Chapter 4

Managing Illness through Power

Regulation, Resistance, and Truth Games

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

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

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

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

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

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

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

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

Power and Resistance

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

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

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

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

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

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

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

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

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

Malingerers and Their Practices of Simulating Illness

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

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

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

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

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

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

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

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

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

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

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

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

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

3. Continual Observation (Surveillance). Carefully watching the soldier or veteran on a regular and at times unobtrusive basis over a prolonged period—at a field hospital, rehabilitation facility, outpatient clinic, or alcohol and detoxification unit, among other sites—offers opportunities to establish the veracity of the diagnosis and symptoms, or to determine that the presentation of clinical signs is missing, inconsistently manifested, or wildly exaggerated (Roussy and Lhermitte 1917; Yealland 1918). "Occasionally an unskilled malingerer may be detected flagrante delicto. … The appropriate treatment for a paraplegic man, who is discovered walking in the ward when he thinks he is alone and unseen, is to send him to the military authorities for punishment" (Hurst 1918: 28).
4. Verification of Records. A standard technique for determining the validity of claims is through collecting and confirming information about the soldier. This includes such methods as contacting relatives and reviewing family history, obtaining any previous medical records, and ascertaining military details that, in the United States for example, can be obtained through national service records and the national POW register. This gathered body of evidence may then be compared against patient-supplied information to confirm or challenge the truth claims of the ill soldier.
5. Confession by Person or Body. A confession, in this context, is not about a soldier admitting to a disorder but rather about a soldier owning up to shamming ill health. Confessing is a multifaceted phenomenon, a process with various dimensions: whether the confession is voluntary or forced (as under tribulations), conducted in the presence of medical or military personnel, judged as credible or fanciful, deemed to be punishable or not, and communicated by bodily signs and/or spoken words. In the military, confessions do not seem to be a major technique for producing truth about maladies or malingerers. Writings by psychiatrists, neurologists, and other types of physicians suggest that confessions of simulating disorders are an uncommon occurrence and not always straightforward, depending in part on whether the traumatic experience is a recent or distant event. An admission of guilt of malingering is not necessarily a true statement: "a confession is by itself no sure indication of simulation [of insanity]. A genuine psychotic may try to achieve

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> early release from certification by asserting that he has simulated" (Atkin 1951: 385). "Very rarely a malingerer confesses that he is shamming [convulsions or hysteria], but a confession should only be accepted if it is not forced from a man and it fits with the facts. … Such cases should be sent back to duty at once, but without punishment" (Hurst 1918: 28).
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> As well as by an admission through speech, a confession of malingering can come from the body itself through the presentation of dubious movements or other corporeal signs. As an American military publication for the Second World War warned troops, "the malingerer posing before a psychiatrist as a nervous-breakdown case will almost invariably meet with an unpleasant surprise. It is difficult to escape detection for the simple reason that a man cannot fake the dilation of the pupils in his eyes. This dilation, which can't be faked, accompanies the symptom of extreme jumpiness, which sometimes can" (Bresnahan 1999: 203). Here the body speaks the truth, disclosing to medical and psychiatric experts the true state of a soldier's health. Malingering, therefore, involves a double betrayal: the first, the act to conceal one's actual conditions; the second, discursive and bodily actions that reveal that actuality.

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

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

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

The health specialists who authored this report conclude,

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

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

Constructing Cowardice: Lack of Moral Fiber

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

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

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

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

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

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

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

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

Reassessing Deviant Soldiers

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

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

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

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

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

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

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

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

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

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

On Whose Authority?

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

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

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

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

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

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

Notes

1. Some of the terms related to resistance that Foucault used in his writings are "contestation," "perpetual agitation," "transgression," "struggle," "rebellion," "insurrection," "ruse," "opposition," and "interruption" (Hequembourg and Arditi 1999; Pickett 1996; J. J. Reid 2006).
2. The word "fragging" comes from a fragment of a grenade, and means killing a commanding officer by someone in the unit. Although popularized during the Viet Nam War, fragging was present throughout the twentieth century as a type of resistance among soldiers.
3. There is a deep-rooted literature on malingering, dating from about the 1870s, that deals with the simulation of disease or illnesses, both physical and mental, in relation to accident and life insurance and railway and tramway accidents; and to the establishment of state-sanctioned workers' compensation

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

4. The feminine is not only attributed to the soldier, but also to the type of care offered to the soldier. An article, "War Psychiatry," published in the *British Medical Journal* (June 16, 1916), identifies femininity—the women's touch in the care of wounded soldiers—as a contributing factor to malingering. Thus, "Simulators had a wholesome dread of the army doctor, but in these centers his visits were made at too long intervals. Infirmaries and lady volunteers were also responsible for much exaggeration by the wounded. Their very devotion tended to encourage morbid sentimentality in the men" (25).
5. Picric acid is a yellow-tinged explosive.
6. We are using the word "soul" in a way that is similar to Foucault (2001) and Rose (1999). That is, the soul is that which is ontologically distinct from the mind and the body. Although we have not developed the idea in any depth, we would maintain that it is a discursive-material entity.
7. Brandon (1996: 127) outlines the following official beliefs about the LMF policy: "1. Courage equated with character, and that it was possible to identify and select those with the 'right stuff.' 2. LMF was a dangerously contagious state. 3. The maintenance of morale depended on early identification and removal of 'waverers'. 4. Disposal of those unwilling to continue operational flying was not a medical decision. 5. Unless rigorous measures were taken, the operational efficiency of Bomber Command would be compromised."
8. Compare this remark to one by Foucault (1979: 135) in his discussion of docile bodies and soldiers: "By the late eighteenth century, the soldier has become something that can be made; out of a formless clay, an inapt body, the machine can be constructed." The British Army report cited here metaphorically suggests otherwise; that the clay of men is not a neutral material that can be manipulated any which way but rather varies in its own qualities and thus deviates in innate potentialities and limitations.

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