"People get flashbacks. People drink to get rid of it. Drink and drugs, whatever. But you can't get rid of it. It's always gonna be there. You can't do anything to get rid of it." Soldier Edward Wallace is a normal person, but he does not deal with normal situations. As a soldier he is put into life threatening situations on a regular basis, and after his work is over he is supposed act as if nothing happened. He is supposed to act as if nothing has changed. But the truth of the matter is, when war is in the mix everything changes.

Often a soldier, like Edward Wallace, goes through changes in his mind, his body and his soul. Change can be a good thing. But for soldiers returning from the Iraq and Afghanistan war, like many from the wars before them, change means dealing with extreme pain and unrest within their bodies and their minds. Most often these wounds are silent and inconspicuous, a potent combination if triggered at the right time. These wounds are referred to as “signature wounds.” Post Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI) are the clinical or scientific terms for the “signature wounds” from the Iraq/Afghanistan war. The most recent figures from the Warrior Transition Battalion (WTB) stationed on Fort Carson, in Colorado Springs Colorado, puts documented cases of PTSD and Traumatic Brain Injury (TBI) at 52% and on the rise. The Rand Report states, “Of the 1.64 million service members who had been deployed for OEF/OIF [Afghanistan/Iraq] as of October 2007, we estimate that as of April 2008 approximately 303,000 Operation Enduring Freedom (OEF)/ Operation Iraqi
Freedom (OIF) veterans were suffering from PTSD or major depression.”² These figures are not quite as high as the percentages I received from the Warrior Transition Battalion on post at Ft. Carson, but remain significant across the spectrum of US armed forces. There are many other cases of PTSD and TBI that remain undocumented and undiagnosed. The question is, how do we treat and re-assimilate these wounded soldiers back into society? How do soldiers treat and cope with the wounds themselves?

Some soldiers turn to prescription drugs and medication to cope with the “invisible wounds” and injuries suffered in war. Soldiers can also turn to alcohol and elicit (recreational) drugs as a method of coping with combat stress and symptoms of PTSD. Soldiers are often treated with prescription medications by clinicians and use other drugs to help ease the transition from war to the civilian life. Medication is necessary to ensure the stability and comfort of a soldier and it is often used successfully to help treat soldiers dealing with multiple and rapid redeployments to theater. Medication in the military is normalized, by which here, I mean that there is a routinized clinical practice that is observed and maintained to help treat soldiers with post war difficulties and stress. “Recreational” substance use- alcohol, recreational drugs (marijuana, narcotics, ecstasy) and recreational prescription use- in the military is also normalized. There is a culture that can be identified, even one that is monitored and controlled by medical institutions and care providers, around heavy drinking and prescription drug use that occurs frequently upon returning

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² Rand Invisible Wounds of War Study, Rand Corporation, March 24, 2009
home from war. Soldiers are looking for a way out, an escape route from their wounded minds, bodies and souls.

On the one hand, soldiers can explore the route of clinical medication and institutionalized medicine, and on the other hand soldiers can explore the route of drinking, partying and other drug use as a way of “self-medication.” Soldiers can also pull from both routes of treatment, operating in a self-determined middle ground of treatments and coping mechanisms. In light of these factors we arrive at a conceptual disconnect. Is there a line between “proper” clinical medications and “self medication” beyond the scope and purpose of what a drug is intended for? Is it possible to successfully navigate a middle ground between the polarities of treatment? I intend to conceptually explore the line between normalized clinical medication and normalized “self-medication.” I intend to illuminate how both treatment routes can be used, normalized and socially accepted and how they may be incorporated together as an integrative treatment route (or middle ground).

No method of treatment is perfect and it is important to identify how soldiers themselves are coping and what treatment routes they are taking. In this paper, I argue that each method of treatment is its own dynamic that is normalized and socially accepted. These methods must be analyzed as separate entities but careful attention must be paid to how they are intertwined and navigated by soldiers at the same time (middle ground). By this I mean the contested middle, where a soldier as an individual actor, draws from each normalized treatment ‘scope’ to help alleviate the stress and pain from returning from war. In one context, individuals might be resistant to the institution and clinical procedures and could turn to personal
methods for anxiety, stress and other symptom relief. While in another context soldiers may ascribe to clinical help, but use these treatment options in their own ways, or in ways that are accepted by their social groups. For the specificity and scope of the paper I will focus primarily on alcohol and prescription drugs and the ways they are normalized and socially accepted.

These substance use patterns exhibited by soldiers go hand in hand with the high-risk behaviors that soldiers are routinely exposed to, which they become accustomed to during active duty. In World War II there have been many documented cases of amphetamine use to increase patrol time, along with cigarettes being issued as part of their rations. Following World War II the use of illicit drugs such as marijuana and heroin in Vietnam was widespread and highly publicized. Substance use, such as heavy drinking, as a means to cope with the stresses and horrors of combat have been employed in almost every war since the creation of America and even while fighting for freedom from Great Britain. “Rations of rum were deemed essential for soldiers’ morale in the American revolutionary army and the picture of the hard-drinking US serviceman has persisted,” (Bachman, Freedman-Doan, O’Malley 1999: 672). Until 1980, when a zero tolerance policy was adopted regarding illegal substances, substance use while on tour and upon returning home was almost a normalized factor of every day military procedures (Bachman 1999: 672). Upon the insertion of this new policy, substance abuse immediately became stigmatized and carried career consequences for servicemen and women caught while using.
Often people, not just soldiers, feel excessive pressure from their physical and social environments throughout life. When stress levels reach a breaking point there are a few predictable stress responses such as difficulty sleeping, inability to concentrate and a hyper awareness or vigilance in every day activity (McElroy, Townsend 2009: 268). A Ft. Carson neuropsychologist, Lonnie Nelson, described the concept of stress to me during an interview with him.

