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Psychologists' Views and Experiences of Antidepressant Treatment for Depression

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Abstract

Research has raised doubts about the effectiveness of antidepressants, particularly for mild to moderate depression, as well as concerns about associated adverse effects of the medication. Despite these concerns and the relative efficacy of psychotherapy, antidepressant use continues to rise while the use of psychotherapy as a treatment for depression has declined. This qualitative study aimed to investigate psychologists' views of antidepressants arising from their experience of working therapeutically with depressed clients. In particular, it sought to understand the experiences that influence psychologists' views about antidepressants, any dilemmas they experience in regard to working therapeutically with depressed clients, and the approaches (including decision-making) they adopt in relation to antidepressant treatment and psychotherapy for depression.

Sixteen clinical psychologists, with a minimum of five years' experience, were recruited via an advertisement. Six of the psychologists were male and ten were female. Primary employment was distributed evenly across the public mental health system and private practice. The psychologists participated in semi-structured interviews focussed on exploring their experiences and views of working therapeutically with depressed clients, specifically those who have used or are using antidepressants. A process of thematic analysis, guided by an interpretive approach, was conducted on the data.

The results of the thematic analysis showed that psychologists' views of antidepressants are influenced by a number of experiences. These included the dominance of the medical model in the mental health system; their work context – private or public; their observations of the impact of antidepressant treatment and therapy on client wellbeing; and the influence of factors relating to the client. The subsequent approaches adopted by psychologists in relation to antidepressant and/or psychotherapy treatment for depression centred on client wellbeing and involved balancing a desire to empower the client with the importance of being pragmatic. Overall, antidepressant treatment was deemed useful to the extent that it improved client wellbeing; however when it disempowered the client and/or prompted disengagement from therapy it was viewed as compromising recovery by preventing clients from addressing the underlying causes of depression and acquiring coping skills, which could

help prevent relapse in the future. Whilst holding these views, the psychologists ultimately respected clients' choices and approached the treatment of depressed clients on a case-by-case basis.

A model is proposed to represent these influences on psychologists' views of antidepressants and the approaches they adopt when working with depressed clients. This study contributes a new and important perspective on client antidepressant use and psychotherapy to the field of research on depression, and considers implications for psychology/psychotherapy practice and future research directions.

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Chapter One – Introduction, Literature Review and Purpose

INTRODUCTION TO THIS STUDY

This thesis study is a qualitative investigation of psychologists' views and experiences of working therapeutically with depressed adult clients, specifically regarding antidepressant treatment. According to the World Health Organisation, depression is the leading cause of disability worldwide and a key contributor to the global burden of disease (World Health Organisation, 2008). The New Zealand Mental Health Survey carried out between 2003 and 2004 found that 16% of adults had experienced major depressive disorder in their lifetime and 5.7% in the last 12 months (Oakley Browne, Wells, Scott, & McGee, 2006; Wells et al., 2006). Depression is often a chronic disorder with high rates of relapse and recurrence, contributing to immense personal suffering and placing a severe social and economic burden on society (American Psychiatric Association, 2013a; Fava, 2003). It is also associated with high mortality, as it is the largest single risk factor for suicide (Exeter, Robinson, & Wheeler, 2009). Consequently, effective treatment of depression is a priority for the current Government in New Zealand.

Treatment for depression typically involves psychological treatment, also referred to as psychotherapy, and/or antidepressant treatment. According to evidence from clinical trials, both psychotherapy and antidepressants are effective treatments for depression (Elkin et al., 1989). However, the rate of antidepressant use, relative to any alternative, has increased considerably over the last two decades and continues to rise in Western countries (Lieberman, 2003; Moore, et al., 2009). For example, in New Zealand antidepressant prescriptions increased by 37% between 2006/07 and 2011/12, while the number of recipients rose by 35%, such that one in nine adults are prescribed antidepressants each year (Read, Cartwright, & Gibson, 2014). As antidepressants have become the principal treatment for depression, the number of patients receiving psychotherapy for depression has correspondingly declined (Olfson & Marcus, 2009). In response, researchers have raised concerns about whether antidepressants are being overprescribed, particularly for mild to moderate depression, where current evidence suggests they are only of modest benefit compared with placebo treatment (Kirsch, et al., 2008; Pigott, Leventhal, Alter, & Boren,

2010). Further, there are concerns regarding long-term use of antidepressants and associated adverse effects (Moret, Isaac, & Briley, 2008; Reid & Barbui, 2010).

This study aims to investigate psychologists' views of antidepressants given their experience of working therapeutically with depressed clients. In this thesis study, psychologists are regarded as key informants who can provide a unique perspective on the issues related to antidepressants, psychotherapy and the interaction between the two; an area that is seemingly under-investigated. The published research to date appears to have largely focused on quantitative analysis to examine the efficacy of antidepressant treatment and psychotherapy, and although previous research has explored patients' views and experiences of antidepressants, a literature search found no studies on psychologists' views or experiences of antidepressant treatment for depression. Thus this study seeks to offer a new and important perspective on the treatment of depressed clients with regard to antidepressants and psychotherapy.

The first chapter of this thesis provides an overview of the relevant literature that forms the context for this study. Chapter Two outlines the methodology, while Chapter Three presents the results of thematic analysis of psychologists' views and experiences of client antidepressant and/or psychotherapy treatment for depression. Finally, Chapter Four presents a proposed model to represent the influences on psychologists' views of antidepressants and the approaches they adopt when working with depressed clients, and discusses this within the context of psychology practice and depression research; additionally, it considers the implications for clinical practice with depressed clients, discusses the limitations of this study, and the implications for future research directions.

This current chapter begins with a brief overview of depression, including the theoretical models developed to understand depression and guide treatment. A review of the alternative treatments for depression is then outlined, including the efficacy of psychological and antidepressant treatments, and a comparison between the two. Finally, research on the views and experiences of patients regarding treatment for depression is presented, before concluding with a consideration of psychologists' views and experiences, as well as the study's research aims and questions.

DEFINING DEPRESSION

Depression has been experienced by humanity, and documented by record keepers for thousands of years, and there are a number of similarities between the ancient descriptions of depression and the symptoms we now associate with it (Nestler et al., 2002; Schotte, Van Den Bossche, De Doncker, Claes, & Cosyns, 2006). Although widely recognised as a condition, it was not until the 1960s that depression was defined and diagnosed as ‘major depressive disorder’, based on a collection of depressive symptoms described in the Diagnostic and Statistical Manual (DSM); a manual used for diagnosis and classification of mental disorders (American Psychiatric Association, 2013b; Nestler et al., 2002; Schotte et al., 2006). Since then changes have been made to the diagnostic criteria, however prior to outlining the current definition of depression it is important to distinguish depression from normal expressions of sadness, such as grief.

Grief and depression share many characteristics, such as intense sadness and social withdrawal, yet distinguishing between these two conditions is important as they represent the difference between normality and disorder (Horwitz & Wakefield, 2007). Historically, depression, or melancholia as it was known, was understood to be a disorder due to the observation that the experienced symptoms were considered disproportionate to the person’s circumstances (Horwitz & Wakefield, 2007). On the other hand, grief was and is recognised as a normal reaction following the experience of loss, which varies considerably depending on the individual. The American Psychiatric Association (2013b) notes a few key differences to help distinguish depression from grief; these include the presence of feelings of worthlessness or suicidal thoughts, persistent low mood with little or no variation, as well as significant impairment in daily functioning, experienced in addition to the normal response of grief following a significant loss. Thus, according to the current DSM – DSM-V – the experience of grief does not exclude a person from being diagnosed with depression, however caution is advised in the context of bereavement (American Psychiatric Association, 2013b).

As noted above, DSM-V provides the current definition of depression, classifying major depressive disorder as discrete episodes lasting at least two weeks and consisting of persistent low mood and/or a loss of interest or pleasure (American Psychiatric Association,

2013a). Associated symptoms include significant changes in weight or appetite, sleep disturbance, psychomotor agitation or retardation, fatigue or loss of energy, low self-worth or excessive guilt, poor concentration or indecisiveness, and recurrent thoughts of death, suicidal ideation or a suicide attempt (American Psychiatric Association, 2013a). A diagnosis requires that at least five of the nine symptoms be present and cause clinically significant distress or impaired functioning, not due to the effects of a substance or medical condition (American Psychiatric Association, 2013a). Major depressive disorder can be further classified as mild, moderate, or severe. This classification is based on measurements such as the Beck Depression Inventory (Beck, Ward, Mendelson, 1961) and the Hamilton Depression Rating Scale (Hamilton, 1960). A more chronic form of depression is referred to as persistent depressive disorder (dysthymia) and can be diagnosed when the mood disturbance lasts for longer than two years (American Psychiatric Association, 2013a). Defining depression is a necessary step for diagnosis, treatment, and research (Schotte et al., 2006). It is also important to consider the theoretical models of depression, as these inform treatment.

Psychological models of depression

Cognitive model

The cognitive model of depression was originally proposed by Aaron T. Beck in 1967. Central to the model is the notion that depression is caused by a negative thinking pattern, consisting of a negative view of the self, the world, and the future (Sacco & Beck, 1995). This is referred to as the 'negative cognitive triad', which according to the model is thought to create a cognitive vulnerability to depression (Beck, 1967). The model proposes that this cognitive vulnerability develops through early life experiences, such as parental loss, leading to the development of cognitive structures referred to as 'schemas', which selectively guide information processing (Beck, 2008; Sacco & Beck, 1995). The model is essentially a 'diathesis-stress' model, proposing that exposure to stressful events later in life may activate the dysfunctional schemas leading to the negative cognitive bias and consequent errors in information processing (Sacco & Beck, 1995). Thus the major symptoms of depression are regarded as a direct result of this negative thinking pattern, which influences and is reinforced by the individual's behaviour and emotions (Beck, 2008; Sacco & Beck, 1995). Another important aspect of the model is that the stressful life events that trigger

depression appear to be specific to the individual and related to the underlying vulnerability (Sacco & Beck, 1995). Consequently, in some vulnerable individuals mild stressful life events may lead to depression (Beck, 2008).

Interpersonal model

The interpersonal model of depression is based on the interpersonal theories proposed by Meyer (1957) and Sullivan (1953) and is centered on the relationship between mood and the social and interpersonal context (Markowitz & Weissman, 1995). Consistent with the cognitive model, it is a 'diathesis-stress' model and proposes that vulnerability to depression develops through early life experiences. However, the focus is on the quality of the mother-child attachment bond (Bowlby, 1969) and the acquisition of interpersonal skills (Hammen, 2003). According to the model, stressful interpersonal experiences during childhood may disrupt normal child development, resulting in dysfunctional coping styles and difficulty regulating emotion (Rudolph, et al., 2000). The model proposes that these vulnerable individuals lack adequate interpersonal skills and are consequently prone to generating stress and also respond to negative interpersonal events in ways that exacerbate stress and increase the risk of developing depression (Hammen, 2003). Once depression has developed, interpersonal functioning is further compromised contributing to additional interpersonal stress and maladaptive relationships, which are likely to maintain depression (Markowitz & Weissman, 1995; Rudolph et al., 2000).

Behavioural model

Behavioural models of depression consider reduction in the frequency of behaviour to be central to the development and maintenance of depression (Lewinsohn & Gotlib, 1995). Skinner (1953) proposed that this reduction in behaviour was due to an interruption of established patterns of behaviour, which had previously been positively reinforced by the environment (Lewinsohn & Gotlib, 1995). Ferster (1966) expanded on this by suggesting three possible mechanisms that could explain the reduction in behaviour: (1) sudden environmental changes leading to a loss of reinforcement, such as the loss of a spouse or job; (2) shifts in reinforcement contingencies; and (3) engagement in behaviour leading to punishment, which obstructs the opportunity for positive reinforcement (Lewinsohn &

Gotlib, 1995; McAuley & Quinn, 1975). Thus according to this model the environment plays a key role in the development and maintenance of depression by reducing behaviour and engagement in social interaction via positive and negative reinforcement (Lewinsohn & Gotlib, 1995; McAuley & Quinn, 1975).

Biological models of depression

Consistent with the cognitive and interpersonal models, biological models of depression are based on the 'diathesis-stress' model (Schotte et al., 2006). According to biological models, vulnerability to depression develops as a result of genetic factors and innate neurobiological disturbances, including dysregulation of the stress response and neurotransmitter 'imbalance' (France, Lysaker, & Robinson, 2007; Nestler et al., 2002). Depression is often considered a stress-related disorder; accordingly biological models have proposed that hyperarousal of the stress system, involving the hypothalamic-pituitary-adrenal (HPA) axis, may trigger depression following even mild stressful events in some individuals (Nestler et al., 2002). There is an inherent assumption that depression is largely the result of a biological problem, requiring medical treatment. This medical understanding of depression – referred to as 'the medical model' in this thesis study – advanced following the discovery of antidepressants, and has become the dominant discourse in society (France et al., 2007). From this perspective, depression is viewed as an illness resulting from a singular cause, specifically neurochemical imbalance (Read & Sanders, 2010). This will be discussed further in the context of antidepressant treatment, as the two are closely intertwined. It is important to note that despite considerable support in the public arena, biological models of depression have been criticised by researchers and clinicians for being overly simplistic and failing to integrate social, psychological, and behavioural causal factors (France et al., 2007; Hammen, 1992).

An integrated biopsychosocial model of depression

The biopsychosocial model is an integrated model for understanding mental disorders and was first proposed by psychiatrist George Engel (1977), following critique of the medical model for the reasons noted above. This model has been applied to depression and is

consistent with the understanding of depression as a heterogeneous disorder with a wide variety of causal pathways (Schotte et al., 2006). An integrated model of depression that considers psychosocial and biological factors is an important direction for treatment and research (Hammen, 1992; Schotte et al., 2006). According to this model, biological and psychological factors in depression are reciprocally connected, such that one's emotions and self-image are influenced by biological processes, just as biological functioning is equally affected by one's experiences and emotions (Schotte et al., 2006). Research has provided support for this understanding, demonstrating that like genetic factors, stressful experiences during childhood can contribute to dysregulated biological systems, creating a psychobiological vulnerability that increases the risk of depression following stressful events (Browne & Finkelhor, 1986). Thus according to this model, vulnerability to depression develops via an interaction between biological and psychosocial factors (Schotte et al., 2006).

EFFECTIVE TREATMENTS FOR DEPRESSION

Despite the proposed biopsychosocial model, treatment of depression has developed along two distinct pathways (e.g., depression is caused by biological versus psychosocial factors) (Friedman, et al., 2004). This has led to the development of pharmacological and psychological treatments for depression. However, there is growing support for the combination of psychotherapy and pharmacotherapy (de Maat, et al., 2008; Pampallona, Bollini, Tibaldi, Kupelnick, & Munizza, 2004), which is consistent with the biopsychosocial model of depression. Effective psychological treatments include cognitive therapy, also referred to as cognitive behavioural therapy (Gloaguen, Cottraux, Cucherat, & Blackburn, 1998), interpersonal psychotherapy (Elkin et al., 1989), and behavioural activation (Ekers, Richards, & Gilbody, 2008). In New Zealand, cognitive-behavioural therapy is the most commonly offered psychological treatment for depression. It is important to note that electroconvulsive therapy (ECT) is also considered an effective treatment with severe depression and in instances where other treatments have been unsuccessful (Pagnin, de Queiroz, Pini, & Cassano, 2004).

Antidepressant treatment has developed over the last 50 years and its superiority to placebo has been demonstrated in numerous controlled clinical trials (Fournier, et al., 2010). Research has shown the effectiveness of both psychotherapy and antidepressant treatment depends on a number of factors, including the nature of the depression (e.g., severity and chronicity), therapist effects, the therapeutic relationship, as well as various client factors, such as motivation to engage in treatment, life circumstances, and personal understanding of depression (e.g., beliefs about causes, symptoms, and chronicity of depression) (Friedman et al., 2004; Klerman, Weissman, Rounsaville, & Chevron, 1984; Wampold, 2010).

Psychological treatments

Cognitive therapy

Cognitive therapy (CT), developed by Beck (1967), includes both cognitive and behavioural techniques and as noted above is also referred to as cognitive behavioural therapy (CBT) (Young, Rygh, Weinberger, & Beck, 2008). CT is based on the cognitive model of depression and thus focuses on changing maladaptive cognitions and schemas, which developed in early life, as well as the interaction between thoughts, behaviours, and emotions (Young et al., 2008). Behavioural strategies are also used throughout CT, particularly in the early stages of treatment. These involve 're-activating' the client and include techniques such as scheduling activities and pleasant events (Carr & McNulty, 2006). CT also focuses on teaching clients strategies for identifying and managing stressful life events that may precede relapse (Carr & McNulty, 2006). CT is typically conducted in an individual setting and the frequency and duration of therapy is dependent on the needs of the client, however it is recommended that therapy be 'tapered off' and the client offered 'booster' or follow-up sessions after the termination of therapy (Beck, Rush, Shaw, & Emery, 1979).

A number of studies have been conducted demonstrating the effectiveness of CT for the treatment of depression (Gloaguen et al., 1998; Greenberg & Goldman, 2009). For example, in a meta-analysis of 48 clinical trials, involving 2765 patients with non-psychotic, non-bipolar major depression or dysthymia, of mild to moderate severity, Gloaguen et al. (1998) found that CT was significantly more effective than the control conditions (waiting-list or placebo). Further, in the National Institute of Mental Health (NIMH) Treatment of

Depression Collaborative Research Program (TDCRP), Elkin et al. (1989) investigated the effectiveness of CBT and interpersonal psychotherapy for the treatment of outpatients with non-bipolar, non-psychotic major depression. They found significant improvements at posttreatment compared with pretreatment for those receiving CBT (Elkin et al., 1989).

Interpersonal psychotherapy

Interpersonal psychotherapy (IPT) evolved from psychodynamic theory and was developed specifically for the treatment of depression. Originally based on the work of Harry Stack Sullivan (1953), IPT assumes that the social and interpersonal context is key to understanding depression (Carr & McNulty, 2006; Klerman et al., 1984; Weissman, 1979). Four areas of interpersonal difficulty have been identified as central to IPT: (1) grief related to the loss of a significant other; (2) role disputes involving significant others; (3) role transitions, such as moving jobs or houses, starting or ending a relationship, becoming a parent, or diagnosis of an illness; and (4) interpersonal deficits, particularly social isolation and difficulty forming and maintaining relationships (Carr & McNulty, 2006; Bleiberg & Markowitz, 2008). The therapist aims to support the client to develop more effective strategies for coping with the relevant interpersonal difficulties (Bleiberg & Markowitz, 2008). IPT is an individual, focused therapy, which typically runs for 12 to 16 weeks (Bleiberg & Markowitz, 2008).

There are a number of studies that support the use of IPT for the treatment of depression (de Mello, de Jesus Mari, Bacaltchuk, Verdelli, & Neugebauer, 2005; Elkin et al., 1989; Weissman, 1979). For example, in a meta-analysis of thirteen controlled trials investigating the efficacy of IPT in treating depressive spectrum disorders, de Mello et al. (2005) found that IPT was more effective than placebo in nine of the studies. This included greater remission rates for those receiving IPT, however this did not reach statistical significance. Those receiving IPT also had significantly less depressive symptomatology at the end of treatment compared with those in the placebo group (de Mello et al., 2005). Further, the results of the NIMH TDCRP showed that those receiving IPT were significantly improved on measures of depressive symptoms and general functioning at posttreatment compared with pretreatment (Elkin et al. (1989).

Behavioural activation

Behavioural activation (BA) is structured, brief, and centred on a psychosocial approach, targeting behaviour change to treat depression and prevent relapse (Dimidjian, Martell, Addis, & Herman-Dunn, 2008). BA is based on the behavioural model of depression and is thus concerned with the interactions between the person's behaviour and their environment, and the role this plays in maintaining depression (Dimidjian et al., 2008). The treatment aims to increase sources of reward through planning pleasant events and reducing escape and avoidance behaviours in order to increase activation and involvement in life (Dimidjian et al., 2008; Weissman, 1979). There are a number of techniques involved in BA, however an example of implementation is the development of a structured daily action plan (Ekers et al., 2008).

There is a growing source of empirical support for the BA approach to treating depression (Cuijpers, Van Straten, & Warmerdam, 2007; Ekers, et al., 2008; Weissman, 1979). For example, in a meta-analysis involving 17 randomised controlled trials and 1109 patients with a primary diagnosis of depression, Ekers et al. (2008) investigated the efficacy of behavioural treatments for depression compared with controls or other psychological treatments. They found that behavioural treatment was significantly superior compared with control/non-treatment options, and produced equivalent results to CBT, with no significant differences in posttreatment symptom level, recovery rates, or dropouts (Ekers et al., 2008).

Antidepressant treatment

Discovery of antidepressants and their mechanism of action

Throughout the first half of the twentieth century, psychotherapy and ECT were considered the standard treatments for depression, however during the 1950s a major revolution took place with the discovery of psychoactive drugs (Lieberman, 2003; Svenaeus, 2009). In 1952, a drug called iproniazid was used to treat tuberculosis. It was observed that this drug had psychoactive properties, causing terminally ill patients to become cheerful, energetic, and more socially active (Lieberman, 2003; López-Muñoz & Alamo, 2009). This was considered to be a 'side effect', which appeared by chance, however a few clinicians saw the potential

for a 'primary effect' in the treatment of psychiatric disorders (López-Muñoz & Alamo, 2009). During this time, iproniazid was not referred to as an 'antidepressant', and it was not until almost a decade later that antidepressants arrived on the market to specifically treat depression (Lieberman, 2003; López-Muñoz & Alamo, 2009). Iproniazid was an example of the first class of antidepressants, referred to as monoamine oxidase inhibitors (MAOIs).

The monoamine neurotransmitters, serotonin, noradrenaline and dopamine, facilitate neural transmission between important areas of the brain, including the brainstem, autonomic nervous system, limbic system and cortex. These pathways are considered central in controlling many behavioural functions, including mood and anxiety responses (Nash & Nutt, 2007). It is argued that MAOIs increase the synaptic availability of monoamines, by reducing their breakdown via inhibition of the enzyme monoamine oxidase (Lieberman, 2003). Not long after the discovery of the MAOIs, a second class of antidepressants emerged. These became known as tricyclic antidepressants (TCAs), and like the MAOIs their discovery was completely accidental (López-Muñoz & Alamo, 2009). It is thought that these agents also increase the availability of the monoamines, serotonin and noradrenalin, by blocking the specific transporter and thus inhibiting their re-uptake in the synapse (Nash & Nutt, 2007).

The discovery of MAOIs and TCAs led to a shift in the way mental disorders were understood. Scientists began proposing that these drugs may correct a specific 'chemical imbalance' in the brain, which they believed to be the underlying cause of the disorder (López-Muñoz & Alamo, 2009). This led to the monoamine theory of depression, which proposed that depression is caused by reduced monoamine transmission (Nash & Nutt, 2007). This explanation was widely accepted, and as noted earlier, shaped the cultural discourses around depression (France et al., 2007). Despite wide acceptance by the public, this explanation is now considered too simplistic. Research into the mechanism of action of antidepressants has shown they work through a series of complex interactions that cannot be explained by a single neurotransmitter system (D'Aquila, Collu, Gessa, & Serra, 2000; Schwaninger, Weisbrod, & Knepel, 1997). Further, there has been no conclusive evidence to support this 'chemical imbalance' theory and the biological basis of depression remains unknown (D'Aquila et al., 2000; Nash & Nutt, 2007; Reid & Stewart, 2001).

Despite inconclusive evidence, the monoamine theory supported the development of new antidepressant agents, designed with high specificity. For example, the selective serotonin reuptake inhibitors (SSRIs) are highly selective for the serotonin transporter and consequently have fewer side effects than MAOIs and TCAs (Nash & Nutt, 2007). SSRIs also have greater safety and tolerability compared with MAOIs and TCAs, however they do not appear to be more effective than their predecessors (Anderson, 2000; López-Muñoz & Alamo, 2009; Nash & Nutt, 2007). For example, in a meta-analysis comparing the tolerability and efficacy of SSRIs against TCAs in depressed patients, Anderson (2000) found that while there was no significant difference in efficacy between SSRIs and TCAs, significantly more patients discontinued treatment with TCAs due to side effects. Consequently, SSRIs are currently considered the agent of choice and are widely prescribed (Svenaeus, 2009).

Increase in antidepressant prescribing

As noted earlier, the rate of antidepressant use has increased dramatically in Western countries over the last two decades (Moore et al., 2009). In the United States, antidepressants have become the most commonly prescribed medication (Olfson & Marcus, 2009). In an analysis of the 1996 and 2005 Medical Expenditure Panel Surveys, Olfson and Marcus (2009) found that during this time the rate of antidepressant treatment increased from 5.8% to 10.1%, or from 13.3 to 27.0 million individuals across the population. An analysis of the General Practice Research database showed that in the United Kingdom antidepressant prescribing nearly doubled from 1993 to 2005 (Moore et al., 2009). Similarly, in New Zealand, Exeter et al. (2009) found that antidepressant prescriptions increased from treating 7.4% of the population aged over 15 years in 2004 to 9.4% in 2007. This increase in antidepressant prescribing has paralleled society's growing belief in the medical model of depression, as well as the widening use of antidepressants for other psychiatric disorders (Nash & Nutt, 2007; Svenaeus, 2009).

Some researchers have argued that the dominance of the medical model of depression despite inconclusive evidence is reflective of the power of pharmaceutical companies and the medical profession, supported by popular media, to shape society's view of the world (LaFrance, 2007; Read & Sanders, 2010). The dominance of this view has contributed to changes in clinical practice that may explain the rise in antidepressant prescribing (Olfson &

Marcus, 2009; Reid & Barbui, 2010; Svenaeus, 2009). Firstly, the increased safety and tolerability of SSRIs compared with MAOIs and TCAs, led to a shift in prescribing away from specialty care to primary care, which increased the availability of antidepressants (Lieberman, 2003; Olfson & Marcus, 2009). For example, in an Australian retrospective study, McManus, Mant, Mitchell, Britt and Dudley (2003) found that general practitioners (GPs) prescribe 86% of subsidised antidepressants, and many patients never come into contact with a psychiatrist. Secondly, alongside the rise in antidepressant prescriptions the number of people receiving psychotherapy for depression has declined (Olfson & Marcus, 2009). Further, in their study, Moore et al. (2009) used the general practice research database to examine the reasons behind the rise in antidepressant prescribing in the United Kingdom. They found that the increase in antidepressant prescribing is largely due to repeat prescriptions given as long-term treatment. Thus it appears that not only are more people receiving antidepressants, they are also less likely to receive psychotherapy, and more likely to remain on antidepressants for a longer period of time.

Alongside the rise in antidepressant prescribing, the prevalence of depression also appears to be increasing in Western countries (Olfson & Marcus, 2009; Svenaeus, 2009). For example, using two cross-sectional surveys in the United States, Compton, Conway, Stinson and Grant (2006) found that the prevalence of depression increased from 3.3% in 1991-92 to 7.1% in 2001-02. However, this phenomenon should be interpreted with caution, as researchers have suggested that developments in our understanding of depression have led to greater emphasis on detection and treatment, resulting in increased numbers of help-seekers and a more liberal application of the diagnostic criteria (Nash & Nutt, 2007; Svenaeus, 2009).

