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The Reluctant Therapist: An examination of the therapeutic relationship and the role of the Therapist in supporting clients on medication.

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Turning and turning in the widening gyre

The falcon cannot hear the falconer;

Things fall apart; the centre cannot hold;

-W.B Yeats. The Second Coming

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Abstract

A common misconception of many talking therapies, psychotherapy included, is that the therapist is the expert in the therapeutic. However, this is recognised to be incorrect by the various psychotherapy disciplines who are in agreement that clients are the most knowledgeable experts of their lives and furthermore possess the desire and resources for self-actualisation. The role of the therapist is considered as a facilitator to assist this exploration of resources within the client to bring about change in their lives. The relationship between client and therapist is considered paramount in providing a foundation for successful outcomes in therapy. However many factors are considered to hinder this relationship. Some consider medication to inhibit emotional contact and consequently the efficacy of therapy. This paper examines the underlying aspects contributing to the perception that medication negatively impacts therapeutic outcomes. This is achieved by exploring the role of therapy as a treatment for mental health issues, the importance of the therapeutic relationship, the position of the therapist within this, and the uncertainty and resistances which contribute to reluctance in some therapists.

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CHAPTER 1

1.1 Introduction

Psychotherapy, a talking therapy of the caring and mental health profession, aims to through the creation of a therapeutic relationship, to alleviate symptoms, identify and explore causality and facilitate a process of self-actualisation in order to bring about awareness of felt limitations toward living a fuller experience of life (Rogers, 1957). Each individual experiences a number of minor and major life events and stresses as part of everyday normal life which may result in significant emotional distress. There is wide variation in how people respond to and deal with this distress. Some individuals may not cope well and may not have the social supports to assist them through these challenges. Many reach out to GPs for help. The outcome of which is usually a prescription of antidepressants (A Vision for Change 2006, p.45). A *Vision for Change* (2006) reports the prescribing of medication as a dominant feature of Irish mental health care services and that the vast majority of people who receive mental health care will at some point receive a prescription for medication (2006 p.235).

The original intention of this paper was to explore the impact that medication may have on therapeutic outcomes and to explore the effect it may have on the therapeutic relationship. This arose from an awareness that a therapist may refuse to or be reluctant to work with clients who present on medication or who continue to take medication throughout the course of the therapeutic treatment. However, as the research developed it became clear that there are many layers to consider when exploring the role medication may play within the therapeutic space. While many individuals attend therapy for a short

period and then fail to return, the onus for returning and continuing and for the successful outcome of therapy is assumed to be the client's, as it is the client who needs to be motivated to continue. However considering the importance of the therapeutic relationship, in which two contributing members explore and create meaning through language in an effort to relieve one individual of experienced distresses, the original question then broadens to consider the role of the therapist and what influence the therapist may have on therapeutic outcomes if a client is taking medication.

The topic of medication as a therapeutic treatment for mental health has been ongoing and is gaining increasing attention. There are differing opinions between and within the mental health approaches about the effectiveness of medication long term. There is a concern that antipsychotics and antidepressant drugs are increasingly being prescribed for common psychological complaints for those who may not need treatment by medication (Moncreiff 2002, Whitaker 2010, Breggin 2003). Therapists may set boundaries for themselves as to the clients with whom they may choose to work, for some there is reluctance to work with clients who are medicated, holding the belief that it should be communicated to such a client that work at depth is not possible as medication can inhibit emotional contact and consequently the efficacy of therapy, maintaining that withdrawal of drugs should be suggested (Hammersley & Beeley, 1996). Medication is considered to be a contributor or cause of 'stuckness' in therapy and therapists may place perceived limits on the capacity to which they can work with a client to this effect. However, many empirical studies have proven the efficacy of both psychotherapy and drug treatments for depression (DiMascio 1979, Antonuccio, Danton & DeNelsky, 1995) and that psychotherapy and psychopharmacology can provide positive outcomes above either treatment alone (Kahn,

1991; Weissman, 1983 in Frelmuth 1996, Carr 2007, Azzone 2010, Jindal & Thase, 2003, de Jonghe, F et al 2001).

