

# ACCEPTANCE OF DIAGNOSIS IN PSYCHIATRY AND INFLUENCE ON TREATMENT IN THE LIGHT OF CREATIVE PSYCHOPHARMACOTHERAPY

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## SUMMARY

*In this paper, we focused on the complexity of diagnosis in psychiatry and problems during its communication, and its acceptance / non-acceptance, both by the patient and family members of the patient, which has a significant impact on the success of treatment. It is not uncommon for somatic diseases to be related to mental illness, which due to damage to certain organs requires adequate psychiatric therapy. The treatment process is a joint agreement between the patient, his / her family members and the psychiatrist regarding the explanation of the illness, how to take the medication and the agreement with the patient about the psychotherapy that would suit him / her best. Psychosocial support to the patient(s) is also very important in the treatment of psychiatric patients, because only with such support do we empower sick people, their families and the social environment, and the result is successful treatment and reintegration into everyday life in the community.*

**Key words:** *diagnosis in psychiatry, stigmatization, treatment, creative psychopharmacotherapy*

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## INTRODUCTION

Spiritual or mental illness is, in the broadest sense, any disorder of brain function that affects a person's thoughts, feelings, or their ability to communicate with their environment. Mental health is defined as a state of well-being in which each person realizes their potential, copes with the daily stress of life, can work productively, and is able to contribute to their community (Westerhof & Keyes 2010).

Psychiatry (Greek psyche - soul, iatrea - treatment) is a medical discipline that deals with the observation, diagnosis, and treatment of mental disorders to achieve the best possible individual mental health, as well as the health of the community/humanity. The history of psychiatry is linked to the history of care for the mentally ill. Its pre-scientific period dates back to the beginning of the development of civilization until the middle of the 19<sup>th</sup> century. It is marked by mystical and religious interpretations of the onset of mental illness, which were thought to be caused by supernatural causes.

Through historical development, we can follow it through three successive periods: the period of "asylum", dynamic and diagnostic psychiatry. Psychiatry has been reorganized from a discipline where diagnoses played a marginal role, to a discipline where they have become the basis of its specialty.

A psychiatrist is a doctor of medicine who is trained to diagnose, prescribe medication and treat a patient based on interviews, taking anamnestic data and determining psychopathology.

It can be seen from practice that medicine, both among the people and with most doctors, is divided into somatic medicine and psychiatry. Diagnosis in psychiatry is more difficult than in somatic medicine because somatic medicine has certain biological markers that help determine a certain disease. For the time being, there is no verified biological marker on the basis of which a 100% reliable diagnosis of a mental disorder, ie a psychiatric diagnosis, would be made. Based on the expressed feelings, thoughts, and behavior of the patient, the psychiatrist decides to perform additional diagnostic procedures, in order to confirm/exclude the organic etiological influence. This is done in order to draw the clearest conclusions, and thus the diagnoses as well as the method of treatment.

Also, psychiatric diagnosis is dynamic and may change over time. Most often, in the initial diagnosis, there are not enough identified symptoms within the clinical picture that would indicate that it is a clearly defined disease/disorder because during the development of the disorder, the clinical picture changes. This requires vigilance of the clinician and determination of the changes that have occurred during the treatment, ie until the correction of the first diagnosis.

Understanding of the mechanisms used to effectively communicate with psychiatric patients, and mental health service users about their diagnoses from the psychiatric spectrum is limited (Milton & Mullan 2014).

Getting a diagnosis has a calming effect on some patients, while for others, it has signs of stigmatization and fear that they are "crazy" and that there is no cure,

or that they have to be treated and go to a psychiatric clinic all their lives. Patient self-education (inadequate education), primarily through irresponsible media, such as the Internet, is the next big problem in diagnosing and communicating the diagnosis to the person who needs it because they offer negative perceptions about mental disorders, diseases, and people suffering from them. Negative "sensationalist" news sells faster and better in the print media, and today primarily in the electronic media. Due to such social assumptions, the course of treatment of people who have mental problems is difficult after learning that they have a psychiatric diagnosis.

Often patients are dissatisfied with the diagnosis and accompanying treatment. They do not go for check-ups with the same psychiatrist, and this can again lead to a misunderstanding of the clinical picture itself because the other psychiatrist they turn to for a check-up did not see the patient's condition at the first examination, which can make a different diagnosis. The control is also performed after the patient has taken a prescribed drug for a certain period, which changes the clinical picture of the initial diagnosis, and the period of action of the drug is significant in the clinical picture and treatment.

