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CHAPTER 13

Integrative Psychotherapy

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Psychotherapy integration has become a dominant movement (Castonguay, Reid, Halperin, & Goldfried, 2003). Convinced that "pure-form" orientations have neither provided a satisfactory understanding of psychopathology nor resulted in sufficiently effective treatments for the majority of their clients, many psychotherapists have integrated constructs and methods belonging to diverse approaches. In fact, "eclectic/integrative therapy" is the most frequent self-identified orientation among clinicians (Mahoney, 1991).

Although a number of innovative treatments have emerged from within the integration movement (see Norcross & Goldfried, 1992; Stricker & Gold, 1993), integrative therapists have failed to devote considerable attention to research (Castonguay & Goldfried, 1994). There is currently, no convincing empirical evidence that integration has fulfilled its promise to provide treatments that are more effective than traditional, "pure-form" approaches. The goal of this chapter is to present an integrative treatment for generalized anxiety disorder (GAD).

Our integrative therapy is based on an interesting convergence of ideas and research findings. Thomas Borkovec had conducted experimental trials on CBT for GAD for over 12 years. Toward the end of this period, several significant findings emerged. First, Cassidy (1995) found that clients with GAD reported greater role-reversed and enmeshed relationships with their primary caregivers in childhood than did matched nonanxious controls. Shortly thereafter, Pincus and Borkovec (1994) found that clients with GAD also had more interpersonal problems, especially in being overly nurturing

and intrusive in their relationships with others. Finally, interpersonal dimensions that remained untreated by cognitive-behavioral therapy (CBT) predicted outcome at follow-up (Borkovec, Newman, Pincus, & Lytle, 2002). After many years of focusing on the intrapersonal anxiety process of clients with GAD, Borkovec concluded that it would be necessary to address their interpersonal problems as well if further increments in therapeutic efficacy were to be accomplished. Thus he envisioned an additive therapy investigation that would contrast CBT with and without therapeutic interventions focused on interpersonal functioning.

Independently of Borkovec's research and insights, Michelle Newman and Louis Castonguay arrived at similar conclusions with regard to the effectiveness of CBT. Having graduated from the State University of New York at Stony Brook, they were fully trained in cognitive and behavioral techniques. However, their backgrounds combined with additional training in humanistic, psychodynamic, and interpersonal therapies convinced them that several important dimensions of human functioning were not explicitly or systematically addressed in the CBT literature. Furthermore, repeated clinical observations led them to conclude that successful CBT often required more than the skilled application of learning-based techniques prescribed in treatment manuals. Their own process and outcome research also led them to believe that CBT could be improved by addressing (differently and more frequently) clients' interpersonal difficulties, exploring developmental events at the core of clients' view of self and others, deepening clients' emotional experience, and attending more adequately to the complexity of the therapeutic relationship (including alliance ruptures). Thus the arrival of Newman and Castonguay at Penn State provided an exciting opportunity for collaboration in mutual efforts to improve the effectiveness of CBT.

This chapter begins with a description of the conceptual and empirical bases of the integrative treatment. The general structure of the treatment protocol (within the current investigation) and the therapeutic rationale provided to clients are then presented. Also described are the techniques that were added to CBT to address two specific factors involved in the etiology and/or maintenance of GAD: interpersonal problems and emotional avoidance. Preliminary process and outcome data are then briefly reviewed.

THEORETICAL AND EMPIRICAL BASES FOR AN INTEGRATIVE THERAPY FOR GAD

To date, CBT has demonstrated strong efficacy for GAD. Studies suggest that it is superior to no treatment, analytic psychotherapy, pill placebo, nondirective therapy, and placebo therapy (Borkovec & Ruscio, 2001).

Furthermore, CBT has the largest effect sizes when compared to other therapy and control conditions, and improvement is maintained for up to 1 year following treatment termination (Borkovec & Ruscio, 2001). Moreover, CBT is associated with maintenance of gains or further improvements during the follow-up period (Borkovec & Newman, 1998; Borkovec & Ruscio, 2001).

