New York

The Prozac, Paxil, Zoloft, Wellbutrin, Celexa, Effexor, Valium, Klonopin, Ativan, Restoril, Xanax, Adderall, Ritalin, Haldol, Risperdal, Seroquel, Ambien, Lunesta, Elavil, Trazodone War

As it approaches its tenth year, our nation's longest war is showing signs of waning. Meanwhile, our soldiers are falling apart.

By Jennifer Senior   Published Feb 6, 2011

From a series of portraits documenting the stress faced by Marines patrolling Afghanistan's Helmand Province. The men in these pictures have no known health problems themselves.
(Photo: Louis Palu/Zuma Press)

The first time I meet David Booth, a 39-year-old former medic and surgeon's assistant who retired this past spring after nineteen years in the active Army Reserve, I make the awkward mistake of proposing we go out to lunch. It seems a natural suggestion. The weather is still warm, and he has told me to meet him in the lobby of his office downtown, so I assume he wants to go out, not back to his desk, when I show up around noon. But it turns out that in the six months he has been at his job, Booth has never left his office in the middle of the day, except to run across the street, and he is simply too polite to say so. From the moment we step outside, it's clear how unusual this excursion is for him. As we walk, he hews close to the buildings on his right ("If a building's to my right, no one is going to walk by me on my right"), and when we arrive at the restaurant, he quietly takes a seat at the table closest to the door, his back against the wall. His large brown eyes immediately start darting around.

"How's your sleep?" I ask him.

"I don't," he answers.

Depending on the war, post-traumatic stress can have many expressions, but this war, because of its omnipresent suicide bombers and roadside explosives, seems to have disproportionately rendered its soldiers afraid of two things: driving and crowds. Movie theaters, subway cars, densely packed spaces—all can pose problems for soldiers, because marketplaces are frequent targets for explosions; so can any vehicle, because IEDs are this war's lethal booby trap of choice. Booth manages his driving anxieties by leaving his Long Island home every morning at 4:30 a.m., when there's no risk of traffic (especially under bridges, which militants in Iraq are always blowing up), and avoiding the right lane (in Afghanistan and Iraq, one generally drives in the middle of the road to avoid setting off IEDs). Once he gets to the city,

Booth parks around the corner from his office and has managed to arrange his life so that he never encounters more than a handful of people. The only real logistical challenge is lunchtime, which he handles by ordering in, picking up from a grill across the street, or skipping entirely. I ask if he goes to restaurants in the off-hours. "Not very much," he answers, pointing to two sets of scars, one near his jugular and the other stretching down his spinal column. "I reach for a glass, and I can't feel pressure, so I'll knock the glass over. It's hard not to feel self-conscious."

On September 6, 2006, as Booth was returning from a mission in Kirkuk, his Humvee rolled over an IED. He spent three years in San Diego in a Warrior Transition Unit, or WTU, where most badly injured soldiers go to convalesce, and four surgeries later, though he'd broken his neck, he was able to walk normally again. He no longer has any sensation in his right hand, though, and he lives with back spasms, headaches, stiffness in his neck, tingling and numbness in his right arm, and pain radiating down his spine and right side. Once a week, he goes to cognitive-behavioral therapy near his home, and he follows a carefully scripted drug regimen: Valium for spasms, Lyrica for pain, Topamax for headaches, and, on occasion, Klonopin for anxiety. "And that's a lot less than what I used to be on," he tells me. "Percocet for pain. Ambien for sleep, but they don't want you on it for a long time because it's habit-forming. Flexeril for spasms, but that makes you drowsy. OxyContin. Zoloft."

Zoloft was only one of the antidepressants he took. "I don't remember them all," he says. "In the WTU, people kept what they were taking to themselves, unless they were talking to a friend. It's almost admitting …" Four seconds of silence tick by. "That you're broken. And you don't ever want to admit that. Because you're used to being able to do things. And I was a medic. What I did was fix things."

