Academic/Research Article

Working therapeutically with clients taking psychotropic medication: Is it a help or hindrance?

By Grushenka Arnold

Although prescribing medication does not fall under the remit of counsellors and psychotherapists, it is essential that we have a basic understanding of how psychotropic medication may affect the therapeutic process

Introduction

The utilisation of psychotropic medication (PM) within the mental health care field has changed considerably over the past 25 years (Angermeyer, Auwera, Matschinger et al, 2016). PM is a broad term that refers to medications that affect behaviour, mood, thoughts or perception. Continual innovation and research have divided both professional and public opinions on the use of PM when offered as an effective treatment option (Purdy, Little, Mayes & Lipworth, 2016).

At the turn of this century, a new trend of prescribing medication for numerous conditions developed; if there was a condition, there was a medication for it, says Hart, (2000). Such conditions include social phobia, eating disorders, premenstrual syndrome, depression and anxiety. Discussions relating to prolific prescribing were encouraged in order to urge experts to be mindful and consider both the associated risks and benefits of prescribing such medications (Hart, 2000).

This article explores the question should counsellors and psychotherapists have an informed understanding of psychotropic medication and introduces a small-scale study of accredited therapists and their views and experiences of working with clients taking PM and its impact on the therapeutic process.

Types of PM

Types of PM can be grouped into various classes depending upon the ailment it is intended to treat, for example, antidepressants for depression, antipsychotic medications for psychosis, anxiolytics for anxiety and mood stabilizers "… including lithium, lamotrigine, carbamazepine, and valproate for diagnosis such as bipolar disorder (BD)" (Olfson & Marcus, 2010, p. 1457). Prescribing PM for people with BD can be a complex process because the same medication used to treat depressive symptoms can induce mania. On the contrary, medication used to reduce mania may cause 'rebound' depression (Geddes & Miklowitz, 2013).

According to Veseth et al. (2019) therapists describe the process

of working with individuals taking PM as challenging at times. This is because some individuals may be resistant to taking medication as they do not want to take it, or they may be non-compliant and not take it when it has been prescribed. Further, pharmacological interventions are central to clinical work when working with individuals with BD. One therapist described the use of medication as the "bedrock of therapy" when working with individuals with BD (Veseth et al, 2019, p. 69). This is because, the authors noted, therapists' accounts of working with individuals without PM included some individuals terminating therapy too soon, having to be hospitalized, engaging in self-harm or dying by suicide in the absence of medication. With these factors in mind, lithium was a major factor in a positive treatment outcome in one of the therapist's experiences, as it anchored the individual with BD (Veseth et al, 2019).

Winters (2000) argues that while not every individual that presents for treatment requires medication, it may be necessary in some instances. Chemical changes are needed to alleviate severe depression and cannot be achieved by some individuals on their own. Thus, medication can be helpful in facilitating a positive change (Winters, 2000).

A study by Niven, Goodey, Webb, & Shankar (2018) demonstrates the prolific prescription of PM in the absence of multi-disciplinary teams (MDTs) with individuals displaying challenging behaviours. They suggested that clinicians are quick to prescribe rather than explore other options that may be more beneficial in terms of treating mental health issues. Their research highlights the importance of MDTs when exploring an individual's treatment options – it underpins the importance of professionals coming together with different skill sets to optimize treatment options.

Results demonstrated that the therapists that had participated in the survey would welcome guidance in terms of how best to work with clients taking PM or psychiatric drugs that have been prescribed for a particular disorder

Psychotropic medication, psychotherapy or both?

Cuijpers, Reynolds, Donker, Li, et al. (2012) found that medication was more efficacious than psychotherapy for individuals presenting with dysthymia (persistent depressive disorder), postnatal depression and depressed women experiencing infertility. Interestingly, they found combined treatment demonstrated no significant difference. However, this study focused solely on short-term outcomes (Cuijpers et al, 2012).

Some studies have indicated that in cases of acute treatment of depression, research has demonstrated cognitive behavioural therapy (CBT) to be efficacious and have an 'enduring effect' as an alternative to individuals taking medication, whereas medication did not indicate efficacy over a period of time (Driessen & Hollon, 2010). CBT with medication combined demonstrated efficacious treatment for individuals with BD (Driessen & Hollon, 2010).

Thibodeau, Quilty, De Fruyt, et al. (2015) conducted a randomised double-blind study exploring the efficacy of two antidepressant medications and three approaches to therapy (CBT, psychodynamic and supportive therapy) over a six-month period. Findings demonstrated that both psychotherapy and PM together were an effective treatment when examined over a period of six months or more. (Thibodeau et al, 2015). However, this research was limited in both the number of antidepressants and the forms of therapy.

