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Review

INTEGRATING THE CONCEPT OF CREATIVE PSYCHOPHARMACOTHERAPY AND GROUP PSYCHOTHERAPY IN CLINICAL PRACTICE

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SUMMARY

Modern psychiatric treatment is largely dictated by national and international guidelines rested on evidence-based data, including psychopharmacotherapy and psychotherapy. An alternative to the rigid application of official guidelines and criterion for the standards of treatment in psychiatric practice is the concept of creative psychopharmacotherapy. It is a concept based on the integration of different approaches to a person as whole, mental disorders and their treatment into person-centered clinical practice. In this sense, group psychotherapy and creative psychopharmacotherapy today are part of the overall integrative efforts in psychiatry. Neuroscientific discoveries suggest that they share similar neural pathways that lead to changes in brain function and symptoms relief. Various integrative elements make group psychotherapy and psychopharmacotherapy in combination more effective and efficient. The integration of the concept of creative psychopharmacotherapy and group psychotherapy into everyday clinical practice can improve treatment options as well as clinical practice by creating opportunities for research and development of new modalities of overall treatment.

Key words: *creative psychopharmacotherapy - group psychotherapy - clinical practice*

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INTRODUCTION

> *„Our ideas are only intellectual instruments which we use to break into phenomena; we must change them when they have served their purpose, just as we change a blunt lancet that we have used long enough."*
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> *Claude Bernard*

The treatment of people with mental disorders during human civilization contained a number of unusual methods, many of which were ineffective, and some of them inhumane and dangerous. Significant discoveries and understanding of human physiology and pathophysiology from the second half of the 19th century resulted in the view of mental illness as a brain disease. In the early 20th century, Sigmund Freud's psychoanalytic theory and Adolf Meyer's theory of mental illness as a psychobiological response to stress combined with earlier patterns of adaptation led to the development of "psychological" treatment. At the same time, a certain number of psychiatrists were developing "biological" treatment. The discovery of psychotropic medicines in the mid-20th century led to tremendous changes in the treatment of people with mental disorders, including the transition to community treatment.

The modern approach in the treatment of people with mental disorders is based on several basic concepts derived from different perspectives of mental disorders such as psychoanalytic, disease perspective, cognitive and learning perspective, humanistic and social perspective (McHugh & Slavney 1998). Different views on mental disorders have resulted in the development of different therapeutic procedures, including psychoanalysis and psychodynamic psychotherapies, psychopharmacotherapy and other forms of somatic therapy, behavioural and cognitive therapy, client-centered therapy, as well as reform of psychiatric institutions.

The growing changes in psychiatric treatment are accompanied by a change in the doctor-patient relationship, which is by itself an important therapeutic tool. The traditional paternalistic relationship has been redefined into a partnership and collaborative approach. Furthermore, in addition to psychiatrists, other health and non-health professionals are involved in the treatment of people with mental disorders. The polarization between the biological and psychological models in the diagnosis and treatment of mental disorders is overcome as an ineffective and fragmented approach. An integrative approach to mental health and mental disorders is being developed. The multidimensionality of mental health problems is recognized, which results in the development of a multidisciplinary, interdisciplinary and transdisciplinary team approach.

In the late 20th and early 21st centuries, there has been significant progress in medicine, including psychiatry, in the scientific understanding of disease and in the development of technologies for diagnosis and treatment. At the same time, this has led to an excessive focus on disease and organs, over-specialization of medical disciplines, fragmentation of health services, and weakening of the doctor-patient relationship (Heath 2005). In response, the concept of person-centered medicine and practice is developed. Person-centered medicine is oriented towards the promotion of health as a state of physical, mental, socio-cultural and spiritual well-being,

as well as the reduction of disease. It is based on mutual respect of dignity and responsibility of each individual (Mezzich et al. 2009). Integrating person-centered medicine into psychiatric practice does not only mean individualized care and respect for the patient's rights, but includes recognizing the patient as a person with all his individual subjectivity beyond what characterizes his disease, status or role of the patient (Botbol & Lečić-Toševski 2013). In person-centered medicine, the patient is understood as a unique human being (Balint 1969).

The evidence-based medicine movement has significantly marked clinical practice. The standard of care becomes the application of the latest and best research evidence. The need to make an intervention based on the highest level of evidence obliges clinicians to understand the levels of evidence and determine the best evidence to use as a basis for clinical intervention. In addition to evidence-based practice, medicine and value-based practice have evolved in recent decades, making a new interdisciplinary field of psychiatry, philosophy in psychiatry (Fulford 2008). Value-based practice should be complementary to evidence-based practice that involves the systematic synthesis of available evidence into a specific clinical issue (Stewart 2014).

