Emotion, Space and Society 10 (2014) 63–70

Contents lists available at SciVerse ScienceDirect

Emotion, Space and Society

journal homepage: www.elsevier.com/locate/emospa

Shifting from nervous to normal through love machines: Battle exhaustion, military psychiatrists and emotionally traumatized soldiers in World War II

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ARTICLE INFO

Article history:
Received 10 September 2012
Received in revised form
2 April 2013
Accepted 3 April 2013

Keywords:
Battle exhaustion
Deleuze and Guattari
Feminism
Love
Military psychiatric practice
World War II

ABSTRACT

At the onset of World War II, both military and civilian psychiatrists were keen on designating internal factors, such as, cowardice, an overbearing mother, or a henpecked father as determinants of war neuroses. By the end of the war, the notion that anyone could break down under extreme pressure displaced most other explanations of war neuroses. In this paper, using feminist emotional geographies as a framework, I look at how love contributed to this shift. I read three types of texts created through the practices engaged by military psychiatrists in the Canadian Army during World War II at three different sites—in units treating only exhaustion, at a convalescent depot, and at a field dressing station. These texts as both the outcome and record of Canadian military psychiatric practices in World War II form the basis upon which I read how love as a machine (a lá Gilles Deleuze and Félix Guattari) passes through both psychiatry and the military as it contributes to enacting a reality in practice (a lá Annemarie Mol).

At the onset on the Great War, debates over what constituted battlefield breakdowns were informed by contemporary ideas about the etiology of traumatic neuroses. Diagnoses of hysteria were on the rise after Jean-Martin Charcot demonstrated scientifically through the use of photographs that anyone, not just middle class women in America, could develop symptoms (see Didi-Huberman, 2003). Disputes over the origins of onset of hysteria, neurasthenia, and other traumatic neuroses can be organized around emphases on the psychical, the physical, or a combination of both. Psychical explanations, put forth by psychiatrists and psychoanalysts, relied on the central claim that war neuroses were psychical breaks arising from repressed sexual desire and emotional reactions to trauma (see Smith and Pear, 1917; see also Leese, 2002; Lerner, 2003). Physical explanations were located in neurology, the foremost rival to the rise of psychiatry in the late nineteenth century, and tended to focus on the physiological changes in the body as a result of trauma (see Mott, 1919; Myers, 1915). In clinics with neurologists, forensic psychologists, and psychiatrists, explanations emerged that focused on a symbiotic relationship between internal and external factors, as was the case with Hermann Oppenheim's research in his private clinic (Holdorff and Dening, 2011; Lerner, 2001).

Debates raged on throughout the inter-war period and psychical understandings of combat trauma became dominant. By the onset of the Second World War, military psychiatry subscribed to the idea that breakdown in battle was the effect of a key unresolved tension in the psyche. Psychiatrists traced war neuroses to internal factors such as weak moral fiber (coward), an overbearing mother (mama's boy), or a henpecked father (milquetoast). Incentives to reduce the high number of neuropsychiatric cases among combat soldiers[1] led to extensive screening programs in most militaries.[2] Collection and scrutiny of criminal, education, and medical records was

[1] By soldiers, I mean people in the armed services engaged in battle, mostly the infantry. However, screening was also part of sorting through the psychiatric characteristics of pilots and sailors as well as those in ground, service, artillery and armored units.

[2] Harry Stack Sullivan was the architect of military screening practices in the United Sates, ones that were integral to the enlistment practices of other militaries including Canada and Britain. Prior to being part of the military, he worked on early intervention for treatment of mental illness as part of a public health agenda. The design of the questionnaire focused on markers of mental illness that would predict combat breakdown. The principles underlying early intervention for treatment fueled the interpretation of the lengthy psychological questionnaires and the 15 min in-depth interviews, where the potential enlistee was naked, punched, and scrutinized for visible markers of inadequacy. Shephard (2000: 197—201) describes the initial impact of the policy decision among American army recruits by the unorthodox and demeaning methods of Sullivan. After Sullivan was fired, "the policy of selection he had initiated was not at first reversed. If anything it was intensified: selection procedures were made both stricter and more consistent" (200).

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http://dx.doi.org/10.1016/j.emospa.2013.04.001

introduced alongside personality tests—all with the purpose of screening out those with mental illness as well as those with behaviors that could lead to mental illness, including cowardice, homosexuality, extreme aggression, and physical disability. If any of the so-called morally weak slipped through the screening process, they were either discharged or assigned non-combat duties.

Yet out of this certainty, by the end of the Second World War, military psychiatrists were mostly in agreement that breakdown on the battlefield could happen to anyone. After having experienced the failure of screening techniques,[3] military psychiatrists sought out in more detail *who* it was that was breaking down in battle. During the first part of the Second World War, breakdown rates were similar to that of the Great War ranging from 1 in 4 to 1 in 3, peaking in longer drawn-out battles (Copp and McAndrew, 1990; Figley and Nash, 2007; Shephard, 2000). A typical conclusion drawn by military strategists from the consistency in breakdown rates as well as in what type of soldier was breaking down during combat—in both the European and Pacific war theaters—was that *everyone* has a breaking point.

