the bed, where he is first treated in the recumbent position, especially in motor affections of the lower limbs. Afterwards, he is treated sitting down, then standing up, walking, running, etc. The apparatus for faradizations supplied to the medical services is the type used; the dry cells may be advantageously replaced by Leclanché batteries, which are connected up in series. A spool of fine wire is used, and as stimulators at first pads, then revolving cylinders, then a metal brush. The current is at first feeble and then gradually increased; the poles are first applied to the affected parts of the skin surface (ears, neck, lips, sole of the feet, perineum, scrotum). Care must be taken to proceed gently at first … then,

if need be, the strength of the current is increased and more energetic mea-
sures used (Roussy and Lhermitte 1917, 168)

In more recent wars, those in the past thirty years or so, third location
decompression (TLD) is one of the methods used to treat soldiers' psyches
as they transition from being a soldier to being a veteran. Decompression
is "a process designed to allow service personnel returning from deploy-
ment to adapt to the home environment in a graduated way, with the
aim of reducing the potential for maladaptive psychological adjustment"
(Hacker Hughes et al. 2008: 534). TLD refers to managing the decom-
pression process in a pleasant, relatively isolated place, removed from
what soldiers will most likely be facing on returning home. Several NATO
countries have developed TLD programs, including Australia, Belgium,
Canada, France, the Netherlands, the United Kingdom, and the United
States (de Soir 2011). The success of TLD for supporting soldiers transi-
tioning from deployment to domestic life comes from diverse sources,
including spouses, the armed forces, and the soldiers themselves (Marin
2007; McRaven 2012; Sourbeer 2008). According to a Veterans Affairs Can-
ada newsletter article, decompression sessions have three goals:

1. *Release*—Decompression gives Canadian Forces members a chance to
   switch from their combat state of mind before returning to their families
   and communities. "After soldiering with adrenaline running 24-hours a
   day, many troops have to get stuff off their chests," said [Tom] Martineau
   [Peer Support Coordinator, Operational Stress Injury Social Support Pro-
   gram, Kingston, Ontario].
2. *Relax*—Canadian Forces members participate in a number of leisure ac-
   tivities to help them unwind, including sports, cultural events or just
   chatting with comrades.
3. *Reassure*—Educational sessions focus on adjusting back to "normal" life,
   the mental health impact of serving in hostile areas and spotting the signs
   of OSIs. Participants learn about programs and services they can turn to
   for help. (*Salute!* 2008, n.p.)

For the Canadian Forces, like many of the NATO countries, TLD takes
place in a nice hotel in Cyprus. Over a five-day period, soldiers adjust to
postdeployment life while attending seminars, undergoing psychological
testing, and taking in the local attractions.

For addressing the psychological health of combatants, these two ac-
counts obviously represent different treatment modalities for different
types of soldiers. Each entails a particular form of power and knowledge
as well as a specific kind of military psychiatric practice. The use of fara-
dization illustrates an exercise of an anatomopolitics of the body through
the deployment of disciplinary power—inflicting pain on the soldier's
fleshed body to restore physical and functional capacities in line with

military objectives. The location, intensity, and duration of the electrical current are strategically arranged and closely observed for bodily reactions by the psychiatrist.[1] TLD illustrates a form of biopolitics, because it is a general policy managing a distinct group with the aim of improving soldiers' resiliency and effectiveness.

We present these two accounts not to claim that over recent history treatment methods for weary warriors have undergone a progressive and continual shift in sophistication or in modalities, nor to suggest that the shift in treatment focus is simply from the bodies of soldiers to their minds.[2] In fact, faradization, when applied to soldiers in the Great War, was accompanied by other psychiatric techniques such as hypnosis, encouragement, and disciplinary suggestion (Yealland 1918). In the intervening generations and wars between these accounts, there have been both changes and continuities in the way soldiers are treated for emotional wounds. Lessons of treatments from previous wars are seemingly forgotten and in part rediscovered by military psychiatrists in later conflicts. Old practices ladened with terms and theories from the past, resurface, contending for acceptance alongside newer practices, phrases, and approaches. Faradization as a treatment for soldiers' psychological wounds has not disappeared.

In the early decades of the twenty-first century, the traumatized soldier is the object of analogous fixes. More generally, we argue that for over a century now, the body, the mind, and even the soul have been points of psychiatric treatment practices in military environments. These two accounts reveal a number of the dimensions and thus debates and choices over treatment methods including techniques for individuals and for groups of soldiers that tend to be more reactive than preventative; tensions among goals for redeployment to combat, reintegration to civilian life, and care or cure for illness; and effects of power that are intrusive and coercive or supportive and flexible, or some mixture of all. Whatever the style of methods used for fixing soldiers, sets of authority relationships, most evidently but not exclusively military, frame each encounter. Treatment involves the application of both psychiatric techniques via practices emanating from medical sciences directed at the minds and bodies of ill soldiers; and techniques involving ideas and practices arising from religious, moral, and spiritual knowledge directed at soldiers' souls.

In this chapter we discuss three distinct, though interlinked, ways of organizing power and exercising knowledge to treat soldiers enduring extreme psychological and emotional distress—that is, those focusing on the body, the mind, and the soul. We consider actual examples of treatments used by military psychiatrists in wartime and of pastoral care for weary warriors in different time periods, different armed forces, and different

places of combat.[3] Fixing soldiers' bodies, minds, and souls involves organizing personnel and facilities across a diverse geography of treatment sites, protecting and stabilizing the injured bodies, ravished minds, and troubled souls of combatants, and then providing an assortment of supports and services for mending or repairing them. Treatment measures for weary warriors, then, can be thought of as regimens for managing the movement and deployment of large numbers of people under military authority and wartime contingencies. Within all these treatments of curing, counseling, and consoling, the intention is to restore the body, reaffirm masculinity, and preserve—as far as possible—the soldier's health, sanity, and spirituality.

Curing Soldiers' Bodies

From the vantage point of the military as an institution, the recovery of soldiers' wounded bodies is a means to another end—namely, redeployment with a full return to the unit (RTU). Failing RTU, assignment to other military duties is possible for the partially fixed soldier who can still function, but only within a set of identifiable limits. Failing both, the unfixable soldier undergoes further discipline and control by means of evacuation, segregation, or even expulsion from the military. The belief that individuals "afflicted with mental disorder are the outcasts of society—a troublesome waste product [is] an idea which the Army, at any rate, must get rid of without delay, and without compunction" (Lepine 1919, xvi). In war, an army's objective is one of "maintaining at its maximum the numbers and value of the effectives in the firing line, of using to the last man all reserves at the base" (xxi). These are the words not of a military commander but of a clinical professor of nervous and mental diseases at the Université de Lyon who had overseen the treatment of some six thousand patients.

A Canadian physician serving at the XI General Hospital, in Boulogne, France, during the Great War, Robert D. Rudolf observed that the major complaint among soldiers was not psychological, but based in the body, as a type of myalgia, with "indefinite but very often crippling pains and tenderness in the various groups of muscles" (Rudolf 1915: 257). His description of the wounded soldier's initial arrival echoes the diagnosis and immediate treatment message in the forward psychiatry used in the exhaustion units in the Second World War and foreshadows contemporary use of TLD centers for transitioning soldiers from Afghanistan:

> When they first arrive they are tired out and generally sleep for most of the first few days, unless their condition keeps them awake. A few, however, are a stage farther than this in exhaustion and cannot sleep at all for a time. They

are undressed, thoroughly washed and put into clean beds between sheets; and it must seem to many of them as if heaven could really exist on earth, as they lie there clean, warm, well fed, with nothing to do and no sound of firing in their ears. (Rudolf 1915: 256)

In his report, there is no mention of nerves, shock, or breakdowns.[4] Granted, the majority of nerve cases would have taken a different path through the Canadian medical services and may not have been admitted to any general hospital, yet it seems strange that, even as a physician, Rudolf made no mention of the connection between ambiguous pain patterns and the diagnostic category of hysteria.[5] The upbeat and optimistic patina of his remarks is reinforced by his comments about the usefulness of putting into practice Frederick Walker Mott's (1916: 553) idea of the "atmosphere of cure." Although psychotherapy and abreaction were included in treatment regimens for nerve cases, Mott did not see a need for these treatment modalities. The atmosphere of cure, employed in Allied hospitals across France, reduces all ailments—no matter the diagnosis ascribed to an ill body—to one treatment approach that tends to the cheerfulness on the part of the doctor and nurse, diversion from the recollection of the trauma of war, and the "comfort, welfare, and amusement" of each patient (553).

Recall that in the first decades of the twentieth century psychiatry and neurology were vying for dominance over the mind as object of the field of study. During the Great War, a number of English and French physicians, among others, wrote texts on *physical* treatments for soldiers suffering shock, nerves, and trauma (Fox 1917; Lepine 1919; Roussy and Lhermitte 1917; Yealland 1918). Robert Fortescue Fox, honorary director of the Red Cross Clinic in London, England, for the treatment of disabled soldiers wrote a comprehensive text on physical remedies. He noted, "many men coming back from the field are seriously ill. Besides surgical and medical infections, they have wounds or disorders of the nerve centers. And the nervous injury is shown not only by many forms of paralysis and functional nervous disorder, but by disturbances of the circulation and nutrition" (Fox: 5). Fox accordingly catalogued the therapies and remedies in terms of climatic, hydrological, mechanical, and electrical treatments. Climatic therapies (akin to spa and waters therapy) for Fox meant using scientific knowledge of sunshine, humidity, winds, and mean temperatures throughout Great Britain to treat disabled soldiers. A related set of methods for fixing soldiers concerned rest, and quiet, tranquil conditions, such as resort facilities.

Hydrotherapy involved remedial baths, medicinal waters, and springs, with baths classified by temperature ranges as cold or cooling, subthermal, thermal, and hyperthermal baths. Remedial baths ranged from douche baths, shower baths, needle baths, hot air and vapor baths,

whirlpool baths, and sand baths; sand baths entailed an ancient practice of covering the affected limb with heated sand, mud, or peat. Mechanical treatment methods include massage, physical exercise, and medical gymnastics deploying weights, cords, and pulleys. This physical education could include "systematic exercises directed towards the re-establishment of the lost functions—motor re-education, helped by massage and passive movements" as well as physiotherapy (Roussy and Lhermitte 1917: 169). Participation in some recreational and sport activities as well as some agricultural labor, factory work, or domestic duties in the facility were regarded as therapeutic measures, too (Kloocke et al. 2005; Lepine 1919).

Electrical remedies, medical electricity, or electrotherapy (faradism and also called galvanism) for neurasthenia or shell shock were not intended to be the only treatment modality. As Fox describes,

> Electricity can never play the sole part in the treatment of these conditions; but it is a valuable aid. The full-body bath is employed first, with a mild sinusoidal current; also cerebral galvanism, positive pole on the forehead. This should be done only by skilled persons, and either a cell battery or a small earth-free generator must be used. At a later stage the high-frequency spark up and down the spine has a bracing effect, and tends, amongst other good effects, to raise the blood pressure, which is frequently low in neurasthenic patients. (Fox 1917: 166)

The use of electrical shock by means of a pad electrode was endorsed by Yealland as effective in treating disorders of speech, hearing, and vision among veterans. Even the mere presence of the faradic battery served as "an implement of suggestion" to improve the attitude of a patient (Yealland 1918: vi). Roussy and Lhermitte claimed that faradization "is of special value in psycho-sensorial and sensory disorders due to shock, nervous crises, and most of the psycho-motor disorders. It really depends on producing a kind of 'crisis,' which we should try to obtain at the first séance [*sic*; read: instance]. The latter often has to be continued for some hours, until the patient is finally 'mastered'" (1917: 168).[6] Throughout the Great War the use of electrotherapy faced sharp criticisms by medical professionals and by soldiers in Germany as well as in England. At the end of the war, in Germany "there were mutinies following the use of electrotherapy, which the soldiers felt was torture and abuse, and when those affected went to court and brought lawsuits against the military doctors who had treated them" (Kloocke et al. 2005: 54).

Another bodily treatment involved diet control and the frequent prescription of warm milk, a bread-and-water diet, or rice pudding with tea until the symptoms improved (Roussy and Lhermitte 1917). This had been a common measure of treatment dispensed in asylums before the

turn of the twentieth century for patients with nervous disorders not able to sleep. In the German armies in the Second World War, particularly in the early years, "soldiers suffering from mental and physical strain more often showed psychosomatic reactions [than war neurosis disorders], for example peptic ulcers. Eventually, there were so many of them that they were put together in special 'stomach battalions' in which all soldiers shared the same diet" (Kloocke et al. 2005: 46).

For certain medical officers serving U.S. forces in the Pacific during the Second World War, where there were few psychiatrists, the complaints of troops under their care and supervision were not surprisingly fundamentally physiological in nature. One American regimental surgeon observed, "some Pacific troops had engaged in hard labor under aerial bombardment and strafing and in tropical conditions for more [than] eight months straight. … Many were completely worn out, and had severe back and abdominal pains. … Observations like these tended to stress the need for rest periods and/or breaks from routine" (Bresnahan 1999: 145–46). Other medical reports noted environmental stresses associated with the heat and humidity and rugged terrains that are important in making soldiers' bodies ill. The diagnosis of tropical neurasthenia, with symptoms of weight loss, little physical stamina or endurance, exhaustion, and low morale was treated much like everything else: limited tours of duty, rotation of troops, and, for serious cases, stateside evacuation.

With a rapid increase in the number of mortar blasts and other explosions in Pacific combat in 1943, medical officers reported on what some called "blast concussion with implications for brain physiology," a term and diagnosis reminiscent of the debate in Europe over shell shock during the Great War. Bresnahan (1999) gives the following account:

> Many medical officers, even those with prior psychiatric training, seemed to have been taken aback by their experiences with soldiers who had sometimes literally been blown ten feet by a mortar blast or other explosion. "I thought I knew something about psychiatry," one medical officer remarked, "but with the sudden shockingly brutal, dramatic, precipitating factor in front line action to contend with, I've seen cases I've rarely seen in civilian life." His report referred specifically to "blast concussion" as a specific disease entity in which a shell or mortar or bomb explosion does not hit a person directly but always knock them unconscious for several minutes. Typically, the victims could not walk unassisted after regaining consciousness and had severe headaches, joint pains, and irritation of eyes for at least a week. The medical officer speculated that the "underlying pathology is the production of tiny petechial hemorrhages in the brain and other parts of the body." The cases improved after a few days and wanted to rejoin the squads but "every time they hear an explosion—even a distant one—they go into the syndrome immediately." (Bresnahan 1999: 146–47)

Recurring and lingering effects from such blast concussions, in the form of tremors and panic episodes, meant that soldiers were not really fit for combat duty, which frequently resulted in evacuations.

Combat flying fatigue received some attention by the nascent field of aviation medicine in the Great War and became the subject of further study and analysis during the Second World War. One such study was prepared for the Air Surgeons Army Air Forces into the experiences of the U.S. Eighth Air Force in their first year of combat from July 1942 to July 1943 in the European theater of operations from bases in England. The study examined the pilots, navigators, bombardiers, and gunners in heavy bombers; the B17 Flying Fortress and the B24 Liberator with missions deep into Germany (Hastings, Wright, and Glueck 1944). While the purpose of the study was to report on facets of psychiatry among combat flying personnel, the report did draw attention to physical aspects of combat flying which the authors called flying fatigue. One purpose of this term was to normalize a certain amount of fear and stress with combat flying, and another was to distinguish that realm of belligerent behaviors and breakdown with more serious forms of depression, severe anxiety, and emotional illness that the report called "operational fatigue."

Flying fatigue the report defined as "ordinary fatigue and the physical and mental symptoms of it," adding that it is "the same as the fatigue any individual would suffer if he had insufficient sleep, rest, relaxation, and had been exposed to the nervous strain of flying" (Hastings et al. 1944: 26). Other contributing factors or causes of flying fatigue were high-altitude missions and missions too close together on consecutive days. The report emphasized that flying fatigue "does not imply that the individual is emotionally sick" (27) and therefore does not require specialized treatments. Rather, combat flying personnel displaying flying fatigue "can be cured readily by giving the individuals two to five days of rest" (27). The body of the soldier is the object of treatment, not the mind.

"Operational fatigue," by contrast, was the term used to describe a breakdown in emotionally stable individuals. The symptoms were that the face of the aircrew member was "pale and drawn. He is tense, irritable, and frequently has a tremor of the fingers. The irritability is especially apparent when discussing the combat situation, the patient becoming aggressive and belligerent on little provocation. He quarrels easily … over trifles … [and] frequently begins to avoid his fellows in an effort to avoid quarrels" (Hastings et al. 1944: 70). Other symptoms of operational fatigue were loss of appetite, weight loss, severe anxiety, and intense dreams or nightmares. Rest and cessation from flying were insufficient treatments for a cure. Additional treatment measures recommended were a thorough

examination of the patient and observation for three to four days. After assessment was completed, there was usually a two- to four-day period of narcosis or sleep therapy, giving doses of a sedative drug to produce a prolonged sleep for twenty out of twenty-four hours, doses that were repeated depending on the severity of the stress. A convalescent period of three to four days with a high-caloric diet prepared the aircrew member for a two-week program of physical reconditioning as well as short-term day leaves from the hospital. From these three to four weeks of active therapy, the U.S. Eighth Air Force found that about 70 percent of the patients returned to combat flying while the remaining 30 percent returned to their units for ground duties.

From this discussion, we see that several treatment mechanisms are embodied through individuals. In other words, certain kinds of knowledge manifest as a materiality through the bodies of individual soldiers. Treatments are techniques not only for fixing bodies, but also for addressing military requirements.

Counseling Soldiers' Minds

Psychiatric practices for treating soldiers tend to concern the interior lives of warriors. This is the soldier as psychological being with attitudes, beliefs, feelings, deep reminiscences, morale, morality, intelligence, and personality. From a human sciences perspective, fixing soldiers centers on the person, a modernist concept that represents "a bounded sphere of thought, will, and emotion; the site of consciousness and judgement; the author of its acts and the bearer of a personal responsibility; an individual with a unique biography assembled over the course of a life" (Rose 1989: 217).

Wartime conditions generate psychological and emotional effects as well as physical and functional effects. These effects produce anxieties, traumas, psychoses, and neuroses that—at least some specialists argued— were distinctive and associated with new technologies and sheer slaughter of human beings. Psychological attributes and effects of wartime conditions identified during the Great War were "the sudden departure, the leap into the unknown, the separation from one's dear ones, the frightful uncertainty as to what might befall one, the great flame of patriotism, which sustains, but also exacerbates the nervous tension … the anxious waiting of results, the violent emotions and in of battle, the commotions and shocks [and, in terms of morale,] the heavy losses, the general and continuous danger, the need of living perpetually on the alert, and above all, the duration of the war [from 1914 to 1918]" (Lepine 1919: xviii, xix).

Such psychological strains of combat conditions have reappeared in subsequent wars and conflicts throughout the twentieth century and into the twenty-first century. For aircrew engaged in combat in the Second World War, so-called normal events for bombers involved "watching close-in and constant enemy fighter attacks, flying through seemingly impenetrable walls of flak, seeing neighboring planes go down out of control and at times explode in the air, returning with dead or seriously wounded on board and other such experiences, [all of which] imposed a severe and repeated stress" (Hastings et al. 1944: 5). Some authors suggest that recent wars in Iraq and Afghanistan—which include novel battle situations such as terrorist tactics (suicide bombers and IEDs) and pervasive battlefronts in both civilian and military zones—have made currently serving military service members more at risk for PTSD than in the past (Simms, O-Donnell, and Molyneaux 2009). But what does more at risk for PTSD really mean?

Following D-Day and the invasion of Normandy by Allied troops in June 1944, fierce battles and heavy losses ensued over the next several months, both of wounded casualties and soldiers presenting with battle exhaustion or neuropsychiatric casualties. Copp (2003), in a study of Canadian troops in Normandy writes, "The intensity of combat was imposing an extraordinary burden on men's minds as well as on their lives" (87; see also Copp 2006; Copp and McAndrew 1990). The senior psychiatrist for the Second British Army explained the soaring rates of battle exhaustion: "The initial hopes and optimism were too high and the gradual realization that the 'walk over' to Berlin had developed into an infantry slogging match caused an unspoken but clearly recognizable increase in the incidence of psychiatric casualties arriving in a steady stream at the Exhaustion Centres and reinforced by waves of beaten and exhausted men from each of the major battles" (quoted in Copp 2003: 111). CEUs were set up to deal with anticipated cases of battle fatigue because psychiatrists had convinced the military command that troops invading Normandy were at higher risk of developing battle fatigue given their experience in previous campaigns.[7]

Leading up to the Second World War, military and psychiatric authorities assumed that screening programs would detect and remove the unfit and unsuitable recruits, including those predisposed to mental illness or a nervous breakdown. As well, American military leaders and likely the general population in United States at the time, believed "that sturdy, well-adjusted soldiers of strong character would be able to withstand the stresses of war…. In the opening days of World War II, only 35 psychiatrists were involved with the military. By the end of the war, this number had risen to nearly 1000, just short of one third of all American psychia-

trists" (Pol 2006: 145, 146). In addition to psychiatrists, the U.S. military drew on the services of anthropologists, psychologists, sociologists, and other social scientists to assist in understanding the dynamics of wartime stresses on combat troops. In 1944 a University of Chicago professor of psychiatry writing about psychiatric casualties of war noted "recent information indicates that approximately 30 per cent of casualties in battle zones are psychiatric in nature. In some places, the proportion is even higher. With early treatment, however … it is expected in view of British experience that 70–80 per cent of these men can be returned to duty" following treatment (Slight 1944: 156–57). The potential of psychiatric treatment to an armed force thus seemed substantial with a success rate of fixing and returning to full duty between one-in-five to one-in-four of total military casualties.

Underpinning the psychiatric treatment of weary warriors is a history of different aims and practices along with divergent theories and beliefs about probable causes and favored professional cures. We can identify four such treatment regimes organized around reassurance and restoration, aversion, psychoanalysis, and social psychology. Each treatment regime focuses on the soldier's state of mind as an object of inquiry and action, but the regimes differ in how the body and mind are understood and treated.

Reassurance and restoration methods devote considerable attention to physiological elements and physical remedies. There is no sharp Cartesian mind-body dualism here for psychiatric casualties in battle zones:

> The treatment required is often the simplest variety, including rest with the aid of sedatives as necessary, good food, quiet, and reassurance. The success of these measures is dependent on their early application and before the casualty is removed too far from the combat zone.… [Such treatments are effective in] acute forms of emotional disorder associated with fear, panic, anxiety, or confusion and due to physical strains, to excessive fatigue, loss of sleep, exhaustion, hunger, and other forms of deprivation. They may thus be of a transitory nature if treated immediately. More lasting forms of disorder must be removed from the combat zones for prolonged treatment or even returned to this country. (Slight 1944: 158–59)

Aversive therapy, sometimes called active treatment, is a type of conditioning and consists of a psychiatrist scripting a situation (stimulus) and the ill soldier being subject to discomfort, pain, or another negative repercussion.[8] Ruth Kloocke, Heinz-Peter Schmiedebach, and Stefan Priebe (2005) describe how German psychiatrists in both World Wars treated soldiers suffering from psychological trauma and stress. They point out that for the first few years of the Great War most German soldiers with psychological injuries from combat were discharged and provided state

pensions, but that as the war dragged on "the same patients were re-examined and in some cases pensions were withdrawn.… [M]any of the 'neurotics' who had been previously discharged as incurable were subjected to a new system of treatment" (46–47). Neurotics were separated from the chronically mentally ill and malingerers, and if treatment was considered useful, these patients were sent "to specialized stations where so called 'active treatment' was administered, alongside certain forms of psychotherapy. Different forms of aversive therapy were included under the heading of 'active treatment.' These were effective with a mixture of hypnosis, discipline and punishment" (47).

Suggestive hypnosis, as developed by a Hamburg neurologist, involved three elements in order to work: "absolute self-confidence on the part of the doctor, complete subordination on the part of the patient, and the creation of an atmosphere in which the success of the cure was a foregone conclusion" (Kloocke et al.: 47). Some British specialists during the Great War also practiced treating war shock in soldiers via suggestion under hypnotism of the patient, reporting promising results and suggesting that "the soldier is peculiarly susceptible to suggestion; the whole training and discipline make him respond to the authority of the Medical Officer" (Eder 1917: 130).

