Combination of Gestalt Therapy and Psychiatric Medication

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1. Introduction

The psychiatric drug treatment has been a part of treating psychic difficulties for 60 years. In their practise, Gestalt therapists relatively frequently encounter patients who take psychiatric drugs. The topic of psychopharmacotherapy and its combination with psychotherapy is nevertheless omitted in the Gestalt literature or mentioned only briefly in connection with another aspect of Gestalt therapeutic work (e.g. Stratford and Brallier, 1979; Harris, 1992a, 1992b; Aviram and Levine Bar-Yoseph, 1995; Resnikoff, 1995; Philippson, 1999, Sabar, 2000; Miller, 2001; Brownell, 2011a and others). It is not an easy task to describe the combined use of Gestalt therapy and psychopharmacotherapy as each of the approaches is founded in a different paradigm and derives from a different understanding of health and illness. We nonetheless assume that some basic knowledge of psychiatric drugs also belongs to the responsible practise of a Gestalt therapist, as well as the effort to find one's own understanding of the use of medication, which is congruent with the Gestalt therapy approach.

In this chapter we utilize our practice as psychiatrists who work as Gestalt therapists and also have experience of pharmacological treatment. We are trying to offer a way of thinking about psychiatric drugs and at the same time not losing the focus on the individuality of each patient and the dialogical essence of the psychotherapeutic encounter. We are introducing our effort to find ways of overcoming the dichotomic thinking of "psychotherapy versus medication".

When a patient takes medication, the therapist could be tempted into the I-it approach (Buber, 1996), as if the patient was an object of treatment. However, the therapist encounters a person with a unique story, a unique way of contacting, a unique way of creative adjustment. Medication belongs to the story, to the way of contacting and to the creative adjustment. A therapist opens up to a humane meeting of I-you right now and here with this patient and the whole context of his/her life, including the medication. The patient enters the therapeutic situation affected by a number of influences: s/he may have had a sleepless night or a delicious lunch or s/he may have taken Prozac in the morning. The therapist also enters the therapeutic situation affected by external influences: s/he has just had a cup of a strong coffee or had a fight with the spouse the previous night or has just finished a demanding therapeutic session. Two people are meeting and the psychiatric drugs are one piece in the mosaic of the whole complex situation of their meeting.

When writing this chapter, we had on our minds the non-reduceable complexity of the therapeutic situation and the essential importance of human encounter. However, we intentionally narrow our focus on taking medication later in the text, in order to increase the awareness connected to this partial aspect of the field.

2. Medication as a Part of the Therapeutic Situation

If a patient takes psychiatric medication it affects the whole therapeutic situation. The medication modifies the course of the therapy, interferes in the therapeutic relationship and affects the therapy results. It presents a considerable external influence, which is usually independent of the psychotherapy or the therapist. It may be a difficult situation for a therapist, but not an exceptional one. There are many independent influences in psychotherapy[1] and medication is just one of them.

The medication could bring about a significant shift in the patients' experiencing themselves and their environment, as well as in their behaviour. This will be present in the way they are in a therapeutic

[1] The external independent influences are thought to be responsible for 40 per cent of the effect in psychotherapy, compared to the specific intervention (e.g. Gestalt) which is only responsible for 15 per cent (Lambert, 1992).

situation. For instance, an antidepressant can help a patient to mobilize energy, which can significantly affect the course of the psychotherapeutic sessions. We can imagine medication in this case may have a similar impact on the patient as being in love. This also gives the patient energy and bypasses their awareness and control. The influence without a direct link to the psychotherapy (being in love) will have a significant impact on the course of psychotherapy. All of a sudden, the patient has possibilities which used not to be accessible in psychotherapy; s/he feels an influx of energy, believes in her/his abilities and plans changes in her/his live. These possibilities arose without a direct connection to the process of psychotherapy. Being in love opens the way to undreamed-of personal potential, but when it disappears, the effect may fade away. The effect of some medication may be similar even if it does not take such a dramatic form. Other drugs may have different effects, for example they may help regulate emotions and integrate experiences. It is important for the therapist to thoroughly explore and to become aware of their attitude to such influences on the therapeutic situation coming from an independent external factor.

However, as Gestalt therapists we do not consider any factor to be independent, we see the situation in a holistic way. We can look at the medication as the best possible way of allowing the patient to cope with a difficult situation at the moment. Taking the medication is connected to the patient's current need, which arises within the whole field of present and former relations to their outside world as well as to themselves. The medication interacts with other elements of the field in various ways: often it serves the function of support, but it may also emphasize limitations and stigmatize, it may be used to manipulate the outside world and it may have other tasks, some of which will be described in the text that follows. It is essential to bring to awareness in a phenomenological way how the medication enters and influences a psychotherapeutic situation.

3. Combination of Psychotherapy and Pharmacotherapy

Opinions on the combination[2] of psychotherapy and pharmacotherapy have been gradually changing since the first psychopharmaceuticals appeared in the 50's. Some psychotherapists at first refused the combination for fear that the medication would hide important feelings and conflicts which are the subject of psychotherapeutic work (Holub, 2010). A shift occurred when a larger number of people with serious mental problems became psychotherapy patients, e.g. patients with borderline personality disorder or with psychosis. In these cases pharmacotherapy was not a disincentive, on the contrary it allowed patients to manage the psychotherapeutic process and benefit from it.

The last two decades have been a period of rapid development in psychopharmaceuticals. New psychopharmaceuticals emerge with few side effects. These drugs can be prescribed not only by psychiatrists, but also by general practitioners and other specialists. The drugs are prescribed for the treatment of a wider spectrum of psychological states and at a lower intensity of difficulties. As a result, the use of psychiatric drugs is more and more widespread and often replaces psychotherapy even in cases where it used to be a first choice method. As medication provides a fast alleviation of symptoms, patients can perceive psychotherapy as not sufficiently effective or too slow or expensive.

However, when we free ourselves from the dichotomic thinking (medication versus psychotherapy), we can see that these two approaches can collaborate in favour of patients, they can favourably complement one another. The combination of psychotherapy and pharmacotherapy is a very common clinical practise. A great number of researches prove that the combination has a bigger therapeutic effect than using each method separately (Wright and Hollifield, 2006). However, it is not clear to what extent these results may be generalized. Furthermore, they apply only to those patients in psychotherapeutic treatment who were diagnosed with a psychiatric diagnosis[3].

