Fog of War:

Psychopharmaceutical "Side Effects" and the United States Military

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Abstract

The unprecedented reliance today on psychiatric drugs to maintain mission readiness in war and to treat veterans at home has been the subject of ethical debate in the United States. While acknowledging these debates, I advocate for an ethnography of how US soldiers and veterans of the Iraq and Afghanistan wars themselves articulate political and ethical tensions in their experiences of psychiatric drug treatment. Detailing one army veteran's interpretations of drug effects as narrated through the lens of his current antiwar politics, I examine the radicalizing transformations of self and subjectivity that he attributes both to his witnessing drug use in Iraq and to the neurochemical effects of his own medications. Playing on the biomedical notion of "side effects," I highlight surprising political and ethical openings that can surface when psychopharmaceuticals and war intersect. Psychotropic medication use offers a critical realm for furthering the ethnographic study of the lived tensions and contradictions of military medicine and medicalization as revealed in militarized embodied experience.

Keywords: Military psychiatry; psychopharmaceuticals; subjective experiences of psychiatric drug treatment; side effects; US soldier and veteran mental health

The unprecedented reliance today on polydrug psychotropic therapies by the US military and Veterans Affairs to maintain readiness in war and to treat veterans at home has been the subject of growing ethical debate and public attention (Levine 2011; Senior 2011; Tilghman 2013). Although the use of licit and illicit psychoactive compounds in war has a deep history, as recently as 2006 the US Department of Defense developed initial criteria for psychiatric medication use in deployed environments, heralding what may become a revolutionized role for FDA-approved psychiatric drugs in the practice of US military operational psychiatry (Schneider, Warner, and Benedek 2011:156; Assistant Secretary of Defense 2006).1 Reported prescription trends in the US military are suggestive of this revolution: the period between 2005 and 2011 saw a 682% increase in the number of psychotropic drugs prescribed to US troops, including the off-label use of antipsychotics (Friedman 2013). It is now estimated that at least one in six active duty service members is on some form of psychiatric drug, with both active duty personnel and veterans consuming multiple drugs in prescribed cocktail combinations (Thompson 2008; Tilghman 2013).2 With the US military relying on an all-volunteer force in the so-called "Global War on Terror," an unprecedented pattern of prolonged and repeated deployments has encouraged the use of psychiatric medications in the effort to, in the words of the Army Medical Department's motto, "conserve the fighting strength." Sedatives, stimulants, mood stabilizers, and antipsychotics are increasingly dispensed in the effort to stretch further an already taut military force, and to address the fallouts of being at war upon return home.

Psychotropic polypharmacy in military and VA health care settings has been met with significant resistance among military and civilian health professionals, with many pointing out that the detrimental effects and occupational hazards of psychiatric polypharmacy in combat remain unclear and understudied (Kautz, Thomas, and Caldwell 2007; Lawver, Jensen, and Welton 2010; Meijer and de Vries 2009).3 Others have criticized the heavy reliance on psychiatric medication as symbolic of a broader process of medicalization that resignifies experiences of war in the sanitized and pathologizing language of biomedicine (Brock and Lettini 2012; Hautzinger and Scandlyn 2014).4 Citing the reevaluation of selective serotonin reuptake inhibitors (SSRIs) due to their reported association with cases of suicide among children, adolescents, and young adults aged 18 to 24 years—the latter the age group of most of today's US military service members—some have suggested that medicationinduced violence and mania are a strongly probable factor in the rising suicides recently reported among active duty personnel and veterans (Breggin 2010; Gibbons et al. 2007).

While acknowledging these debates, in this article I advocate for ethnographic understanding of how US military service members and veterans of the Iraq and Afghanistan wars themselves experience and interpret psychotropic drug treatment in and after war. Drawing on 15 months of ongoing ethnographic research that began in 2014 and includes interviews with 35 veterans of the wars in Iraq and Afghanistan, I detail one army veteran's experiences of psychotropic medication use. While on deployment as an army intelligence analyst in Iraq in 2006, Jonathan witnessed the medicating of his sergeant after her attempted suicide; he also underwent heavy psychiatric medication use himself after leaving the military in 2007. Focusing on Jonathan's interpretations of drug effects as recounted to me over two lengthy interviews and from his present vantage point as an antiwar activist, I examine Jonathan's radicalizing transformations of self and subjectivity that he attributes both to his witnessing drug use in war and to the neurochemical effects of his own medications.

My analysis of Jonathan's accounts of the experiential, moral, and political dimensions of prescription psychotropic drug use plays on the biomedical notion of 'side effects.' Medical anthropologists have documented the varied cultural interpretations of drug action and experiential knowledge about psychotropic medications, including ideas of what makes for a 'good' and 'bad' drug (Carpenter-Song 2009; McKinney and Greenfield 2010; Schlosser and Hoffer 2012). Addressing the notion of 'side effect' more specifically, scholars have challenged the notion that there must be a 'primary' effect to which all other effects are subordinated as 'secondary,' demonstrating how people variably interpret the bioneurological and behavioral effects of medication in light of cultural ideas about efficacy and outcome (Etkin 1992; Kamat 2009; Martin 2006). As Jonathan's observations of medication use in Iraq will illustrate, circulation of psychotropic medications into overseas deployed settings further challenges the notion that pharmacologic side effects are stable and inhere in drugs themselves. Aspects of drug action seen to be 'secondary' side effects that pose inconveniences at home can become potentially lethal 'primary' risks in a combat zone, raising broader questions about the dynamism of the therapeutic value of psychotropic drugs.