In order to overcome the many polarizations present in psychiatry, clinical practice today is largely based on a biopsychosocial and person-centered approach with a tendency to integrate evidence-based and value-based practices (Fulford et al. 2012), and respect for rights and ethical principles. In this context, in everyday practice there are numerous challenges related to the education of clinicians, the culture of the organization, the cultural context, available resources and technologies.

CREATIVE PSYCHOPHARMACOTHERAPY AS A CHALLENGE IN PSYCHIATRIC PRACTICE

> *„Creative psychopharmacotherapy is much more than prescribing mental health medicines in rational manner and carefully control their use“*
>
> *Miro Jakovljević 2015*

Discoveries of new receptor subtypes and their mechanisms, brain imaging techniques, and modulation of gene expression have led to a better understanding of mental disorders and the consequent development of receptor-specifically targeted psychotropic drugs that are more effective, less toxic, and better tolerated (Sadock et al. 2017). Although modern medicines are relatively safe and well tolerated, there are still quite unpleasant side effects of medicines that are sometimes very serious. In the use of psychotropic medicines, it is crucial for each patient to determine the best and most effective medicine at any stage of treatment of his disease with careful monitoring of side effects, and rapid and appropriate response during the overall course of psychopharmacotherapy (Jakovljević 2009). When using any procedure in the treatment of persons, the basic postulate is not to harm ("primum non nocere"), which is one of the basic principles in modern psychopharmacotherapy. In everyday application of medicines, it is crucial how to do the least damage or avoid harmful and unpleasant side effects, and to achieve the best possible effect of the medicine and the best possible response of the patient to the medicine (Jakovljević 2009, 2021).

Prescribing medicines is governed by a number of clinical guidelines (algorithms), legislation, regulations of medicine regulatory agencies, and health insurance institutes. Clinical guidelines provide clear and targeted guidance for diagnosing and treating a variety of mental disorders. Their use should facilitate the clinical decision-making process, reduce the risk of unnecessary or harmful interventions and support treatment that achieves the best possible outcome with minimal risk and tolerable cost (Jašović et al. 2013). Although successful implementation of the guidelines can lead to improved quality of care, there are a number of obstacles to their implementation in clinical practice (Fischer et al. 2016). Prescribing medicines in practice is often not in accordance with the criterion of standards for the use of psychopharmacological medicines. For example, benzodiazepines are prescribed more frequently and much longer than recommended (Kroll et al. 2016) or antipsychotics are prescribed for mental disorders where indications are questionable (Rao et al. 2016). This raises questions of the adequacy of clinical practice, the question of the adequacy of the criterion of standards and guidelines, the possibility of harmonizing practice and guidelines, the question of classification of psychopharmaceuticals and treatment managed by diagnostic categories and nosological entities.

Giving a critical review of the clinical outcomes of modern psychopharmacotherapy, taking into account Bernstein's concept of creative psychopharmacology (according to Jakovljević 2010), van Prague's concept of functional psychopharmacology (1990), and taking into account numerous theoretical assumptions about mental health in psychiatry, psychology, anthropology, sociology, religion and other related branches, Professor Miro Jakovljević develops the concept of creative psychopharmacotherapy (Jakovljević 2007, 2008, 2009a, 2009b, 2010, 2013, 2015, 2019, 2021). According to Jakovljević (2013), the concept of creative psychopharmacotherapy could improve everyday clinical practice and bridge the gap by increasing the effectiveness of treatment. In summary, creative psychopharmacotherapy is the art and practice of treatment with medicines based on creative psychopharmacology, learning organization, transdisciplinary creative psychology and person-centered psychiatry (Jakovljević 2013). What is key to integrating this concept into everyday clinical practice is, in fact, what creative psychopharmacotherapy is not. Creative psychopharmacotherapy is not all that is still,

to a large extent, resented to the psychiatric practice. Which means it is not dogmatic and authoritarian practice, irrational polypharmacy, impersonal and only technical practice, fragmented care and treatment, marketing practice, accidental polypharmacy or polypragmatism that increases side effects, is not harmful and toxic or practice that increases nocebo effect, is not the antithesis of modern or postmodern psychiatry and is not charlatanry in psychiatry (Jakovljević 2013).