Any given person under enough stress, they will develop psychopathology, and it doesn’t matter who you are or what your makeup is. There is a breaking point for everyone. The further you can get people away from their individual breaking point, wherever that may be, the better off...Anything that manages stress is going to be helpful...family or actions. For some people, that’s a source of stress. It depends on the individual.

Stress is theorized as being an internal defensive process to external stressors, whatever those stressors may be. For soldiers stress comes directly from combat and the nature of their work. Being on constant alert in theater takes its toll on the brain and the soul. The stressful combat environment in war ensures a hyper vigilant state in a soldier’s mind. This hyper vigilance is hard to move past once a soldier is back home in safety. Chaplain Arredondo on Ft. Carson alludes to this idea of hyper vigilance at home that simply cannot be turned off.

[you will] always be looking over your shoulder when your driving. And you’re at home in a safe zone. Being able to say to yourself, ‘I don’t need to check out people that are here are in the United States.’ They’re not going to pull out a gun a shoot me. And I don’t need to carry my weapon with me any more. They’re used to carrying their weapons. And being on alert on guard.³

³ Field Work Ft. Carson Colorado, Data reserves (NVIVO database), Colorado College
Stress is a phenomenon that lingers in a soldier’s mind and PTSD is a response to lingering stress that consumes most soldiers after war. In soldiers, stress can manifest itself in many ways but the most visible, and most common, is PTSD after returning home. Soldiers, as people, must navigate different methods to deal with stress and anxiety that is a natural part of their occupation.

Most soldiers thrive on adrenaline, and when this chemical primer is taken away it is only natural to search for other chemical substances and dangerous activities to replace the rush they get from war. When the idea of adrenaline loss is compounded with behavioral health issues such as PTSD soldiers find themselves feeling very empty not only in their minds but their bodies and souls as well. The Iraq war has seen the highest reported instances of behavioral health issues ever recorded in the Military. This is due in large part to the reduction of the stigma around receiving treatment for mental health issues after returning from combat. This potent ‘stigma’ that is gradually being dissolved around the military, and especially at Fort Carson, derives much of its gusto from the macho or ‘suck it up’ attitude found in many militaristic ideals. It a can even be seen in the Army motto “Are you Army strong?” Hautzinger (2010) describes this attitude, “The main problems that Soldiers identified with being labeled as having PTSD were “not being able to handle” combat and “looking weak,” on the one hand, and “letting people down,” especially their fellow Soldiers, on the other hand soldiers emphasized how weakness affects one’s own sense of self as well as the respect of equals and superiors” (Hautzinger 2010: Michigan Paper pg 8).
Many of the problems associated with PTSD were previously derived from soldiers refusing to get help and then blowing up in an instant from a trigger that provided them with a dangerous flash back. As the culture is shifting around the Army, the phrase “Army strong” now points to a different direction. Hautzinger (2010) notes “General Mark Graham is up on stage at the Warrior Care Summit in June of 2009. The Summit is his parting contribution before he resigns garrison command of Ft. Carson, designed to bring behavioral health care at the post to a whole new level” (Hautzinger 2010: Michigan Paper pg 12). General Graham, Garrison commander at Ft. Carson is in charge of shifting Ft. Carson’s reputation of neglect and ignorance of mental health issues to a post that is on the forefront of treating and reducing the stigma around mental health issues. At Ft. Carson the culture is shifting to the idea if a soldier seeks help, they are being “Army strong”\(^4\) and their manliness is no longer fully in question. Hautzinger alludes to this cultural change in the army, “Army programmers have clearly registered the problematic symbolic dichotomy in soldiers’ minds between being Army Strong and invulnerable on the one hand, and implications that those with PTSD are falling victim and weak on the other. In response, a none-to-subtle effort has been made to extend the core metaphor of Army strength to those seeking help” (Hautzinger 2010: Michigan Paper pg 13.) However, the idea of coping with the symptoms of PTSD, even though the disorder is much more transparent in today’s Army, remains a much more complicated issue with problems yet to be discovered.

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\(^4\) Sarah Hautzinger, Michigan Paper 2010: 14
PTSD is a complex phenomenon, or disease as many providers refer to it, that has yet to be understood fully and may never be understood completely. This is surely due to the almost opaque nature of warfare to the outside observer. There is a significant amount of pain that is associated with war. A pain that carries multiple dimensions and manifests itself in many different ways. Pain is a significant symptom of PTSD and when soldiers turn to substances, they are attempting to dull pains that have built up during their tour of duty. Psychotherapist Edward Tick alludes to the concept of pain in veterans, not only the concept of physical pain, but something that could be argued as much more painful, moral pain.

