30 August 2016

An Open Letter to
The US Senate Committee on Armed Services
and
The US House Committee on Armed Services
And
The US Senate Committee on Veterans' Affairs
And
The US House Committee on Veterans' Affairs

Concerning Mental Health Treatment and Suicide in the United States Armed Forces and the Veteran Community

Dear Committee Members,

I am a 2007 graduate of the United States Naval Academy and former Lieutenant in the US Navy. I am also a veteran who struggles with thoughts of suicide. I am writing to share my experience and express my concern with the current mental health services model in the DoD and VA. I firmly believe that the rates of mental illness and suicide within the veteran community and active duty personnel are partly due to the overprescribing and unrestrained use of psychotropic drugs along with the failure to formally communicate and monitor the known adverse effects of these drugs. Psychotropic drugs include antidepressants, antipsychotics, tranquilizers, stimulants, and mood stabilizers.

I would like to establish four uncontested realities. *First, there is no single psychological or physiological motivator for suicide. Second, due to bio-statistical variation, response and tolerance to medications and drugs can vary significantly across a population. Third, to date, no known physiological dysfunction of the brain has been found to be characteristic of any major mental illness. Fourth, psychotropic drugs alter otherwise normal brain physiology.*

In 2010 I began a fully funded US Navy graduate education program in Naval Engineering at the Massachusetts Institute of Technology in Cambridge, MA. In my second semester, I began to experience anxiety secondary to a stressful academic load and a troubled romantic relationship. It is critical to note that at no time prior to or during my distress was I suicidal or clinically depressed, simply anxious. I voluntarily sought treatment from a psychiatrist and was prescribed the benzodiazepine Ativan (lorazepam) and the SSRI Zoloft (sertraline). It is critical to note that I was not informed of potential for physical dependency to benzodiazepines. I complied with treatment, using the medications as prescribed, and finished the graduate education program.

Following graduation in 2012, I was transferred to Puget Sound Naval Shipyard in Bremerton, Washington. My psychiatric care was transferred to a new military provider at Naval Hospital Bremerton. Despite being exposed to less stress, my condition worsened. I was transferred to the SSRI Paxil (Paroxetine) and further diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) and placed on Adderall XR (amphetamine and dextroamphetamine). While my condition stabilized for several months, likely due to euphoria associated with amphetamine, it continued to deteriorate over the following two years. It is critical to note that the only notification I received from my psychiatrist of the significant withdrawal effects associated with Paxil was the comment "You don't want to miss a dose."

In the summer of 2014, while my condition continued to deteriorate, the adverse effects from the combination of psychotropic drugs began to mount. Short term memory loss, cognitive dysfunction, sexual dysfunction, disturbed sleep, and emotional flatness are a few among many. Following my psychiatrist's guidance, I tapered off the combination of drugs over a two-month period, only my condition was not the same as when I had begun treatment. What has ensued in the year and a half since discontinuation can only be described as horrific and life-altering. The most notable symptoms include searing headaches, muscle tension, tremor, seizure-like episodes, memory loss, cognitive dysfunction, dizziness, and a level of terror-like, irrational anxiety that I could never have previously imagined possible and simply cannot be expressed in words. Intrusive suicidal ideations due to the persistent and intense physical and psychological suffering have become a fact of everyday life.

However, what has been most distressing during the months of both acute and post-acute withdrawal is the wholesale denial by mental health professionals that my suffering could be related to the drugs. My experience has repeatedly been labeled a 'relapse' of my original condition, despite the indisputable fact that my symptoms did not exist in any form prior to exposure to psychotropic

drugs, and which correlated with the use and discontinuation of several strong psychotropic drugs. Instead, new diagnoses and offers of stronger medications abounded. Knowing that what I was experiencing was not an organic disorder, but rather neurological dysfunction induced by exposure to several psychotropic drugs, I refused further pharmaceutical treatment. In the time since, I have learned that many patients experiencing the same distress from psychotropic drug use and withdrawal, as well as the invalidation of rational personal observations, commit suicide or succumb to the pressure of clinicians and comply with further psychotropic treatment.

After consulting with numerous private and public psychiatrists and psychologists, I have found a very strong confirmation bias within the mental health community that resists any challenge to the current prescribing methods of psychotropic drugs. I have repeatedly encountered a total repudiation of the potential long-term, persistent adverse effects and likelihood for worsening a patient's psychological state despite the growing body of independent scientific research and anecdotal evidence that supports my experience. It rises to a level of groupthink that I have never before encountered in any societal institution.

I would like to reiterate the four indisputable realities I mentioned above. *First, there is no single psychological or physiological motivator for suicide. Second, due to bio-statistical variation, response and tolerance to medications and drugs can vary significantly across a population. Third, to date, no known physiological dysfunction of the brain has been found to be characteristic of any major mental illness. Fourth, psychotropic drugs alter otherwise normal brain physiology.*

Considering my personal experience, the abundance of patient anecdotal evidence and a growing body of scientific evidence, it is apparent that a significant portion of the population is intolerant and subject to neurological destabilization and dysfunction from exposure to psychotropic drugs. Consequently, they are likely to endure previously inexperienced and severe levels of distress and despair, leading to suicidal ideations and actions.

From what I have witnessed as a patient, the psychiatric community is not capable of critically assessing the evidence and instituting the changes required to address the issues I have raised. I am asking that as legislators, you objectively consider all the evidence concerning short and long-term exposure to psychotropic medications, and realize that, as the institution of psychiatry is wholly dependent on the ability to prescribe psychotropic drugs, it is inherently biased and incapable of critical self-assessment.

Two legislative actions I feel would have significant impact while maintaining patient access to psychotropic drugs are:

1. Requirements for formal and documented 'Informed Consent' signed by the patient that includes: (1) acknowledgement that the drugs are altering otherwise normal brain physiology, (2) full disclosure of the known effects of psychotropic drugs, (3) the potential for adverse outcomes based on scientific research independent of bias and conflicts with the pharmaceutical industry, and (4) disclosure of legal actions previously taken against the drug or class of drug.

2. Recommendations for 'therapy-first' approach to non-life threatening mental health cases rather than the current 'pharmaceutical-centric' approach.

The United States military has long been an instigator for positive change within the broader institutions and norms of our society. Critical assessment of the current pharmaceutical approach to mental health is one such opportunity with the potential to save many lives.

Sincerely,

David M. Cope

BS Ocean Engineering, United States Naval Academy, 2007
MS Mechanical Engineering, Massachusetts Institute of Technology, 2012
Naval Engineer, Massachusetts Institute of Technology, 2012
Disabled Veteran, 2015