Spend five minutes in Booth's company, and it's hard not to be moved by the redrawn contours of his life. He's in pain and can't sleep ("You don't realize how much you lift your head when you sleep"); he hasn't set foot in a grocery store in well over three years and has gone to the movies just once, at eleven in the morning, when the theater was practically empty. But it's also hard not to marvel at his resilience. He's laconic and uncomplaining; he's still golfing (he likes the peaceful sensation of the green, likes that it's a physical activity he can still do); he is comfortable talking about his struggles. When confronted with the reality that he could no longer be a surgeon's assistant—his right hand won't permit it—Booth took several interview and résumé-writing courses and found a job across the country, at a security company, where he took charge of its human-resources department, overseeing hundreds of employees. If the Army's Medical Review Board no longer found him fit for duty, he wasn't going to protest. "You can't spend the rest of your life in the Army, just trying to heal," he says. "You're going to spend the rest of your life healing one way or the other anyway."

I mention that he strikes me as the type of person people would be eager to help heal—surely his new acquaintances in New York are trying to cobble together a social life for him? "A lot of people are trying," he says. He laughs uneasily. "It's hard." He says that he had a girlfriend back in San Diego. The relationship didn't last. "It's a lot to ask of somebody."

I ask if being in New York is any better, since New Yorkers tend to

be more open about their psychological pain than most people, discussing their drug dosages at dinner parties.

He gives me a pained, strained look that makes me realize how foolish—how cavalier and beside the point—this question is. "Yeah," he finally says. "But it's getting into the dinner party that's hard. That's not going to happen. I was very outgoing before. Now I keep to myself."

Even at the lowest point of the Global War on Terror—in April 2004, say, when the number of casualties was spinning out of control and it looked like there was no end in sight—morale among our troops ran fairly high. Yet today, with casualties tapering and a slightly improved prognosis for stability, our troops, by every conceivable external measure, are falling apart. Veterans of the Iraq and Afghanistan wars make up a disproportionate number of the jobless; the Army's divorce rate, which used to be lower than the civilian population's, has surpassed it and is higher still among those who've deployed. A spokesman at Fort Drum, home to the 10th Mountain Division here in New York State, tells me by e-mail that one-quarter of its 20,000 soldiers have "received some type of behavioral health evaluation and/or treatment during the past year." Defense Department spending on Ambien, a popular sleep aid, and Seroquel, an antipsychotic, has doubled since 2007, according to the *Army Times*, while spending on Topamax, an anti-convulsant medication often used for migraines, quadrupled; amphetamine prescriptions have doubled, too, according to the Army's own data. Meanwhile, a study by the Rand Corporation has found that 20 percent of the soldiers who've deployed in this war report symptoms of post-traumatic stress and major depression.The number climbs to almost 30 percent if the soldiers have deployed more than twice.

"I feel like people with my symptoms are becoming the majority of the Army," says a major from the New York area who recently started taking Effexor, an antidepressant, and a variety of sleep meds after a second tour in Iraq. "Feeling anxious when you don't have a reason to, being a little depressed, having low-grade anhedonia, not sleeping well—this is the new normal for those of us who've been repeatedly deployed."

The Army's own research confirms that drug and alcohol abuse, disciplinary infractions, and criminal activity are increasing among active-duty service members. Most ominously, a growing number of soldiers can't handle the strains of war at all. Until three years ago, the suicide rate of the Army, the branch with by far the most men and women in this war, was actually lower than the American population's—a testament to the hardiness of our troops, given that young men with weapons are, at least as a statistical matter, disproportionately prone to suicide. But in 2008, the Army suicide rate surpassed that of the civilian population's, and the Marines' surpassed it shortly thereafter. So grim is the problem that this summer, the Army released a remarkably candid suicide report. "If we include accidental death, which frequently is the result of high-risk behavior (e.g., drinking and driving, drug overdose)," it concluded, "we find that less young men and women die in combat than die by their own actions. Simply stated, we are often more dangerous to ourselves than the enemy."

In other words, nearly as many soldiers are dying at home today as are dying abroad.