My use of 'side effects' also pushes the boundaries of the term's biomedical definition to capture the moral and political transformations of self and subjectivity that emerge in Jonathan's accounts of medication use. These transformations are 'side effects,' not only because they lie outside the bounds of clinical and pharmacologic understandings of drug action but also because they suggest the collateral effects of medicalization in and after war. As we will see, for Jonathan these collateral effects included the moral contradictions he perceived in medicating soldiers to keep them alive for war. Articulated from marginalized positions of dissent—from the 'side' in this sense—these felt contradictions may spiral out to produce wider unintended effects like forms of resistance to US military hegemony and its institutional cultures, as they did for Jonathan. Taken together, the multiple valences of drug side effects proposed here suggest that psychotropic medication use offers a critical realm for furthering the ethnographic study of the lived tensions and contradictions of military medicine and medicalization as revealed in militarized embodied experience (MacLeish 2013a, 2015).

Methods

The 35 veterans interviewed as part of this research enlisted in the military, represent all branches of the US Armed Services, resided in the southern United States at the time of the interview(s), and with the exception of three, deployed to Iraq, Afghanistan, or both. Semi-structured interviews and focus group interviews lasting one to four hours, including follow-up interviews in several instances, were conducted to explore how veterans make sense of their military service and their transitions out of the military. Many, including Jonathan, were informed of the research through their affiliations with local and national veterans' organizations sampled across the broad political spectrum. Semistructured interviews were also conducted with 15 family members of veterans, including spouses, children, and parents, as well as participant observation at military health conferences, clinical trainings, and veterans' workshops. From October 2015 to April 2016, interviews were conducted with the research assistance of two undergraduate student-veterans at the University of North Carolina at Chapel Hill.

Although use of psychotropic medications in and after military service surfaced in multiple interviews, in this article I focus on one veteran whose radical antiwar politics was admittedly unusual among those we

interviewed. I do so because the ambivalent feelings Jonathan associates with medication use offer particularly rich insight into how service members and veterans may invest powerful meaning in medications in institutional and political contexts of war making. Jonathan's interpretations of drug effects as articulated from his current politics also attune us to how relationships between people and medications are themselves living things: drugs come alive to those who consume them in ways that may transform as life circumstances, personal values, and subjectivity change.

Moreover, while the form of Jonathan's politics has proven more exception than rule among the veterans we interviewed, his attunement to and struggles with the felt contradictions of soldiering and of military medicine's "management of life exposed to death" (MacLeish 2015:11) were not unusual. We have encountered many individuals who, even as they were deeply proud of their service or staunchly committed to military values, also chafed against the imperatives of military medicine, challenged aspects of military institutional culture, and openly questioned justifications for the wars. I therefore see my close attention to Jonathan's experiences—experiences that are both profoundly singular and yet broadly resonant in some aspects—as part of a larger effort "to take seriously military voices in the way that we, as anthropologists, have other subaltern, marginalized, disruptive ways of knowing" (Gutmann and Lutz 2007:327).

Medication experience and interpretations of drug action

Anthropologists and other social scientists have become increasingly interested in the subjective experiences of psychiatric medication in global contexts that have seen the proliferation of psychopharmacological drugs for the treatment of mental distress (Jenkins 2010a; Oldani, Ecks, and Basu 2014). Proposing the interrelated notions of the "pharmaceutical self" and "pharmaceutical imaginary," Jenkins (2010b) has called for ethnographic studies of the subjective experience of psychopharmaceuticals alongside the globalizing institutional processes shaping consumption. Attention to psychiatric medication experience has illuminated how people interpret and negotiate understanding of drug action and 'effects' (Carpenter-Song 2009; Floersch 2004; Foltz and Huefner 2014; Martin 2007), and the experiential knowledge they claim in relation to the drugs they consume (McKinney and Greenfield 2010), with many scholars emphasizing "the paradoxical, contradictory, and ambiguous feelings often associated with psychiatric medication treatment" (Schlosser and Hoffer 2012:29). Alongside inquiries into the subjective experience of psychiatric medication, anthropologists have also explored the sociocultural aspects of the circulation of psychopharmaceuticals in cultural and institutional settings, illuminating the heterogeneous therapeutic practices and treatment experiences that result (Good 2010; Jain and Jadhav 2009; Lakoff 2005; Raikhel 2010). Experiences of psychotropic drug treatment among military service members and veterans expands these lines of inquiry, raising questions about transformations of self, subjectivity, and experience that can occur when medications are consumed in the institutional and geopolitical contexts of war making and US military power.

