A discourse analysis of psychotherapists' account of their work with people who are taking prescribed anti-depressant medication

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Declaration Form

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of *Doctorate in Psychotherapy* (DPSYCH) is entirely my own work, and that I have exercised reasonable care to ensure that the work is original, and does not to the best of my knowledge breach any law of copyright, and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of my work.

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Acronyms

BDI- Beck Depression Inventory

BPT- Body Psychotherapy

CBT- Cognitive behavioural Therapy

DA- Dopamine

EEG- Electroencephography

EBM- Evidence Based Medicine

fMRI- Functional magnetic resonance imagery

GP(s) - General Practitioner(s)

IP- Identified Patient

IPT- Interpersonal Therapy

LDA- Lacanian Discourse Analysis

MDD- Major Depression Disorder

MEG-Magnetoencephalography

MBCT- Mindfulness- Based Cognitive Therapy

NE- Norepinephrine

PET- Positron emission tomography

RCT- Randomised Controlled Trial

SSRI- Selective Serotonin Reuptake Inhibitors

WHO- World Health Organisation

5HT- 5-hydroxytryptamine

Abstract

Rates of depression are growing worldwide. Depression usually involves symptoms such as negative thinking, feelings of helplessness and a loss of energy and it can also affect physical ill health. The causes of depression can be attributed to a number of interrelated factors including biological, psychological and social elements. Recommended treatment interventions for symptoms of depression include anti-depressant medication and psychotherapy. Certain anti-depressants can cause unpleasant side effects with some people. There is little research or literature investigating the clinical observations and insights of psychotherapists regarding the impact of anti-depressant medication on their work and the potential issues therein. Within this Discourse Analysis study, individual interviews were carried out with seven psychotherapists from varied therapeutic orientations. The semi-structured interviews enquired as to whether and how psychotherapists make any adjustments to their therapeutic approach when working with people taking anti-depressant medication. The transcribed interviews were analysed using a Lacanian Discourse Analysis (LDA) method. Section one of the findings found diverse experiences of working with clients and emerging conflict in application of their theoretical model to clinical practice. Section two examines operative discourses shaping the participants speech; these included the dialectic between 'psychology and biology', 'discourses on depression' and the discourses on 'the body'. Section three of the findings is entitled the 'shared medical world' and it encapsulates the multiple conscious and unconscious relationships when working with clients and the different roles that a psychotherapist can embody. This study highlighted some of the complexities when working with symptoms of depression and potential effects of medication but emphasises the importance of therapists to critically situate themselves in a position that they can attend to the meaning of the medication for themselves and the client in the therapeutic relationship. The psychotherapist can take into account what the client knows of his or her own symptoms, medication and recovery; but the therapist also needs to hold a flexible hypothesis and situate themselves somewhere on the 'continuum of positions' and critically consider what therapeutic model and skills are appropriate in light of the presenting client. This research has implications for psychotherapists in collaboration with medical practitioners for treating depression, and recommends that psychotherapy is a prioritised treatment for all cases of depression over anti-depressant medication, but if anti-depressant medications are prescribed, it is important that psychotherapy is offered. This research offers a therapeutic lens for conceptualising and working with clients who have symptoms of depression and taking anti-depressant medication. There are also implications for future research related to this area of work.

1. CHAPTER 1 – Research Overview

1.1 Introduction

The causes of depression can be attributed to a range of biological, psychological and socio-environmental factors (NICE 2009). People with symptoms of depression can also suffer from ill health and social isolation, and experience family dysfunction (WHO 2008). Those who have recurring depression and who do not get adequate treatment have less chance of recovery and have higher mortality rates (Gilbert 2013). Research shows that with the right interpersonal support, people's mental health can improve and there can be a complete remission of depressive symptoms (Hollon and Sexton 2012). Bio-medical interventions such as anti-depressant medication are commonly prescribed to treat different severities of depression but there can be complications and reported side effects for some clients (Whitaker 2010). Psychotherapy is also a recommended treatment for depression, but it is not always offered to clients (Barth et al. 2013). The purpose of this study is to interview psychotherapists about their work with clients who are taking anti-depressant medication. This chapter outlines the aims and objectives of this research and provides a rationale for carrying out this study. This chapter also provides a methodology overview by briefly discussing the design method and its implementation. The remaining part of this chapter will give an overview of the project.

1.2 Background to the Study

Psychotherapy is a process entailing a verbal exchange between two or more people with the aim of reducing mental distress and enabling long-term positive changes in the person or persons (Corsini 2005). There are many different types of psychotherapy models, based on particular theories of the human condition (Feltham and Horton 2013). Theories influence the techniques used by the psychotherapist to help the client deal with mental distress such as the symptoms of depression. The term depression covers a wide spectrum of symptoms, from difficulty in concentrating, negative thinking, and feelings of shame and guilt, to catatonic states of lifelessness and disability. Psychotherapy has been shown to be helpful in relieving symptoms of depression and improving the person's overall mood (Roth and Fonagy 2005; Barth et al. 2013). The medical discourse of psychiatry is based on bio-chemical theories that assert that the aetiology of depression is pathophysiological and is treatable with anti-depressant medication (Stahl 2013). Anti-depressant medications are designed to act on the central nervous system where they affect changes in the neurotransmitters and hormones which affect thinking, emotions and mood (Wegmann 2008).

I am a practicing psychotherapist with experience of working with clients across a broad range of psychological issues. My clinical training and experience has lead me to question the prescribing practices that I see in the clinic for clients with mild or less complex psychological issues. My clinical experience and the literature (Barth et al. 2013) indicates that in some cases clients have the ability to overcome their psychological stress through insight gained in psychotherapy alone. Over time in my psychotherapy work, I have developed a growing curiosity about how to best work with clients who are taking anti-depressant medication. This curiosity is inclusive of clients who agree or who disagree with using medication, and clients who experience side effects from anti-depressant medication. For example with some clients, an increase in the level of the anti-depressant medication prescribed may have been a contributory factor in experiences of drowsiness, and anxiety and a disconnection from or discontinuation of therapy. Additionally clients have reported that the side effects of medication are more unpleasant than the symptoms of depression. For the purpose of this study, I am acknowledging my potential bias about treatment with antidepressant medication and acknowledge this position in the presentation and interpretation of the findings. I reflect on this in the final chapter.

1.3 Aim and Objectives

The aim of this research is to explore how psychotherapists talk about how they approach their work with clients who are taking prescribed anti-depressant medication. This discourse analysis considers how psychotherapists describe their work with those clients and inquire into what, if any, strategies they employ to address any perceived impact the anti-depressant medication may have on the client and the psychotherapeutic process. This research aims to offer original insight into this complex work and provide some suggestions for psychotherapy practice.

1.3.1 Objectives

The objectives are:

- To identify how psychotherapists orientate their work with clients who are prescribed and taking anti-depressant medication
- To inquire if psychotherapists adjust their techniques and tailor their modality when a client is taking anti-depressant medication
- To explore if there are any benefits of or limitations to working with clients who are taking anti-depressant medication as perceived by psychotherapists
- To examine some of the complexities of working with potential effects of medication and symptoms of depression.

1.4 Justification for the Research

The World Health Organisation (WHO 2012) indicated that the global rate of depression continues to rise. Gilbert (2013 p459) estimates that about "one in five people are at risk in suffering a depressive episode at some time in their lives". Depression "rank[s] very high in worldwide tables of illness and disability (Feltham 2013b p4). Mental illness such as depression can be more debilitating than most chronic physical conditions (Layard et al. 2012), In England, "a person with depression is at least 50% more disabled than someone with angina, arthritis, asthma or diabetes" (Layard et al. 2012 p1). Yet a quarter of all those with mental illness are in treatment, compared with the vast majority of those with physical conditions. Although it is claimed that psychotherapy can improve psychological health and reduce symptoms of depression (Roth and Fonagy 2005; Nice 2009), it is not always the first utilised mental health intervention for depression (Cuttcliffe and Lakeman 2010).

According to some authors, the use of psychotherapy is on the decline (Deacon 2013; Olfson and Marcus 2010). The rising rates of depression have corresponding rates of prescription of anti-depressant drugs (Moncrieff 2010; Olfson and Marcus 2010), most notably Selective Serotonin Reuptake Inhibitors (SSRIs). Some research supports combined treatment of psychotherapy and medication (Hollon et al. 2002; Nice 2009; Hollon and Sexton 2012), but research has reported that anti-depressant medication has not only physical effects on clients but they can carry meanings for both clients and psychotherapists (Karp 2006; Kirsch 2009). Certain research has questioned the effectiveness of some of the SSRI drugs in combating certain severities of depression and has critiqued some of the side effects (Kirsch and Moncrieff 2007). There can be not only adverse side effects but according to Double (2011), anti-depressants can also be over relied on, addictive and Healy (2004) stated that they can make symptoms of depression worse. With all these elements to consider, psychotherapy has a role as a "mental health intervention" in the treatment of some depressive symptoms and at particular stage in the course of a person's depression, especially if clients are prescribed and taking anti-depressant. There is also an argument that some symptoms of depression may be untreatable where Kandel (1999) claims that psychotherapy in general does not directly affect the course of a disease such as depression. By taking into account clinical observations and insights of psychotherapists, this research can contribute to psychotherapy practice and inform other mental health professionals in the field (Vanheule 2009).

1.5 Methodology Overview

The research methodology for this study is discourse analysis. Practicing psychotherapists were invited to attend a semi-structured interview and discuss their work with clients who are taking anti-

depressant medication. A Lacanian Discourse Analysis (LDA) was the research design used to analyse transcriptions taken from the semi-structured interviews conducted. LDA puts a particular set of psychoanalytic concepts to draw attention to connections in the text and explore the possible emergence of discourses in the language used by the participants (Parker 2010). By analysing the content and the linguistic construction of the participant's speech, this helped examine possible extra-intentional meanings occurring in how participants employed language to describe their work but also how they were used by language. The LDA theoretical framework is outlined by Parker (2005; 2010); Pavón-Cuéllar (2010); and Parker and Pavón-Cuéllar (2013).

1.6 Project Overview- Layout of Thesis

Chapter two presents a literature review on various understandings on depression. Theories on neuroscience, psychoanalysis, biopsychosocial theories and medical writings on the aetiology and assessment of depression are explored. Research on biological and psychological treatments and a combination of both psychotherapy and anti-depressant medication are reviewed. Chapter three outlines the methodology design which includes a detailed outline of the philosophical underpinnings of discourse analysis and in particular the LDA approach. Included in this chapter are descriptions on the process of carrying out the research, from seeking ethical approval to gathering the data through semi- structured interviews to outlining how the data was organised and the analytical process was undertaken. Chapter four presents the findings across all the interviews. Chapter five is the discussion chapter which embeds the findings in extant literature. Chapter six highlights the main findings and conclusions, the strengths and limitations of this study while reflecting on implications for future practice and research.

2. CHAPTER 2 – Literature Review

2.1 Introduction

In current mental health discourses, there are a number of conceptual and empirical theories that draw from a range of biological, psychological and social models of the human condition to try to answer questions about the nature, aetiology and best treatment for depression. Discourses enable people to construct and imbue meaning into talk about mental ill health and therapeutic treatments (Speed 2011). The following sections contain a critical examination of literature from different disciplines on medical concepts, diagnostic categories, bio-medical treatments and psychotherapy practices. In section one I will critically review the concept of depression through the bio- neurological, psychosocial, psychoanalytical lens and will include literature on the biopsychosocial view of mental health. Additionally, I will discuss the medical model and its approach to assessing depression as a mood disorder. Section two contains an examination of research on anti-depressant medication and different psychotherapy models in the treatment of depression. Section three contains an examination of combined treatment approaches and reflects on some of the benefits and challenges of a dual approach.

2.1.1 Literature search strategy

Literature was sourced around terms, concepts and theories relating to depression and pharmacological treatments stemming back to the 19th Century. More recently, psychotherapy journals and on line research databases such as Psycharticles (American Psychological Association), PsycINFO, MEDLINE and Google Scholar were accessed for relevant meta-analysis and systematic reviews on both anti-depressant medication and psychotherapy within the last twenty years. There was no literature found that was specifically concerned with psychotherapists experience of working with clients taking anti-depressant medication.

2.2 Section 1: Understanding Depression

Depression ranges from mild to severe and transitory to chronic and it can occur for variable lengths of time and at different stages of a person's life (Stahl 2013). Some people experience "mild" depression and sporadic low moods or "major" catatonic states where a person is speechless and motionless for long periods of time (Kramer 2005; Daniels 2009). Depression can have serious long term consequences for people and their personal relationships (NICE 2004; 2009; Hollon and Sexton 2012) and suffering for longer periods before getting treatment increases negative outcome and reduces recovery rates (Oquendo et al. 1999; Stahl 2008). "Self-harm and suicide risk factors are

associated with depression" (Gilbert 2013 p459). Almost one million people commit suicide every year and a large proportion of them had experienced depression (WHO 2012). There are many theories of depression and a definition will depend on what epistemological standpoint a person takes to interpret what they conceive it to be. I will now review the main disciplines and focus on some of the common discourses about depression therein.

2.2.1 Discourses on Depression

Depression results from a complex interaction of biopsychosocial factors (Myers 2007). Some critical psychiatrists' state that depression is a natural component of the human experience (Szasz 1961; 2007) and can be an appropriate reaction to life events (Browne 2007). Depression can be synonymous with a person's personality and identity where individuals may display certain traits such as a negative outlook on life, indecisiveness or confusion (Kramer 2005). Some people can claim that "depression is part of who they are" (Karp 2006 p23). Psychosocial stress can precipitate and contribute to someone experiencing depression (Monroe and Harkness 2005; Zimmerman et al. 2011). Depression can be associated with bereavement (Leader 2009) and loss (Freud 1917) and early traumatic experiences that can re-appear as depressive symptoms later in life (Rothschild 2000).

Genetic factors are also considered as significant. The Caspi et al. (2003) longitudinal study on gene expression maintained that depression traits and characteristics can be hereditary, for example, a person might have a genetic vulnerability that can be activated by a family and environmental setting. Greenwood et al (2003) asserted that there are certain inheritable genes that can activate a "learned helplessness" in people. Gender is also significant as epidemiological findings point to a female majority in the prevalence, incidence and morbidity risk of depressive disorders (Piccinelli 2000; Stahl 2008). Pregnancy, the post- natal and the menopause may contribute to symptoms of depression (Hasler 2010). There is also correlation between age and physical health in depression (Gallagher et al. 2010). Aging in males can also lower testosterone production and consequently contribute to low moods and other symptoms of depression (Weggman 2008). Considering that healthy blood flow is essential for transport of important hormones and chemicals to sustain positive energy and moods, cardiovascular disease can lead to depression and vice versa (Stahl 2013). Depression will be explored further through a neurobiological lens.

2.3 Neurobiology and Depression

Neurobiological research asserts that depression involves molecular, functional and structural alterations in several areas of the brain (Myers 2007; Stahl 2013). These theories assert that depressive states have specific biomarkers that suggest pathophysiological disruptions at the level of

neurotransmission and specific circuitry (Maletic et al. 2007). Such cellular, chemical and functional alterations can be identified through the use of scanning technologies (PET, fMRI, EEG, MEG) (Fonagy 2004). Although some of the results of these studies have been challenged (Angst 2007) there is increasing evidential consensus that the specific regions of the brains of depressed people tend to be hypoactive, namely the left frontal lobe which is active during positive emotions but less active during depressed states (Stahl 2008). It is likely that at a neurobiological level that depressive states involve complex and disparate brain systems but some core structures have emerged from the literature.

2.3.1 Neurons and Neuronal Circuits

The neuron is a nerve cell that utilises electrical and chemical signals to relay messages throughout the nervous system (Stahl 2013). Neurons play an important role in contributing to the subjective experiences of emotion, alerting the organism to significant encounters and preparing the body for action (Levenson 2003; Levenson et al. 2007). The biological aetiology of depression theorises that depression is due to a deficiency in the regulation of the certain neuronal circuits and transmitters in the trimonoaminergic neurotransmitter system. Serotonin is the most extensively studied neurotransmitter in depression (Hasler 2010; Whitaker 2010). Serotonin (5-HT) is a hormone found that has many functions including mood regulation, appetite and sleep. It was suggested in some research that serotonin was the most likely underactive pathway in the nervous system for those who were depressed (Whitaker 2010 p68). However, a more recent meta-analysis yielded no evidence that the serotonin transporter gene alone was associated with the risk of depression (Risch et al. 2009). The most recent research suggests that the entire trimonoaminergic neurotransmitter system maybe malfunctioning in various brain circuits and that a depletion of these neurotransmitters induces depression but there are still confusing results around what exactly the process involved that contribute to depression (Stahl 2013). This suggests that there is conflicting evidence for prescribers around specific types of depression symptoms. This has an impact on reliable results for neuro-pharmacologically based treatments.

2.3.2 Molecular Biology

Certain studies have focused on the biological vulnerability of certain gene types in interaction with environmental stressors (Stahl 2008). Molecular genetics has focused on the promoter gene (SLC6A4) and its involvement in the uptake of serotonin at brain synapses. In the gene- linked region, the short (S) allele has lower transcription efficiency than the long (L) allele (Fonagy 2004; Zalsman et al. 2006). Although there is inconclusive evidence on direct association with depression, the Dunedin

longitudinal sample has demonstrated that in the presence of three or more negative life events, the likelihood of diagnoses of major depression for those with the S allele increases from 10 % to 28-32%. With people with the L genotype, the risk of an episode of major depression increases by 10-16% (Caspi et al. 2003). Despite advances in genomics, the question of how genes specifically influence neurodevelopment, synaptic plasticity, neuronal connectivity and efficiency in neuronal information processing in depression is currently under investigation (Human Genome Project Information Archive 2013). Stahl (2013) asserts that the key genes all converge on the trimonomine neurotransmitter system. Recognising that genes are a significant contributory factor to symptoms of depression but there is a lot that researchers do not know about how genes operate on the trimonomine neurotransmitter system; and how they can be specifically and consistently identified to improve treatment.

2.3.3 Neuroanatomy

Studies have reported that "recurrent depression has a neurodegenerative component" (Catell 2004 p43). Empirical studies assert that specific kinds of neglect in childhood and early trauma experiences can affect neuro-physiological brain development (Spitz 1947; Kandel 1999; Siegel 1999; Mate 2010). Disinhibited blood flow in the prefrontal cortex can cause a developmental anomaly which can result in not only disturbances in emotional processing but also in memory and "decline in cognitive functioning" (Catell 2004 p43). Disturbances in neuroanatomical functioning not only affects a person's characteristic negative patterns of thinking but can deficit coping skills, judgment and decision making, and impair a persons' ability to perceive and understand (Damasio 2000). Despite neuro-biological research on certain areas of the brain, researchers have yet to discover a definite biological marker and an explicit brain region directly connected to depression but it is suggested that there is a dysfunctional network of areas (Angst 2007; Deacon 2013). Neurobiology is only a singular perspective in considering the wider complexities involved in a person's experience of depression but there is an acknowledgement of importance of the environment and how molecular and genetic elements are sensitive and responsive to external factors and certain life events. This requires a systems level approach which includes taking in account a person's psychological involvement in environmental and social systems too.

2.4 Psychosocial views of Depression

Life stresses can play a significant role in the onset and persistence of depression (Monroe and Harkness 2005; Zimmerman et al. 2011). According to Catell (2004), there is a correlation with people who present with symptoms of depression and certain chaotic lifestyles that are punctuated by

family problems, violence, sexual issues, and difficulties with employment, drug abuse and alcoholism. Inadequate social support can precipitate a person's risk of depression and reduce recovery rates (Schotte et al. 2006). Layard et al. (2012 p13) asserted that "depression is higher in the lower quintiles of incomes". Possible explanations for this may include a combination of a few factors including unemployment, dependency on social welfare (learned helplessness), higher alcohol and drug use in families and the locality, less financial opportunities for recreation and leisurely activities. An evolutionary perspective of depression suggests that a low lethargic mood could cause a person to slow down in order to cope with adaptive challenges and if there is a potential harm threatening a person (Nesse 1998; Barrett et al. 2002). This would concur with the psychological theories that propose a person needs time to adapt to significant events such as separation, bereavement (Kübler-Ross 1969) or loss (Freud 1917). Depression maybe associated with a person gaining insight that can be overwhelming and painful. Ghaemi (2003) referred to this as the depressive realism model where a limited illusion in "ignoring painful realities" may be healthy. A person can learn how to ignore, avoid, and forget challenging ideas and experiences. "Normal non-depressed persons have some lacunae of insight, some psychological blind spots, which are necessary for normal emotional functioning" (Ghaemi 2007 p126). Illusions can be either maladaptive or adaptive depending on the context of the person and their situation (Ghaemi 2003 p214). In contrast to this depressive realist model, the cognitive distortion model appears to better apply to many persons with severe depressions and it tends to be associated with some impairment of insight (Ghaemi 2007 p122). The depressive realism model argues that depression is associated with more insight, and the cognitive distortion model argues that it is associated with less but distorted insight (Ghaemi 2007 p127).

2.4.1 Psychoanalytical Views of Depression

In Freud's (1917) "Mourning and Melancholia", he was concerned with how human beings respond to the experience of loss. Freud "held that depression is phenomenologically similar to mourning (Ghaemi 2003 p212). Freud contrasted "mourning" and "melancholia" by entailing that they can present similar symptomatic expression, "profound painful dejection, cessation of interest in the outside world, loss of capacity to love, [and] inhibition of all activity" (Freud 1917 p244). Melancholia can mimic mourning but the distinct difference relates to the hostility felt for the lost other or object and the melancholic internalises the rage and directs it at oneself. Leader (2009 p34) asserts that "while the mourner knows more or less what has been lost, this is not always obvious to the melancholic". The melancholic possesses qualities of the lost object and so the cause which made the person desire the object has withdrawn, resulting in confusion and disappointment with all empirical objects as none of which can fill the place as the cause of desire (Žižek 2006). According to Leader (2009 p173), "the melancholic may complain of illnesses or bodily symptoms which turn out

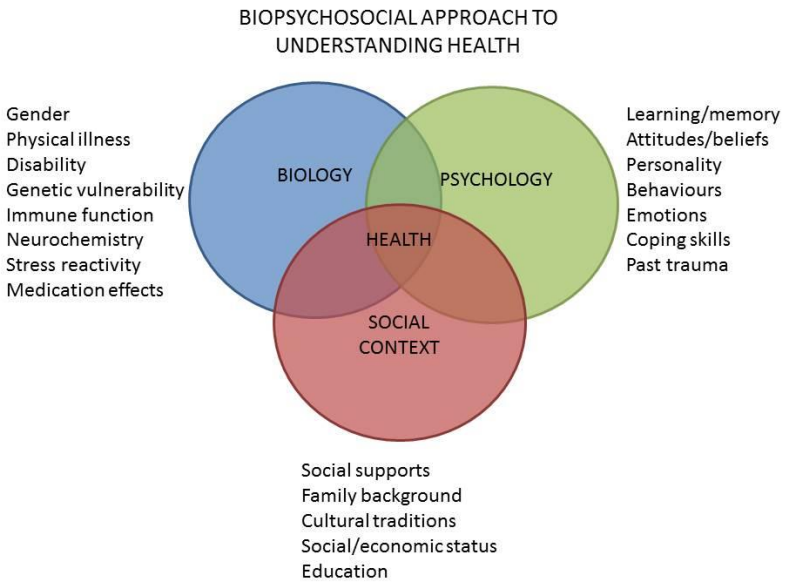
to mirror those of the lost person". The melancholic is situated between two worlds "the world of the dead and the world of the living" (Leader 2009 p175). A part of the person dies with the lost object and a part of the lost dead object lives on in the person.

This loss can be theorised through the "Oedipal" separation, the primal loss and alienation that is experienced in early childhood, where the others absence sets up a sense of loss and inner tension and this can be traumatic. In infancy, these bodily prototypes of this tension and trauma "are experiences of hunger and thirst" (Verhaeghe 2004 p261). When the infant experiences these bodily sensations, they have visual and auditory perceptual impressions and an infant can represent these sensations psychically by means of unconscious phantasies involving objects relations (Hinshelwood 1989). Klein (1967) referred to this as the "depressive position" and splitting it is an attempt to deal with sense of hate and bad feelings. Verhaeghe (2004) maintains that psychopathologies emerge from how we process these depressive reactions in relation to the ambivalent relations with the other. This is what Freud termed as psychoneurosis (Freud 1906) and a secondary process can develop to allow some form of symbolisation to verbalise this depressive response to loss and inner tension and perceive the other as separate. The depressive position is a pre-condition for "language acquisition" to manage the loss or lack that was being experienced (Kristeva 2001). If the opportunity of symbolisation is missed at some level or there is an impossibility of translating heightened somatic arousal into the psychological representations and symbolisation, this is where severe depression, extreme anxiety and panic can occur. Freud referred to this as actual neurosis (Freud 1906) where trauma can remain in the body.

2.4.2 The Biopsychosocial View of Mental Health

The biopsychosocial model promotes the idea that depression is multifactorial, involving genetic, biological, and psychosocial factors (Lakhan 2006). Figure 1 below is a biopsychosocial chart to highlight the all-combining nature of biology, psychology and social influences on a person's mental health.

Figure 1: Biopsychosocial approach to understanding health



The biopsychosocial theory proposes a combination of a person's internal physiology in conjunction with a person's psychosocial interaction with the environment. This interaction involves genetics and physiological changes where particular clusters of neurons form specific circuits in the brain. These changes impact a person's emotions which are psychological responses to these physical changes that form mental processes (Siegel 2001 p70). Cognitive processes, such as the understanding and the evaluation of meaning, attitudes and thoughts, function together to produce behaviours (Siegel 2001 p70). These cognitive processes are important in psychotherapy treatment.

A number of types of depression have been identified through the biopsychosocial formulation. One is the reactive type, which proposes that depression is a reaction to a particular external event (Stahl 2008). A biological or physical depression is "endogenous in nature, it comes from within and there are physiological changes in the body's system" (Weggman 2008 p52). The "mixed type" is a combination of the reactive and biological types; when severe psychological stress occurs, bio-physiological changes may take place (APA 2013). Atypical depression is a more severe physical depression, with co-morbid symptoms of anxiety and panic disorder (Weggman 2008). Gaudiano and Miller (2013 p816) proposed that "empirically-supported biopsychosocial theories are underrepresented in mental health treatment". Brondino (2009) found that stigma pertaining to mental ill-health improved following presentation of an environmental explanation for depression. Deacon (2013) asserted that the biopsychosocial approach to mental disorders is neglected in comparison to the dominant biomedical paradigm. Medicalization refers to the practice of redefining and treating non-medical problems as medical and minimising the importance of environmental factors (Satel and

Lilienfeld 2010). Smail (2010 p235) maintains that human beings are perpetuated by the medicalization of suffering and difference because it sanitises and simplifies. He claimed that a psychological analysis of personal distress must… diagnose not individuals but their environments" (Smail 2010 p235). However, the medical model has a specific format for understanding depression.

2.4.3 Medical Diagnosis of Depression

The presentation of depression symptoms entails different levels of severity and variable duration. Some forms of depression have a remitting and relapsing course, and symptoms may persist between episodes (NICE 2009). Diagnosis is a "medical concept which covers both the process of identifying a disease, and the designation of that disease" (Moncrieff 2010 p371). Reaching a 'diagnosis' involves investigations and observations that help to identify the nature of the underlying disease that is thought to be causing the individual's symptoms (Moncrieff 2010). When a person presents to a GP or a psychiatrist with symptoms, they are usually assessed on the characteristics of the symptoms and there is an attempt to identify and classify. Classificatory systems are agreed conventions in order to guide diagnosis and treatment (Nice 2009). Establishing the correct treatment is often the main practical function of diagnosis in medicine. The Diagnostic and Statistical Manual of Mental Disorders (DSM) is "a common reference for psychiatrists and doctors" (Stahl 2008 p454) and considers that symptoms of depression are "signs of an underlying disorder" and they can be diagnosed as a particular type of depression (Vanheule 2012 p13). Vanheule (2012) argues that the inductive method can pose problems for measurement, classification, verification, diagnosis and treatment. Illich (1976) maintains that diagnosis can bring with it dehumanization, labelling, the pathologization of many human activities, and iatrogenesis. This demonstrates that medical diagnoses can possibly inflict added problems for a client who maybe already suffering.

2.4.4 Classes of Depression

In the DSM 5 (APA 2013), depression is referred to under the title "depressive disorders". Depressed mood is not necessarily a psychiatric disorder as it can be a normal reaction to certain life events, or a symptom of some medical conditions or a side effect of medication. The depressive disorders listed in the DSM 5 include:

a. Disruptive mood dysregulation disorder
b. Major depressive disorder
c. Persistent depressive disorder (dysthymia)
d. Premenstrual dysphoric disorder
e. Substance/ medication-induced depressive disorder and

f. Unspecified depressive disorder (APA 2013 p155).

There are some commonalities across the different classes of uni-polar (as distinct from bi-polar) depression; in particular, symptomatic low mood is common to all categories. All these different classes of depression have a complicated diagnostic process for evaluating the severity and longevity of symptoms. I will go into detail for one example and will outline the diagnostic components of major depressive disorder. A major depressive episode will be assigned if five or more of the nine symptoms from the list below are present, including either 1 or 2 on the list:

1) depressed mood…feels sad, empty, hopeless.

2) markedly diminished interest or pleasure in all, or almost all, activities during the day.

3) significant weight loss and appetite.

4) insomnia or hypersomnia.

5) psychomotor agitation or retardation nearly every day.

6) fatigue or loss of energy every day.

7) feelings of worthlessness or excessive or inappropriate guilt, which may be delusional.

8) diminished ability to think or concentrate, or indecisiveness, nearly every day.

9) recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or specific plan for committing suicide (APA 2013 pp160–161).

A person is diagnosed with major depression if the symptoms are present during the same two-week period and are causing significant distress or impairment in social functioning and additionally the episode is not attributable to physiological effects of a substance or to a medical condition (APA 2013).

Another tool that medical practitioners use to conceptualise and understand depression is the Beck Depression Inventory-II (Beck et al. 1996). This questionnaire instrument is used to measure the somatic-affective and cognitive dimensions of depression (Beck et al. 1996). Vanheule (2012 p132) claimed that the Beck depression inventory instrument "has good psychometric properties" but he asserts that "large amounts of discrepancy remain unexplained by accepted factor models". He indicated that consistency in general in medical diagnosis is poor. Foucault (2003 p5) was critical of the function of psychiatric diagnoses and referred it as the "classificatory gaze", a "gaze which is only

sensitive to surface divisions". The classification approach is typical of the medical approach to sickness and it has its own linguistic-conceptual diagnostic ordering (Szasz 2007). Depression symptoms and associated complaints are treated as if they were objective indicators of disease. Stahl (2013) asserted that symptoms can be mapped onto specific hypothetically malfunctioning brain regions but there is inaccuracy in correlating categorical diagnoses with underlying biological patho-physiological disorders. Researchers have yet to discover a specific biological marker to reliably inform the diagnosis of any mental disorder (First 2002; Bracken et al. 2012; Deacon 2013). Bentall (2009) is against the "paternalist-medical" model of treatment and claims that there is a "ruthless manipulation" of truth by the powerful financial and political; the Big Pharma and finds diagnostic categories in psychiatry as arbitrary as star signs. Moreover, Pilgrim (2007) concludes that the interests of the pharmaceutical industry have helped to sustain the practice of psychiatric diagnosis (Pilgrim 2007).

2.4.5 Summary of "Understanding Depression"

In summary, there were significant scientific advances in neuroscience over the last century that have contributed to contemporary understandings of depression; certain technology can detect biological components through brain scans, physiological volume, measures of hormone levels and chemicals that are common in depressed people. However, the literature has pointed to methodological inaccuracy and discrepancy in exactly correlating underlying biological disorders with diagnoses. Neurobiology is only a singular aspect and it can be seen that more is needed to accommodate the complexity of a person's past and current relationship with inter-personal and socio-environmental factors. Certain psychoanalytic theories proposed that early relationships are significant in shaping a person's propensity for experiencing depression. The biopsychosocial approach supports us in holding multiple perspectives that propose combining causal possibilities for the aetiology of depression. Empirically supported psychosocial interventions are underrepresented in mental health treatment compared to the dominance of the biomedical model of treatment (Deacon 2013). Healy (1997) discussed pharmaceutical advocates in the industry with invested interests where they promoted the idea that depression was commoner than was generally realised and people often went undiagnosed. The next section will focus on both the biomedical and psychological treatment of depression, namely anti-depressant medication and psychotherapy.

2.5 Section Two: Treating Depression

2.5.1 Introduction

The key goal of an intervention for a person who is experiencing depression should be complete relief of symptoms, which is associated with better functioning and a lower likelihood of relapse (NICE 2009). Talking therapies such as psychotherapy "can bring a degree of comfort and resolution to some sufferers but not predictably. Likewise for medication" (Feltham 2013b p4). This section will look at both the biological treatment of anti-depressant medication and the psychological approach of psychotherapy. The development of the modern antidepressant era will be reviewed and there will be a comparative analysis of the different types of SSRIs and documented side effects. The second part of this section will review some psychological therapies, therapeutic models and research in response to depression.

2.5.2 Evolution of Anti-depressant Medication

Mental health services response to symptoms of depression has changed significantly over time. In the early part of the Twentieth Century, physical interventions were popularised in response to the latest developments in science and medications (Szasz 2007). From the 1930s, British and American journals described "shock" treatments such as Electro-convulsive therapy (ECT) as the most popular intervention. This therapy was originally used to treat schizophrenia but there were apparently more effective in depressive symptoms, particularly in involutional melancholia (Moncrieff 2011). ECT was regarded as acting to rectify "putative neuropathological basis of depression" (Moncrieff 2011 p178). NICE (2009) still advocates ECT in the treatment of catatonia, prolonged or severe manic episodes and schizophrenia. From the 1930s and 1940s, sedatives, amphetamines and other stimulants were used and marketed as antidepressants and were used to treat neurosis with depressive symptoms in primary care (Rasmussen 2006). In the late 1950s and 1960s, a new drug was developed called "imipramine". This type of try-cyclic medication also had side effects of been "strongly sedating" and impairing on intellectual functioning and it was "generally found to be unpleasant" (Moncrieff 2010 p180). Despite this, Kuhn (1957) claimed that "imipramine" had "potent anti-depressant action" and reversed bio-chemical or physical substrate of depression. Other reports at the time claimed that "imipramine" had no specific antidepressant action (Moncrieff 2011 p181). "Although less popular than the more recently discovered selective serotonin re-uptake inhibitors (SSRI's), imipramine is still in use today" (Bentall 2009 p48). This arguably demonstrates that despite drugs such as imipramine having over sixty years of contradictory reviews, they are still being marketed and prescribed.

The use of anti-depressants and ECT helped to establish the idea that depression was a "treatable psychiatric condition" (Moncrieff 2010 p183) and presupposed that treatment can target the infected agent and specific organic elements of the body (Foucault 2003). Foucault (1997 p296) questioned

> the medicalization of madness, in other words, the organisation of medical knowledge around individuals designated as mad, was connected to a whole series of social and economic processes at a given time, but also with institutions and practices of power.

In the 1970s there was an anti-psychiatric movement by some radical psychiatrists (Laing 1960; Szasz 1961; Browne 2013). The "damage done by medicine" according to Illich (1976 p6) and "to the health of individuals and populations is very significant". "Medicines have always been potentially poisonous, but their unwanted side-effects have increased with their power and widespread use" (Illich 1976 p9). In response to the anti-psychiatric movement, there were attempts to reinforce biological psychiatry and purge the influence of psychoanalysis and psychosocial theories (Whitaker 2010). Anti-depressant companies "launched an aggressive campaign to search for more anti-depressant compounds" (Moncrieff 2011 p186). The DSM III in the 1980s did away with the ideas that depression was reactive or neurotic and was promoted as acting on 'disease' and they work by reversing underlying physical pathology. Different classes of antidepressants such as tri-cyclics and newer, second generation antidepressants like the SSRIs were promoted and prescribed (Hougaard 2010). The major difficulty of treating depression before SSRIs was the high risk of suicide with patients coupled with the lethality of the available drugs (Lane et al. 1995). The choice of appropriate medication is usually made "based upon adverse-effect profiles, poor history of good results, and safety" (Catell 2004 p48).

2.5.3 General Principles of Anti-depressant Action

People who receive anti-depressants can experience improvement from treatment. When this improvement reaches the level of reducing symptoms by 50% or more, it is referred to as a response (Stahl 2008 p512). The paradigm of treatment has shifted dramatically in recent years and the goal of treatment is complete remission of symptoms but with the different chemical components of the anti-depressant medications, it is difficult to reach complete remission (Stahl 2013). If anti-depressants do help a person into remission, the person has a less likely chance of relapse, but if the anti-depressant medication does not, relapse rates can get worse and more treatments are required. Stahl (2013) recommends that intervention needs to be as early as possible before the depression gets worse. The recent NICE (2009) guidelines recommend that the use of anti-depressants is restricted to people with more severe conditions, but this is not always the case, SSRIs are also used to treat milder depressions, anxiety and eating disorders (Double 2011). Moreover, there have been exaggerations as to the results that certain anti-depressant drugs can provide (Hammersley 1995). This raises the

question about not only why exaggerations need to be made but more poignantly who is really benefitting from the marketing spin.

2.5.4 Selective Serotonin Reuptake Inhibitors (SSRIs)

SSRIs were referred to as "magic bullets" when they were originally introduced to the market (Weggman 2008). The table below (Table 1) reviews five commonly prescribed SSRI medications: Celexa, Lexepro, Prozac, Paxil and Zoloft. Each of these has its own specific mechanism of action on the trimonoamine neurotransmitter system (Stahl 2008). The mechanism of action and the side effect information are sourced from the website (www.drug.com) and from some of the official websites from the pharmaceutical manufacturers and Stahl (2008; 2013). Also reviewed was the Official Journal of the Association of Medicine and Psychiatry (2003).

2.2.5 SSRI Comparison Chart

Table 1: SSRI comparison chart

Names	**Citalopram (Celexa)**	**Escitalopram (Lexapro)**	**Fluoxetine (Prozac**	**Paroxetine (Paxil)**	**Sertraline (Zoloft)**
Logo					
Common side effects	Nausea Dry mouth Drowsiness Insomnia Increased sweating Diarrhea Sexual dysfunction Fatigue Anxiety Agitation Anorexia	Anxiety Headache Nausea Insomnia Sexual dysfunction (decreased libido, impotence) Dry mouth Drowsiness Fatigue Dizziness Anorexia	Nausea Headache Insomnia Nervousness Anxiety Drowsiness Anorexia Dizziness Anxiety Agitation Tremor Sexual dysfunction	Nausea Drowsiness Dry mouth Dizziness Constipation Anxiety Nervousness Fatigue Sexual dysfunction Increased sweating Insomnia Hallucinations	Tremor Nausea Headache Insomnia Diarrheal Dry mouth Sexual dysfunction Drowsiness Dizziness Fatigue Agitation Anorexia

2.5.6 SSRI Side Effects

Despite SSRIs development from previous anti-depressant drugs such as tricyclics, there are still reports of iatrogenic side effects (SEE TABLE 1). There is significant negative publicity towards some of the side effects of SSRIs by some clinicians and professionals in the field (Van Praag 2005; Moncrieff, 2010; Double 2011). A biological explanation for side effects could suggest that most of

the pharmaceutical properties of anti-depressant medication activate neurons in the CNS, serotonin and some react with norepinephrine. These are major neurotransmitters of the CNS and have millions of synapses and connections to other parts of the brain such as the "cellebrum", the "hypothalamus" and the "basal ganglia" that are involved in "memory, learning, sleep, appetite, the regulation of moods and behaviours, respiratory, cardiac and gastrointestinal activities" (Whitaker 2010 p69- 70). Healy (2004 p267) proposed that there is sometimes dangerous levels of "elevation of blood pressure" where Stahl (2008 p531) maintained that it is not possible for a "systemically administered SSRI to act only at desirable receptors in the desirable places; it must act everywhere". He also asserted that the side effects of SSRIs are the "cost of doing business" (Stahl 2008 p531). Considering some of the severe side effects, the "cost of doing business" is ironically at the further expense of a person's mental health. There is also warning of the suicidality risks from SSRIs (Breggin 2008; Valluri et al. 2010). The rates of suicides and for suicidal acts are consistently high with SSRI's despite different modifications of the drug (Healy 2004 p241). It appears that the cost of business is paradoxically costing lives!

2.5.7 Discontinuation Problems

Some of the types of SSRIs are reported as dependent and addictive (Young and Haadad 2000; Double 2011). SSRIs are lethal-in-overdose and there are hazards on withdrawing from anti-depressants (Healy 2004 p241). The pharmaceutical companies, GlaxoSmithKline and Eli Lili insisted that SSRI drugs were not addictive, and asserted that dependence could also be translated as a habit (Double 2011). But there are withdrawal side effects if these drugs are reduced or discontinued (Moncrieff 2011). The side effects can be termed as "antidepressant discontinuation syndrome" and Schatzberg (2007) divided the somatic symptoms into clusters such as disequilibrium, dizziness, vertigo, gastrointestinal symptoms, flu like symptoms, fatigue, lethargy, sensory disturbances and sleep disturbances. There were also psychological disturbances including anxiety, agitation, crying spells and irritability. One reason for this could be that the brain has to reregulate the balance of receptors (Blair and Tremblay 2006). Side effects of 'coming off' anti-depressants can be interpreted as symptoms of depression and consequently clients can be put back on the medication as soon as withdrawal symptoms occur (Double 2011). Anti-depressants "must be withdrawn gradually" Hammersley (1995 p9) which demonstrates not only the power of the drug but also how clear instructions need to be outlined for the client and consideration for a person's sensitivity in the reduction of the medication.