For most of the past decade, the Army has downplayed the collateral damage this war has had on our soldiers' nerves. Until *The Nation* brought the practice to light last spring, the Army sometimes assigned the label of "personality disorder" to those suffering from post-traumatic stress, often rendering them ineligible for disability; Warrior Transition Units have continually earned harsh scrutiny, most recently from the Army's inspector general himself. Under the direction of Peter W. Chiarelli, the four-star general

and vice-chief of staff, the Army has at least made an effort to lend some transparency to its troubles and to address them more aggressively. The problem is that the Army woke up to its mental-health crisis quite late, and the more closely Chiarelli looks into the issue, the more confounding it seems to be to solve.

(Photo: Louis Palu/Zuma Press)

For starters, the United States has never had an all-volunteer corps of soldiers who've spent a whole decade in battle—men and women who, by turns, have repeatedly subjected themselves to the horrors of war and the trials of reintegration back home. "Don't ever underestimate what three, four, five deployments does to you," Chiarelli tells me this November, as we fly down to Fort Stewart, Georgia, whose 3rd Infantry Division was just returning from Iraq. "It's uncharted territory, as far as I'm concerned." Even without repeated deployments, the life cycle of a soldier is a model of brutal compression and, therefore, almost certain to cause distress. "At 24 years of age," says a striking footnote on page one of the Army's suicide report, "a Soldier, on average, has moved from home, family, and friends and resided in two other states; has traveled the world (deployed); been promoted four times; bought a car and wrecked it; married and had children; has had relationship and financial problems; seen death; is responsible for dozens of Soldiers; maintains millions of dollars' worth of equipment; and gets paid less than $40,000 a year." Now consider what happens when this cycle repeats itself for a decade. "Moving, divorce, death, financial turmoil," says Lily Burana, author of the memoir *I Love a Man in Uniform.* "Those are the top stressors in a life. And this is what you get every freaking year in the Army."

> "I didn't want to be one of those soldiers who wound up shaking a baby."

It took a long time for the Army to concede that repeated deployments may be lurking behind its escalating suicide rate. Initially, it seemed to argue that the newest generation of soldiers was less psychologically stable. (From 2004 to 2009, the suicide report noted, the Army waivered in a large batch of kids with drug and other criminal records in order to meet its recruitment targets.) But now, based on a more granular analysis conducted by the National Institute of Mental Health and a team of researchers from Columbia, Harvard, the University of Michigan, and the Uniformed Services University, Chiarelli believes that it's not the marginal characters in the Army who are committing suicide in greater numbers. It's the old hands. "I'll tell you point-blank," he says, "though I've avoided this conclusion for two years: Where we're really seeing the increase in suicide is in the population that would never have contemplated suicide—but because of successive deployments, or a single deployment, or an event in a deployment, they go into this danger area."

The nature of this conflict is also quite unusual. As in Vietnam, the enemy blends in with civilians, rendering everyone a potential threat; but unlike in Vietnam, this war is fought in cities as much as in the hinterlands, which means soldiers are never allowed to mentally decompress. There's no front in this war,

and no rear either, which means there's no place to go where the mortar rounds aren't. "I was up at Walter Reed the other day," Chiarelli tells me on the airplane, "and I ran into a young kid who lost both his legs, *wayyyyyy* up. I asked him, 'How did it happen?' You know what he said?" He pauses, looks at me intently. He's big and barrel-chested, with crow's feet so pronounced they look like they've been stamped into his temples with a fork. "He said, 'Sir, I was standing in line at the PX to get shaving cream, and a 120-millimeter mortar came in and took off both my legs.' "

And on top of this unremitting combat anxiety, our soldiers have to cope with unremitting domestic anxiety of a sort that previous generations never knew, because these soldiers are Skype-ing with their families several times a week, even from the mountains of Afghanistan. At first, the Army believed this constant contact might help mitigate loneliness. Now, Chiarelli frankly acknowledges, he's not so sure, "because technology just drags you back home, where your 22-year-old wife is having trouble finding a job and has a couple of kids she's taking care of on her own." Many soldiers are also addicted to Facebook, whose tagging function is proving a mixed blessing. "Soldiers are seeing pictures of their loved ones in bars, pictures of their loved ones in outrageous behaviors with sexual overtones," says Colonel Kathy Platoni, a clinical psychologist in the Army Reserve who's been deployed four times. "Everything they're hanging on to is demolished. What's sustaining them is torn away."