[2] The combination of psychotherapy and pharmacotherapy can be arranged in two ways. Either it is an integrated treatment (the psychotherapist also prescribes the medication), which offers the possibility of exploring the topic of drugs together with a patient; on the other hand it emphasizes the asymmetry of a therapeutic relationship. Or it is a parallel treatment (one specialist provides psychotherapy and another prescribes the medication), which comes with a clear division of roles and external support for the psychotherapist, yet it makes considerable demands on the collaboration of the psychotherapist and the doctor.

[3] There are also studies not supporting this prevailing opinion. Holub (2010) presents 3 studies, where adding benzodiazepines to psychotherapy when treating panic disorder, agoraphobia and post-traumatic stress disorder aggravated the prognosis of the illness in comparison to a sole psychotherapy (Marks *et al*., 1993; Westra, Stewart and Conrad, 2002; in Holub, 2010).

Psychopharmaceuticals can be a significant support to the psychotherapeutic process in reducing excessive, paralysing anxiety and depressive experience. They can also be helpful in bridging interruptions in psychotherapy. On the other hand, psychotherapy can support pharmacotherapy, because it enables patients to be more aware of their attitude to drugs and the experience of using them. A limiting factor (but not always unwelcome) in the combined therapy is that the drugs may keep patients in a more passive attitude and allow them not to assume responsibility for their state and the psychotherapeutic process (Holub, 2010). Medication may be necessary for some patients, but their use is limited by the risk of addiction and a possible decrease both in patients' motivation for psychotherapeutic work and in their ability to build their own skills necessary for coping with difficulties (Williams and Levitt, 2007). It is important for a Gestalt therapist not only to become aware of both above-mentioned advantages and limitations of the combination, but also to find a way of exploring them in a dialogue with the patient and to see them in the context of the whole psychotherapeutic situation.

4. Relationships with the Medication

Medication is a part of the wider field of the therapeutic situation, along with other external influences over the patient, such as her/his job or physical illness. The drug is a component of the field which is, just like any other component, potentially important in the process of therapy. When the patient for example, due to the medication, is less tensed or sleepy, it changes the whole therapeutic situation, the drug affects the process of therapy and also the experience the therapist has of being with the client. Hence the drug takes part in the current organization of the relational field. It works through its direct pharmacological effect on the patient as well as through its psychological effect on the patient and the therapist. In the text which follows we will explore various possible relationships in the triad of therapist-patient-medication.

4.1. How the Medication Can Affect the Patient and the Process of Psychotherapy

Psychopharmaceuticals change the functioning of the organism on the biological level and in that manner they cause a change of psychic functions. Apart from that, medication (as well as psychotherapy) work through the placebo effect[4]. Further in the text we will focus on the biological effect of psychopharmaceuticals. Gestalt therapists can use their skill of phenomenological observation for a non-judging description of how the medication affects the patient's way of being and contacting as well as the whole psychotherapeutic situation. For that purpose, therapists can use models of contact styles (retroflection, projection, etc.) or the contact sequence (withdrawal → recognition → mobilisation → action → contact → assimilation → withdrawal →). This allows them to observe how the medication affects different stages of the psychotherapeutic process.

According to the kind of effect on the patients' experiences we can classify the most common drugs[5] into two main groups:

1. fast and temporary (benzodiazepine anxiolytics);
2. slow and long-term (antidepressants, antipsychotics, mood stabilizers).

4.1.1. Medication with Fast and Temporary Effect: Benzodiazepine Anxiolytics

Benzodiazepines cause a fast relief of anxiety, which accompanies most mental difficulties. Psychotherapists should be well acquainted with these medicaments, as they are very popular among patients and also because in some cases they may be a valuable aid to psychotherapy. It is so especially in short-term situations, when a patient experiences escalated tension and anxiety (post-traumatic and crisis

[4] Placebo can also trigger self-healing processes. The changes in the brain after administering a placebo, detectable by modern monitoring methods are similar to those following the administration of effective drugs or after psychotherapy (Libiger, 2003).

[5] In this paper we only deal with the groups of drugs most commonly used by patients who are in psychotherapeutic treatment. We do not describe any other groups of drugs such as hypnotics (inducing sleep), cognitives (improve cognitive functions) and psychostimulants (increase vigilance).

states). A disadvantage of long-term and regular use is that the organism may become addicted to these medications at the level of biological functioning. From the psychotherapeutic process perspective, these drugs may present a "short-cut" for some patients in coping with their own problems and they may allow them to depend on expert help from outside[6].

Benzodiazepine Anxiolytics - Psychiatric Use

Characteristics: Anxiolytics are drugs that dissolve psychic anxiety and bodily tension. They have a wide range of usage, since anxiety, mental strain, inner tension, restlessness and aggression appear as a part of many psychiatrically treated experiences. The most widespread group of anxiolytics are benzodiazepines[7]. They affect the symptoms vigorously and quickly, their effect is temporary and relatively short-lasting.
Effects and Indication: Anxiolytic effect: They alleviate all kinds of anxiety. Hypnosedative effect: They help with falling asleep and staying asleep; they attenuate anxiety and aggression (including psychic and physical withdrawal symptoms of addiction to alcohol and other psychoactive drugs). Myo-relaxing effect and anticonvulsive effect: They relax muscle tensions and convulsions of different origins.
Some Well-Known Representatives: alprazolam, bromazepam, clonazepam, diazepam.
Practical Use: With regards to side effects and their addictive potential, benzodiazepines are only intended for temporary or irregular use. When used regularly and for a long time, they present a considerable risk of addiction (tolerance to the drug evolves during use; to achieve the same effect it is necessary to gradually increase the dose; if discontinued suddenly, there is a risk of withdrawal syndrome and a fast recurrence of symptoms which were the reason for using the drug). To prevent the development of addiction, it is recommended to only use the drug at the time of acute problems; to gradually reduce the dosage as soon as the anxiety reduces, or when a non-addictive drug (e.g. antidepressant) applied at the same time starts to be effective; in sub-acute states and in crises the lowest effective dose is recommended, with the lowest possible regularity of use.

The effects of benzodiazepines start and subside fast and they are to a high degree similar to the effects of alcohol. If a patient takes benzodiazepine anxiolytics a short time before a psychotherapeutic session, s/he may feel more relaxed, slower and more reconciled during the session than without the drug. Benzodiazepines, similarly to alcohol, make it easier to withdraw from contact and to "dilute the experience", so they contribute to the deflection from an unpleasant experience. *"I don't care... I don't have to deal with it right now...".* In this manner they can temporarily enable the avoidance of too painful experiences and therefore the existential encounter with other people, oneself and with life challenges.