Isaac Bonilla was in pain every minute of his postwar life - not just physical pain from his wounds, but also moral pain from his betrayal and loss of his Puerto Rican brothers. He was additionally in pain, as many minority group veterans are from fighting “the white man’s war.” He was usually medicated, but his soul’s pain waited as if a booby trap was inside him, ready to explode again at any moment. Pain like his that is carried for life is not just an indication of too much stress, or a psychological stressor being triggered. Rather, it is a marker of moral trauma.5

Tick describes the different levels that PTSD and TBI can encompass and alludes to the pains that are certain to be received while participating in war. With complex emotional, bodily and soul issues that almost every soldier who has seen combat has to deal with upon returning home self medication is certain. However, a fine line exists between self-medication, prescribed medication, and abuse or addiction. It is necessary to determine where that line falls. Soldiers, once civilians, must exist as they did before they observed and participated in the horrific nature of warfare.

5 (Tick 2005: 116)
Substances have proven to be a viable way to maintain veterans and in some cases active duty soldiers day-to-day existence. But the line remains.

Ultimately, a soldier’s response and coping mechanism depends entirely on his or her own self. Michael Foucault in the History of sexuality describes a person in relation to the institutions that a person occupies and exists within. The medical institutions of the army are set in place to regulate and ensure the care and comfort of each returning soldier. However, when it comes to a person’s individual health it is essentially up to them to decide how to cope with their situation. Foucault alludes to this idea in the third volume of his work, ‘The Care of Self.’

One seeks to make oneself as adequate as possible to one’s own status by means of a set of signs and marks pertaining to physical bearing...It is then a matter of forming and recognizing oneself as the subject of one’s own actions, not through a system of signs denoting power over others, but through a relation that depends as little as possible on status and external forms.6

Thus, according to Foucault, a soldier himself/herself determines a great deal of how to cope with the stress, anxiety and other problems that are associated with returning home from war. Yet, much of the “self” is in relation to the social groups and normalizations that a soldier is accustomed to by being a soldier. As I alluded to in the introduction, a soldier can seek many different routes to cope with war. Some soldiers take it upon themselves to cope beyond what the medical institution of the Army has to offer. And, in essence, they are actively resisting the faculties and regulations of the institution that is designed to help them, whether it is conscious or not. Other soldiers wander the middle ground, between active resistance to the medical and regulated realm and full participation with medical professionals and

6 (Foucault 1986: 85).
Army response programs. Furthermore, a soldiers journey to recovery, while being reliant on “self” is also normalized and socialized within their social circles, so that patterns of treatment methods can be observed and contextualized. These methods, which I have highlighted already, are concepts of “self-medication” through alcohol and abuse of prescription drugs, clinical care and use of prescription drugs, and a middle ground where both “self-medication” and clinical care is implemented to help alleviate symptoms of PTSD.

Before I continue, it is necessary to highlight and fully explain the theoretical concept of normalization that will be the backbone of my analysis into the polarity of treatment routes soldiers can explore after returning from war. The idea of normalization was conceived by sociologist Wolf Wolfensberger, who defined the term as being about stigmatized or deviant individuals becoming incorporated into everyday life and their behaviors becoming accommodated, and sometimes even valued (Parker 2004: 205). Since then, the concept of normalization has been restructured and redefined, especially in terms of drug use. Parker (2004) defines normalization in terms of a “multi-dimensional tool kit, which highlights the way illicit drugs consumption, particularly by conventional ‘ordinary’ young people, has grown in importance within lifestyles which are themselves evolving in response to structural and global changes in post modern societies” (Parker 2004: 206).

Therefore, the term normalization can be used in reference to a larger theoretical paradigm, or conceptual framework, that relates to not only the behavior and normality of smaller social circles, but also to the larger institutions that most small social circles interact with. For the context of my paper these social circles will
pertain to the intimate Army units and the individual soldiers themselves in contrast with the larger medical institutions designed to help. Both entities are normalized and accepted by society in their own right. The idea of normalization can be intertwined with the idea of individual “self” to completely highlight the different methods soldiers maintain in search for a response to the stress, and anxiety imposed upon them by the nature of war.

Most of my data was collected through field research and formal interviews on Ft. Carson military base in Colorado Springs Colorado. Interviews and field notes were collected during the summer of 2010 and will provide the bulk of the substance in my argument throughout this paper. For the research process I collaborated with two professors and three other students all working within the same framework of the military but each with different research focuses. Other scholarly literature, newspaper articles, magazine articles, Internet blogs and statistical studies have been reviewed to help inform my discussion throughout the paper. Each subject has been given a pseudonym to ensure the privacy of the informants and research subjects.

Recent studies from 2004 to 2006 by the Substance Abuse and Mental Health Administration has shown that nearly 7.1 percent of veterans7 (about 1.8 million persons 18 or older) from the most current war met the criteria for a substance abuse disorder. This figure certainly leaves out a significant portion of the population that either did not respond or lied about their substance abuse patterns.

7 National Institute on Drug Abuse
during the research survey. The National Survey on Drug Use and Health (NSDUH) reported on substance use, dependence and treatment among veterans. The report provides estimates of substance use, dependence, and treatment for the year 2003. The survey compared substance abuse patterns of American civilians to those reported by veterans. The survey found that an estimated 3.5% of veterans used marijuana in the past month before the survey compared with 3.0% of the non-veteran counterparts.8

Similarly the heavy use of alcohol was more prevalent among veterans, 7.5% users, than among non-veterans with 6.5% of the population being considered as heavy users. Further, an estimated 0.8% of veterans received treatment for a substance abuse disorder compared to 0.5% of non-veterans. These trends indicate more substance abuse problems among veterans than the remaining civilian populations. It cannot be proved if combat stress is the leading cause of these elevated numbers around substance abuse but logic certainly points in that direction.

