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Exploring the Overmedicalisation of Antidepressant Medication: A Mixed-Methods Study Utilising Semi-Structured Interviews and Content Analysis

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Abstract

The medicalisation of mental health has contributed to increasing reliance on antidepressant medication across the United Kingdom, with Wales exhibiting particularly high prescribing rates. This mixed-methods study explores how future mental health practitioners perceive antidepressant use in relation to Welsh Government policy. Semi-structured interviews were conducted with four psychology students (*N* = 4) recruited via purposive sampling, and data were analysed using thematic analysis alongside a manifest content analysis of policy documents. Findings suggest partial convergence between policy and participant perspectives in valuing holistic, trauma-informed care; however, differences were identified in perceived implementation. Participants anticipated continued reliance on pharmacological approaches due to systemic pressures, limited psychoeducation, and restricted access to psychological interventions. These findings are exploratory and reflect perceptions rather than direct clinical experience. The study is limited by a small sample size, which, although appropriate for the depth required in thematic analysis conducted alongside content analysis within the given timeframe, restricts generalisability. Additionally, direct prescriber perspectives were not included due to challenges in obtaining NHS ethical approval. To address this limitation, a publicly available open letter authored by Dr Davis and fellow general practitioners was incorporated to contextualise contemporary practitioner concerns regarding the overmedicalisation of mental health in Wales. Future research would benefit from

recruiting a larger, medically oriented sample, including practising prescribers, to enhance the applicability and depth of the findings.

Keywords: Antidepressants, Overmedicalisation, Mixed-methods, Wales, Psychology, Policy

Crynodeb

Mae meddyginiaethu iechyd meddwl wedi cyfrannu at ddibyniaeth gynyddol ar feddyginiaeth gwrth iselder ar draws y Deyrnas Gyfunol, gyda Chymru'n arddangos cyfraddau rhagnodi arbennig o uchel. Mae'r astudiaeth dulliau cymysg hwn yn archwilio canfyddiad ymarferwyr iechyd meddwl y dyfodol o'r defnydd a wneir o wrth-iselyddion mewn perthynas â pholisi Llywodraeth Cymru. Cynhaliwyd cyfweliadau lled-strwythuredig gyda phedwar myfyriwr seicoleg (*N=4)* gafodd eu recriwtio drwy samplu pwrpasol, a chafodd data ei ddadansoddi gan ddefnyddio dadansoddi thematig ochr yn ochr â dadansoddiad cynnwys amlwg o ddogfennau polisi. Mae canfyddiadau'n awgrymu cydgyfeiriant rhannol rhwng safbwyntiau polisi a chyfranogwr wrth werthuso gofal holistig sy'n ystyriol o drawma; fodd bynnag, cafodd gwahaniaethau eu hadnabod mewn gweithrediad canfyddedig. Roedd cyfranogwyr yn rhagweld dibyniaeth barhaus ar ddulliau ffarmacolegol oherwydd pwysau systemig, seicoaddysg gyfyngedig, a mynediad cyfyngedig at ymyriadau seicolegol. Mae'r canfyddiadau hyn yn rhai archwiliol ac yn adlewyrchu canfyddiadau yn hytrach na phrofiad clinigol uniongyrchol. Mae'r astudiaeth wedi'i chyfyngu gan faint sampl bach, sydd, er ei fod yn briodol ar gyfer y dyfnder sydd ei angen mewn dadansoddiad thematig a gynhaliwyd ochr yn ochr â dadansoddiad cynnwys o fewn yr amserlen a roddwyd, yn cyfyngu ar gyffredinolrwydd. Yn ogystal, ni chafodd safbwyntiau uniongyrchol rhagnodwyr eu cynnwys oherwydd yr heriau'n sicrhau cymeradwyaeth foesol gan y GIG. Er mwyn mynd i'r afael â'r cyfyngiad hwn, cafodd llythyr agored a awdurdodwyd gan Dr Davis a'i gyd-feddygon teulu eu hymgorffori er mwyn rhoi cyd-destun i bryderon ymarferwr cyfoes ynghyd gor-ddibyniaeth ar feddyginiaeth o fewn iechyd meddwl yng Nghymru. Byddai ymchwil y dyfodol yn elwa o recriwtio sampl mwy, o safbwynt meddygol, gan gynnwys rhagnodwyr sy'n ymarfer, er mwyn gwella cymhwysedd a dyfnder y canfyddiadau.

Geiriau Allweddol: Gwrth iselyddion, Gor-feddyginiaethu, Dulliau Cymysg, Cymru, Seicoleg, Polisi

Introduction

Antidepressants remain among the most frequently prescribed medications in the United Kingdom, primarily employed to alleviate depressive symptoms by regulating neurotransmitters such as serotonin and noradrenaline, which influence mood and emotional functioning (NHS, 2024a). While pharmacological interventions have proven beneficial for many, contemporary research highlights increasing concern regarding the systemic overreliance on antidepressant medication as a first-line response to mental distress (Davies et al., 2023). In Wales, antidepressant use has doubled from 3.5 million prescriptions in 2010 to 7 million in 2023, reflecting a broader national trend towards the medicalisation of psychological distress (Mind Cymru, 2024). This escalation raises critical questions about whether the dominant biomedical model can adequately address the multifactorial origins of depression and anxiety. Its continued dominance may risk marginalising the psychosocial and contextual dimensions essential for sustainable recovery and holistic mental health care (Crowe et al., 2023).