In the treatment of psychiatric patients, psychosocial support to the patient(s) is very important, because with such support we empower sick people, their families, their social environment, and the result is a successful (re)inclusion in everyday life in the community.

When we talk about the aspect of somatic diseases, almost every disease requires treatment or medication that will either alleviate the symptoms that the person feels, or lead to a complete cure. The experiential aspect of the disease is rarely mentioned in public, or rather how a change in somatic health leads to a change in the mental state of the patient, and these changes are common in sudden and chronic diseases, when a person learns of the loss of health. In practice, very often this process that patients go through is shown by the Elisabeth Kübler-Ross model, which is characterized by five stages: denial, anger, negotiation, depression, and acceptance (Kübler-Ross & Kessler 2014).

Today, more than 450 million people worldwide suffer from mental disorders. Long-term treatment, reduced productivity, sick leave, psychological and existential burden on the individual, family and society, all indicate that these people with mental disorders need the help and support of loved ones, but also of their whole community (Chen & Lawrie 2017).

This paper aims to show the complexity of diagnosis in psychiatry, and the problems during its conveyance, as well as its acceptance by the patient and family members of the patient, which has a significant impact on the success of patient treatment.

## **HISTORICAL DEVELOPMENT OF PSYCHIATRY**

Since psychiatry was constituted as a specialist branch of medicine, we can follow three successive periods in its development: the period of "asylum", dynamic and diagnostic psychiatry (Ackerknecht 1985).

At the end of the 17<sup>th</sup> century in Europe and the beginning of the 19<sup>th</sup> century in America, specialized asylums were opened to treat a small number of seriously mentally disturbed individuals. Relying on biology, psychiatrists believed that the symptoms of mental illness stem from various changes in the brain and nervous system in general, which shaped the way patients were treated (pharmacological shock, various forms of aversive therapies, lobotomy, and electro-shock).

In the late 19th century, the Viennese neurologist Sigmund Freud revolutionized the interpretation of the nature of mental disorder, and his psychoanalytic theory served as the basis for the development of dynamic psychiatry. In contrast to asylum psychiatry, which was primarily aimed at identifying a small number of distinct diagnostic categories, the basic principle of dynamic psychiatry was to link neuroticism to normal behavior and to classify both as variants of a common developmental process. The focus was on internal mental processes. Symptoms are no longer viewed as a direct expression of the disease but as a result of a complex interaction between unconscious dynamics and repressive processes. For this reason, the very nature of the treatment of the mentally ill is changing, which now dictates that the problems of the individual can only be eliminated by intensive exploration of his most intimate thoughts and feelings in exchange with the therapist, to understand the manifested symptoms that stem from the person's most intimate history (Horwitz 2002).

The dynamic stance was incompatible with the cultural climate that emerged in the 1960s. The social context surrounding psychiatry required its complete transformation if it was to survive as a branch of medical science. In that period, medicine adopted new methods that were more appropriate to the conceptions of science of that time, and which emphasized the requirement that the entities of the disease be precisely defined and subjected to scientific analysis.

Psychiatry has been reorganized from a discipline in which diagnoses have played a marginal role, to one in which they have become the basis of its specialty. Diagnostic psychiatry, in contrast to the dynamic, defines mental disorder based on the presence of "obvious" symptoms, which are direct indicators of mental disorder, and is particularly interested in the causal factors of their occurrence.

Mental disorders are understood as "natural" entities that exist in the body, and that produces special symptoms that a person manifests. The diagnostic model

looks for the primary causes of the disorder in brain dysfunction, rather than in dysfunctional childhood. This leads to a change in treatment, ranging from intrapsychic personality exploration (in a dynamic model) to find the best medication to relieve symptoms (in a diagnostic model).

### **The relationship between patient and psychiatrist**

Every relationship between a patient and a doctor, in this case, a psychiatrist, goes with a transfer or transfer, which we define as the transfer of emotions that the patient experienced in childhood towards important characters to the psychiatrist. In the first place, they are mother, father, brother, sister, grandmother, grandfather, teacher, etc. These are the people who lived with the child and provided him with the opportunity to develop emotional connections in the earliest childhood. Transfer most often occurs in situations where there is someone younger and weaker, someone who has a need in relation to someone older, stronger, more powerful who is in any way able to satisfy that need. In such situations, patients often act as children who look with big eyes at a powerful and saving great man, who will solve their problem, fulfill the need, and preferably fulfill it immediately. The patient regularly sees an omnipotent and omniscient figure in the doctor. A person who is ideal, and who will be happy to solve all the problems that come with the patient, to help them overcome their disease and to achieve happiness in life. Such fantasies and unrealistic demands will often disappoint the patient because, as a rule, they will not be met (Klajn et al. 1999).