Anthropologist Catherine Lutz discusses the idea of substance abuse as a result of combat stress in her ethnographic work, “Homefront.” In her discussion of veterans returning from Vietnam she recounts a story of a young soldier driving drunk and being pulled over by the sheriff. An informant who was a third party observer to the story received the account.

Being new to Fayetteville in the early 1970’s, criminal lawyer Kirk Osborne took a sheriff’s nighttime ‘ride along’ to get his bearings. As the squad car he was in turned down one road just north of town, a great halo of light suddenly appeared ahead of them on the highway.

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8 The NSDUH Report November 10, 2005
The apparition drew closer, until they could see that in fact a salvo of sparks caroming off a car’s underbody. The driver was a soldier just back from the war in Vietnam, so completely smashed that he had not noticed his flat tire through the burning off of every iota of rubber and the cacophonous grinding down of the steel rim.

The man who eventually staggered from the car was barely twenty and had already seen more horrors than the average person would care to consider. He had emerged alive from a year of bullets flying by his ears, perpetrating murders and mayhem. His soul was broken, yet his still a human being attempting to recapture some sort of order and relief for himself (Lutz 2001: 131). He is attempting to dull his pain. His story is all too similar to many kinds of stories that are told by Americans about returning soldiers. It may seem as though this could happen to anyone, not just soldiers, but the frequency it occurs in military towns and around bases cannot be ignored.

Military culture is no stranger to alcohol. Nor is American culture. According to the National Survey on Drug Use and Health (NSDUH) slightly over half (51.2%) of all Americans ages 12 and above reported being current drinkers of alcohol, which means nearly 126.8 million Americans partake in the consumption of Alcoholic beverages regularly. Alcohol is a substance (along with tobacco) that has become normalized into the American culture that is deemed to be ok to use on an occasional basis, regardless of the potential harmful and addictive effects it can have. Among young adults (18-25) in the United States in 2007 the rate of binge drinking was 41.8%, and the rate of heavy drinking was 14.7%. These figures represent a large part of the young adult population, which is the majority age group

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9 2007 Substance Abuse and Mental Services Administration (NSDUH)
for most active duty soldiers, who indeed partake in some sort of binge drinking or heavy drinking. Thus the culture around alcohol and young adults fosters a normalized sense of substance abuse that often manifests itself at a subtle level, but poses huge problems to greater society. Even though alcohol abuse has been a mainstay in military culture for almost all the wars this country has seen, the rates of alcohol consumption, in the wake of the most recent wars in Iraq and Afghanistan, are notably high.

Increased alcohol consumption can be a good indicator of high stress levels at the work place. For soldiers, the work place is war and war is very stressful. The drastic rise in alcohol use is represented in the increase of active duty soldiers seeking treatment for alcohol dependence, which has almost doubled since 1998. The figures have jumped from 7.2% of active duty soldiers reporting alcohol abuse problems in 1998 to 11.4% seeking help in 2009. However, this surely cannot encompass the entire scope of the problem, as all active duty personnel do not commit themselves to help even if they have a problem.

The hard drinking US Army soldier is a theme in most soldiers' lives. Drinking is romanticized, accepted and normalized into many unit's culture before and after war. When soldiers return from war their lives exist normally, except each soldier takes normal activities to the next level. They push the limits on any social and individual activity in hopes to take their mind off the war they had become so familiar with. To an average civilian, a soldier's lifestyle is over the top, and more than the usual. Soldiers drink too hard, put themselves into danger too often and

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10 USA Today “Alcohol abuse by GIs soars since ’03” 6/19/2009 (source Army Times)
drive their motorcycles and cars too fast. But in the end these practices, for the soldier, are entirely normal, and have been normalized since the inception of battle. They are normalized because each person in their close knit social network exercises the same practices. It is rare for a soldier to hang out entirely with civilians and not their battalion. And when this social network is rarely infiltrated by outside cultural practices, certain social behaviors, such as heavy drinking and thrill seeking becomes normalized. Soldier Stuart Gallup, informant in the project, alludes to this idea of heavy drinking with his unit:

I like to do a lot of outdoors stuff. I'll go out and do a bunch of things just to keep me occupied. I'll go to the gym, go run or do something. Then normally, a lot of us, a lot of us, especially in an infantry battalion drink, a lot, a lot. Most people will tell me, like civilian people I know will tell me its not normal what we do. Do you hang out with the guys from the infantry a lot? That's all I really hang out with, I only have a few civilian friends. Mostly we all hang out as a group, especially in my platoon, we're pretty closeknit.\(^\text{11}\)

Civilians who are not accustomed to the military lifestyle often express their concerns to Gallup. However, soldiers rely on each other and their normalized high intensity lifestyles, with excessive drinking as a way to cope with civilian life back at home in the states. In this instance PTSD cannot be the sole reasoning to drink excessively, but merely auxiliary to the normalized social behavior that each soldier becomes accustomed to while deployed and while becoming closer to fellow soldiers.

Later in the interview, Gallup ventures into using drinking as a means to cope with the high intensity lifestyle that is associated with the military. It is often

\(^{11}\) NVIVO Data base, Colorado College
not explicitly said by soldiers, as they are made to feel like addicts, but many notice that they do in fact seek routes to feel stable again, and some are much more normalized, especially in a small unit.