This paper thus seeks to explore what influence or impact the therapist may have on the efficacy of psychotherapy with medicated clients by exploring the position of the therapist in therapy, the therapeutic relationship, and the dynamic of resistances and reluctances that present in psychotherapy for the therapist. Within this relationship there is dual contribution by both client and therapist; the role of the therapist is as facilitator for the learning, holding central the perceptions and experiences of the client (Rogers 1951).

Research speaks to the levels of resistance within clients, and it is widely accepted that therapists have undergone extensive analysis or personal therapy in order to absolve their personal issues from interfering within the therapeutic relationship (Fink, 1997). The impact the therapist has on the therapeutic relationship and awareness of their influence on the patient is essential for the efficacy of the therapy. The objective of this paper is to explore the therapeutic relationship and the therapist's role within this relationship. What is the impact of the therapist, a subjectivity bringing individual, on the therapeutic relationship and on the effectiveness of the therapy for the client? This will be addressed by exploring resistances on the part of the therapist within the relationship, their resistances and potential reluctance held by some, to engage in the work with certain individuals, for the purpose of this research, medicated individuals.

For the purpose of this research the terms analyst/therapist and analysis/ therapy are used interchangeably.

1.2 Why Therapy?

Mental health problems are a major national and international challenge; one in four people suffer from mental health problems (WHO, 2001), with one in five persons experiencing a depressive episode during their lifetime (HSE, 2007). According to a report by the HSE the vast majority of adults would turn to their GP as their first point of professional contact if they thought they had a mental health problem (2007).

Psychotherapy is an effective intervention for a wide range of mental health problems in people of all ages. Carr (2007) presents evidence that psychotherapy, either alone or in combination with other treatments is effective for a wide range of mental diagnoses and many studies have proven the efficacy of both psychotherapy and drug treatment for depression. The average success rate for treated cases ranges from 65 to 72% (*ibid.*, p.v). Psychotherapy is an area of the caring profession in which the general aim is to reduce mental distress, alleviate symptoms, explore a person's own resources and capacity for self-determination and ability to improve their life overall wellbeing (Roth & Fonagy 2005, ICP 2014). Humanistic psychotherapy, places the highest value on the uniqueness of each client and human potential for self-actualisation to assist in bringing about awareness of felt limitations toward living a fuller experience of potential and autonomous life (Rogers 1951, Vision for Change, 2006). Most psychotherapy models are primarily psycho-social treatments involving the use of language exchange between to individuals, a client and therapist.

Western culture has become reliant on pharmaceutical advancements and complicit in a prescriptive culture reliant on medicalised processes to cure. For many who seek help to

relieve themselves of mental or emotional distress, psychotherapy is not always the initial intervention. A reliance on psychopharmacology has led to pharma-centric practices and discourse which permeates through all fields of the mental health profession, even some psychotherapists of humanistic and integrative disciplines resort to referring for prescription (Breggin, 2003). This practice functions on the procedural approach of the medical model; presentation, examination, diagnosis, prescription and treatment (Laing 1971) based on bio-chemical theories, asserting the aetiology of psychiatric disorders as caused by biological complications. In this medical model, all mental 'disorders' are thus considered diseases of the body, implying a prescriptive treatment and certainty of a cure.

Psychotherapists are thus faced with a challenge, especially in the humanistic and integrative models, to keep central the subjectivity of the client and their experience, within the dominance of this medical discourse. Many orientations of psychotherapy have become complicit in the adopting of the procedural approach of the medical model to mental illness in the search for 'curing' (Mulligan, 2012).

The origins of any field, when it becomes legitimised, become the foundation of and fulcrum for future models (Rappaport, 1997). It is this central discipline that sets up the position of what is appropriate or inappropriate, good or bad, what works or does not (Greeson, 1967). For psychotherapy, that centre is psychoanalysis and what occurs in the work and the therapeutic relationship is based on early psychoanalytical models and methods. Approaches alter and adapt this centre model accordingly, and this straying from the origin can often be met with uncertainty, such as the active involvement on the part of the therapist. Freud and Breuer introduced the notion of talking therapies into the

psychiatric domain with the idea of allowing patients express to the analyst their innermost desires, fears and anxieties to relieve symptoms.

