'Exploring Integrative Humanistic Approaches to Treating Generalised Anxiety and Panic Disorder'

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Abstract

The aim of this study is to explore how integrative humanistic psychotherapists experience treating clients suffering from Generalised Anxiety Disorder (GAD) and Panic Disorder (PD). It seeks to explore the many varied approaches, attitudes, preferences and complicating factors which pertain to the integrative humanistic treatment of these disorders where it is felt there is a general lack of pre-existing research. Using a qualitative approach, the study sets out to explore as many themes as practically possible by interviewing experienced, fully accredited psychotherapists who experience GAD and PD presenting in their practice on a regular basis. For this, a series of four semi-structured depth interviews were undertaken, from which the data was deciphered using the method of thematic analysis. This method was chosen due in particular to the subjective nature of the subject matter. This exploration was then launched from a base of having extensively examined pre-existing research and theory, so as to gain as great an understanding as possible in to the many perspectives of differing disciplines and philosophies alike. The most surprising findings were the sometimes wildly opposing views and styles held by participants – all from very a similar training and background - towards the treatment of GAD and PD. However, it can also be said that equally as many common, very human threads emerged in how humanistic psychotherapists address these disorders. Further issues which emerged through the data related to the impact which psychoactive medication and the introduction of the medical model have on the psychotherapeutic treatment of GAD and PD, as well as attitudes and preferences surrounding complimentary techniques employed by therapists in the therapeutic process. The study further considered recommendations and possible implications for treating GAD and PD from an Integrative and Humanistic approach in the future.

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Finally, to the participants, whose insights have been invaluable.

Declaration

I hereby declare that the work laid out in this dissertation is entirely my own, except where otherwise stated. It is a project that has not been submitted or accepted for a degree in this, or any other university.

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Carl McNamara

19th of April, 2013

“Always stiff, all day long.

Nothing's right till it's all wrong.

It makes no sense until I'm tense.

Always laughing at your expense”

The Ramones - *'Anxiety'*

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Chapter 1

Introduction

Chapter 1 - Introduction

1.0 Introduction

With ever increasing numbers of individuals from all areas of society now suffering with symptoms of Generalised Anxiety Disorder (GAD) and Panic Disorder *without Agoraphobia* (PD), there has never been such a need for the psychotherapeutic profession to monitor whether these problems are being adequately addressed. Having high comorbidity rates with depression, both GAD and PD are presenting to mental health professionals and point of contact services at an ever increasing rate. Stein (2003) tells us that "anxiety disorders are commonly seen in primary care, affecting about 10% of patients", however, according to Barlow and Waddell (1985), anxiety dwarfs all other problems seen by (mental health) practitioners with 30%-40% of the population presenting with anxiety.

Anxiety is a natural state which under normal circumstances, is considered an appropriate anticipation of, or reaction to a stressor. It is an important stimulus that provides information to the individual enabling them to activate protective responses. However, when it grows in to what Passer & Smith (2009) describe as "a chronic (on going) state of diffuse, or free floating anxiety that is not attached to specific situations or objects" (P. 790), it may then be categorised as Generalised Anxiety Disorder and becomes a state which necessitates attention. This has 3-5% prevalence (Morrison, 2006, P 276) among the population with 70,000 people experiencing symptoms of this disorder at any one time in Ireland, affecting twice as many women than men (Barry, 2009, P. 89).

Panic Disorder, which is believed to have a comorbidity rate with GAD in excess of 55% (anxietycanada, 2012), has a lifetime prevalence of 3% (Morrison, 2006: 254). Newman, Holmes, Zuellig, Kachin, & Behar (2006) further state that adults of college going age (18-22) are the most susceptible, having a 12% chance of suffering an unexpected panic attack,

with Dr Harry Barry of 'Flagging the Therapy' (2009, P. 112) telling us that PD affects an estimated 150,000 people in Ireland alone.

1.1 Aims and Objectives

The overall aim of this study is to explore opinions, attitudes, styles and complicating factors that influence the treatment of GAD and PD so as to paint a clearer picture of how they are being addressed by today's contemporary psychotherapeutic community. By doing this, it is hoped that certain trends and themes may become evident and as such, further insight and understanding may emerge in to what makes certain approaches and combinations of styles effective and whether there may be a potential movement towards any clinical preferences.

Specific objectives to be covered in pursuing the overall aim of this research will be:

- To explore the preferred approaches of therapists when confronted with GAD and PD in their practice.
- To explore the use of complimentary techniques such as mindfulness and relaxation in addressing these disorders.
- To explore the integrative introduction of various other schools, such as the psychodynamic and cognitive-behavioural approaches.
- To explore the concept of retraumatisation and reactivation of symptoms within the therapeutic space.
- To explore the importance of the therapeutic relationship in treating anxiety disorders.
- To explore the impact of anti-depressant and anti-anxiety medications and general attitudes towards the medical model in treating GAD and PD.
- To explore any remaining insights and observations which participants may deem pertinent to the research aims at hand.

Chapter 2

Literature Review

Chapter 2- Literature Review

2.1 Introduction

This literature review shall focus not only on the aspects which define and characterise GAD and PD, but the general themes, attitudes and trends that shape their humanistically orientated, psychotherapeutic treatment.

2.2 Psychoanalytical Perspective of Anxiety and Panic

Traditionally viewed by Freudian psychoanalysis as having three separate facets – the neurotic, the reality and the moral – anxiety is seen as an unpleasant inner state that people seek to avoid and "the fundamental phenomenon and main problem of neurosis" (Freud, 1926d, p. 144). Wolfe (2005, p. 25) however, tells us that Freud struggled to unify his concept of anxiety due to "on the one hand, his belief that the psychological level of explanation would eventually be reduced to neurobiological laws, and on the other, his inability to transcend his psychological metaphors".

In common with both GAD and PD, neurotic anxiety is seen to be free-floating and was differentiated by Freud from "real danger" in the sense that "neurotic danger is thus a danger that has still to be discovered" (Freud, 1926d, p. 165). Helmut & Horst describe this anxiety neurosis as being "experienced as inevitable, uncontrollable, and potentially fatal" (1992; 518p), characteristics that can very well be used to describe symptoms especially of PD, which shall be seen below.

However, modern analytic, psychotherapeutic and psychiatric thinking has broken away from its devoutly Freudian view of symptoms and their causes to evolve into the more contemporary diagnoses which appear in today's DSM IV-tr (LeDoux, 2003, p 229). It must however be noted, that even 115 years ago, Freudian psychoanalysis had an accurate take on the epidemiology of panic in the individual and even more so for PD *with agoraphobia*

describing how panic attacks act as the prototype for agoraphobia and other anxiety disturbances by leading to avoidant behaviour. Helmut and Horst (1992) even go so far as to opine that "panic disturbances" in the DSM manual are largely the same as how Freud delineated panic attacks in 1895.

2.3 Existentialist Perspective of Anxiety

If viewed through an Existential, humanistic eye, we see that anxiety has traditionally been viewed as both a condition of *being* and a fundamental drive towards the reaching of one's potentiality. Thinkers such as Kierkegaard, Goldstein and Rank had long posited that coupled to the awareness of being is the awareness of an imminent sense of non-being when confronted with the four 'givens' of human existence – death, freedom, isolation and meaningless (Yalom, 1980). This realisation becomes manifest as anxiety, which Yalom tells us, "is the subjective state of the individual's becoming aware that his existence can become destroyed, that he can lose himself and his world, that he can become "nothing"" (May, 1983, P. 109-110).

Existentialism has also traditionally put forward the notion that anxiety is inherent too, in all change, be it not just negative changes, but positive growth also. Rollo May (1983, P. 111) outlines this duality beautifully by stating; "anxiety occurs at the point where some emerging potentiality or possibility faces the individual, some possibility of fulfilling his existence; but this very possibility involves the destroying of present security, which thereupon gives rise to the tendency to deny the new potentiality". Famously referring to anxiety, Kierkegaard described it as being "the dizziness of freedom" (as quoted in May, 1983, P.112).