Literature Review

Historically, depression has been conceptualised within a predominantly biomedical model that prioritises symptom reduction through pharmacological intervention (Edinoff et al., 2022). Conrad and Barker (2010) argue that this paradigm has accelerated the medicalisation of emotional distress, whereby experiences such as grief, loneliness, and existential anxiety are reclassified as disorders requiring medical treatment. Psychological suffering is thus reframed as pathology, reinforcing medication as the default therapeutic response and limiting scope for social or psychological explanations (Conrad & Barker, 2010). Such medicalisation, as Davies et al. (2023) note, positions patients as passive recipients of expertise rather than active agents in recovery. The implications extend beyond clinical encounters, shaping public understandings of mental health and cultural norms surrounding distress (Purebl et al., 2023).

The Welsh context offers a compelling case study. Despite the Together for Mental Health (TMH) strategy (Welsh Government, 2012b), which aimed to achieve

parity between mental and physical health, prescribing rates continue to escalate (Davies et al., 2023). The strategy's independent evaluation acknowledged progress in policy coherence but identified persistent barriers to access, including limited capacity within psychological services and long waiting times (Welsh Government, 2023). These structural limitations normalise antidepressant prescribing, as general practitioners face systemic pressure to provide immediate solutions to complex psychosocial issues (Iacobucci, 2019). Consequently, pharmacological intervention remains the path of least resistance in under-resourced primary care.

Data from the National Health Service (NHS, 2024b) indicate that 89 million antidepressant items were dispensed across the United Kingdom in 2023–2024, a 3.3% increase from the previous year, making antidepressants the most frequently issued medication class. Although England, Scotland, and Northern Ireland exhibit comparable trends, Wales demonstrates a disproportionately sharp rise relative to its population size (Public Health England, 2020; The Pharmaceutical Journal, 2018). The persistence of these trends raises pressing ethical and psychological concerns. Overprescription heightens the risk of physiological dependence and withdrawal-related distress (Cartwright et al., 2016; Muntingh et al., 2021) while simultaneously restricting access to evidence-based, non-pharmacological interventions such as Cognitive Behavioural Therapy (CBT), Acceptance and Commitment Therapy (ACT), and Mindfulness-Based Cognitive Therapy (MBCT; Beck, 2011; Liu et al., 2023).

Furthermore, Woods (2019) argues that biomedical dominance obscures the influence of trauma, socioeconomic adversity, and social isolation on mental health outcomes. In contrast, the biopsychosocial model offers a more integrative conceptualisation, situating medication within the broader psychological and environmental determinants that shape recovery (Woods, 2019). Revisions to the National Institute for Health and Care Excellence (NICE, 2023) guidelines acknowledge these complexities by emphasising gradual tapering, shared decision-making, and prioritising psychological therapies before medication. Despite these reforms, implementation remains inconsistent. Horowitz et al. (2023) contend that withdrawal management is still inadequately addressed, often leading to the misinterpretation of withdrawal symptoms as worsening depressive symptomology.

Arguably, such misclassification perpetuates unnecessary continuation or reinstatement of medication, reinforcing long-term dependency (Lewis, 2018). Limited access to psychoeducation, information on side effects, withdrawal risks, and therapeutic alternatives further undermines patient autonomy (Iacobucci, 2019).

Efforts to reform antidepressant prescribing in Wales have yielded several policy recommendations. The National Assembly for Wales (2019) report proposed nine strategies to mitigate antidepressant-related harm, including national prescribing indicators, expansion of psychological therapies, and recognition of prescription drug dependence. Nonetheless, implementation remains inconsistent, with the biomedical model persisting as the dominant framework (Boldero et al., 2024). Despite growing advocacy for trauma-informed and person-centred approaches (ACE Hub Wales, 2022), pharmacological management remains the default response. This enduring disconnect between policy rhetoric and clinical reality raises questions about the operational viability of Welsh mental-health strategies.

Arguably, addressing the overmedicalisation of antidepressant medication requires both social and clinical reform. From Maslow's (1943) humanistic perspective, antidepressants may relieve acute distress temporarily but do not meet higher-order psychological needs related to belonging, esteem, and self-actualisation. Psychological interventions, by contrast, support autonomy, resilience, and sustained personal development, principles aligned with a biopsychosocial understanding of depressive symptomology (Woods, 2019). However, in a system where access to therapy remains constrained, and funding continues to favour pharmacological responses (Wakefield et al., 2021), this imbalance risks entrenching dependence rather than facilitating recovery.

Accordingly, this study examines the overmedicalisation of antidepressants in Wales using a mixed-methods design. Semi-structured interviews with psychology students, positioned as future mental-health practitioners, are triangulated with a manifest content analysis of policy documents to explore divergences between policy commitments and operational practice. The research seeks to identify the systemic, ethical, and psychological factors sustaining high levels of antidepressant prescribing, and how these intersect with education, trauma-informed practice, and patient empowerment. By integrating practitioner perspectives with institutional discourse, the

study advances a shift toward biopsychosocial and trauma-informed frameworks that prioritise psychological well-being over medical expediency.

Method

Ethical approval was granted by the Wrexham University Central Ethics Committee (20 January 2025).

