

THE ATTORNEY'S GUIDE TO
DEFENDING VETERANS
IN
CRIMINAL COURT

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Chapter 10

TBI, PTSD, and Psychiatric Drugs: A Perfect Storm for Causing Abnormal Mental States and Aberrant Behavior

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I. INTRODUCTION

Recent years have seen a marked increase in the prescription of psychiatric drugs to activity duty military personnel and to veterans. Until the Iraq and Afghanistan wars, soldiers were rarely if ever sent into combat while taking psychiatric drugs,¹ but now it is commonplace, and may occur in 20% or considerably more of combat troops.² Nearly all soldiers returning from combat with psychiatric diagnoses will be placed on multiple psychiatric drugs and maintained on them during treatment at the VA. Bart Billings in the next chapter will provide further data on the over-medication of soldiers and veterans.

1 See Brett J. Schneider et al., *Psychiatric Medications in Military Operations*, in *COMBAT AND OPERATIONAL BEHAVIORAL HEALTH* 151, 154 (2011); see also *The Wounded Platoon* (PBS Frontline documentary broadcast May, 2010).

2 A June 2010 internal report from the Defense Department's Pharmacoeconomic Center at Fort Sam Houston in San Antonio showed that 213,972, or 20 percent of the 1.1 million active-duty troops surveyed, were taking some form of psychotropic drug: antidepressants, antipsychotics, sedative hypnotics, or other controlled substances. HECTOR MORALES, DOD PHARMACOECONOMIC CENTER, WTU PRESCRIPTION MEDICATION ANALYSIS & REPORTING TOOL (PMART) (2010).

Evidence pertaining to violence and suicide induced by the newer antidepressants has been growing for years.³ Recently, public concern has been expressed about the increased prescription of psychiatric medications, especially antidepressants, to military personnel.⁴ At the same time, the military has voiced concern about escalating rates of suicide among active duty soldiers.⁵

Combat soldiers and veterans frequently suffer from Post-Traumatic Stress Disorder (PTSD) and/or Traumatic Brain Injury (TBI). The two disorders are often combined, for example, where an improvised explosive device (IED) explodes beneath a military vehicle causing the occupants trauma to the brain as well as severe psychological stress. Soldiers suffering from PTSD and TBI are frequently treated with psychiatric drugs.⁶ Some of these drugs, especially antidepressants, stimulants, and benzodiazepines, closely mimic the effects of both PTSD and TBI, and are likely to worsen their condition.

I have previously examined the risks associated with antidepressants in general⁷ and I have examined many cases of antidepressant-induced violence, crime and suicide.⁸ I have also examined in detail how these adverse drug effects present serious hazards to military personnel.⁹ The 2010 article was written in association with my testimony before the U.S. House of Representatives, Committee on Veterans Affairs, February 24, 2010.¹⁰ Rather than repeat what I have done in earlier books and articles, in this summary overview article I will, for convenience, refer at times to my own publications