Patients are those who give a positive or negative meaning to medicines, diseases/diagnoses, and treatment, on which depends their adherence and commitment to instructions, cooperation, and healthy living. Therefore, the psychiatrist should pay special attention to determining whether the patient has an optimistic or pessimistic belief system, what their expectations are for treatment, whether they are a pharmacophobe or a pharmacophile, or if they have a realistic attitude towards medications. Make an effort around the patient and hear his / her life story, what are the family relationships, etc. One of the best ways for a psychiatrist to understand a patient is a multidimensional individualized and personal approach from seven perspectives that includes a clear definition of the mental disorder and comorbidity that the person suffers from (Jakovljević et al. 2012, Mešanović et al. 2020). It should be clear about the patient's personality, vulnerability and resilience, the way of thinking, the values that follow, how they behave in health and illness, what his / her life and family story is, what he/she believes in and what are the capacities for mental and spiritual growth and development (Jakovljević 2016).

### **Psychiatrist**

A psychiatrist is a doctor of medicine, a doctor, a person who, after graduating from medical school, worked in general practice and acquired practical clinical knowledge and then completed psychiatric clinical practice as a trainee to pass a specialization in psychiatry. A psychiatrist works in a health institution (public or private practice) and treats patients with psychopharmaceuticals and psychotherapy. Unlike a psychologist who can have training in psychotherapy and engage in psychotherapy, a psychiatrist can also prescribe medication to a patient for both somatic diseases and psychopharmaceuticals. The psychologist in the psychiatric team is in charge of psychometrics and participates in diagnostic preparation, and the psychiatrist makes a psychiatric diagnosis with full responsibility for its validity and initiates treatment procedures by making a therapeutic plan and monitoring its implementation.

### **Why is the meeting with the psychiatrist challenging?**

The clinical questioning of the patient in psychiatry differs greatly from a clinical questioning of the patient in internal medicine or surgical branches of medicine. Clinical treatment of patients involves distinguishing between subjective and objective symptoms. In psychiatry, this is more difficult to distinguish, because the mentally disturbed personality of the examined patient is the focus of the whole procedure. A psychiatric patient is not always able to provide accurate subjective information about the experience of his illness but distorts or denies it. According to the contents of his psychopathological experiences (hallucinations or insanity), the mentally ill person has a "positive" judgment of reality. The unreliability and subjectivity of autoanamnesis in psychiatry is common and extremely difficult for the professional work of psychiatrists, and heteroanamnesic data are given more importance on the onset and development of mental disorders than they are in other clinical medical branches.

Psychiatry as a clinical medical branch cannot, in most of its entities, base the diagnosis of a mental disorder on a pathohistological finding like other branches of somatic medicine. No pathoanatomical substrate or post mortem characteristic, specific or pathognomonic for many mental disorders has been identified.

Psychiatry cannot use experiments, that is, experimental research on humans, or even less on a model, in its research, even approximately like other medical professions. The model in psychiatric research, first of all, cannot be used because all other animal species, except man, do not have cognition in their psychic totality and do not have the ability to speak.

The etiology and pathogenesis, in a state of mental disorder, have not been deciphered in modern scientific psychiatry for most mental disorders or diseases. The etiopathogenesis of mental disorders cannot be explained by scientific knowledge from biological disciplines on which modern scientific medicine is based.

Mental disorder is certainly caused by brain dysfunction, at least at the molecular neurotransmitter level of neuronal dysfunction. The explanation of the occurrence of mental disorders today is necessary to be based on the achievements in the field of developmental psychology. At the same time, it is necessary to take into account all three known factors in the development of mental disorders (biological, psychological, and sociological), equally and connected by dynamic interaction.

The advantage of psychiatry in relation to other medical disciplines is the clear obligation of holistically profiled scientific research. Psychiatry has already contributed today, that all branches of scientific medicine respect the psychic category in a somatically ill patient.