2.5.8 Research on SSRIs

Treatment with SSRIs has garnered some criticism with growing placebo responses in randomized controlled trials (RCTs) (Gelenberg et al. 2008; Kirsch 2009). A number of meta-analyses suggest that the advantages of antidepressant over placebo are small and possibly clinically meaningless (Rapley et al. 2010; Kirsch 2009). Kirsch et al. (2008) found lowered placebo response in the more severely depressed groups, while antidepressant response remained rather stable irrespective of severity. Some positive reports of antidepressant medications assert that they can support a person in managing some symptoms (Kramer 2005). Kramer (1997 pxv) asserted from his clinical experience that antidepressant sometimes improved "self-image" and "changed personalities" for the better. In Karp's study, clients reported that taking medication was definitely a "radical transformation of self" (Karp 2006 p94). Hollon et al. (2002) were critical of antidepressant medication by claiming that they do not do anything to resolve underlying family or relational issues that may be driving the depression. Research with SSRI antidepressants has generated a lot of mixed reports of their effectiveness. Kirsch & Moncrieff (2007) referred to them as having "dichotomizing results". Despite some positive reports for occasional symptom remission for some clients, there is very little solid evidence of long-term efficacy of antidepressant medication (Bracken et al. 2012). Certain research claims that long term treatment with antidepressants might even harm patients in the long run (Fava 2003; Moncrieff 2006; Fava et al. 2007). Further to treating some of the above mentioned symptoms, two common reasons for considering the use of medication for the treatment of depression is primarily to prevent suicide and secondly to facilitate some other treatment, such as psychotherapy (Catell 2004; NICE 2009).

2.6 Psychosocial Treatments of Depression

2.6.1 Introduction

Psychotherapies are "listening-and-talking-based methods of addressing psychological and psychosomatic problems and change (Feltham 2013a p3). Psychotherapy aims to produce changes in "cognition, feelings and behaviour" (Holmes and Lindley 1989). In order to for this change to occur, Frie (2001 p.18) asserted that people need to be "agents of their own actions". The concept of agency here implies one who desires, makes decisions, and controls one's own volitional actions (Jennerod 2006). Although clients may desire change, they may not be able to bring it about on their own. An objective of psychotherapy can be to facilitate this change to take place within the relational context (Frie and Reis 2001). Psychotherapists use different models and rely on different theories to carry out their work with clients. The number of psychotherapies and theories has grown from the 1960s to

1997 by 600% (Feltham 1997). Wampold (2008) gives an estimate of an excess of 250 therapeutic models. This provides some basis for an understanding of the complexity of offering a united definition of psychotherapy. There is also a wide variety of therapeutic models suggested for depression (Ingram 2009) but I will provide a critical review of some of the mainstream models of psychotherapy in consideration of working with depression, specifically:

a. Psychoanalysis
b. Cognitive behavioural therapy (CBT) & mindfulness (MBCT)
c. Interpersonal psychotherapy (IT)
d. Humanistic therapy
e. Body and sensorimotor psychotherapy
f. Integrative and eclectic
g. Systemic and family therapy

There will be also be a critical examination of some of "psy-discourses" (Parker 1997) on which these models are based, and an appraisal of research regarding the efficacy of these models for treating depression.

2.6.2 Psychoanalysis

The practice of psychotherapy has its roots in the 19th century and it is widely acknowledged that Breuer and Freud were the originators of psychoanalysis. Breuer referred to the concept of psychoanalysis as a "talking-cure" (Breuer 1893 p30) but it was Freud who further developed the theories and techniques of psychoanalysis; he approached symptoms differently from the common "objective-biological" categorisations of his day (Dalzell 2011), starting instead with the words and speech of the person (Freud 1890). Freud first discussed patients' symptoms and problems in terms of their subjective associative memories and significant life events (Vanheule 2012). The main postulates that govern psychoanalytical theory suggest that most of mental life, including cognitive thinking and feeling effects, are unconscious (Freud 1890). Freud sought to explore how unconscious drives manifest in symptomatic behaviour and offered sympathy to the therapist, stating that psychotherapy may be one of those "impossible professions in which one can be sure beforehand of achieving unsatisfying results" (Freud 1937 p377). Freud could be alluding to how clients may unconsciously "fear the removal of their symptom" and can become resistant to change. The psychoanalytical approach does not initially aim to remove a symptom, but rather aims to help a client to understand the conflict that causes the symptom (Fink 2004).

Psychoanalysts from various traditions can approach clinical work differently, but most psychoanalytic practitioners utilise concepts such as the unconscious, repression, transference, slips of the tongue, dreams, free association and interpretation to guide their practice (Freud 1905; Winnicott 1958; Kernberg 1984; Stern 1985; Bollas 2013). Lacanian psychoanalysts pay particular attention to a person's idiosyncratic use of language to understand formations of the unconscious (Lacan 1977; Nobus 2000; Richardson 2001; Verhaeghe 2004; Leader 2009; Parker 2011; Ruti 2012). Considering Freud's (1917) theory of "Mourning and Melancholia", a psychoanalyst might be interested in what appears to be lost, and by exploring ambiguous feelings, a psychoanalyst is concerned with phantasy formations around the lost object. Lacan (1978) terms this lost object as producing a "lack" and a psychoanalyst might address what is structured out of consciousness and how symptoms are attempting to heal psychical unconscious conflict (Verhaeghe 1995).

Feltham (2013b p51) proposed that "many have questioned and totally refuted the concept of the unconscious" but psychoanalytic theory proposes that transference occurs at an unconscious level in a psychoanalytic relationship with the analyst. Lacan claims that "transference is the putting into operation of the unconscious" (1978 p267). Transference can present as an unconscious demand for love or a desire to be loved (Freud 1917 p442). Transference is not directly associated to the analyst as such, but rather the subjective position that the analyst represents. The analysand places the analyst as "the possessor of knowledge", the "subject supposed to know" (Lacan 1978 p442). The analyst must represent the missing object and must be in the place of the object *a* and incorporate the object cause of desire for the client. Working through the transference thereafter entails moving beyond the function of the object *a*. Transference can also present as negative transference where hate and hostility is directed toward the psychoanalyst. If the transference love (or hate) is returned, this can be referred to as countertransference. For Sands (2000 p72) "transference allows therapists to distance themselves" from clients and some psychoanalytic therapies have also been criticised for "accentuating" and "fetishising the negative aspects of the past" (House 2010 p46). In short term therapeutic work, transference "may be considered not to arise or to be noted but not worked with, or not to exist" (Feltham 2013b p99).

2.6.3 CBT & Mindfulness

Behavioural therapies developed in a different theoretical trajectory to the psychological theories of Freudian psychoanalysis. In the 1920s, the behaviourists Watson and Skinner suggested that human beings are stimulated by the environment and learn coping strategies to not only survive but to function in society. Behavioural therapy (BT) can support clients in adapting behavioural responses to external demands (Wilson 2002). CBT offers a slightly different interpretation by suggesting that

thinking is a precursor of the emotion that leads to problematic behaviour (Beck 1979; Beck and Weishar 1989; Mooney and Padesky 2000). The treatment involves collaboration between therapist and patient to identify distorted cognitions which are:

> derived from maladaptive beliefs or assumptions. These cognitions and beliefs are subjected to logical analysis and empirical hypothesis-testing which leads individuals to realign their thinking with reality (Clark 1995 p155)

Ghaemi (2003 p213) associates the "cognitive distortion model" with major depression and argued that "fixed false beliefs" and distorted thinking can contribute to "seeing the world too much as is". Cognitive methods could include questioning distortions and educating the participant about depression (Manicavasgar et al. 2011). Following an episode of depression, CBT can reduce relapse significantly but it does not eliminate depression (Layard et al. 2012 p13). Mindfulness-based cognitive therapy (MBCT) is a modified form of CBT that is designed to aid in preventing the relapse of depression, specifically in individuals with Major Depressive Disorder (MDD) (Zindel 2002; Hougaard 2011). Mindfulness and mindfulness meditation focus on becoming aware of incoming thoughts and feelings, accepting them, but not attaching or reacting to them (Bates 2011). Parker (2011) asserted that CBT takes its cue from psychiatric systems and the theory takes for granted descriptions of pathology.

2.6.4 Interpersonal Therapy (IPT)

The two principal empirically-based psychotherapeutic interventions for mood disorders are CBT (NICE, 2008) and interpersonal psychotherapy (IPT) (Roth and Fonagy 2005; Weissman, Markowitz & Kerman 2000). In IPT, the therapist follows DSM criteria and employs several measures such as the Beck Depression Inventory (BDI) to identify and rectify the problem. The success of shorter therapies such as CBT and IPT could arguably be due to their problem-focused, time-limited, researchable, measurable protocols (Mulligan 2012). What often escapes research design is the argument that short term therapy can initiate short term symptomatic change but does not accommodate the complexity involved in understanding depression. Bracken et al. (2012 p430) assert that short-term mechanical treatments rely on psychiatric discourses in their "technological assumptions" that mental health problems arise from "faulty mechanisms, involving abnormal thoughts, feelings, behaviour" and pathophysiology that needs to be corrected. IPT is short and structured, like CBT, but it also combines psychodynamic and humanistic theories (Klearman et al. 1974).

2.6.5 Humanistic Therapy

Humanistic therapy is known as the "third force" in relation to psychoanalysis and the cognitive-behavioural approach, but distinguishes itself through its perspective approach to the individual. It is sometimes referred to as the "human potential" or the "self-awareness movement" (May 1983). The humanistic approach has adopted various concepts from the existentialist movement such as "freedom, choice, courage, authenticity and acceptance of death" (Feltham 2013b p38). Humanistic therapy is not a problem focused therapy such as CBT but a "person focused" therapy that emphasises empathy, compassion and unconditional positive regard toward the client (Rogers 1961). Roger's work tried to show how a supportive therapeutic relationship can be more healing than medical and psychiatric treatment (Bentall 2009 p57). He carried out research on his humanistic method in the psychiatric setting which was the beginning of the term "process research in psychotherapy" (Bentall 2009 p57). More recently the humanistic writer Bentall (2009 p42) asserted that "empathy and warmth are the most powerful tools available to the clinician". O'Donnell (2006 p96) proposed that by offering "concern, preoccupation, interest, empathic care", this is enough to return the transferential love of a client, and the client "will show the one who cares that that is not enough" (O'Donnell 2006 p103). Considering depression through the humanistic lens, May (1981 p143) referred to the "pervasive sense of purposelessness and vague despondency always threatening to become severe depression". Van Deurzen (2005 p40) asserted that with depression a client may "feel depleted of inner strength through having given up the fight for life". The humanistic essence proposes working with a person in the "here and now" with the aim of supporting the client in becoming fully aware his or her present experience and accepting the limits of the human condition. If mild depression is where the depressive realism hypothesis best describes matters, then the therapeutic corollary of the depressive realism hypothesis is existential psychotherapy (Ghaemi 2003 p128). Maslow (1954) developed the concept of self-actualisation, maintaining that if a person was given a suitable environment and his or her appropriate needs were met, a person can self-actualise. Parker (1998 p80) asserted that in humanistic psychology there is "an assumption that deeper meanings need to accessed and touched" and refers to this as a "traditional humanist fantasy of the pure subject as an active reflective independent agent" (Parker 1997 p4).

2.6.6 Body and Sensorimotor Therapy

Body and sensorimotor therapy is a form of psychotherapy that considers the most basic sensorimotor level of a person's experience as the primary entry point for treatment (Rothschild 2000; Panksepp 2010). This therapy aims to resolve limitations in thinking, feeling and behaviour that are caused by traumatic experiences, "psychological issues are sometimes best approached via the body" (Totten

2013 p306). The theory proposes that the body and movement can be resourced to support the client in tolerating "unbearable sensations of trauma" (Rothschild 2000 p5). This somatic awareness re-stimulates the sensory messages between the mind and the body through the brain to locate the physiological imprints of trauma and "areas of tension" (Ogden 2006 p209). Interventions such as manoeuvring body postures and gestures can initiate feelings of empowerment. Papadopoulos and Röhrict (2013) carried out a study with clients with chronic depression and it was effective in assisting clients to identify and connect repressed anger with feelings of sadness which resulted in enhanced levels of self-confidence and improvements of depressed mood.

2.6.7 Integrative or Eclectic Psychotherapy

Integrative and elective psychotherapy is an attempt to combine interventions from more than one theoretical psychotherapy approach (Stricker and Gold 2005). Psychotherapy integration has become intertwined with the evidence-based movement in stressing that various client problems necessitate that the therapist use different solutions (Corsini et al. 2005). Various psychotherapy theories including technical eclecticism, theoretical integration, common factors, and multi-theoretical psychotherapy are considered integrative psychotherapy (Norcross and Goldfried 2005). This flexibility in approaching client work can be sensitive to the clients' ability for change and the therapy is tailored in response to how the client presents. The therapist can assess what model might benefit a client at that particular time in order to bring about change. Recent research suggests that "patients with depression and their doctors should consider psychotherapies and explore which of the different types might be best suited for a particular patient" (Barth et al. 2013).

2.6.8 Systemic and Family Therapy

Family and systemic therapy explores multiple relationships and sees the client as part of a system and "individual pathology" is viewed in the context of a person's social group (Goldenberg and Goldenberg 2004). Systemic therapy comes from a postmodern paradigm that offers multi-perspectives to examine the family and the wider social system in which the client is involved (Anderson 1997; Patterson 1998). This postmodern view suggests that freedom and choice of personal agency are compromised by larger organising structures outside of awareness and out of the clients' control (Drewery and Winslade 1997). A theoretical hypothesis might propose that the client's agency over aspects of his or her life has been lost. A systemic theory suggests that families can unconsciously designate an "identified patient" (IP) or in this case a "depressed" member of the family (Laing 1984 p94; Patterson 1998). Family and systemic therapy is considered a beneficial treatment when individuals live in stressful social systems and have limited access to social support

relationships (Carr and McNulty 2006). Bentall (2009) asserted that distress in human beings is usually caused by unsatisfactory relationships with other human beings. The therapeutic relationship is considered the corner stone of all therapy (Clarkson 2003) and the therapeutic alliance seems remarkably robust across treatment modalities and clinical presentations (Castonguay and Beutler 2006; Nice 2009).

2.6.9 Psy-complex

Psychotherapy models rely on different forms of knowledge to structure the way a person, as therapist or client, participates in the therapeutic enterprise (Parker 1997). Psychotherapy models can be criticised as being part of a "psy-complex" where psychological therapies rely on "repertoires, templates and complexes within which [therapists] and clients fabricate varieties of truth" (Parker 1998 p.77). The ability of "diagnosticians to impose their own stereotypical distinctions on others is made possible by the wider systems of power and politics called the psy-complex" (Parker 1999 p205). Spinelli (1996 p56) asserted that psychotherapists don't know what they are doing, even if they insist on pretending they are experts". House (2010 p85) maintains that clients find it difficult to think about their experiences outside of therapeutic discourses. Additionally, Bracken (2002) holds a suspicion around discourses such as trauma and how it is used to explain causative factors that simplistically medicalise and objectify human experiences. Therapy can become a way of speaking within a "psychiatric discourse" (Speed 2011 p124). Deacon (2013 p855) states that psychotherapy research has "adopted the biomedical model in recent decades". This paradigm, according to Bracken et al. (2012 p430) "is not context dependent" and does not take into account the "postmodern environment". The postmodern turn in psychotherapy and psychoanalysis promotes "different voices and outlooks" (Frie 2003 p2) and posits a necessary critical voice in conducting and evaluating evidence-based research across different psychotherapeutic models (Barth et al. 2013).

2.6.10 Researching Psychotherapy and Depression

Researching psychotherapy models in the treatment of depression can be complex because recovery from "illness" to "wellness" is not always a short linear process and symptom remission is not always transparent. Accounting for variables in a methodological design is one element but a significant factor to consider is the unique subjectivity of a person experiencing depression and his or her engagement in the psychotherapy process. Although the evidence varies between different modalities, CBT and IPT are considered the most effective treatments in research trials for reducing symptoms of depression, having significantly more success than other therapies (Hollon et al. 2002; Craighead et al. 2007). The success of CBT in adults may relate to its ability to help clients disengage their attention from threatening stimuli (Pollack 2001) but ILardi and Craighead (1994) found that clients

feel a sense of hope and show improvement before any techniques are applied. Additionally, Feltham (2013b p119) highlighted that "CBT was more researchable than many other approaches (because more methodical and manualisable)". Although NICE (2009) recommends that therapists should use set frameworks and manuals to guide treatments, House (2010 p256) maintains that "effective practitioners do not practice by following manuals, but learn how to use their intuition" to work with the clients. A manualised approach in some circumstances might not configure what the person needs at that time and might not apprehend the complexity and context of a clients' situation. For some theorists, psychotherapy is as much of an art as a science and some therapists prefer to rely on clinical intuition and experience instead of scientific evidence (Welling 2005; Gaudiano and Miller 2013). Bracken (2012) asserted that modalities and techniques become of secondary importance to the significance of attending to relationships, meanings, values and cultural beliefs.

Budd and Hughes (2009 p510) suggest that psychotherapy mostly works by nonspecific factors. Vanheule (2009) criticised bio-medical research designs such as RCTs and EBM that apparently serve "highest quality" treatment guidelines such as NICE (2009) guidelines. These research practices are based on a paradigm that is antithetical to the psychotherapies, which work with symptoms and the process of change. Instead, Vanheule (2009) asserted that research should start from the complexity of clinical practice and the therapeutic encounter to build on therapists' clinical observations and insights that take into account clients' perspectives. Deacon (2013) maintains that research on the process of change for clients is largely ignored. Research should be based on "real world clinical practice" (Weisz et al. 2012) and needs to take in account the variability of different modalities and their mechanisms (Bateman and Fonagy 2008). Subsequently, Epstein (1995 p6) maintains that "society is reluctant to allocate substantial funds to address its problems" which suggests that economics dictates the current and future praxis of psychotherapy research and treatment for depression.

2.6.11 Summary of 'Treating Depression'

The last two decades have seen the widespread acceptance of depression as a chemical imbalance (Moncrieff 2011). Anti-depressant medication is based on a disease-centred theory of drug action premised on the assumption that depressive disorders are a consequence of neurotransmitter imbalances (Whitaker 2010). There is a considerable amount of side effects of anti-depressant medication, both during treatment and when clients discontinue them. Psychotherapy is a psychological treatment and certain research recommends CBT and IPT as preferable treatments for certain types of depression; certain research designs and psychotherapy practices are based on biomedical epistemologies and, according to some authors, this has contributed to a reduction of the use of psychotherapy in the field (Deacon 2013). The next section reviews the combined treatment of

anti-depressant medication and psychotherapy, looking at some of the benefits and challenges of the dual approach.

2.7 Section 3: Combining Psychotherapy and Anti-depressants

2.7.1 Introduction

Both anti-depressant medication and psychotherapy have been validated as treatments for depression (O'Hara et al. 2000; Roth & Fonagy 2005; NICE 2009). NICE (2009) asserts that a combination of anti-depressant medication and psychotherapy can benefit clients who have more severe symptoms of depression. The next section contrasts the two treatments and examines research on psychotherapy used in combination with anti-depressant medication; there is also a review of literature that critically comments on the complexities of the dual approach. There will also be a discussion on the meaning of medication and the dynamics of professional relationships in the medical field.

2.7.2 Comparative Studies of Psychotherapy and Anti-depressant Medication

Barth et al. 2013 reported that psychotherapy is more effective in the treatment of mild to moderate depression, appearing to have more enduring effects than anti-depressant medication. The success rate for CBT is similar to that of anti-depressant medication, but the effects of CBT are more long-lasting (Layard et al. 2012 p13). Another report stated that relapse rates following anti-depressant treatment are about double those following CBT (Vittengl et al. 2007). Despite this, Marcus and Olfson (2010) assert that two-thirds of all depressed clients are treated pharmacologically, with only about a third receiving psychotherapy. Gaudiano and Miller (2013 p814) claim that "many patients and their family members express clear preferences for psychotherapy over medications", while asserting that there are more positive expectancies toward the effects of psychotherapy compared with medication. Despite this, the "use of psychotherapy is on the decline while the utilisation of pharmacotherapy continues to increase" (Deacon 2013 p855). Deacon (2013) claims that a possible reason for this is the polarizing influence of the biomedical model on psychotherapy research. However, some biomedical research, in particular advances in neuroscience, can provide guidance for the development of psychological conceptualizations of mental illness and treatment that go beyond a reductionist biological aetiology. These advances can be translated into practical clinical applications such as research assertions that psychodynamic therapy can have biological benefits and have a significant impact on serotonin metabolism (Viinamäki et al. 1998). Other research that asserts that CBT can have bio-chemical effects and can influence thyroid hormone levels in sufferers from major depression (Joffe et al. 1996). Cappas et al. (2005 p376) promote brain-based psychotherapy and asserted that therapeutic experiences can positively transform the brain, building memories and forging lasting neural change.

This can support positive attachment and help clients in regulating traumatic emotional states. Anti-depressant medication is also reported to positively increase neural neuro-genesis; Ostow (1962) observed that one of the principal effects of psychopharmacological agents in anti-depressants is on unconscious affect, which led him to argue that affect is a significant determinant of behaviour and of illness. Kandel (1999) asserted that perhaps in these cases, the unconscious is more important than Freud appreciated. Kandel et al. (2005) asserted that there is a growing positive theoretical and practical combination of psychotherapy, neural science and psychopharmacology in treating mental illness.

2.7.3 Dual Treatment for Depression

Depending on a number of factors, a combination of psychotherapy and anti-depressant treatment can be complementary in treating a person with depression (Hollon et al. 2002; Catell 2004; Nice 2009; Roth and Fonagy 2005). There is evidence to suggest that the combination of CBT and anti-depressant medication is useful in major depression, schizophrenia, and anxiety states (Nice 2009; Hollon et al. 2002). The psycho-educational part of CBT can enhance compliance with medication and reduce the frequency of hospitalisation, but Kandel (1999) asserts that psychotherapy in general does not directly affect the course of a disease such as depression. In other studies, IPT has been validated as a therapeutically effective treatment in conjunction with anti-depressants in controlled clinical trials for MD (O'Hara et al. 2000; Etkin et al. 2005). Karp discussed how having a psychotherapist present when someone is prescribed anti-depressant medication can support the client "from desperation to resistance to hope to acceptance to eventually embracing medication" (Karp 2006 p66). Psychotherapy can support clients in decision-making, and Corsini (2005 p488) stated that psycho-pharmaceutical drugs may facilitate psychotherapeutic work by "improving cognitive functioning, enhancing memory, promoting abreaction, or contributing to a sense of confidence and enhanced optimism. At a particular point of a person's illness, medication can be used to recoup a client's strength (Kramer 2005).

Other situations may occur where psychopharmacological drugs such as anti-depressant medication may cause challenges and reduce a client's motivation in therapy, or induce them to prematurely discontinue therapy (Cuttlife and Lakeman 2010). Loose (2002 p215) proposed that some clients do not want or seek therapeutic help because they have a "perfect" solution at hand, a mood altering substance. Gilbert (2013 p461) asserted that "anti-depressant medication does not help people to retrain or understand the origin of their vulnerabilities to depression, or learn new coping skills". Clients can regard prescribed drugs "as a crutch" or an "admission that they have failed to develop the necessary insight to work through their problems" (Corsini 2005 p488). Hammersley and Beeley

(1996) suggested that the resolution of problems cannot be assumed until all the drugs are withdrawn and repressed material has been allowed to come to the surface. Clients need to have access to feelings and to think clearly (Hammersley and Beeley 1996). Karp (2006 p104) spoke about "medication relieving people of responsibility" which might have the effect of undermining a person's ability to manage his or her own mental health. Adding more antidepressants to cure their depression has already been done and has mostly failed (Ghaemi 2003 p126). However, understanding the phenomenological impact of taking the drug opens up another dimension that can be positively utilised in treating a client.

2.7.4 The Meaning of Medication

Anti-depressant medications are objects that assume meaning (Kirsch 2009) and can influence people's thoughts, feelings, and moods. For some, it appears that "psychiatric medications create another layer to the search for self because they influence feelings and moods" (Karp 2006 p97). Attending therapy can allow the client to converse about the meaning he or she attributes to taking medication and how he or she interprets the symbolic message of prescription. Psychotherapy could provide an opportunity to explore side effect symptoms that may emerge from the taking of medication (Murawiec 2009). Karp (2006 p117) proposed that the psychotherapist has an opportunity to distinguish "pill from person". Anti-depressants can sometimes make the symptoms worse (Hammersley 1995) but the psychotherapist, with the client, can collaboratively distinguish between symptoms of illness and symptoms of medication. Murawiec's (2009) study explores clients' interpretations of and responses to emerging side effects, and uses talking about medication as symbolic leverage to explore the nature of a person's illness. Increasing the clients' motivation and self-esteem are important (Hammersley 1995 p43). Verhaeghe (2008 p309) suggests that a psychoanalytic aim would be to encourage "subject amplification" and to explore possible childhood diseases and parental reaction to them which might bring to light family and cultural attitudes to medication and unconscious investments of taking medication. Clients can have distorted ideas of drugs and challenging the clients' beliefs about drugs can be part of the role of the psychotherapist (Hammersley 1995 p43).

2.7.5 Professional Relationships

Few studies have examined the client–therapist relationship in the context of prescribed anti-depressant medication. Some published studies that have examined the relationship (Krupnick et al. 1994; Weiss et al. 1997; Zuroff and Blatt, 2006) and all found an association between therapeutic alliance and positive outcome with clients who were taking anti-depressant medication. Karp did not

prioritise the therapist's training, but emphasised "the patient's belief in the therapist" (Karp 2006 p141). He similarly claimed that the effectiveness of medication is intimately linked to "[the] patient's faith and trust in those who prescribe them" (Karp 2006 p57). He proposed that "empathy and intimacy" are core to the professional relationship with clients (Karp 2006 p61). There was no literature found on the subject of psychotherapists' responses to engaging with clients who are on anti-depressant medication.

Bracken et al. (2012 p431) asserted "that improvement in depression comes mainly from non-technical aspects of interventions", that working with medication is more about context and that healing occurs through relationships and values (Bracken 2012 p430). Moerman (2002) suggests that "hope" and "meaning" are very significant factors in the course of a client's self-healing and anti-depressant medication can offer a sense of hope (Moerman, 2002). House (2010) asserted that the very presence of a person can work to "action the patient's own powers of healing". Trans-modern epistemologies are currently challenging the medical model and current psychotherapies by focusing on "human potential" (Mowbray 1995; House 2010), and Brown (2007, 2013) focuses on the science of psychoneuroimmunology by pointing to self-esteem and the "internal locus of control" of the person.

2.7.6 Summary of "Combining Psychotherapy and Anti-depressants"

Although they have distinct methods of therapeutic function and are based on different epistemologies, both psychotherapy and anti-depressants have been validated as effective treatments for various types and severities of depression. A dual approach is also recommended for more severe depressions and for certain aspects of the work such as supporting clients' compliance with medication. Psychotherapy is considered not only a way of working with clients and their symptoms, but also of working with the effects of anti-depressants, at times exploring the meaning of medication. Considering both pharmacological and psychotherapeutic insights in a practical clinical approach can further inform and enrich the treatment. The literature search and review did not uncover literature specifically accounting for psychotherapists' experience of working with the complexities of clients engaged in a dual treatment of psychotherapy in combination with anti-depressant medication prescription.

3. CHAPTER 3 – Methodology

3.1 Introduction

The aim of this research was to explore how psychotherapists account for and approach their work with clients who are taking prescribed anti-depressant medication. This qualitative study entailed carrying out semi-structured interviews. This chapter outlines the methodological design of Discourse Analysis (DA) and illustrates how Lacanian Discourse Analysis (LDA) was used to analyse transcripts from the interviews but also attempts to justify LDA as an appropriate approach to achieving the aim of this research. DA and LDA are both concerned with language and the discourses operative in a person's use of language. LDA puts a particular set of psychoanalytic concepts to open up a text to explore possible extra intentional meanings communicated. LDA is transformative (Parker 2013). LDA allows for a connection with the subversive radical tradition in critical psychology that wants to change the world rather than simply interpret it (Parker and Pavón-Cuéllar 2013). Descriptions of the LDA approach are outlined mainly in the work of Parker (2010; 2005), Pavón-Cuéllar (2012) and Parker and Pavón-Cuéllar (2013). This chapter also describes in detail the procedures that were used to access participants, the method of gathering and analysing the data, and it reflects upon ethical considerations that emerged through the research process and how these were addressed.

3.2 Design: Discourse Analysis (DA)

This study explored how psychotherapists talk about how they approach their work with clients who are taking prescribed anti-depressant medication, an overall aim being to enquire what, if any, strategies psychotherapists employ to address any perceived impact the anti-depressant medication may have on the client and the psychotherapeutic process. The question of what methodology would facilitate the aim of this research and support the enquiry into clinical observations by psychotherapists was considered. The critical work of Foucault called into question any social practice that claimed it was improving the welfare of the individual (Dreyfus and Rainbow 1982). Foucault (1975) criticised psychoanalysis and the psychoanalytic institution by claiming it was a "regime of truth" and believed subjects were manipulated into "confessional practices" to exercise their own surveillance (Foucault 1975 p155). Foucault (1997) also examined the human sciences and questioned whether the natural "scientific" worlds were indeed knowable, accessible and analysable without recourse to the constitutive forces of discourse. For him, there was a very special relationship between discourse and power (Verhaeghe 1995). In considering these critiques, discourse analysis (DA) appeared to be an appropriate choice of methodology, providing a range of conceptual and

methodological resources for thinking critically about theory and practice of psychotherapy (Parker 2013).

Foucault (1970) originally coined the concept "discourse" in 1970 but the roots of DA started in the 1950s when there was a move away from the theories of cognitive psychology, initiating less focus on individuals, their intentions and cognitions, and moving toward a more structural aspect regarding how language shapes individuals and society (Willig 2008). A discourse means anything written or communicated using signs, but a discourse is not just a simple, transparent medium which enables the communication of thoughts from one person's head to another (Potter and Weatherell 1987). DA reveals the way texts are constructed out of available symbolic resources, or what Parker referred to as "existing bits of language and sets of statements about the world, behaviour and internal mental states" (Parker 1992 p3). These "sets of statements" are discourses, and in the process of using discourses, people find themselves caught up in meanings, connotations and feelings they cannot control (Parker 1992). Parker (1992 p4) asserted that:

> Discourses do not simply describe the social world, but categorise it, they bring phenomena into sight. A strong form of the argument would be that discourses allow us to see things that are not 'really' there, and that once an object has been elaborated in a discourse it is difficult not to refer to it as if it were real.

DA studies have reflected upon the way that psychology constitutes certain kinds of objects ranging from cognitive mechanisms to personality types (Potter and Wetherell 1987; Edwards 1992). Another example of this is the social practice of psychiatry and the reliance on DSM to diagnose diseases, identify "abnormal" personalities and medically treat mental illness. DA can critically examine underlying meaning, knowledge and power that contributes to systems of discourse and, more significantly, how they are deployed (Taylor et al. 2001). Psychiatry justifies and deploys its practice through medical, pharmaceutical and political discourse (Moncrieff 2010).

To prepare the conditions for critical innovative research, the principles of "history", "theory" and "subjectivity" were considered. Regarding history, in place of a fixed method abstracted from context, this research was concerned with the phenomena "as historically constituted" (Parker 2013 p223). This means that this methodology was "orientated to noticing how the phenomenon has come into being and how it changes" (Parker 2013 p223). This supported me in becoming aware of how and where discourses emerged and how they changed. A second principle to adhere to is that research "must bring theory to bear on the way it is conceptualised" (Parker 2013 p224). This means that competing theories guided me, and I developed a theory that was "useful for our purposes in research" (Parker 2013 p223). This reflects the idea that a researcher must invent the methodology anew (Banister et al. 2011). The third principle was to "embed some kind of account of subjectivity into the

research process" (Parker 2013 p224), whether it be the subjectivity of those inhabiting the discourse we describe or the subjectivity of the researcher in the form of reflexivity. I would like to discuss the concept of subjectivity in more detail. Similar to Foucault, Lacan supports us to recognise the need to study different discourse functions. Lacan differs to Foucault in that he believes it is an oversimplification to say that subject is plotted by social discourse. For Lacan, the subject is not simply a linguistic construct. He dissolves the subject where the subject is deprived of its status as master of meaning (Alcorn 1994).

3.2.1 DA and Subjectivity

DA was given particular impetus and a critical twist by the arrival of structuralist and post-structuralist ideas from France (Parker 1992). Certain movements such as linguistics and structuralism influenced both Foucault and Lacan's theories, but both Foucault and Lacan were also active agents in pushing the boundaries of certain structuralist theories. Their unique approaches embody significant differences creating a challenge for incorporating them in a single research study. Structuralism is the study of human language, culture and society as structures and it is interested in the role of language in the construction of social reality. Post-structuralism conceptualises the self as unfixed, variable, contradictory and constantly negotiated. Structuralist and post-structuralist theories have dismissed individual experience of the self as if subjectivity "was only an effect of language or work of fiction" (Parker 1997 p3). This is what Parker (1997) termed "blank subjectivity". The post-structuralist subject is conceived as an effect of discourse. Lacan disputes certain kinds of boundaries put upon a subject and criticises certain modes of structuralism by saying that the "subject is no one's" and the subject is not an "entity". Post-structural theories posit the subject as a passive entity; Lacan's subject is more active and resistant. The rejection of any attention to internal space or agency is contradicted by what Parker (1997) calls the mirror image of blank subjectivity, "uncomplicated subjectivity", which, as Parker (1997) claims, is uncomfortably close to "traditional humanist fantasy of the pure subject as an active reflective independent agent" (Parker 1997 p4). By introducing certain strands from psychoanalysis, there is a consideration of "complex subjectivity" that assumes the existence of "individual intentions and desires as formed through and mediated by social and cultural forms" (Georgaca 2005 p75). Psychoanalysis can be useful for the discourse analyst by positing that people can be moved by language but can also be active agents in moving language (Parker 1997). Parker (1997 p2) asserted that psychoanalysis is a great source of "theoretical and methodological ideas…the conceptual system can be opened up to further enrich discourse analysis".

3.2.2 The Subject of Psychoanalysis

Freud's psychoanalytical work undermined the idea of the "thinking-subject", and he emphasised the existence of unconscious processes that affect people's knowledge, thoughts, desires and behaviour. Freud (1923 p235) claimed that

> psychoanalysis is the name (1) of a procedure of investigation of mental processes; (2) a method (based upon investigation) for the treatment of neurotic disorders; and (3) of a collection of psychological information attained along those lines, which is gradually being accumulated into a new scientific discipline.

There have been significant developments in psychoanalysis since Freud's "new scientific discipline" and discourse analysts have criticised certain psychoanalytic theories for claiming to explain "underlying motives and causes for behaviour" (Parker 1997). Despite this criticism of psychoanalytic causality, discourse does need some account of how it is that a writer and a reader, a speaker and a listener, an agent and a receiver, are moved by language (Parker 1997). Some forms of discourse analysis have attempted to use psychoanalysis in this way (Hollway 1989; Frosh and Baraitser 2008; Parker 2010; 2005; 1992). Psychoanalytic interpretive strategies can throw light on the psychological processes, or perhaps the conscious and unconscious ''reasons'' behind a specific individual's investment in any rhetorical or discursive position (Frosh & Baraitser 2008 p350). According to Laplanche and Pontalis (2004 p367)

> psychoanalysis is a method of investigation which consists of essentially bringing out unconscious meaning in words, the actions and the products of the imagination (dreams, phantasies, delusions) of a particular subject.

Frosh (2007) maintains we need to locate psychoanalysis in language if it is to be a helpful addition to discourse theory. When "discourse theory has turned to psychoanalysis, it is commonly to Lacanian theory, with good reason" (Frosh et al. 2008 p40). Lacanian analysis is already quite compatible with studies of rhetoric, social construction and discourse (Billig 1999).

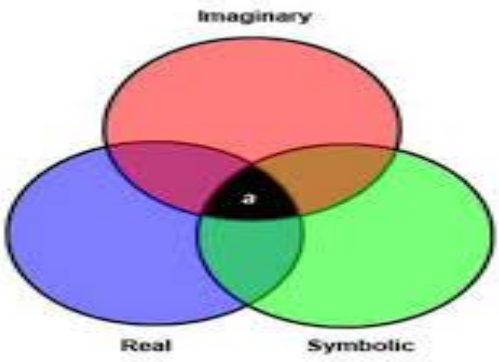
3.2.3 The Lacanian Subject

Lacan (1977) reinterpreted Freud in the claim that as humans we use metaphors, symbols, language, gestures to represent our unconscious desire. He said that communication of this desire through language is always a failure and that it has to be a failure, and that's the reason why we keep on talking and trying to achieve successful communication (Verhaeghe 1995). Lacan (1971) asserted that we use 'signifiers' as representations of what we mean to express, the 'signified' is what is interpreted. A "signifier is not a symbol, but a symbol that belongs to the symbolic system of language" (Pavón-Cuéllar 2013 p22). Lacan asserted that our unconscious is "structured like a

language" (Laplanche and Pontalis 1988 p293) and this proposition has implications for the way subjectivity should be understood in Lacan's work. For Lacan, when a person speaks, something is always repressed. A person "cannot tell the whole truth" (Pavon-Cuellar 2012 p332) and they become a split subject, "the subject is the subject of the unconscious" (Evans 1996 p195). The language that we use incompletely and imperfectly represents this unconscious.

Lacan's theory claims that "subjects don't simply take in knowledge, they reproduce it" (Alcorn, 1994 p41). Lacan recognised that "conflict" in discourses can contribute to the production of "original discourse" (Alcorn 1994 p41). By producing discourse in response to discourse conflict, Lacan's subject can through a restricted sense constitute itself, thus structuring subjectivity. Central to Lacan's (1975) theoretical propositions are the concepts of the 'imaginary', the 'symbolic' and the 'real' (Appendix 1). In Parker's (2005; 2010; 2011) and Pavón-Cuéllar's (2010) application of discourse analysis they negotiate the complex relationship between the subject and language through these different "registers". For Lacan these three registers structure human experience, moreover, the interplay of these three registers constitute subjectivity. Lacan used the metaphor of "the borromean knot" (Lacan 1977) to display interlocking symbols of rings where the imaginary, the symbolic and the real represent the interplay of psychical registers. See Figure 2.

Figure 2: The borromean knot



In brief, the 'imaginary' is the content, it is what is spoken, the thing that is described; the 'symbolic' is the words and linguistic construction used to describe the thing, and the 'real' is what cannot be spoken, it is unconscious, beyond description, it is the thing to be described. Figure 2 illustrates how each of the 'imaginary', 'symbolic' and 'real' are connected and interplay with each other in language. Lacan's theories are much more than a method of clinical psychoanalysis but a radical revolution in understanding subjectivity (Parker 2011) and Lacan wanted to assure the discipline of psychoanalysis "its place among the sciences, a problem of formalization" (Lacan 1977). Lacan's

theories have been adapted by contemporary theorists to analyse meaning outside of the clinic and in particular in analysing discourses (Parker and Pavón-Cuéllar 2013; Moore 2012; Pavón-Cuéllar 2012; Parker 2005; 2010). Lacan cautions psychoanalytic researchers about the utility and application of psychoanalysis and how researchers need to remain true to the psychoanalysis' objective and to articulate truth, the truth of the subject, and the theory of a specific situation (Moore 2012). This then requires the researcher to distinguish between theory for psychoanalytical practice and theory for psychoanalytical research.

3.2.4 Lacanian Psychoanalysis Outside of the Clinic

Psychotherapy privileges the symbolic aspect of communication and verbal exchange of words in its praxis. Similarly this research was interested in how language was used by psychotherapists to construct "versions of social reality" and account for how they achieve their "social objectives" (Willig 2008 p161). From the conceptual resources in the selection of discourse analysis methods, Lacan's psychoanalytical theoretical frame of analysis was chosen because of its capability to achieve the aims of the research and explore the multifarious dimensions of psychotherapy work with clients who are taking anti-depressant medication. Although Lacan only applied his theory to working analytically with clients, his theories are applicable through the LDA method and relevant as my research topic is concerned with psychotherapists and psychoanalysts' clinical work and how this work is communicated. Moreover, Lacan was interested in conceptualising how "psychotherapy differs from psychoanalysis" (Parker 2005 p15) and this is appropriate as I will be interviewing a combination of psychotherapists and psychoanalysts in this research. LDA differed from Foucaudian analysis as Foucault was a philosopher who wrote and lectured whereas Lacan was a clinician and researcher interested in the "subjects position in discourse and those problems attending to the analysts attempts to use discourse to reposition subjects" (Alcorn 1994 p28). Previous researchers have all demonstrated and conducted psychoanalytic investigations outside the perceived traditional setting (Frosh 2013; Young 2013; Moore 2012; Parker 2010; Frosh 2007). Despite this, Hook (2008) has pointed out the difficulties inherent in the attempt to replicate clinical psychoanalysis in non-clinical environments. This included Lacan's injunctions against the lures of "mastery, individuality and truth" which stem from treating psychoanalysis as an idealized form of knowledge. Frosh and Baraitser (2008) called upon critical reflexivity as a key tool in research to destabilise any hegemonic formations. Parker recommends that we need to take care to see psychoanalysis itself, including Lacanian psychoanalysis as a historically-constituted system of theory and practice, rather than a universal truth about the human subject (Parker 2011). Lacan, like Freud, was wary of rigid definitions (Moore 2012). This requires the researcher to be aware of how LDA puts a particular set of psychoanalytic concepts to work in our critical reading of a text where the concepts are used as

tools to open up a text in such a way as to draw attention to connections and to "analyse the text rather than colonize it with psychoanalytical theory" (Parker 2010 p169).

3. 3 Lacanian Discourse Analysis (LDA)

3.3.1 Introduction

Discourse, according to Lacan is the necessary structure which should be taken as something that goes far beyond more or less occasional speech (Lacan 1991). Discourse is the very basis for the interpretation of speech (Loose 2002 p241). Lacan's theories of discourses are careful analytic descriptions of possible orientations of the subject (Alcorn 1994 p43). Foucault worked with the content of a discourse but Lacan adds another dimension and looks at how the formal relationships between four discourses and how these relationships produce particular social bonds (Verhaeghe 1995 p4). Lacan offers theories of four discourses which are the "discourse of the master", "discourse of the university", "analytic discourse" and the "hysterics discourse" (Lacan 1991; Bracher 1994; Verhaeghe 2001; Verhaeghe 2004). This research methodology is guided by Parker's (2005; 2010; 2013) provision of seven elements of Lacan's theories to support the framing of analysis.