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- 3 PETER R. BREGGIN & GINGER ROSS BREGGIN, TALKING BACK TO PROZAC (1994); M. Teicher, C. Glod, & J. Cole, *Antidepressant Drugs and the Emergence of Suicidal Tendencies*, 8 DRUG SAFETY 186, 186-212 (1993).
 - 4 Mark Thompson, *America's Medicated Army*, TIME, June 5, 2009, <http://www.time.com/time/nation/article/0,8599,1811858,00.html>; Kim Murphy, *A Fog of Drugs and War: More Than 110,000 Active-Duty Army Troops Last Year Took Antidepressants, Sedatives and Other Prescription Medications*, LOS ANGELES TIMES, Apr. 7, 2012, <http://articles.latimes.com/2012/apr/07/nation/la-na-army-medication-20120408>.
 - 5 Elizabeth M. Lorge, *Army Responds to Rising Suicide Rates*, ARMY NEWS SERV., Jan. 31, 2008, <http://www.army.mil/-news/2008/01/31/7222-army-responds-to-rising-suicide-rates>.
 - 6 See Andrew Tilghman & Brendan McGarry, *Medicating the Military: Use of Psychiatric Drugs has Spiked; Concerns Surface About Suicide, Other Dangers*, NAVY TIMES, Mar. 17, 2010, available at http://www.navytimes.com/news/2010/03/military_psychiatric_drugs_031710w/.
 - 7 Peter Breggin, *Suicidality, Violence and Mania Caused By Selective Serotonin Reuptake Inhibitors (SSRI's): A Review and Analysis*, 16 INT'L J. RISK & SAFETY IN MED. 31, 31-49 (2003/2004); Peter Breggin, *Recent U.S., Canadian and British Regulatory Agency Actions Concerning Antidepressant-Induced Harm to Self and Others: A Review and Analysis*, 7 ETHICAL HUM. PSYCHOL. & PSYCHIATRY 7, 7-22 (2005); Peter Breggin, *Recent Regulatory Changes in Antidepressant Labels: Implications for Activation (Stimulation) in Clinical Practice*, 13 PRIMARY PSYCHIATRY 57, 57-60 (2006); PETER BREGGIN, BRAIN-DISABLING TREATMENTS IN PSYCHIATRY (2008) [hereinafter BRAIN-DISABLING TREATMENTS IN PSYCHIATRY].
 - 8 PETER BREGGIN, MEDICATION MADNESS: THE ROLE OF PSYCHIATRIC DRUGS IN CASES OF VIOLENCE, SUICIDE AND CRIME (2008) [hereinafter MEDICATION MADNESS].
 - 9 Peter Breggin, *Antidepressant-Induced Suicide, Violence, and Mania: Risks for Military Personnel*, 12 ETHICAL HUMAN PSYCHOL. & PSYCHIATRY 111, 111-21 (2010).
 - 10 *Id.*, written as background for Exploring the Relationship Between Medication and Veteran Suicide: Hearing Before the H. Comm. On Veterans Affairs, 111th Cong. (2010), available at <http://democrats.veterans.house.gov/hearings/Testimony.aspx?TID=65592&Newsid=525>.

which contain more lengthy analyses with many scientific citations. My latest review of antidepressant adverse effects directly addressed the military.¹¹

This chapter addresses how these drugs can worsen PTSD and TBI, including increased risks of violence, suicide, and a broad array of abnormal mental and behavioral states. It will also more briefly discuss the negative impact of stimulants, benzodiazepines, mood stabilizers, and antipsychotic drugs especially where they overlap with symptoms of PTSD and TBI.

II. OVER-MEDICATION OF PTSD AND TBI PATIENTS

As Dossa and Boswell note in Chapter 6, when “shell shock” was first described surrounding World War I, it was thought that the symptoms were physical in origin from the bombardment. Eventually, the pendulum swung toward recognizing the psychological aspects of the stress response and the diagnosis of PTSD was developed. Nowadays, with so many victims in the Iraq and Afghanistan wars, there’s renewed interest in the original concern about close-head injury in the form of TBI. In both theory and practice it often remains difficult to distinguish the symptoms of physical trauma to the brain from the symptoms of psychological trauma to the mind. Military and other healthcare providers are often unable to fully disentangle the two syndromes. In short, the symptoms of TBI and PTSD can be difficult to distinguish from each other, and frequently aggravate each other.

No medications are approved for the treatment of TBI or closed head injury in general, but psychiatric drugs are nonetheless commonly given to patients with TBI. They are also commonly given to patients with PTSD. As a result, patients with PTSD, TBI or both are routinely given psychiatric drugs, often many at one time.

Patients with head injury are especially susceptible to the adverse effects of all psychoactive substances, including psychiatric drugs.¹² This is consistent with my own observation that psychiatric drugs always impair brain function when given in therapeutic doses, so that psychiatric drugs administered to head injury patients will inevitably add to their degree of cognitive impairment and overall mental dysfunction.¹³

Two selective serotonin reuptake inhibitor (SSRI) antidepressants are approved for use in treating PTSD, Paxil (paroxetine) and Zoloft (sertraline). However, the Veterans Administration¹⁴ and the Department of the Army¹⁵ recommend the use of *all* SSRIs in the treatment of PTSD.

The Department of the Army has now expressed caution about recommending the use of any other medications other than antidepressants for PTSD, which probably

11 Peter Breggin, *Psychiatric Drug-Induced Chronic Brain Impairment (CBI): Implications for Long-Term Treatment with Psychiatric Medication*, 23 INT’L J. RISK & SAFETY IN MED. 193, 193-200 (2011) [hereinafter *Psychiatric Drug-Induced CBI*].

