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Review

CREATIVE, PERSON CENTERED NARRATIVE PSYCHOPHARMACOTHERAPY (CP-CNP): FROM THEORY TO CLINICAL PRACTICE

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SUMMARY

Modern psychopharmacotherapy is a hot and controversial topic, glorified by some and vilified by others within the field of psychiatry that is by itself deeply divided and stigmatized. Mental disorders are multifactorial and polygenic phenomena with polymorphic clinical manifestations and poorly defined endophenotypes. They are characterized with high rate of morbidity, comorbidity, disability, mortality, and treatment failures. These relentless and commonly tragic disorders represent heavy burden on patients, their families and society and there is an urgent need to improve treatment successfulness in psychiatry. The best treatments are those that utilize and integrate multiple modalities. The time is ripe for psychiatry to find its transdisciplinary integrative soul and increase treatment effectiveness. Creation and fostering hope, meaning, personal responsibility, spirit of optimism and commitment can significantly contribute to overall positive response to pharmacotherapy, but in the other way round drug treatment can contribute to creation and fostering hope, meaning, personal responsibility, spirit of optimism and commitment. This paper addresses the concept of creative person-centered narrative psychopharmacotherapy (CP-CNP) as a transdisciplinary integrative strategy for improvement of the therapeutic effectiveness in patients with mental disorders. CP-NCP represents a set of tools that can allow higher effectiveness and efficiency in treatment of major mental disorders in a systemic way.

Key words: *mental disorders – resilience – antifragility - creative psychopharmacotherapy - person-centered narrative medicine - personal recovery*

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INTRODUCTION

> *"Psychopharmacology, the study of psychotropics, or brain-mind-altering substances, is a fascinating field at the confluence of neurochemistry and behavior"*
>
> *Dan J. Stein 2008*

Modern psychopharmacotherapy is a hot and controversial topic, glorified by some and vilified by others within the field of psychiatry that is by itself deeply divided and stigmatized. Mental disorders are multifactorial, multidimensional and polygenic phenomena with poorly defined endophenotypes, high rate of morbidity, comorbidity, disability, mortality, and treatment failures. All psychiatrists would like to offer to their patients the optimal treatment, but in everyday clinical practice commonly do not achieve their desired level of success. Mental health care in general is in a state of crisis. Despite the significant progress in understanding etiology and pathogenesis of mental disorders and development of a number of new mental health medications (MHMs), treatment outcomes of many mental illnesses in our "century of mind" and "COVID-19 syndemic age" remain poor in both short term and long term course of the treatment. Huge number of psychiatric patients does not respond in satisfactory way with respect to the magnitude of therapeutic response, the persistence of the remission and the length of life. From time to time a real war of viewpoints happens about the usefulness and effectiveness of psychopharmacotherapy. Psychopharmacotherapy as well as the entire field of mental health service and treatment in psychiatry, is at a crossroads, facing important decisions about the desired treatment goals and outcomes, just symptomatic remission or full personal recovery, only decrease illness or increase wellness also. Creative Person-Centered Narrative Psychopharmacotherapy (CP-CNP) offers an overarching theoretical framework that permits the integration of different levels of explanation from neuroscience, clinical psychopharmacology, psychodynamics, evolutionary psychobiology and positive psychology. It is a comprehensive/holistic concept encompassing a wide array of psychological methods and pharmacologic strategies that are aimed to achieving optimal treatment outcome. The key terms of this concept are: the focus on person in treatment instead of blockbuster and stratified medicine approaches, synergistic drug combinations, enhancing resilience and salutogenesis, not only decreesing illness but also increasing wellness, reconstructing disease and therapeutic narratives, and promoting creativity, therapeutic alliance and partnership. Instead of simply sympathizing with the patient and suggesting mental health medication CP-CNP practitioner creates an opportunity for the patient to go inside and recognize and then mobilize some of her/his resources and strengths. CP-CNP is much more than prescribing mental health medicines in rational manner and careful control of their use. It is relational, contextual, multimodal, personalized and individualized application of the creative, dialectical thinking and systemic information processing strategy. CP-CNP includes not only creative and rational use of mental health medicines and their combinations, but it is also about creating favorable treatment context,

re-constructing narratives that fuel mental health problems, resilience and antifragility enhancing and fostering patients' creativity and personal mastery. It is an alternative to dogmatic, rigid and authoritarian application of official treatment guidelines and marketing based practice. I do not take credit myself only for CP-CNP model presented here because it represents the clinical experience, experimentation, research, writing, and invention of hundreds scientists, philosophers, academic and clinical psychiatrists and psychologists.

CP-CNP AS TRANSDISCIPLINARY INTEGRATIVE LEARNING ORGANIZATION

"Learning organization is a group of people working together collectively to enhance their capacitiesto create results they really care about"
Peter Senge

Modern psychopharmacotherapy is expected to be practiced in normative, evidence-based way according to rules of official guidelines. However, in clinical practice treatment approach is commonly too dogmatic, not rarely pseudoscientific and misguided by official treatment guidelines, and followed by poor or not satisfying treatment outcomes. Fortunately, initiatives known as personalized medicine, person-centered medicine and precise medicine have tried to find optimal treatment options for each patient and so improve general treatment successfulness. CP-CNP represents an art and practice of the learning organization (Table 1) in the frame of transdisciplinary, integrative, narrative, the person-centered and neuroscience based psychiatry (Jakovljevic 2010, 2013a,b, 2015). Each therapy is a learning process which involves systemic and dialectic thinking, and promoting creative mental model, personal mastery, therapeutic vision and therapeutic dialogue. The more complicated treatment case, the more art of soft skills and learning with the patient is needed for a successful therapeutic outcome.

Creating with patients a patient's "a new self-in-the world" by challenging and transforming unhelpful mental loops and mental model that reinforce problems and illness as well as illuminating potential solutions and learning a new way of "being in the world" is a fundamental part of CP-CNP.

Evidence based vs. evidence biased psychopharmacotherapy and debunking myths on mental health medicines

There are many misbeliefs and pseudoscientific myths about MHMs and their use in clinical practice (see table 2) that may have negative impact on the treatment of psychiatric patients (Jakovljevic 2007). Mechanistic (single-cause" and "single-effect" thinking strategies of information processing have produced a lot of oversimplifications, false beliefs and myths regarding treatment of mental disorders. Unfortunately even well-educated patients and members of their families as well as some physicians may be under influence of these misconceptions and myths.

