

Therapeutic Interaction: A Perception of Therapist towards Patients with Anxiety Disorder

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Abstract: *The present research was conducted (a) to describe the socio-demographic information of psychotherapist providing therapy to patients of anxiety disorder (b) to examine the therapeutic interaction on various variables of therapeutic participation, resistance and dysphoric concern (related to patient's responses), and directive support for the patients (variable related to his/herself). It was hypothesized that therapist would rate significantly high on therapeutic interaction (therapeutic participation, directive support, resistance and dysphoric concerns) with anxiety patient. Sample comprised of thirty five psychotherapist providing therapy to diagnosed anxiety patients in OPD (Outdoor patient department). Psychotherapy Process Inventory was administered to assess perception of therapeutic interaction of psychotherapist. Descriptive statistics and one sample t test were calculated for the analysis of data. Results revealed that most of the therapists, possessed MS degree in Clinical Psychology. Results indicate that there is a significant high rating on therapeutic interaction, therapeutic participation, directive support, resistance and dysphoric concern of the psychotherapist who are providing therapy to the anxiety patients. Therapeutic interaction is perceived by the therapist as supportive, whereas participation, resistance and dysphoric concerns of the patients were also perceived high by the therapist in initial sessions. Findings will be helpful for psychologist and other professionals to plan the therapeutic interventions for anxiety patients.*

Keywords: *Anxiety disorders, therapeutic interaction, therapeutic participation,*

I. Introduction

Psychotherapy is the psychological treatment process in which a trained person deliberately establishes a professional relationship with the patient with the objectives of removing, modifying, or retarding existing symptoms, mediating disturbed patterns of behaviour, and promoting positive personality growth and development.^[1,2]

Most practitioners of any theoretical perspective concerned that a positive relationship between patient and therapist is a necessary precondition for psychotherapy. Fiedler's found that therapists of different school of psychology agree upon a warm, accepting, and understanding relationship.^[3, 4,5] Every school of thought gives appropriate significance and emphasize upon quality of therapeutic relationship between therapist and client.^[6,7,8,9,10] Therapeutic processes involve therapists and clients developing a therapeutic relationship on the one hand, and the therapist using specific strategies on the other.^[11] The growth of therapeutic relationships follows distinct stages involving planning, contracting, assessment, therapy, managing resistance or ambivalence about change and disengagement.^[12] Akhtar, Verma, Pershod, and Verma described that therapeutic relationship may have three phases: orientating, working, and terminating. The trace of phases covers one to one relationship, discussion on mutually agreed goals and termination of relationship after achieving the mutually argued goals.^[13]

The therapist should form a collaborative partnership in which clients are experts on the specific features of their own situation and therapists are experts on general scientific and clinical information relevant to psychological development and the broad class of problems of which the presenting problem is a specific instance.^[14] Wilkins pointed out the research concerning the impact of patient expectations on future therapeutic outcome is fraught with difficulties.^[15] Client's motivation, desire for therapy, and expectations of change may have more to do with prompting the patient to primarily become involved in therapy than with directly influencing the therapeutic process or its outcome. Therapists spend a great deal too preliminary time in therapy attempting to facilitate patient's exploration and understanding of how they may help or hinder their own functioning. If client take responsibility for his or her inability to adapt, cope, or perform particular activities, the therapist will be able to assist the patient through the process of therapeutic change.

There are some certain characteristics attached with same disorders that may influence the person and eventually the therapeutic process. People with peak anxiety may preoccupied with their thoughts process and may not be adherent to therapy.^[16,17] The anxiety disorders are a group of mental disturbances characterized by anxiety as a central or core symptom. Although anxiety is a commonplace experience, not everyone who

experiences it has an anxiety disorder. Anxiety is associated with a wide range of physical illnesses, medication side effects, and other psychiatric disorders.^[18]

