

Substitution:

By changing medication. Before switch;

- revise the patients response,
- consider ethical background, and
- choose the proper antidepressant drug with less SD effect [e.s. SARI (Nefazodone) , NaSSA (Mirtazapine), NDRI (Bupropion), NRI (Reboxetine), or serotonin enhancer (Tianeptine)]

In this review, the nature and extent of sexual problems that occur with antidepressant therapy were described. Their recognition and management depend on the awareness of the clinical team and their willingness to discuss this aspect of their patients lives. It is hoped that question about sexual function will become an accepted part of the doctors repertoire in assessing the effects of illness, surgery, or medications, in addition to measures to prevent such problems.

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Integration of Therapeutic Approaches in Working with Children

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Introduction:

Research on both primates and humans suggests that psychological influences result in permanent alterations of a neurobiological nature. Similarly, psychological interventions in a treatment context may have a profound impact on neurophysiology. Clinical case examples demonstrate that “biologically based” disorders may be rich in unconscious meaning. Clinical understanding of the meaning of symptoms may be instrumental in ensuring patients’ compliance with pharmacotherapy regimens and in the removal of other resistances to treatment.

Knowing that the “decade of the brain” is well launched and remarkable discoveries from the neurosciences fill the pages of our journals, the time may be ripe for a reexamination of the continued relevance of psychodynamic thinking to both clinician and researcher, especially in working with children and adolescents. Two trends in contemporary psychiatry have been increasing: 1) The “either-or” polarization of the psychodynamic and the biological. 2) The devaluation of psychodynamic understanding and therapy as increasingly irrelevant.

To adopt psychotherapeutic approach in treatment is not "antibiological" and it has much to contribute to modern clinical practice.

Psychological Versus Biological Etiology:

Much of the polarization between the biological and psychodynamic perspectives arises from a failure to appreciate the complex relationships between psychosocial and neuro-physiologic factors in the etiology and pathogenesis of psychiatric disorders. It is common place in clinical practice today to hear that patients have a "chemical imbalance". This oversimplified and reductionistic explanation is problematic and gives a misleading impression that this imbalance is the cause of illness that needs to be fixed by chemical means. It implies that psychotherapy is useless, and that personal efforts and responsibility have no part to be included in the plan of management. To assume, as we all do, that biochemical processes underlie mental activity and behavior does not imply that they are the causal agents but rather constitute mediating mechanisms. They are influenced by the information inputs we receive from our body and environment and by the subjective meaning of that information for us. It is that meaning which largely determines feeling thinking and behavior. This concept is best understood through developmental perspective during phases of development in children.

Neurochemical and neuroanatomical changes in the brain may be causally related to psychosocial influences in the environment and to the meaning attributed to those influences. As a corollary to this point of view, psychotherapeutic interventions may result in permanent alterations in brain functioning. In dealing with pediatric psychology and psychopathology, we are now aware that the functional effectiveness of synaptic connections can be altered by learning experiences connected with the environment, specifically, through regulation of gene expression. It is only insofar as our words produce changes in each other's brains that psychotherapeutic intervention produces changes in patients minds. From this perspective the biological and psychological approaches are joined. Although psychotherapy uses the language of meanings, there can be little doubt that in as much as events of learning and memory have an impact on the brain, it can be viewed as a biological process; in as much as triggering of neural mechanisms by psychological / environmental etiological factors. Painful events, such as separations or losses, early in life may sensitize receptor sites, leading to vulnerability to depression in children. Ideas and images associated with depressive states occurring early in life, could ultimately act as conditioned stimuli capable of eliciting a major depressive episode even without a concrete loss or external stressor in the environment. It might be concluded that major depression is best treated with a combination of medication and psychotherapy. Simple equations of depression with single neurotransmitters are no longer tenable, as our knowledge of the complexity of the neurotransmitter systems has increased with more and more sophisticated neuroscience research. Primate research has been of extraordinary heuristic value in demonstrating the impact of

psychological trauma on brain functioning as well as ultimate structure; on plasma cortisol levels, the opioid system, the hypothalamic secretion, and lasting alterations in the sensitivity of noradrenergic receptors. The psychodynamic notion that psychological trauma may be more or less damaging, depending on the critical developmental phase during which it is inflicted is also supported and is of relevance in working with children.

A link between myelination of the nervous system and certain kinds of bonding behavior has been found with actual morphological changes in the brain following social deprivation.