Although the development of psychiatric drugs with more favorable side-effect profiles has been key to arguments for their feasibility in deployed settings, the turn to prescription psychopharmaceuticals in war was neither straightforward nor inevitable. While the use of psychoactive substances for performance enhancement has been an area of active research and interest, the documented use of medications to treat symptoms associated with current psychiatric diagnoses in military personnel involved in active combat is

limited and has a contentious history within US military psychiatry (Schneider et al. 2011:152). Military psychiatrists during the Vietnam War were among the first to become interested in the widespread use of new psychoactive compounds like prochlorperazine (Compazine) and chlorpromazine (Thorazine) during combat. The use of these compounds in theater was controversial, however, with critics arguing that they could impair the soldier's ability to integrate emotional experiences and thus cause long-term harm. Standard use of psychotropic medication in the military soon fell out of favor after the war and remained uncommon for the treatment of ongoing mental disorders during combat operations (Sonnenberg, Blank, and Talbott 1985:324).

While sentiment would begin to shift in the mid-1990s with the development of 'cleaner' psychiatric drugs, namely SSRIs, the post-9/11 counterinsurgency wars in Iraq and Afghanistan have seen a critical and marked turn to the widespread use of psychiatric medications in deployment. Changes in US Army doctrine reveal how policy has shifted over the past 20 years. The initial army field manual on combat stress control, published in 1994 and updated in 1998, focused on triage and nonpharmacologic interventions aimed at normalizing and minimizing combat stress, with little guidance provided on the role and dispensing of psychopharmaceuticals. The new field manual published in 2006 reflects a growing acceptance of psychotropic medication use in combat zones: for reemerging symptoms of a previously diagnosed mental disorder, to refill a previously prescribed medication, and for those newly diagnosed with mental health problems. Because contemporary counterinsurgency operations in locations including Iraq and Afghanistan no longer have true 'rear' areas that allow for military personnel to be treated away from the frontlines, advocates argue that it is increasingly essential to treat mood and anxiety disorders in situ. In contemporary conditions of counterinsurgency, psychopharmaceuticals offer a key technology in the provision of 'forward' treatment—treatment as proximate to battle as possible with the goal of expediting return to combat (Schneider, Bradley, and Benedek 2007:156).5 By this logic, the easy availability of medications through a Combat and Operational Stress Control team, a battalion aid station, or a division mental health section enables more troops to remain 'mission-capable' without leaving station, and in many cases, without dismissal from operational roles. FDA-approved medications and the ease of their dispensability are shifting ideas of what constitutes definitive, baseline care in theater, while also generating new possibilities—and concerns—for operational readiness while medicated.

If we understand drug experience to be interactionally co-produced in a manner shaped by the 'social grid' of institutional and social relationships (Longhofer, Floersch, and Jenkins 2003), medication use among service members and veterans generates questions about how this coproduction shifts as drugs and the people who consume them move in and out of civilian and military settings, regimes of values, and institutional contexts of war making. Unlike drugs such as malaria chemoprophylaxis, whose development was and continues to be driven by the protection of military personnel stationed in malaria-endemic regions, FDA-approved psychiatric medications travel into deployed environments. Inspired by Appadurai's notion of the social life of things, van der Geest and colleagues (1996:170) observed, "As things, pharmaceuticals move easily from one regime of value and knowledge to another. They can be separated from the expertise that developed, produced, and prescribed them." Separated too from the therapeutic contexts in which they are routinely prescribed and consumed, psychiatric medications in war suggest the dynamic qualities of biomedical therapeutics including the variability and contextual nature of interpretations of drug action and side effects (cf. Etkin 1992; Kamat 2009). Thus while drowsiness from a routine antidepressant might be a nuisance or disruption to one's lifestyle at home, the same side effect can, in a combat environment, "have life-threatening consequences" (Lawver et al. 2010:952).

Dependencies between the ‘mission-readiness’ of soldier and unit also mean that consumption of psychotropic drugs in a deployed environment can involve dispersed notions of accountability and risk that differ from concerns raised in their use at home.

Soldiers’ and veterans’ interpretations of drug effects must also be situated within a broader American public imaginary in which violence shadows the bodies and lives of military personnel and veterans (Hautzinger and Scandlyn 2014; MacLeish 2013a; Wool 2015a). Framed in the terms of an epidemic, the subject of medication and war shapes public perceptions of the moral economy of military violence and suffering. High-profile events reported in the media have generated considerable public attention around medication and war. Psychoactive medications, alone or more often in combination, have emerged as prime suspects in military-related mass shootings and war crimes.6 Public attention around war and medications often conjoins concern for the military’s objective to maintain mission readiness ‘at all cost’ with socially produced ideas about pharmacological determinism. Such imaginaries are important to the broader context in which service members and veterans experience and interpret drug effects, and the public atmosphere in which their accounts are received.

Jonathan

Jonathan and I meet at a coffee shop on a quiet weekday summer afternoon. With his college semester over, his obligations these days are less but still keep him busy: activist work as the chapter president of an international veteran’s peace organization, with time in between for research in the library and the occasional choir practice. The coffee shop is nearly empty, which makes it easy for us to identify one another. Jonathan has a thick beard and is broad-shouldered with the carriage and habitus of a man who cut an imposing figure before lost jobs and episodes of homelessness and hospitalization left their mark.