Antidepressants have increasingly been approved for the treatment of a wide range of conditions aside from depression, which is likely to contribute considerably to the rising rate of prescribing (Lieberman, 2003; Nash & Nutt, 2007; Olfson & Marcus, 2009). Since the introduction of MAOIs and TCAs, there is some evidence that antidepressants have effectively been used for the treatment of anxiety disorders and the relief of chronic pain, both of which are often comorbid with depression (Bespalov, van Gaalen, & Gross, 2010; France, Houpt, & Ellinwood, 1984). More recently, antidepressants have been used to treat other conditions, such as eating disorders (American Psychiatric Association, 2000),

obsessive compulsive disorder (Bandelow, et al., 2012), and posttraumatic stress disorder (Ipser, Seedat, & Stein, 2006).

Efficacy of antidepressants

In the context of rising rates of antidepressant use, there has been renewed scrutiny regarding their efficacy (Olfson & Marcus, 2009). A number of studies have concluded that antidepressants are superior compared to placebo in the treatment of major depressive episodes (Ball & Kiloh, 1959; Joffe, Sokolov, & Streiner, 1996). For example, in a meta-analysis of 49 clinical trials from 1966 to 1995, Joffe et al. (1995) found that the mean effect size for antidepressants was 1.57 compared to 1.02 for placebo, indicating that 69% of patients on antidepressants did better than the average person in a placebo group. Further, in the NIMH TDCRP, Elkin et al. (1989) found that after 16 weeks of treatment, imipramine – an SSRI – plus clinical management (CM) was significantly more effective than placebo plus CM. Despite these findings, doubts have been raised about the long-term benefits of antidepressants and more recently the efficacy of antidepressant treatment has come under critical examination. In the following section of this review, research regarding the enduring effects of antidepressants will be presented, followed by a critical review of the evidence regarding the effectiveness of antidepressant treatment.

In a naturalistic follow-up study of the NIMH TDCRP, Shea et al. (1992) found that at 18 months after treatment the percentage of patients who recovered – defined as eight weeks with minimal or no symptoms – and remained well, did not differ significantly across the treatment groups (CBT, IPT, imipramine plus CM, and placebo plus CM). Further, the group receiving imipramine plus CM had the highest rate of relapse – at 50% – among patients who had recovered. This was a significant finding and raised concerns about the long-term benefits of antidepressants and the risk of relapse following discontinuation of treatment. In order to reduce this risk, the current practice guidelines recommend that antidepressants be continued for four to nine months following the resolution of symptoms in the acute phase (American Psychiatric Association, 2010). This is referred to as ‘continuation treatment’, while ‘maintenance treatment’ is recommended in some cases following this phase to reduce the risk of a recurrent episode of depression.

There are a number of studies that support the efficacy of antidepressants in continuation and maintenance treatment (ten Doesschate, Bockting, & Schene, 2009; Geddes et al., 2003). The assumption accompanying these stages of treatment is that symptoms resolve before the underlying pathophysiology of the disorder, thus the risk of relapse decreases as the underlying pathophysiology is repaired by antidepressant treatment (Geddes et al., 2001). In a systematic review of 31 randomised clinical trials including 4410 participants, Geddes et al. (2001) found that the average rate of relapse on placebo was 41% compared to 18% on antidepressants. They concluded that antidepressants reduced the chance of relapse by 70% and the treatment effect appeared to endure for up to 36 months. This finding has been critiqued by researchers as very few studies had follow-up past 12 months, providing limited information on long-term treatment (Fava, 2002). Further, it is important to note that many of the patients in the placebo group had been withdrawn from antidepressant treatment, which may have contributed to higher rates of relapse or recurrence. As noted by Fava (2002), studies such as this suggest that antidepressants are reasonably effective at preventing relapse while the person remains on the drug, however they do not provide information on the effectiveness of antidepressants to change the course of depression, casting further doubt on the enduring benefits of antidepressants.

There is some evidence that antidepressants may not be effective at changing the course of depression (Viguera, Baldessarini, & Friedberg, 1998). For example, in a review of 27 studies on depression risk over time, involving 3037 patients, diagnosed with non-bipolar major depression, Viguera et al. (1998) analysed the continuation and discontinuation of antidepressant treatment. They found that although those who remained on antidepressants had significantly lower rates of relapse compared with those who discontinued antidepressants, the length of antidepressant treatment did not appear to affect the risk of relapse once the antidepressant was discontinued. Thus whether a person had discontinued antidepressants soon after resolution of their symptoms or had been maintained on medication for months or years made no difference. The authors concluded that these results do not support continuation and maintenance treatment on antidepressants (Viguera et al., 1998).

Despite evidence that antidepressants are superior compared to placebo in the treatment of major depressive episodes, recent meta-analyses of efficacy trials for antidepressants

have demonstrated only modest benefits compared with placebo treatment (Barbui, Furukawa, & Cipriani, 2008; Kirsch, Moore, Scoboria, & Nicholls, 2002; Kirsch et al., 2008). For example, in an analysis of 47 placebo-controlled clinical trials of antidepressants submitted to the U.S. Food and Drug Administration (FDA), Kirsch et al. (2002) found that the mean difference between the antidepressant and placebo groups was less than two points on the Hamilton Depression Rating Scale, and approximately 80% of the medication response could be explained by the placebo response, leaving at most 18% due to a true drug effect. The superiority of antidepressants over placebo has been further undermined by suggestions that the side effects of the medication may increase the placebo response of antidepressants due to 'unblinding', which raises patients' expectation of improvement (Kirsch et al., 2002; Pigott et al., 2010). This is an important consideration as it may enhance the apparent efficacy of antidepressants.

Researchers have argued that the apparent efficacy of antidepressants may also be inflated by publication bias (Pigott et al., 2010; Turner, Matthews, Linardatos, Tell, & Rosenthal, 2008). Evidence-based treatment is useful to the extent that the literature is unbiased and inclusive of clinical trials regardless of the outcome. Selective publication, specifically inclusion or exclusion of clinical trials based on their outcome, could contribute to unrealistic estimates of antidepressant effectiveness (Turner et al., 2008). Turner et al. (2008) analysed reviews for 74 studies submitted to the FDA, involving 12,564 patients. They found that of these studies, 31% were not published. Consequently, the published literature indicated that 94% of the clinical trials had positive outcomes, whereas according to the FDA analysis only 51% were positive (Turner et al., 2008). Overall this led to a 32% increase in effect size, suggesting that the published literature may be misleading and inflate the apparent efficacy of antidepressants (Turner et al., 2008).

Stringent exclusion and inclusion criteria employed in clinical trials may also inflate the efficacy of antidepressants, and as many participants are not representative of those seeking treatment for depression, the generalisability of the findings may be limited (Pigott et al., 2010; Wisniewski et al., 2009). The Sequenced Treatment Alternatives to Relieve Depression (STAR*D) study was funded by the NIMH to examine the effectiveness of various treatments for depressed patients who did not respond to initial treatment with an antidepressant (Rush et al., 2004). It sought to examine patients typically seen in real world

settings, thus unlike most clinical trials it employed broad inclusion criteria and only excluded patients requiring inpatient detoxification (Nelson, 2006; Sinyor, Schaffer, & Levitt, 2010). Wisniewski et al. (2009) used data from the STAR*D study to evaluate whether clinical trials recruit participants representative of depressed outpatients. They found that of 2,855 participants with major depressive disorder only 22.2% met the entry criteria for clinical trials. The participants in this sample were more likely to be younger, white, married, more educated, and have on average a shorter duration of illness. They experienced significantly better outcomes, including fewer side effects, and greater response and remission rates, compared to the non-efficacy sample (Wisniewski et al., 2009). The researchers concluded that current efficacy trials imply a more positive outcome that may not be realistic in clinical practice (Wisniewski et al., 2009).

There is also considerable evidence that the efficacy of antidepressants depends on the initial severity of depression (Fournier et al., 2010; Khan, Leventhal, Khan, & Brown, 2002; Kirsch et al., 2008). In a meta-analysis of 35 clinical trials, involving 5,133 patients, Kirsch et al. (2008) examined the relationship between depression severity and efficacy across all clinical trials submitted to the FDA for four new-generation antidepressants. They found that the efficacy of antidepressants reached clinical significance, defined by the National Institute of Clinical Excellence (NICE) as a three-point drug-placebo difference on the Hamilton Depression Rating Scale, only in the most severely depressed patients (Kirsch et al., 2008). They also observed a negative relationship between depression severity and the placebo response, namely patients with less severe depression were more responsive to placebo. The researchers concluded that the increased benefit of antidepressants in the severely depressed patients was due to a reduced placebo response rather than a greater response to medication (Kirsch et al., 2008). This is an important finding, as Kirsch et al. (2008) avoided publication bias by including all clinical trials. In another meta-analysis, involving six studies and 718 patients, Fournier et al. (2010) found that antidepressant efficacy increased with greater symptom severity, and mild to moderate depression showed nonexistent to minor improvements with antidepressants. The researchers have argued that antidepressants should only be prescribed to patients with the most severe depression, unless other forms of treatment have failed (Kirsch et al., 2008).

Short-term adverse effects

There are a number of adverse side effects associated with antidepressant treatment. The most common symptoms arising after commencement of antidepressants include nausea, headache, dry mouth, diarrhea, constipation, agitation, and dizziness (Moret et al., 2008; Svenaeus, 2009). It is also common for patients to experience a flattening of emotion, and in some cases this may persist with long-term use. Consistent with this, functional magnetic resonance imaging has demonstrated reduced response to positive and negative stimuli after taking an SSRI for seven days (McCabe, Mishor, Cowen, & Harmer, 2010). These side effects typically resolve within a few days or weeks of starting the antidepressant, however they are unpleasant and likely contribute to the high rates of non-adherence (Hollon, Thase, & Markowitz, 2002), particularly considering the clinical effects of antidepressants take at least three to four weeks to be experienced (Bschor, Bauer, & Adli, 2014).

Long-term adverse effects

Short-term side effects are transient, however there are some adverse effects that persist with long-term use and others that may appear at a later stage, following partial or full recovery from the depressive episode (Moret et al., 2008). Long-term adverse effects include sexual dysfunction, hyponatremia (low serum sodium concentration), bleeding disorders, weight gain, diabetes mellitus, sleep disturbance, osteoporosis, and increased risk of birth defects during pregnancy (Andersohn, Schade, Suissa, & Garbe, 2009; Moret et al., 2008; Reid & Barbui, 2010). Of these, the most common long-term effects include sexual dysfunction, weight gain, and sleep disturbance (Moret et al., 2008). Emotional numbing, mentioned above, is another long-term effect described by some patients as unpleasant, however this will be discussed further in the context of patients' views and experiences. Antidepressants may affect any or all three phases of the sexual response cycle (desire, arousal, and orgasm) (Reid & Barbui, 2010). In a review on the effects of SSRIs on sexual function, Rosen, Lane and Menza (1999) reported that up to 80% of people taking an SSRI may experience sexual dysfunction. Further, both SSRIs and tricyclic antidepressants are associated with steady weight gain over long-term use. This is consistent with the finding that long-term use of antidepressants, defined as greater than 24 months, at moderate to high doses is associated with an 84% increase in the risk of developing diabetes (Andersohn

et al., 2009). These adverse effects are concerning, and as will be discussed in a later section, negatively impact the quality of life for a number of patients.

The appearance of adverse effects during long-term treatment with antidepressants may be explained by evidence indicating that, at least in some cases, antidepressants lose their effectiveness over time (Byrne & Rothschild, 1998; Fava & Offidani, 2011). This has been termed tachyphylaxis, or antidepressant tolerance, and defined as a return of depressive symptoms following full recovery, despite maintenance treatment with a previously effective antidepressant (Katz, 2011). According to a review of the literature, this phenomenon has been found to occur in 9% to 57% of patients in published clinical trials (Byrne & Rothschild, 1998). Further corroboration was provided by the STAR*D study, which found that with each treatment step, relapse rates increased in those who had achieved remission, despite maintenance treatment on the previously effective antidepressant (Nelson, 2006). Coupled with this documented loss of efficacy over long-term use, there is evidence that the effectiveness of antidepressants may not extend past six months (Fava & Offidani, 2011). For example, in a controlled study of 395 patients who responded to fluoxetine, Reimherr et al. (1998) found that after 24 weeks, fluoxetine significantly protected against relapse compared to placebo (fluoxetine, 26%; placebo, 48%), however this was not the case by 62 weeks (fluoxetine, 11%; placebo, 16%). The most common strategy in response to this phenomenon is to increase the antidepressant dose, however this has produced mixed results (Byrne & Rothschild, 1998; Fava, 2002). Fava and Offidani (2011) conclude that although antidepressants are effective in acute treatment, their use has been overextended and the implications of this may be detrimental.

Antidepressant withdrawal

It is well established that following discontinuation of antidepressant treatment a number of patients experience withdrawal symptoms, which in some cases may prolong antidepressant use and can be misdiagnosed as a relapse or recurrence (Haddad & Anderson, 2007). This phenomenon has been termed 'antidepressant discontinuation syndrome' and has led to claims that antidepressants are drugs of dependence or addiction (Nutt, 2003). Symptoms include dizziness, nausea, headache, fatigue, gastrointestinal symptoms, irritability, panic attacks, sleep disturbance, and in rare cases mania and

hypomania have been observed (Haddad, 2005; Robinson, 2006). The symptoms usually appear within a few days of stopping the antidepressant and are more likely with higher doses and long-term use (Haddad, 2005). It is relatively common to experience withdrawal symptoms, for example, Tint, Haddad and Anderson (2008) found that following antidepressant discontinuation over 3-14 days, 46% of 28 patients experienced at least three new symptoms. The symptoms may last up to three weeks and resolve rapidly after restarting the antidepressant (Zajecka, Tracy, & Mitchell, 1997). Gradual tapering of antidepressants, rather than abrupt discontinuation has been recommended to reduce the likelihood of experiencing withdrawal symptoms (Haddad and Anderson, 2007).

It is important to distinguish between 'physical' and 'psychological' dependence (Nutt, 2003). A number of researchers have argued that antidepressants should not be considered drugs of dependence, as they do not meet the criteria for 'substance dependence' as defined by ICD-10 or DSM-V (Haddad, 2005; Lichtigfeld & Gillman, 1998). Despite this technicality, the experience of withdrawal symptoms may still contribute to prolonged use of antidepressants in some individuals. This is due to 'psychological' dependence, which is defined as fear of the anticipated consequences following drug discontinuation, leading to continued use (Nutt, 2003). The impact of this on patients' views and experiences of antidepressants will be discussed subsequently.

Comparison of antidepressant treatment with psychological treatments

Relative efficacy

A number of studies have demonstrated that psychotherapy is at least as effective as antidepressant treatment in the acute and maintenance stages of treatment for depression (Blackburn & Moore, 1997; Spielmans, Berman, & Usitalo, 2011; Rush, Beck, Kovacs, & Hollon, 1977). In the first study comparing cognitive therapy (CT) with antidepressant treatment, Rush et al. (1977) randomly assigned 41 chronically depressed outpatients to receive either CT or imipramine. They found that both groups had significantly improved symptomatology at the end of 12 weeks, however CT showed significantly greater improvement with 78.9% of patients experiencing a marked reduction in symptoms or complete remission, compared to 22.7% in the imipramine group (Rush et al., 1977).

Further, in a randomised controlled trial, Blackburn and Moore (1997) assigned 75 outpatients with recurrent depression to three treatment groups: antidepressants for acute and maintenance treatment, CT for acute and maintenance treatment, and antidepressants for acute treatment followed by CT for maintenance treatment. They found that patients in all three treatment groups improved significantly and there were no significant differences between treatments in the acute or maintenance stages (Blackburn & Moore, 1997). These findings are important as both Rush et al. (1977) and Blackburn and Moore (1997) employed a sample of patients with chronic depression, which is often difficult to treat. The researchers argued that CT is a viable treatment option, even for more severe and chronic depression.

Despite these findings, evidence regarding the relative efficacy of psychotherapy and antidepressant treatment for severe and chronic depression has been mixed and remains controversial (Elkin et al., 1989; Hollon & Shelton, 2001). In the NIMH TDCRP, Elkin et al., (1989) found no significant differences between treatment groups for the less severely depressed patients, however in the more severely depressed and impaired patients, imipramine plus CM was significantly superior to placebo plus CM, as was IPT, while there was little support for CBT with this sample. Advocates for the psychotherapies have argued that the quality of psychotherapy is likely to impact on treatment outcome (Jacobson & Hollon, 1996). This is supported by the analysis of site differences in the TDCRP, which revealed that the site with the greatest prior experience with CBT, showed no differences between CBT and imipramine plus clinical management with the more severely depressed patients (Elkin et al., 1989; Hollon & Shelton, 2001). Thus inadequate delivery of psychotherapy, as with medication, may undermine its relative efficacy and help explain inconsistencies in the literature (Hollon & Shelton, 2001).

Since then, other studies have found evidence in support of psychotherapy as an alternative treatment for severe and/or chronic depression. These findings have further illustrated that the effectiveness of psychotherapy may be limited by therapist experience and inadequate delivery of psychotherapy (DeRubeis et al., 2005; DeRubeis, Gelfand, Tang, & Simons, 1999). In a mega-analysis involving data from four key trials (including the TDCRP), DeRubeis et al. (1999) compared CBT with antidepressants in the treatment of severely depressed patients. They found no significant differences between CBT and antidepressant treatment, however

the overall effect sizes favoured CBT (DeRubeis et al., 1999). Further, in a controlled trial, DeRubeis et al. (2005) randomly assigned 240 outpatients with moderate to severe depression to receive antidepressant treatment, CT, or a placebo. They followed 'best practice' guidelines for the delivery of antidepressant treatment and CT, and found that at eight weeks, both active treatments were superior to the placebo group, with antidepressants showing a slight advantage; however at 16 weeks, both active treatments had an equivalent response rate (DeRubeis et al., 2005). They found a significant difference favouring antidepressant treatment over CT at only one site, and this appeared to relate to the experience of the cognitive therapists as well as patient characteristics, such as comorbidity (DeRubeis et al., 2005). These findings provide further support for psychotherapy as an alternative treatment option, even among severely depressed patients.

Relapse and recurrence

There is considerable evidence that psychotherapy, unlike antidepressant treatment, has enduring effects, leading to lower rates of relapse and recurrence of depression (Hollon et al., 2005; Imel, Malterer, McKay, & Wampold, 2008). As discussed earlier, antidepressants only appear to prevent relapse for as long as treatment is continued. During a 12-month period, Hollon et al. (2005) compared patients who had responded to CT with those who had responded to antidepressant treatment. The CT group was withdrawn from treatment at 16 weeks while those in the antidepressant group were randomly assigned to either continuation treatment on antidepressants or placebo withdrawal (Hollon et al., 2005). They found that CT significantly reduced relapse compared to antidepressant withdrawal. Further, there was no significant difference between continuation treatment on antidepressants and discontinued acute CT, indicating that brief CT may be an alternative to continuation and maintenance treatment on antidepressants (Hollon et al., 2005). Further, in a meta-analysis of 28 clinical trials, involving 3381 patients, Imel et al. (2008) examined the relative efficacy of psychotherapy and antidepressant treatment. They found that at posttreatment there was no significant difference between the two treatments, however at follow-up psychotherapy was significantly superior to antidepressant treatment. Further, consistent with Hollon et al. (2005), they found that discontinued acute psychotherapy did not differ from continuation treatment on antidepressants at follow-up (Imel et al., 2008).

Thus following withdrawal from treatment, acute psychotherapy appears to offer an advantage over antidepressant treatment, and seems to be of equivalent efficacy to continuation treatment on antidepressants.

There is some evidence that continuation treatment with psychotherapy may further reduce relapse and recurrence rates and offer an advantage over continuation treatment on antidepressants (Paykel et al., 1999; Vittengl, Clark, Dunn, & Jarrett, 2007). This is important considering the high rates of relapse and recurrence following acute treatment for depression. In a meta-analysis of 28 studies, involving 1880 patients, Vittengl et al. (2007) found that following discontinuation of acute CBT, 29% of patients relapsed within one year and 54% within two years. They concluded that these rates, while high, were significantly lower than those associated with antidepressant treatment (Vittengl et al., 2007). However, following acute CBT, continuation treatment with CBT significantly reduced relapse-recurrence compared with an inactive condition. Further, continuation treatment with CBT reduced relapse-recurrence by 14% compared with continuation treatment on antidepressants at later follow-up (Vittengl et al., 2007). The researchers argued that acute and continuation treatment with CBT has an enduring effect superior to antidepressant treatment, and continuation treatment with CBT may be particularly useful for patients with high risk for relapse-recurrence, particularly those with multiple major depressive episodes (Vittengl et al., 2007). Researchers have suggested that this is likely related to the development and implementation of compensatory skills, which increase resiliency to stressful life events (Greenberg & Goldman, 2009).

Combination of antidepressant treatment with psychotherapy

The combination of antidepressant treatment and psychotherapy has been thoroughly investigated over the last 15 years. Despite mixed results, a number of studies have found combined treatment to be superior to antidepressant treatment (de Maat et al., 2008; Pampallona et al., 2004), and slightly more efficacious than psychotherapy on its own, particularly for severe or chronic depression (de Maat, Dekker, Schoevers, & de Jonghe, 2007; Friedman et al., 2004; Keller et al., 2000). For example, in a meta-analysis of 16 randomised controlled trials comparing antidepressant treatment alone with combined treatment, Pampallona et al. (2004) found that in the short-term (i.e. less than 12 weeks),

combined treatment led to significantly greater improvement compared with antidepressant treatment alone. Further, in trials of 12-24 weeks, combined treatment was significantly more effective than antidepressant treatment alone, suggesting that combined treatment is also superior in the long-term (Pampallona et al., 2004). In another meta-analysis of seven randomised controlled trials involving 903 patients, de Maat et al. (2007) compared psychotherapy with combined treatment. They found that combined treatment was more effective than psychotherapy alone, however this was only significant in moderate chronic depression, while there was no evidence of differences in mild and moderate non-chronic depression (de Maat et al., 2007). It appears that psychotherapy maintains its preventative effect in combination with antidepressant treatment, while the effects of antidepressants tend to be more robust, as they are less dependent on therapist skill (Hollon & Shelton, 2001). Consequently, researchers have argued that combination treatment may be superior to psychotherapy or antidepressant treatment alone, particularly for more severe or chronic depression (Segal, Vincent, & Levitt, 2002).

Related to this, researchers have suggested that antidepressant treatment may facilitate symptom relief so that patients are better able to engage in psychotherapy (Friedman et al., 2004). This is consistent with evidence that antidepressant treatment works faster than psychotherapy (Keller et al., 2000), and has led to another form of combined treatment, referred to as sequential treatment, which involves initial treatment with antidepressants followed by psychotherapy (while remaining on or off antidepressants) to prevent relapse and recurrence. Segal et al. (2002) have argued that this form of treatment may be particularly beneficial for patients with severe or chronic depression, as well as those who fail to respond to initial antidepressant treatment. In a six-year follow-up study, Fava et al. (2004) randomly assigned 40 patients with recurrent depression, who had successfully been treated with antidepressants, to receive either CBT or clinical management (CM). They found that CBT significantly lowered the rate of relapse (40%) compared with CM (90%). In another study, Paykel et al. (1999) assigned 158 patients who had partly remitted with antidepressant treatment to receive either CT and CM, or CM alone during 20 weeks, while remaining on antidepressants for continuation treatment. They found that at 68 weeks follow-up, the CT group had a significantly lower rate of relapse (29%) compared with the CM control group (47%) (Paykel et al., 1999). These findings provide support for the

sequential use of antidepressant treatment and psychotherapy, and highlight the value of psychotherapy at preventing relapse.

Section summary

Reviewing the treatments for depression, including their efficacy, is relevant for this study as these findings shape the recommendations that inform clinical practice and thus influence the views and experiences of clinicians and patients regarding treatment. Longstanding research supports the use of psychological treatments, such as CBT, IPT, and BA, in the treatment of depression. However, the discovery of antidepressants led to a shift in the way depression is understood. Specifically, antidepressants were viewed as correcting a 'chemical imbalance' in the brain, leading to dissemination of a medical understanding of depression. Despite inconclusive evidence to support this theory, the medical model of depression has taken root in society and the rate of antidepressant prescribing has risen exponentially, while the number of patients receiving psychotherapy for depression has declined. In terms of efficacy, numerous clinical trials have demonstrated the superiority of antidepressants over placebo. However, doubts have been raised about their enduring benefits due to studies showing high rates of relapse following discontinuation of antidepressant treatment. This led to recommendations regarding continuation and maintenance treatment to reduce the risk of relapse and recurrence, however there is evidence that antidepressants only continue to be effective for as long as they are continued. More recently, studies have critically examined the efficacy of antidepressants, finding only modest benefits compared to placebo particularly for mild to moderate depression, and suggesting that their apparent efficacy may be inflated by publication bias and exclusion of participants reflective of real world patients. There are also well established short- and long-term adverse effects associated with antidepressant treatment. On the other hand, psychotherapy has been shown to have relative efficacy for mild to moderate depression, and there is some evidence it may be an effective treatment for severe and chronic depression. Notably, there is conclusive evidence that psychotherapy is superior to antidepressant treatment at reducing the risk of relapse and recurrence, leading to growing support for the combination of antidepressant treatment with psychotherapy,

particularly for severe or chronic depression. The next section will consider the views and experiences of patients and psychologists regarding treatment for depression.

VIEWS AND EXPERIENCES OF TREATMENT FOR DEPRESSION

Based on the findings from international research, the New Zealand practice guidelines for depression recommend a psychological intervention alone should be offered as an initial treatment for mild depression, while patients with moderate to severe depression should be offered the choice of antidepressant treatment or a psychological intervention, where a combined approach is recommended for severe depression (New Zealand Guidelines Group, 2008). However, research has shown inconsistencies between the guidelines and what takes place in real world settings (Van Geffen et al., 2007). For example, despite the efficacy of psychotherapy for the treatment of depression, patients are most commonly treated in primary care settings with antidepressants alone (van Schaik et al., 2004). This is reflected in a cross-sectional survey of general practice patients in the United Kingdom (Churchill et al., 2000). Eight hundred and eighty-five patients completed the survey and 260 reported that they were treated for depression, of these, 75.8% reported receiving antidepressant treatment, 28.5% visited a counsellor or psychologist, and 8% were referred to a psychiatrist (Churchill et al., 2000). Further, in their study of the British general practice research database, Moore et al. (2009) found that 79% of new depressive episodes were prescribed antidepressants, despite recommendations for directing antidepressants to patients with more severe depression. Thus it appears that in real world settings, doctors prescribe antidepressants at a greater rate than recommended by the practice guidelines.