Studies not only support the kindling model based on psychological trauma, such as separations, but they also support the idea that the brain is possessed of remarkable structural plasticity. We now know that morphological changes in brain cells occur nearly every day and that massive trauma is not necessary to induce such changes. The influence of psychosocial factors on neurobiological processes can be seen in changes that occur as a result of psychotherapy as well as in neurochemical changes that follow drug administration in the subjective meaning given to the environmental stimulus is critical in effecting synaptic changes. The foregoing survey of the mutual influence of psychology and biology in the human psyche attests to the inseparability of brain and mind. Medicalization of psychiatry is dangerous, in the sense that psychiatry might become "mindless". Mindless psychiatry loses the domain of meaning. We need to integrate the essential role that meaning plays in management, even in disorders with significant biological underpinnings as epilepsy, autistic disorder or generalized anxiety disorders. Following treatment procedures in adult psychiatry, psychotherapeutic interventions outdated pharmacological ones in treating child and adolescent psychiatric disorders. Integration of both procedures is to the best outcome.

Psychopharmacotherapy:

Progress in pediatric psychopharmacological research has suffered notable delay, especially compared with the achievements in adult psychopharmacology. Despite a substantial and increasing use of psychotropic medications in children and adolescents only few of these drugs have been systematically studied for efficacy and safety in patients of pediatric age. With the exception of the stimulants, whose effects have been extensively studied in children with attention deficit hyperactivity disorder, most of the remaining psychotropic drugs do not have any specific labeling for pediatric patients, other than a standard exclusionary statement that "safety and efficacy have not been established in children". This lack of data has forced physicians and families to make difficult choices, based on the extrapolation of information from studies of adults with similar conditions, resulting in considerable "off-label" use of these drugs. In some instances (e.g. tricyclic agents in attention deficit hyperactivity disorder), off-label use is supported by research; however, the soundness of other treatments (e.g. clonidine in

attention deficit hyperactivity disorder) is poorly documented, thus raising the concern in lay and professional communities. The pediatric use of psychotropic medications is of enormous public health relevance: given the high rates of children who suffer from some form of severe emotional, behavioral, or mental disorder, many of them may benefit from the judicious use of medications.

Developmental pharmacokinetics:

A fundamental understanding of developmental pharmacokinetics is a necessary prerequisite for safe, effective administration of psychotropic medication to children and adolescents. Unfortunately, and despite the increasing use of drugs in this age group, few pharmacokinetic studies are available to guide our clinical practice. Although generalizations can be made from adult literature, they are insufficient and ineffective. Accurate knowledge about drug absorption, distribution, metabolism and excretion are lacking. Compared to adults, children are known to be rapid metabolizers. In pharmacokinetic studies, newborns and infants are considered quite different from children, who, in turn, differ from adolescents, whereas minimal differences have been found between late adolescents and adults. In drug efficacy studies, age groups should be selected based on developmentally determined physiological and psychopathological variables. Practically, puberty is used to separate children from adolescents. A chronological cutoff around 12 years is often used to separate children from adolescents (even if girls have, on average, earlier sexual maturation than do boys). Pediatric drug dosing has been often empirically determined by practitioners through trials and errors. Dose-response and pharmacokinetic studies are needed urgently to rationally identify the appropriate dosing for drug efficacy trials. The death of researchers in pediatric psychopharmacology is a major obstacle to the development of this discipline. Training programs in child psychiatry should emphasize psychopharmacology as a main area of both research and clinical activities.

Recently, many initiatives have been undertaken by NIMH to define obstacles to pediatric psychopharmacological research and identify possible solutions.

Safety and efficacy

Evidence for drug efficacy must come from adequate and well-controlled studies in the targeted patient population. Recent regulations allow evidence of drug efficacy in children to be derived from data about drug efficacy in adults, if convincing proof of similarity in psychopathological features and pharmacological response exists across the age groups. Such continuity in psychopathological features has been shown for some disorders, such as obsessive-compulsive disorder, major depression, and schizophrenia, but not for others.

However, similar treatment response cannot be inferred across the age groups based only on similar psychopathological or associated biological features. For instance, the

phenomenology of major depressive disorder is similar across the age groups, but an apparent discrepancy remains between the efficacy of tricyclic antidepressants in adults vs that in children. Safety of drugs must always be supported by appropriate research in the targeted age group. Some medications may be safe in adults but can produce toxic effects in children.

In infants, chloramphenicol can result in the "gray syndrome". In young children, valproic acid can cause liver failure; tetracyclines, tooth discoloration; and Phenobarbital, delay in intellectual development. Because of the influence of development on psychopathologic features and pharmacological effects, there is no substitute for clinical research in children. In particular, our knowledge of long-term drug effects is grossly incomplete. For most drugs, it is practically unknown if a long-term use results in sustained improvement and salutary effects on prognosis, or possible toxic side effects. In children, research on the long-term pharmacological effects is particularly important, owing to potentially longer exposure to drug and negative influence on development. Directly related to drug safety in children is the current lack of knowledge bridging between preclinical and clinical drug toxicology.