Pharmacotherapy as part of psychotherapy training

King and Anderson (2004) claim that the use of PM together with therapy is the "standard of care for many mental health disorders" (p. 329). Thus, psychotherapists must understand the impact that PM use may have on therapeutic outcomes. The authors comment that it is not sufficient to have an awareness of PM and its effects and suggest psychotherapists must be educated on pharmacotherapy at master's level (King & Anderson, 2004).

Interestingly, Aston et al. (2021) point out that the BPS (British Psychological Society) require that doctoral training courses in clinical psychology include training in psychopharmacology so trainees have an awareness of the "impact and relevance" (Aston et al, 2021, p. 360) of medication and other approaches from a multi-disciplinary perspective. The researchers continue that courses can vary in terms of the material they teach related to PM.

Survey findings by Aston et al. indicate that 98% of participants (clinical psychologists) had involvement in their client's use of PM, despite the fact that only 49.7% of respondents had attended specific training related to PM.

A survey by Blair et al. (2021) was carried out on 1,230 therapists in the UK. Results demonstrated that the therapists that had participated in the survey

would welcome guidance in terms of how best to work with clients taking PM or psychiatric drugs that have been prescribed for a particular disorder.

Benefits of training

Training in psychopharmacology allows the therapist to be aware of what to look out for when working with a client. These may include benefits, values, medication compliance, side effects, dosage adherence, medication change/alteration and other poly-drug use not disclosed i.e., drugs and/or alcohol (King & Anderson, 2004). Most recent research indicates that up to 2019, there was little guidance offered to psychotherapists in terms of how best to support clients who are prescribed PM and how best to navigate a range of issues that may arise (Blair et al, 2021). Guy, Davies, et al. (2019) published *Guidance for Psychological Therapists*, which may have been hugely beneficial to many therapists. Interestingly, in the survey by Blair et al. (2021), the researchers reported that one in five therapists felt inadequately trained when topics arose around PM from clients. Results from their study also demonstrated the importance and need for training in PM for therapists.

Becoming unstuck

According to Hart (2000), one benefit of taking PM is that it may facilitate an individual to become unstuck and allow them to advance through their therapeutic process and overcome obstacles that may have been compounded by anxiety or depression. PM can initiate and influence chemical changes within the brain required to lift the individual out of depression, although side effects from taking PM can be uncomfortable and unwelcome (Winters, 2000).

The first key theme identified was the lack of modules offered academically to inform therapists and equip them with knowledge regarding PM

However, side effects from PM can be a welcome alternative to the symptoms of the ailment being experienced (Winters, 2000). Further research is required in order to explore the potential impact taking certain medication may have over a long period of time (Cartwright et al., 2016).

The present study

For this article a study was undertaken to explore psychotherapists' experiences of working therapeutically with individuals taking psychotropic medication, and to explore if it is a help or hindrance to the psychotherapeutic process. Four fully-accredited therapists, all with a number of years' experience ranging from five to 25 years in practice were invited to participate in this study (Therapist 1, 2, 3, 4 = T1, T2, T3 and T4).

The research was a qualitative design using semi-structured interviews to gather psychotherapists' experiences of working with individuals in practice that are taking, or may have taken, PM in the past. Interpretive Phenomenological Analysis (IPA) was implemented in order to analyse and explore data for superordinate and subordinate themes (Smith, Flowers & Larkin, 2009). Emerging and recurring themes were analysed and coded (with descriptive title and numbers) (Leech & Onwuegbuzie, 2007).

The types of medication the therapists had experience working with included selective serotonin reuptake inhibitors (SSRIs), mood stabilisers, anti-anxiety medication, anti-depressants, anti-psychotics, sleeping tablets, illicit drugs bought on the street, 'over the counter' medication and caffeine tablets/energy drinks.

Superordinate/key themes and sub themes

Findings from the therapists' experiences were organised into five superordinate themes: 1) Modules on PM not part of training; 2) Presenting issues/symptoms and diagnosis; 3) Types of medication prescribed; 4) Therapists' beliefs and understanding of PM; and 5) Experiences working with clients taking PM.

Modules on PM not part of training

The first key theme identified was the lack of modules offered academically to inform therapists and equip them with knowledge regarding PM. All four therapists encountered individuals either taking PM or had worked with individuals taking PM in the past. Only one therapist had covered modules on PM during training. T4 explains that they "didn't really pay attention in training, because it didn't feel relevant at the time … because as psychotherapists, we do not prescribe". Not having more in-depth knowledge about medication was one of the biggest obstacles facing this particular therapist.