[why do you think army drinks more than civilians?] The army life takes a lot out of you, a lot, and especially in the infantry. It takes quite a toll. Especially people coming back from deployments, people are trying to make up for what they lost. and then also for some people they use it as a coping mechanism.¹²

Thus, it is normal in a soldiers perspective to drink excessively to deal with what they have seen in war. This normalization is especially true when soldiers are together in small groups they become accustomed to during war. Drinking as a social practice is a factor of every soldiers life, after returing home, and a practice that may be frowned upon by many institutions in the civilian and medical world. Drinking during and after war has been throughout history and remains a very cultured and socialized process today. Hank Nelson, an infantryman understands the signs of PTSD after returning from war, and highlights the normative way that soldiers deal with the symptoms.

Some signs of PTSD: excessive drinking, trouble sleeping, chronic sleep issues, jumping at sudden noises, getting anxious, short temper. Okay, again we're army infantry. I know very few Army guys that don't drink a lot. The guys who have been deployed over the new guys who have not been deployed I'd say we drink a little more excessively. The next one was sleep problems, that kind of goes hand in hand with drinking sometimes. I used to have a horrible time going to sleep, like I could not sleep for the life of me; any tiny little noise would wake me up and so I started taking Ambien and some other sleeping thing and that worked out for a while. And I got tired of going to the hospital for refills so I just started drinking and that kind of resided and now it just comes and goes but for the most part sleep's good.¹³

¹² NVIVO Database, Colorado College
¹³ NVIVO Database, Colorado College
Nelson understands that his symptoms are fluid and constant, making him search endlessly for a method of acceptable and successful coping. In his words we see that he attempts to walk the line between committing to the institution and using his own methods while caring for himself. Not only does he drink more than an average person would but he also ascribes to taking sleeping medication laid out for him by a practitioner. He does not allude to any other prescription drugs that might be available to him, but the idea that he is acting within two different normalized processes, in the medical realm and in self-interest, remains true.

Soldiers have certain normalized social practices around substances such as alcohol as a means to cope and may refuse medical attention because of this. Other soldiers may seek help from the institution but not fully participate in the treatment available to them. Neither socialized alcohol abuse nor institutionalized medicine may fully treat a soldier dealing with anxiety and stress, but a polarity in normalization can be seen. Often a soldier will attempt to act within the institution or be made to participate in regulated treatment plans without full interest and will turn to substances after getting nothing from the treatment program. Soldier Wilson Lemmons discusses how this process occurs. “With a lot of the guys you basically have to escort up to counseling. But just because they sit in the session doesn’t mean they’re getting anything out of it. Unfortunately a lot of guys didn’t know how to deal with the stress so they would turn to alcohol and drugs and it was tough seeing that happen to a lot of good guys” (NVIVO Database Colorado College). This does not happen very often, however, as medical institutions are in place for a reason and are trusted to be effective the most of the time.
Some soldiers give themselves entirely to the institutionalized medical processes and question soldiers who take a different routes. In their eyes “proper” and regulated medical treatment is the only and most effective way to deal with the symptoms of PTSD and combat stress. Most times soldiers who subscribe to these thought processes have seen first hand how self-medication and coping through drinking and abusing medication can turn into a problem. Seargent David Qazar accepts that drinking is apart of military culture but is under the impression that it’s the wrong way out. Qazar realizes the problems that can come with long term heavy drinking, especially when drinking is used as a means to escape from the stresses of deployment.

Army culture is, army culture, because the army’s changing. You still have alot of these old school guys who I’ve heard them say, ‘oh its ok just get a beer, you’ll drink your problems away.’ It’s not the answer these days because alot of guys are so messed up, just so lost when they come back from deployment. In Colorado Springs you can tell when a unit comes back from deployment because down town is flooded, and they’re all drunk. Its like the first thing they do. Its what we do. In our off time. you can ask wade over there. 98% of the people in the army, they drink.

Qazar continues in the interview by voicing his concerns with soldiers abusing medications while drinking heavily at the same time. He has first hand experience as to why walking the line between medication and alcohol can be a dangerous prospect. It can leave soldiers without a grasp on reality and in a worse state than they were before exploring different treatment routes for symptoms of combat stress, PTSD and physical pain from the war.

You have some of the people now, that have mental issues start doing drugs or start drinking with their meds. It can get really bad. I had a soldier, who is actually a mutual friend of ours who got hurt around the same time I did, and when I got back and seen him,
he was drinking and taking his meds, he was just all out of it. Couldn't get a handle on things. I actually had to beg him to go to counseling.\textsuperscript{14}

Thus, drinking though normalized and socially accepted, can turn into a problem habit and means of coping with symptoms of PSTD. Drinking and other substance use can buffer symptoms in the short term but can also lead to addiction and depression problems in the long term. Sometimes the comfort that is gained from using alcohol and other substances is only short lived and will only mask the persisting problems they are facing within their mind and bodies. More significant issues in the long term can often be the outcome of such practices. Therefore many soldiers commit themselves to the medical institution available to them in search for an alternate solution.

Today, clinicians and psychologists, as a part of the medical institution, are providing soldiers with a regiment of drugs to help deal with combat stress, in theater and post war. These drugs are not illicit, but regulated, normalized and highly researched. Yet they are being used in new and different ways in all attempts to help a soldier cope or even just to get a good night sleep. Prescription drugs are a new component to war, with certain unforeseen consequences becoming apparent in recent years. Soldiers are overdosing, purposefully and accidentally, and are abusing these readily available drugs in theater as well as at home. Some become dependent and others a different person due to these highly regulated and institutionalized drugs.