Safety and Efficacy of Already Marketed Medications

Because many psychotropic agents are used off label, some data about their safety and efficacy in children already exist. These data, however, have never been systematically reviewed to update drug labeling. In 1994, the FDA requested that pharmaceutical companies review the exact data relevant to pediatric use of marketed medications and propose revisions to current labeling information. These reviews are in progress. In parallel, NIMH has asked leading researchers to review the current evidence for safety and efficacy of psychotropic drugs in children and to determine whether continuity exists between children and adults in psychopathologic features and response to drug use. These reviews are likely to conclude that data to determine safety and efficacy in children are insufficient, especially data about long-term effects, and that more research is needed.

Combination Therapies

Polypharmacy has become common in child psychiatry, partially as a result of frequent comorbidity. Children with concurrent attentional, affective, and tic disorders may be prescribed various drugs, including stimulants, antidepressants, clonidine, and mood stabilizers. Almost no data, however, exist about the efficacy and safety of these combinations and the rationale for their use is not always sound. Moreover, the combined use of pharmacological with psychosocial therapies is ubiquitous, but traditionally understudied. Research on combined treatment is clearly needed. Recruitment of children and adolescents into controlled clinical trials is difficult and has often resulted in small sample sizes. Beside the rating scales for different disorders, there are few universally accepted scales that are reliable and valid

indicators of clinical change and pharmacological response in children. Continuous efforts are needed to develop and refine our research methodology.

Child Treatment

Child treatment has a long history. In the various schools of thought, the emphasis has largely been on the child as an individual, although parents may be consulted. Nonetheless, child treatment often occurs in the context of a larger treatment program, which may include guidance for parents, family therapy, group therapy, and school consultation. The therapist may modify the child's behavior by intervening within this system. Fundamentally, however, the therapist works with the child directly, attempting to make modification in the intrapsychic structure of the child's personality. It is assumed that individual treatment with the child alone may place the child in a loyalty conflict with the parents, undermining the goals of treatment.

In the current practice of child treatment, the therapist typically meets once or twice a week with child for one-hour sessions, using approaches that involve the release of emotion, the use of play, reductions through corrective experiences, and verbal explanation. Child treatment can be insight-oriented, supportive, or aimed at developing personality structure within the child. A good relationship between therapist and child is considered a basic requirement, and play is used to aid self-expression, enabling the child to gain mastery over unpleasant experiences in a permissive and accepting environment. Enhancing communication and social skills are additional goals of child therapy. Therapy is most effective when a variety of modalities are addressed, including behavior, affect, sensation, imagery, cognition, socialization, and medical concerns.

Administration of drugs, within this context, to control unacceptable behavior or alleviate an emotional or thought disorder is complementary to treatment program and ensures better outcome.

Family Therapy

Psychological dysfunction is seen as a product of transactions in the family system, and symptoms reflect the patterns of interaction. The unit of treatment is viewed as relationships within the family rather than the child within the family. Family therapists promote identification through joining strategies, which can be particularly instrumental in families with children.

Through such approach, parents identify with the appropriated modeling by the therapist and children benefit from the corrective emotional experience. Including children in family sessions adds to the complexity of treatment and necessitates that the therapist be comfortable with nonverbal, play-oriented modes of communications as well as interpretation of meaning on a metaphoric level. Parents and children have often been treated separately, and even with the advent of family therapy plan. Family therapists sometimes view the child as a barometer of family or marital tensions, or they may work to

improve communication between the parents, which may or may not ameliorate the child's symptoms. Current trends in the field of family therapy include a more eclectic tendency as well as new recognition of the need for outcome studies on the effectiveness of therapeutic interventions.

Effort to Integrate Child and Family Work

Although clinicians have voiced concerns that the child's relationship with the therapist could be compromised by including the parents in the treatment, individually oriented therapists have included parents, either by working with families as a group or separately with child and parents. A systemic approach could be used even if the therapist sees only an individual or a subunit of the family. Family interviews are an aid in the diagnosis of children, and developmental concepts enrich family therapy efforts. Recent authors have appreciated the potential effectiveness of integrating psychotherapy approaches, an integration of child and family therapy. The therapist may see a particular individual for short segments of individual work and have parallel sessions with other family members as well. A cotherapist can be used to help coordinate the process. The therapist engages in negotiations with the family early in the assessment process about what kinds of sessions to use, holding out the possibility of changing formats as therapy proceeds. Children contribute to their own problems as well as to the stress within the family; addressing the mutual influence of individual and family levels may enhance the effectiveness of therapeutic practice. One cannot oversee the interaction between child psychopathology and family dynamics.

