

America's Medicated Army + New Studies Linking SSRI to Suicide

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Using drugs to cope with battlefield traumas is not discussed much outside the Army, but inside the service it has been the subject of debate for years.

America's Medicated Army by Mark Thompson, is an unusually balanced, informative, insightful article that sheds light on the spiraling use of antidepressant drugs and sleeping pills in the military. The fact that the article was published in TIME Magazine (June 2008) a major mainstream magazine with international circulation, is an indication that the drug-induced suicide problem within the military is a major problem.

TIME reports: "For the first time in history, a sizable and growing number of U.S. combat troops are taking daily doses of antidepressants to calm nerves strained by repeated and lengthy tours in Iraq and Afghanistan. The medicines are intended not only to help troops keep their cool but also to enable the already strapped Army to preserve its most precious resource: soldiers on the front lines. Data contained in the Army's fifth Mental Health Advisory Team report indicate that, according to an anonymous survey of U.S. troops taken last fall, about 12% of combat troops in Iraq and 17% of those in Afghanistan are taking prescription antidepressants or sleeping pills to help them cope. Escalating violence in Afghanistan and the more isolated mission have driven troops to rely more on medication there than in Iraq, military officials say."

The Pentagon does not keep statistics about the use of prescribed mind-altering drugs. But it is estimated that 20,000 troops in Afghanistan and Iraq were taking SSRI antidepressants -such as Prozac, Paxil and Zoloft -and / or sleeping pills such as Ambien.

The latest Army report reveals that in one month, January, 2009, the number of suicides by deployed soldiers was 24-six times as many as killed themselves in January 2008, the year in which the suicide rate surpassed all other years. There were 128 confirmed suicides plus another 15 suspected suicides in 2008.

"This is terrifying," an Army official said. "We do not know what is going on."

Actually, it is becoming ever clearer what is going on:

"Last year the U.S. Food and Drug Administration (FDA) urged the makers of antidepressants to expand a 2004 "black box" warning that the drugs may increase the risk of suicide in children and adolescents. The agency asked for - and got - an expanded warning that included young adults ages 18 to 24, the age group at the heart of the Army. The question now is whether there is a link between the increased use of the drugs in the Iraqi and Afghan theaters and the rising suicide rate in those places."

"Nearly 40% of Army suicide victims in 2006 and 2007 took psychotropic drugs - overwhelmingly, selective serotonin reuptake inhibitors (SSRIs) like Prozac and Zoloft. While the Army cites failed relationships as the primary cause, some outside experts sense a link between suicides and prescription-drug use - though there is also no way of knowing how many suicide attempts the antidepressants may have prevented by improving a soldier's spirits.

"The high percentage of U.S. soldiers attempting suicide after taking SSRIs should raise serious concerns," says Dr. Joseph Glenmullen, who teaches psychiatry at Harvard Medical School. "And there's no question they're using them to prop people up in difficult circumstances."

Science-uncontaminated by drug industry influence-substantiates the increased risk of suicide for people treated with anti-depression drugs. Three recently published suicide studies-two reviewing health records of veterans treated at Veterans Affairs facilities and one review from a major hospital in Rome-are compelling:

1. A 2007 retrospective analysis of VA datasets by Gibbons and colleagues [1] involved the identification of all veterans who received treatment for "new onset depression" in 2003 or 2004. Using E-codes (numbers) to identify all patients with depressive illness, the research team then divided these patients into two groups: those who received antidepressant drug therapy, and those who did not. Next, they reviewed the same E-code database to identify the depressed subjects who made suicide attempts during the same time interval. Finally, they calculated the rates of suicide attempts for each treatment group.

The significant finding: the use of SSRI antidepressants (e.g., Prozac, Zoloft, Paxil) was associated with a higher rate of suicide attempts, compared to those not exposed to the drugs: The suicide attempt rate per 100,000 in the drug-treated group of veterans was 364 compared with 335 in the drug-free group.

2. A 2009 VA study by researchers from the VA, the University of Michigan, and Columbia University identified the outcomes of more than 880,000 VA patients who received treatment for depression between April 1999 and September

2004. [2] Suicide rates were compared for five different "12-week, post treatment" periods. For each patient, outcomes were compared according to a total observation period of 60 weeks (5 x 12 weeks).

The findings confirm that the highest risk period for suicide among veterans receiving treatment at a VA facility, are the first 12 weeks following the use of antidepressants: Over all time-periods, the suicide rate was 114/100,000 person-years. In the first 12-week periods, suicide rates (per 100,000 p-y) were: 568 following psychiatric hospitalizations; 210 following the start of a new antidepressant (defined as: switch to a new antidepressant; addition of a second antidepressant for combined therapy; or initiation of an antidepressant within 6 months of treatment with a different drug); 193 following other medication starts; and 154 following dose changes.