Despite its therapeutic value, there is room for improvement in CBT for GAD. Replicated findings show that at best, it leads only to an average of 50% of clients achieving high end-state functioning. One interpretation of this finding is that some clients need to receive more sessions of CBT to benefit fully from this intervention. To test this hypothesis, Borkovec and colleagues (2002) conducted a trial that substantially increased client contact time from a prior study (Borkovec & Costello, 1993). Despite almost twice as much contact time, however, the rate of high end-state functioning was not improved.

A second hypothesis is that CBT has failed to address important factors in the etiology and/or maintenance of GAD. Guided by this hypothesis our research group (Newman, Castonguay, & Borkovec, 1999a) examined theoretical criticisms of CBT, as well as applied and basic research, and determined that the addition of techniques designed to address interpersonal problems and to facilitate emotional deepening might improve the effectiveness of CBT for GAD.

INTERPERSONAL AND EMOTIONAL PROBLEMS

Several authors with a cognitive-behavioral orientation have criticized CBT for overlooking the importance of the client's interpersonal reality (e.g., Coyne & Gotlib, 1983; Goldfried & Castonguay, 1993; Goldfried & Davison, 1994; Robins & Hayes, 1993). For these authors, CBT has placed too much of an emphasis on appraisals of self in relationships, and has devoted insufficient attention to clients' potential contributions to their own interpersonal difficulties.

Summarizing these critiques, Robins and Hayes (1993) have suggested that the traditional view of clients' cognitions has failed to consider fully that clients' constructions of past and current relationship (e.g., scripts for how to behave with others, expectancies about reactions of others) are at the core of clients' views of self. Although they argue that such constructions often determine clients' actions toward others, they also assert that interpersonal behaviors can become habitual over time and therefore deserve to be addressed on their own, in addition to the cognitions themselves.

Moving beyond the critiques of models underlying CBT, several CBT therapists have incorporated constructs and intervention methods de-

veloped in humanistic, psychodynamic, and interpersonal traditions. Guidano and Liotti (1983), for example, note the influence of early attachment on an individual's view of self and patterns of interpersonal relating. In addition such techniques as examination of past and present interpersonal behaviors, use of the client–therapist relationship, and examination of the clients' impact on others have become an intrinsic part of the theoretical framework and intervention focus in CBT for personality disorders (Beck, Freeman, Davis, & Associates, 2003). Furthermore, the role of an early invalidating environment, is central to Linehan's (1993) dialectical behavior therapy for borderline personality disorder.

Writing specifically about anxiety disorders, Barlow (2002) has advised clinicians to consider the interpersonal context within which clients' difficulties are maintained, as well as comorbid personality disorders. Chorpita and Barlow (1998) have also highlighted the contribution of attachment patterns to specific vulnerabilities (i.e., cognitions of uncontrollability and unpredictability) that may be at the core of anxiety.

Jeremy Safran (Safran & Segal, 1990) has offered a particularly insightful integration of complex interpersonal issues within a CBT perspective. Guided by the work of such therapists as Sullivan, Kiesler, and Bowlby, he has argued that individuals construct internal models of relationships based on their early relationships with caregivers. These models, labeled by Safran as "interpersonal schemata," determine perceptions of others and guide clients' interpersonal behaviors in ways that typically confirm and reinforce these schemata.

The integrative treatment presented in this chapter has been informed by Safran's model of interpersonal schema. This model provides a comprehensive and coherent integration of cognitive, interpersonal, and emotional issues. It is important to note, however, that our integrative treatment is considerably different from the approach described by Safran. Whereas several techniques described in Safran and Segal's (1990) approach have been incorporated into the present integrative treatment, (e.g., procedures to deal with alliance ruptures), others have been added or modified to better address the needs of clients with GAD. In addition, whereas Safran and Segal's (1990) protocol focuses simultaneously on cognitive, interpersonal, and affective dimensions, this is not the case in the present treatment. For empirical and theoretical reasons described later, our treatment provides CBT and non-CBT techniques in two distinct therapeutic segments. The non-CBT techniques are labeled "interpersonal/emotional processing" (I/EP), because they are specifically designed to address interpersonal problems and to facilitate emotional deepening. Within a session lasting 2 "standard therapy hours" (i.e., 1 hour and 50 minutes), therapists consecutively conduct 55 minutes of CBT and 55 minutes of I/EP.