More recent decades have experienced a growing acceptance by doctors and psychiatrists of the benefits of psychotherapy and its contribution as a separate resource for patients. There is a wider and growing acceptance of the importance of considering and working with the client as a whole, whether physically ill, unhappy, traumatised or socially isolated. On the other side of this acceptance, there is a similar need for therapists to be more open and willing to provide therapy as part of a combined treatment approach. *A Vision for Change* purports that the ideal mental health service model should be consist of “a balanced range of options that includes medical, psychological and social interventions” (2006, p 235). This range of specific interventions should be tailored to the individual, yet each have equal importance in their treatment.

Casacalenda et al. (2002), state that psychotherapy is as effective as antidepressants, however initial response to psychotherapy may be enhanced, and the intervals between depressive episodes lengthened, if offered as one aspect of a combined treatment plan with GP or psychiatric prescription of antidepressants (Friedman et al., 2004 as cited in Carr, 2007). Medication can be the component that enables the client to leave the house and indeed to sit in the therapeutic space. As outlined in *A Vision for Change* (2006), O’Farrell (1999) similarly emphasises the importance of therapists being open to the idea of combining medication and counselling, sometimes needing support beyond the therapist’s way of working.

Psychotherapy is proven to be effective on its own and increasingly the evidence suggests that it can be equally, if not more effective when used in combination with a medicated approach. Psychotherapists thus need to adapt to and work within a biopsychosocial discourse, accepting a multimodal treatment course, maintaining congruent in their position within the relationship as a vehicle of help (Shohet & Hawkins 2006), and remaining open about their lack of knowledge with regards to other aspects of treatment such as medication. The role of the therapist to prioritise the client experiences and potential within this biopsychosocial context, and to re-emphasise the subjective story behind it all, to centralise their experiences prior to and of diagnosis and medication.

CHAPTER 2

2.1 The Therapeutic Relationship

The quality of the relationship between therapist and client is paramount to the therapeutic process and is the best predictor of therapeutic outcomes (Lambert, 1992). Integral also is empathy, provided by the therapist, not only in forming the relationship, but also in increasing client ability to feel accepted, understood, and their experiences felt validated. Bordin considers the collaboration between therapist and client as, “one of the keys, if not the key, to the change process” (Cooper & Lesser, 2011, p.33 in Lynch, 2012). In a good therapeutic relationship the therapist is empathic and collaborative, the client is cooperative and committed to recovery (Carr, 2007). Carr (2007) deduces from Bruce Wampold’s meta-analyses review in 2001 that 46-69% of the effects of psychotherapy are due to the therapist’s capacity to form relationships and specific therapeutic technique. “Clearly, the person of the therapist is a central factor contributing to the outcome of psychotherapy.” (*ibid.* p.47).

Rogers (1957) placed emphasis on the responsibility of the client, the therapist’s presence as a facilitator for this, consciously avoiding decision making or responsibility for the client. In this way, the dynamic of power within the relationship lies with the client and not with the therapist. Verhaeghe (1995) states that symptoms at some level are an attempt to heal psychological disturbance. If symptoms cannot be produced there is a possibility that psychopathological behaviours can occur. Symptoms are substitutions for repressed material and feelings and what the client does not remember will be repeated in the transference with the therapist (Freud, 1914). The aim of Person- Centred Therapy and

models of 'talk' therapy is to provide a safe, confidential and respectful relationship, within which the client can explore and empower themselves to understand, accept, transform and cope with the vulnerabilities which give rise to their difficulties. Within this context the client can begin to explore his/her relationships, and as in any other relationship, both the client and therapist will react emotionally throughout the process (O'Farrell, 1999). It is within this space that infantile attitudes and reactionary habits can be explored and also transferred inappropriately. Responsibility for the client does fall onto the therapist in this space, as they must be present to support them through the therapeutic resistance in order to reveal the true self, a process which is arduous, slow (Rappaport, 1997) and scary (Rowan 1998).