3.3.2 Seven Coordinates of LDA

A Lacanian approach to discourse "has consequences for the way we think of 'criteria' for research" (Parker 2005 p175). LDA is a suggestive format rather than a prescriptive set of procedures (Parker 2005). Parker's (2005; 2010) seven elements do not represent a fully formed step-by-step method of analysing discourse for texts. In common with much discourse analysis, the notion that there should be a fixed method or "grid for reading text is anathema to Lacanian psychoanalysis" (Parker 2005 p167). Lacanian concepts will be modified in certain ways when it is brought to bear on transcript material (Parker 2005 p166). Not all of the concepts need to be applied all of the time but concepts can be used on what has become structurally available in the text. The role of LDA is to disrupt to the text, to "disintegrate" narratives (Frosh 2007). Parker recommends not adding one's own interpretation but promotes a moment by moment reconstruction of consciousness and to explore how the participants are using language and how the language is using them in their descriptions of what they say they are doing. Parker's (2005; 2010) seven coordinates to analysing text will be outlined and following that there will be a discussion around each of them. See Table 2.

Table 2: Seven Coordinates of LDA

1) formal qualities of text

(i) language is a system of differences without positive terms

(ii) a signifier that represents a subject for another signifier

(iii) non-sensical signifiers

2) anchoring of representation

(iv) quilting points

(v) positions of mastery

(vi) retroactive determination of meaning

3) agency and determination

(vii) difference between imaginary and symbolic

(viii) the discourse of the Other

(ix) object petit *a*

4) the role of knowledge

(x) a relation to knowledge

(xi) clinical structures

(xii) discourse of the hysteric

5) positions in language

(xiii) no metalanguage can be spoken

(xiv) a subject of statement and a subject of enunciation

(xv) the message in reverse

6) deadlocks of perspective

(xvi) no agreement

(xvii) sexual difference

(xviii) the eruption of the real

7) interpretation of textual material

(xix) discourse of the master

(xx) the discourse of the university

(xxi) the discourse of the analyst

3.3.3 Formal Quality of the Text

In considering 1), the "formal quality of the text", Parker asserts that (i) "language is a system of differences without positive terms" (Parker 2005). This task of analysis here is to search for patterns and connections between signifiers in the formal use of language. A signifier is a sign which refers to other signs but there is relationships of mutual opposition in the way signifiers work in the language system. This analysis will look at "connections that differentiate from each other and holds them in tension rather than divining connections that reveal an underlying order" (Parker 2005 p168). The participants' speech is materialized through the connection, but also in its "separation, distinction and contradiction" (Pavón-Cuéllar 2010 p154). In (ii), analysing a "signifier that represents a subject for another signifier" (Lacan 1979 p198), the analysts' job is to explore how the signifier is put to work. For example, if there is a repetition of signifiers, or certain signifiers are used in particular places and replace each other, this could indicate that signifiers are keeping something out of the signifying chain or something that is repressed (Parker 2010). Signifiers get their value by their structural relation to other terms, not by a connection to a signified meaning or to a referent outside language (Parker 2010 p160). It is not the job of the Lacanian discourse analyst to imagine what is been kept out but to comment only how something could be kept out. Regarding (iii), the non-sensical signifiers (Parker 2005), signifier's can be reduced to non-meaning and become non-sensical. If something is non-sensical, there could be meaning in the nonsense and the analyst is interested in the "symbolic value of non-sense" (Pavón-Cuéllar 2010 p25). It is the task of the research analyst to search out the signifying elements that do not make sense and specifying the role these nonsensical elements have in organizing and disrupting the flow of a text. It is the aim to see beyond the signification "to what irreducible, traumatic, non-meaning, he is as a subject, is subjected to" (Lacan 1978 p251). If something is non-sensical, the real subject appears in the gap of knowledge and this is a sign of "discursive deficiencies" (Pavón-Cuéllar 2012 p99).

3.3.4 Anchoring of Representation

In (iv), by observing "quilting points", this is where there is a cluster of signifiers where a discourse is organized (Lacan 2006). Quilting points are what analysts of the text construct from its different manifestations (Parker 2010 p162). In observing how signifiers are used in speech, these could be signs of "anchoring points" or Lacan named them as "points de caption" (Lacan 1977). Understood in this sense, "points de capiton" are where the "signified and signifier are knotted together" (Lacan 1977 p268) but there is a slippage of meaning beneath them. Foucault (1975) claimed that discourse is "usually codified" and narrowed in order to function as a "point of reference and point of rallying" (Foucault 1975 p1604). The points of reference are anchored in particular representations of

knowledge. Parker (1998 p77) asserted that psychotherapeutic domains contain "repertoires, templates and complexes" that "fabricate varieties of truth and story core experiences into being". For (v), "positions of mastery" indicate what signifiers are in the dominant position over the rest. Other signifiers can be in more dependent positions that circulate around the master signifier (Parker 2010 p162). The master signifiers operate as anchoring points in the different discourses. There is usually a battle to occupy the position of this master signifier (Pavón-Cuéllar 2012).

In (vi), this considers "retroactive determination of meaning" in a text. This is where there is a "retroactive determination of meaning at work when we have the topic of the dialogue reworked and transformed" (Parker 2010 p163). This can be significant to observe how themes throughout the text are selected and represented to make points and how they can have a retroactive effect of the whole text. For example, something said at the beginning of an interview by a participant can shift in meaning by something that is said at a later time in the interview, causing a re-configuration of meaning that "retroactively gives rise to sense" (Parker 2010 p355). There is a temporal logic at play in the text and analysis of the discourse will search out anchoring points that serve as the conclusion. But they may not appear in a linear format and the narrative sense can be made post hoc (Frosh & Barasiters 2008 p354).

3.3.5 Agency and Determination

A way of negotiating the complex relationship between the subject and language is to notice the difference between what Lacan (1975) calls different 'registers' (Parker 2010 p163) In (vii), the difference between imaginary and symbolic states that the imaginary is the thing which is described (Pavón-Cuéllar 2010 p5) and the symbolic are the words used to describe "imaginary reality" (Pavón-Cuéllar 2010 p25), the subject can be caught in between their own ego identifications and the symbolic language they are using. This can relate to how similarity and opposition are constituted and reproduced. The imaginary aspects of interaction would pick up on textual operations that "hold antagonistic positions in relation to each other" (Parker 2010 p171). There can also be an implication between full speech and empty speech (Parker 2010). Where full speech is a demonstration of the truth by producing metaphors, empty speech is full of the imaginary object of the perceived ego (Pavón-Cuéllar 2010).

In (viii), the unconscious is treated as Lacan argued it should be, as "discourse of the Other" (Parker 2005), "with the Other here being the symbolic system that holds culture in place and determines the location of each individual subject" (Parker 1997 p8). This notion of the unconscious also extends to the most important principles, that of "insistent variation, inconsistency of sense in language" (Parker 2010 p162). It allows and accounts for the contradictory ways in which these mesh with structures of

power that are relayed through text. The speech we produce is always thus shadowed by an Other sensibility (Fink 2005). In other words, speaking is never merely a function of ego discourse; it remains always the enunciative possibility for an Other tongue, for the Lacanian unconscious which precisely is the processes of signification beyond the control of the speaking subject. What Verhaeghe (2001 p22) referred to as "I don't know what I am going to say" but when a person speaks they have to continue to try make sense out of what was said. In (ix), this concerns the *object petit a*. Object petit *a* is something indefinable. According to Lacan, this is what people are both searching for in communication and it is driving the exchange between them (Lacan 1978 p257). It is that what keeps the desire to speak going, it is that what cannot be articulated, what cannot be grasped. In communication, it is the surplus product or left over that is unattainable. The user of language is the worker and he or she are been put to work by language and they are separated from the product of their work, the meaning, the signified.

3.3.6 The Role of Knowledge

When a person is faced with the field of language, this has consequences for the knowledge and how a person is able to appropriate when he or she speaks. In (x), by analysing the "relation to knowledge" is to trace the points in a text where knowledge is presumed (Parker 2005 p172). This supposition of knowledge in a text will indicate where authority and power are supposed to or presumed to lie and it is asked "what does the Other want of me" (Parker 2010 p164). In (xi), Lacan outlines four "clinical structures" to steer the analysis and to presuppose the kind of 'Other' that is addressed by them. There is the 'obsessional', 'hysteric', 'psychotic' and 'perverse'. In (xii), the discourse of the hysteric (Parker 2005), the hysteric always questions, accuses the other and dramatizes their conflicts. They are the barred subject and "a doubtful enunciating subject who splits" (Lacan 1965 p199). (For a more in-depth review of the discourse of the hysteric: See Appendix 2)

3.3.7 Positions in Language

Discourse analysis regards "meanings" as not fixed but plural and constantly shifting. Discourses do not define positions but it is the activity of speaking that defines. This concerns the positions taken up by the subject but also how the subject is positioned by discourse. There is no escaping that a position must be taken. In (xiii) is what Parker (2005) refers to as "no meta-language can be spoken". The activity of speaking sometimes pretends to escape such positioning but is always included as a position. The subject assumes a position but when they speak, the participant is divided between signifiers; hence, their positions in language are divided between (xiv) "a subject of statement and a subject of enunciation" (Parker 2005 p165). The activity of speaking produces a division in the

subject, a separation between, on one hand, the things they say and how they say it. Within that, the discourse analyst is looking for material that could be "extra-intentional" (Hook, 2008, 5). In LDA, "we must be able to detect clues of assumed opposition between the structural position of the subject and the ideological articulation of the structure for his position" (Pavón-Cuéllar 2012 p257). Activity of speaking opens up the dimension of truth (Parker 2010 p166). In analyzing how the participant, who is the enunciator of speech, enunciates and also how they attempt to make sense of what was enunciated. First we have the telling of the word, the enunciated act and then we have the enunciating of the enunciated fact (Pavón-Cuéllar 2012 p95) and then we are analysing the "enunciating structure" that linguistically shapes what was told. When speaking, a position is always positioned in relation to the text and what is said might mean the opposite, (xv) "the message in reverse". The way a response may send the message back to the speaker as if in reverse, thereby revealing some truth that was concealed in the original message such as "communication in which the sender receives his own message back from the receiver in an inverted form" (Lacan 1977 p85).

3.3.8 Deadlocks of Perspective

Lacanian research does not directly aim at understanding subjective meaning or for an agreement between perspectives. That would be "on the line of imaginary", the illusion of agreement between the two signals (Parker 2005 p163). LDA seeks out the "deadlocks in perspectives" (Parker 2005 p175). For "no agreement" (xvi), Parker (2005 p176) discusses where something that operates at a point of breakdown of representation, at the point of trauma or shock. It is not to seek out weakness in text but strength as it draws attention to deadlocks that structure the text. It may be a failure of agreement that may be more rich material for the data analysis in the dialogue between the agent and the receiver. Another way to understand the different perspectives is to look at it through the optic of sexual difference (Parker 2005). In (xvii), the Lacanian idea supports the analyst in avoiding the reductionist designation of gender to real underlying biological "sexual differences" and highlights how categories such as man and woman are organized in relation to each other as signifiers. This binary opposition is ideological and Parker (2010 p167) asserts that "binary oppositions organise other axes of power and subjection such as race and class". In (xviii), it is related to the deadlock of perspective is the "eruption of the real" (Parker 2005). The real is where there is an "unsymbolisable" existence somewhere in the material world. The "real" is beyond description, it is the thing to be described (Pavón-Cuéllar 2010 p5). Eruptions of the real may become present where the participant meets with the reality that there is not enough words to describe the thing to be described, the real becomes present in gaps, silences and when the language breaks down. The real subject cannot be present in that which is articulated, and they only appear in the gaps of his or her discourse (Pavón-Cuéllar 2012 p99).

3.3.9 Interpretation of Textual Material

Lacanian discourse analysis does not attempt approach a text in hermeneutic mode as something we can understand, this understanding is from our own structural system and not from the participants framework (Parker 2005). In LDA we are not expected to make interpretations and not "to add an interpretative cognitive construction to the interpretative construction" (Pavón-Cuéllar 2012 p305). But we may interpret the discursive construction built of the analysed literal words that are used. We may piece together the building materials of the literal signifiers, re-situating these words in their structural positions (Pavón-Cuéllar 2012 p305). Lacan was critical of the classical psychoanalytic method offering a reductive interpretation of meaning. He was also critical of phenomenological approaches to human subjectivity as he claimed that they "focus too strongly on imaginary phenomena" (Vanheule and Geldof 2012 p115). Lacan was also outspokenly challenging of Ricoeur's idea of an interpretative "leap of faith" (Pavón-Cuéllar 2012). There are lessons to be drawn here against the forcing of interpretation in discourse analysis (Parker 2005). The task of a discourse analyst is to work on "the line of the symbolic". The interpretations are themselves structured into patterns and positions in discourse (Parker 2005; 2010). In (xix), the "discourse of the master", the agent speaks from the position of the master signifier (Parker 2005), but a master who is in truth a barred "split" subject that does not fully grasp what they pretend to grasp (For a more in-depth review on the master discourse; See Appendix 2) In (xx), the "discourse of the university" places psychological knowledge as the agent, this agent, speaking from within knowledge as if there were fixed grounding points of truth as master signifiers. Foucault (1977) discussed this as "where the mind becomes the target of professional knowledge". The university discourse is guaranteed by the apparent objectivity of science, it is infallible and cannot be questioned once the master, who knows is supporting the university discourse. In (xxi), the "discourse of the analyst" (Parker, 2005) is positioned as objet petit *a*. The objet petit *a* is the necessary condition for every symbolic system (Loose 2002 p232). The objet petit *a* is what the agent and receiver are looking for in communication, it is the object cause of desire, but it is the unattainable object and this propels people to continue speaking. This position is underpinned by knowledge. Although this concept was instigated by Lacan around the positioning of the analyst in the clinical encounter with clients but in LDA, the research analyst is in a different position can take up the idea of explaining, or to unfold what was spoken (Pavón-Cuéllar 2012 p308). The discourse analyst not only deciphers the code in a text but engages in a process of "reciphering" (Badoui and Foucault 1965 p470) (for a more in-depth review on the discourses, See Appendix 2).

3. 4 Researcher Positioning and Reflexivity

This LDA enquiry is deemed reliable and scientific by virtue of being methodical, systematic and critical. Findings were written in a consistent and coherent format and with continual reflexivity to achieve a more rigorous account of the phenomena emerging from the data while clearly sourcing interpretations which will illuminate a transparency in the practice of discourse analysis. Findings are considered reliable 'if a reader… can also see what the researcher saw, whether or not he agrees with it (Giorgi 1975 p93). Rigor is

> associated with openness, scrupulous adherence to a philosophical perspective, thoroughness in collecting data, and consideration of all the data in the subjective theory development phase (Burns and Grove 2001 p64).

Discourse analysis research is still part of the psy-complex implicated in a practice of representation and it leads us to privilege our accounts that are developed over others who speak outside the discipline (Parker 1992). The researcher is seen as thoroughly embedded in discourse, constituted by discourse which then gives meaning to the speech of an interviewee. This researcher's interest and involvement was considered throughout the process, counter transference in the broadest sense of the term (Parker 1997). Because of this, there was close observation to reflexivity, the subjectivity of the researcher and the subjective process which confluences the subjective perceptions of the researcher on the data. Moreover, the conscious or unconscious impact that this subjectivity had on the gathering and the presentation of the data. The reflexivity argument has a number of implications in relation to the employment of psychoanalysis (Frosh and Baraitser 2008 p360). Subjectivity is not treated as the idiosyncratic perspective of an individual disconnected from the shared objective reality. Subjectivity in this research is employed as a resource for the reading, a resource that drives us to as close as we could be to an objective account (Parker 1994). For Frosh and Baraitser (2008 p359) "reflexivity points to a potentially subversive procedure in which the conditions of emergence of knowledge are analysed as well as the apparent objects of knowledge themselves", they encourage a consideration of the subject as a source of meaning-making agency, using the props of the research situation to actively reconstruct her/his consciousness in the flow of social experiences.

In the Lacanian tradition, the analyst is not the expert but understood as the subject supposed to know (Lacan 1977). All knowledge becomes temporally and interpersonally positioned, it makes it contingent, strategic and provisional, it is arbitrarily suspends on a fixed point, a full stop or perhaps linked with Lacan's (1956) idea of ''points de caption'' or a quilting point (Parker 2005). It was my task as a researcher to comparatively reflect upon how positions interplayed between me as a researcher and of the researched participant and through the language re-created, there was a conjointly reproduced knowledge. This kind of reflexivity required me to keep an honest gaze on

what I bring to the research process. It was important for me to not only acknowledge my position as a researcher in the conjointly reproduced knowledge in the presentation and interpretation of the findings but also be transparent around some critical views I hold towards medication in treating milder symptoms of depression. This was addressed through transcription procedures that allowed close scrutiny of the researcher's words (in interview transcription), through diaries recording, everything that strikes the researcher and even supervision meetings (See Appendix 6 for an example of reflective analysis on one interview transcript). It is also reflected on in chapter six.

3.5 Research Beginnings and Ethical Considerations

When the research topic was chosen, the methodology was designed and when the participant sample was considered, I applied for ethical approval from the Research Ethical Committee (REC) at Dublin City University (DCU). Ethics committees play a crucial part in ensuring that no poorly designed or potentially harmful research is permitted. They have an important "gatekeeping role in all research involving research subjects" (Darlington and Scott 2002 p22-23). I sought ethical approval in anticipation of interviewing a sample of psychotherapists who were experienced in working with individuals who are prescribed anti-depression medication. In this request, I explained that the interview process involves asking the participants about their work as psychotherapists with clients who are taking anti-depressant medication, a topic of general interest in the psychotherapy field. I was approved for ethical approval on the 13/04/2012 (Appendix 5). Although ethical permission was sought and gained with the Research Ethical Committee (REC), there were ethical considerations along the way. Ramcahran and Cutcliffe (2001) asserted how every action and decision in research involves an ethical dimension. Research principles such as justice, autonomy and integrity were upheld throughout the research process (Kenny 2012) and I reflected upon these in the next section (3.5.1).

3.5.1 Participant Recruitment

The reasons for recruiting research participants who were working in private practice was that it was thought that they could answer my research question. I did not invite psychotherapists who were working for a statutory organization such as the Health Service Executive (HSE). This decision was taken to avoid recruiting and interviewing anyone whose autonomy in their work could be compromised by organizational ethics or policy. Psychotherapists in the HSE are most likely working on medical teams and engaged in set practices with GPs and psychiatrists. It was considered an appropriate criterion in my study to acquire participants who were autonomous over their own therapeutic work. It was considered important in the recruitment process to narrow my sample to a

homogenous group of practitioners who worked in a community context and to go for a more in-depth analysis with a similar sample. Although it was the aim of the study to find out how psychotherapists approach the work from different modalities but the sample was considered homogenous based on their experience of working in private practice and with the expected client group. In the discourse analysis procedure, richer data is strived from analysing data from the transcripts from a small homogenous group.

In recruiting participants for this study, I considered a few options. Contact details of psychotherapists were sourced through their professional accrediting bodies' website, where they provide a public list of psychotherapists. They can be identified on Irish psychotherapy websites such as the Irish Council for Psychotherapy (ICP) http://www.psychotherapy-ireland.com/find/; the Irish Association of Humanistic and Integrative psychotherapy(IAHIP); http://iahip.org/find-a-therapist; and the Irish Federation of Psychoanalytic Psychotherapy (IFPP) website http://www.ifpp.org/pract.html. In order to acknowledge and facilitate potential participants' autonomy and self-agency, I originally displayed posters (Appendix 4) in psychotherapy centres. These centres can be identified through an internet search. Potential participants were invited to contact the researcher if they would be willing to participate. When there was no initial response to any of the letter and posters in psychotherapy centres, I followed up with invitation letters (Appendix 3) and personal phone calls. Some participants responded by email but interviews were arranged by phone call. I followed ethical codes of justice and fairness that "ensured that participants are fully aware of the purpose of the research and understand their rights" (Bell 2005 p44). Plain language letters (Appendix 9) describing the research in greater detail was forwarded to the participants that responded.

3.5.2 Inclusion/ Exclusion Criteria

In discussing the appropriate candidates for this research, psychotherapist participants were required to have accreditation with a nationally recognised psychotherapy organisation. The participants were psychotherapists who practice from a variety of different psychotherapeutic modalities. The following are examples of the different psychotherapy organisations in Ireland, IACP, APPI, IAHIP, IFPP and the National association of Cognitive Behavioural Therapy (CBT) in Ireland. An essential inclusion criterion required participant to be engaged in the receipt of regular clinical supervision and participants were expected to be practicing psychotherapists for more than 5 years. All participants were required to be currently working with clients who were taking anti-depressant medication (See Appendix 7).

3.5.3 Transparency

Informed consent (Appendix 8) in this study involved making sufficient and accessible information available to participants about the purpose of study potential benefits and risks, what participation was required and allowing sufficient time for participants to consider the information and come to an independent decision about participating. This was not only allowing autonomy but also respecting the integrity of the participant. It was important that participants were not coerced into this research. Participants were informed that they retain overall control within the interview regarding the nature of the material shared. It was expressed to the participants that they have the right to decide not to take part in the study without having to justify their decision or be subjected to a query regarding it (Bell 2005). Also, the interviewer left an open-ended opportunity at the end of the interviewer to discuss any concerns that come out of participating in the research. The participants were given the opportunity to contact the researcher if they need any after-support from the interview or if they needed any more clarification around anything contained in the research.

Having a check list for the interview schedule supported me in covering certain ethical obligations (Bell 2005). Blaxter et al. (2001) asserted that "research ethics is about being clear about the nature of the agreement" you are entering into with your research subjects or contacts. During this arrangement procedure, I reminded the respondents of the aim and some of the objectives of the study and a few requirements pertaining to the interview such as an estimation of the time needed to carry out the interview, "recording equipment being used" and place of the interview (Bell 2005 p164). Before beginning of each interview, participants were given another copy of the plain language statement. It was important to "give the respondent time to read and re-read the protocol at his or her own pace, and to negotiate any additions or changes to it with the researcher" (Hart and Bond 1995 p199). Ethical research involves ensuring informed consent of those you are going to interview. It is about reaching agreements about the uses of the data, and how the analysis will be reported and disseminated (Bell 2005 p46). Participants were offered the opportunity to clarify aspects of the research and were briefed on significant aspects of the interview. The informed consent procedure "reduces the legal liability of the researcher" (Bowling 2002 p157). All interviews were conducted by me, the researcher.

3.6 Method of Gathering the Data: Interviews

The preferred data collection method was semi-structured interviews and the interviews were all audio-recorded. Semi-structured interviews were used to gather participant data in the form of in-depth rich subjective accounts of engagement in psychotherapy. Smith (1995 p10) asserted that semi-

structured interviews are "especially suitable where one is particularly interested in complexity or process or where an issue is controversial or personal". Additionally, the semi-structured form of interviewing

> allows the researcher and participant to engage in a dialogue whereby initial questions are modified in the light of the participant's responses and the investigator is able to probe interesting and important areas which arise (Smith & Osborn 2008 p57).

In the preparation process, I reflected on what I needed to know, why I needed to know this information and considered how the questions will be analysed. This supported me in refining my research questions (Bell 2005). In semi-structured interviewers, the ordering of questions is less important and the interviewer is freer to probe interesting areas and can follow the interviewee's interests or concerns. An ideal goal would be to get the interviewee to speak with as little prompting as possible. This researcher followed Kvale's (2007) guide to conducting this interviews where he considers the psychoanalytic interview as a qualitative endeavour. He stated "Freud regarded the therapeutic interview as a research method: It is indeed one of the distinctions of psychoanalysis that research and treatment proceed hand in hand" (Kvale and Brinkmann 2009 p41). I reflected on Kvale (1999; 2007; 2009) for interview quality and to consider what the range of issues that needs to be covered to get data to answer the research question.

Semi- structured interviews generally last for a considerable amount of time which is usually an hour or more. I devised an interview schedule that incorporated some guiding questions related to engagement in psychotherapy (Appendix 7); one of which I used as a general opening question. In this research, the interviewee's were initially asked questions about their psychotherapy model, with the opening question of "tell me about what therapy model you practice from". This is a broad question and from this I tried to illicit general descriptions of the psychotherapy model. When I felt I had enough information as a bed of knowledge, I proceeded to ask the question of "what is it like working with clients who are taking anti-depressant medication?" This again is a broad question to get the interviewee to describe the experience of working with clients who are taking anti-depressant medication. Smith and Osborn (2008 p61) asserted that "a good interview technique…[will] often involve a gentle nudge from the interviewer rather than being too explicit". I asked the interviewee to give examples about their descriptions. The interviews did not follow the sequence on the schedule and there was a continual gauging around the pace and direction of the participants' answers. Questions were asked in the pursuit of clarification around the nuances of the participants' complicated work. In the transcribing and analysing phase, there was a more detailed examination of the data.

3.7 Data Analysis

There were a few stages to the process of analysing the data. I tried to be consistent in these stages, from reading the text, to transcribing, to delineating categories, to analysing the text with LDA concepts and cross- interview analysis. I will outline these stages below.

3.7.1 Stage One: Transcribing

When an interview was carried out, I transcribed it within a few days. The process of reflexivity was addressed through transcription procedures and it allowed a closer scrutiny of the process. I kept a diary and recorded everything that I felt noteworthy during the transcribing process. Smith et al (2009) described this process as "exploratory noting" (Smith et al. 2009 p88) it proves useful in attempting to identify any pre-understandings and perceptions in relation with the participants (Willig 2008). Additionally, I critically reflected on the interview process and transcripts with supervisors throughout interview process. There was a discussion around significant aspects of the interviews which supported me in strengthening my technique for preparing for upcoming interviews. There was an appropriate amount of meetings with supervisors to sustain the support needed. When I carried out 7 interviews, and after applying some concepts of the LDA method to a few of the transcripts, there was recognition that there was sufficient data gathered. There was certain depth of analysis and a concentrated examination of the data carried out. This number of participants is deemed to be an appropriate sample size for a discourse analysis study and doctorate degree level research.

3.7.2 Stage Two: Re-Reading the Text & Delineating Categories

I decided to take one interview transcript at a time, concentrate on the content of the interview and emerging significant elements of the transcript relevant to the research question. By reading and re-reading each individual transcript, I then recorded significant comments that reflected how I felt about various aspects of the narrative, certain aspects that influenced the conditions of the exchange and dialogue in the text. I initially carried out an individual interview analysis "Analyzing, interpreting and legitimizing data" can be carried out in each single case (Onwuegbuzie and Leech 2007 p259). This supported me in carrying out an in-depth inquiry of the data gathered by each participant before engaging in the cross analysis. For the purposes of analysis, it was separated into extracts. These extracts were groupings of dialogue in the interview. For example, P: 1- Ex 20 which represents Participant one, extract twenty. I further split the transcript into two sections in all transcripts (See Appendix 6). The first section was participants discussing their psychotherapy practice and then the second section was their descriptions on their work with clients on anti-depressant medication. There was a particular focus on how versions of psychotherapy models were constructed "moment by

moment" (Pavón-Cuéllar 2010) in certain ways in their descriptions of how they carry out their work with anti-depressant medication.

LDA provides a technique of carrying out a commentary on the text through a reconstructing the words already used by the participants. In this case it was the material signifiers of the participant's language that were re-used and re-told with my hands piecing together the building materials of the literal signifiers, "re-situating these words in their structural positions" (Pavón-Cuéllar 2010 p305). Throughout the passages "signifiers", "captions" and "phrases" were used as headings to further delineate different sections. "Signifierisation" embraces all the processes that usually come under the psychosocial heading of "categorisation" (Pavón-Cuéllar 2012). Categories are nothing more than signifiers implying structural relations between signifiers; categorisation is just a form of signifisation that reduces things and people to signifying categories (Pavón-Cuéllar 2012 p69). Frosh refers to this process as a "re-transcribing the text into idea units…and linking them with related notions" (Frosh 2007).

3.7.3 Stage Three: LDA Coordinates

I began to apply an additional element of analysis (LDA) to each transcript. Lacanian concepts were tested against the discourse of the participants in a "reversal" approach, the "discourse was applied to the (Lacanian) concepts, so to implement their application to analysis, as well as their positioning among other concepts" (Pavón-Cuéllar 2012 p337). The Lacanian concepts were put to use in pure analytic style, to bring about an awareness of how participants use language but how they were also used by language. How subjects agency was configured through the different imaginary, symbolic and real registers. Master (S1) signifiers were identified, phrases and reflection on how attempts at how a subjects agency was re-configured when it spoke through discourses. Also, observing patterns, connections, contradictions and recognition of deadlocks in perspectives and how the subject implemented and was implemented by presumed knowledge. Each text was approached individually and presented to the supervisors during this analysis period. An example this process carried out on one interview shown in Appendix 6.

3.7.4 Stage Four: Cross-interview Analysis

This stage of analysis incorporated a cross-interview interpretation of all of the individual data analyses of the interviews. The cross analysis entailed comparing significant aspects of the interviews where it was relevant for comparison and differentiation. These comparisons aimed to be "emergent, interactive and flexible" (Onwuegbuzie and Leech 2007 p249) but not over comparative as to sacrifice dense description of individual cases or not too dense as to neglect relevant, useful

comparison among cases. Although the participants were discussing their work in different contexts and in their own idiosyncratic way which was considered relevant, the cross interview analysis focused on integration. Three particular elements guided this process of integration:

1. Similar content across discourses
2. Similar structures of the discourses (linguistic structures)
3. Interruptions in the text

Number one included a contrasting of the use of signifiers across the interviews, what Foucault referred to as the material of the signifier, the content of discourse (Pavón-Cuéllar 2012 p69). Number two refers to linguistic constructions and discursive patterns in the text and number three refers to interruptions which include gaps, breaks and eruptions of the real in the speech of participants, which can be indicative of the unconscious. Pauses in the speech of the participants are represented like this […] is the text. Young (2013 p283) described it as observing "content, linguistic formulations… interruptions and reflexivity in the material". From this process, I assigned groupings and categories. Thus, moving between the individual particular cases and the patterns across accounts allowed for a complex and rich further unfolding of the data. "Reliability is the extent to which a test or procedure produces similar results under constant conditions for all occasions" (Bell 2005 p117). In approaching all the transcripts with this frame, this method of analysis is considered to be consistent and reliable in its application.

3.7.5 Stage Five: Reporting the Data

In gathering the findings, this was a cross-interview interpretation of all of the individual data analyses of the interviews. There was a lot of data to examine and in order to organize it and present it systematically; I gathered the data into significant categories. The findings are outlined in a map (Figure 3) to support the reader and present the findings in a clear linear format. The findings initially revealed two areas pertinent to the research question. Firstly, there will be a review of diverse experiences that emerged in the findings. There will be a review of the participant's therapeutic models they practiced from, which was the first question that was asked in the interview. Following this, there are three categories that explores the diverging discourses that emerged from the data which led into an overall category entitled 'shared medical world'. There was a process of "reciphering" (Badoui and Foucault, 1965) through the speech of the participants presenting the data across three sections.

3.8 Confidentiality

Confidentiality of the participants or other people in any research was significant in this research process. Eysenbach and Till (2001) assert that researchers generally agree on the importance of ensuring participants' anonymity; confidentiality can never be guaranteed completely, but it can be maximized by adopting a combination of measures (Mann and Stewart 2000 p57). Participant anonymity is commonly achieved by removing or disguising all identifiable personal details, so that readers cannot make connections between these details and the identity of specific individuals (Kraut et al. 2004). In this study, confidentiality was safeguarded by not mentioning participants accrediting bodies that they are affiliated with. Also I removed certain details around personal disclosures that could have identified the participants. In pursuit of confidentiality of the participants' clients, I asked participant not to name or refer to any identifying characteristics of their clients. When the details of certain clients and other practitioners in the field were mentioned, I left all names blank and removed detail in the findings that could identify anybody. Transcripts were safely secured on a password protected computer.

3.8.1 Data Management

Storage access, retrieval and erasure of data are important in safeguarding confidentiality. The one to one interviews were recorded on a digital device and then saved onto a computer that was password protected and an encrypted USB device was used for backup. The interviews were erased from the recording device once stored on computer. Each interview was transcribed verbatim and identifying details were removed such as locations and participant and therapist names. Transcripts were identifiable by number only. A log of names and identification numbers were stored separately from the transcriptions on the password protected computer. Transcripts will be kept for four years after submission of the thesis to DCU and ethical approval was granted for this. The requirements of the Data Protection amendment act (2003) state that information on individuals should not be kept any longer than is necessary and in accordance with this principle that the researcher will dispose of the data by deleting information held on computer; shredding of transcripts and burning of audiotapes after 5 years following the award of Doctorate being obtained.

3.9 Summary of Methodology

This methodology chapter aimed to discuss discourse analysis and describe in detail how LDA guided the analysis of the transcripts from the interview. DA seeks not only to analyse and interpret but LDA aims to be transformative. Contrary to most qualitative research methods, LDA's role can try be disruptive to the text, to "disintegrate" (Frosh 2007) findings. Lacan believes it is an

oversimplification to say the subject is a linguistic construct. Similar to Foucault, Lacan supports us to recognise the need to study different discourse functions but Lacan differs to Foucault in that he was interested in how the subject was positioned in discourse but moreover how discourse can be used to reposition subjects. As discussed, Parker's (2005; 2010) seven key elements of Lacan's theory are offered as conceptual coordinates to help in not only making sense of the text but in transforming discourse. It is not a step by step format to be abided by but this discourse analysis aims to be methodical in its application of theory but it also facilitated a "spontaneous" activity toward what becomes available in the text (Pavón-Cuéllar 2010 pxv). This research was systematic in an attempt to outline the significant practical steps and ethical considerations that I took at every stage in this research project. This research enquiry is deemed scientific by virtue of being methodical, systematic and critical. Findings are considered reliable if there is transparency, thoroughness and reflexivity in collecting, analysing and presenting data. The next chapter presents the Findings.

4. CHAPTER 4 – Findings

4.1 Introduction

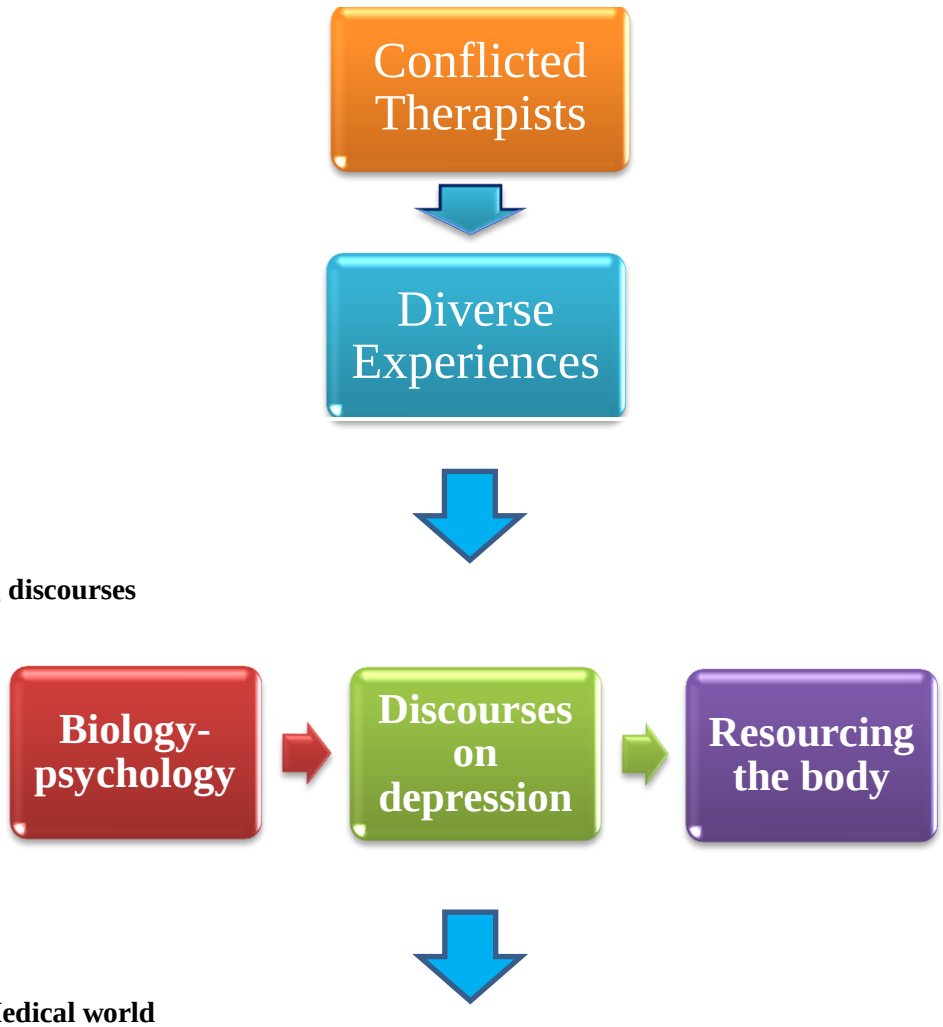
This chapter reviews the findings of the study. Although the participants discussed their work in different contexts and in their own particular way, this chapter presents a cross-interview interpretation of all of the individual data analyses of the interviews. There was a focus on comparing and contrasting content across the interviews by observing material signifiers, linguistic constructions and interruptions in the text. Significant elements were identified in passages within and across the interviews, and these were synthesised into different categories throughout three sections. Some of the findings are highlighted by DA research theory and LDA methodology (Parker 1992; 2001; 2005; 2010; Pavón-Cuéllar 2012; Alcorn 1994; Verhaeghe 1995; 2004; Žižek 1994; Lacan 1977; 1991; 1998; Foucault 2001; 2003). The findings found diverse experiences of psychotherapists working with clients and emerging conflict in application of their theoretical model to clinical practice. Through the analysis of the data, operative discourses were examined and emerged dialectic tension between the disciplines of 'psychology and biology', 'discourses on depression' and the discourses on 'the body'. The idea of a psychotherapist working in a 'shared medical world' encapsulates the reality of a psychotherapist comprehending multiple meanings and messages and having to configure how to work with possible conscious and unconscious relationships of not only the client but in the work other professionals. Figure 3 presents a map of the findings.

4.1.1 Map of Findings

The map in Figure 3 is a visual representation of the structure of the findings. The first category is entitled "conflicted experiences" arising from the participants' work. There is a reflection on how the "conflicted therapist" spoke about the theoretical models while discussing the clinical reality of working with clients who are taking anti-depressant medication. There will also be a brief introduction giving information about the training and modalities of different participants. Category two presents "diverging discourses" which includes the dialectics of the "biological-psychological", "discourses on depression" and discourses on the trauma which is titled "resourcing the body". There will be a look at one main category that emerged from the findings that includes participants' discussions on working with clients and other mental health professionals in what I term as a "shared medical world". There is a focus on the "agency of the client" which considers the clients taking up their own agency to make choices and decisions around the taking of the medication. "Roles of the psychotherapist" considers various positions the therapist takes up in the work in different contexts and "GPs and psychiatrists" reflects upon data discussing the significance of the prescribers in the dynamic. A central idea presented in this section is termed the "multi-agency matrix" which attempts

to encapsulate the multiple intermittent "agencies" involving the client's relationships with the psychotherapist, GPs and psychiatrists, anti-depressant medication, and the discourse of the Other. The "multi-agency matrix" will be developed further in section three but there will also be a reflection on the continuum of positions that psychotherapists take when working with clients who are taking anti-depressant medication.

Figure 3: Map of findings



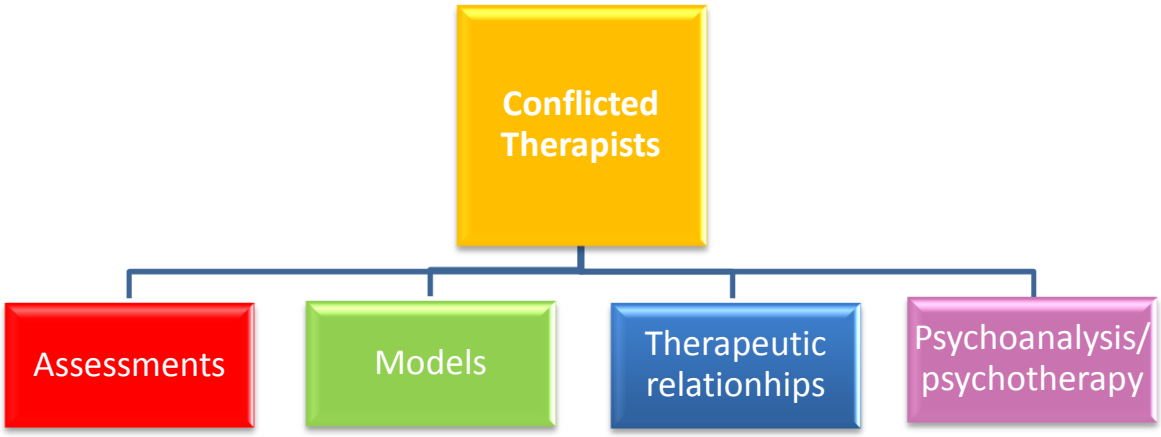
4.2 Section 1: Conflicted experiences

Psychotherapy and medical practices rely on discourses to guide their work. According to Pavón-Cuéllar (2012 p263), a discourse is a way to "control, command and master consciousness". The findings reveal participants' attempts to master their work through their speech. Within their mastering attempts, participants were "divided and proletarianised by a contradictory discourse" (Pavón-Cuéllar 2012 p263). There were different levels of contradiction and conflict within participants' own speech and across the interviews of different participants. There were mixed ideas about how anti-depressant medication functions and the implications it has for the participants' psychotherapeutic practices.

4.3 Conflicted Therapists

The elements that emerged throughout the participants' accounts of their work are categorised by: assessment/interpretation, therapeutic models, relationships and transference, and contrasting elements between psychotherapy and psychoanalysis; see Figure 4.