Research Design

A mixed-methods design was employed to examine the overmedicalisation of antidepressant medication in Wales, integrating qualitative thematic analysis with quantitative manifest content analysis. This design enabled triangulation between subjective perspectives and objective policy data, facilitating a comprehensive understanding of prescribing practices (Krippendorff, 2013; Braun & Clarke, 2006). The qualitative component consisted of semi-structured interviews with psychology students exploring perceptions of antidepressant use, access to psychological therapies, and systemic drivers of overmedicalisation (Appendix A). The secondary component, a manifest content analysis, examined policy and procedural documents to determine how institutional discourse represents prescribing practices, therapeutic priorities, and patient rights.

The design was grounded in a critical realist perspective, acknowledging the coexistence of systemic structures and individual experience. This approach allowed for examination of observable policy patterns alongside interpretative meanings ascribed by future practitioners.

Participants

Four psychology students were recruited from a Welsh University using purposive sampling to ensure disciplinary relevance and insight into psychological practice. Inclusion criteria required participants to be over 18 years old and enrolled in a psychology programme. Participants were excluded if they were at risk of being adversely affected by the subject matter, specifically individuals with a history of

personal or familial antidepressant use experienced as traumatic or distressing, or those currently taking antidepressant medication perceived in this way.

This exclusion criterion was implemented to minimise the risk of psychological harm. Four semi-structured interviews were conducted, a sample size appropriate for in-depth qualitative exploration and consistent with Braun and Clarke's (2006) guidance for small-scale thematic studies. The emphasis on depth rather than breadth yielded rich, detailed accounts aligned with the study's exploratory aims.

Data Collection

Semi-structured interviews were conducted online via Microsoft Teams for accessibility and convenience. Each interview lasted 25-45 minutes and followed an ethically approved schedule addressing the research aims. Questions explored perceptions of antidepressant prescribing, the availability and value of non-pharmacological alternatives, withdrawal and dependence, patient autonomy, and trauma-informed or person-centred approaches. The format ensured coverage of core topics while allowing elaboration, supporting reflective and detailed responses (Dejonckheere & Vaughn, 2019). All interviews were audio-recorded, transcribed verbatim, anonymised, and stored securely and pseudonymised.

Data Analysis

Two complementary analytic methods were employed to enable triangulation.

Thematic Analysis

Interview transcripts were analysed using Braun and Clarke's (2006) six-phase framework, which involves data familiarisation, coding, theme identification and refinement, and interpretive analysis of latent meaning. Thematic analysis was conducted in Microsoft Word, where data extracts were organised into tables, and initial codes were systematically applied using colour coding to enhance clarity and consistency. These codes were then iteratively reviewed and grouped by conceptual similarity, facilitating the development of coherent, analytically robust themes.

Thematic analysis was selected for its flexibility and suitability in capturing participants' experiences and perceptions of antidepressant use (Squire et al., 2024). The approach enabled the identification of recurring patterns while retaining contextual depth.

Manifest Content Analysis

To complement the interview data, a manifest content analysis was undertaken using Welsh policy documents published between 2022 and 2024, including reports from the All-Wales Medicines Strategy Group (2022, 2024), the National Institute for Health and Care Excellence (2022), and Welsh Government publications (2024a, 2024b). Following Krippendorff's (2013) six-stage model, key phrases and meaning units were systematically coded for frequency and categorised into subthemes reflecting institutional priorities.

Triangulation

Findings from both analyses were synthesised to identify any areas of convergence and divergence between policy frameworks and participant perspectives.

Results

This study employed thematic analysis in conjunction with manifest content analysis, thereby forming a mixed-methods design. The results of each analysis are presented separately to reflect the distinct data sources and analytical procedures. Table 1 displays the results of the thematic analysis of interview data, while Table 2 presents the findings from the content analysis of national Government and policy documents.

Thematic Analysis

Table 1 displays the seven key themes were generated through thematic analysis. These include concerns about routine prescribing practices, limited patient psychoeducation, withdrawal and dependency experiences, and systemic barriers that

restrict access to non-pharmacological interventions. Additional themes reflect limited awareness of alternative psychological roles and an endorsement of more holistic, person-centred approaches to mental health. Each theme is accompanied by corresponding sub-themes, data-driven codes, and illustrative participant quotes, demonstrating how the analysis was grounded in lived experience and perception.

Table 1

Breakdown of data generated using thematic analysis

Codes	Sub-theme	Theme	Illustrative Quote
Psychological career advice focuses heavily on clinical routes. Need for education. GP training. Structural barriers to entering early intervention roles	Lack of Accessible Pathways into Non-Pharmacological Mental Health Roles	Systemic Barriers to Psychological Workforce Readiness	“I think everyone knows about clinical psychology. Everyone knows. Everyone knows about those very competitive jobs… but that wide array of maybe a bit lower-level jobs that you can get into just after finishing your undergraduate degree - not as advertised or not as known.” “There’s so many different charities and non-profit organisations that maybe don’t require that amount of education… they’re just not advertised enough.” “Even the lecturers might not be aware of how many different paths you can take after a psychology degree.”
Call for intermediary roles. Gap in psychological services. Underuse of psychology graduates in non-clinical settings. Feasibility of	Bridging Gaps Between Support Workers and Clinical Psychologists	Demand for Intermediary Roles in Mental Health	“Yeah, I think we need to do one in the meantime, but we also need a mix of those people in and on the resources, we provide patients, especially when it comes to the mild to moderate depression... Maybe you do not need a full-on psychological assessment and clinical psychologist and psychiatrist. Maybe it's just a matter of some self-help... maybe could make quite a bit of a difference.” “Maybe you do not need a full-on psychological assessment and clinical

