

## Chapter 3

# Classifying Bodies through Diagnosis

## *Knowledges, Locations, and Categorical Enclosures*



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 soldiers, 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.<sup>1</sup> 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.<sup>2</sup> 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.<sup>3</sup>

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.<sup>4</sup> 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).<sup>5</sup>

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).<sup>6</sup> 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.<sup>7</sup> 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]).<sup>8</sup> Ensclosed 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
<i>Granatschock</i>	Gross Stress Reaction	Gulf War Syndrome
Hysteria	Hysterotraumatism	Irritable Heart
<i>Kriegsneuroesen</i>	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	<i>Névrose de Guerre</i>
Nostalgia	<i>Nostalgie</i>	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	<i>Schreckneurosen</i>	<i>Scrimshanking</i>
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.<sup>9</sup> 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 as 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
<i>Posttraumatic Syndrome</i>	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.<sup>10</sup> 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).<sup>11</sup>

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.<sup>12</sup> 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).<sup>13</sup> 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.<sup>14</sup> 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-trodden path might be to locate psychiatric wounds (hysterical mutism, hysterical 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 warriors. 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 descriptions of what was referred to as shell shock rested on the assumption 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 Westminster'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 offers 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	Not affected.	As in Case 1.	As in Case 1.
Movements			
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.<sup>15</sup> 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.<sup>16</sup> 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.<sup>17</sup> 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-



propriately. 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 *Symptomsverschiebung*, 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 having 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 ownership 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 rendered helpless while ensconced in a tightly woven hierarchy are in a difficult 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 disciplinary 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.