3. A retrospective, case-control analysis of all adult patients (aged 18 or older) admitted to the Psychiatric Intensive Care Unit of a major hospital in Rome, between April 2004 and March 2007. There were 109 admissions following a serious suicide attempt, and 489 non-suicide-attempt admissions.

The researchers summarized their key findings as follows: 70% of the individuals who attempted suicide had received drug therapy in the 3 months prior to the serious event--39% were taking antidepressants and 43% were on a benzodiazepine. Whereas only 16% of non-suicide-attempters were treated with antidepressants, and 23% were on benzodiazepines.

The significant suicide risk these drugs pose is further exacerbated by the absence of any scientific evidence of their effectiveness for--neither for depression nor for post traumatic stress disorder (PTSD) for which they are prescribed for soldiers.

TIME cites two recent reports from Rand and the Institute of Medicine which raise doubts about just how much the new medicines can do to alleviate PTSD. The Rand study, released in April, says the "overall effects for SSRIs, even in the largest clinical trials, are modest." Last October the IOM concluded, "The evidence is inadequate to determine the efficacy of SSRIs in the treatment of PTSD."

"Chris LeJeune could have told them that. When he returned home in May 2004, he remained on clonazepam and other drugs. He became one of 300,000 Americans who served in Iraq and Afghanistan and suffer from PTSD or depression. "But PTSD isn't fixed by taking pills - it's just numbed. And I felt like I was drugged all the time." So a year ago, he simply stopped taking them. "I just started trying to fight my demons myself," he says, with help from VA counseling."

The Army cites failed relationships as the primary cause of suicides. However, the problem-for persons in and out of the military who seek "mental health services"-is that they are victimized by a failed paradigm of care.

Clinical guidelines and practice parameters in psychiatry are formulated on the basis of a corrupted medical literature that has been hijacked by Big Pharma.

Lacking objective diagnostic and therapeutic tools, psychiatry's paradigm of care is governed by a "pharmaceutical imperative"-even after the pharmaceuticals prove lethal. The Department of Defense practice parameters in psychiatry are governed by a longstanding mandate requiring psychiatrists to use psychoactive drugs-even against their best professional judgment. We know of psychiatrists who were severely punished for using non-drug approaches-even when those approaches are more effective and less toxic than drugs.

Reference:

1. R.D. Gibbons, C.H. Brown, K. Hur, S.M. Marcus, D.K. Bhaumik, and J.J. Mann, "Relationship Between Antidepressants And Suicide Attempts: An Analysis of the Veterans Health Administration Data Sets," *American Journal of Psychiatry* 164 (2007): 1044-1049.
2. Valenstein M, Kim HM, Ganoczy D, McCarthy JF, Zivin K, Austin KL, Hoggatt K, Eisenberg D, Piette JD, Blow FC, Olfson M. Higher-risk periods for suicide among VA patients receiving depression treatment: prioritizing suicide prevention efforts. *Journal of Affective Disorders*, 2009 Jan;112(1-3):50-8.
- 3) M. Raja, A. Azzoni, and A.E. Koukopoulos, "Psychopharmacological treatment before suicide attempt among patients admitted to a Psychiatric Intensive Care Unit," *Journal of Affective Disorders* 113 (2009): 37-44.

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America's Medicated Army
By Mark Thompson

Seven months after Sergeant Christopher LeJeune started scouting Baghdad's dangerous roads - acting as bait to lure insurgents into the open so his Army unit could kill them - he found himself growing increasingly despondent. "We'd been doing some heavy missions, and things were starting to bother me," LeJeune says. His unit had been protecting Iraqi police stations targeted by rocket-propelled grenades, hunting down mortars hidden in dark Baghdad basements and cleaning up its own messes. He recalls the order his unit got after a nighttime firefight to roll back out and collect the enemy dead. When LeJeune and his buddies arrived, they discovered that some of the bodies were still alive. "You don't always know who the bad guys are," he says. "When you search someone's house, you have it built up in your mind that these guys are terrorists, but when you go in, there's little bitty tiny shoes and toys on the floor - things like that started affecting me a lot more than I thought they would."

So LeJeune visited a military doctor in Iraq, who, after a quick session, diagnosed depression. The doctor sent him back to war armed with the antidepressant Zoloft and the anti-anxiety drug clonazepam. "It's not easy for soldiers to admit the problems that they're having over there for a variety of reasons," LeJeune says. "If they do admit it, then the only solution given is pills."