Autonomous learning

An interesting sub theme found within the data was how therapists navigate obtaining knowledge of PM and how it works. It emerged that if a client presents and they are taking PM for a particular issue, the therapists would then 'Google' the medication to get a better understanding of what the client might be taking and what it is specifically used for (T1, T2, T3).

T2 stated: "We are not educated on medication". Thus, there is a requirement for autonomous learning on the part of therapists. According to T3, there are an "awful lot of clients" presenting who are taking PM. Due to limited training, T2 felt that as therapists, we are "going through the dark" when it comes to knowledge on PM.

T1, T2 and T3 suggested that CPD courses, or modules on training courses, would be helpful to gain some understanding of the use of medication within psychotherapy. T3 said when a client came in to a session and had a "list of medications" they "had no idea what half of them were; I had no idea how they worked together, which is something I still find quite difficult to get my head around and fully understand". The consensus from the surveyed therapists revealed that when the issue of medication arose it created internal conflict.

T4 spoke about their "self-doubt" and disclosed they often wondered "Am I able to help them? Am I doing all I can? Am I a good enough therapist? Am I helping this person at all?" T4 continued: "It would be helpful to know how medications work and what the potential side effects are. If someone is thinking of taking medication, it would be helpful for us to know what to expect and how it might impact the therapeutic work". Similarly, T3 spoke about their own "inner critic" when in the room with a client and doubting themselves when it came to knowledge of PM. T3 described experiencing "imposter syndrome" in the early days of practice, because they felt they did not know enough about medication to support the individual at the time.

T4 explains their experience with an individual on medication for a long period of time: "If a client has been on medication for some time and it might not be working, I'm a bit drowning in a sense because I don't really know what to say and just refer them back to their GP."

Some clients did not want to take medication or be "seen to have a mental health disorder" when they had come to therapy for a different reason

Presenting issues, symptoms and diagnoses

T1 detailed working with an individual with "really bad anxiety" that was prescribed anti-anxiety medication by their GP. In this case the medication did not agree with the client and the prescription was changed by their GP. T1 felt that there was a noticeable change five weeks into the therapy as the individual presented as "more stabilised". The therapist noticed that a mild dose of anti-anxiety medication helped the client "slow down" and it had "taken the edge off". In this instance the therapist felt PM had "lifted" the client so they were able to function, calm down and take back control. This aligns with research by Hart (2000), demonstrating that medication supports the individual to become 'unstuck'.

Resistance to taking PM

Participants detailed their experiences of client resistance to taking PM if it was prescribed by their GP. T4 explains that some clients did not want to take medication or be "seen to have a mental health disorder" when they had come to therapy for a different reason, for example, relationship break-up, personal development, values exploration, intrapersonal conflicts, interpersonal relationships and family dynamics, which in some instances led to depression.

In T4's experience, clients also did not want to be "labelled". T2 noted from their own experience: "It's not so much the actual PM helping or hindering the process, but more so the labels placed upon individuals that might help or hinder."

Side effects

T2 noticed that individuals can be reluctant to take PM because of the side effects. The therapist added that some people do need medication and can take PM short-term or long-term depending on the symptoms or diagnosis they have been given. T2 explains that in their experience, talk therapy is always more effective in terms of outcomes.

T1 described working with an individual with debilitating anxiety that was also experiencing depressive symptoms and this was "getting in the way" of doing the work. When prescribed anti-anxiety medication from their GP, this helped to "lift" the client's mood. PM supported the individual in accessing that part of them that was required to work through their own process. In this instance, it was found that medication helped. It is worth keeping in mind though, that while PM can help in some instances, T2 observed that the side effects of medication exacerbated one individual's anxiety symptoms.

T2 spoke about their experiences with clients presenting with side effects from anxiolytic medication – medication that reduces anxiety – that were "keeping the anxiety alive" for one client. In this instance, anxiolytics appeared to increase anxiety and caused leg/limb tingling in one of their clients, adding further stress to their daily life. T2 continued that in their experience it was a case of "the worse the condition, the more the medication" and revealed one client

had overdosed on their medication because they were feeling suicidal. With this in mind, T2 explains: "I always refer back to the GP … because we are not equipped to understand these medications."

T2 also recalls a client experiencing disassociation because of the amount of medication they were on, noting that one client had contacted them out of hours and did not remember doing so.