Even with an intact marriage, the challenge of repeated reintegration into the home front can be dislocating. Soldiers come home to find their sons doing chores they once did, their wives with independent lives, their professional duties in flux. It's no accident that 80 percent of all Army suicides in 2009 happened Stateside, after the euphoria of homecoming had worn off. It's why the Army now requires follow-up visits to a behavioral-health specialist six months after soldiers return. Complicating matters, nearly half of today's Army comes from the National Guard and Reserve, whose soldiers return from each tour not to an Army base but to small towns or big cities, where their jobs are hardly assured and their peers are far less likely to identify with their experiences. "They go back to a community that says, 'Oh, you were in Iraq. Did you kill anybody?' " says Thomas H. Bornemann, director of the Carter Center Mental Health Program, who treated soldiers at Fort McPherson during the Vietnam War. "They're dealing with voyeurs wanting to know intimate things, things they're going to find hard to talk to their wives about." Nor do they necessarily see doctors who know anything about combat medicine. "The Guard and Reserve, that's the population I'm really scared of," Chiarelli says. "I've got 45 more suicides in the National Guard this year than last year. *Forty-five*." And in fact, the Army would later release data saying the number of suicides from the National Guard and Reserve nearly doubled between 2009 and 2010.

Feelings of idleness and inutility aren't unique to the home front, of course. They can also descend on a soldier while he or she is still in theater. Platoni notes that she spent the last quarter of her most recent tour on a quiet installation in northern Afghanistan, where the soldiers saw little combat. She suspects that's precisely why she saw so much of them. "Monotony, boredom, a lack of value and meaning and purpose to your mission—these are factors," she says. "Especially that loss of a sense of purpose: What am I doing here? I'm not suffering like my buddies in the south. There's a tremendous feeling of guilt."

It's an agonizing paradox, but one that many mental-health professionals now entertain: Our troops may be in such horrible distress right now because the operational tempo of this war has slowed down, and they're fighting—doing—less.

Chiarelli is sitting in the chow hall at Fort Stewart, having lunch with eleven soldiers who've just returned from Iraq. "When I was growing up in the Army," he tells them, "if anyone wanted to see a psychiatrist or psychologist, they'd have to go to the fifth floor. So nobody wanted to go in the elevator and press five." Everyone smiles nervously. It's not every day that a four-star general joins you for burgers. "So now we have behavioral-health people in the primary-care clinics," Chiarelli continues. "You don't have to go to the fifth floor. But I know the stigma's still there, believe me. How about screening?" Psychological evaluations are supposed to be mandatory. He's checking to see if they've happened. "Have you had any screening since you've been back?"

He looks around the table. The soldier nearest him replies yes, he had one, but it was perfunctory. Chiarelli purses his lips. "Anyone else?"

The table's silent for a few moments. Then a 26-year-old staff sergeant named Douglas Johnson, who just spent twelve months as a chaplain's assistant in Mosul, speaks up. "I had some issues prior to deployment," he says. "I had aggression, I had no patience with people. When I got back, they did another screening just to check on me. And it was pretty good."

This answer seems to relieve Chiarelli. "Are you in a good place now?" he asks.

"Yes, sir."

"Taking medication?"

"Yes." Paxil, an antidepressant.

"Is it helping?"

"Yes, sir. I can always tell the days I forget to take it."

The group laughs. Then Chiarelli asks a more loaded question: "Anyone ever hear of those who are overmedicated?"

The group is silent again.