[6] A Gestalt therapist does not judge such an attitude if it appears, but sees it as the best available way for creative adjustment and helps to make it an aware choice.

[7] Non-benzodiazepine anxiolytics are used less frequently. Buspiron (BuSpar) and hydroxyzine (Atarax) fall into this category, and also antidepressants and antipsychotics. These drugs are not addictive and their effect lasts longer. However, the anxiolytic effect does not come so fast and expressly as in the case of benzodiazepines.

Therapists may experience the feeling of "pseudocontact" with the patient, as we know it with patients addicted to alcohol (Carlock, Glaus and Show, 1992). The contact process may first seem to go smoothly and easily, yet the full contact may not be achieved.

We can regard taking benzodiazepines as a creative adjustment. For the patient using drugs actually presents the best possible and available way of handling the difficult situation. If we observe the effect of benzodiazepines in a phenomenological way, we can see they slow down the contact cycle and make it smoother. They only have a short-lasting effect, but they can interrupt the vicious circle of anxiety and activate the patient's self-healing forces. We present several examples of such effects:

- Some perceptions can be so strong they lead to a massive anxiety that blocks awareness. If benzodiazepines moderate the intensity of perceptions, they can help the patient become at least partially aware and free to make conscious choices to handle the situation[8].
- They reduce the urgency of the situation and slow down the mobilization of energy (e.g. hyperventilation during the experience of strong anxiety) and thus can help the patient make the choice of an appropriate action more easily.
- They reduce the overall readiness (to fight or flight) of the organism and so they help to stop greater and greater mobilization of energy. Thus they can make it easier for the patient to complete a contact cycle and to withdraw (e.g. into sleep). At the same time they contribute to the postponement of the perception of a new need and to the beginning of another contact cycle.

Short-term use of benzodiazepines during an acute crisis is reasonable. Here it brings calmness, during which the self-healing processes of the body can be activated to a level when the further use of medication may not be necessary. It is useful to build skills in psychotherapy which will eventually replace the effect of a potentially addictive medication (e.g. various forms of relaxation or functional deflection). Psychotherapeutic support thus has a significant role in the timing of reducing the dosage or discontinuation of benzodiazepines.

4.1.2. Slow and Long-Term Medication (Antidepressants, Antipsychotics, Mood Stabilizers)

Compared to the fast acting benzodiazepines the full expression of effects of these drugs is developed over a longer period of time (days, weeks up to months)[9].

4.1.2.1. Antidepressants

Antidepressants - Psychiatric Use

Characteristics: They adjust the concentration of neurotransmitters (serotonin, noradrenalin, dopamine etc.) on the neural connections in the brain and through a complex mechanism bring about such changes in the brain's functioning which lead to the reduction or elimination of not only depressive experiences but also other difficulties related to dysregulation of the neurotransmitter system (anxiety, impulsiveness, aggression, suicidality). The most widespread group of antidepressants is SSRI, affecting the regulation of serotonin.
Indication: Depression, anxiety disorders (panic disorder, generalized anxiety disorder), phobic disorders (social phobia, agoraphobia), obsessive-compulsive disorder, post-traumatic stress disorder and anxiety-depression reaction to stress, food intake disorders: mental anorexia, mental bulimia, personality disorders (especially serotonin has an effect on emotional instability, impulsiveness, aggression and

[8] Benzodizepines can also work through a psychological mechanism and can e.g. help prevent panic attacks. Patients with panic attacks who have a strong fear of a new attack of anxiety are recommended to always have a small dose of benzodiazepines on them, which would help them in case of a panic attack. This safeguard allows them to deflect the fears of a new panic attack. This way the fear of a possible panic attack is diminished, the general level of anxiety is reduced and a panic attack may not come at all. *"I only imagine taking Diazepam and I instantly feel the anxiety gets reduces..."*.

[9] To induce the effect a whole series of changes on the intracellular level up to the genome level is needed. This mechanism of effect will cause the change to be of a longer-lasting type.

suicidality).

Some Well-Known Representatives:[10]
citalopram, fluoxetine, fluvoxamine, milnacipran, mirtazapine, paroxetine, sertraline, venlafaxine.

Practical Use:
SSRI and other new antidepressants are well tolerated and have only very few side effects. They are commonly prescribed by psychiatrists, neurologists and general practitioners. There is no risk of addiction. The effect of antidepressants is experienced only after several days; the full expression of their effect is experienced only after several weeks. Before the antidepressive or anxiolytic effect of antidepressants arrives it is favourable to temporarily use fast-affecting benzodiazepines as well. Long-term use of antidepressants is recommended especially when the depressive experience appears again after the withdrawal of medication. The length of medication use needs to be longer then the time of remission between two episodes of depression. In the case of three and more subsequent depressive episodes a life long use of antidepressants is recommended (Seifertova *et al*., 2008).

Antidepressants can function as long-term softeners of experiences. Patients who take antidepressants describe the experiences as though they come to them from a greater distance, with a lower intensity and sharpness. That is why it may not always be appropriate to automatically use antidepressants in cases such as the sadness caused by the death of a close person. Here antidepressants may not only postpone, but sometimes even stop the natural process of mourning.

In the case of depression, antidepressants may contribute to a functional desensitization. The feelings of despair and hopelessness are not perceived in such a harrowing way by the patient. This blunting of intensity of hurting experiences paradoxically enables the patient to work and profit from psychotherapy. It can help the patient share such "wrapped-up" experiences with the therapist and not to stay isolated with them. This way the fixed *Gestalt* of depression is disrupted in therapy (see chapter 21 about depression).

Antidepressants can contribute not only to the functional desensitization, but also to the mobilization of energy. In cases of more serious depressions, the antidepressant can help to gradually restore the sources of energy, which is then mobilized for necessary actions by the patient. *"I didn't trust the antidepressants... But after about two months I felt I slowly started to enjoy common things again. And that I became a bit more active...".*

Antidepressants also attenuate anxiety. In comparison with benzodiazepines, their anxiolytic effect is reached progressively, more slowly and less obviously, it lasts longer and there is no risk of addiction.