According to DSM-V anxiety disorders include phobia, social phobia, generalized anxiety disorder, obsessive compulsive disorder, posttraumatic stress disorder, and acute stress disorder.^[19] A patient with anxiety disorder has recurrent, inexplicable attacks of intense fear. Anxiety attacks alone are not sufficient for the diagnosis; a person must be worried about the potential of having another attack. Anxiety attacks sometimes lead to fear and avoidance of being in places where escape would be difficult if another were to occur, known as agoraphobia.^[20]

Prognosis of anxiety disorder based upon many factors. Most anxiety patients may never receive treatment. Data from different studies indicated that only about 25% of individuals with anxiety disorder ever receive treatment or remit.^[21,22] Anxiety disorders are much more common among woman than men. The focus of anxiety, the prevalence of anxiety disorders, and the specific symptoms expressed may be shaped by culture.^[20,23] There are many effective treatments for anxiety disorder ranging from therapy to self -help and medication. There are a variety of forms of psychotherapy, but in most cases, the therapist tries to help the client identify and overcome the cause of the symptoms. Most clients are seen individually, but some are seen in group therapy, and because of financial pressures, more use is made of time limited psychotherapy.^[24]

There are some certain outcome studies that are related to treatment of anxiety disorder patient. Researchers found that patient of anxiety disorder are motivated and have insight.^[12,25] It came into notice that treatment process is a complex phenomenon. It involves many factors regarding therapist variable and variables related to therapist personality, expectation of both (therapist and client) from therapy and different perceptive of school of thoughts related to treatment are equally important.

II. Objectives

This study aims to find out the nature of interaction and process of therapy between therapist and patient with anxiety disorder exclusively regarding the perception of therapist toward therapeutic relationship. Perception of every person is of prime importance because it affects the performance. Different therapist views the initial therapeutic interaction differently due to their perspectives. Further these views are related to therapist himself as well as of patient. Generally it is assumed that patients with anxiety disorder are easy to treat but do not get engaged with therapy process for longer duration. Even they respond to therapy in follow up of 12 months with 50% ratio.^[26] Thus this study is designed to investigate the perception of therapist about therapy process with anxiety patients.

III. Hypotheses

Keeping in view the literature review following hypotheses was formulated:

Therapist would rate significantly high on therapeutic interaction (therapeutic participation, directive support, resistance and dysphoric concerns) with anxiety patient.

IV. Methodology

4.1 Participants

The sample size was comprised of 35 psychologists who are dealing with diagnosed anxiety patients from OPD of psychiatry departments. Samples were recruited from different Hospitals of Lahore that included Mayo, Services, Jinnah, Ganga Ram Hospital and Punjab Institute of Mental Health. Purposive sampling technique was used to collect the data. Therapists who were dealing with anxiety patients and having an experience of two years were included in this research. Data was gathered from those therapists who have taken minimum four and maximum eight sessions with adult anxiety patient. Qualification of therapist was Postgraduate diploma, MS and PhD in clinical psychology.

4.2 Measures

A socio-demographic form, along with standardized scales of Psychotherapy Process Inventory was used in this study.

4.2.1 Demographic Form

Demographic information form was used to collect information such as age, gender, marital status, education, year of experience of therapist and therapeutic techniques used for anxiety patients.

4.2.2 Psychotherapy Process Inventory

The psychotherapy process inventory yield four factors and is to be completed by the therapist.^[1] It is a process inventory that yields information about the therapist's perception of both his and her own and the patient's behavior. The factors reflected the degree to which the patient is being resistant, the degree to which

the therapist is providing appropriate and active support, the amount dysphoric concerns expressed by the patient and the degree to which the patient is participating activity in facilitating his growth. Expected mean scores and factors composition are 3.00(0.60), 2.63 (0.70), 2.61 (0.60) and 3.15(0.59). It is 74 item checklists and each item carries a labeled five point rating scale. Reliability coefficients of this inventory were .92, .87, .83, and .79.^[27]

4.3 Procedure

In order to conduct this research, some ethical considerations were kept in mind. Permission to utilize the scale was taken from the author through e-mail. Official permission was sought from the administration of the selected departments for the data collection. The consent form was given to the participants and the nature of the study was explained before administration of the questionnaire. The questionnaire was given to the participants to be completed by the therapists. The duration of administration was of 30-40 minutes. Statistical analysis was performed by using Statistical Package for Social Sciences version 17.0. Descriptive statistics was used to calculate the frequency and percentage to describe the socio- demographic variable. One sample t-test was applied to determine the therapeutic interaction of therapist with anxiety patients.

