ClinicSearch

Journal of Clinical Anatomy

Jose Luis Turabian *

Open Access

Short Communication

Have Psychiatrists and General Practitioners Become Traffickers of Psychodrug?

Jose Luis Turabian *

Health Center Santa Maria de Benquerencia. Regional Health Service of Castilla la Mancha (SESCAM), Toledo, Spain

***Corresponding Author:** Jose Luis Turabian, Health Center Santa Maria de Benquerencia Toledo, Spain.

Received date: April 10, 2023; Accepted date: April 18, 2023; Published date: April 28, 2023

Citation: Jose Luis Turabian (2023). Have Psychiatrists and General Practitioners Become Traffickers of Psychodrug?, *Journal of Clinical Anatomy* 2(2). **Doi:**10.31579/2834-5134/020.

Abstract

Mental health problems are now taken for granted as they involve mental illness. Until some time ago, it was understood that, unlike other physicians, psychiatrists and general practitioners (GPs) were trained to treat biological and psychosocial illnesses, including economic, moral, racial, religious, or political “diseases” (1). But currently, there are no longer differences between medical specialties: every disease must be based on a biological alteration. Thus, most GPs and psychiatrists use the medical model of mental illness and treatment focused on psychoactive drugs. However, not all mental health problems are mental illnesses, nor are these “biological bases” adequate to describe the individual experience of people (2). This approach leads to an overdiagnosis of emotional problems such as mental illnesses, and an overtreatment with psychoactive drugs (3, 4). Thus, currently, the prescription of psychoactive drugs (antidepressants, anxiolytics, hypnotics, and antipsychotics) is considerable and is increasing exponentially; in addition, a large proportion is prescribed by GPs (5); Adolescents are increasingly being prescribed multiple psychotropic medications that are not approved for people under 18 and have not been studied in combination (6). Depression in older adults, which is less frequent than in other age groups, receives a greater number of prescriptions for psychotropic drugs (7). Therefore, psychiatrists and GPs are becoming "traffickers" of psychoactive drugs (8). With this model focused on psychoactive drugs, mental illness is neither understood nor is the patient helped quite the contrary. This implies a deep crisis in which psychiatry and general medicine find themselves, having embraced the pure pharmacological approach in their management of emotional and psychological disorders and having become, due to the weakness of the variables they manage, a scapegoat for the manipulation of scientific evidence by the research sponsored by the pharmaceutical industry (9-11).

Keywords: prescribing; psychotropic drugs; pharmacology; psychiatry; general practice; long-term outcome.

Since the 20th century, psychiatry has adopted a physical treatment approach (with insulin comas, electroconvulsions, and lobotomy), with the appearance of being “a medical specialty like any other.” From the 60s of the 20th century, new psychoactive drugs arrived, which took over the emblematic treatment post of psychiatry. In addition, they can be prescribed on an outpatient basis and thus reach a large clientele and compete with social workers, psychologists, and psychotherapists (2).

The biologistic trend in medicine, and also in psychiatry, brings with it earlier, more intense, and longer-term use in mild clinical conditions and in mental health situations that are reactive to everyday life contexts (personal problems, partner, family, work, socioeconomic, etc.) of psychotropic drugs (12). In reality, the idea that "depression" is a frequentand under-diagnosed problem is relatively recent,appearing in the 1960s with the promotion of antidepressants by the pharmaceutical industry and the Diagnostic and Statistical Manual of Mental Disorders (DSM) (2). However, the DSM diagnostic system has dubious validity (13). For example, the discrimination between anxiety and depression in real life is inconsequential (depression and anxiety are a continuum) (14, 15), and on the other hand, it favors over-diagnosis. Thus, it is estimated that more than one in five American adults lives with a mental illness (57.8 million in 2021). And even further calculating the potential number of people who could be labeled with mental disorders if the DSM criteria were faithfully applied, they are almost half of the Western population(16).