2.4 Aetiology and Symptoms of Generalised Anxiety and Panic disorder

It is generally thought that the aetiology of these anxiety disorders is influenced by both genetic (Hettema J, Prescott C, Meyers J, et al, 2005, 62: 182-189.) and environmental factors

and the interactions between each, with both disorders tending to run in families (Maddux & Winstead, 2008: 382).

Encompassed within the environmental and familial factors, are issues of Attachment and Object Relations which play a vital role in the causation of GAD and PD. It is the work of theorists such as Bowlby (1969, 1988), Ainsworth (1965) and Winnicott (1952a, 1971) which greatly inform how modern psychology has come to understand how the psychical structures and schemas of these disorders are organised. Passer & Smith (2008, P. 669) say that with regards to 'anxious-ambivalent' and 'insecure-avoidant' attachment styles, studies have continually shown that these are continually linked to patterns of anxiety.

On the biological level, the quality of attachment formed in infancy largely defines the normal levels of autonomic arousal and anxiety which the child will find comfortable to tolerate throughout its whole life. The mother (or primary carer) will greatly influence future modulation of anxiety levels "by entering the baby's state with him" (Gerhardt, 2004, P. 22). This comes through the form of touch, vocalisation and facial mirroring. By mirroring the voice, soothing a tense baby by holding him, or stimulating a baby through smiling eyes, "and all sorts of non-verbal means", Gerhardt (2004, P. 23) tells us that "she (the mother) gets the baby back to his set points where he feels comfortable again". This process becomes internalised by the child and depending on whether being adequately met or not, informs the emotional regulation of the child and becomes a blueprint for future patterns of anxiety throughout adulthood. However, if these needs are not met, or met by the caregiver who themselves may have poor emotional regulation, the child may grow to be unable to effectively monitor his own internal state. It has even been observed that a baby's regulatory system will synchronize with that of the mother, mirroring the over aroused autonomic regulation of the anxious mother (Gerhardt, 2004, P. 18).

It is therefore important to recognise that GAD is not just a psychological state, but also a physiological one and is characterised by cognitive, emotional, somatic and behavioural aspects (Seligman and Rosenham, 2002). Found upon Axis I of the Diagnostic and Statistical Manual of Mental Disorders (DSM IV – TR), GAD's essential feature is excessive and uncontrollable worry "about a number of events or activities and is identified as such if occurring more days than not for a period of at least 6 months" (DSM IV – TR, 2000:472). It becomes manifest in the sufferer through the effects of continual hyperarousal of the sympathetic branch of the Autonomic Nervous System. This autonomic hyperarousal is usually accompanied by accelerated heart rate, shortness of breath and dizziness (DSM IV – TR, 2000:473) and is often accompanied by "at least three additional symptoms from a list that includes restlessness, being easily fatigued, difficulty concentrating, irritability, muscle tension and disturbed sleep (DSM IV – TR, 2000:472).

These physiological and psychological affects, changes and symptoms of GAD overlap with the symptoms experienced by sufferers of PD, the main feature being the occurrence of panic attacks which are characterised with intense, sudden onrushes of anxiety that can be disturbing and can leave a long lasting residue of dread and disability (Barlow, 2002). This builds to a peak rapidly, usually within 10 minutes or less, with the average panic attack lasting for a duration of 10 minutes (Barry, 2009, p 114). This sudden onrush of anxiety and intense fear usually occurs in the absence of any real danger and under DSM IV-tr (2000: 430) criteria, is accompanied by at least 4 of 13 somatic or cognitive symptoms including palpitations, sweating, trembling, perceived shortness of breath, choking, chest pain or discomfort, nausea or abdominal distress, light-headedness, derealisation or depersonalization, fear of losing control, fear of dying, paresthesias and chills or hot flushes. Accompanied by an "urge to escape" (DSM IV – TR, 2000:430), we are told "they are such excruciating experiences that patients will do nearly anything to avoid them. Many patients

develop such a fear of having them that they avoid situations or circumstances that they associate with Panic Attacks" (Morrison, 2006: 254). These intense and aggressive symptoms are in contrast to the constant low grade autonomic arousal which delineates GAD, yet are intrinsically linked due to their origins.

Pathophysiologically speaking, the mechanisms behind anxiety symptoms and their resulting disorders have not been fully defined as yet, however, are believed to be due to disrupted modulation within the central nervous system. "Physical and emotional manifestations of this dysregulation are the result of heightened sympathetic arousal of varying degrees" (clevelandclinicmeded, 2012). Further research has found that "patients suffering from anxiety are generally more sensitive to physiologic changes than non-anxious patients, and panic disorder sufferers are even more sensitive to these than GAD patients" (clevelandclinicmeded, 2012). Goldstein and Chambless (as cited in Mineka, S., & Zinbarg, R., 2006), describe how sufferers of PD develop what they describe as a "fear of fear". Due to the process of interoceptor conditioning, the conditioned stimulus of panic attacks are actually the body's own internal sensations (Razran, 1961). This means that when low-level somatic sensations of anxiety precede and are consequently paired with higher levels of anxiety/panic, the low-level somatic sensations of anxiety come to further elicit high levels of anxiety and panic (Mineka & Zinbarg 2006) and a feedback loop of symptoms emerges.

2.5 Complimentary Techniques - Meditation, Mindfulness, Relaxation and Breathing Techniques.

There has been considerable research into the efficacy of complimentary techniques such as mindfulness, meditation, breathing techniques and progressive muscular relaxation in the treatment of anxiety disorders. These techniques involve learning to consciously relax the body and mind by regulating autonomic arousal, thus lowering the frequency of which the sufferer is experiencing unpleasant, worry/panic-inducing thinking patterns.

However, the majority of the psychotherapeutic related research in to these techniques has been conducted when applied in conjunction with cognitive therapies such as Cognitive-Behavioural Therapy (CBT) and when integrated in to their own therapies, such as the Mindfulness-Based Cognitive Therapy (MBCT) of Jon Kabat-Zinn. Although primarily developed to prevent patients from relapsing into major depression (Teasdale, Segal, Williams, Ridgeway, Soulsby & Lau, 2000), MBCT was found to have significant success in treating anxiety symptoms through mindfulness based meditation techniques (Yong Woo, Sang-Hyuk, Tae Kyou, Shin Young, et al ,2009). Further to this, experienced meditators have been shown to process stress more efficiently as their experience increases (Goleman & Schwartz, 1976; Schwartz, Davidson, & Goleman, 1978). Similarly, recent studies now show that mindfulness based meditation holds great promise in treating the symptoms of anxiety in children. (Semple, Randye, Reid, Elizabeth, Miller, 2005) and other research has shown the efficacy of meditation alone, in greatly soothing symptoms of anxiety (Coppola & Spector, 2009).

It may also be noted that studies have been carried out in both the efficacy of Applied Relaxation (AR) techniques such as Progressive Muscular Relaxation (PMR) and the use of Breathing Techniques in the treatment of GAD and PD. In the case of AR, one study conducted in the Netherlands found that 53.3% of patients practicing AR recovered on the STAI-trait at six-month follow-up (Arntz, 2003). In the case of breathing techniques, especially the practice of diaphragmatic breathing, benefits have long been recognised regarding "promoting a subjective state of relaxation as well as physiological effects that are contrary to hyperventilation and autonomic nervous system arousal. As a result, breathing retraining is often used to counteract the chronic anxiety seen in GAD and the hyperventilation associated with sudden, unexpected fight-or-flight activation in PD" (Hazlett-Stevens & Craske, 2009). Further to this, breathing techniques have been found to

significantly reduce symptoms of agoraphobia, depression, irritability, muscle tension and fatigue and the prevention of breath holding and hyperventilation (Davis, Eshelman & Mckay, and 2008: 28).