During Vietnam, soldiers famously used a combination of dope and Jimi Hendrix to chill out and psych up. Today's soldiers essentially listen to both Prozac and Metallica to achieve the same balance. Drugs are very much part of the program—DOD-approved, the exact opposite of countercultural. Johnson, in fact, got his Paxil in a clinic in Mosul, three months before his tour was scheduled to end. "I was having some severe temper issues," he told me, "and I had a brand-new baby waiting for me at home. I didn't want to be one of those soldiers who wound up shaking a baby." If he ever went on a mission and forgot his Paxil, he adds, he'd just ask his friend, who took it too: "It was pretty likely that someone was, if not on the same dose, then on something pretty close."

Walk into any of the larger-battalion-aide stations in Iraq or Afghanistan today, and you'll find Prozac, Paxil, and Zoloft to fight depression, as well as Wellbutrin, Celexa, and Effexor. You'll see Valium to relax muscles (but also for sleep and combat stress) as well as Klonopin, Ativan, Restoril, and Xanax. There's Adderall and Ritalin for ADD and Haldol and Risperdal to treat psychosis; there's Seroquel, at

subtherapeutic doses, for sleep, along with Ambien and Lunesta. Sleep, of course, is a huge issue in any war. But in this one, there are enough Red Bulls and Rip Its in the chow halls to light up the city of Kabul, and soldiers often line their pockets with them before missions, creating a cycle where they use caffeine to power up and sleep meds to power down.

Because of the value the Army places on mission focus, however, doctors in theater are generally reluctant to prescribe anything that could seriously compromise it. Rather, it's when soldiers return home that prescription-drug use and abuse spikes sharply upward: Depression and boredom set in, suppressed pain surfaces with a vengeance, hypervigilance morphs into insomnia, and meds are very easy to access, because they're the most expedient way to treat pain and distress. Roughly one in seven soldiers at Fort Hood were on antidepressants or antipsychotics alone at some point last year, according to *USA Today*—and those were just the soldiers the Army knew about, the ones who weren't discreetly seeking treatment off-post in downtown Killeen. (Nor did that number include sleep meds, amphetamines, or painkillers.) More troubling, nearly one-third of all active-duty Army suicides in 2009 involved prescription drugs, according to the report released this summer. Some of the case histories Chiarelli sees are eerily reminiscent of the toxicology reports one reads after a celebrity suicide. (From a 2009 Salon story about the suicide of Timothy Ryan Alderman: "0.5 mg. of Klonopin for anxiety three times a day; 800 mg. of Neurotin, an anti-seizure medication, three times a day; 100 mg. of Ultram, a narcotic-like pain reliever, three times a day; 20 mg. of Geodon for bipolar disorder at noon and then another 80 mg. at night; 0.1 mg. of Clonidine, a blood-pressure medication also used for withdrawal symptoms, three times a day; 60 mg. of Remeron, for depression, once a day; and 10 mg. of Prozac twice a day.")

"We're very anti-medication," Chiarelli is told at one of our final stops in Georgia, by a neurologist at Eisenhower Army Medical Center at Fort Gordon.

"I hear this everywhere I go," the general replies. " 'We're anti-medication, we're anti-medication.' But why do I get these sheets of paper"—profiles of suicides—"with twelve medications listed on them?" He mentions that he's had two- and three-star generals confide in him that they were addicted to pain medication in the aftermath of their service, and that it took their wives to point it out to them. "Are you guys different?" asks Chiarelli. "Is this place a soda straw that no one else passes through?"

In fact, this residential facility that Chiarelli is visiting is different. It treats alcohol and substance abuse, PTSD, traumatic brain injuries, depression, and pain management all under one roof. Stephen N. Xenakis, a psychiatrist and former commander at Eisenhower, was an early proponent of this kind of integrated program. Like many doctors, he believes that one of American medicine's greatest failings is its fragmentation into narrow-caliber silos, with doctors seeing ailments solely in the context of their own specialties. No population, says Xenakis, suffers more outrageously from this structural deficiency than returning soldiers. Doctors seldom take the totality of their extraordinary experiences into account. "Soldiers are in an environment that has dust particles and toxins we don't even recognize," Xenakis tells me. "There are pressure waves and blasts. They're carrying packs, at altitude, that weigh 90 pounds. They're in a different sleep cycle than normal. They're in situations that are almost always stressful, if not traumatic." Yet when they return home, he says, they're shunted into all those individual silos, with each specialist seeing only what he or she is trained to see: A headache. Insomnia. Paranoia and irritability. A ruined knee. "So as doctors," Xenakis continues, "we say, 'Okay. We're going to track this psychological