Figure 4: Conflicted therapists



4.3.1 Assessments

Most participants asserted that they always approach their work by carrying out an assessment as a way of determining how to best work with the client. The assessment may help the therapist interpret and formulate a hypothesis. One of the participants articulated that it is "knowing the difference between doing it, and knowing what you are doing and knowing why you are doing it" (P: 3 - Ex: 10). Another participant described how the therapist "must have some idea or where the memory is or where they trauma is, that depends a lot on your assessment" (P: 7- Ex: 10). "The important thing is really, first of all, knowing the history and getting a sense" (P: 7 - Ex: 18). Another participant asserted that the "assessment is really important in the way you might get a sense of which way you might work" (P: 1 - Ex: 1). The signifiers "knowing" and "sense" appear to be significant in the observation that takes place in an assessment; the "felt sense" of the practitioner him/herself, in order to "get a sense of it" (P: 5 - Ex: 6).

There appeared to be a difference between how the participant therapists "think" and how they "act", between their conceptualising a case from a model, and considering how the presenting client would influence how they would intervene: "you would decide how you would work […] see what stage they are at" (P: 3 - Ex: 25). The "directive or non-directive way of approaching a client" (P: 3 - Ex: 34) could depend on what model they used. The model that a therapist uses can impact how he or she decides how to work with the client, but it can mutually depend on how the client presents, and this will further dictate how a model is applied. In addition, the model used will influence the "process of changing" (P: 6 - Ex: 8). The participants were speaking from within the university discourse where they were relying on few elements to guide how they would work. In the university discourse, knowledge takes the position of the agent and the agent needs to be "guaranteed" by the master and

we can see the participants' speech reverting to previous stated knowledge where certain signifiers were used such as "theory", "history", "hypothesis", "knowing" and "models". The speaking agents relied on what Parker (2001 p75) referred to as the "theoretical architecture of the psy-complex".

4.3.2 Diverse Psychotherapies

Participants approached their work using different modalities. These models shaped how the participants considered how he or she worked. Some participants did not "use diagnoses or that" (P: 5- Ex: 34). Certain models, such as psychoanalysis, psychoanalytic psychotherapy, cognitive behavioural, humanistic, systemic (family therapy) and eclectic models were described in the participants' accounts. The eclectic modality was referred to, and when a participant was asked what he meant by "eclectic", the reply was:

> I suppose eclectic means as far as I understand that I don't hold dogmatically to an approach so I try and react or be present to whatever the client is presenting with (P:1 - Ex: 3)

This participant asserted that a client may need a more practical approach such as "more supportive work" (P: 1- Ex: 4).

Participant two discussed how she "would always try to use their (clients) language and I always try to work towards not using my language" (P: 2 - Ex: 14). She claimed that working with the transference is a basis of psychoanalytic psychotherapy "whether that is individually or in the group" (P: 2 - Ex: 3). Participant two asserted that if a client is "floundering" or "suicidal", then maybe antidepressants can be used for "containment" (P: 2- Ex: 57).

When participant three was asked about her model, she said it was "a mixed bag" (P: 3 - Ex: 4). She asserted that "I would have been one of these purists and said that psychotherapy could solve everything and psychoanalysis could solve the world, let alone the client" (P: 3 - Ex: 26), but she "[had] seen remarkable changes with medication (P: 3 - Ex: 26). "Drugs make them (clients) less tense and upset" and often "frees them up to do the work" (P: 3 - Ex: 42). The participant was discussing how difficult it can be to direct clients to medication, "nobody ever likes to say this person could do with an antidepressant and that's a horrible moment but sometimes the result is very very good" (P: 3 - Ex: 26).

Participant four used a "version of humanistic integrative" (P: 4 - Ex: 10). The humanistic aspect was looking at how the person (client) was "able" or "not so able" about "being themselves" (P: 4 - Ex: 69). This participant asserted that "I am not against that kind of work or medication or anything like that" (P: 4 - Ex: 59), but "I am not sure, I have never been sure what valium means and you want them to recover fully and in some places that is not going to happen" (P: 4 - Ex: 65).

Participant five asserted that he wants clients "to achieve to their full potential" (P: 5 - Ex: 2). This participant discussed how he also observed "non-verbal communication as well in the body" (P: 5 – Ex: 11). Participant five claimed "I am not actually that familiar with the range of anti-depressants and the impact that they have on people" (P: 5 - Ex: 25). This participant talked about the effectiveness in treating someone with medication as opposed to psychotherapy, "I am not so sure it can address the underlying causes and underlying view and perception a person has on themselves, perhaps it can?" (P: 5 - Ex: 30).

A defining feature of systemic therapy was to look for "different viewpoints" (P: 6- Ex: 7). Participant six used signifiers such as "thinking", "beliefs", "perceptions", "perspectives", "views", "ideas", "difference", and "change" to describe certain elements about her practice. This participant used therapeutic tools to work with clients such as offering "suggestions", "being curious", "asking questions", "testing solutions" and "exploring choice". Participant six said that she is always interested in what part the medication plays in a client's life generally. She "would always ask people what their relationship to medication is and how important is it and do they think, do they have an idea when they would like to come off it. Have they ever tried to?"(P: 6 - Ex: 30).

Participant seven claimed "I don't practise from any model, I have my own, a mixture of various different methods" (P: 7- Ex: 1), but in the same extract he claimed "there is a lot of common ground between what they [the models] do" (P: 7- Ex: 1). This participant asserted that "my emphasis would be on a deeper experiential type of therapy", and central to the process is the "trust in the relationship" (P: 7 - Ex: 2). Participant seven asserted "I don't like anti-depressants because of the message it gives"; in a later extract, he asserted that it "hits at the very heart of your own management of your own life. That's way more lethal than the drug itself" (P: 7 - Ex: 46).

4.3.3 Therapeutic Goals

One participant outlined that it would be a therapeutic goal to "start to look at the issues and then hopefully come off the medication and for them (clients) to achieve a level of understanding and eh change has begun to happen for them" (P: 6 - Ex: 18). She asserted that "therapy can help people come off it (anti-depressant medication)" (P: 6 - Ex: 30). Participant seven asserted that there can be a sense that there "*is* something there" (P: 7 - Ex: 18), and the therapist's role is to "open that up and what will come will come (P: 7 - Ex: 20), but sometimes "nothing is happening" (P: 7 - Ex: 65). It was about "getting in touch with what they have defended against" (P: 7 - Ex: 3). This participant claimed that "you have to find ways to get them into an altered state and open up the defences, then they have the strength to go through it then" (P: 7 - Ex: 4). It was the client's job to "let it happen" (P: 7 - Ex: 66). If therapists have enough experience "they (therapists) are doing the same things" (P: 7 -

Ex: 81). For one participant, it was not about "trying to change someone, it was about letting them emerge" (P: 3 - Ex: 33). She asserted that the client has to "realise what formed that kind of compulsion" (P: 3 - Ex: 9). When another participant was asked whether the goal of psychoanalysis is to bring the unconscious to conscious awareness, she replied "I wouldn't say it's a goal" (P: 2 - Ex: 24). She discussed "clues" in the language used by the clients "about their sense of 'it'" (P: 2). For participant seven, a goal of therapy was to get the person to fully experience, so the trauma could become memory. The participant said that he knows what he needed to get into with a client and he relied on trust and bringing them into an altered state and regression. This was also significant as one participant asserted it was important to "[have] enough trust in the relationship that they feel safe enough to go into it" (P: 5 - Ex: 18). Most of the participants emphasised the importance of the therapeutic relationship.

4.3.4 Therapeutic Relationships

The term "therapeutic relationship" was used by some participants. One participant said that that the relationship "is the central aspect of any therapeutic effect" (P: 1 - Ex: 3). This is re-asserted by a number of participants, but one participant spoke from the university discourse to assert that:

> all the research seems to say that it doesn't matter what model you are trained in, it's the quality of the relationship experienced by the client, that produces the possibility of change for the client (P: 4 - Ex: 19).

For one participant, the relationship was used to build "psychological mindedness" (P: 1 - Ex: 12). For another participant, she observed "all the relationships" in a person's life (P: 6 - Ex: 31). A frequently used phrase in psychotherapy, and by the participants, was "meaningful relationship" (P: 1/ P: 4/ P: 5). The term such as "meaningful relationship" was referred to as "shaping experiences" which helped create "healing", "psychic growth" and "psychic change" (P: 1; P: 4).

There were attempts by participant four to understand his experience of meeting the other person and finding out "does my experience match what's happening to you" (P: 4 - Ex: 23). This participant maintained a client's "self-relationship" can be a "fragmented self-relationship". This was the basis of neurosis, "the basis of neurosis is the fragmented self-relationship […] system has broken down in most cases [this] has happened in early childhood" (P: 4 - Ex: 3). It was about "meeting the person where they are, without judgement, without criticism" (P: 4 - Ex: 2). Later, this participant said "I will meet you where you are, and by meeting you where you are, I will get access to the difficulty, the relationship space will simply re-enact the difficulty that you are having" (P: 4 - Ex: 12). Working with transference was referenced by a few participants; this was not just restricted to psychoanalytic practitioners.

Regarding the transference relationship, one participant (P: 4) spoke about how developmental problems in a person's self-relationship could be detected through a "transference" which could lead to uncovering a "block" in development from a previous relationship (P: 4). Lacan claims that "transference is the putting into operation of the unconscious" (Lacan 1978 p267). One participant observed "that is all connected to her […] what's going on for her in her transference" (P: 2 - Ex: 44). Another participant described "seeing the therapeutic relationship as a microcosm of what is going on in other relationships outside where difficulties may arise and that" (P: 5 - Ex: 2). The difference between psychotherapy and psychoanalytical approaches to client work was prevalent across the different interviews.

4.3.5 Psychotherapy and Psychoanalysis

Much of Lacan's work was about conceptualising how "psychotherapy differs from psychoanalysis" (Parker 2005 p15). A few participants tackled the difference between the two (P: 1/ P: 2/ P: 3/ P: 7). A participant asserted that the difference was a "big question" (P: 3 - Ex: 20). Participant three identified distinctions made between the conscious and unconscious elements when working, "the basic premise on which I work is that the unconscious informs all sorts of things about us, our thoughts, our behaviours and our feelings" (P: 2 - Ex: 3). This participant recognised unconscious processes in Freudian slips, and the process of dreaming as trying to work out something that our unconscious is finding it hard to deal with. A psychoanalyst can use a "blank response" to allow for "neutrality" but they can also make "interpretations" (P: 2 - Ex: 13). One participant's requirement from the client was for them to "speak in an uncensored way" and "nothing is prohibited" (P: 3 - Ex: 20). Whereas they referred to psychotherapy as about "fixing subjectivity", psychoanalysis is about letting someone "emerge", "and so many of them came in to speak and they emerge from their own subjectivity" (P: 3 - Ex: 11). Participant four discussed how some clients are not "ready" for psychoanalysis and "not able to go there".

4.3.6 Diverse Experiences

The participants reported diverse experiences in the interviews. In particular, participants asserted that there were "trials and tribulations" (P: 5- Ex: 24), "pros and cons" (P: 1:-Ex- 20), "plus and minus" (P: 6- Ex: 5) of working with clients who are taking anti-depressant medication. Some were "positively inclined toward medication" (P: 1 - Ex: 37) as anti-depressant medication could not only change "serotonin levels", but "biological and psychological changes can happen" when someone was on medication (P: 1- Ex: 7). Anti-depressant medication can affect "thinking" and the "perception of the world changes" (P: 6 - Ex: 16). Participant six asserted that anti-depressants can keep someone on an "even keel" (P: 6 - Ex: 27), they can "take off a really difficult edge" (P: 6 - Ex: 18). Another

participant discussed how, in some circumstances, he is "very very pro medication" (P: 1 - Ex: 14). But there were also contrary experiences; one participant asserted that he was "not that familiar with anti-depressants" (P: 5 - Ex: 25) while another participant stated that it is "not a happy moment for the client to make that the decision to go on medication but sometimes the result is very very good" (P: 3 - Ex: 26), "the results have been phenomenal […] absolutely" (P: 3 - Ex: 25). Another participant claimed that it (anti-depressant medication) can actually temporally relieve some depression, but it can "move some into an over active state, manic state" (P: 7 - Ex: 26). One participant talked about the medication "filling in on missed brain chemistry" (P: 3 - Ex: 28). This alludes to mediation providing positive support for a client but it also leaves the impression that a person is physically missing something that can be filled and fixed by medication.

The overt tension between psychotherapy and anti-depressant treatments propelled contradictions in how the participants' discussed how the therapy work was impacted. In some cases "opposite senses" were interplayed (Pavón-Cuéllar 2012 p253). Anti-depressant medication "is not actually solving anything" (P: 7- Ex: 27), it "arbitrarily invades" (P: 7- Ex: 46), but it still has "a function if they are natural substances related to that" (P: 7 - Ex: 46). For some, anti-depressant medication "makes it (therapy) just slightly bearable and there is the whole thing about the placebo effect and that you know" (P: 2 - Ex: 57). Another participant said "that if the client is suicidal, then maybe antidepressants can be used for containment" (P: 2- Ex: 23); and another participant asserted that medication is "horrible" but on the contrary "it will save someone's life" (P: 6 - Ex: 42).

One participant asserted:

> I would think it [anti-depressant medication] is a positive thing and perhaps working with more chaotic clients who may struggle to engage in any psychotherapeutic process (P: 1 - Ex: 13).

Another participant said that sometimes anti-depressant medication is useful "if a client is floundering" (P: 2 - Ex: 67). This participant continued to assert that:

> I think psychotherapists are confused about anti-depressant and anti-psychotic and valium or whatever because that distinction is not made because they do not know much about it (P: 2- Ex: 68).

This confusion was exposed in some participants articulation that it was a "bit of trial and error that some anti-depressants work for some people and not for others" (P: 5 - Ex: 28), "it is a matter of trial and error in trying to find the medication that works for the particular individual" (P: 5 - Ex: 29). When referring to medication, participant six used the phrase "cocktail of stuff" in a positive and negative context. Firstly, they said that a client took "a cocktail of stuff so that she could function really well and stay on a reasonably even keel and knowing that sometimes she will go up and

sometimes she will go down" (P: 6- Ex: 27). Then shortly after in a later extract, this participant asserted that a client took a "whole cocktail of stuff for depression, I would say that it is not at all helpful to them […] they are numbed by it" (P: 6 - Ex: 29). The word "cocktail" can also be associated with the combination of alcoholic spirit drinks, a socially accepted drug that can induce similar intoxicating effects for people to socialise and "function" but consumed in large quantities it can produce severe ill effects for the person and society in general.

Near the beginning of participant one's interview, he asserted that "it (anti-depressant medication) doesn't mean anything" (P: 1 - EX: 9). This participant later asserted that "I don't think anyone in the medical community know how SSRIs work" (P: 1 - EX: 17). As the interview progressed the participant discussed many positive examples of anti-depressant medication relating to their work. Near the end of the interview, they asserted that "I have never articulated my views on medication in this way and I found myself been generally positively inclined toward medication" (P: 1 - EX: 37). It could be argued that the medical discourse was recalibrating meaning throughout the interview and shifting the participant from a negative into a more positive standpoint regarding their outlook on medication but the punctuation point at the end had a signifying effect on the whole exchange around the meaning of anti-depressant medication, from "not meaning anything" to not knowing "how SSRIs work" to the participant becoming "positively inclined". According to the Verhaeghe (1995), the medical discourse acts at an imaginary level and this participant was arguably lured into an imaginary position. The 'imaginary' signified is precisely that which appears to make sense (Pavón-Cuéllar 2010 p25).

Throughout other interviews, "anti-depressants" had a paradoxical nature that could be understood as good or bad, a help or a hindrance. However, there were also contrasting perspectives on participants' own psychotherapy work. Anti-depressant medication was sometimes seen as "no solution" and psychotherapy was "the only thing that offers anything" (P: 7- Ex: 65), or, in another context, another participant asserted that there is a "stigma attached to it [medication] but also a stigma coming to psychotherapy too" (P: 5 - Ex: 29). For participant six, anti-depressant medication was deemed to function in a similar way to systemic therapy, the participant claimed that medication can also "help her (client) re-connect with her friends and social life" (P: 6- Ex: 30). Then, the participant took an anti-therapeutic stance and considered some elements of therapy counter-productive; "talking and talking and talking [….] keeps the trauma alive" (P: 6 - Ex: 32). In the gap […], the subject of the unconscious emerged to assert "keeps the trauma alive". There appeared to be an intermittent discourse unconsciously swaying the participant's opinions and reshaping what she thought about not only anti-depressant medication, but her own work. The participant had identified with the position of anti-depressant medication and her psychotherapy work was posited as the enemy signifier "keeping

the trauma alive". In LDA, "we must be able to detect clues of assumed opposition between the structural position of the subject and the ideological articulation of the structure for his position" (Pavón-Cuéllar 2012 p257). When the participant spoke about their therapy work with clients taking medication, the language appeared to shift the speakers into ideologically opposing positions. There were similar conflicts occurring across the interviews between how the participants spoke about their modality in contention with the clinical reality of working with clients on anti-depressant medication.

4.3.7 Summary of Conflicted experiences

There appeared to be underlying revelations in participants' expressions of how they worked and of the techniques they embraced but also the therapists appeared conflicted by the different positions they took up in speaking about their work. The university discourse guided participants to discuss aspects of their work: these were categorised through assessments, models, therapeutic relationships and some of the differences between psychotherapy and psychoanalysis. The first section outlined certain diverse experiences within participants' discussions, and pros and cons observed across the interviews of working with clients who are taking anti-depressants. Other discourses emerged from the participants' discussions on their work with clients who were taking anti-depressant medication. Section two will elaborate further on these discourses.

4.4 Section 2: Diverging Discourses

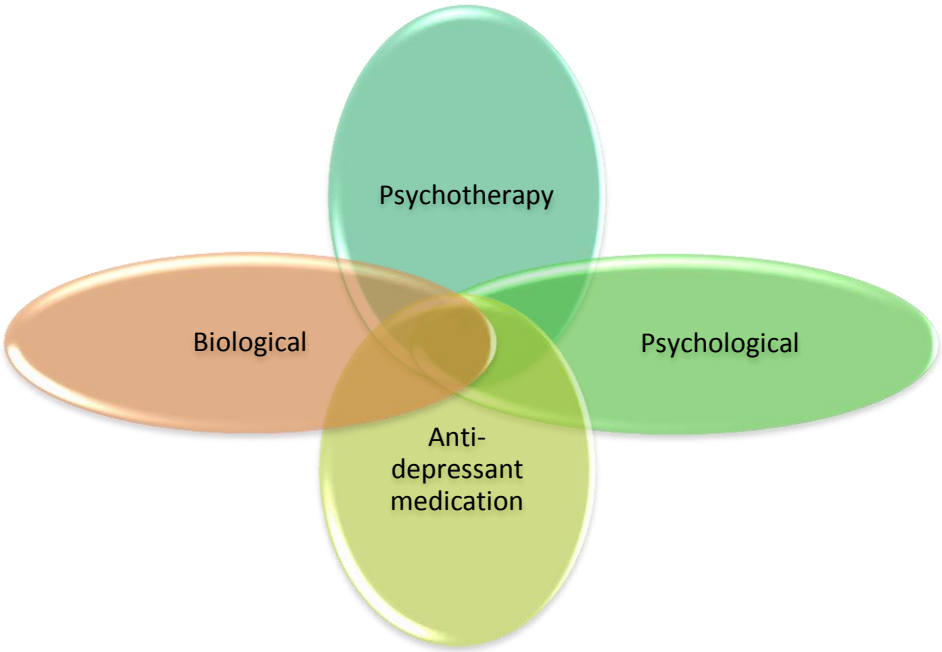
Various discourses are operative in how the psychotherapist participants think when they talk about their practice. The first discourse will look at the dialectic relationship between the 'biological and psychological' fields of thought; more specifically how the signifiers "biological" and "psychological" were used in the speech of the participants. The second is an examination of how the different discourses on depression were interpolated in participants' discussions. The third discourse, entitled "resourcing the body" examines the participants' discussions of, not only the physical body and body parts, but also how those concepts were used as metaphors to describe therapeutic work with clients who were diagnosed with depression and were prescribed anti-depressant medication. In particular, the interpolation of certain signifiers "trauma", "heart" and "love" produced metaphors that had symbolic reverberations.

4.4.1 Biological and Psychological

Figure 5 below represents the participants' account of psychotherapy and how certain aspects of their work was anchored in a dialectical tension between the biological and psychological (social) realms; the interconnecting oval shapes illustrates how the practices of psychotherapy and anti-depressant

medication rely on different disciplines of knowledge but are interdependent and at times overlap with each other. Figure 5 aims to show how the impact of psychotherapy on the biological and psychological aspects of the person and how anti-depressant medication has a similar impact. But from the participants' discussions, there is also a place where psychotherapy and anti-depressant medication meet and appear and do the same things.

Figure 5: Biological and psychological



4.4.3 Biological

For participant one, biology operated as a dominant discourse, in his speech the signifier anchored knowledge of his work; "biology" was the agent of change or the "cause of change" (P: 1 - Ex 31). He discussed how "there is something about the biology that elevates the mood" (P: 1 - Ex: 19). The signifier "biology" was used frequently in reference to what SSRI anti-depressant medication does. "SSRI" and "biology" became synonymous and was connected to changing "serotonin levels" (P: 1 – Ex: 22); the biological represented the physical realm and that of chemistry compounds. He asserted that anti-depressant medication was used as an "instrument" to fix the mechanical "hard-wiring" of a trauma. Anti-depressant medication was referred to as a "blunt instrument" (P: 1- Ex: 34).

Another participant discussed how people who needed anti-depressants had "missed brain chemistry" (P: 3 - Ex: 28). One participant discussed how there is "possibilities" when working with medication and asserted how medication can actually help "get closer to the energy and feeling" (P: 4 - Ex: 58).

He continued by saying that the worry and anxiety can be too much for somebody and medication can help prevent them from "running away from it". He referred to medication as the "margin of possibility" (P: 4 - Ex: 64), where the medication can give the client a "margin there and you can navigate" (P: 4 - Ex: 65). However, he admitted that certain aspects of a person's biology were challenging to work with, "that's the line with that kind of medicated experience that it is difficult to work with" (P: 4 - Ex: 64). There was confusion in this statement between whether the participant was referring to the "medicated experience" being difficult to work with or the person who is experiencing depression that 'needed' medication.

4.4.4 Psychological

Participant one asserted that there could be psychological changes connected to the biological intervention of anti-depressant medication. Participant three asserted that "clients go on something like that because they are […] able to think better for themselves" (P: 3 - Ex: 41). It was curious that there was a pause in the sentence or the speech was interrupted, which could be revelatory of the unconscious. The participant finished the sentence by saying "[…] able to think better for themselves". This emerging discourse can construe that the medication can support the clients "to think" but it could also insinuate that the medication actually helps clients "think better" *about* themselves. Medication could therefore be considered a helpful aid for the therapist, or it could be interpreted as doing the work of the therapist, changing negative thoughts and shifting self-perceptions. 'Medication' could be a signifier that represents 'psychotherapy'. Another participant asserted something similar around medication affecting a persons' psychological outlook, if there is a "biological basis for beliefs, perceptions and observances" (P: 6 - Ex: 5).

Another participant was not sure about what medication did, but asserted that medication could address certain symptoms; however, but he doubted whether anti-depressant medication "could address the underlying causes and underlying view and perception a person has on themselves, but perhaps it can?" (P: 5 - Ex: 30). This is what Pavón-Cuéllar (2012 p110) referred to as "a doubtful enunciating subject who splits between his identification with the enunciated I who thinks (S1) and his alienation in what the language (S2) thinks at the place of the doubting subject." He was unsure about what anti-depressant medication could do but as he spoke, the language in the act of speaking was in the process of convincing him otherwise.

4.4.2 Dialectic tension between the Biological and Psychological

Psychological and biological discourses were discussed throughout the interviews, and there was a striking dialectic relationship between the "biological" and the "psychological" realms. They are

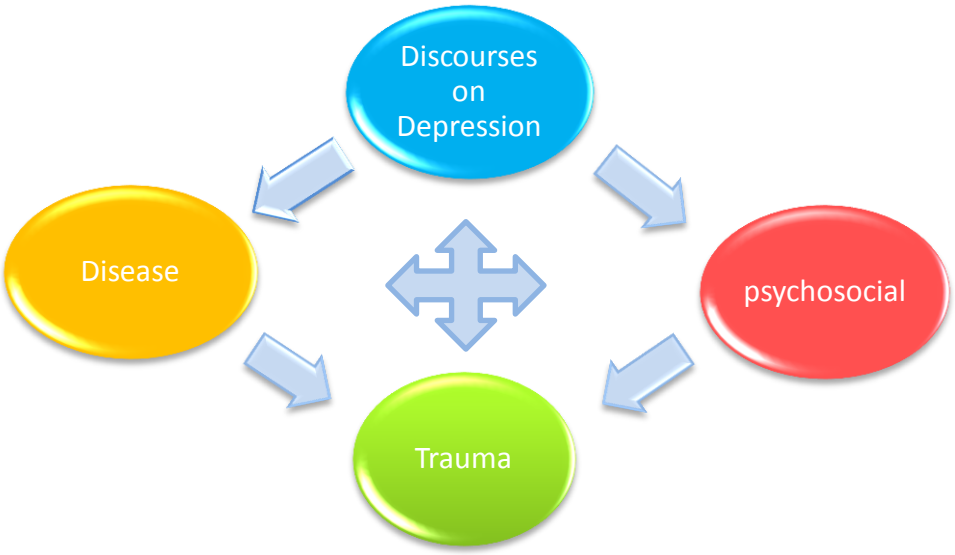
considered dialectical because they are contradictory but necessarily interrelated. The participants asserted a mixture of references and used the signifiers in different contexts. The signifiers "psychology" and "biology" acted in "positions of mastery" and operated in the dominant positions over the rest. Other signifiers circulate around master signifiers (Parker 2010 p162). Some participants discussed their work through psychologically based interpretations, while some had a biological basis, but both had reverberations within how participants understood their practices and communicated their experiences of working with medicated clients.

The psychological represented therapeutic verbal interventions in socially interacting with a client through conversation, and the biological represented the bio-chemical, pertaining to treatment by anti-depressant medication. But there was a flux between the two positions. The signifiers "biology" and "psychology" were "reworked" or recalibrated by replacing each other at times. CBT was a model used by participant one and this provided not only change in "behaviour" and "personality" but provided "psychological" and "biological changes" (P: 1- Ex 4). The more participant one discussed his work in the interview, the more he reworked and re-clarified the meaning of what he termed "biological" and "psychological". When this participant mentioned that therapy can cause "psycho change", he later clarified that it can cause "structural change" which later he referred to as "psycho-bio-social and neurological change" (P: 1 - Ex: 22). The participant reversed their position from the psychological to the biological. This participant arguably returned to the university discourse and used "biology" as a master signifier as if there were fixed grounding points of truth.

4.5 Discourses on Depression

A lot of discussion was concerned with working with clients who experienced depression and there were considerations about what depression was. For some, depression has to do with the biological realm, and one participant termed it as being like an "illness", a "disease", a "disorder" (P: 6 - Ex: 26). For another, it had to do with "missed brain chemistry" (P: 3 - Ex: 28) that will "need chemical assistance" (P: 3 - Ex: 33). For one participant "there is no evidence of it (bio-chemistry) whatsoever" (P: 7 - Ex: 51). There was a mixture of discourses on depression across the interviews, and Figure 6 illustrates how these discourses, such as disease and the psychosocial, were points of reference that were interwoven with each other at times. The trauma discourse was also referenced across the interviews relating to disease and psychosocial discourses.

Figure 6: Discourses on depression



4.5.1 Deciphering Discourses on Depression

One participant asserted that there is mixed theories on depression in contemporary literature:

> that people think it is an illness that someone acquires and people who fall into a depression with old age or anxiety from a car accident and there is a trauma or it could be pregnancy or post-natal (P: 3 - Ex: 48).

There are a number of discourses here, describing depression as a disease, and describing the natural factors that are involved; depression is also referred to as a reaction to a traumatic experience.

Another participant asserted that the

> trouble is that it (depression) has been objectified so depression is not now something that is part of your experience that you are trying to manage, it's an illness that you have contracted like TB (Tuberculosis)" (P: 7 - Ex: 43).

Another participant tried to express what depression was through measuring it on a "spectrum", through varying degrees of "severities", "levels", "types", "stages" – "[a] myriad of factors" (P: 2 - Ex: 6). She then referred to "personalities" as a causative factor in depression. When participant three was asked to explore about what she meant when she said "clinical" depression, she asserted that "depression seems to be very low and the weepiness, there are classical clinical indicators of depression" (P: 3 - Ex: 24). In order to describe depression, this participant used the phrase "classical indicator" which could be referred to as the university discourse relying on the apparent objectivity of science, something Foucault (1989) acknowledged as the "factual discourse" that stands behind the "regimes of truth" such as psychiatric practices and diagnoses.

The aetiology of most psychiatric diagnoses presupposes that with depression there are biological organic complications. One participant discussed primary and secondary causes of the depression and how this is conceived by psychiatry by treating the bio-chemistry of the person. This participant asserted that anti-depressant medication works with secondary causes as opposed to primary causes, "the difference is you are seeing these as a result rather than a cause but they are secondary causes" (P:7 - Ex:45). This participant discussed the situation when a client presents with features of being "miserable and depressed", saying "psychiatrists ask what is wrong with the bio-chemistry that's causing it" (P: 7- Ex: 46).). Earlier in the interview he asserted that treating the bio-chemical part of a person is "not actually solving anything" (P: 7 - Ex: 27).

There were mixed views and descriptions of what anti-depressants do. They work for a short period with a client, "bringing down" the symptoms of depression. Participant seven asserted that the:

> trouble with some of the antidepressants is that most of them, the SSRIs are actually natural neurotransmitters, or serotonin or noradrenaline, like Effexor is a mixture of those two, they can actually temporally relieve some depression but they can move some into an over active state, manic state (P: 7 - Ex: 26).

This participant considered some medications as "natural" but also alluded to the harmful effects of anti-depressants because it gives a person "false serotonin" and reduces the person's own ability to regulate his or her own body, but nevertheless they have "a function if they are natural substances related to that" (P: 7 - Ex: 46). This participant additionally claimed that if a client needs anti-depressants and is not taking them, he or she could "do foolish things […] manic attacks and overdrive" (P: 7 - Ex: 24). However, later he asserted that "it [anti-depressant medication] damps down, it turns you into a zombie effectively (P: 7- Ex: 26), "thousands of people going around like zombies now […] it arbitrarily invades (P: 7 - Ex: 46). This resonates with the idea that medication such as anti-depressants dehumanise people.

Participant seven maintained that how someone is living and their lifestyle can disrupt the neurotransmitters, "it is a question of what is causing what" (P: 7 - Ex: 28), and additionally "there is no evidence of it (bio-chemistry) whatever". However, he then claimed that if there was some evidence, some disturbance in bio-chemistry, "it's because of the way you are living and the way you developed. It is not something that is happening out of relationship to your life and environment" (P: 7 - Ex: 51). He continued to assert that "reductionism is wrong" (P: 7 - Ex: 55). He asserted that conceiving depression in a reductionist way "only partly works".

There were interesting comparisons between depression and cancer; participant seven asserted that "medicine only partly works […] cancer is related to your lifestyle" (P: 7 - Ex: 28). In this dialogue,

the participant asserted that both depression and cancer are secondary symptoms, the cause of both being related to how a person is living and the "way you developed". This participant categorised medical treatment as handing yourself over, "same as people with cancer handing themselves over to chemotherapy" (P: 7 - Ex: 47). Introducing the signifier 'cancer' into the discussion introduces other meanings such as disease, a potentially fatal disease. Throughout the dialogue in the interview, the signifier "depression" was "a signifier that represented a subject for another signifier" (Parker 2005); the signifier "depression" represented another signifier "cancer" which can also represent something else through other connotations. This participant was arguably equating depression to a potentially fatal disease of the body, but the cancer metaphor was used paradoxically to remove depression from the disease discourse into a psychosocial "how you are living" discourse, with the purpose of alluding to depression as related to a person's lifestyle. By introducing the metaphor "cancer", there could be many interpretations around different meanings in this signifying chain but by equating the seriousness of cancer with the seriousness of depression; what could be signified and left over is the sense that although 'depression' can be caused by how a person is living, but it is still a matter of life and death.

4.5.2 Depression and Trauma

There was a lot of discussion about trauma as a significant cause of depression. "I am thinking about people who fall into a depression […] there is a trauma" (P: 3 - Ex: 48). One participant asserted that "once I know there is an alcoholic in the family you can be pretty sure there is a lot of trauma and anxiety" (P: 7- Ex: 10). Another participant discussed when a person experiences a breakdown, "the breakdown is the re-experiencing of the trauma" (P: 2 - Ex: 25). Participant four asserted that depression is like "pressing something down". Another participant described how when "something very traumatic happens, the simplest one (trauma) to take is grief, the person isn't able to get in touch" (P: 7 - Ex: 5). When the participant was asked how he would relate trauma to depression, he replied:

> because if you're using energy to contain this from making natural progression, it's obviously zapping energy, so you are going to get exhausted and you don't have any energy to really enjoy life, you live a constricted life, you get depressed (P: 7 - Ex: 42).

This idea of keeping the trauma from natural progression and that containment being a contribution to the tiredness is a significant discourse that raises the question of trauma embodying a physical form "somewhere".

4.5.3 The Bio-physiology of Trauma

A participant discussed the physiological basis of trauma and its relation to memory as the person having "frozen the experience at that point" (P: 7- Ex: 6), saying that, in order to know where to go, he, as the therapist, "must have some idea where the memory is or where the trauma is" (P: 7 - Ex: 10). He continued to explain his hypothesis around this:

> You see for anything to come into memory, first statement is that we don't know where memory is stored […] you know it may be stored in cells or in the brain but anyway, for anything to get into memory of recall which is sort of general recall […] in the area of the brain, the hippocampus, hypothalamus and all that that is linked to the body (P: 7 - Ex: 12).

In analysing this segment, different discourses that "relate to knowledge" were operating at points in a text where knowledge is presumed (Parker 2005 p172). Trauma was presumed to be stored in the bio-physiology of a person they continued to assert that, "it is not generally understood, certainly not at all by psychiatrists" (P: 7 - Ex: 29). There was an attempt at mastery by the participant but when they spoke they were castrated. The split lies between the intersection of the imaginary, symbolic and the real, where meanings keep on being displaced. It is not fully known where to locate trauma, whether in "the cells or the brain" (P: 7 - Ex: 5); memory as "studies" (university discourse) show that "it is in the hippocampus […] that's not a good description […] we don't know where memory is stored" (P: 7 - Ex: 12). Attempts at description fail when they meet the real. The real is beyond description (Pavón-Cuéllar 2010 p5); it cannot be described as it is outside of language and cannot be signified. In a parallel analysis, psychoanalytic theory suggests that a traumatic event can instigate repression, keeping something out of consciousness. Ruti (2012) asserted that trauma disturbs a person's ability to gain anchoring points in language; it destroys the "point de capiton" reducing the symbolic reference points for a person.

4.5.4 Therapeutic Interventions on Trauma

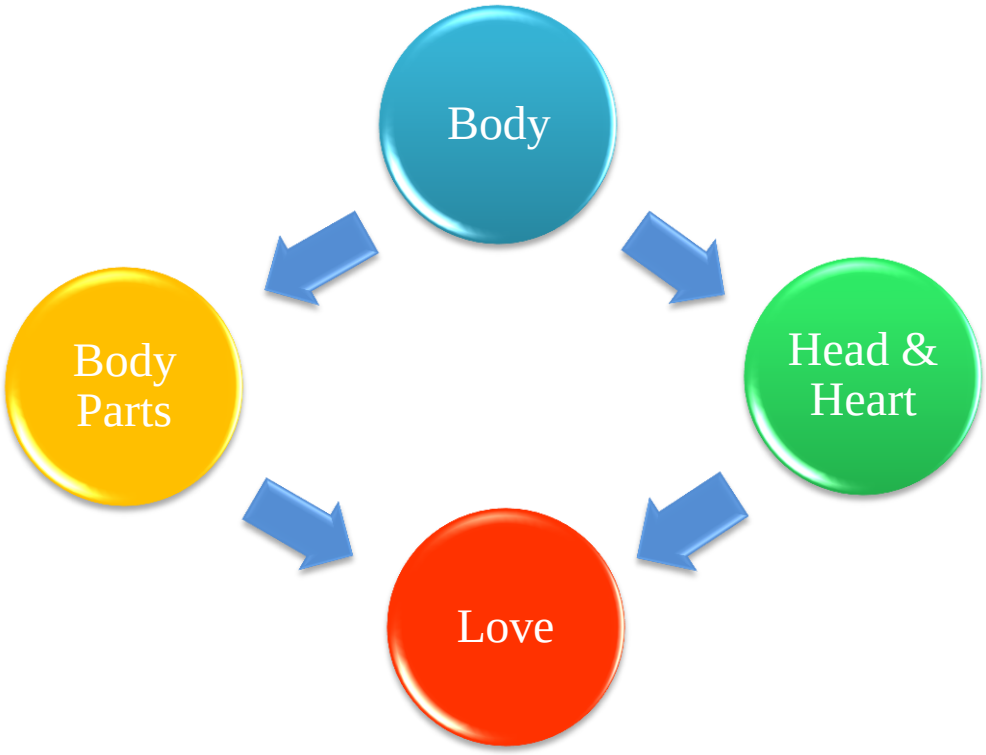
Trauma was a significant feature in the participants' descriptions of their therapy work. Participant four stated that a therapeutic intervention "will re-orientate your system to go through that trauma" (P: 4 - Ex: 68). Participant seven asserted that a goal of therapy was to get the person to fully experience so that the trauma could become memory, and then become the past. According to participant seven, trauma is something that is not experienced, it is un-experienced, it is pushed out of consciousness, it is "out of time" (P: 7 - Ex: 12). He emphasised how he would carry out "a deeper experiential type of therapy bringing people through traumatic experience" (P: 7 - Ex: 2), for clients to fully experience and to get the "full story of what happened them" (P: 7 - Ex: 39). The goal is to unblock the "things

that are blocked" (P: 7 - Ex: 16). Trauma was not only associated with current or past stress but also associated with "former life experiences of other people […] into past lives" (P: 7 - Ex: 71). This could be seen as an incarnation of trauma from one person to another person, originating in a different time, possibly a "different continent" (P: 7- Ex: 73). The signifier "trauma" was used in the motif of past lives by reducing its original context to non-meaning; it becomes a nonsensical signifier, but there was symbolic value to the imaginary reality. The non-sensical signifier was an avatar, an embodiment of an abstract idea, slotted in to "carry on this transcendental consciousness that underpins the conscious imaginary" (Pavón-Cuéllar 2012 p283). In a persons' speech there must be a feeling of "ontological consistency, continuity and stability, unity or community, society or individuality, not-withstanding his division and dissociation" (Pavón-Cuéllar 2012 p283). In the participants' attempts to articulate their therapy work through various discourses of depression; the signifier 'depression' was encrypted through biological, physiological, to social, to memory, into trauma discourses into discourses on past lives. The body was also resourced as a symbolic reservoir, and anti-depressants were discussed in relation to their effects on the body.

4.6 Resourcing the Body

Across the interviews, participants attempted to symbolise the complex challenges of the psychotherapy encounter with clients who are taking anti-depressant medication. The body was used to support the participants as a "quilting point", those points in the text where a discourse is organised (Lacan 1966). In the participants discourse, there were attempts to locate "something […] somewhere". Discussions on the body ranged from movement of the body to physiology and neurotransmitters, references to body parts, i.e., the head and limbs, and even to body organs such as the brains, heart and lungs. Some of these were used in different contexts, and were used metaphorically, which had further connotations for the symbolic meaning. Figure 7 expands upon illustrates the connectedness in the body in relation to body work, the human heart and love.

Figure 7: Resourcing the body



4.6.1 Mapping the Body

A few participants emphasised that the body was significant in their work. One participant asserted that he observes "body responses, sometimes looking for what is not said as well as what is actually said" (P: 5 - Ex: 2). These "body responses" (P: 5 - Ex: 3) were "beyond the verbal into movement" (P: 4 - Ex: 55). For another participant "it is about allowing your body, just to be. Rather than trying to hold it, to surrender to the experience" (P: 4 - Ex: 36). These two participants were trying to interpret the body as signifying and saying something. Participant four asserted that the body takes on five different positions and these indicate different developmental "realities" that have shaped "certain ways of being you" (P: 4 - Ex: 34), "physical templates shaping physical and emotional realities" (P: 4 - Ex: 34). He continued "[the] body is the fundamental ground of being" (P: 4 - Ex: 34). However, he expanded on the connection between the mind and the body by saying "there is no alternative because your brain doesn't know how to scratch your nose, you need to be able to come down into the other parts of yourself to be able to do that […] and it's that movement" (P: 4 - Ex: 18).

Participant five asserted that it is important to notice what is going on in the body and "use that to work with the other aspects and that, with the cognitive and with the emotional" (P: 5 - Ex: 9). He asserted that a part of his work is to support the client:

> to notice what they are aware of in their body and heaviness and that is there anything they can do physically to alleviate that even expertise but also just to notice the cues, is there a physical cue as a trigger that a depressive episode is coming, to just even notice that what is going on in the body (P: 5 - Ex: 9).

One participant asserted that the senses "eyes, ears, feelings, can be captured in an experience[…] somewhere" (P: 7 - Ex: 1), "It is the client's own ability to regulate his or her own body" (P: 7 - Ex: 27), "We recognise the threat by firing the body, all our experiences are in the body not in the brain" (P: 7 - Ex: 12), "this is a feedback system in the body" (P: 7 - Ex: 13).

4.6.2 Body Parts and Medication

There is a reference to a client with severe depression as a "headless chicken" or "chicken-less head". This phrase "headless chicken" has a symbolic significance. As a cultural phrase, it can refer to racing around and trying to do the work of two people. Participant four also discussed clients with severe depression by using the metaphor of "missing a limb", saying, "if they don't have any arm, that's the way they are structured" (P: 4 - Ex: 66). The participant here is confronted with some of the limitations of therapy, the "impossibility" through the client's limitations, the "inability". "I can't help you to grow that arm, no matter what I do" (P: 4 - Ex: 61). The phrase of "missing a limb" was aligned with the idea that a client may need medication. If a person was medicated, it was an indication of a person's "ability" for therapy. And their "ability" is dependent upon how the "brain is structured" and if it is structured in this way or that way, "cognitively they may not be able to handle some therapy [but] there are possibilities when working with medication" (P: 4 - Ex: 58).