alternative psychological support roles.			psychologist... maybe it's just a matter of some self-help." "Having a more flexible workforce of psychology students in mental health services could make a difference while people wait for therapy."
GP time pressures lead to rapid prescribing. Medication as default first-line treatment. Suppression of symptoms over root cause exploration. Short assessments leading to automatic prescriptions. Quick fix	Pharmaceutical Normalisation and GP Time Pressures	Overprescription as a Systemic Quick-Fix	"I think people go there. The patient from the patient perspective, they think it's just the go-to kind of quick fix kind of thing. I also think that the GPs these days also think it's quite easy to prescribe or give a quick fix." "I was handed a prescription after two minutes. No conversation, no alternatives, no talk about therapy - just straight to medication." "I didn't feel like there was any real interest in the problem. It felt like a system of quick fixes and nothing else."
Unawareness of withdrawal symptoms. Big pharma. Minimal awareness of long-term effects. Lack of	Lack of Accessible Information on Side Effects, Withdrawal, and Alternatives	Insufficient Patient Psychoeducation on Antidepressants	"I think a lot of people don't get informed when they do go on the medication about how hard it could be to come off them... There's not enough psychoeducation where you learn about all of that as a patient who is on the medication." "I don't think there's enough resources for someone trying to actually come off antidepressants."

personalised education or tapering guidance			“Even when people are trying to taper, they’re not guided - they’re just expected to manage alone.”
Trapped in medication cycle. Increased withdrawal risk. Chemical imbalance worsened through dependency.	Withdrawal Symptoms and Lack of Tapering Support	Consequences of Antidepressant Dependence	“People get stuck on the medication thinking, ‘I just can’t come off it, it’s too hard.’” “Sometimes that low can be even lower than when they first started… the shift in the chemical imbalance hits hard.” “They almost feel zombified under the influence of the medication.”
Value of holistic methods. Increased awareness to reduce stigma. Lack of funding and time for alternative therapies.	Support for Mindfulness, Nature, and Early Intervention	Support for Holistic and Person-Centred Care	“Simple things like walks in the forest are great… this should be promoted more.” “What really helped me was something I don’t think a doctor would ever recommend - nature therapy and meditation.” “There are so many wonderful therapies… but it’s like there’s no funding or time for them.”
The DSM needs rewriting, Overlap in symptoms.	Perceived Diagnostic Ambiguity in the DSM-5	Critique of Diagnostic Frameworks in Mental Health	"The DSM needs rewriting... there are overlaps into far too many different mental health disorders. If you've got one thing, you could then have this, or you could have that. What actually does someone have?" "Especially when you look at the DSM-5 - it’s so broad. There's so much overlap and things like that. You can't really specialise in it all."

	"People are often over-diagnosed for things that might not actually be depression… they could be responses to past trauma, but the DSM doesn't account for that well."

Content Analysis

Table 2 demonstrates the results of a manifest content analysis conducted on key national policy documents relating to mental health and medication guidance in Wales. These include publications from the National Institute for Health and Care Excellence (2022), the All Wales Medicines Strategy Group (2022, 2024), and the Welsh Government (2024a, 2024b). The table synthesises extracted meaning units into concept codes, which were then categorised into sub-themes and overarching themes. This categorisation enabled the identification of key priorities within the policy discourse, particularly in relation to therapeutic interventions, medication safety, human rights, integrated care systems, and data-driven decision-making. The table represents a structured framework that provides insight into the policy emphasis on evidence-based practice, trauma-informed care, and equitable access to mental health support.

Table 2

Breakdown of data generated using content analysis

Meaning Units	Refined Concept Codes	Sub-Themes	Themes	Frequency Codes
Evidence-based decision making- make decisions based on scientifically rigorous and relevant evidence. Making use of the Trauma Informed Wales Framework to help everyone in Wales to understand how trauma and adversity can impact people and their role in supporting those affected by trauma. The right to good physical and mental health is one that belongs to all; it is a fundamental human right to everyone without exception.	Safety	Conditions for effective mental health intervention.	Safeguarding	74
	Support			603
	Risk			162
	Trauma			93
	Trauma-informed			32
	Evidence-based			16
	Right/s			149
	Equality			21
	Preventative			4
	Consent			7
	Ethical/			0

	Ethical practice Multi-agency			 2
NHS Wales finds itself under unprecedented financial pressure. For this reason, optimising the value that NHS Wales achieves from its medicines is a central ambition of this strategy. Optimise the value that NHS Wales achieves from its investments in medicines. There is a need for financial security to underpin good mental health and well-being.	Pressure Economic Financial problems/pressure Limited resources Waiting times	Barriers to effective treatment options.	Systemic challenges to mental health provisions.	15 27 10 4 12
Data and technology are to be used to improve value, patient outcomes and safety. Use available prescribing data to identify areas where work can be undertaken to improve safety, efficiency and patient outcomes.	Innovation Data Technology Modernisation Improvement	Incorporating statistical insight	Advancing care through actuarial assessment	14 113 25 0 52

Have routine data collection on access to, uptake of and outcomes of treatment in the pathway.	Efficiency			8
	Digital			37
Commissioners and service managers should ensure that people can express a preference for NICE-recommended treatments and that those treatments are available in a timely manner, particularly in severe depression.	Pain management	Managing the psychological and physical impact of medication use	Holistic understanding	5
	Withdrawal			48
	Side effects			45
Some people need extra support.	Complex			28
People need to be listened to	Need for treatment			1
Use psychological and psychosocial treatment manuals to guide the form, duration and ending of interventions.	Emotional			36
	Patient-centred			1
Consider the least intrusive first.				
Treatment may need to be adapted to accommodate psychological aspects.				
Patient-centred assessment and engagement.				