Table 1. Creative person-centered narrative psychopharmacotherapy (Jakovljevic 2019)

1. Therapeutic journey based on integrative learning organization with both "evidence based-practice and practice-based evidence", also value - and narrative-based practice. In addition to rational "risk- benefit" thinking CP-CNP is grounded on lateral, dialectic and systems thinking, imagination and inductive (down-up) and deductive (up-down) logic.
2. Psychopharmacotherapy closely joined with soft skills, psychotherapy and life-coaching.
3. Therapeutic goals drive treatment: In addition to clinical remission personal recovery is final goal, drug treatment is rooted in creative, dialectic and systems thinking in addition to treatment guidelines.
4. Treatment goals of therapeutic journey: in acute phase - clinical remission; in stabilizing phase - social recovery; in stable or final phase - personal recovery.
5. Treatment goals are defined from seven perspectives: disease/illness perspective, person-centered perspective, cognitive-axiological perspective, behavioral perspective, spiritual/transpersonal perspective, narrative perspective and systematic integrative perspective.
6. Responsible benefit-risk ratio evaluation, "poly-pharmacotherapy as soon as needed" strategy.
7. Not only decreasing illness, but also increasing wellness, personal growth and enhancing salutogenesis, resilience and anti-fragility by resetting self-awareness, self-esteem, self-motivation, self-affirmation, hedonic capacity, positive, systems and dialectic thinking and creative behavior.
8. Focus on self-determination, self-actualization, self-transcendence, positive mental health and quality of life; patients are stimulated to be more proactive subjects and participants and "the stars of treatment"; alliance is much more than compliance.
9. Partnership and shared decisions between doctors and patients and their families, not paternalism. Patients and their families have also access to the information. Doctors and patients together know what is the best; patients are best experts on their life; joint therapeutic visions and shared decision.
10. Therapeutic goals drive and define treatment. In addition to clinical and social remission, personal recovery of "a new self in the world" is valued; drug treatment is rooted in creative and systematic thinking in addition to treatment guidelines.

Table 2. Harmful myths about mental health medications (MHMs) that prevent their rational and effective application

Myth 1. Strict adherence to official treatment guidelines (OTGs) increases treatment effectiveness and efficiency. - *Fact:* Strict following OTGs provide better legal security.

Myth 2. OTGs are undoubtedly evidence-based practice. - *Fact*: OTGs in clinical practice may be evidence-biased practice.

Myth 3. Universality of OTGs: TG is applicable to all patients with the same diagnosis at all times. - *Fact*: TG is just a frame of reference, but treatment should be always personalized.

Myth 4. All MHMs within one drug class are alike or the same when used in equivalent doses. - *Fact:* Small pharmacodynamics or pharmacokinetic differences may be associated with essential differences in clinical effect in some patients

Myth 5. Monotherapy should be preferred as a good clinical practice in contrast to polypharmacy what is bad clinical practice.- *Fact:* The use of a single MHM is the simplest and safest, but commonly not effective enough. Creative poly-pharmacotherapy covering more pathological mechanisms and increasing therapeutic effectiveness should be the rule rather than exception

Myth 6. MHMs are ineffective. - *Fact:* MHMs are very effective if used properly.

Myth 7. MHMs represent symptomatic, cosmetic treatment and psychotherapy is etiological/causative treatment. - *Fac*t: MHMs stimulate neurogenesis and improve neuroplasticity underlying positive thinking, mood improving and appropriate behavior.

Myth 8. MHMs are for morally weak people - *Fact:* MHMs are for individuals suffering from mental illness.

Myth 9. MHMs are addictive because after the sudden stopping (e.g. paroxetine) appears abstinence syndrome and illness exacerbation. - *Fact:* MHMs are generally not addictive, but the sudden stopping may be followed by the syndrome of sudden medication withdrawal what may be also case with some non-psychiatric medications.

Myth 10. MHMs change personality and self - *Fact:* Untreated mental disorder change personality and self as well as mental disorders may reflect personality and self-disorders.

Myth 11. MHMs are toxic and dangerous drugs. - *Fact*: MHMs are relatively safe and non-toxic if used properly.

Myth 12. MHMs should be stopped as soon as possible. - *Fact:* MHMs should be stopped when personal recovery is achieved in agreement with the patient.

Myth 13. MHMs may the cause of violent, auto-destructive, or suicidal ideation and behavior. - *Fact:* MHMs are unlikely to create new auto-destructive, suicidal, or violent ideation and behavior.

Myth 14. There are no significant differences between MHMs belonging to the same class, for example between SSRIs. - *Fact:* Global effectiveness of the same MHM class, e.g. SSRIs, is similar, but they have also specific effectiveness.

Myth 15. Some MHMs with many mechanisms, e.g. non-selective monoamine reuptake inhibitors known as tricyclic antidepressants are “dirty drugs”. - *Fact*: There are no dirty medications, there is only wrong selection and use of medications.

Myth 16. MHMs should be used only for treatment of severe forms of mental disorders. - *Fact*: Appropriate use of MHMs in mild episode of mental disorders may prevent developing severe forms of mental disorder.

MHMs are among commonly prescribed medications all over the world, but from time to time they are accused to be “little more than a deceptive product of greedy, lying pharmaceutical companies that sell hope to the hopeless”. Modern pharmacopsychiatry is commonly accused for the major medicalization of living problems in modern society. Patients may be significantly affected in different harmful ways by negative views on MHMs as well as by evidence-biased and marketing-based stories and by anti-psychiatric myths through public media. As MHMs work not only by pharmacodynamic mechanisms, but also on the account of the meaning they have for the patients, debunking these myths related to the psychiatric glorification and anti-psychiatric vilification is of the great importance.

Person-centered approach: Each patient is a unique, responsive, and responsible subject

Different kind of treatment goals lead to different kinds of treatment outcomes. Mental disorders are multifactorial, multidimensional and etiopathogenetically complex phenomena and that is why explanatory models and therapy should refer to integrative explanatory pluralism rather than to biological reductionism (Jakovljevic & Crncevic 2012). The more effective psychopharmacotherapy means the more is selective, specific and person-centered. Person-centered approach represents a paradigm shift: from seeing parts to seeing wholes: from seeing patients with mental disorders as helpless reactors to seeing them as active participants and partners in therapy and shaping their reality; from reacting to the present to creating the future predicated on the joint vision of treatment goals (see table 1 and 3). Person-centered approach refers to the specific mental models of the patients, their thoughts and beliefs about themselves, other people, the world and the future, about the good and evil, the normal and abnormal, the health and disease.

The specific psychiatrist-patient relationship is the foundation on which science-based psychopharmacological knowledge can result in success or failure. The absence of therapeutic relationship and alliance leads

commonly to treatment non-adherence and consequently to treatment failure. Numerable different personalized factors need to be considered when making selection of MHMs treatment. It is very important to identify the characteristics by which the patient is a unique.