### **Psychiatric examination**

From practice, we learn from patients that their first examination by a psychiatrist is the most difficult. Most often, patients spend the night thinking about what awaits them, what will be asked of them, what questions will be asked. When they come to a psychiatrist, the examination is generally a pleasant conversation, and unlike the examination in somatic medicine, which sometimes involves unpleasant and painful examinations, this is not the case in psychiatry. The examination consists of anamnesis and determination of mental status, as well as making a working diagnosis. The doctor received the anamnestic data from the patient and close family members, as well as from the escort, which can be anyone who has the requested data about the given person. The conversation that takes place should be in a calm and comfortable office, without interference during the conversation. Conducting a conversation quickly and indifferently, with an examination leading to a conclusion (after a conversation conducted rigorously), often prevents the patient from disclosing important information. Monitoring the history of the current disease using open-ended questions so that the patient can tell their story in their own words requires an equal amount of time and allows the patient to describe related social circumstances and to detect emotional reactions. The personality profile obtained may indicate adaptive tendencies (e.g., adaptability, conscientiousness) or maladaptive (e.g., egocentrism, addiction, poor frustration tolerance). Conversations can reveal obsessions (unwanted and disturbing thoughts or urges), compulsions (instincts to perform irrational or

inappropriate acts) and illusions (strong false beliefs) and determine whether anxiety is manifested by somatic symptoms (eg headache, pain) in the abdomen), psychological symptoms (eg phobic behavior, depression) or social behavior (eg withdrawal, rebellion) (Kaličanin 1999).

The patient should also be asked for an opinion, regarding psychiatric treatment, including somatic or mental disorder medications (psychopharmacotherapy) as well as for psychotherapy, so that this information can also fit into the treatment plan. Observation during the conversation can provide evidence of mental or somatic illness. Body language can reveal evidence of preferences and feelings that the patient denies. Observations and questions are used to determine mental status to assess several areas of mental function, including speech, expression of emotions, thinking and perception, and cognitive function.

Speech can be assessed by recording spontaneity, syntax, speed, and amount of utterance. A patient with depression can speak slowly and quietly, while a patient with mania can speak quickly and loudly.

The expression of emotions can be assessed, following the patient's description of their feelings. The patient's tone and color of voice, body position, hand movements, and facial expressions are taken into account.

Thinking and perception can be determined by observation, not only of what is being talked about but also of the way it is being talked about. Abnormal content can take the form of delusions, ideas of relationships, or obsessions. The psychiatrist can determine whether the thought is connected and targeted and whether the transitions from one thought to another are logical. Psychotic or manic patients have disorganized thoughts or a sudden escape of thoughts.

Cognitive functions include levels of patient awareness, attention (or concentration), orientation toward a person, place and time, memory, abstract thinking, and judgment. Cognitive abnormalities most commonly occur with delirium or dementia and addiction, but can also occur with depression.

A psychiatrist can help a sick person only if he or she accepts appropriate procedures that lead to treatment, such as coming to a psychiatrist and conducting an interview, which is very often therapeutic in itself. This may mean that the person overcomes the fear of talking about their problem, with experts who help the sick person, in understanding their condition, to cope with their problems, and not to give up on the proposed treatment. During such conversations, a family member or friend can be a pillar of support. At that moment, the psychiatrist has a very delicate task ahead of him. He is obliged to preserve the so-called "noble distance" towards the patient. To talk to him humanly and, in addition, to convey information about

the disease, to present all the possibilities of treatment and the possibility of recovery, because that determines the patient's attitude towards treatment. It remains for psychiatrists to make a diagnosis based on a description of the clinical picture.

Today, we distinguish four types of physician-patient relationship models. Paternalistic (maternalistic) model, in which the doctor/psychiatrist knows best what is good for the patient's recovery, which is why patients should obediently follow the advice, recommendations, and medical prescriptions. Until recently, this model dominated, and today it is increasingly abandoned. But it still lingers only in some specific situations. The technical-business relationship is based on an offer that the patient can accept or reject if he does not want. This model has two types: Autonomous information model - the doctor/psychiatrist is expected to present all relevant information and knowledge, and the patient makes autonomous decisions based on his knowledge, interests, and value systems; Autonomous interpretive model - the doctor is expected to present knowledge, information and suggestions, and to leave the patient an autonomous decision in accordance with his needs, knowledge and values. And fourth, is the Partnership or Collaborative Model, which is based on creating a relationship of mutual respect and trust between physicians/psychiatrists and patients. It is based on the high autonomy and proactive role of the patient in his / her treatment, as well as in shaping a common vision of therapeutic goals and personal recovery of the patient. Everything is done on the principle of consensus and therapeutic contract techniques are often used. However, in practice, when we encourage patients to have autonomy, they often complain and say "you are a doctor, you know what is best" and thus transfer all responsibility for the success/failure of treatment to the doctor/psychiatrist (Jakovljević 2016).