Vision for 2024-2034: No wrong door. So people can present at any point in the system and be guided to the right support without delay and without having to explain their needs multiple times.	Consistency Reliable/ Reliability Accessible Streamline Trust Honest	Foundations for effective depression management	Building trust and stability in treatment	1 0 20 0 32 1
Listen to people so we can understand how to improve services. Make sure services and organisations in Wales follow this strategy and carry out the right assessments so they give people the right support. Make sure all staff have the right advice so they can support everyone in the right way. Reassure the person that although treatment has not worked, other treatments can be tried and may be effective.	Listen Collaboration Informed History Continuity	Ensure treatment plans are appropriate and devised by knowledgeable staff to instill trust.	Importance of patient-practitioner relationship	12 17 61 17 3

Shared decision making				
Treatment options for less severe depression, guided self-help, printed or digital materials that follow the principles of guided self-help, including CBT, BA, problem-solving, or psychoeducation. They can be delivered in person, by telephone or online. Avoid potential side effects of medication. There was some evidence that counselling and short-term psychodynamic therapy may be effective, but these treatments did not appear to be as cost-effective. Some evidence for Individual problem-solving therapy, which appeared to be cost effective	CBT Therapy Psychoeducation Communication Appropriate prescribing. Problem-solving Tailored Preferred Flexibility	Therapeutic Engagement	Tailored intervention to improve patient outcomes	24 110 2 22 7 3 5 12 4

Individual intervention is delivered by a practitioner with therapy-specific training and competence. Where appropriate, raise awareness of non-pharmacological interventions. Have clear criteria for entry to all levels of a stepped care service	Training Outreach Education Visibility Competence Psychological awareness	Valuing skilled roles in the psychological sector	Promoting the visibility of therapeutic roles to future practitioners	44 1 59 1 19 0
Possible side effects include increased bleeding risk or long-term sexual dysfunction and difficulty stopping antidepressants. If a person has mild withdrawal symptoms when they stop taking anti-depressant medication, monitor their symptoms. Advise people with depression of the potential for increased agitation, anxiety and suicidal ideation in the initial stages of treatment if they develop marked or prolonged agitation. Advise the person with depression and their family to be	Dangers Harm Harm Prevention Responsible / Responsibility Continued monitoring	Prescribing risk	Acknowledgement of antidepressant harm	1 129 8 12 1

vigilant of mood changes. This is particularly important during high-risk periods, such as starting or changing treatment and times of persistent stress. Reduction of avoidable medicines-related harm aims to minimise the risk associated with prescribing, supplying, monitoring and taking medication. Where an adverse event does occur, robust systems should be in place for reporting.	Transparency Accountability Recognition Learning	3 4 7 33

Discussion

This study explored the overmedicalisation of antidepressant medication in Wales through a mixed-methods design, integrating psychology students' perspectives with analysis of government and policy documents. This approach identified seven key areas of convergence and perceived divergence between student perspectives and policy discourse, particularly regarding ethical practice, access to psychological interventions, the implementation of trauma-informed and patient-centred care, and the integration of psychology graduates into the workforce. The subheadings below present the key findings identified through the triangulation of qualitative interview data and content analysis.

Prescribing Practices: Quick Fix vs Stepped Care

This theme was identified through the analysis of student interviews as a perceived concern that antidepressants may be used as a quick fix, often due to time constraints in GP settings. In contrast, the content analysis of policy documents emphasised stepped care models and the prioritisation of non-pharmacological options. Students described antidepressants as the default response to distress, perceiving that GPs may prescribe medication rapidly due to consultation constraints and pressures within primary care services. This perceived reactive approach contrasts with policy frameworks such as NICE (2023) quality standards, which advocate a stepped care model. Under this model, the least intrusive and most cost-effective interventions, typically psychological therapies, should be offered before pharmacological solutions are considered (NICE, 2023). However, despite these official guidelines, the perceptive findings of this study may suggest that such principles are not consistently translated into frontline practice. This apparent disconnect, as reflected in student accounts, may be explained by Normalisation Process Theory (May et al., 2020), which suggests that even well-evidenced guidance can fail to embed in practice when organisational pressures reinforce entrenched routines such as default prescribing.

This discrepancy between policy and practice is echoed in the literature. Crowe et al. (2023) and Wakefield et al. (2021) attribute the sustained increase in antidepressant prescribing to systemic failures, such as long waiting lists, resource constraints, and the limited availability of psychological therapies, all of which were reflected in the perceptions of interviewees in this study. As a result, this study tentatively suggests that GPs may feel compelled to offer immediate pharmacological relief, even in cases of mild to moderate distress, where talking therapies would be more appropriate (Davies et al., 2023).