Integrating this concept into everyday clinical practice represents a strong support for the development of recovery-oriented services and practices. It is a unique professional support to the personal and unique journey of the patient towards recovery. So, it is a strictly individualized and personalized practice that develops and nurtures the relationship with the patient as a human being in the specific context of providing and receiving help through a two-way exchange of professional and experiential knowledge and experience. It is a relationship based on the perspective of the patient's life world as a person in which the choice of methods and modes of treatment is based on joint decision-making. Joint decision-making is not a formal choice that a patient makes or does not make based on information obtained from clinicians. It is an open conversation in which the creativity of the patient and the creativity of the clinician are encouraged. Creativity of patients and clinicians is a fundamental tool of this concept in which it is possible to create new meaningful ideas, interpretations, contexts and methods in psychopharmacotherapy (Jakovljević 2013). It seems that through this concept, psychiatrists can re-establish their identity as physicians who in treatment of mental disorders have the skills and knowledge to integrate in their psychopharmacological expertise psychological, social, spiritual, and other interventions. For a long time, the prevailing opinion has been that psychiatrists are only doctors who are trained in the psychofarmacological treatment of mental disorders, and that all other aspects such as psychological, social and spiritual should be dealt by other professionals. In the integrative, holistic, transdisciplinary, context- and person-centered psychiatry that underlies this concept, the psychiatrist clinician is more than an expert prescribing only medicine. Its role in a unique therapeutic relationship with each individual patient as a person is to support and facilitate the process of healing, recovery, and movement toward well-being and positive functioning.

Although monotherapy is an ideal (Sadock et al. 2017), a combination of medicines is present in everyday practice, which is often the subject of expert discussions. The concept of creative psychopharmacology advocates a change in the philosophy of treatment towards individualized and person-centered psychopharmacology that includes contextual, systemic and creative thinking (Jakovljević 2015). In fact, this means that in their day-to-day work, psychiatrists need to be more than good at using all the treatment tools currently available. Also, it means that by encouraging the patient's creativity and allowing their own creativity to come to the fore, opportunities are created to improve existing tools and develop new ones. Moving away from rigid adherence to official guidelines and standards criterion, psychiatrists give themselves the opportunity to use multidimensionality in thinking about how to prescribe multiple medicines at the same time, how to monitor and manage side effects, reduce nocebo and strengthen placebo effects, understand relationships and psychodynamic developments in these relationships, think about context and create a favourable treatment environment, how to document all this, evaluate and how to measure the outcomes of the activities undertaken in the treatment process. At the same time, it is important to keep in mind to create such a situation in which the combination of medicines achieves better effect and eliminates adverse interactions. Which means that in addition to the professional skills of applying psychopharmacological therapy, key psychotherapeutic skills such as motivation, empathy, openness, cooperation, honesty, providing corrective experience, catharsis, setting goals, establishing time-limited relationships, etc. should be developed and used (Shwartz 2010). Treatment results are better when the therapist establishes an atmosphere of cooperation, trust, and expectations of future well-being (Greenberrg 2017). The ultimate goal is to give the patient confidence and a framework to be an active part of their progress, which is important especially if they continue to benefit from treatment. In this way, the patient is given the opportunity to attribute therapeutic success and profit to his own efforts.

Group psychotherapy in psychiatric practice

> *„Honesty towards oneself and others is fundamental. There must be a love of truth, even if it is disagreeable and contrary to personal advantage. "*
>
> *S.H. Foulkes 1975*

Since the establishment of group therapy, the development of group analysis and the transfer of psychotherapy from the couch to the circle, to this date, group psychotherapy have gone from a phase of initiation, expansion to a phase of consolidation over the last few decades (de Chavez 2019). Today, group psychotherapy is a widely accepted modality of psychiatric treatment that is applicable to all therapeutic conditions, and in inpatient and outpatient care. Group psychotherapy is also widely used by non-psychiatric professionals as an additional treatment for somatic diseases. The number and scope of group psychotherapies is large, so Yalom & Leszcz (2005) state that it is more correct to talk about group therapies instead of a unique group psychotherapy. Group psychotherapy is based on many theories. Different forms of psychological treatment use group resources for a common purpose. Several modalities of

group psychotherapy are used, which include group analytical therapy, cognitive and behavioural group therapy, psychodrama, trauma-focused group therapy, integrative group psychotherapy, interpersonal group psychotherapy, relational group therapy, group therapy based on mentalization and others.