V. Results and Discussion

Table 1

Demographic Information of the therapist variables (N= 35)				
Variable	<i>f</i>	%	<i>M</i>	<i>SD</i>
Age				
21-30	16	44.4%	1.80	0.86
31-40	11	30.6%		
41-50	7	19.4%		
51-60	1	2.8%		
Gender				
Male	8	22.2%		
Female	27	75.0%		
Marital Status				
Married	18	50.6		
Unmarried	17	47.2		
Education				
ADCP	6	16.7		
MS	9	52.8		
PHD	10	27.8		
Year of Experience				
1-10	26	72.2	1.34	0.63
11-12	6	16.7		
21-30	3	8.3		
Therapy use for Anxiety patient				
CBT	15	41.7		
Psychoanalytic	9	25.0		
CCT	6	16.7		
Behavior therapy	4	11.1		
Reality therapy	1	2.8		

Note. *f*= frequency, %= percentage, *M*=Mean and *SD*=Standard Deviation

Table 2

One sample T-test for the therapist rating on therapeutic interaction (therapeutic participation; resistance; dysphoric concern and directive support) with anxiety patient (N=35).				
Variable	<i>M</i>	<i>S.D</i>	<i>t</i>	<i>Sig</i>
Therapeutic interaction	233.37	15.69	87.94	.000
Therapeutic Participation	69.80	9.48	43.57	.000
Resistance	71.37	6.06	69.63	.000
Dysphoric concern	46.25	7.31	37.41	.000
Directive support	54.31	5.05	63.69	.000

df = 34, *p* < .05

Results (Table 1) indicated that most of the therapists were related to the age group of 21-30 year (46 %). Most of the therapist comprised of female (77%). Findings showed that 51% of the therapists were married. Results also indicated that of 54% of the therapists have MS degrees in Clinical Psychology. Almost 74% therapists had experience of 2-10 years. Most of the therapists (43%) used cognitive behavioral technique in dealing with anxiety patients. Results in table 2 indicate the rating patterns of therapists were significantly high for therapeutic interaction (*t*= 87.94, *p*<.05); therapeutic participation (*t*= 43.57, *p*< .05); directive support

($t=63.69$, $p<.05$); resistance ($t= 69.63$, $p<.05$) and dysphoric concern (37.41 , $p<.05$) of the psychotherapist who are working with anxiety patients.

The present research focused to investigate the perceptions about therapeutic interaction of therapist with anxiety patient. Therapeutic process is an interaction between two individuals in which perception plays important role. It is evident that therapeutic alliance is vital aspect for successful therapeutic outcome.^[28] The findings (Table 2) are consistent with prior research.^[29] Previous studies also revealed that the therapist rated high on therapeutic process for the patients suffering from anxiety disorder.^[17,30,31] Some researchers showed that there is good therapeutic interaction between therapist and client.^[28, 32,33] Another prior research also showed that relationship of therapist and client which proved that 66 % therapist have normal interaction with the client while interaction of 44 % is good. This is valid of there is gender difference besides the experience of the therapist.^[34]

Therapist's perception towards therapeutic process may have two forms: perception towards self and patient's responses. Therapist accurate perceptions related to patients suffering from anxiety disorder and patient's behavior related to anxiety (i.e. resistance, dysphoric concern, apprehensions, nervousness, restlessness, unrealistic fears etc.) may enhance support toward patient in therapeutic relationship.^[20] The support provided by the therapist is also known as directive support.^[1] Consequently it may improve the participation in the therapeutic process.