Policy texts reinforce this dissonance, although ‘risk’ was referenced 162 times, suggesting a rhetorical emphasis on cautious prescribing; this impetus does not appear to be reflected in the clinical experiences as perceived by students, a notion also reflected in the policy documents, where ‘safety’ was referenced only 74 times. This disparity highlights a potential inconsistency between policy discourse and practical implementation, suggesting systemic efforts to mitigate risk may remain fragmented and potentially superseded by pressures to expedite patient care (Iacobucci, 2019).

Patient Education and Psychoeducation: Neglected vs Mandated

This theme was generated through analysis of the interviews, where students consistently reported a perceived lack of psychoeducation, particularly around withdrawal symptoms, medication side effects, and tapering guidance. In line with these insights, the content analysis revealed that although policy documents reference ‘patient rights’ 149 times, ‘psychoeducation’ appears only twice. This suggests that, while patients' rights are frequently emphasised, education surrounding medication use is not consistently framed as a specified right. Interviewees also documented the perceived psychological impact of antidepressant use, particularly distressing withdrawal symptoms that may occur without adequate support. While NICE (2023) guidelines emphasise the need for informed consent, shared decision-making, and gradual discontinuation, this study may indicate a gap between regulatory guidance and participants' perceptions and experiences. These findings align with Lewis (2018), who reports that GPs have historically underestimated withdrawal symptoms, often

misattributed as worsening depression symptoms, prompting medication continuation or reinstatement and contributing to long-term dependence (Horowitz et al., 2023).

The psychological distress associated with abrupt cessation is also well documented (Muntingh et al., 2021), and yet the emotional and cognitive toll of withdrawal may remain insufficiently supported in practice (Crowe et al., 2023). This apparent lack of psychoeducation may neglect the psychological needs for safety, understanding, and autonomy identified in Maslow's (1943) hierarchy, where informed engagement forms a foundation for psychological security and recovery. This potential neglect appears to undermine the principles of trauma-informed care and safe prescribing endorsed in the 2019 Welsh Assembly recommendations (National Assembly for Wales, 2019). While policy documents referenced 'side effects' 45 times and 'withdrawal' 48 times, the term 'psychoeducation' appeared only 22 times, suggesting that although harm is acknowledged, less emphasis may be placed on patient education as a preventative tool. Again, this discrepancy may indicate a misalignment between routine practice and the psychological education and support that patients are expected to receive under the NICE guidelines (2023).

Role of Non-Pharmacological Interventions: Undervalued vs Acknowledged

This theme was derived from student interviews, in which participants emphasised the importance of holistic approaches such as mindfulness, nature-based therapies, and early psychological intervention, which they felt were rarely promoted. Meanwhile, the content analysis revealed that, although the term 'therapy' appeared frequently, at 110 times, specific references to 'alternative' or 'integrative approaches' were notably absent or minimally represented in the policy documents.

Students reported that they perceived options such as mindfulness, nature therapy, and other holistic methods to be rarely promoted in practice, a notion partially reflected in the content analysis, which revealed that patient-centred care was only mentioned once across all documents. While NICE (2023) guidance includes CBT and psychoeducation as non-pharmacological options, integrative therapies receive minimal attention in policy documents, with 'CBT' only appearing 24 times and 'mindfulness' not appearing at all. Advocating for psychological intervention, Liu et al.

(2023) highlight the benefits of acceptance and commitment therapy (ACT) and mindfulness-based cognitive therapy (MBCT), which enhance emotional resilience, increase psychological flexibility, and reduce relapse rates by addressing root causes rather than merely alleviating symptoms. These approaches align with cognitive and behavioural theories that prioritise adaptive functioning and long-term mental health maintenance, as conceptualised initially by Beck (2011), who emphasised the central role of cognitive restructuring and belief systems in sustaining psychological well-being.

However, despite their evidence base, such strategies have been reported as being chronically underutilised in Wales (Hughes et al., 2024). The content analysis revealed that although psychological interventions are acknowledged, specific alternative approaches are either deprioritised or remain notably underrepresented within policy narratives, which may contrast with the vision set out in the TMHS strategy (Welsh Government, 2021b). This policy omission also appears to depart from the biopsychosocial model proposed by Woods (2019), which advocates for treating mental health through the interaction of biological, psychological, and social dimensions, an approach more aligned with students' perceptions of the need for integrative, early interventions.

The Overlooked Role of Psychology Graduates: Workforce Crisis vs Wasted Potential

This theme was developed through analysis of participant accounts, in which students highlighted a perceived lack of accessible career pathways into non-clinical mental health roles, noting limited visibility of intermediary positions and unclear progression routes. These concerns were partially reflected in the content analysis, which revealed that while policy documents referenced 'training' 44 times and 'education' 59 times, there was no direct mention of workforce development strategies aimed at integrating psychology graduates into mental health services, potentially indicating a lack of recognition of their contribution to the sector. Students described perceived systemic barriers to entry-level positions and a widespread lack of awareness of intermediary psychological roles, such as wellbeing practitioners or

assistant psychologists. While policy documents emphasised ‘pressures’ 15 times, the role of the ‘economy’ 27 times, and ‘financial problems’ 10 times, they did not appear to articulate a practical vision for alleviating these pressures through psychological expertise.