Based on the theoretical and clinical contributions described above,

as well as the research findings presented below, we have identified four types of difficulties that are important targets for GAD treatment and that have not been systematically addressed by traditional CBT. These difficulties include (1) current interpersonal relationship patterns, (2) origins of current relationship problems, and (3) interpersonal difficulties that may emerge in the therapeutic relationship, (4) avoidance of emotion. These issues are briefly described here to highlight their importance in our conceptualization of GAD and to present empirical support for their therapeutic value. The ways in which each of these dimensions is addressed in the clinical context of our research program are described later in this chapter.

The Role of Current Interpersonal Problems in GAD

Evidence clearly demonstrates that interpersonal difficulties are associated with GAD. For example, clients with GAD worry more often about interpersonal issues than about any other topic (Roemer, Molina, & Borkovec, 1997). In addition, the most common comorbid Axis I diagnosis among persons with GAD is social phobia (Barlow, 2002), and nearly 50% of clients with GAD have one or more personality disorders (Sanderson, Wetzler, Beck, & Betz, 1994), which by definition involve maladaptive and enduring ways of relating to others. Moreover, persons with GAD report more interpersonal distress and rigidity than nonanxious controls, and they score significantly higher than clinical norms on most Inventory of Interpersonal Problems Circumplex Scales (Alden, Wiggins, & Pincus, 1990; Pincus & Borkovec, 1994). These findings suggest that relationship problems may contribute to the development or maintenance of GAD.

There is also evidence that interpersonal problems are not sufficiently addressed within CBT approaches. Research by Castonguay, Hayes, Goldfried, and DeRubeis (1995) found that CBT therapists emphasized intrapersonal issues (e.g., links between thoughts and emotions) more than interpersonal issues (e.g., relationship patterns of clients). They also found that CBT therapists focused more on the impact others had on clients than on the clients' potential contributions to their own interpersonal difficulties. Other studies showed that a focus on interpersonal issues was positively related to clients' improvement in psychodynamic therapy, but not in CBT (Castonguay et al., 1998; Kerr, Goldfried, Hayes, Castonguay, & Goldsamt, 1992).

In an attempt to understand how cognitive therapists deal with interpersonal issues, Hayes, Castonguay, and Goldfried (1996) discriminated between a focus on clients' cognitions about others and an effort to promote change in clients' patterns of interacting with others. Although cognitive therapists focused more frequently on clients' cognitions about others, such a focus was *negatively* related to outcome. While therapists'

direct attention to real interpersonal difficulties of the client was significantly less frequent, it was related to positive change at the end of treatment.

These studies suggest that CBT therapists focus less on interpersonal issues than on intrapersonal issues, and that the way they typically focus on interpersonal issues is not effective. These studies further suggest that CBT therapists may improve their effectiveness by considering the ways with which interpersonal issues are dealt within psychodynamic and interpersonal therapies.

A recent study demonstrates the limitations of CBT in dealing with interpersonal problems in GAD. Borkovec and colleagues (2002) found that most interpersonal problems assessed were minimally responsive to CBT, and that the degree of remaining interpersonal problems was predictive of failure to maintain follow-up gains. This study is in line with previous evidence showing that Axis II comorbidity predicts poorer response to CBT (e.g., Durham, Allan, & Hackett, 1997; Hofmann, Newman, Becker, Taylor, & Roth, 1995). Such evidence points to the necessity of using therapy techniques to address interpersonal problems, including clients' maladaptive ways of relating to others.

Developmental Origin of Interpersonal Problems

CBT researchers have acknowledged the potential role of early attachment patterns in the development of anxiety (Chorpita & Barlow, 1998). Similarly, CBT conceptualizations have been influcenced by the work of Bowlby (1982), who theorized that diffuse anxiety is the typical consequence of some forms of insecure attachment. For example, Safran and others (e.g., Guidano & Liotti, 1983), have suggested that childhood patterns of attachment shape individuals' core views of self, as well as their recurrent ways of interacting with others.