Data from the Defense Logistics Agency (DLA) shows that use of psychiatric drugs has increased overall by 76\% from 2001 to 2009. More specifically the use of

\textsuperscript{14} NVIVO Database, Colorado College
anti-seizure drugs has increased by 70%, the use of sedatives and anti-anxiety drugs has increased by 170% and anti-psychotic use has increased by almost 200%. Technology in psychiatric drugs has increased dramatically since the last significant wars American troops have fought in. Through the technological advances practicality has also increased dramatically and the successful use of psychiatric drugs can be seen abundantly. One in six military personnel take some form of psychiatric drug, whether it be for pain, sleep, nightmares or other symptoms of PTSD. The benefits and specific purposes of these drugs are obvious upon further investigation. In essence, they are used to take the hyper emotions and hyper arousals that are experienced while on tour and numb them for more successful reintegration into civilian life.

Almost 14% of active duty soldiers are prescribed some sort of opiate drug, which largely reflects the high demand by soldiers returning from theater to help cope with the mental and physical wounds suffered in war (Tilghman, Army Times 17 March 2010). Modern American medicine relies heavily on prescription and fabricated drugs to help ease and alleviate pain for all patients. Although these drugs are expensive, they are very effective and efficient when taken properly. However, prescription drug use in the military is a relatively new phenomenon that has not been explored to such an extent in previous wars. 17% of active duty military personnel are taking some sort of antidepressant and 6% of all deployed troops are prescribed an antidepressant to help with day-to-day operations in theater. This
compares to the rest of the United States where only 10% of the population is currently prescribed an antidepressant. 16

Treatment responses to issues of PTSD and combat stress are becoming more advanced and medications are being used in new and unforeseen ways, often with great success. When dealing with PTSD care providers are often trying to control and regulate multiple different and unrelated symptoms such as anxiety, sleep deprivation and physical pain. Lonnie Nelson a neuropsychologist on Ft. Carson feels that treatment options from providers, when implemented in the correct way, can be very efficient and effective in helping soldiers cope.

I think it can be used appropriately...in many cases, it is not. Places particularly helpful...sleep, pain management, and controlling nightmares [beta-blocker]...If you’ve ever had a really bad headache, if you can imagine having one of those for eight out of the sixteen hours that you’re awake...being awake for twenty hours instead of sixteen because you can’t sleep. When you do sleep, having nightmares...Not a great scenario...you’re going to be pretty edgy.

The problems that clinicians are facing while dealing with soldiers suffering from these symptoms are significant. It is not easy to treat a headache, sleep deprivation, depression and anxiety- to name a few- at the same time. Therefore, clinicians are looking to use medications in different ways, all in hopes of successfully comforting a soldier as he/she tries to transition back into civilian life.

If you can get somebody's sleep normalized, keep them from having nightmares...that’s going to increase their pain threshold, so they can take more before they get edgy, and...they’re going to have less background tension, because they’re resting well, so they’ll be less likely to get the headaches...And if you can help to head the headaches off before they become uncontrolled...migraines...All great uses of medications...Perfectly appropriate...very helpful. Probably do a lot of good.

16 Military Times
In treatment, the problems do not lie within the medications but rather in the way they are implemented and if a soldier fully commits to the treatment program. Medication and the medical institution are very normalized processes in terms of receiving treatment for illness. However, PTSD and combat stress have not been historically treated effectively. Trying to treat symptoms of PTSD and combat stress with different medications is a relatively new phenomenon. New ways to treat these symptoms are constantly being explored and soldiers feel there is fine line that needs to be walked upon by practitioners for the most effective treatment possible.

Soldiers do not want to be treated like babies, addicts or people with mental disabilities. Instead a middle ground within the normalities of a medical practice must be reached. Over medication and therapy will not be effective and undertreatment will not entirely address the issues present. Soldier Hank Nelson thinks that the institution is capable of treating these soldiers with symptoms of PTSD but urges that there is a right way to do it.

There's a fine line between getting the job done and overdoing it as far as treating. When you come back it's 'oh talk to us, talk to us, tell us your feelings, tell us your feelings, do you need help, do you want help, do you want drugs? here's some drugs, take some drugs.' And that's overdoing it. But you don't want to go too far back and underdo it and be like 'hey if you need help, holler. I'm going to be over here at the coke machine.' So to find a median, that's going to be a challenge to find a median to where you're not talking to these grown men like they're babies but not completely, because there are people who come back with just a bag full of issues, and you don't want to ignore those guys.

The challenge for the medical institution, within their normalized practices, is to break away from routines and practices that are ineffective. These processes might be over-medication and not enough counseling which raises issues of dependency.
and full soldier participation. If a soldier feels as if he/she is being smothered by his care provider, he/she might be resistant to participate in the programs and may become more isolated and their problems exacerbated, and on the other hand if he/she feels that they are not getting enough attention he/she might behave in a self-destructing or detrimental manner.

With the use of prescription drug increasing substantially there are many trade offs that need to be considered by a practitioner when facing a soldier dealing with PTSD symptoms, both active duty and veterans alike. Drugs will respond differently in each patient and the trade offs while using them should be carefully considered. Lonnie Nelson understands the tricky line that all practitioners must walk on a regular basis and how each case brings new problems to the table that must be worked through.