4.1.2.2. Mood Stabilizers

Mood Stabilizers - Psychiatric Use

Characteristics:
They balance and stabilize mood oscillation, reduce the frequency and intensity of manic, depressive and mixed episodes of mood disorders. The effect becomes fully expressed after several weeks up to months of use.

Indication:
Bipolar affective disorder, schizoaffective disorder. Mood stabilizers have effects which benefit patients also with different diagnoses: aggression attenuation; suicidal tendencies attenuation, emotional instability and anxiety attenuation. This effect is often used in treatment of emotional instability of patients with personality disorders.

Some Well-known Representatives:
carbamazepine, lamotrigine, lithium carbonate, valproic acid.

[10] Here we only present antidepressants of the 3rd and 4th generation most commonly used nowadays.

Practical Use:
In case of bipolar disorder they are prescribed in the 3rd appearance of a phase of the illness (mania or depression) at the latest and they are intended for long-term up to life-long use.

Mood stabilizers are drugs which may help grounding. They reduce intensity and slow down the "upper phases" of the contact cycle (mobilization of energy and action); on the other hand they strengthen the "lower phases" of the contact cycle (being aware of perceptions, the integration of an experience and withdrawal). They reduce excessive intensity of an experience and thus allow for more appropriate action and the experience of contact. The advantages of such effects are evident when the drug tempers the ongoing mania or depression episodes. In between the episodes, when the patient can function as fully fit, the attenuation of energy mobilization and activity is sometimes perceived as unpleasant. Long-term use of the drug is nevertheless usually necessary in order to prevent serious manias or depressions. Psychotherapy allows conciliation with the limitations brought by the illness and the medication and focuses on supporting the functional areas of the patient's life.

In patients with unstable emotional experiencing (diagnosed as personality disorder) the mood stabilizers may function as an "internal reinforcement" or a "frame", allowing for structuring and bearing the experience without the necessity to reduce the unbearable tension by impulsive actions. In these cases, psychotherapy has a similar task and can theoretically eventually replace medication.

4.1.2.3. Antipsychotics

Antipsychotics - Psychiatric Use

Characteristics:
The drugs intended for treatment of psychotic symptoms of various psychiatric disorders, especially of schizophrenia and schizoaffective disorder. They also have anti-manic and antidepressive effect, they stabilize mood and have a positive effect on personality integration and the ability of self-regulation.

Indication:
Besides schizophrenia and other psychotic disorders they are also used in treatment of bipolar affective disorder and behavioural disorders, including aggressiveness of various etiology (personality disorders, mental retardation, dementia, sexual deviation).

Some Well-known Representatives:
amisulpride, aripiprazole, clozapine, olanzapine, paliperidone, quetiapine, risperidone, sulpiride.

Practical Use:
The first choice drugs of today are antipsychotics of the 2nd generation, which are better tolerated and are less stigmatizing compared to older medications[11]. They also have antidepressive and anxiolytic effect. They improve activity, sociability, emotional flattening and cognitive damage in patients with schizophrenia.

Antipsychotics can be seen as drugs helping to make clear and strengthen the border between the body and the environment. A person in the acute phase of psychosis does not experience himself as clearly distinct from the environment, in the psychological sense s/he "has no skin" (Spagnuolo Lobb, 2003a, p. 264). S/he may experience an immediate threat from events not directly related to her/him or feel that her/his own experiences have the power to directly affect the environment. S/he lives in a state of being permanently under threat and the psychotic symptoms represent a creative adjustment which helps them

[11] Older antipsychotics of the 1st generation are effective, but they have a higher number of significant side effects and can contribute to the secondary stigmatization of psychotic patients. Representatives: chlorprothixene, chlorpromazine, haloperidol, levopromazine, perfenazine.

survive in such a difficult arrangement of the field (for further detail see chapter 20, on psychosis). Antipsychotics reduce the clogging number of inputs, help create a functional distinction between experiences coming from the external and internal environment and contribute to integration. We can imagine the antipsychotics creating a "hippopotamus skin" (Rahn and Mahnkopf, 2000, pp. 204-214). This function is useful when the patient experiences an acute psychotic state. However, after it subsides the patients often perceive unfavourably the overall inhibition and the experiential stiffness which may accompany taking antipsychotics. Long-term use of medication is an important prevention in patients with chronic schizophrenic illnesses, as it reduces the frequency and intensity of further psychotic attacks. Psychotherapy can suitably complement the drugs' effects and helps to create the feeling of a long-term safe, hospitable base and the experience of stable relationships (Spagnuolo Lobb, 2003a), which allows a safe delimitation of one's self and its needs.

In patients with borderline personality disorder the antipsychotics play a stabilizing role, they decrease impulsiveness and increase the ability to self-regulate. They allow patients to structure and integrate an intensive and chaotic experience. It is then easier in therapy to work on bringing the impulses into awareness and controlling them. It could be easier then, to consciously slow down the mobilization of energy and to meaningfully aim the action. Such an action then does not have to result in compulsive repetition of a fixed *Gestalt*, which temporarily inhibits unbearable tension, but instead there could be a fuller experience of contact. This effect of antipsychotics is usually useful mainly at the time of decompensation, which can even reach the level of a psychotic experience. Apart from these periods, psychotherapy aiming in a similar direction, towards building one's own skills and competences for coping with very intensive experiences and impulsive actions, is irreplaceable.

4.2. How a Patient Can Relate to Medication

Medication is present in psychotherapy, although it is rather in the background for most of the time. At a time of crisis or in breakpoint periods the medication can come to the foreground. For example, a patient in crisis needs more drugs and speaks about it in therapy, or feels better and meditates over not needing the drugs any more. In these periods, taking medication becomes a figure. The relationship a patient has with her/his medication affects the whole field. That is why it is necessary for the therapist to help in a non-judging, phenomenological way to become aware not only of how the drug affects the patient, but also of how the patient relates to the medication.

The patient can adopt two extreme attitudes to the medication or can oscillate between them. On the one hand, the patient can be convinced s/he does not want the medication and the psychotherapy should be sufficient. The patient can fear that *"when I start taking medication, it is really serious, I'm a lunatic".* S/he can be under the influence of introjects such as *"I have to manage on my own, no chemicals can do it for me"* or *"I can't make it easier for myself just like that".* Such introjects can point to the fact that it is difficult for the patient to receive support from the environment. An offer of medication in the course of therapeutic work or even a mention of this possibility can make the patient feel insecure and ashamed[12]. It could be a substantial and new experience for some patients, to consciously depend on the help from outside in a form of medication, to admit one's weakness and to allow oneself to accept this form of support from outside.