There are standardized clinical criteria, and based on them, diagnoses are made. The best known is the International Classification of Diseases and Disorders (ICD), while the second most commonly used diagnostic criterion in psychiatry is the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association (APA) (Frances 2013).

### **Classification of mental disorders**

The first classifications in psychiatry originated in ancient Egypt, Mesopotamia, and India. Classifications of various mental disorders (depression, dementia, epilepsy) also emerged in ancient medicine. In the 18th century, divisions of mental disorders into classes, genera, and species appeared (in 1763, F. B. de Sauvages; and in 1769, W. Cullen). The forerunner of modern classifications is Emil Kraepelin, who divided all mental disorders into manic-depressive psychosis

and dementia praecox. Eugen Bleuler introduces the term schizophrenia, which he divides into catatonic, paranoid, hebephrenic, and schizophrenia simplex. The beginning of the International Classification of Diseases (ICD) was the "Bertinoll Classification" from 1983. The first five versions of the ICD contained only a classification of the causes of death, and only in the sixth does the classification of diseases appear. The World Health Organization has included a chapter on mental illness in this edition of the ICD. The tenth edition of that classification is in current use, ICD XI is expected in 2021.

The first official manual of the American Psychiatric Association (APA), more precisely DSM-I (1952), counted 198 nosological categories, as well as its successor DSM-II (1968), in which the classification was extended to 221 clusters of mental disorders, reflected the position dynamically oriented psychiatrists. In the period that follows, the classification system is increasingly dedicated to identifying symptoms that are easily measurable and recognizable, which would be crucial for diagnosing a particular psychiatric disorder. Today, the current DSM-5 classification is used not only in clinical application but also for research purposes. Emphasizing the importance of the reliability of diagnoses, by psychiatrists, was an intellectual tool, which justified the development of new classification systems, as well as the increase of nosological categories (DSM-5 2015, ICD-11 2018).

Numerous changes in the classification of mental illnesses can be summarized in several points for better visibility:

- classifications of mental disorders are more diverse and extensive compared to those in the period of "asylum psychiatry;
- they lead to the inclusivity of an increasing number of behaviors in the field of psychopathology;
- thanks to the progressive spread of the discourse of psychiatry, an increasing number of clients find themselves in the context of given diagnoses, which results in the erosion of normalcy;
- there are changes in the conditions in which treatment is performed with mentally ill persons, from asylum and closed institutions to offices and therapy rooms;
- The number of mental health workers is expanding;
- By conceptualizing mental disorder as a brain disease, and emphasizing the need to eliminate symptoms, pharmaceutical companies are doubling, and constantly placing new drugs on the market.

### **What is a psychiatric diagnosis?**

Medical diagnosis is the process of finding out which cause (s), or which condition is causing the symptoms, and indications of a patient's existing dysfunction or

mental illness. The main goal of psychiatric diagnosis is communication between health experts, which will serve to find out the best treatment and prescribe medication. When diagnosed, it has a calming effect on some patients, while for others it is a stigma. Diagnosis can be a sign of help to recognize the suffering of the patient. To open the door for him, which will lead to the solution of his problem, but also, to lead the patient to the thought that his suffering is a product of the diagnosed disease. Psychiatric diagnosis may change over time, depending on the developmental characteristics of the clinical picture and the patient's response to therapy used at the beginning and during treatment (diagnosis ex iuvantibus) (Frances 2013).

### **Comorbidity**

The connections of mind, soul, and body are manifold. In real-life illnesses, isolated diseases of one organ or one system are rare. The disease of one part entails the disease of another, or other parts of the organic system, which go simultaneously, or directly one after the other. These are usually comorbidities, psychosomatics, somatopsychics, and a condition in which somatic illnesses mimic the picture of a mental disorder. The term "comorbidity" was introduced into medicine by Alvan Feinstein after realizing that comorbid diseases lead to many problems because comorbidity affects the detection, prognosis, therapy, and outcome of treatment (de Groot et al. 2003). Comorbidity is the simultaneous occurrence of two or more diseases together. In psychiatry, comorbidity means that at least one of the disorders is psychiatric (Begić 2014).

There are three types of comorbidities, pathogenic, diagnostic, and prognostic. When a certain disease leads to certain complications or diseases that are then considered to be etiologically related, we speak of pathogenic comorbidity. Diagnostic comorbidity will occur where diagnostic criteria are based on specific patterns of symptoms, which are individually nonspecific. Disorders that predispose to the development of another disorder have prognostic comorbidity (Rouillon 2001).