12 JONATHAN SILVER ET AL., TEXTBOOK OF TRAUMATIC BRAIN INJURY, 558 (2d ed. 2011).

13 BRAIN-DISABLING TREATMENTS IN PSYCHIATRY, *supra* note 7; *Psychiatric Drug-Induced CBI*, *supra* note 11.

14 Matt Jeffreys, *Clinician’s Guide for Medications for PTSD*, U.S. DEPT. VETERANS AFF., Jan. 7, 2009, <http://www.ptsd.va.gov/professional/pages/clinicians-guide-to-medications-for-ptsd.asp>.

15 Memorandum from Herbert A. Coley, Army Medical Command, to Commanders, Medcom Regional Medical Commands (Apr. 10, 2012) http://cdn.govexec.com/media/gbc/docs/pdfs_edit/042312bb1.pdf.

means that the antidepressants, already heavily prescribed, will be prescribed in even greater numbers. To bolster the use of the SSRI antidepressants, it cites Charles Hoge.¹⁶ Hoge observed:

RCTs (randomized controlled trials) that led to licensure of SSRIs showed within-group reductions in PTSD scores virtually identical to those seen in psychotherapy trials, and psychotherapy trials that included nonspecific supportive control conditions showed effect sizes comparable to those in medication trials.¹⁷

A comparison between antidepressant and psychotherapy trials would in fact suggest that antidepressant medication should not be used or that it should be used only as a last resort. First, since the effects of both are identical in reducing PTSD scores, psychotherapy should be the treatment of choice because it does not cause the huge variety of adverse effects associated with antidepressants including suicidality, violence, and mania. Second, the drug studies used to gain FDA-approval for the treatment of PTSD were inconsistent with actual treatment conditions. For Zoloft (sertraline) the two main studies were conducted on veterans with a 12-year mean duration of PTSD and the studies lasted only 12 weeks.¹⁸ It was also reported that two other similar Zoloft studies failed to show a positive effect. The two key Paxil (paroxetine) studies also lasted 12 weeks with a similar 13-year duration of PTSD.¹⁹ The short duration of treatment and the long duration of the disorder in the subjects make these studies largely irrelevant to the most important use of these drugs in the military, which is the acute treatment of PTSD with drug exposure lasting many months or even years in duration. Third, the use of check-list evaluations does not capture the real effectiveness of a treatment. Unlike drug treatment, psychotherapy not only produces far fewer serious adverse effects, it also improves self-understanding, self-direction or autonomy, and a broad array of life skills.

A. Acute Symptoms of TBI

Since the injury inflicted on the brain by TBI is global in nature and therefore affects overall mental and emotional functioning, damage from TBI can be described in a variety and potentially infinite number of ways. The individual's basic personality or identity often seems changed to outside observers, especially friends and family members long acquainted with the person. Drawing on the work of Keltner,²⁰ Gordon et al. in Chapter 8 offer the following list of TBI symptoms:

- Memory loss;

16 Charles Hoge, *Interventions for War-Related Posttraumatic Stress Disorder: Meeting Veterans Where They Are*, 306 JAMA 549, 549-51 (2011).

17 *Id.* at 550.

18 ZOLOFT, PHYSICIANS' DESK REFERENCE 2587 (Thomson PDR, 2007).

19 PAXIL, PHYSICIANS' DESK REFERENCE 1531 (Thomson PDR, 2007).

20 Norman L. Keltner, *Biological Perspective: Traumatic Brain Injury—War Related*, 43 PERSPECTIVES OF PSYCHIATRIC CARE 223, 223-26 (2007); Norman L. Keltner, *Biological Perspective: Traumatic Brain Injury—War Related*, 44 PERSPECTIVES OF PSYCHIATRIC CARE 54, 54-57 (2008).

- Memory problems;
- Cognitive difficulties;
- Attention impairments;
- Fatigue;
- Depression;
- Anxiety;
- Sleep disturbance;
- Deficient word finding;
- Lack of motivation; and
- Irritability.

Note that none of these symptoms are specific to neurological injury, except perhaps “deficient word finding,” but even that is common under psychological stress. Once again, it is important to realize that lists of TBI symptoms are basically attempting the impossible—a comprehensive description of how a human being can become injured by generalized brain dysfunction.