It must also be pointed out that not all research has shown to be positive for such techniques. There is also much evidence for 'relaxation induced panic and anxiety' with one study on the effects of meditation by Shapiro (as cited by Perez-De-Albeniz, Alberto and Holmes, Jeremy, 2000) stating that "subjects reported significantly more positive effects than negative from meditation. However, of the twenty-seven subjects, seventeen (62.9%) reported at least one adverse effect, and two (7.4%) suffered profound adverse effects.

However, while there is plenty of research linking the usage of these techniques to cognitive based therapies (Kabat-Zinn, 2003; Sharma, Mao & Sudhir, 2012; Donegan & Dugas, 2012), there is still a dearth in research surrounding the attitudes towards, and employment of these techniques by more humanistically trained therapists.

2.6 A Third Force – The Integrative Humanistic Approach

Possibly due to the subjective and qualitative nature of studying the efficacy of humanistic psychotherapies, finding research on the subject of their treatment of GAD and PD has proven to be quite problematic with most studies acknowledging from the outset, these very same difficulties. One such study (Elliott, Partyka, Alperin, Dobrenski, et al, 2009) calls for an increase in single subject case studies, rather than research of a quantitative nature, in order to gain greater insight in to treatment and efficacy. Another such study by (Levitt, Stanley, Frankel and Raina 2009), which was conducted to evaluate efficacy of humanistic psychotherapies was given the decidedly wry tagline of 'Using Thermometers to Weigh Oranges' - illustrating the associated frustrations in carrying out such research.

However, speaking from an exclusively integrative approach, Horvath and Greenberg (1994) continually remind us that the therapeutic relationship is now seen universally in all approaches as an integrative common factor in psychotherapy. Wolfe (2005, P. 182, 187), espouses the importance of a strong therapeutic alliance and the "interconnectedness of relationship factors and tasks" in the successful treatment of anxiety disorders. Similarly, Barry (2009, p 92, 115) tells us that in the foundation of effective treatment of GAD and PD, empathy is required to create the correct conditions for therapeutic change. The quality of empathy, identified alongside congruence and unconditional positive regard by Rogers (1951, 1959) as a core condition of a Person-centred, therapeutic relationship, is at the very foundation of effective, humanistic psychotherapy.

A further three common factors are identified by Wolfe (2005, p182) relating to current integrative treatment practices for anxiety disorders. Firstly, he tells us that a focus on symptoms is the crucial starting point, rather than a regressive approach such as the psychodynamic. Next, we are told that "exposure therapy is a necessary – if not sufficient" condition of treatment. Lastly, Wolfe informs us that the treatment of anxiety disorders by the different approaches is still largely a "work in progress" and that "all perspectives are in the process of developing treatment interventions focussed on underlying psychic structures that presumably govern the symptoms of an anxiety disorder" (2005, P. 183).

In the field, Wolfe insists that after the goal of symptom reduction is addressed, the integrative practitioner must then address two further goals – those of "analysis and modification of defences against painful self-views and healing the self-wounds" (2005, P. 191). Relaxation, mindfulness and other symptom reduction techniques, although playing what Wolfe (2005, P. 186) describes as a "necessary, but insufficient role", cannot produce "a comprehensive remission of an anxiety disorder". It is therefore necessary to begin "healing the self-wounds" as well as engaging in the emotional experiencing that is particularly

involved in “acquisition and maintenance of personal identity and self-esteem” (2005, P. 197). Modifying toxic self-appraisals and resolving catastrophic conflicts (P. 208) may then hopefully bring fruition to the therapeutic process.

Obstacles that have been identified by Wolfe (2005, P. 194), as being a hindrance to an effective, integrative approach in the treatment of anxiety disorders such as GAD and PD, may be the differences, both political and theoretical, between disciplines. “What has been sundered by the polemics among psychoanalytic, behavioural, and humanistic therapists needs to be (re) integrated” (2005, P. 194).

It is decided that some consideration should also be given to the safe trauma therapy of Babette Rothschild, especially in clients who are suffering from symptoms of dissociation, panic attacks and avoidance. Rothschild (2000, P. 79) gives the analogy of how therapy of this nature such be treated akin to a pressure cooker, not immediately releasing all of the pressure contained in the underlying experiences and psychical structures which inform the aetiology of the anxiety disorder. There is a very real danger of eliciting such symptoms especially if a more uncovering approach is taken in identifying underlying causes. Dual awareness, which Rothschild (2000, P. 129, 130), refers to as “a prerequisite for safe trauma therapy and as a tool for braking and containment”, may be necessary for the integrative therapist to practice if engaging in a regressive style therapy. “A normal process among the non-traumatized, dual awareness simply involves being able to maintain awareness of one or more areas of experience simultaneously. Acknowledging the split between the experiencing self and the observing self has helped many clients to tolerate being in situations where they are prone to anxiety attacks”.

Through Rothschild's methods and ways of providing braking and containment for the client, it is hoped that the client can re-enter, and consequently learn to more easily inhabit what

Daniel Siegel refers to as the 'Window of Tolerance'. This concept refers to the optimal zone of autonomic and emotional functioning. In this zone, “various intensities of emotional and physiological arousal can be processed without disrupting the functioning of the system” (Siegel, 1999, p. 253).

2.7 Use of Medication and its Implications upon Therapeutic Process

There are large volumes of research pertaining to efficacy in the use of selective serotonin reuptake inhibitor (SSRI's) (Kirino, 2012), (Hoffman & Mathew, 2008), Serotonin norepinephrine reuptake inhibitors (SNRI's) (Dell'Osso, Buoli, Baldwin & Altamura, 2010) and benzodiazepines (Hoffman & Mathew, 2008) in the treatment of anxiety disorders such as GAD and PD. However, clinical efficacy of medication is not a concern of the research being conducted here, but rather on how the integrative humanistic psychotherapist experiences the intervention of the medical model and its implications in treating clients with GAD and PD. As such, more qualitative research and writing was sought to find a greater depth of feeling into the subjective experience of the therapeutic alliance/relationship and it's relation to medication.

Firstly, the 'holding environment' which medication provides must be acknowledged. However, it is opined by Dr Harry Barry that medications “are useful in helping the person with severe GAD arrive at a point where they can become involved in talk therapies”, but “are less effective than talk therapies” over time (2009, p93, 94). In relation to these psychoactive medications, Häfner (1987, p203) is of the opinion that “the most that can be achieved is that the blockade of severe anxieties enables the affected individual to successfully use his own capacities to cope with anxiety. Chronic states of anxiety, especially anxiety neuroses, require psychotherapy”. However, in one study on the effects of (SSRI) medication on the psychoanalytic process (Awad, G. A., 2001), it was found that symptom removal caused by medication did not cause patients to give up on analysis. Further to this,

the researcher concluded that although the influence of medications on the analysis is a complex matter, it strengthened the patient/analyst alliance through decreased symptoms.

When speaking of tranquilisers in relation to the treatment of anxiety disorders, Dr Barry (2009, p 88) deems it as "unfortunate" that these have traditionally been the drug of choice in treatment and that "they can be helpful in acute short-term anxiety situations but are felt to be more a hindrance by most experts in the field". Lynch (2001, p 216) elucidates that "the resulting sedation (of continuous prescription) may reduce the person's ability to work though the issues relating to their crises". Surely this is an issue affecting many facets of the therapeutic relationship such as immediacy and other here-and-now phenomena, as well as impacting upon the levels and timbre of emotional expression being experienced by both therapist and client in the therapeutic space. Being medicines that are psychotropic in nature, it only stands to reason that there will be a consequential distortion of the consciousness of the client to one degree or another.

