Chapter 7

The Soldier in Context

Psychiatric Practices, Military Imperatives, and Masculine Ideals

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

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

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

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

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

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

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

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

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

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

Context, Mangles, and Processes

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Militarization of Psychiatric Wounds

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

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

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

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

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

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

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

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

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

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

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

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

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

Psychiatrization of Military Bodies

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

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

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

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

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

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

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

"Did You See the Sunrise?"

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Fit of Psychiatry and the Military

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

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

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

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

Notes

1. Our use of "his" and "himself" are intentional uses of gendered pronouns.
2. Note that we use the word "wounds" here as opposed to "psychiatric illness"; the latter resists the dominance of both psychiatry and the military as disciplinary apparatuses.
3. Foucault notes that overcrowding in asylums limited contact between the psychiatrist and the insane or abnormal. But the principle still holds: in order for psychiatric power to operate well, the psychiatrist must have contact with the mad. This is not the case in the military.
4. For details about the structures in place for caring for wounded soldiers, see E. Jones and Wessely (2005a); Leese (2002); Lerner (2003); Shephard (2000).

   We draw out descriptions of the field practices from a number of sources. The sources we cite here are those with the most systematic descriptions of both the conditions leading up to the implementation of forward psychiatry as well as of forward psychiatry itself. Our account of the development of forward differs slightly from all these sources.
5. PIE was introduced after the Second World War to describe the principles. See Artiss (1963) for a discussion of PIE.

6. See the discussion in this volume, chapter 3, about classification and diagnosis.
7. John Appel, S. Alan Challam, E. W. Cochran, Roy Grinker, Martin R. Plesset, William D. Sharp, Herbert Spiegel, and Melvin Thorner were among the American military psychiatrists who, at the beginning of the Second World War, argued for the predisposition thesis; by the end of the war, they had abandoned it, replacing it with a complex set of factors contributing to combat breakdown including low morale, harsh natural environment, boredom, lack of appropriate training, bodily stress (e.g., trench foot), sexual deprivation, ineffective leadership, isolation, and lack of wider context for military campaigns, among others (R. Greene 1976).
8. For rates of breakdown in the early years of Viet Nam, see Binneveld (1997: 97), Shephard (2000: 340), and Wanke (2005: 18, 24).
9. The racialization of his trauma plays out in complex ways in this episode, indicative of the other ways race plays out in the series. African American culture is celebrated through references to jazz and sports usually, but not always, via TC. *Magnum, P.I.* is not a series that is often analyzed in the literature on 1980s primetime television in media studies. For racialized representations of characters on 1980s primetime television, see Greenberg and Collette (1997) and Stroman, Merritt, and Matabane (1989). See Brislin (2003), Gray (1995), and Hamamoto (1994) for insights into African American, Pacific Islander, and Asian representations, all of which play some role in the characterizations in *Magnum, P.I.*
10. The gendered aspect of delayed stress in this episode is central. The choice to bring this issue to the fore through a storyline of a female nurse who is now a surgeon layers the militarization of psychiatric wounds in interesting ways.
11. A remake of *The Manchurian Candidate* was released in 2004, with the setting changed from Korea and the Korean War of the early 1950s to Kuwait and the First Gulf War of the early 1990s.