Electrotherapy is another technique of active treatment prescribed for neurotic soldiers. Painful sensations of an electric current combined with military exercises and military subordination enforced on the patient were used at Maghull for British rank and file soldiers (Lerner 2003). Similar techniques were applied by physicians and specialists in the armies and military care facilities of other countries, although some specialists saw such therapy as a primary method while others viewed it as secondary or tertiary importance in cases of war shock (Eder 1917; Yealland 1918).

To a considerable extent, the psychoanalytic ideas, techniques, and influences of Sigmund Freud on modern societies came through military institutions and wartime in 1914–18 and still more so in 1939–45 (Bresnahan 1999; English 1996; E. Jones 2006; Pol 2006). Corresponding treatments involved the analysis of dreams, hypnosis, and free association by psychoanalysts like William H. R. Rivers at Craiglockhart in Britain. Also part of the psychotherapeutic treatment regime was the practice of interviewing soldiers to determine their family background and relationships with their parents and siblings, which often segued into the so-called talking cure of encouraging weary warriors "to re-experience their trauma in psychotherapy sessions" (Pol: 146). In the words of a psychiatrist working in the American military in the Second World War, "individuals who have some unresolved Oedipal ties or sibling hostilities with consequent guilt manifestations are more susceptible to break under the strain of combat"

(quoted in Bresnahan: 143). The deeply distressed soldier or the jittery aviator had failed to meet the expectations of manhood because of a substandard childhood, inferior heredity, an anxious personality, or some other character defect. The upshot of such psychoanalytical analysis in the Pacific theater was the evacuation of neurotic soldiers—a mass departure to hospitals in the United States, usually to mental wards of veterans' hospitals, resulting in a further medicalization and institutionalization of weary warriors. Others were simply discharged from military service without access to support.

Social psychology emphasizes the place of the individual within different groups and organizational contexts. Rather than focus on past experiences from childhood or the rather fixed nature of individual predisposition, this approach presents arrangements and future possibilities in networks of relations and group dynamics for helping to prevent combat stress and to alleviate certain kinds of combat breakdown. Psychiatrists attempt to connect social capital of the individual (group cohesion, leadership, and sense of trust) to the symbolic and cultural capital of the military setting (battle morale, combat duty, and national patriotism). A prominent twentieth-century military psychiatrist remarked, "perhaps the most significant contribution of World War II military psychiatry was recognition of the sustaining influence of the small combat group or particular member thereof, variously termed 'group identification,' 'group cohesiveness,' 'the buddy system,' and 'leadership'" (Albert Glass quoted in Pol 2006: 148). In this vein, to prevent and to address psychological stresses of combat, militaries introduced group discussions and materials on morale, though with limited success and sometimes with unintended consequences (Bresnahan 1999: 222–24; Pol: 147). In the Canadian army in Europe during the Second World War, "[s]enior officers were deeply concerned by the suggestion that men who had recovered from the symptoms of battle exhaustion should not be returned to combat, and the recommendations made by [army medical officers and psychiatrists] were ignored. Instead, attention was focused on various initiatives to improve morale" (Copp 2006: 181). These measures stressed the importance of building team spirit, offering a new policy of forty-eight-hour leaves, and explaining the Canadian government's war service gratuities policy. This is not to overlook the more practical aspect of using the talking cure among a group of soldiers: there were so many soldiers breaking down during peak battle times that the most expedient way to process the wounded was to process the mentally wounded in groups.

Social psychology treatment regimes grew in popularity during the second half of the twentieth century. In the United States, so-called rap groups emerged as part of self-help groups among Viet Nam War veter-

ans to deal with "Vietnam Syndrome" and delayed stress (Shatan 1973). In Canada, as a result of the psychological wounds peace-keeping soldiers endured throughout the 1990s, a network of federally funded peer support programs for veterans with OSIs was established (Grenier et al. 2007; Linford 2013). Even in the twenty-first century, the introduction by several NATO countries of TLD center programs for service personnel returning from deployment was intended to promote recognition, renewal, and reintegration of the soldier (Hacker Hughes et al 2008) by treatment techniques releasing, relaxing, and reassuring combat troops (*Salute!* 2008).

Caring for Soldier's Souls

We follow Foucault (1979, 2000a, 2007), Rosi Braidotti (2006), Margaret McLaren (2002), and Nikolas Rose (1989), among other social theorists, in understanding the soul as having an existence, a "bodiless reality" continually produced in, and by the body (Foucault 1979: 17). The soul and related notions of ethics, religion, and spirituality encompass notions of faith and sacrifice, good and evil, mercy and salvation, truth and obedience, perhaps a relationship to a guiding power or God, and a hereafter or other world. Most practices associated with the soul include sacredness, prayer, benediction, confession, reflection, guidance, meditation, or contemplation. Foucault developed the concept of pastoral power as a model of procedures for the governance of people and their souls. Pastoral power in a sense is "exercised over a flock of people on the move," "a beneficent power" by which the duty of the pastor is "the salvation of the flock," and "an individualizing power, in that the pastor must care for each and every member of the flock singly" (Golder 2007: 165). The idea of exercising power over an individual while maintaining connections to a wider group, beyond just immediate kin or community, sets up the relationship to care for the connections individuals have with each other as humans.

Given our interest in weary warriors, we are intrigued about the application of pastoral care in the armed forces. We situate pastoral power within the field of practices and relationships concerned with treatments of soldiers, while attending to the spirit and psyche of exhausted combatants. From this standpoint, traumatized soldiers are also troubled souls, struggling with crises of faith and conflicts of conscience.[9] The military is an institution where pastoral and religious activities have been situated and exercised for centuries (Bergen 2004). We suggest that pastoral power is not coincident with that exercised by the military and nor is pastoral power, in the guise of military chaplains, totally assimilated by military command. At certain times and places, however, from the perspective of

frontline soldiers the work of pastoral care through chaplains has seemed indistinguishable from the practices and objectives of military leaders. At other times, though, pastoral care is regarded as serving a distinctive and valuable service for soldiers of all ranks in a military.

A military chaplain is "a minister sent by the church and accepted by the military to care for the souls of the men and women in the smaller and closely-knit community of service life" (Zahn 1969: 225). As a formal religious institution, the chaplaincy derives from the Christian past (Benham Rennick 2011; Bergen 2004); in more recent times, however, the chaplaincy has evolved to become more of an interfaith organization with numerous denominations or religious groupings represented and served by Catholic priests, Jewish rabbis, Protestant ministers, and Muslim imams in militaries in Britain, Canada, the United States, and other nations (Bourque 2006; Crerar 1995; Crosby 1994; Fowler 1996; Slomovitz 2001; Snape 2005).[10]

"Pastoral power is a power of care. It looks after the flock," wrote Foucault (2007: 127); it is then a type of biopolitics. In a military context, pastoral power has other important qualities and relationships. Typically, the chaplain or pastor in an army wears a military uniform and has an officer's rank although he or she does not exercise military command over troops in the conventional hierarchical manner of a formal organization. The rank does carry with it certain privileges and responsibilities, of course, and also has a symbolic importance. As Zahn suggests (1969: 224–25), "the pastor in uniform constitutes an affirmation—rightly or wrongly so—that there is no basic incompatibility between the values represented by the religious community and the war being waged by the secular ruler." Other factors that may contribute to the status and influence of the military pastor are the self-regulation by at least some soldiers through self-refection, guidance by one's conscience, meditation, and confession; "the clergy's natural unworldliness"; and, compared to most troops, "their comparatively high level of education" (Snape 2005: 135). Additional resources available to military chaplains are their religious traditions and practices, physical symbols, and sacred spaces (Benham Rennick 2011: 167). Images of the military chaplain through the ages are of a warrior of Christ, a holy person, an aloof figure detached from the frontlines, an engaged rabbi, a pastor on the battlefield (Crosby 1994; Slomovitz 2001), "obedient rebels" (Crerar 2006), a trusted confidante, and a go-between playing "a neutral role in the competitive and hierarchical military environment" (Benham Rennick: 167; see also Bergen 2004; Fowler 2006; Hadley 2006).

The work of military chaplains falls into three interconnected types: tasks related to religious considerations, tasks related to the military organization, and tasks related to counseling and treating individual soldiers and perhaps their families. Ministering to the spiritual and moral needs of

all ranks in their own faith involves performing religious ceremonies and services of a variety of kinds in a variety of locations, as well as facilitating opportunities for worship by soldiers of other faiths. Military-related work involves upholding armed forces values, promoting self-discipline, advising commanding officers on personnel issues, working with military medical staff, delivering educational lectures to the troops on such matters of sexual morality as fornication and adultery, and encouraging the morale of the troops (Bourque 2006; Crerar 1995; Crosby 1994; Fowler 2006; Zahn 1969). Tasks related to counseling and treating include assisting the sick and wounded and giving first aid; rescuing and carrying the wounded; visiting hospital wards; retrieving, identifying, and burying the dead; writing letters of condolence to relatives; and offering counsel to veterans and their family members on reintegration (Crerar 1995). Interestingly, many aspects of pastoral work—talking with and listening to soldiers' thoughts and concerns, having empathy for them, spending time with troops, forming relationships of trust and confidence—prefigure or parallel psychoanalytical techniques. It should not be surprising, then, that Freud saw the role of the psychotherapist as a teacher, enlightener, and confessor.[11]

In an empirical study of religious faith in the contemporary Canadian military, Joanne Benham Rennick (2011) highlights the role of religion as a resource for helping solders deal with trauma and stress, including PTSD. She writes, "Beyond the traditional pastoral duties, modern-day chaplains dedicate a significant portion of their time to counseling individuals. Many of those who approach the chaplains for their service suffer from stress associated with military duties" (63). In the Canadian Forces, chaplains have a remarkable measure of independence to circulate among personnel. This structural feature of their role, in addition to their work practices of absolute confidentiality and not being obliged to keep records of those who ask for advice and support, means that chaplains are frequently "the first people to identify personnel who are showing symptoms of operational stress injuries" (63). Military personnel may initially approach a chaplain rather than a social worker or a mental health specialist "because of the fear of stigmatization" (78). For soldiers struggling with stress, depression, or trauma, a military chaplain can present an alternative viewpoint, that of human spirituality to that of the human sciences of psychoanalysis or psychotherapy, while maintaining confidentiality. And it is only when believed necessary to do so, that a chaplain shares information with other specialists.

"Pastorship is a fundamental type of relationship between God and men and the king participates" (Foucault 2007: 124). A frequent issue of pastoral practices in the armed forces concerns the question of tensions

among the various roles military chaplains play. They often deal with cross-value predicaments, ethical dilemmas, and divided loyalties. "When faced with the real needs of the soldiers in his [*sic*] pastoral care, to whose voice should the chaplain listen? To that of his God, his church, or the leaders of his country's army?" (Hadley 2006: 3). To further complicate the circumstances of religious forms of treatment other voices can be added, including those of the soldiers, their families, or the military's medical staff. A study of chaplains in the RAF reported that religious leaders insist, "The presence of a chaplain in a military unit … does not indicate that 'the Church' has given its formal approval to war in general or to any specific war that may be in progress; instead, [the chaplain] is there merely to serve as a specialist promoting religious services and providing sacraments only [a chaplain] is qualified to perform and provide—just as other specialists (the doctor, the dentist, the psychologist, etc.) are there to provide equally limited services" (Zahn 1969: 225).

A British scholar observes that military commanders in both World Wars "were concerned with using the army's chaplains to sustain a vigorous sense of purpose and righteous enthusiasm" (Snape 2005: 245). The military role of chaplains was significant and multifaceted: "chaplains undoubtedly provided enormous support for solders both individually and collectively; they developed a powerful moral and religious idiom with which to inspire them, they entertained them in their idle hours, they offered support in their domestic problems, they prepared them for battle, tended to their wounds and provided a vestige of dignity in death" (137). From her study of the contemporary Canadian Forces (army, air force, and navy), Benham Rennick (2011: 167) maintains that chaplains negotiate structural realities (much like a social worker) and manage potential tension among their own roles as chaplains, by means of bypassing "the chain of command to resolve issues," maintaining confidences, and "dealing with irrationalities within the system by mediating between the bureaucratic and hierarchical elements of military society and basic human needs for familiarity, community, and support" (167).

Calls for a closer relationship between pastoral care and professional forms of treatment sound like welcome suggestions for greater collaboration in attending to the mental health of soldiers (Seddon et al. 2011). However, we question the taken-for-granted obviousness of benefits from closer working relationships between professionals treating soldiers with deep emotional distress. Some research strongly indicates that "chaplains are important sources of non-stigmatized consolation and comfort who provide an alternative to the professional mental health resources" (Benham Rennick 2011: 170). Yet tighter and more-formal linkages between chaplains and mental health professionals risk imbuing relations between

a soldier and a chaplain with overtones of professional power, other diagnostic labels and records, perceptions of stigma, and a loss of confidentiality within the military system, thereby corralling the frayed edges of power relations and knowledge claims into a more unified system. In addition to the further diffusion of psychiatric knowledge and power into spirituality and religion, such collaborative schemes could result in contracting pastoral practices as frontline crisis intervention and safe contacts for emotionally stressed soldiers, making soldiers become less of a knowing subject and more of a known object. Pastoral care has implications, therefore, for what counts as relevant and appropriate knowledge and who gets to interpret and use it in what ways. As part of an agentic resistance strategy within a military truth regime, military chaplains offer a respectful pathway for knowledge coming from soldiers with combat trauma in the form of personal accounts, experiences, and illness stories. As well, chaplains take up knowledge production in a biopolitics that may also be called popular epidemiology or lay knowledge about stress, health, and care (G. Williams and Popay 2006).

Pastoral care and power, while rooted in ancient religious institutions, has long been associated with military institutions (Bergen 2004) and remains a feature in twenty-first-century armed forces. Pastoral power is exercised through an expanded interfaith space in which chaplains receive training in stress management and suicide prevention (Bourque 2006). "The provision of the security and comfort offered by the sacraments and other services performed by the pastor of the military parish is seen as necessary or helpful to the military organization solely in terms of its contribution to morale" (Zahn 1969: 235). More than that, in terms of treatment of soldiers with anxiety and trauma, military chaplains are "helping personnel order their experiences, providing comfort in the face of suffering, loneliness, and fear and interpreting some of the violence they see in their role" (Benham Rennick 2011: 163). This, in a pastoral sense, is the art of fixing soldiers.

Facilities for Fixing Soldiers

"The essential function of psychiatric power," writes Foucault (2006: 143), "is to be an effective agent of reality, a sort of intensifier of reality to madness." In treatment within a military context, especially one during wartime, the question is whose reality? The answer, in part, depends on where and when the treatment is taking place, the distribution of care in space and time. For fixing combat soldiers there are multiple locations, from each of which power emanates, passes along, and is exercised through

encounters, gestures, relationships, protocols, decisions, and movements over time. Schematically, the organization of combat-related treatment has encompassed four zones as social spaces: (1) In the field and war front: first aid posts, forward medical stations, casualty clearing stations, field hospitals, ambulance trains, combat exhaustion units, evacuation ships and hospital ships, and mobile field hospitals; (2) At home or in an allied territory: rest homes, convalescent hospitals, civilian general hospitals, veterans' hospitals, neurological facilities, asylums, and other mental health facilities; (3) Post deployment facilities: OSI centers, trauma units, TLD centers, self-help groups, and warrior transition units; and (4) Disciplinary mechanisms: discharge from the military; court-martial proceedings; jail; placement in concentration camps; work in factories, farms, or mines; detoxification centers; and homelessness. To illustrate the way that fixing strategies are caught up in specific social spaces, we offer two brief examples.

First, the organization of methods of treatment for war neurotics among German troops in the Second World War comprised a range of medical and military techniques and locations, both of care and of compulsion. From resting places and recreation areas with return to active duty for those who recovered, to special wards in army hospitals, to lunatic asylums for mentally ill soldiers, to special services in the reserve army for maladjusted soldiers, to delinquent battalions for so-called bad characters. The treatment was sometimes the same as the cause: if warfare wounded the soldiers, warfare would fix it. For soldiers with psychological problems who did not recover enough and were thus unable to carry out duties, "they were court-martialed or sent to a concentration camp" (Kloocke et al. 2005: 49). These increasingly radical treatment techniques and locations meant "the therapeutic arsenal took on a new quality" (56) one more threatening and coercive in discourse and effect.

Second, the evacuation of American troops suffering neuropsychiatric problems from the Pacific theater of the Second World War illustrates the care/compulsion dynamic in fixing ill soldiers. Shipping neuropsychiatric patients home was the last priority, ranked after the critically ill and seriously wounded troops, and only when ships were available. Transports were not outfitted for psychiatric care for the month-long voyage to the United States.

> The merely "psychoneurotic" were crammed into stifling bunks adjacent to their psychotic shipmates, and were often not allowed on deck ostensibly for safety reasons, but more likely because of the dearth of experienced staff to supervise them. Supplies of sedatives were scant, as were attendants trained to administer them, and frankly and/or violently psychotic patients were often locked up in cages for the duration of the voyage.... The cages into

> which these ill American soldiers were locked were donated by Australian and New Zealand zoos, most of which had been used to confine gorillas. (Bresnahan 1999: 134–35, 135)

We have here a mid-twentieth-century case of the medieval ship of fools approach to madness (Barchilon 1988)—a way of dealing with persons diagnosed with serious emotional and psychological injuries. Psychologically wounded warriors were evacuated to the United States, confined in the bunks and holds of naval boats or even cages under military supervision, experiencing little if any pleasure from the oceanic voyage. Unlike in the allegory, the destination was known, to the west coast of America, usually to hospitals and asylums, not to a family home, not for a time at least. And, again, unlike the fable of the ship of fools, there was no public spectacle when these ships arrived at the docks on the west coast; rather, these abnormal, deviant soldiers arrived at night, hidden from the gaze of the media, slipping under detection by the civilian population.

The advent of actual spatial treatment locations is influenced by a number of things, including medical considerations of time and distance from the front and point of casualty whereby the implementation of the military strategy of rapid treatment and redeployment causes security concerns for safe distances from the front to avoid attacks to healing spaces (E. Jones 2006: 450). Facilities often differentiate between officers and the rank and file in order to preserve the authority of military hierarchy. The capacity to engage in official religious acts alongside personal decisions by particular military chaplains affect the positioning of facilities for fixing soldiers (Crerar 2006; Fowler 2006).[12] Frontline facilities rely on the availability of local buildings. For example, all over France during the Great War the military used cellars and wine vaults, monasteries and churches, hotels, spas and resorts, or lunatic asylums for therapeutic space.[13] Frontline facilities also rely on speed, flexibility, and mobility. For example, a twenty-first-century U.S. Army Forward Surgical Team with roughly twenty members can set up an entire surgical unit in one hour, including a unit with six hours of postoperative intensive care (Gawande 2004).

While the reality in and of treatment facilities for ill soldiers may be concentrated in the military, that reality is also shaped by, acted on, and worked through medical and nursing staff, other patients, military chaplains, and family members. Even in treatment practices that involve separation and isolation, there is much external to hospitals, rest homes, or transition units that influence the organization and workings of these treatment sites. Realities of the outside world make their appearances in convalescent facilities or psychiatric units in several ways: through dreams, thoughts, nightmares, and panic attacks; in the form of family background identified in assessments and discussed in interviews; in re-

gards to one's military obligations and national duties via lectures and talks by chaplains and officers; and in referencing a soldier's current troubled status to normalcy in the outside world. Both desirable and horrible aspects of realities contend for attention.

In the institutional world of treatments, the subjectivity of the ill combatant is not only that of patient. They are of course complex hybrid subjectivities that unevenly play out in specific facilities. There are cross-links among military personnel with specific ranks and from specific branches of the armed services that carry with them particular brands or types of masculinities (Belkin 2012; M. Brown 2012). As soldier-civilians or veterans, ex-soldiers become citizen-soldier-veterans that are part of families as parents, sons and daughters, and siblings. They have deeply personal histories that combine experiences of race, social class, gender, and family that come to constitute their understandings of themselves and others. As well, ill combatants are ethical beings, drawing on spiritual and religious guidelines and beliefs that are shaped within and outside how they are as soldiers or civilians.

Whatever else they may be, facilities for fixing soldiers are not independent and homogeneous places of complete exclusion from civil society or internally monolithic sites of traumatized soldiers. Facilities as organizations take on several roles and functions. From the perspective of Foucault's earlier works, treatment facilities are disciplinary orders for administering and regulating military personnel, sometimes within and sometimes outside formal military services; a force field or configuration of power relations with a fundamental dissymmetry of authority and status; and places with practices of medical(ized) observation, diagnosis, and therapeutic interventions that can be either close to the battlefield, or located at more distant positions as a safe haven. Just as facilities can be a dumping ground for deviant soldiers, a purposefully segregated institutional place of isolation and surveillance, they can also be a site of differential support for fixing the bodies, minds, and souls of soldiers who have experienced the horrors of warfare.

Treating Weary Warriors

Historically based and organizationally situated treatments of wounded warriors are mediated events. Treatment is much more than just the application of care to a patient. It also involves techniques of compulsion and contestation over roles. There is a dark and troubling side to fixing combat soldiers with trauma. Treatment measures have included electroshock therapy, reenactments of shell blasts by using mortars, and the talking

cure. Soldiers have been restrained in shackles, stigmatized with highly moralistic labels, confined in cages in the holds of ships for weeks, and overmedicated. In the modern history of treatment, many weary warriors have been rehabilitated and returned to active service. Others, in the name of treatment in times of armed conflict, have been demoted in rank or discharged altogether; criminalized; sentenced to hard labor; or doomed to lunatic asylums, concentration camps, or other total institutions. Conflicts invariably arise over the performance of roles within treatment regimes, between frontline doctors and headquarter commanders (Bresnahan 1999), among buddies in rap groups, and within a psychiatrist as a member of a medical review board. Treatment regimes, techniques, methods, and associated terminologies compete for acceptance and application in fixing ill combat solders. Basic approaches such as psychoanalysis and social psychology vie for acceptance in military environments, in tackling the treatment for the emotional breakdown of soldiers. For military chaplains, issues of their pastoral roles relate to allegiances to denominational superiors, army commanders, government officials, or defense departments. These realms feed into an overarching military and psychiatric imperative: fix these soldiers, for we want them back as warriors.

Notes

1. Some readers may regard these features of electroshock therapy or faradization as resembling those in penal torture. They would not be far wrong, as a review of Foucault's work on discipline and punishment shows (Foucault 1979).
2. Following from our discussion in chapter 1, we reject dualistic thinking that rigidly separates mind from body and that typically ignores the soul as a discursive-material entity (see chapter 4). Moreover, we do not assume the physical body is a unified and neutral subject. We engage with the ideas of Foucault and various feminists, and expand upon them in our understanding that there are permeable boundaries between and amongst bodies, minds, and souls of soldiers who suffer extreme distress as a result of combat.
3. This distinguishes our approach of looking at concrete practices and working institutions from that of Foucault, who tended to discuss medicine, psychiatric power, and pastoral care in reference to texts and theoretical developments. Apropos Foucault, we explore how treatments function and the relations of power that permeate treatment practices and institutional facilities. Moreover, within our feminist poststructural analytic, we approach the assemblage of treatments for weary warriors in reference to the material-discursive elements of practices and relationships among bodies.
4. Rudolf wrote about irritable heart and paralysis from fright later in the war (Rudolf 1916a, 1916b).

5. Reports of diffuse pain and migrating aches surfaced in the diagnostic parameters of GWS.

6. See also Leese (2002) for a description of the use of faradism to treat hysteria.

7. One of the CEUs had already operated relatively successfully, at least according to the military command, in the Italian campaign. During the Battle of the Scheldt, a psychiatrist was ensconced in a field dressing station for the First Canadian Army, even farther forward than the CEUs, to deal only with cases of battle exhaustion (Copp and McAndrew 1990: 141).

8. Aversive theory is akin to trauma re-enactment of the late twentieth century, except in the instance that the re-enacting was done on location with live artillery fire and threat of death.

9. Admittedly, the topics of pastoral power and religion are vast and extend over many histories, raising issues of the relationships of church and state, faith and civil society, and religious and military institutions, whereas spirituality and other worldliness intersect with the materiality and hellish world called war. A related topic concerns resistance to exercises of pastoral power (Foucault 2007: 204–14), a subject that we do not fully examine here.