Psychotherapeutic orientations maintain that through this relationship and the medium of language the patient engages with another person. Martin Heidegger's work offered reflections on how we come to know "through shared understandings with others" (Heidegger, 1962) and maintained that "meaning emerges through language and is shared through language" (Richardson, 2003, as cited in Mulligan 2012), and so in the being with another, a responsive container, from which the work emerges. Binswanger's conceptions of individuals' subjective experiences encourages returning the focus of the relationship to the client experience to creating meaning which might otherwise be reduced to psychopathology (Smyth, 2011). Because the analyst is an active participant in this experience the patient is consciously and unconsciously perceiving aspects of the analyst, which the analyst has no way of knowing (Aron, 1991, 1996; Levine 1994; Ponsi, 2004). Interpretation offered in analysis, is a bi-personal and subjective process through which meaning emerges. This "creative expression of (the analyst's) conception of some aspect of

the patient” is as subjective as a pianist performing Mozart (Aron, 1996 p.94). The analyst carries out a task of his profession, not as a passive contribution but as a shared meaning, created through the dynamics of two people.

2.2 The Position of the Therapist

The humanistic therapist aims to provide a client-centered space in which the client can experience unconditional positive regard, from where they may achieve their potential through actualisation:

“In my early professional years I was asking the question: How can I treat, or cure, or change this person? Now I would phrase the question in this way: How can I provide a relationship which this person may use for his own personal growth?”

(Rogers, 1961/89 p.32)

Until recent decades the role of the analyst was an anonymous, neutral one (Gill 1987, Hoffman 1983, 1992) however, theorists now maintain that this position of “alleged objectivity” (Shohet & Hawkins 2006, p.8) is not possible because in the therapy the analyst is an active participant who has personality, vitality, subjectivity and expression which cannot be concealed from the client (Anastasopoulos & Papanicolaou 2004).

Maria Ponsi (2004) notes the quite recent phenomena of the acceptance and consideration of the personal aspects of the clinician, in contrast to the previously held belief and assumption this should be carefully concealed and hidden from the patient, preserving anonymity and remaining abstinent and neutral (Gill, 1987; Hoffman 1992a; Ponsi 2004).

Today many believe and maintain that this original ideal is not possible as the analyst is a personality bearing individual and an active participant within the relationship (*ibid.*). Carr (2007) reports that client recovery is dependent upon the delivery of a high quality

psychotherapy service for which therapists must be adequately trained and have regular supervision.

Richard L. Rappaport in *Motivating Clients in Therapy*, 1997 presents a case for the active responsibility of the therapist as a *motivator* in therapy which is rarely spoken about. This may be due in part to *motive* being the root of the word and concept, a *motive* of the therapist, which in the therapeutic world may be opposed to for its connotations of having an agenda or being directive in therapy, which may be different from a client's. Rappaport (1997) claims responsibility for motivation should lie with both therapist and client. In the early to middle phases of therapy, the therapist functions as a motivator, providing motivation to change. Therapists who fail to be overtly motivating often fail to reach successful outcomes with clients or may result in clients who fail to continue therapy. For most therapists, the onus of motivation to change lies within the client, and so failure of the therapy is thus assumed as the client's failure and their lack of desire to change (*ibid*).

The client, in presenting to therapy has some level self-motivation and the role of the therapist is to positively influence the client in their desire to continue until they feel supported and safe enough to motivate themselves within the work. Lacan similarly noted that if there is a desire in therapy, it is that of the analyst, not the patient, which is the driving force for the work (Fink, 1997). As previously mentioned, the process of therapy is arduous and scary. Resistance to the work presents itself when the notion of change arises. Clients tend to fear the removal of their symptom and look for any excuses to leave; this presents itself in missed sessions, showing up late, expression of reluctance to continue, and the frequent creation of superior ways their time and energy could be better spent (Mulligan 2012, Fink 1997, Freud SE XII, 1913). Their defensiveness to the work appears

to them as though the therapy is going nowhere, this can be referred to as ‘stuckness’ in therapy. Bugental (1981) refers to resistance as a “defensive wall the patient puts between himself and the threats that he finds linked to being authentic” (p.103, cited in Rowan, 1998).