Evaluating the TBI patient is complicated by anosognosia, the patient’s inability to recognize physical or mental dysfunction.²¹ The individual fails to fully appreciate the degree of his or her impairment, and will not communicate it to the healthcare provider or family.

Traumatic brain injury often results in insomnia, emotional instability, irritability and anger, depression, fearfulness, obsessive preoccupations, and impaired self-control manifested by heightened irritability, anger, and impulsiviss. *This sympathetic nervous system hyperactivity or over-stimulation closely resembles and can be identical to some of the symptoms displayed during PTSD, and it can also be mimicked by the adverse effects of psychiatric drugs, including stimulants, benzodiazopines, and antidepressants.*

B. Chronic Symptoms of TBI

Brain injuries of all kinds, including trauma brain injury and chronic exposure to psychiatric drugs, can lead to a common result in the form of Chronic Brain Impairment (CBI).²² These symptoms fall into four categories: (1) cognitive deficits, (2) apathy or indifference, (3) emotional instability or lability, and (4) anosognosia. *Similar effects will be found in chronic cases of PTSD, except they will not be organic or physical in origin, and identical symptoms of organic origin can be produced by all psychiatric drugs*

21 JONATHAN SILVER ET AL., *supra* note 12, at 307-323.

22 *Psychiatric Drug-Induced CBI, supra* note 11; and PETER R. BREGGIN, *PSYCHIATRIC DRUG WITHDRAWAL: A GUIDE FOR PRESCRIBERS, THERAPISTS, PATIENTS AND THEIR FAMILIES*, ch. 3, 19-38 (2013), Chapter 3, pp. 19-38 [hereinafter *PSYCHIATRIC DRUG WITHDRAWAL*].

C. Acute Symptoms of PTSD

The United States Department of Veterans Affairs, National Center for PTSD described the "three main PTSD symptom clusters" as follow:

- *Re-experiencing.* Examples include nightmares, unwanted thoughts of the traumatic events, and flashbacks.
- *Avoidance.* Examples include avoiding triggers for traumatic memories including places, conversations, or other reminders. The avoidance may generalize to other previously enjoyable activities.
- *Hyperarousal.* Examples include sleep problems, concentration problems, irritability, increased startle response, and hypervigilance.²³

The third bullet, hyperarousal, is very consistent with many aspects of TBI, especially sleep problems, concentration problems, and irritability. Fatigue is common to both PTSD and TBI. PTSD is associated with increased rates of Major Depressive Disorder, Substance-Related Disorders, Panic Disorder, Agoraphobia, Obsessive-Compulsive Disorder, Generalized Anxiety Disorder, Social Phobia, and Bipolar Disorder, all of which can emerge after the PTSD.²⁴ Much the same can be said about close-head injury and TBI.²⁵

The above list of symptoms leaves out the most characteristic and often disabling emotions associated with PTSD, which are guilt and shame. These symptoms require treatment with an engaged, empathic therapist and/or empathic educational approaches as discussed by Dr. Billings in the following chapter. Thus, the National Center for PTSD removes the most human and important aspect from the diagnosis of PTSD, feelings of guilt and shame, and thereby plays down the importance of empathic therapy.²⁶

As noted above, TBI patients frequently suffer from anosognosia. Drs. Dossa and Boswell observed that this is also true of PTSD victims who are unable to recognize the degree of their impairment. However, genuine anosognosia is due to brain injury, in this case TBI. The lack of self-perception found in PTSD is associated with psychological functions and purposes, including the impulse to deny the traumatic experiences.

The cognitive aspect of TBI may be more apparent because of the specific physical injury to the higher centers of the brain, so that the injury causes specific or amplified problems with short-term memory loss, concentration, and attention. TBI may also cause subtle neurological signs and, in severe cases, lobotomy-like effects. A mild euphoria may be manifested, at least in the early phase.

Glasser et al. in Chapter 8 also have observed the similarity between TBI and PTSD symptoms:

The *New England Journal of Medicine* article cited earlier in this chapter found that shock waves from exploding IEDs hitting the brain cause

23 Matt Jeffreys, *Clinician's Guide for Medications for PTSD*, U.S. DEPT. VETERANS AFF., Jan. 7., 2009, <http://www.ptsd.va.gov/professional/pages/clinicians-guide-to-medications-for-ptsd.asp>.

24 AM. PSYCHIATRIC ASS'N, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 465* (4th ed. 2009) [hereinafter *DSM-IV*].