In developing countries mental health is not of prime concern in health policies as stigma is attached to it. Hence, patients with psychiatric problem are reluctant to approach mental health professional. However, if patients approach to the therapist, may experience extreme anxiety which resulted in high resistance in initiating treatment. Further it may lead to other issues like adherence with treatment as well as to comply with regime or mode of treatment.

VI. Conclusion

Findings of the present study have important clinical implications. Clinicians from various schools of psychology may benefit from using a collaborative approach with their clients. It will be helpful for psychologists and other professionals to plan the therapeutic interventions for anxiety patients. Furthermore, it will highlight the importance of initial contact of patient and therapist in therapeutic process. The sample size was small so the results of the study cannot generalize to the whole population. This study involves views of therapist only so, in future researches patients' rating can be included. Data was restricted to only adult patients of anxiety disorder while the study can be replicated with patients having other psychiatric problems.

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References

- [1]. L. R. Wolberg, *The Technique of Psychotherapy*. (New York: Grune & Stratton, 1977).
- [2]. M. J. Lambert, and D. E. Barley, Research summary on the therapeutic relationship and psychotherapy outcome, in J. C. Norcross, (Ed.), *Psychotherapy relationship that works: Therapist contributions and responsiveness to patients*. (New York: Oxford University Press., 2002)17-32.
- [3]. F. Fiedler, The concept of an ideal relationship. *Journal of Consulting Psychology*,14, 1950a, 239-45.
- [4]. F. Fiedler, Comparison of therapeutic relationships in psychoanalytic, nondirective and Adlerian therapy. *Journal of Consulting Psychology*,14, 1950b, 426-45.
- [5]. F. Fiedler, Factor analysis of psychoanalytic, nondirective, and Adlerian therapeutic relationship. *Journal of consulting psychology*, 15,1951, 32-38.
- [6]. N. Sundberg, and L. E. Tyler, *Clinical psychology: An introduction to research and practice*. (New York: Appleton-Century-Crofts, 1997).
- [7]. G. M. Burlingame, D. T. McClendon, and J. Alonso, Cohesion in group therapy. *Psychotherapy* 48, 2011, 34-42.
- [8]. L. W. Samstag, J. C. Muran, and J. D. Safran, Defining and identify alliance ruptures, in D. P. Charman, (Ed.), *Core Processes in Brief Psychodynamic Psychotherapy: Advancing Effective Practice* (Hillsdale, NJ: Erlbaum, 2004), 87–214.
- [9]. A. P. Goldstein, *Structured learning therapy*. (New York: Pergamon Press, 2003).
- [10]. B. D. McLeod, Relation of the alliance with outcomes in youth psychotherapy: a meta-analysis. *Clinical Psychology Review*, 31, 2011, 603–616.
- [11]. G. Kelly, *The Psychology of Personal Constructs*. (New York: Norton, 2004).
- [12]. A. Carr, (2000). *Therapeutic relationship stage*. (London: Psychology Press, 2000).
- [13]. S. Akhtar, V. K. Verma, D. Pershod, and S. K. Verma, A phenomenological analysis of symptoms in obsessive compulsive neuroses. *British journal Psychiatry*. 127, 2002, 342-348.
- [14]. G. Cocchin, Hypothesizing circularity and neutrality revisited: An invitation to curiosity. *Family Process*, 26, 1989, 405-13.
- [15]. W. Wilkins, Expectance of therapeutic gain: An empirical and conceptual critique. *Journal of Consulting and Clinical Psychotherapy*, 40, 1973, 69-77.
- [16]. G. B. Cassano, and M. Savino, Depression and panic and other anxiety disorders. *The British Journal of Psychiatry*, 2, 2002, 258-260.
- [17]. J. L. Lebow, *Hand Book of family clinical Therapy*. (Canada: Wiley, J. & Sons, 2005), 354.