10. Some chaplains are female, which stands in contradistinction to many formal religious doctrines. Note here that the soul is being taken up narrowly by the military institution. Whereas we might take up a conceptualization of the care of the soul through psychiatric practice, the military does not. The soul falls under the purview of spiritual leaders within specific religions.

11. Parallel to psychotherapy and psychoanalysis, care of soldiers' souls have been assigned to both chaplains and psychiatrists culturally through television shows, as, for example, Father Francis J. Mulcahy, an American Catholic priest, in *M*A*S*H;* and Major Grace Pedersen, an Australian psychiatrist, in *Combat Hospital.*

12. In the Second World War, Canadian Navy and Air Force chaplains "were normally at arm's length from the killing fields of their ships and squadrons," whereas Army chaplains "came into closest contact with the enemy" (Fowler 2006: 36). See also Crerar (2006: 14) on similarly varied practices in the Great War.

13. In the Great War, Canadian forces in Britain procured prewar health spas and resorts in England to treat wartime soldiers with nervous disorders, whereas the British operated hospitals that were part of the lunatic asylum network. However, this difference in treatment facilities largely disappeared when Canadian troops returned home, as "they were sent to existing provincial lunatic asylums for treatment" (Humphries and Kurchinski 2008: 110). For Australian soldiers during the Great War, a long voyage home meant psychologically wounded soldiers had engaged in some form of treatment. Nonetheless, upon arrival, a similar system to that of Canada and Britain emerged. Many soldiers with psychiatric illness were admitted to civilian asylums funded by individual states. Soldiers not finding places in the asylum were admitted to Australian auxiliary hospitals, which were private mansions, transformed into military psychiatric care facilities (Tyquin 2006: 79–80).

Chapter 7

The Soldier in Context

*Psychiatric Practices, Military Imperatives,
and Masculine Ideals*

———————◆———————

(1) *Immediacy.* Behavior disorders are best treated as soon after their
occurrence as possible, before the complexities of "chronicity" (which
possibly includes ritualization of the symptom) have had an
opportunity to further add to the patients' problems.
(2) *Proximity.* Behavior disruptions are best treated in close proximity
to the place of their occurrence and as transactions with the customary
milieu. Casualties should be kept away from hospitals, on the job,
and in their social frame whenever humanely possible.
(3) *Expectancy.* Psychiatrists in combat observed that psychiatrically
disabled soldiers could be provided with a few comforts, rested,
interviewed in the third day and returned to the unit on the fourth,
and that this treatment produced better results than any other. This
knowledge enabled them to *expect* restoration of function, and
to respect the anxiety of their patients without being frightened
by it into stereotyped concepts such as "long-term treatment."
—Kenneth L. Artiss, "Human Behavior under Stress"

Like physical injuries, the natural course of most injuries caused
by stress is to heal over time. But also like physical injuries, stress
injuries heal more quickly and completely if they are promptly
recognized and afforded the proper care, if only a brief period of rest.
—Charles R. Figley and William P. Nash, "Introduction:
For Those Who Bear the Battle"

In previous chapters we focused on the *effects* of the inter- and intra-actions
of various apparatuses. Our understanding of the unfolding of the practice
of diagnosis, the policy milieu for veteran benefits, soldiers' subjectivities,
and treatment regimens that it is a fractured, irregular process playing
out as a series of discontinuities. Diagnostic practices that classify bodies
along the lines of clinical observations disclose how soldiers come to be

designated as ill through the systematic application of a power/knowledge formation that holds within a set of values surrounding emotional distress and mental breakdown that tend to be restricting, exclusionary, and debilitating. Recalling the history of health-care and disability benefits for veterans discloses some of the institutional mechanisms of both the military and civil society that make visible soldiers' war wounds and the barriers soldiers with ill bodies have to navigate in order to have partial financial security. Individual negotiations of war-induced psychic trauma are flashpoints of experience that inform the generation of the multiple, variegated warrior subjectivities. Variation over time of treatment modalities have an impact on the ways in which soldiers live their lives as the walking wounded both in the military and in civil society. In this chapter, rather than focus on the effects of military psychiatry on soldiers we focus on *how* these practices do what they do—that is, how apparatuses articulate with each other and what effects that articulation generates.

When taking embodiment seriously, we recognize that parts of an analysis may seem trivial or pedantic. But we do not want to reinforce this impression. We argue that disciplinary apparatuses are embodied. They mark bodies both in the sense of the bodies they encounter and in the spaces they take up. There are certain processes that hold soldiers and veterans with emotional wounds in place—fix them—as ill bodies during the breakdown of the psyche as well as years afterwards in veterans' everyday lives. These fixing processes draw from multiple sources—discourses within and about psychiatry, masculinity, and the military; and the practices that enact soldiers and veterans as weary warriors—that shape the ways both individuals as ill bodies and people who encounter these ill bodies make choices and act. We have chosen to draw out two processes—*the militarization of psychiatric wounds* with the impact on soldiers as ill bodies and on the *psychiatrization of the military bodies* with the impact on veterans as ill bodies; we elaborate on these two processes in order to illustrate what it is we mean by fixing weary warriors in an ongoing generative process that changes with every moment.

To this end, we try to think of embodied entities and events *relationally.* These relations and elements are *fluid,* whether biophysical processes of bodily stress, stable authoritarian institutions like the military or the state, or masculine expressions of identity. Within a positive ontology (following Deleuze and Guattari 1987; see also Bray and Colebrook 1998), there is a relational aspect of elements composing a *dispositif* (Foucault 1980b: 194–95) just as there is an interactionist aspect (Barad 2003). Nancy Tuana (2008: 188) refers to this notion as "viscous porosity." She argues that viscous porosity is "a means to better understand the rich interactions between things through which subjects are constituted out of relational-

ity." To demonstrate her arguments about the permeability of the borders, shells, or skins of bounded entities, she reads the events of Hurricane Katrina as a natural, geophysical phenomenon. The phenomenon of the hurricane interacts with New Orleans as both a physical city and social place, while interspersing the (porous) flesh of humans and their interactions with both. Her tracing keeps in play a generative idea of what emerges from a set of events from the macroscale of the state to the intimate scale of acquiring toxic bodies.

With regard to weary warriors, a similar tracing—though not as drastic an example as Tuana's—can be made. Rather than solely concentrating on the discursive aspects of embodiment which is a common feature in making sense of soldiers' experiences of war, it is important to account for the material consequences of specific discursive constructions of weary warriors. Any psychological disorder raises questions as to whether a veteran deserves a pension or other support in a state system that values a notion of a strong, healthy, heroic sense of soldiers serving the patriotic cause while continuing to be the primary organizer and arbiter of soldiers' lives after they again enter civil society.

Another possible tracing is following an embodied stream of relations, interactions, and intra-actions crystallized in a specific practice that enacts a soldier as a weary warrior. Does it matter if a soldier is inscribed with a diagnostic category of PTSD rather than mTBI? Yes, it does. A contemporary claim that a soldier's body is ill because of a microlevel endocrine system disruption, rather than a psychiatric disorder arising from fear, places the soldier in a more legitimate position socially to seek assistance for emotional distress and other debilitating bodily sensations. Does it matter if a soldier is inscribed with a diagnostic category of mTBI rather than chronic mTBI? Yes, it does. Chronic is an epitaph that undermines the legitimacy of the claims a soldier makes about illness, bodies, and experience; popularly and often times medically, the term chronic produces the weary warrior as a malingerer. Does it matter if a soldier is inscribed with a diagnostic category of PTSD or chronic mTBI? Yes, but in comparison to the distinction between the others, it matters much less. Soldiers with PTSD and chronic mTBI follow a similar medical treatment regime, but soldiers with chronic mTBI are still socially associated with a wound caused by an external event, most likely the detonation of a bomb. Tracing a set of relations and interactions that feed into the constitution of an entity or an event entails going back and forth in time, jumping back and forth across spaces, and looking back and forth at every point to see what is happening with other entities and events; a daunting task indeed. Most tracings by magnitude have to be incomplete. Yet maintaining a generative outlook is exactly what embodiment is about.

In this chapter we focus on the multiple layers of embodiment and try to hold onto the notion that embodiment is a multifaceted, discursive-material generative process that holds together a set of *resonances* from the relations, interactions, and intra-actions of multiple agents. We think it is useful to trace the connections among these relations (as disclosures) so as to map out some of the processes through which weary warriors come to be who they are in specific historical contexts. We first position context as part of an embodied apparatus. We then detail two specific processes, the militarization of psychiatry and psychiatrization of the military. To that end, we offer a tracing of a weary warrior through characters of a 1980s television show, *Magnum, P.I.,* to demonstrate the complexity of interaction between the militarization of psychiatric wounds and the psychiatrization of military bodies as processes.

Context, Mangles, and Processes

The context a soldier lives in, whether in military service or in civil society, comprises a multifaceted jumble of relationships with family members and friends, other soldiers and officers, and military and civilian physicians. Expressions of illness differ depending on what aspect of a relationship is privileged at any given time. In the doctor's office, migratory pain, memory lapses, and nightmares might be the focus of the discussion, whereas with friends, feeling unwell may never be part of a conversation. Although the elements that create a social environment for a person as a patient overlap considerably with those of the same person as a friend, the elements come together in different ways; these elements then change the character of what happens in the interactions of those relationships.

One way to understand context as something complicated and far-reaching, yet comprehensible and versatile, is through Susan Hekman's (2010) use of disclosure. She draws on Andrew Pickering's (1995) work on the mangle of scientific practice. Pickering uses the concept of mangle, defined as the entanglements of human and nonhuman elements as well as their interactions, to describe how science, scientific practice, and scientific knowledge come into being. This entanglement does not determine a path that science must take because even discoveries are in part an effect of the social relations affecting the scientist. There is a high degree of flexibility in the potential emergence of scientific practice. For Hekman, the mangle is useful in understanding the emergence of a subject through the relationship between words, language, and ideas, and the materialities of everyday living (see chapter 5 in Hekman 2010). She recognizes that, in the mangle, discourse is not the only thing that is constitutive; the material

world is, too. This insight breaks down the false binary of human/nonhuman and emphasizes that neither the social nor the natural world are simply givens; there is some play—or agency—via interactions, intra-actions, and effects among the elements. Disclosure and the verb "to disclose" describe the process through which realities become available to people as a result of the concepts they use to make sense of the world around them.

Pickering talks about scientific practice and Hekman writes about subjects; we use these insights as a basis from which to argue that while individuals, professionals, and institutions have relatively distinct understandings of the world (through of the process of disclosure), the contexts within which these understandings emerge have paths that can, to some extent, be traced. We couple this notion with a positive, generative ontology that emphasizes potentiality. Through these tracings we can bring into focus the deep discursive-material connections, inter- and intra-actions, and effects of the relationships, elements, and events that generate what we understand as weary warriors.

The context, with a dense network of intricate linkages, hosts a legion of elements that feed into potential explanations for the very existence of weary warriors. Paul Lerner (2003) in his account of male hysteria in Germany between 1890 and 1930, places the construction of the relationship between war and psychiatry alongside the history of traumatic neurosis. Traumatic neurosis, a popular psychological diagnostic category among German physicians in the 1890s, set the cause of psychological breakdown in an external event. When coupled with a system that awarded pensions to those suffering trauma from, say, railway accidents or war, traumatic neurosis paved the wave for medical claims of economic-goal behavior such as simulation, malingering, and faking. In contrast, male hysteria as a diagnosis represented that which was problematic in the German state in its race to modernity. Cast as a pathological entity lacking willpower and self-control, a construction reinforced by a German masculinity based on physical fitness and emotional rigidity, the male hysteric freed the state from its responsibility of compensating individuals who had suffered neurosis as a result of trauma and paved the way for an attack by authorities against social insurance for soldiers and workers. Lerner (33–36) notes that although the number of social insurance claims for the diagnostic category of traumatic neurosis was economically inconsequential, politically the notion of the greedy, whining, morally weak, pension-monger set up the opposition to attack the social insurance system.

In contrast, Ben Shephard (2000), in a history of the relationship between soldiers and psychiatrists in the twentieth century, argues that juxtaposing approaches for defining nervous disorders among soldiers set up a framework through which he could read various accounts of war

neuroses. On the one hand, realists were interested in getting the soldiers back into the fighting theater quickly, which was an approach valued by the military as an institution that posed challenges to military psychiatrists. On the other hand, dramatists were interested in sorting through the minutiae of the manifestation of symptoms among soldiers individually and collectively, and then writing them up, which was an approach valued by psychiatry as an institution that was not always effective as a military strategy. Shephard's (xxii) juxtaposition provides an entry point into the discussion of what constitutes the traumatized soldier, for the two approaches work most effectively when in tension with one another. He argues that at many points over the century, the absurdity of some claims (trauma scales for measuring the impact of traumatic events on individuals in all countries; 396) and the promising insight of others (some type of repression follows a traumatic experience; 389) make it clear that the psychological wounds of the soldier are probably inevitable (397).

Unlike either Lerner or Shephard, reading context through disclosure is like twisting a kaleidoscope of circumstances and experiences one way, and then another. Doing so produces patterns that can then be read critically as part and parcel to a particular configuration of power/knowledge; a configuration that may, for example, designate moral weakness, lack of positive male role models, overbearing mothers, or psychiatric illness as *the* cause of nervous exhaustion in combat. The complexity of this milieu—as laid out here—is often played down by soldiers suffering deep emotional distress as they make their way through their daily lives, lives that usually include some form of treatment and almost always a set of coping strategies for recovery. Even though warriors' entanglements in the mangle are fodder for generating manifold and competing accounts of weary warriors, elaboration of context is still important—not because all influences can be traced, but because a certain set of elements can be foregrounded in an account of weary warriors that can provide insight into a different way of thinking about emotional distress.

Twisting the kaleidoscope of circumstances and experiences of weary warriors permits us to alight on some of the *processes* that generate the distinctiveness of the way in which the elements of the embodied apparatuses of psychiatry and the military come together to produce weary warriors. Foucault (2006: 222) argues that because psychiatry functions as power over madness and abnormality, as a disciplinary apparatus it is well positioned to be plugged into other disciplinary apparatuses—including the military. This plugging does not happen as either a matter of course or haphazardly; there are processes that permit apparatuses to articulate in both ordinary and unique ways, producing something other than what either can offer on its own. Both psychiatry and the military are

part of a similar array of elements, ranging from the intense regulation of administrative tasks to the organization of specific spaces. Both psychiatry and the military also draw on similar sets of discourses, such as orderliness, deference, and *masculinity,* as a way to frame soldiers with invisible wounds and broken embodiments. The sets of elements we found when the kaleidoscope's twist came to rest were two processes that mediate the plugging in of the apparatuses of psychiatry and the military: the militarization of psychiatric wounds and the psychiatrization of military bodies.

The power of the psychiatrist that Foucault discusses in *Psychiatric Power* (2006: 184) relies on the notion that the psychiatrist himself must be present everywhere, and it is through his expression of knowledge that power comes to function in the asylum.[1] When applied within the military, the psychiatrist's power is not simply, nor even complexly, transferred from the asylum to the battlefield. Rather, a transformation of psychiatric practice for emotional wounds takes place in the face of the immediacy of battlefield needs. Although the organization of the disciplinary apparatus of psychiatry is similar to the military (in that the general in the battlefield parallels the position of the psychiatrist in the asylum), the presence of psychiatric illness, especially in those suffering emotional distress in combat, is not necessary for the functioning of the military. In fact, it is most undesirable. There has been, we propose, a militarization of psychiatric wounds—not in the sense that psychiatry as a science or discipline has been militarized as part of being further developed as a specific knowledge base (although this may indeed be the case), but as an integrated configuration of power/knowledge where the *purpose* of the practice tending to psychiatric wounds is actually delineated by military imperatives.

Weary warriors, historically, have been seen to be an unfortunate though inevitable result of war. It was only after the nearly unbelievable numbers of soldiers with psychiatric wounds during the Great War that military establishments sought some action to reduce emotional breakdown in combat. The knowledge in psychiatry in the first decades of the twentieth century focused on neurasthenia and hysteria, following the works of Jean-Martin Charcot and Sigmund Freud. It is easy to understand, at least on the surface, that when soldiers began exhibiting symptoms similar to those of neurasthenics and hysterics the military turned to psychiatry. But just as the power in the asylum did not easily transfer to the battlefield, the soldiers produced through the military, even with psychiatric wounds, did not respond the same ways as did the mad in the asylum. Alongside the transformation of the social practices of psychiatry, including the social practices of diagnosis, explanation, and treatment, the soldier as both a category and a fleshed body underwent a transformation, shaped by the military's need for emotionally stable soldiers. Increasingly over the

twentieth century and into the twenty-first century, the military drew and continues to draw on psychiatry as a knowledge base, and has introduced policies and practices that serve military interests in securing a force that would not collapse in combat. This psychiatrization of military bodies—a process beginning at recruitment and extending through battle and long afterwards—sets each and every existing and potential soldier's body as a possible psychiatric case.

We offer a reading of how the apparatuses of psychiatry and the military provide specificity to the context within which soldiers break down. Soldiers, who have endured deep emotional distress as a result of combat come to be constructed as ill, come to act and react in particular ways, come to understand themselves and be understood as a soldier with invisible wounds, and come to be part of a treatment protocol or be considered as recovered. We trace a series of folds, events, and practices within psychiatry and the military to flesh out parts of the specific relationship between the two and how they function together to develop, block, utilize, disclose, and enact on demand aspects of each apparatus on its own and in conjunction with the other. We argue that these practices generate definitional boundaries of psychiatric wounds and mediate the relationships among the various elements constituting psychiatry in the military.[2] We also look at the military practices that deal with classifying and sorting emotionally wounded bodies based on psychiatric knowledge and practices derived from that knowledge. We review psychiatric practices associated with battlefield emotional casualties, intended to either reduce the overall number of psychological wounds or to treat in situ those experiencing emotional distress.

Militarization of Psychiatric Wounds

The history of psychiatry is closely linked to the history of military psychiatry; this was particularly true at the onset of the Great War. Debate among psychiatrists at the time questioned whether the neuroses and hysteria among civilians were the same among soldiers. The distinction between peace and war neuroses framed much of the discussion among military psychiatrists, particularly psychoanalysts (Culpin 1920; Ferenczi and Abraham 1921; Lumsden 1916; Ross 1919). Interwar and post–Second World War interests in dealing with the emotional distress of combat soldiers and war veterans tended toward securing pensions, maintaining mental hygiene, and readjusting to civilian life (Drought 1944; Gilbert 1945; Grant 1944; Micale and Lerner 2001; Russell 1930). These debates both informed and were informed by specific military psychiatric field

practices (see analyses in Leese 2002; Lerner 2003; Shephard 2000). These practices serve as an entry point into a demonstration of how psychiatry and the military plug into each other: The practice of tending to psychiatric wounds is delineated by military imperatives just as the need for frontline troops is circumscribed by the treatment for war nerves.

The psychiatric power Foucault so aptly described took on a different patina when introduced through military mechanisms. The battlefield general, the principal person through whom military power was channeled, was no psychiatrist. Thus, the prominent power position held by the psychiatrist in the asylum can only be transferred unevenly to the military. Unlike those in the asylum who had at least some contact with the fleshed incarnation of psychiatric power—that is, the psychiatrist—the vast majority of soldiers had no contact with a general.[3] Indeed, an intricately designed ladder of superiors stood in for the general and facilitated the hierarchical orderliness of the military, a hierarchy in which psychiatrists were inserted as officers. The circulation of psychiatric power within the military framed by the principles of order, hierarchy, and rank—and imbued with the values of duty, honor, and courage—worked toward the maintenance and creation of good soldiers, soldiers that could be returned to active duty. Implicit within the practices was the assumption that nerve casualties are inevitable and it is the psychiatrist's duty to figure out which soldiers are salvageable and which are disposable within the context of fighting the enemy.

A key practice emerging during the Great War that acutely demonstrates the articulation between the military and psychiatry as embodied apparatuses is forward psychiatry. Forward psychiatry is a system whereby psychiatric treatment principles are enacted on the battlefield and just behind the frontline. During the Russo-Japanese War of 1904–5, the Russians had two systems of evacuation—one for nervous soldiers and one for the physically wounded. Both were situated close to the front and initiated through evacuation hospitals (Wanke 2005). Although not particularly successful and pretty much forgotten in European and North American militaries, the idea of forward psychiatry emerged in some field practices. Prior to a full-on implementation during the Great War, for example, care for all wounds—both physical and psychiatric—involved a system of medics, dressing stations, and field hospitals along the frontlines. Medics brought in the visibly wounded and rounded up the others that were crouching, hiding underneath mounds of dirt, wandering around dazed in the field, crying inconsolably beside the body of a dead friend, or lying unconscious anywhere—in a trench, a foxhole, or beneath a dead body. Dressing stations were used to sort through the wounded, and the more serious cases were evacuated to the field hospital behind the

fighting lines. In addition to the battles themselves, the routine of trench warfare spawned broken-down bodies: extensive periods of waiting and watching for bombs to go off, gases to be released, and snipers to shoot; building new and reinforcing stretches of the trenches while living with rats, continual flooding, ongoing rains, and ever-present mud; engaging in regular nighttime forays into the land between the trenches to dig fox-holes, lay out barbed wire, rescue wounded soldiers from the day's fight-ing, and recover dead bodies; and preparing for the next time to rush the enemy's trenches with bayonets.

Because of the massive number of soldiers breaking down in battle emotionally throughout 1914 and at the beginning of 1915, the existing structures were rendered ineffective for treating nerve cases.[4] Each mili-tary dealt with remedying the structures in different ways. The French, for example, shared the use of the hospitals built along the western trenches with the British because they had no other place to evacuate the wounded soldiers to. By 1915, most psychiatrists in Britain and Germany had volun-teered or been pressed into military service, and many public and private hospitals in both countries had been taken over by the military to care for the evacuees (Leese 2002: 34–35; Lerner 2003: 42–43). Psychiatrists on both sides of the trenches were in agreement that soldiers with traumatic neu-roses, hysteria, and mental illness needed quick treatment if they were to be of use to the military. The French implemented forward psychiatry in 1915. All nerve cases were diagnosed as hysteria, brought to the hospitals on the frontline, treated with Joseph Babinski's so-called cure by persua-sion, and returned to action. Babinski, trained by Jean-Martin Charcot at the Salpêtrière, believed that war neuroses were forms of hysteria. And, because hysteria arises from the relationship between the psychiatrist and the patient, so too does the cure. Early intervention through a combination of physical and psychological therapies, as for instance simulation (in-cluding electroshock therapy) and persuasion, provided the most success in returning soldiers to the frontline (Babinski and Froment 1918). The French military refused the diagnosis of hysteria as legitimate and treated those so diagnosed as cases of insolent insubordination, a policy that sup-ported both the diagnosis of hysteria (or pithiatism) and the painful and stringent therapeutic practices used in Babinski's treatment.

In Germany the implementation of a standardized and centralized sys-tem for caring for psychiatric wounds by the end of 1915 was based on pre-vention. Reliance on effective leadership not just among officers, but also among small units of troops, was the cornerstone of the approach. Thus, when nervous breakdowns happened to soldiers, the military treated them as having an organic illness, provided them with some rest and talk, and returned them to the frontline. War neuroses were different, and were a

matter of discipline rather than medical treatment. Neurotic soldiers were a detriment at the front and were evacuated as quickly as possible, treated away from the frontline, and returned to duty in other sectors of the war economy.

In the British military a new system was implemented in 1916 that set a different path that a psychologically wounded warrior would take and located the authority for diagnosis early on in this path. The new system included a casualty clearing station, regimental aid post, advanced dressing station, a base or field hospital, and, for the most extreme cases, evacuation. The regimental officer at the post made quick diagnoses and tagged soldiers with scribbled pieces of paper attached to the toe by a wire. Two categories of shell shock were noted: shell shock–S, referring to nervous shock, and shell shock–W, referring to a wound by concussion. This differentiation between somatic and psychic wounds fell away, and was eventually replaced with NYD(N) by 1917. Rather than depending on the French hospitals, which were used rather heavily, the British military evacuated the most severe cases back to Britain by ship.