MULTI-TARGETED TREATMENT AND SYNERGISTIC THERAPEUTIC MEDICATION EFFECTS

It is right time for modern psychiatry to find its authentic transdisciplinary integrative soul

Creativity is a multi-level, multifaceted process so that CP-CNP is multi-level and multitargeted treatment approach. Modern psychiatry is characterized with many different neurobiological, psychological, social, and even spiritual theories about roots and pathogenesis of mental disorders. The biological theories have mainly focused on genetic predisposition and epigenetic mis-regulations, neurotransmitters dysregulation, disruption of biological rhythms, low-intensity neuroinflammation, oxidative stress and neuroendocrine dis-balance, neuro-plasticity dis-regulations, etc. Psychosocial theories emphasize unconscious conflicts between love and hate, rage and guilt, between ideals and self-perception, or they refer to suppressed negative emotions, problems in the early mother/father-child relationship and insecure attachment, learned behavior of helplessness and hopelessness, punishing experiences and lack of positive reinforcement, faulty information processing and maladaptive beliefs, and so on. Consistently to existence of many theoretical approaches, there are many treatment approaches. However, as none of the multiple theories provides an adequate explanation for all aspects and types of mental disorders, so none of the fragmentary treatments is successful. CP-CNP, predicated on the circular feedback bio-psycho-socio-spiritual model of mental disorders from seven perspectives, is multi-targeted integrative and comprehensive treatment (see table 1 and 3).

Medications with mental health effects and neurobiological targets of psychopharmacotherapy

Quite a number of the MHMs are available (see table 4). The treatment selection should be based on neurobiological targets (table 5), drug specific pharmacodynamics and pharmacokinetics and on patient specific characteristics (see table 6).

Despite our increasing research and knowledge about the presumed pharmacodynamics and pharmacokinetics of mental health medications, it is sad to say that we still do not know enough what is going on in the brain and mind of patients with mental disorders. We have different theories and concepts but few proven facts about neurobiology of mental disorders and therapeutic mechanisms (see table 5).

Selecting medications, types of mental disorders and treatment strategies

"Good clinicians practice rational poly-pharmacy, and those who do it expertly are leaders in their field"
Doran

A number of different factors need to be considered when making selection of MHMs (see table 3). It is very important to identify the characteristics by which the patient is a unique. Rational choice of MHMs has been limited by a lack of reliable biomarkers to distinguish sub/categories of mental disorders, relying instead upon self-report symptoms and clinical signs. For this reason it is important to use different perspectives in deeper understanding mental illness and therapeutic mechanisms in a holodigmatic and transdiciplinary way. The staging concept of mental disorders, the circular feedback model of mental disorder and the concept of disorders of neuronal network coalitions and dynamics are important in CP-CNP and selecting MHMs (see table 6). Due to process of neuroprogression major mental disorders are progressive developing pathological conditions which involve: 1. diathesis or "at risk stage"; 2. prodromal phase; 3. clear symptoms phase; and 4. residual state or post-illness episode state.

Strategy "monotherapy before polytherapy" is generally proclaimed in psychiatric literature. Many patients usually try several different medicines before finding the right one. The fact is that mental disorders are the result of abnormalities in the complex interactions between several neurotransmitter and psychobiological systems rather than in the abnormalities of any only one simple system. In clinical practice it is very difficult to achieve a full remission or recovery with drug monotherapy, so polypharmacy (COMBOs) of MHMs should be rather a rule than an exception.

Table 3. Treatment goals from 7 perspectives

Perspective	Treatment goal
Disease/Illness or medical perspective	Clinical remission/recovery
Person-centered perspective	Personal recovery
Cognitive-axiological perspective	Positive thinking & circulus virtuous
Behavioral perspective	Assertive & Creative behavior
Spiritual/transpersonal perspective	Life mission and spiritual values
Narrative perspective	Reconstructing narratives and life story
Systematic integrative perspective	Positive mental health and well-being

Table 4. MHMs and other biological forms of treatment

1. **MHMs with antipsychotic effects:** *High potent D-2 receptor antagonists* - fluphenazine, haloperidol; *Serotonin-dopamine antagonists (SDA)* – sertindol, ziprasidone, risperidone, paliperidone, lurasidone, iloperidone; *Multiple Antagonized Receptors Targeted Antipsychotics (MARTA)* - clozapine, olanzapine, quetiapine, asenapine; *Dopamine modulators – aripiprazole, sulpiride, amisulpride*.
2. **MHMS with antidepressant (AD) effects/mechanisms:** *Reversible type A monoaminoxidase inhibitors* (RIMA) – moclobemide, *RIMA*/*SSRI* - brofaromine; *Phosphodiesterase inhibitors* – rolipram; *Non-selective monoamine reuptake inhibitors* (so-called tricyclic antidepressants) - imipramine, amitriptyline, doxepin, etc.; *Selective serotonin reuptake inhibitors (SSRIs*) - fluvoxamine, fluoxetine, sertraline, paroxetine, citalopram, escitalopram; *Selective noradrenaline reuptake inhibitors (SNaRI)* - maprotiline, reboxetine; Serotonin noradrenaline reuptake inhibitors (SNRIs) - venlafaxine, duloxetine; Noradrenaline dopamine reuptake inhibitors (NDRIs) - bupropion; *Noradrenaline specific serotonin antidepressants (NaSSA)* – mirtazapine; *5-HT2/alpha2NA receptors antagonists* - mianserin; *Serotonin antagonist and (weak) reuptake inhibitors (SARI)* - trazodone, nefazodone; *Selective serotonin reuptake enhancers (SSRE*) – tianeptine; *Melatoninergic (M1, M2 receptors) agonist/5-HT2C antagonist* – agomelatine; *Multimodal ADs* (5-HT1A agonist, 5-HT1D partial agonist and antagonist of 5-HT3, 5-HT1D and 5-HT7 receptors) – vortioxetine;
   Other medications and supplements: MAO-B inhibitors – selegiline; Benzodiazepine receptors (BZ-R) agonists - alprazolam, NMDA receptors inhibitors - ketamine, es-ketamine; S-adenosyl-L-methionin (SAMe); agonists 5-HT1A receptors – buspirone; Hypericum extract (St. John's worth); amino-acid precursors – L-tryptophan, phenylalanine, tyrosine; Omega-3 fatty acids.
3. **MMHMs with mood-stabilizing effects**: Lithium, *Antiepileptics*: carbamazepine, valproate/valproic acid, BZ-R agonists – clonazepam, lamotrigine, topiramate, gabapentine;
   SDA: risperidone, paliperidone; *MARTA* - olanzapine, quetiapine; *DA modulators* – aripiprazole.
4. **MHMs with anxiolytic effects/mechanisms:** *BZ-Rs agonists* (benzodiazepines –BDZs): diazepam, lorazepam, oxazepam, bromazepam, alprazolam, etc.; *Gabaergics:* pregabaline; *SSRIs:* escitalopram, paroxetine, fluvoxamine; *SARI:* trazodone; *MARTA* in small doses: quetiapine, olanzapine.
5. **MHMS with hypnotic effects**: *BZ-Rs full agonists:* nitrazepam, flurazepam, midazolam; *non-benzodiazepine BZ-Rs partial agonists* - zolpidem, zaleplone; *antihistaminics* - diphenhydramine; *M1/2 agonists:* melatonin, agomelatine.
6. **Other biological therapies**: Electrostimulative therapy (EST), Transcranial magnetic stimulation (TSM), Magnetic seizure therapy (MST), Vagus nerve stimulation (VNS), Deep-brain stimulation (DBS), Light therapy (phototherapy), Sleep deprivation.