Even though historians of military psychiatry and war neuroses agree that there was a shift over the course of World War II, explanations for the shift vary dramatically, ranging from understanding emotional casualties of war being inevitable (Jones and Wessely, 2005) to a pendulum swing between tender (dramatist) and tough (realist) approaches to diagnosing and treating war neuroses (Shephard, 2000).[4] What I am interested in is *how* this shift took place. How did psychiatric thought in the military break away from a firm belief that weak soldiers could be identified prior to enlistment and routed from armed services toward a universal idea that anyone could be weak given a particular set of circumstances in a relatively short period of time?

In order to address this question, I sought out detailed accounts of specific conceptualizations of emotional traumatized soldiers. I found some accounts in texts generated by Canadian psychiatrists during late World War II in a routinized military psychiatric practice, that of record-keeping and report-writing. In these accounts, I found several instances where psychiatrists expressed love as part of their understanding of emotionally traumatized soldiers.[5] Before presenting my readings of a set of these texts, I first locate my arguments vis-á-vis the feminist emotional geographies literature on love. I then lay out my conceptualization of love as a machine (à la Gilles Deleuze and Félix Guattari). I next draw out the notion of an enactment of a reality in practice (following Annemarie Mol's work on multiple ontologies) to show how love as a machine is part of the practice of forward military psychiatry.

1. Feminist emotional geographies

Feminist geographers have a long-standing interest in how discourse and materiality play out in the everyday lives of individual women. Attention to emotion as part of the everyday has rejuvenated interest in the discursive and the material and has led feminist geographers to the task of teasing out how conceptualizations of emotion constitute place and space (Bondi, 2005; Dawney, 2011; Morrison, 2012; Thien, 2006; Tolia-Kelly, 2013) and how emotions are integral in understanding healthy bodies (Parr, 2008; Parr and Davidson, 2010). Feminists have also explored how place and space figure into emotions across a range of topics, including for example, geospatial technologies, social ontologies of practice, rhythms of sound and body in public festival spaces, and yoga practice in gentrified areas (see Duffy et al., 2011; Kern, 2012; Kwan, 2007; Simonsen, 2007). Feminist geographies of love, a growing part of feminist emotional geographies, are increasingly attentive to various aspects of love as both a concept and a topic of inquiry (Morrison et al., 2012).

Traversing the terrain of feminist emotional geographies and feminist geographies of love is not only complex, but also rife with possibilities. In reading the literatures side by side, I found three lines of inquiry outside the expected discussions of space and place: the process of conceptualization, accessing the non-apparent, and ontological claims about knowledge production. Conceptually, feminist geographers seem to be committed in general to keeping both the discursive and the material within conceptualizations of love in emotional geographies, without compromising the politics of both everyday life and the collective. Critical inquiry among feminists interested in women's bodies and emotions seeks to disclose that which is not obvious even when scrutinizing topics that are mundane and commonplace, like love as feeling, desire, affect, and passion. Ontologically, feminist geographers are attending to inquiries about embodied emotions, including love, in non-essentialist terms. These three themes frame my inquiry into the generation of emotionally traumatized soldiers as nervous at the beginning of the Second World War and as normal at its end.

Psychiatric understandings of combat soldiers' emotional trauma as well as the soldiers themselves rely heavily, if not exclusively, on diagnostic categories, rather than the routinized, ordinary military psychiatric practices that produce the categories. In this study, instead of focusing on psychiatric practice in the military as military psychiatrists would, I focus on a set of specific practices by psychiatrists in the military, that is, a set of mundane, everyday practices that psychiatrists engage in because they are a part of being in the military.[6] The information generated from these practices—in the form of text—can show how military psychiatrists come to understand emotionally traumatized soldiers. By refocusing on habitual practices, I am able to observe some of the non-apparent mechanisms in play—like that of love—that contribute to the wider shift in understanding emotionally traumatized soldiers as normal instead of nervous. By focusing on the *doing* of military psychiatry, I can position myself to examine *how* the shift actually took hold. As a rich source of information, the texts generated by military psychiatrists for the military can show (at least partially) how the shift from nervous to normal took place. In particular, they can show how a fused notion of discourse and materiality plays out through a routinized practice in understanding individual soldiers as well as groups of soldiers who have broken down in battle; how seemingly innocuous descriptions of assessment strategies, disease categories, and treatment regimes come to redirect a hierarchical institution's view of emotionally traumatized soldiers; and how love as an embodied emotion surfaces in the texts as a mechanism through which this shift takes place.

[3] The rejection of screening was not based on the invasion of privacy or principles of rights, as might be expected in the twenty-first century; rather, screening did not produce the desired effect, that is, fewer battlefield breakdowns. As noted, screening actually intensified, but the purpose for the screening was no longer linked to battlefield breakdown; rather, screening was linked to mental combat fitness.

[4] For a range of views on this shift in the context of World War II and other twentieth century wars, see for example Binneveld (1997), Figley and Nash (2007), and Micale and Lerner (2001).

[5] My use of "emotionally traumatized soldier" places my thinking in a contemporary timeframe. I only use this term to give me conceptual distance from terms used at the beginning and end of World War II, that is, war neurotics and exhausted soldiers, respectively.

[6] Much of the literature in military psychiatry focuses on the narrow definition of practice that solely involves the psychiatrist and the soldier (see, for example, Kennedy and Zillmer, 2006; Figley and Nash, 2007). I am using practice more generally as an act, event, or encounter that military psychiatrists engage in as part of their military duties as a psychiatrist.