Because of my particular biases...neuropsychologist...I don’t like any drugs that dull a person’s cognitive abilities...Benzodiazepines, narcotics...they impair judgement, all kinds of other unpleasant things. That’s just my bias. Some people don’t mind...if somebody’s a little bit fuzzy as long as they’re calm. That’s what the benzodiazepines do...It’s a tradeoff. I would rather have somebody sharp and on edge. At least you can talk to them...There are long-acting antidepressants, SSRIs. Also good drugs. There are mood stabilizers that are very helpful that don’t have cognitive side effects. A lot of people are on Zoloft, great drug. Put it in the water, as far as I’m concerned. It depends on the drug, and the side effect profile of the drug...If they’re in theater, honestly, I wouldn’t want them on anything that could have any kind of cognitive side effects, any kind of suppression of their reaction time..... It’s a complicated set of trade-offs, depends on the situation of the individual.

As each case presents itself, a new set of trade offs that needs to be dealt with. It is up to the practitioner and the institutional training and knowledge that they have received to ensure the comfort and stability of a soldier suffering from symptoms of
PTSD. As time progresses these problems and new treatment methods are becoming more and more normalized. Yet, while these treatment processes evolve and become normalized, unforeseen problems and complications also are apparent. Though institutional treatment methods are regulated and normalized, problems with dependency and abuse loom ominously in the distance. These problems go hand in hand with issues associated with heavy drinking and partying. Dependency and abuse can be the result of both normalized coping routes for soldiers. However, in this case it is the institution that is the catalyst for recurring substance use issues and dependency. Over-medication and over-treatment in response to pressing symptom exposure is the primary reason for treatment complications and dependency among soldiers. Thus, even though this treatment route is normalized and perhaps more socially accepted than other coping methods, such as drinking, there are many problems that have yet to be solved and consequences that remain hidden.

Massachusetts Veterans Epidemiology Research center performed a study looking at the long-term effects of high dose benzodiazepine (Valume etc.) use and the consequential effects of drug dependence and sometimes-fatal toxicities in patients with brain trauma, previous alcohol and drug use problems or post traumatic stress disorder. John A. Hermos and his research partners set out to determine whether the patients with an increased risk of receiving long-term, high dose, benzodiazepine prescriptions may be associated with increased risks for toxicities and dependence.\textsuperscript{17} In a previous study Hermos et. al. found that “patients

\textsuperscript{17} (Hermos et. al. 2007: 910)
prescribed very high average daily doses were more likely to have PTSD and substance abuse diagnoses and to be concurrently prescribed a second benzodiazepine, an opioid analgesic, and other psychotropic drugs. These associations suggested that patients with PTSD and substance abuse were receiving benzodiazepines in doses and/or combinations that had potential risks” (Hermos ET.AL. 2007: 910). Soldiers that are given the combination of these drugs could be susceptible to accidental overdoses and could also use the drugs to commit suicide. Lonnie Nelson is also wary of recent drug use prescriptions by clinicians he is familiar with.

They have been using Seroquel for sleep issues with increasing frequency and that bothers me. Seroquel is an anti-psychotic. It should not be used for sleep, in my opinion. Apparently, there are some guys that say that nothing else helps, so their docs prescribe it. There are different types of anti-psychotic and all have different effects on the neurochemistry of the brain. Seroquel is an atypical anti-psychotic, it is very depressing to the central nervous system. Cortical excitability is decreased on Seroquel which is why some of these guys find it very helpful for sleeping. Go figure ...I really hope they do [carefully consider the role a person is playing in theatre before prescribing a specific drug/side effects profile].

Risks that are associated with these types of clinical behavior and disposition are overlooked in favor of a positive result, such as better sleep. Seroquel is not a benzodiazepine but comes from the same family of drugs and is used for the same purpose. Through their work and critical thinking Hermos ET. Al. and Howard Nelson are assessing the professional and clinical prescriptions given to veterans and others suffering from PTSD and other trauma patients. The researchers key concerns with these clinical practices are that the beneficial effects for prescribing benzodiazepines for PTSD and anxiety related symptoms are usually short lived;
there is also the possibility for persistent withdrawal and craving that might exacerbate symptoms, and coexisting substance abuse conditions may occur (Hermos Et. AL. 2007: 912).

Even though medical institutions are regulated and normalized there are still concerns that need to be highlighted after continued research. Being very beneficial and necessary to a soldier with symptoms of PTSD, the medical institutions must be utilized to their full capacity. However, when coming up with new and innovative ways to treat soldiers risk should be assessed and precaution should be taken at all times, especially in regard to the use of prescription medication. Throughout this paper I have explored the different routes that soldiers can take to help cope with symptoms of PTSD. Some soldiers take it upon themselves to use substances, such as alcohol, to help deal with the symptoms they experience after returning from war. Some soldiers apply themselves to the medical institutions designed and dedicated to help soldiers with the specific problems associated with PTSD. There is also a middle ground in treatment and coping that soldiers can walk, and do so regularly. Soldiers can subscribe to “self-medication,” which is normalized among their small social circles, and soldiers can also commit to the medical institutions at the same time. However all of these treatment methods come with risks of dependency and problematic and long-term substance abuse. The scope of this paper is not intended to deal with such ideas as long-term substance dependence as a result of treatment and individual coping methods, but certainly should be addressed in further research. It would be beneficial to look at the patterns of Vietnam and older veterans when attempting to delve into this topic, as this
research will become more important as the United States continues to move towards putting the Iraq/Afghanistan wars in the rear view mirror. In the last section of this paper I want to discuss some of what has been already been written on distinct substance abuse patterns that are directly related to combat exposure and how that might translate into the future.