Notably, there were no references across any documents to expanding structured pathways specifically for psychology graduates. This omission may be significant, as psychologically informed staff are well-positioned to deliver early-stage psychological support, enhance service capacity, and contribute to preventive care, thereby helping reduce demand for high-intensity services (Crowe et al., 2023). Moreover, this gap may reflect a shortcoming in implementing the TFMH framework (Welsh Government, 2012b), which emphasises the timely delivery of psychological interventions, equitable access to support, and the development of a diverse, skilled workforce. The absence of structured pathways for psychology graduates appears to be inconsistent with these principles, particularly the commitment to stepped care and early intervention. This suggests that while upskilling and competence are prioritised rhetorically, the workforce expansion necessary to operationalise these goals, especially at lower-intensity levels of care, may remain insufficiently addressed (Boldero et al., 2024).

Trauma-Informed Care: Emphasised in Policy vs Missed in Practice

This theme was evident in the interview data, where students reported that trauma was often perceived to be overlooked or misdiagnosed as depression, leading to medication-based responses rather than appropriate therapeutic interventions. Meanwhile, the content analysis revealed that policy documents referenced ‘trauma’ 93 times and ‘trauma-informed care’ 32 times, indicating a strong rhetorical commitment to trauma-sensitive practice (National Assembly for Wales, 2019). However, students’ accounts suggest a perceived lack of meaningful implementation at the clinical level. ACE Hub Wales (2022), which strongly influences current mental health policy, advocates for embedding trauma-informed principles across all services to improve the efficacy and accuracy of treatment options. However, the findings of this study may indicate a disconnect between these policy ambitions and students’

perceptions of current practice, informed by their training as emerging practitioners within a BPS-accredited psychology degree.

Psychology students, as future practitioners, also expressed concern that trauma-informed care may not be consistently prioritised in service delivery. Where accurate, this perceived gap could undermine policy credibility and contribute to poorer patient outcomes, as trauma histories may be insufficiently explored and addressed (Karrouri et al., 2021). In support, Beck's (2011) cognitive theory underscores how unresolved trauma can shape dysfunctional core beliefs and maladaptive thought patterns, which risk being misinterpreted as primary mood disorders when trauma is not appropriately assessed. Thus, despite the frequent appearance of trauma-related language in policy documents, students' accounts may suggest challenges in fully operationalising these commitments, potentially conflicting with the Welsh Government's own strategic frameworks (2019) and raising concerns regarding patient care.

Overprescription: Acknowledgement vs Policy Deflection

This theme was evident within the interview data, where students described the use of antidepressants as routine and excessive, reflecting a perceived culture of default prescribing within primary care (Davies et al., 2023). The content analysis revealed that while policy documents reference 'harm' 129 times, they tend to frame overprescription in softened or euphemistic terms such as 'prescribing beyond clinical need' or 'suboptimal prescribing'. This lexical choice may suggest a tendency to minimise or deflect the issue's systemic severity (Boldero et al., 2024).

Wakefield et al. (2021) echo students' perceptions of an entrenched culture that prioritises medication over other interventions. This supports Conrad and Barker's (2010) theory of the social construction of illness, which describes how emotional distress is increasingly framed as a medical problem requiring pharmaceutical intervention, even when social or psychological responses may be more appropriate, reinforcing concerns that pharmacological intervention is often prioritised over psychological alternatives (Conrad & Barker, 2010).

More critically, policy documents consistently appear to avoid explicit acknowledgement of the scale, drivers, or consequences of overprescription, despite empirical confirmation from the NHS (2024b) and Mind Cymru (2024) that antidepressant prescribing in Wales is rising at an alarming and unsustainable rate.

Arguably, the Welsh Government's response to the overprescription of antidepressants may be viewed as insufficiently transparent or urgent, raising questions regarding alignment with its ethical and clinical obligations under NICE (2023) guidelines, which emphasise the principle of non-maleficence and the prioritisation of proportionate, evidence-based care.

Patient Voice: Disempowerment vs Empowerment Ideals

Interview data revealed that students reported feeling disempowered by clinical encounters, citing a lack of choice, explanation, or involvement in treatment decisions. The content analysis findings partially reflected these perceptions, indicating that 'transparency' was mentioned only three times, 'continued monitoring' was mentioned only once, and 'harm prevention' was referenced across all policy documents only eight times.

Despite policy assertions promoting shared decision-making, students reported perceptions of disempowering medical interactions, including accounts of antidepressants being prescribed with limited investigation and insufficient discussion of psychological alternatives and/or long-term risks. This perceived disconnect contrasts with NICE (2023) guidelines, which mandate collaborative care and shared decision-making, and with the National Assembly for Wales (2019) Recommendation 1, which calls for more transparent communication about the risks associated with dependence on SSRIs and SNRIs. Furthermore, Recommendation 2 advises that antidepressants should only be prescribed following unsuccessful therapeutic intervention or in cases of severe depression, a threshold that, according to student accounts, may not always be consistently upheld. Although 'listen' was mentioned 12 times, 'collaboration' 17, and 'trust' 32 times, 'honesty' was referenced only once. Similarly, patient-centred care' appeared only once. This limited emphasis on honesty and transparency may undermine the conditions necessary for genuine shared

decision-making, suggesting that patient empowerment is more rhetorically endorsed than meaningfully operationalised in practice (Davies et al., 2023).

