Psychotropic Drugs Originate Permanent Biological Changes that go Against of Resolution of Mental Health Problems. A View from the General Medicine

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Abstract

The biologistic tendency of medicine, and also of psychiatry, brings with it an increasingly early, more intense, longer-term use in mild clinical conditions and in mental health situations reactive to contexts of daily life (personal problems, couple, family, work, socioeconomic, etc.) of psychotropic drugs. However, practical experience in general medicine indicates that psychotropic drugs cause permanent biological changes that can structure and chronify mental illnesses that would have evolved towards improvement without psychotropic drugs: they produce functional changes in thoughts, feelings and behaviours that over time make structural / organic and permanent. In this way the general practitioner in his continuity of care over time sees the results of psychotropic drugs: passive patients, unable to understand and face the causes and consequences of their situation; These patients with many years of psychopharmacological treatment continue to suffer similar levels of mental symptoms, but also their contextual situation has seriously deteriorated in a chronic way; they are unrecoverable patients. Current prescribing practices for psychotropic drugs need to be reformulated in light of the consideration of vulnerabilities and permanent adverse effects of treatment.

Keywords: Prescribing, Psychotropic drugs, Primary health care, Long-term outcome, Prognosis.

Introduction

The economic, social, and health costs of mental distress are increasingly burdening individuals and societies in Europe. Yet, overmedicalization of mild symptoms is also well documented. This accumulates in more pressures and demands on health care systems (Doblytė, 2020). However, although anxiety / depression is very prevalent, knowledge is scarce as to whether an intensive biologistic approach to mental health changes the way general practitioners help their anxiety / depression patients (Rut et al., 2021).

Long-term antidepressants are increasingly used by adults, although they may not always benefit from them and despite an increased risk of adverse events. Thus, psychotropic drugs are now the third most commonly prescribed drug class in the United States (Mojtabai & Olfson, 2011; Scholten et al., 2020). Unfortunately, evaluations of long-term antidepressant use are rare, especially in older age groups (Batelaan et al., 2021; Karter, 2020). Furthermore, polypharmacy is highly prevalent in patients with mental disorders (Govaerts et al., 2021) and psychotropic drugs prescribing without a recorded psychiatric diagnosis has increased substantially over the past decade (Mojtabai & Olfson, 2011). On the other hand, anxiety / depression is frequently overdiagnosed and overtreated in adults (Rajaraman, 2013).

Overall, there is no good literature on the long-term impact of psychotropic drugs used to treat adult symptoms (Cañada et al., 2021). Anxiety / Depressive symptoms are volatile over time but empirical studies of intra-individual variations of depressive symptoms over longer periods are sparse (Engel et al., 2020). Trial meta-analyzes suggest that psychotropic drugs are only marginally effective compared to placebos and document a profound publication bias that increases their apparent efficacy. These meta-analyzes also document a second form of bias in which researchers do not report negative results for the prespecified primary outcome measure, while highlighting in published studies positive results for a secondary or even new measure as if it was their primary measure of interest (Pigott et al., 2010).

In this scenario, the objective of this article is to reflect from the experience of the different “logics” or ways of understanding mental health, especially anxiety / depression, and on the negative effects of treatment with psychotropic drugs, as well as the need for an approach comprehensive / adequate that allows understanding the dynamics of the disease and establishing diagnostic and management strategies in general medicine less biologistic.

Methods

This article is based on the review of selected articles, and personal experience of the author, to reflect, conceptualize, synthesize, and discuss the possible implications, for intensive use of psychotropic drugs in general medicine. For the literature review, a pragmatic approach was used that was based on a non-systematic or opportunistic narrative review considered the bibliographic references of selected articles and opportunistic searches on the Internet. This article should be understood as a personal view, based on the author's experience and the literature review as described above.

Discussion

Terms like "antidepressant" and "antipsychotic" are metaphors. They are analogies with "antibiotic", which was the medical triumph of the twentieth century. The terms "anti" invaders replaced the metaphors and models of the past by which psychiatrists made sense of the phenomena of insanity and deviance. We have constructed the idea of most psychiatric illnesses in the model of an alien process afflicting a host, so treatment is to eradicate (remove by the root) that process. We look past the phenomena to our conceptual model of cause, and approach the treatment as we would approach anti-biotic treatment. That is, we delineate the alien pathogen or process and apply the appropriate specific 'anti-' medicine and increase the dose until it is eradicated. By virtue of the antibiotic metaphor, we have tolerated and justified side-effects and 'collateral' harms to the health of patients some of whom now describe themselves as 'survivors' of psychiatric treatment (Rosenman, 2016).