While the headline-grabbing weapons in this war have been high-tech wonders, like unmanned drones that drop Hellfire missiles on the enemy below, troops like LeJeune are going into battle with a different kind of weapon, one so stealthy that few Americans even know of its deployment. For the first time in history, a sizable and growing number of U.S. combat troops are taking daily doses of antidepressants to calm nerves strained by repeated and lengthy tours in Iraq and Afghanistan. The medicines are intended not only to help troops keep their cool but also to enable the already strapped Army to preserve its most precious resource: soldiers on the front lines. Data contained in the Army's fifth Mental Health Advisory Team report indicate that, according to an anonymous survey of U.S. troops taken last fall, about 12% of combat troops in Iraq and 17% of those in Afghanistan are taking prescription antidepressants or sleeping pills to help them cope. Escalating violence in Afghanistan and the more isolated mission have driven troops to rely more on medication there than in Iraq, military officials say.

At a Pentagon that keeps statistics on just about everything, there is no central clearinghouse for this kind of data, and the Army hasn't consistently asked about prescription-drug use, which makes it difficult to track. Given the traditional stigma associated with soldiers seeking mental help, the survey, released in March, probably underestimates antidepressant use. But if the Army numbers reflect those of other services - the Army has by far the most troops deployed to the war zones - about 20,000 troops in Afghanistan and Iraq were on such medications last fall. The Army estimates that authorized drug use splits roughly fifty-fifty between troops taking antidepressants - largely the class of drugs that includes Prozac and Zoloft - and those taking prescription sleeping pills like Ambien.

In some ways, the prescriptions may seem unremarkable. Generals, history shows, have plied their troops with medicinal palliatives at least since George Washington ordered rum rations at Valley Forge. During World War II, the Nazis fueled their blitzkrieg into France and Poland with the help of an amphetamine known as Pervitin. The U.S. Army also used amphetamines during the Vietnam War.

The military's rising use of antidepressants also reflects their prevalence in the civilian population. In 2004, the last year for which complete data for the U.S. are available, doctors wrote 147 million prescriptions for antidepressants, according to IMS Health, a pharmaceutical-market-research firm. This number reflects in part the common practice of cycling through different medications to find the most effective drug. A 2006 federally funded study found that 70% of those taking antidepressants along with therapy experience some improvement in mood.

When it comes to fighting wars, though, troops have historically been barred from using such drugs in combat. And soldiers - who are younger and healthier on average than the general population - have been prescreened for mental illnesses before enlisting.

The increase in the use of medication among U.S. troops suggests the heavy mental and psychological price being paid by soldiers fighting in Iraq and Afghanistan. Pentagon surveys show that while all soldiers deployed to a war zone will feel stressed, 70% will manage to bounce back to normalcy. But about 20% will suffer from what the military calls "temporary stress injuries," and 10% will be afflicted with "stress illnesses." Such ailments, according to briefings commanders get before deploying, begin with mild anxiety and irritability, difficulty sleeping, and growing feelings of apathy and pessimism. As the condition worsens, the feelings last longer and can come to include panic, rage, uncontrolled shaking and temporary paralysis. The symptoms often continue back home, playing a key role in broken marriages, suicides and psychiatric breakdowns. The mental trauma has become so common that the Pentagon may expand the list of "qualifying wounds" for a Purple Heart - historically limited to those physically injured on the battlefield - to include posttraumatic stress disorder (PTSD). Defense Secretary Robert Gates said on May 2 that it's "clearly something" that needs to be considered, and the Pentagon is weighing the change.

Using drugs to cope with battlefield traumas is not discussed much outside the Army, but inside the service it has been the subject of debate for years. "No magic pill can erase the image of a best friend's shattered body or assuage the guilt

from having traded duty with him that day," says *Combat Stress Injury*, a 2006 medical book edited by Charles Figley and William Nash that details how troops can be helped by such drugs. "Medication can, however, alleviate some debilitating and nearly intolerable symptoms of combat and operational stress injuries" and "help restore personnel to full functioning capacity."

Which means that any drug that keeps a soldier deployed and fighting also saves money on training and deploying replacements. But there is a downside:

the number of soldiers requiring long-term mental-health services soars with repeated deployments and lengthy combat tours. If troops do not get sufficient time away from combat - both while in theater and during the "dwell time" at home before they go back to war - it's possible that antidepressants and sleeping aids will be used to stretch an already taut force even tighter. "This is what happens when you try to fight a long war with an army that wasn't designed for a long war," says Lawrence Korb, Pentagon personnel chief during the Reagan Administration.