The comorbidity of somatic diseases and psychological disorders has, in the last few decades, become a major challenge to the health of modern society. The number of studies proving their association is growing, and show how it leads to numerous and varied negative outcomes. From pronounced functional disability, through poorer therapeutic outcomes to increased health care costs. It should be noted that the problem of health is not only comorbidity, but also the coexistence of several chronic diseases, and multimorbidity. The challenge is to optimize the health of the individual, despite multimorbidity and comorbidity, and to organize and provide care to patients with comorbid conditions (Begić 2014, Begum et al. 2009, Benedetto et al. 2010).

### **Stigmatization**

In today's society, as in previous historical periods, people with mental illness have very often encountered, and continue to experience, condemnation from the environment, and often their own self-condemnation because they "allowed themselves" to "mentally disintegrate", leading to loss of their fundamental freedoms, from the inability to vote in elections to, for example, the automatic loss of the right to care for their own children (Oyserman & Swim 2001, WHO 2001, Brown & Bradley 2002).

Stigmatization (stamping) is the attitude of an individual, group, or community by which we mark someone as less valuable because they have some characteristic (stamp), such as a different skin color, a different life orientation. Discrimination is the process of disallowing persons to participate in activities that are available to other persons (without stigmatizing features) (education, employment, participation in sports, cultural, social activities ...) (Halgin & Whitbourne 1994, Bagley & King 2005, Petz 1992, Esser & Lacey 1988, Ivezić 2006).

The portrayal of mental illness in the media has long been recognized as misleading and stigmatizing. Chen and Lawrie (2017), following campaigns by several advocacy groups to address this issue, set a goal to assess the impact of the media on mental health reporting over time. They repeated the research they had conducted 15 years earlier, using the same methods. Nine British daily newspapers were surveyed, over 4 weeks, and coded by a scheme to analyze mental health reporting versus physical health. Of the 963 identified articles on health - 200 wrote on mental health and 763 on physical health. Over half of the articles on mental health had a negative tone: 18.5% indicated an association with violence, compared to 0.3% of articles on physical health. More citations were from patients with mental disorders than from patients with physical disorders (22.5% vs. 19.7%) and treatment and rehabilitation were mentioned equally. The clinical images of mental health topics described in the printed media continue to be burdened with topics of violence, with some apparent progress in reporting in recent years, providing a voice to people with mental illness. Despite several prominent government and charitable campaigns, mental illness and people with mental illness continue to experience stigmatization and stereotyping. While it is encouraging that people with mental disorders are increasingly represented in the print media, and there appears to have been an overall increase in non-stigmatizing articles, much remains to be done to address the inaccurate and stigmatizing links to violence and to raise profiles about mental illness as a whole. The question, about the special reasons for the negative headlines about mental illness, which are ongoing, and what could or should be done with them, both in the print and in the growing

number of electronic media, is open. There is a clear need for more reporting on mental health in general, and a need for more accurate reporting on violence, and in particular for more reporting on innovative research advances and effective methods of treating mental disorders. Much can be achieved through further ongoing engagement, between patients, psychiatrists, and the media, with an emphasis on realistic depictions of patients' lives and recent research advances (Chen & Lawrie 2017).

On the other hand, we are witnessing that psychiatric wards in general hospitals are very often in basements, in spaces that have not been renovated, and that completely inadequate spaces are still being set aside for psychiatric patients. At the same time, we psychiatrists are being perceived as if we couldn't do anything else in the field of medicine, so we ended up in psychiatry (Kamaradova et al. 2016, Pajević & Hasanović 2017, Avdibegović & Hasanović 2017).