Conclusion

Student perspectives, informed by lived and observed experiences alongside the theoretical and empirical knowledge developed through BPS-accredited psychology training, suggest a perceived lack of trust in the mental health care system, underpinned by concerns that ethical standards and safeguarding practices may not always align with NICE (2023) guidelines. While based on a small, non-generalisable sample, these perceptions are tentatively supported by concerns raised by Welsh GPs in the aforementioned open letter (Davies et al., 2023). Instead, participants' accounts suggest a perceived emphasis on surface-level symptom reduction, often described as a 'quick fix' approach.

These findings may indicate that, although psychological support is widely referenced in Welsh policy, its implementation, as perceived within this sample and examined through content analysis of Welsh Government documents, may not fully align with the intended delivery of a trauma-informed, psychologically focused, person-centred model of care. Content analysis findings indicate that policy discourse emphasises biomedical framings, which may contrast with the integrative biopsychosocial model proposed by Woods (2019), designed to address the psychological and social dimensions of distress.

Drawing on the available evidence, this study suggests that policy narratives position therapeutic intervention as a first-line treatment; however, content analysis indicates that practical implementation may be constrained by systemic and financial pressures (Wakefield et al., 2021). This apparent disconnect aligns with May et al.'s (2020) normalisation process theory, which explains how routine practices such as default prescribing may become embedded despite formal guidance.

Student accounts further suggest that systemic pressures may be alleviated through psychologically informed recruitment initiatives; however, content analysis indicates that such initiatives are underrepresented and under-resourced in policy documentation (Liu et al., 2023). Participants tentatively linked this to unmet

psychological needs for autonomy, purpose, and belonging, consistent with Maslow (1943), which they perceived as insufficiently addressed within the prevailing medical model (Conrad & Barker, 2010).

Students also suggested that education *may* function as a mechanism to improve practitioner awareness of inappropriate prescribing, echoing Conrad and Barker's (2010) critique of medical dominance. They further indicated that increased staffing and funding *may* enhance motivation to challenge overmedicalisation. The COM-B model (Michie et al., 2011) provides a useful framework for conceptualising such change by targeting capability, opportunity, and motivation. COM-B is a behaviour change model that explains behaviour as the interaction between Capability, Opportunity, and Motivation, which together generate Behaviour.

While policy documents reference biopsychosocial care, content analysis indicates continued alignment with biomedical frameworks. Woods (2019) supports the application of COM-B to facilitate system-level change, and participants similarly advocated for more holistic, needs-led approaches.

Limitations and Recommendations for Future Research

A key limitation of this study is the small qualitative sample (N = 4), which is not intended to be generalisable but rather to provide in-depth insight into student perceptions of antidepressant prescribing practices. While these accounts offer valuable perspectives, the limited sample size limits the extent to which the findings can be extrapolated to broader populations of students or practitioners.

A further limitation is the reliance on an open letter reflecting general practitioners' perspectives as an indirect source of practitioner insight, rather than direct engagement with prescribing clinicians. This approach was necessitated by time constraints.

However, it is important to note that this study employed a mixed-methods approach, incorporating both qualitative interviews and a structured content analysis of policy documents. The content analysis provided a systematic and transparent examination of policy discourse, generating quantitative insights into the frequency and emphasis of key terms. This component enhances the robustness of the study by

enabling a broader understanding of systemic patterns, which, when considered alongside the qualitative data, supports a process of triangulation. As such, while the interview data offer depth and insight into perceptions, the content analysis contributes to a more comprehensive and analytically grounded interpretation of the findings.

Future research should prioritise securing direct interviews with practising GPs to facilitate objective, applied contextual understanding. Such work would enable more robust triangulation of perspectives, strengthening the validity of findings and providing a more comprehensive and clinically grounded understanding of prescribing practices, decision-making processes, and systemic pressures influencing antidepressant use in Wales.

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Appendix A: Interview Schedule

Background question

Q1- Have you encountered discussions throughout your degree concerning the use of antidepressants in treating mental health issues?

Awareness of Antidepressant Prescription Practices

Q2- How familiar are you with the prescription rates of antidepressants in Wales?

Q3 – Do you feel that antidepressants are commonly prescribed for mental health conditions, such as depression and anxiety? If so, why or why not?

Perceptions of Overprescription

Q4 – In your opinion, do you think antidepressants are overprescribed in Wales? Can you explain your reasoning?

Q5 – What factors do you think contribute to the potential overprescription of antidepressants?

- **Follow up –** Can you think of a situation where an alternative to antidepressants might be appropriate or more beneficial?

Attitudes toward alternative treatments

Q6- From what you have learned in your studies, do you think there are enough non-medication-based treatments available for those with mental health conditions?

Q7- What are your views on the accessibility and effectiveness of alternative treatments like CBT or counselling in Wales?

Role of Policy and Education

Q8- Have your studies covered any policies or guidelines that you think may influence how antidepressants are prescribed?

Psychological and Social Implications

Q9- How do you think overprescription of antidepressants might affect patients psychologically or socially?

Q10- In your opinion, could the overprescription of antidepressants contribute to a more significant societal issue, such as the over-medicalisation of mental health problems in Wales?

Closing Questions

Q11- In your view, what could be done to reduce the overprescription of antidepressants in Wales, either at the policy or healthcare level?

Q12- Is there anything else you would like to add about your views on antidepressants or overprescription that we have not covered today?