The concept of addiction must also be considered (Lynch, 2009, P. 88), concerning, the very real effects related to withdrawal (Lynch, P. 158), (Gelder, Mayou & Geddes, P. 201, 2006), (Passer & Smith, P. 871, 2008), and attitudes towards adverse/side effects (Lynch, P. 69, 158) and how such phenomena impact upon the different qualities and facets of the therapeutic process. There is also a lack of research pertaining to the attitudes of therapists towards possible over-prescription of such medications (Lynch, P. 28, 2005). With over 26 million prescriptions currently being written annually for anti-depressant medications in Britain alone, it is felt that there is a lack of research relating to the humanistic, psychotherapeutic view of this occurrence.

2.8 Conclusion

Theoretical perspective, aetiology, symptomology and confounding factors have all been examined in this chapter as potential secondary data which may be pertinent to findings (Heppner, Kivlighan, & Wampold, 1992, P. 507). It is clear that such a distinctly human state has many differing traits and convoluting variables.

Chapter 3

Methodology and Sampling

Chapter 3 - Methodology and Sampling

"All social research sets out with specific purposes from a particular position, and aims to persuade readers of the significance of its claims" (Clough & Nutbrown, 2007:4)

3.1 Introduction

This chapter will outline in detail, the methodology selected by the researcher in carrying out this study and will explain why such methods were chosen and how they are used to collect new data (Denscombe, 2007). Discussed within shall be issues pertaining to design, procedure and ethics, as well as an examination of certain limitations and pitfalls experienced throughout the course of the study.

3.2 Research Design

Due to the subjective and often abstract nature of the subject matter, a Qualitative style of analysis was adopted for this study as it was decided that this would be the most appropriate methodology for capturing the richness in detail of the interviewee's insights and experiences. With the nature of client work, many themes pertaining to the treatment of GAD and PD in the therapeutic setting are quite abstract and as such, would not fit comfortably here, into a quantitative structure. Consequently, the data was collated through semi-structured, one-to-one interviews, which allowed the interviewer the opportunity to pursue and explore themes, concepts and opinions raised by participants (May, 1993; Flick, 2011). This style of Qualitative inquiry has been described by McLeod (2003, P. 73) as being "a process of systemic inquiry into the meaning which people employ to make sense of their experience and guide their actions" and as such, was adjudged to be wholly appropriate for investigation in to therapeutic attitudes towards the treatment of GAD and PD.

3.3 Participants

The chosen sample was taken from fully accredited therapists who were members of either the Irish Association of Counselling and Psychotherapy (IACP), or the Irish Association of Humanistic and Integrative Psychotherapy (IAHIP), or both. It was decided that there would be no discrimination shown with regards to whether a participant is accredited by the IACP or the IAHIP as to a), not limit the prospective sample, and b), to allow for any minor nuances between related professional perceptions pertaining to either code. It was also deemed prudent that participants should be fully accredited under their regulatory bodies for no shorter than 2 years. This length of experience, it was assumed, would be sufficient in ensuring credibility, dependability and transferability in attaining validity for the research undertaken.

In all, four participants agreed to take part. These were comprised of four female, humanistically trained psychotherapists between the ages of 35 and 55, three of whom were members of the IAHIP and one IACP. All four of the participants work in private practice, two of whom work part time in a statutory organisation.

3.4 Recruitment

The participants were recruited through a combination of snowball sampling and email invitation. Email addresses were procured from the publically available member lists of both professional bodies and a total of 32 invitations were sent out to therapists from the geographic area of South Dublin. These emails contained in them a brief description of the general themes and nature of the research (See appendix A). Two replies were received from these initial emails and from the resulting two interviews, a further two individuals were procured through the snowball sampling method which is the act of gathering further participants for research through interviewees who have already taken part in one (Coolican, 2004; McLeod, 2003, P. 30).

3.5 Materials, Equipment and Procedure

Two of the interviews were conducted over the phone, in private, using a speaker phone in order to make recording possible. The remaining two were carried out face-to face in the therapy rooms of these two participants. All four semi-structured depth interviews were recorded by electronic recording equipment, and transferred to a digital sound storage programme on the researcher's personal computer. The interviews lasted between 18 and 38 minutes and were each scheduled to take place at the interviewee's convenience. Further to this, a hard-copy of the schedule of questions was offered to the participants if desired (See appendix B). This offer was taken up by just one of the individuals taking part.

3.6 Ethical Considerations and Informed Consent

Before consent was granted, participants were made aware of the purpose of the research and made aware of the educational institution and thesis supervisor under whom the research was being carried out under. Participants were then told that all information garnered would be treated confidentially and used solely for the purpose of this research project (See Appendix C). Furthermore, they were told that each individual would be assigned an alias to insure that their participation would be covered by blanket anonymity and all transcriptions would be held in a secure location for no less than 6 years so as to guarantee best practice. After being informed that participation was completely voluntary and that they may terminate the interview at any time, the recordings began. The subsequent recordings were then transferred to a password protected computer hard dive and then permanently erased from the recording equipment. Once each interview was fully transcribed to computer, the analysis of the data could begin.

Due to the nature of the data gathering procedure and the broad themes and subject matter being researched, there were no major concerns surrounding confidentiality or the possibility of compromised, participant beneficence (Bell, 2005).

3.7 Thematic Analysis

The researcher employed a thematic analysis approach towards deciphering the therapist's attitudes, opinions and observations regarding the treatment of GAD and PD in the clinical setting. A qualitative analytic method widely used in psychological research, thematic analysis is a good way of encoding qualitative data of a subjective nature (Clarke & Braun, 2013). Once all interviews were transcribed, alpha-numerical indications of the frequency of incidents and prevalence of each emergent theme were assigned and calculated within the data: “a theme captures something important about the data in relation to the research question and represents some level of patterned response or meaning with the data set” (Braun & Clark, 2007, p. 82). It was through 'repeated reading' (Clarke & Braun, 2013) that these themes were identified within the transcripts in order to find patterns of meaning brought forth by the interview questions asked by the researcher. Gradually, these themes and the more detailed data which comprised them began to emerge and a comprehensive and clear patch work of ideas became evident. A method of coding was used to more accurately discern relevant sub-themes and trends.

When sufficient themes and sub-themes had been identified and collated, detailed analysis of each were carried out for the purposes of research findings, discussion and recommendations.

Chapter 4

Findings and Discussions

Chapter 4 – Findings and Discussions

4.0 Introduction

The purpose of this chapter is to disseminate and discuss raw data that has been gathered through four interviews that were conducted on the topic of how GAD and PD are experienced by the therapist in clinical practice. Shown in *fig. 4.1,* all four participants are fully accredited, practicing psychotherapists who come from a background of humanistic training. They were selected from the IACP and IAHIP websites and all four are self-employed in private practice. Participants have between 8 and 15 years of post-accreditation experience. To honour anonymity protocol outlined in the Methodology section (3.6), participants were assigned aliases.

Fig. 4.1

Alias	Accreditation Body	Post-Accreditation Experience	Professional Employment
Jill	IAHIP	12 Years	Private practice and statutory organisation
Angela	IAHIP	15 Years	Private practice
Maria	IAHIP	11 Years	Private practice & private hospital
Selma	IACP	8 Years	Private practice and statutory organisation

The interviews were carried out separately and were of a one-to-one, semi-structured depth style (May, 1993; Flick, 2011). This allowed the interviewer the opportunity to pursue additional information and themes brought forth by participants which was not anticipated by the primary questioning. The qualitative data which the interviews returned was thematically analysed through coding techniques described on page 20. Coding was applied to the interview transcripts which were comprehensively read and re-read (Clarke & Braun, 2013).