Table 5. Neurobiological targets of psychopharmaco-therapy

- Neural circuits and neurotransmission modulation and balancing
- HPA axis modulation
- Decreasing oxidative stress
- Decreasing neuroinflammation
- Neuroprotective and antiapoptoic effects
- Modulating mitochondrial functioning
- Neurogenesis stimulation and neuroplasticity improvement
- Restoring circadian rhythms
- Modulating epigenetic mechanisms

In general, creative COMBOs (see table 6 and 7) with an additive, synergistic therapeutic effect between two or more MHMs make the overall treatment benefit greater than that achieved by either of the medications alone. Rapid remission and complete recovery can be achieved in majority cases only with rational drug combinations and creative poly-pharmacy. Today it is more and more clear that many patients not only benefit from multiple medications, but also polypharmacy regimen may be essential to achieving and maintaining their recovery. Major shift in philosophy of over the past 20 years is that synergistic polypharmacy came from the Dog-house to the Penthouse in clinical practice (Doran 2003).

Phases of treatment and selection of medication

Theoretical concept of the therapeutic journey through 3 phases: 1. acute treatment phase – clinical or symptoms remission; 2. stabilizing or continuing treatment phase - functional/social recovery 3. maintenance treatment or relapse prevention treatment phase – personal recovery; is searching for very high "therapeutic to side effect ratio" in efficient way in order to reach wanted destination of breaking the patterns of mental disorder and achieving personal recovery and positive mental health as soon as possible.

Acute phase of treatment: Is psychopharmacotherapy first choice or last resort?

As duration of untreated mental disorder is correlated with worse later treatment outcome, early diagnose and properly selected medications are essential for positive outcome. Inverse correlation between shorter duration of symptoms, no matter of the first or the recurrent episode, and treatment response underlines the importance of early treatment. The goal of treatment of

Table 6. MHMs selecting triangle

Patient's characteristic
- type and clinical picture of mental illness
- stage phase of illness, neuronal network coalition dysfunction, mental disorder between
- vicious and virtuous circle
- patient's narrative
- previous experience with treatment
- pharmacophylic or pharmacophobic features
- placebo or nocebo proneness
- age of patient
- comorbid somatic/neurologic diseases
- comorbid psychiatric disorders
- other medications prescribed

Pharmacodynamic and pharmacokinetic drug specific
- risk-benefit profile
- pharmacodynamics profile (therapeutic mechanisms)
- pharmacokinetic profile
- type of formulation
- dosing
- side-effects and adverse events
- safety in overdose
- cost

Treatment goals and therapeutic alliance
- remission of symptoms as soon as possible
- patients as proactive partners, not as objects of treatment
- inducing placebo, preventing nocebo response
- enhancing resilience and anti-fragility
- promoting and fostering patients' creativity
- creating appropriate illness and therapeutic narrative
- personal recovery, post-illness growth, new life story & mental health

acute phase is to achieve as complete as possible symptoms remission as well as soon as possible. According to the many international treatment guidelines duration of this treatment phase is usually about 2-4, sometimes 6-8 weeks. Should a MHM prove ineffective or poorly tolerated, switching to a different medication is recommended. Here is an important question when to switch and when to augment. Switch is recommended when there is no response or response is partial to the first trial; the switch or augment if there is a partial response to a second trial, and to augment when there is no response to a third trial. The use of monotherapy with single mental health medication, either with single-action or multiple action, is always the simplest and the most wishful treatment. However, the fact is that in too many cases monotherapy, both by single-action and multiple-action is unsuccessful or only partially effective. As successive trials of monotherapy are commonly followed by treatment resistance, according to CP-CNP concept starting monotherapy is indicated only for mild episode. MHMs differ significantly in their antipsychotic, antidepressant, anti-obsessive/compulsive, energizing, anxiolytic, sedative and hypnotic effects making some of them more or less effective for different psychotic and non-psychotic, typical and atypical, agitated and inhibited types of episodes of mental disorders. In moderate and severe episode of mental illness an additive, synergic effect between two or more MHMs produces the greater overall therapeutic benefit than that achieved by either medication alone (Table 8). According to majority of international guidelines different combinations of medications with different actions are recommended for treatment-resistant mental disorders. However, many so called treatment resistant mental disorders could be prevented by appropriate intelligent, balanced, and rational synergic combination (syn-combos, see table 9). The ideal treatment is to apply the least number in least doses needed to achieve optimal remission.

When selecting MHMs for resolution of an acute episode of the mental disorder clinicians should prioritize 1. specific efficacy (percentage of responders with specific clinical type and clinical picture, and degree of improvement), 2. specific tolerability profiles and presence of comorbid states, 3. speed of onset and time interval until symptoms/clinical remission, 4. effectiveness and risk -benefit ratio, possible drug-drug interactions, 5. subjective preferences of the patient, 6. cost-effectivenes; 7. rules of insurance and reimbursing agencies. If the first choice medication treatment appears to have had partial benefit then new medication/s or their combination can be added or replace some of the previously prescribed. In the case of the failure of the first or previous medication treatment there are options to a switch to the second choice combination or augmentation with agents that are not considered as official or primary choice drugs (Kasper et al. 2002).

Table 7. Basic treatment strategies in clinical practice

Serial monopharmacy and switching strategies: Stopping the medication to which the patient is not responding and prescribing another medicine, usually from an another group of the same class.

Augmentation strategies: Adding another agent to an ongoing medication that has been insufficient

Combination strategies: Starting with two or more compounds with a well-established efficacy as a single agent for the treatment of the mental disorder.

Creative combination strategies: Starting with appropriate number of compounds and supplements, all with a well-established effectiveness as a single agent, to cover all pathophysiological mechanisms of the mental disorder.

Table 8. Some examples of some synergistic drug combinations

Antipsychotics
- risperidone or paliperidone in the morning or during the day + clozapine or olanzapine or quetiapine in the evening,
- aripiprazole in the morning + clozapine, or olanzapine or quetiapine in the evening
- haloperidol or fluphenazine + clozapine or olanzapine or quetiapine
- paliperidone long acting injection every 4 weeks or every 3 months + clozapine or olanzapine or quetiapine per os in the evening
- aripiprazole long acting injection every 4 week + clozapine or olanzapine or quetiapine per os in the evening

MHMs with antidepressant effects
- escitalopram or sertraline or fluoxetine or paroxetine in the morning + trazodone or mirtazapine in the evening
- escitalopram or sertraline or fluoxetine or paroxetine in the morning + maprotiline in the evening
- reboxetine in the morning + trazodone or mirtazapine in the evening
- escitalopram or sertraline or fluoxetine or paroxetine in the morning + agomelatine in the evening
- escitalopram or sertraline or fluoxetine or paroxetine in the morning + olanzapine or quetiapine in small doses in the evening

Mood stabilizers
- lithium carb + valproate
- lithium carb + lamotrigine
- lithium carb or valproate or lamotrigine + olanzapine long acting injection, or paliperidone long acting injection, or aripiprazole long acting injection

Anxiolytic drugs
- alprazolam or clonazepam + escitalopram or fluvoxamine or paroxetine or sertraline or fluoxetine
- buspirone + alprazolam, or klonazepam or diazepam, etc.