Military families wonder about the change, according to Joyce Raezer of the private National Military Family Association. "Boy, it's really nice to have these drugs," she recalls a military doctor saying, "so we can keep people deployed." And professionals have their doubts. "Are we trying to bandage up what is essentially an insufficient fighting force?" asks Dr. Frank Ochberg, a veteran psychiatrist and founding board member of the International Society for Traumatic Stress Studies.

Such questions have assumed greater urgency as more is revealed about the side effects of some mental-health medications. Last year the U.S. Food and Drug Administration (FDA) urged the makers of antidepressants to expand a 2004 "black box" warning that the drugs may increase the risk of suicide in children and adolescents. The agency asked for - and got - an expanded warning that included young adults ages 18 to 24, the age group at the heart of the Army. The question now is whether there is a link between the increased use of the drugs in the Iraqi and Afghan theaters and the rising suicide rate in those places. There have been 164 Army suicides in Afghanistan and Iraq from the wars' start through 2007, and the annual rate there is now double the service's 2001 rate.

At least 115 soldiers killed themselves last year, including 36 in Iraq and Afghanistan, the Army said on May 29. That's the highest toll since it started keeping such records in 1980. Nearly 40% of Army suicide victims in 2006 and 2007 took psychotropic drugs - overwhelmingly, selective serotonin reuptake inhibitors (SSRIs) like Prozac and Zoloft. While the Army cites failed relationships as the primary cause, some outside experts sense a link between suicides and prescription-drug use - though there is also no way of knowing how many suicide attempts the antidepressants may have prevented by improving a soldier's spirits. "The high percentage of U.S. soldiers attempting suicide after taking SSRIs should raise serious concerns," says Dr. Joseph Glenmullen, who teaches psychiatry at Harvard Medical School. "And there's no question they're using them to prop people up in difficult circumstances."

The Trauma of War

Before the advent of SSRIs - Lilly's Prozac was the first to be approved by the FDA, in 1987, followed by Zoloft from Pfizer, Paxil from GlaxoSmithKline, Celexa from Forest Pharmaceuticals and others - existing antidepressants had many disabling side effects. Impaired memory and judgment, dizziness, drowsiness and other complications made them ill suited for troops in combat. The newer drugs have fewer side effects and, unlike earlier drugs, are generally not addictive or toxic, even when taken in large quantities. They work by keeping neural connections bathed in a brain chemical known as serotonin. That amplifies serotonin's mood-brightening effect, at least for some people.

In 1994 then Major E. Cameron Ritchie, an Army psychiatrist, was among the first to suggest that SSRIs should deploy with Army combat units. In a paper written and published after she returned from a combat deployment to Somalia, Ritchie noted that the sick-call chests used by military doctors "contain either outdated or no psychiatric medications." She concluded, "If depressive symptoms are moderate and manageable, medication may be preferable to medical evacuation."

By 1999, military docs were debating the matter among themselves. Nash, a Navy psychiatrist, wrote that Navy doctors - who also provide Marines with medical care - had "sharp differences of opinion" over letting troops in war zones use SSRIs. Skeptics argued that their "real safety" in combat had not been proved. Supporters countered that their use could "avoid depleting manpower resources and damaging individual careers through unnecessary removals from operational duty." Nash reviewed the medical literature and reported that SSRIs "can be safely administered to deploying and deployed personnel."

The trickle of new drugs became a flood after the invasion of Iraq in 2003.

Details of America's medicated wars come from the mental-health surveys the Army has conducted each year since the war began. If the surveys are right, many U.S. soldiers experience a common but haunting mismatch in combat life: while nearly two-thirds of the soldiers surveyed in Iraq in 2006 knew someone who had been killed or wounded, fewer than 15% knew for certain that they had actually killed a member of the enemy in return. That imbalance between seeing the price of war up close and yet not feeling able to do much about it, the survey suggests, contributes to feelings of "intense fear, helplessness or horror" that plant the seeds of mental distress. "A friend was liquefied in the driver's position on a

tank, and I saw everything," was a typical comment. Another: "A huge f_____ bomb blew my friend's head off like 50 meters from me." Such indelible scenes - and wondering when and where the next one will happen - are driving thousands of soldiers to take antidepressants, military psychiatrists say. It's not hard to imagine why.

Repeated deployments to the war zones also contribute to the onset of mental-health problems. Nearly 30% of troops on their third deployment suffer from serious mental-health problems, a top Army psychiatrist told Congress in March. The doctor, Colonel Charles Hoge, added that recent research has shown the current 12 months between combat tours "is insufficient time" for soldiers "to reset" and recover from the stress of a combat tour before heading back to war.

