Chapter 6

Fixing Soldiers

The Treatment of Bodies, Minds, and Souls

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Curing Soldiers' Bodies

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Counseling Soldiers' Minds

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Caring for Soldier's Souls

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Facilities for Fixing Soldiers

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

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

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

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

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

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

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

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

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

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

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

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

Treating Weary Warriors

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

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

Notes

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

5. Reports of diffuse pain and migrating aches surfaced in the diagnostic parameters of GWS.
6. See also Leese (2002) for a description of the use of faradism to treat hysteria.
7. One of the CEUs had already operated relatively successfully, at least according to the military command, in the Italian campaign. During the Battle of the Scheldt, a psychiatrist was ensconced in a field dressing station for the First Canadian Army, even farther forward than the CEUs, to deal only with cases of battle exhaustion (Copp and McAndrew 1990: 141).
8. Aversive theory is akin to trauma re-enactment of the late twentieth century, except in the instance that the re-enacting was done on location with live artillery fire and threat of death.
9. Admittedly, the topics of pastoral power and religion are vast and extend over many histories, raising issues of the relationships of church and state, faith and civil society, and religious and military institutions, whereas spirituality and other worldliness intersect with the materiality and hellish world called war. A related topic concerns resistance to exercises of pastoral power (Foucault 2007: 204–14), a subject that we do not fully examine here.
10. Some chaplains are female, which stands in contradistinction to many formal religious doctrines. Note here that the soul is being taken up narrowly by the military institution. Whereas we might take up a conceptualization of the care of the soul through psychiatric practice, the military does not. The soul falls under the purview of spiritual leaders within specific religions.
11. Parallel to psychotherapy and psychoanalysis, care of soldiers' souls have been assigned to both chaplains and psychiatrists culturally through television shows, as, for example, Father Francis J. Mulcahy, an American Catholic priest, in *M*A*S*H;* and Major Grace Pedersen, an Australian psychiatrist, in *Combat Hospital*.
12. In the Second World War, Canadian Navy and Air Force chaplains "were normally at arm's length from the killing fields of their ships and squadrons," whereas Army chaplains "came into closest contact with the enemy" (Fowler 2006: 36). See also Crerar (2006: 14) on similarly varied practices in the Great War.
13. In the Great War, Canadian forces in Britain procured prewar health spas and resorts in England to treat wartime soldiers with nervous disorders, whereas the British operated hospitals that were part of the lunatic asylum network. However, this difference in treatment facilities largely disappeared when Canadian troops returned home, as "they were sent to existing provincial lunatic asylums for treatment" (Humphries and Kurchinski 2008: 110). For Australian soldiers during the Great War, a long voyage home meant psychologically wounded soldiers had engaged in some form of treatment. Nonetheless, upon arrival, a similar system to that of Canada and Britain emerged. Many soldiers with psychiatric illness were admitted to civilian asylums funded by individual states. Soldiers not finding places in the asylum were admitted to Australian auxiliary hospitals, which were private mansions, transformed into military psychiatric care facilities (Tyquin 2006: 79–80).