It is here that the involvement of the therapist is crucial for the work to continue, the therapist must provide the motivation the client is currently lacking (Rappaport 1997), as it is the analysts desire, not the clients that supports their continuation (Fink 1997). Freud recommends here that therapists manifest a “serious interest” in patients (SE XII, P139) and “prevail on (them) to continue their analysis” (SE XII, p130 as cited in Fink, 1997). Lacan posits the “desire of the analyst” as a functional role in the therapy, as opposed to the countertransferential feelings experienced, or personal desires of the analyst. In this role, the analyst must strongly express their want and desire for the client to return and continue. Ursula O’Farrell (1999) in *Courage to Change* acknowledges that therapists too can feel the stuckness in the face of the clients fear and confusion. The therapist, though lacking in power (Rapapport, 1997), must assume the role of motivator and convey their desire for the work to continue.

CHAPTER 3

3.1 Sitting With Uncertainty

When experiencing *stuckness* or a block to the work, the therapist must be capable of tolerating the accompanying unknowing and uncertainty, and be willing to sit with it and maintain the core conditions of therapy. This ability stems from the belief and knowledge that the unknowing is part of the work, and that the experience, though uncomfortable and resisted, offers opportunities for the client to sit closely with the confusion from which the next part of the work can progress (O'Farrell, 1999). O'Farrell notes that a therapist suggesting action in these moments can portray a sense of respect for the client, *only if or contingent upon* the basis that they move in the direction suggested (*ibid. p.199*).

The *analyst desire* as perceived by Lacan, is a role to be played, as though by an actor, irrespective of their true feelings for the client (Fink 1997). The psychotherapeutic approach differs in its perspective to the clinician's role, in that the portrayal of desire for the client to return and the motivating of them to continue stems from the fundamental belief in the possibility of change. The therapist in this approach provides unconditional positive regard for the client, accepting them where they are in their experience and in a non-directive manner (Rogers, 1957).

While the psychotherapeutic approach has much in common with Lacan's concept of the *analyst desire* in that Lacan's concept requires the analyst to put aside countertransference feelings, which are of value in the analyst's own analysis but should not be revealed to the patient (Fink 1997), this is also true for the psychotherapeutic therapist to some extent. In contrast to Lacan and the analytic approach, however the psychotherapist endeavours to

remain congruent and thus open and transparent within the relationship (Rogers, 1957). This involves awareness on the part of the therapist, of their own uncomfortableness with uncertainty or unwillingness to admit not knowing, maintaining awareness of the fine line between their desires and those of the client. This level of astute awareness of self and reactions to situation and others is crucial for protection of the counsellor and the benefit of the client (O'Farrell, 1999) especially in the resistant or stuck phases of the work. Rogers' (1951) congruent therapist brings all of himself to the relationship, and does not deny any part of himself to the relationship, aware of his own defences or blocks and his own perceptions. In the belief that the client has within them the necessary means and potential for self- actualisation, this is conveyed to the client through the congruence of the therapist before them, the unconditional positive regard and the empathetic containment of the relationship.

Lacan emphasises the enigmatic desire of the analyst that does not tell the client what to do or say but simply conveys a sustained desire for the patient to continue. According to Jacques-Allain Miller (1993) this is the very force which keeps the patient returning, this enigmatic question mark left by the analyst, the not knowing, the lack in the Other (in Fink 1997). Being uncomfortable with uncertainty allows for a "climate of respect and trust between therapist and client", rather than fighting the resistance (O'Farrell, 1999). This requires trust in the process, in being vulnerable, in showing lack so that the client begins to accept themselves as the therapist has accepted him.

When traversing this stuckness in therapy, the therapist should be assured with the knowledge that this resistance and uncertainty is what is necessary, an interference in the free flow of awareness of the full creative potential of consciousness (Bugental, 1978).

Rowan (1998) suggests personifying the resistance and talking to it, to bring it into the room and give it a place and allow for a dialogue. The active role of the therapist here is crucial to encourage the engagement with the resistance, while preserving the centrality of the client and their experience. According to Brammer et al. (1989, pg 225) the goal is “not to overcome this resistance, but to explore it, because it can reveal the answer ...” (Rowan, 1998)

3.2 Who Is Resisting?

“There is no other resistance to analysis than that of the analyst” (Freud, SE III, p.60)

In the circumstances where a therapist chooses not to work with or is reluctant to work with a certain ‘type’ of individual, the questions must be asked, why them? The therapist must know, through their own personal processes and trainings that this choice is a form of resistance on their part. As previously mentioned, clients are observing the therapist, consciously and unconsciously registering therapist responses and conveyed attitudes. The reluctance or lack of desire to work with clients in certain circumstances, will intrude on the therapeutic relationship.