### **Fear of illness**

Impaired mental health is something that people have been afraid of, something they shy away from, something they're ashamed of, something they tend to not accept and thus, unfortunately, affect the quality of their own lives as well as the lives of their loved ones, and beyond. This is understandable because, despite the tremendous advances in medicine, neuroscience, and related disciplines, which have revealed many secrets of the human brain, it seems that there is still so much unknown in the realm of the mental, intellectual, and spiritual. The age-old stigma and fear of "madness" and mental illness classify mental disorders as something "most terrible" that can happen to a person. The fear of losing oneself is equal to the fear of death. Perhaps this is the answer to why someone seeks help only when suffering becomes unbearable, when thoughts become "black" and when "a drop overflows a glass". No matter how figurative this is with the drop, it has its symbolic and real meaning. How many times has self-medication been resorted to through alcohol, pills, and various narcotics, to forget the trauma as soon as possible? How many times have people tried to get a quick boost of pleasure from gambling, and how do all of these things repeat themselves, as if we are not learning from our negative experiences? When people feel mentally disturbed, they seek help from "paraprofessionals", healers, sorcerers, convinced that they are not mentally ill but that their evil spirits have disturbed their happiness and health, often as an expression of God's punishment for sins they committed, as a way to avoid psychiatric diagnosis. And in the case when there is a somatic problem, then we suddenly get in a hurry to get diagnostic tests, to find out what is happening in our body. We spend the least time thinking and taking care of our soul. The soul should be our strongest and quietest trump card, and

yet, it is the one thing that trembles and waits for the test results, it trembles from various check-ups, and it strengthens us when everything stops. The question is how many souls can endure all this. Not noticing the quiet signals that the soul sends, and burdened day by day with various problems before seeking help, once a person hits the bottom, they can feel as if it had hit them all at once, unaware of the fact that they have been draining their own mental health reserves for years.

After the 1992-1995 war in Bosnia and Herzegovina, mental illness became widespread. With little knowledge about mental health, the stigma of mental illness has spread significantly in many communities. To combat these prejudices effectively, mental health professionals have undertaken mental health promotion strategies that can empower individuals and educate the communities in which they live, in order to turn to psychiatric services for psychiatric diagnosis and timely involvement in necessary treatment, in a resolute and a timely manner (Hasanović et al. 2006, 2021, Hasanović 2021).

## **STAGES IN ADAPTING TO HEALTH LOSS (ELISABETH KÜBLER-ROSS MODEL) AS THE BASIS OF CREATIVE PSYCHOPHARMACOTHERAPY**

### ***Denial***

Denial is most often the first emotional reaction when getting a diagnosis. It manifests itself in not accepting the diagnosis and seeking a second opinion. Denial helps reduce the initial shock and allows patients to resume daily activities. Although in most cases it lasts for a short time, the person may fail to overcome this phase which greatly complicates later treatment. At this stage, it is not recommended to insist on a quick recovery from this period that the patients find themselves in unless due to refusal they do not adhere to the necessary treatment and doctor's recommendations. Primarily, in this situation, the task of the psychiatrist/psychotherapist is to accept denial as part of the patient's self-protection, and it is by no means desirable to insist on confrontation. The patient needs to be provided with relevant and truthful information about the disease. Patients are encouraged to focus on their future, to concretize goals outside the hospital environment, and to initially reinforce behaviors that are incompatible with denial, such as praise for participating in physical activities or taking prescribed medications.

### ***Anger***

Anger is the name for the phase, in which the realization of loss occurs, to which patients often react emotionally. In this period, idealizations of the loss are common that affect the opinion that the loss is impossible to make up for. The most common emotional reaction is anger, resentment, and / or aggression. The

anger phase is characterized by the question: "Why me?" People can be angry at themselves, others, and especially their loved ones. Often patients express anger towards the medical staff, which is a thing that should be given special attention and awareness. The task of the psychiatrist/psychotherapist at this stage is to direct the patient to activities that would make it easier for them to gain control over their aggression. Patients should be encouraged to take responsibility for their own behavior as well as a willingness to seek and accept help. Relaxation techniques have been shown to help overcome anger and aggression.

### ***Negotiation***

Negotiation is a phase in which patients try to delay the demands of the disease. The contract most often refers to the question of whether the patient can compensate for the loss of health by some action or change in lifestyle. Such behaviors very often complicate treatment, and during this period it is necessary to use paraphrasing and reflective techniques in communication with the patient, in order for the patient to become aware and realistically see their desires in a safe environment. Periodic education about the disease is also important so that the patient is better acquainted with all aspects of their disease.

### ***Sadness and depression***

Sadness and depression is the stage in which the feeling of loss of health occurs, and the inability to change the fact that the person is ill. Such cognition can cause sadness and depression. The task of the psychiatrist/psychotherapist at this stage is to encourage the verbalization of the patient's feelings, to help set specific goals, and to point out irrational beliefs about the disease, if the patient has them. This phase marks a shift toward accepting the disease because it shows an understanding that the diagnosis is final.

### ***Acceptance***

Acceptance is the phase, in which the patient accepts that the diagnosis is real and that they should direct their resources toward controlling their condition. At this stage, the patient becomes less preoccupied with the loss, and their interest in things that will make their daily life with the disease easier - increases. This usually means focusing on specific situations in the patient's life - planning daily activities, harmonizing the requirements of the disease and obligations at school or work.