However "depression" cannot be described outside of the experience of the patient feeling it. People who receive this diagnosis have a wide variety of heterogeneous problems (2). The utility of psychiatric diagnoses often varies with context. Thus, the false positives or negatives of the General Health Questionnaire would not be equally distributed among all classes of patients, but rather it depends on how they take their problems, in turn determined by social expectations (17). In addition, the model of attention focused on psychotropic drugs is based on the theory of organic chemical alteration. However, there is no evidence that psychiatric illnesses, psychiatric symptoms, or particular emotional feelings are caused by a chemical

imbalance due to specific brain alterations (2, 18-20). Nor is there any evidence to support the view that antidepressants partially or fully correct an underlying biological abnormality. Antidepressants act in a similar way to alcohol, opiates, cannabis, and benzodiazepines: producing a state of mental intoxication that causes sedation and a pleasant experience, which indirectly improves depression scales; but they do not correct underlying diseases (2). However, this state produced by psychoactive drugs suppresses or masks the symptoms of the underlying disease, and this effect is mistakenly interpreted as improvement or remission of the symptom or psychiatric disease (2).

On the other hand, this mental state of intoxication brings as consequences to the patient's passivity and the production of irreversible or chronic brain biochemical alterations. Practical experience in general medicine indicates that psychotropic drugs cause permanent biological changes that can structure and chronicle mental illnesses that would have progressed to improvement without psychoactive drugs: they produce functional changes in thoughts, feelings, and behaviors that become structural/organic and permanent over time; In addition, the sensitivity of the person towards their context and the relationship with the people around them decreases, in such a way that they counter-act that patients can make decisions and face changes in life circumstances (2, 12, 21).

The mental alterations produced by psychoactive drugs are ignored and interpreted as changes in the disease. Research on psychotropic drugs presents a "biased publication" of studies with positive effects of psychoactive drugs. In addition, many of these studies assess several different measures of benefit or outcome, publishing those associated with what they define as positive outcomes, and ignoring the rest. On the other hand, many psychiatric disorders have a fluctuating course, with occasional spontaneous improvements and depending on changes in the patient's context. Thus, most research on psychoactive drugs is meaningless (2).

Although it is warned of the little use of associating a second psychotropic drug, psychiatry, and general medicine are progressively tending towards the prescription of poly-psychotropic drugs: start with two antidepressants, plus one or two benzodiazepines, plus an added off-label antipsychotic, etc.) (22) and the risks are forgotten (23), with very little interest in help for those who want to withdraw psychoactive drugs (2, 24). In addition, it is not known that the prescription of psychoactive drugs changes the doctor-patient relationship (25).

Studies on effectiveness and evidence-based practice do not help to clarify the situation. Different research methods are more appropriate for many mental health problems. The “gold standard” is considered to be the “randomized controlled trials”, but the personal stories provide a counterbalance to the impersonality of the numbers. Mental health problems are frequently the result of reactions to complex events in the context where people live (2). Unfortunately, evaluations of long-term antidepressant use are rare, especially in older age groups (26-28) and psychotropic drug prescribing without a recorded psychiatric diagnosis has increased substantially over the past decade (29).

In short, a “pharmaceuticalisation” of life has been reached. However, the evidence shows that only one in nine people benefit from antidepressants: the remaining eight are unnecessarily at risk of adverse drug effects, and the effect size of antidepressants is modest and based on clinical relevance scales is questionable (30). Current psychoactive drug prescribing practices need to be reformulated taking into account vulnerabilities and permanent adverse effects of treatment (31, 32). Furthermore, much of the antidepressant treatment in general practice is for people with minimal or mild symptoms, whereas people with moderate or severe depressive symptoms may not receive it. There is considerable scope for improving depression care through better treatment allocation with psychotropic drugs (33). In conclusion, GPs and psychiatrists must stop acting as traffickers in psychotropic drugs.