Through continual coding and reduction of the subject material, 4 primary themes then emerged which informed the experiences of the four participating therapists when treating GAD and PD.

The themes which emerged through the process of thematic analysis are;

- Theme A: Preferences and Attitudes Regarding Differing Approaches and Styles and the Therapeutic Relationship.
- Theme B: The Use of Complimentary Techniques
- Theme C: Issues of Symptom Activation in Therapy/Working with the Client
- Theme D: Medication – Difficulties, Benefits and Impact on Therapy

4.2 Theme A: Preferences and Attitudes Regarding Differing Approaches and the Therapeutic Relationship

This section shall examine the varying approaches, styles and attitudes of the four participants in addressing GAD and PD, which emerged through the semi-structured depth interviews outlined in Chapter 3 – Methodology and the line of questioning laid out in Appendix C.

4.2.1 Approaching GAD and PD from a Humanistic Perspective

Having each been trained from a humanistic, integrative perspective, and coincidentally, all in the same institute, (but at different times) each participant initially expounded the importance of the 3 core Rogerian conditions (Rogers, 1951, 1959) in their work with particularly anxious clients. The most striking observation being a commonality amongst all participants, and echoing Roger's core condition of unconditional positive regard, was the need for the therapist to be non-judgemental and to (Angela) *"just meet the person where they're at – wherever they're at"* and seeing the person (Jill) *"in their totality"*. It was this notion of meeting the client where they're at which most strongly informed how each

approached working with GAD and PD. We shall in this section, examine the preferences of interviewees towards treating these disorders.

However, before continuing, it must be acknowledged that Angela divulged not to gravitate towards any specific approaches at all, rather preferring just to hold the anxiety of the client as this *“may be something different. Something that they may not have experienced before”*. She further described her style as *“about tolerating the tension that the client holds”*, which in turn, serves to provide through therapy, a corrective experience of attachment which parallels with the issues of mirroring and autonomic modulation discussed within section 2.4 (P. 5) of the literature review. From here, she referred to Daniel Siegel's (1999) concept of the 'Window of Tolerance', previously examined in section 2.6 of the Literature Review. Through Angela's style of working, she attempts to provide for the client, an experience of this optimum state in the therapeutic space, so that the client may themselves learn to more adequately modulate their own levels of anxiety, partly through mirroring Angela's.

For the other three interviewee's (Jill, Maria & Selma) however, their individual ways of working meant integrating quite a solution focussed, CBT style therapy when initially addressing GAD and PD. Maria went so far as to say that she is now primarily CBT focussed in style when treating anxiety, deciding on it to be *“the most valuable in working with anxiety-disorders and panic”* and as such, enabled therapy to be *“symptom focussed”* and gave clients coping skills which enabled them to *“actually learn the trigger points which actually cause the panic attacks, in order to, I suppose, actually avoid them in the beginning”*. Unbeknownst to Maria or not, she is directly touching upon the first of Wolfe's (2005, P. 182) three common factors of treating anxiety-disorders as outlined in section 2.6 of the Literature Review – that of having a starting point that is symptom focussed.

While pursuing the theme of integrativeness, three of the four participants cited the need to embrace a well developed sense of integrativeness when addressing GAD and PD in the clinical setting, echoing Horvath and Greenberg (1994). It was the opinion of Jill that *"all forms of therapy really, have their uses, but really, you know, it's not one size fits all. I think all people are very unique, very diverse and individual, so I suppose, drawing from different schools and models, I find, is I suppose the most effective way to help them with their anxieties"*. This outlook towards practice would most surely resonate with the psychotherapeutic aims of Dr Harry Barry's (2009) view of approaching the anxiety-disorders from a more holistic and complete direction.

Expanding on the integrative theme, Selma professed her enthusiasm towards employing an existential approach in the treatment of GAD and PD. She noted that often clients *"panic about death. Panic about their life meaning nothing. They don't know where they're going which causes huge anxiety to* [sic] *people…, so I think by helping them to look at the meaning of their own life probably helps"*. This directly corresponds to the fundamental mechanism of Existential psychotherapy in which it is hoped by Yalom (1980), that the client will come to live a more 'authentic life', through examining their purpose for existing. This also relates to van Deurzen's (2010, P. 161) thinking where she tells us that a "possible refocus to life in the context of our finiteness and the finality of life, which makes us aware of our responsibility to make the most out of what we have got" may be the agitator for a new liberating, impetus in life.

Furthering the integrative line of enquiry, the theme of the psychodynamic approach emerged among two of the interviewees – Maria and Jill. When initially asked if she would find herself using a psychodynamic approach, Maria decided *"not necessarily"*. However, she went on to say that *"I think the more somebody understands where their anxiety is rooted, it's very useful, because at least they know it's not just something that came down out of the stars.*

(pause) and if you go back in to the early childhood, you'll find that there's maybe tensions in early childhood, in the family". This observation recalls how Gerhardt (1994) suggests that poor emotional regulation can be passed on from the care giver. Maria also believed that *"psychodynamic and CBT integrate really, really well with each other"*, further reinforcing the values of integrativeness espoused by both Horvath and Greenberg (1994) and Wolfe (2005) in section 2.6.

When speaking of working in a regressive, psychodynamic style, Jill suggested that she'd *"often use it when something surfaces. Then we'd look at the very real experiences and sensations (of anxiety and panic) that are being experienced in the here-and-now, and maybe link them to the past, to the incidents in the past, but the client has to be willing, you know, and make definite links for themselves, and realise that the same feelings there are here in the now. That can be very fruitful"*. It must be noted however, that according to Malan (1979), when therapist and client are engaged in a regressive, uncovering style therapy, the risk of the client becoming retraumatised takes on a greater urgency. It is here that an awareness should be held towards the various methods of braking and containment practiced in Rothschild's (2000) approach discussed in section 2.5. Jill later pointed out that *"I think if somebody is going through a psychodynamic approach of a trauma in the past, I think it can be reactivated sometimes"*.

Speaking on the issue of symptom activation in relation to a psychodynamic approach, Maria remarked *"you'd be surprised at how mundane the trigger might be"*. She further recalled an incident of retraumatisation that occurred due to a therapy session which took place in surroundings that elicited memories in her client of past hospitalisation for mental breakdown. Triggers of symptom activation and retraumatisation in relation to the psychodynamic approach are touched upon below in section 4.4 However, these triggers are

not exclusive to the psychodynamic approach, but can be elicited within any of the approaches discussed above in this section.

4.2.2 The Role of Empathy and Importance of the Therapeutic Relationship

The role of empathy in treating GAD and PD was variously described as being (Jill) *"vital"*, (Maria) *"huge, absolutely huge"* and (Selma) *"massive"*, no surprise when we consider how integral this quality is to effective humanistic psychotherapy (Rogers, 1951, 1959). Angela had a unique way of describing the role of empathy in treating GAD and PD by saying *"it's all we have. There really isn't anything without empathy. Without empathy, it's* (the therapy) *simply reactivating what was there before. All you have is somebody out of control in their panic"*. She further decried the importance of empathy by noting that *"very few people get the opportunity to explain what it's like for them to suffer from anxiety"*, highlighting the overarching importance of the empathic therapeutic alliance to all modes of psychotherapy (Barry, 2009; Horvath and Green, 1994).

Speaking on the subject of empathy and the therapeutic relationship, Jill expressed that *"the alliance is the most important thing, probably, in the therapy, you know what I mean? You can't underestimate* [sic] *how valuable that is – the caring from one human being to another"*, later saying with respect to empathy and the Rogerian approach - *"everything else are just methods"*, which directly relates to Wolfe's reflections upon the importance of the therapeutic alliance in the successful treatment of GAD and PD in section 2.6 of the Literature Review.