In contrast, the research suggests that many patients hold negative or mixed views of antidepressants and prefer psychotherapy to medication (van Schaik et al., 2004). This is reflected in the high number of patients who discontinue antidepressant treatment prematurely, despite recommendations for continuation and maintenance treatment (Aikens, Nease, & Klinkman, 2008). For example, in a study of antidepressant treatment in the United States, Olfson, Marcus, Tedeschi and Wan (2006) found that of 829 depressed patients selected from the Medical Expenditure Panel Survey (1996-2001), 42.4% discontinued treatment in the first 30 days and only 27.6% continued to take

antidepressants for longer than 90 days. Consequently, it is important to consider the views and experiences of patients regarding treatment for depression, as this can increase understanding of treatment for depression in real world settings and the impact on patients' wellbeing. It is also important for this thesis study, as it provides the context for psychologists' views and experiences of working therapeutically with depressed clients.

Patients' views and experiences

While the medical model of depression has spread among clinicians and the general public, there is evidence that many patients view their depression in the context of psychological and social factors, influencing their preference for treatment (Brown et al., 2001; Cornford, Hill, & Reilly, 2007). For example, in a qualitative study of 23 semi-structured interviews, Cornford et al. (2007) explored how depressed primary care patients view their symptoms. They found that the participants experienced problems distinguishing between the onset of depression and 'normal' responses to adverse events, such as grief following bereavement. Consequently, many participants were ambivalent about antidepressant treatment, as they believed that a change in circumstances was most needed and therefore taking antidepressants would be insufficient (Cornford et al., 2007).

Consistent with this view, a number of studies have found that patients prefer psychotherapy or talking therapies, such as counselling, to antidepressant treatment (Churchill et al., 2000; Dwight-Johnson, Sherbourne, Liao, & Wells, 2000; van Schaik et al., 2004). For example, Dwight-Johnson et al. (2000) administered questionnaires and completed telephone interviews with 1187 depressed primary care patients in the United States to examine their treatment preferences. They found that of those who desired treatment for depression, 67% preferred counselling to antidepressants (Dwight-Johnson et al., 2000). Further, in a systematic review of the literature, van Schaik et al. (2004) found that across 13 studies involving depressed patients, counselling and psychotherapy were preferred over antidepressants. The reasons for this included fears around undesirable side effects and the addictive nature of antidepressants, and the belief that psychotherapy solved the underlying causes of depression (van Schaik et al., 2004). Thus it seems patients tend to view their depressive symptoms within the social context and consequently express ambivalence towards antidepressants and prefer psychotherapy.

Despite this, the research suggests that patient experiences and views towards being on antidepressants are complex, and although many prefer psychotherapy for the reasons outlined above there are also many patients who hold positive attitudes towards antidepressants. In support of this, qualitative researchers have observed that the act of taking antidepressants and viewing depression as a medical illness requiring a pill can alleviate stigma and self-blame for some patients, as they perceive that it removes personal responsibility for the causes of depression and can validate and legitimise their distress (Knudsen, Hansen, Traulsen, & Eskildsen, 2002; Lafrance, 2007). Paradoxically however, they have also observed that many patients experience stigma while on antidepressants. For example, in their interview study on young women's changes in self-concept while on antidepressants, Knudsen et al. (2002) found that for many women taking antidepressants was experienced as a 'double' stigma, due to the combination of being diagnosed with a stigmatising disorder and then taking antidepressants, which they thought signified failure to cope with their emotional problems.

Further, alongside mixed or negative experiences, many patients report positive effects and benefits while taking antidepressants (Cornford et al., 2007; Garfield, Smith, & Francis, 2003). For example, in their qualitative study, Cornford et al. (2007) found that many patients believed antidepressant treatment was at least partially effective and helped dull the depressive symptoms. Similarly, in an interview study of 51 depressed general practice patients, Garfield et al. (2003) found that 49 participants discussed both positive and negative effects on antidepressants. The positive effects included gaining a sense of control over the depression, relief from the associated physical symptoms, and a return to normal functioning including the ability to perform social roles (Garfield et al., 2003). However, this led to a dilemma for some patients as they felt that antidepressants had a paradoxical role, aiding the return to normal functioning while at the same time reducing the sense of being 'normal' (Garfield et al., 2003). Malpass et al. (2009) expand on this dilemma in their systematic review of 11 qualitative studies. They observed that although some patients are better able to function on antidepressants, this 'enhanced' self is often rejected as 'artificial' and not viewed by patients as their 'real' self. Thus it is possible that improved functioning on antidepressants may come at a cost for some patients, as this must be weighed against a

loss of self-efficacy and 'normalcy', which is likely to increase with long-term use of antidepressants.

Consistent with this, mixed experiences have been observed in other qualitative studies that consider patients' experiences of agency while on antidepressants. For example, Stevenson and Knudsen (2008) analysed two qualitative studies based on semi-structured interviews on discourses of agency involving mood-modifying medicines. They found the majority of participants perceived that recovery ideally involved the non-medicated person working actively to solve his or her problems. Yet some thought that to work actively, medication was required to relieve the symptoms of depression and could be seen as a 'tool' to facilitate agency.

A large number of patients report several negative effects while on antidepressants. According to research, these negative effects appear to be greater in real world settings than in clinical trials, and researchers conclude that the impact on patients is often underestimated by doctors treating depression (Hu et al., 2004; Van Geffen et al., 2007). In a study of patients' experiences on antidepressants, Van Geffen et al. (2007) analysed 258 reports submitted to an internet-based medicine reporting system in the Netherlands. They found that 78% of the patients described a total of 630 side effects that they perceived as negative. The most frequently reported side effects included weight gain, sexual dysfunction, drowsiness, insomnia, and apathy (Van Geffen et al., 2007). A number of patients also reported on the ineffectiveness of antidepressants. The researchers concluded that this is a relevant issue for patients and may contribute to the high rates of discontinuation, especially as the side effects often appear before the perceived benefits of the antidepressant (Van Geffen et al., 2007).

Further, some patients experience undesirable emotional and interpersonal effects on antidepressants, which can cause considerable distress and impact on their daily functioning (Malpass et al., 2009; Price, Cole, & Goodwin, 2009). In a recent New Zealand study, Read et al. (2014) surveyed 1829 adult recipients of antidepressants on their experiences and beliefs about antidepressants. They found that a large portion of the sample experienced adverse emotional and interpersonal effects while on antidepressants. These included 'feeling emotionally numb' (60%), 'feeling not like myself' (52%), 'reduction in positive feelings'

(42%), and 'caring less about others' (39%). The findings showed that the experience of adverse effects was not related to the level of depression prior to antidepressant treatment, thus the authors concluded that these effects were caused by the antidepressants rather than the depression (Read et al., 2014). In another study, Price et al. (2009) interviewed 38 depressed patients who had taken an SSRI and experienced undesirable emotional effects that they attributed to the SSRI. They found that most participants experienced a reduction in the intensity of all emotions, and although this was initially perceived to be a positive effect, over time it became an unwanted side effect, as they experienced few positive emotions, difficulty making decisions, and expressed concerns that this 'emotional blunting' may prevent them from resolving their own emotional problems (Price et al., 2009). Thus the use of antidepressants may in fact have a negative impact on wellbeing and reduce the quality of life for a subgroup of patients.

The general public, as well as depressed patients, tend to express concerns around the addictive nature of antidepressants and the potential for developing dependence on them (Priest, Vize, Roberts, Roberts, & Tylee, 1996; van Schaik et al., 2004). For example, in a qualitative study, Leydon, Rodgers and Kendrick (2007) explored 17 patients' views on discontinuing antidepressants following long-term use. They found that the major barriers to discontinuation were fears of relapse and withdrawal symptoms, and these appeared to outweigh any perceived risks of long-term use (Leydon et al., 2007). Consistent with these findings, 55% of the participants in Read et al.'s (2014) study reported withdrawal symptoms and 27% reported fear of addiction. Further, in another qualitative study of nine focus groups, involving 74 patients, Haslam, Brown, Atkinson and Haslam (2004) found that many patients expressed fears around experiencing withdrawal symptoms, and this conflicted with reassurances from the doctor that antidepressants were not drugs of dependence. Other participants spoke of developing a psychological dependence and feared discontinuing antidepressants, as they did not know how they would cope without medication (Haslam et al., 2004). These fears led some patients to discontinue antidepressants prematurely, however in others they appear to contribute to unnecessary long-term use despite recovery from depression and the experience of undesirable side effects (Haslam et al., 2004; Leydon et al., 2007). This is concerning as Haslam et al. (2004)

conclude that the side effects can have an equally negative impact on daily functioning as the depression itself.

Psychologists' views and experiences

As noted earlier, a literature search on this topic found no other studies of psychologists' views or experiences of antidepressant treatment for depressed clients. However in a 2007 study, Williams and Levitt interviewed fourteen eminent psychotherapists on their understanding of the role of agency in psychotherapy and the place of psychopharmacological treatments for mental health problems in general. They used grounded theory to analyse the data and developed a conceptual model that included the role of psychopharmacological interventions in the process of enhancing agency. The authors found that the psychotherapists viewed medication as necessary at times and believed it could facilitate agency by helping clients address their problems, however it could also impair agency by reducing motivation, causing addiction and failing to teach skills. Secondly, they concluded that the experienced psychotherapists took a holistic approach that considered the role of both biological and psychological factors, with client agency being central to their decision-making in regard to psychopharmacological treatments.

This thesis differs from Williams and Levitt's (2007) study in that it is specifically interested in psychologists' views and experiences of antidepressant treatment for depression rather than psychopharmacological treatments in general; an area that has not been previously researched. For this reason, a broad approach was sought rather than adopting a specific focus, such as agency, however many of the findings of this study can be viewed as building on those of Williams and Levitt's (2007) work.

RESEARCH AIMS AND QUESTIONS

Considering the doubts about the effectiveness of antidepressants for mild to moderate depression and the relative efficacy of psychotherapy, particularly in preventing relapse, as well as the adverse effects associated with antidepressant use and the difficulty that some

patients experience stopping antidepressants, it is important to further investigate experiences of antidepressant use, in order to inform the treatment received by help seekers. This is especially important as antidepressant prescriptions continue to rise, as do the number of patients receiving antidepressants for long-term treatment. This study aims to investigate psychologists' views of antidepressants given their experience of working therapeutically with depressed clients. In this thesis study, psychologists are regarded as key informants who can provide a unique perspective on the issues related to antidepressants, therapy and the interaction between the two.

The study aims to develop an in-depth understanding of:

1. The experiences that influence psychologists' views about antidepressants;
2. The dilemmas, if any, that psychologists experience in regard to working therapeutically with depressed clients; and
3. Given the above, the approaches (including decision-making) that psychologists adopt in relation to antidepressant treatment and psychotherapy for depression.

The research questions guiding this study are:

1. What experiences influence psychologists' views of antidepressants?
2. Based on these experiences, what approaches do psychologists adopt in relation to antidepressants?

The contribution this study seeks to make to the field of research on depression and psychology/psychotherapy practice is a new and important perspective on client antidepressant use and psychotherapy. The intention is to provide a holistic view of the complex contexts psychologists work within, and gain insight into how they deal with the contradictions and pressures when working with depressed clients, including how they make sense of the role of antidepressants in the treatment of depression.

Chapter Two – The Methodology of This Study

This study aims to investigate psychologists' views of antidepressants given their experience of working therapeutically with depressed clients. In particular, it seeks to develop an in-depth understanding of the experiences that influence psychologists' views about antidepressants, any dilemmas that arise in regard to working therapeutically with depressed clients, and the approaches (including decision-making) they adopt in relation to antidepressant treatment and psychotherapy for depression. It uses qualitative data collected from interviews with 16 clinical psychologists.

This chapter outlines the qualitative approach of this study, including the steps taken to ensure the validity and reliability of the findings. The method is then described, including the recruitment of participants, participant demographics, and the process of data collection. The chapter concludes with a description of the process of data analysis.

THE QUALITATIVE APPROACH OF THIS STUDY

Qualitative research has largely developed in response to criticism and awareness of the limits of quantitative methods as a means to study human experience (Flick, 2009). For most of the twentieth century, quantitative research has been esteemed as the method of choice for advancing scientific knowledge (Guba & Lincoln, 1994). However, researchers in psychology and the other social sciences have argued that these scientific findings lack relevance and applicability to everyday life as they have been stripped of any context and meaning (Guba & Lincoln, 1994). In contrast, rather than examining cause and effect relationships or describing the distribution of a phenomenon in a population, qualitative research aims to uncover the meaning of a phenomenon, such as antidepressant treatment, for the people involved (Merriam, 2009). Qualitative researchers are concerned with understanding the way people interpret their experiences and make sense of the world within their cultural and social contexts (Flick, 2009; Merriam, 2009). Bryman (2016) notes that an exploratory stance offered by a qualitative approach is preferable when there is little or no research on the area under investigation, as is the case with this thesis study.

Over the last few decades there has been a proliferation of qualitative approaches, each sharing fundamental characteristics but differing in their underlying epistemological assumptions (Guba & Lincoln, 1994). In the next section I will outline these different paradigms and situate this research accordingly.

Situating this research

Qualitative research is often referred to as 'post-positivist', distinguishing it from positivist or quantitative research, as it assumes that meaning is socially constructed and thus that there are multiple realities or interpretations, rather than one fixed reality (Merriam, 2002). Within the post-positivist paradigm there are three main approaches, including interpretive, critical or postmodern (Merriam, 2002). Most qualitative research, including this study, falls under the 'interpretive' approach (Merriam, 2009). In essence, interpretive qualitative researchers seek to understand the meanings people have constructed about their experiences and how they see the world (Merriam, 2002). There are different types of interpretive studies, including basic qualitative research, phenomenology, ethnography, grounded theory, and narrative analysis (Merriam, 2009). The study type will depend on the focus of the study and how the research question is asked (Merriam, 2002). This study is a basic qualitative study, as it focuses on understanding how clinical psychologists make sense of their experiences of client antidepressant use and psychotherapy. There is no added dimension, unlike with the other types of qualitative research, and it exemplifies all of the 'shared characteristics' (Merriam, 2002, 2009), as outlined in the next section.

Characteristics of qualitative research

There are several key characteristics that all qualitative research has in common. As previously discussed, the primary focus of qualitative research is to deepen *understanding* of the process of meaning-making for people within a particular context (Merriam, 2009). The aim is to develop an emic (or insider) view of the phenomenon of interest (Merriam, 2009). Secondly, the primary instrument for data collection and data analysis is the researcher. According to proponents of qualitative research, the human instrument is best equipped to respond appropriately and adaptively to the data despite some recognised

shortcomings and biases; these are discussed in a following section (Merriam, 2002, 2009). Thirdly, the process of qualitative research is inductive. This means that rather than test hypotheses, qualitative researchers develop and contribute to theories and hypotheses (Carr, 1994; Merriam, 2002, 2009). Lastly, the final product of a qualitative study is richly descriptive and captures the complexities and contradictions that arise when people try to make sense of their world (Carr, 1994; Marecek, Fine, & Kidder, 1997; Merriam, 2002, 2009). Due to the in-depth nature of these four features, the qualitative research sample is often small and selective (Carr, 1994; Merriam, 2009).

Validity and reliability

Validity and reliability are important aspects of all research (Brink, 1993). Validity refers to the accuracy and truthfulness of the findings, including the extent to which they can be applied within the area of research, while reliability refers to the consistency of the findings, such that if the process were repeated, the results would remain the same (Brink, 1993). In qualitative research a major threat to the credibility and trustworthiness of the findings is the subjectivity of the researcher. This subjectivity is a unique – and usually positive – aspect of qualitative research, however if unchecked researcher bias may distort the findings (Brink, 1993; Merriam, 2009). Thus it is important that the researcher takes steps to reflect on and manage their own responses to the data (Brink, 1993). In doing so the research process becomes part of the inquiry, such that the analysis reflects the perspectives of the participants – in this study, clinical psychologists – as well as the researcher’s interpretation of these perspectives, referred to as ‘reflexivity’ (Flick, 2009; Namey & Trotter II, 2015).

In order to facilitate reflexivity and produce trustworthy results within this study, it is important to recognise the active role that I, as researcher, play in identifying the themes and patterns that are of interest (Taylor & Ussher, 2001). Bryman (2016) notes this process of selection is likely to be inextricably linked to the values and assumptions of the researcher. Thus it is important that I acknowledge my position as a clinical psychology student with a background in physiology. I believe my training has provided me with an understanding of the complexities of treatment for depression, however my own clinical approaches towards treating depression are in the early stages of development; a position I believe supported me to engage openly and flexibly with the data set. I also integrated the

following strategies to support accurate reflection of the psychologists' views and experiences rather than my own biases or assumptions.

Firstly, I met regularly with my primary supervisor, Dr Claire Cartwright, for review of the research process, including recruitment of participants, initial coding and development of themes, and write up of the results. I also recruited another doctoral student to review the coding process and check for accurate representation of the data. Secondly, I kept a research diary and documented the process in detail, including my observations, feelings and responses, particularly during data collection and data analysis. These were also discussed with Dr Cartwright. Lastly, I went over the data as a whole and checked that the themes and quotations were representative of the data set.

Thematic analysis

Thematic analysis is a widely used method for analysing qualitative data and reporting on patterns or themes both within and across data sets (Braun & Clarke, 2006). Unlike other approaches to qualitative analysis that are tied to specific theoretical positions, thematic analysis offers a flexible approach that is compatible with a range of theoretical frameworks (Braun & Clarke, 2006; Namey & Trotter II, 2015). Braun and Clarke (2006) note that thematic analysis can provide a rich and detailed description of the entire data set, which is particularly useful if the area under investigation is lacking research or the participants' views on the subject are unknown, both of which are relevant to this thesis study. Accordingly, thematic analysis is used in this study to analyse the data from psychologists' interviews that focussed on their views and experiences of antidepressant treatment for depression. A broad topic such as this fits best with an inductive, 'data-driven' approach that evolves through the process of coding (Braun & Clarke, 2006). Braun and Clarke (2006) outline six-steps to guide the process of thematic analysis, including familiarisation with the data, generating initial codes to organise the data into meaningful groups, searching for themes, reviewing themes to ensure they are distinctive and internally consistent, defining and naming themes and, finally producing the report. These steps and their application in this study are described in the final section of this chapter.

METHOD

In order to meet the aims of the study, 16 clinical psychologists from a wide range of backgrounds were interviewed. The interviews were recorded and transcribed by an approved university transcriptionist; NVivo computer software was subsequently used to manage the data. Finally, a process of thematic analysis was conducted on the data using Braun and Clarke's (2006) method.

Ethical approval for this research was granted by the University of Auckland Human Participants Ethics Committee on 26 June, 2013 for three years (reference number 9691).

Recruitment

Following ethics approval, participants were largely recruited via an online advertisement, which was distributed to members of the New Zealand College of Clinical Psychologists (NZCCP). The advertisement was also placed in the newsletter for the New Zealand Psychological Society (NZPS) (see Appendix A for the advertisement). Clinical psychologists were further recruited via networking and word of mouth.

Participants

Sixteen clinical psychologists with a minimum of five years' experience, including experience working therapeutically with adults on antidepressants, participated in an interview. Six of the psychologists were male and ten were female. The 16 psychologists ranged in age between 37 and 56 years, while the mean age was 48 years. With regard to years of practice, the psychologists ranged between six and 30 years, while the average length of practice was 15.9 years. The psychologists came from a variety of professional backgrounds, however at the time of the interview seven were primarily in private practice, six worked primarily for a District Health Board (DHB), and three worked in both private practice and for a DHB. Three of the psychologists worked in specialist adult services, however in order to protect their identity these services are not named. The psychologists were asked to identify their main therapy approaches. As shown in Table 1 below, all of the psychologists identified cognitive behavioural therapy (CBT), acceptance and commitment therapy (ACT), and/or

dialectical behaviour therapy (DBT) as one of their main therapy approaches. As noted earlier, CBT is the most commonly offered psychological treatment for depression in New Zealand. Some people named a number of other approaches, including emotion-focused therapy, mindfulness, narrative therapy, dynamic psychotherapy, motivational interviewing, schema-focused therapy, and relationship/sex therapy. Thirteen of the psychologists were based in Auckland and the remaining three were based in Christchurch, Wellington and Palmerston North.

Table 1

Participant demographics

Characteristic	Number of participants who endorsed the characteristic (n=16)	% of participants who endorsed the characteristic
Gender		
Female	10	62.5
Male	6	37.5
Age		
37–49	8	50.0
50–56	8	50.0
Years practice		
6–15	8	50.0
16–30	8	50.0
Primary employment		
DHB	6	37.5
Private practice	7	43.8
Both/other	3	18.8
Approach		
Emotion-focused therapy	1	6.3
Mindfulness	6	37.5
CBT, ACT, DBT	16	100.0
Narrative therapy	2	12.5
Dynamic psychotherapy	2	12.5
Motivational interviewing	1	6.3
Schema-focused therapy	1	6.3
Relationship/sex therapy	1	6.3
Location		
Auckland	13	81.3
Outside Auckland	3	18.8

Data collection

Interviews

The clinical psychologists expressed their interest and desire to take part in the interview by emailing me in response to the advertisement. I responded by sending them the Participant Information Sheet and Consent Form (Appendices B and C respectively), which they completed prior to the interview. Participants were also asked to complete a demographic form, detailing their name, age, gender, years of practice, current and previous places of work, and main therapy approaches (Appendix D). They often completed this on the day of the interview and either emailed it to me or gave it to me in person.

The interviews took place in a setting chosen by the psychologists. In ten instances this was the work-place, five were telephone interviews, and one was via Skype. The interviews lasted for between 35 and 90 minutes, however the average length was 56 minutes (see Appendix E for the Interview Schedule). The interviews were semi-structured and the questions focussed on exploring the psychologists' experiences and views of working therapeutically with depressed clients, specifically those who have used or are using antidepressants. This included: any benefits or negative effects that they observed clients experience from antidepressant treatment; ways in which antidepressants assist or alternatively are unhelpful to therapy progress; the circumstances in which clinical psychologists would or would not recommend antidepressants for treatment of depression; long-term use and withdrawal from antidepressants by clients; and any dilemmas that clinical psychologists experience in regard to working therapeutically with clients on antidepressants.

Throughout the interviews, the psychologists were asked to speak generally about their experiences and also to think of specific examples of therapeutic work with clients, while protecting their anonymity. These examples were elicited through questions such as, "Can you think of a time in the past where this has arisen with a client, so that I can understand more about what happens?" Further, I often brought their attention back to the impact on the client, the therapist and therapy, as well as how they manage any dilemmas or complexities. Although there were a number of questions, the psychologists were also encouraged to talk about anything they considered to be relevant and important with

regard to client antidepressant use. This was facilitated by asking whether they had anything to add at the end of the interview, and also contributed to varying interview lengths.

Data analysis

NVivo 10 computer software was used to manage the data and facilitate a process of thematic analysis using Braun and Clarke's (2006) method. As noted earlier, Braun and Clarke identify six steps to guide the process of thematic analysis; the steps and their application are described below.

Step 1: Becoming familiar with the data

The interviews were transcribed by an approved university transcriber. According to Braun and Clarke (2006), transcription can be an important first step to becoming familiar with the data, however it is not necessary. As I did not transcribe the interviews, I was conscious of taking extra time to read and re-read each interview transcript before coding the data. I began a research diary for the analysis and read through the interviews consecutively. As I read through the interviews I wrote down any ideas, questions or initial thoughts that I had in response to the data. This enabled me to start forming ideas around possible patterns.

Step 2: Generating initial codes

Once familiar with the data, I went carefully through the first four interviews and in the margin of each page I wrote a brief statement to summarise each unit of data, referred to as 'initial codes' (Braun & Clarke, 2006). The initial codes varied between a line and several lines and were determined based on meaning. This was a thorough process and resulted in a comprehensive list of codes, which I transferred into my research diary. If a code was repeated within the data, I put a tick next to the relevant statement to indicate the number of times it was represented. I also used highlighters to indicate interesting segments and patterns. Following this process I met with my primary supervisor to review the initial codes and discuss possible themes.

Step 3: Searching for themes

During this review process, I went through the initial codes and organised them into potential themes. I established six potential themes, which seemed to represent the data to date. These were: 'impact of the system/context', 'role of doctors', 'value of therapy', 'approach to treating depression and attitude towards antidepressants', 'benefits of antidepressants and associated difficulties in therapy and on the client', and 'clients' beliefs and attitudes'.

Step 4: Reviewing themes

In order to determine whether the potential themes fit the data as a whole, I initially went through interviews five to eight and carefully checked the data against the themes. I then reviewed this process in supervision. The themes generally seemed to fit the data, however I collapsed the theme titled, 'role of doctors' into the systems theme and renamed the remaining five themes to more meaningfully capture the data. The revised themes were: 'negotiating the system', 'the value of therapy and its limitations', 'the value of antidepressants and when they're problematic', 'what the client brings', and 'considering what is best for the client'.

I then allocated a different highlighter to each theme and colour coded the next four interviews to further check whether the themes accurately represented the data. I decided to incorporate any data about psychologists' views about depression (for example that it stems from a genetic vulnerability combined with life experience) into the theme, 'considering what is best for the client', as these views inform the psychologist's attitudes and approach. I also noticed that the theme regarding therapy was often occurring in combination with other themes, as it was inherent in what the psychologists were saying. Consequently, I decided to include anything about therapy under this theme.

The next step was to upload all of the interviews to NVivo. I then went through the entire data set and organised the data into the themes and also established several subthemes within each of these. I approached this in a manner that was inclusive and comprehensive in order to support accurate reflection of the data set. This involved re-coding the data and establishing connections between the themes. An important part of this process was to

ensure the themes were distinct from one another and internally consistent. To facilitate this process I kept a record of my thoughts and any interesting observations.

Next, I recruited another doctoral student, also completing thematic analysis, for peer review of the research process. The doctoral student reviewed a portion of the data coded within each theme as well as a selection of the interviews to check for accurate representation of the data set. As a result of this process, some modifications were made to the themes, including the themes some of the data were coded under. My primary supervisor also provided regular feedback throughout the process of analysis and interpretation of the results.

Step 5: Defining and naming themes

During this stage I met with my primary supervisor to review the process and define and refine the themes and subthemes. We decided it was appropriate to rename the first three themes, documented in the section above, to more accurately represent the data. Thus these themes were renamed: 'working within the mental health system', 'perceptions and experiences of antidepressant treatment', and 'perceptions and experiences of therapy'. The themes and subthemes are presented in the results section (Table 2, p. 47). Also presented in the results section (Figure 1, p. 46) is a thematic map (Braun & Clarke, 2006), developed during this stage to represent the themes and subthemes. This demonstrates that the theme, 'working within the mental health system' and associated subthemes, provided the context for the psychologists' experiences and views of antidepressant treatment and psychotherapy for depression, and influenced each of the themes in the study.

Step 6: Producing the report

I wrote the analysis for each theme before going through the data for the next theme. I used quotes to capture the 'story' and made connections between the data and the research questions. As recommended by Braun and Clarke (2006), prevalence was represented using terms such as, 'the majority of participants', 'many participants', or 'a number of participants'. Finally, I went over the written analysis as a whole and made links between the themes in order to tell a cohesive 'story' about the data and minimise repetition.