References

1. Szasz TS (1974) The myth of mental illness.Foundations of a theory of personal conduct.New York: Harper & Row, Publishers
2. Moncrieff J (2009) A Straight talking introduction to psychiatric drugs. PCCS Books: Ross-on-Wye, Herefordshire, UK.
3. Rajaraman M (2013) Depression overdiagnosedand overtreated in U.S. adults. Clinical PsychiatryNews Digital Network; May 3.
4. Batstra L, Frances A (2012). Holding the Line against Diagnostic Inflation in Psychiatry.Psychother. Psychosom; 81: 5-10.
5. Ramanuj P, Ferenchick EK, Pincus HA (2019) Depression in primary care: part 2— management. BMJ; 365: l835.
6. Cosgrove L (2022) This Teen Was Prescribed 10Psychiatric Drugs. She’s Not Alone. The New York Time; Aug. 27.
7. Mojtabai R (2014) Diagnosing depression in older adults in primary care. N Engl J Med; 370(13): 1180-2.
8. Shem S (2000) Mount misery. Barcelona: Editorial Anagrama.
9. Mysterud I (2017) Deadly Psychiatry and Organized Denial. By P. C. Gøtzsche . Psychol Med; 47(7), 1335-6
10. Peter C. Gøtzsche (2015) Deadly Psychiatry andOrganised Denial. Denmark: People’s Press.
11. Doblytė, S. (2020). Under- or Overtreatment of Mental Distress? Practices, Consequences, and Resistance in the Field of Mental Health Care. Qual Health Res; 30(10):1503-16.
12. Turabian JL (2021) Psychotropic Drugs Originate Permanent Biological Changes that go Against ofResolution of Mental Health Problems. A View from the General Medicine. J of Addict Dis & Ment Heal; 1(3).
13. Pérez-Franco B, Turabián-Fernández JL (2006) [Is the orthodox approach to depression in primary care valid?]. Aten Primaria; 37(1): 37-9.
14. Kendler KS, Gardner CO Jr. (1998) Boundaries of major depression: an evaluation of DSM-IV criteria. Am J Psychiatry; 155: 172-7.
15. Merikangas KR, Zhang H, Avenevoli S, Acharyya S, Neuenschwander M, Angst J (2003) Zurich Cohort Study. Longitudinal trajectories ofdepression and anxiety in a prospective community study: the Zurich Cohort Study. Arch Gen Psychiatry; 60(10): 993-1000.
16. CDC (2023) About Mental Health.
17. Kessler D, Lloyd K, Lewis G, Gray DP (1999) Cross sectional study of symptom attribution andrecognition of depression and anxiety in primary care. BMJ; 318(7181): 436-9.
18. Healy D (2015) Serotonin and depression. BMJ; 350: h1771.
19. Moncrieff J, Horowitz M (2022) Why it is important to discuss what antidepressants do. BMJ; 379: o2350.
20. Wise J (2022) “No convincing evidence” that depression is caused by low serotonin levels, saystudy authors. BMJ; 378: o1808.
21. Kwon D (2018) Effects of Antidepressants Span Three Generations in Fish. Fluoxetine dampenedstress responses in zebrafish embryos exposed to the drug—and their descendants. The Scientist; Dec 10.
22. Kessler DS, MacNeill S J, Tallon D, et al. (2018) Mirtazapine added to SSRIs or SNRIs fortreatment resistant depression in primary care: Phase III randomised placebo controlled trial (MIR). BMJ; 363: k4218.

23. Gerhard T, Stroup TS, Correll CU, et al. (2020) Mortality risk of antipsychotic augmentation for adult depression. PLOS ONE 15(9): e0239206.

24. Breedvelt JJF, Warren FC, Segal Z, Kuyken W, Bockting CL (2021) Continuation of Antidepressants vs Sequential Psychological Interventions to Prevent Relapse in Depression: An Individual Participant Data Meta-analysis. JAMA Psychiatry; 78(8): 868–75.

25. Turabian J (2021) Psychotropic drugs prescription block the positive effects of the doctor-patient communication and relationship. Arch Psychiatr Ment Health; 5: 014-7.

26. Batelaan N, Scholten W, Rhebergen D, Van Balkom A (2021) Why we need to evaluate long-term antidepressant use in older patients with depression. Age Ageing; 50(3): 690–2.

27. Karter JM (2020) Conversations with clients about antidepressant withdrawal anddiscontinuation. Ther Adv Psychopharmaco.

28. Govaerts J, Boeyckens J, Lammens A, et al. (2021) Defining polypharmacy: in search of a more comprehensive determination method applied in a tertiary psychiatric hospital. Ther Adv