25 JONATHAN SILVER ET AL., *supra* note 12.

26 PETER BREGGIN, *THE HEART OF BEING HELPFUL: EMPATHY AND THE CREATION OF A HEALING PRESENCE* (1997); see also information about the Center for the Study of Empathic Therapy online at www.empathictherapy.org.

symptoms of a serious concussive injury: headaches, confusion, memory loss, dizziness, sluggishness, mood changes, memory problems, emotional instability, and the so-called lack of “executive functions” — basically a loss of self control along with the significantly reduced effective cognitive functions. In reading the article, *anyone familiar with the symptoms of PTSD would quickly see that these TBI symptoms are similar to the symptoms of a patient diagnosed with PTSD, long considered an injury of the mind and not the result of damage of the brain.*²⁷

Amnesia for the event is likely to occur in both TBI and PTSD. PTSD often has specific hallmarks, such as vivid nightmares, flashbacks to the event or events, avoidance of anything similar to the trauma, and heightened alertness for dangers specific to the traumatic period of time.

In many cases, the symptoms of TBI and PTSD are so similar that it is difficult to tell them apart. Surprisingly, the brain injury aspects of the trauma may tend to clear up over time while the psychological aspects may worsen with time or even first flagrantly surface months or years afterward. However, the negative effects of prescribing psychiatric drugs can be tragic, in part because they can worsen TBI and PTSD.

D. Chronic Symptoms of PTSD

Persistent or recurrent PTSD can become very disabling. Although caused by psychological trauma, it can be difficult to distinguish from the Chronic Brain Impairment (CBI) caused by TBI and chronic exposure to psychiatric drugs. The symptoms, as noted above, include cognitive dysfunction, apathy or indifference, emotional instability or lability, and psychological denial that can look like the anosognosia associated with physical injury to the brain. Once again, the chronic symptoms of PTSD can mimic and aggravate the chronic symptoms associated with TBI and longer-term psychiatric drug treatment.

III. ADVERSE MEDICATION EFFECTS

The FDA’s reanalysis of drug-company data showed an increased rate of suicidality in children, youth, and young adults up to age twenty-four who were exposed to antidepressants in short-term clinical trials.²⁸ This has resulted in a black box warning at the top of all FDA-approved antidepressant labels. This age group, adults under age twenty-five, obviously includes many active duty military personnel. The real world the rates of suicidality would be much higher than those in the clinical trials. Controlled clinical trials educate and inform the patients in more detail about risks, require weekly monitoring, last no more than several weeks, avoid drug combinations, and *exclude suicidal patients*. In addition, they provide great hope to the subjects and their families who seek to find

27 Christine L. MacDonald et al., *Detection of Blast-Related Traumatic Brain Injury in U.S. Military Personnel*, 364 N. ENG. J. MED. 2091–100.

28 Marc Stone et al., *Risk of Suicidality in Clinical Trials of Antidepressants in Adults: Analysis of Proprietary Data Submitted to US Food and Drug Administration*, 339 BRIT. MED. J. (2009).

a cure by participating in the experimental clinical trials.²⁹ Children and youth are like canaries in the mineshaft and we can expect that older adults will also suffer from the risk of suicide, a fact demonstrated by a review of the literature.³⁰

The following excerpt is taken from the warning section the FDA-approved Zoloft (sertraline) label as of October 2008, as found in the *Physicians' Desk Reference* for 2009, which describes an activation or stimulant-like array of adverse effects similar to those from stimulant drugs:

The following symptoms, anxiety, agitation, panic attacks, insomnia, irritability, hostility, aggressiveness, impulsivity, akathisia (psychomotor restlessness), hypomania, and mania, have been reported in adult and pediatric patients being treated with antidepressants for major depressive disorder as well as for other indications, both psychiatric and nonpsychiatric.

Note the specific mention of "irritability, hostility, aggressiveness, impulsivity," and mania, an array of symptoms that individually or together can cause or aggravate suicide and violence, especially in already stressed soldiers. Identical or nearly identical warnings and information can be found in all antidepressant labels *These warnings closely parallel many of the symptoms associated with head injury and, especially with PTSD, including the over-stimulation or activation syndrome.*

In the section on clinical worsening and suicide risk, the Zoloft label recommends informing patients and caregivers about this array of adverse drug effects. The probability that these warnings will be given to military personnel is not high, and of course, on deployment, their families will be unavailable to monitor them.