CHAPTER SUMMARY

Hence, this thesis study employs a qualitative approach to investigate psychologists' views and experiences of antidepressant treatment for depression. More specifically, a basic interpretive approach is applied to gain an in-depth understanding of how clinical psychologists make sense of their experiences of client antidepressant use and psychotherapy. Sixteen clinical psychologists were recruited via an advertisement to participate in semi-structured interviews focussed on exploring their experiences and views of working therapeutically with depressed clients, specifically those who have used or are using antidepressants. An inductive process of thematic analysis was conducted on the interviews, guided by Braun and Clarke's (2006) method. Overall, a systematic method was applied to the process of data collection and data analysis, and external reference points of view were used to mitigate subjectivity, including regular reviews with my primary supervisor and peer supervision to review the coding process. Reflexivity was further facilitated via a process of self-reflection and documentation of my observations, feelings and responses, which was maintained throughout the process of data collection and data analysis.

Chapter Three – Thematic Analysis

This chapter presents the results of thematic analysis of psychologists' views and experiences of antidepressant treatment for depression. It includes the experiences that influence their views about antidepressants, any dilemmas they experience in regard to working therapeutically with depressed clients, and the approaches (including decision-making) they adopt in relation to antidepressant treatment and psychotherapy for depression. The following five themes emerged from analysis of the data: 1) working within the mental health system; 2) perceptions and experiences of antidepressant treatment; 3) perceptions and experiences of therapy; 4) what the client brings; and 5) considering what is best for the client. Each of these themes contained at least two subthemes.

This chapter discusses these five themes and associated subthemes, summarised in Table 2. Quotes from the study participants are provided to illustrate the themes and give a sense of the participants' views and experiences. A thematic map was developed, as suggested by Braun and Clarke (2006), to illustrate the relationships between the themes and related subthemes within the data set and to provide a visual image of the findings of the study. This map is provided below in Figure 1.

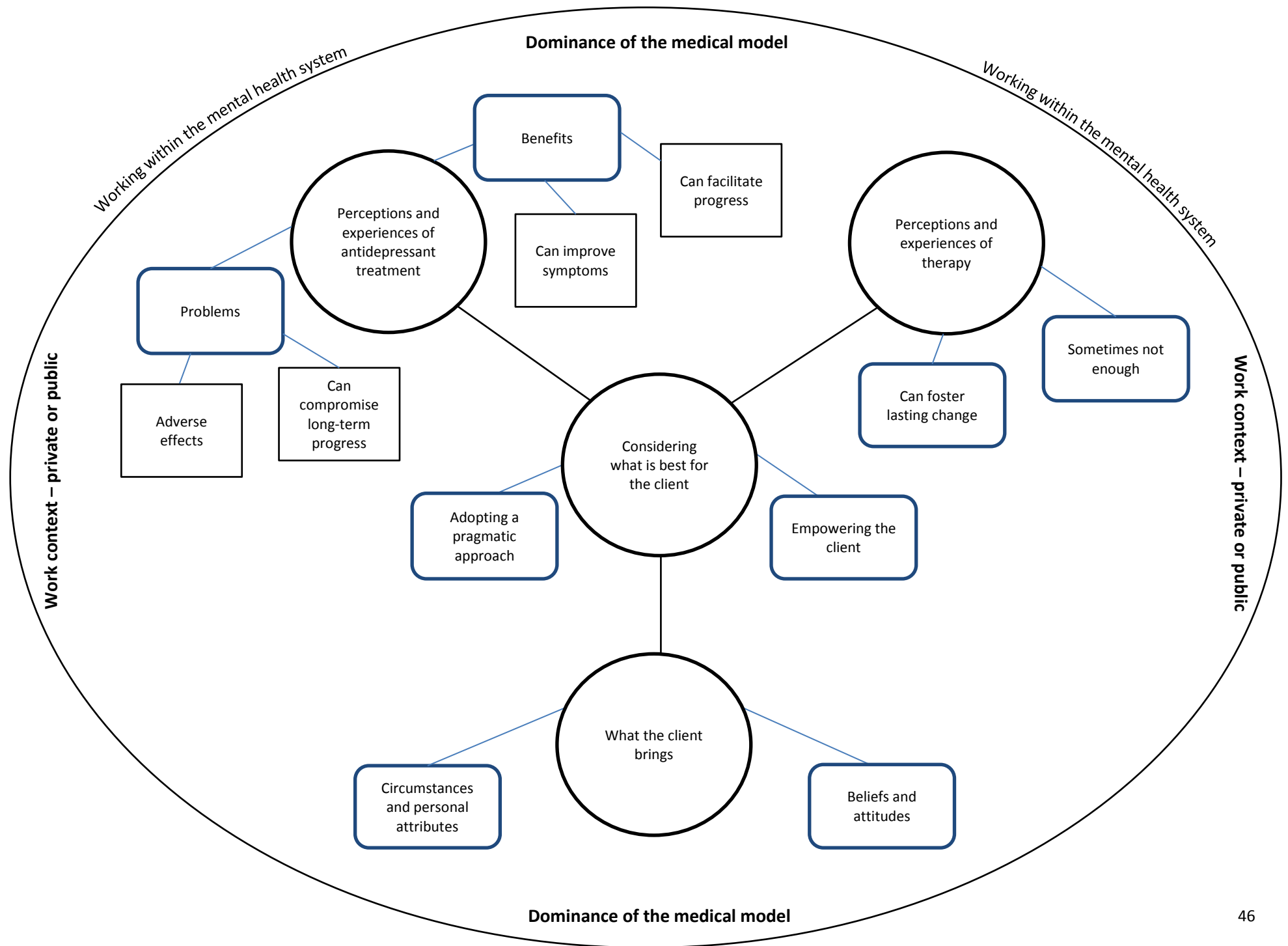


Figure 1: Thematic map showing themes and subthemes.

Table 2

Overview of themes and related subthemes

<u>Working within the mental health system</u>
Dominance of the medical model
Work context – private or public
<u>Perceptions and experiences of antidepressant treatment</u>
Benefits
Can improve symptoms
Can facilitate progress
Problems
Can compromise long-term progress
Adverse effects
<u>Perceptions and experiences of therapy</u>
Can foster lasting change
Sometimes not enough
<u>What the client brings</u>
Beliefs and attitudes
Circumstances and personal attributes
<u>Considering what is best for the client</u>
Empowering the client
Adopting a pragmatic approach

Prior to presenting the results, it is important to acknowledge the psychologists' theoretical framework for understanding depression, as this is likely to inform their treatment approach. The need to recognise the theoretical understanding which underpins an individual's practice is supported by research demonstrating that therapist effects, including their expectations and beliefs about treatment, are one of a number of factors that influence treatment outcome (Wampold, 2010). In order to evaluate this, participants were asked about their understanding of the main causes of depression and whether they view depression as due more to biological or psychosocial factors (refer to Appendix E for the Interview Schedule). All 16 participants commented on the interaction between biological

and psychosocial causes of depression. Overall, 10 participants expressed the view that psychosocial causes have a greater influence on the development of depression, four participants viewed psychosocial and biological factors as equally important, and two participants expressed the view that biological factors play a greater role compared with psychosocial factors in the development of depression.

WORKING WITHIN THE MENTAL HEALTH SYSTEM

The majority of psychologists, across both private and public settings, spoke of the dominance of the medical model in society generally and also in their places of work. Many observed that therapy was seen as secondary to antidepressant treatment and some reflected that this was not evidence based and had a number of associated problems. It seemed that the psychologists' places of work, in particular whether they worked in public or private settings, influenced their experiences and subsequent views and approaches towards treating depression.

Dominance of the medical model

In this subtheme, psychologists discussed their observations of the mental health system, which were predominantly consistent with a medical understanding and approach to treating depression. Several reasons were given to make sense of this, including the higher level influences of government, the power of the medical profession, and society's desire for medication to be the answer. Many participants talked about problems with the dominance of the medical model, including the passivity of this approach and the observation that it can disempower clients from changing and devalue the role of therapy in the treatment of depression. Participants also spoke about the negative impact of this approach on the practice of both psychologists and doctors, which has direct implications for the quality of treatment received by the public.

An observation that was shared by the majority of participants, and which provides support for the dominance of the medical model within the mental health system, is that most clients seen by psychologists for treatment of depression are already on antidepressants.

For example one participant, working in the public system, commented on this with reference to GPs prescribing,

You can't get out of your GPs door without swallowing an antidepressant so just about everybody is on some medication for better or worse (Participant 5).

Although this was particularly the case for psychologists working in the public system, many private psychologists had similar experiences. For example, in response to a question about the differences between clients who are on antidepressants and those who are not, a participant working in private practice said,

I can think of only one at the moment, but actually she's not depressed so she's got no reason to be on an antidepressant. I just think that so many of them are on an antidepressant I can't answer that question (Participant 12).

In order to explain this, psychologists in both public and private settings spoke of the notion that in reality antidepressants are considered the first line of treatment and are made readily accessible while therapy is not. In support of this, many participants pointed out that psychology is often only considered if the person does not respond well to antidepressant treatment. For example a participant working in the public system said,

We don't get to use psychology as the first line of treatment. So mostly they've been on antidepressants for a while and they are not working well for them for whatever reason (Participant 11).

A number of participants expressed frustration at this practice of prescribing antidepressants as the first line of treatment for depression and acknowledged that it is not evidence based. Some spoke of the need for a change in culture and their desire to see psychology as a first line treatment, prior to antidepressant treatment. However, other participants acknowledged the financial dilemma; that is, that antidepressants are cheaper than therapy. For example,

I don't particularly like the fact that antidepressant use is so much more freely available than psychological treatments. I think that is problematic, it's not evidence based, it's got a thousand million problems with it (Participant 5).

I mean I would like there to be a change in culture really, where doctors don't prescribe antidepressants as a first line treatment. I don't think that's something we can easily influence. But there needs to be a shift in culture for that, and of course there's a huge economic cost in that as well. Antidepressants are cheap (Participant 6).

Many participants talked in depth about the inaccessibility of therapy in both public and private settings, and how difficult it is for clients in either setting to access a psychologist. A

few participants took this a step further and observed that financial concerns rather than wellness is at the root of this, which they perceived was exemplified by the significant difference in government subsidy for antidepressants versus therapy. For example, a psychologist in private practice commented on this with regard to her experience of working with GPs,

I've had doctors say to me 'well I prescribe antidepressants because counselling therapy is too expensive. There's no funding for it'. So there's an example of where people are medicated even when a doctor knows that counselling and therapy would be a better intervention (Participant 1).

Another participant perceived that the dominance of the medical model in society is supported by the position of power held by the medical profession and the pharmaceutical companies:

Consciously or unconsciously psychiatry and medicine have no interest in psychology rising in prominence because what would they do. There's no room for them in their power, they've got all the power at the moment, why would they give that up to us. Same with all the drug companies, they've got all the power at the moment, why would they give it up when they can make billions, fly the planet, but they don't care (Participant 16).

Alongside perceptions of higher level influences, many participants also spoke about society's support for and belief in the medical model of depression. Reasons given for this included the attractiveness of viewing depression as an illness that simply requires a pill to correct a chemical imbalance in the brain. Some commented that this is seen as more socially acceptable and removes the need to do or change anything, whereas talk therapy is considered 'scary' and difficult. For example,

I think for a lot of people it really is a very attractive idea, you know, just take a pill. That idea of, oh I actually have an illness, it's not depression, it needs to be treated. It's a chemical imbalance in my brain. It needs to be balanced by a drug ... I have an illness and therefore I can be a patient and I can be treated and it makes it a much more passive approach rather than the person being actively involved in psychological treatment (Participant 6).

On the other hand, many participants pointed out problems with this approach. For instance, some perceived that localising the problem in the person and labelling them as 'sick' facilitates a narrow understanding of clients' distress. A few participants elaborated on this and discussed how being given a pill can be invalidating for clients, as other contributing factors may be disregarded and seen as unimportant, for example,

They are given a pill and they feel that that's not the acknowledgement they were wanting and also that therefore people see them as sick as opposed to in need of better

communication, or a whole lot of things that actually need changing in their lives (Participant 14).

Other participants elaborated on problems they perceived with the dominance of the medical model. In particular they believed that the passivity of this approach could disempower clients, and remove their autonomy and belief in their ability to make changes in their lives:

It points people away from autonomy and having a sense of control over their lives and their mood. 'I've got bad genes therefore I'm going to battle depression all my life'. And it's like no, you know. I'm in the business of helping people to change (Participant 15).

Further, a few participants perceived that it could be difficult for clients to oppose the medical model. Related to this, one participant commented on the way that the widespread use of antidepressants can suppress change, not only at an individual level but across society, by 'silencing' people who are depressed:

We pay a drug company big dividends to keep people quiet. It's a bit 1984 but it is what it is. I get the feeling if people could use all their depression and switch it over into anger we would have evolution. But unfortunately it stops change. We keep everybody medicated and quiet who is depressed, who actually could see what's wrong in life, because they are acutely aware of what's gone wrong with society (Participant 16).

Some participants working in the public system talked about the implications of holding a perspective that contrasted with the dominant medical discourse. A few described feeling like they were a 'lone voice' and spoke about the challenges of keeping a different perspective of clients' difficulties 'alive' in their teams. Another participant discussed the implications of holding a different view to colleagues and the medical model, particularly with regards to risk if something went wrong,

I think as psychologists we see things quite differently from the majority of our colleagues and that produces dilemmas all the time, especially around medication ... A lot of our practice is looked at, and probably the overarching views of people like coroners and Health and Disability Commission and investigative people would be why didn't you offer this, because they would see antidepressants as being a first line treatment. And so you would have to have a really strong clinical reason for opposing that, especially if other team members were pro that (Participant 4).

Several participants talked about how the system itself reinforces the medical model. This included messages communicated directly via psychiatrists and GPs, as well as indirectly by the way the system is structured to prioritise contact with doctors and a focus on

medication. A few participants commented on how these messages inherently undermine therapy, for example,

I think our actual psychiatric system is very medical model, people come here and end up seeing a psychiatrist and are referred by their GP who is also a doctor ... I guess antidepressants also reinforce the idea that people have a medical problem that is going to be fixed with a medical solution and that therapy is a non-essential bit of fluff on the side (Participant 4).

Once they leave the service, if their mood started to go downhill or they go back and see their GP, the GP won't ask anything about what happened in terms of therapy. They will only ask about the medication, and again if things start to slip they won't reinforce the skills they learnt in therapy ... immediately their medication is put up, it gives them an immediate story that it is the medication that is the help not the therapy again (Participant 16).

Other participants observed that the dominance of the medical model, reinforced by antidepressant use, can lead clients themselves to disregard other factors and view their depression largely in biological terms, which can impact negatively on engagement in therapy. For example, the following participant, who viewed biology as playing a significant role in depression, described how a strong belief in the medical model can undermine therapy and is a potential problem of antidepressants,

They (clients with a strong belief in the medical model) say my depression is caused by biology and the only way out of my depression is through biology. And then they don't engage or consider more psychological variables including their cognitive patterns and their lifestyle and behaviours. So that is I think a big risk of antidepressant use and I think that can impact, certainly impact on psychological therapy a lot whereby people won't want to engage or participate or don't value it (Participant 7).

Some of the psychologists expanded on this notion that belief in the medical model can contribute to difficulties in therapy. They stated that viewing depression as a biological illness gives psychologists less leverage and increases dependence on antidepressants. The following participant observed that therapy is often hard work for people and over-emphasis on the medical model can undermine the effort required to change and interfere with progress in therapy,

What you're asking the client to do might be something really hard, like looking at their own thoughts or doing thought records or doing CBT or I might ask someone to practice certain skills depending on what they're depressed about ... and I think it gives us less status in terms of what people see as important ... I think that affects the therapy progress quite a lot cause people are getting a mixed message. On the one hand they are getting a message being referred to a psychologist, but on the other hand your main treatment will be taking pills and that presents difficulties (Participant 4).

Further, some participants expressed frustration around decisions made by psychiatrists and GPs that they perceived hindered their therapeutic work with clients. For example, a participant working in private practice discussed instances where GPs had prescribed antidepressants in response to a client's request, yet where this conflicted with what was taking place in therapy:

There are times when I am seeing someone and they go to see their GP and their GP puts them on antidepressants and they come back and say to me, 'oh by the way I've started on antidepressants', and I just think ahhh, you know. It's quite frustrating because we might just be starting to make some good work, but it's not happening quite fast enough for them. And so they are going, 'well I want something a bit quicker and a fix, and my GP suggested this and I told him that I was doing therapy and that was only helping a little bit or wasn't helping much', and so they've gone on the antidepressants which can then hinder what I'm trying to do (Participant 3).

Many participants, but particularly those working in the public system, discussed the repercussions of having a shortage of psychologists. Some described how a small number of psychologists are required to service a large region, which tended to result in an 'overloaded' psychology waitlist. For example, one participant described the resulting pressures facing psychologists and observed that this approach does not support clients' wellness in the long-term,

We are supposed to fix people up really quickly and biff them back out and then open the door again three months later when things still aren't better, as opposed to being able to walk alongside them for the duration of the journey, which is actually what's useful (Participant 14).

A number of participants observed aspects of doctors' practice that they perceived to be inadequate. This included poor assessment of patients' distress, careless prescribing, lack of treatment review, and failure to provide adequate information on other treatment options and possible side effects, or to educate their patients about withdrawal from antidepressants. The following participant commented on his perception that some doctors prescribe antidepressants without adequate assessment or offering a range of treatment options,

I don't think there's always good assessment of what's contributing to people's distress and misery. So I think giving a medication of any kind without adequate assessment and considering and recommending a range of treatment options is a bit dodgy. I think its short term expedience. Get that done in 15 minutes in your pressured GP surgery (Participant 5).

On the other hand, several participants also spoke positively about the practice of psychiatrists and GPs and some sympathised with them, acknowledging the challenges they face within the mental health system. In particular, they acknowledged that although GPs may value therapy they are under pressure to respond to patients' distress with limited time and few viable treatment options other than antidepressants. As one psychologist said,

I think GPs get the flak over it and people think GPs just prescribe, but actually when you talk to them I think they've got their hands tied. It's cheaper and easier, for the patient (Participant 9).

Another participant acknowledged the pressure placed on GPs by patients who adhere to a medical model of depression and subsequently expect their GP to prescribe them antidepressants,

I do think people have this expectation of I'm depressed, my doctor will give me a pill and that will fix it (Participant 15).

Work context – private or public

Many participants spoke about their work context and how this has shaped their experiences and views as well as approaches towards treating depression. In particular, differences between public and private settings were often discussed. Participants working in the public system described seeing clients with the most severe and complex problems, which seemed to support an openness towards antidepressants and the view that they are one part of a complex picture. This contrasted with those working in private practice who tended to see higher functioning individuals with mild to moderate depression. Many observed that these clients generally responded well to therapy, but were prone to disengage if they were on antidepressants and believed these were working well. Consequently, participants working in private practice tended to express greater caution around potential problems with antidepressant treatment compared to those working in the public system.

Throughout the interviews, a few participants made direct links between their experiences at work and the beliefs they had developed about the causes of depression and subsequent treatment approaches. For example, a participant working in the public system commented

on how her experiences in this context had changed her beliefs and increased her openness to viewing depression as a combination of psychosocial and biological factors,

When I was freshly trained and full of beans I might have been more purely psychosocial. Over the years, partly being in this environment (public system), there seems to be a whole combination of biological and psychosocial things (Participant 14).

Another participant, who believed that biological factors play a greater role than psychosocial factors in depression, talked about how his work had shaped his views, as he described being exposed to the significant role that biology plays in depression,

I work with people with brain issues all the time and I see very strongly the biology of depression and not just the psychological variables, and so for me it's a no-brainer and I don't understand the confusion that people have or the conflict that people have around antidepressants (Participant 7).

Many participants working in the public system commented on the severity and complexity of the mental health of the clients they see. This is demonstrated by the following participant who acknowledged that these clients are often considered difficult to treat:

The people who come to this clinic tend to have multiple, long term, ongoing problems and they have essentially failed other treatments. So they are often complex, multi-diagnostic, regarded as difficult to treat (Participant 5).

In response, it seemed that these participants tended to view antidepressants as a useful treatment 'tool' and an often necessary adjunct to therapy. For example,

The level of chronicity in terms of it's gone on for years, complexity and severity of people we see, most of those people wouldn't be able to function in a therapy relationship without some medication on board. It would be too anxiety provoking. They wouldn't be able to tolerate the feelings that come up. They wouldn't be motivated to get here. They wouldn't be able to eat and sleep enough to be able to actually function in therapy, all of those things. So it enables people to get into the therapy relationship and to tolerate attaching to somebody and starting to look at really hard stuff that they've avoided most of their lives (Participant 10).

Further, several participants working in the public system spoke of the limited efficacy of antidepressants due to the complex social issues their clients are exposed to, such as the effects of poverty, unemployment, social isolation, and trauma. In response, they often expressed the view that antidepressants are one part of a complex picture and unlikely to make a significant difference. For example,

I think the marker of 'oh the antidepressants made a difference' would almost be a fantasy in the lives of clients in the public mental health system where they're not working, they're in bad relationships, and they've had a history of violence or hurt or PTSD. So they are

dealing with so much on so many levels that for one little thing to make an impact ... (Participant 14).

In contrast to those working in public settings, participants in private practice described the clients they see as high functioning, with less severe depression. A few participants distinguished between clients who are funded via the primary health organisations (PHOs) and those who pay for their own therapy. As one participant said,

Realistically I wouldn't see the really severe ... I get individual private clients just off the street and they are usually still pretty high functioning, probably more high functioning than the PHO ones (Participant 3).

Many noted that these clients frequently respond well to therapy alone, particularly when the depression is mild or where situational factors, such as bereavement, play a central role in contributing to the depression. For example, the following participant working in private practice discussed her view that antidepressants could be unhelpful when prescribed in these situations,

If somebody has experienced bereavement, especially if it's recent and then they're given an antidepressant for that it just doesn't seem functional to me. It seems like you need to work through the bereavement in order to get to a point where you consider whether or not you are actually depressed ... In the context of a relationship breakup, again if it's relatively recent, then it doesn't really make much sense to me, if it's more protracted then possibly. But also if it's mild depression; if it's mild and they're willing to engage in treatment then I don't see any value in adding an antidepressant to their treatment at all ... I think you just get all the inappropriate attributions which is even worse under those circumstances because they can do so well out of therapy and actually out of relatively short term therapy (Participant 12).

Some participants expanded on this theme and emphasised that antidepressant treatment in these contexts could hinder the client's recovery from depression, as although they may feel better, it could prevent them from engaging in the work of recovery, particularly if they attribute their progress to antidepressants. As a result, they said, they were cautious around suggesting antidepressants, as they did not want to disempower clients from making changes in their life. This is illustrated by the two participants quoted below,

With the mild ones the antidepressants lift them up to a level where things are actually okay and therefore they think 'I don't need therapy' (Participant 3).

I am not going to throw an antidepressant into the mix early because I don't want people to feel that I feel the only thing that will fix them is the pill. I want them to feel that I believe that they can make these changes and they don't need a pill to make these changes (Participant 11).

Further, a few private psychologists acknowledged that the cost of therapy could increase the likelihood that clients will disengage if they perceive they are getting better on antidepressants. A psychologist working in private practice commented on his experience of this,

People have to pay money to come and see me and so if they're getting better and it's going to cost them 150 bucks to come and see me then they are more likely to go well thanks but I'm just getting better anyway, I really don't need that psychotherapy mumbo jumbo (Participant 7).

Overall, it seemed that participants working in private practice were more likely to perceive it better for clients to do therapy without antidepressants. As one private psychologist said,

My stance is if people can do without antidepressants they're better off to have therapy without them unless they are really incapacitated (Participant 1).

In summary, psychologists in both public and private settings perceived the mental health system to align predominantly with the medical model of depression, which had significant implications for their practice and the treatment received by the public. Interestingly, it seemed that participants' work context, particularly whether they worked in private or public settings, shaped their views and approaches towards the use of antidepressants in the treatment of depression. Most notably those working in the public system tended to be more open to antidepressants compared with those in private practice, which seemed to relate primarily to differences in the complexity and severity of the cases they encounter.

PERCEPTIONS AND EXPERIENCES OF ANTIDEPRESSANT TREATMENT

This theme includes participants' experiences of antidepressant treatment for their clients, and views on the associated benefits and problems. All of the participants thought antidepressants can relieve the symptoms of depression, and several spoke of how this medication can assist clients to engage in the active work of recovery and thereby facilitate progress in therapy. Thus many participants spoke positively about antidepressants, particularly for use with clients suffering from severe depression, which some participants acknowledged was consistent with research. On the other hand, many also spoke of the way antidepressants can compromise progress in the long-term, especially where their use can

interfere with agency and get in the way of change. Further to this observation, all participants spoke of the potential adverse effects of antidepressants for clients.

Benefits

Can improve symptoms

In response to questions about the benefits of antidepressant treatment, participants frequently spoke about their observation, as well as clients' report, that the symptoms of depression tend to improve as a result. Many participants recalled clients who reported feeling better after starting on antidepressants, and the majority referred to the way that antidepressants seem to 'give a lift' and 'take the edge off' intense emotions. Several participants also spoke of cognitive changes that they observed, including increased flexibility of thinking and greater access to cognitions. These improvements seemed interconnected and some participants described observing a subtle shift or flow on effect, which, in some cases, led to further improvements.

The majority of participants talked about their perception that the symptoms of depression tend to improve once a person starts taking antidepressants. Although these changes were often described as subtle, a few participants recalled clients who experienced a dramatic improvement on antidepressants. For instance, one participant shared an example of a client who experienced a complete resolution in his depressive symptoms within two weeks of starting on Fluoxetine,

I saw one person that I would say would be the poster boy for antidepressants. He had been clinically and quite severely depressed, started on 20mg of Fluoxetine and within probably a week was starting to look better and brighter and within about two weeks reported a full resolution of all his depressive symptoms and he just looked like a different man. I would say it saved his life probably in all respects (Participant 7).

Although many participants observed that clients could experience changes relatively quickly on antidepressants, a few commented that the placebo effect was in operation, particularly when clients reported improvements very soon after starting on antidepressants:

I think the placebo effect is huge because often they are making reference to improvements that really technically aren't possible yet, they've only been taking the drug a couple of days,

it's not the two weeks or four weeks or however long it's supposed to take, so that's definitely in operation (Participant 14).

The most frequently stated improvement was the observation that antidepressants can give clients a lift in mood and energy. Several participants described how this facilitated behavioural activation, enabling them to do the everyday activities they had been struggling with, such as getting out of bed or going to work. In addition, some commented that this lift in mood can lead clients to feel more normal or 'like themselves' again. For example, one participant observed,

Ordinary things take less effort; you know the classic it's hard to get out of bed when you're depressed, the routine things are really, really effortful and kind of getting back to feeling more normal and just being able to go about your day ... They have been depressed and they are more themselves again (Participant 15).

Many participants commented on how this lift in mood can assist clients to re-engage with life, which often involved re-connecting with family and friends as well as engaging in enjoyable activities. For example, the following participant described the changes she observed in one of her clients after she started taking antidepressants,

After she took the antidepressant I think one of the big things for her was she started to feel like she could re-engage with the world a little bit ... she's in a singing group and she's re-engaging with friends that she hasn't seen for a long time (Participant 11).