Medication 'masking' problematic issues

T1 spoke of a crossover between therapy and medication; PM can be an extra support, but it was found that it can also "mask" something else. In one instance, T1 recalls a client who came to therapy for support for heightened anxiety. It transpired that the client was drinking 15 cans of energy drinks a day. T1 described this as something they may have missed because the client may not have disclosed this organically; in this case it was disclosed during exploration and conversation. The therapist explained how this impacted them, as they questioned themselves internally: "How am I supposed to work with that?" Again, this demonstrates the need for sufficient training and knowledge on what to look out for.

Therapists' beliefs and understanding of PM

T1 and T3 both describe PM as "another tool in the box". PM can be a "facilitator" and the use of PM and therapy used together can be viewed as a "dual relationship" (T3), which ultimately may support the individual through their own process.

PM has its place

A common sub theme among all four therapists was that medication "has its place" along with its "pros and cons" (T1).

Another challenge described was the risk of an individual taking street drugs or engaging in recreational drug use

T2 described their beliefs as "adaptable", but also felt that a client is better trying the process of therapy without the aid of medication first, so as to avoid the possibility of learning being compressed in some way. If a client is struggling, and depending upon their individual process, referral back to their GP is always recommended.

Therapist experiences of working with clients taking PM

T1 and T3 narrated their own personal experience of anxiety and panic attacks, which informed their own understanding and beliefs. When asked what informed their own beliefs about medication T1 explains: "Probably my own experience because there was a time where I went through really bad panic attacks; it was related to something that was happening in my life at the time. I was getting them at night time … and [they were] really scary'. I was finding it difficult to function during the day because I wasn't sleeping." Following a visit to their GP, T1 was prescribed sleeping tablets. Although they knew they had them, they never took them, but the idea that they were there in case they could not sleep was enough to settle their racing mind. Having this experience encouraged T1 to read more about medication in relation to its use for anxiety management.

It was found that autonomous research and attending personal therapy was also influential in terms of learning about PM (T1, T3). T4 found that a big challenge for them is "not knowing enough about medication". T3 spoke about the challenges they faced when working with individuals taking PM – the biggest being personal bias and judgement. T3 explained that their own judgement and bias can be a challenge "because of how fast some GPs prescribe medication after speaking with an individual for such a short space of time". This aligns with research by Niven et al. (2018) that GPs can be too quick to prescribe. T3 describes a time they were in university and a friend was going through a difficult time. Following a visit to the GP, the friend was prescribed antidepressants after only speaking with the GP for 10 minutes. T3 was surprised with how quickly the prescription was issued without further exploration of any mitigating factors that may have been affecting their friend. T2 also felt that GPs were "quick" to prescribe because they are working from a medical model.

Another challenge described by T1 was the risk of an individual taking street drugs or engaging in recreational drug use, for example, anxiolytics or cocaine, and then going 'cold turkey' after using it for a sustained period of time. Although the therapist did not work specifically with addiction, they were able to implement a different approach (harm reduction) in order to address underlying concerns that were leading the individual to opt for illicit 'street bought' drugs in the first place.

Therapeutic setting

T3 and T4 both work in private practice and clinical settings e.g., mental health facility/hospital setting. In private practice, individuals were generally on a low dose of antidepressants or anti-anxiety medication, says T4. This did not appear to have a direct effect on the sessions, or on the process itself (T3 and T4). However, working in a hospital

setting, where there were more complex diagnoses, the dose was sometimes higher depending on the individual, says T4. In these cases, both therapists felt that there was a lack of engagement from the client and a sense that the client was not fully present. T4 found that in community settings, individuals might present with anxiety or depression, but in a hospital setting they were inpatients because of a psychiatric diagnoses. For example, one individual they were working with was diagnosed with schizophrenia; the medication they were taking, the therapist felt, was affecting their ability to focus and be "present".

Conclusion

Although counsellors and psychotherapists do not prescribe medication, it is an issue that frequently arises in the therapy room. One would be remiss not to draw attention to the need to advocate for modules on PM being part of all psychotherapy training.

Overall findings of this research indicate that all four therapists felt that PM did not hinder the therapeutic process in general. It was also found that therapists felt it had no effect on overall outcomes for the majority of clients. Further, in most cases therapists stated that, in their experience, PM helped the therapeutic process.

Proficient knowledge around PM would enhance confidence in some therapists, eliminating self-doubt and encourage them to perform to the best of their ability in practice. Robust modules related to pharmacotherapy and psychopharmacology are of paramount importance and should be included in curricula during psychotherapy training. Possessing sufficient knowledge of PM is key to facilitating therapists to support clients who may be taking PM.

One must be mindful though that there are pros and cons to taking medication and, to reiterate the response of two therapists in this research "it has its place". Having knowledge and understanding of how medication can work is of paramount importance for both therapist and client in the therapeutic relationship.