As the war wore on, these field practices shifted. Fighting grew more intense; as more and more nerve cases emerged, the French continued to use Babinski's strict and authoritarian *traitement brusqué.* The more the definition of hysteria among soldiers became strictly delineated, the stronger the support the French state had for the forward treatment centers. The design of French forward psychiatric practices, in part devised out of necessity, were informed by the Russo-Japanese immediate treatment field practices implemented a decade before (MacLeod 2004). Locating the illness outside the body in the relationship between the military psychiatrist and rattled soldier—as suggestion or auto-suggestion—proved effective in returning soldiers to the front (Shephard 2000: 98). The German military shifted focus and treated nervous breakdowns primarily as hysteria (following Robert Gaupp, Max Nonne, and Karl Bonhöffer) rather than as traumatic neuroses (following Hermann Oppenheim) (see Lerner 2003: 61–85). Coupled with the limitations of evacuation by train, Germany built a series of hospitals just behind the frontline, somewhat like France, and used them both for soldiers and for hysterics from across the country. The hysterical soldiers could be more easily treated through reenactments of the onset of the hysteria, such as the clap of gunshot, the stench of decaying bodies, and the strewing of mud in the trench from bombs. The most severe cases of German hysterics, too, could be more easily redeployed to the front.

For the British there was an increase in the number of cases treated in situ and returned to the front. Charles S. Myers (1915), the British Army doctor saddled with the coining of the term "shell shock," urged that the

treatment of psychiatric wounds be separated from other wounds but still be located close to the front. He boiled down his approach to three basic practices: (1) promptness of treatment in (2) a suitable environment with (3) psychotherapeutic measures such as hypnosis (War Office Report 1922). As the safe transport of evacuees became less certain with the increase in submarine warfare, it made sense to treat psychiatric wounds closer to the front. The American psychiatrist Thomas Salmon is credited with the development of the three central principles of forward psychiatry: (1) proximity, (2) immediacy, and (3) expectancy, known together as PIE—upon ending his tour of the front in 1917.[5] The principles demanded proximity to the battlefield, immediacy of treatment, and expectancy of return to the front. The architecture of this system, elaborated in more detail by Charles Myers at the beginning of the Second World War (Myers 1940), is still used today in most militaries. The American military uses BICEPS, a masculine acronym, detailing more specifically what PIE entails: brevity, immediacy, centrality, expectancy, proximity, and simplicity. The simple and straightforward therapeutic measures are to be administered as soon as possible after onset, near the fighting, away from other types of therapies. These measures last between twelve and seventy-two hours so that the soldier with psychiatric wounds can return quickly to active duty.

These frontline practices have been shown to both inform and be informed by the discussion and debate going on in military psychiatric circles, as well as in civilian psychiatry. By the end of the Great War military psychiatrists came to an uneasy consensus that war neuroses were much like peace neuroses, especially in that the cause of the neurosis was firmly situated in the individual's constitution, sexual repressions, or family background. Causes of neuroses, the equivalent to blame in most cases, were found to originate in weak fathers and overbearing mothers, lack of volition, an early sexual repressed conflict over survival of the self and the species expressed in the moment of battle as an unresolved intrapsychical conflict over duty and escape, or emotional instability, among others.[6] These debates were not, and have not, been definitively or even satisfactorily resolved. Causes of war neuroses in the twenty-first century are similarly situated as demonstrated by any cursory reading about the Fort Hood shooting and by the American, British, and Canadian veteran suicides from service in the Afghani and Iraqi wars in the widely available media reports—both mainstream and alternative. Even with the development and implementation of psychiatric practices designed to reduce the incidence of war neuroses, rates seem to be roughly the same now as they were in the Great War, if delayed stress is taken into account.

Psychiatrization of Military Bodies

Once plugged into each other, the military and psychiatry as embodied apparatuses feed each other discursively and materially. The inter- and intra-actions among the relations generate new ways for articulation. As practices develop, they become closer in step with each other as the goals, values, and understandings of what constitutes psychologically sound masculine fighting troops begin to fuse. Over time, seemingly independent military and psychiatric practices merge, transforming into hybrid forms of psychiatrized military practices and militarized psychiatric practices. By the mid twentieth century, military psychiatry had spawned a reorientation of war neuroses such that each and every prospective, existing, and past soldier's body composed a potential psychiatric case. This premise underlay most of the military psychiatric practices implemented in the field for the rest of the twentieth century and set the stage for the first decade of the twenty-first century. Empirically, what this means is that psychiatric practices now span the military's bodies as recruits, deployed troops, and veterans. Our task here is to show how some psychiatric practices in the military psychiatrize bodies, or make them scrutinizable as psychiatric objects.

The imperative of creating a military force that would not break down in battle has been of paramount importance to all states throughout the twentieth century. Militaries took up this task enthusiastically, primarily because of the interest among civilian psychiatrists in early intervention strategies to prevent mental illness throughout the 1920s and 1930s (Mullahy 1970). The enthusiasm was also fed by the need to cost out the impact of psychiatric wounds operationally (strategically), so a commander could better predict casualties. Morale-wise militaries could better situate individual soldiers and troops more generally to deal with combat. As well, financially, fewer breakdowns would mean that the pensions would go to the most deserving. Also at play during this time were notions about what military bodies in a country at war looked like. In the United States, in preparation for the Second World War, Harry Stack Sullivan's military work involved psychological screening, a practice used to identify who would most likely break down in combat or develop psychiatric issues after service. Screening built on his civilian work around early intervention for treatment of mental illness as part of a public health agenda fed two societal needs: the mobilization of a country for war (Shephard 2000) and the marshaling of potential heroes for the cause. Recruits were thoroughly tested with pages and pages of psychological questions and follow-up interviews, and then were trained. Cowards, homosexuals, and the disabled

were denied entry into the military, tightly circumscribing military bodies as masculine—brave, courageous heroes-in-the-making; handsome family men serving as nation-building role models and supreme exemplars of physical fitness. Those who passed the screening tests but were morally weak, had sensitive constitutions or were mentally ill, were either kicked out or assigned noncombat duties.

Troops, once deployed, were still subject to psychiatric scrutiny as military bodies. Although the intention of screening at the onset of the Second World War was to cut down on those recruits who were predisposed to combat stress, field observations refuted the basic premise that those prone to nervous conditions were the ones that broke down in combat (R. Greene 1976: 376-435). American military psychiatrists in the South Pacific, North Africa, and northern Germany found many of the assumptions going into the war untenable: fresh troops, recruits with troubled backgrounds, and those with borderline mental and physical health problems were not most likely to break down, just as seasoned troops, recruits with uncontested life circumstances, and those physically fit and of sound mental health were not most likely to emerge from combat unscathed emotionally or psychologically.[7] Multiple sets of relations, including the circumstances of warfare and changing technologies (see Dupuy 1990), bodily stress from the natural environment (R. Greene 1976), and the impact of the civilian psychiatric shift toward preventative practices (Binneveld 1997: 161–77) contributed to the consensus, by the end of the Second World War, that troops react in various ways to combat and that everyone has a breaking point.

To find that breaking point became the golden ring among military psychiatrists, resulting in an intensification of the psychiatrization of military bodies. During the American Viet Nam War, for example, psychiatrists were deployed to the battlefield to make clinical observations while troops were engaged in combat in order to follow physiological and biological evidence of battle stress (Binneveld 1997: 98–99). Stress hormones were relatively low among combatants, which indicated that they had low stress levels (which seems implausible) or had found a way to deal with stress in the moment, even if under tenuous situations for long periods of time (which is a more likely scenario). By the end of the Viet Nam War it was clear that no matter the care taken to prevent war neuroses, its onset was still an issue. Although breakdown rates in the field diminished as a result of psychiatric testing and the introduction of more-extensive psychological training for combat troops, they were replaced by a consistent rate of about one in three troops suffering combat stress after return from battle, ranging from weeks, months, years, and nearly even lifetimes.[8]

Through organizational practices developed specifically to treat and monitor symptoms of nervous breakdown as psychiatric wounds, the military bodies of soldiers continued to be psychiatrized. The intensity of psychiatric scrutiny in deployment through field treatment practices (e.g., CEUs in the Second World War), for soldiers returning from the front (e.g., through education and awareness workshops and TLD centers for troops returning from the Afghanistan War), and for veterans through outpatient and nonmedicalized treatment centers (e.g., the network of Canadian OSI clinics and the American Defense and Veterans Brain Injury Center) show how military bodies are continually made into psychiatric objects (see discussion of treatment in chapter 6). Indeed, recent education attempts by the American military to heighten awareness about the potential for PTSD, depression, and TBI targets veterans and family to be on the lookout for postdeployment stress (Centre for Military Health Policy Research 2008). Keeping a watchful eye over veterans is not only a task for veteran services as it was in the past, but also for family members and the veteran. Ongoing surveillance of the *possibility* of psychiatric wounds transforms all military bodies into psychiatric bodies. Underlying these organizational practices is a crucial tension between duty (military) and cure (psychiatric medicine). No matter the etiology of the war neurosis or the personnel needs of the military, the tautness of connection between military imperatives and broken-down war bodies wore thin, and the management of war neuroses emerged as the mediated accord between the two apparatuses. As a management strategy, the arrangement of all these military psychiatric practices generates unique subjects in that soldiers with psychiatric wounds or with scars from emotional distress do not remain soldiers, nor are they cured. Rather, they take up a liminal space that renders them viscously porous entities that do not fit either the military routines of service or psychiatric routes for treatment.

Liminality is a useful concept to help account for collective and individual experiences of both the militarization of psychiatric wounds and the psychiatrization of military bodies. As a concept liminality brings with it its own embodiment, neither quite distinct from one apparatus or another, nor unable to exist without both. The spaces depicted by the concept are constitutive of the bodies that inhabit them just as the bodies are constitutive of the spaces as both driven and ill. One cannot forget that the liminal spaces generated are shaped by masculinity, both in the power/knowledge circulating as well as in the reality disclosed by our concepts. We next discuss how masculinity shapes both the militarization of psychiatric wounds and the psychiatrization of military bodies as processes.

"Did You See the Sunrise?"

Magnum, P.I., a popular 1980s American television series that is still broadcast as reruns some thirty-five years later, illustrates some of the ways in which the embodied apparatuses of psychiatry and the military plug into one another through the militarization of psychiatric wounds and the psychiatrization of military bodies. that . Masculinity, too, plays a part in these processes—as both a set of scripts for individual soldiers and veterans to take up and as the context within which knowledge/power patterns the intra- and interactive aspects of embodied apparatuses. Although fictional, the characters in *Magnum, P.I.* are a useful foil against which to show how both the militarization of psychiatric wounds and the psychiatrization of military bodies can work. In addition to *Magnum, P.I.*, there are several television series that have as pivotal characters soldiers living with psychiatrized bodies. What is important to remember in this part of the analysis is not that there is a truth to be uncovered, but rather that the material-discourses circulating within psychiatry, the military, and masculinity generate familiar subject positionings into which society can easily see weary warriors slipping.

The series focuses on four main male characters—Thomas Sullivan Magnum (played by Tom Selleck), Jonathan Quayle Higgins (John Hillerman), Theodore "TC" Calvin (Roger E. Mosley), and Orville "Rick" Wright (Larry Manetti)—all of whom have military backgrounds and have suffered emotionally as a direct result of combat. Complex flashbacks, threaded throughout the mysteries, murders, and thefts that a private investigator would routinely come across in a detective series, expose the crevices in the characters' emotional make-ups and thus reveal their psychological wounds. Each of the characters has a deep sense of honor, chivalry, and loyalty, and all have been deeply affected by their war-time experiences. Jonathan Higgins epitomizes the military code of ethical conduct. He is a baron and studied at the Royal Military College at Sandhurst to become an officer, yet he signed up as a common soldier after he refused to tell on a fellow student when threatened with expulsion. By military standards he had an illustrious career: he served as a sergeant major in the British Army, acted as a commando in MI6, and was involved with UN peace-keeping forces. Upon retirement, he took up the position of majordomo of a rich and famous author so he would have time to write his memoirs. As part of his project, and to the annoyance of the other characters in the series, he continually tells the stories he writes about.

Told as fragments over the eight-year run of the series, Higgins' stories often have an edge to them, but it is only when he recounts the decimation of a village and the massacre of men, women, and children by British

soldiers in 1953 during the Mau Mau Revolution that the extent of the impact of his trauma is revealed to the viewer (*Magnum, P.I.* 1982: 3.5).[9] The trauma for Higgins is not about witnessing the brutalities of war: it is about being responsible for the soldiers who committed the atrocities. Physically wounded from a skirmish, he stayed behind while ordering the rest of the unit to continue trailing the Mau Mau soldiers who had killed and mutilated two other British soldiers. Ever the professional soldier, Higgins' code tightly circumscribes him as an honorable man; he recommended courts-martial for everyone, including himself. But the military exonerated Higgins and reprimanded the unit. Thirty years later, the trauma still festers in all the soldiers involved, for—as Higgins put it—a court-martial would have punished the men for their actions, but as it was the soldiers were forced to live with their memories of their acts and the effects of emotional distress and psychological trauma from combat

Higgins' story discloses his own psychological wound—not as a psychiatric illness in need of treatment, but as a constant reminder of the destructive nature of war. As he tells of past horrors, he accounts for his trauma through a military lens as a concoction of personality, military training, the military as an institution, masculine ideals, moral illness, treatment for morality, trusting friendships, and the routine of his once extraordinary life. Masculinity, too, shapes how Higgins sees his psychological wound. The entwinement of masculine values with the military values of order, honor, and responsibility encourage soldiers to distance themselves from the stigma of battle fatigue and thus permit Higgins to recover, at least in the moment, from a potential relapse so he can recount his story without reliving his traumatic past, in honor of those living in terror. Such distance keeps masculine ideals in place and emotional wounds neatly tucked away in the past where they belong. It is only when others need assistance that the characters engage with their wounds so that those around them can be suitably empathetic and that they themselves can be seen as heroes once again.

This distancing from ongoing effects of past war trauma is true for the other three characters, all of whom to some extent dealt with the effects of trauma from the American Viet Nam War. In the first three years of the series, there were more than a handful of episodes that dealt directly with the tribulations of living with delayed stress. While chasing down the murderer of a beautiful young woman, Magnum has flashbacks of combat in Viet Nam as well as a flashback of saving Rick's life (*Magnum, P.I.* 1981: 1.6). At the end of the episode, against the backdrop of a sandy beach, ocean, and volleyball net, Magnum gingerly approaches the topic of the flashbacks he has been having. He asks TC, "You ever think about 'Nam? I mean have memories flashed through your head without really even

thinking about it?" (*Magnum, P.I.* 1981: 1.6; transcription by authors). The brief pause before TC answers tells the viewer that yes, he does, but he tells Magnum that he does not. This interaction draws out the masculine norm of not talking about emotions and reinforces the idea that any mental issue, particularly about not being in control of one's own thoughts, is to be kept quiet in case anyone should think one is ill, unstable, or in need of a psychiatrist. Masculinity, like psychiatry, masks unreason and keeps it in its place.

Only through minor characters does the impact of delayed stress on the lives of veterans fully manifest. In one episode, Magnum crosses paths with a surgeon he knew in Viet Nam and investigates the deaths of three of her patients (*Magnum, P.I.* 1982: 3.12). Karen (Marcia Strassman), accused of poisoning the patients, is still coming to terms with the deep emotional distress she encountered as a nurse in Viet Nam. By the end of the episode, her troubles, as they are constructed through the script, have merely been identified, and the emotional work before her is just beginning.[10] What is interesting about this specific storyline is that conventional gendered stereotypes of women being emotional and men not dealing with their emotions, usually part of sustaining masculine dominance, are reversed: the woman has yet to begin dealing with the psychological impact from her traumatic war experiences and the men have dealt with their emotional distress arising from combat. Mixed up in this representation is the marginalization of noncombat troops (nurses) within the military, who are not being diagnosed with and treated for delayed stress. These inversions indicate how psychiatry in the military deals with traumatized psyches. The military has recognized and is organized around diagnosis and treatment of psychiatric wounds among combat troops who, with few exceptions, are male.

The processes of the militarization of psychiatric wounds and psychiatrization of military bodies continually frame the bodies of Magnum, Higgins, TC, and Rick as seemingly well-adjusted veterans. Throughout the series, individual episodes contribute to the unfolding story of how weary warriors live among us and show the extent of how the construction of their subjectivities are still mediated by psychiatry and the military as embodied apparatuses. "Did You See the Sun Rise?" (*Magnum, P.I.* 1982: 3.1, 3.2) shows how militarization and psychiatrization work together to weave various elements and events that in turn disclose the complexities of living with psychiatric wounds from war trauma. Masculinity as material-discourse shores up these embodied *dispositifs* within which weary warriors navigate their lives and gives form to the way veterans express who they are. The plot slowly stretches across the two-hour time slot. TC meets up with Nuzo (James Whitmore Jr.), someone he served with in Viet

Nam, and together they concoct what appears to be a plan to kill Ivan (Bo Svenson), the Russian commander of the POW camp where TC, Nuzo, and Magnum were held for three months. Mac (Jeff MacKay), Magnum's friend and Navy contact, is killed with a car bomb intended for Magnum. Unbeknownst to Magnum, Mac was sticking close to him because naval intelligence linked Magnum to an assassination to take place imminently orchestrated by Ivan. After his death, Magnum figures out that Ivan is actually in Hawai'i, that TC and Nuzo are experiencing an incident of delayed stress, and that the target is a Japanese prince visiting Oah'u. Magnum figures out that Nuzo has been drugging TC in an attempt to reactivate TC as a killing machine to assassinate the Japanese prince. Magnum is able to break through to and bring home TC, who in a drug-induced haze filled with flashbacks thinks that he is killing Ivan.

Integral to the storyline is the belief that delayed stress is a justifiable, but not quite naturalized, response to war, even for the most elite warriors. Although cowardice and dastardly acts in combat are moral weaknesses, psychological and emotional difficulties as results of war are different, and more acceptable. No matter the way weary warriors deal with deep emotional distress, the naturalization of trauma holds steady. Magnum, a former Navy SEAL and naval intelligence officer with an exemplary career, spent time in a psychiatric hospital after returning home from the war. As career military, he did what he was supposed to do to fix himself: he got help and got over it. His psychiatric problems are not a routine part of his life, nor are they a recurring theme in the series. It is only when something is stirred up in his psyche that his breakdown is mentioned. And when it is mentioned, he is quick to point out that his problem now is not part of his war memories, something that is then reinforced through the story (e.g., *Magnum, P.I.*, 1982: 2.15; 1984: 5.3).

In contrast, TC, a college graduate and football tight end sensation, volunteered after graduation and did three tours in Viet Nam as a Marine Corps helicopter pilot. Though deeply affected by his wartime experiences in combat and as a POW, he never sought treatment and kept the effects of his choices to himself; that is, breaking up with his wife and not seeing his children for years (*Magnum, P.I.* 1986: 7.11). His military sense of duty and service dovetails with his strategy of denying the impact of his trauma. He kept himself tightly wound, refusing to display acts of fraying or break-down; these are the marks of a good warrior. Both strategies of fixing and denial fit with the military code because both strategies naturalize onset of delayed stress. As a result, Magnum and TC, like the other military characters, are afforded the appearance of a stigmatizing weakness because they have proven themselves to be good warriors. Their moral fortitude, courageous valor, and inexorable honor, made even clearer by surviving

captivity, sets them apart from other combatants, those who are weaker in body and spirit.

This militarization of psychiatric wounds, where soldiers and veterans engage with trauma and emotional distress through the set of values espoused by the military, also carries with it the idea that when problems do exist there is some external force or enemy to blame. In this episode (*Magnum, P.I.* 1986: 7.11), the framing of brainwashing consists of taking advantage of warriors at their most vulnerable, exploiting a weakness, burrowing into a psychiatric wound. Strengthening this idea are other discourses, such as those attributing brainwashing techniques to the Chinese, Korean, and Russian militaries in the second half of the twentieth century and setting up military conflict as "us and them" through the Cold War mentality. What appears in the episode is a rendition of *The Manchurian Candidate* (1962), where psychiatric wounds were later exploited for military ends.[11] Nuzo's character as an undercover Russian operative trained by Ivan in North Viet Nam works well against the 1980s backdrop of Cold War global politics between the United States on one side, and the Union of Soviet Socialist Republics and China on the other. He shows how reprehensible "they" are by exploiting the unwritten military code of "buddies" and "escaping" from the POW camp with Magnum and TC. Buddies understand, trust, and support each other; reinforce each other's masculine identity; and protect each other from the enemy. The bond created from the intensity of the POW experience facilitates the reunion with TC and paves the way for Nuzo to activate the programming experiments carried out in the camp. Camaraderie, strength of military honor, and orderly conduct contort into a weakness when Nuzo drugs TC, through bubblegum and then a hypodermic needle, to facilitate a more forceful psychological manipulation. The drugging is even more shameful in that TC is a teetotaler, something a buddy would know and respect.

Still, TC cannot be held responsible. His initial brainwashing and later drugging are external culprits and easily blamed for his actions. TC acts honorably, helps his buddy, and cannot be held responsible for the deceptive act of the enemy who exploits an Achilles heel. Yet it is the same Achilles heel that Magnum exploits, though he does so honorably, and brings TC back to a reality where he belongs. Thus, there is no challenge to his masculinity as a result of mental weakness or (resurfaced) emotional distress. TC is a blameless victim who was exploited at his most vulnerable when Ivan—not Vietnamese, but Russian—broke down TC's psyche using nearly unbearable distress and took advantage of his weakened state in order to serve the goals of another military. The reactivation of a human being, an ex-combat troop, reinforces the idea that psychiatric wounds arising from war trauma are deeply imbricated in the military relations

within which they emerge. And, as the series shows, when left alone the tessellated layers of war trauma are only one factor in shaping a person's identity. The wounds only become a problem when the context shifts and the military dimensions are brought to the fore. Unfortunately, for most veterans, unlike TC, the effects of the militarized wounds seep into everyday life, transforming immediate environments into a plethora of external causes that could ignite another destructive traumatic reaction.

"Did you see the Sunrise?" (*Magnum, P.I.* 1982: 3.2) lays out some of the possible expressions (disclosures) of the process of the psychiatrization of military bodies. It illustrates how behavior is under the sway of the psyche and becomes part of the way psychological wounds are understood. Controlling behavior is part and parcel to military training. Soldiers are told what to do: they submit to authority, follow the hierarchy, and defer to rank. Soldiers are also trained to act morally and with honor, and to serve their country with pride. This tension between receiving instruction and acting morally is accentuated in this storyline when TC engages in the act to assassinate the prince of an American ally. Hence, when behavior is beyond one's ability to control—for if anyone could have controlled behavior, it would have been TC as a former elite Marine—then there is something wrong with the soldier. In TC's case there had to have been a deep psychic injury in order for him to permit Nuzo to control him, even though Nuzo used hallucinogenic drugs. In the psychiatrization of military bodies, a competing category of masculinity is created whereby the role of the psychologically wounded soldier is tightly circumscribed and distanced from military codes so that mental problems cannot be used to justify unsoldierly acts. The rationale would be that the soldier is no longer a soldier but rather a mental patient. But like other concepts in the mangle, the meaning of "unsoldierly" is changeable for other acts of violence, acts that are not necessarily linked to national security, as was TC's act.

TC's apparent psychological collapse and Ivan's success in creating a live ticking bomb throws into doubt much of what the U.S. military has to offer veterans as part of a recovery and ongoing support for psychological distress. Even the notion of delayed (mental) stress shows that soldiers and even ex-combat troops are continually (re-)constituted as military bodies. Through the diagnostic category of *delayed* stress, the veteran maintains a connection to the psychiatric power circulating in the military sometimes long after soldiers are deployed in combat. Resistance to such a connection is common, as evidenced by Magnum's insistence in several different episodes that his actions are *not* related to delayed stress (e.g., *Magnum, P.I.* 1982: 2.15; 1984: 5.3). This resistance in part plays out the masculine ideal of an independent will and extreme individualism, more

characteristic of Magnum than of TC. We call this a "don't psychiatrize me as a military body" strategy that reasserts agency in the constitution of the veteran's own subjectivity. The colonization of the idea that all nervous disorders among veterans have to be linked to an injured psyche sets up the veteran to reengage with the military only through psychiatry and psychiatric power. The resolve to crack open the label of delayed stress slices both ways: it can free a veteran of the heaviness of trauma (as in the case of Higgins) or impede emotional healing (as in the case of Karen). The tensions among camaraderie, honor, delayed stress, mental stability, control of behavior, agency, and global politics, destabilized through the relationship between Nuzo and TC, are refortified as Magnum puts the pieces of the puzzle (mangle) together.