- [18]. S. V. Argyropoulos, and D. J. Nutt, Neurochemical aspects of anxiety. In D. J. Nutt, J. C. Ballenger, Anxiety disorders. (Oxford: Blackwell, 2003),83-99.
- [19]. American Psychological Association. Diagnostic and statistical manual of mental disorders, 5 (APA: Washington D.C, 2013).
- [20]. S. S. Wiltsey, S. S. Bhar, M. Spokas, T. Creed, D. Perivoliotis, D. Farabaugh, P. M. Grant, and A. T. Beck, Training and consultation in evidence based psychosocial treatments in public mental health settings: The ACCESS model. *Professional Psychology: Research and Practice*, 41(1), 2010, 48-56.
- [21]. W. J. Magee, W. W. Eaton, H. Wittchen, K. A. McGonagle, and R. C. Kessler, Agoraphobia, Simple Phobia, and Social Phobia in the National Comorbidity Survey. *Achieves of General Psychiatry*, 53(2), 1996, 159-168.
- [22]. C. L. Woodman, R. J. Noyes, D. Black, S. Schlosser, and S. J. Yagla, Comparison of the course and outcome of generalized anxiety disorder and panic disorder: A five year follow-up study. *Psychosomatics*, 37, 1996, 91-92.
- [23]. G. Skoog, and I. Skoog, Obsessive compulsive disorder. *Archives of General Psychiatry*, 56, 1999, 121-136.
- [24]. S. S. Bhar, B. D. Thombs, M. Pignotti, M. Bassel, Jewett, J. C. Coyne, and T. B. Aaron, Is longer-term psychodynamic psychotherapy more effective than shorter-term therapies? Review and critique of the evidence. *Psychotherapy and Psychosomatics*, 79, 2010, 208-216.
- [25]. R. E. Hales, S. C. Yudofsk, and G. O. Gabbard, *The American Psychiatric Publishing Textbook of Psychiatry*, 5 (Boston: McGraw-Hill, 2008).
- [26]. R. C. Durham, J. A. Chambers, R. R. Macdonald, K. G. Power, and K. Major, Does cognitive-behavioral therapy influence the long-term outcome of generalized anxiety disorder? An 8–14 year follow-up of two clinical trials. *Psychological Medicine*, 33(3),2003, 499-509.
- [27]. P. E. Baer, P. W. Dunbar, J. E. II. Hamilton, and L. E. Beutler, Therapists' perceptions of the psychotherapeutic process: Development of a psychotherapy process inventory. *Psychology Reports*, 46 (2), 1980, 563-570.
- [28]. R. B. Ardito, and D. Rabellino, (2011). Therapeutic Alliance and Outcome of Psychotherapy: Historical Excursus, Measurements, and Prospects for Research. *Frontiers of Psychology*, 2, 2011, 270. doi: 10.3389/fpsyg.2011.00270
- [29]. J. E. Nelson, B. G. Elizabeth, R. B. Andrew, A. P. Charles, S. S. John, and P. W. Juan, Patients rate physician communication about lung cancer. *Cancer*,117, 2011, 5212–20.
- [30]. O. Ray, and C. Kasir, *Therapist relationship*. 9 (New York: McGraw Hill Companies, 2002).
- [31]. E. B. Ansell, A. Pinto, R. D. Crosby, D. F. Becker, and L. M. Anez, The Prevalence and Structure of obsessive compulsive personality disorder in his panic psychiatric outpatients. *Journal of Behavior Therapy and Experimental Psychiatry*, 41, 2010, 275-81.
- [32]. L. G. Castonguay, M. J. Constantino, and H. M. Grosse, The working alliance: where are we and where should we go? *Psychotherapy (Chic.)* 43, 2006, 271–279.
- [33]. R. Elvins, and J. Green, The conceptualization and measurement of therapeutic alliance: an empirical review. *Clinical Psychological Review*, 28, 2008, 1167–1187.
- [34]. U. Hentschel, Therapeutic alliance: the best synthesizer of social influences on the therapeutic situation? On links to other constructs, determinants of its effectiveness, and its role for research in psychotherapy in general. *Psychotherapy Research*, 15, 2005, 9–23.