Why Seek Help from a General Practitioner if You Need a Heart Operation?

The Case for Specific Treatment Techniques and Treatment Environment in the Treatment of Anxiety Disorders

Jared U. Balmer, Ph.D.
WayPoint Academy

Six decades of psychotherapy outcome studies have proven that therapy is effective (T.P. Asay and M.J. Lambert 2006, Bergin, 1971, Bergin & Lambert, 1978, Meltzoff & Kornreich, 1970, Smith, Glass, & Miller, 1980). The mathematical summaries of the research literature, known as meta-analysis, have shown that the average treated person is better off than 80% of the untreated sample (Smith et al. 1980). Furthermore, researchers have discovered that improvement is sustained. However, the notion that psychotherapy will forever safeguard a person from psychological disturbance is unwarranted (Nicholson & Berman, 1983). Research shows that certain groups of clients may be more vulnerable to relapse, including those with substance abuse problems, eating disorders, recurrent depression, and those diagnosed with personality disorders (Lambert & Bergin, 1994).

Since the legitimacy of the effectiveness of psychotherapy has well been established, the ensuing question is: what leads to the positive outcome? This question produced no shortage of claims from practitioners across the mental health spectrum, each vying for their preferred brand or technique of psychotherapy. The question focused on the differential effectiveness between schools of psychotherapy—a hotly contested issue with surprising results.

The Dodo Bird Effect

In 1975, following a meta-analysis of psychotherapy outcome studies, Luborsky, Singer, and Luborsky announced the now famous "dodo bird verdict" that is borrowed from *Alice in Wonderland* where the dodo bird proclaims that all have won and, therefore, all must receive a prize. Luborsky, et al., "cleverly used the "verdict" to illustrate the empirical conclusion that all of the different therapies appeared to be equal in effectiveness" (Tallman & Bohart 2006). The "verdict" came as disappointing news to different schools of psychotherapy who often proclaimed superiority over other schools.

Nevertheless, during the ensuing decades, the dodo bird verdict has been established by hundreds of studies—w*ith one exception* (more on the exception later in the article). Faced with the notion that "my brand of psychotherapy is no better than all the others," researchers repeatedly attempted to discount the "verdict" (Fisher, 1995). However, as the dodo bird verdict has increasingly taken root among researchers and practitioners,

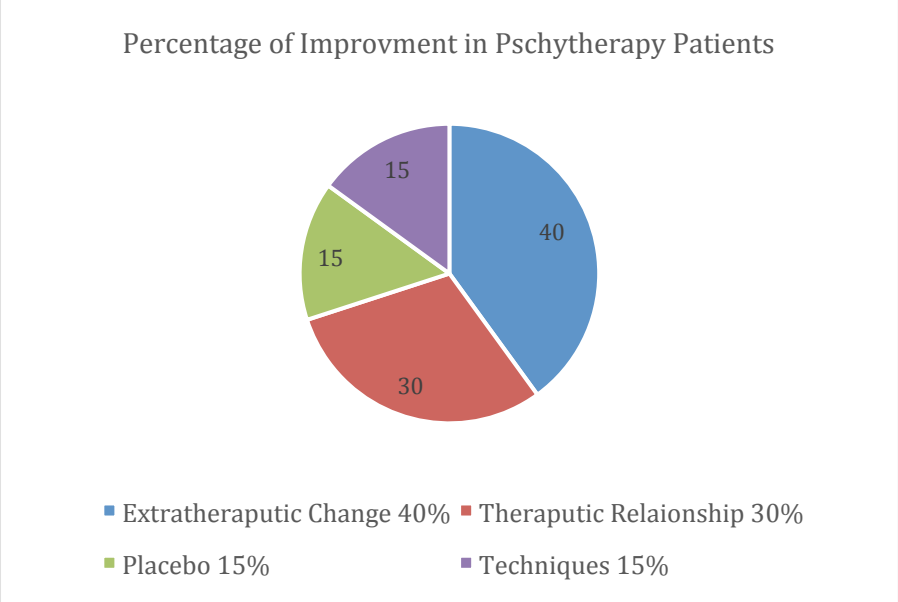
unfortunately, some practitioners who are unfamiliar with the research findings, continue in the false belief that their brand of psychotherapy rules supreme.