The second part of the two-part episode (*Magnum, P.I.* 1982: 3.2) ends with a confrontation between Magnum and Ivan, wherein the two processes of the militarization of psychiatric wounds and the psychiatrization of military bodies collide:

> Ivan: If you are going to shoot me, do it now.
>
> (Pause.)
>
> Ivan: You won't. You can't. I know you, Thomas. I had you for three months at Doc-Wei. I know you better than your mother. Your sense of honor, and fair play. You could shoot me if I was armed and coming after you. But, like this, Thomas, never. Good-bye, Thomas. *Dasvidaniya.*
>
> (Ivan turns, and begins to walk away.)
>
> Magnum: Ivan?
>
> Ivan: Yes?
>
> Magnum: Did you see the sunrise this morning?
>
> Ivan: Yes. Why?
>
> Cut to close up of Magnum's eyes. Cut to upper body shot. He raises his arm and fires the gun. The frame freezes with the blast to Magnum's right, with the sound of the shot echoing and fading over the frozen image. (*Magnum, P.I.* 1982: 3.2; transcription by authors).

By shooting Ivan without blinking an eye, Magnum tidily sweeps away uncertainty, pushes psychiatric illness aside, and reestablishes a militarized masculinity that rationalizes a revenge murder under the auspices of national security—at least on the surface. As Michael Ignatieff (1998: 158) has written, "There are human and inhuman warriors, just and unjust wars." The tale seemingly supports the need for military vigilance in time of peace. Just by tracing these two processes, linking psychiatry and the military with a masculinity lens undermines the simplicity of the popular message. Magnum's act could be said to disclose a path through the mangle that rationalizes murder and restores normalcy. TC gets "fixed"

by going stateside for debriefing and Magnum goes back to being a private investigator.

The Fit of Psychiatry and the Military

What happens when a soldier breaks down during combat or a veteran exhibits delayed stress? What practices, interactions, and processes take place that assemble a context for dealing with the deep emotional distress of combatants? How, in other words, do soldiers or veterans become weary warriors? In this chapter we have offered a way of thinking about power/knowledge apparatuses that, in the context of soldiers, intermingle in embodied ways to generate weary warriors of different kinds. Following Hekman (2010) we have suggested that the identities of soldiers are real; and that these realities are disclosed through concepts and understandings of specific subject positions. And, following Pickering, we have portrayed the soldier in context as a mangle of practices and pathways, of a discursive-material mode, from which emerge various subject positionings of warriors. These contexts are a series of entanglements of knowledge and power configurations and multiple connections and disconnections. As well, these contexts are any number of disclosures and enclosures generated by diagnostic categories and decisions about the true state of the exhausted soldier. To better understand the circumstances and experiences of weary warriors, we have examined in some depth the militarization of psychiatric wounds and the psychiatrization of military bodies.

The militarization of psychiatric wounds and the psychiatrization of military bodies are simultaneous processes, most of the time working together to construct illness and generate ill bodies in ways that are specific to the contexts within which all this happens. In contrast to the organizing presumption that emotional breakdowns can happen to anyone, anywhere, anytime, given the right set of circumstances, more-recent popular accounts focus on the specificity of particular bodies that are psychiatrized. Alongside and interactive with the militarization of psychiatric wounds, military bodies are subject to psychiatric power. As the practice of psychological screening shows, all military personnel are treated as potential psychiatric cases. Military troops train for strength, agility, and endurance as well as for obedience to authority, deference to rank, and honor in death. Just as psychiatric power circulates through the military training practices that shape the psychological make-up of individual troops, psychiatric power also circulates between the experience of trauma and its somatic and psychological articulation. Both somatic and

mental stress, thus, push the boundaries of a combat troop's capacity to deal with different types of trauma, depending on the context.

We have looked in this chapter at how the practices of the military and psychiatry function and articulate with each other and with other mechanisms in civil society, and with what effects. Taking seriously the entanglement of deep discursive-material connections, inter- and intra-actions, and effects of the relationships, elements, and events, we are better able to disclose the multiple effects of the processes that generate weary warriors as flexible, porous, and in flux—liminal—rather than as inflexible regulated entities. Taking context into account for us means identifying and then tracing some of the processes that connect various elements within embodied apparatuses that are plugged into each other. This idea of context is active, generative, and (ontologically) positive. The soldier in context occupies temporal dimensions, spatial considerations, and personal and professional expectations, all interacting in fluid relations for fixing or holding in place the ill soldier. Thus, rather than relying on the phrase "depending on the context" or getting stuck in an endless cycle of exceptions, we can use context as constitutive in and of itself to speak about disclosures, entanglements, and mangles in a way that has substance, a substance where diagnostic categories and treatment modalities matter deeply to soldiers and veterans, as well as to psychiatrists and military leaders.

Notes

1. Our use of "his" and "himself" are intentional uses of gendered pronouns.
2. Note that we use the word "wounds" here as opposed to "psychiatric illness"; the latter resists the dominance of both psychiatry and the military as disciplinary apparatuses.
3. Foucault notes that overcrowding in asylums limited contact between the psychiatrist and the insane or abnormal. But the principle still holds: in order for psychiatric power to operate well, the psychiatrist must have contact with the mad. This is not the case in the military.
4. For details about the structures in place for caring for wounded soldiers, see E. Jones and Wessely (2005a); Leese (2002); Lerner (2003); Shephard (2000).
   We draw out descriptions of the field practices from a number of sources. The sources we cite here are those with the most systematic descriptions of both the conditions leading up to the implementation of forward psychiatry as well as of forward psychiatry itself. Our account of the development of forward differs slightly from all these sources.
5. PIE was introduced after the Second World War to describe the principles. See Artiss (1963) for a discussion of PIE.

6. See the discussion in this volume, chapter 3, about classification and diagnosis.

7. John Appel, S. Alan Challam, E. W. Cochran, Roy Grinker, Martin R. Plesset, William D. Sharp, Herbert Spiegel, and Melvin Thorner were among the American military psychiatrists who, at the beginning of the Second World War, argued for the predisposition thesis; by the end of the war, they had abandoned it, replacing it with a complex set of factors contributing to combat breakdown including low morale, harsh natural environment, boredom, lack of appropriate training, bodily stress (e.g., trench foot), sexual deprivation, ineffective leadership, isolation, and lack of wider context for military campaigns, among others (R. Greene 1976).

8. For rates of breakdown in the early years of Viet Nam, see Binneveld (1997: 97), Shephard (2000: 340), and Wanke (2005: 18, 24).

9. The racialization of his trauma plays out in complex ways in this episode, indicative of the other ways race plays out in the series. African American culture is celebrated through references to jazz and sports usually, but not always, via TC. *Magnum, P.I.* is not a series that is often analyzed in the literature on 1980s primetime television in media studies. For racialized representations of characters on 1980s primetime television, see Greenberg and Collette (1997) and Stroman, Merritt, and Matabane (1989). See Brislin (2003), Gray (1995), and Hamamoto (1994) for insights into African American, Pacific Islander, and Asian representations, all of which play some role in the characterizations in *Magnum, P.I.*

10. The gendered aspect of delayed stress in this episode is central. The choice to bring this issue to the fore through a storyline of a female nurse who is now a surgeon layers the militarization of psychiatric wounds in interesting ways.

11. A remake of *The Manchurian Candidate* was released in 2004, with the setting changed from Korea and the Korean War of the early 1950s to Kuwait and the First Gulf War of the early 1990s.

Chapter 8

Soldiering On

Care of Self, Status Passages, and Citizenship Claims

———◆———

> One thing I do know: everything that is sinking into us like a stone
> now, while we are in the war, will rise up again when the war is over,
> and that's when the real life-and-death struggle will start.
> —Erich Maria Remarque, *All Quiet on the Western Front*

> Returning troops faced bunting, bands, speeches, and hidden fears.
> —Desmond Morton, *A Military History of Canada*

The psychologically wounded veteran is a major figure in contemporary society. Despite new methods in psychiatric training, popularity of counseling, and transformations in psychiatric care, the matter of soldiering on for the weary warrior after the military campaign and returning home remains a vexing issue of public policy-making around the world. The concept of "soldiering on" commonly refers to perseverance, resolve, determination, and firmness, qualities and actions associated with the ideal image of the masculine fighting soldier. It is often equated with a discourse of returning home and the culturally anticipated processes of overcoming challenges, making adjustments, and getting on with one's life. Families, too, are implicated in this discourse of soldiering on: they are asked, indeed expected, to stay brave in the face of awkward reunions or setbacks in transitions, to conquer their own anxieties and fears about the returning veteran, and to monitor the state of mental health the veteran displays.

We suggest here, as elsewhere in the book, that, as veterans returning home, weary warriors are enacted through specific practices arising from various forms of power relations: biopower of psychiatry, disciplinary power of the military, and the sovereign power of the nation-state. These

power or force relations frame the private struggles of the returning veteran in terms of care of the self and the place of the family in relation to the fighting soldier and the returning psychologically wounded veteran. Also a part of the return and transitioning for the soldier is a collage of normative images or discourses on who a weary warrior is and the role of the family in the soldier's demilitarized life. Whether positive or negative, some normative material-discourses have been more prominent than others over the past 125 years in the modern history of the weary warrior.

As an embodied subject, the weary warrior may be present in a material way, to family and others, but almost totally absent in a discursive way, ignored culturally, withdrawn socially, and distant emotionally from even those most intimate with the veteran. In recent times across several nations, we have observed, relative to wars in earlier decades, an upsurge in community recognition and official commemoration of the biological deaths of veterans. In itself, body counts are significant to consider theoretically (see Hyndman 2007). It is also significant for another reason: together with this increasing public remembrance of the fallen soldier, there is an ongoing official contestation of soldiers with traumatized psyches by government authorities, and general disregard by the public, over the *social death* of veterans living among us.

Similarly, the *political life* of weary warriors as veterans is full of organizing and mobilizing to gain profile, express shared struggles, incite state action, and thus secure rights and services in order to secure a sense of fairness and quality of life. The unevenness in the way in which the nation-state has responded to the lived circumstances of, and political claims by, psychologically wounded soldiers bears scrutiny. We maintain that the will of the state, as exercised through sovereign power, can be to acknowledge, to assist, or to abandon individual veterans or groups of veterans with certain embodied subjectivities and contested illnesses.

In this chapter we examine this conception of soldiering on, showing it to involve images, discourses, and actions. Soldiering on by psychologically traumatized veterans relates to the impact of war on civilian populations generally and families more specifically (Finkel 2013; Linford 2013; Thomas 2009). Soldiering on, we maintain, involves the (re)cultivation of the civilian self and the care of the psychologically wounded veteran by the veterans themselves, by some peers and by family members, and either civilian or military psychiatrists or mental health-care workers associated with recovery, addiction, and support centers. A politics of claims making and social change is a formative part in soldiering on by veterans in their struggles for recognition of wounds and distress as a result of combat. In these struggles, a series of relationships are activated and issues are contested in military, state, and political institutions. In this sense, we make

the case that it is not just those soldiers diagnosed with war shock, combat fatigue, delayed stress, or PTSD, that are traumatized veterans: all veterans now have become potential psychiatric cases for the military because of the way in which due processes and resources from welfare states care for and support of veterans form.

Reconstitution of the Distressed Subject

In previous chapters we challenged standard images of the military as a stable, closed, and formal system by drawing attention to tensions that mask acts of resistance and discretion operating within these institutional systems. We also reject the early Foucauldian view of soldiers as thoroughly docile bodies and static machines by emphasizing instead that the soldier can be an unstable identity, generated through multiple practices and contested relationships. In particular, we suggest that the veteran can be thought of as an embodied subject constitutive of material and discursive forces within a specific power/knowledge configuration. By the end of the Second World War, psychiatrists were in agreement that nearly anyone could break down, given the circumstances of war. So, it comes as no surprise that, with regard to Viet Nam veterans in the United States, a psychiatric consultant claims, "The individual [soldier] becomes totally submerged in the goals and needs of the military organization [because] military training requires submission to the aggression of superiors" (Tanay 1985: 30–31). There is much truth in this observation, yet our analysis in previous chapters casts doubt on the absolute nature of these claims. In various conflicts over the past century, when ill soldiers have not performed in accordance with their commands, a frequent diagnosis was that they had been unduly influenced by their civilian personality, usually in the form of family upbringing, a character flaw, or possible suffering from nostalgia. Militaries continually adjusted recruitment screening and training programs with a view to improve the emotional breakdown ratio among combat soldiers, reflecting the reality that their success is always limited. Allegations of malingering and of insubordination, among other issues facing military authorities, also indicate that total submission and complete indoctrination rarely if ever occurs in military organizations, however powerful and coherent they may appear to insiders as well as outsiders.[1]

Likewise, we resist adopting images of civil society as an open, democratic, and supportive social world for veterans, especially traumatized veterans. Demobilization—the shift from active duty and military service to private civilian life—may be thought to be a form of deinstitutionaliza-

tion. We think here in terms of changing primary social locations from within the largely authoritarian institutional domain of military life (with pockets of total institutional spaces) to a generally more diversified array of social structures. However, we cannot overlook the fact that civilian life takes place within a context of small social organizations and large institutional sectors, including families, support groups, and mental health–care facilities, in addition to psychiatric professions, judicial systems, veterans' groups, and government bureaucracies. It is more apt, then, to think of the demobilization of veterans, indeed of postdeployment life, as a type of reinstitutionalization.

A conventional account of demobilization sets up a *status passage* comprising three phases: separation from a soldier's present military identity; transition from that to another, civil identity; and finally the incorporation into a new (or former) personal identity in civil society (Glaser and Strauss 1967; Jenkins 2004: 150–51). The place the traumatized soldier takes up in society is clearly absent. Sociologically, reconstitution of the subject is a formal pattern of rituals and institutionally approved and regulated changes in status, with a beginning and end to the status passage. John Wilson and G.E. Krause (1985) describe the homecoming experience as made up of three major phases. The first phase is the return from the war zone to the United States and "the initial return to a civilian way of life." The second phase is the homecoming period, which they define as "the first six months home from the war." Here "the relative degree of support from significant others and a meaningful community are important" (113). Following these is a third phase of favorable assimilation; that is, stabilization, positive adaptation, normal personality functioning, and constructive character changes, such as personal growth. It is worth noting that Wilson and Krause do note a fourth outcome, not quite an alternative phase, of nonassimilation or failed adaptation reflecting, they suggest, the presence of posttrauma stress, character disorder, or neurotic traits. Recognition of the potential of psychological or emotional effects of war in soldiers' lives postdeployment indicates more that this is a disruption rather than a manner in which some veterans live their lives.

The theme of *returning home* is another influential way of talking about civilian life after military service and how the subject of the warrior is or ought to be reconstituted. Returning home after military deployment is often described as "getting back to 'normal' [after their] return, … to pick up where they left off, [recognizing that some] post-homecoming frictions are normal and predictable" (Lyons 2007: 311). In this context, reconstitution of the veteran is a process of renormalization and reunification. Parts of a family are reconnected by a soldier returning to a household and local community. One's self, too, becomes of site for normality to take

hold. Previous roles and relationships become part of daily life again by veterans and others alike. It is a return to being a spouse, a parent, a sister or brother, a son or daughter, an aunt or uncle. An affirmation of one's bundle of social roles and overall identity facilitates the process of coming back to one's previous life, one's true self. In this idealized process of returning home, the dominant discourse on the reintegration of veterans into civilian life highlights the emotional process of seeing loved ones, full of joyful occasions of reconnecting. The experience of war is to be packaged and neatly tucked away, not to be shared with intimates because it would spoil the moment, the occasion, the relationship, the ideal. Adjustments to private life including the tweaking of relationships to keep unreason at bay are to be expected and may take some time, some missteps, but not too long and not too many. With reintegration the goal, returning home is but a transitional phase with a few ups and downs that can be smoothed over with the aid of information and advice from government agencies and veterans' services. In the end, a new balance is established for veterans, their families, and their social networks, ones that hold together a normal life, at least on the surface.

Another far more critical discourse on returning home is to be found in clinical literature and in military memoirs, along with news stories in the popular press and social media and in cultural products such as war movies, plays, and books. It is remarkably evident in works dealing with Viet Nam War veterans in the United States and, to a lesser degree, in works on recent conflicts in Iraq and Afghanistan. As a disruption to the theme of coming home is the issue of *coming to terms* with the symptoms, diagnoses, and treatments associated with war neuroses, battle fatigue, and delayed stress. Coming to terms with disabling and disabled identities, as well as psychiatric labels and interventions are implicated in the identity reformation of distressed military subjects (Gerschick and Miller 1995). Status passages for weary warriors are neither so straightforward, nor portrayed so positively or optimistically, nor so patterned in adjustments from service in the armed forces to family life in civil society. Their status passages are more unpredictable and multidirectional, framed as troubling for the path to normality. They entail both adaptation and deterioration to things like pain, anger, and turbulence alongside recovery, gratification, and composure. Of course, the passages are not temporally or spatially confined. They span not just weeks, months, or a few years of adjustments, but decades of ravaged minds. It is not just in hospitals and psychiatrists' offices that breakdowns take place: they occur in the bedroom, on the street, and on the steps of the courthouse. An American study published in 1981 documented that while most Viet Nam veterans were "unscathed by their experience," several years after the war was over

an estimated "500,000 to 800,000 Vietnam era veterans, particularly those who endured the most severe combat-related stress and psychic trauma, were still encountering varying degrees of inability to adjust successfully to civilian life" (quoted in Fuller 1985: 9).

"Coming home from the war," notes a former U.S. Army nurse, "turned out to be a devastating experience, however, for many Vietnam veterans" (Van Devanter 1985: 156). She adds, "many women have indicated that they just felt generally very different from their old selves and from their families and their friends when they returned" (158). In addition to strained relations over gendered roles and expectations, veterans may be returning in other concrete embodied terms with substance use issues, behavioral problems, and remoteness from family and friends. The affective distance between their traumatized self and their previous self produces intense anguish, grief, and despair. When home, discharged soldiers confront employment challenges and prolonged unemployment. There may be sudden onset of bodily sensations that were never part of their experience during deployment. Depression, anxiety attacks, flashbacks, hallucinations, fatigue, and emotional numbing are relatively common among Viet Nam veterans. "There is a striking absence of preparation of war survivors for the adaptive crisis which awaits them upon return to the civilized world [and in certain cases an] existential crisis, questioning the meaning of life" (Tanay 1985: 30, 34).

Viet Nam veterans returned from a deeply unpopular war and a failed military campaign in Southeast Asia. No heroes' parades or even warm welcomes were there for these soldiers when they returned home. There was only a collective sigh of relief that the war was over and the attitude toward demobilized soldiers—most of whom were conscripted—held a hint of disdain. A commonplace occurrence for Viet Nam veterans was to be shunned and stigmatized from the general American public, government agencies, and even other veterans groups. "Unlike WWII veterans who returned home to a hero's welcome, the Vietnam veteran returned home feeling defeated and witnessing antiwar protests and marches. There was little or no time for readjustment. Some men had to make the transition from the rice paddies of Vietnam to home within 36 hours!" (Woods, Sherwood, and Thompson 1985: 253). These observations indicate how the logistical process of demobilization and the cultural meaning of homecomings are shaped by technological developments in transportation and by generational-based assessments of wars and veterans.

The subject of the ill soldier, the weary warrior, results from the circulation of meanings in customs, stories, myths, symbols, narratives, and rituals. Over the twentieth and early twenty-first centuries, we identify seven figures apparent in the cultural domain of public beliefs and social

attitudes toward psychologically wounded veterans and in self-perceptions held by veterans themselves (Childers 2009; Galovski and Lyons 2004; Haley 1985; Silver 1985). In brief, the seven figures of shaping weary warriors as veterans are

1. The good warrior. Soldiers who did their duty and served their country with honor and are publicly recognized as heroes
2. The troubled hero. A good warrior, yet with some internal struggles that, overall, are not incapacitating
3. The outlaw. The shunned, feared, and reviled veteran who is regarded to be aggressive and explosive in his (her) actions
4. The misfit. More oddball than outlaw, and thus less threatening in reference to prevalent societal norms and practices
5. The forgotten (abandoned) soldier. Not publicly recognized, hidden from sight, dealt with by the military and the state in trivial ways, and marginalized from military and nation-state histories
6. The disadvantaged outsider. Outcasts of society who are homeless, jobless, and in hopeless poverty
7. The survivor. A soldier, who, despite various travails, engages post-deployment life without either direct engagement or marginalization.

Clearly this typology is merely heuristic, an exploratory schema with porous boundaries holding the shape of each category. Even so, each type readily generates images that facilitate an understanding of *how* weary warriors are mediated discursively through ideas about what constitutes an honorable veteran and materially through the practices in which both the veterans and the people associated with veterans' issues engage.

For example, the survivor, if a POW, may feel blameworthy and remain trapped in silence. Some survivors see themselves as under a personal duty to live a good life in order to validate those sacrificed, which can be seen as a form of survivor's guilt (Childers 2009). A survivor, if a witness to atrocities and genocide, may well be struggling with recurring nightmares of death and destruction, and take up the role as moral witness to humanity for failed policies and practices (Dallaire 2003). Less dramatically, the survivor may adopt a pragmatic stance or perhaps a fatalistic viewpoint claiming to be one of the lucky ones, being dutiful, and getting on with living, and may have what can be referred to as "delayed stress" or "delayed trauma." And there are the survivors who are active political subjects, possibly organizing around mental health issues and doing battle with various state and social institutions (Doucette 2008). In the rest of this chapter, we bear in mind the wide-ranging scope of various veterans who live with the experiences of war and the ways in which

they deal with their experiences of emotional distress and psychological wounds.

Private Struggles over the Care of the Self

Crucial to the work of soldiering on for the traumatized soldier is the care of the self. For weary warriors, such caring practices are not merely solitary activities, but also involve both formal and informal relationships of solidarity, support, and surveillance. The embodied soldier is an embedded subject positioned in configurations of interpersonal and bureaucratic relations as well as mutual dependencies and shared experiences with other shattered fighters. We note three aspects to the practices of the care of the self by weary warriors as veterans: caring about others, specifically one's comrades; struggling to care for one's self; and caring with others in veterans' support groups.

Helen O'Grady observes, "care for the self has tended to be a male preserve, while caring for others has been assigned to women and attributed the customary devaluation" (2004: 109). O'Grady grants "the reality of men's care for others" and that men are not always more oriented toward the self than others. However, she maintains that the self orientation applies as "a general claim about the common effects of gender socialization processes" (112). Within the armed forces and military establishments, distinctive socialization processes seem at work that, while unquestionably organized for males, masculine in nature, with an element of machismo, contain a philosophy of care for the other. The norm of care for the self is subordinated to the value of care for others in the unit; individual safety and survival is secured through mutual support and commitment. Care of the self is placed under the authority of superior others and, equally important, under the scrutiny of significant others. As Cameron March and Neil Greenberg (2007: 247) state, "The essential ethos for the U.S. and British Marines was: 'Mission, Men, Self'—always in that priority." This suggests, to us, that care of the self and of others are contingent and situational practices. *The Red Badge of Courage,* written by Stephen Crane ([1895] 2004), a classic novel about the American Civil War, provides an illustration of the solidarity of a company or regiment and the felt sense of responsibility to one's comrades:

> He suddenly lost concern for himself, and forgot to look at a menacing fate. He became not a man but a member. He felt that something of which he was a part—a regiment, an army, a cause, or a country—was in a crisis. He was welded into a common personality which was dominated by a single desire. . . .

> There was a consciousness always of the presence of his comrades about him. He felt the subtle battle brotherhood more potent even than the cause for which they were fighting. It was a mysterious fraternity born of the smoke and danger of death. (Crane [1895] 2004: 34–35)

Warriors develop a deep connection to the soldiers close by for which care becomes a key in maintain an interdependent relationship. Having to depend on someone to protect you inspires you to protect and care for those around you, especially during battle. Breaking up these relationships can be a source of danger. Soldiers' jitters, preoccupations, and, in extreme cases, nervous breakdowns disrupt the tightly woven fabric of the so-called battle brotherhood. These ties, however, are strong and remain long after battle, breakdown, and reunification (RTU). Soldiers take these connections and draw on them after the war is over and military service is done.