The issue is how to combine family, subsystem, and individual interviewing in order to explore effectively the interplay between levels within the family system and to determine whether the family, subsystem, and individual treatment are indicated separately or in combination, at one time or in stages over time. Active involvement of the family contributes to regular attendance and compliance to medical treatment.

Play as a Bridge

Play is a natural bridge between the domains of child treatment and family therapy. It is fundamental to the various approaches of child treatment, and its usefulness has been appreciated by child therapists. Play is not a diversion; it is central to the work with children. In addition, parents have been included in play therapy; of "conjoint play therapy", the child is seen for a diagnostic workup, which is followed by a session with the parents to plan treatment. Then family members are seen for treatment in flexible combinations of dyads. In play therapy, the therapist is an appropriate role model who demonstrates new ways of communicating and interacting with the child.

Family therapists have made efforts to incorporate play into work with families by using specific techniques that allow young children to participate meaningfully in family sessions. These techniques include the family art evaluation, the conjoint family drawing, the family puppet interview, and video playback as well as the use of visual aids, mobiles, and

balloons to convey the cumulative effects of stress and anxiety. Furthermore, techniques for involving young children in eliciting the family system, communicating feelings, setting goals, structuring change, and reassessing the family system. There is emphasis on the importance of incorporating play into family sessions as a medium of communication. Such family sessions are treatment in their own right or preparation for the child to be seen in individual treatment.

Thus, child treatment and family therapy have been combined or have enriched each other, and the use of play is a common ground between the two approaches.

An integrated approach that combines play therapy and family therapy is particularly useful for addressing symptoms in young children and helping the parents to learn about developmental characteristics of young children and how to enhance their learning through play.

Integrating Parental, Educational And Community Resources With Psychopharmacology:

Families, teachers, community representatives, patient advocates, pediatricians, and other practitioners are central to all aspects of research and management including hypothesis development, study design, implementation, and knowledge exchange. Without their input and support, pediatric management and research will be difficult to conduct and of limited influence. Lack of communication between community tools and psychiatrists has been a serious obstacle and often

translated into suspiciousness toward treatment services and misconceptions about its purposes. Under such conditions, the stigma traditionally attached to mental illness renders psychopharmacological research even more difficult to conduct.

Some investigators still do not evidence adequate understanding of the family context and appreciation of the importance of cultural factors in determining attitudes, expectations, concerns, and biases. The training of clinical investigators has far ignored these essential aspects of intercommunication. Confusion between the roles of research and medical provider can generate misunderstanding and disappointment, especially if research participation is seen as the only opportunity to receive care.

Adequate feedback is not always given to parents and physicians during and after studies, thus inducing a feeling of being "used" for academic exercises of little personal relevance. Ultimately, participation in research should be viewed by children and families as an opportunity to gain personally relevant knowledge, in addition to a contribution to the advancement of science.

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Mini-Reviews

Psychodynamics of Pharmacotherapy

By
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Introduction:

Through out history 1940, 1950 psychoanalysis dominated landscape of psychiatry and there was reluctance to combine medications with psychotherapy for fear of:

- Psychotropic medications alleviate anxiety and depression that motivate patient to tolerate frustration.
- Interference with development of transference and its role.

The belief of incompatibility of psychotherapy and medication persisted to the 1960, 1970 despite the opposite results of the studies.

Although at a while Anna Freud was convinced that addition of medication allow analysis to continue.

Specific Diagnostic Categories

Schizophrenia:

Integrated therapy reduced relapse rate by affecting high E.E, social training and adjustment, as well as improving

compliance factors.

- Major Depressive disorder:

Different target symptoms in patients are attacked. Medications work more rapidly than psychotherapy so relief acute distress. Psychotherapy enhances social functioning so extend the relapse free period.

- Bipolar I Disorder:

Combined therapies lead to reduction in relapse rate and hospitalizations. Patients no longer view themselves victims of illness beyond their control and gained sense of mastery over the illness. Patients need assistance in mourning losses during manic phase. Assistance of patients to identify the stressors that produce the relapse.

- Personality Disorder:

Combined treatment suggested that medications may affect temperaments while psychotherapy address character.

One Person Model Therapist

Psychiatrists must accustom themselves to think about both E.E, social training and adjustment, as well as improving mind and brain, and require flexible shifting back and forth between