Some participants attempted to explain their work with bodies and emotions using comparisons with medical treatments for other parts of the body that needed medication. Participants compared anti-depression medication with other medication that treats organs such as the heart and the lungs, as if depression could be located in a physical organ. Participant three discussed how "clients who go on something (medication) like that because they are already debilitated, or with the OCD that accompanies anorexia, they are able to think better for themselves" (P: 3 - Ex: 41). She continued:

> it is very difficult for the person with anorexia to ingest anything, to take anything , and that is literally what is happening, when the brain is functioning below par and em then they take something like anti-anxiety medication and suddenly they can start taking stuff in (P:3 - Ex: 41).

In this extract, the signifier "depression" seems to operate as if it referred to "anorexia". The signifier "anti-depressant" can also be referred to as an "anti-anxiety drug". These chains of signifiers opened up a few possibilities of interpretation and this extract alluded to the multiple connotations of

depression as a disorder such as anorexia, and treating the body and the brain through medication. Discourses are organised around the body, the body is a symbolic order.

4.6.3 Head, Heart and Body

One participant frequently referred to the "head, heart and body" trilogy, but there were references to each of these concepts in different contexts across the interviews. The inter-relating arenas of "the head, heart and body" (P: 4 - Ex: 2) were also referred to as the "head, heart and body" which represented other signifiers such as "cognitive, emotions and the physical body" or "thoughts, feelings and senses". There were discussions of "different strands of the body, emotion and cognition", and participant four asserted that he is "trying to figure out what has been compressed or what is not working" (P: 4 - Ex: 52). The participant described clients "knowing themselves, being themselves and expressing themselves [as being] fragmented" (P: 4 - Ex: 54). There is a "breakdown" (P: 4 - Ex: 24). The participant located the breakdown as occurring along the "head, heart and body". In discussing how he applies his theory in practice, the participant said that a "combination of head, heart and body" was involved: (P: 4 - Ex: 2)

> people who are caught in the energetic experience of the problem and are reactive to it […] or are caught in the intellectual aspect of it […] and the basis of it all, there is a biological experience and by having the three strands it allows me to meet that person in the triangle (P: 4 - Ex: 2).

He said "the cognitive, the emotional and the physical" were "the core conditions of being part of this species". He mentioned that clients "experienced" the "gap" somewhere between the "head, heart and the body" as in the "thinking, emotions and the body-movement". However, the gap remained, since the brain might be unavailable to make sense of it, and what "if the brain is unable to understand the experience" (P: 4 - Ex: 69). This participant was a humanistic practitioner but through their speech, they were coming across as a CBT therapist, discussing the disconnection between thoughts, feelings and the bodily behaviour, referring to the clients needing to "bring [their] brains in to make sense of it" (P: 4 - Ex: 51). They were arguably attempting to be reductionist to simplify and explain how they practiced, "we try to make sense of what we see with our brains and that is part of the function of the brain to collate and identify and assimilate meaning" (P: 4 - Ex: 54). However, participant seven asserted that psychotherapists do not connect with the head, but it is closer to the heart, through love.

4.6.4 Love

The heart had physical and metaphorical connotations in the interviews (P: 3; P: 4; P: 7), not only as a bodily organ, but as a symbol, a symbolic metaphor to express something else, and that something was love. One participant mentioned that Freud spoke of the aim of psychoanalysis as helping the

client to “love and to work” (P: 3 - Ex: 10). “He (Freud) was really talking about impairment” (P: 3 - Ex: 9). Another participant said that people have been “heavily traumatized and have not experienced love” (P: 7 - Ex: 65), and they asserted that “love is the key” (P: 7 - Ex 66). Trauma was central to this participant’s therapeutic approach, but, interestingly, this was superseded and replaced, by “love” when he asserted that if a person experienced trauma, there was usually an absence of love. They then asserted that if a psychotherapist could “love enough, there was no need for any another method or technique” (P: 7- Ex: 82) and so love became central component of the treatment. The therapist *was* the method, they (therapist) “have their own (method)” (P: 7 - Ex: 1). This participant located love in the “heart”, “the actual organ, closer to the heart than the brain but it was much more than the heart organ” (P: 7 - Ex: 72). By analysing the formal quality of this text, the participants “method” was replaced by the “therapist”, and when they discussed their work with the client, the signifier “trauma” was replaced by “love”, if a therapist can love enough, there was no need for a method, but the signifier “love” could also be represented by “heart”. This participant also said that “the heart is automatically relating to other hearts” (P: 7 - Ex: 63). There is a curious over-determination of signifiers representing the subject for other signifiers but what is of interest here is not so much the signified meaning of these signifiers but how these signifiers were structured. It appeared that certain signifiers and metaphorical substitutes were recurring in this text and acting as quilting points. This could indicate ‘repression’, something kept out in order to keep the signifying system in place. In this circuit of communication, the participant did not speak about anti-depressant medication, “to name the object would disrupt the communication that is taking place” (Parker 2010 p164). But equally, I did not ask about the possible impact of medication in relation to the content of the dialogue.

When asked what the participant meant by “love”, he replied that “that was now in the field of [the] spirituality realm” (P: 7 - Ex: 59), a spiritual discourse encapsulating “a different order” (P: 7 - Ex: 83). There is another order at play here and a crescendo of signifiers such as trauma, love, heart and spirituality and the circuit of signifiers eventually peaked “when we relate to the divine” (P: 7 - Ex: 63), “with whatever we call God” (P: 7 - Ex: 60). God is the ultimate signifier, the master of the master, the supra-agency. God is a potent signifier and represents ideals that many are willing to live and die for. Other potent signifiers are justice, nation and ideological causes (Žižek 2004). Could psychotherapy be an ideological cause when the participant asserted that it is “the only thing that offers anything” (P: 7 - Ex: 65)? This was an example of what Parker (1992 p11) referred to as an “ideological dilemma”. The participant was operating within discourses in different layers of meaning to make sense out of his therapy practice, from trauma, body to spiritual discourses. Additionally, some of what was spoken about here could be to do with transference, as transference can manifest itself in the guise of love and hate but psychoanalysis is a treatment that aims to bring about a cure through love in the transference. Freud (1917) asserted that melancholia was a loss of capacity to love

and one participant asserted that if a therapist can love enough, that is all they will need. Lacan tells us that "every crossing of discourse is also a sign of love" (Lacan 1998 p144). It can be argued that working with love in the transferential relationship with clients is creating a symbolic order and the building the therapeutic alliance.

4.6.5 Summary of "Diverging Discourses"

Section two of this chapter explored emerging discourses within the participants' discussions around their therapy practices with clients who are taking anti-depressant medication. There were significant elements across the interviews and participants discussed their work in relation to the disciplines of 'biology' and 'psychology'. Signifiers were used to represent disciplines and through discourses to express intricate elements of the work. The use of these signifiers was evocative of how participants constructed their work, but also, in some participants, illustrated how discourses reconstructed what had already been said, yielding a retrospective of meaning within each interview. Different discourses were operative in the participants' communication of their understanding of depression, and different discourses on disease, socialising and trauma influenced their work. "Resourcing the body" encapsulated references to the body and anchored meaning for understanding causes and treatment of depression, offering a symbolic grounding for therapists to negotiate their approach in response to the effects of medication. In particular, there were reflections on body parts, limbs and organs such as the heart, but certain signifiers were replacing each other, such as heart and love, they were related to the divine and God was related to everybody. The over-determination of signifiers was arguably operating to keep something out of the text, "something […] somewhere", but was arguably mirroring the therapist and client's search for a symbolic order to create the therapeutic alliance; but trauma reduces the "point de capiton" creating therapeutic challenges. The next section discusses the "shared medical world" that psychotherapists and other professionals "share" and work in with clients who are prescribed anti-depressant medication.

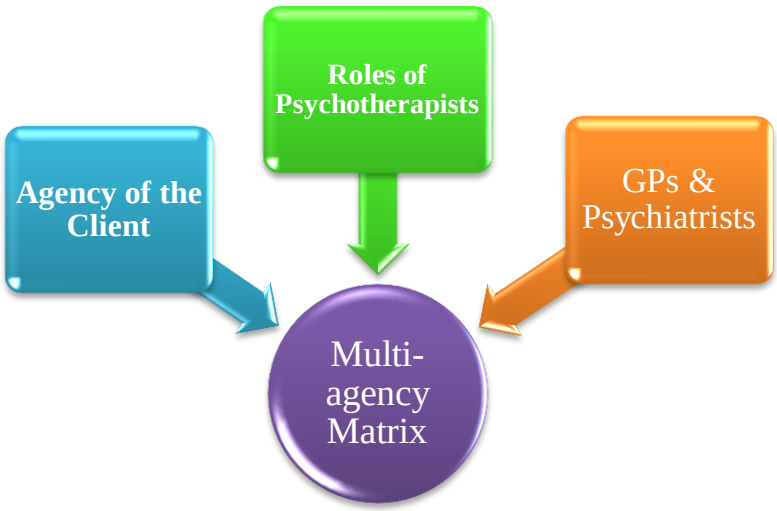
4.7 Section Three: "Shared Medical World"

4.7.1 Introduction

This section is called the "shared medical world" as this phrase tries to encapsulate the psychotherapists' experience of working with clients and if the client is prescribed and taking medication, the psychotherapist is sharing the treatment of a client with other professionals from the medical discourses such as GPs and psychiatrists. A concern for any psychotherapist is working with the client to bring about change, and the clients, at some level, are required to be agents of this change. The concept of agency implies one who desires, makes decisions, and controls one's own

volitional actions but a persons' agency can be compromised by numerous factors beginning with act of speaking and using language; a person "cannot tell the whole truth" (Pavón-Cuéllar 2012 p332), they are a split subject (Lacan 1977). Some participants considered other factors possibly impacting the work they do and the different roles they embody. There was also the impact of the medication and working with other professionals such as "GPs and psychiatrists", the prescribing agents. This set of relationships is termed the "multi-agency matrix", as it relates to how a psychotherapist situates themselves in order to work with the client in the complex dynamics involved. Some of these relationships can be operating at an unconscious level and psychoanalysis provides theories to consider these elements. Figure 8 is a map diagram for this take section portraying the various agencies but there is also a reflection of the 'continuum of positions' that psychotherapists can take in trying to configure how to work in the complexity and ambivalence of working with the impact of anti-depressant medication. See Figure 8.

Figure 8: Shared medical world



4.7.2 Agency of the Client

The suggestion that anti-depressant medication has an impact on the agency of clients and the clients' ability to speak and make decisions emerged through some of the interviews. One participant asserted "they (clients) take the medication and don't ever want to speak to anyone" (P: 3 - Ex: 4). Another participant asserted, "it [anti-depressants] did not stop clients from talking to their doctors, but it didn't help" (P: 2 - Ex: 61). This participant discussed clients' awareness and said that "people themselves don't seem to act on it (anti-depressant medication) either or take up their own agency around it either so what's that about?" (P: 2 - Ex: 47). This idea of anti-depressant medication

inhibiting a client from speaking or making decisions with regard to the taking of anti-depressant medication indicates a sort of passive attitude toward not only taking the medication, but around the clients own mental health. This has a potential implication when a psychotherapist is considering how to work with a client.

One participant asserted "psychotherapy can bring about change but it is essentially the work the person does and your job is to assist that and make it safe enough and possible enough" (P: 7 - Ex: 65). He is asserting that the clients do the work, but it is up to the psychotherapist to facilitate this to create what another participant referred to as "the possibility of change" (P: 4 - Ex: 32). Participant two discussed how anti-depressant medication "makes it [therapy] just slightly bearable and there is the whole thing about the placebo effect and that you know" (P: 2 - Ex: 57). This could be interpreted that the participant was referring to the medication "makes it [therapy] slightly bearable"; alluding to the medication helping her to tolerate the work. She also references the "placebo" idea and that the act of taking a pill can affect a person despite the fact that the pill might not have any pharmaceutical properties. It refers to the impact of the power of belief in alleviating symptoms of depression. This indicates that there might be other discourses operating and that the taking of the medication has a meaning for the client that potentially causes or creates what another participant referred to as "the possibility of change" (P: 4 - Ex: 32). According to participant two:

> we need to make our own assessment as to whether this person is in a position to use what they have or not and depending about the level of anti-depressant medication (P: 2 - Ex: 68).

She is implying that it can "depend on the level of anti-depressants" whether a client is "in a position to use what they have". From the assessment, the therapist considers these two inter-relating factors: the ability of the client and the level of anti-depressant medication.

Participant seven asserted "I think that all therapists, if they have been working with a lot of experience, they are doing the same things" (P: 7- Ex: 81). This was significant as, at the start of his interview, this participant said in relation to different methods "there is a lot of common ground between what they [models] do" (P: 7- Ex: 1), and "an important part for therapists is to get them [clients] to realise that they can handle it, they have the strength" (P: 7- Ex: 41). A therapeutic model may be "a trial [as] to whether it can be effective or not, that you either reach it or you don't" (P: 7- Ex: 65). Another participant discussed how "sometimes it [psychotherapy] is not enough" (P: 3 - Ex: 27).

4.7.3 Roles of the Psychotherapist

Some participants considered the client's ability to make decisions and bring about his or her own change, but there were also considerations of the therapist's ability to make decisions through assessment and clinical practice to "make it safe" for the client. Different practitioners considered this in different ways; some admitted they needed to make judgment calls for the client (P: 3 - Ex: 13; P: 5 - Ex: 23), some were directive (P: 1 - Ex 15), while others were non-directive (P: 2 - Ex: 37). One participant discussed how she embodied different roles: that of the "medic" and that of the "analyst", that of "liberator" and that of "fixer" (P: 3). This participant is suggesting that the psychotherapy needs to embody a dual role depending on what the client is able for. This participant also asserted that "it is very good for us [psychotherapists] to throw up our arms and say no no no no medication" (P: 3 - Ex: 27). This sentiment clearly asserts that if therapists do not think that the client should be medicated, it is acceptable to "throw up our arms and say no….". The same participant asserted that medication is "horrible" but, on the contrary, believed "it will save someone's life", it is "phenomenal". The signifiers "horrible" and "phenomenal" embody a contradictory tension that further conflicts what role the psychotherapist potentially takes up and potentially what model they practice from.

Participant five, referring to psychotherapy and anti-depressant medication asserted that the "combination of the two can help" (P: 5 – Ex: 22), while participant two also asserted "yes I think that both can be worked with effectively" (P: 2 - Ex: 68). However, for others it "depends on the level of anti-depressants" (P: 5 - Ex 14). One participant stated "there are some psychotherapists that won't even take on working with clients unless they are "medically stable and in some cases on medication" (P: 3 - Ex: 25). These "therapists have recognised their limitations" (P: 3 - Ex: 25). This participant then observed that psychotherapists are becoming more open to medication and even suggested the possibility that psychotherapists should be qualified to prescribe: "even though you are not a doctor we are going to give you an MD and give you six months training in medications and off you go" (P: 3 - Ex: 27). This hypothetical scenario symbolised the psychotherapist as wearing two hats, that of the psychiatrist and psychotherapist, embodying a dual role, arguably two conflicting roles. The idea of a psychotherapist acting as a psychiatrist was not teased out by the participant and it was not further queried by the interviewer. What can we infer from the participants statement? To focus on the symbolic aspect of what the participant said at the expense of the imaginary could lose something significant. Was there a motif of "there is no problem" and "everything is workable" (P: 3 - Ex: 28) despite the "insurmountable disparity between both discourses" (Pavón-Cuéllar 2012 p252), and the "limitations" (P: 3 - Ex: 25) of both practices. There was arguably an illusion of agreement into "one version of reality" (Parker 2010 p167) and a keeping out of what Verhaeghe (1995) called the

"impossibility" and "inability". By keeping the absence of any detail out of the text, this helped structure and kept the discourse running in a "shared medical" 'perfect' world. The participant and interviewer were arguably both duped by this illusion.

Participant five discussed how a number of clients admitted "they (clients) have not had a good experience, not so much with the medication. It was the medical team behind them" (P: 5 - Ex: 26). This participant was referring to clients' negative experiences of working with medical prescribers, saying that it is not so much down to the prescription of anti-depressants or the diagnoses that clients are given, but the medical professionals working with them: "they couldn't talk to or relate to the GP or psychiatrist" (P: 5 - Ex: 26). He is asserting that it is important for clients "to relate" (P: 5 - Ex: 26). Another participant discussed how this sharing with other professional medical practitioners such as doctors and psychiatrists was not currently working "hand in hand" (P: 6 – Ex: 31), possibly implying that the relationship is not a collaborative working relationship.

4.7.4 GPs and Psychiatrists

The other significant professionals involved in the "medical world" are the prescribing agents, the GPs and psychiatrists. The participants discussed recognising a change in how doctors had become "pro-active" and more open to psychotherapy, a "general change in psychology and psychiatry" (P: 3 - Ex: 56). This participant also questioned GPs' involvement, asserting that, while some GPs are "intuitive" and "gifted", specialists should be prescribing to "our" clients, and that clients need to be under the review of psychiatrists. The re-view of psychiatrists is what Foucault (2003) referred to as the medical gaze.

> It should be the psychiatrist who reviews it really and prescribes for things such as depression, anxiety or OCD (obsessive compulsive disorder) that is a specialisation of psychiatry" (P: 3 - Ex: 39).

In the next extract this same participant asserted

> you know that GPs don't dish out cardiac medications or kidney medications or whatever the reason. People go, if the heart is in trouble to a cardiac consultant and if the kidneys are in trouble, they would go to a nephrologist, and it is those specialisations that prescribe (P: 3 - Ex: 40).

Another participant commented on the duration that clients are on medication: "like more than six months and they shouldn't be on them for that long, the GPs don't know that and don't necessarily act upon it" (P: 2 - Ex: 47). This is alluding to GPs not taking up their own agency around assessing and managing the prescriptions they give to clients, or once a prescription is given, GPs can become inattentive to medication protocol. Another participant asserted "GPs should not prescribe" (P: 6- Ex:

26). Participant seven asserted that "psychiatrists do not know what they are doing and ask what is wrong with the bio- chemistry that's causing it" (P: 7 - Ex: 28), they do not have an understanding of what depression is and "it is not well understood" (P: 7 - Ex: 29).

One participant suggested that there are connections between some psychotherapy models and the medical model and considered the "marrying" (P: 5 – Ex: 16) of medication and therapy. This included certain therapeutic models complementing the medical model such as CBT but this participant suggested that mindfulness can be useful to support the "client to pay attention on a moment to moment basis to what's going on but with an attitude of openness, acceptance and non-judgment" (P: 5 - Ex: 12). Or it could be interpreted that mindfulness is used to enforce "openness, acceptance and non-judgment" (P: 5 - Ex: 12) around the taking of anti-depressant medication. There is arguably a therapeutic discourse operating to reinforce a medical discourse of prescribing medication, "the employment of a discourse is also often a practice which reproduces the material basis of the institution (Parker 1992 p13). The therapist practicing CBT and mindfulness is arguably the handmaiden to medical practice, unconsciously colluding and reinforcing compliance with taking medication, unconsciously enforcing "acceptance" and endorsing a "non-judgement" of medication.

There was reference to potential difficulties for clients who may struggle to reflect or explore their "inner" or "past" events and experiences. One participant recommended the "CBT approach and the medical approach working better together than a psychoanalytic approach" (P: 3 - Ex: 48). One participant asserted that with CBT and medication, "I think it's easier to function again and use CBT techniques in conjunction with [anti-depressant medication] to help them [clients] to function" (P: 5 - Ex: 31). This suggests that forms of psychotherapy such as CBT can complement medical and psychiatric practices by targeting the identified pathology such as "negative thoughts" in a similar vein to anti-depressants targeting "faulty" neurotransmitters. Some participants conceptualised a mechanistic genesis of depression and proposed a mechanistic treatment, through the reparation of "hard wiring" of thoughts and feelings (P: 1 - Ex: 18).

Another participant articulated:

> CBT doesn't make the cut. I don't believe in CBT, [laugh], well I think people sometimes need to find meaning in their lives (P: 3 - Ex: 48).

This participant asserted that clients should be offered treatment other than medication, but if people say they want medication, they have the right to say that and also that they do not ever want to speak to anyone, "you have to allow for the fact that you might think it [therapy] suits someone and they mightn't want it" (P:3 - Ex: 4). However, she stressed "I really think people would benefit a lot and it would be good if people have that (psychoanalysis) offered over medication" (P:3 - Ex: 48).

What the psychotherapist believes about medication may not be as relevant to what the client thinks. However, what was revealing in some participants' assertions around some of the interventions they use, and how certain discourses were operative in they approached their work differently because of the prescription of anti-depressant medication. This mainly entailed how participants carried out the assessment and approached their work with the client and the impact of the prescribing agents such as GPs and psychiatrists. Foucault (2003 p57) asserted that the medical doctor relies on the practical knowledge of medicine "as the restitution of an eternal truth". And the general public relies on the doctor as subject supposed to know. The doctor, according to Foucault (2003 p264) is "an alienating figure" but remains "the key to psychoanalysis". He was referring to doctor holding the medical gaze in the synonymous act of "caring" and "controlling" the client and this same dynamic is potentially set up in the transference in the therapeutic setting.

4.7.5 Multi-agency Matrix

Some participants considered the influence of the different medical personal involved, and the level of interaction and influence they have on the therapeutic process. There are a number of relationships that need to be considered, the relationship between the therapist and client, the client and the prescriber and there are also other possible unconscious relationships that influence the therapist and client, such as the meaning of the medication and the discourse of the Other, which is the collection of words and expressions in a language (Pavón-Cuéllar 2012). When a person speaks they are subjected to laws of language and this not only shapes what people say but can also provide extra- intentional meanings. All these interrelations are termed the "multi-agency matrix". Figure 9 illustrates the different dynamics that are potentially operative in the therapeutic setting:

Figure 9: Multi-agency matrix

Some participants spoke of not only making judgement calls on what way to work, or being directive or non-directive about how to work with the client, but about judging what the clients were able for and their "ability to respond" (P: 3 - Ex: 2). Participants were gauging other dynamics that he or she is involved in with the client, and the dilemmas that may unfold when working with a client on medication. This participant described a paradoxical situation:

> [I] can't really get rid of the drugs until such time you open up the experience [of depression] but the catch twenty two is that you can't open up the experience because of the drugs, but in fact you can start and she was able to go into a couple of experiences but she wasn't really feeling strong emotion, but never the less it is beginning to open (P: 7 - Ex: 24).

This was significant in relation to participants discussing the difficulty of working with someone on medication, and how anti-depressant medication is working against him and as he claimed can get in the way of a person "going into" what they deem an unresolved experience. Participant seven continued:

> [I] have to do a titrating job, bringing the drugs down and bringing the experience up, but it can take months to get people off drugs particularly lithium cause it is so damaging and people who have a tendency to go manic go crazy if they stop it suddenly (P: 7 - Ex: 24).

This participant admitted the difficulty of the "titrating job" of a psychotherapist working with some anti-depressants, "but never the less it is beginning to open" (P: 7- Ex: 24).

Some of the participants indicated that "knowing" what way to work and what to do is not easy, and psychotherapists rely on "intuition" (P: 3 - Ex: 53) or get a "felt sense" whether someone is ready to work in a particular way (P: 1 - Ex: 27). Participant three expressed that anti-depressant medication makes "the conscious unconscious". She asserted:

> instead of making the conscious unconscious through medication, we make the unconscious conscious, I suppose we want to believe as therapists and analysts that that what we are doing is enough and sometimes it is not (P: 3 - Ex: 27).

When the participant was queried about her statement "making the conscious unconscious through medication", the participant laughed and diverted the answer. This might suggest that the participant did not know the reason why medication makes the conscious unconscious or it could have been what the psychoanalyst refers to as a "Freudian slip" by the participant, a dose of the participant's own medicine, a "discourse of error" (Lacan 1977 p121).

The laugh from the participant was possibly revelatory; Lacan asserted that the "joke defies sense" (Lacan 1977). The unconscious also extends to that of "insistent variation, inconsistency of sense in language" (Parker 2010 p162). If we consider what the participant said as a symbolic phrase that could be providing something extra-intentional, it could be an example of an "intermittent" agency, the agency of the "discourse of the Other" (Parker 2005). The "big Other", according to Žižek (1994) is the name for social substance that interferes with a subject never fully dominating the effects of his or her speech and the final outcome is always something other than what was intended or anticipated. The participants' attitude to medication is unclear here, there appears to be what Pavón-Cuéllar (2012 p261) refers to as a "blind spot" in what she assigns to the meaning of how the anti-depressant medication works. If the intention of psychoanalysis is to make the unconscious conscious, "get in, do the therapy, make the unconscious conscious", and anti-depressants "make the conscious unconscious", this idea sets up anti-depressant as an antithesis to psychoanalysis. One is trying to evoke consciousness and the other is repressing consciousness. The participants statement expressed a limitation of working with a client on anti-depressant medication but the participant was not sure how to explain what she had said, she had "reached her limitation", it was "not enough" (P: 3 - Ex: 27), it was beyond description. It was an "eruption of the real" (Parker 2010 p168). The psychotherapist has to consider what the medication means to the client but also possible unconscious meanings that are operating for the therapist but how the discourse of the Other can operate in language to position the speaker and produce extra-intentional meanings.

4.7.6 Agency and the Unconscious

The participants employed certain discourses through language to describe and convey their therapy work, but each participant who employed language was subjected to the symbolic laws of language and, as I outlined, thus became an employee of the discourse of the Other. Lacan refers to the subject having a conscious and unconscious element, and every subject, as an agent, is a split subject (Lacan 1977). The term agency can also be understood in the Lacanian sense in how signifiers in language can operate as an intermittent agency in constituting the speech of a subject and can further influence the client and the therapeutic process. This implies that there are unconscious intermittent relationships occurring all the time in therapy work. Figure 9 illustrates that a number of relationships can be operating at an unconscious level for the client, impacting on the agency of the client and the therapist. It is the psychoanalyst's job to account for unconscious elements in the work.

One participant asserted that sometimes medication is not suitable for a client, but asserted "I can't say that because she (client) has to learn it and realise it for herself" (P: 2 - Ex: 48). She went on to say that the anti-depressant medication is considered in the transference, "it's up to the individual or the group to come to the conclusion" (P: 2 - Ex: 29). This participant, who was working psychoanalytically, stated that she "can't say", even if her opinion contradicts what she really thinks: "I completely disagree with that diagnosis […] I think it is a total waste of time but I have never said anything" (P: 2 - Ex: 43). Saying that "a client doesn't need medication" (P: 2 - Ex: 43) is the participant's own conclusion, but by working psychoanalytically, she has to censor her opinions in order to create the transference with clients, "it's not for me to […] say" (P: 2 - Ex: 48). By maintaining the analytical position and not acting as the subject who knows, the analyst resists the demand for his or her opinion. He or she is avoiding taking the master or university position and this ideally keeps clients speaking and invites original discourse to emerge from the client.

A psychoanalyst can respond in the form of an interpretation, and one participant asserted that they try and stay neutral, but LDA claims that we are always in *some* position: "no metalanguage can be spoken" (Parker 2005). In other words, there is no metalanguage of the transference, no vantage point outside the transference from which the analyst could offer an interpretation, since any interpretation he or she offers "will be received as coming from the person that the transference imputes him to be" (Lacan 1977 p231). By carrying out an interpretation, analysts are "structured into patterns of discourse" (Pavón-Cuéllar 2012 p34). The therapist operating from the analyst's position can interpret the transference, and not only bring to awareness intermittent discourses, such as medication, medical prescribers but even family members might appear in the transference, and this emergence could reveal what further meaning these positions might imbue. The "transference is the transportation"

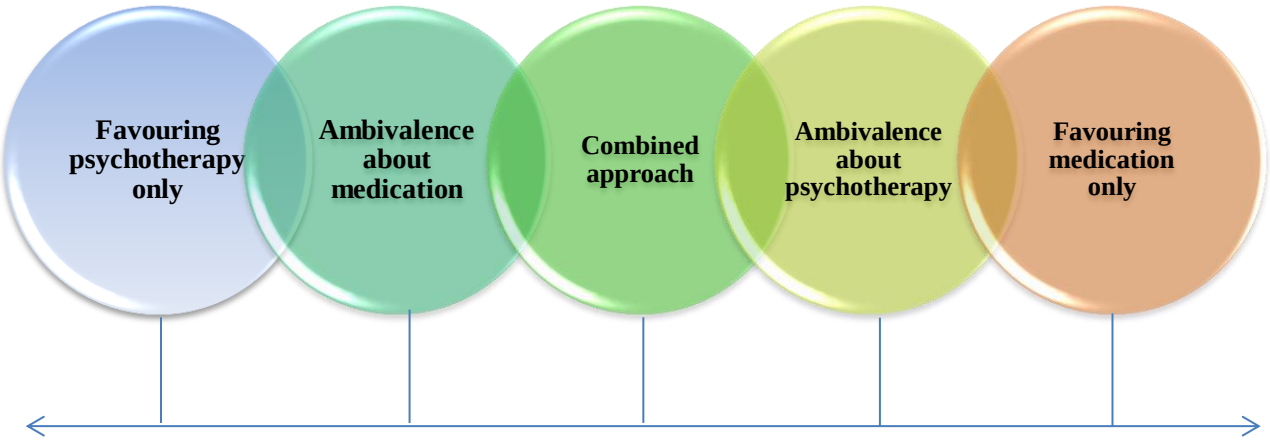
(Loose 2002 p246) to get insight into unconscious operative meanings and clients' investment in his or her sickness and medical treatment.

One participant asserted that anti-depressants "are in the room" and "anti-depressant medication could be taking up a certain positions in the therapy" (P: 2 - Ex: 79). Anti-depressant medication could be seen as a "cure" and a client might feel they "need" it, or the client could be "coerced" and "directed" to take it by prescribers or family and all this could be occurring unconsciously. Another participant claimed the "more silent the better without being too persecutory" (P: 3 - Ex: 56). According to Foucault (1989 p264), the psychoanalyst stays silent behind the couch and is transformed into an "absolute Observer, a pure and circumspect Silence, a Judge who punishes and rewards in a judgement that does not even condescend to language". But psychoanalysts use the silence as an intervention with a possible purpose to confront the client with his or her desire. The psychotherapist, working psychoanalytically, can consider these possibilities to open up options for reconceptualising and repositioning how to work and how to therapeutically re-orientate the desire of the client within the multi-agency matrix.

4.7.7 A continuum of positions

The participants expressed different responses toward their psychotherapy practice and anti-depressant medication. From the interviews carried out, the findings encompass different positions taken by the participants in their consideration of working with clients who are taking anti-depressant medication, from favouring psychotherapy alone, to ambivalence about medication, to a combined approach, to ambivalence about psychotherapy and the position of advocating medication alone. Participants' responses can be situated along a continuum of psychotherapy discourse to medical discourse. See Figure 10.

Figure 10: Continuum of positions



Throughout the findings, I examined different discourses that positioned the participants and shaped the beliefs around not only his or her therapy practice but also medication. The speech of the participants was shifting the participants along this continuum; positioning and re-positioning the participants on different points even in one passage of speech. One participant asserted that "sometimes it [anti-depressant medication] not useful…is horrible… [and]… sometimes it is phenomenal […] absolutely" (P: 3 - Ex: 26).

For some participants, they were advocating psychotherapy alone, claiming that psychotherapy "is the only thing that offers anything" (P: 7 - Ex: 22). One participant asserted "it is very good for us [psychotherapists] to throw up our arms and say no no no no medication" (P: 3 - Ex: 27). She referred to "the purists" that think that "psychotherapy could solve everything and psychoanalysis could solve the world, let alone the client" (P: 3 - Ex: 26), she also expressed that "it would be good if people have that [psychotherapy] offered over medication" (P: 3 - Ex: 48). More specifically, this participant advocated psychoanalysis over other modalities. Another participant stated that they were "not actually that familiar with the range of anti-depressants and the impact that they have on people" (P: 5 - Ex: 25). By not acknowledging the existence of anti-depressant medication could be indicative of an invisible discourse operating and keeping out the significance of the meaning and possible impact of the drug. Moving into the more ambivalent position about medication, some participants acknowledged medication but "were unsure what anti-depressants mean" (P: 4) and another statement asserted that "nobody knows how SSRI work" (P: 1- Ex: 9). For one participant medication "only partly works" (P: 7 - Ex: 55). One participant claimed that anti-depressant medication blocked the therapy work, working against the therapist, "making the conscious unconscious" (P: 3 - Ex: 27).

Some participants advocated a combined approach of therapy and medication or as one participant referred to as "marrying the two" (P: 5 - Ex: 12). One participant highlighted that it is important that clients are "medically stable and in some cases on medication" (P: 3 - Ex: 25). This same participant asserted that medication can "free them up to do the work". It was difficult to interpret whether the participant was referring to the medication freeing her up and her work or the client. But for another participant, the therapeutic work can depend on the ability of client and "depend on the level of anti-depressants" (P: 2 - Ex: 68). A combined approach for some participants was "to help them [clients] to function" (P: 5 - Ex: 31), Participant five advocated CBT and medication and asserted that "both can be worked with effectively" (P: 2 - Ex: 68). This position considers an openness to "more possibilities when working with medication" (P: 4 - Ex: 58) in the dual treatment, but the psychotherapist that takes that position could be duped by the illusion that the two can work "effectively" despite the limitations of both.

Moving into the ambivalent attitude towards psychotherapy one participant asserted a belief in medication keeping a client on an "even keel", if the client was "floundering", or "structured that way", "missing a limb" and medication was the needed to "fill the gap" (P: 4 - EX: 66), and client might not want to talk, or as one participant asserted that "they are not able to go there". In taking the "medication only" position, one participant asserted that psychotherapy is "not enough" (P: 3 – Ex: 21), for another participant "therapy keeps the trauma alive" (P: 6 - Ex: 32). A participant asserted that "clients have the right *not* to talk" (P: 3 - Ex: 30), "medication is phenomenal […] absolutely" (P: 3 - Ex: 26), and for another participant, the more they spoke about anti-depressant medication, the found themselves in harmony with the medical discourse, more positively inclined toward medication. Another participant asserted that it can be "impossible" to therapeutically work with a person with symptoms of "deep" depression. This can be referred to as "psychotic depression" (Verhaeghe 2004) and there not only medication needed but anti-psychotic medication are sometimes needed to what one participant referred to as "help build a therapeutic relationship" (P: 7- Ex: 46). This requires a reconsideration of working with the transference in the therapeutic relationship (P: 7- Ex: 47).

The positions taken by participants along the continuum did not always fit with his or her therapeutic model, as I referred to the participants as "conflicted therapists". Some participants at times took an "absolute" position at either end of the continuum but all the therapists appeared to flux in positions and respond by conceptualizing an eclectic configuration, consciously embodying different roles in response to the different presenting clinical realities they spoke about. The psychotherapist has to consider the multiple positions that are occurring at any one time, possibly holding split ideological positions. This highlights the potential impact of working in the multi-agency matrix and how any verbal exchange carries a flux of conscious and unconscious meanings, continually shaping and repositioning the therapists and the clients. So whatever position a psychotherapist consciously takes on the continuum, the client might impute the therapist to be somewhere else on the continuum through a transferential dynamic. But can we approximate where a psychotherapist should be situated on the continuum at any one time? There is probably no standard text book answer but it could be important for a psychotherapist to ask what is guiding them to take a certain position, what beliefs are shaping and intuitively guiding the work; is it scientific research, medical knowledge, a therapeutic theory and model, clinical experience or all these combined in light of how the client is presenting. Psychotherapists need to critically reflect upon the meaning of the position they uphold in the unfolding dynamics. If psychotherapists are advocating a position somewhere on the continuum from "psychotherapy alone" to "medication alone", it is important to understand the forces and possible invisible discourses that could be situating and re- positioning the therapists. As one participant asserted: "knowing the difference between doing it, and knowing what you are doing and knowing

why you are doing it" (P: 3 - Ex: 10). Therapist should try and take a critical position on what is best practice and taking into account the singularity of every client and the originality of their context.

4.7.8 Summary of Shared Medical World

This section looked at how psychotherapists need to make informed decisions regarding how they work and must consider the wider dynamics and the impact on the client's agency. The findings reflected how psychotherapists can embody different roles by considering the ability of the client and managing elements of the impact of the anti-depressant medication, a dual role balancing between the fixer and the analyst, the medic and liberator. The psychotherapist is not only working with the client, but in a 'shared medical world' with other professionals such as the GP and/or the psychiatrist who prescribes the medication, and wider dynamics that may emerge within the transference in the therapeutic relationship. Psychotherapists can not only take up different roles but different positions on the 'continuum', from advocating psychotherapy alone to favoring medication alone. But psychotherapists have to critically examine the reasons why they are situated at a particular juncture on the 'continuum' at any one time in working with a client and they may be required to hold different theoretically based positions at once, taking into account possible unconscious elements impacting and fluxing the positions in the therapeutic relationship.

4.8 Conclusion of Findings

This chapter presented diverse experiences of working with clients on anti-depressant medication. Certain conflict emerged throughout the discourses in how the participants discussed the application of their theoretical model to clinical practice. Participants discussed the models they practiced from, their methods of assessment, and how they varied their approaches when considering individual clients. The participants were using language to express their work, but, simultaneously, they were being used *by* language, and were receptors and reproducers of discourse. Operative discourses shaped the participants speech; these included the dialectic tension between 'psychology and biology', 'discourses on depression' and the discourses on 'the body'. Participants appeared to have mixed ideas as to the function of anti-depressants, some therapists did not know much about anti-depressant medication, and other participants were positively inclined. For psychotherapists, anti-depressant medications had psychological effects in addition to their impact on the brain, and psychotherapeutic interventions affected the biology in addition to having psychological impact. There were cross-overs and switching of places with the signifiers "psychological" and "biological". These terms were used by participants in different contexts to explain what they conceive depression to be and how to work with it. Participants were speaking from within different depression discourses such as medical, disease and trauma discourses but tried to stitch over contradictory elements to continue to make

sense out of their work. Resourcing the body involved participants' attempts to try to linguistically locate "something […] somewhere", and from that, body parts were utilised and discussed in symbolic attempts to operationalise the participants therapy models in the clinical work. However, there were gaps, non-meanings and deadlocks in perspectives in the participants' discourses, and this possibly exposed some unconscious elements structuring the participants' speech. Master signifiers such as the heart and love, including God, were used to express psychotherapeutic interventions in working with the body and trauma. This was arguably positioning psychotherapy practice into an ideological dilemma as the "only thing that offers anything" but as one participant stated "sometimes it is not enough".

Multiple meanings and messages were considered by participants and they had to configure how to work with conscious and unconscious relationships and overcome complex challenges. The findings reflected various ways for psychotherapists to situate therapeutic interventions in different contexts. Also considered were the different roles of the psychotherapist and his or her ability to apply the therapeutic model, recognising that sometimes it is not enough to work within a particular model. The recognition was about the knowledge of therapy models and research and the clinical experience to know what to use and when, and perhaps reliance on judgement of the psychotherapist to consider the context of the clinical reality. Another challenge for psychotherapists was situating their work alongside other professionals in a 'shared medical world'. Some of the participants considered the impact of intermittent medical agencies such as GPs and psychiatrists on the client but also had implications for the therapy practice. Some of the therapeutic models were considered as working in conjunction with a medical world that use terms, concepts and frameworks to understand and treat depression, including clinical indicators, severities and stages that doctors and psychiatrists use. However, the different therapy models provided different flexibility for different contexts; CBT and mindfulness were chosen to work with clients who needed more supportive work; they encouraged awareness but arguably colluded with the medical model and facilitated passive acceptance of medication, to control. Some participants advocated something more than CBT and working psychoanalytically considered meaning and unconscious discourses operative when working with a client on anti-depressant medication.

By thinking critically about the nature of clients taking anti-depressant medication, this opens up many possibilities of the various positions taken up by different agencies, whether conscious or unconscious and psychotherapists need to critically position their work in the multi-agency matrix and try and avoid mirroring the medical discourse of controlling the client. Psychotherapists have to hold different therapeutic possibilities and embody conflicting discourses where they could be situated on the 'continuum of positions'; sometimes upholding different positions simultaneously, embodying

diverse discourses. The shifting positions on the continuum in order integrate the dialectic theories of knowledge and to embrace the unfolding complexity of events. In the therapeutic dialogue, the therapists positions are constantly revolving along the continuum and discourses are operative in this rotation, Lacan (1998 p144) asserted that "every crossing of discourse is also a sign of love". As one participant asserted if a therapist can love enough, that is all a therapist needs. There will be a critical discussion of these findings in the next chapter.

5. CHAPTER 5 – Discussion

5.1 Introduction

This study was concerned with psychotherapists' accounts of their work with clients who are taking anti-depressant medication and the participants were asked what, if any, strategies they employ to address any perceived impact the anti-depressant medication may have on the client and the psychotherapeutic process. The methodology design for this qualitative research was discourse analysis and certain Lacanian psychoanalytic concepts were introduced into the data to analyse how participants used and were moved by language (Parker 2005). There were conflicting experiences described and a diversity of discourses spoken by the participants. Different positions were taken by the participants evidenced in their continual attempts to make sense of what was spoken. This research was concerned with exploring possible discourses that were operative in how these diverse experiences were communicated. The participants described various ways of conceptualising their work, through assessments and therapeutic modalities, and discussed certain interventions in different contexts for responding to the impact of the medication. Some of the key findings are:

1. Participants appeared conflicted in what they thought about anti-depressant medication but similarly conflicted in how they understood and applied their therapeutic models. There appeared to be underlying messages that anti-depressant medication does the same work as the therapist; some participants considered the medication as doing a better job. Some participants expressed the view that they did not know anything about anti-depressant medication or how it worked, and were unaware of potential significance. Some participants expressed the view that while anti-depressant medication was horrible, it saved lives and could be phenomenal. Other participants were positively inclined, and, for some, the medication helped fill the gap, as if clients were missing something – biochemistry, a limb or the client's head. Participants considered that too much medication could contribute to a person becoming dehumanised, manic, a zombie even.
2. Therapeutic and medical discourses were operative in the participants' accounts of the work. The signifiers "biology" and "psychology" produced a dialectical tension that shifted meaning in how participants conceptualised their work. Discourses on "depression" and discourses of "the body" were used by participants to try to orientate and to respond to the different parts of the work, as if to try to map and identify "something […] somewhere". Other therapeutic, spiritual and abstract discourses such as trauma, love and past lives were referenced to situate the work "beyond the biochemistry". Psychotherapy was posed in ideological position as the

only thing that offers anything, but, in this regard, the findings noted that sometimes psychotherapy is not enough; psychotherapists are not only conflicted, but castrated.