The combatant struggling to engage in self-care after coming home is the second example of soldiering on by weary warriors. The traumatized veteran is a figure of stress-injured military personnel, primarily in the sense of an abnormal or deviant self (after Foucault 2003). Not so much a docile body as a diminished mind, the psychologically wounded soldier lives at the edges of the self. The relationship these veterans have with themselves, their own sense of self, is portrayed in a considerable body of literature as permanently altered in personality, markedly damaged in capacity, and with considerably limited agency in everyday living. Emotionally, soldiers feel some type of self-guilt, self-blame, and self-doubt, while negotiating daily life through damaged self-esteem. In the aftermath of being traumatized, it seems "one can no longer *be oneself* even to oneself" (Brison 2002: 40; emphasis in original). Practices of the self, in this context, are practices of struggle in relation to one's body, one's thoughts, and one's own soul.

Yet practices of struggle do suggest that some degree of movement, agency, and resistance is still in effect. Studies speak to battling "the enemy inside" (Baird 2010) and the link between an operational stress disorder and thoughts and acts of suicide (Coleman 2006), and the juxtaposition of "public peace, private wars" (Muir 2007). Soldiers write about their emotional experiences, likening themselves to "empty casing[s]" (Doucette 2008), finding solace in the thought that "this, too, shall pass" (Richardson 2005), and describing acts of self-care to preserve their sanity (Graves [1929] 1995). These conceptions of the damaged self can be seen to imply that care of the veteran requires medical treatments and psychiatric interventions. A frequent reference in this domain of the traumatized self is the image of "ghosts" as part of the legacy of combat, whether in regards to the Great War (Barker 1991, 1993, 1995), the Viet Nam War (Isaacs 1997; Kwon 2008; Moore and Galloway 2008), the Iraq War (Wasinski 2008), the

Afghanistan War (Steele 2011), or conflicts elsewhere (Mithander, Sund-
holm, and Holmgren Troy 2007).

Healing the traumatized self to allow some kind of moving on for
veterans can entail remembering and reaffirming as much as forgetting
(Achugar 2008). More than forty-five years after a battalion of the 7th
U.S. Calvary battled North Vietnamese regulars in November 1965, two
veterans recount, "All along our war and our battles remained fresh in
our memories and our nightmares. We had a lot of unfinished business
that could only be conducted on those long-ago battlefields. We had old
ghosts, old demons that tugged at our hearts and minds and sent some of
our comrades in search of a name for what ailed us, and help in dealing
with that ailment" (Moore and Galloway 2008: xvi).

Erich Maria Remarque's novel, *All Quiet on the Western Front* ([1929]
1996), provides a compelling example of how warfare produces in com-
batants, in this case among young German soldiers during the Great War,
a sense of detachment from their former selves: We're no longer young
men. We've lost any desire to conquer the world. We are refugees. We are
fleeing from ourselves. From our lives. We are eighteen years old, and we
had just begun to love the world and love being in it; but we had to shoot
at it. The first shell to land went straight for our hearts" (61). Remarque
elaborates on this uncoupling and separation from one's self: "And even if
someone were to give us it back, that landscape of our youth, we wouldn't
have much idea of how to handle it. The tender, secret forces that bound
it to us cannot come back to life" (84). This separation is also perceived by
the traumatized young veterans in generational terms: "in front of us there
is a generation of men who did, it is true, share the years out here with
us, but who already had a bed and a job and who are going back to their
old positions, where they will forget all about the war—and behind us, a
new generation is growing up, one like we used to be, and that generation
will be strangers to us and will push us aside" (199). The fear expressed
here is that no one will understand burnout and the broken embodiments
of young veterans as they struggle to understand themselves, many not
knowing what to do, while melancholy and confusion make their way
into their thoughts whether their "conscious self likes it or not" (200).

This literary account of young German soldiers during the Great War
is uncannily echoed in a historical account of American veterans who
served in the Viet Nam War: "Life, as they say, went on day by day for all
of us. We took the good with the bad and kept moving ahead, each in his
own way, always with an inner understanding that we had already seen
both the best and the worst that men can do to other men, and that noth-
ing—not even the passage of four decades—can fully erase these images"
(Moore and Galloway 2008: xvii–xviii).

A third example of the practices of attention to the self by weary warriors is caring with others in veterans' support groups. These particular practices relate, in a Foucauldian sense, to technologies of the self in which veterans constitute themselves in an active manner by drawing on the mental health service users' movement (Rogers and Pilgrim 2001), existing models of self-help and mutual aid groups, and, in 1970s and 1980s American culture, rap groups as part of consciousness-raising practices. In a number of countries from the 1960s onward, anti-psychiatry critics, consumer survivor groups, and patients' rights movements emerged that questioned established theories and practices of treatment. These critics slammed the hierarchy of asylums and authority of specialists while at the same time advancing the interests of marginalized groups of sick and mad persons. The principles on which these groups emerged included self-advocacy and group solidarity (Foucault 2004, 2006; Rogers and Pilgrim 2001). More than coping mechanisms, these activities represent practices in social critique and social change. They represent a *depsychiatrization*—in lieu of the more common process of deinstitutionalization—of how the troubled self should be labeled and how health professionals should best treat that self. Peer support, as one example of this technology of the self and one with antecedents to practices in the Great War, emerged as a preferred intervention by many American veterans during and after the Viet Nam War. "It is known," write March and Greenberg (2007: 251), "that military personnel who do want to speak about their operational experiences prefer to speak to a peer rather than to other forms of support such as medical staff or managers."

The Operational Stress Injury Social Support (OSISS) program is a formal peer support program in collaboration between the Canadian forces and Veterans Affairs Canada (Grenier et al. 2007). It arose at least in part from a recognition that "[m]ost providers of mental health services in the Canadian military are now civilians, who find themselves at a disadvantage when trying to understand and empathize with the particular work-related situations facing their clients" (268). Relationships between service consumers (i.e., veterans) and clinicians and therapists raised issues of suspicion and trust, and of power relations and accountability. Peer support became seen as a way of addressing these issues and as a way of cultivating cohesion among veterans (Linford 2013). Thus, the OSISS program includes a self-care regime that is described as "what you do for yourself. It is recognizing your own limits and being kind to yourself. It is understanding what you need and making sure your needs are met at work and at home. Self-care is utilizing your team of colleagues and consultants. It is staying involved in your personal relationships, and it is respecting the choices of others" (278).

Beside such formal peer support groups and inpatient programs attached to the military and veterans' administrations, as in this Canadian example, other more independent and informal self-help programs, support groups, recovery programs, and veteran-driven meetings are noteworthy practices of care of the self via caring for others. One example is the Viet Nam veteran rap groups and similar storefront group approaches. Steven Silver explains the purpose and the success of these rap groups:

> The emotional and often physical isolation of the past is altered by joining with others sharing basically the same experience. This process is aided by the desire of most veterans to see their relationship in Vietnam as positive and supportive, and in many cases more so than they actually were. This makes joining with other sharers of the trauma easier—it is a return to a supportive system, rather than an initiation of one. It is not necessary that it once did exist, or that it did to the degree the mythos presents [the mythos here being the prevalent beliefs of American culture with regard to the Viet Nam veteran]. It is only necessary that it exists now. (Silver 1985: 50)

Through a weary warrior joining with other sharers of combat trauma, we catch sight of "the interplay of the care of the self and the help of the other" (Foucault 1988b: 53) through "the talks that one has with a confidant, with friends, with a guide" (51).

The Family, the Military, and Psychiatry

The state, psychiatry, and the military have been interested in the family for centuries. While the nature of these interests has undoubtedly changed over time, as have the assumptions and models of family life that underlie practices, military concerns and psychiatric customs remain primary in policies and services for and about the families of weary warriors. Through state propaganda, military recruitment campaigns and general practices, nationalist cultural practices, and through discourses of health professions, the family has been represented in numerous ways. Some depictions contradict one another; all depictionsare contextual in meaning and consequential for the way in which configurations of power and knowledge impact weary warriors.

In 1678 a Swiss physician, Johannes Hofer, wrote a paper on an illness among soldiers serving in foreign campaigns. Hofer called the illness *nostalgie,* or *mal du pays,* a "pain which the sick person feels because he is not in his native land, or fears he is never to see it again" (Babington 1997: 8). Symptoms of this homesickness, this yearning for family, according to Hofer, included, "melancholy, incessant thinking of home, disturbed sleep or insomnia, loss of appetite, anxiety, [and] cardiac palpitation" (8). In the

late 1700s an Austrian physician echoed Hofer's diagnostic category of nostalgia, noting, "When young men, who are still growing, are forced to enter military service and thus lose all hope of returning safe and sound to their beloved homeland, they become sad, taciturn, listless, solitary musing, full of sighs and moans" (8). Anthony Babington writes that in 1863, during the American Civil War, a military surgeon in the U.S. Army recorded that "many a young soldier has become discouraged and made to feel the bitter pangs of home-sickness, which is the usual precursor of more serious ailments. That peculiar state of mind, denominated nostalgia by medical writers, is a species of melancholy, or a mild type of insanity, caused by disappointment and a continuous longing for home" (14). Two decades later, near the end of the nineteenth century, a U.S. government study concluded that "young men of feeble will" and married men away from home for the first time were most prone to nostalgia (14). During the Great War some British servicemen were dubbed "home men," signifying that their primary allegiance was seen to be to their families rather than to their king or country (Barham 2004: 314). From an early age, then, in modern warfare and psychiatry, the private domain of family life has been an object of disquiet, among other things, in the public realm of military and state affairs.

One conception sets up the family as a source of troops and other valuable resources, or, in other words, the family is "the regular purveyors of material to the military machines" (Barham 2004: 117). In Britain, during the Great War, conscription was introduced in 1916 with the passage by Parliament of the Military Service Act. This legislation was called the Bachelor's Bill because "all male British subjects between the ages of 18 and 41 who were either unmarried or widowers without dependent children were called up to enlist" (25). This illustrates a claim made by Foucault (2006) that "the obligation of military service was imposed on people who clearly had no reason to want to do military service: it is solely because the State put pressure on the family as a small community of father, mother, brothers and sisters, etcetera, that the obligation of military service had real constraining force and individuals could be plugged into this disciplinary system and taken into its possession" (81). Beyond the image that Foucault presents of the pressured family are those of the reluctant or resistant family, often portrayed in popular culture in terms of the worried mother not wanting her son or sons to enlist (Crane [1895] 2004; Findley 1977). As well, other notable images of family in relation to the military include the patriotic family, with recruits and relatives of soldiers identifying with heroic images of loyal service and steadfast sacrifice for one's country (Barham 2004: 177; Morton 2004; Remarque [1929] 1996); and the hopeful traditional family, the belief of a father "that the military life might

prove to be the making of his son" (Barham: 177), or the hope of parents and siblings "that war service might have transformed a wayward and burdensome son and brother into a manly patriot" (179). All these images center on the processes of recruiting troops and mobilizing related materials for the military. The resources which families provide for a military or war effort include embodied conscripts or volunteers as well as finances through war bonds and taxes, the rationing and donation of goods and services, and expressed symbolic and moral support or, conversely, active or passive political opposition.

Once the soldier becomes part of the military, the family itself becomes psychiatrized—that is, the family becomes the source of a soldier's psychological traits and identifiable strengths or weaknesses. Since the early notions of nostalgia and homesickness for soldiers serving in foreign lands, which can be considered a precursor to the psychiatrized understanding of emotional illness as combat stress, the family has been regarded as a cause of something as benign as emotional distraction and as serious as nervous troubles or mental disorders. In the late nineteenth century family history became a topic of growing interest by militaries when recruiting and screening applicants, when diagnosing ill soldiers, or when disciplining soldiers. Attention has been devoted to learning about a soldier's education, his general demeanor, his physical stature, his health and medical history, and his parents and other family members' health, especially any record of nervousness, hysteria, or insanity in his mothers, sisters, or aunts. A troubled, problematic family history of a soldier could "assist the military authorities in casting him as a constitutional inadequate, for whom they did not need to assume any special responsibility nor make a focus of intensive therapeutic zeal" (Barham 2004: 21). If it is assumed that a soldier can have a predisposition to exhaustion, shock, or fear, then it follows that the family is implicated in that susceptibility.

A comparable line of concern is the idea that families can be a distraction to the timely recovery of ill soldiers. A belief among military surgeons in the American Civil War (prior to the advent of military psychiatry) was that "soldiers who were sent to hospitals near their homes were always more liable to contract nostalgia than those who went to hospitals near to the Army which they belonged" (Babington 1997: 16). Much-more-recent clinical literature on the stressors of war likewise view the family as a source of "loyalty conflicts" (Nash 2007: 23) for those deployed and especially in combat operations, conflicts triggered by emotional stress or depression and feelings of guilt and helplessness about domestic matters at home (23–24).

Families are not always regarded as a source of mental or emotional problems for soldiers. Families can also be indispensable support systems

for healing, through their practical assistance along with love and hope (Greene and Greene 2012). A psychotherapist who worked with U.S. veterans and their families has concluded, "spouses, family, or close friends are the *last line of defense* against the hostile world and death" (Marrs 1985: 88; emphasis added). Here the image of the family for the veteran is a safe haven, "an emotional support system outside of the hospital" (Racek 1985: 284). As a natural support system and private world of love, the traumatized soldier finds understanding and assistance in whatever adjustments need to be made in soldiering on after the public war is over.

When Foucault wrote about the family he usually was referring rather conventionally to a married couple, parents, and children. Fundamentally, the type of power Foucault saw exercised in the family was that of sovereignty, but not a form of sovereign power derived from the state. Instead the sovereign power of the family operates as an independent form, intrinsic to "the order of inheritance, relationships of allegiances and obedience" (Foucault 2006: 114; see also Taylor 2012). It is this idea of the family alongside the values of domesticity as a foundational societal unit and of deep-seated systems of commitments and obligations that appear in debates over the role of the family in providing postdeployment for the traumatized veteran. To give one instance of this role of the family, "In the absence of an official policy or programme of community care in the inter-war period [between 1919 to 1939], to a large extent it fell to ex-servicemen and their families to manufacture alternatives to the chronic destines [of permanent incarceration in asylums or mental institutions] that would otherwise have greeted them" (Barham 2004: 366; see also Tyquin 2006).

At the same time that the family is cast as the last line of defense in the support of the weary warrior, the family is also an emotional battle-field and a place of stress (Finkel 2013). For some veterans living with, PTSD, the family can become an uncivil place in civilian life. Anne Rogers and David Pilgrim (2001: 121) point out, "[s]ituations may arise in which relatives may care about a person but at the same time [may] be very distressed or frightened by their actions." Family members' fears are compounded by the emotional distance psychological wounded veterans foster in their intimate relationships. "Many times veterans will push away their spouse although loving them, because their negative self-image is so strong they cannot stand to be loved" (Marrs 1985: 88). Tying the loose threads of this emotional sensitivity are marred lines of communication that are "one of the factors increasing the veteran's alienation, thereby causing them to further distance themselves from their support systems" (Marrs 1985: 92). The weary warrior who demonstrates general indifference or conveys a lack of affection while exhibiting undependable behaviors will be regarded by his closest social connections as not being part of

the family. Indeed, strains put on a family by a traumatized soldier have multiple effects, including, but certainly not limited to, caregiver burden and burnout; financial hardships of modest salaries, loss of earnings, and accumulated household debts; persistent anger, aggression, and violence within homes; secondary traumatization of parents, spouses, and among children of veterans presenting as depression or emotional distress; high rates of divorce; and significant rates of suicide among veterans themselves (Gomulka 2010; Muir 2007; Racek 1985; Waysman et al. 1993). At its most extreme, the family becomes a site of relatively contained conflict with high levels of discord, little cohesion or expressiveness among family members, and a general lack of structure in the way the family operates (Waysman et al.).

There can also be troublesome normative gazes of masculinity and military beliefs across generations. Of British veterans of the Great War, "it was generally fathers of the old school who were most resolute on checking their sympathies for their distraught sons" (Barham 2004: 178). Old-school fathers would perceive their son's melancholy, nervousness, frailty, and anguish "as an exhibition of weakness, a failure to live up to the expected standards of manliness," rather than as resulting "from a legitimate war-related disability" (178). Consequently, silences would hide the harsh realities of military service. Of American veterans of the Second World War compared to their sons of the Viet Nam War, "Considerable value conflicts also undermine the veteran's support base within his family. 'Tell it like it is,' and 'Grin and bear it' are mutually exclusive concepts resulting in a clash of the veteran as survivor and the veteran as troubled hero, outlaw, or misfit. Many fathers who fought in the Second World War cannot understand their sons' alienation, and are thereby preventing them from seeking relief and understanding" (Marrs 1985: 98).

Parallel to the psychiatrization of the family as a source of psychiatric problems for the recruit, the family members, too, become objects of psychiatric and mental health practice interventions. The military family has always been a site of surveillance of the troubled veteran through loving care and attentiveness; however, in recent decades, families are more formally plugged into military and psychiatric apparatuses. In a sense, family members have become stand-ins for the psychiatric care system, with spouses in particular acting as mental health workers in absentia. Who better than a spouse or parent to know the weary warrior as a person and his inner thoughts, his life plans, and his unique biography as an individual? In this context, the family is a place of welcome and acceptance as well as a site of watchfulness and surveillance as family members monitor the veteran, sometimes quite closely, for signs of erratic behavior, outbursts of anger, and other symptoms of OSIs and postdeployment

trauma. The returning veteran becomes an object of concern and a target of studied observation and potential disclosures by family members. Relatives are deployed in looking for signs of recovery, mental breakdown, relapse, or stability; and for the presence or absence of particular bodily behaviors and emotions. By means of intimate knowledge and personal interactions, spouses and other significant relations take on a disciplinary role in observing the returned warrior; in identifying what is normal and abnormal in the warrior's actions, thoughts, and personality; and in engaging in the practices that enact the veteran as a weary warrior. One effect of this constancy of surveillance by family members can be an emotional distancing by loved ones as well as by the weary warrior who has come home.

The military family, moreover, has become a therapeutic project in itself, an object of professional counseling, advice, and information, and various psychiatric therapies. Traditionally, the military family in grief over the "loss of husbands, sons, fathers, brothers or friends in war" (Muir 2007: 61) or the loss of wives, daughters, mothers, or sisters, would receive some official recognition of the loss from the military and perhaps some assistance from veterans' groups or religious counselors and others in the community in dealing with the emotional and practical work of loss. Gradually over the twentieth century and into the twenty-first century, the family came to be seen as not just a source of recovery for the traumatized veteran, but also as a site requiring mental supports for recovering and adapting to the challenges associated with the weary, demobilized warrior (Rogers and Pilgrim 2001). In the words of a former military personnel and counselor with veterans, "Most frequently the immediate family has no conception of the nature of the problems which cause the veteran to behave in these ways which are destructive to the family" (Racek 1985: 284).

Family involvement in the treatment of psychologically wounded veterans has branched out over time from participating in the veteran's treatment as a patient to ensure a connection with the real world. Family therapy is a significant type of intervention with sessions involving just the spouses, then perhaps including children, then individual therapy session with the spouses and the children. Sometimes psychological counseling is offered to extended family members of both the veteran and the spouse. In the United States, family-oriented interventions for veterans with PTSD from military operations in Iraq and Afghanistan, and their intimate partners include behavioral conjoint therapy, cognitive-behavioral conjoint therapy, emotionally focused couple therapy, strategic approach therapy, support and family education programs, and strong bonds for couples (Monson, Taft, and Fredman 2009). In the Canadian Forces, the

OSISS program includes a family peer support coordinator role that focuses on families of military members and veterans with an OSI in order to provide one-on-one assistance, to organize psychoeducation group sessions, and to present program outreach briefings.

The weary warrior's family thus becomes a consumer of psychiatry and a site of psychiatric practice. Family-oriented interventions for veterans and family peer supports connect the family to other systems of power and knowledge and the intrafamilial relationships "become the domain of investigation, the point of decision and the site of intervention for psychiatry" (Foucault 2004: 146). Elsewhere Foucault called this process an internal *disciplinarization* of the family in which, through the transfer of disciplinary techniques of power into families, "the family becomes a micro-clinic which controls the normality or abnormality of the body, of the soul" (Foucault 2006: 115). At the same time, another process is at work here which we call the "refamilialization of the veteran's life": the family as the reference point and site for reintegrating the weary warrior into civilian life and the social world; and for rebuilding and strengthening the family system itself in response to the strains of the traumatized combat veteran returning home.

The Social and Public Death of Traumatized Veterans

There has been a change in death in modern wars. Across nation-states veterans of both old and recent armed conflicts, while biologically alive, are socially dead; this is especially true for severely weary veterans. With medical advances and increases in treatment practices, with continued misconceptions and denials over mental health conditions, and with the intensification and fragmentation of warfare techniques, more soldiers injured in combat are surviving from blasts, burns, wounds, and head injuries; however, among these weary warriors more are returning home in a state of *social death*. The academic and clinical literature has not caught up with this development although there are instances of recognition of social death in cultural and philosophical works.[2]

Unlike fallen comrades who have passed to the next world, weary warriors survived. But to the extent they are socially dead they may be of this world but are not fully in our world. What Barham (2004: 1) calls "the prolonged afterlife of wars" includes a dark and distressing discourse about the psychologically traumatized veteran, possibly with serious emotional damage and mental illness and a loss of self-identity. Media accounts report of family members describing a relative returned from combat as "not the same person anymore," "a shell of his former self," "not all there any-

more," and "as good as dead."[3] In a detailed historical study on treating the trauma of soldiers and civilians in France from 1914 to 1940, Gregory M.Thomas (2009: 126) remarks that "mentally alienated veterans sequestered in asylums were considered *les morts vivants*—'the living dead.' They were survivors of the war, but they were as good as dead to their families, who saw them rarely and could no longer count on them for financial or emotional support…. Even those who escaped institutionalization were seen to inhabit a realm that was somewhere short of truly living." Sociologically, the socially dead veteran is an incomplete person; with the loss of basic self and public identity, the veteran is a "non-person" (Goffman 1959: 152). While nonpersons may be physically present in everyday relations, in certain ways they are regarded and treated as someone who is simply not there.

Conceptualized as a nonperson, the weary warrior no longer exercises the attributes and capacities of a so-called normal person. On a persistent basis, they lack self-awareness, emotional regulation or self-control, self-caring, a sense of belonging, and active engagement in their surroundings. They may no longer really know themselves or others once close to them. Social death, then, is embedded in the living bodies of profoundly damaged veterans. Socially dead veterans are of this world yet remain linked, however tenuous and contested, with various relationships of power and knowledge that are severing them from it. The social death of a weary warrior therefore is entangled in the biological death of others—their comrades, enemy soldiers, and innocent civilians as well as their *living relationships,* however fraught with tension, with intimates, family, friends, psychiatrists, and health-care practitioners. The Great War poet and veteran, Siegfried Sassoon, in his 1917 poem "Survivors" wrote of

> their haunted nights; their cowed
> Subjections to the ghosts of friends who died,—
> Their dreams that drip with murder

Viet Nam veterans from the 1960s write of how they and their comrades were condemned "to carry their own memories of death and dying through their lives" (Moore and Galloway 2008: xv).

Social death is not an anonymous death, just as the weary warrior's life is not an anonymous life. Both are embedded and embodied sets of "interrelations, constituted in and by the immanence of his or her expressions, acts and interactions with others and held together by the powers of remembrance: by continuity in time" (Braidotti 2006: 252). Social death extends to those around the traumatized soldier trying to survive the day (Dekel and Solomon 2007). The social death we talk about here

is not, however, inevitable. Without some form of attention, the crevices apparent in veterans who have survived deep emotional distress and psychological wounds would most certainly break the veteran apart. The attention veterans get—whether through emergent self-reflection, sought-out assistance, or as a result of close scrutiny by family and friends—keeps the broken pieces together in some semblance of order sometimes just to get through the day. Indeed, the piecing together itself is a process of *styling one's self* to make a self sustainable (Braidotti, 252). Sustainability supersedes survival in this case, and pushes social death away, to at least an arm's length, in order to create more space within this liminality.