A *Medication Guide* for all age-groups at the end of each antidepressant label states, "The prescriber or health professional should instruct patients, their families, and their caregivers to read the *Medication Guide* and should assist them in understanding its contents." From my interviews of military health care providers at two consecutive military stress conferences, the medication guide is rarely if ever given to medicated soldiers in deployment or during post-deployment treatment and rehabilitation.³¹

A bulleted list of danger signs associated with the use of antidepressants is provided in the antidepressant *Medication Guide*:

- Thoughts about suicide or dying
- Attempts to commit suicide
- New or worse depression
- New or worse anxiety
- Feeling very agitated or restless
- Panic attacks
- Trouble sleeping (insomnia)
- New or worse irritability, acting aggressive, being angry, or violence

29 BRAIN-DISABLING TREATMENTS IN PSYCHIATRY, *supra* note 7.

30 *Id.*; *Psychiatric Drug-Induced CBI*, *supra* note 11; and PSYCHIATRIC DRUG WITHDRAWAL, *supra* note 22.

31 17th and 18th Annual International Military and Civilian Combat Stress Conferences, Los Angeles, May 2009 and May 2010.

- Acting on dangerous impulses
- An extreme increase in activity and talking (mania)
- Other unusual changes in behavior or mood

Identical warnings are also found in the *Medication Guide* for mood stabilizers such as carbamazepine (Equetro).³² *These bulleted warnings describe over-stimulation, as well as the risk of suicidality and violence, associated not only with antidepressants, but also TBI and especially PTSD. Every one of these potentially dangerous symptoms is also commonly seen in both TBI and PTSD, posing the risk of worsening these common military disorders. The combination of antidepressants, TBI and PTSD is volatile and dangerous.*

A. Behavioral Risks Associated with Antidepressant-Induced Mania

The section on Manic Episodes in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* states that antidepressants can cause the symptoms and behaviors associated with mania: "Symptoms like those seen in a Manic Episode may also be precipitated by antidepressant treatment such as medication."³³ These symptoms specifically include criminal behavior, antisocial behavior, "irritability, particularly when the person's wishes are thwarted," assaultive behavior, physically assaultive behavior, physically threatening behavior, suicidal behavior, and shifts from anger to depression.³⁴ Stimulant drugs can also cause many of the same symptoms, including depression, suicide, violence, mania and psychosis.³⁵

As the diagnostic manual states, SSRI antidepressants as well as antipsychotic drugs can cause akathisia (psychomotor agitation). This extremely distressing inner state, usually accompanied by hyperactivity, can cause suicide, aggression, and worsening of psychosis or behavioral dyscontrol.³⁶ The hazards of akathisia, hypomania or mania are high-risk in active duty soldiers and will be further aggravated by PTSD or TBI.

B. Medication Spellbinding

I developed the concept of medication spellbinding (intoxication anosognosia) to describe how psychiatric medications often impair the individual's judgment regarding their effects.³⁷ An individual taking an effective dose of these psychoactive substances is not likely to fully perceive the resultant adverse mental effects. Any emotional distress that develops may be self-attributed to other sources such as the individual's mental illness or to stresses in the environment. This can lead to suicide in despair over one's own mental condition or to violence when the painful feelings are blamed on others. From mild states of drug-induced irritability, anxiety, and depression to extreme states of

32 Validus Pharmaceuticals, Medication Guide No. EQ-043-10, *Equetro Medication Guide* (2010), <http://equetro.com/pdf/equetro-medication-guide.pdf>.

33 DSM-IV, *supra* note 24, at 361. There is a large scientific literature confirming high rates of mania induced by antidepressant drugs, reviewed in Breggin 2008 and 2011.

34 *Id.* at 359-61.

35 PSYCHIATRIC DRUG WITHDRAWAL, *supra* note 22

36 *Id.* at 801.

37 Peter Breggin, *Intoxication Anosognosia: The Spellbinding Effect of Psychiatric Drugs*, 19 INT'L J. RISK & SAFETY IN MED. 3, 3-15 (2007); and PSYCHIATRIC DRUG WITHDRAWAL, *supra* note 22, at ch. 9, pp. 109-118.

psychosis and mania, the individual may fail to fully appreciate the effects, may attribute them to something other than the drug, and may take out-of-character and dangerous actions.