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REFERENCES

Angermeyer, M., Auwera, S., Matschinger, H., Carta, M., Baumeister, S., & Schomerus, G. (2016). The public debate on psychotropic medication and changes in attitudes 1990-2011. *European Archives of Psychiatry & Clinical Neuroscience, 266*(2), 165-172. https://doi.org/10.1007/s00406-015-0660-7

Aston, A., Smith, S., De Boos, D., & Tickle, A. (2021). Do clinical psychologists have a role in clients' use of psychotropic medication? A mixed methods investigation exploring current forms of involvement. *Psychology & Psychotherapy: Theory, Research & Practice, 94*, 359-377. https://doi.org/10.1111/papt.12281

Blair, L., Heydon-Hatchett, V., Davies, G., Guy, A., & Davies, J. (2021). Therapists' perspectives on working with clients taking psychiatric drugs: Findings from a mixed-methods survey. *Counselling and Psychotherapy Research, 21*(4), 1,008-1,020. https://doi.org/10.1002/capr.12403

Cartwright, C., Gibson, K., Read, J., Cowan, O., & Dehar, T. (2016). Long-term antidepressant use: Patient perspectives of benefits and adverse effects. *Patient preference and adherence, 10*, 1401-1407. doi:10.2147/PPA.S110632

Cuijpers, P., Reynolds, C. F., Donker, T., Li, J., Andersson, G., & Beekman, A. (2012). Personalized Treatment of Adult Depression: Medication, psychotherapy, or both? A Systematic Review. *Depression & Anxiety, 29*(10), 855-864. https://doi.org/10.1002/da.21985

Driessen E. & Hollon S.D. Cognitive behavioural therapy for mood disorders: Efficacy, moderators and mediators. *Psychiatric Clinics of North America, 33*(3), 537-55.

Geddes, J. R., & Miklowitz, D. J. (2013). Treatment of bipolar disorder. *The Lancet, 381*(9878), 1672-1682. https://doi.org/10.1016/ s0140-6736(13)60857-0

Guy, A., J. Davies, & R. Rizq (Eds.) (2019). Guidance for psychological therapists: Enabling conversations with clients taking or withdrawing from prescribed psychiatric drugs. APPG for Prescribed Drug Dependence.

Hart, V. (2000). The Balance of Psychotherapy and Pharmacotherapy. *Perspectives in Psychiatric Care, 36*(2),38.

King, J. H., & Anderson, S. M. (2004). Therapeutic Implications of Pharmacotherapy: Current Trends and Ethical Issues. *Journal of Counselling & Development, 82*(3), 329-336. https://doi.org/10.1002/j.1556-6678.2004.tb00318.x

Kramer, P. (1997). *Listening to Prozac*. Penguin.

Leech, N. L., & Onwuegbuzie, A. J. (2007). An array of qualitative data analysis tools: A call for data analysis triangulation. *School psychology quarterly, 22*(4), 557.

Niven, A., Goodey, R., Webb, A., & Shankar, R. (2018). The use of psychotropic medication for people with intellectual disabilities and behaviours that challenge in the context of a community multidisciplinary team approach. *British Journal of Learning Disabilities, 46*(1), 4-9. https://doi.org/10.1111/bld.12206

Olfson, M., & Marcus, S. C. (2010). National trends in outpatient psychotherapy. *American Journal of Psychiatry, 167*(12), 1456-1463.

Purdy, S., Little, M., Mayes, C. & Lipworth, W. (2017). Debates about Conflict of Interest in Medicine: Deconstructing a Divided Discourse. *Bioethical Inquiry, 14*(1), 135-149. https://doi.org/10.1007/s11673-016-9764-7

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative Phenomenological Analysis: Theory, method and research*. Sage.

Thibodeau, M. A., Quilty, L. C., De Fruyt, F., De Bolle, M., Rouillon, F., & Bagby, R. M. (2015). Latent classes of nonresponders, rapid responders and gradual responders in depressed outpatients receiving antidepressant medication and psychotherapy. *Depression & Anxiety, 32*(3), 213-220. https://doi.org/10.1002/da.22293

Veseth, M., Stige, S. H., & Binder, P. (2019). Medicine and meaning: How experienced therapists describe the role of medication in recovery processes in bipolar disorder. *Counselling & Psychotherapy Research, 19*(1), 66-74. https://doi.org/10.1002/capr.12193

Winters, K. (2000). Why patients should take psychotropic medications. *Perspectives in Psychiatric Care, 36*(2), 38.