Colonel Joseph Horam says antidepressants have made "a striking difference"

in the way troops are treated in war. A doctor in the Wyoming Army National Guard, Horam served in Saudi Arabia during the first Gulf War and has been deployed to Iraq twice during this war. "In the Persian Gulf War, we didn't have these medications, so our basic philosophy was 'three hots and a cot'"

- giving stressed troops a little rest and relaxation to see if they improved. "If they didn't get better right away, they'd need to head to the rear and probably out of theater." But in his most recent stint in Baghdad in 2006, he treated a soldier who guarded Iraqi detainees. "He was distraught while he was having high-level interactions with detainees, having emotional confrontations with them - and carrying weapons," Horam says. "But he was part of a highly trained team, and we didn't want to lose him. So we put him on an SSRI, and within a week, he was a new person, and we got him back to full duty."

It wasn't until November 2006 that the Pentagon set a uniform policy for all the services. But the curious thing about it was that it didn't mention the new antidepressants. Instead, it simply barred troops from taking older drugs, including "lithium, anticonvulsants and antipsychotics." The goal, a participant in crafting the policy said, was to give SSRIs a "green light" without saying so. Last July, a paper published by three military psychiatrists in *Military Medicine*, the independent journal of the Association of Military Surgeons of the United States, urged military doctors headed for Afghanistan and Iraq to "request a considerable quantity of the SSRI they are most comfortable prescribing" for the "treatment of new-onset depressive disorders" once in the war zones. The medications, the doctors concluded, help "to conserve the fighting strength," the motto of the Army Medical Corps.

These days Ritchie - now a colonel and a psychiatric consultant to the Army surgeon general - thinks the military's use of SSRIs has helped destigmatize mental problems. "What we're trying to do is make treating depression and PTSD - especially PTSD, which is quite common for soldiers now - fairly routine," she says. "We don't want to make it harder for folks to do their job and their mission by saying they can't use these medications." Ritchie, who communicates "six times a day" with her colleagues in the war zones, says she is unaware of "any bad outcomes" resulting from soldiers taking SSRIs.

William Winkenwerder Jr., who issued the 2006 policy as the Pentagon's top doctor before stepping down last year, says the new medicines are working well. "Combat presents some unique and important caveats - obviously, those who are being treated have access to firearms, and they may be under significant stress, so they need to be very carefully evaluated, and good clinical decisions need to be made," Winkenwerder tells *TIME*. "It's my belief that is happening."

"In a Total Daze"

And yet the battlefield seems an imperfect environment for widespread prescription of these medicines. LeJeune, who spent 15 months in Iraq before returning home in May 2004, says many more troops need help - pharmaceutical or otherwise - but don't get it because of fears that it will hurt their chance for promotion. "They don't want to destroy their career or make everybody go in a convoy to pick up your prescription," says LeJeune, now 34 and living in Utah. "In the civilian world, when you have a problem, you go to the doctor, and you have therapy followed up by some medication. In Iraq, you see the doctor only once or twice, but you continue to get drugs constantly." LeJeune says the medications - combined with the war's other stressors - created unfit soldiers. "There were more than a few convoys going out in a total daze."

About a third of soldiers in Afghanistan and Iraq say they can't see a mental-health professional when they need to. When the number of troops in Iraq surged by 30,000 last year, the number of Army mental-health workers remained the same - about 200 - making counseling and care even tougher to get.

"Burnout and compassion fatigue" are rising among such personnel, and there have been "recent psychiatric evacuations" of Army mental-health workers from Iraq, the 2007 survey says. Soldiers are often stationed at outposts so isolated that follow-up visits with counselors are difficult. "In a perfect world," admits Nash, who has just retired from the Navy, "you would not want to rely on medications as your first-line treatment, but in deployed settings, that is often all you have."

And just as more troops are taking these drugs, there are new doubts about the drugs' effectiveness. A pair of recent reports from Rand and the federal Institute of Medicine (iom) raise doubts about just how much the new medicines can do to alleviate PTSD. The Rand study, released in April, says the "overall effects for SSRIs, even in the largest clinical trials, are modest." Last October the iom concluded, "The evidence is inadequate to determine the efficacy of SSRIs in the treatment of PTSD."

Chris LeJeune could have told them that. When he returned home in May 2004, he remained on clonazepam and other drugs. He became one of 300,000 Americans who served in Iraq and Afghanistan and suffer from PTSD or depression. "But PTSD isn't fixed by taking pills - it's just numbed," he claims now. "And I felt like I was drugged all the time." So a year ago, he simply stopped taking them. "I just started trying to fight my demons myself," he says, with help from VA counseling. He laughs when asked how he's doing. "I'd like to think," he says, "that I'm really damn close back to normal."