Bergin and Garfield (1994), reflecting on the current state of this issue, wrote:

> With *some exceptions,* there is massive evidence that psychotherapeutic techniques do not have specific effects; yet there is tremendous resistance to accepting this finding as a legitimate one. Numerous interpretations of the data have been given in order to preserve the idea that technical factors have substantial, unique, and specific effects. The reasons for this are not difficult to surmise. Such pronouncements essentially appear to be rationalizations that attempt to preserve the role of special theories, the status of leaders of such approaches, the technical training programs for therapists, the professional legitimacy of psychotherapy, and the rewards that come to those having supposedly curative powers.

Enter the Common Factors

Researchers who have nothing to lose or gain by discounting the dodo bird verdict have turned to the question of: why is there no difference in outcomes between the schools of psychotherapy, or have simply asked—what does it mean? Their aim is to find the variables for change that cut across different approaches to therapy and make them all equally effective (Arkowitz, 1992), the genesis of the research of common factors. Aiming to identify the common factors that contribute to the improvement in psychotherapy patients, the factors examined are a) Extratherapeutic Change, b) Therapeutic Relationship, c) Expectancy (placebo effects), and d) Techniques that have been commonly accepted (Lambert, 1992).



Extratherapeutic Change

As a young therapist, I was under the illusion that my therapeutic technique was the single most important variable effecting change in my patients. Well, I was wrong. Meta-analysis showed that client variables accounted for 40% of the improvement in psychotherapy clients. In reality, what the patient brings to the therapy session proves to be the most significant factor for change. Among others, variables that the patient brings to psychotherapy are: severity of disturbance, motivation, capacity to relate, ego strength, psychological mindedness, and the ability to identify a focal problem (Lambert & Anderson, 1996). For example, it is easy to surmise that an adolescent with severe social phobia who refuses to leave his or her room possesses poor motivation for therapy and may view mental health professionals with suspicion. These extratherapeutic variables will often influence the duration of psychotherapy. Other factors that may influence the length of treatment are the length of time or strength the disorder has persisted, the presence of an underlying personality disorder, and the social support for the patient (Mann, Jenkins, & Belsey, 1981).

Relationship Factors

Extratheraputice factors account for 40% of patient change in psychotherapy—the lion's share of what is responsible for change in the patient. Next are the empirical findings that suggest that relationship factors account for approximately 30% of client improvement (Lambert, 1992). How the client and the therapist relate to each other - the therapeutic alliance - received the most attention among researchers over many decades. Several studies have identified the characteristics of a good therapeutic relationship: therapist empathy (Bischoff & McBride, 1996), being engaged in the therapy process, understanding what was happening, and being understood (Howe, 1996). Therapist characteristics include: acceptance, empathy, caring, competence, support, and being personable (Kuehl, Newfield, & Joanning, 1990). A host of qualitative and quantitative research has shown that the client's perception of the therapeutic relationship is of the utmost importance in the process of therapy (Maione & Chenail 2006).

Expectancy and the Placebo Effect

Meta-analyses over the past three decades have demonstrated that expectancy and placebo effects have positive influences on the change process in clients (Asay & Lambert, 2006). Lambert (1992) has shown that these factors account for 15% of the variance in client change and is as important to the change process as therapeutic techniques. Decades ago, Jerome Frank (1973) suggested that expectancy is a common healing bond that connects all forms of psychotherapy. More recent studies demonstrate that the expectations the client brings to therapy have a positive effect on the outcome (Garfield, 1994). In addition, it is well understood that placebo effects do have a critical impact on the outcome of client change as demonstrated by the NIMH Collaborative Depression Study (Elkin et al., 1989).

Therapeutic Techniques – and the all-important exception

Over the past four decades, a host of meta-analyses has shown that all therapies are equally effective and have the same impact on client outcome as the placebo effect—*with one exception*. Comparative studies indicate a superior effect of a certain therapeutic technique when applied to a selective group of clients. The superior technique is "exposure" therapy, which is delivered through a cognitive behavioral approach applied to clients who suffer from anxiety – general and phobic disorders in particular (Emmelkamp, 1994; Marks, 1978; Morgan et al. 2013).