Over two interviews, the first of which lasts four hours, Jonathan’s reflections are winding and undisciplined. They never follow a clean narrative of ‘being at war.’ A prolific and broad reader, Jonathan makes references to Žižek, Nietzsche, and Lacan as he recounts his time in the military and life since in tableaus of people, places, and things. He has an easy demeanor and a caustic wit, and he makes his politics apparent from the start. But, he tells me, he did not always think this way. When he enlisted in the army at 17 years, he had a high school diploma, few job prospects, and a long family history of male relatives in the military. He found purpose after the events of September 11, 2001: “I really believed in the mission and I was excited to go to Iraq.” When he signed up, Jonathan told the recruiter he wanted a desk job. But he also said that when he enlisted, he was ready to kill. Trained as an army intelligence analyst, he deployed to Iraq in 2006. At the age of 20 years, he was one of three ‘intel’ people in his unit at a forward operating base north of Baghdad. Like many enlisted service members who were tasked with jobs they were not trained for, Jonathan ended up doing a full day at his desk job followed by several hours on combat jobs that changed over the course of his 12-month tour.

Jonathan was discharged from the military in 2007 after four years of service. He tells me that the army messed up his paperwork when he shipped out, delaying the date for the completion of his contract so that he only barely made it into the group whose service obligation the army planned to involuntarily extend under a stop-loss order.7 To avoid being stop-lossed, Jonathan tells me he worked out an understanding

with his commanders that would allow him to be honorably discharged for minor misbehavior. However, just before Jonathan's contract expired, a new division commander was brought in who gave Jonathan a general discharge, consequently eliminating his GI Bill benefits.8 It also took several years before he was able to access VA disability coverage.

Jonathan's experiences with stop-loss and the circumstances of his discharge were important to the development of his current politics. Yet he also makes clear that they form just one side of a multifaceted critique of the military that began taking shape during his service concerning what he calls "ideologies of militarism": ideologies, he explains, that structure the class and racial inequalities of military institutions and drive US imperialism. In Jonathan's narrative of his radicalization from soldier to activist, he recalls for me other moments of stirring consciousness in Iraq that would bloom into antiwar activism and scholarship in the years after his discharge. Among them, he recounts the use of psychotropic drugs by his sergeant.

War on drugs

In deployed settings, where the therapeutic treatment and rehabilitation of the individual service member is directly linked to the 'operational readiness' of the unit, medication treatment can involve dispersed accountability and risk, as well as forms of social witnessing. Jonathan illuminated these aspects of drug taking when he told me a story about his sergeant who attempted suicide during their deployment in Iraq and was consequently given medications. As Jonathan described it, "They sent her back for an 'eval' (evaluation) for two weeks and she had to be on observation and stuff. And then they loaded her up with meds and gave her like three days to stabilize and then sent her back (to the forward operating base)." He told me how he and others first came to suspect that his sergeant was on medications:

> I'm sure the stuff she was on was the hardcore stuff. Like I know that she was on some of the crazy sleeping meds, like Ambien. I remember the Ambien because she would like have these sleepwalking episodes. Oh man, like one time … well, she was a band geek, a good girl. I liked her a lot. She brought her flute to Iraq and one time she got found walking around the base in Iraq playing flute as if she were in marching band. It comes out that she was on Ambien and antidepressants and doing this.

When psychoactive medications move into combat settings, they engender new ideas about risk, adverse effects, and contraindication. In the deployed environment, the sleepwalker is a threat not just to herself but also to others. While framed here in near comical terms, Jonathan made clear the broader repercussions of sleepwalking on base: "Somebody thinks it's a good idea to get our troops hopped up on medications on the base with guns. These are people with clearances, you know? Would you put these people in charge of your nuclear missiles?" On a forward operating base in Iraq, prescription drugs seek to mark the point at which violence tips from authorized, metered, and technical skill to uncontrolled disaster. The movement of medications across institutional, political, and social landscapes and regimes of value illustrates the dynamic—and potentially volatile—qualities noted more generally of psychotropic drugs (Carpenter-Song 2009; Floersch 2004), pointing in this case to how concerns for drug action and side effects are shaped by institutional settings of counterinsurgency warfare.

In describing how his sergeant's medication use 'came out' to him and others, Jonathan also highlighted how consuming drugs on deployment can demand forms of witnessing and generate socially distributed experiences of risk on deployment. Given the unpredictable nature of her day-today movements on and outside the base, Jonathan's sergeant was ordered to keep her medications on her at all times. Because of the distinctive rattle that the bottle of pills made in her pocket as she walked—a sound Jonathan remembers would announce her approach—he and others in the battalion took to calling her "Rattlesnake." As an aural signal of their sergeant's presence and vulnerability, the rattling sound of tablets offers a powerful metaphor for the ways drugs communicate and position the consumer vis-à-vis others when dispensed in theater. Psychotropic medications in particular occupy a highly ambivalent position, serving both as a warning to others ("she is a potential hazard") and as a symbol of the individual's fulfillment of duty ("she is following orders"). In consuming drugs, military personnel like Rattlesnake simultaneously enact both the durability and tenuousness of their obligation to the unit and to 'the mission.' They are also seen to generate risk for others, creating a different moral economy around drug consumption than at home. For in the setting of counterinsurgency warfare, although psychoactive medications are consumed by the individual, their associated safety concerns are borne by many. As one former Marine put it blankly, "Who would ever want a guy on meds out there next to you?" When used by the individual to treat symptoms associated with psychiatric diagnoses in the deployed environment, psychotropic medications ride the cusp between order and volatility, linking together the mission-readiness—and endangerment—of self and whole.