3. Some participants considered psychotherapy and the medical model working well together; for others it was not working hand in hand, and, for some, medication was working against psychotherapy. The findings reflected upon multiple conscious and unconscious elements operative in the therapeutic relationship. Various roles of the psychotherapist were explored in response to the impact of anti-depressant medication and in consideration of the influence of other professionals such as GPs and psychiatrists. Certain intermittent factors were considered by participants in light of the impact that they have on clients in taking up their own agency around the medication. Participants reflected upon the meaning of medication and how its presence may be influencing the work. The participants could be situated somewhere on the 'continuum of positions', sometimes upholding different positions simultaneously, embodying conflicting discourses. Participants tried to get a sense of what the client might be ready for and how the therapist might situate his or her work, whether to work as a psychotherapist (fixer) or psychoanalyst (liberator) in the multi-agency matrix.

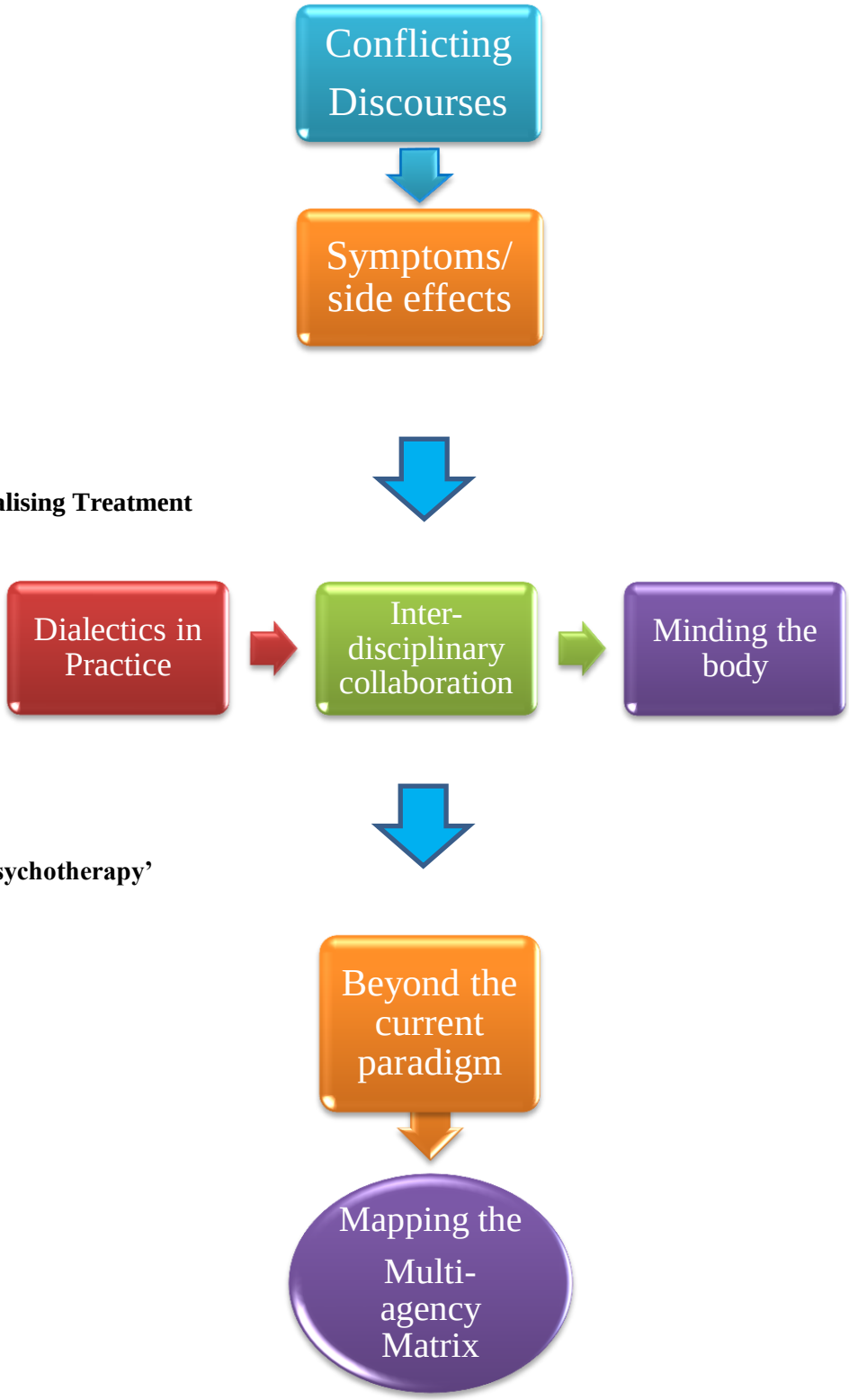
The literature reviewed has resonated with the findings of this study, but other significant research was identified in light of the findings. There is a further examination of analysed data found in the findings and relevant research. The map below is a visual representation of the main components of this discussion chapter. See Figure 11.

Section one of this chapter will explore "dichotomising discourses" that emerged in the participants' accounts; these reports are mirrored in mixed results in contemporary research on depression and anti-depressant medication. Specific attention is paid to psychotherapy work in attempting to conceptualise and distinguish between symptoms of depression and side effects of anti-depressant medication. Section two is entitled "reconceptualising treatment" and will critically reflect upon the dialectical tension between the biological and psychological discourses that influence psychotherapists in evaluating what therapeutic models to use in response to different clinical realities. There are many competing and conflicting discourses in mental health practice, and there is an exploration of the idea of "inter-disciplinary collaboration", between the discipline of psychotherapy and other related disciplines. There is also an examination of literature on the body and a reflection on deeper meanings in the body, medicine and recovery. Section three is entitled "situating psychotherapy" and it explores how psychotherapy work can be situated with in the medical world, specifically in relation to how psychotherapists critically reflect upon the way to work with clients, taking into consideration other

influences and unconscious dynamics in the multi-agency matrix that potentially tempts the therapist to dominate at the expense of the clients' desire.

Figure 11: Map of discussion

Dichotomising Discourses



5.2 Section 1: Dichotomising Discourses

The findings presented conflicting discourses for psychotherapists working with clients who are taking anti-depressant medication. The diverse reports of the participants' experiences resonated with Derrida's (1981) use of the old Greek word "pharmakon" that means both "cure" and "poison". He used it as an example to expose the undecidability and ambiguous nature of words, concepts, text, meaning and empirical knowledge. This sensibility echoed how the object of anti-depressant medication embodied contradictory meanings for participants. A person taking anti-depressants may experience the medication either as a "cure" or a "poison", and there is a similar ambiguity for the psychotherapist as to whether the medication is seen as a help or a hindrance. Some of the research in the literature on anti-depressant medication suggests that it generates "dichotomizing results" (Kirsch and Moncrieff 2007).

5.2.1 Conflicting Discourses

Throughout the findings, I analysed various conflicting discourses. Findings on the benefits of anti-depressant medication vary across studies, but some significant research suggested that there are only marginal differences between anti-depressant medications and placebos (Kirsh 2009). At the same time, some research asserted negative reports of severe side effects not only from taking medication as Hammersley (1995) expressed that anti-depressants can sometimes make the symptoms worse, but also from discontinuing it (Catell 2004; Breggin 2008; Valluri et al. 2010). Pharmaceutical companies warn of side effects on their websites and instructions for use, but this is not always communicated to the client by the medical prescriber. One participant's dilemma in this study was the view that while anti-depressant medication is horrible, it saves lives. In Karp's (2007) study, people reported that anti-depressant medication "saved" them. Another participant in this study reported that anti-depressant medications are no solution, but accepted that some anti-depressants were "natural" and are required for clients occasionally. This "natural" discourse was arguably hiding behind the medical discourse, where the practice of prescribing anti-depressant medication claims to be "natural and hides its own political artifices" (Pavón-Cuéllar 2012 p282). This is what Pavón-Cuéllar (2012) refers to as the "mythical naturalization" within discourses. It is a political device employed in pharmaceutical marketing to legitimate medical practices such as psychiatric diagnosis and the prescription of drugs for treatment (Koerner 2002; Moncrieff 2012). Some medical discourses appeared to be operating within the participants' configuration of his and her therapeutic modality in response to medication, accepting medication as "natural" part of the treatment.

One participant referred to a person who needs medication as "missing a limb", stating that he or she is a "headless chicken… [or a] … "chicken-less head", and that taking medication is "filling in on

missed brain chemistry". For another participant, medication is a "foreign body" that "arbitrarily invades". This participant lamented of the "titrating job" that psychotherapists have, claiming that some of the side effects turned people into zombies**.** The reference to the "zombie" has symbolic resonance and directs our attention to the fictitious figures of books and films who have died but who keep on living, traumatising others; the living dead. Another interpretation may be that the anti-depressant object is the zombie, an alien force "arbitrarily invading" not only the client but also the therapeutic relationship. However, the philosophical idea of the zombie outlined by Chalmers (2010) suggests the dualist idea that some parts of the person are disconnected and separate in themselves, lacking conscious experience (Chalmers 1996) or even lacking agency – the ability for volitional control. Or the zombie reference might indicate that the psychotherapist feels threatened or terrorised of the difficult out–of–control behaviour from the client. This reverberates with some research that claims that long-term treatment with anti-depressants might even harm clients (Fava et al. 2007; Fava, 2003; Moncrieff 2006). Certain anti-depressants can increase "elevations of blood pressure" (Healy 2004 p267). Some medications can reduce life expectancy (Bracken et al. 2012) while all are "lethal-in-overdose" (Healy 2004 p241). While suicide is usually associated with feelings of depression (Gilbert 2013), certain anti-depressant medications can induce suicide ideation for some clients (Healy 2012; Valluri et al. 2010), playing around with the idea of death. The "possibility of a client to kill himself is perhaps the greatest fear for most counsellors" (Feltham 2013b p98). Other side effects from SSRI medication include agitation, decreased libido, disorientation and neuromuscular desensitisation (Catell 2004). There is a sense that anti-depressant medication is providing something to a client on one level, but, in a different way, it is taking something away. It permits people to keep on living, but at a price; they are the living dead.

The side effects of medication resonate with Leader's (2009 p181) assertion of the "real world" of the "melancholic", involving "terrifying motifs as endless purgatory… unutterable pain and angst, and the call of the dead". There is perhaps something revealed by contrasting the side effects of medication with the melancholic experience. The melancholic experience is not only mourning the loss of an object, but involves an ambiguous sense of not knowing what was lost. The melancholic endures a fusion of feelings of love and hate, and is not ready to separate from the object. The illusive object pathologically lives on in the person (Žižek 1992). The desire for the object has withdrawn and melancholy stands for the presence of the object itself deprived of desire for itself. Klein (1967) asserted that the function of the depressive position is for a person to manage the loss or lack that was being experienced. This position is a pre-condition for language acquisition (Kristeva 2001). It is an opportunity to symbolically reorder the person's world, to distinguish between the world of the living and the world of the dead (Leader 2009). If a person takes an anti-depressant tablet to fill in what was lost, the drug will do nothing for this melancholic loss of desire, "no drug can fill this place to make it

essential" (Loose 2002 p123). If we consider the "pharmakon" concept of cure or poison, taking the medication could not only compound desire but propel the confusion further. This could leave a person feeling more dejected; not only never really sure what was lost, but also not really sure what was gained, what is real and what is phantasy, what is alive and what is dead. A psychotherapist's role is not only to try to interpret the depressive symptoms, but also to consider the conscious and unconscious investment in the clients taking of the anti-depressant object. A part of the work is to consider what this investment is, and to decipher with the client this confusion between what might be a depressive response to a loss and potential side-effects of medication, while also considering the possibility that they might be the same thing, and that the medication could be accentuating the ambiguous sense of not knowing what one has or has lost.

5.2.2 Symptoms and Side Effects

Moncrieff (2010) claims that there are mixed messages around the impact of taking anti-depressant medication. There are also unclear messages around side-effects and withdrawal effects if these drugs are reduced or discontinued (Double 2010; Breggin 2012). Medical prescribers can interpret the effects of withdrawals from anti-depressant medication as returning depression symptoms, and put clients back on medication, in some cases increase medication (Whitaker 2010). This confusion concurs with findings of this study, where some participants perceived the risk of clients going into overdrive and into a manic state, not only as a result of taking anti-depressant medication, but also as a result of discontinuing it; other participants discussed clients needing the medication to engage in psychotherapy. Participants in this study were situated at different junctures on the 'continuum of positions' depending on the clinical context they were discussing.

In Kramer's (1997) experience of working with depressed and medicated clients, he questioned whether he was "listening to Prozac" or to the client's real self. Akin to this, Karp (2006 p88) commented that anti-depressant medication can create "another layer to the search for the self because they influence feelings and moods" (Karp 2006 p97). Karp (2006) also asserted that medication can restrain and repress important parts of the person. For one person in Karp's research, they wanted to cry but he couldn't and he "knew that it was the prozac" (Karp 2006 p109). This resonates with the statement by one participant that medication is blocking something. The pharmaceutical action of anti-depressant medication was not well understood by some of the participants of this study; one participant asserted that anti-depressants make the "conscious unconscious", but, while unable to relay why this was the case, arguably had a sense of something working against her. This idea of "another layer to search" has implications for a psychotherapist whose therapeutic role can be to try to help the client in exploring possible meanings contained in the symptoms and side effects. Potential side effects could be explored in light of symptom formation (Murawiec 2009). Exploring and

carrying out interpretations on side effects of medication such as anxiety, insomnia, hallucinations and sexual dysfunction could be also revealing in making sense and unravelling the meaning within the presenting symptoms. Psychotherapy can give support to the client in trying to recognise the link between possible symptoms and side effects, and in trying to negotiate a consensual reality with the client to symbolise these conflicting experiences.

5.2.3 Summary of "Dichotomising Discourses"

There was clearly no homogenous response by the psychotherapists in addressing how to respond to the complex issues that arise when working with clients who are taking anti-depressant medication. There were positive and negative reports around some of the side effects of anti-depressant medication. A therapist's role can be to assess and formulate a working hypothesis that takes into account the complexity of cases. In considering these conflicting experiences, there is a possibility that the side effects may be an accentuated melancholic reaction to taking the anti-depressants; the confusion of investing in an object and realising that it was not as expected. The medication will arguably do nothing to resolve depression resulting from melancholic origins, but the psychotherapist has an opportunity to support the client to symbolically re-order his or her world, to distinguish between symptoms and side effects, using the anti-depressant object as symbolic leverage to extrapolate the investment and meaning of taking it. Therapists need to configure how to engage with the different "layers" of meaning. This requires a critical reconceptualization of theory, what models to use, what way to work and where to position themselves on the 'continuum' when working with clients who are taking anti-depressant medication.

5.3 Section 2: Reconceptualising Treatment

Dual treatment by psychotherapy and anti-depressant medication is recommended in some clinical cases. To prescribe anti-depressant medication without the offer of psychological support is to omit a necessary part of the treatment. In addition, some participants held the belief that to provide only psychotherapy for a person might not be sufficient if a person is "floundering", is "missing brain chemistry" or is experiencing what one participant referred to as a "deep depression". When the participants discussed their therapeutic models, some reconceptualised how they practiced when they considered the clinical reality of working with clients on anti-depressant medication. There was a dialectical tension between the biological and psychological discourses. However, in both the findings of this study and in the psychotherapy literature, there are attempts to integrate contradictory disciplines such as biology and psychology in an "interdisciplinary collaboration". The body emerged as a significant feature in conceptualising the treatment of depression in conjunction with medication.

In this section, there will also be a review of how the body and movement can be resourced in psychotherapy to explore cultural meanings, medicine and healing for the client.

5.3.1 Dialectics in Practice

The philosophical concept of dialectics supposes that the world consists of opposite but not necessarily opposing ideas or concepts (Russell 2006). From the findings in this study, we note the series of oppositions at work in the dialectical tension between the psychological and biological discourses in relation to psychotherapy treatment and treatment by medication. In theory, there is an "insurmountable disparity between both discourses" (Pavón-Cuéllar 2012 p252), but the findings reflected the interdependence of these twin discourses but how one never fully eclipses the other (Derrida 1976). There is what Parker (1999 p4) refers to as a "unity of opposites". In considering symptoms of depression, there is a sense of the participants trying to distinguish between what might be "pathological" neurotransmitters (biological) and what might be a "normal response to pathological social systems" (psychological) (Karp 2006 p184). By focusing on the biological and psychological discourses in isolation, a therapist carrying out an assessment could miss the wider context of the person's experience of depression and the possibilities for treatment. The findings of this study highlighted the complex interplay of forces in the biological and psychological discourses underlying all therapeutic interventions and, within this context, psychotherapists have to consider what model they will use and how they will practice.

The participants expressed various theoretical ways of working, including humanistic, psychoanalytic and systemic models, but all participants discussed embodying different roles in different contexts, sometimes using supportive interventions such as CBT. NICE (2009) guidelines prioritise CBT as a psychological treatment over other psychotherapy models for mild to moderate depression, and in conjunction with medication for major depression. The success of CBT may relate to its ability to help depressed people disengage their attention from threatening stimuli (Pollack 2001), and supporting clients in managing their thoughts can instigate psychological control. The therapist using this model can also support clients in keeping mood diaries and identifying stressful environmental factors. Despite the "highest quality" treatment recommendations of the NICE (2009) guidelines, the CBT approach presupposes an anti-holistic ontology of the person, and a criticism of that epistemology is that thinking and an emotional state cannot be "effectively split off and treated as relatively isolatable and autonomous from the rest of someone's being" (House 2010 p294). For some theorists, there is no duality, "thinking and the emotional form an indissolubly interdependent unity" (Damasio 1994; Goleman 1995).

Parker (1998) asserts that terms like "cognition" and "emotions" are functions of discourse that presuppose that they are lying under the surface "steering", "pushing" or "motivating behaviour". Parker maintains that "thinking, development and social behaviour are still embedded in wider regimes of knowledge" (Parker 1998 p78) and that psychotherapeutic discourse specifies the way we think and feel about problems and solutions. Althusser (1966 p56) referred to these as "ideological formations" and it can be argued that psychotherapists rely on these ideological formations in attempts to justify what they do. But there are arguably more sinister discourses unconsciously operating within the theory and practice of psychotherapy and that psychotherapists buy into these discourses due to the dominance of the medical discourse. Some of the participants were positively inclined towards clients taking anti-depressant medication, to fill the gap or to take the edge off and keep the client on an even keel. This is arguably resistance, an attempt to avoid the negative transference of a client experiencing a "deep" melancholic depression, or what Leader (2009 p181) referred to as "the call of the dead". The therapist can respond by incorporating the tools of CBT interventions and attempts to control the thoughts and feelings of clients. This also resonates with how psychiatric diagnosis justifies the provision of care for adults, but disguises attempts to control people with behavioural problems (Moncrieff 2010). Diagnosis can bring with it dehumanization and the pathologization of human activities can inflict iatrogenesis (Illich 1976). The practice of psychotherapy and the therapeutic modalities appear at some level to collude with practices in the medical matrix, resonating with Foucault's (1989) mantra: to care for is to control!

A hidden ideology behind CBT's success might be that behind the magic of symptom removal lies the typical capitalist logic that favours short term, cost-effective measures, while the "big pharma" endorse the long-term "solution". Lacan remarked that the discourse of capitalism is the "cleverest discourse" ever devised by humans (Parker and Pavón-Cuéllar 2013). The technological interventions of CBT can be compared to what one participant referred to as the "blunt instrument" of anti-depressant medication, and Bracken et al. (2012 p430) asserted that the techno-paradigm of CBT is "not context dependent", so that psychotherapists need something more than the "bio-medical idiom to encapsulate problems with feelings, thoughts and behaviours and relationships". Critically looking "beyond the bio-chemistry" into the context does not mean that therapists should ignore medical discourses, but it may be about becoming aware and working in collaboration with other mental health treatments without becoming controlled and caught in the "imaginary" bio-medical paradigm (Verhaeghe 1995). But the imaginary is only that which appears to make sense.

5.3.2 Inter-disciplinary Collaboration

Psychotherapists can consider different realms of knowledge that inform different theories of depression. In the literature review, there was a look at neurobiology and psychosocial perspectives on depression. In considering the treatment of different severities of depression, some participants in this study asserted that clients can have a debilitating depression and maintained that sometimes therapy is not enough and medication might be needed. These participants took at combined response on the 'continuum of positions'. Conceptualising a suitable therapeutic approach when working with different severities of depression and medical treatments would benefit from an inter-disciplinary approach which is open to multiple perspectives. Advances in neuroscience have provided insights into mental illness and therapeutic treatments that are of concern for psychotherapists rather than medical interventions. Molecular genetic research considers the connection between certain genes and life event stresses that can predispose certain people to experiencing depression (Caspi et al. 2003; Fonagy 2004; Stahl 2008). Systemic and family therapy might provide useful interventions in helping to alter the way in which parents and children respond to heritable characteristics, so as to positively influence genetic expression (Gabbard 2000; Carr and McNulty 2005). Knowledge of biological mechanisms can be beneficial for psychotherapists, but, reflecting on the findings, what therapists know about anti-depressant medication is limited, while some participants asserted that there is also a limit to what psychotherapists know and what they can achieve in his or her practice. The participants were not only conflicted therapists, but arguably 'castrated' therapists, as sometimes what they do is not enough. A therapist's role could be to focus on the client's subjective experience of the depression, the diagnosis, the medication and the clients' idea of what it means to get well, but not necessarily changing the course of the disease (Kandel 1999). The therapeutic relationship can help in trying to decipher with the client the meaning and nature of patterns of the symptoms of the depression. A humanistic participant asserted his role could be to sit with, at the "edge of their [client] experience**,** not trying to change their thinking but sitting with their loss".

Those participants who were situated at either end of the 'continuum' in some of their perspectives might be missing more "possibilities for change" for the client. In treating the biological aspects of a person with anti-depressant medication, this can also facilitate psychotherapeutic work by improving "cognition, memory, sense of confidence and optimism" (Corsini 2005 p488). Gaudiano and Miller (2013) termed the phrase "interdisciplinary collaboration". There can be recognition of the limits but a focus on the strengths of what anti-depressant medication and psychotherapies can offer. Also, if medication is prescribed, whether the psychotherapists believe in its relevance or not, the anti-depressant medication is still is taking up a position, whether in its physical or psychological capacity. A therapist can also try to support the client in understanding the psychological position the anti-

depressant medication object is taking up, and how the meaning of the drug fits into the client's conception of recovery. This considers the potential message the anti-depressant carries, and while one participant asserted that anti-depressant medication can undermine a person's ability to manage his or her own mental health but for others anti-depressant medication can provide a message of hope.

5.3.3 Minding the Body

The signifier "trauma" was operative in participants' discourses on depression, but there were also reflections on trauma discourses and the body. Bracken et al. (2012 p433) asserted that "we will always need to use knowledge of the body to identify organic causes of mental disturbance". An objective of psychotherapy treatment, in particular body and sensorimotor psychotherapy, is to create a psychological and physical "homeostasis" that allows the client to feel secure (Ogden 2006). It works with psychological and somatic aspects of a person to explore past repressed traumatic experience (Panksepp 2010). Some participants asserted that their therapy work was about making it safe for clients to re-experience trauma. Considering that van der Kolk (1989) asserted that "trauma is repeated on behavioural, emotional, physiological and neuroendocrinological levels", the question remains whether retriggering the repressed "traumatic" memories in a safer environment can interrupt and prevent the progression of a depression. According to Cappas et al. (2005 p378), there could be a therapeutic interruption of the "overconsolidation of the traumatic memory". Psychotherapists with knowledge of the psychological, emotional and physiological components of stress and trauma can promote more specific therapy work, to "prepare the body for action" (Levenson et al. 2007). Therapy work can raise awareness and promote conscientious preparation in order to manage progressive symptoms.

A psychoanalytical perspective proposes that if trauma cannot be symbolised, it can remain in the body and can at a later stage develop into more severe depression, anxiety and panic. This coincides with Stahl's assertion (2008) that depression and relapse can occur if symptoms are not adequately treated in the first place. The psychoanalytical theory proposes that actual pathology occurs as an effect of primary disturbance in the relation between the subject and the Other (Freud 1978; Verhaeghe 2004). Verhaeghe (2004) suggests that the primary resource of treatment is "through the therapeutic relationship". He continues:

> It is this that will enable the subject to build up a secondary elaboration and, through the transferential relation, embed the original bodily arousal into signifiers, enabling symptoms to be constructed…exploration [of] the minimal original inscriptions of the somatic in the Symbolico-Imaginary order (Verhaeghe 2004 p309).

This emphasises that the therapist can look for residual signifiers from the original relationship to the Other and the signifiers inscription on the body; things like childhood diseases and the parental

reaction to them. But working with actual neurosis may require a different approach than psychoanalytical interpretation, more specifically, a "therapeutic goal is subject amplification" (Verhaeghe 2004 p309). Verhaeghe (2004) suggests that when a person is in this state of actual neurosis, the therapist him/herself could produce signifiers and significations from within the university or master discourse to support the client to signify and amplify possible developmental trauma wounds. Trauma destroys the "point de capiton" but through the therapeutic relationship, signifiers can be quilted together in a consensual reality to restore cultural reference points, a knitting of signifiers of the flesh (Ruti 2013). Moreover, the body and body movements can also be used as a reference for language to provide a symbolic re-orientation of symptoms, a "symbolic reordering" (Leader 2009 p120). The therapist can support the client in producing the link between the symbolic and the body and consider what Bracken and Thomas (2010 p23) refer to as the "symbolic meaning of disease and disturbances in bodily function".

However, as discussed, anti-depressant medication is also an object that carries meaning, and one participant in this study referred to the anti-depressant as "holding a position" and can help or hinder a persons' recovery. A psychotherapist can try to distinguish not only between the physical side effects of medication that "arbitrarily invade", but also the meaning attributed to this invasion. However, the "invasion" can also instil hope, which could account for placebo effects; Moerman (2002 p70) asserts that:

> Much of the meaning of medicine, of the meaning response (and in the narrowest sense, the placebo response), is a cultural phenomenon engaged in a complex interplay of the meanings of disease and illness. The modern triumph of a universalist biology tends to blind us to dramatic variation in the ways that people experience their own physiology based on who they are and what they know.

The psychotherapist can attempt to bring the meaning of medication into sight and situate the anti-depressant medication in the "Symbolico-Imaginary order" for the client (Verhaeghe 2004 p309). By observing signifiers around medication, the therapist can explore residual signifiers about the messages of medicine and early experiences of volitional taking of medication or parental enforcement of taking medication. Moreover, by exploring how the wider culture of prescribing and taking anti-depressant medication is possibly shaping a client's identity, the psychotherapist can actively use these insights into the client's experience "based on who they are and what they know" to bring about the necessary conditions for what Bracken and Thomas (2010 p25) refer to as the "emergence of recovery".

5.3.4 Summary of "Reconceptualising Treatment"

Across the findings and the literature, there are different discourses operative on how psychotherapists conceptualise their work. To conceptualise and treat depression through a biological lens alone can be to miss out on the provision of psychological support. Depression involves a combination of genetic, social, psychological and cultural dimensions, and this section highlighted the interrelating discourses of biology and psychology. In theory, these conflicting discourses can be conflicting disciplines as they rely on different epistemologies, but, in practice, they need to be complementary. Some psychotherapy models are at risk of aligning its practice within the bio-medical paradigm and mimicking the psychiatric control of clients. However, it could be argued that psychotherapists consider interdisciplinary dialogue between psychotherapy and medical theories and practice. There needs to be an integration of knowledge, including knowledge of the brain and the body. This takes into account not only the client's language of the body, but also the body can be used as a language to signify developmental wounds; psychotherapy is about identifying cultural reference points to heal and repair trauma through the building of a consensual reality with clients. There can be not only a symbolic re-orientation of symptoms, but also a re-ordering of the deeper meanings of medication based on who clients are and what they know.

5.4 Section 3: Situating Psychotherapy in a 'Shared Medical World'

Psychotherapists are working in a 'shared medical world', which means that they are providing treatment with other mental health professionals from different 'medical' disciplines. Foucault (2003) claims that we cannot tolerate a world without medical power and so we have to find ways to work with it. The working arrangements of psychotherapists and other professionals such as doctors and psychiatrists may vary depending on a client and the treatment set up. However, current literature does not account for some of the dynamics that occur and the impact of anti-depressant medication on interpersonal processes in psychotherapy; this section will reflect upon therapeutic elements that can promote recovery but that are not always accounted for in mainstream paradigms of mental health treatment. The psychotherapist has to consider the complex dynamics of work with clients, but it is also the therapist's role to critically situate him/herself along the "continuum of positions" and configure themselves in the multi-agency matrix to avoid colluding with other discourses that dominate in the mental health arena. It is the psychotherapists' job to prepare for the conditions of change, but recovery and healing begins by attending to the desire of the client, based on who the client is and what they know.

5.4.2 Beyond the Current Paradigm

The participants discussed a variety of models for different clinical contexts. Although CBT is prioritised in certain research, one meta-analysis suggests that there is "little evidence that specific cognitive interventions significantly increase the effectiveness of the therapy" (Longmore 2007 p27). Longmore (2007) suggested that there can be changes for clients and shifting of symptoms before any application of cognitive interventions in the therapy. This suggests that there are other factors in the therapy process that can initiate change and begin to improve people's mental health. Castonguay (2011 p129) suggested an integrative approach to working with depression and specifically attends to "alliance rupture" and "negative therapeutic reactions". One participant stated that it was the quality of the relationship experienced by the client that produces the "possibility of change" for the client. Connections between the therapeutic alliance and positive outcomes appear robust across treatment modalities (Castonguay and Beutler 2006). Bracken et al. (2012) assert that techniques become of secondary importance to relationships, meanings, values and cultural beliefs.

Psychotherapy can try and "prepare the conditions" for therapeutic change but one participant asserted that she "follows the lead of the client" and supports the client in imagining beyond the confines of what Karp (2006) referred to as pathological social structures, and, more specifically, what Foucault (1997 p282) referred to as powerful, dominating "coercive practices…such as those of psychiatry". If medication is prescribed, Karp (2006 p57) claimed that the effectiveness of medication is intimately linked to a "patient's faith and trust in those who prescribe them" and similarly it may not be so much about the psychotherapist's training, but about the clients belief in the therapist. Freud (1906) asserted that clients might "fear the removal of their symptom" and the prospect of therapy might feel unsafe. It is the client who makes the changes, but it can also be the therapist's job to make it safe for the client to change, to "prepare the conditions" for the "possibility of change". Brown (2013) referred to self-esteem and the "internal locus of control" as central to the healing of the person; House (2010 p298) asserted that it is "essentially non possessive love that facilitates the clients healing" and one participant asserted that if a therapist "can love enough that was all they need". Or what Groddeck (1951 p29) asserted that "where to be human is enough… [the] very presence can provoke to action the patient's own powers of healing".

Some participants spoke about "intuition", "getting a sense" and a "knowing how" to approach and work with certain clients. House (2010 p305) asserted "that good and effective therapeutic practice is 95% inspiration and intuition and 5% theoretical perspiration". This also resonated with what Gaudiano and Miller (2013 p815) asserted in saying that psychotherapy is "at least as much art as science ... preferring to rely on clinical intuition and experience instead of scientific evidence".

However, intuition should be based on knowledge and experience in the context of the therapeutic intervention and Gaudiano and Miller (2013) further asserted that there needs to be a trans-diagnostic approach to theory and treatment. Psychotherapists can use some theoretical map to guide them in critically situating themselves in responding to the complex work but psy-architecture and diagnostic labels should be used "secondarily in terms of exploring and explaining the precise nature of patient's problems" (Vanheule 2012 p134). A psychotherapist can consider the client as a human paradigm and recovery begins with his or her own signifying system, the words of the client, based on who they are and what they know. This can be a process of identifying what Ruti (2012 p3) called "the client's singularity of his or her own being" allowing the therapist to attend to what is particular and original in a client's discourse. Therapy can be a process of "letting the client emerge through their own speech". However, working in the multi-agency matrix, it is easy to get lost, stuck or silenced. One participant asserted that when a client takes anti-depressant medication, "they do not want to speak to anyone." But this is arguably a role for the psychotherapist to prepare the conditions for speech through signifying words or signifiers of the flesh; the body.

5.4.3 Mapping the Multi-agency Matrix

In the "shared medical world", the client's compromised ability to make decisions and assert him/herself emerged throughout the findings. According to some psychotherapy literature on therapeutic change, clients need to be "agents of their own actions" (Frie 2003 p18). Clients may desire change but may not be able to bring it about on their own. According to Frie (2003), agency takes place within the relational context and remains a vital part of the dialectical process of becoming what defines us as human beings. A predominant challenge for the psychotherapist is to work not only with the client's agency, but also to consider the influence of other dynamics possibly impeding agency. Therapists and clients are both confronted with multiple influences and messages in the social domain and there is also a risk that psychotherapists can also be impeded through medical persuasion. A psychotherapist can be situated somewhere on the 'continuum of positions' in his or her perspective on how they consider the significance of medication (See 4.7.7). Psychotherapists are caught up and have no choice but to share the medical world with other professionals such as GPs and psychiatrists and shift positions on the continuum to orientate themselves and the client in the multi-agency matrix; but they do have a choice how to work with the client, what model to use and how to prepare the conditions for therapeutic change.

Verhaeghe (2004 p270) commented that some clients want "immediate relief", a quick fix and "external intervention" from professionals. In this research, some of the participants were situated at particular point on the 'continuum of positions' and looked favourably on anti-depressant medication,

sometimes ‘medication lone’ was required. This position was arguably propelled for its swift painless “external intervention” to “to take the edge off” and keep the client on an “even keel”. This is arguably why SSRIs became so attractive, marketed as they were referred to as “magic bullets” (Weggman 2008). The magic bullet has symbolic resonance, not only in the striking image it evokes of the medication taking aim and targeting a specific part of the body, but the concept might also allude to the anti-depressant object as a political weapon to control, to wound and leave a person half dead, a zombie. Pharmaceutical companies and political advertising sanction the killing, but medical prescribers are the silent assassins, and psychotherapists are arguably guilty accomplices. Psychotherapists are arguably slaves to the desire of the medical discourse as the invisible presence of the anti-depressant possibly gives the illusion of making the therapist’s job easier too. This also reflects a possible sharing of the burden with medical professionals or it could have connotations of passing the book to the medic! Bio-medical concepts, diagnoses and psychiatric practices can relieve not only clients of responsibility in his or her mental health but psychotherapists too.

Clients may come to psychotherapy confused and may desperately seek to know what is wrong with them, imploring that the “expert” therapist cures them and makes them better. If we are to consider Foucault’s (2003) assertions around the power of the medical gaze and how it can be potentially mirrored in psychoanalysis, the client can appear to be under the observation of the “eye that knows and decides”, the “eye that governs” and the eye that dissects, “isolate[s]” and “classif[ies]”; the client becomes the passive and silent object of knowledge (Foucault 2003 p89). The dialectical conditions in the therapeutic relationship are under potential threat of repeating this medicalised dynamic. Psychotherapists can adopt a medical gaze, use medical knowledge, sharpen the therapeutic tools and begin operating. Therapists could take up the “expert” position as the subject who knows, “the restitution of eternal truth” (Foucault 2003). This could be moving away from who the client is and what he or she knows. However, the client can ask advice to the therapist around medication. There can be an appeal to the discourse of the master to guide as to the right thing to do; for example, should a client go on medication, increase the level or stop taking it? The psychotherapists response can depend the context of the case and the modality guiding the intervention, but a temptation for the therapist is to be lured into the “fixer” or “medic” role and to direct the client one way or another, “to make a masterly intervention that will resolve everything in one fell swoop and without any effort on the side of the patient” (Verhaeghe 2004 p270).

If the psychotherapist turns into the master, the client becomes a slave to the desire of the therapist. The therapist can then take his or her place with the other masters in the matrix, such as the doctors and psychiatrists who “know” what is wrong with the client, who prescribe and provide the illusion of

"magically" targeting and removing the problem. The therapeutic implication of the analyst discourse, as indicated by Lacan (1991), suggests that the psychoanalyst

> should oppose the at least acknowledged will to dominate…that at least acknowledges not because it should be concealed but because, after all, it is always easy to slide towards the discourse of domination (Lacan 1991 p70–71).

It can be tempting for the therapist to become a master in the dominating discourse, to become a "dominatrix" (Žižek 2006). One of Kant's (1790) famous dictums asserts that every person is to be regarded as an end in himself or herself, and he claimed there is nothing more dreadful than that the actions of one man be subject to the will of another.

The therapeutic encounter is always at risk of this dynamic if a practitioner reduces the client's subjectivity to the captured object of knowledge in therapeutic or medical diagnostics. However, by the therapist holding the "subject supposed to know" position and not producing knowledge, this signals that the knowledge gained by the client will be the only knowledge that concerns the client in the truth of their subjective desire. Richardson (2003 p96) asserted that allowing the client to "achieve the freedom that comes with the disclosure of truth"; the "disclosive process is liberating" (Richardson 2003 p97). Žižek (2006 p4) asserts that the "agent as an analyst reduces himself to the void, which provokes the subject into confronting the truth of his desire". The analyst takes the place of the object *a*, which is the object cause of desire for the client. The concern then if antidepressant is taken, Loose (2002 p123) asserted that "the problem is that the place of this object is ultimately always empty. No drug can fill this place to make it essential". In addition, if a drug is taken, Loose (2002 p123) asserts that the "trajectory of the drives circles around the object. The trajectory misses the aim because the object is a void". The psychoanalyst could represent the missing link, as it is precisely the missing link that designates the place of the subject and keeps a person desiring (Loose 2002). Verhaeghe asserts that when an "agent tries to grasp the Other but comes up against an impossibility each time" (2004 p114). When the client meets the impossibility, he or she comes into conflict with the discourse of the Other, and, by resisting, agency is born (Alcorn 1992 p29). This can reorient the client as a speaking agent to create "original discourse". According to Mitchell (1993), clients may learn to recognize the role of agency in events that were previously experienced more passively.

Some of the participants attempted to distinguish between psychoanalysis and psychotherapy in their work and consider when it was appropriate to work with one model than another. Working psychoanalytically offers a client to produce original discourse that transcends the imaginary capture

of the certain therapeutic and medical discourses. Melman (2006 p67) distinguishes between psychotherapy and psychoanalysis by asserting that if he works with his client as the psychotherapist, "the only thing I can hope for is that he will get back into the normality…this is common sense, common sense at the expense of his desire". But Melman (2006 p67) maintains that by working psychoanalytically this can allow a client to be "a dupe of his desire but to gain access to existence. To no longer live as if he were dead". This resonates with the zombie referred to by one participant, the dehumanised subject existing between two worlds, a person is neither alive nor dead, but working psychoanalytically can provide an opportunity for a transition, for a person to symbolically reorder his or her world. This is not to realign the client's thinking and behaviour to pathological reality, but to liberate their being and activate existence; potentially creating an opportunity to bring the dead back to life. But as one participant asserted, "the client might not be ready to go there".

5.4.4 Summary of "Situating Psychotherapy"

There is much to consider in the therapeutic encounter with a client who is taking anti-depressant medication. The psychotherapist has to situate him/herself in a shared medical world and engage therapeutically to facilitate the client to be his or her own agent of change. The psychotherapist has to consider what way to work with a client based on knowledge of their therapeutic modality, but the therapist can critically appraise how they situate themselves on the 'continuum of positions' and build a workable hypothesis to prepare the client for change, beginning with the words of the client. This section critically reflected on the psychotherapist relying on certain theoretical foundations and taking an absolute position on the continuum. By taking a master position could be mimicking the medical discourse and thus directing the client. This act could establish a transferential dynamic that could be unconsciously repeating a potentially dominating relationship that keeps the client in a passive position, a depressed position; a slave to the desire of others. There are already masters in the client's world, such as the prescribing agents, the GPs and psychiatrists. There is a place for some psychotherapy work in building psychological mindedness and "correcting" thinking processes, but we can consider clients as caught between certain controlling discourses and having a marginal capacity to resist being controlled. It could be a therapist's choice to work psychoanalytically to situate him/herself in supporting the client to resist the discourse of the Other; resisting implies agency, promoting a client's ability to counteract certain forces in his or her life. If the client might not be ready to go there, it is up to the therapist to prepare the possibilities and potential for change and make the path safe to allow the client to confront his or her own desire. To evoke in the client his or her desire for desire itself. Desire can be accessed through the verbal exchange and by encouraging the client to speak; they enter into the multi-agency matrix. This was central to the findings where participants in this study had diverse experiences and were conflicted in applying their theoretical

model to clinical practice. This conflict emerged when they used discourses to "master their consciousness", to master their work. The conflict was situated in the dialectic tension between 'psychology and biology', 'discourses on depression' and the discourses on 'the body' but a major conflict was in the 'shared medical world' encapsulating the multiple conscious and unconscious relationships when working with clients and the different roles that a psychotherapist can embody. The psychotherapist has to situate themselves somewhere on the continuum of positions and by reflecting on where they are positioning themselves and where they are being positioned can be insightful to the discourses operating in the verbal exchange.

5.5 Conclusion of Discussion

The findings and the literature indicated that there are conflicting reports in the use of anti-depressant medication for treating depression. This was reflected in research that reported medication as sometimes reducing symptoms, but also causing side effects. The psychotherapist can try to decipher the "pharmakon" of the anti-depressant medication: establish whether it is a poison or a cure, and interpret what might be symptoms of depression and what might be side effects of medication. A comparison can be made between the symptoms of the melancholic experience and the side effects of medication. In the melancholic experience, a person has an ambiguous relationship with the lost object. He or she cannot let go of it and tries to psychologically embody what was lost, but when what is perceived to be the desired object is attained, the person is not only disappointed by it but the ultimate horror of the melancholic experience is that a person has nothing more to desire, thus being deprived of desire itself. Taking anti-depressant medication to fill the void does nothing for the melancholic ambiguous sense of loss, and arguably compounds the problem. Melancholia and medication are now in the place that must be empty in order for desire to occur.