In *Medication Madness*, I describe 50 cases of violence, suicide, crime, and other abnormal mental and behavioral states induced by antidepressants and other psychiatric drugs.³⁸ Only one of these individuals grasped that his distress was drug-induced and he was unable to stop taking the antidepressant due to equally distressing withdrawal symptoms. He threatened to shoot the people who came to his aid and then killed himself.

As previously noted, stimulant drugs such as Ritalin (methylphenidate) and Adderall (amphetamine) can also produce bizarre and out-of-control behavior, including violence, suicide, psychosis, and mania.³⁹

Benzodiazepines used to treat anxiety and insomnia, as well as other sedative drugs used for sleep, can cause paradoxical effects similar to over-stimulation. Xanax (alprazolam) is especially noted for causing abnormal behaviors, can cause mania and depression, and is frequently involved in combination with antidepressants in cases of violence, suicide, and crime.⁴⁰ However, any tranquilizing or sedative drug from the anti-anxiety agent Ativan (lorazepam) to the sleeping medications Ambien (zolpidem) and Sonata (zaleplon) can produce these effects.

Antipsychotic drugs, including newer ones such as Abilify (aripiprazole), Geodon (ziprasidone), Risperdal (risperidone), Seroquel (quetiapine), and Zyprexa (olanzapine) produce lobotomy-like effects on the brain, causing especially overwhelming apathy, indifference, and docility.⁴¹ The medication spellbinds and chronically impairs the individual in a manner that crushes autonomy and motivation, rendering the individual apathetic and unable to pursue his or her self-interests in the legal arena. However, they can also cause akathisia with extreme agitation and anxiety which can aggravate or mimic the stimulation symptoms associated sometimes with TBI and commonly with PTSD.

C. Chronic Brain Impairment

I also developed the concept of Chronic Brain Impairment (CBI) to describe the frequent effects of long-term exposure to any and all psychiatric drugs.⁴² These include cognitive decline, apathy, emotional instability, and anosognosia, or the failure to appreciate these adverse effects. Individuals taking psychiatric medications over a long period of time can become increasingly unable to protect and promote their interests in or outside the legal arena.

IV. DISCUSSION: CLINICAL IMPLICATIONS

Prescribers, clinicians, patients and their families need to recognize that psychiatric drug exposure, TBI, and PTSD are a dangerous combination. In both the acute and chronic

38 MEDICATION MADNESS, *supra* note 8.

39 BRAIN-DISABLING TREATMENTS IN PSYCHIATRY, *supra* note 7; MEDICATION MADNESS, *supra* note 8.

40 *Id.*

41 BRAIN-DISABLING TREATMENTS IN PSYCHIATRY, *supra* note 7.

42 *Psychiatric Drug-Induced CBI*, *supra* note 11.

phases, the symptoms of all three can mimic and reinforce or aggravate each other. Too often the patient's worsening condition will be attributed to TBI or to psychiatric disorders such as PTSD when that worsening condition is due instead to psychiatric drug adverse effects. The failure to recognize the role of psychiatric drugs in the patient's decline can lead to increased doses of the offending drugs. In these cases, a carefully supervised drug withdrawal will commonly lead to dramatic improvement.⁴³

The military and the VA need to pay more attention to the human element in treating patients with TBI and PTSD, and in particular to problems associated with guilt and shame. These issues are best addressed by empathic, caring therapy, often with involvement of the family.

In general, it is best to treat TBI and PTSD without resort to psychiatric drugs, which are more likely to worsen the patient's condition. Empathic therapies offer the best short-term and long-term result.

In regard to the legal arena, TBI, PTSD and/or psychiatric drug exposure can cause suicide, crime, and violence. Unfortunately, patients are typically started on or continued on psychiatric drugs during legal proceedings. Exposure to any psychiatric drug can compromise the individual's ability to represent his or her own best interests by impairing judgment and by dulling motivation and self-interest. All the antipsychotic drugs, including Risperdal (risperidone), Zyprexa (olanzapine) and Seroquel (quetiapine) are especially suppressive of motivation and self-interest, and can impair an individual's capacity to be self-determined and to aid counsel.⁴⁴ However, any psychiatric medication can produce effects that render the individual unable or less able to act effectively on his or her own behalf in legal proceedings.

