

## 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 admiration, 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 perhaps 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 Boenhof-fer (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*, *Granatfernwirkung*, 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.<sup>1</sup> 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.<sup>2</sup> Roughly one in three American soldiers serving in Iraq and Afghanistan develop some degree of PTSD postcombat.<sup>3</sup> 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.<sup>4</sup> 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 Wesley 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.<sup>5</sup>



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.<sup>6</sup> 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.