problem, and we're going to track this immunological problem, and we're going to track their headaches and their musculoskeletal pain and their insomnia.' " He slowly breathes out. Though he retired in 1998, Xenakis has been urging the chairman of the Joint Chiefs to consider integrated medicine for quite some time. "When in fact it's a system problem we're dealing with," he says. "And that's how you get this poly-drug problem."

Chiarelli's not unsympathetic to this kind of logic. He's a systems guy. "If the general were a doctor, he'd be a surgeon," says Richard W. Thomas, the assistant surgeon general who frequently accompanies Chiarelli on his trips. "He'd be hot lights, cold steel." The trouble is that mental-health questions don't lend themselves to precise, technical fixes cost-engineered to reflect limited resources. In theater, the Army relies on a highly subjective psychological questionnaire that most of the experienced officers can ace, knowing just which boxes to check in order to avoid further observation by mental-health professionals. The Army is so short on mental-health personnel that Chiarelli is pushing telebehavioral therapy, whereby soldiers disembark from their tours abroad and debrief with psychotherapists via satellite. It's not a very orthodox form of treatment, he knows, but his response to traditionalists is: As opposed to what? While few people are trying harder to make the Army a less psychologically destructive place than he is, Chiarelli has little patience for the kinds of open-ended, searching questions that are posed by doctors like Xenakis. "Psychiatrists—they're the worst," he blurts out at one point while we're at Eisenhower, as his meeting with doctors there draws to a close. "I once had a meeting with a bunch of psychiatrists and psychologists where I had to kick every single one out of the room. Everybody had an opinion."

"Potholes, lately. Those have been a big deal." I caught up with David Booth two weeks ago—at his office, this time—where he is wearing a TENS Unit, or transcutaneous electrical nerve-stimulation device, in order to blunt some of his pain; the cold weather's made his body even tenser than usual.

Potholes? I ask. "I got blown up, and my vehicle rolled," he explains. "It's the shake of the vehicle."

Booth continues to lead a cloistered life. He still arrives at the office before the sun's up, still stays in at midday, still hasn't gone to the movies, still gets his groceries delivered, still isn't seeing anyone. ("Someone said to me the other day that I'm 'unapproachable,' " he says, "and I was like, 'Yeah, I can see that.' ") But he was recently promoted to director of operations, and his workplace, a gleaming mini-NORAD that could double as a set for *CSI,* is filled with former policemen and servicemen. "My personal life … there isn't one, and I'm not happy with it," he says. "But my professional life is a different life. I'm busy, I'm working, I'm providing a service."

I look around the room. He's brought me into a training space, filled with model suitcase bombs and other types of explosives. I mention the irony in a soldier recovering from an IED injury spending his time surrounded by fake explosives. He shrugs. "If the point is that I'm trying to get back to where I was before I was injured …"

So this normalizes things, I say. Provides continuity. He nods. He remains identified with those in Afghanistan and Iraq. "I would have gone back again and again and again, if I could have."

For all of his difficulties, David Booth is a success story, adapting as well as is humanly possible to circumstances that most civilians would find unimaginable. He hasn't vanished from sight, or pretended

he's fine, or numbed himself with whatever substances he has at his disposal. He hasn't totaled his car or crashed his motorcycle; he isn't hitting his kids or screaming at his wife. Yet even those who have the wherewithal to seek help can lose heart. Healing can be a glacial process. "I sometimes make excuses not to go to therapy," admits Booth. "Because it's like opening wounds, you know?"