But more than generating concern for safety alone, for Jonathan witnessing psychiatric drug treatment during his tour in Iraq attuned him to profound contradictions at the nexus of medication use and war. After describing to me how his battalion had dubbed his sergeant Rattlesnake, Jonathan's tone shifted as he turned to thinking about her medicated return to duty. He explained feeling troubled by the ways medication served to maintain mission readiness over and against his sergeant's well-being. "It's pretty underhanded," he said, pausing. "I mean, the lady tried to kill herself. She was 26. And then they send her back less than a month later, back to the same job, same people, *same exact situation*. Because you know, it can't be that the mission is wrong. The unit itself can't be messed up. Because it's the army: 'of course we're always right,' you know?" (emphasis his).

In his ethnography of the everyday experience of being at war for soldiers at Fort Hood, Kenneth MacLeish (2013a) identified military institutions as sites of biopolitical regulation, where soldiers' bodily and mental experiences are imbued with moral and political stakes. Jonathan's resistance to the use of medication in his sergeant's case underscores the particular problematic of military power whereby soldiers are authorized to enact violence while simultaneously protected from and exposed to it (MacLeish 2015). Indeed, Jonathan seemed deeply pained when he asked me how it could "ever be okay" to prescribe medications in order to return someone to the same conditions that encouraged their suicide attempt in the first place.9 In Jonathan's view, psychiatric medications were used in Rattlesnake's case to reshape human "being" (Jenkins 2010a) by altering capacities for living—for living, that is to say, through suffering, violence, and death. What Jonathan saw as a perversion of the therapeutic value of drugs highlights the tensions of medicalized efforts to keep soldiers healthy and alive in and for war, tensions that deeply unsettled his belief in the institution he had pledged to serve, and in the war he had been committed to fight.

Despite both voluntary and involuntary encounters with mental health staff, Jonathan never himself took psychiatric medications during his 12-month deployment. Yet the very fact that his experiences of psychotropic medication on deployment were not his 'own' is telling of the expansive nature of drug side effects in militarized settings. Where a soldier's medication use is perceived to have implications for the safety and readiness of others, side effects suggest the ways interpretations and experiences of drug action are co-produced through forms of witnessing and ideas of disseminated risk in contexts of counterinsurgency warfare. Jonathan's accounts—rendered as witness to another's medication use while also told through the lens of his current radicalized politics—reveal the many lateral and longitudinal dimensions along which drug side effects in war reverberate out: between and among soldiers at a forward operating base in Iraq, and over a young man's life trajectory.

"I have that experience now": Medication and transformations of self

Although Jonathan did not take psychiatric medications while in the army, he did in the years after his discharge. As he described it, life after the army began with a road trip across the United States, breaking up with a girlfriend, and falling in love with the woman who would become his wife, and then later, his ex-wife. Governed by broken relationships and lost opportunities as much as hopeful beginnings, those years immediately after leaving the army were punctuated by spells of homelessness and periodic psychiatric hospitalizations in the VA system. It was in 2009 when "it all finally broke down":

> I had been married for a year, year and a half. It was a bad marriage. I'm thinking that it was also anger. Political anger, feelings of unresolved betrayal. I would have these army dreams every night. I gained a hundred pounds that winter. Poverty. I had just run out of money at that point and going to school on my own without GI Bill help. Looking for a job, couldn't find anything. Suddenly I had the worst depression in a hundred years. I'm in the middle of that. There was just a lot going on. Other vets in my community were killing themselves and I was making the funeral circuit.

As his situation worsened, Jonathan made the decision to check himself into the emergency department of his VA hospital. He arrived alone and told the staff that he was suicidal. While hospitalized, Jonathan was prescribed five psychiatric medications including the SSRI citalopram. The rest he cannot recall by name. "They loaded me up with these antidepressants and you know, they'll warn you those things take a while to kick in. They usually say you have to be on them for about a month for them to be effective." Jonathan took his medications diligently, hoping he would improve. As his relationship with his wife became increasingly tumultuous, he also complied with his medications as a gesture to her that he was committed to making things work. But by the second week on the medications, Jonathan began experiencing what he described as severe side effects. "It just kind of crept up on me somehow," he told me. "Soon I couldn't sleep, which comes and goes anyways. It's hard to tell what that is. But I'd also just get manic about little things."

One evening about three weeks after his hospitalization, Jonathan and his wife had a particularly fierce argument. As they often did when they fought, they moved into the bathroom and shut the door to muffle their voices from their young son. When the argument escalated further, Jonathan grabbed a nail cutter from the medicine cabinet. Threatening to kill himself, he cut and dug into his wrists in front of his wife. Recounting for me that moment, Jonathan described feeling as if his words and actions were not his own. "Suddenly, and I think this was where the meds kicked in, things just got blown way out of proportion. Normally, I would try to calm down. There's a de-escalation process I would go through, a communication thing. But instead my reaction was, 'I'm just going to kill myself.' It was automatic. Click. Throw the switch. I'm going to die."