The possibility has been raised that antidepressant drugs could increase chronicity in mood and anxiety disorders. Unfortunately, the largely unproven assumption that "what makes patients feel better is best to keep them well" has hampered the progress of pharmacological research in anxiety / depression (Fava, 2020).

There are reasons to be careful about prescribing antidepressants too easily. First, the overall sizes of the positive effects found are small and the long-term effects of antidepressants are not examined; furthermore, a lower efficacy of psychotropic drugs in patients with milder symptoms cannot be ruled out. Second, although drug treatment is often the first choice for physicians due to its low cost and ease of prescription, there are psychological alternatives that have been shown to be equally or more effective (Cañada et al., 2021; Penninx, 2019).

Evidence shows that only one in nine people benefit from antidepressants - the remaining eight are unnecessarily at risk of adverse drug effects. The effect size of antidepressants is modest compared to placebo, and is based on scales of questionable clinical relevance. Mood disturbances often reflect real life circumstances. Many depressive presentations respond to judicious "watchful waiting." Most cases of depression, even severe or persistent, are successfully treated with psychosocial interventions, which are preferred by patients, are beneficial for self-esteem and social functioning, and have no adverse effects. Thus, it can be cited that benzodiazepine users are admitted to present neurocognitive alterations in terms of executive functioning in addition to those of the mental health problem that motivates the treatment (Braillon et al., 2019); cognitive decline after oral administration of sedatives, such as benzodiazepines, is a serious side effect (Shiga et al., 2021). On the other hand, it has been reported that years of treatment with psychotropic drugs alter the lipids in the brain of young monkeys (Gaines, 2021); And the effects of antidepressant exposure during early development can pass down through three generations of offspring — at least in zebrafish (KWON, 2018; Vera-Chang et al., 2018).

Continuous drug treatment with antidepressant medications can stimulate processes that run counter to the initial acute effects of a drug. Antidepressant medications can constitute a form of iatrogenic comorbidity, which increases chronicity and vulnerability to depressive episodes (Fava, 2020). The neurochemical interpretation and construction of anxiety / depression creates a new problem for the patient as it prevents their recovery in several ways. The scientific and market-oriented rationales that underpin neurochemical recovery obscure the bodily affective relationships and social conditions that allow the self to change, and this may be especially important in responses to gender-based mental health, preventing a process on the emotional self (Fullagar & O'Brien, 2013).

The dominant treatment in mental health focuses on the management of symptoms and thus relies exclusively on the role of psychotropic drugs. Psychopharmacological medication and psychological treatments have different goals (Hammersley, 1995). There is a well-established approach in medicine that says that if the symptoms of a disease are effectively eliminated, it can be assumed that the disease is being treated. This approach leads clinicians toward symptomatic treatment, which is more accessible and tangible than the internal experience of the patient. Emotional distress leads to biochemical changes in the brain and thus thoughts, feelings, and behaviours are biochemically mediated. However, the medical model assumes that it happens the other way around, and that changes in thoughts, feelings and behaviours cause biochemical changes, and therefore, drug treatment will lead to amelioration of distress. This bilateral relationship between distress and chemistry assumes that the external factors of life experience, relationships and events could be mitigated by the change in the psychological state of the patient. Psychotropic drugs change brain chemistry, decrease symptoms, reduce anxiety, and consequently affect a person's thoughts, feelings, and behaviours. It is assumed that the person can thus more effectively control her problem once her anxious mood is removed. The underlying assumption is not that anxiety is an inappropriate or undesirable state, but that it has no deep meaning (Hammersley, 1995).

In a non-biologist model it is assumed that anxiety and depression are something in relation to the person's life. In addition, from this perspective, the disorder itself is

therapeutic, since the appearance of signs of distress, such as symptoms and changes in mood and behaviour, which are caused in the individual, make him adjust his understanding of the self, relationships interpersonal or your life. There is a basic difference between the biomedical and psychological models of emotional distress that is related to the direction of causality. The psychological model assumes that the interaction between past experience, interpersonal relationships, and current events, with the patient's thoughts, feelings, and behaviours, lead to changes in mood and symptoms. The medical model views disease as the primary cause of symptoms and leads to changes in thoughts, feelings, and behaviours, which interact with the patient's interpersonal relationships, current events, and past experiences.

These models lead to different conclusions about the therapeutic options. Rather than seeing the resolution of distress as the goal of treatment, the psychological model recognizes that feelings of emotional distress may be appropriate, unavoidable, and even acceptable, especially for a limited time. The approach in the medical model of causality is about the biochemical mechanisms through which all psychological processes are mediated. The disease is seen as an imbalance that must be restored with drugs and leads to the idea that some people have to take drugs for the rest of their lives to maintain this balance. The need to confront internal psychological reality is also neglected. The patient who has been treated with drugs and its symptoms have been alleviated, will be more reticent, or will be less motivated to seek real and possibly more painful solutions (Hammersley, 1995).