4.3 Theme B: The Use of Complimentary Techniques - Mindfulness, Breathing Exercises and Grounding

Three of the four interviewee's (Jill, Maria & Selma), showed great regard for use of complimentary techniques in the context of working with GAD and PD in session. Forms of

these techniques which were utilised by participants and explored throughout the course of the interviews were Mindfulness, breathing techniques and grounding.

Conflictingly, Interviewee Angela once again exhibited a certain antipathy towards the introduction of any similar relaxation inducing technique, going so far as to say that she *“wouldn't be introducing anything to 'distract', really”*. This can be seen in a sense to mirror Wolfe's (2005) second conclusion that a degree of exposure is a necessary ingredient for effective treatment of anxiety-disorders, yet disregards his first whereby a focus on symptoms is the crucial starting point.

Again, it was 3 out of the 4 of participants who showed great motivation towards using mindfulness techniques in session, in aiding clients with their immediate symptoms, describing it as (Selma) *“very useful”* and Jill having stated she *“sees the benefits of mindfulness first hand”* - benefits long recognised and studied from a cognitive-Behavioural perspective by theorists such as Jon Kabat-Zinn, examined in 2.5 of the literature review. Participant Maria espoused the benefits of mindfulness by opining *“mindfulness is very useful. It* (anxiety) *brings you to a place where you're not in the present moment.... the more you focus on the anxiety, the more anxious you become. So therefore it's very important with mindfulness, to learn how your senses bring you back in to the present moment”*. This, with practice, becomes a powerful tool for the client in aiding them to return to Siegel's (1999) 'Window of Tolerance' and helps to illustrate how researchers such as Goleman (1976, 1978) and Schwartz (1976) have long since acknowledged that the practice of mindfulness has been shown to help people process stress more efficiently, consequently lowering overall levels of anxiety.

In a similar fashion to the use of mindfulness by interviewees, the benefits of breathing techniques were acknowledge, not just in session with particularly agitated clients, but with

symptom management in general. Having incorporated this in to her work with many clients, participant Maria went in to particular detail on the subject saying that she *"uses it on a regular basis"* and would ask clients to *"practice them* (breathing techniques) *just for 2 minutes every day to get them in to the habit"*, but that *"you can't ask people to do any longer"* due to the generally aroused state which clients will present in the beginning of therapy. However, by gradually introducing conscious, diaphragmatic breathing techniques, the therapist is directly teaching the client tools that can be used to counteract the hyperventilation and fight-or-flight symptoms mentioned in section 2.5 of the literature review, which are so intrinsically linked to GAD and PD (Hazlett-Stevens & Craske, 2009).

Maria continued on espousing the benefits of breathing techniques, by mentioning how useful they can be in calming particularly distressing anxiety, as well as *"full blown"* panic attacks. She described how she *"would actually breath myself, and try to get the client to breath in timing, to regulate, to try and get them to that grounded... (state)"*. This relates to with remarkable clarity from the literature review, the observed phenomenon of how the baby's regulatory system will synchronize with that of the mother (Gerhardt, 2004) and illustrates how therapy can aid in giving the client a corrective experience of what Bowlby (1988) termed as the 'Secure Base'.

Selma acknowledged that she would be inclined not to use breathing techniques in the 1st session with a client as she *"tends to find people are a bit anxious anyway, and you don't want to bring them in to something that they think, 'what's this?', and they think it's a bit of a loony thing, listening to your own breathing"*. Selma here reintroduces the question from the literature review of whether or not there is scope for greater research in to how accepting clients (and therapists) may, or may not be towards the introduction of these methods within the humanistic therapies.

Addressing symptoms through the use of grounding techniques also emerged as being of great practical use by two participants (Maria and Selma), especially with regard to specific panic attack activation within session. Selma tells us that grounding can be used as a method to *"bring a panic attack to its end very quickly"*, hopefully reducing its length to below the 10 minute average duration put forth by Dr Harry Barry (2009, P. 114) in 2.4 of the literature review. Maria employed grounding in the same manner as Selma, but went on to say that *"once they're* (the client) *back in themselves, it's very helpful then to use this place to look at what the triggers were that led up to it* (the panic attack)*"*, therefore being able to use them as a foil for being better able to understand and explore the possible psychodynamic and existential dynamics which are informing and fuelling the aetiology of the disorder.

4.3.1 Further Observations Regarding Complimentary Techniques

Varying degrees of enthusiasm can be seen to have emerged from the data towards the use of these techniques, with no participants showing any inclination towards using any methods associated with the applied relaxation techniques examined within the literature review. However, it can be said that both Jill and Selma viewed most complimentary techniques as *"useful"* and *"helpful"*, respectively, whereas Maria, showing her great esteem for these symptom addressing means, went to considerable lengths in explaining and describing her practice of these with clients. As noted throughout this section however, Angela it can be said, largely saw them as a distraction to her style of working with anxious clients. Referring to her quote in section 4.2.1 regarding her holding of the client's anxiety, she said that *"that's the only 'skills' that I'd be using"*. Taking the varied opinions of each of the interviewees into account, it would be wise to recall how Wolfe (2005) described the techniques described above as playing a "necessary, but insufficient role", and that they can not produce "a comprehensive remission of an anxiety disorder" by themselves.

Certain pitfalls can also be seen to be elucidated by participants, with Jill noting that some *"sorts of clients who are quite sceptical, you know, people in high states of anxiety, sometimes aren't susceptible* [sic] *to the introduction of mindfulness and relaxation and grounding"*. Similarly, Selma noted that *"you can offer them* (the differing techniques)*, but it's really up to the client whether they take them on board"*. At this juncture it would be pertinent to recall the research surrounding 'relaxation induced panic and anxiety' by Shapiro (as cited by Perez-De-Albeniz, Alberto and Holmes, Jeremy, 2000) and consider its possible implications for clinical practice if introducing techniques employed to elicit relaxation.

Under the theme of 'Complimentary Techniques', Maria wished to express her opinion on the dangers of using various other techniques not considered in the reviewed literature, citing 2 examples of clients suffering psychiatric breakdown through attending reiki and cranio-sacral therapy due to what she termed *"great movement of energies"*.

4.4 Theme C: Issues of Symptom Activation in Therapy – Using the Triggers Within the Therapy

There were some quite paradoxical attitudes among interviewees towards the possibility of retraumatisation and symptom activation and the management of each within session. Each of the participants however, acknowledged that although (Selma) *"they're not common"*, clients have experienced panic attacks while in session and that retraumatisation has happened to one degree or another. Maria ventured that *"when a client hits off a trigger, you have to be very careful as it can uncover a multitude of things"*. In each of the four interviews, active symptoms of panic attacks and their triggers were used as a means to explore material for the benefit of the therapeutic process, with Selma using them within the therapy by *"link(ing) them to past feelings and experiences. Although, this can recall forgotten traumas"*. However, the use and management of this process varied spectacularly along the spectrum.

Angela viewed it *"as a gift to the psychotherapist to be in the presence of someone having a panic attack. It's the gift that allows the therapist to accept the client. It goes back to holding them and not getting 'spooked' as therapist – not wanting to change it* (the experience of having a panic attack) *for them.. (long pause) it's just about accepting"*. This approach can be related back to the concept that a degree of exposure and experiencing is necessary in the treatment of anxiety-disorders (Wolfe, 2005), as well as relating to the relevance of factors that pertain to the attachment theory of Bowlby, Winnicott and Ainsworth explored within the literature review. Angela goes on further to say *"if they are reintroducing the event of the trauma, then I manage them around what the experience was that led up to the attack"*. In further managing the client, Angela said she would *"find out what they want, what they need, what they think they need and actually use it* (the attack). *It's making it different for them than it was before, because maybe the primary carer couldn't hold them in that, so they didn't learn that skill for themselves"*. Again we see another example here of a participant referring back to the quality, or lack thereof, of attachment experienced by the client in childhood. This shows a commonality between participants whereby considerations towards adequate parenting and attachment are of a high priority when attempting to provide a corrective experience to positively influence the treatment of GAD and PD.