Table 9. Some interesting evidence-based and practice-based COMBOs according to Stephen Stahl (2013)

Combos for unipolar depression
- triple-action combo: SSRI/SNRI+NDRI
- California rocket fuel: SNRI + mirtazapine
- arousal combos: SNRI + stimulant or modafinil
- lithium combo: 1st line agent + lithium
- thyroid combo: 1st line agent + T3/T4
- serotonin 1A combo: 1st line agent + buspirone (?pindolol)
- insomnia anxiety combo: 1st line agent + eszopiclone/zolpidem or benzodiazepine
- serotonin 2A combo: 1st line agent + SARI + mirtazapine + SDA/DPA
- dopaminergic combo: NDRI/NRI + stimulant + modafinil + DA agonist (e.g. pramipexol)
- heroic combo: high dose SNRI/SSRI + alfa2 antagonist + NDRI/NRI + stimulant

Bipolar combos
- atypical + lithium (evidence-based)
- atypical + valproate (evidence based)
- Li-Vo: lithium + valproate (practice-based)
- La-Vo: lamotrigine + valproate (practice based - caution)
- La-Li: lamotrigine + lithium (practice-based)
- La-Li-Vo: lamotrigine + lithium + valproate (practice-based – caution)
- lami-quel: lamotrigine + quetiapine (practice based)
- Boston bipolar brew: any combo but antidepressant
- California careful cocktail: any combo + antidepressant
- Tennessee mood shine: atypical + antidepressant
- Walt Disney's combo: any combo containing ziprasidone
- California sunshine: ziprasidone + lithium + transdermal selegiline or ziprasidone + lithium + venlafaxine

Schizophrenia combos
- - the second line treatment of positive symptoms: clozapine or conventional AP + SDA or DPA
- - the third line treatment: first line AP + mood stabilizer

AP: antipsychotic; DPA: dopamine partial agonist; NDRA: noradrenalin dopamine reuptake inhibitor; NRI: noradrenaline reuptake inhibitor; SDA: serotonin dopamine antagonist; SNRI: serotonin noradrenaline reuptake inhibitor; SSRI: selective serotonin reuptake inhibitor

Therapeutic communication soft skills and creating alliance and partnership with patients may be as important as the prescribing medication. When patients are respected, empathized with, included in medication decisions they are feeling better and are more ready to cooperate in the treatment. In addition to appropriate medications prescription inducing placebo and reducing nocebo responses is very important from the very beginning.

Treatment in stabilization/continuation phase

Major shift in treatment philosophy has happened over the past 10 years. In clinical practice in many patients, treatment is started with multiple medications because polypharmacy regimen with different medications may be essential to achieving and maintaining full remission. Both taking too much and taking too little MHMs is not good. The right medications for the right patient at the right time for an appropriate long time with appropriate psychosocial and spiritual support is the motto of CP-CNP. Successful treatment of an acute episode of major mental disorder as soon as possible is a commendable accomplishment, but it is just the first of the three goals of treatment. Stabilization and maintenance of clinical remission requires psychotherapeutic communication skills more and more in addition to pharmacotherapy. Therapeutic alliance is more than compliance. Well-established therapeutic relationship and partnership with patients are crucial in this treatment phase. The goal of stabilization phase treatment is to preserve clinical improvement and stabilize remission and prevent worsening or relapse of the episode of illness and to achieve at least 6 month long complete remission. MHMs should be used for an appropriate period of time as well as at an appropriate dose to sustain remission Dosage adjustment or augmentation are important to achieve optimal treatment outcome. Instigating and supporting patients to stay on stabilizing MHMs is crucial because many patients do not take all their prescribed medications or commonly miss doses. Specific communication approach and soft skills are needed to the so called “difficult” medication patients such as the patients preoccupied with side effects, the “naturalists”, the non-adherent patients, the misinformation overload patients, the patients who need to be in charge and so on (see Doran 2003).

Treatment in maintenance phase

Mental illness for most patients is manifested as recurrent episodic disorder and with each new episode the illness severity tends to worsen, and treatment response may lessen by time. Mechanisms of recurrences are related to brain sensitization, fragility, kindling and conditioning processes. Prevention of new episode and supporting personal growth and well-being, resilience, antifragility, and personal recovery is the final goal of the treatment. Duration of maintenance prophylactic treatment is very individual and varies from case to case. According to some recommendations patients with three episodes of any major mental disorder, including the index episode or two episodes where one was very severe or with family predisposition should receive long-term treatment for at least 5 years. It is to be noted that numeric precepts for number of episodes or length of extended maintenance treatment serve only as a flexible guideline and treatment decision should be always individualized and personalized. Patients with a history of severe episodes and serious suicidality or strong family history of mental disorders or psychotic episodes are considered for extended or lifetime treatment even if they have less than three episodes. Risk-benefit ratio is crucial when considering the length of maintenance treatment. If each new episode increases risk for long-term deleterious consequences, suicide, job loss, marital discord, divorce, psychophysical deterioration, medical comorbidities, and so on, extended treatment is recommended to be done as long time as it is possible. Although discontinuation of MHMs is generally associated with increased risk of appearance of new illness episode, intermittent medication maintenance treatment may be successful option in many cooperative patients. In such cases, the taper or dosage decreasing should be slow and cautious during at least 6 months, because rapid discontinuation may result with exacerbation or appearing new severe episode. In the case of the reappearance of mild symptoms medication treatment should be restarted promptly, before a fully exacerbation and developing serious illness state. In general, whenever MHMs by the time passing become unnecessary, they are recommended to be reduced in number and dosage slowly and discontinued carefully. In order to achieve the final goal of the treatment “patients need to learn the specific skills of positive psychology: how to have more positive thinking and emotion, more engagement, more meaning, more accomplishment and better human relations (Seligman 2012). If not, when medication treatment is stopped, mental illness could appear again.

PERSONAL RECOVERY, INCREASING RESILIENCE AND ANTI-FRAGILITY: How to Improve Therapeutic Outcome

"The good physician will treat the disease, but the great physician will treat the patient"
Sir William Osler

CP-CNP is more than a single approach. The emphasis on the neuroscience-based and rational psychopharmacology continues to be essential but the therapeutic communication as art of objective support for positive subjective experience, personal growth and self-helping skills is also very important. The central skill in the provision of therapeutic relationship involves empathic understanding, congruence, respect and good rapport. A five stage model may be helpful in helping patients to obtain personal recovery, resilience and antifragility: 1. practice therapeutic communication with

kindness and empathy, establish rapport (matching, pacing and leading), and create therapeutic context; 2. identify, assess and define problems related to illness and disease; 3. define treatment goals and plan interventions; 4. promote self-helping skills, resilience and antifragility; 5. consolidate resilience, antifragility, personal growth and full personal recovery.

