The Role of the Therapist Within the Gestalt of a Clinical Residential Setting

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This article supports the notion that within a well-integrated, multidisciplinary residential treatment setting, a multiplicity of dyadic relationships contributes to the change process of the client and does not pivot exclusively on the dyadic relationship between client and the individual therapist.

In most cases, the placement of a child in a residential treatment setting is implemented after one or more failures in outpatient therapy. The weekly visit(s) to the therapist could not effect desired behavioral changes, resulting in the youth needing a more restrictive approach.

In addition to formal therapy, delivered by professionals, a residential treatment setting uses additional elements to establish change processes in the child. In addition to the single dyadic relationship between child and therapist, multiplicities of other relationships are called into play. These relationships are forged from a number of delivery systems including (but not limited to): educational processes, the structure of daily living activities, recreational and leisure activities, a regimented and predictable environment, a well-designed therapeutic milieu, and vigilant oversight of possible medical interventions including psycho-pharmacological approaches to behavioral change. The totalities of all of these building blocks produce something more than the sum of its parts. They produce the gestalt of the overall program.

On occasion, parents and referring professionals myopically focus on the therapist’s “power” to effectuate change in the child. By doing so, they undervalue the gestalt of the program and “place all the chips” on the services provided by a single magical individual therapist for an hour or two a week.

The literature clearly speaks volumes of the overall importance of the fundamental dyadic relationships between the change agent and the child. In
reviewing the professional literature, Eisenstein (1994) and Marmor (1994) have written extensively about the power of the change agent. The data indicates that the dyadic relationship between client and therapist is a better indicator of outcome than the therapeutic modality employed by the therapist. That is to say, the relationship between therapist and client is more important than whether or not the therapist utilizes Transactional analysis, Rational-Emotive Therapy, Neuro-Linguistic Therapy, Rogerian Counseling, Cognitive-Behavior Therapy, or any other form of therapy. While these findings are supported by a host of researchers (e.g., Bergin & Lambert, 1978; Beutler, 1979; Dobsen, 1989; Gaffan et al., 1995; Lambert & Bergin, 1994; Rachman & Wilson, 1980; Robinson, Berman & Neimeyer, 1990), many clinicians embrace the latest “hot brand” of therapy in search for the “holy grail” or the “magic bullet.” (Note: one exception to these findings is that behavioral techniques have been found to be highly effective in the treatment of phobias and panic disorder) (Asay & Lambert, 2002). What all the researchers agree on is that fact that therapy works. In essence, when it comes to psychotherapy, it is the nature of the dyadic relationship that usually towers over the applied technique.

But if residential treatment is called for, is it that simple? Do we simply hook-up Johnny with Suzy Magic or Joe Wonderful and never worry about the gestalt of the program? Not so. Such logic would suggest that the child simply needs a place where he has great difficulties escaping the efforts of establishing a productive therapeutic relationship. Such practice would lead to “programmatic ware-housing,” while Suzy Magic or Joe Wonderful work their magic.

In the minds of most responsible change agents, the value of a sound, well thought-out, and dynamic therapeutic milieu is paramount to the desired outcome. Such change agents understand the reality that the therapeutic milieu, the gestalt or program “allows” the therapist to be more effective than an outpatient therapist who does not have the benefit of a 24 hour a day structured, controlled, and predicable milieu available to them. In other words, if change is principally based on the creativity, whiz, genius, and applied techniques of the therapist, than the credit for such change should not myopically be accredited to the therapist alone, but shared between the dyadic relationship and the milieu with all the multiplicities of one-on-one relationships across a number of staff. In addition, a witty, clever and dynamic therapist who conducts individual therapy in a vacuum of the larger therapeutic milieu is probably not the
optimal change agent in any residential setting. No amount of communication and sophisticated articulation of clinical data to parents and referral sources can hide the fact that such a therapist is not operating in the most effective manner.

But using recent investigations through meta-analytic techniques, Asay & Lambert (2002) asserted that the therapeutic relationship between client and therapist accounts for 30% of the change, while extra therapeutic variables, (e.g., environment, motivation) count for 40% of the change. The residual 30% of the variables are evenly divided between placebo effects and other techniques. Asay & Lambert (2002) asserted that while “some practitioners, especially the inexperienced, imagine that they or their techniques are the most important factor contributing to outcome, the research literature does not support this contention” (p. 30).

Because many residential treatment environments are highly controlled around the clock, one may not want to underestimate the role of the therapeutic milieu with its multiplicity of relationships. It is not difficult to assume that the most potent therapeutic approach in a residential setting is based on the dynamic relationships of the client and therapist, in conjunction with other important relationships that are being nurtured on a daily basis by a number of other staff. These other critical relationships with direct care staff, educators, and others can often be further supported by a vibrant therapeutic milieu.

Assuming a child is offered two hours of individual therapy per week, what impact or role do the remaining 166 hours of the week have? To suggest that the change process pivots on the back of the therapist is a horrible oversimplification and misinterpretation of the literature. Trieschman, in his book “The other 23 Hours” (1969), asserts that the child-care worker is the most important figure of the child in the institution. He goes onto ask the questions: “Are the events and interactions of the day thought of merely as time-fillers between psychotherapy sessions, or only as providers of life’s necessities such as eating, sleeping, and recreation?” (p. 2).

Our own informal research with our clients validates Trieschman’s assertion. Over the last eight years, Island View has administered an exit questionnaire where we ask program graduates to list one or more people that were of greatest impact in their change process. Aggregated findings from
this questionnaire show that while the primary therapist is mentioned 75% of the
time, childcare workers are mentioned 100% of the time. What is equally
important is that many graduates routinely list some of their peers as having
played an important role in the healing process! My own professional opinion
would suggest that other residential treatment facilities show similar results.

Residential treatment is at its best when a multi-disciplinary staff,
along with a therapeutic and supportive milieu of peers, all work together to
impact each individual program participant. Each discipline and sub-program
within the therapeutic environment must focus on making a contribution to the
change process of each individual participant. This gestalt of residential
programming is bigger than the sums of all its parts.

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