Group psychotherapy is therapeutically effective (Hasanović et al. 2011, 2012). There is good evidence for its effectiveness in treating multiple mental disorders, including disorders related to the use of psychoactive substances and somatic diseases (Burlingame et al. 2013). Research suggests that there are no differences or differences are small in the effectiveness of different modalities of group psychotherapies (Lambert 2013). Although group psychotherapy in the treatment of people with mental disorders is widespread in inpatient and outpatient settings and shows good results, there is still insufficient research to prove this effectiveness. There is particularly little research that meets the strict criterion of evidence-based medicine. The lack of randomized clinical trials is misconnected as a lack of effectiveness of group psychotherapy. The reason why group psychotherapy is not included in the recommendations of national and international guidelines (Tost et al. 2019) is also stated. However, neuroscientific discoveries, especially interpersonal biology, are trying to uncover unique ways in which group processes affect the brain, which will certainly contribute to a better position of group psychotherapy. Understanding the principles of neuroscience that illuminate how interpersonal relationships shape the brain can help identify group interaction methods that encourage neuroplasticity, support neurological integration, and lead to well-being and satisfying relationships (Badenoch & Cox 2010).

The atmosphere of successful therapy depends on a numerous factors that work in all well-helping situations, including hope, trust, freedom, belief, liking, or inclination (Wolberg 2013). Psychotherapy tries to alleviate emotional suffering and improve the adjustment of the personality by planned psychological interventions. In this process, psychological interventions are not the only ones that contribute to improvement. The individual is constantly affected by various factors that serve to alleviate the symptoms. These factors also act during psychotherapy and are often referred as nonspecific factors of which the most prominent are the placebo effect, relationship dimension, emotional catharsis, suggestion, and group dynamics.

Group psychotherapy also has its specific therapeutic factors, which Yalom (1995) defines as mechanisms of therapeutic action that act by favouring changes and contributing to the therapeutic process inherent to the group or dynamic interaction. According to Yalom (1995), group therapeutic factors include hope, altruism, cohesion, universality, interpersonal learning, guidance, catharsis, corrective recapitulation of the primary family group, existential factors, development of social skills, and imitative behaviour. MacKenzie (1990) classifies these factors into four general groups: support factors, self-discovery, learning from other group members, and psychological work. According to Wolberg (2013), the development of an individual in a group is a series of processes that are closely related to the outcome. What develops during the group in the individual is the manifestation of empathy, support, challenges, confrontation and interpretation, availability of identification models, opportunities for the introduction of projective identification, research exploration and joint problem sharing. Group psychotherapy provides numerous benefits for patients. In summary, this includes: developing the ability to relate to others (meeting others and building a support network, gaining insight and getting to know oneself through others, sharing experiences and thoughts with others that can be part of the healing process and overcoming obstacles), experience of free thinking without fear of being condemned (a place to think without worrying about condemnation, a safe space), silence (silence can be therapeutic), confidentiality (all group contents remain in the group) (Yalom & Leszcz 2005).

As with all interventions, the principle of "do no harm" applies to group psychotherapy. Since group therapy is rooted in open expression of feelings and interaction among members, this can foster an atmosphere in which members feel insecure. Also, the principle of privacy and trust in a group format with a larger number and heterogeneous members can be violated, which requires that the group therapist possess the knowledge, skills, planning skills and multidimensional and creative thinking.

INTEGRATING GROUP PSYCHOTHERAPY AND CREATIVE PSYCHOPHARMACOTHERAPY

> *Today, the question is no longer whether the combination of psychotherapy and medication is beneficial but rather how the combination is beneficial.*
>
> *Glen O. Gabbard 2014*

In hospital and outpatient settings, group psychotherapy is often used in combination with other therapeutic approaches. In this combined modality, the goal is to make integration of different forms of treatment suitable, to see opportunities for synergy, complementarity, facilitation, and sequencing of therapy (Nevonen & Broberg 2006). Clarity about the principle of modality integration is useful in ensuring maximum benefit for the patient. Integrating therapeutic modalities allows clinician to use complementary gain of each approach. Combining treatments may also have risks or may be contraindicated if the second modality is unnecessary or not complementary to the initial therapeutic modality (Bernard et al. 2008).

The combination of group psychotherapy and pharmacotherapy is common in clinical practice not only for patients with psychotic but also for patients with nonpsychotic disorders. It is used to ensure medicine compliance, improve patient social skills and social inclusion, and as one of the additional or major treatments of patients after hospital treatment (Sperry 1995). The addition of medication may be necessary when the symptoms of a group member become an obstacle for his development in the group. Combination treatment is most often used in patients with depressive disorder, anxiety disorders, personality disorders, psychotic and other disorders. There are benefits of both therapeutic interventions. Group psychotherapy improves self-esteem, modulation of emotional reactions, and development of social and interpersonal skills. On the other hand, medications help reduce the symptoms of anxiety, depression, manic, psychotic, and disorganized thinking, and suppress pathological ruminations, compulsiveness, and impulsivity.