Jonathan's wife called 911. She told the operator that her husband was trying to kill himself. When the police arrived, the situation quickly deteriorated. As Jonathan described it, with him now lying and bleeding on the floor of their small bathroom, he had inadvertently blocked the door, preventing his wife from exiting. Arriving police officers responded to the scene as an unfolding domestic violence incident. As Jonathan himself admits, his response to the officers did not help to deescalate the situation. "I told them to screw off. But part of this I think was the meds. I kind of vaguely remember being in the bathroom and they were kicking down the door with their guns out." Dragged out of the bathroom and restrained, he was taken that night to a prison isolation unit. In thinking back to those events, Jonathan asserted the key role his medications played in changing his life forever: "I had a bad reaction, I got even worse, and I ended up in jail."

He vividly recalled the disorienting experience of being taken to the prison isolation unit. "I'd been on the antidepressants for about three weeks. And they dragged me off to jail and threw me in the suicide room, the room with those big rubber walls. The rubber room with shit on the walls. They stripped me naked and left me standing there." Jonathan was kept naked in isolation where he says they must have had him put his hands on his head. Since they did not tell him to relax, he stood that way, waiting for what felt like a week. "The first clear memory that I have after that was the guard telling me, 'You don't have to just stand there like that.' I was like, 'Where am I?' Without coordinates to anchor him in the world, Jonathan felt space and time fall away. "When I got out to go to the arraignment, I thought I had been there a week. I asked the guard how many days I had been in there because there was no clock. He told me, 'You've only been here a day.'" Jonathan was stunned that only a day had passed. "It felt like a week. Because you don't know. You fall asleep for twenty minutes, wake up. You think it's been all night."

The hours chained in the cell took Jonathan back to his time in Iraq. Like many of his peers, while in Iraq Jonathan served in operational roles that he neither trained for nor expected to do. Among them was the 'tactical questioning'—in Department of Defense verbiage—of Iraqi detainees. The objective of tactical questioning, Jonathan explained to me, was to obtain time-sensitive intelligence information from detainees. In recalling how unprepared and untrained he and others were, he explained how they borrowed psychological intimidation techniques from "24," an American television show starring Kiefer Sutherland who plays a counterterrorism agent. "This was the 'expertise' they were drawing from: 'This is how Jack Bauer would do it,'" he told me, shaking his head at the absurdity of it. Jonathan would not remain in this position for long. He was transferred out of the detention center and into another job on base after just a few weeks. He hinted at the reason for his transfer: "I got 'fired' because they were afraid that one of the detainees that I had tactically questioned would file an abuse report. Technically, well …

what it comes down to is if you can break the guy then you can send them up the chain and then you just count it as 'one more bad guy we got.'" Puffing his chest, Jonathan pronounced this last part in a deep and boasting baritone, in a manner thick with irony.

During his imprisonment, Jonathan was plunged back into his days in Iraq with sudden immediacy. Despite his disorientation at the time, he described his hours in jail as a watershed moment. His imprisonment, Jonathan explained, became a conduit to the past and to the suffering of Iraqis he had tactically questioned. Running his fingers nervously through his beard, he told me, "The whole time I kept thinking, Jesus, I now know what I was doing to those Iraqis. This is torture, solitary confinement. I can see it. All I could think those hours was that. I have that experience now. I can understand what that means." Jonathan experienced his slide into disorientation, sensory confusion, humiliation, and imprisonment—all in the haze of heavy psychiatric medication—as an embodied revelation into the violence and harm he carried out against Iraqi detainees.

Reflecting back on that turning point in his life, Jonathan made clear that he attributes the events that transpired over those weeks, including his marital problems and subsequent divorce, to his drugs: "I think a lot of my marriage problems go back to that, too. We never did process that trauma together." Importantly, while Jonathan's drugged revelations allowed him insight into and allowed him to speak of what he did in Iraq, his interpretations of drug action simultaneously eclipsed agency in the events that transpired at home. Indeed, in the years since his divorce, Jonathan tells me that his ex-wife accuses him of failing to take responsibility for his behavior during that time in their lives. "Maybe so," he told me, "but I still don't know how much of that was the meds and how much was the situation." If medications enabled insight of a political kind for Jonathan, his narrative about the effects of his drugs simultaneously committed his marriage to a failed fate at home.10

Political side effects

By Jonathan's account, the side effects of his psychiatric medications were not only neurobiological and behavioral in nature; they were also political and ethical. His descent into psychiatric drugging and imprisonment brought the hidden into view: secret violence, shadowed by the legal cover of 'tactical questioning,' partially surfaced as embodied experience under the haze of medication. These are effects articulated from the 'side,' that is to say, from the margins: from locations and experiences of vulnerability but also of political consciousness and critical citizenship. They attune us to what Byron Good (2012:528) calls the "eruption of the political," to the moments when that which is largely unspeakable is partially spoken. For Jonathan, this has meant the surfacing of memories of what he did in war, and his ongoing work to reckon with the violence he carried out. Drugged imprisonment also enabled a type of relational subjectivity. This, too, is a sort of 'side' effect. In linking his experience to that of the detainees he once questioned, Jonathan experienced a sideways or horizontal consciousness, one that extended him in time and space toward the Other. While this cannot be a complete or leveling process in the context of US military power and the racialized geopolitics of interrogation, for Jonathan it attuned him to vulnerability in a manner he had not before realized.