Adapting a person to the fact that they are ill, may include any or all of the above reactions, and they may, from time to time, recur to a greater or lesser degree. When adapting to illness, both fear and feelings of helplessness can occur which, on the one hand, can be strong motivators for persisting in healing. On the other hand, they can lead to feelings of hopelessness, but also harmful behaviors for the patient.

Research has shown that patient satisfaction with treatment depends largely on communication between medical staff and patients. Lack of communication has a negative effect on the mental and somatic condition of the patient, but also the patient's health behavior. Research shows that a patient's adherence to medical advice and treatment recommendations is weaker if communication with medical staff has been impaired (Havelka 1998).

Milton and Mullan (2014) conducted a systematic synthesis of studies, which present data on the communication of psychiatric diagnosis. By reviewing the comprehensive databases, and by manual search, they found 30 quantitative and qualitative papers that they included in the study. Most studies were descriptive. The rate of informing clients and patients about their diagnosis has increased over the past decade. Diagnosis announcements to clients and patients in practice were not always satisfactorily addressed. The individual characteristics of clients and patients, as well as clinicians, influenced whether the diagnosis was discussed during its communication. The results of the intervention studies, which aimed to facilitate the communication of diagnoses, showed significant improvements in the satisfaction and mood of service users, and the communication skills of clinicians. This study highlights the existing gap in the communication system between clinicians and service users (clients and patients). To help clinicians in effectively talking with individuals about their mental health, communication protocols and training must be further developed and evaluated. Such developments would benefit from well-designed randomized controlled trial protocols, which should take into account and prioritize the advantages service users have, and address stigma-related concerns (Milton & Mullan 2014).

## **CONCLUSIONS**

Mental disorders and mental illness have been associated with numerous controversies throughout human history, and to this day, despite progressive advances in science, and especially in neuroscience - where much is known about the intracellular maintenance of vital functions - there are still many open questions. to which we need to respond in order to complete our knowledge of this area. In order to be able to treat people with mental disorders, it is necessary to discover the causes and make the most etiological diagnosis.

Making a psychiatric diagnosis is a complex, and complicated, process of the relationship between the psychiatrist, the patient, the patient's family members, and the treatment team. This process requires commitment, an adequate physician-patient relationship,



interdisciplinary teamwork, and high mutual trust between the patient, his family, and the therapy team, led by a psychiatrist. The way the diagnosis is communicated to the patient is very important. The weight and way of experiencing 'ugly' news depends on how it is conveyed. The patient should be presented with the disease itself, but also the method of treatment. It is necessary to make an adequate treatment plan, introduce regular check-ups, agree on taking pharmacotherapy according to the principles of creative psychopharmacotherapy. The importance of psychotherapeutic treatment and regularity of taking an adequate dose of medication and psychotherapy sessions should be pointed out, and the patient should be explained that he is not alone. It is important to include family members, who should also be available for all possible questions, because they are our 'extended' hand during the treatment. The sooner the patient accepts the diagnosis, the more successful the treatment will be. By involving the family, the patient will see that they are not alone, and it will be easier for them to accept and embrace the fight for healing.

Psychiatric diagnosis is dynamic, and the best effects of treatment after a working diagnosis are achieved by vigilant monitoring of changes in the expression of changes in symptoms and clinical picture, after introduction into the therapeutic process, which brings expected and unexpected changes. If changes occur, which indicate that the diagnosis should be corrected, and thus the therapy, the treatment team agrees, and the patient is informed of the new situation as well as family members. By aligning therapy with changes in diagnosis, significant improvements in mental health are obtained when the patient is transferred to outpatient treatment if treated in hospital, or outpatient treatment is continued with a newly established therapeutic concept corresponding to the final diagnosis (called discharge) if the patient transfers from inpatient to outpatient treatment.

More meaningful communication protocols and trainings need to be further developed, and evaluated, to help clinicians talk effectively with patients about their mental health. Such developments would benefit from well-designed protocols of randomized controlled trials, in which service users should take precedence and address stigma-related concerns together. Thus, accepting a psychiatric diagnosis would be in the function of a more favorable outcome of psychiatric treatment.

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Dino Hodžić: 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.

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

Izet Pajević: made substantial contributions to conception and design, and interpretation of data, participated in revising the manuscript and gave final approval of the version to be submitted.

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