After eventually lowering activation in the client through grounding and mindfulness, Jill would *"'walk the walk' with people and encourage them to see they're safe in the here-and-now while experiencing past trauma"*. Here, Jill is not only relating her way of working to the elements of exposure eluded to by Wolfe (2005) within the literature review, but she is highlighting the importance of the alliance within therapy in being able to hold a safe and trusting space in which the client can sit in their distressing anxiety. She also referred to the outright fear and quality of sensation experienced in a panic attack, saying; *"they* (the client) *often think they're going to die, or they have a brain tumour"*, echoing Helmut and Horst's

(1992; 518p) psychodynamic description of anxiety neurosis being “experienced as inevitable, uncontrollable and potentially fatal”.

4.4.1 Issues of Safety - Braking, Anchoring and Learning ‘Self Tools’

Interviewees were asked whether they practiced with an awareness of the safe Trauma Therapy of Babette Rothschild. Responses again, varied greatly, especially when taken in to consideration the huge similarities in core training, undergone by participants.

Interviewee Angela, when the subject of safe Trauma Therapy arose, asked the researcher *“what does that involve?”*. Once outlined, Angela simply reiterated the chief tenet of her style of working - *“again, it's about acceptance”*. Maria on the other hand, spoke of her awareness of 'braking' and 'anchoring' by saying *“it's important to bring them back to the present moment and keeping them there. Literally bringing them back to their senses. It's about not dissociating”*. In these two replies, two very different attitudes towards the management of symptom activation and retraumatisation within the clinical setting are being revealed. In essence, they are completely paradoxical perspectives towards ways of working within the therapy – one of experiencing, the other of containment, both coming from two therapists who completed the exact same training course. This raises further questions regarding how the approaches of two individual therapists towards the treatment of anxiety disorders can be seen to be so wildly differing and asks to what degree, issues of safety in trauma therapy should be a), taken in to account in session and b), taught as a matter of course within training.

When speaking of practicing a contained style of therapy when treating GAD and PD, Selma ventured that *“it gives the client a sense of control that they can get through trauma and that they have the tools within them self. They have all they need within themselves to heal them self. That can be freeing for people to know that, because a lot of people come in to*

counselling and don't know what it's about. They think they're going to a pro to 'fix' them". From this insight, we see shadows of the holistic blue print outlined by Dr. Harry Barry in his text 2009 'Flagging the Therapy', whereby he suggests strategies for pathways out of anxiety that employ a large degree of autonomy and self-empowerment.

4.5 Theme D: Medication – Its Use and Implications for Therapy

Each participant expressed opinions of the use of medication in treating GAD and PD, however, two interviewees (Angela & Selma) initially seemed quite reticent to enter freely in to this avenue of inquiry with Selma stating when queried, that it *"makes me a little uncomfortable"*. However, both Jill & Maria seemed either happy, or quite enthusiastic, to aid in this line of enquiry.

4.5.1 Medication – Difficulties and Benefits

What should be noted, is that each of the four participants acknowledged that there at least (Angela) *"is a place"* for anti-depressant and anti-anxiety medications in the treatment of GAD and PD, while Maria opined that a *"combination of medication and therapy is of huge benefit to generalised anxiety. The meds calm symptoms down enough so the client can engage in therapy"*, echoing the opinions of Barry (2009) in the literature review regarding the usefulness of SSRI medication in helping the client reach a point where they can engage effectively with talk therapies. Maria later estimated that *"50%"* of her clients are on psychoactive medications. However, Jill was of the view that it is *"very difficult to work* (with clients) *with high doses of medications"* which coincides with Lynch (2001, P. 216) who has stated that "the resulting sedation may reduce the person's ability to work through the issues relating to their crisis" suggesting that anti-anxiety medications have an adverse effect upon the facets of immediacy and here-and-now phenomena within the therapeutic relationship. This view of Lynch is further supported by the observations of Jill where she states; *"emotions are dampened down, you know, I think, ehmm, it sort of limits people's full*

experience of the emotions that they are carrying within. It sort of numbs down feelings and …., it does make the therapy more difficult, yes".

4.5.2 Collaboration – Working with Psychiatrists and G.P.'s

Another avenue of inquiry which wasn't anticipated in questioning but which was broached by each participant was the theme of always working in conjunction with psychiatry if medication is a present factor, when addressing GAD and PD. In fact, Selma highlighted the importance of this collaboration due to the nature of this area being what she described as *"a minefield"*. Maria, who overall showed most positivity towards psychiatry, said; *"if the balance is correct, and the psychiatrist or doctor want their patient to engage in therapy, it's a very powerful combination. It's huge. They* (the medications) *help the client to learn skills to work on anxiety"*, clearly resonating with the opinion of Häfner (1987) in the literature review which suggest that SSRI's provide a 'holding pattern' that allow the client to successfully use their own resources to cope with anxiety.

When asked whether there has been a notable difference in the relationship between psychiatry and psychotherapy in treating GAD and PD in more recent times, Jill ventured that *"it's changing"*, however *"most hospitals put patients on medication and then send them for 6 weeks of CBT and leave it at that and of course, in my opinion, they* (the client) *need longer than that"*. On this subject, it was the opinion of Maria that *"there's a lot more togetherness now"*. Selma further suggested that *"it can be difficult for therapists, the ins- and outs of medication and wanting to advise patients on meds, (laughs) because we can't, even though clients may have gotten worse since taking them. That's why a good working-relationship* (with a psychiatrist) *is very valuable"*.

4.5.3 Side-effects, Withdrawal, Addiction

It emerged that three of the four participants have experienced secondary elements of medication such as side-effects, withdrawal and addiction having an impact on therapy with

clients presenting with GAD and PD to one degree or another. Angela was not inclined to comment on this issue in any great depth.

Maria was quite animated in declaring that *"side-effects are big, withdrawal is big and addiction is big!"*. She continued; *"so for example, and this actually would be quite a common one, somebody would be going to their GP for anxiety, now if they're giving them something like Xanax or Valium, which you still see quite a bit, they can get hooked on them in a week and that is a real danger of addiction in them* [sic] *and that's something I would look out for. Some (GP's) are happy to give out the Xanax and the Zimmovane"*, however, she *"overall, would see drugs being of benefit"*. With respect to these sedative medications such as Diazepam, Dr Barry (2009, P 88) reflects on the prescription of these drugs as being "unfortunate" and "are felt to be a hindrance by most experts in the field". Lynch (2001, P. 159), while discussing associated complications with the more modern SSRI's, believes "that there are parallels here with addiction to prescribed drugs such as benzodiazepine tranquillisers, and in earlier times, to amphetamines and barbiturates". On the related issue of withdrawal, Maria said *"there is huge problems with withdrawal, no matter what 'they' say. One of the problems is that the anxiety tends to return. That's when they* (clients) *really have to reinforce all of the skills that they've gotten"*.

With respect to side-effects, Jill was quick to mention that *"doctors put you* (the client) *on meds, but some meds cause more anxiety before kicking in and some just don't agree with people at all. It sends them off their tree. In this situation, doctors* (GP's) *don't give enough info on side-effects, but psychiatrists will, but it's a grey area"*. This perspective on side-effects would strongly resonate with Lynch (2005, P. 158) where he states: "many people feel worse when they take the new anti-depressant drugs. Many people's experiences of symptoms such as anxiety, agitation, insomnia, numbness and unreality is heightened".