However, all is not lost: taking account of the psychoanalytic theory that the melancholic symptoms need to be symbolised, the psychotherapist practitioner has the opportunity to symbolically re-route a person's desire, and the object of medication can be used as symbolic leverage to acquire insight into what the client needs to let go of in order to be free of the dead object(s) that lives on in them. The psychotherapist has to consider the impact of anti-depressants on the client, and his or her investment in consuming the product and explore what he or she hopes to gain from taking it. This is fundamentally looking at the invisible order of the object of medication and what position it is holding in the therapeutic relationship. The phantasy of the therapist can also be considered; it could be that the external intervention of medication suits the therapist, providing a quick fix and keeping the client on an even keel. If the client does not have to make much effort, the therapist may unconsciously feel that he or she does not need to make much effort either. Psychotherapists need to critically reflect on

where they are situated on the ‘continuum of positions’ and how this potentially impacts the therapeutic model they refer to and the skills they use. Psychotherapists should question why they are taking a certain position and be critically aware of the knowledge and beliefs that inform their practice and shape his or her work with clients who are taking medication.

Psychotherapists need to operate a dual role between the fixer and the liberator and configure what role fits with the presenting client. But there are pitfalls of taking a “fixer” role that uses a discourse that arguably mirrors bio-medical and psychiatric practices that are set up to control behaviours. CBT in particular presupposes an anti-holistic ideology of a person, and guides the therapist to monitor thoughts, dissect feelings and control behaviours as a way of “helping” clients to adapt to compliance, realign to ‘normality’ and be coerced into common sense. Not only do clients fear the removal of their symptoms, but psychotherapists may fear the symptoms and find it difficult to tolerate the unpredictability of a client, unknown, the uncertainty or the negative transference, what Leader (2009 p181) referred to as “the call of the dead”. However, the real tragedy is that, if anti-depressant medication is perceived as making the conscious unconscious, and keeping desire buried, psychotherapists could equally be suspect of favouring medication and not wanting to listen for the unconscious. The clients unconscious might be too obscene for the therapist and the therapist becomes complicit and comforted in the position of the one who knows and who is in control. If this occurs, the client’s desire will experience a second death. However, the resilient nature of the human condition is that there is the possibility that that which is repressed will rise again and symptoms will keep attempting to return to life in the hope that somebody is listening. It is the responsibility of the psychotherapist to support the client to begin re-symbolising his or her world; to begin mapping a consensual reality with the client with the aim of producing original discourse to the clients’; to evoke the potential for desire and capacity for love.

6. CHAPTER 6 – Conclusions & Implications for Future Practice and Research

6.1 Introduction

This research analysed psychotherapists' account of their practice and experience of working with clients who are taking anti-depressant medication. The participants used discourses to describe their work, but the discourses were also operative in shaping what was communicated. LDA research aimed to analyse various elements in the language used, and explore possible extra-intentional meanings in the speech of the participants. This chapter will draw together key findings and conclusions. It will discuss the implications of the study for future psychotherapy practice, training, and concerns for related professional medical practices involving GPs and psychiatrists. I will also comment on possible implications for current policy and potential research opportunities. Methodological considerations will be discussed and a reflection on personal learning from this research endeavour will be offered and also a reflection of how the research process has enriched my own clinical practice.

6.2 Key Findings

The central thesis of this research is that psychotherapists working with clients on anti-depressant medication need to take into account that they are working in a shared medical world with diverse and conflicting discourses. By considering the meaning of the medication in the complex relationship dynamics, the therapist can critically situate him/herself in the dialectical process around who the client is and what they know in order to produce original discourse with the client. Psychotherapists need to reflect upon where they are situated at any one time on the 'continuum of positions' (4.7.7) and consider what theory and knowledge is shaping their position while reflecting upon what skills and interventions are needed to prepare for the conditions for change to occur. The main findings are as follows:

1. The participants in this study appeared to be conflicted when encountering certain clinical complexities and there were attempts to reconfigure ways of responding to the different contexts of their work. Certain discourses appeared to be operative in shaping how participants spoke about the object of anti-depressant medication. There were diverse experiences of the medication, from creating more possibilities for change, to taking the edge off and natural elements that supported the therapist or arguably did the work of the therapist; where in other contexts, clients with symptoms of depression who are taking the anti-

depressant medication can be interpreted as a foreign invader terrorising the psychotherapist with manic side effects. Some participants did not know how anti-depressant medication worked or perceive any impact from the medication in the therapeutic encounter, but this was arguably the discourse of deception, the invisible order of the medical discourse.

2. Participants were trying to account for his and her work through the dialectical tension of the psychological and biological discourses, but these binaries collapsed through the speech of the participants. Psychotherapy and anti-depressant medication were signifiers at the mercy of the machinations of language and were spoken through multiple discourses on depression, disease, trauma; psychosocial, spiritual and bio-medical discourses, arguably representing participants struggle to make sense of their clinical work, but also attempted articulation around transference and signs of love in the therapeutic relationship. The participants were attempting to situate their therapy work with clients experiencing depression and consider the impact of medication by using metaphors of the body and trying to locate "something […] somewhere".
3. A significant finding in this study considered the "shared medical world" and reflected upon how psychotherapists try to situate their work with the client in conjunction with anti-depressant treatment. There were considerations of agency, and the clients' ability to make decisions and express opinions around the taking of the medication. There was also a reflection on conscious and unconscious relationships between the therapist, the client and medical prescribers that can be operative when working with a client. The psychotherapist can try and situate themselves in a critical position and work with a flexible hypothesis to try and make it safe for the client to emerge, to confront his or her own desire.

The findings highlighted the multiple discourses that shape and guide psychotherapists, but also the intermittent discourses that can be operative at an unconscious level in how the psychotherapist configures how he or she works and perceives the impact of anti-depressant medication. I will discuss this in more detail and reflect on key conclusions from this research.

6.3 Key Conclusions

From the findings and reviewed literature, the practice of psychotherapy requires a critical re-conceptualisation and redefinition in theory and practice when considering the potential impact of treatment with anti-depressant medication. The key conclusions are as follows:

1- Discourses are always operative in how psychotherapists configure their work, but there is a need to critically evaluate what therapists are doing especially when there is medication

involved. A therapist needs to appreciate the physical and psychological impact of medications in the therapeutic relationship and consider the side effects which might be an accentuated melancholic reaction to taking the anti-depressant, creating more confusion of not knowing what was lost and what was gained by taking it. The presence of depression and the medication are now in the place that needs to be empty in order for a person to desire. But the therapist can interpret potential side effects in conjunction with symptoms of depression as part of the same process. The symptoms and side effects are arguably two sides of the one coin. They are part of the one inscription to be deciphered.

2- Psychotherapists can incorporate conflicting knowledge in coordinating their practice. Psychotherapists need to consider interdisciplinary collaboration with other theories, practices and professionals, despite evident contradictions. Various therapeutic techniques can be applied through university discourses to shape the therapists' work, but there is a risk that they can be misused and mimic bio- medical models designed to monitor clients and control behaviours. The signifying lines of speech from the client need to be considered before the psychological architecture of the therapeutic models are consulted. The body can be resourced as a therapeutic tool to explore signifiers of the flesh and restore the "point de caption" that was ruptured by traumatic experiences. By negotiating a shared narrative reality with the client, this can create cultural reference points to re-orientate what the client knows of his or her own sickness, medicine and recovery.

3- Psychotherapeutic work needs to acknowledge transferential dynamics in the multi-agency matrix in which clients and therapists are involved. Awareness of the dynamics with other professionals and medical practices in the shared medical world can provide key insight into the ideology of sickness and medicine and what might be needed to actively bring about the conditions that are necessary for change to occur. There is a risk that in the psychotherapist taking up the medical gaze, a position of domination as the "subject who knows" and reduce the client to a submissive position. The therapist could be re-enacting the relationship with the doctor and psychiatrist, but what is of importance is for the psychotherapist to reduce him/herself to the void and support the client in confronting the truth of his or her desire. There is another ethical choice to be made by a practitioner, to work as a psychotherapist or a psychoanalyst, to collude with the medication on one level and guide the client to adopt a position of common sense or to free the client to transcend the strictures of a pathological social system in order gain access to his or her own existence.

6.4 Methodological Considerations

In carrying out this research, it emerged from the literature reviewed that there is insufficient research specifically around therapy work with clients on anti-depressant medication. The research method was designed to provide a range of theoretical and conceptual tools to gather and analyse data from semi-structured interviews. There were strengths and limitations in using this methodology and I will reflect on both.

6.4.1 Strengths

One of the main strengths of the research design was that it supported me in achieving the aim of the study, which was to enquire how psychotherapists approach their work with clients who are taking anti-depressant medication. This study helped me in carrying out the objectives of exploring participants' therapeutic models and the benefits and limitations of working with clients on anti-depressant medication. Every individual case provided an extraordinary amount of rich data, and cross interpretation of seven interviews could be considered too much for a study of this size, but, through rigour and determination, I felt I made adequate use of all interviews. There is a lot of rich material for further articles, presentations and potentially for future research. The DA methodology brought to light contrasting discourses in the literature reviewed and the participants' accounts of their work. This provided insights into the presence of intermittent discourses operative in language. LDA was a suitable choice as I felt that it gave me many options for analysing and interpreting the data. In the participants attempts to 'master' their practices through speech, LDA highlighted signifying elements in the speech, significant gaps revealed unconscious aspects that highlighted how participants were conflicted and slaves to the real master, language; this supported me to explore possible extra intentional meanings. LDA is based on conceptual psychoanalytic coordinates drawn from Lacan's writings around his clinical work but Parker (See 3.3.2) outlines seven coordinates that were used to open up the text in such a way that it provided plenty of options to interpret and analyse what became structurally available. Parker was a useful resource for this research as he offers a radical critique for psychotherapy and all psy-discourses (Parker 2007; 2011) and he demands "radical changes in its practice" (Feltham 2013b p7).

Although Lacan does not directly provide a procedure for analysing discourse in research, but his analytical theory was applicable to my method on numerous levels. Firstly, Lacan's training of analysts and teachings were centred on his clinical work and I was interested in interviewing psychotherapists and psychoanalysts about their clinical work with clients. Secondly, LDA was appropriate as there was a parallel process occurring between how Lacan distinguished between

psychoanalysis and psychotherapy, and how I was distinguishing between the participants' discourses on their application of the different modalities. Thirdly, Lacan's used his theory of the four discourses to steer his clinical practice, but by analysing the shifting of the positions of the researcher and participants in the interviews, this mirrored the work with clients in the therapy setting. There is an obvious difference between the therapy setting and the research setting, but when the participants spoke they also entered into taking up one of the agent positions of the four discourses, they were either positioned as speaking from the master, hysteric, university or the analytic discourse. LDA looks at the formal relationships between these discourses and how there is always a negotiation through the discourses in a persons' desire to master his or her consciousness. When the participants spoke, they were subjected to the laws of language, they were conflicted and castrated but this produced a constant recycling of discourse and knowledge and a coming into new life through original discourse. Lacan tells us that "every crossing of discourse is also a sign of love" (Lacan 1998 p144). LDA supported me in exploring not only the intricacy of the participants as professional psychotherapists, but also as human beings who are trying to symbolise and situate themselves in the multi-agency matrix.

6.4.2 Limitations

The LDA method allowed for exploration of the participants' accounts of their experiences, the selection of the data and the analysis was confined to my analysis and interpretation. Although there was a reflexive process occurring throughout, the question could be asked: 'when is an interpretation an interpretation'; it could also be questioned whether the interviewees would agree with my interpretation. One ethical response to this hypothetical query would be for the researcher to negotiate the analysis *with* the interviewee; that would also be a way of taking discourse analysis in a psychosocial participatory direction (Parker 2005). In this study, only one interview per participant took place, but that one interview was considered adequate in providing data for appropriate analysis. There have been certain criticisms of Lacanian theory; in particular, Lacan's understanding and application of linguistics (Evans 2005). However, Lacan used extra–clinical data sources and clinical information to formulate and reformulate subjects such as linguistics to elaborate on psychoanalytical theory. Psychoanalysis borrows concepts from other disciplines, disciplines such as linguistics, anthropology, mathematics and philosophy but it is an autonomous discipline not dependent on any of them having reworked certain concepts in a unique way (Moore 2012). Moreover, Freud and Lacan used extra–clinical data sources and clinical information obtained from others as "an opportunity to question, validate, and elaborate on psychoanalytic theory" (Vanheule, and Verhaeghe 2002 p340).

Throughout the analysis I tried to represent the participants' accounts of their work by using their own words, phrases and sentences as much as possible, but I also tried to be transparent and to acknowledge my position as a researcher in the presentation and interpretation of the findings. I am a practicing psychotherapist and admittedly hold some critical views towards medication in treating milder psychological issues, but I have tried to be reflexive around this and to balance the literature I reviewed with the gathering and interpretation of the data. Although I used a Lacanian psychoanalytic method in this research, I am not a psychoanalyst in practice, but I am inspired by psychoanalytical theory to guide and reflect upon my clinical work. Again, my role was a researcher using a certain design and method of analysis for a particular purpose. In recruiting participants for this study, I was able to gather what I consider a balanced sample of psychotherapists who practiced from different modalities, but my analysis could be accused of favouring psychoanalysis over other modalities. Although I tried to balance the content through the cross-interview interpretations, I acknowledge that I gravitated more towards interpreting certain participants in my analysis; a possible reason for this is that I felt that certain participants answered my questions in more detail but this could also reflect that certain interviews were longer than others and there were more data to choose from. The participants practiced from a variety of models, but one therapeutic approach that emerged strongly in the data and the literature as a model for treating depression was CBT. I did not interview any specifically trained CBT therapists but I had tried to recruit some but none of them responded to my advertisement. Some of the eventual participants used CBT interventions, and certainly most of the participants had opinions about CBT.

6.5 Implications of this Study

This research has produced original findings in exploring psychotherapists' accounts of their work, and I will explore possible implications of the study. These have been subdivided into five sections, namely, implications for:

1- Psychotherapy practice
2- Future research
3- Training and education
4- Prescribers of anti-depressant medication (GPs and psychiatrists)
5- Mental health policy

6.5.1 Implications for Psychotherapy Practice

Psychotherapists are working with people who are by their nature complex, living within multifaceted social systems, and therapeutic change can have multiple connotations depending on the context of

the client's situation and how he or she presents. Certain research has contributed to therapeutic guidelines and promoted CBT as a recommended modality in treating depression and in conjunction with anti-depressant medication. With this model, psychotherapists can use elements to support clients in complying with medication, for supportive work around managing thoughts and behaviours, managing stress, but this study and certain critical literature does not believe that the CBT approach deals adequately with the complex issues that arise when working with clients who are experiencing symptoms of depression and taking anti-depressant medication. Relying on the formulaic models from university discourses does not account for the totality and desire of the person attending psychotherapy. This research found that human elements in the therapy encounter such as hope, presence, self-esteem, love and belief in the therapist are required before any modality is consulted.

The role of the therapist can be to decipher with the client different discourses that consciously and unconsciously circulate meaning in the shared world in the therapeutic relationship. It is the therapist's role to critically ask questions, to offer interpretations around what symptoms might hold in place for clients, but, central to this study, the therapist must critically consider the position of anti-depressant medication, as the commodity of anti-depressant medication is not just a neutral product, but represents an invisible order (Žižek 1989). It is an object that carries meanings for both the therapist and the client. The psychotherapist can consider the symbolic value of the client's investment in taking the medication and what the client hopes to gain from taking it. This can open up a valuable dimension that is arguably core to not only the meaning of a persons' illness but the clients hypothesis for change; by keeping in mind that clients might be looking for short term effects, quick fixes or the magical external intervention of medication where the client does not have to make much effort (Verhaegue 2004). But therein lays a possible pitfall for psychotherapists, the invisible order of the anti-depressant could be potentially pulling the strings and the psychotherapist may feel he or she does not have to make much effort either. The taking of medication might sustain the illusion of relieving the psychotherapist of his or her duty. But the psychotherapist can consider where they are situated on the 'continuum of positions' to clients taking anti-depressant medication and critically explore why they are taking that position or simultaneously holding a few positions and how that can be applied therapeutically.

A possible new therapeutic lens for psychotherapists to consider when working with clients who are taking anti-depressant medication *is* for psychotherapists to consider symptoms/ side effects of anti-depressant medication as a language to be deciphered. Firstly, if we consider the psychoanalytic theory of the melancholic experience, of not only a person experiencing ambiguity around what was lost but moreover embodying the desired object but simultaneously disappointed by it. Melancholia stands for the presence of the object itself deprived of the desire for itself. In this context, the taking of

the anti-depressant medication could represent the taking an object to make things better, to fill the void and fill the gap through a magic cure. The reason a person could be further propelled into more melancholic ambivalence after taking the medication is that they realise nothing has changed, he or she is further disappointed, where the presence of melancholia and the medication are now in the place that needs to be empty in order for a person to keep desiring. The void object has further compounded desire. Whatever the investment or expectation, whether conscious or unconscious of taking the anti-depressant medication will never be met. Potential side effects of anti-depressant medication *are* symptoms of depression, if not mimicking the symptoms of melancholia. The presence of anti-depressant medication confronts the person with the real horror of the melancholic experience; the person unconsciously senses that the 'quick fix' of medication can never replace the lost object and will never suffice, and the desire for desire itself is still doomed, a further reminder that person's desire is dead. Maybe this is the reason that there is rarely full remission of symptoms with anti-depressant medication, the medication may work for a while but symptoms/ side effects are signs, a return of the repressed seeking to deciphered and therapeutically re-ciphered.

However the psychotherapist can consider where they are situated on the 'continuum of positions' in relation to clients taking anti-depressant medication and critically explore why they are taking that position or reconsider their simultaneously holding of a few sometimes conflicting positions and how that can be applied therapeutically. If the client takes anti-depressant medication and this suits the therapist too, this could be indicative of the resistance of the therapist. Resistance might take the form of deception in the guise of passive or enthusiastic acceptance of medication to take the edge off, to control, to fill the gap and to make the conscious unconscious. Psychotherapists do not want to hear the unconscious (Melman 2006). It is too obscene. Truth and freedom come at a price and working analytically, the analyst must tolerate the painful resistance to change of the client and what Freud (1906) referred to as the guarantee that the practitioner will be sure of unsatisfactory results. It is arguably less painful to ignore the transferencial love and hate of the client, the melancholic destitution, what Leader (2009 p181) referred to as "the call of the dead". It is easier to fall into the discourse of domination, to care, to control, correcting thoughts, and common sense is easier. The true work of psychotherapy and working psychoanalytically is concerned with the painful responsibility to shatter the illusion and sit with the uncertainty, the horror and the hate. The therapist working analytically can amplify the intermittent noise of Other medical discourses, challenging the capitalist discourse of the quick fix by allowing the client to confront his or her desire. To avoid the short cut to common sense in order to free the client to gain access to their own existence. In order for therapeutic change to occur; the client has to desire; to desire change and the therapist must reduce him or herself to void, to be the object cause of the clients' desire to invite original new discourse, a new script. By

shifting positions and crossing discourses increases the possibilities of change, producing signs of love for the client who has lost the capacity to love.

6.5.2 Implications for Training & Education

Psychotherapists in training could be educated around working with clients who are prescribed and taking medication. He or she will be sharing a medical world with other practitioners, whether directly or indirectly, and without adequate training and insights around the impact of medication, therapists can get caught up in and blinded by dominating medical discourse. Training psychotherapists can consider the multiple positions that a therapist can situate themselves along a 'continuum' in responding to clients who are taking anti-depressant medication. Where a therapist positions him or herself or where they can be positioned by possible unconscious factors needs to be continually critically examined by the therapist. Increasing awareness of underlying complications that can occur when clients who are treated with anti-depressant medication is crucial for a therapist in training. It would be beneficial if all psychotherapists knew more about the pharmaceutical action of the various commonly-prescribed anti-depressant medications, and how taking, reducing and stopping anti-depressant medication can produce severe side effects. It would benefit therapists to have a grounding of knowledge in these areas (Daines et al 2007). Side effects can add to the stress of clients' already disturbing symptoms and worst case scenarios of inciting suicide ideation and possible suicide attempts. Such issues can be incorporated into a psychotherapists approach to assist clients in preparing for such events and managing side effect symptoms from the outset through to completion of therapy, and, where appropriate, supporting clients in reducing and discontinuing the prescription.

Some therapeutic models are recommended for short-term symptom relief, but a psychotherapist can offer much more and consider what it is required for more sustaining therapeutic effect. Questioning and interpreting the nature of a symptoms might provide more of a catalyst for long-term change compared with trying to reform behaviour through step by step shorter therapies such as CBT. Psychotherapists should be critical of the therapeutic models they use, the discourses driving them, and the mechanisms involved, critically evaluating how to apply them appropriately, and when to adapt and respond to different contexts of the client work. Learning therapeutic modalities is only one part of training; the clinical reality is different; and the psychotherapist has to make sense of the various complex scenarios that can occur. Exploring case examples and case studies can prompt students to critically review theoretical frameworks and the different roles that psychotherapists can take in response to clients' symptoms of depression and side effects of medication. The process of distinguishing between symptoms of depression and side effects of medication can be a resource to the client in the therapeutic exploration of any ideologies of sickness, medication and health that

could be operating at an unconscious level. There can be also reflections on transference and counter-transference issues in the therapeutic encounter, and consideration of how a therapist can unconsciously collude with medical discourse and similarly with clients, passively ignoring the impact of medication. Psychotherapists can get caught in this ambivalence when working with the more severe melancholic depressions and the resistance of working with all clients who at some level "fear the removal of their symptom" (Freud 1937 p377).

6.5.3 Implications for GPs and Psychiatrists

Some the findings and the literature recommended the benefits of combining psychotherapy and anti-depressant medication, recognising that both treatments can be complementary in treating some symptoms of depression. The 'hit and miss' nature of anti-depressant medication, the undermining message of the medication, and its potentially severe side effects point to the importance of including psychotherapy as a priority in the treatment plan. In current mental health practice, anti-depressant medications are prescribed for mild and moderate symptoms of depression even though they are recommended only for more severe depression. The clinical reality is that clients are not always consulted about their treatment preference and are not always offered psychotherapy. Moreover, clients are not warned of potential side effects of anti-depressant medication. GP and psychiatrists could take the client's needs and preferences into account. Prescribers could also relay to clients not only potential side effects, but also certain limitations of drugs such as anti-depressants, and encourage discussions with psychotherapists on what service users want from anti-depressant medication. Further to this, when appropriate, anti-depressants can "be withdrawn gradually" (Hammersley 1995 p9). Psychotherapists can support the client to manage their own way of reducing drugs (Hammersley 1995 p43).

Medical doctors and psychiatrists are guided by the Hippocratic Oath in their work with clients where there is an ethical obligation or "duty of care" that upholds the mantra: "do not harm" (Richardson 1996 p92). In prescribing anti-depressant medication, there is an ethical imperative to consider the severe side effects that can induce clients to commit suicide (Breggin 2008). Feltham (2013b p98) referred to the "possibility of a client to kill himself is perhaps the greatest fear for most counsellors". It should be mandatory that psychotherapy is also offered as psychotherapists could offer a more comprehensive assessment and support for clients in these situations (Gilbert 2013). The fact that anti-depressants are prescribed should not obviate a psychiatrist or doctor's obligation to discuss the possibility of psychotherapy and to at least offer therapy as an option in the treatment plan. Gaudiano and Miller (2013) have asserted that "fewer psychiatrists are providing psychotherapy in part due to increased financial incentives for providing pharmacotherapy". Psychotherapy can be included in the

treatment because of the higher risk for relapse with medication alone but because it can be a "response to social problems which works at the interface of the personal and the political" (Parker 1999 p104). Psychological support can help clients to make sense of and attribute meaning to the effects of the drugs. Treatment with medication alone is to miss out on vital aspects of considering the person as the locus of control, the agent of change and emphasising their role in the own recovery. Psychotherapists could be part of the process of assessment, involved in dialogue around psychiatric diagnosis and consulted about treatment options, there is potential for increased interdisciplinary collaboration to provide a more unified treatment plan. Moncrieff (2010) asserted that psychiatric diagnosis authorises the allocation of state funds, but forecloses any debate about the area of policy. Smail (2010 235) discussed what we do about these structures is not a matter for psychology, but inescapably, for politics. Epstein (1995 p6) asserted that society needs to "allocate substantial funds to address its problems".

6.5.4 Implications for Policy

In Ireland, since the Primary Care Strategy of 2001, multi-disciplinary primary care teams and centres have been rolled-out. Primary care can be the first point of contact for assessment, diagnosis and treatment regarding health, but psychotherapists in the community are not always considered when people present with symptoms such as that of depression. Psychotherapy could be a prioritised mental health intervention for different severities of depression, either as a sole treatment or in conjunction with medication. According to findings from a study by the National Office for Suicide Prevention (2013) some people who had committed suicide had been in contact with GPs in the weeks previous to their death, and they presented with physical ailments but no apparent mood or obvious depressive symptoms. This could be what psychoanalytical theory refers to as "actual neurosis" where the theory proposes that if trauma cannot be verbally symbolically expressed, it can be left in the body, returning as physical symptoms. Rising levels of depression worldwide and unexplained occurrences of suicide is major concern in Ireland. It could be suggested that psychotherapists need to be included in the assessment period of initial client contact where they can offer a different perspective on conceptualising physical and psychological symptoms and offer an alternative voice in the interdisciplinary treatment plan.

People seeking help with symptoms of depression would greatly benefit from the opportunity to make informed decisions about their care and treatment in partnership with their practitioners. Speed (2011) encourages service users to actively resist the psychiatrisation of their experiences by resisting medical discourses that stigmatise, while asserting that there could be new ways of talking about mental health. To resist what Parker (1999 p 104) referred to as the "relentless psychologization of

society and the proliferation of diagnoses of forms of unhappiness"; to construct alternative moral-political communities, and these provide points of reference for people with problems to see that they may be able to live without their problems (Parker 1999 p205).

The question of responsibility for the client's mental health also needs to be considered and continually negotiated. There needs to be transparent communication between doctors, psychiatrists, psychotherapists and the subject of therapy themselves, clients. If clients do not have the capacity to make decisions, healthcare professionals following the Department of Health's advice on consent and the code of practice that accompanies the Mental Capacity Act (NICE 2009) may be required to act in the client's best interests.

In Ireland, 'A Vision for Change' was published in 2006 that set out a ten-year plan to shift the delivery of mental health services from old style institutional care to a more modern community based service and person-centred treatment for mental illness. One of the main recommendations of the original 'Vision for Change' report was the establishment of multi-disciplinary community mental health teams. In 2010, the Independent Monitoring Group reported structural failings in the HSE in the specific context of mental health services, and reported problems with cross-departmental co-operation on mental health policy and overall lack of communication within the HSE. My research was based on interviews with community-based psychotherapists, and participants asserted that they were not yet working "hand in hand", and that there was lack of communication. There appears to be a chasm in communication between GPs, psychiatrists and community based therapists. From this we can infer that there needs to be better "interdisciplinary collaboration" between primary health care and psychotherapy supports in the community, especially in relation to case conceptualisation, treatment plans and continued support. Therapists need to be able to have conversations with those who refer the clients and consult around a psychiatric history (Daines et al 2007). This could greatly benefit and support therapists to "address the complexity of therapeutic change" (Castonguay 2011 p131). I interviewed psychotherapists in the community and not therapists working in the HSE who are directly linked to a clinic but there is also an opportunity for research looking at this area of public and private psychotherapy practices with a focus on the differences between the practices and treatment models.

6.5.5 Implications for Future Research

Continued psychotherapy research is essential in order to ensure that psychotherapy is considered as a valued treatment for psychological issues such as symptoms of depression "in a highly competitive healthcare marketplace" (Deacon 2013 p855). Arising out of my examination of the literature and the research findings, I will indicate areas of research that would contribute to current and future

psychotherapy in the field. The influence of the bio-medical model in psychotherapy research such as RCTs needs to be critically reviewed and more focus on treatment process (Deacon 2013). This can serve to stimulate new and creative theoretical, clinical, and empirical projects toward specific processes of change (Castonguay 2011). More research could be carried out on the clinical reality of working with clients who are specifically experiencing side effects from anti-depressant medication and explorations of the meaning of medication for clients. Certain research is not based on "real world clinical practice" (Weisz et al. 2012) and but it can start from the complexity of the therapeutic encounter and clinical practice and build on therapists' clinical observations and insights, taking into account the client's perspective (Vanheule 2009). Moreover, research on clients' experiences of psychotherapy and anti-depressant medication would cover a different perspective from this research, but would be complementary to the findings of this study.

From the biological perspective, recent evidence of how depressed brains are affected on the level of neurotransmission, endocrine function and specific circuitry, and neuro-scientific research through brain scanning, has confirmed anti-depressant medication as affecting those areas. The relational aspect of psychotherapy is also beneficial to influencing and increasing functions of the brain such as memory, synaptic connections and hormones, but, nevertheless, a biological perspective on psychotherapy's mechanisms remains to be clearly defined. Further research could usefully gather evidence of psychotherapy's specific role in brain and biological changes. Brain-based research and psychotherapy process research can be combined to show evidence based benefits of psychotherapy for the brain, hormones and the re-building of memory in the treatment of depression. There are opportunities for research to treat people with a genotypic predisposition to depression; long-term research studies could explore different vulnerable groups with the specific genotype and offer some preventative psychotherapy from different models. There is research that recommends short-term therapeutic interventions, but this is arguably typical of the capitalist logic that favours short, cost-effective measures. Short term therapy can result in short term temporary change (Mulligan 2012). There is a need for more long term research on the longer treatments, such as psychoanalytical psychotherapies, for mild, moderate and more severe depressions.

6.6 Personal Reflection as a Researcher

The process of carrying out this research continually challenged me to maintain a questioning and critical stance. In particular, as a practising psychotherapist, it was important for me to check in with myself and to approach each step of the research process with careful evaluation. This research required the construction of a methodological framework to systematically gather insights into the complexity of psychotherapists' accounts of their clinical work. The research process required me to

rethink my own epistemological and ontological assumptions about the world, and made me reflect on the nature of scientific research, and how the subject-object/researcher-researched divide is not so wide. As a researcher, I was the one enquiring into another person's reality, but I could never fully adopt an objective standpoint. From the outset, I acknowledged that I hold some critical views about the use of anti-depressant medication to treat milder symptoms of human suffering and the dominance of medical discourse in addressing human suffering as a category of illness defined under the broad heading of depression. This prompted the use of the transparent tool of reflexivity, but what was significant was that when reflecting on the discourse with the participants, I was caught in symbolic orders and anchored in shifting realms of knowledge. This was the nature of this research method; it revealed how language operates and how we use and are used by a shared language in an attempt to grasp consciousness, to communicate and achieve social objectives. By bringing to awareness possible unconscious discourses, we become existentially conscious of interpolating coordinates that control our destiny. As a researcher, I had to keep asking myself when working with the participants and interpreting their speech: what is being said here and why is it being said? To answer the "why" question, I looked at the question "how is it being said" and that led to question "what is *not* being said?" This continual loop of questioning my own process blurred the subject- object divide and supported me in trying to situate myself into the participants' world, the therapeutic encounter between client and psychotherapist. I have endeavoured to be true to their positions by using their words as part of the report while taking into account that my perspective will have also influenced the interviews, analysis and interpretation of the data.

6.7 Personal Reflection from a Psychotherapist's Perspective

In carrying out this research endeavour, my appreciation of the complexity in a therapeutic encounter with a client has increased. I am more sensitive to the notion that a psychotherapist needs to wear many hats and consider multiple perspectives. The findings have brought to light the interconnectedness of everything, from interrelation of the micro neurons in our brains to complex socio- cultural environments that humans share. Moreover, I have greater awareness of how a minor glitch in the persons living system can result in a major negative ripple effect and can contribute to a person experiencing different severities of depression and poor treatments, either medical or therapeutic can sustain the misery for some people. Considering these elements, psychotherapists can design and implement treatment to successfully improve clients' mental health. How therapists conceive of doing that is conditional on the assessment, modality and hypothesis for change for the client, but also the unique disposition of the presenting client. Every client that presents is looking for and hoping for change; however, some are unsure of what needs to change. For some, it is a matter of life and death; doctors are bound by the Hippocratic Oath in their duty of care to clients, commanding

them: "do not harm", psychotherapists while not bound by this oath have an ethical and moral responsibility to provide appropriate levels of care. Every therapeutic interaction is an ethical intervention. I now take more notice of the language of clients, of medication, symptoms and side effects, and this study has prompted me to ask more questions of my clients, my supervisors and of myself and configure where I am on the 'continuum of responses' at any one time. Further to that, I critically question my own conflicted self and how I conceptualise my practice, and the limitations in what I can achieve and being human with a client is sometimes enough; through self-reflexivity, I can try critique what discourses and unconscious forces that could be blinding me and shaping what I see.

6.8 Conclusion

This research has explored psychotherapists' accounts of how they practise with clients who are taking anti-depressant medication. The research has illuminated the complex, dynamic, multidimensional, multifactorial and evolving nature of psychotherapy work with such clients. An overarching impression emerges from this thesis, concerning the theories and practise of professional psychotherapists, and how they approach their work in the medical field. Do psychotherapists choose to see or are they blinded by the obscene object of medication? It concerns the psychotherapist's role in the future, and how psychotherapists can contribute to the interpretation and treatment of depression. When considering depression, we understand that it has interpersonal components and that we are working with human beings, so that step-by-step models and therapeutic templates can only guide our practice so far; there needs to be flexibility to work with the unexpected. As psychotherapists, we must situate our work within the context and ambivalence of clients' lives.

The taking of the medication and the physical effects cannot be separated. Psychotherapy practice can explore the meaning of depression symptoms and potential effects of medication; they are arguably two sides of the same coin. Central to this is for psychotherapists to critically challenge the language of dominant medical discourse and to try to re-order and re-prioritise the subjective world of the client in the search for personal meaning to their suffering and the message of the prescription of medication. The psychotherapy process is less about the technicality of approach and more about the truth of the clients' desire. I believe the central issue is about the reflexivity of the practitioner working with flexible hypotheses, supporting the voice of the client among intermittent agencies and ideologies, and therapeutic attempts at freeing up the desire of the client in a multi-agency matrix. The real disease is not depression but the infecting discourses that are spread throughout culture and arguably sustained by medical and pharmaceutical companies that seek to control subjects and reinforce the status quo of the pathological capitalist system, ruthless in its attempt to bleed the poor, control the mad and keep the sick sedated. But symptoms are signs of rebellion, the return of the

repressed, signifying a revolution against the Other and a resistance against the pathological social systems. The psychotherapist is faced with the ethical choice, to further compound the clients' desire or seek to re-cipher the truth to set the clients desire free.

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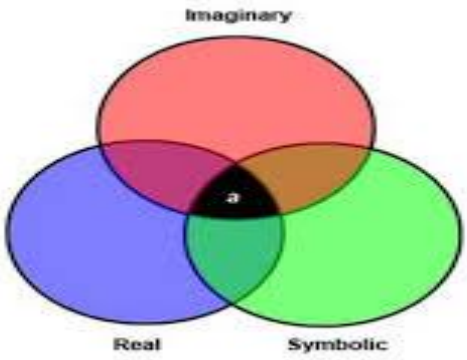
Appendix 1 Jacques Lacan's Theory of the "Real, Imaginary and Symbolic"

Central to Lacan's (1975) theoretical propositions are the concepts of the real, imaginary, and the symbolic. In Parker's (2005; 2010; 2011) and Pavón-Cuéllar's (2010) application to discourse analysis they negotiate the complex relationship between the subject and language through these different "registers". Lacan used the metaphor of "the borromean knot" as a metaphor to display interlocking symbols of rings where the imaginary, the symbolic and the real represented the interplay of psychical registers (Lacan 1975). I will discuss each of these psychical registers in detail, beginning with the imaginary.

Figure 2



Imaginary

Lacan's concept of the imaginary relates to the infantile stages of ego development. The "imaginary" register represents a stage where the infant has anxiously not gained bodily and somatic coordination. The infant's visual perceptions, which by this age are relatively advanced and Lacan (1977) tells us how, through glimpsing in the mirror, the child first begins to conceive of itself as a coherent and unified body (Lacan 1977). The infant develops an ego agent which aligns with the visual sense of self. But this is not the actual self, but only visual representation of the self. The imaginary pertains to what can be representable through the senses (Richardson 2003). Through a process of identification with the "mirror" image of itself, the ego is formed. Lacan's use of the 'mirror' term describes a representation of integrity, in which the mother presents her own vision to her infant (Lacan 1966). This image of self comes to be the image around which the child will attach to linguistic words of the social, whether it is positive or negative. The child's perception of their specular image produces the fiction that they are whole have clearly ascertainable identity, when what is happening is really that the child is identifying with an image that comes from elsewhere, from outside. Thus, rather than

being the source from which communications flow, the ego is created only in relation to something outside itself, coming into being as an 'imaginary capture', a moment of mistaken self-identification that is the beginning of a permanent tendency whereby the subject seeks imaginary wholeness to stitch over conflict, lack and absence (Lacan 1977). Through psychical development, a child can move beyond the imaginary register or rather, the imaginary register is "written over" by external linguistic expressions (Lacan 1975).The imaginary is structured by the symbolic.

Symbolic

The symbolic register represents the language into which we are born into and alienated but this language also shapes and structures how we experience the world. Language precedes our existence and is something that the child must enter into so as to articulate its needs. The infant must learn the language of its parents and culture so as to achieve this. But something is always lost in the articulation of these needs, "in so far as his needs are subjected to demand, they return to him alienated" (Lacan 1977 p690). But something is always lost in the articulation of these needs, lost between our desire and the demand which is heard. Our desire is articulated through language and speech. Lacan (1977 p690) asserts:

> ...in so far as his needs are subjected to demand, they return to him alienated. This is not the effect of his real dependence, but rather the turning into signifying form as such, from the fact that it is from the locus of the Other that its message is emitted.

And in subjectifying it in some way it becomes his or her own idiosyncratic use of language. It is "the symbolic order which is determinant of subjectivity" (Evans 1996 p203). This subjectification is characterised particularly through the limitations of prohibition, the law and ideals that are reaffirmed or disapproved by representatives of culture and society. The symbolic dimension of the symbolic order involves the signifier. The symbolic involves imaginary and real elements to its symbolic dimensions and the imaginary, symbolic and the real triad can be seen within language as the signified, signifier and letter respectively (Chiesa 2007). The function of the symbolic can be seen through the relation of one signifier to another. This chaining is seen in the relationship of the signifier 1 (S1) and signifier 2 (S2). For Lacan the unconscious is seen represented by signifiers both as symbols and as letters (the dimension of the real of Language). Thus through this real of language the unconscious can present itself independently of the subjects own participation. The subject can be spoken by language. (Chiesa 2007) The symbolic can help us to coordinate the real which it partially represents (Levinson 2010).

Real

The ‘real’ is a concept regarded by Lacan as everything else that escapes and cannot be translated into language and ultimately “resists symbolisation absolutely” (Evans 1996). Richardson (1992) asserts that “the real is not reality”. He continues to say that “reality is what is already structured by the Symbolic and the Imaginary. But the real, as distinct from reality, is the impossible to describe or express… defying our powers of anticipation or comprehension” (Richardson 1992). Badiou (2001) calls the real an event which escapes language and our normal conscious life is structured around the repression of the real (Badiou 2001). According to Lacan, we can never psychically conceive of the “real” as it is in the realm of the “the body” and in the realm of the “biology” (Evans 1996). According to Lacan (1958), “reality is precarious …and the ‘real’ feelings are deceptive.

Appendix 2 Jacques Lacan's Four Discourses

Lacan's Theories of Discourse

Discourse, according to Lacan is the necessary structure which should be taken as something that goes far beyond more or less occasional speech (Lacan 1991). Lacan offers theories of four discourses which are the "discourse of the master", "discourse of the university", "analytic discourse" and the "hysterics discourse" (Lacan 1991; Verhaeghe 2001; Verhaeghe 2004; Bracher 1994). Lacan's theories of discourses are careful analytic descriptions of possible orientations of the subject (Alcorn 1994 p43). Lacan analyses how the formal relationships between the discourses and how these relationships produce particular social bonds (Verhaeghe 1995 p4). The four discourses set up four positions. These four positions are represented by algebraic symbols, **S1** and **S2**, $ and ***a***. The S1 symbol represents the master signifier, S2 represents knowledge, $ represents a spilt or repressed subject and ***a*** represents object *a*, which can mean surplus or the object of desire (Evans 1966). These terms can be rotated over four different positions, each discourse been represented by a matheme. Lacan captures particular qualities of text through theoretical mapping of discourses through "mathemes" in a quadruped.

Each discourse assumes that there is a speaker and a receiver or an agent and the other. There is usually a purpose to the communication of between the agent and the other. The message that is sent is usually called a product. If we are to take the idea that within every communication, there is partly a failure, we could see then that there is some "truth" that is not sent. This truth is usually is situated hidden in or underneath the agents speech as repressed (Verhaeghe 1995 p4).