Psychotropic drugs block the expression of feelings, affect the problem-solving process, and make the person passive. In the model of psychotropic drugs, since they are symptomatic treatments, and do not treat the underlying cause of depression, it can recur. It is important to realize that psychotropic drugs treat symptoms and not the connections of these symptoms (Hammersley, 1995). Psychotropic drugs block emotions, limit memory and memory processing, reduce activity, produce tolerance, and produce physical and psychological dependence. Psychotropic drugs make people inaccessible, even at low doses, to psychological therapies, since they interfere with thoughts and concentration and make the person withdrawn and passive (Hammersley, 1995).

Thus, when the doctor prescribes one or more psychotropic drugs, he must be aware that he must modify his doctor-patient relationship so that the "psychotherapy" or advice that occurs within the psychosocial effect of the doctor-patient relationship is adequate and useful. Drugs can make the effect of the "doctor in himself as a drug" more difficult, favoring an insignificant relational context, where the doctor does not delve into the true meaning of the symptoms, and the patient tends not to get involved, to withdraw emotional, to be passive before the prescribed drug (Turabian, 2018; Turabian, 2018; Turabian, 2019).

According to the medical model, suffering is unnecessary and undesirable, serving no purpose. Exhibiting feelings, especially crying is often seen as being a "non-cooperator facing the problem", and thus psychotropic drugs are prescribed. The consultation is often seen as unsatisfactory, by the doctor and the patient, if there is no tangible result, so instead of exploring the underlying causes, a drug is prescribed (Hammersley, 1995). Psychotropic medicines, in the main, suppress psychological processes: Neuroleptics suppress motivation and imagination and interfere with regulation of body shape and movement; Benzodiazepines suppress behavioural control and discrimination; Selective serotonin re-uptake inhibitors suppress the erotic core. Suppression is essential to their effect, not a side-effect of their attack on a specific disease process. Suppression of psychological processes, however necessary, has consequences and the advantages and disadvantages of those suppressions have to be weighed at the outset and throughout treatment (Rosenman, 2016).

And it must also be taken into account that a classic concept in medicine is that what is functional becomes organic, and what is organic produces functional symptoms. The non-specific "functional" psychosocial effects of the prescription of psychotropic drugs can continuously turn into chronic "organic" effects. Functional disturbances become, without clear boundaries, organic, more durable, and often irreversible. The more frequent and severe functional disturbances occur, the more one can count on an organic defect. Both somatic and mental disorders are the consequence of "biography", genotype and phenotype (Siebeck, 1957).

In this line of research, it is increasingly recognized that chronic treatment with psychotropic drugs can lead to structural remodeling of the brain. Emotions and other aspects of mental function are not like the components of a machine, each with a specific function; instead, they are embedded in complex overlapping biochemical pathways (Woolfson, 2019). Indeed, human clinical studies present an intriguing picture: psychotropic drugs may contribute to the loss of cortical gray matter in patients (Vera-Chang et al., 2018; Anonymous, 2012; Vernon et al., 2012; Maestroviejo, 2012).

Psychotropic drugs have multiple and complex cellular actions beyond the manipulation of neurochemical transmission; after an initial increase in intra-synaptic neurotransmitter concentrations, antidepressants downregulate presynaptic receptors and increase neuronal activation. Additionally, antidepressants activate second messenger proteins and modulate neurogenesis by regulating proteins such as brain-derived neurotrophic factor (Malhi et al., 2020). The changes in thoughts, emotions and behaviours produced by psychotropic drugs can be due to all these effects: loss of cortical gray matter, hypocortisolism and behavioural disruption and multiple and complex cellular actions beyond the manipulation of neurochemical transmission(Vera-Chang et al., 2018; Anonymous, 2012; Vernon et al., 2012; Maestroviejo, 2012).

Conclusions

Psychotropic drugs cause permanent biological changes that can structure and chronify mental illnesses that would have evolved towards improvement without psychotropic drugs. Psychotropic drugs change thoughts, feelings and behaviours that over time become structural and permanent. In this way, the general practitioner in his continuous care over time sees passive patients, unable to understand and face the causes and consequences of their situation; These patients with many years of psychopharmacological treatment continue to suffer similar levels of anxiety, but also their contextual situation has seriously deteriorated in a chronic way; they are unrecoverable patients. Current prescribing practices need to be reformulated in light of consideration of the vulnerabilities and adverse effects of treatment.

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