A number of participants discussed their observation that antidepressants can 'take the edge off' intense emotions, such as anger, anxiety or sadness. Some noted that this can reduce arousal and provide distance from the distress, making feelings more accessible. Thus although clients still feel emotion they are more regulated and less overwhelmed by it, as one participant working in the public system said,

Antidepressants can help give people a little bit of a buffered intensity of emotion ... The intensity of painful emotions is just a little bit more less raw, and that can be helpful in terms of people still experience emotions, still have distress, still have problems to solve, yet are less overwhelmed by the intensity of the general dysphoria and despair, which is a good thing (Participant 5).

Another participant described how this could provide clients with a greater sense of control over themselves and their mood, which can aid further engagement in life:

Feeling less at the mercy of their mood ... feeling more in charge of themselves I think would be the flavour of it. They feel they can get on with things (Participant 15).

As with the emotional changes, many participants talked about cognitive changes that they observed. These included a reduction in rumination and negative thinking, which a couple of participants observed could result in reduced suicidality; increased flexibility of thinking such that clients are able to consider more positive perspectives; and greater access to cognitions. For example, the following participant described her impression of a depressed client's thinking style and how this can change after taking antidepressants,

They just get stuck in their ruminations and obsessions and negative thought processes and self-loathing and they get stuck inside themselves and they can't get their focus outside of themselves and they get completely preoccupied and self-absorbed and antidepressants for some reason get you back in here and now and reality and paying attention to what is happening rather than what you imagine in your whole internal world (Participant 10).

Although these changes were often described as subtle, some participants commented on how they were interconnected and could result in further changes via a positive feedback loop. For instance, the following participant described a client where he perceived that antidepressants facilitated a shift in thinking, fostering a sense of confidence and agency, which then enabled her to try things out, perpetuating the gains she had made:

Her thinking has shifted from 'I can't do this' to just a little bit more hopeful and a little bit more confident to 'maybe I can'. It's shifted from being completely lacking in any kind of confidence, and it just slowly built back up. And as she built that confidence she tried things and it reinforced to her that she could do things and sort of gained a bit of momentum in that way ... and she made quite a quick climb out of that low point (Participant 13).

Can facilitate progress

Throughout the interviews, participants often discussed how symptom improvement on antidepressants can facilitate the recovery process. Many perceived that this enabled clients to engage in the active work of recovery, and helped them improve at a rate that would not have been possible without antidepressants. Subsequently many discussed how this could benefit therapy, particularly considering the limited time and resources available. Several participants believed that with severe depression, antidepressants were often necessary in order for people to get better, and a few participants stated that in some cases, antidepressants were needed for clients to function optimally.

The majority of participants discussed how taking antidepressants can enable clients to engage in therapy. In particular, participants working in the public system described the

usefulness of antidepressants with clients who are so severely depressed they would be unable to attend therapy without antidepressants. As one participant said,

Therapy wouldn't be possible if people were dead and some people would be dead if they didn't have antidepressants. So it assists people in getting here and actually being able to be in the process of therapy. Some people wouldn't actually come to therapy, they would be too afraid to have an interaction with someone else or to talk about anything if they didn't have enough of a lid on things. So my sense is it puts enough of a lid on things for people to be able to engage in therapy most of the time and get involved in doing the work (Participant 10).

Many participants made reference to the severity of depression and some differentiated between mild, moderate and severe depression. Consistent with the comment above, it seemed that participants perceived antidepressant treatment to be most beneficial with moderate to severe depression. Some linked these observations with the research. For example,

I think if the person is severely depressed and they've taken an antidepressant ... it does make it easier to engage them in therapy and they might be more inclined to do their homework, they might be more responsive in the therapy setting than they would be otherwise ... that's also what the literature says ... It's hard to know whether you are just seeing what the literature says you ought to see or whether you actually are seeing it yourself. But I think for the most part you do tend to see that (Participant 12).

That's where the research is. So the research for medication and therapy is generally around moderate to severe depression (Participant 9).

A participant working in the public system pointed out that the process of being prescribed an antidepressant can be validating for people and communicate to them that their distress is being taken seriously, which she perceived can then open the door to further treatment and facilitate engagement in therapy:

So the first thing is that they've been given a sense that they're not just being silly or a pain in the neck, that there might be something actually wrong and we're taking it seriously. That also opens doors so then potentially they get to see a psychologist (Participant 14).

There seemed to be a strong emphasis on how symptom improvement resulting from antidepressant treatment can enable clients to 'do the work' required to change, thereby assisting the therapeutic process. For example, the following participant working in the public system described how antidepressants can increase clients' capability to address the factors maintaining their depression,

If people can be a little bit more activated to solve their problems then that can be really useful. I don't see any clash at all between psychological treatment and having somebody

who is more capable. If it can increase peoples' capability to be active, to get out of bed, to not be so withdrawn, to not be overwhelmed with emotion, then I don't think that's treatment done, I think that's treatment enabling because then we can start to steer down whatever the things that have contributed to that person staying depressed and their relationships being whatever, and their activities not being reinforcing and leading to their sense of capability. So absolutely I think that's one of the ways that antidepressants can help a therapeutic process (Participant 5).

A number of participants spoke of how antidepressants can facilitate faster progress and help people get better more quickly than they would without antidepressants. They considered that this could make therapy easier and enable clients to get more out of therapy resulting in more effective treatment. For example, one participant described his experience of how this shift can take place in therapy after a client starts taking antidepressants,

There are those clients where you are struggling with them, you feel like it is really heavy going or they are not taking on board the suggestions and so forth and the antidepressants kick in and all of a sudden they are taking the suggestions you are making and they are running with them and you are making progress. I guess in the best case it's like the difference between effective therapy and ineffective therapy (Participant 15).

Related to this, a few private psychologists discussed the usefulness of antidepressants when working with clients who are government funded, as they perceived that the combination of antidepressants and therapy enabled these clients to make the most of the six sessions they were allocated. For example, one participant described how antidepressants can facilitate a shift from behavioural to cognitive work within six sessions,

About half of the clients that I see are within that CBT, six sessions of CBT that are government funded through the PHOs. So for those people if they're on antidepressants, and they're working well, then you can move off the behavioural side of things if you're using CBT and start the cognitive work within six sessions (Participant 9).

Several participants provided examples or impressions illustrating how antidepressants can 'give a lift', 'take the edge off' intense emotions, and facilitate cognitive changes, assisting therapy and supporting clients' progress towards recovery. For instance, the following participant provided an example illustrating his perception of how the lift in mood associated with antidepressants supported a client to engage in therapy,

I can think of an example where a person was hopeless and utterly sort of nihilistic, not refusing to engage, but just not engaging, unmotivatedly sitting, a warm body in a chair so to speak. And with antidepressants became lifted a little and was more willing to participate in some of the behavioural and cognitive strategies that I was wanting to work on with her, and before that I don't think I would have got anywhere without that (Participant 7).

Some participants talked about the way that ‘taking the edge off’ intense emotions can facilitate more effective therapy, as they perceived that this increased the accessibility of feelings which were then able to be addressed in therapy. The participants who made this observation tended to work with the most severe cases, and were working in the public system. For example,

Some people believe that antidepressants make people’s feelings inaccessible. But I haven’t found that, it makes people more regulated so that you can actually work with the feelings, this is my experience, where otherwise they would be so uncontrollable that you actually can’t (Participant 10).

Other participants referenced the cognitive changes that can take place once a person starts taking antidepressants and how these facilitate progress in therapy. They observed that the accompanying cognitive flexibility resulted in clients being more receptive to the ideas and strategies introduced in therapy:

I notice that they’re more able to take the ideas of therapy on board. I think that’s probably the main thing that I’ve noticed, sometimes I will be working with someone and they’re not using antidepressants and their level of depression is such that it’s quite difficult for them to have the cognitive flexibility to take on board new ideas (Participant 11).

Several participants talked about instances where they believed that antidepressants were necessary. This was primarily in situations involving an acute episode of depression where they felt antidepressants were needed for the person to function. Additionally a few participants who expressed an accepting attitude towards antidepressants, thought that some people might need to be on them long-term in order to function optimally and improve their overall quality of life. For instance, a participant working in private practice held this view and the following comment is the explanation she provides for these clients,

For some folk the way I put it to them and explain it is that their neuro-transmitters might always need a hand. Like for somebody whose thyroid isn’t working properly so I take my thyroxin every morning to help my thyroid function properly (Participant 2).

Some participants expressed frustration around instances where they believed that a client needed to be on antidepressants but where the client was rigidly opposed to taking them. In such cases they perceived that progress could be stalled, prolonging the length of depression and hindering the effectiveness of therapy. As one participant said,

It’s a bit frustrating if you really think they need to be on them. Again it means that some of the depressive problems that they have can’t be dealt with as quickly or as well and

psychological therapies are not being addressed, so your progress obviously is not going to be as good (Participant 8).

Problems

Can compromise long-term progress

In response to questions about any unhelpful aspects of antidepressant treatment, the majority of participants observed that although antidepressants can lead people to feel better and assist the recovery process, there are also various ways they can compromise long-term progress. Many believed that antidepressants could mask the causes of depression and facilitate avoidance of emotional pain, reducing motivation to 'do the work' and interfering with the acquisition of coping skills. As a result, these participants discussed how this detrimental aspect of antidepressant use contributed to difficulties in therapy and could lead some clients to disengage or leave prematurely. Several participants observed that clients are likely to attribute progress to antidepressants, which could also undermine therapy as well as disempower clients from engaging in the process of change. Further, the majority of participants believed that clients could become dependent on antidepressants, hindering long-term progress and, together with the above factors, increasing vulnerability to relapse.

Many participants expressed the view that antidepressants can act like "a band aid, not a cure" (participant 3). They emphasised the importance of the client addressing the underlying causes of depression, which involved understanding what contributed to the decline in mood and learning how to prevent this happening in the future. There was a widely held belief among participants that antidepressants can interfere with this process and subsequently leave people vulnerable to relapse. For instance, the following participant shared an example of a woman whose mood improved significantly on antidepressants, however he doubted the longevity of this change as he did not believe she had gained the insight necessary to prevent relapse off antidepressants,

The client left happy and satisfied, with the antidepressant bringing her mood up quite quickly, but I wondered if she really understood what brought her mood down in the first place. If she stops the antidepressant, it then leaves her vulnerable to experiencing it again ... I think that happens quite regularly with people who don't want to talk about the stuff;

the antidepressant gets them back on track, but they don't look at why they ended up there (Participant 13).

In a similar vein, many participants discussed how antidepressants can facilitate detachment or avoidance of emotional pain that may be contributing to the depression, and subsequently hinder long-term progress by preventing people from changing aspects of life that are not working for them, as one participant said,

I am aware that people can end up on antidepressants when they're not actually addressing something in their life that is feeding into the depression. You know, so if someone is unhappy in their work or in a relationship, taking something like an antidepressant just detaches them from the situation and allows them to carry on (Participant 1).

It seemed that participants held slightly different views on emotional numbing, which is a side effect of antidepressants, depending on whether they worked in the public or private system. This appeared to relate to the severity of depression experienced by the clients they see. Those in the public system spoke more often about the benefits of 'taking the edge off' intense emotions, whereas those in private practice tended to discuss more unhelpful aspects. In particular, they perceived that the emotional numbing associated with antidepressants could prevent people from learning how to accept and manage their emotions. For example,

I think my preference is for people to not be on them because I think it has this numbing effect on the emotions which is unhelpful. For me it's much more important to teach a person to sit with those emotions and to tolerate those emotions. And what we're actually saying to a person is that you don't have to have these emotions, that falls apart fairly soon I think. So you are talking very different approaches (Participant 6).

Another way in which the emotional numbing associated with antidepressants can make therapy more difficult, noted some participants, was that clients are less affected by their circumstances and therefore have less material to bring to therapy. Consequently, they perceived that for this reason some clients on antidepressants were unable to learn from their experiences and develop new skills to cope, which again left them more vulnerable to depression in the future. As Participant 3 described,

They come back in and they say 'oh I've had a really good week, I haven't had anything' and so I actually have nothing to work with. And those things are still there and they are still happening and without the antidepressant they would still be getting upset about it. And so if I don't have the stuff to work with then it's really hard to give them any skills or tools to go on with later, cause even on antidepressants they will still have situations eventually that they get really upset about. It's just their level of tolerance is higher so it takes something a little bit more significant before they'll start to get really distressed (Participant 3).

Other participants talked about their perception that antidepressants could be enough of a solution for some clients, who were then not motivated or desperate enough to do the work in order to change. They observed that in these cases, although the symptoms of depression have improved, the improvement may only be short-term. For example, a participant working in the public system who generally spoke positively about antidepressants viewed this as a problem,

When they get a person to a place where things are good enough and they are not motivated or desperate enough to do the work, you see this happen all the time, the options are stay on medication for the rest of your life or try and come off it at some point and you will probably relapse (Participant 10).

In a previous theme, it was noted that belief in the medical model of depression can lead clients to disengage from therapy. In this theme, a number of participants observed that the experience of feeling better on antidepressants can also lead clients to disengage from therapy or leave prematurely, as they are no longer motivated to attend. This conflicted with the observation that antidepressants can facilitate therapy progress. Many participants expressed this dilemma and observed that for some clients antidepressants facilitate engagement and progress whereas for others they can prompt them to disengage. For example,

For some people it works really well for them and can assist the progress, generally does sort of assist the progress. I guess where the problem comes for me sometimes is when people withdraw from therapy because they are feeling so well, and that can happen. That's a tension (Participant 9).

Some commented that disengagement on antidepressants can make therapy more difficult. For example, the following participant observed that some clients start to attend therapy less regularly as result of feeling better on antidepressants and consequently may overlook experiences that would be valuable to work through in therapy,

They come along and say, 'oh no I'm feeling really good so maybe I don't need to come for two weeks' ... I'm thinking of one particular client who told me she had a fight with her husband and got really upset over something last week, but things have been really good this week. And I said 'okay, tell me about that fight'. She said, 'oh it's nothing really, I realised that I over-reacted and it wasn't really a big deal'. Then I kept persisting and she started to recall it and we went back through it and she became very distressed about it in the session and we were able to work out her interpretation of the situation, that her husband didn't love her and that he was going to leave her for someone else. It was actually a really huge thing, but because it was two weeks ago she kind of got over it and didn't see it as a big deal, and it was a really valuable thing to work with (Participant 3).

A number of participants observed that clients make attributions about progress on antidepressants, as “when they start to feel better they don’t know if it’s the medication or the therapy” (Participant 1). Most participants perceived that clients “are more likely to attribute progress to the antidepressant than either therapy or their own actions” (Participant 11). Some talked about how these attributions can undermine therapy and also take away ownership of change from the person. For example, one participant who described this as her biggest problem with antidepressants said,

Clients make attributions about change when you’re working with them in therapy and so whilst they might be doing well in therapy they will make attributions that will be about the antidepressant ... that means they’re not making any attributions about the things that they’re doing, that they themselves are doing in order to create their own change. So it’s all about the antidepressant. It’s not about the therapy. In the worst case scenario it’s all to do with that, so there’s no ownership of change because it all belongs to the antidepressant (Participant 12).

A few participants perceived this to be particularly problematic if changes occurred very quickly alongside changes to the antidepressant. They acknowledged that this reinforced a focus on medication and biology, which meant that other factors were not taken into consideration.

If there is an apparent too quicker effect of the medication ... the client, therapy, changes in the environment, changes in any other regime are not considered anymore. It is seen as purely a biological disorder (Participant 16).

Another participant described his observation that when a client stops taking antidepressants and starts to feel worse, this sends the message that the antidepressant is most important, which undermines therapy and the importance of acquiring coping skills. He acknowledged that this can subsequently threaten the client’s engagement in therapy.

It’s difficult, especially if you are trying to teach them skills. Their actual experience is they stopped taking the medication and started feeling worse, so therefore it’s the medication that is holding them together. So it’s difficult to then convince them to actually come back, to engage in therapy, although you could put a convincing argument across and say well that’s because you haven’t learnt these skills. But the client is more likely to say I stopped taking the tablets so therefore I had a relapse (Participant 6).

There was a strong sense that over-emphasis on the importance of antidepressants or over-reliance on antidepressants as the solution to a biological problem is disempowering and gets in the way of change. Many participants perceived that this could remove agency from the client and hinder them from making changes in their own life to improve their mood.

I think that can be a downside of antidepressants ... I think that then gives people the idea that the only way to change is with medication ... as opposed to feeling that I've got the ability to change what happens in my life, I've got agency to make changes and that I can without an antidepressant ... I can make a difference in my life and I can have a life where I don't feel depressed and that this is something that I do myself, it isn't just something that I take a pill and it magically happens (Participant 11).

Another participant pointed out that ultimately the goal is for people to get better. However, she believed that it was most important that the change originated from the client rather than from the antidepressant, as she perceived that antidepressants could undermine the process of strengthening the client's belief in their own capability,

Ultimately of course you want the client to get better, but you want them to be responsible for that, because they are capable of that and you want them to realise that they are capable of that and that they have the skills that they need in order to make this crappy situation that they are in work and feel better. So when there's an antidepressant on board I think you are always competing with that (Participant 12).

Related to this impression, a number of participants discussed how some clients were dependent on the idea that they "need something external" (Participant 12) and believe they are unable to recover on their own. The following participant observed that holding an external locus of control can be a trigger for people who are prone to depression, which he acknowledged is problematic if use of an antidepressant reinforces this,

The locus of control issue becomes an even bigger problem because one of the variables that might help trigger a person to be vulnerable to depression is having an external locus of control and then medication simply serves to compound that external locus of control (Participant 7).

While the majority of participants perceived that clients could become dependent on antidepressants, there was variation in the way this was expressed. Some participants clarified that "it's not like a dependence on alcohol or other illicit drugs" (Participant 10), saying that they were cautious about referring to antidepressants as 'addictive'. However, some participants did think there was a physical element and recalled clients who described it as a "physical dependence like an addiction" (Participant 12). More often though, participants discussed what they perceived to be psychological dependence on antidepressants. This involved their observation that many clients stay on antidepressants due to a fear of re-experiencing depression:

I do think some people can become psychologically dependent in that they don't want to risk trying to come off them because they are afraid of going into the black hole again (Participant 15).

Further, several participants observed that in addition to this, some clients become dependent on antidepressants as the solution to their problems, such that they turn to antidepressants in order to cope with stressful life events or manage unpleasant emotions instead of developing other skills to cope. Some described the antidepressant as a “safety net” (Participant 4) and others perceived that clients can become “stuck on the antidepressant” (Participant 6), as they feel vulnerable without it. One participant shared an example of a client, who uses antidepressants as her primary strategy to manage stressful life events,

Every time things become stressful in her life, her immediate thing is to go back to the doctor and ask to change the antidepressant or increase the dose. So she’s kind of quite reliant on that ... she keeps persisting with them because she’s fearful that if she goes off them she might really plummet and be back to when she was really, really bad (Participant 3).

Other participants described clients who became preoccupied with searching for a quick fix or an external solution, which distracted them from addressing the causes of depression and engaging in therapy. Some participants observed that in these cases progress was often compromised and clients could feel “disappointed and disillusioned” (Participant 10) when the antidepressant was “not the quick fix they had hoped for” (Participant 14). The following participant offered this example,

I’ve had one client who spends a lot of time on the internet looking at medication options and you know we try and work through some therapy and we get a few sessions in every time and then he’d be wanting to talk about a change in medication. And so his focus kept on getting pulled away from the stuff he should be doing and back to the quick fixes (Participant 13).

Adverse effects

When discussing unhelpful aspects of antidepressant treatment, participants spoke most frequently about side effects. This included their observation that clients generally experience initial side effects that tend to subside. However, many observed clients who experienced side effects that persisted with long-term use and in some cases counteracted the benefits derived from antidepressants. These included weight gain, sexual dysfunction, anxiety, sleep difficulties, and emotional numbing. Several participants discussed other adverse effects they observe clients experience on antidepressants, such as frustrations with the process of finding the right antidepressant, disappointment when the

antidepressant fails to work adequately, or resistance to taking antidepressants due to side effects or stigma. Many participants also discussed the difficulty some clients have withdrawing from antidepressants and several were concerned that this may contribute to long-term use.

Several participants discussed side effects commonly experienced by clients when they start taking antidepressants, including feeling nauseous, agitated, experiencing headaches, dizziness, gastrointestinal problems, increased anxiety, and disturbed sleep. Some participants observed that clients can feel worse than they did before taking the antidepressant, and in some cases experience a drop in mood and increased suicidality. For example,

People find it hard to focus. They feel really low. Sometimes even lower than what they originally did before they started. They might be preoccupied with suicidal ideation. They might be finding it really hard to sleep. It can interfere with your sleep to begin with too. And it can interfere with your eating patterns. Sometimes you feel nauseous to start with (Participant 10).

In addition, many participants recalled side effects that they perceived a number of clients continue to experience with long-term use of antidepressants. There seemed to be overlap between these long-term effects and the symptoms of depression. Most of these participants observed that although a client's mood may improve, these side effects can have a serious impact on their functioning, including how they feel about themselves and how they manage their mood. Weight gain was considered one of the most common and most distressing long-term effects,

They can put on weight, that's a significant one. Lots of people do put on weight, some people don't but the majority of people do ... some people can put on up to 20 kilos in the space of a year or two. It's a significant amount of weight. So that then becomes a self-worth issue and can contribute to their depression in other ways. That's a tricky one really. It's probably the biggest side effect of antidepressants (Participant 10).

Sexual dysfunction, affecting both men and women, was another long-term effect frequently discussed by participants. One participant who largely worked with couples commented that "SSRIs are used to treat premature ejaculation, so their ability to decrease or raise our orgasm threshold is well documented". He observed that some people who go on antidepressants subsequently experience difficulty reaching orgasm, which impacts negatively on their relationships and mood,

What tends to happen is people have difficulty reaching orgasm and then they start going off sex, so you get this real vicious cycle that's actually not real helpful for depression. So for some people their sexual function has been fine, their sexual relationship has been fine and suddenly they are having difficulties in that area, adding quite a major negative lifestyle factor (Participant 15).

Another participant observed that for some clients, agitation and increased anxiety are initial effects that subside, whereas for others they persist with long-term use,

Quite a few people on SSRIs report an increase in agitation when they start antidepressants, and for some people it backs off but for a lot of people it doesn't. And so actually their anxiety gets worse and they tend to feel jittery rather than their mood dropping down (Participant 13).

Difficulties with sleep were mentioned by a few participants as a long-term effect of antidepressants. For example, the following participant recalled a client whose mood improved on antidepressants but who continued to experience significantly impaired sleep,

While her mood is now good and she's back to doing what she wants with her life the side effect that is most pronounced with her is sleep disturbance. So she finds she is sleeping for three hours a night at the moment and that has been for quite a while, a couple of months, so she is very fatigued by that while her mood is still good and so it's how do I live with this side effect. That's quite problematic (Participant 16).

As noted in a previous theme, emotional detachment or numbing is a side effect of antidepressants. In this theme, a number of participants recognised it as a long-term effect. They acknowledged that at first clients may consider this a desirable effect as they are no longer experiencing the dips in mood, however over time they perceived this may become unpleasant. For example,

Some will report that the window of mood that they get is almost unpleasant in that it's better than being down but they also realise that they are no longer experiencing true sort of pleasure or enjoyment either, so that their mood is stuck within a band ... that would probably be one of the most common things that their mood feels stuck and restricted in a way. Even though it's better than it was before, once they've been going on for a little while it feels unpleasant (Participant 12).

One participant wondered whether this experience was influenced by the severity of depression experienced by the client prior to taking antidepressants. For example, he perceived that emotional numbing may be experienced more negatively by those with milder depression,

People who have more severe depression, they are just so grateful that they are not getting the lows, they are kind of aware that they are not getting the highs, but they are like oh God,

I just don't want to go back to that place again. People with milder depression they are more like, no I don't like this, doing my life in cotton wool (Participant 15).

Other participants observed that emotional numbing could lead clients to feel detached from their experiences and as if they are no longer themselves. In response to this, one participant commented that clients sometimes describe feeling "like somebody is messing with their head" (Participant 15). In addition, the following participant observed that some clients would prefer to have low mood than experience this sense of detachment or depersonalisation,

The general flatness people can experience with some of the medication, the sense that they lose themselves. They are not suicidal, they are not depressed, but they are just not engaged in the world anymore. They will talk quite a lot about that and they would prefer to be almost unhappy and engaged than they would disengaged but not even really living (Participant 16).

A number of participants talked about the initial process of 'getting it right' on antidepressants, which they perceived to be a common experience among clients. This involved finding the "right one at the right dose" (Participant 2), which for some clients could be a long and difficult process of trialling several antidepressants,

I certainly have conversations with my clients about being tolerant of the trial and error process of finding a medication that works for you ... for some it's a pain and it's many weeks or months, unless you're one of the unlucky ones, you might have to go through that three or four times to find something that's effective for you, if you've got the patience for that (Participant 15).

Many participants observed that antidepressants sometimes fail to work adequately and fall short of people's expectations. Some recalled clients who did not experience any benefit from antidepressants and others where antidepressants were either insufficient or appeared to work initially and then stopped working. For example, the following participant commented on this and also acknowledged that sometimes the costs of taking antidepressants outweighed the benefits,

There's certainly people who have taken an antidepressant and don't report specific or sufficient benefit, and they may or may not report a whole range of side effects as well. So maybe even if they were going to get some kind of 'positive benefit' the side effects might be so intolerable that they wouldn't want to do that ... A common story is that it seemed to help for a little while then it doesn't seem to help or it doesn't help enough ... So did the antidepressant help, sometimes a little bit, often less than clients wish for (Participant 5).

Further, several participants perceived that most clients resist antidepressants and "want to come off them" (Participant 11). Although this was often associated with the nature of the

side effects, some observed that stigma contributed to this. This related to the view that antidepressants differ from medication taken for physical health conditions, and signify personal failure or inadequacy,

There's still a lot of stigma about taking antidepressants, clients end up feeling like what's wrong with me that I have to take a pill like this. It's quite different from a pill for a headache or a pill for a physical health condition. There's still often a sense of failure or what's wrong with me that I need these pills. That can have quite a marked effect in my experience, with some people (Participant 1).

During the interviews, participants were asked about their observations of clients' withdrawal from antidepressants. Interestingly, a number of participants had difficulty answering this question, as they observed that often clients remain on antidepressants following the completion of therapy. Despite this, many did recall clients who experienced withdrawal symptoms once they stopped taking antidepressants. This tended to occur when clients stopped abruptly, either by choice or because they forgot to take the antidepressant. The withdrawal symptoms recalled by participants included insomnia, vomiting, anxiety, agitation, panic attacks, electric shock sensations, headaches, dizziness, and nausea. In addition, many participants said it was common for clients to experience a dip in mood following withdrawal from antidepressants, and a few observed that some clients become suicidal. For example,

People will often stop them suddenly ..., and then that can be really dangerous because people can get quite suicidal and quite unwell quite quickly. You know, severe panic attacks and not sleeping and not eating and vomiting and diarrhoea and all that sort of stuff (Participant 10).