Agent other

_____====> _____

Truth Product

The first of Lacan's discourse is the masters discourse (see diagram below). In the master discourse, the agent is usually represented as S1, Signifier 1. The agent is placed on the top left of the quadruped. When S1 is communicated to S2, this is represented as S1 $\rightarrow$ S2. When this

communication is transmitted, there is usually a product, or it can be seen as a lost object, *object a*. This is what is given to the receiver and lost to the agent. If the agent takes the position of the master or 'master- signifier' which is represented as S1, they are pretending to be one and undivided. The master can be one who pertains to know and the one who pertains to have the answer. This is where Lacan added in the psychoanalytic element by saying that there is always an aspect of communication that is unconscious as it is "repressed", there is always something that escapes knowledge and that is not said. There is always something they do not know, hence they are divided (*$*). This is known as the spilt subject with the symbol (*$*). The agent has a conscious part and an unconscious part. The split symbol represents an aspect of truth, although the truth is repressed or part of the truth that wants to be expressed fails. In this position, the master's full knowledge is only an illusion. The master's assumes full knowledge until the moment they speak and they lose the knowledge to the other, as the other keeps the master in the position of the knower. This set up is known as the master's discourse. The master's discourse is represented as:

The master's discourse

S1 ====> S2
---- ----
$ a

The 'hysteric discourse' represents the discourse of the normal neurotic, the one who does not know or is unsure. The hysteric refuses to follow the master (Bracher 1994 p122). The hysteric is in the agent's position as the one who is communicating. They are seen as the divided split subject been represented through the symbol (*$*). This discourse puts the hysteric in the position of the agent, but this time when the agent- hysteric speaks, they turn the receiver into a master which is represented as S1. This communication looks like this *$* → S1. The hysteric is constantly challenging or complaining to the master (Parker 2005 p173). The master is meant to know. Although the hysteric refuses to follow the master, they remain in solidarity with the master as their anxiety, insecurity is searching for identity and the ideal (Lacan 1991 p107). The product from this communication is knowledge represented as S2 and it is situated under S1. "This knowledge is beside the point" (Verhaegue 1995). The product of this is knowledge which is represented as S2 becomes lost and more S2 signifiers will be reproduced as the hysteric can never be satisfied. The *object a*, the "lack" is driving the hysteric.

The hysteric can never be content because of this lack and it will continue striving. The object *a* can never be put into words so the hysteric keeps on reproducing signifiers (S2), always increasing the distance between the "the final truth" (Lacan 1969). The hysteric can never know his own truth, that's why the object *a* is in the place of truth. The hysterics discourse is represented as:

Hysterics Discourse

$		S1
-----	====>	-----
a		S2

In the university discourse, the knowledge takes the position of the agent as S2. This is seen as a regression of the master discourse. The agent is the "constituted knowledge" as S2 aims to communicate to the other as an object of knowledge, *object a*, the one who causes desire and reaffirms the position of the university. This looks like S2 $\rightarrow \alpha$. The truth, or the real truth is that university discourse needs to be "guaranteed" by the master S1. This guarantee is like that of the apparent objectivity of science, as it appears infallible and cannot be questioned once the master, who knows it, is supporting the university discourse (Lacan 1969). The university is represented in this matheme.

Discourse of the

University

S2 a

----- ====> -----

S1 $

The last discourse is the discourse of the analyst. In the place of the agent, we find the position of the *object a*, the cause of the desire of the other, which in this position is the analysand, or the receiver of communication. The *object a* "founds the listening position of the analyst" by seeking to express about its divided nature, this is represented by $\boldsymbol{a} \rightarrow \$$. This relationship is the basis for the transference as the analyst represents "subject supposed to know", the supposed hidden truth. The product of this relationship is the master signifier, S1 which is situated under the (*$*) paradoxically turning the client into a subject. The knowledge functions at the position of truth, S2, but it must stay hidden as the *object a* is the desire and the analyst must never give its knowledge; hence it would seize to be an analyst. The analyst's discourse is represented as:

Analyst's Discourse

a $

----- ====> -----

S2 S1

Verhaeghe (1995) maintains that these are the most important Lacanian structures, without any doubt the most "important part of the Lacanian formalization" (Verhaeghe 1995) where he claimed that "these structures permit us to steer the clinical practice in a very efficient way". Much of Lacan's work on discourses is only applicable to the analytic setting, to guiding the direction of the treatment and conceptualizing how psychotherapy differs from psychoanalysis (Parker 2005 p15) but there is some very significant concepts and ideas from Lacan that are applicable to comprising of Lacanian discourse analysis.

Appendix 3 Letter of Invitation

Nigel Mulligan

Dublin City University

Nigel.mulligan@XXXXXXXXXX

Date:

Dear XXXXXXXXX,

My name is Nigel Mulligan and I am a psychotherapist currently studying psychotherapy in Dublin City University. I am currently carrying out qualitative research with psychotherapists and psychoanalysts. The research aims to find out how psychotherapists and psychoanalysts approach their work and respond to clients who are taking anti-depressant medication. My academic supervisors are Dr. Gerry Moore and Prof. Anne Matthews.

I am writing to you to see if you would allow me to interview you. The interview would only last between 60-90 mins. If you want to know more about any details of the research you can contact me on the details above. Moreover if you were interested, you could call or email me and we could arrange a suitable time to carry out an interview.

Yours Sincerely,

Nigel Mulligan

Appendix 4 Poster Advertisement

Research study about psychotherapy

If you are a psychotherapist, would you like to take part in a qualitative study that will explore the work of psychotherapists with clients who are taking prescribed anti-depressant medication?

This research aims to find out how psychotherapists approach their work and respond to clients who are taking anti-depressant medication. With the participant's permission, interviews will be carried out and they will be recorded by audiotape. They will be approximately 1.5 hour. Transcripts will be taken and later analysed by researcher. Informed consent for participation will be sought. The interviews will aim to begin in September 2012. Participants will be expected to be practicing psychotherapists for more than 5 years.

If you are interested and are will to participate, you can call or email Nigel on the details below.

Researcher: Nigel Mulligan

Contact number: XXXXXXXXX

Email: nigel.mulliganXXXXXXXXX

(This researcher is a Doctorate candidate of Psychotherapy within the School of Nursing and Human Sciences at Dublin City University).

Appendix 5 Ethics Letter

Dublin City University
Ollscoil Chathair Bhaile Átha Cliath

DCU

Dr. Anne Matthews
School of Nursing and Human Sciences

1st May 2012

REC Reference: DCUREC/2012/082

Proposal Title: **A qualitative study of psychotherapists' accounts of their work with people who are taking prescribed anti-depressant medication**

Applicants: Dr. Anne Matthews, Mr. Gerard Moore, Mr. Nigel Mulligan

Dear Anne,

Further to expedited review, the DCU Research Ethics Committee approves this research proposal. Materials used to recruit participants should note that ethical approval for this project has been obtained from the Dublin City University Research Ethics Committee. Should substantial modifications to the research protocol be required at a later stage, a further submission should be made to the REC.

Yours sincerely,

DCU
Office of the Vice-President for Research

Dónal O'Mathúna

Dr. Donal O'Mathuna
Chairperson
DCU Research Ethics Committee

Office of the Vice-President for Research
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Appendix 6 Interview Four

This is an example of a within case analysis of one interview transcript from the interview with participant four (P: 4). It is broken up into three sections. A similar procedure was carried out across all interviews before the eventual cross- interview interpretation of data. In LDA we are not expected "to add an interpretative cognitive construction to the interpretative construction" (Pavón-Cuéllar 2012 p305), but we may interpret the discursive construction built of the analysed literal words that are used. We may piece together the building materials of the literal signifiers, re-situating these words in their structural positions (Pavón-Cuéllar 2012 p305). Throughout the passages "signifiers", "captions" and "phrases" were used as headings to further delineate different categories.

Section 1:

Section one contains the participant describing his psychotherapy practice and model. Section two entails the participant discussing his work with clients who are taking anti-depressant medication. In section three, I re-emerged significant elements from section one and two through a theoretical lens and reflected on the LDA concepts and coordinates.

Humanistic and Integrative:

When participant four was asked what psychotherapy model do they practice from and could they explain that, he replied, "humanistic and integrative". In his explanation of that, he said the best way to explain is to talk about "experience". He continued to say:

> Experience is probably the best way to do it […] what I am working with is the basis of Rogerian theory, and into that I have woven a number of other strands that suit the way I work. So I work with a base of Rogerian theory with an integration of some other theories such as object relational theory and some Gestalt and quite a strong imput from [Wilhelm] Reich and [Alexander] Lowen, which would be the body work, the body process piece and that kind of constitutes the theoretical framework that I am working from (P:4 - EX: 1)

The participant continued to comment on these strands of modalities by saying

> that there would be little bits of analysis coming in at times but the object relations piece kind of holds that for me, which covers the psychoanalysis piece and all that area (P:4 - EX: 1)

Later on in the text they summarized by saying "That's my version of humanistic integrative" (P: 4 - EX: 10).

Relationships:

This participant emphasised the "relationship" and it appears to be a significant recurrent signifier throughout the text. It was especially referenced within the therapeutic model where it was about "the relationship of meeting the person where they are, without judgement, without criticism (P: 4 - EX: 2). Later they said "I will met you where you are, and by meeting you where you are I will get access to the difficulty, the relationship space will simply re-enact the difficulty that you are having" (P: 4 - EX: 12). This is returned to again when they say that "all the research seems to say that it doesn't matter what model you are trained in, it's the quality of the relationship experienced by the client, that produces the possibility of change for the client" (P:4 - EX: 19). Was there an attempt to justify what he was saying by quoting "all the research"? The following is a notable sentence where the participant asserted "so there is slowness in the work at that level. Em, which takes time to develop and it is about learning to slow down to meet [….] the person and out of the relationship space the work can come then" (P:4 - EX: 30). In this sentence, there is a slight pause in the sentence just after the participant saying that they are there to "meet" the person. After this, there are gaps in the speech and then "out of the relationship" the sentence is recovered, and as if not only the speaking about the work continued but the "work can come then" (P: 4 - EX: 30). In P:4 - EX: 3, he described that the "self-relationship" as a "fragmented self-relationship". This was the basis of neurosis: "the basis of neurosis is the fragmented self-relationship […] system has broken down in most cases has happened in early early childhood". In the next extract, the participant continued in their description of fragmented self-relationship:

> Yes I can't be me so therefore I can't express me, I can't show me, because I don't know how to be me, and being me is not just thinking who I am, it's feeling who I am, and it's been able to experience that feeling of who I am" (P: 4 - EX: 4).

The participant discussed this self-relationship again, when they are discussing depression. They referred to the concept "depression" as a word signifier that you would help the client "interpret through them, different strands of the body, emotion cognition. You are trying to figure out what has been compressed or what is not working" (P: 4 - EX: 52), they continued, "we try make sense of what we see with our brains and that is part of the function of the brain to collate and identify and assimilate meaning" (P: 4 - EX: 54). The participant asserted that "knowing themselves, being themselves and expressing themselves will be fragmented (P: 4 - EX: 54). There is a "breakdown", participant four said that "I am imagining […] wondering what's that about […] is it me that is sad or what, we need to explore our joint relationship around you" (P: 4 - EX: 24), "finding a way of expressing, experimenting and exploring that […] to risk the intimacy (P:4 - EX: 26). The participant named the breakdown as occurring along the "head, heart and body".

Head, Heart and Body:

In discussing how the participant applied the theory into practice, the participant said that they would work with the client using their own "head, heart and body". They gave the example of looking at the "combination of head, heart and body" (P: 4 - EX: 2)

> people who are caught in the energetic experience of the problem and are reactive to it […] or are caught in the intellectual aspect of it […] and the basis of it all, there is a biological experience and by having the three strands it allows to me meet that person in the triangle" (P:4 - EX: 2)

They said "the cognitive, the emotional and the physical" were "the core conditions of being part of this species".

Another interesting signifier was the word 'gap'. There was an emphasis on the developmental where the participant had an interest in what "created the fear in the first place" (P: 4 - EX: 14). They are looking for an "imprint […] usually the parental figures (P: 4 - EX: 8), "and who said what to whom and what kind of modelling did you get and that" (P: 4 - EX: 16), "back drop to childhood, and you can begin to tease out the kind of codes that went on in there" (P: 4 - EX: 16). The participant continued to say that that was "where you get an understanding of what created the gap and then the next piece is a development piece can you risk engaging with that gap" (P:4 - EX: 17). And not only get an understanding, but express this "gap". The participant asserted that they would ask the client to "mime this to me, this gap, what would it look like, so you have position and movement, emotional response and reaction you got cognitive integration in that" (P:4 - EX: 32).

One of their initial comments was that they would try get "the person to connect themselves up in that" (P: 4 - EX: 2), "bring my brain in to make sense of it" (P: 4 - EX: 51). They said that a significant part of the therapy is allowing them to translate that into a cognitive sense which allows them to "figure it out", "the flow of information has broken down somewhere" and "therefore their brain has no mechanism for recognising themselves, and they have to make it up and that never works". When I (interviewer) asked the participant would you know if it's the head, the body, or the emotional. They replied by saying that "I will know it by checking out my experience of the person" (P: 4 - EX: 12).

Apprehending Experience:

"Experience" was a signifier which was used a lot this participant, but when further asked about it, they asserted:

> Trying to get to them (client) to understand where they are stuck, what's in your way, can we look at that together, can we share the difficulty and the puzzle of it and try figure something out[…] which is different from coming at it like, here is my set of spanners, here is your problem, now your fixed […] out […] and it's not based on a solely analytic mode, which might give you some sort of existential, intellectual understanding of why you have a limp, we are going to get you to process the experience of the limp itself (P:4 - EX: 2).

When the participant was asked how would he know if he was experiencing the client "would they be assuming, guessing or feeling if a client was sad?". The participant replied with an interesting angle on how he experiences the gap between private space and shared space. They discussed:

> what I am seeing, how I am understanding what your saying or I am feeling in regards what you are saying, is that accurate, does that make sense, and if it doesn't, I will let it go […] I am getting closer to you, rather than trying to fix you. I might be able to meet you at the edge of that gap, and the gap can be ok" (P: 4 - EX: 14).

Later they asserted, "I am here to meet you and anything I experience, is me experiencing me and that's how I see" (P: 4 - EX: 23). We don't experience anything or anyone other, we only experience ourselves (P: 4 - EX: 23). Describing my experience of meeting you and finding out does my experience match what's happening to you (P: 4 - EX: 23). In P: 4 - EX: 43, the participant discussed that it is "where psychotherapy is at its best when a person is confused about their experience of being themselves". In particular, body work, "essentially it is about allowing your body, just to be. Rather than trying to hold it, to surrender to the experience" (P: 4 - EX: 36).

Body-work:

So there is a very strong body aspect in the humanist tradition and the body aspect for me holds those possibilities for me to work through and up and down that space (P: 4 - EX: 2).There was an emphasis on the body aspect to the "three strands". They continued to emphasise the body in between the body by saying in that

> no matter how much I educate myself in the brain, my brain can't scratch my nose, I need my hand and I need to be able to do that and I need to be able to experience it, it's that disconnection where you have the brain operating out of some sort of sense identity that is fixed (P: 4 - EX: 18)

They continued by saying "because there is no alternative because your brain doesn't know how to scratch your nose, you need to be able to come down into the other parts of yourself to be able to do that…and it's that movement" (P: 4 - EX: 18). The participant's discussed that the body takes on five

shapes that are significant to signifying different developmental "realities" that have shaped "certain ways of being you" (P: 4 - EX: 34).

> that we have five body shapes [...] those five templates encapsulate the everything or any kind of shape that humans beings have […] of those five basic forms and I think there is an evolutionary reality in that….So each of those five forms are connected to five core developmental periods in childhood […]You know it is not standardised and that but you have a schizoid structure, oral structure, sphinx structure, psychotic structure and a rigid structure (P: 4 - EX: 34).

"You get caught in one let's just say, and you will develop a certain way of being you" (P:4 - EX: 34), they continued "This can even happen early on or possible happen in the birth itself and it went on into the family system (P:4 - EX: 34). A "physical templates" (P: 4 - EX: 34) shapes the physical and emotional reality (P: 4 - EX: 34). "Which comes first the chicken or the egg, you can have a body before you can have any feelings or any thoughts. The body is the fundamental ground of being."(P: 4 - EX: 34)

> each of the five has a particular core neurosis in it, which is like dropping a pebble in a pond and everything else is affected by that (P:4 - EX: 35)

There was another very interesting reference to the chicken later in the extracts when they were referring to a person damaged to the brain and possibly needing medication. When they referenced "Headless chicken or chicken-less head"

> Of the physical experience cause the brain is unavailable to make sense of it, and it isn't about a headless chicken or about chicken-less head, you need both. And if the brain is unable to understand the experience. Em because of some damage to the brain, em. There is nothing you can do about that, so you are limited in that sense to explore that piece (P: 4 - EX: 69).

Beyond the verbal: movement and sound

When the participant was discussing the skills and theory of been able to work with the bio-energetics, physicality of the neurosis as well as the psychological, they was saying that by "discussing that the experience they are trying to get in contact with is pre verbal" and that is made up of "movement and sound rather than words" (P: 4 - EX: 36). The participant explained that:

> if someone cannot fully understand or can't really cognitively understand em and it can't really understand words and sometimes the word aren't said, how would they know that or how would it affect their body, or is it through sense or energy. Yes it is the energy, its not a cognitive experience, it is energetics" (P: 4 - EX: 37).

"The energy is what you are doing with your arm, how are you doing that, that is your energy" (P:4 - EX: 38) There are a few significant elements to consider here. The signifier "body" is replaced by "sense" which is in turn replaced by the word "energy". The word is placed in to explain that what is beyond words.

> Ok can we go beyond the need for words and that, can you let the sound of this come out, can we let the position of this come out, a familiar thing is that a person can try be in that place, don't just look at yourself, can you be in that position. Does that make sense and in that early stage, that can be pre- verbal (P: 4 - EX: 39).

Section 2:

Spectrum of problems:

The participant was discussing certain levels of working and treating the person for something that they are never going to recover from and the "medication to take the edge of something".

> Yeah I would have experience of working with someone on anti-depressant medication, from a range of medications, from avert heavy medication for deep psychological problems that they are never going to recover from and someone who would go get a mild valium because they want to do some work and they want to take the edge of before even beginning that work. So I would of meet clients across that spectrum (P: 4 - EX: 55).

The participant saw related damage to the brain as "cognitive disorder". There are parts of the brain that cannot be cured or suffer from cognitive "disorder." They claimed that some clients would have a chemical problem that can only be treated with chemicals. The chemical imbalance would cause them to have that "disorder" (P: 4 - EX: 56). When P: 4 discussed "bi-polar", they said that "it came from the "medical model" and they have "worked with people who will not recover fully themselves because they are wounded or damaged chemically" (P: 4 - EX: 57). And it cannot be "cured". "The chemical workings of the brain are never gonna, they are never gonna hold to this piece of themselves (P: 4 - EX: 57).

"Possibilities" of working with Medication:

In the following extract, the participant was discussing how medication can actually help "get closer to the energy and feeling". That the worry and anxiety can be too much for somebody [and] medication could help them from "running away from it". They asserted:

> Again it depends on the […] yeah yeah so I would have experience with this person let's say that's doing this work, get to this gap into this piece and this piece is causing this anxiety and this anxiety is like the froth and the fear I need to get to the fear in order to get to the piece beyond that [...] but I am having difficulty with the strength of the anxiety which is causing me to worry and in some way and then I go to the doctor and he gives me something to take the edge off that which allows me to hold with a possibility instead of running away from it, been pushed out of by worry or anxiety. It quietens the anxiety and allows me to get closer to the energy or the feeling. That make sense? (P: 4 - EX: 58)

There are notable first-hand and second hand positions being pushed around there. It could help the therapy and "allows me to get closer to the energy of the feeling" is very interesting as there is an allusion to trying to get somewhere, to the "gap", to the "piece" and then to the "energy" and the medication can help that. Also there a few positions being shifted around here. They have put themselves in the position of the person going to the doctor "then I go to the doctor and he gives me something to take the edge off". But also, the participant said that they are having the difficulty and "strength of the anxiety […] is causing me to worry". There are arguably multiple-contradictory positions being interplayed here. There is a sentence that insinuates that the participant psychotherapist is "having difficulty with the strength of the anxiety which is causing me to worry", and it's the participant that needs "something to take the edge off" (P: 4 Ex 58).

There is a discussion of how medication may only be temporary and people can come out of psychiatric services "with no medication and no apparent psychiatric problems". They continued to assert:

> Ah absolutely it does, I am not against that kind of work or medication or anything like that, like there is a problem where I have come across people who have been diagnosed by the psychiatric services and I have seen them on a couple of occasions where people have walked out of a couple of years therapy with no medication and no apparent psychiatric problems (P: 4 - EX: 59).

But then interestingly the participant discusses:

> Rather than trusting the persons experience of been able to hold themselves through it [...] like you know you have come across that and seen people who say they don't want to go on medication, I don't want to get drugged out. I want to become normal. I want to stay more alive to myself and a psychotherapist can become quite useful there to let that person hold that experience (P: 4 - EX: 61).

Then the participant goes on to say "but there is […] some are […] they are never gonna get beyond this, they are never gonna manage this and that can be difficult you know?" (P: 4 - EX: 61).

There appears to be a dilemma here between "trusting the person's experience of them being able to hold it themselves" and they are "never gonna get through this". But later in the extract, there is a very interesting reference to medication acting as a "missing limb":

> Like if you come in here with one arm missing, I can't help you to grow that arm, no matter what I do. That can be very difficult to work with someone, at that level because you are constantly paying attention to the point of [….] em where they may implode and there is no clear line there where you may be able to hold this experience of contact and looking at yourself and explode and running away and running away at that level could be into complete madness and chaos" (P: 4 - EX: 61).

This extract could be alluding to limits of psychotherapy in working with someone where they "can't help you to grow your arm" and "paying attention to the point where they may implode" and there is no clear line there where you may be able to hold this experience of contact" and the possibilities of "madness and chaos" (P: 4 - EX: 61).

The "margin" of Medication:

The idea of someone being "caught in themselves", "gone off somewhere" and "not being able to reach" someone is significant here.

> Take someone who is very much caught in themselves, say with schizophrenia, it's not always possible, it's not easy to hold the line and where you can make contact and where you have gone off somewhere yeah. Because if you go off somewhere, I can't reach you, you know? I can only manage this. I don't know at what point your going to start imagining your Napoleon again, or your going to start imaging your Buddha and that's the line with that kind of medicated experience that it is difficult to work with (P:4 - EX: 64)

In the next extract they discuss how the medication can give them a margin to "navigate" with the person.

> Because you can't tell and the person can't tell you and it just happens like that and the person is gone. And the medication can give them a margin there and you can navigate that and learn to know when to pull back and you can be able to recognise not when it is happening and then pull back and let's stop (P:4 - EX: 65).

They continued by saying

> And you don't get that worth people who are just on mild anti-depressants and that kind of thing, that end of the scale. I am not sure, I have never been sure what valium means and you want them to recover fully and in some places that not going to happen (P: 4 - EX: 65)

In this extract they asserted that they have "never been sure what valium means" and they asserted that "the medication is in the mix and it is an unknown entity. In the next extract, there is recognition of desire to wanting a client to be off medication:

> Like you would like them to be off medication and be ok but with some people that's not going to happen, so medication can be good to hold them at that level but if there is an underlying thing, that would, such as the biochemical thing is beyond, like if they don't have any arm, that's the way they are structured (P: 4 - EX: 66).

The recognition of desire to wanting a client to be off medication but the by-the –way "underlying thing" of the…? What is the "thing" here? The "underlying thing" and the "Bio-chemical thing". The "thing" is a signifier that appears to be beyond the symbolic in the real, the unknowable. This is an interesting reference to mental health as physical component of bodily Infra-"structure". The real appears to be structuring the speech similarly just as a "limb" would structure a body or even a missing limb, the disconnection, the gap in the speech and the missing some-thing.

Primal Scream:

When the participant was asked was there any relation to his terminology between the "bio-energy" or the "bio-chemical", is there any connection with the with the body work who you may feel this person would need to be on medication or not. The participant discusses the "primal scream" therapy as a "possibility". The following extracts are significant.

> The Grof stuff and holotropic stuff, the pre-natal, the experience of the womb and theory that would say that that is where it began. And in order to get back to that you need to do the work of being in the womb […] being in the […] you would also get the analytic model that would say it's not about your womb at all, it's about your brain and how you think and the complex you can simply understand yourself and deal with it. Deal with the existential reality of it and your all fucked up and that's the way it is, there is nothing you can do (P: 4 - EX: 67)

Later in the extract they continue to say:

> The bio energetic piece is actually saying that if the person can risk experiencing themselves, they have much better opportunity to know themselves and therefore they would have much better opportunity to express themselves. And it's that movement that will allow sanity to prevail, and been comfortable in my skin, but that isn't possible as I said if someone is suffering from chemical imbalance and they simply can't be cured. So there is a range of different approaches […] you know primal scream – 'Yanov', (P:4 - EX: 67)

In the next extract they assert:

> He (Yanov) would have done all this primal scream stuff which is very much about going back in into the womb and going through the birth process again. And if you can re live that and negotiate that movement, which is exclusively movement, position and sound, there is no brain there and it used to facilitated very strongly and heavily over, that that will re-orientate your system and go through that trauma that happened in coming into existence (P:4 - EX: 68)

And in the next extract they say:

> And the mind […] so I am coming, If the person is not able to tolerate the experience of being themselves, to the extent that they need heavy heavy medication and they need to keep themselves in some even keel, above that experience, we are talking about the emotional energy, em, there is no point in inviting that person to drop down into that hole (P: 4 - EX: 69).

From these extracts, after much discussion, there appeared to be a "impossibility" of uniting the phrases "bio-chemical" and "bio-energy". All the the bio-energy can do working with how a person can experience themselves and the emotional energy, but unless they are on some "even keel", there is "no point" as they "cannot be cured".

Newtonian- Cartesian paradigm:

When the participant was asked about mental illness and the psychotherapy/ psychiatry relationship, they replied "It is yeah and that's unfortunate, cause they complement each other so well and history has separated them" (P:4 - EX: 73)

> that whole movement comes from the scientific explosion that happened. I think we are still caught in that idea. You exist in your brain and the rest of you is like an appendage. Also, the whole psychiatric model and the medical model it is part of, have aligned themselves with that Freudian analytic space than the humanistic space (P: 4 - EX: 77).

They continued to say that they don't think psychiatrists are encouraged to form a relationship which would go against what current research says that works interestingly enough. They said that regarding the Newtonian- Descartes emphasis on the mind- ego rationale, the participant claimed that "it is the illusion that knowledge equals wisdom, but it doesn't" (P: 4 - EX: 80).That is our cultural neurosis that somehow, at a certain age you move completely into your brain (P: 4 - EX: 84). The participant criticises "reality therapy" as "if you change the thinking then the feeling […] change […] in a sense the body thing comes the positive way, if you feel the feeling the brain will reorient (P: 4 - EX: 75). When the participant was asked about how anti-depressants impact the body, they replied "Well that's

a whole medical question, it's to do with genetics…. (P: 4 - EX: 70) If I did, I would just be another theorist offering… variations to the meaning of that (P: 4 - EX: 72).

Four Feelings and Four movements:

The participant further discussed "that when you get when you feel anger when you feel threatened, but if can't express that energy your brain is gonna covert it into some sort of action". The participant claimed that that us "a reaction not a response where if your felt it first and then responded if it was the culture that said lets feel it first and then decide the action, but the culture we live in says don't feel it and of course the action happens" (P:4 - EX: 84).

The participant claimed that the feeling happens in the body first.

> That's in the body, it seems deceptively simple but if you can't discharge the water from your eyes, that water will stay in your internal organs. and if you can't do that for long enough, the water will stay in your…. Some level off atrophy will happen (P:4 - EX: 84)

This participant suggested: "They all have many many nuances but my experiences in terms of the body (P: 4 - EX: 83).

Section 3- LDA

Introduction:

In this section, there will be an integration of Lacan's discourses (Lacan 1991; Verhaeghe 2004) with the transcript material and there will also be an observation of the "psy" discourses that are at play in the transcript from the participant. Parker (1998 p77) asserted that therapeutic domains contain "repertoires, templates and complexes" within which therapists and clients "fabricate varieties of truth and story a core of experience into being". It can be seen through this participant's account that they were discussing certain aspect of their practice, and there are certain discourses at play structuring their speech. There were some very noteworthy signifiers, phrases and ideas delineated from the extracts of this participant (P: 4). In these speech extracts, there are specific materials found in the symbolic, real and imaginary domains, with practical and linguistic "tools" for working therapeutically such therapeutic "slogans", re-useable signifiers, "ideas" of healing and recovery. In analysing through LDA, we are concerned in how the participant, who is the enunciator of speech, enunciates and also how they attempt to make sense of what was enunciated. First we have the telling of the word, the enunciated act which is the enunciating of the enunciated fact (Pavón-Cuéllar 2012

p95) and then we are analysing the "enunciating structure" that shapes what was told. In LDA, it is our job to discover what may be extra-intentional and an unsuspected truth (Pavón-Cuéllar 2012).

Disintegrating "Humanistic and Integrative":

There was a "version of humanistic integrative" (P: 4 - EX: 10) outlined by the participant. According to the participant's therapy practice, the humanistic aspect was looking at how the person (client) was "able" or "not so able" about "being themselves". The speech of the participant spoke of how the psychotherapy practice was carried out and applied where there was a possible developmental problem in a person's self-relationship. This could be detected through a "transference" which could lead to a "block" in development from a previous relationship while growing up. This "block" could be figured out in the "therapeutic relationship". The "person" (client) is facilitated to "being themselves" and helped to "experience themselves fully" through the therapeutic relationship.

Parker (2001) questions the "self- present humanist subject", claiming that there is a repression operating and "to believe that one is a subject who masters the field of signifiers that is perfectly transparent to oneself as one uses language is as grandiose and self-defeating in humanist discourse as it is when psychological experts in positivist domain (Parker 2001 p73). Foucault rejected 'conceptual or philosophical' humanism on a basis that it was western subject-focused metaphysics and where the appeal to humanist values as covering up strategies of domination (Dreyfus and Rainbow 1982). This also can be identified as the discourse of the master, which represents the "desire to master the other". The master has to deny (repress) being castrated ($), it does this by attempting to unify and control a field of knowledge (Loose 2002 p244). The master in the position of the knower and there is always something they do not know, hence they are divided ($).

The field of knowledge is "the battery of signifiers [which] confronts each individual subject, it cannot be mastered by anyone subject" (Parker 2001 p69). There were interesting assertions on how the participant psychotherapist and the "person" could work with each other, and at what level they could experience each other or not. The participant therapist could "meet the person where they are at". But where the "at" is and how can it be located was not specified by the participant. The participant said that they can only "experience the other through themselves". This was alluding to some level of inter-subjectivity through which therapy was hinged on and performed. Vanheule et al. (2003) introduced the philosophical underpinning of Lacan's notion of inter-subjectivity, stating "that in every inter-subjective dimension of social experience, there is the master/slave relationship". So if the participant met the client "where they were at" in order to "identify the problem", one of them would have to uptake these positions, arguably the Master or Hysteric discourse and "that is not an unusual situation" (Verhaeghe 1995). According to the Lacanian idea, the structural realities of

subject/other and slave/master are transcribed into roles or performances and conflicting interests are pursued (Vanheule et al. 2003). Vanheule et al. (2003) asserted that "a battle begins within the domain of the imaginary order: each subject has a preconceived image of the other and this impresses upon the reflections of her or his own identity" (Vanheule et al. 2003 p324). There seems to be attempts by the participant to understand his experience of meeting the other and finding out "does my experience match what's happening to you" (P: 4 - EX: 23). This could leave the participant trying to "identify" with the symptom of the person. The intersubjective relationship of the participant and the client could get stuck in the line of the imaginary, possibly restricting movement throughout the discourses.

The impossible trinity- "Head, Heart and Body"

Regarding the "integrative" part in the descriptions outlined by the participant where they "integrated" theories of the "head, heart and body". It could be seen that the signifiers "head, heart and body" were representing a subject for other signifiers "cognitive, emotions and the physical body" or "thinking, feeling and behaviour" These bundles of signifiers were "anchoring representation". Every time the participant attempted to signify something around these signifiers, it failed as the real thing to be signified got "over-determined and changed into another thing before being signified" (Pavón-Cuéllar 2012). This happened a couple of times where the "signifiers" were been used and then replaced. A lot of the signifiers revolved around the "body", which was a master signifier. The physical body and body parts were arguably the last place to describe as it was "beyond speech" and this was "where the "gap" was. The "gap" was another frequently used signifier, there was an impossibility of speech and "gap" was literally a stop-gap in understanding. Further to this impossibility, there was an "inability" (Verhaeghe 1995) of "integrating" (Frosh 2008) the "thinking, emotions and body" (P: 4). The participant mentioned that they "experienced" the "gap" somewhere between the "head, heart and the body" as in the "thinking, emotions and the body- movement". But the gap remained as occasionally the brain is unavailable to make sense of it, and what "if the brain is unable to understand the experience (P: 4 - EX: 69).

Parker (1998) also asserted those terms like "cognition" and "affect" as in emotions are functions of discourse, that they are not lying under the surface "steering", "pushing" or "motivating behaviour". "Thinking, development and social behaviour is still embedded in wider regimes of knowledge" (Parker 1998 p78). Certain "cognitions" could lead to a certain amount of illusory "intellectualisation". There could also be "an assumption that deeper meanings need to accessed and touched" (Parker 1998 p80). Participant four discussed the client was not "ready" and "not able to go there", that the client needed to be "fully" experience themselves. Participants four asserted that if the client wants to "recover fully" (P:4 - EX: 65), they "will re-orientate your system and go through that

trauma" (P:4 - EX: 68). A discourse in some psychoanalytic circles is that of "trauma", if you find that, you find present day solution to present day misery (Parker 1998)This is what Parker (1998) was referring to as a "discursive complex", in the way psychoanalytic discourse structures our talk in therapeutic domains…how we understand our distress and find a cure" (Parker 1998 p80).

Positions in discourse:

Psychological knowledge functions as an agent in relation to the other "the knowledge about human behaviour and thinking which is presented as "universal"…giving a "representative character to its findings" (Parker 2001 p68). Generalizable knowledge is "a set of signifiers that define the nature and limits of a discursive field" (Parker 2001 p69). There are two predominant discourses that get interplayed out in this participant's language, and there is a turning between the master position and sometimes the university position. Regarding the university discourse, the psychological knowledge acts as the agent. Foucault (1977) discussed about "where the mind becomes the target of professional knowledge". Lacan referred to this as the "university discourse" and the university position desires to "master the object" (Loose 2002 p246). It is the reverse of the masters position. If the master position cannot be grounded by truth, it hides behind "a recognised and approved paradigm of collective authority" (Verhaeghe 2004). When participant talked about the "gap" a few times and arguably where signifiers such as "experience", "energy" and "body" were exhausted, there was a linguistic urge to reframe was been said. These were the framed different bodily states, such as "the schizoid structure, oral structure, sphinx structure, psychotic structure and a rigid structure" (P: 4 - EX: 34). It was a possible aim to "fix subjectivity in [a] predetermined grid usually that of a biographical difficulty with one's parents (Frosh 2007 p643). This is what Loose (2002) was asserting about the university discourse where "general and objective knowledge is generated in order to grasp the object that so far has escaped science" (Loose 2002 p246) but the object cannot be grasped. The more the participant framed and explained the experience through the structure, the essence of the person was arguably going further away "further alienating" (Verhaeghe, 2004) from "where there are at". This is the ironic idea about psychotherapy is that the "discursive structure of talking therapy, as it must rely on theory as a guide for practicing the therapy" (Parker 2001). The "normal human being who is artificially forged by the psychology of the masters… is evidenced by models" (Barthes, 1957 p52).

Encounters (eruption) of the real:

In the participant's attempt to uphold the master's position (S1→ S2) and their desire to master the object in the university's position (S1→**a**), there were occasional "eruptions" of the real (Parker 2005; Pavón-Cuéllar 2012). It mainly emerged when the participant was discussing anti-depressant medication. There was what Parker (2005) called "the deadlock of perspective". The language was

interesting when they discussed certain "margins of possibility" of working participants, and there were "certain" limitations of psychotherapy work. The participant discussed participants who have severe mental health difficulties as "missing a limb" and suggested that was why they may need medication. There is a reference to a client as someone who has severe depression as a "headless chicken" or "chicken-less head". This phrase "headless chicken" is a highly symbolic phrase. As a cultural phrase it can mean "racing around like a chicken with its head cut off trying to do the work of two people". From what can we infer from this statement? It was a way of describing the person they were working with who was missing something that the medication filled the "gap" and allowed some work to take place. The medication can give him a "margin there and you can navigate" (P: 4 - EX: 65). But there is a contradiction as the participant then asserts that "that's the line with that kind of medicated experience that it is difficult to work with" (P: 4 - EX: 64). In the speech of the participant, it was like if they were on medication, this "medicated experience" was aligned with the difficulty of the "missing limb". The medication was an indication of a person's ability. It is way the "brain is structured" and if it is structured in this way or that way, "cognitively they may not be able to handle some therapy". "Like if they don't have any arm, that's the way they are structured" (P: 4 - EX: 66). The participant here is confronted with some of the limitations of therapy, the "impossibility" through limitations of the client, the "inability". "I can't help you to grow that arm, no matter what I do" " (P: 4 - EX: 61). That can be very difficult to work with someone, at that level because you are constantly "paying attention to the point of em where they may implode" and "there is no clear line there where you may be able to hold this experience of contact" or the "level could be into complete madness and chaos" (P:4 - EX: 61).

The participant asserted that "I have never been sure what valium means (P:4 - EX: 65). The "biochemical thing is beyond" (P: 4- Ex: 66). Pavón-Cuéllar (2012) asserted that there is always "in communication, a rupture, an impassable gap of information" (Pavón-Cuéllar 2012 p188). Not so much the speaker but discourses push the knowledge out of the speaker's speech. "Can't reach you know" and there is an impossibility and inability of knowing as knowledge about it can be "repressed". The "thing is beyond" (P: 4- Ex: 66). It is structured out just as the brain can be "structured" out. This is the "real". It was forcing the participant in the hysteric position; the hysteric cannot reach the truth of what causes "the division", the gap of knowledge, missing limb. And the use of anti-depressant medication here was an imagined reality. The participant is just another "theorist offering […] variations to the meaning of that" (P: 4 - EX: 72). The effect of the signifier "medication" was also an unknown contradictory aspect of working with a person, sometimes "filling the gap" and "navigating" and sometimes "difficult to work with".

Appendix 7 Interview Schedule

Inclusion Criteria

- **Age:**
- **Male____ Female____**
- **Where did you complete your training?**
- **With which psychotherapy organisation(s) are you accredited?**

Guide Questions for semi-structured Interview:

- Tell me about your psychotherapy approach?
- How would you describe your work with individuals who are taking prescribed anti-depressant medication?
- Can you give examples please?
- How would you describe the impact that anti-depressant medications have on your clients and what strategies do you employ to address any perceived impact the anti-depressant medication may have on the psychotherapeutic process?
- Can you give examples please?
- Can you describe how you distinguish between the effect of medication and possible symptoms of depression?
- Do you encounter any challenges and/or limitations in your psychotherapy practice with clients who are taking anti-depressant medication?
- Can you give examples please?

Appendix 8 Informed Consent Form

INFORMED CONSENT FORM

Research Study Title:

A qualitative study of psychotherapists' work with people who are taking prescribed anti-depressant medication

This study is being carried out by Nigel Mulligan. Investigator's Status: Doctorate in Psychotherapy Student in DCU

Investigators Contact number: **XXXXXXXXXX**

Clarification of the Purpose of the Research

I have chosen to do a study with psychotherapists who work with people who are prescribed and taking anti- depressants medication for depression. This is a qualitative study. Twenty participants will be interviewed. The interviewer will carry out semi-structured interviews with participants and these interviews will be recorded and transcribed (typed). Interviews will be held at mutually convenient times and location.

Confirmation of Particular requirements as highlighted in the plain language statement

You are invited to take part in this study the purpose of which is to explore how you work with clients that take anti-depressant medication. All information will be treated confidentiality and all data will be protected and stored in a safe place and confidentiality of the names of the participants will be ensured. Each participant will sign consent to participate in the study. All participation is voluntary and you may withdraw at any time. You are free to call me at the above number if you have any questions regarding any part of my study.

Participants- please complete the following (circle Yes or No for each question)

Have you read the plain language statement? Yes/ No?

Do you understand the information provided Yes/ No?

Are you aware that your interview will be audio-taped? Yes/ No?

Did you receive the informed consent Yes/ No?

I have read an understood the information in this form. My questions and concerns have been answered by the researcher and I have a copy of this consent form? Therefore I consent to take part in this research.

Participants Name: **Participants Signature:**

Witness Name: **Witness signature:**

Date: **Date:**

Appendix 9 Plain Language Statement

PLAIN LANGUAGE STATEMENT

Researcher/ Interviewers name: **Nigel Mulligan** Contact number: **XXXXXXXXXX**

Title: ***A qualitative study of psychotherapists' work with people who are taking prescribed anti-depressant medication.***

Research Supervisor (s): Prof. Anne Matthews/ DR. Gerard Moore, School of Nursing and Human Sciences, Dublin City University

Introduction:

The researchers name is Nigel Mulligan and his contact number is 0861053208. This researcher is a Doctorate student of Psychotherapy within the School of Nursing and Human Sciences at Dublin City University.

Aims and Objectives of Research:

This research will aim to find out how you approach their work and respond to clients who are taking anti-depressant medication. It will aim to identify what if any challenges and/or limitations that you may encounter when working with clients who are taking anti-depressant medication. From this, it will look at if you tailor your approach and adjust their techniques in their work.

Details of research:

This research will be a qualitative study. It will aim to enquire how you approach your work with clients who are taking anti-depressant medication. I will ask you to talk about how you understand your work when there is anti-depressant medication involved. You will be expected to be practicing psychotherapists for more than 5 years. Twenty participants will be interviewed through a process of semi-structured interviews. Through your permission the interviews will be recorded and transcripts will be then the narrative account of your work will be analysed by myself by identifying themes that emerge from the data. Informed consent for participation will be sought. Some basic details will be taken from the participants such as age, sex and professional background.

The interviews will aim to commence in September 2012. All the participants will be invited to voluntarily participate in this research project and it is completely optional. The proposed duration of this process of interviews, transcripts and analysis will be 8 months. The individual interviews will be approximately 1 hour. You will be assured of confidentiality. This project is not funded by any external agency but however it is a required element of the Doctorate in Psychotherapy, School of Nursing and Human Sciences, Dublin City University.

Confidentiality:

The data will be kept private at all times. Participants need to be aware that mentioned names and place names will not be included in the completed work. The information provided can only be protected within the limitations of the law. The participation in this study is completely voluntary and the participants are under no obligation to participate and they have the right to withdraw at any time.

If there is any more clarification needed around details of research in DCU, you can contact DCU ethics department on 017005000.