A specific type of death of the veteran we additionally consider is the *public death* and the power of the fallen soldier. In his work, Foucault wrote about the disappearance of "the great public ritualization of death" (Foucault 2003: 247; also see Foucault 1979). He correspondingly wrote about death being outside the power relationship; that power has no control over biological death. For Foucault, "the end of life [also meant] the end of power" (2003: 248). The public death of deceased soldiers is connected with the emergence of the military dead, in the latter half of the nineteenth century and early decades of the twentieth century, as a specific mortuary category administered by military and state authorities. By the time of the Great War, with massive civilian and combat casualties, military deaths were "differentiated from other kinds of death [and] nation states took fuller responsibility for the bodies of dead soldiers" (Wasinski 2008: 116). "Warriors have been placed into a separate but included caste, one outranked often only by royalty and the priesthood. This was due, in simple terms, to the unique role played by warriors—they killed people. Soldiers endured war and approached and encountered the ultimate unknown, death. Those who have worked and lived with death have always occupied a position apart from others" (Silver 1985: 46).

In the military and in warfare, power clearly does exercise influence over matters of life and death (Sledge 2005). The continuance of sovereign power relations in death is apparent in whether to issue a pardon or discharge or to execute a soldier for cowardice; the determination of the nature and cause of a soldier's death and the implications such a decision has for the provision or not of survivor benefits or pensions as well as for stigma or honor. In the United States Army, for example, dedicated units of mortuary affairs, staffed by hundreds of personnel, undertook the management of dead American soldiers in Iraq. Technical practices and protocols included the collection and refrigeration of bodies; the identification of bodies (by such methods as dog tags, dental records, or DNA tests); the evacuation of bodies followed by medical inspections; the preparation

and clothing of bodies in new uniforms; and making, where possible, "the bodies viewable for the relatives" (Wasinski 2008: 118). The Army was also responsible for "the repatriation of personal belongings of the dead soldier"; the announcement of the death to the family, as a rule in person by two officers; organization of the funeral and paying for the burial; arrangement of a personal letter to the family from the U.S. president; and ensuring death benefits in the thousands of dollars are paid to the family of the dead soldier.

The reach of state power into military deaths has long extended into keeping memories alive through remembrance events, cenotaphs and other war memorials, and dedicated cemeteries for fallen soldiers. In recent decades the military death is not always a silent or private affair. There is a heightened emphasis of military deaths as a public event with media attention and displays of public emotion and sympathy. This marks a relative shift in the nature of remembrance of past military conflicts in Korea in the early 1950s, Viet Nam in the 1960s and early 1970s, and the Gulf War in the early 1990s.[4] Increased ritualization and public commemoration of military deaths is demonstrated by the formation of virtual war memorials, the belated recognition of forgotten warriors and civilian victims of past wars, the naming of highways of heroes, the publicizing of military fatalities flown home from overseas, and the regular showing on television and Internet sites of the latest soldiers killed in battle in Afghanistan or in other conflicts. This public commemoration is often accompanied by rhetorical support for the troops not only by military and political leaders and not just by grieving families and friends, but also by other grateful citizens and communities.

Such public markings of military casualties are not without controversy. They invariably generate ambivalence: patriotism and support as well as anti-war protest and opposition. A competing mixture of discourses arise that commemoration of military deaths advances a government's political agenda. Discourses of military death acknowledge individual sacrifices but also invade private lives of grieving families; they glorify militarism and warfare and also generate expressions of pacifism. Furthermore, competing discourses on military death are claimed to publicize the success of one's adversary—by connecting the coffins with enemy action—and thereby weaken public morale or national resolve, and raise questions about national security plans and military operations or underlines the necessity to continue a mission. Overall, a paradox operates that while vigorous public debates circulate around the *public death* of fallen soldiers killed in military service, mentioning the *social death* of traumatized veterans is taboo, largely unmentionable in civil society.

Nation-States, Social Policy,
and the Political Activism of Veterans

Weary warriors' politics is a distinctive part of veterans' politics and of disability politics more generally. Actually soldiering on is a multiple politics, concerning social status, identity formation, ontologies, weary warrior entitlements to material and symbolic public resources, and state responses of actions and inactions. The activism of traumatized combat veterans includes a range of activities across a range of institutions and a range of policy fields. These veterans are seeking to influence policies and decisions within institutions of the state: political executives (chancellors, presidents, or prime ministers and their cabinets); legislatures (upper and lower branches); civil service bureaucracies; the courts and police (civilian and military); and, of course, the armed forces and veterans' administrations. The politics of soldiering on, which by definition focuses on institutions of the armed forces and government decision makers, does reach beyond the state. In their advocacy, veterans seek connections with societal institutions that include the mass media and social media; health, medical, and legal professions; families and local communities; interest groups and social movements representing veterans; and other groups such as embodied health movements. As we noted earlier in this chapter, some veterans are suspicious and distrustful of state organizations and devote their political activism to self-organizing and nongovernmental organizations. Overall, though, veterans in all countries and across recent centuries have engaged with the politics of nation-states.

In a cultural and material sense, weary warriors are striving to close the gap between the public rhetoric of "support our troops" and "honoring our veterans" and the personal reality for many old soldiers, of struggling on their own and feeling abandoned by their county. For weary warriors soldiering on involves living with contradictions; one of which is the conflict between the discourse of loyal service, personal sacrifice and national remembrance, and the lived experience of invisibility, marginalization, and inequality within society. Compensation for combat-related damages, pains, and losses is a fundamental claim by veterans and, in fact, a widespread basis for social policy responses by nation-states. Social policies and other public services that are compensatory in nature focus on the needs of disabled veterans who participated directly in war efforts as well as for surviving spouses and bereaved families (Gal 2007). Such policies and practices operate for the returning warriors, the soldier citizens, the disabled veterans, across welfare states (Cowen 2005; Gerber 2003; Guttmann and Thomas 1946; Larsson 2009; Morton 2004; Morton

and Wright 1987; Neary 2011; Neary and Granatstein 1998; Thomas 2009; Tyquin 2006).

The politics of weary warriors includes a variety of identity politics. Informal networks, formal organizations, and collective alliances form around the embodied subjectivities, marginalized conditions, and social struggles of traumatized combat veterans. In France following the Great War, "many wounded soldiers stuck in hospitals began to band together to form associations for moral support and material assistance" (Thomas 2009: 108). Discharged soldiers also joined, and such organizations proliferated through the country. "Associations focused on the practical concerns of ameliorating discharge procedures and improving pensions. They organized social gatherings for soldiers and established permanent centres to disseminate information about veterans' rights and pension laws" (Thomas 2009: 109). DavidGerber (2003: 603) notes of contemporary Western societies, "the disabled veteran's experience of post-disability social integration has been a collective one that is intensely shared with his cohort of conscripted and professional military personnel." Sharing particular issues and challenges, they mobilize in ways to confront the dominant norms and images of the veteran, highlighting that weary warriors are often treated differently and unfairly by governments as compared to other veterans in their own country and conceivably to veterans in other countries. Activism by veterans, as identity politics, contests certain forms of knowledge as the only regimes of truth; seeks to gain acceptance of veteran's bodily symptoms and possibly a diagnostic designation for their conditions; and, thus, establishes a more visible and positive image of veterans as psychologically wounded warriors. In addressing negative cultural representations and medical discourses, traumatized veterans are engaged in collective self-assertions by forming group identifications (Gerber 2003; Oritz 2010; Turner 1988).

Rather than being constituted invisibly by authorities as ineligible claimants for benefits or portrayed negatively as a stigmatized medical category, veterans' political actions endeavor to become recognized publicly as social groups, and as active political constituencies and deserving members of social policy communities. In this manner, identity politics resembles a process of making weary warriors real, practicing a type of ontological politics: "a politics that has to do with the way in which problems are framed, bodies are shaped, and lives are pushed and pulled into one shape or another" (Mol 2002: viii).

National governments and state agencies are intriguing institutions for weary warriors. In specific times and places, states are curious and distinctive combinations of being responsive and helpful along with being resistant and hostile to the needs and claims of veterans. The state's rela-

tionship to sick soldiers involves several functions: the symbolic recognition and commemoration of most (though not necessarily all) veterans; the regulation of identities and statuses through program definitions and historical discourses; and the provision of income benefits, such as disability pensions, and of services such, as housing and health care, to veterans and their families. As a result of struggles and claims, the state is at times a site of contestation and, at other times, of collaboration between government agencies, military services, and veterans' associations.

This multifaceted and contradictory nature of states is reflected in works on the link between warfare and welfare in modern states. Some literature claims that military conflicts have been an affirmative trigger for the expansion of social rights of citizenship and welfare states in Europe and North America from the late nineteenth century through the twentieth century (Klausen 1998; Neary and Granatstein 1998; Skocpol 1992; Titmuss 1958; Turner 1986); other literature posits a negative tradeoff between public spending on defense and the military on the one hand, and public services and social programs on the other hand (Gal 2007). While the research is diverse and the evidence is mixed on these perspectives, it is clear that state structures and policies are not neutral or indifferent in matters pertaining to veterans and weary warriors. National governments and other state institutions frequently relate to disabled veterans, specifically weary warriors, in highly contentious and deeply problematic ways. Veterans often struggle with a state politics that endures as a top-down and inside-out deployment of sovereign power.[5]

A customary view of the state in relation to veterans is as a provider of benefits and services to ex-military personnel and their families, made available earlier in the history of modern social welfare than for most other groups in society, and at a level more generous and more politically supported than for comparable social benefits for civilian populations. Gerber (2003) clearly expresses this perspective: "Increasingly, since the nineteenth century, the state has undertaken to provide all veterans, but especially disabled veterans, with generous pensions and a vast array of medical, rehabilitation and reintegration services.... [I]n the twentieth century, veterans, and especially disabled veterans, … became both a project of the modern Western welfare states and pioneers on the frontiers of social welfare policy" (899). Behind this apparent willing recognition of veterans' needs by state authorities and the liberal provision of services, various motives and discourses are in play (Barham 2004; Bryson 1992; Gerber 2003; Morton 2004; Thomas 2009; Titmuss 1958): patriotic gratitude and/or civilian guilt; national self-interest "to ensure the continued readiness of individuals to participate in the war effort" (Gal 2007: 111); official concerns over civil unrest by distressed and unemployed veterans;

growing legitimacy of claims expressed as positive rights in terms of the state's duty and obligation to those who served; financial considerations by state treasuries about assuming too much of the costs of care for injured, ill, or disabled veterans; and "the political clout of veterans and the degree of public sympathy for their sacrifice" (Gal: 111).

In *Psychiatric Power,* Foucault remarks on "the problem of the cost of abnormality that we always come across in the history of psychiatry" (2006: 220). The same can be said about providing pensions to veterans. "Acrimonious standoffs between aggrieved ex-servicemen and the state in the prolonged afterlife of wars are the stuff of modern life, involving the competing claims of war pension agencies, veterans' associations and divergent medical authorities" (Barham 2004: 1). Peter Barham suggests that for working-class men who had fought in the Great War, this military pension provided by the British government "was perhaps in this period the single most important site on which the struggle for equality and for social justice was conducted" (8). In concrete terms, the struggle for war pensions meant gathering evidence on personal medical history and family background, and assembling documentation to prove that a veteran's condition was due to military service. This knowledge work to obtain a pension may be repeated by a veteran in order to keep a pension if it is reviewed by government agencies, and to appeal a rejection of a pension claim once or perhaps more depends on the review procedures available.

The French parliament just after the end of the Great War enacted a pension law in 1919 as to whether a soldier's condition was caused or aggravated by the war that "officially removed the burden of proof from the soldier. A great victory for wounded and sick soldiers, this change meant that wounds and illnesses were assumed to have been caused or aggravated by the war unless proven otherwise" (Thomas 2009: 96–97). The pension law provided for a right to health care for pensioners, including medical and pharmaceutical care and the transportation costs to hospitals. However, this change in France in legislated national policy on military pensions did not mean it was simple to claim a war disability–related pension, or that the public administration of benefits was implemented in a timely and efficient fashion, or that it was not subsequently open to reassessment and possible reduction or cancellation by military administrations.[6] "Though the law of 1919 purported to inaugurate a new era in military pensions, veterans often found that they still had to fight for what was due to them" (142).

This history of pensions to veterans illustrates important lasting effects on the roles and relationships of the state, medicine, veterans, and politics. One such effect has been the general bureaucratization of the state via the formation of new civil service bureaucracies and the categorization of

veterans in administrative systems A second effect is that pension policy developments after the Great War provided for a general medicalization veteran and disability policy-making, creating an authoritative space for neurology and psychiatry in the design of pension laws and the determination and administration of disabilities. In many countries, the meager level of military pension benefits generated a third effect—the pauperization of many veterans, forcing them to resort to stigmatizing forms of public relief and residual sources of charity (Cohen 2001; Morton 2004; Thomas 2009), inciting as a fourth effect the further politicization and activism of veterans throughout the twentieth century and into our own time.

Uneven Terrains

To think of soldiering on as a relatively straightforward process of shifting identities from an official militarized status to a demilitarized status is problematic, we contend, because the soldier is diminished or spoiled even before demobilization. As well, the ill veteran retains, as part of the self, an identity that has been scarred by battle. The politics of soldiering on is a particular illustration of the politics of citizenship: the struggle by a marginalized group for recognition and inclusion in a political community and the rightful access to state resources of pensions, services, and social policy benefits.

   Demobilization does not automatically or necessarily mean a demilitarization for the weary warrior. Indeed, it can mean an intensification of military-based norms, practices, identities, memories, and flashbacks. Postdeployment exchanges one field of struggle and battle to another and does not necessarily entail a quiet civilian life, but rather suggests a life in sharp contrast to both the deployed life and the civilian life the soldier came from. Yet the life remains altered, even upturned, a life filled with various tactics, strategies, moves, and countermoves. Soldiering on, as a field of intertwined discursive codes and material experiences, has a dynamic and contingent character of individual bodily conditions, interpersonal relationships, and memberships in social groups. It also engages public beliefs and attitudes, social policies and bureaucratic procedures, and the responses of actions and inactions by armed service establishments and veterans' organizations. Soldiering on as a process enacts weary warriors via triumphant returns for some veterans or troubled homecomings for others. It may involve public celebration and private indifference or, conversely, private acceptance of a diagnosis of mental illness but public shame and discrimination toward emotionally damaged veterans

(Barham 2004). As well, soldiering on may usher in an exciting, new, or renewed life just as easily as could introduce a grim existence through social death.

With demobilization from the military, soldiering on for the weary warrior is often a new kind of mobilization individually and perhaps collectively through support groups. In other words, the civilian life of the ill veteran is another form of combat. Life is an uneven continuation of war by other means and to other places, of carrying out and living with war neuroses. There are the invasive nightmares, acute anxiety attacks, clashes with old friends or family members, confrontations with mental health practitioners, and battles with government agencies.

Care of the traumatized self by caring with others in veterans' support groups is not necessarily implicated within neoliberal technologies of responsibilization. Rather, we notice a remilitarization of the self that relies on the reformulation, if not magnification, of past military roles and relationships. We see the success of the rap groups as part of self-care that scripts the context within which veterans return to a supportive system with other combatants who shared similar wartime experiences; in effect, an RTU. This time, however, rather than prepared for combat, the veteran is prepared for healing. Indeed, the dominant expectation in nations today is for veterans to engage with and submit to the protocols and treatment modalities of psychiatric and psychological care specialists. What is interesting is that combat veterans' peer-support and rap groups are activities mainly assumed by contemporary weary warriors, and are not often imposed on them by state authorities (Shatan 1973; Silver 1985). However, rap groups and similar forms of self-care can pose risks to veterans, such as carrying the burden and the personal responsibility for grappling with trauma. Then again, veterans' self-care groups offer benefits of a level of self-control, understanding, and safety missing in other parts of their lives. There is space away from systems of psychiatrization and medicalization and a place for networking and mobilizing for policy reforms. In this way, rap groups by veterans and similar self-care techniques can produce alternative discourses and practices, rooted in strong interpersonal supports and relationships by subjects who are not economic rational actors in a neoliberal project, but rather are psychologically wounded combatants.

Notes

1. Consider these remarks in a recent book by Donald Savoie (2010: 16) on power in modern societies: "The military has been a powerful organization throughout its history partly because it has a single, clear purpose and does not toler-

ate dissent in its ranks. It settles disputes internally, and its members submit to the organization's common purpose, or leave." We see here the classic themes of discipline, hierarchy, mission, and obligatory submission.

2. We have come across quotes attributed to Plato that say, "only the dead have seen the end of war" and, "death is not the worst that can happen to man." We have also come across a line from John Milton: "To live a life half dead, a living death." Other philosophical and literary remarks along these lines can be readily found.

3. A British article, "Soldier Death Leap" (http://www.thelondonpaper.com 24 July, 2009, 4), states, "An Iraq veteran who watched the coffins of eight colleagues being laid to rest killed himself just days later by jumping off a tower block. … Although he returned three years ago, his mother said: 'To me, he was dead when he came back from Iraq. When he saw the bodies of those eight soldiers being brought back from Afghanistan, it must have done something to him, because he saluted at the TV and then a few days later he was dead.'"

4. In another example of the deployment of state power in the death of combat soldiers, Christopher Wasinski (2008: 119) notes that as part of a historical search and recovery policy by the American armed forces, "the United States is still expending a lot of energy on the recovery of bodies from the Second World War, the Korean war, and the Vietnam war."

5. In the United States, the Readjustment Counselling Program for Vietnam Veterans, introduced in 1979, was deliberately "placed outside the physical and administrative structure of the VA [Veterans Administration]. The plan was submitted and approved to place the centers in communities in storefront settings with a chain of command and budget process totally apart from the traditional bureaucratic functions of the VA's Department of Medicine and Surgery." The reasons for this were twofold: "1) to overcome the inherent destruct of the VA 'organization' felt by the client Vietnam veteran population; and 2) to overcome the distrust of the program felt by those within the VA itself who had long questioned from the traditional perspective the nature of post-traumatic stress disorder and the new treatment methods being implemented under the program" (Fuller 1985: 9–10). This move away from conventional veterans' mental health service delivery represents a partial demedicalization and depsychiatrization of supports to stressed combat veterans.

6. In Germany, pensions to soldiers with shell shock from the Great War were ended in 1926 (Thomas 2009: 213).

Chapter 9

Military Bodies
and Battles Multiple

Embodied Trauma, Ontological Politics, and Patchwork Warriors

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> For now that it was all over, truce signed, and the dead buried,
> he had, especially in the evening, these sudden thunder-claps
> of fear. He could not feel.
> —Virginia Woolf, *Mrs. Dalloway*

> The guys coming back from Afghanistan, my heart goes out to them,
> because I know what they are going through. Somebody has to support
> them, because there is going to be a lot of screwed-up guys, man.
> —Murray Bradshaw (Canadian Viet Nam veteran), in *After Shocks*

> If you're fine after what you've just experienced then
> there is something quite wrong.
> —Major Grace Pederson, psychiatrist in *Combat Hospital*

Weary Warriors has surveyed aspects of a global phenomenon in a historical period that still occupies the world: the age of war neuroses.[1] The persistence of neurotic soldiers as a recurring crisis implicates a bundle of relations having to do with the association between mental health and military capacity through the practices of military psychiatry. Soldiering, and its breakdown, is intimately tied to masculinity, its ideal, and its practices, as well as to the truth games played by soldiers, psychiatrists, scientists, physicians, chaplains, family members, bureaucrats, and politicians. In these crises, at stake are soldiers' and veterans' identities, their subjectivities, and their ongoing reconstituting presence in the various spaces of battle, convalescence, homecoming, and everyday life.

For our work, we had three overall objectives. Our first was to highlight how the conceptual categories of soldiers' neurotic minds, bodies, and souls emanate from specific practices in military psychiatry as well as how the physical expression of war neuroses are located firmly in soldiers' ill bodies, and to illustrate how these conceptual categories and constitutive processes have shifted over time in particular places and specific military conflicts, disclosing the porosity of both the categories and the soldiers' ill bodies. Our second objective was to elaborate on specific processes through which soldiers and psychiatrists in the context of many other actors (human and nonhuman) engage that generate, reinforce, and contest the enactments of psychologically and emotionally traumatized warriors. Our third objective was to extend the critical thinking and understanding of the practices that create, strengthen, and dispute the discourses about and the material existences of the broken embodiments of combat soldiers as well as the materiality of the discursive practices shaping their ravished minds, ill bodies, and troubled souls.

We accordingly sought to disentangle various sets of social practices and relations that give rise to the emergence of traumatized soldiers—specifically, practices and relations such as psychiatry, the military, and masculinity through venues such as hospitals, popular culture, the family, and state institutions. We accomplished this task by taking up atypical lines of inquiry, not always focusing on the obvious, and challenging conventional understandings of what a weary warrior is. We showed the impact of material-discourses on the way illness is experienced and we examined how specific forms of knowledge about emotional distress among soldiers and veterans circulate within psychiatry, the military, in the pastorate, and in society. Moreover, we focused on concrete cases to illustrate particular formations of power, knowledge, and resistance in how soldiers suffer trauma. We presented examples of how psychiatry and the military construct ill soldiers by means of diagnosis, regulation, punishment, disregard, and public policy. We conceive these ways of diagnosing, managing, subjectifying, fixing, depicting, and governing as having discursive-material effects on soldiers suffering psychic and emotional breakdowns in or after combat.

We employed poststructural and feminist theories for explaining the role of power and knowledge in the causes, onsets, symptoms, and treatments of trauma in combat soldiers. Discourse (as a set of material practices) plays a central role in shaping understandings of (an ontologically multiple) reality as well as expressing relations of power. Indeed, we paid close attention to the presence of multiple and often competing discourses about the health and illness of combat soldiers. Names of symptoms, diagnoses, and illnesses are unstable and contextual, alongside being con-

tested by various established professions and practitioners (Moss and Teghtsoonian 2008). We approached a history of weary warriors as a set of disjunctures in processes and contradictions in events that are manifest in official memories and countermemories. We were interested in how identities formed and in how soldiers took on any number of subject positions (via repeatable, recognizable scripts) depending on such factors as location and time period. Eschewing binary oppositions, while accepting the possibility of tensions, we embraced the coexistence of likelihoods and paradoxes, durability and frailty, human agency and social structure.

We have drawn out the notion of embodiment in the complex of an apparatus as lived bodies that are deeply discursive and deeply material at the same time that, in specific spaces, generates multiple embodied subjectivities and multiple ontological realities (Braidotti 1993; Grosz 1994; Hekman 2010). Within these discussions, ill bodies, minds, and souls are more than just ailing biological entities just as they are more than products of failed idealizations of healthy bodies. Ill bodies, just like ill minds and ill souls, are an effect of power relations and the production of situated knowledges in regard to both the material bodies and the bodily discourses of individual lives. So, too, are notions of masculinity, spirituality, and the relational extensions of soldiers, including family, friends, and psychiatrists. Thus, one of our arguments in this book is that the discursive and the material simultaneously constitute the subjectivity of the neurotic, traumatized, ill soldier.

Another argument made throughout the book is that over time a shift has taken place in the manifestation of symptoms of war neuroses and the description of the soldiers' ill bodies. Weary warriors engage in various struggles—in multiple battles (after Mol 2002). This is particularly evident in the proliferation of names for war neuroses and attempts by military psychiatrists and the militaries themselves to prohibit the use of certain terms at various times, such as shell shock, exhaustion, and fatigue; and to promote the adoption of other terms, such as PTSD, OSI, or TBI, for diagnostic, treatment, and benefits purposes. Soldiers' combat trauma comes in different forms and is interpreted, negotiated, or imposed in various ways. The use of any one of these terms discloses a particular reality that has material effects on soldiers' and veterans' lives, effects we have discussed throughout the pages of this book. More generally, in different sites, personal and collective relationships and procedures shape the shattered combatant's experiences in the numerous conflicts. "The practices of power unite the discursive and the non-discursive [material] into an indistinguishable whole" (Hekman 2010: 57). Yet, as we have shown, that indistinguishable whole is uneven with puncture marks, serrated edges, and crumpled surfaces.