To eliminate or significantly reduce phobic anxiety through exposure therapy, numerous studies have shown that the following elements must be present: the provoking stimuli must be clearly identified, the assistance of the client with cognitive and in-vivo exposure until the anxiety subsides, and guidance of the client in mastering thoughts and feelings linked with the fear-evoking stimuli. Overwhelming evidence supports that achieving lasting reduction in fears and compulsive rituals is a function of exposure (Emmelkamp, 1994). Additional research suggests that the treatment of anxiety through exposure therapy is more successful when a cognitive-behavioral intervention is used (Barlow, Craske, Cerny, & Klosko, 1989).

Therapy Settings

Clients with moderate to severe anxiety disorders cling to avoidance to "manage" their symptoms. Avoidance as a coping mechanism is frequently fueled by shame, particularly with adolescents. Avoidance, with the comorbitity of shame, keeps many clients from seeking help (Balmer, & Bulloch, 2013). Severe cases of adolescents with anxiety disorders (i.e. generalized anxiety disorder, social anxiety, phobias, OCD, etc.) find themselves avoiding outpatient therapy and display such symptoms as school avoidance and other forms of social isolation. In such cases, day-treatment or residential treatment often become the only viable avenue to therapy.

If residential treatment is indicated, two critical variables must be considered. First, the clinical personnel's specialization and expertise in the technique of the treatment of anxiety disorders. Second, the nature of the therapeutic milieu in which the client is treated.

Clinical Expertise

Not all physicians are experts in all medical specialties. One would not access an ophthalmologist to treat a cold, nor a pediatrician to perform an open-heart surgery. One would find it difficult to trust a physician who claims expertise in *all* specialties. Likewise, not all mental health professionals are experts in all areas of psychotherapy. The above cited research supports the fact that specialization is particularly critical in the treatment of anxiety, where technique often is more important to the change process than

the therapeutic alliance between clinician and client. For example, the elimination of opihidiophobia (fear of snakes) can never be achieved through the therapeutic alliance alone. When it comes to phobias, therapeutic technique takes center stage.

While Cognitive Behavioral Therapy (CBT) has proven to be the preferred choice in treating anxiety in general and OCD in particular, "many, if not most children and adolescents with OCD do not receive CBT for a variety of reasons. Many clinicians are not trained in CBT or OCD and may not be familiar with the unique developmental challenges that arise in the treatment of children" (Wagner 2003*)*.

Therapeutic Milieu

In a residential setting, the one-on-one or group therapy interaction of the professional staff with a given client typically varies from 1-8 hours per week. The rest of the waking hours are spent in interaction with the child care and teaching staff. All staff are charged with the task of implementing and maintaining a therapeutic environment or milieu. In each case, such a milieu must be designed for a particular client population. It followes that a milieu designed for chemical dependency clients would differ significantly from a program designed for clients who suffer from Reactive Attachment Disorder, and a milieu serving a wide variety of clinical disorders would radically differ from a program that serves clients with anxiety disorders (Balmer, 2006).

A residential treatment program, serving a wide variety of diagnostic categories and charged with implementing a therapeutic environment, must find a "middle ground" that addresses the needs of all clients—a one-fits-all program. Inevitably, such a middle ground is based on compliance. Thus, compliance to daily tasks and social morae becomes the measuring device for progress. However, adolescents with moderate or severe anxiety without overt behavior problems are typically compliant. Moreover, clients with anxiety will often use compliance as an avoidance technique, shielding them from the discovery of their pathology which is often cemented by feelings of shame. Clients with anxiety disorders primarily engage in avoidance to "manage" their symptoms but typically are not oppositional (Balmer, & Bulloch, 2013). They benefit little from a therapeutic milieu that focuses on compliance. They are best served in a homogenous group where *all* clients organically understand the debilitating effects of anxiety. Such a group is better positioned to act as a cohesive support community and is thereby less impacted by volitional, non-compliance and acting-out behaviors of clients who demand the "grease for the squeaky wheel."

Summary

Among all the diagnostic categories, the treatment of anxiety is unique. Successful treatment is based on specific treatment protocols, including: cognitive, virtual reality, and most importantly, in-vivo exposure techniques. These highly specialized treatment techniques, delivered by specialized, trained clinicians and other support staff, often take

a superior position in the change process and rival those of the therapeutic alliance between therapist and client. Clients with moderate and severe anxiety benefit most from a therapeutic environment that is designed with the central theme of exposure as opposed to compliance.

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