Practicing Therapeutic Communication and Establishing Therapeutic Context

"Many wanted to get appointment with Hector, not only because he looked like a true psychiatrist, but also because he knew a secret which all good doctors know, and which is not learned in school: he was sincerely interested in people"

Francois Lelord: Hector and the Search for Happiness

Treatment context may be a constraint for achieving therapeutic outcome or a challenge and an opportunity for creativity and better therapeutic outcome. The context in which we are creative is linked to our beliefs, values, knowledge and skills.Therapeutic communication is one of the most complex neural processes in the brain which involves humanity, awareness, mindfulness, observation, mentalization, imagination, optimism, empathy, kindness, constructive dialogue and learning. Establishing therapeutic context can be explained as the U process which involves 1. co-sensing transforming perception (mental models, team learning: dialogue and practice fields, systems thinking); 2. co-presencing transforming self and will (personal visions, building shared vision), and 3. co-realizing transforming action (team learning: prototype and adjust, systems thinking) with concrete working models from which feedback can be garnered and further creation made (see Senge 2006). Therapeutic context is grounded on practicing therapeutic relationship principles and task/goal principles (see Greenberg et al. 1993). Relationship principles involve 1. complementary salutogenic communication and well-being orientation, 2. increasing reflexivity, creativity and empathy, 3. rapport, 4. respecting diversity in interpretation and treatment of mental disorders, 5. therapeutic alliance and collaborative partnership. Task/goal principles involve 1. resilience, antifragility, and personal growth; 2. clinical and social remission as soon as possible, 3. personal recovery and positive mental health, 4. treating the both illness and disease, 5. understanding mental disorder and life story of the patient. Helping patients decide to start and continue taking appropriate mental health medications, associated with therapeutic narratives and communication, is one of the essentials of CP-CNP. Motivational interview, therapeutic communication and therapeutic alliance are important initial part of the creating therapeutic context. Therapeutic communication promotes ever-helpful placebo response and makes nocebo response less likely. Cooperative and collaborative partnership honoring patients' autonomy is not only offering patients what they lack, be it medicines, knowledge, insight or skills, but also activating their own motivation and resource for change and treatment success in connection with their personal goals, values, aspirations and dreams. Making diagnosis with the patient as part of therapeutic alliance is more effective than making diagnosis on the patient. Motivational interview is a skillful clinical method of meeting patients in their model of the world for eliciting their own good motivations for treatment success. Rapport is based on taking a genuine interest in the patient as a person, on being curious about who he/she is and how he/she thinks, feels and behave and on being willing to see the world from their point of view. Creating rapport involves matching the patient's mental model, pacing and leading to improve their mentalization for positive transformation (see Prljaca et al. 2021) and emotional decontamination (see Hamidovic et al 2021).

Restoring psychobiological basis of resilience and anti-fragility

Wind extinguishes a candle and energizes fire

Nassim Nicholas Taleb (2013)

Resilience is a complex psychobiological and multidimensional process, very important for understanding of mental health, salutogenesis and pathogenesis, therapeutic and healing mechanisms (Jakovljevic & Borovecki 2018, Selimbasic & Hasanovic 2021). It may be defined as a collection of protective and salutogenic factors that modulate the relationship between a stressful event, adversity or disease, and positive outcomes. Resilience is about the whole person, it includes biological, psychological, social and spiritual dimension of human existence and enables individuals and communities not only to survive and adapt to challenges and adversities but also to be better off, and to grow and thrive (post-traumatic growth, anti-fragility) in addition to overcoming a specific adversity. It is a complex process ranging from surviving to thriving. It includes positive transformation and personal growth, an indivisible part of mental health and health in general, well-being and quality of life as well as recovery and treatment outcome. Resilience is the ability to reframe the things, most notably moving from feeling disappointment to seeing opportunities and new possibilities. Resilience-enhancing psychological intervention such as redefining mental illness, positive mood induction and creating pleasant states of mind, relaxation exercises, breaking ruminative patterns, reframing and cognitive restructuring, ego-strengthening, improving social skills, etc. It is very important to note that "some resilience factors contribute to the development of other resilience factors, and, in consistency with a cascade model, together they contribute to predict personal recovery (Echezarraga et al. 2018). Pleasant mental states which involve feelings of love, hope, agency, purpose, positive goals, communion, gratitude, and joy can be induced in many different ways, not waiting for pharmacodynamics effects of MHMs in several weeks.

When we see an attractive smiling face, the orbitofrontal cortex responsible for processing sensory rewards is activated. Some research showed that one smile can generate the same level of brain reward stimulation as up to 2000 bars of chocolate.

The model of primary, secondary and tertiary resilience (Jakovljevic & Borovecki 2018) explains how appropriate resilience enhancing interventions may help in obtaining favorable therapeutic response. The level of and pace by which personal recovery is established is a function of brain resilience, external resources like support, nature of illness and chosen drug treatment. However, resiliency as a treatment target has been largely neglected in the field of therapeutics (Davidson et al. 2015) so the lack of favorable treatment outcome may be commonly related to the treatment focus only on symptoms and illness. The route of clinical, functional and personal recovery lies not only in decreasing illness, but also in enhancing resilience, antifragility and increasing wellness (Jakovljevic 2017). Full personal recovery does not mean only the absence of symptoms of mental illness, but also the presence of resilience and anti-fragility, improved mentalization and dialectic thinking, proper meaning/purpose and quality of life and mental wellness. The concept of resilience enhancement promotes strengths and potentials for wellness which are present in patients instead focusing only on their weakness and pathology. Each patient is unique, responsive and responsible person and within every person there is a force that drives them to strive to self-realization, self-understanding, self-transcendence, and a sense of coherence and control over their own life. Enhancing patients' resilience by emphasizing their strength and opportunities and covering up weakness is an ambitious goal that aims to promote positive mental health in spite of the presence of symptoms and drug treatment failure. Good news is that resilience can be enhanced through learning and training. Resilience training can result in augmented neuroplasticity and balance of neural circuits that modulate reward and motivation, emotion regulation, cognitive reappraisal and executive function, novelty seeking, harm avoidance and fear response, self-directedness, cooperativeness and adaptive social behavior, and self-transcendence.