Another extreme attitude may be taken by a patient who desires the medication and by taking it reduces unpleasant experiences in psychotherapy or avoids them. S/he may resign the responsibility for her/his state and from the effort of a general change. They can perceive themselves as a helpless object: *"the depression causes the problems; it is the lack of serotonin".* If her/his experience changes and s/he feels relief, s/he can say: *"That Prozac I'm using now is excellent, it changed me completely and I manage now what I used not to".* They project their own abilities and responsibility for the change on the medication. They can then get used to reducing unpleasant experiences by means of medication, especially by instantly effective benzodiazepines, at every occasion of discomfort. In this manner they do not make use of the potential of situations in which they can discover possible sources of their own self-support.

[12] This situation can prove to be a difficult topic even for a therapist, as the Gestalt approach was in the past overburdened by its emphasis on self-support. In order for the therapist to be able to guide the patient to a free choice of source of support, it is necessary that the therapist her/himself has a clear idea of whether s/he is willing to accept support from outside (e.g. in a form of collaboration with a psychiatrist).

Psychotherapy can be understood as a process in which one builds the ability in each moment to balance the use of self-support and acceptance of external support. In the course of psychotherapy, both patient and therapist build a realistic attitude (least burdened by introjects) regarding the particular way the medication affects their cooperation. Thus both can learn to accept the medication as one of the external sources of support here and now. In a period of increased pressure, when the psychotherapy is not available or when the patient experiences intensive inconvenience, the patient has an option to get support from the medication. S/he can consciously and freely consider this option and make a decision in a competent way.

4.3. How a Psychotherapist Can Relate to Medication

During a psychotherapy in which psychopharmaceuticals take a place, a therapist can come up with following questions: What effect do psychopharmaceuticals have right now on the process of psychotherapy: do they speed it up or slow it down? What function does medication serve in a therapeutic relationship and in the whole field of the therapeutic situation? What does it mean for the patient, the therapist and their relationship, if the dose of psychopharmaceuticals is in the course of psychotherapy increased or decreased, when the drugs are discontinued or recommended?

In order for the psychotherapist and the patient to freely explore answers to these questions, the therapist needs to become aware of her/his personal relationship towards psychiatric drugs brought into the field of the psychotherapeutic situation. A psychotherapist who does not reflect and acts out for example her/his persistent scepticism and aversion towards medication harms her/his patients in the same way as a doctor who, focusing only on psychopathological symptoms in complex experiential states, hastily prescribes drugs for each feeling of discomfort and thus prevents the natural flow of the psychotherapeutic process (Fain *et al*., 2008; in Holub, 2010).

The attitude to psychiatric drugs is different with individual psychotherapists and it also gradually develops during their practice depending on the working context and selection of patients. For a therapist it is important to realize what relationship s/he has towards a particular drug of a particular patient. S/he can try the following experiment: to sit the medication on an empty chair and talk to it. S/he can for example say: *"Drug, I am glad we complement each other's work. Thanks to you I don't have to worry about the patient so much".* Or s/he can say: *"Drug, I don't like you, because you interfere with my therapy. The patient has become dependent on you and I would really like to get you out of the therapy. But I can't, as the patient wants you. I feel powerless, you make me angry. He likes you better than me. Thanks to you the patient is making progress".* Maybe the therapist finds out s/he does not know anything about the drug, that s/he needs more information on its characteristics, to get to know it and then to continue exploring her/his relationship to it.

The therapist also needs to examine her/his own relationship to drugs in general. For example s/he can be ruled by an introject: "*The proof of a well-done psychotherapy is that the patient does not need any medication".* S/he can have the impression that the drug devalues her/his work and her/himself in the therapeutic role. "*If a patient needs to take medication, it means I am not a good-enough therapist for her/him".* Such a competitive approach by the therapist will necessarily also affect the therapeutic process.

Exploring the relationship to medication will probably open the topic of the therapist's attitude to the medicinal system, to diagnoses, to psychiatrists. The therapist needs to become aware of how her/his attitude to these general matters affects her/his work with a particular patient. Otherwise, there would be a risk that s/he could project her/his approach (disapproving or admiring or dependent etc.) to the medicinal system on the medication the patient is using. The therapist does not need to tell the patient about her/his attitude, but it is necessary that s/he is aware of how the attitude affects their therapeutic interventions and the whole therapeutic situation. It may be useful for the therapist to ask certain questions: What is my opinion on the psychiatric drugs and of the psychiatric system in general? Do I or anybody close to me have any personal experience with psychiatric drugs? What kind of experience is it and how does it affect my attitude to psychiatric drugs? The answers to these questions map the pre-understanding of the therapist, they need to brought into awareness and bracketed, so that they do not block the natural flow of contact with the patient.

5. Medication as a Support on the Journey

It has proved useful for us to describe taking medication in psychotherapy by means of a metaphor. It may be important for each therapist to find her/his own metaphors that will serve as cognitive maps. A therapist can for example imagine that for patients, medication serves the function of a jacket in winter. Some people only need a thin jacket, others need a much thicker one, and some none at all. Some people cannot survive the winter without a jacket, for others it would be enough to have a jacket tied round her/his waist to have it at hand.

We would like to offer another metaphor to readers, which serves us well in our practice. It is a metaphor which depicts psychotherapy as a journey: The patient is on a path and the therapist accompanies her/him. When the patient's legs cannot bear her/him well, s/he needs a crutch. This is the drugs' role. For example an antidepressant can prop up a person who is in a deep depression, so that s/he can continue looking for the path. The drugs will not show the way, but they make walking easier while searching for it. In this manner, we can have a look at the combination of psychopharmaceuticals and psychotherapy. Medication can serve as a crutch to the patient and psychotherapy as a remedial exercise[13].

A crutch can label a person unable to walk without external support as handicapped. We can also see the crutch as allowing the person to make use of the remaining potential for moving. There is an important thought shift: the crutch does not only mean the patient is handicapped, that the patient limps, it also means her/his possibilities with a crutch are greater than without it. The crutch allows the patient to make use of her/his remaining potential – s/he can go to work, go shopping etc. When the psychotherapist does not want to compete with the medication, s/he has to be capable of exactly this kind of thought shift. To perceive medication as an external support enabling the patient to realize her/his potential, which would not be possible without the crutch.