Stuckness in psychotherapy, according to Hammersley & Beeley (1996), is experienced when clients are unable to get in touch with their feelings despite working on presenting issues. They attribute medication to this experience in clients. Drugs and medication have a limiting capacity on the brain and alter how one feels and acts (Golombok et al.,1988) and in acting on the central nervous system can numb emotional aspects of personality, inhibiting emotional connectedness, contact with symptoms and responses considered necessary to resolve them.

From the initial encounter or revealing of medication dependency, the client will be observing the therapist reaction. If the therapist is dissatisfied or unwilling to continue, though he may do his best to conceal it from the client, the client will register what is conveyed to him. The resistance is set up in the relationship, not by the client but by the therapist. If the therapist is not congruent, he may miss this and assume resistance is with the client, or at the fault of the medication. As Freud said, “the patient’s resistance is your own” (SE III, p.60).

In certain contexts clients are offered psychotherapy as part of a multimodal programme which also includes medication (Carr, 2007). The results of a USA Consumer Reports survey of 4,100 adult psychotherapy clients concluded that patients benefited very substantially from psychotherapy, that long-term treatment did considerably better than short-term treatment, and that psychotherapy alone, regardless of the orientation did not differ in effectiveness from medication plus psychotherapy (Seligman, 1995). The report also shows similar outcomes for clients who received medication and those that did not. Multimodal programmes combining both psychotherapy and medication for certain ‘disorders’ are more effective than either treatment alone to facilitate recovery (Azzone 2010; Carr, 2007).

Considering the above information, the question remains as to why therapists are unwilling or reluctant to work with medicated clients? Hammersley & Beeley (2006) maintain there are implications when working with medicated clients as drugs can remove the symptom, preventing the clear thought process and access to feelings that are required to define and work through problems. The drugs may also mask the re-experiencing of the emotional pain as issues are worked through. However, as Rappaport (1997) maintains, in the very act

of presenting to therapy, the client has some level of motivation for the work. It is the therapist who must thus adapt to the person as a whole and their life-world experience as a whole, accepting all of them for who they are. Psychotherapists must adapt to the biopsychosocial model of treatment in which clients are negotiating their unique subjective experiences.

Guggenbuhl-Craig (1971) writing on the motives underlying becoming a therapist: “No one can act out of exclusively pure motives” (as cited in Shohet & Hawkins, 2006, p.8), there is a tendency for the therapist to become dependent on successful clients and the praise that corresponds with this, wanting the praise for success, but not the blame for failure. The reluctance to work with clients on medication may be attributed to the fear or anxiety of failing, attributing this to the medication impacting the capacity of the client to connect emotionally at the depth and successfully negotiate therapy (as desired by the therapist). Mulligan (2012), notes that Freud sympathised with the therapist and their task, “one can be sure beforehand of achieving unsatisfying results” (Freud 1937, p.377). However, if the therapist has not explored their own material, desires and motives at depth, and are dependent on the ‘success’ of their clients for self-esteem (Shohet & Hawkins, 2006) they may become the resistance within the therapy, rather than the medication (as they perceive it) holding the medication responsible for the block within the therapy and for the potential to fail.

The therapist has a responsibility to be present for the client, supporting them through resistance to reveal the true self, a process which is scary and so generally avoided (Freud SE XII, 1913, Rowan 1998).

3.3 Therapist Reluctance

For some therapists there is a reluctance to work with certain clients for varying reasons; perceived language or culture barrier, fear of working with disabilities, self-harm, certain forms of addiction or dependency including medication.

Scientific advancements in medicine have contributed to a surge in psychopharmacological treatment for mental health issues. In 2012, 2.3 million prescriptions were written for anxiety and depression drugs in Ireland (Byrne 2015). This is indicative of dominant psychiatric discourse, in which treatment is founded on the medical model: the process of assessing, diagnosing and treating biologically which has been adopted into the mental health field.