Several participants observed that withdrawal from antidepressants can be managed effectively when clients are provided with sufficient information and support to titrate the antidepressant down very slowly. Even so, many acknowledged the difficulty some clients experience trying to come off antidepressants, particularly with long-term use,

I've seen people have a lot of difficulty getting off SSRIs after long-term use and really struggle to get rid of it. They become quite agitated when they attempt to and feel unwell and have to titrate the dosage down, down, down, down, so taking microscopic quantities really before they can get off it, and it's taken maybe a year to get off the drug after prolonged use (Participant 7).

One participant perceived that the experience of withdrawal symptoms, which could be very unpleasant for some clients, contributed to the opinion that antidepressants are addictive,

People run out and feel hideous and have intense dysphoria. Some people, not everybody ... Some folk say it was just awful. You know, my life was bad and then I stopped taking the antidepressant that I wasn't told was addictive, because in common parlance that's addictive right, and they just feel run out and suffer a lot more (Participant 5).

Many participants discussed their observation that often clients decide to go back on antidepressants due to the unpleasant nature of withdrawal effects. Some conceived that this, in combination with other factors, may contribute to long-term use of antidepressants, as well as a pattern of 'on-again, off-again' use of antidepressants. As one participant said,

That continual yo-yoing, I think I'm feeling okay therefore I'll try and come off them. Oh I don't like the side effects, I don't like feeling my emotions. I'll come back on them again. I'm worried about my weight gain. I'll come off these antidepressants. Oh I'm not feeling so good now. I'll come back on them again (Participant 6).

Overall, this theme drew attention to psychologists' experiences of client antidepressant use and the perceptions they, as therapists, develop in response. The majority of participants spoke about the benefits of antidepressant treatment, in particular that antidepressants can improve the symptoms of depression and facilitate changes, which they perceived could assist clients to re-engage with life and provide the impetus to address the underlying causes of depression. On the other hand, the participants also discussed problems with antidepressant treatment, in particular that antidepressants can compromise long-term progress by disempowering clients and thwarting change. All of the participants discussed the adverse effects which can be experienced by clients on antidepressants.

PERCEPTIONS AND EXPERIENCES OF THERAPY

Throughout the interviews the participants frequently discussed their experiences of therapy with depressed clients and spoke about what they felt to be the benefits of therapy as well as its limitations. In contrast to the passivity of the medical model, participants perceived therapy as fundamentally concerned with fostering agency and empowering clients to change. The majority of participants acknowledged that therapy involved hard work, and could be slow and difficult, particularly with severely depressed clients. Consequently, many perceived that the effectiveness of therapy was limited by the severity of depression as well as by the client's receptiveness.

Can foster lasting change

Throughout the interviews, participants often commented on the value of therapy for producing lasting changes and reducing the likelihood of depression reoccurring in the future. In particular, they discussed the way therapy engages clients to look broadly at the underlying causes and contextual factors contributing to their depression. Many perceived that subsequently clients could gain insight, which combined with information and learning new ways of coping, could improve their ability to manage their mood in the future. A number of participants observed that therapy empowers clients by facilitating agency, and many remarked that therapy works and can be effective on its own. Overall there was a sense that, unlike antidepressants that relieve symptoms, therapy is a more effective treatment in the long-term.

A thread running through this theme concerned psychologists' unique ability to engage with clients. This was considered to be an important step towards building the client's motivation to engage in the change process. For example,

We're used to engaging with people and also some people who don't want to engage. Generally most of the psychiatrists and key workers want psychologists to engage with people because we're a rare commodity and so if we engage with someone that's actually seen as very positive and helpful (Participant 4).

Most of the participants discussed the importance of addressing the underlying causes of depression and adopting a holistic approach to look at what is going on in the client's life. This involved considering lifestyle factors, such as nutrition, sleep, alcohol, exercise, and enjoyable activities, as well as broadly considering the client's context and seeking to understand why they are currently experiencing low mood. For example,

We look at what's underlying the depression ... If there are clearly things that are happening in their lives that are contributing. Like I think of a recent client, looking at her lifestyle, she's getting up at half past four in the morning, got this enormous day and getting home exhausted at six o'clock and going to bed at seven and you know a cycle like that. By the end of the week she's exhausted and run down and not taking breaks at work. Not even aware of herself enough to hydrate herself regularly. Those are obvious things that are going to end up with people exhausted and burnt out and risking depression. So if that's what's going on it's obvious it needs to change (Participant 1).

Another participant discussed the importance of considering the client's context when seeking to understand changes in mood, as opposed to focusing primarily on medication.

She described this as a challenge in her work setting where the medical model took precedence,

I see that far too much in the multidisciplinary team, instead of people going well of course she's a lot worse because her mother has just visited her from somewhere and been mean to her like she always was, you know, people go 'oh she's having a relapse, we need to change the medication'. They do it in a context-less way. So often in the team meeting I'll simply be saying, 'how come things are worse, what's happened recently?' (Participant 14).

Many participants talked about how taking this approach can encourage introspective reflection and provide clients with insight into what caused their depression and what is currently contributing to it, as well as what they can do differently in order to change. For example, the following participant described how providing clients with a thorough assessment and feeding back a formulation can be empowering, as this provides them with choices and emphasises what they can do to change,

You evaluate people's lifestyle really and their choices, as well as what's going on internally, psychologically, their core beliefs, their expectations of themselves and a range of things. So you can give them feedback about well these are the things that are probably in your case contributing to your depression and this is what you can do about it. So that information and that awareness can be empowering in itself because it gives them choices. You're looking at their life from outside, doing an objective appraisal psychologically through that lens. That's often very useful for people to realise what they might be doing (Participant 1).

In addition to increasing clients' insight into their depression, some participants spoke of the importance of providing clients with information, which could be empowering:

I think an empowered person is better than a disempowered person, and helpful information, including what we don't know, is really important to share (Participant 5).

The majority of participants discussed how alongside increasing the client's understanding of their mood, it is important for them to learn new skills so they are able to manage their mood and cope more effectively in the future. This involved becoming aware of early warning signs, using techniques to improve mood, and changing the way they think about themselves and the world. For example,

I view my role as helping them to be able to cope better, to help them develop coping strategies, help them see the world in a different way and view themselves in a better way ... I think basically it's about trying to improve their functioning and their coping and give them strategies to help get themselves back up again when they go down (Participant 3).

If they can actually look at what caused the low mood, they can look at early warning signs, ways of coping, stress tolerance, all that kind of stuff, which is stuff they can incorporate into their lives (Participant 13).

Furthermore, some participants talked about the importance of teaching clients skills to manage their emotions. This often involved learning to accept emotions rather than avoid them, as one participant said,

Part of the work might be around trying to sit with some of those emotions and learn to accept them and not be afraid of your own emotions (Participant 13).

Many participants discussed how these key aspects of therapy help to empower clients by giving them a sense of agency, as the focus is on what they can do to get better. For example, the following participant commented on her perception of this and acknowledged the importance of emphasising what the client has done to change distinct from the antidepressant,

Part of therapy I think is helping them to identify the things that they do that make a difference to them above and beyond what the medication does ... they get to learn the skills that are necessary in order to create their own change and look after themselves when they need to and things like that (Participant 12).

A few of these participants observed that therapy was most empowering if done without an antidepressant, as they perceived that under these circumstances it was easier for clients to attribute changes to themselves. For example,

If people start improving with therapy then it's really clear that that's their doing rather than the pill ... What I see when people are able to do that (therapy without an antidepressant) is they feel very empowered because they know that the gains that they've made are through the work that they've done, not through a chemical intervention. So it actually feels much more their own. They can own it (Participant 1).

Throughout the interviews, several participants observed that therapy plays a significant role in preventing relapse. This was emphasised particularly around the process of withdrawal from antidepressants. A few observed that as clients "come off antidepressants and start feeling their emotions again" (Participant 6), they can use the skills they have learnt in therapy to manage their mood without an antidepressant. This is exemplified by the following participant, who described her sense of how therapy facilitated a young man's recovery in the public system,

The young man that I'm seeing, I think even if at times he becomes depressed again, he's resilient enough and got enough skills that he wouldn't become as depressed as he was, like needing hospitalisation, needing to be watched in terms of safety, all of that stuff. I don't think that would happen again (Participant 4).

Consistent with this, a number of participants argued that therapy could produce lasting changes and compared with antidepressants was a more effective treatment for depression in the long-term. Some discussed their perception that therapy is the cure while antidepressants simply focus on symptom relief. For example,

I am certainly of the opinion that medication relieves symptoms but it's psychological treatments that cure. So I think psychology is the place to start, not biology (Participant 15).

Many participants spoke about the effectiveness of therapy and some observed that clients can progress well in therapy without an antidepressant. For example, the following participant, working in private practice, commented that very rarely does she perceive antidepressants to be necessary and she often sees clients make good progress with therapy alone,

I've been in private practice, I think it's about seven years, and I would say in that time there's maybe five people where I've thought it would be a great idea if you considered antidepressants. It's not a big number. There are people who are moderately or quite severely depressed, and can make really good progress in therapy without an antidepressant (Participant 11).

Some participants connected these experiences and perceptions with what they know from the research. For example,

I don't think everybody who is 'just depressed' needs to be on an antidepressant. I think if we can find other ways to help people respond to being depressed, then that's good. The evidence is that our treatments can be just as effective as antidepressants without relapse, without such a rate of relapse. So I don't think that everyone who's depressed or even a bit vegetative should take an antidepressant (Participant 5).

The research shows that therapy can change the brain chemistry as well as meds (Participant 1).

Sometimes not enough

On the other hand, the majority of participants discussed what they perceived to be limitations of therapy. In particular, many described instances where they had determined that therapy was not enough on its own and where clients were unable to engage in therapy, either due to the severity of their depression or personal factors, such as their circumstances or personal attributes. Most participants thought that compared with antidepressant treatment, clients tend to find therapy difficult and recover slowly,

particularly if they are severely depressed. Consequently, a few participants discussed issues pertaining to risk.

When discussing situations where therapy was not enough on its own to shift the depression, participants often described the client and themselves as 'stuck', and observed that the client was not able to take the ideas of therapy on board in order to make changes and move forward. For example, the following participant, working in private practice, described this as a situation where she might suggest to the client that they consider antidepressant treatment,

If you're feeling like the person is not able to take the ideas on board. It's when you see the person fortnight after fortnight or maybe week after week, usually my private clients are fortnightly, and you are doing the same each session, you are working on the same thing, and the person is not able to take that outside the session and run with it. And so they are starting to feel a bit stuck and you are starting to feel that they might need a bit of help, just finding a way to move forward (Participant 11).

Another participant, working in the public system, described her experience of therapy with clients who were not on antidepressants, and whom she perceived as 'stuck' and unable to utilise the skills she had taught them in therapy,

I think for some people they just keep getting stuck and going around and around in their head and they just literally, no matter how many skills you've taught them, like it's hard to teach them skills when they're in that kind of stuck process anyway, but in terms of taking anything on board, when you're in that state it's so hard to be rational and to be able to think about what you could do to help settle yourself, because you are constantly triggering negative mood states and so there isn't a way in (Participant 10).

Most of the participants referred to the severity of depression when making these comments, and perceived that clients experiencing severe depression were often unable to engage in therapy or obtained little benefit from therapy without antidepressants. Many observed clients with severe depression who had developed very negative thinking patterns and in therapy were unable to consider different perspectives. For example,

When they are really low they just get stuck on a particular way of thinking and it just seems like there is no way out of that. That's the way it is and you push against that a little bit in therapy and see if it is able to be challenged or reframed and looked at from different perspectives. But often when they are really low it's just like no, they can see logically what you are doing but it makes no impact and they just go no, it's not the case at all (Participant 13).

In addition to experiencing difficulty engaging in cognitive work, other participants observed how hard it can be for depressed clients to engage in behavioural change, such as acting

against an emotional impulse and scheduling activities. Some acknowledged that lacking energy and motivation is a problem specific to depression, thus engaging in effortful activities is particularly difficult for people who are experiencing severe depression. This is exemplified by the accounts of two participants quoted below,

I think that's the major problem for psychotherapy, the things that we do are quite effortful. People are not in their best frame of mind, and we are getting them at their worst to do effortful things and they just don't engage (Participant 7).

I've had a number of clients over the years who have come to me with depression, sort of moderate level depression, and who are not on antidepressants and we've worked together for a little while and I have noticed that it's really difficult for them to get the benefit from therapy. Everything is really hard ... I think that one of the very, very hardest things for people to do when they're depressed is to act opposite by doing something and scheduling something when the last thing you want to do is do anything (Participant 11).

Other participants expressed the view that therapy, particularly without antidepressants, can be too exposing for some people who are unable to tolerate the process of being in a therapeutic relationship. In particular, they acknowledged how difficult it can be for these clients to talk about themselves and their painful emotions and experiences. For example, the following participant described her perception of therapy for these clients when they are not on antidepressants,

There are a lot of people that just simply would not tolerate it (therapy). They wouldn't be able to because it's just too exposing, that idea of actually being in front of another person and talking about your stuff that you've put away forever is too shame inducing, it's too anxiety provoking, it's too scary to actually enter into the process (Participant 10).

Related to this, another participant acknowledged that therapy is much harder and more complex than simply taking an antidepressant.

Going, 'no my childhood wasn't happy, and no my partner treats me like shit'; those are all much harder than just saying 'it's something I can control'. Actually that would be the difference I think. The biological feels like something you can be more in charge of. Psychosocial is much more complicated (Participant 14).

A few participants observed that therapy is not for everyone. Some commented that it could be that the timing is not right for the person and others suggested that alternative approaches or circumstantial changes were needed rather than therapy. In addition, some participants stated that some people were not psychologically minded and therefore not suited to therapy. The following quotes capture these impressions,

I think for some people if they're not very psychologically minded they might not get enough improvement and that's good enough for them. I can think of one guy from a wee while ago who I think found therapy really hard and probably wasn't a great candidate (Participant 8).

Sometimes they are not ready to sit still and look at anything yet, and that's fine. Often they need to try a whole lot of other things and of course therapy's not right for everybody by any means ... For lots of them any sort of psychological therapy, forget about it, it's just not going to touch the sides. They just don't want to go there or they can't go there or it's too dangerous to go there and they need to do exercise or sport or yoga or religion or whatever, you know, it's not going to be psychology anyway (Participant 14).

Interestingly, one participant commented on the limitations of working from individualistic therapy models, which do not take into consideration the impact that society has on the individual's wellbeing and the need for structural change:

There are things that are completely out of your control ... therapy has moved to this kind of completely individual model of we all have agency in our own lives, if only we can change, we can change our whole life. I don't really know if I believe it. I think society needs to think of itself and how we support one another and be more part of groups again. We can't all be individuals who maintain our wellbeing as individuals for 80 years ... so the models we use where it's all about if only you could think differently you can be this functioning individual again don't work and I think that's a defunct model (Participant 16).

In addition to being more difficult compared with antidepressant treatment, many participants described recovery in therapy as slower, particularly with severe depression. A few participants observed that this can be problematic if the client is severely depressed and suicidal. For example, one participant perceived that the length of time therapy can take opposes the public expectation for people to get better quickly, creating a significant dilemma. She said,

The client's family wants their brother, sister, mother to feel better and they get scared, especially if the person is suicidal. They don't want to see them in pain like that. So if a psychologist says 'don't worry it will take a few weeks' ... it's a really high dilemma. It's a public expectation. And the public lack of tolerance which is actually a right lack of tolerance of seeing people in distress (Participant 4).

Hence, the majority of participants perceived that therapy was a better long-term treatment for depression compared with antidepressants. In particular, they believed that therapy supported clients to address the underlying causes of depression and learn skills to cope, which empowered them to change and helped prevent relapse. On the other hand, the majority of participants also discussed their perceptions and experiences of the limitations of therapy. Many observed situations where therapy was not enough on its own and where

clients obtained little benefit from therapy without antidepressants, which generally related to the severity of depression.

WHAT THE CLIENT BRINGS

Throughout the interviews, participants frequently discussed the client's influence on the process and outcome of treatment. This is consistent with research, which asserts that the client and factors in the client's life impact on therapeutic outcomes (Wampold, 2010). Central to this theme is the role of the client's beliefs and attitudes in shaping the process and outcome of both antidepressant treatment and therapy. In particular, there was a sense in the current study that progress in treatment was closely related to the client's motivation and willingness to change. Participants also discussed the impact of the client's life circumstances and personal attributes on treatment.

Beliefs and attitudes

During the interviews, many participants discussed the impact of the client's beliefs and attitudes on antidepressant treatment and therapy. Several observed that from the outset, the course of treatment is determined by the beliefs and attitudes held by the client. These seemed to subsequently impact on the outcome of treatment by influencing the client's motivation to 'do the work' as well as the attributions they make about change. Further, many participants discussed the expectations clients form about treatment in response to their beliefs and attitudes, including the possible consequences of these.

The majority of participants acknowledged that clients hold diverse beliefs and attitudes about both antidepressants and therapy. As the following participant pointed out, these lie on a continuum,

People have strong feelings about being on medication, either from 'whatever's wrong with me will be totally fixed by medication and why am I seeing you?', to 'pills can't help me, only therapy can' (Participant 4).

Many participants observed that clients' beliefs about the causes of depression as well as their beliefs and attitudes towards treatment determine the choices they make about

antidepressants and therapy. For example, several participants perceived that clients who have a strong belief in the medical model are unlikely to see a psychologist, as they do not value therapy:

If you think something is caused by biology it wouldn't make sense to seek a psychological treatment ... a bit like going to see your psychologist for your dental problems (Participant 5).

In the public system there is so little psychology available that somebody really has to want it ... the people who completely believe it's biological are probably never going to see me because their GP will say, what do you think about psychology and they go oh no, no point (Participant 11).

On the other hand, a number of participants recalled clients who had negative attitudes towards antidepressants and subsequently did not want to be on them or refused to take them:

There are some people who don't want to take medication even though it would help them, or it's worth a trial is more accurate, because they've got a philosophical problem with antidepressants. And so they don't try a treatment that could reduce their suffering because of some noble cause or something or another (Participant 5).

Several participants discussed the impact of these beliefs and attitudes on the outcome of treatment. For instance, many described clients who valued therapy and were motivated and willing to change. As a result, they observed these clients tended to engage in therapy and respond well to treatment. For example, the following participant observed that some clients who refuse antidepressants respond well to therapy,

For some people who choose, 'no I don't want medication', some of them are very motivated to engage in therapy and they will work hard because their reasons for not taking medication might be around, maybe they like more natural approaches, holistic approaches and philosophically they don't want medication, and people like that can manage very well in therapy (Participant 13).

It seemed that the client's motivation and willingness to 'do the work', whether or not they were on antidepressants, was an important factor in determining their progress in treatment. This is illustrated by the following quotes,

If they make the decision to come off the antidepressants they are actually making more of a commitment to work through whatever issues they have. They want this sorted, not just masked by an antidepressant. So there's a real willingness and readiness to get to the core issues. So they usually respond well (Participant 1).

If people are motivated towards change then medication can really help in that process ... It's about willingness to do the work (Participant 16).

In contrast, some participants recalled clients who were sceptical of therapy and more likely to view depression as a biological illness rather than an interaction between psychosocial and biological factors. As a result, they perceived that these clients were difficult to engage in therapy and less motivated to 'do the work'. As one participant said,

There are definitely some who are more sceptical of the therapy as they see it as more of a biological thing ... they can be quite hard to engage. When you're doing things like talking about pleasurable activities and that sort of thing, they are really sceptical and they don't believe that that's going to help (Participant 3).

A few participants perceived that it is more difficult for these clients to actively engage in therapy, as they do not view themselves as capable of changing their mood or circumstances. For example,

I think it can be harder for them to really be active in therapy and I think as a therapist it feels like progress can be a bit slower and you're much more cautious with people. They won't necessarily see themselves as able to effectively change things (Participant 8).

Related to this, some participants commented on the way clients' beliefs can affect the attributions they make about change. For example, these participants regarded clients who subscribe to the medical model of depression as more likely to attribute improvement to the antidepressant, while other clients make alternative attributions:

It depends a little bit on the client's belief about the worthwhile nature of the medication; if they subscribe to a more medical model then they are more likely to put their improvement at the feet of the medication. Some people really hook into mindfulness very quickly and find that very useful, even when they use it as a distraction technique, and they find that they grab hold of something and they attribute their improvement to that (Participant 9).

As alluded to in a previous theme, some participants expressed concern that a strong belief in the medical model and the tendency to attribute improvement to the antidepressant could facilitate dependence on antidepressants and disempower clients from changing, which could then increase vulnerability to relapse in the future. For example, the following participant commented on her impression of the consequences of this belief,

I think that makes it more likely that they will relapse because it makes them not be active on their own behalf. It makes them actively not change those things that probably made them vulnerable to getting the depression. It makes them think that an external imposed pill is the difference rather than how they need to change their life or change their beliefs or change the way they think or be more skillful or whatever it is that they need to do. So I think it has an enormous impact (Participant 4).

Another participant observed that the client's beliefs about depression and the role of antidepressants can influence their chance of relapse by shaping their expectations around what might happen once they stop taking the antidepressant:

I suppose it depends on what their thinking is around depression and how it manifests, but they are either thinking 'that was just a phase and the medication has helped keep the phase stable and when I stop everything will just go back to normal'. Or they think 'the antidepressant has been holding off, holding off, holding off the depression, so if I come off it the depression is going to come back' (Participant 12).

The significant impact of clients' expectations on treatment was articulated by a number of participants in various forms. Firstly, several participants noted that the placebo effect is facilitated by the client's expectation that antidepressants will help them. As one participant said,

I see some people who can be incredibly placebo driven by the medication so they need to have one dose and they can already be feeling effects (Participant 16).

Similarly, a few participants discussed how this can also work in the reverse, where clients who hold more negative beliefs about antidepressants are less likely to have a positive experience and may experience a greater number of side effects. For example,

There's quite a bit of research to show that if people aren't comfortable taking the pills, the pills don't work as well. Their attitude towards the antidepressant medication impacts on the outcomes, which again can point to the placebo effect ... I think I recall reading they are more likely to get side effects if they really don't feel comfortable taking the antidepressants (Participant 1).

Some participants discussed the possible impact of holding unrealistic expectations about antidepressants. In particular, they recalled clients who strongly believed in the medical model and subsequently expected antidepressants to cure them of depression. In response, they perceived that some of these clients were disappointed when antidepressants fell short of their expectations, while others continued to search for a medication to solve their problems:

One of the things that happens I think with clients too is that their expectations of medication aren't always realistic. So they have this thought that the solution lies in medication and if they don't feel better that means that they need more or a different medication, whereas in fact an antidepressant might be as effective as it's going to be but it isn't exactly going to solve their life's problems (Participant 5).

Circumstances and personal attributes

In addition to the client's beliefs and attitudes, participants spoke about the impact of the client's life circumstances and personal attributes on their treatment and recovery from depression. Circumstances were diverse and included whether the client was on or off antidepressants, the perceived origins of their depression, whether they were seen in a public or private setting, as well as other individual differences in circumstance. Participants were prompted to discuss any cultural differences they observe in terms of clients' response to antidepressant treatment. Hence, the personal attributes discussed in this section include personality traits as well as cultural differences.

Participants were asked whether they observe any differences in terms of progress between clients who are on or off antidepressants. There was not a general consensus and the majority of participants had difficulty responding to this question or could not think of any differences. Some expanded on this and said the reason for their difficulty was that they viewed antidepressants as one of a number of factors that play a role. As one participant said,

Those who are on antidepressants and aren't, similar progress. I think it's difficult to say because there have to be other factors involved as well other than the antidepressants. It has to be the motivation of the client and the rapport you have with the client as well so I can't really say (Participant 6).

As discussed in previous themes, a consistent topic throughout the interviews related to differences based on the severity of depression. In this theme, participants observed differences in treatment response based on the severity as well as the perceived origins of depression. There was a general consensus that antidepressants were most effective with clients experiencing severe depression and less effective where situational factors appeared to play a significant role. This is exemplified by the two participants quoted below,

I suppose that people who have a more severe kind of depression I think do better (on antidepressants). People for whom psychosocial stresses are not such an important variable in the origin of their depression probably do better (Participant 7).

When it's not a clinical depression and the situation they are in is pretty stinky, you know of course they feel bad; the antidepressants don't change that (Participant 15).

A few participants observed that clients who are seen in private practice are generally more motivated to engage in therapy, as they are paying for it:

In private practice it's a huge expense for clients to come and see you so they are much more motivated to actually work with you (Participant 6).

Throughout the interviews, many of the participants discussed the role that circumstantial factors play in clients' recovery from depression and response to treatment. These ranged from generic factors, such as stage of life, bereavement, employment status, social isolation, or poverty, to more specific factors relating to individual clients. The impact of these factors is illustrated by the following participant who observed that the Māori clients she sees are exposed to adversity and poverty, which can impact significantly on their progress and engagement in therapy,

What I definitely notice with Māori clients is they're often in a much more adverse social situation ... I might see someone in their 20s and they might have more children than other people and they'll have less money, so I think usually there's a lot of things going on ... And those things I think definitely impact on progress in therapy, so I wouldn't just put it down to not taking an antidepressant ... a lot of them are in quite hard relationships or have a lot of family stress and those things really affect people's ability to engage, even just to turn up (Participant 8).

These comments seemed to indicate a widely-shared notion that like antidepressants, circumstantial factors can account for differences in progress between individual clients. This is illustrated further by the following participant, working in the public system, who observed that occasionally clients with severe depression can do well in therapy without antidepressants. She perceived that having a significant support network and meaningful employment were key factors that enabled these clients to progress in therapy,

There's the odd person who has been able to manage without antidepressants and probably those people have got significant support systems. I would probably say that's the biggest difference and they've also got reasonably functional lives outside of here ... Either they are a parent or working or volunteering or something, so there's something to engage them, there's some meaning in their life and there's a good support system. Those are probably the biggest factors that make it easier for people to do psychological work. So they can come here and they can do the hard work and they've got some other stuff to go to. They're not going home to endless space of time to ruminate (Participant 10).

A few participants acknowledged that many of these influential factors are integral to the environment or society and lie outside the bounds of treatment for depression. As one participant said,

We are in the community and we are not enclosed, we can't bullet proof everybody from what is going on in their life. If we were in a therapeutic environment where the environment supported people who were depressed to slowly get better in a safe way, but our society doesn't actually support that either (Participant 4).

Consistent with this, some participants acknowledged that changes in circumstance can have a significant impact on the recovery process above and beyond the impact of treatment. For example,

You know sometimes if people are coming off antidepressants, the circumstances that brought them into depression in the first place have changed since then. So they come off the antidepressants and they can adjust quite well and not need a lot more therapy (Participant 1).

A number of participants discussed the impact of personal attributes on the individual's response to treatment. These included personality traits, psychological mindedness, level of intrinsic motivation, and propensity to build rapport with the therapist. This is exemplified by the following participant, who described two very different responses to receiving a diagnosis of depression,

Some people seem just a little more helpless and unable to consider psychosocial things. Other people they go 'oh I've got depression, that's fantastic, it explains what's going on' and they work really hard to manage their illness (Participant 13).

In terms of cultural differences in response to antidepressant treatment, a few participants thought there were no cultural differences while the remainder were relatively uncertain and had difficulty providing an impression. Despite this, the most consistent observation was that clients of Asian descent seem more open and accepting of antidepressant treatment compared with other cultures. For example,

A lot of the Asian populations like medication; they come to a doctor and expect to get prescribed medication (Participant 13).