It is similar to other kinds of support. If the patient does not have enough self-support, s/he needs more support from outside. This applies not only to medication, but also to a more structured and active approach by the therapist. At the beginning of the therapy, the patient usually comes with a greater need of external support. Then s/he gradually builds a greater reliability on her/his own resources to balance the external sources of support. Especially at the beginning of the psychotherapeutic process medication can play a significant stabilizing role in cases of substantial psychic difficulties. Thanks to their biological effects they can increase the patients' own competences and activate their own potential. For instance, an antidepressant may enable a depressive patient to mobilize energy, to come out of isolation and to establish relationships. Sometimes it is then possible to gradually reduce or discontinue the medication, but the patient's competence stays, if it has been assimilated and strengthened in psychotherapy. In the course of psychotherapy it is important that the patient is able to accept the fact that the medication does not provide her/him with something more and new, but that it helps her/him awaken her/his own potential[14].

The therapist and the patient together thus become aware not only of the role the medication plays in the patient's life and in the process of psychotherapy, but they also explore the new possibilities the medication brings for life and what options it opens for the psychotherapeutic work. The patient for instance experiences an intensive fear of her/his own aggressive tendencies. This fear paralyses her/him so much that s/he is even unable to talk about it in therapy. The only way s/he can manage the fear presents in compulsive rituals. Medication attenuates the fear, reduces it, so it does not block the patient's whole horizon. Apart from the fear the patient can now also see a supportive therapist, who is sitting opposite and listening to him.

We can see psychotherapy as a remedial exercise. When the patient only leans on the crutch and does not take the remedial exercise, s/he does not prepare her/himself for walking without the crutch and may become reliant on it, may stay handicapped. Or the patient puts the crutch away after some time even without any remedial exercise, but then s/he has bigger problems with walking than s/he would have if s/he had been doing the remedial exercise prior to putting the crutch away and preparing for it. Thanks to the remedial exercise, the patient can discover new knowledge of her/his body, can learn how to treat it appropriately, may get new motor abilities and a new relationship with her/his own body.

The patient can for example cope with depression only with medication. If on top of that s/he works in psychotherapy, s/he not only overcomes her/his current problems connected with depression. Thanks to psychotherapy s/he enlarges the spectrum of her/his capabilities. S/he learns to recognize and cope with the

[13] We are aware of the limits of this metaphor, which focuses on the patient's functioning as an individual and does not consider the context.

[14] This is so on the biological level as well: An antidepressant does not deliver any new serotonin; it merely allows for making use of the amount already present in the body.

warning signals of oncoming depression, s/he learns to make use of sources of support from outside and of her/his own support and s/he may get to hear the existential message hidden in her/his depressive experience.

As Gestalt therapists, in our work with patients we focus on extending the spectrum of capabilities by means of psychotherapy, in the same way that the remedial exercises support the remaining functional muscles. This approach comes to the foreground of our work. At the same time it is necessary to consider that the medication serves the patient like a crutch. In this case, the medication is always present in the background of our psychotherapeutic work.

Medication can play different roles in the life of the patient and in the process of psychotherapy. Schematically we can distinguish two functions of medication: a temporary crutch or a permanent prosthesis. This is a very simplified distinction, but it proves useful for a basic orientation for the therapist, as a rough delineation of a differentiated psychotherapeutic work when the use of medication is present in the background.

5.1. Medication as a Temporary Crutch

With some patients we can imagine the function of psychotherapy as a remedial exercise for a person after a leg injury. The medication can be then seen as a crutch which could be put aside after some time. It may be beneficial to use such a metaphor when the patient takes medication, but would like to function without it eventually and this possibility is real. The patient her/himself comes with the idea of withdrawing from taking medication and is willing to bear the discomfort it may bring. S/he wants to take an active part in the psychotherapeutic work; s/he is willing to become aware of her/his attitudes, to change them if needed and to make changes in their lives. The patient gradually learns to make use of the possibilities brought by medication (e.g. it attenuates a paralysing anxiety when s/he is on a crowded bus) even without the medication (e.g. in case of rising anxiety s/he learns to work with breath and body grounding).

For the therapist and the patient the medication can then become a temporary ally in the process of psychotherapy. They can intentionally and pragmatically utilize the alliance with the medication and work with it in the same way as with other sources of external support, such as the patient's steady job or her/his family background. The therapist helps the patient consider the right moment to discontinue the medication, the moment the patient has sufficient self-support as well as other sources of external support. The therapist also helps the patient explore whether her/his own potential, enabled by the medication, could be available without the drug.

There could be a point at which the patient with affected mobility could manage to move with nothing more than remedial exercises, but s/he has got used to moving with a crutch. In such a case the function of medication has changed, now it is used as a crutch which the patient is not willing to give up. The medication no longer functions as an external support and instead begins to limit the patient in her/his looking for new creative ways of adjustment.

It is important that the therapist does not push for a change in such a case. Using medication is a form of creative adjustment for the patient, the drug has a certain important function for the patient, for example it serves as protection. The therapist respects the function the drug fulfils for the patient and helps the patient become aware of what the use of medication brings her/him and how it limits her/him. Medication can provide safety to the patient; protect her/him from too much stress in demanding life situations. But it may also inhibit the patient's ability to experience and to be in touch with other people. The therapist may work with the medication as a protective strategy differentially – to value it, confront it, evade it. The therapist helps the client to become aware of and to accept responsibility for the current ratio between receiving external support and depending on one's own resources.

Michaela has been experiencing long-lasting anxiety in connection with socially stressing situations. The anxiety is sometimes so strong that it prevents her from leaving her house. Her general practitioner has sent her for a psychiatric examination, where she was diagnosed with a social phobia. The psychiatrist prescribed Neurol (alprazolam – the drug dissolving anxiety, potentially addictive), which she should use in case of escalated anxiety. The psychiatrist also prescribed Seropram (citalopram – antidepressant with a good anxiolytic effect) for a long-term use and recommended psychotherapy.

For Michaela it proved very useful to take Neurol in the time of anxiety, but she was worried about becoming addicted. It calms her down to carry it with her as a first aid, but not to use it. She has been using Seropram once a day for several months. Apart from that, she regularly attends psychotherapeutic

sessions. However, she cannot imagine her functioning without Seropram. The drug protects her from anxiety and allows her to live in the way she was used to. She learns in therapy that the medication allows her not to have to change anything. She is afraid of change and the responsibility attached to it. The medication works as a protection for Michaela, she can't imagine her current life without it.