While Jonathan's embodied insight during his imprisonment was not the single turning point in his turn to antiwar activism, by his account it was a critical one. It also opened him up to radically questioning his military experience and his actions during deployment. During our first interview, Jonathan drew heavily on the notion of moral injury to articulate his dissent against the wars and to contend with the violence he committed while in Iraq. Contemporary notions of moral injury have been promoted by a group of clinicians, scholars, and advocates to address dimensions of war-related stress that arise from violations of moral conscience. Brock and Lettini (2012:13) describe moral injury as the "deep-seated sense of transgression includes feelings of shame, grief, meaninglessness, and remorse from having violated core moral beliefs." For Jonathan, moral injury has been important to how he grapples with the civilian deaths and injuries he caused, and with injuries to himself. "To me, the moral injury in Iraq was also a very particular kind of moral injury. It was that I participated in this detainee abuse. That is mostly mine. Or the awareness that the intel work that I did led to this dropping of a bomb and it was on the wrong house. Instead of killing terrorists it killed an innocent family. How do you deal with that?"

Jonathan's revelations in the wake of medication use suggest the links between the political and the psychological (Good 2012; Good et al. 2008). Yet these political side effects do not emerge *de novo*. Jonathan's turn to the notion of moral injury as an interpretive framework for making sense of the moral dimensions of his experiences relates to his present antiwar radicalism but also to contemporary politics of war and war suffering. Proponents have posited the notion of moral injury as a nonmedicalized—even anti-medicalized—language for addressing spiritual and moral dimensions of being at war. Yet as MacLeish (2013b:5) has suggested, in drawing on the idiom of injury and assuming that aversion to killing is an innate part of human morality, moral injury shares with posttraumatic stress disorder the capacity to transform "the politics of doing war violence … into matters of pain and healing."

While Jonathan's understandings of the harm he inflicted against civilian Iraqis appears to construct injury as amoral exception rather than constitutive of war itself, in our interviews he also challenged the notion of moral injury to do political work. Articulating a broader critique of the Iraq war, Jonathan spoke of moral injury as not only the harm that he committed and the wounds he suffers but as a problem of imperialism and occupation:

> You know, the way that we've sold this war ideologically, to the troops and to the people, and the way that we tried to sell it to the Iraqis and it didn't work, it's like we're going to be this civilizing influence. "You're a bunch of savages." Basically it's the same kind of imperialistic thing of "We're going to teach you democracy." And the piece they're missing is that violence doesn't work, it just doesn't, right? You can't solve your problems by shooting them up, you know?

Coaxing the language of moral injury to speak to his antiwar politics, Jonathan broadened the terms of the moral crisis of war beyond his own wounding to question the collective narratives that have endorsed and enabled war. But in speaking of imperialism and ideology, Jonathan's radical politics also come up against the limitations of an idiom of injury that casts American troops, the American people, and Iraqis as victims alike.

To think of such revelations as political and moral side effects of Jonathan's drug use is thus not to valorize them as straightforwardly emancipatory, subversive, or even anti-medicalizing. Rather, it is to recognize how drug effects mark for Jonathan new awakenings to what it means to make war. The particular form of Jonathan's radicalization also attunes us to the language of moral injury as its own kind of political side effect, a collateral product of the medicalization of military experiences and of politics around war suffering whose traction in Jonathan's critical consciousness is enabled by his medication experiences. Here, political side effects of drugs and war work in mutual provocation.

Conclusion

How do soldiers make sense of the drugs they and others consume during and after war? In this article, I have advocated for ethnographic inquiry into prescription psychotropic drug use as an important realm for exploring the lived tensions and contradictions of the medicalization of militarized embodied experience. Jonathan's story of Rattlesnake and of his medicated imprisonment attune us to how the social life of prescription psychoactive drugs in and after war involves the movement of medications into new institutional settings and regimes of value. But it also involves the ways medications acquire lives of their own through their animation by human actors (Martin 2006, 2007), including by those who do not directly consume them.

In narrating moments of political awakening during and after his military service, Jonathan brought drugs to life in complex ways. Psychotropic medications appeared at one level to possess an isolable neurochemical agency that piloted the people taking them, overriding conscious action in ways that worked to relieve accountability: medications 'made' Rattlesnake sleepwalk on a heavily armed military base and 'made' Jonathan act erratically in his suicidal encounter with his wife and the police. Yet at another level, drugs also catalyzed for Jonathan what would become a willful—and painfully so—process of labored reflection and critique. In his powerful narrative of soldier-turnedantiwar-activist, medications are ultimately agents of revelation and reform even as they committed Jonathan to a kind of chemical servitude in the short-term. Drugs also have uneven effects. In Jonathan's telling, they are the discrete 'cause' of particular events while playing more ambiguous roles in others. Contrary to the ways pharmaceutical marketing underscores the targeted and discrete effects of individual drugs, in reality every psychiatric drug has a "complex spatial, temporal, and functional configuration of effects that will not map onto a single system, symptom, behavior, or experience" (Kirmayer and Raikhel 2009:6). It is this complex configuration of effects—and more precisely its *ambiguity*—that allows Jonathan to own responsibility for the harm he carried out against Iraqi prisoners while leaving largely unquestioned his troubled relationship with his wife.