Generally the stereotype around here is that the Asian cultures are much more looking for the physiological and the biological treatments (Participant 14).

In summary, this theme highlighted the significant impact of factors relating to the client on the process and outcome of treatment. Many participants acknowledged that the client's beliefs and attitudes shape treatment by influencing their motivation and willingness to engage with antidepressants or therapy. Furthermore, participants discussed the impact of clients' circumstances and personal attributes, which were diverse and unique to each individual client. Thus it seemed that multiple factors, many of which were independent of treatment, could significantly impact on the client's progress and recovery from depression.

CONSIDERING WHAT IS BEST FOR THE CLIENT

Throughout the interviews, participants discussed the approaches they adopt and the decisions they make in response to their perceptions and experiences of antidepressant treatment and psychotherapy for depressed clients. Overall, it was evident that the client is at the centre of their approach. This involved promoting the client's autonomy and making decisions they perceived would ultimately empower the client. However, the majority of participants discussed how they must balance this with pragmatism, considering the risks and benefits of antidepressant treatment given the circumstances, in order to get the best possible outcome for each client.

Empowering the client

During the interviews, the majority of participants discussed the importance of sharing information and providing depressed clients with an overview of the treatment options. Many perceived that this empowered clients by facilitating a process of informed decision making, which enabled them to choose how to manage their own treatment. Participants described various other ways they aim to strengthen the client's agency. These included facilitating reflection rather than giving answers, addressing unhelpful attributions, and presenting antidepressants as one part of the picture whilst emphasising the value of therapy. In addition, several participants discussed their views on how to negotiate the mental health system as well as changes they would like to see in order to empower clients further.

Most of the participants viewed sharing information as a key part of their role. A significant aspect of this entailed supporting clients to make informed decisions by providing them with information and exploring the various treatment options, and then respecting the choices they make even if this conflicts with what they, as therapist, think is best. Some participants spoke of sharing their opinion with clients, particularly if they thought antidepressants were needed, whilst being clear that whatever the client chooses is most important. For example,

If the person, despite all my knowledge and me imparting it to them, decides they don't want it (antidepressant treatment), I'm very clear that we will keep working collaboratively

but that if we're working and I still think it's needed ... I say, 'I won't hold back but whatever you decide you know you best. I know the technical stuff best so between us we're going to make a pretty cool functional team here so whatever you decide I'll absolutely respect that. But that won't stop me if I still think we're on the wrong track, I will say so, but it's still your decision' (Participant 2).

Other participants described being more cautious about expressing their opinion on client antidepressant use and instead using questions to encourage reflection and support the client to find a solution. This is illustrated by the participant quoted below,

It's their journey. So with antidepressants, if they feel they're helpful, if they feel they're not helpful, if they're not sure ... I would always be just asking them questions and asking them to reflect on it and asking what they notice and what they can figure out (Participant 14).

A thread running through these comments concerned the importance of giving clients a voice. As the following participant pointed out, empowerment and strengthening clients' ability to make decisions is often a crucial part of recovery for clients with depression:

I think particularly depression is so much borne out of other people's stuff, so the sense that they have not been allowed to have their own voice, and that just sort of flattens people. So there's more people-pleasing, you know, often needing to do that to survive. So as they're working their way out of depression, I think their ability to say 'I do like this and I don't like that' and 'I won't have this and I will have that' is absolutely crucial to their wellness in a way that is perhaps not the same with anxiety or something else (Participant 14).

The participants discussed several ways they sought to empower clients and engage them actively in treatment. For example, some spoke of empowering clients by encouraging them to discuss their treatment with their doctor rather than speaking on their behalf. As one participant said,

Usually I leave it with them (talking to GP) because I like them to take a bit of control and autonomy, cause that's sort of part of the therapy, getting them to be more independent and functional rather than doing everything for them (Participant 3).

Further, several described working with clients where they are at and being led by them as opposed to imparting their own personal views as therapist. The following participant provided an example of this,

If the client is coming and telling me it's their dopamine or their serotonergic system that's not functioning then that's what I will work from. They don't need to know my personal views on whatever it happens to be. If that's what they are saying then that's fine, that's where we're going to operate from and you can still do stuff in therapy even if they're coming from a very biologically driven model (Participant 12).

In order to manage the dominance of the medical model within the mental health system and the related messages clients receive about antidepressants, a number of participants discussed the importance of taking a holistic approach when providing information on depression and treatment options, such that the value of therapy is emphasised and antidepressants are only viewed as part of the picture:

I explain that there is this biology bit and we know that making some changes there can be useful, so I present it as another option. I say, 'you don't have to use it, but for some people this is another part of the jigsaw puzzle' (Participant 11).

A few participants stated that when the psychoeducation process is managed in this way, such that the value of therapy is emphasised and the role of antidepressants is explained, clients are more likely to remain engaged in therapy even if they believe that the antidepressant is working:

I think if you get the education process right then people are more likely to engage (in therapy), even if they understand that the antidepressants are working. They understand that the depression is multi-variable about biology and psychosocial factors (Participant 7).

Although many participants spoke of providing clients with information on antidepressant treatment, there were also several who described being cautious about suggesting antidepressants. Some participants described this as an area of contention, as they were concerned that by suggesting antidepressants they might contradict the goals of therapy and disempower clients from making changes. For example, the following participant articulated this dilemma,

I think about it pretty carefully before I would ever suggest it (antidepressant treatment) ... I don't want to pre-empt the therapy process with an antidepressant. I don't want to throw people into an antidepressant. I'm quite aware of that, I don't think antidepressants are the answer. I guess I think they're a tool ... I don't want them to think that they have to take an antidepressant otherwise they are not going to get better. And that's the dilemma is that I don't want to make people feel like unless I take an antidepressant nothing's ever going to change for me. But what I do want to sometimes suggest to people, and it's not all that often, but sometimes I suggest that an antidepressant might just help things move forward (Participant 11).

Another participant described being careful about the timing of suggesting antidepressants, particularly when the client is expressing painful emotions. She perceived that this might communicate that you are unable to tolerate their suffering and hinder them from working through their distress:

There's a delicate negotiation because often what they need to do is keep going through the horrible feelings and come out the other side ... If you start going 'oh have you thought about medication?' as if you are saying to them 'your distress is too much for me, I can't handle this, you need to go away and deal with it somewhere else'. It can be quite a rejecting thing ... you sort of imply that they are not going to be able to cope or I am not going to be able to cope (Participant 14).

In order to empower and motivate clients to engage in the active work of recovery, some participants talked about reiterating the value of therapy and emphasising changes the client had made in addition to taking an antidepressant, particularly if they begin to attribute their progress to antidepressants or if they are at risk of disengaging from therapy prematurely. For example,

If I get an inkling of that (client disengaging from therapy) then I talk about it, cause it's no use keeping people in therapy if they don't want to be there, that's counterproductive. So I talk about the relapse prevention work, signs of relapse and what to do and things like that. For many clients, if I felt that they were attributing their progress just to the medication, I would voice my concerns about that and say that I felt the risk of relapse would be lessened if the therapeutic work could be continued for longer (Participant 9).

I will say to them, 'it's (antidepressant) been really helpful but you've done this. The antidepressant didn't take your feet out the door and join a singing group'. I think it's an easy attribution to people. And then when we talk about it a little bit more people usually do recognise that the antidepressant possibly just got them over the hump in the road (Participant 11).

Related to this, the majority of participants expressed the opinion that therapy should be prioritised while the focus on antidepressant treatment should be lessened. This involved changing current practice to include more short-term antidepressant use or trialling therapy prior to prescribing antidepressants, particularly with mild to moderate depression or where the client has recently experienced a negative life event, such as an affair or bereavement. This is illustrated by the following participants, who shared examples of how they manage these situations within their practice,

I tend to encourage doctors to send them to me and if I am seeing them regularly then I can assess if I think they need antidepressants, but just start some therapeutic work first and then keep reviewing that need, it's much simpler to do it that way (Participant 1).

You continue being the idea of coming off the medication and talking about it. So you are trying to weaken the idea that they have to be on it life-long, so you keep on building hope that things can change (Participant 6).

Other participants expressed the desire to see broader changes consistent with this at a system level, in order to empower clients and hopefully improve their chance of recovering

from depression. For example, a few participants said they would like to see more psychological input at a primary health level so that the public is provided a more holistic perspective rather than predominantly the medical model of depression:

I think psychologists working alongside people who prescribe, to inform them and shift the way of thinking of depression as a biological illness to there's many ways of dealing with depression. I think psychologists are a lot more skilled than say a GP at knowing what those options are ... A psychologist in every GP practice; that would be interesting (Participant 13).

Interestingly, a number of participants said they preferred that medical professionals prescribed antidepressants, as this enabled them to focus on therapy and support clients to change rather than become side tracked by medication,

The room isn't contaminated with that (medication), although I'm interested and of course will talk to people of the side effects, I can quite easily go, 'well that's not my job and if you want to see me ... let's talk about change'. So it becomes much clearer the focus of what we are doing in the room (Participant 16).

Many participants described providing clients with support whilst empowering them. An important example of this was the role that psychologists can play when clients are coming off antidepressants. Many viewed this as a critical time for clients to be engaged in therapy in order to gain support as they build on the skills they have learnt. For example,

It's pretty good for them to be having some therapy sessions at that point (reducing antidepressant) just to remind people of the skills they got in therapy when they were recovering, so to really work those again (Participant 11).

Adopting a pragmatic approach

Throughout the interviews, the majority of participants described the complexity of working out what is best for each client and a few acknowledged that it is not as straight-forward as following treatment guidelines. This often involved adopting a trial and error approach and being open to 'whatever works', which could include using antidepressants as a 'tool' to support the recovery process. Many discussed the guidelines they use and have created around client antidepressant use, including when they would consider suggesting antidepressants and their views on long-term antidepressant use.

Many participants commented on the process of deciphering the best course of treatment for individual clients with depression and acknowledged that it is not black and white.

Several talked about being informed by best practice guidelines, while a couple acknowledged the difficulty of applying research findings to individual clients. For example,

I just don't think it's straightforward. I mean, you read all these studies and they find a statistically significant difference between groups but when you have an individual in front of you, is this going to help or not ... It's not clear ... Who knows what best practice is. Anyone prepared to say what best practice is on a general population basis, how does that affect the individual sitting in front of you? How do you know? You just don't, but that's just the uncertainty of life. There is certainly a dilemma in that (Participant 5).

Related to this, the same participant pointed out that the research trials exclude clients with severe and complex problems, which raises a dilemma, as these are the majority of the clients seen and treated with antidepressants in the public mental health system:

I'll tell you the biggest dilemma about antidepressants; they've never been trialled on suicidal people. Anyone with serious problems has been excluded from the research trials ... So we are actually recommending drugs that haven't been tried on the people that we most routinely see (Participant 5).

In response, a number of participants spoke of adopting a trial and error process of figuring out what works and what is helpful for individual clients. Subsequently, some said they encourage clients to try antidepressants and find out what works best for them. This included participants working in private practice who were cautious about suggesting antidepressants. For example, the following participant described this dilemma using the analogy of taking migraine medication,

I guess it's whether I come at some point to the place where I say to them, 'you know, I think you can do this without an antidepressant. At the same time I have the thought that maybe taking an antidepressant might be really helpful for you. A bit like you can live through a migraine without taking migraine medication, but would you want to do that, and you could do that and it's painful and it's uncomfortable and you come out the other end eventually, but then it has a cost. Or do you take that migraine medication, because it's there, because it's helpful, because it allows you to get through that faster?' (Participant 11).

On the other hand, this process seemed to be more straight forward for those working in the public system who generally described being open to trying anything that might be helpful, particularly when clients have severe depression and nothing else seems to be working:

You want to try anything you can when someone's in a low place and especially if the therapy is getting stuck because that person is so low, then maybe medication is useful to just bring them back up to a point where they are safe and more able to engage (Participant 13).

Consistent with this, the majority of participants working across both public and private settings described the severity of depression as an indicator of when to encourage client antidepressant use. Other factors taken into consideration included suicide risk, the client's progress in therapy, as well as their level of suffering. As one participant said regarding the factors she uses to determine whether to suggest antidepressant treatment,

Risk, severity and level of suffering; level of suffering goes with the severity, so if the person is clearly not functioning and really suffering with that and/or is at risk to themselves ... If things were stuck you might be getting them to think about or rethink about trialling medication (Participant 10).

Another participant highlighted the significant role that risk plays in determining whether or not to encourage antidepressant treatment. She spoke of the process of weighing up the pros and cons and acknowledged that what you might do philosophically tends to differ from what you do practically as it comes back to risk, particularly for those working in the public system:

Safety is a big determinant and risk is actually our main focus ... I guess it's all weighed up, once again we get back to risk and thinking about how much risk there is in not offering someone an antidepressant versus how much risk there is of side effects or negative effects of antidepressants. So weighing those two up is a dilemma. What philosophically you might offer versus what practically speaking given that we are a secondary service that deals with acutely unwell people, generally severe and complex. If things go wrong there's a higher risk (Participant 4).

Many participants talked about the benefits of using a combined approach of therapy and antidepressant treatment, particularly with moderate to severe depression, which a few linked with the treatment guidelines for depression. For example,

I quote best practice guidelines and I talk about a two pronged treatment approach, both antidepressant medication but also talking therapy and unravelling what started all of this off (Participant 2).

In these cases most described using antidepressants to support therapy, which involved using them to facilitate initial engagement and treat the symptoms of depression, and subsequently reducing them as people became more skillful. This is supported by one participant's comment that, "pills don't give you skills, although they can help you get them" (Participant 5), and is demonstrated by the following participant who discussed how she uses antidepressants alongside therapy,

If they come to me and they are really low sometimes I say, 'look this is going to take a while and you are struggling to function so how about we get the antidepressants in there to give

you a little bit of a boost, just to help you along the way, until the work that we're doing is going to start to have a significant effect' (Participant 3).

A few spoke specifically about the placebo effect and how this can be used to support the recovery process. For example, one participant observed that the placebo effect operates across various forms of treatment, including naturopathy, crystal healing, and medication, each of which can be viewed as a 'tool',

I think it's really unhelpful to be black and white about any of these things. They're tools, they work for some people, and they don't work for other people (Participant 14).

Another participant talked about focusing on what works for individual clients, such as antidepressant treatment, and not being concerned about the reasons for this:

If someone takes an antidepressant, if they feel better, even if it's not due to the alleged serotonin hypothesis, I don't really care ... if it works, I say focus on what works (Participant 5).

The participants were asked about their views and experiences of long-term antidepressant use. Several perceived that occasionally a client might need to stay on antidepressants for a number of years, possibly indefinitely, in order to uphold their quality of life. For example, the following participant described supporting these clients through a process of reducing the antidepressant as low as possible,

We try to get people down to as low as we can, for them to be able to maintain a good quality of life ... so they might do slow reductions over time, or you might be in therapy and you'll do the slow reductions while you are in therapy and you get to a point where your life is a good enough quality and you are happy to stay on that amount of medication and then you will be discharged ... a lot of time people just need a little bit of support or a bit more resilience than what life has given them, and that's okay too, I mean why make it hard for yourself? (Participant 10).

There was a sense that in some cases long-term antidepressant use could hinder progress whereas in other situations it might be the best possible solution to maintain the client's quality of life. This dilemma was highlighted by the following participant, who described the criteria he uses to determine whether long-term antidepressant use is a helpful solution for a particular client,

I don't implicitly believe that long-term antidepressant use is bad or good. Sometimes I think that might be helpful and sometimes I think it could be because people aren't attending to solving the other problems in their lives. It depends ... So is antidepressant long-term use helping them do the best they can or is it actually holding them back from getting the help to do the best they can? That would be my criteria (Participant 5).

Several participants acknowledged that while the system is not ideal, they had adopted an accepting and pragmatic approach to work effectively within it. For example,

I think you just learn to live with it (the system). You learn that this is how it is, that GPs are going to prescribe and so you just learn to work with that (Participant 12).

Overall, this theme was concerned with the approaches psychologists adopt in relation to antidepressants, given their perceptions and experiences. It seemed that empowerment of the client was at the centre of their approach and informed their decisions around antidepressants. However, alongside this the participants described taking a pragmatic approach and 'doing what works' in order to find the best possible solution for each client. This involved following best practice guidelines and balancing empowerment with the risks and benefits of antidepressant treatment, while ultimately respecting the client's choice.

CHAPTER SUMMARY

In summary, the results of the thematic analysis showed that psychologists' views of the role of antidepressants in treating depression are influenced by an array of experiences. These included the dominance of the medical model in the mental health system; their work context – private or public; their observations of the impact of antidepressant treatment and therapy on client wellbeing; and the influence of factors relating to the client. The subsequent approaches adopted by psychologists in relation to antidepressant and/or psychotherapy treatment for depression seemed to centre on client wellbeing, and involved balancing empowerment of clients with the need to be pragmatic given the limitations of the mental health system and consideration of factors relating to the client. There were some common considerations, including the use of antidepressants as a 'tool' to support recovery and an adjunct to therapy with severe depression; the potential for antidepressants to disempower clients, compromise recovery and undermine therapy; the value of therapy for producing lasting change and preventing relapse; the importance of empowerment and strengthening client agency; and the desire for a more holistic view of depression within the mental health system. Overall, the psychologists used their clinical judgement, based on research and experience, to make informed decisions aimed at improving client wellbeing, given the unique qualities of each case.

The following chapter considers these findings within the context of psychology practice and depression research. Specifically, the discussion probes the dominance of the medical model in the mental health system and discusses psychologists' decision-making regarding their approach to working with depressed clients and the role of antidepressants in facilitating or compromising recovery. Implications for clinical practice with depressed clients as well as future research directions are also considered.

Chapter Four – Discussion

This study aimed to investigate psychologists' views of antidepressants given their experience of working therapeutically with depressed clients. In particular, it sought to develop an in-depth understanding of the experiences that influence psychologists' views about antidepressants; the dilemmas, if any, that psychologists experience in regard to working therapeutically with depressed clients; and given this, the approaches (including decision-making) that psychologists adopt in relation to antidepressant treatment and psychotherapy for depression.

The results of the thematic analysis in the previous chapter indicate that a number of experiences influence psychologists' views of antidepressants and the approaches they adopt when working with depressed clients. A proposed model to represent these influences and approaches is presented in Figure 2. This will provide the focal point of the discussion. Following this, implications for clinical practice with depressed clients will be discussed, along with the limitations of this research, and implications for future research directions.

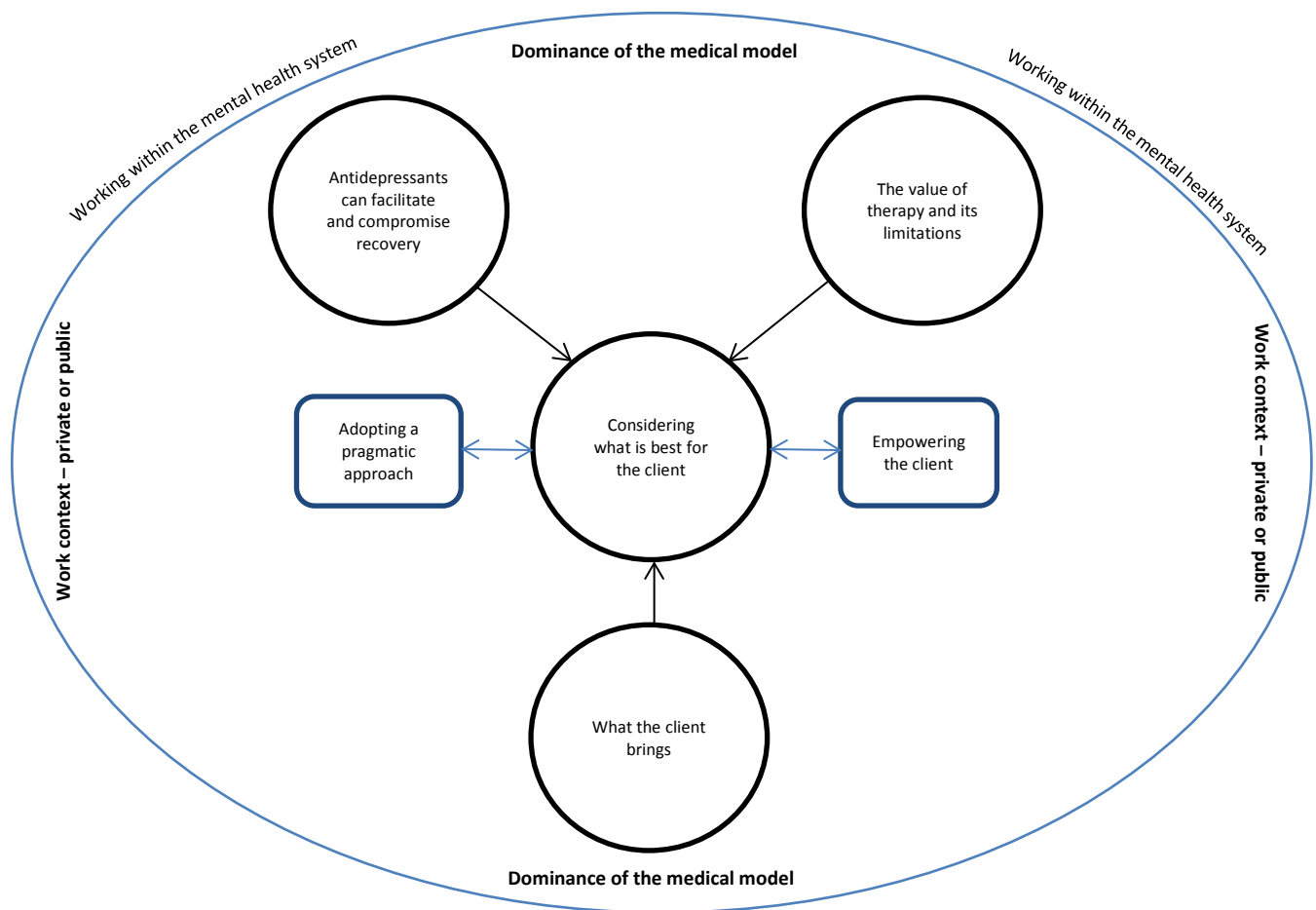


Figure 2: Model of the influences on psychologists' views of antidepressants and the approaches they adopt when working with depressed clients.

Dominance of the medical model

The majority of psychologists interviewed for this study discussed the dominance of the medical model in the mental health system, which combined with their work context – private or public – provided the context that influenced their views and experiences, and forms the outer circle of the model. Throughout the interviews, psychologists expressed some frustration about the dominance of the medical model in the mental health system. This was supported by their observation that antidepressants are considered the first line of treatment, while psychotherapy is viewed as secondary and not funded to the same degree. Several psychologists observed that clients tend to experience difficulty accessing psychotherapy, and consistent with research (Loh et al., 2006; Young, Bell, Epstein,

Feldman, & Kravitz, 2008), some perceived that GPs and psychiatrists do not provide adequate information on other treatment options, such as psychotherapy.

The psychologists believed this practice of prescribing antidepressants as the first line of treatment for depression contradicted what is known about the efficacy of psychotherapy, particularly for mild to moderate depression (Greenberg & Goldman, 2009), as well as evidence supporting the superiority of combined treatment, particularly for severe or chronic depression (de Maat et al., 2007; Pampallona et al., 2004). The use of antidepressants as the first line of treatment is not in line with the New Zealand practice guidelines that recommend psychological intervention alone as an initial treatment for mild depression, while patients with moderate to severe depression should be offered the choice of antidepressant treatment or a psychological intervention, and a combined approach is recommended for severe depression (New Zealand Guidelines Group, 2008). The psychologists' views in this regard are also consistent with some researchers' concerns (e.g., Jureidini & Tonkin, 2006) that antidepressants are being overprescribed and studies showing inconsistencies between the evidence and what takes place in real world settings (Van Geffen et al., 2007).

Several of the psychologists in the study perceived problems with the dominance of the medical model, most notably the negative impact this can have on client agency and thereby on therapy. They noted that the structuring of the system to prioritise contact with doctors and medication led clients to view their depression in predominantly biological terms, typically believing a pill is required to correct a chemical imbalance in the brain. Some thought this could have a negative impact on client engagement and progress in therapy, as clients are receiving a 'mixed message' that they may benefit from therapy but on the other hand have a biological illness requiring a pill. Participating psychologists generally viewed the medical model as disempowering and facilitating a passive approach, undermining the importance of the client's agency and belief in their ability to change. In support of this, some psychologists shared examples of clients who held a strong belief in the medical model and were difficult to engage in therapy, less motivated to 'do the work', and less likely to view themselves as capable of changing their mood or circumstances.

The psychologists' concerns are supported by research demonstrating that patients who subscribe to biological explanations for their depression are less likely to see value in psychotherapy and more likely to be pessimistic about recovery (Deacon & Baird, 2009; Haslam & Kvaale, 2015). In the literature this is termed 'prognostic pessimism' and is defined by Lebowitz, Ahn, and Nolen-Hoeksema (2013) as, "a belief that mental health problems are relatively permanent and difficult to cure or treat effectively" (p. 518). This is illustrated by a recent study, in which Kemp, Lickel, and Deacon (2014) administered a bogus biological test to a group of depressed participants, informing half that their depression was caused by low serotonin and the other half that their serotonin levels were normative. Participants in the chemical imbalance condition were more pessimistic about their recovery, less likely to view themselves as capable of regulating their depressed moods, and viewed medication as more credible and effective compared with psychotherapy.

Further, many psychologists perceived that the medical model of depression with its biochemical solution is not only disempowering and creating of passivity, but facilitates a narrow understanding of clients' distress, which leads to other contributing factors being disregarded by both the client and other mental health professionals. A consequence of this, discussed in literature examining the impact of the medical model on depressed patients, is that depression is then viewed as a decontextualised problem of the individual, which can be invalidating, pathologising, and ultimately stops change (Lafrance, 2007). A number of the psychologists also observed this and offered examples to support this position. Further, the medical model of depression opposes an integrated view of the condition, such as that provided by the biopsychosocial model, which views depression as a complex interaction between psychosocial and biological factors (Schotte et al., 2006). The psychologists' views were in line with an integrative paradigm, and some stated they were unable to separate psychosocial and biological factors, viewing them as equally important in contributing to depression.

Researchers have argued that in contrast to an integrative model, the medical model of depression encourages a divide between psychotherapeutic and pharmacological approaches (Deacon, 2013; Read & Sanders, 2010). Consistent with this, many of the psychologists acknowledged that the medical model opposes psychological models, which

they perceived were empowering, holistic, and consider the person's context. They observed the impact of holding a view that contrasts with the dominant medicalised discourse, both on themselves personally and on the treatment they offer for depression. For example, some described feeling undermined by the system and the practice of both psychiatrists and GPs, others spoke of feeling like a 'lone voice' in their teams where they sought to provide a psychological perspective of clients' distress, and many in the public system spoke of the pressures facing psychologists, specifically that a small number of psychologists is expected to provide short-term treatment to a large number of clients experiencing severe and complex problems. Hence, the medical model both forms the context and contributes to the dilemmas that influenced the psychologists' views and experiences of working therapeutically with depressed clients in both public and private settings.