A theme from our analysis is the always present contention of knowledge claims, including claims of what knowledge is, regarding combat-related trauma and emotional breakdown in terms of the causes, the prevalence, the diagnoses, the treatments, and the postdeployment supports for weary warriors. This contention of knowledge claims provokes debates, impositions, and resistances between and among psychiatric, military, pastoral, and governmental actors and institutions. As a consequence, war neuroses and soldiers' ill bodies have become the battleground on which the flows of psychiatric, military, pastoral, state, and familial power play out. These struggles have been going on for over a century in the armed forces: in the bodies of military personnel, in screening and recruitment practices, in treatment facilities on and off the battlefield, in military courts, in and around families, in society's depictions of trauma and mental stress, in national defense and veterans departments of government, and in welfare state programs.

Unlike Ben Shephard's (2000) account of military psychiatry over the twentieth century, we see that military psychiatrists were neither dramatists nor realists; rather, each one continually negotiated the tension between the practice goals of psychiatry and military imperatives through their psychiatric (diagnosis, treatment) *and* military (report-writing, grading, boarding) *practices.* The tension between the objectives of psychiatry and the military is only an organizing tool. The forces that facilitate the various shifts in naming war shock, generating traumatized soldiers as subjects, treating war neuroses, and supporting veterans include power and knowledge configurations that sit snugly within psychiatry and the military as apparatuses. It is through military psychiatric practices that the generation and transformation of psychologically wounded soldiers were constituted as the result of individual flaws throughout the interwar period yet considered normal throughout the second half of the twentieth century. The same force relations within different configurations of power and knowledge are seeking to differentiate the physiological effects of brain trauma and postconcussion syndrome from the psychological effects of posttraumatic combat stress and operational injuries at the beginning of the twenty-first century.

Over this time frame a unique double movement has taken place. First, there has been *a structured normalization of struggles* over the broken embodiments of combat soldiers and *a naturalization of trauma.* State propaganda is a notable element of this process of structured normalization (Matsumura 2004). This does not mean that combat and psychiatric disorders are regarded as wholly legitimate, or that they are socially accepted. Stigma, silence, and shame are perennial themes in the modern history of weary warriors. We suggest, rather, that war neuroses have become inte-

gral to operational goals of the military while remaining tightly connected to the individual soldier's body. With this integration, war trauma itself has been naturalized; the inevitability of psychological difficulties and emotional strain, including delayed mental stress, *must* be managed by armies using military psychiatry.

Second, and at the same time, there rages on *a vital contestation of praxis* that takes place through the various disputes over relevant theories and effective techniques for nervous disorders among soldiers. Critical tensions exist between the aims of psychiatric care and military duty, both of which rest on masculinist claims about knowledge and masculinist ideals of the ideal soldier. These tensions play out in specific processes that generate, maintain, and disrupt the linkages within embodied apparatuses that are then plugged into another one through the intertwined processes of the militarization of psychiatric wounds and the psychiatrization of military bodies. Implicated in this double movement is the experience of weary warriors as "bodies-in-time … embodied and embedded fully immersed in webs of complex interaction, negotiation and transformation with and through other entities" (Braidotti 2006: 154). Accompanying this coexistence of a structured normalization of struggles/naturalization of trauma and vital contestation of praxis is the ontological politics of weary warriors.

The Ontological Politics of Weary Warriors

Our work here has shown that an ontological politics of weary warriors emerge across several sites: whether wartime neuroses are the same as peacetime neuroses in terms of etiology; whether shell shock, Vietnam Syndrome, or GWS actually exists; and whether and to what extent the abnormal soldier is well. These questions beg a related one: Who "is entitled to define the norm, against those who deviate from that norm"? (Foucault 2003: 61). We have argued that there exist multiple ontologies of soldiers' ill bodies, ravished minds, and troubled souls, and that it is through the various practices in which the cast players engage that enact soldiers traumatized by the war as weary warriors. For us, it is clear that culture, no matter its scale, is not the differentiating factor that determines onset or form of battlefield breakdown. Similarly, we refuse the notion that there is a timeless, organic disease that manifests differently in each armed conflict. Nor do we embrace the idea that a war neurosis or traumatized soldier exists solely through the relationship between a therapist and a patient. We maintain that the bodies, minds, and souls of soldiers are discursive-material entities that are generated in a continual process of

becoming, and that the practices and effects of power fuel the mechanisms through which weary warriors themselves are enacted. Picking apart the complexities of specific sites yield access to these many mechanisms, some of which we have described across these pages.

An ontological politics also exists in the truth games of applying the classificatory knowledge of psychiatry; in distinguishing between real and simulated illnesses and efforts to detect malingering (the performance of making something real); in determining the resonance of how soldiers come to integrate war trauma into their ideas of what a soldier is or should be; and negotiating the dissonance between life after military service for individual veterans and what family life is really like for veterans and their meaningful others. Snippets of harmony and discord provide fodder for an ontological politics of the place of religious, faith-based, and spiritual outlets within military environments during war and peacetime. Likewise, the presence of ghosts as entities acknowledged by cultural writers as well as many combat warriors with severe trauma demonstrates the embodied nature of a nervous or emotional breakdown. The role of veterans' groups in challenging interpretations by governmental officials of their eligibility or not for particular services and disability compensation for those diagnosed with a war neurosis is charged with the same ontological tensions of psychiatric legitimacy and military authority. The seeming rigidity of a military institution, we have argued, is not a supreme universal simply producing purely docile military bodies. Soldiers' bodies resist warfare, resulting in an uneven exterior surface, continually mediated by the military through clinical scrutiny and multiple interventions, and as we have observed, through an intensification of the psychiatrization of military bodies.

Cultural representations of war trauma portrayed in literature, film, and television also are caught up in the ontological politics of weary warriors. For instance, what is the reality, if any, in *Mrs. Dalloway* by Virginia Woolf ([1925] 1996)? This fictional work, which features among other characters a veteran, is certainly influenced by Woolf's own struggles with mental illness and her troubling encounters with doctors as well as by the contested phenomenon of shell shock from the Great War. The words of Woolf seemingly echo in the lived experience of the Viet Nam veteran quoted at the front of this chapter; a Canadian veteran of an American war who, in turn, projects his knowledge of what is real for veterans postdeployment onto "the guys coming back from Afghanistan" (M. Reid 2010: 40). One of the main characters in *Combat Hospital* (2011), Major Grace Pederson, is a psychiatrist who deals with a wide range of psychiatric problems, almost all of which address some facet of PTSD.[2] Written into the storyline, however, is a tension significant in the wars in Iraq and Afghanistan; that tension

concerns the psychiatric distinctions between PTSD and mTBI. The reality of war trauma does not have a fixed, given status, but rather a changeable form within cultural and historical settings. The politics of ontology is about who gets to determine what belongs to the real, when it belongs, and how it belongs.

Ontological politics of weary warriors, therefore, involves actions and inactions by numerous individuals, groups, and institutions (i.e., the human and the nonhuman) with regard to the making, unmaking, and remaking of social realities in all the aspects noted above. It also involves struggles over shaping what is, could be, or ought to be made more real or less real (Law and Urry 2004: 396; Oksala 2012). Annemarie Mol (1999, 2002) offers a view of an ontological politics that we find congenial to our work. She defines it as "a politics that has to do with the way in which problems are framed, bodies are shaped, and lives are pushed and pulled into one shape or another" (2002: viii). It concerns "the conditions of possibility we live with" (1999: 86). She maintains that "*ontology* is not given in the order of things, but that, instead, *ontologies* are brought into being, sustained, or allowed to wither away in common, day-to-day, sociomaterial practices" (2002: 6; emphasis in original). To be part of the military, individuals require being established as military bodies, assembled, evaluated, and trained, and then directed to carry out particular tasks, commands, and routines. These activities occur through relations of power, interconnections of knowledge, and exercises of resistance that can result in multiple struggles, multiple battles. Of the jumble of relationships that comprise a soldier's social world, aspects that are privileged at any given time—the political ontology of the moment—affect what opportunities exist for meaningful interactions, what issues are up for discussion, how topics are framed discursively and materially, and what interventions are on hand.

These struggles are unmistakable when military bodies with emotional wounds and embodied trauma come up against established biomedical paradigms and clinical practices, and confront military understandings of what constitutes a real illness for soldiers whether it is the trenches of Europe, foxholes on Pacific Islands, or the mountains of Afghanistan. Veterans' activism and activism on behalf of veterans during and after wars has been a constant feature in modern times. Much of this activism has been undertaken by women.[3] More than political lobbies for pensions and access to a range of services, veterans' groups across nations have organized around raising awareness of their experiences of illnesses and mobilized around the legitimacy of lay knowledge vis-à-vis expert knowledge.

We can add a temporal dimension to the ontological politics of weary warriors. Instead of focusing on the linearity of time, we focus on the cycli-

cal, repetitive, discontinuous, and intermittence of time (after Deleuze and Guattari 1987; see also Braidotti 2006). For the individual soldier, there is the prospect of shifting symptoms and fluctuations in health and illness over days, weeks, and months or even a much more extended period of time, possibly over decades in the life of a veteran. The collapse and compression of time in relation to embodied responses to war trauma brings to the fore the issue of when the reality of an illness should be determined and by whom. For social movement mobilization, there is the process of one group of veterans with a contested illness, such as Gulf War veterans, learning from the tactics and achievements of an earlier movement, such as the struggle by Viet Nam War veterans. The struggle for recognition of delayed expressions of trauma in the form of Vietnam Syndrome or GWS, feeds into decisions about the provision of new services and support programs. Issues plaguing soldiers in the battlefield of the Great War seem somehow in accord with current conflicts, which illustrates the relationship of history with the present.

Even though we did not present a chronological account to neuroses in warfare, we have been very interested in exploring assorted configurations of the social relations of power along with the formation and circulation of various kinds of knowledge across a relatively long period of time. Having examined events from the mid to late nineteenth century to the early decades of the twenty-first century, we conclude there is nothing evolutionary about the names ascribed to emotionally tattered soldiers, nor has there been greatly enhanced clarity over the mental or emotional distress that combat soldiers experience. Shifts in the names of war neuroses have changed gradually and unevenly over long periods of time, revisiting previous iterations while marking identifiable points in the shifting nature of competing explanations and struggles in social relations over the applications of power and knowledge in specific places. Thus we reject a view of history as the positive unfolding toward better understandings of war trauma, better treatment regimes, better public images of mentally ill veterans, or better access to needed services and supports. We do not accept a conception of history that is inherently fatalistic about the possibilities of social change in ideas and practices concerning weary warriors, because of the force of psychiatric power or the heavy hand of military hegemony with its bureaucratic inertia.

We generally regard the history of weary warriors as uneven, jagged, contradictory at times, with both positive and negative effects; a history that is contingent and always contextual; a history with instances of learning and change and openness to new diagnoses, as well as opposition to innovative treatments, failing to learn or forgetting past lessons from specific armed conflicts and particular social settings.[4] Postwar social and

political milieus across the globe shape the ways in which nervous sol-
diers and veterans, inextricably tied to psychiatric diagnosis, treatment
practice, and masculine norms, are woven into the fabric of society. No
master narrative, no total history here; no general trend of inevitable prog-
ress. History is a series of discontinuities through which we can, to some
degree, map out certain paths of interaction such as those encountered by
soldiers within the history of psychiatric practice in the military.

Present practices by psychiatrists and other medical personnel in the
military remain tied to past debates over the reality of combat trauma and
over the best means to deploy ill soldiers. Pat O'Malley (2010: 491) aptly
observes, "Mental disorder in the battlefield has been the site of long-term
struggle between military psychiatry which frequently regarded this be-
havior as a symptom of psychogenic injury and the generally more perva-
sive view of military command for whom soldiers who 'broke' were weak
or cowards." While we have written about the psychiatrization of military
medicine, we have also noted a tension between psychiatric practice and
military imperatives. Concerns about malingering and overmedicalizing
the symptoms of combat-related strains remain as salient today as they
were a hundred years ago. In this way, we have engaged in writing a
history of the present (Foucault 1979, 1995). To put this in other terms,
we have written historical accounts or in-depth snapshots that disclose
associations between current terms and practices with earlier ones as-
sumed to have disappeared or been abandoned, or taken on fully as a
real thing. "Writing a history *of* the present means writing a history *in*
the present: self-consciously writing in the field of power relations and
political struggle" (Roth 1981: 43; emphasis in original). As a methodol-
ogy, Mitchell Dean (1994: 21) characterizes the history of the present ap-
proach as the "use of historical resources to reflect upon the contingency,
singularity, interconnections, and potentialities of the diverse trajectories
of those elements which compose present social arrangements and ex-
perience." Drawing out a history of the ravished minds, ill bodies, and
troubled souls of combat soldiers as a set of discontinuities discloses the
various sources of present-day standards and practices. Having done so,
we can now look toward making "intelligible the possibilities in the pres-
ent" (21).

Foucault and Beyond

Weary Warriors draws extensively from and engages vigorously with the
ideas and arguments of Michel Foucault across the many phases of his
thinking and writing. We have employed many Foucauldian notions, such

as *dispositif,* power/knowledge, resistance, classification, death, pastoral power, subjectification, psychiatric power, power-effects, docile bodies, familial power, truth games, and a history of the present. In our work, we advanced some critical interpretations, presented empirical applications, and offered our own conceptual modifications and extensions. Overall we engaged in a sympathetic application and elaboration of concepts from Foucault's considerable oeuvre. Our specifically feminist materialist approach assisted us in reformulating some of Foucault's key concepts in unexpected ways. Our ideas about how social practices are embodied and how these practices contribute to the fragile yet mobile subjectivities of weary warriors supported our empirical applications of feminist theory. Enactments, disclosures, and the ways in which discourse and materiality intra-actively, interactively, and simultaneously exist are part of the ontological generation of a weary warrior. Thus, our contribution to the burgeoning field of Foucault studies includes novel ways to engage his work.[5] In this final chapter we wish to briefly highlight a few concepts used by Foucault—specifically, the military, death, pastoral power, and confession—to indicate the ways in which our work contributes to extending Foucault's ideas theoretically and empirically, and to point toward possible directions for future work.

Foucault, though for a time fascinated with the potential of using war as a framework for examining power, never investigated armies or military power in great depth. As an institution, Foucault viewed the military as the codification of numerous relations of power and as the sovereign power of the sword, the power to kill. True, in some work he did look at the soldier, but usually in terms of his notion of docile bodies, thus emphasizing the hierarchical authority of the military and the passivity and submissiveness of the solider as easily managed and conformist (Foucault 1979). For our analysis this conception was problematic having left out, as it did, possibilities of human agency and resistance through specific and sometimes commonplace practices manifest in acts of military desertion, refusal to obey orders, self-inflicted wounds, malingering, and simulation of illness. So while we recognize the sovereign power and hierarchical authority of military establishments, we also take note of embodied resistance (observed in the Great War) as well as of informal relationships and social dynamics (acknowledged by some psychiatrists during the Second World War) as central to morale and resiliency of soldiers under combat. We were interested in exploring the fluidity of the military: both the changeable and variable elements in the armed forces; and the unstable, unpredictable, and volatile nature of military operations. We paid attention to cultural standards of masculinity, which fits nicely with Foucault's thinking on processes of normalization.

On the topic of death, Foucault viewed the military as a power of death, a machine of violence and destruction. Interestingly, he tended to stress the power of armies in the traditional sense of a repressive and coercive apparatus, and did not explore the more general theoretical claim he made in some works that there is a productive side to power. In his views on the relation between power and death, Foucault seems to follow the English political philosopher Thomas Hobbes, who put forward the proposition for "a general inclination of all mankind a perpetuall and restlesse desire of Power after power, that ceaseth onley in Death" (Hobbes [1651] 1968: 42). We examined Foucault's belief that power ceases with the death of the person and we showed that, for soldiers, power relationships are alive even in the realm of death. Even in death, soldiers are entangled in the sets of relations that were part of their ontological generation. Struggles by family members and friends for state resources, official recognition, and public remembrance of soldiers continue long after their death. We also offered the concepts of *public death* and *social death* to illustrate the empirical complexities of loss of life and the passing away of weary warriors even though both deaths remain part of a collective memory.

Pastoral power is an intriguing analytical notion introduced by Foucault but never fully examined by him. The same can be said of elaborating on the concept of the soul as a bodiless reality (Foucault 1979). We therefore devoted space in this book to consider the role of religious organizations within military contexts with respect to military chaplains and their roles and relationships with soldiers to show how the soul takes on its own embodiment. We noted that the armed forces have long been an institutional space in which pastoral power has operated. Our discussion on pastoral care and military personnel, in which we described the three types of work they commonly perform in the armed forces, concurs with Joanne Benham Rennick (2011: 16) that "religion retains significance for many people, especially in dealing with questions of values, meaning, and morals as well as issues relating to operational stress." But what of the soul, or that which is ontologically distinct from both the mind and the body? (Foucault 2010: 272; 2011a: 159–62). The idea of pastoral power in the context of weary warriors challenges the presumed binary on which war neuroses are defined: it is the mind that is broken, not the body. What happens when the soul breaks? And what does military psychiatry look like then?

Confession, for Foucault, was a concept used to describe a specific disciplinary technology of the self. Confessional practices certainly shape the subjectivity of weary warriors, as manifest in the plethora of autobiographical accounts of experience of nervous breakdowns and the way in which the body can confess mimicry of bodily claims to someone who knows how to read the body medically. Revelations of truths and untruths

are not just of a religious kind pertaining to one's soul, but also to the condition of one's mind and body, the boundaries among them porous. Spanning several processes, from preselection screening to postdeployment programming, recruits, trainees, veterans, and ill soldiers undergo litanies of tests and lines of questioning about childhood memories, family histories, and medical background. In part, this involves "obliging him to recognize himself in his past, in certain events of his life" (Foucault 2006: 270). Such confessional acts, along with being statements and divulgences of biographical truths and thus processes of self-recognition (on the way to some sort of self-knowledge), are relations of power and techniques deployed by psychiatrists and military personnel for the administration and management of soldiers. Confessions take place at different times and in different places as settings infused with particular relationships.

In the power-effects and resistance games as part of the games of truth, the other side of confessions has to be recognized: the nondisclosure, the denial, the misrepresentation, and perhaps the tactical divulgence. There are confessions to comrades and close friends of anxiety and fears of battle just as there are worries about home life shared in confidence with military chaplains. Conceivably there are contrived confessions to psychiatrists intended to secure an evacuation from active duty as well as extorted confessions obtained through techniques of psychiatric and military tribulations. Debriefing sessions at TLD sites serve as depots where incidents of trauma and stressful experiences are expressed in group sessions by individuals or groups sharing stories of battlefield experiences. And there are confessions to comrades in a peer support groups or sympathetic family members of being unwell and needing help. As weary warriors disclose their broken embodiments to others, they manifest their multiple subjectivities—not as an indiscernible mess, but as strategic embodied formulations that can hold a shape for a while as a particular soldier or veteran. We see then how intimate acts of confession about difficult topics and terrible deeds circulate within larger institutional systems, including psychiatry, the military, the family, the church, and the state, and are managed through cultural systems such as soldiering, camaraderie, fatherhood, and fraternity. In this sense, the weary warrior is the effect of multiple institutional processes and power dynamics which, in turn, warriors condition through their bodies, minds and souls, and discursive-material practices.

The Weary Warrior as Patchwork

The weary warrior as an analytical concept has many pieces; it is an ontological multiplicity. Most generally the concept is a theoretical and histori-

cally empirical construction of military personnel with utmost attention to combat soldiers and veterans in the armed forces, including the army, the navy, and the air force. We also have given specific attention to potential recruits, trainees, military deviants (or rejected soldiers), psychiatrists, and family members of those serving in the military.[6] Nonetheless, our prime focus has been on the deep emotional stress, the psychological trauma that combat soldiers encounter during service or as a result of engagement in battle. These are the traumatized subjects, the so-called screwed-up guys, some of which become segregated subjects confined to lunatic asylums. Some soldiers with war neuroses are constructed as dangerous subjects both to themselves (e.g., due to suicidal thoughts) and to their unit as a burden and as a threat to the group's morale. Such constructions of the weary warrior are a frequent cultural form and theme in film noir. Part of being failed combatants includes the emasculation of soldiers because they have failed to live up to the masculine ideal of the armed warrior, thus marring them in civilian life as weak, effeminate, and womanly. Of course, this matters for soldiers who are male and female. In this manner, as embodied subjectivities, weary warriors are military bodies subject to and generated by the practices of psychiatric power. Through the psychiatrization of military bodies, we have shown that any member of the armed forces becomes a potential psychiatric case or, at minimum, a case file with test results and interview notes and perhaps such additional information as a personality profile. From this, the weary warrior may become a diagnostic category, a soldier with the invisible wounds of a ravished mind and troubled soul.

In addition, we examined the construct of weary warrior as a broken embodiment, a fleshed body with the discursive-material realities of physiological symptoms, organic injuries, cultural restrictions, and societal rejection. We examined the weary warrior as a troubled soul with religious needs and spiritual concerns and perhaps a crisis in his or her belief system or faith. We also examined adjusted veterans that can reenact their broken embodiments under specific (and sometimes imposed) circumstances. afield, we have discussed the weary warrior as a moral category, the social construction of deserving and undeserving individuals based on their own conduct as soldiers (acts of heroism or fleeing from fear) and the goodness of the war (the Great War versus the Second World War, or the Viet Nam War versus the Gulf Wars). The weary warrior also carries with him or her competing power/knowledge configurations. There are tensions among what a soldier is feeling sensorially and emotionally, what the psychiatrist is observing physically and in the context of received psychiatric training, and what government bureaucrats cram into their tick boxes on the pension application form. Moreover, we have shown how the subjectivities of weary warriors are effects of the many folds of the mate-

rial part of the body, the relation between force relations, the relational connection between truth and being, and the outside itself.

In the realm of soldiering on, in life after the military, weary warriors of course are part of a welfare state category as clients of various benefits, programs, and services for veterans. A number of veterans, some of whom are weary warriors, also join the ranks of veterans as an active political constituency, bound by shared experiences, and involved in collective political action aimed at raising awareness and challenging prevailing psychiatric, medical, and governmental stances. These are weary warriors as political subjects. O'Malley (2010: 496) makes the point that "subjectivities within the military are not simply formed by military imperatives, but also are shaped by the liberal political environment, an environment that also shapes the nature of the military itself." In this liberal political environment, which is a fair description for Australia, Britain, Canada, and the United States, among other nations, some weary warriors are a discarded group, either abandoned or conceivably departed from family and other personal networks, the socially dead among us.

Without caveats we can say that weary warriors are all of these subjects, a patchwork, a multiple ontology, the effect of numerous material-discourses as well as several configurations of knowledge and power. As with any patchwork, there are discrepancies and disconnections, bindings and links, gaps and holes. As a tapestry, there are tatted patterns, creases brown with age, the folds somewhat automatic. The threads are densely intertwined in some parts, unraveling in others, creating an uneven yet sophisticated brocade with tattered edging. One can even see the effects of the reparation processes, the picking apart and cobbling together in both familiar and unusual ways. The pliability of the patchwork emphasizes that there can always be new folds, new threads, new stitching. Given the wide range of constitutive features shaping ill soldiers, there emerges uniqueness in the weary warrior, a specific discursive-materiality of the soldier's body, mind, and soul in lived spaces. We intend our use of the patchwork to indicate that modern notions of trauma are produced through multiple struggles; that what is real about weary warriors is the ubiquity of battles multiple.

Notes

1. Approximately 2.59 million American military personnel served in Viet Nam. In addition, about 300,000 South Koreans, 49,000 Australians, and 4,000 military personnel from New Zealand served. About 12,000 Canadians served in Viet Nam as part of the U.S. armed forces.

2. *Combat Hospital* (2011) is a Canadian and U.K. production of a multinational medical unit in Kandahar, Afghanistan, 2006.

3. For the Australian case after the Great War, see Tyquin (2006). For American women's involvement after the First Gulf War, see Shriver, Miller, and Cable (2003).

4. On the theme of forgetting lessons from past wars of anticipating the psychological breakdown of military personnel and the subsequent treatments, see Glass (1966) and Slight (1944).

5. We have detailed a reworking of *dispositif* (apparatus) in chapter 1 organized around embodiment that we do not repeat here.

6. Beyond our focus in this book, the analysis can be extended to others figures of combat-related trauma that include child soldiers, POWs, and special forces of a military.

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