V. ANALYTICAL CONCLUSIONS

To address this problem, the following conclusions and recommendations can be drawn from the analysis above:

1. Traumatic Brain Injury (TBI) and Posttraumatic Stress Disorder (PTSD) display many similar symptoms, such as insomnia, hypersensitivity, anxiety, agitation, irritability, and a potentially dangerous loss of impulse control, leading to violence and suicide. This is especially true during the first several weeks or months of PTSD and/or TBI. *Acute* TBI and PTSD, thus, can partially mimic and worsen each other.
2. If TBI and/or PTSD remain inadequately treated over a period of months and years, both are likely to cause similar clinical symptoms of cognitive impairment, apathy or indifference, social withdrawal, fatigue, depression and suicidality, emotional instability or lability, and a general limitation on the quality of life. In the case of TBI, this syndrome is caused by Chronic Brain Impairment (CBI); but in the case of PTSD it is caused by chronic psychological stress. *Chronic* TBI and PTSD thus can mimic and can worsen each other.

43 PSYCHIATRIC DRUG WITHDRAWAL, *supra* note 22.

44 BRAIN-DISABLING TREATMENTS IN PSYCHIATRY, *supra* note 7.

3. Antidepressants, stimulants, benzodiazepines, some mood stabilizers, antipsychotic drugs (akathisia) and other psychiatric drugs can produce insomnia, anxiety, irritability, impulsivity, disinhibition, emotional instability, depression, suicide, violence and mania. This is especially likely to happen within several weeks or months of the start of medication, during medication changes, and during medication adjustments up or down in dose. *Acute* treatment with psychiatric drugs, thus, can mimic and worsen TBI and PTSD.
4. If antidepressants or any other psychiatric drugs are given longer-term (months or years), they tend to produce Chronic Brain Impairment (CBI) similar or nearly identical to the trauma-induced CBI, and also similar to the chronic psychological symptoms of PTSD. *Chronic* exposure to *any* psychiatric drug, thus, can mimic and worsen TBI and PTSD.
5. TBI, PTSD, and antidepressant drugs, separately and together, can greatly compromise cognitive abilities, emotional stability, self-insight, and concern for self. They also cause anosognosia or lack of awareness of their deficits. In the legal arena, this is important not only in regard to causing suicide, violence and crime, it is also important in regard to competency to make judgments during the legal proceedings and to properly assist counsel.
6. Since all psychiatric drugs can cause medication spellbinding and chronic brain impairment (CBI), they can contribute to or cause abnormal mental and behavioral states related to suicide, violence, and criminal activity; and they can compromise judgment and competence during legal proceedings. The risk is increased when the drugs are combined with PTSD and/or TBI.
7. Because psychiatric drugs, TBI, and PTSD produce overlapping symptoms during both the acute and the chronic phases, prescribers and other clinicians are likely to believe the patient's TBI and/or PTSD are getting worse, *when in fact the patient is being made worse by exposure to the psychiatric drugs*. This can lead to a mistaken increase in psychiatric drug exposure, creating a vicious cycle in which the patient is exposed to more of the offending medication, with the result of a much worsened condition.
8. Antidepressants and other psychiatric drugs are almost always poor choices for the treatment of PTSD or TBI, and should never be relied upon as exclusive treatments. Some healthcare providers have found that *short-term, low dose* medications are useful, along with psychotherapeutic approaches; but even this should be done with caution and restraint by experienced clinicians. Routine clinical doses and/or long-term exposure to psychiatric drugs, as well as polydrug exposure, will do far more harm than good to individuals suffering from TBI or PTSD.
9. As I describe in *Psychiatric Drug Withdrawal* (2013),⁴⁵ removal from psychiatric drugs must be done carefully and slowly with experienced clinical supervision in a collaborative team effort involving the prescriber, the therapist, the patient and the family. Withdrawing patients from psychiatric drugs will often produce a dramatic improvement in TBI and PTSD, as well as in drug-induced CBI.

45 PSYCHIATRIC DRUG WITHDRAWAL, *supra* note 22.

10. Although not the focus of this chapter, many empathic approaches are available for the treatment of TBI and PTSD. All require a caring, supportive therapeutic relationship that optimally involves the family as well. For more information on empathic approaches, please see the Center for the Study of Empathic Therapy's website at www.empathictherapy.org.