Moncreiff (2013) and Whitaker (2010) maintain that the current accepted understanding of antipsychotic and antidepressant drugs is as a treatment for a chemical imbalance in the brain, a biological irregularity that can be reversed or cured. Whitaker argues that psychiatric drugs are largely ineffective for the treatment of mental illness, though psychiatrist and psychotherapist Michael Corry (1998), considers medication “an adjunct to psychotherapy, and used judiciously can have marvellous effects” (cited in O’Farrell, 1999, p.205). There is a concern however, that antipsychotics and antidepressant drugs are increasingly being prescribed for common psychological complaints for those who may not need treatment by medication (Moncreiff 2002, Whitaker 2010, Breggin 2003). Moncreiff argues that prescription and treatment are currently based on a disease-centered model, which suggest that drugs work in the same way that antibiotics do for physical pathologies,

by counteracting the biological abnormalities in the brain that are causing the symptoms (2013).

This approach to treatment has permeated society. Antidepressants are being prescribed more frequently than counselling and psychotherapy by psychiatrists and GPs, despite psychotherapy's proven effectiveness. Breggin (2003) notes that humanistic or existential psychotherapists are increasingly likely to recommend medication or psychiatric consultation, when therapy for a particularly distressed client is not progressing. He indicates that the essence of humanistic experience is lost in the effort to fix the brain (*ibid.*). Despite this, it remains the role of the therapist to provide and maintain the core conditions of therapy, the foundation on which the therapeutic relationship can develop and from which the depth of the work can begin, maintaining a space in which the client can achieve what they wish within their capabilities as they present to therapy. Reluctance to work with medication, whether spoken or unspoken, becomes present in the relationship; therapist disbelief in a successful outcome deprives the client of the acceptance, unconditional positive regard and empathy required for the foundation of an effective relationship.

CHAPTER 4

Conclusion

The aim of this research was to explore the impact therapists have on the therapeutic relationship and therapeutic outcomes when working with clients taking medication. Some therapist may be reluctant to work with such clients. The argument for this is related to the impact medication can have on neurological and emotional senses which prevent work at depth, thus considered to impede the efficacy of therapy. It is clear from the research presented that the efficacy of therapy relies on the foundational aspect of a therapeutic relationship and that combined treatment incorporating psychotherapy and psychopharmacology can be more effective than either treatment alone.

Within the therapeutic relationship, two subjective individuals contribute to the aim of the work. Both psychoanalytic and psychotherapeutic approaches consider the role of the therapist paramount to the efficacy of the therapy. The Rogerian approach emphasises the necessity of the core conditions of unconditional positive regard, empathy and congruence for the therapeutic relationship to develop. Through this the client feels accepted, their experiences and perceptions central in the work, contained and held by a congruent therapist, they may begin to accept themselves and change. Motivation in therapy is often considered to reside solely within the client, however the mutual responsibility for a relationship to function infers the need for the therapist to motivate the client when it may be lacking in them. Resistance is also perceived as belonging to or residing within the client however the onus must reside with the analyst to convey to the client an enigmatic desire for them to continue.

If the therapist is unable to sit with resistance they themselves may resist by redirecting the therapy for their own unconscious benefit. Sitting with the uncertainty and providing a space in which the client can explore their experience of it is essential for certain aspects of themselves to be experienced, as this stuckness can provide a window into some form of meaning.

This research concludes that the therapist who is reluctant and not overtly motivating in certain client encounters may be sitting with their own resistances, fears or anxieties. This reluctance may be connected to a fear of failure, which is masked in their perception that the medication will be the cause of negative therapeutic outcome. If, as previously mentioned, the only resistance in the analysis is that of the therapist himself, and the body of research indicates that psychotherapy and psychopharmacology are effective in treating mental health issues, the role of the therapist is to offer an empathetic space for the medicated client to experience and connect with their subjective experiences as much as is possible for them. Reassured by training and depth of self-process, the willing therapist is present is not resistant to the uncertainty but is congruent and accepting of their own vulnerability, allowing for the development of a trusted relationship. The client is accepted and the potential for self-acceptance growth and change is facilitated. Without this the client cannot be heard and change cannot ensue.

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