Little has been written on the substance abuse patterns of modern active duty soldiers and veterans from the most recent war. However, a great deal has been written on the substance abuse patterns among veterans from previous wars. Problems with veterans assimilating back into society with mental health problems, and the clinical diagnosis for PTSD, has been the main focus for the literature written on this topic. However other scholars have sought to understand the scope of substance abuse to self-medication in various different types of psychological distress suffered in war (Reifman, Windle 1996: 557). Much of the psychological distress is usually directly related, but not limited to, combat exposure. One study by Alan Reifman and Michael Windle, through the International Society for Traumatic Stress Studies, sought to see if the amount of combat exposure (retrospectively reported) could predict the self-reported illicit drug use in the year before the interview. Their general hypothesis was that greater combat exposure would lead to a higher probability of illicit drug use and problematic alcohol use. They also sought to investigate two more specific hypotheses.

The first hypothesis was implicitly concerned with the process by which combat exposure could lead to substance abuse patterns. This hypothesis revolves around the idea that psychological distress will mediate the relationship between
combat experience and later drug use or in other words combat exposure leads to stress, and stress leads to substance use as a form of self-medication. The second sub-hypothesis they sought to explore was centered on the idea that all veterans may not be affected by combat exposure equally. Previous studies have shown that there is a strong relationship between combat exposure and alcohol problems in veterans with a predisposition to drink or a pre-service drinking problem (Reifman, Windle 1996: 559). Reifman and Windle extended this logic to the use of illicit drugs being stronger for those who had used illicit drugs in the Army and pre-service than those who had not. Their findings did not fully support their hypothesis but this could have been strained by the restriction of whether one met the criteria for clinical diagnosis of PTSD, depression or anxiety in the year before the interview. It is possible that the hypothesis would be more fully supported if a broader view of psychological distress other than clinical diagnosis of mental health problems. One distinct and potent finding in the research was that younger respondents reported more drug use and declines in drug use from young adulthood to older ages was commonly found. Even though in this study combat exposure was only modestly related to self-reported drug use, it provides a model for further exploration regarding combat exposure leading to significant psychological stress and perpetual drug use and abuse.

Another report by NSDUH surveyed psychological distress and substance use disorder (clinical diagnosis) among veterans, and more specifically veterans from the wars in Iraq and Afghanistan. Of veterans who received care from the Department of Veterans Affairs from 2001 to 2005, almost one third were
diagnosed with mental health problems and one fifth were diagnosed with
substance use disorder. The report found many specific influences that were
attributable to substance abuse problems. For instance veterans aged 18-25 were
more likely than older veterans to engage in substance abuse and generally have
higher rates of substance abuse disorders (clinical diagnosis) and serious
psychological distress (clinical diagnosis). Furthermore veterans with low incomes,
less than $20,000 per year, were much more likely to engage in substance abuse
patterns than veterans with higher annual incomes. The most pertinent figure in
the document was finding that around 1.5% (estimated 395,000 persons) of
veterans aged 18 or older, from 2004 to 2006, had co-occurring substance abuse
problems and high levels of psychological distress. How much of that figure can be
attributed to primary self-medication remains to be seen, but it does continue the
logic that severe psychological distress can lend itself to substance use in a
significant portion of the veteran population.

After returning from war, patterns can be identified when examining
substance use patterns and coping methods among soldiers. First is the route to
treatment and dealing with symptoms of PTSD that a soldier chooses to take. All
treatment paths are normalized, socialized and carries a level of concern in treating
a soldier effectively. Secondly treatment paths and self-medication entail great risks
for future substance use and dependency in most veterans. This idea only promotes
the drastic need for more research and different kinds of research into the field of

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18 The NSDUH Report November 1, 2007
19 The NSDUH Report November 1, 2007
20 The NSDUH Report November 1, 2007
substance use among veterans and active duty soldiers alike. In the realm of Anthropological research it is necessary to further the research on cultured substance abuse, especially around drinking, as this culture may be a catalyst for substance abuse problems and dependency among soldiers. Many interesting problems and cultural disconnects can be highlighted by further research into this context and an attempt at bridging the gap between institutionalized care and self-medication is entirely possible and would be beneficial to everyone associated with the military.

Throughout this paper I have explored the different routes that soldiers can take to help cope with symptoms of PTSD. Some soldiers take it upon themselves to use substances, such as alcohol, to help deal with the symptoms they experience after returning from war. Some soldiers apply themselves to the medical institutions designed and dedicated to help soldiers with the specific problems associated with PTSD. There is also a middle ground in treatment and coping that soldiers can walk, and do so regularly. Soldiers can ascribe to the self-help and substance use method, which is normalized among their small social circles, and soldiers can also commit to the medical institutions at the same time. However all of these treatment methods come with risks of dependency and problematic and long-term substance abuse.

In the realm of Anthropological work it is necessary to further the research on cultured substance abuse, especially around drinking, as this culture may be a catalyst for substance abuse problems and dependency among soldiers. Many interesting problems and cultural disconnects can be highlighted by further
research into this context and an attempt at bridging the gap between institutionalized care and self-medication is entirely possible and would be beneficial to everyone associated with the military.

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