When combining group psychotherapy and psychopharmacotherapy, the group therapist should understand the psychological significance and impact of medications on the patient's sense of personal self-control and attribution of responsibility, emotional availability and connection in the group, and the impact on monitoring psychopharmacological treatment. Prescribing medications can have multiple meanings that affect the patient receiving the medications, other members of the group, and the group as a whole. Meanings can range from encouraging and recognizing a therapist's commitment to caring for a patient to feelings of personal shame and stigmatization and discouragement that psychotherapy is not sufficient (Bernard et al. 2008). The meaning of medicine and fantasies related to medicine can be the focus of group discussion. Fantasies and frequent engagement of group members with medicines may reflect resistance to group processes (Sperry 1995). In combination treatment, patients may respond to a recommendation for the use of medicines with different transference feelings, such as acceptance, rejection, manipulation, and narcissistic injury. Prescribing or discontinuing medication should always be carefully considered in relation to the patient's actual problems and in relation to the transference. Neglecting the negative transference reactions that may occur with prescribing medications can result in resistance to treatment. Cooperation with the patient and consideration of potential impacts, concerns and problems with medicines in the context of group psychotherapy can help reduce resistance, better acceptance and compliance with medication treatment. An empathic understanding of patients 'concerns about different treatment interventions will help respect and provide information on psychological factors that may be relevant to symptoms and other life problems.

In practice, the combined treatment can be carried out in an integrative (one-person model) and unified (two-person model) way. In a unified approach of combined treatment between a prescribing physician and a psychotherapist who conducts psychotherapy, good communication is a sine qua non for successful treatment (Riba & Balon 2008). If the group psychotherapist is also a doctor who prescribes medication, the difficulty may be related to the proper monitoring of medications within the group itself, which is why a special meeting with the patient is indicated regarding the monitoring of medications. In these cases, it should be taken into account that the prescribing and use of medicines has its dynamic and interpersonal aspects that may affect the processes in group therapy. In an approach where the prescribing physician and the group psychotherapist are different persons, clarity in communication, mutual respect, and equal evaluation of both treatment modalities are crucial. Dogmatic overestimation of one modality and devaluation of another will create pressure on the patient and undermine the synergistic benefits that a combination of treatments can provide.

Integrating the group therapeutic approach and the concept of creative psychopharmacotherapy into everyday clinical practice brings benefits not only for the patient as an individual and a person, but also for the overall atmosphere of the environment in which the therapeutic processes take place. Creative psychopharmacotherapy and group psychotherapy, as a learning organization focused on processes and systems thinking, integrated can have a positive and long-term reflection on the inpatient and outpatient setting. Focusing on the context and network of relationships, understanding multiple transfer relations and countertransference, understanding and using projective identification, understanding and managing splitting can in this integrated approach make the therapeutic environment conducive and friendly. Psychiatry, today, is entering the era of "precise psychiatry" – pharmacogenetics and functional neuroimigning, but until all this new knowledge and technology become available to all and part of everyday clinical practice, by integrating previous knowledge, understanding, skills, capabilities and technologies, and their better use, everyday practice can be improved, be more efficient and effective.

CONCLUSION

Group psychotherapy and creative psychopharmacotherapy, although historically derived from two polarized and sometimes impossibly compatible approaches, share much in common. Today, they are part of an overall integrative effort in psychiatry. Neuroscientific discoveries suggest that they share similar neural pathways that lead to changes in brain function and

relief from symptoms. Motivation, empathy, openness, respect, corrective experience, goal setting, catharsis, cooperation, hope, positive expectations, encouraging creativity, recognizing strengths, focusing on interpersonal relationships, encouraging learning and positive functioning in a relationship network are some of the integrative elements that group psychotherapy and psychopharmacotherapy in combination make more effective and efficient. By integrating and using knowledge from psychotherapy, group therapy and creative psychopharmacotherapy, psychiatrists in everyday clinical practice can improve the treatment and treatment outcome for each individual patient.

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Esmina Avdibegović: conception and design of the manuscript, collecting data and literature searches, analyses and interpretation of literature, manuscript preparation and writing the paper; and gave final approval of the version to be submitted.

Maja Brkić: participated in revising the manuscript and gave final approval of the version to be submitted.

Mevludin Hasanović: made substantial contributions to conception and design, participated in revising the manuscript and gave final approval of the version to be submitted.

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