Increasing placebo, and decreasing nocebo response

"If the brain expects that a treatment will work, it sends healing chemicals into the bloodstream, which facilitates that. That's why the placebo effect is so powerful for every type of healing"

Bruce H. Lipton

Our positive and negative beliefs impact all aspects of our life including health and treatment of mental disorders. History of psychiatry is largely the history of placebo response. In CP-CNP it is of utmost importance to practice therapeutic communication inducing and enhancing placebo response in everyday clinical practice (Jakovljevic 2014a,b). Real or sham treatment may be followed by placebo reaction, a pleasant subjective feeling and positive response or by nocebo reaction, an unpleasant subjective feeling or negative response. Placebo and nocebo phenomena are integral to everyday clinical practice and may significantly influence on treatment outcome. Therefore, all psychiatrists should be familiar with these phenomena and be educated to manage them. The concept of some mental disorders as a nocebo reaction to stressful life events may explain high rates of placebo reaction in patients with depression. For psychiatric patients, the prescription of MHMs may have different meanings related to their mentalization capacity and epistemic trust (see Prljaca et al. 2021) and result in feelings of punishment, confirmation of self-blaming beliefs, reinforcement of masochist trends, or ambivalence and resignation regarding the painful feeling of loneliness and isolation, and imply as if the medications could replace the human relationship (Jakovljevic 2014b). In antidepressant trials for adults, the placebo rate is 30-50%, compared with a medication response rate of 45-70%, and it has risen at a rate of 7% per decade over the past 30 years (Mora et al. 2011, Rutherford & Roose 2012, Jakovljevic 2021). According to the "Dodo bird verdict" in psychotherapy 40 percent of change comes from patients' personal resources, both psychological and environmental, 30 percent from common features of therapists such as empathy, warmth, acceptance, and encouragement of risk taking, 15 percent from patients' trust and expectation, sometimes called placebo, and 15 percent from the therapist's specific techniques and theoretical models (see Jakovljevic 2021).

Table 10. Placebo and nocebo from 7 perspectives

- Disease/illness perspective: symptoms fluctuation, spontaneous remission
- Personal perspective: pharmacophilic and pharmacophobic personality traits, treatment motivation and desire for symptoms relief; optimism vs. pessimism, winner vs. looser life - script
- Cognitive perspective: power of positive and negative, self-defeating thinking; trustworthiness or untrustworthiness activation
- Behavioral perspective: positive and negative conditioning; social learning by observation; habituation vs. sensitization; placebo and nocebo games
- Narrative perspective: positive and negative narratives, winner's and loser's scripts
- Spiritual perspective: behind the drive for survive there is faith; nocebo lack of faith
- Systems perspective: positive and negative synchronicity

Table 11. Guiding principles of recovery oriented treatment (Jakovljevic & Borovecki 2018 modified)

1. There are many pathways to recovery to live with love, power, joy, freedom and purpose;
2. Recovery exists on a continuum of improved health and full well-being;
3. Recovery is strongly related to the concept of positive mental health and positive psychology;
4. Recovery is predicated on resilience and antifragility;
5. Recovery involves a process of healing, self-redefinition and self-directedness (life script change);
6. Recovery involves resilient thinking, mindfulness training and new purpose in life;
7. Recovery involves re/joining and re/building a creative life in the community;
8. Recovery involves authentic self-actualization, self-transcendence and self-coherence;
9. Recovery involves supportive environment, family, peers and allies;
10. Recovery involves physical activity and eating for optimal cell health against oxidative stress, inflammation, and insulin resistance.

Placebo can be understood from different angles (see table 10) as a way of the pleasing the patient, resilience and antifragility activation, resetting the brain, natural healing activation, the power of positive thinking/faith, self-fulfilling prophecy, and as a game that people play (Jakovljevic 2021). Some mental disorders, such as depression and anxiety disorders, are a vicious circle in which pessimistic thinking, negative expectations and negative emotions feed on each other. Placebo response is related to positive expectations which can set in motion a positive cycle, in which positive fluctuations in mood and well-being are interpreted as evidence of treatment effect instilling a sense of hope and well-being. In addition to their pharmacodynamics effects, MHMs work also on account of meanings, expectations, and relationships. Patients are always subjects of potential and transformation who give meanings and respond more or less actively to meanings that disease, illness and treatment have for them and psychiatrists (Jakovljevic 2021, Mulahalilovic et al. 2021). Inducing positive emotions and optimism during motivational interview or when creating therapeutic narrative is commonly followed by patient's placebo response. Having pleased patients taking MHMs can be achieved by numerable well-being interventions.

Changing old ill narrative and creating new positive therapeutic narrative

"If compassionate connection is the heart of narrative psychiatry, than eliciting healing stories is its soul"

SuEllen Hamkins 2014

CP-CNP represents the narrative integration of different forms of psychotherapy and neuroscience-based pharmacotherapy. Mental illness, suffering and problems that bring patients to psychiatrists derive in significant measure from the ways they interpret and give meaning to the events of their life in the form of self-defeating and destructive narratives. A life story is an internalized and evolving narrative of the self that incorporates the reconstructed past, perceived present and anticipated future in order to provide a life with a sense of unity and purpose (Jakovljevic & Jakovljevic 2019). Life script is a person's unconscious life plan, an ongoing program for a life drama which dictates where the person is compulsively going with her/his life and the path that will lead there. Some patients with mental illness grew up with self-denying interpretations and meanings and became hostage to toxic life scripts that adversely define and constrain their identity, self-image, and future. The manifestation and outcome of mental disorders may be very different within different life scripts. Narrative psychiatry, established on the logic of narrative, life stories and narrative self, help patients to transform psychological suffering and experience of mental illness into an active process of self-reflection, a source of meaning, and an opportunity for psychological and spiritual growth. Patients come to the clinics with intensely personal life stories of suffering, despair and failure to tell (Lewis 2011, Hamkins 2014) as well as with their losing and sorrowful unconscious life scripts, life plans made in childhood.

Reframing techniques help patients to create new meanings and find different ways of making sense of events and their experiences. Deconstructing narratives that fuel mental illness and developing stories of strength and meaning can be cultivated and nurtured into narratives that are resources for personal recovery. While restitution story „yesterday I was healthy, today I am sick, but tomorrow I'll be healthy again" may work for some illness experience, it can be problematic in the context of some other mental disorders for which cure, or return to previous health as it was once, may not be forthcoming (Jakovljevic & Jakovljevic 2019).

CP-CNP is meaning centered and values oriented therapy because our stories are based on what we value. Stories are how human beings make meaning of their experiences and what they value (see Mulahalilovic et al. 2021). Mental illness is fundamentally about destructive and self-defeating narrative and its reconstruction to one that is hopeful and empowering the patient to construct or co-author a new life story with new values or identity parts. Throw the reconstructed or new narrative patients define the significance of mental illness, what it means to them or those around them, how it has changed them, how it might empower them, etc. Through illness narratives patients form their own explanations about the causes of their illnesses. Therapeutic narrative refers to

explanations how mental health medications work as well as in decisions about using them all the way through therapeutic journey. The restitution narrative presumes the illness to be healed, cured or overcome so that the patient becomes the same or healthy again. The quest narrative is characterized by the patient's search for meaning and the idea that something can be learned or gained from the illness experience. Treatment relies on the reinterpretation, reframing and reconstruction of a life narrative that will give new meaning and direction to the patient's life regarding love, freedom, power, joy, purpose, wisdom and practice (*narrative therapy*).