The therapist helps Michaela realize what function the medication has for her. Michaela says the medication is like "a duvet" for her, which enables her not to be hurt so much. The medication slows down the process of therapy, because when she uses it she feels no need to change anything. On the other hand the medication allows her to continue the therapy at all, as without it she would probably not be able to leave her house. Taking the medication is thus a form of creative adjustment. The drug functions as a retarder of change as well as a prevention from breaking up.

Seropram serves as "a duvet" which the patient needs for her protection. Without it, she would be as though naked, frayed. Without the medication she does not have sufficient support from outside. The medication provides support and increases her competencies. It enables her to go to work and to attend therapy. Michaela feels better with the drug and she functions better in her life.

Michaela sees Seropram as an agent of change. She projects her potential for change and her abilities on the medication. The abilities which do not belong to her self-conception. By using the drug, Michaela increases her competency, but does not perceive it as her work, but as the merit of the drug.

The therapist helps her to own the abilities which she projects onto the medication. Michaela gradually realizes she is the agent of change and that the medication and psychotherapy are sources of support she lacked in her life before. Her attitude: "The drug is the reason I feel better", gradually changes to: "The drug helps me find a way of living life the way I need to".

Patients with a milder depression also often benefit from taking SSRI antidepressants. Here the metaphor of a crutch does not seem to fit so well. People with milder depression do not need a crutch, they can walk, but the way they walk is similar to Andersen's Little Mermaid's walk. She felt pain at every step she took, as if stepping on the blade of a knife. People with a milder depression can perceive their experiences with this kind of increased soreness. Antidepressants can attenuate their perception of the pain, as if The Little Mermaid walked in shoes with thick soles. This allows them also to perceive other things than just pain in their feet; they can look around and make contact.

5.2. Medication as a Permanent Prosthesis

A serious psychiatric illness significantly limits the patient and can reduce some of her/his capabilities for a long time or even for a lifetime. In these cases medication serves as permanent external support, which the patients cannot do without. Using a metaphor, we can say the medication does not stand for a crutch to be eventually put aside. The drug could rather be compared to a prosthesis, which substitutes the missing limb and enables movement. The medication serves the function of a prosthesis especially in cases when the patient suffers from illnesses such as schizophrenia, schizoaffective disorder, bipolar disorder or recurrent depressive disorder with endogenic features.

From the therapist's point of view, the diagnostic evaluation is very important, whether the effect of medication could be rather compared to the function of a permanent prosthesis or a temporary crutch[15]. A realistic evaluation allows one to reconcile to medication and liberates the therapist from excessive demands from her/himself and from the patient. If the therapist is reconciled to the medication, s/he helps the patient to become reconciled to it too. In the spirit of the paradoxical theory of change, a space for new possibilities opens up by doing so. If the therapist has big demands (*"Therapy should be directed towards the discontinuation of medication"*), s/he would limit her/himself to therapy with patients with more serious psychiatric problems and s/he may even succumb to therapeutic nihilism, claiming that psychotherapy has no use for these patients.

Patients in an acute psychotic condition can be a typical example. Their experiencing of themselves is not sufficiently distinguished from the environment (Spagnuolo Lobb, 2003a). People in this condition are overloaded with a lot of information and thus are unable to differentiate external information from their

[15] Such an evaluation has to be done in a dialogue with the patient and the doctor who prescribes the medication. We must realize such a diagnostic evaluation is always only provisional and can be eventually changed. Even in a situation, in which the medication seemed to be a necessary prosthesis, it may happen after a long therapy or due to some extra-therapeutic factors that the patient becomes able to function without drugs.

own psychic creation. The medication (antipsychotics) reduces the amount of information (by reducing dopamine, transmitting the information), reduces the overload and helps the patient organize the information.

Psychotherapy has an important task in the treatment of these seriously mentally ill patients. If we return to our metaphor, we can say the remedial exercise is beneficial even to a person with a prosthesis. Due to the prosthesis, the rest of the body cannot function normally, the prosthesis creates various disproportions in the body, other muscle groups are used. The remedial exercise can at least partially correct this deformation and the effects of imbalance and can keep the remaining limbs functioning for a longer time than without it. In patients with chronic schizophrenia the therapist for instance complements the antipsychotics treatment by working with the background of the patient's experience (which allows for the creation of the figure), spends time on perceiving the time and place as factors allowing for the rhythm and helps the patient with a balanced determining of self, including the clear perception of one's own needs (Spagnuolo Lobb, 2003a, see more in chapter 20).

Jane is a 35-years-old mother of two small children. She has recently returned to work after her maternity leave finished. She has a demanding job as an assistant, where she deals with many colleagues and customers and often deals with conflict situations. She is appreciated for her reliability and responsibility, but she is quite often on sick leave because of problems with her back. None of her colleagues has any idea that it is as the result of her suicidal attempt, in which she jumped off the roof of a house, after which she was hospitalized in a psychiatric ward. Jane has been in treatment for psychosis for 13 years and so far she has been hospitalized four times in an acute psychotic state, in which her perception of the environment and her behaviour was greatly changed by paranoid delusions. She feels she is the chosen one and will save our planet from destruction. She has been using antipsychotics for the whole 13 years, sometimes together with antidepressants and anxiolytics. She attends both individual and group psychotherapy. She tried to withdraw from the medication twice, because of undesirable side effects and pregnancy, but she got so much worse she had to be hospitalized. She got used to taking Zyprexa, although she is tired afterwards, has a bigger appetite and feels emotionally flattened. Lately, she has been overburdened, exhausted from lasting stress. Again she had a feeling her colleagues were talking behind her back and she constructed complex fantasies of conspiracy. She had to increase the dosage. Psychotherapy helped her see the situation clearly and she decided to retire with a partial disability pension, which she had fought for a long time. Now she is glad, as she will have shorter working hours and will be more able to manage the household and her children, in which her husband has also been helpful.

The situation may be more complex in the case of bipolar disorder, where after an episode of mania or depression patients may assume they do not need the medication. Furthermore, they may think the prescribed mood stabilizers flatten their emotionality and prevent them from fully experiencing themselves and their relationships with people. A discontinuation of mood stabilizers will however most likely lead to decompensation, to a manic or depression episode, which could have been prevented by medication or at least postponed or attenuated. The task of therapy in this case is to help the patient become aware of and accept the limitation presented by both the disorder and the psychiatric drugs.