When do psychologists perceive that antidepressants facilitate or compromise recovery?

The topic of antidepressant treatment elicited an array of complex responses and experiences from the psychologists. On the one hand, many viewed antidepressants as potentially beneficial and thought they could improve the symptoms of depression and facilitate recovery, but conversely could produce adverse effects and compromise recovery by disempowering clients. There is evidence that patients similarly hold mixed views about antidepressants (Bogner, Cahill, Frauenhoffer, & Barg, 2009; Garfield et al., 2003; Pollock & Grime, 2003).

It is important to note that the psychologists' experiences of therapy influenced these views about antidepressant treatment. Overall, they believed in the value of therapy to address the underlying causes of depression and prevent relapse. On the other hand, most described the limitations of therapy for some clients and recalled instances where they believed therapy alone was not enough to facilitate change. Thus as shown in the model, the psychologists considered their experiences of both antidepressant treatment and psychotherapy when determining their approaches to working with depressed clients. This involved evaluating whether antidepressants were needed, as well as considering issues of empowerment versus disempowerment.

In terms of the benefits, many psychologists observed that antidepressants could be both necessary and useful. Regarding the former, they believed that severe depression affected the client's ability to engage in therapy, contributing to difficulties for both the client and therapist. The reasons given for this included clients' entrenched negative thinking patterns as part of depression, their severely reduced motivation and energy, and their inability to cope with deeper therapy due to emotional vulnerability. Under these circumstances, many psychologists perceived that clients received little benefit from therapy without antidepressants. This is in line with research demonstrating that antidepressants are effective for many clients with severe depression (Fournier et al., 2010), as well as evidence supporting the use of combined treatment with severe depression rather than psychotherapy alone (de Maat et al., 2007). As noted earlier, research into psychotherapy and antidepressant treatment has shown that progress in therapy is slower than progress on antidepressants (Keller et al., 2000). The participants in this study also observed this and many acknowledged that for this reason, antidepressants were an important treatment option if risk was a concern.

Furthermore, research into the impact of antidepressant treatment on patients has found that antidepressants can be experienced as a 'tool' to support recovery and increase agency (Knudsen, Hansen, & Eskildsen, 2003). Similarly, the psychologists in the study perceived that antidepressants could facilitate recovery by empowering clients to change. These views arose from the observation that antidepressants could improve the symptoms of depression, 'give a lift', 'take the edge off' intense emotions, and facilitate cognitive changes, which the psychologists believed could assist clients to engage in therapy and address the underlying causes of depression. In this regard, many participants viewed antidepressants as potentially "treatment enabling" (Participant 5). This finding is consistent with qualitative studies involving depressed participants, who believed active work was required to solve the underlying causes of their depression, which could be supported by the use of an antidepressant if it relieved the symptoms of depression (Hoener, Stiles, Luka, Gordon, 2012; Stevenson & Knudsen, 2008).

A dilemma arose for many when the psychologists perceived that the experience of feeling better on antidepressants could compromise recovery by preventing clients from addressing the underlying causes of depression and acquiring the coping skills that would help prevent

relapse or recurrence in the future. They perceived this occurred via facilitating avoidance of emotional pain, reducing motivation to 'do the work', and thereby prompting clients to disengage from therapy. As discussed earlier, research into antidepressants and psychotherapy has shown that unlike antidepressants, psychotherapy has enduring effects, leading to lower rates of relapse (Hollon et al., 2005). Consistent with this, many psychologists stated that failure to address the underlying causes of depression and acquire coping skills contributed to dependence on antidepressants and increased the risk of relapse.

In addition, the psychologists recalled a number of adverse effects experienced by clients on antidepressants that could also interfere with recovery. As introduced earlier, a recent New Zealand study surveyed 1829 adult recipients of antidepressants on their experiences and beliefs about antidepressants (Read et al., 2014). The study found the most commonly reported adverse effects included sexual difficulties (62%) and feeling emotionally numb (60%). Additionally, 27% reported fear of addiction and 55% experienced withdrawal effects. The psychologists in the current study also observed these effects and expressed concern that for some clients these interfered with recovery. For example, as found previously, many thought emotional numbing could prevent clients from gaining skills in emotional management (Price et al., 2009), and some observed that the fear of withdrawal effects contributed to long-term use and dependence on antidepressants (Leydon et al., 2007). As noted by Read et al. (2014), many of the psychologists thought that side effects could have a significant detrimental impact on clients' mood and quality of life.

Further, the psychologists perceived that antidepressants could serve to reinforce the medical model of depression. Consistent with the discussion earlier, they thought this contributed to disengagement from therapy and disempowerment by undermining the client's agency and belief in their ability to change. This occurred via the attributions clients made about change, as many observed that clients were more likely to attribute progress to antidepressants rather than to therapy or their own actions, thereby strengthening their belief in antidepressants as the solution to a medical problem. The psychologists thought this further contributed to dependence on antidepressants, which is supported by research showing that acceptance of the biological definition of depression is associated with a tendency to become psychologically dependent on antidepressants (Karp, 1993). According

to the participating psychologists, this appeared to be more problematic with clients experiencing mild depression, who generally respond well to therapeutic intervention yet through placebo effects, can attribute progress to antidepressants. This is an example, represented in the model, where psychologists drew on their experiences of client responses to antidepressant treatment and psychotherapy to make decisions about antidepressants.

As discussed earlier, no other studies on psychologists' views and experiences of antidepressant treatment for depression could be attained. However in their 2007 study, Williams and Levitt interviewed 14 eminent psychotherapists on their understanding of the role of agency in psychotherapy, including the place of psychopharmacological interventions in general. Similarly to the psychologists in this study, the therapists in this earlier research agreed medication was at times necessary and could facilitate agency by assisting clients to engage in therapy; however they also thought medication could impair agency by reducing motivation, causing addiction, and not teaching skills. The researchers concluded that the therapists, "preferred to use psychotherapy because it did not create a dependency on an external agent to create change" (Williams & Levitt, 2007, p. 76). In summary, it seems antidepressants may be used as a 'tool' to empower and facilitate recovery, however when relied upon as the solution to depression, they may disempower clients from changing and compromise the recovery process.

Psychologists' approaches to treating depression

As noted earlier, concerns for client wellbeing and improved mental health emerged as central to the psychologists' approach to treating depression. An important aspect of this was psychologists' belief in and emphasis on empowerment and client agency that emerged across all of the themes. Research has shown that factors relating to the client contribute significantly to variances in treatment outcome (Asay & Lambert, 1999; Wampold, 2001). The psychologists in this study similarly emphasised the influence of the client, termed 'what the client brings' in the model (Figure 2), on the process and outcome of both antidepressant treatment and psychotherapy. Thus, as represented in the model, psychologists' approaches to working with depressed clients involved considering their

experiences and views of antidepressant treatment and psychotherapy, as well as the context provided by the mental health system and the client in order to determine what is best for the individual client. An important aspect of this involved balancing empowerment with pragmatism. Accordingly, empowerment remained a central concern for the psychologists, however to work effectively with clients they adopted a pragmatic approach towards antidepressants, considering the risks and benefits given the client's circumstances.

The psychologists reported a number of strategies they employ to empower clients and foster agency regardless of whether or not clients are on antidepressants. Researchers have argued that empowering clients to make informed treatment decisions is integral to upholding client agency (Sparks, Duncan, Cohen, & Antonuccio, 2010). Similarly, the psychologists viewed this as a key part of their role. They described providing clients with balanced information on the treatment options, including the risks and benefits, and giving primary importance to clients' choices even if this opposed what they thought was best. Thus in contrast to the medical model, they viewed clients as active agents rather than passive recipients of treatment. Further, in order to promote client wellbeing and reduce the likelihood of disengagement from therapy, the psychologists emphasised that their work with clients included making overt the significant role of the client in recovery and the value of therapy at preventing relapse. If indicated, they also addressed attributions that could disempower clients from changing. Overall, this involved providing clients with a holistic view of depression and treatment that presented antidepressants as part of the solution for some people. This position is consistent with the biopsychosocial model provided by Schotte et al. (2006).

When making decisions about antidepressants, the psychologists appeared to combine their knowledge about the efficacy of antidepressant treatment and psychotherapy for depression based on research, with their clinical judgement, and the preferences of the individual client. This approach aligns with that advocated by the American Psychological Association Presidential Task Force on Evidence-Based Practice (2006), which defined evidence-based practice as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (p. 273). Accordingly, the psychologists in the current study generally encouraged the use of antidepressants with severe depression, and in addition provided examples where

antidepressants could be used to facilitate recovery and support therapy. This openness towards viewing antidepressants as a 'tool' was most commonly expressed by psychologists working in the public system with the most severe and complex clients, who although concerned with empowering clients, tended to emphasise the importance of small changes in coping and were less focussed on the origin of these changes. This was particularly true if risk was an issue or the client's level of suffering indicated the need for antidepressants. These psychologists also tended to be pragmatic about long-term use of antidepressants, prioritising the client's quality of life.

On the other hand, private psychologists working with mild to moderate depression expressed greater caution around antidepressants. Many thought that ideally it was best for clients to receive psychotherapy alone or alternatively receive a short course of antidepressants and then taper off as they become more agential in their recovery. The primary reason for this was to mitigate the risk of disengagement and disempowerment, due to clients feeling better and attributing change to the antidepressant. Despite this, there were instances where both public and private psychologists were pragmatic about antidepressants' use as a 'tool'. For example, some spoke of using antidepressants to provide symptom relief and facilitate engagement in therapy (Friedman et al., 2004), while others recalled the usefulness of antidepressants to facilitate faster progress, particularly if the number of sessions was limited. Interestingly, although supporting and empowering clients during antidepressant withdrawal was considered important, many acknowledged this rarely occurred as most clients remained on antidepressants after the completion of therapy. This finding is concerning in light of the earlier discussion regarding the difficulty some clients experience stopping antidepressants due to withdrawal effects (Leydon et al., 2007).

Overall, the majority of psychologists expressed the view that psychotherapy should be prioritised as a first line treatment, especially with mild to moderate depression, while the emphasis on antidepressants should be lessened. On the other hand, when the symptoms of depression were severe and disabling, they considered antidepressant treatment in combination with psychotherapy to be the most appropriate course of action. As noted earlier, this is consistent with the New Zealand practice guidelines for depression (New Zealand Guidelines Group, 2008). Further, antidepressant treatment was deemed useful to

the extent that it improved client wellbeing, but disadvantageous when it disempowered the client and/or prompted disengagement from therapy. This finding is in agreement with the therapists in Williams and Levitt's (2007) study who perceived medication to be helpful unless it impaired client agency. Also consistent with the therapists in Williams and Levitt's (2007) study, was the finding that the psychologists took a holistic approach towards treatment of depression that considered the role of biological and psychosocial factors. Whilst holding these views, the psychologists were ultimately client-centred and approached the treatment of depressed clients on a case-by-case basis.

Clinical implications

This study highlights the dominance of the medical model in the mental health system, specifically that antidepressants are the first line of treatment for depression while psychotherapy is considered secondary. This approach contradicts evidence that antidepressants and psychotherapy have comparable efficacy (Spielmans et al., 2011) and evidence demonstrating the superiority of psychotherapy at preventing relapse (Hollon et al., 2005), as well as the practice guidelines for depression (New Zealand Guidelines Group, 2008). Examination of the divergence of practice from research-based recommendations suggests that greater access to psychotherapy is needed, particularly in primary care. Psychologists hold a holistic view of depression and there are a number of studies (Deacon & Baird, 2009; Lebowitz et al., 2013) that suggest patients who subscribe to biological explanations for their depression are less likely to see value in psychotherapy and more likely to be pessimistic about recovery. Thus it is possible that dissemination of a more holistic view of depression, such as that offered by the biopsychosocial model (Schotte et al., 2006), could be useful to guide the process of psychoeducation and treatment for depression.

Further, this study contributes to the growing body of research on the role of agency in recovery from mental health problems, such as depression, which has several implications for clinicians working with depressed clients. Notably, it draws attention to the potential for antidepressants to be used positively as a 'tool' to strengthen agency and facilitate recovery via symptom relief, whilst recognising a possible negative impact on recovery by disempowering clients and/or prompting disengagement from therapy, which in turn could

prevent clients from addressing the underlying causes of depression and acquiring coping skills. It is important for clinicians to be aware and sensitive to this dilemma when working with depressed clients, particularly considering that feeling disempowered and lacking agency is characteristic of depression.

In response, the study offers a number of suggestions to mitigate the risk of clients' disengagement from therapy as well as to strengthen client agency, whether on or off antidepressants. Firstly, it supports clinicians to encourage clients to take an active role in their treatment. This can be facilitated by a process of informed decision-making, which involves providing clients with balanced information on the treatment options and respecting their treatment preferences and decisions. Secondly, it highlights the importance of explaining the role of both antidepressants and therapy, but most importantly emphasising the active role of the client in recovery, thereby strengthening the client's belief in their ability to change, and instilling hope. To this end, it could be useful to present antidepressants as part of the solution for some people while emphasising the importance of gaining insight into depression and learning skills so the client is better able to manage their mood and cope in the future. Regarding clients who are on antidepressants, the study draws attention to the importance of addressing unhelpful attributions and emphasising changes made by the client over and above taking antidepressants, so that progress is viewed as resulting from their own efforts (Sparks et al., 2010).

The study also has implications for psychology training programmes and psychologists working in public mental health teams. The findings suggest that it could be useful to educate trainees specifically around how to strengthen client agency, particularly when antidepressants are involved. The importance of enhancing client agency and teaching this in psychology training programmes reiterates points raised by other researchers (Angus & Kagan, 2007). Further, the study raises awareness of the frustration and difficulty many psychologists appear to experience due to working in a medicalised system that at times undermines their work with clients. In order to counter this, increasing professional support amongst psychologists as well as providing professional development around how to manage the dominance of the medical model within their work contexts could be beneficial.

Limitations

This study offers a new and important perspective on the treatment of depressed clients. Although a range of participants, representative of the body of clinical psychologists in New Zealand was sought (e.g., across gender and work context), the lack of diversity in ethnicity and regions outside of Auckland is a limitation. The psychologists were not asked to identify their own ethnicity, as it was largely assumed that diversity would be represented by the various clients they work with. However, it is possible that psychologists working for specialist cultural services, such as Māori or Pacific Island, may have different perspectives and experiences of antidepressant treatment for depression. Further, the study only recruited clinical psychologists, as they were considered to have experience in treating depression across both public and private settings. However, it is possible that psychologists of other specialities, such as health or counselling, may offer a different perspective.

Another limitation of this study is that the perspectives of other relevant parties, such as patients or other mental health professionals, were not considered, limiting the application of the findings as it cannot be assumed that the views and experiences of these psychologists are representative of the other parties involved. It is also worth noting that the psychologists' views and experiences of antidepressant treatment may be negatively inclined due to the current practice of prescribing antidepressants as the first line of treatment for depression, which could result in psychologists being more likely to see clients for whom antidepressants have not been successful. Further, the purpose of this qualitative study was to develop an in-depth understanding of psychologists' views of antidepressants given their experience of working therapeutically with depressed clients, thus although it offers an important perspective on antidepressant treatment for depression, it does not provide information on the relationship between antidepressant treatment and wellbeing or recovery from depression.

Future research directions

Given the findings of this study, future research that seeks to clarify the relationship between empowerment and recovery from depression, including the role of antidepressants, would be useful. This would require the use of assessment tools aimed at

measuring wellbeing and sense of agency as well as those focussed on depressive symptomatology. In addition, it would be useful to include long-term analysis of clients' level of dependence on antidepressants and ability to maintain wellness following discontinuation of antidepressant treatment. Related to this, it would be interesting for future research to examine the effect of 'belief in the medical model of depression' on recovery, most importantly recovery off antidepressants. Furthermore, in order to deepen our understanding of the relationship between antidepressant treatment, empowerment and recovery from depression, qualitative analyses of the views and experiences of patients and psychologists on this topic would be beneficial, specifically around the elements that contribute to recovery from depression, both on and off antidepressants.

Conclusion

This study offers a new perspective to the field of research on treatment for depression, specifically the role of antidepressants in clients' recovery from the perspective of clinical psychologists. The psychologists described a number of experiences that influence their views about antidepressants and the approaches they adopt when working with depressed clients. Firstly, the dominance of the medical model of depression in the mental health system prioritises antidepressant treatment and considers psychological treatments secondary, which is not in line with evidence or the practice guidelines. The psychologists believed the passivity of this approach could disempower clients from changing and interfere with their recovery from depression. Secondly, the psychologists' work context – private or public – shaped their views and approaches towards treatment of depressed clients, with public sector psychologists adopting a more open and accepting stance towards antidepressants compared with private psychologists. This seemed to relate primarily to differences in the complexity and severity of the cases they encounter. Thirdly, the psychologists drew on their experiences and views of both antidepressant treatment and psychotherapy when making decisions about antidepressants. There was a general consensus that antidepressants were an important treatment option with severe depression when therapy did not appear to be sufficient, and could be used as a 'tool' to facilitate recovery via symptom relief, yet could also compromise recovery by disempowering clients from changing and/or prompting disengagement from therapy. The psychologists believed

this could prevent clients from addressing the underlying causes of depression and acquiring coping skills, which left them vulnerable to relapse in the future. Fourthly, the psychologists recognised the influence of the client, including their beliefs/attitudes and circumstances/personal attributes on the process and outcome of both antidepressant treatment and psychotherapy. Overall, these four areas informed the approaches adopted by psychologists in relation to antidepressant and/or psychotherapy treatment for depression, which centred on client wellbeing and involved balancing a desire to empower the client with the importance of being pragmatic, given the limitations of the mental health system and consideration of the client. This involved using their clinical judgement, based on research and experience, to make informed decisions aimed at improving client wellbeing, given the unique qualities of each case.

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Appendix A – Advertisement



Are you a Psychologist who has worked with adults on antidepressants?

My name is Jacinda Calkin and I'm a student in the Clinical Psychology doctoral programme at the University of Auckland.

I'm looking for experienced Psychologists (5 years post-graduation) to take part in an interview study, which is investigating

Psychologists' views and experiences of working therapeutically with clients on antidepressants

We would like to understand your views on the pros and cons of antidepressants – the benefits, the side effects, long-term use and withdrawal, and the interaction with therapy.

The interviews will take up to 40 minutes and can be face-to-face or by telephone or Skype.

For further information or to participate in this study, please contact Jacinda Calkin at jhar332@aucklanduni.ac.nz

This study is being conducted by Clinical Psychology Doctoral student, Jacinda Calkin (jhar332@aucklanduni.ac.nz) and supervised by Dr Claire Cartwright (c.cartwright@auckland.ac.nz) at the University of Auckland.

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 26 June 2013 FOR THREE YEARS until 26 June 2016.
REFERENCE NUMBER: 9691

Appendix B – Participant Information Sheet



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Auckland 1072, New Zealand
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The University of Auckland
Private Bag 92019
Auckland 1142, New Zealand

A Qualitative Investigation of Psychologists' Views and Experiences of Working Therapeutically with Clients on Antidepressants

PARTICIPANT INFORMATION SHEET

Researcher:

Jacinda Calkin
Clinical Psychology Doctoral student

Supervisors:

Primary: Dr Claire Cartwright
Secondary: Dr Kerry Gibson
School of Psychology
University of Auckland

My name is Jacinda Calkin and I am currently completing a doctorate in Clinical Psychology at the University of Auckland.

This study focuses on understanding more about the experiences and views of psychologists who work with adult clients using antidepressants, in order to better understand the benefits and the negative impacts of antidepressants on clients and on therapy, as well as any dilemmas that psychologists experience in regard to antidepressant treatment. Participants in the study will be psychologists, with a minimum of five years' experience.

We believe it is important to understand more about experiences of antidepressant use, as previous research suggests limited effectiveness of antidepressants for mild to moderate depression, and indicates that some people experience difficulty stopping antidepressants and/or negative side-effects while on antidepressants. Despite this, the number of people using antidepressants continues to rise.

You have been sent this Information Sheet as you have shown interest in the study. If you are a psychologist with experience of working with adults on antidepressants and a minimum of five years' experience, we invite you to take part in this study, although you are under no pressure to do so. If you do take part you will be asked to complete an interview in

a location of your choice or via telephone or skype. Interviews will last up to 40 minutes. Fifteen to 20 psychologists will be interviewed.

During the interview you will be encouraged to talk about your experiences of working with clients who are on antidepressants. I am interested in your views of any benefits or negative effects that clients experience from antidepressant treatment; the circumstances when you would or would not recommend antidepressants for treatment of depression; long-term use and withdrawal from antidepressants by clients; and any dilemmas that you experience in regard to working therapeutically with clients on antidepressants. If you discuss experiences of working with clients, care will be taken to make sure that no clients are named or identities revealed. The emphasis will be on your views of whether antidepressants are helpful or not, and in what circumstances.

The interviews will be digitally recorded and transcribed by a professional transcriber who will sign a confidentiality agreement. Your name will not be used on the recording and your identity will be protected. Each recording will be assigned a number and the identity of the numbers will be stored in a separate location so that individual recordings cannot be identified. If you decide you wish to withdraw from the interview, you can do that. You can withdraw data up to a month after the interview. This data will be destroyed if you request it.

If you do take part in the study, the recordings will be stored on a locked University of Auckland computer that is password protected and the transcripts will be stored in a locked cabinet at the University of Auckland by Jacinda Calkin. The data will be kept for ten years. All data will then be destroyed when ten years has elapsed. The results from this study will be published in New Zealand and in International Research Journals. However, no individuals will be identifiable in any publications. If you take part in the study, you can request a report on the results of the study and this will be sent to the contact address that you provide.

Researcher	Supervisor	Head of Department
Jacinda Calkin School of Psychology University of Auckland Email: jhar332@aucklanduni.ac.nz Ph: 0212648127	Dr Claire Cartwright School of Psychology University of Auckland Email: c.cartwright@auckland.ac.nz Ph: 3737599 x 86269	Assoc Prof Fred Seymour School of Psychology University of Auckland Email: f.seymour@auckland.ac.nz Ph: 3737599 x 88414

For ethical concerns contact: The Chair, The University of Auckland Human Participants Ethics Committee, The University of Auckland, Research Office, Private Bag 92019, Auckland 1142. Telephone 09 373-7599 extn. 87830/83761. Email: humanethics@auckland.ac.nz

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 26 June, 2013 for 3 years until 26 June, 2016. REFERENCE NUMBER 9691

Appendix C – Consent Form



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A Qualitative Investigation of Psychologists' Views and Experiences of Working Therapeutically with Clients on Antidepressants

CONSENT FORM

THIS FORM WILL BE HELD FOR A PERIOD OF TEN YEARS

Researcher:

Jacinda Calkin
Clinical Psychology Doctoral student

Supervisors:

Primary: Dr Claire Cartwright
Secondary: Dr Kerry Gibson
School of Psychology
University of Auckland

I have read the Participant Information Sheet and I have understood the nature of the research. I have had the opportunity to ask questions and have them answered to my satisfaction.

- I agree to take part in this research.
- I understand that my participation is voluntary and that I am free to withdraw at any time, and to withdraw any data traceable to me up to a month after the interview.
- I agree to be digitally recorded.
- I wish / do not wish to receive the summary of findings.
- I understand that a third party who has signed a confidentiality agreement will transcribe the recordings.

- I understand that data will be stored in a secure location at the University of Auckland by Jacinda Calkin.
- I understand that data will be kept for ten years, after which they will be destroyed.
- I understand that all of the data provided by me will be treated confidentially and that my anonymity will be protected.
- I understand that the results from this study will be published in New Zealand and in International Research Journals.

Name: _____

Contact address: _____

Signature: _____

Date: _____

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 26 June, 2013 for 3 years until 26 June, 2016. REFERENCE NUMBER 9691

Appendix D – Demographic Form

Name: _____ Date: _____

Age: _____

Gender: _____

Number of years practice: _____

Current/previous places of work: _____

Main therapy approaches: _____

Appendix E – Interview Schedule

I'm interested in hearing about your impressions and experiences of client use of antidepressants for depression, and I have some questions to guide that, but as we go please feel free to talk about other areas that I haven't asked about. Also, throughout the interview I'll ask you to speak generally about your experience, however I'll also ask whether you can think of some specific examples of therapy and clients, without giving names, to illustrate what you're saying. This will help give us a clearer picture of these experiences. Hopefully this will make sense once we get started. Do you have any questions?

- *The benefits and negative effects, if any, that clients experience from antidepressant treatment for depression*
 - Generally when antidepressants work well for a client, what are the main things that you notice?
 - Are you able to think of one client in the past – without mentioning their name – who found antidepressants to be helpful, and could you talk a bit about how the client was and the effects of the antidepressant? (Prompt: what was happening for the client? How did the antidepressants help?)
 - On the other hand, what are the main things that you notice when antidepressants are unhelpful or detrimental to a client? (Prompt: what do you notice about side effects for clients? What is most common?)
 - And can you tell me about a time in which a client found antidepressants to be unhelpful or detrimental?
 - Now we'll turn to talking about the impact of antidepressants on therapy. Generally, in what ways do antidepressants assist therapy progress?
 - And can you tell me about an example of therapy in which antidepressants assisted progress?
 - On the other hand, in what ways can antidepressants be unhelpful or detrimental to therapy progress?
 - Can you tell me about an example of therapy in which antidepressants were unhelpful or detrimental to therapy progress? (Prompts: can you explain your thoughts around whether people are better off with or without antidepressants when in therapy?)
 - When you think of clients who go on antidepressants compared with those who don't, what are some of the differences that you see? (Prompt: what about in terms of progress with therapy?)
 - Have you noticed any cultural differences in terms of how people respond to antidepressant treatment?

Prompts to keep in mind:

- Can you think of a time in the past where this has arisen with a client, just so that I can understand more about what happens?
- If they discuss the difficulty of determining whether it is the antidepressant or the therapy that is working, ask: how does this affect the client, the therapist and therapy?
- *The circumstances, if any, when clinical psychologists would or would not recommend antidepressants for treatment of depression*
 - Under what circumstances with clients, would you discuss the possibility of them going on an antidepressant? (Prompt: On the other hand, when would you consider antidepressants to be inappropriate?)
 - Does this in any way relate to the severity or chronicity of depression?
- *Long-term use of antidepressants by clients and their withdrawal from antidepressants*
 - Have you noticed any problems with long-term use of antidepressants, either on health or on the person psychologically?
 - Can you describe any experiences of long-term users trying to come off antidepressants? (Prompt: what about psychological dependence? Do you see this playing a role in long-term use?)
 - What do you notice with withdrawal effects for clients?
- *Causes of depression*
 - What is your understanding of the main causes of depression?
 - Some people argue that depression is a biological illness or on the other end purely the result of psychosocial factors, where would you sit on that continuum? What are your thoughts about it?
 - What is the effect on clients in believing that depression is biologically rooted?
- *The dilemmas, if any, that clinical psychologists experience in regard to working therapeutically with clients on antidepressants*
 - Are there any dilemmas you experience around decisions regarding whether or not a client would be advised to go on antidepressants?
 - Ideally what role would you like to see psychology and psychologists having in the future in regard to antidepressants and the treatment of depression?