Fostering creativity and supporting self-actualization

> *There is no doubt that creativity is the most important human resource of all. Without creativity, there would be no progress, and we would be forever repeating the same patterns"*
>
> *Edward de Bono*

The huge gap between possibility for achieving high treatment effectiveness and poor results in clinical practice may be stitched by more scientific and practical creativity, and less dogmatism. As a multi-faceted process creativity involves combination of different perspectives (see table 3 and 10). Creativity, both on the sides of psychiatrists and patients is fundamental to CP-CNP. Life success in general, and success in treatment of mental illness in particular, depends on levels of the motivation, learning (knowledge, wisdom, skills, values), beliefs and information-processing, self-regulation and creativity (see Jakovljevic 2013). Creativity is a universal quality that exists in all people, but varies from person to person, and usually we differ everyday, ordinary or "little c" creativity and eminent, genius or "big C" creativity. Creativity is an enriching and empowering bi-directional process which improves mentalization, motivation, self-esteem, communication, self-actualization, cooperation and achievement. Mentalization is essentially involved in regulating social interactions between individuals and should accordingly be actively encouraged and maintained in therapeutic discourse. Changing the patient's mental model and paradigms is an essential part of treatment based on mentalization and supports the creation of a new concept of the self and the world and further development in the process of self-actualization (see Prljaca et al. 2021). Integrative good clinical practice opens the door of creative cooperation to pharmacotherapy and psychotherapies, psychosocial and spiritual therapies, in order to achieve optimal therapeutic outcome.

The idea that creative expression can significantly contribute to the healing process has been old one in medicine. In general treatments can be divided into creativity-promoting and creativity-killing ones. The CP-CNP concept promotes prescribing MHMs as a part of creative life reorganization "with a little help of our medication friends". The important role of dopaminergic neurotransmission in creative thinking and behavior is explained by its impact on motivation, mental imagery including hallucinations, visions and vivid metaphors, curiosity and novelty-seeking behavior, epistemophilia and reward-based actions (see Jakovljevic 2013, Khalil et al. 2019). Quite a number of studies confirmed the strong connection between DA system, reward and creativity (Khallil et al. 2019). Creative drive and novelty seeking are influenced by mesolimbic DA while self-transcendence is the foundation for creativity and integrity (Cloninger 2004). Creativity is a multidimensional construct in which different moods influence distinct components of creative thinking. Relationship between creativity and mental disorders differs according to the study approach (Taylor 2017).

There are many creativity stimulating techniques and methods nurturing the therapeutic alliance; 1. asking at least five times daily "why is that like that?" and "how to get what I want" establishing purpose and goals, 2. building motivation, particularly intrinsic, and self-esteem and personal growth, 3. stimulating and rewarding curiosity and exploration, and seeing things through others' eyes, 4. search for constructive ideas and practice brain storming, 5. encouraging confidence and a willingness for self-change, 6. promoting supportable beliefs about creativity; 7. building basic skills; 8. providing opportunities for choice and discovery; 9. focusing on personal mastery and self-competition, 10. opening and closing dialogue with kindness. Using art forms of creative therapy such as music, dance (e.g. 5 rhythms dance), drawing, painting, writing, etc. in addition to pharmacotherapy may significantly help patients in self-expression and personal growth to achieve personal recovery.

Achieving personal recovery and modeling new life story

> *"The great thing, than, in all education, is to make our nervous system our ally instead our enemy"*
>
> *William James: The Principals of Psychology, 1892.*
>
> *"Recovery is personal process that will push you beyond your limits over and over"*
>
> *Brittany Burgunder*

The concept of personal recovery, which involves therapeutics empathy, new way of positive thinking, more positive attitudes and refined communication and therapeutic skills, has become a common thread in psychiatry. In literature personal recovery is commonly described as a unique and personal therapeutic journey to state of well-being to create and live a meaningful and contributing life in a community with or without the presence of symptoms of mental disorders. This concept is based on resilience and anti-fragility phenomenon and ideas of self-determination, self-management and recognition of the right sense of meaning in life (see Mulahalilovic et al. 2021). It includes set of values about patients' right to create a meaningful life for themselves with or without the presence of mental

disorder (Slade 2009, Rufener et al. 2015). Mental disorders are commonly very suffering, painful and disorganized experience, associated with interpersonal conflicts due to dysempathy, wrong mentalization, social withdrawal and professional failure, feeling that life has lost its meaning and that the future seems blocked. It is very important to help patients to realize that something has gone wrong with their life and that something needs to be change. Some patients going through mental illness really discover new dimension in their life and put important things right, but too many of them go on and on, again and again on the wrong life ways. For some patients mental disorder is some kind of a psychological prison in which they put themselves unconsciously. MHMs can help patients to create new mental maps and see the world in more proper way that they are not prisoners of their past and to decide what to change, which life values to follow, by which way to continue their life journey to be in charge of their lives… Recovery oriented treatment approach is predicated on the fact that patients with any type of mental disorder have, more or less a capacity to live a fulfilling and meaningful life when provided with empathy, proper and efficient support and resources. Guiding principles of recovery oriented treatment are presented on table 11.

Personal recovery is measured as the extent to which a patient construct a positive view of self and world and regains or attains a fulfilled and meaningful life, with or without episodes or symptoms of mental disorders. Personal recovery focused psychopharmacotherapy is supported by creating and fostering empathy hope, meaning, personal responsibility, spirit of optimism, changing the helpless and hopeless victim mentality and commitment to building new life scenario which can significantly contribute to overall positive response to pharmacotherapy, but in the other way round MHMs can contribute to better mentalization, creation and fostering hope, meaning, personal responsibility, spirit of optimism and commitment to new life story with more empathy, love, power, freedom, joy, wisdom, and purpose/meaning.

CONCLUSIONS

The time is ripe for psychiatry to find and promote its transdisciplinary integrative soul and increase treatment effectiveness. The concept of transdisciplinary integrative psychiatry applied in an art and practice of clinical psychopharmacology as a science and therapeutic learning organization may help to overcome gap between academic and clinical psychiatry and significantly improve treatment success. The CP-CNP is a comprehensive and holistic concept encompassing a wide array of psychological methods and pharmacologic strategies that are aimed to achieving optimal treatment outcome. The theory and practice of CP-CNP has been a distillation of the forty years of scientific and clinical practice and of the personal experience as principal investigator in many international double-bind clinical trials with MHMs. The CP-NCP model has been presented at many regional psychiatric congresses during the last two decades and promoted through International School of the CP-CNP from 2018 at Department of Psychiatry, Clinical Hospital Centre, Tuzla, Bosnia and Herzegovina.

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