A similar situation can occur in cases of patients suffering from recurrent depressive disorder where patients historically have repeatedly experienced serious depression slumps, especially related to seasons and without any external impulse. It needs to be remembered that the antidepressants serve as a prosthesis for the patient, even though their need in the time between individual phases of depression may not be apparent.

The patient may perceive unpleasant side effects of the medication (inhibition, slowing down, emotional flatness, becoming overweight, physical stiffness), which may then lead to isolation and stigmatization of the patient. At the same time, the patient cannot withdraw from using the drugs without a considerabe threat of a severe deterioration in his mental condition. The therapist understands the patient's problems caused by the medication and also sees realistic reasons for the necessity to use it. The therapist accepts the medication as a limit which reduces the scale of possibilities of creative adjustment both in the patient's life and in the psychotherapeutic work itself. The therapist works with the medication knowing it is an inevitable limit of therapy, similarly to the way psychotherapy works with other limits (e.g. unsupportive background, lack of finances or lower intellectual capacity). The therapist adjusts the therapeutic style to it and helps the patients become aware of the limits in their lives and in the therapeutic relationship. The

therapist helps the patient accept the limitation and apart from that to be able to discover and develop capabilities at hand.

6. Conclusion

The usefulness of a justified combination of psychotherapy and pharmacotherapy is supported by the research of genetic and biological effects of psychotherapy, which exceeds the dualistic separation of the body and mind (Wright and Hollifield, 2006). Williams and Levitt (2007) in their research also come to this holistic approach and they abandon the dichotomy of biology versus psychology. The key word for them is the patient's "agency", i.e. the ability to actively partake in the psychotherapeutic process and to make one's own decisions in life. Psychotherapy helps patients increase their ability to mobilize their "agency" and to use the therapist's interventions for the benefit of self-healing. Medication is useful when it helps the patient increase his "agency" and to become engaged in the psychotherapeutic process (e.g. thanks to medication the patient's mood becomes stabilized and their ability to reflect improves). On the other hand, it is not useful when it reduces the patient's "agency" (Williams and Levitt, 2007). As Gestalt therapists we add that the medication is useful also when it facilitates the patient-therapist contact.

Drugs may be useful in the process of psychotherapy, if they – as one of the sources of support – help reduce the paralyzing extent of anxiety (see also chapter 2. The energy originally imprisoned in an excessive anxiety is then available for the patient as "excitement", allowing for a spontaneous and meaningful contact with the environment. At that point, the therapist is there as a partner willing to establish the working relationship and to open up to a human meeting.

Comment

by Brigitte Lapeyronnie-Robine

These two authors enter into an under-examined topic in specific literature, i.e. the combination, for any given patient, of taking psychotropic pills and a Gestalt therapy. These treatments are two modalities which are, most of the time, considered separately and it is all the more to these authors' credit to consider them together: taking the pills belonging thus to the therapeutic situation.

The authors describe clearly different issues one can be faced with in this combination of treatments: its potential impact on the psychotherapeutic process or on the medical treatment; the kind of relationship with his/her drug treatment established by the patient during his/her psychotherapy; the kind of relationship to medication experienced by the Gestalt therapist.

These issues question our views about health and illness, our ideology about psychotherapy. They will give the reader something rewarding to think about. Limits of effectiveness of any kind of treatment – psychotherapy or medicine – are hinted at in the text. Here I would have valued advanced claims or assumptions: what could be said about the limits of psychotherapy, and particularly Gestalt therapy? As indications for drug treatment are clearly given, so I would have valued indications for Gestalt therapy also being afforded.

Different classes of drugs are described both clearly and concisely; this offers an excellent basic knowledge for Gestalt therapists who are not psychiatrists. For instance, they clearly affirm that a prescription for an anti-depressant must be extended beyond the disappearance of depressive symtoms (I recommend from 3 to 6 months), which might be amazing to any under-informed Gestalt therapist. Similarly, anti-depressants are a primary medication for panic-attacks, while it could be considered that tranquillizers are the most appropriate.

Roubal and Krivkova offer in their last chapter two original metaphors about this combination of psychiatric medication and psychotherapy. These metaphors can be of great support for a Gestalt therapist's practice. They substantiate their remarks with two clinical illustrations. The first describes a depressive phase of a patient: her medication met her need for some protection «like a coat during winter». The second describes some psychotic chronic symptoms of a patient whose medication is an ongoing long-term treatment «like a permanent prosthesis».

If we can modestly consider that using medication can be necessary, momentarily or permanently in the course of somebody's lifetime, I must admit that it's difficult to be both psychiatrist and Gestalt therapist, even if we consider every patient as a whole and medication as being part of the therapeutic situation.

Choosing for instance to increase the dose of anxiolytics when I consider that my patient cannot but be overwhelmed by his/her anxiety, or to change an anti-depressant treatment, can be a failure to support the ongoing therapeutic process. But not doing so could also come within a wrong psychiatric assessment and endanger this patient's life. Any Gestalt therapist-psychiatrist cannot forget that he/she is primarily a psychiatrist. His/her first way of thinking is medical.

I join however these authors when they say that it's sometimes better – for some patients – to be both therapist and *prescriber, in order to avoid reinforcing some splits. That's the issue, I think, for patients with personality-disorders. But to play such a role as an expert in prescription is a very different way to be than as an expert as a Gestalt therapist. The first one displays to the patient that the psychiatrist has some knowledge and knows "what's good" for him/her. The second one offers an expertise in the process of experiencing, thus does not position the therapist in an authoritarian stand.*

In their conclusion, the authors resume the concept of "agency", referring to some other writers, to overcome the dichotomy biology/psychology. Here, as in other places in this chapter, I am reminded of Perls, Hefferline and Goodman's book, and particularly their chapter on the transition from physiology to psychology (and vice versa) comes to my mind as another support to overcome this dichotomy (Chapter 1.5; Chapter 12, A. 1). Gestalt Therapy *considered psychology as a study of creative adjustments. So we might wonder when a creative adjustment is impossible for a patient without medication? This question, which is a central issue for a psychiatrist-Gestalt therapist, could also be addressed by every Gestalt therapist.*