If, as Lutz and Millar (2012:482) argued, war is a "privileged site for morality production," ethnographic attention to the social lives of psychopharmaceuticals in and after war can yield important insight into the role of medicine and medicalization to the "work done to legitimate or condemn particular forms and elements of war." In Jonathan's case, his interpretations of drugs effects are undoubtedly inflected by his thinking about war and occupation today, and by broader contemporary politics of war suffering. Indeed, medications emerge as the perfect antihero in his compelling narrative of self-radicalization. Yet I see this complexity—Jonathan's reading of drug effects through the lens of his current politics—not as detracting from the value of his accounts, but rather as a bid for the importance of ethnography in addressing

medication experience in and after war. Ethnography offers a critical tool in recognizing how "a young person's thinking about war and occupation and his or her own values can change" (Gutmann and Lutz 2010:9), and how this can in turn shape how they relate to and understand the effects of medications. It allows us to attend to the shifting yet situated ways service members and veterans talk about and perceive the role of medications, in ways that can be as dynamic as their understandings of their military service and experiences. In Jonathan's case, this means exploring how he makes drugs taken in the past come alive today in the stories he tells of his time in the army and life since. It also includes recognizing how drugs, with all their associated ambivalence, made him alive: to forms of political consciousness and critical citizenship, and to new beginnings upon returning home.

Notes

1. The 2006 policy has since been replaced by a 2013 policy, which outlines similar but expanded guidelines on the use of psychotropic medications in deployment settings and deployment limitations associated with psychotropic medication use. See Assistant Secretary of Defense 2013. For an example formulary, see Schneider and colleagues 2007.

2. Limitations to these numbers should be noted, including that such generalizations do not acknowledge variations in pharmaceutical use from branch to branch and unit to unit. There is also little data on prescription rates in the US military, in part because Department of Defense record keeping on the distribution and use of medications is lacking and likely underreports use of medications.

3. Concerns for psychiatric polypharmacy resonate with broader critiques of the general trend in the United States toward prescription polypharmacy and which has been described in such apocalyptic terms as "pharmaggedon" (Healy 2012). See Oldani 2014.

4. Overlapping with concerns about medication use for diagnosed psychiatric illness in deployed settings, debates also continue to wage among military health professionals concerning the ethical use of psychoactive compounds as human performance technologies (Wolfendale 2008). The use of psychoactive compounds as performance technologies in the military resonates with broader trends in their use in civilian life.

5. American techniques of so-called forward psychiatry first emerged in World War I and were modeled on British and French psychiatrists' successful treatment of shell shock. As its name implies, key to the strategy of forward psychiatry was keeping troops as proximate to battle and integrated in their units as possible. The principles of forward psychiatry were given the acronym PIE (Proximity, Immediacy, and Expectancy) and became standard practice by World War II. These principles continue to structure what the US military now terms Combat-Operational Stress Response.

6. In the case of former army staff sergeant Robert Bales who was convicted of murdering 17 Afghans in March 2012, Bales's lawyers suggested that a psychotic episode might have been 'triggered' by a volatile mix of prescribed drugs including antidepressants, the sleep agent Ambien, and the psychoactive malarial drug mefloquine. Similar speculation circulated in the media following events including the 2009 and 2014 Fort Hood shootings, and the 2013 Washington Navy Yard shooting. Psychoactive compounds were also blamed for unauthorized violence by military personnel in the Vietnam Era, most infamously the My Lai massacre. See Kuzmarov 2009.

7. Stop-loss was created by the US Congress following the Vietnam War and entitles the President to involuntarily extend the service obligation of military personnel. In his 2004 campaign speech, then-presidential candidate John Kerry described stop-loss as a 'backdoor draft.'

8. When a soldier completes his or her obligation under a service contract and separates from the army, the soldier receives one of five different types of discharges. General Discharge is for service members whose service was deemed satisfactory, but involved situations where the conduct or performance of duty was not so meritorious to warrant an Honorable Discharge. The type of discharge can seriously affect veterans' benefits and employment after service.

9. The role of gender in Jonathan's account is notable given Rattlesnake's position as a female noncommissioned officer during the few years prior to the repeal of the Department of Defense policy officially excluding women from direct ground combat jobs. As suggested by Jonathan's brotherly affection for her, gender may have played a role in his generous reading of his sergeant's case as one of legitimate, deep, and even noble suffering, and the fact that he did not evoke ideas of failed obligation to the unit, as others have documented of combat stress stigma (Hautzinger and Scandlyn 2014; Finley 2011). I seek to explore these and other social dimensions of medication use in future work on this project.

10. On the politics of gendered domestic relationships and caretaking among military and veteran families, see Wool 2015a and 2015b.

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