The subject of weaning was also broached by participants with Angela noting that *"during the course of my work, clients have come off medication with the help of the experience of psychotherapy"*, but refrained from volunteering any further insight to that process. Selma however, was a good deal more detailed in this regard. She believed *"most clients coming to therapy will have already visited a psychiatrist and may have been on meds for some time, and may be at a point in their life when they don't want to continue taking large dose of meds for anxiety. Part of therapy can be seeing when to come off the meds, when the client sees fit"*.

Interviewee Jill opined that *"clients come through as a result of doing counselling and learning better coping skills and not because of the meds. That's all I could really say about the subject. In saying that though, good therapy can happen with people that are on minimum doses of anti-depressants and it can work... but it depends on the dose, the person, the circumstances, how long they've been taking them for and so forth"*.

Again, it would seem that there is a further dearth in research directly relating to the efficacy of an integrative humanistic approach combined with anti-depressant and anti-anxiety medications. In discussing this section, the researcher could only find more qualitative texts pertaining to this matter.

Chapter 5

Recommendations

&

Conclusion

Chapter 5 – Findings, Recommendations and Conclusion

5.1 Introduction

This chapter shall present a summary of the findings of this study, as well as its strengths and limitations and will offer conclusions with in respect to the original research aim, namely to explore opinions, attitudes, styles and complicating factors that influence the treatment of GAD and PD so as to paint a clearer picture of how they are being addressed by today's contemporary psychotherapeutic community.

5.2 Strengths and Limitations

This research was carried out in a qualitative style and employed the use of semi-structured depth interviews to be better able to capture the often subjective nature of treating GAD and PD in the clinical setting. As a result, the strength of this research can be seen to be found in the rich and meaningful insights which emerged from the professional experiences of the interviewees. A quantitative study would not have been suitable for gathering and framing data of such vibrant and descriptive nature. However, this brings in to question the issue of bias and prejudice, both of the researcher *and* participant, in deciding on which issues, perspectives and nuances to investigate and give precedent to, through all the questions, the answers and the discussion. (Creswell, 1994, P. 147).

As with all studies of this nature, the limitations can be seen to lie within the sample size of the study. Ideally, a larger sample size would have been sought in order to elicit more raw data, but due to various constraints of practicality, a sample of four participants was decided upon. Further to this, a greater diversity among participants would have been of more benefit to the research, with all four interviewees being female and having studied in the same institution.

5.3 Findings and Recommendations

This study found there to be two core threads that were a commonality amongst all participants, namely the intrinsic importance of the use of empathy in the treatment of GAD and PD and the fundamental need for a collaborative therapeutic alliance to achieve meaningful relief and growth through therapy. This it may be said, reflects the humanistic, Rogerian training undertaken by each of the four participants and further reinforces Dr Barry's (2009) call for a more holistic and humane strategy for tackling the disorders examined in the research.

From this base starting point, a myriad of approaches and ways of working emerged from the data, highlighting it would seem, the general appreciation of integrativeness towards psychotherapeutically treating GAD and PD. As a result of this leaning towards integrativeness, the research would suggest that there is no ideal, set formula for treating the anxiety-disorders as the person suffering from them is as unique and individual as the combination of approaches and interventions available to the therapist. However, the use of, and regard shown to the various styles and methods which emerged can be seen to fall along a spectrum of varying degrees of enthusiasm and appreciation and often conflict entirely between participants. It is therefore a recommendation of this research project that further study be undertaken in to the efficacy of varying techniques when employed in conjunction with an integrative, humanistic approach. Further to this, as discussed in 4.4.1, it is recommended that steps be taken to evaluate the overall use and need for the practice of safe trauma therapy, outlined in 2.6 of the Literature Review.

The findings also revealed a rather colourful and diverse range of attitudes towards the use of medication and the introduction of the medical model when addressing GAD and PD, again falling along a spectrum of differing regard and appreciation. What can be said with certainty however, is that the work of each of the participants in treating anxiety-disorders has been

impacted to varying degrees of detriment and betterment by anti-anxiety and anti-depressant medications. Therefore, it is a further recommendation of this study that large scale, quantitative research be carried out in to the many convoluting factors which are at play in instances when humanistic psychotherapies and psychoactive medications are combined through course of treatment.

Finally, through both the literature review and the interviews, the research suggests that the treatment of GAD and PD, as well as its study, could benefit greatly from a greater unity between differing schools and approaches, with Wolfe (2005, P. 194) stating; “what has been sundered by the polemics among psychoanalytic, behavioural, and humanistic therapists needs to be (re) integrated”.

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Appendices

Appendix A – Request for Interviewee Letter

Dear_____,

I hope this email finds you well. I am in my 4th and final year of a Bachelor of Arts degree (Hons) in Counselling and Psychotherapy from Dublin Business School, Dublin 2. As part of the research for my Thesis, I plan to interview humanistically trained IACP and IAHIP accredited psychotherapists in order to gain different perspectives on how Generalised Anxiety Disorder and Panic Disorder present in their practice. I will also be looking at what approaches they employ for these two issues, as well as some factors which may impact upon therapy. I believe this is an area worthy of attention. Not only is there increasing numbers of the population currently living with these disorders, but there is a relative lack of research in to the treatment of these disorders by the humanistic psychotherapies.
If you would be interested in participating in a short, informal interview of between 20 and 35 minutes, I would be very grateful for the opportunity to learn from your insights. I am more than happy to meet you at a location and time of your convenience. Please contact me by email (macco66@hotmail.com) or by phone as noted below. I look forward to hearing from you.

Warm Regards,

Carl McNamara

14th of February, 2013.

Dublin Business School

BACAP IV

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Appendix B – Interview Consent Form

'Exploring Integrative Humanistic Approaches to Treating Generalised Anxiety and Panic Disorder'

This study intends to examine the experiences of counsellors and psychotherapists who work with clients diagnosed with Generalised Anxiety and Panic Disorder. This is part of my final year research project (BA Counselling and Psychotherapy - Hons) in Dublin Business School and my research supervisor is Susan Eustace.

The process involves an interview which should take no more than 20-35 minutes and will be recorded. The questions are about your experiences and views of how GAD and PD present in your practice and other factors which impact upon their treatment.

You will not be identified in the results of this research or in any part of the finished project. The information will only be used by the author for this research project.

Under data protection procedures the author is required to keep the transcripts from the interviews for a period of 5 years and will be stored in a secure location during this time.

Participation in this study is completely voluntary, and you may stop the interview at any time, or withdraw your participation.

The purpose and process of this study has been explained to me, and I agree to Participate;

Participant's Signature:________________________________ Date:________________

Appendix C – Interview Questions

As a humanistically trained, integrative psychotherapist;

1) In your experience, are there certain approaches you tend to gravitate towards over others when confronted with anxiety and panic disorders?

2) Have you found any benefit in introducing complimentary techniques such as mindfulness, breathing and relaxation exercises and grounding techniques, either in session, or as 'homework'? If so, could you please elaborate on them?

3) Do you think the more uncovering, regressive, psychodynamic style therapy lends itself at all well in addressing these disorders?

4) More so with respect to panic attacks, have you ever found client symptoms to become specifically activated by therapy? Would you feel the need to practice with an awareness towards the 'braking' and 'anchoring' of trauma therapy?

5) How would you describe the general effectiveness of the main humanistic psychotherapies - Person Centred, Existential and Gestalt - in treating GAD and panic? In your opinion, do they provide much scope for long term, concrete improvement?

6) What are your opinions on the role of empathy in treating these disorders?

7) In your experience, have anti-depressant/anxiety medications significantly altered the degree to which your client engages with therapy, either in a positive or negative way?

8) Have you found any secondary elements of medication to have any considerable effects on therapy, such as side-effects, withdrawal or addiction? Are there any other facets relating to medication, or the medical model, that you'd like to touch on?

9) Are there any further personal insights that spring to mind, in relation to anything that hasn't been touched upon so far?