Despite acknowledging the importance of attachment, evidence from controlled trials suggests that CBT therapists focus less on clients' past and less on their relationship with early caregivers than do psychodynamic therapists (Goldfried, Castonguay, Hayes, Drozd, & Shapiro, 1997; Jones & Pulos, 1993). Nonetheless, a focus on developmental issues has been found to be positively related to outcome in CBT (Hayes et al., 1996; Jones & Pulos, 1993).

Developmental difficulties may be especially relevant to GAD. Basic research shows that persons with GAD report greater unresolved feelings of anger toward and vulnerability surrounding their primary caregivers than do persons without GAD (Cassidy, 1995). Thus our integrative therapy explores developmental origins of clients' current interpersonal difficulties and their potential links with current problems.

Clients' Interpersonal Problems and the Therapeutic Relationship

Respected CBT therapists have recognized that clients' interpersonal problems are frequently manifested in the therapeutic relationship (Beck et al., 2003; Goldfried, 1980). For example, Goldfried (1980) notes that therapeutic interactions may create a rich context in which therapists can observe and change clients' maladaptive interpersonal behavior.

Despite potential usefulness of the therapeutic relationship, research suggests that CBT therapists do not pay much attention to issues emerging between themselves and their clients, at least when they follow manualized treatments (Castonguay et al., 1995; Goldfried et al., 1997; Jones & Pulos, 1993). Interestingly, however, Jones and Pulos (1993) found that although CBT therapists did not spend much time focusing on "transferential" issues, clients benefited from it when they did.

Another issue that has not received a lot of attention in CBT is maintenance of the therapeutic relationship. Although CBT therapists establish and maintain a good working alliance (Raue & Goldfried, 1994), they pay less attention to the ways they can adversely affect relationships with clients (Goldfried & Castonguay, 1993). For example, Jones and Pulos (1993) found that although CBT therapists were more approving and reassuring than psychodynamic therapists, they were also more tactless, condescending, and patronizing to clients. In addition, when compared with psychodynamic therapists, CBT therapists' own emotional reactions more frequently intruded on the therapeutic process. In another study, Castonguay, Goldfried, Wiser, Raue, and Hayes (1996) found that techniques used in cognitive therapy to address alliance ruptures seemed to exacerbate relationship problems and interfere with clients' improvement. Later in this chapter, we describe techniques developed by humanistic and interpersonal therapists to resolve alliance problems. A preliminary study suggested that the integration of these techniques within traditional cognitive therapy increased treatment effectiveness for depression (Castonguay et al., In Press).

Emotional Deepening

In traditional CBT, emotion has been frequently viewed as an epiphenomenon to be controlled, rather than as something to be experienced (Mahoney, 1980). Indeed, studies show striking differences between CBT and other approaches in the manner in which affective experiences are handled. Whereas psychodynamic and interpersonal therapies view evocation of affect as essential to therapeutic change, traditional CBT tends to promote control or suppression of the full range of negative affect (Jones & Pulos, 1993; Wiser & Goldfried, 1993).

Ironically, a focus on affective control in CBT overlooks the theoretical importance placed on affective arousal by CBT experts (Beck, 1976; Foa & Kozak, 1986; Rachman, 1980). Furthermore, a number of studies have found a positive relationship between level of affective experiencing and clients' improvement in CBT (e.g., Castonguay et al., 1996; Foa, Riggs, Massie, & Yarczower, 1995; Jones & Pulos, 1993). Experimental research also supports the value of emotional processing to an individual's well-being and health (e.g., Pennebaker & Traue, 1993).

The failure of CBT to elicit and deepen emotional experience may be particularly consequential in the treatment of GAD. As shown by Borkovec, Alcaine, and Behar (Chapter 4, this volume), basic research suggests that the function of worrisome thinking may be one of avoidance of painful emotions. In fact, persons with GAD report that a major reason for their worry is to avoid thinking about more troublesome emotional experiences. As with any type of fear-motivated avoidance, worry may thus persist via negative reinforcement–it becomes a habit constantly reinforced by its ability to prevent the person from feeling worse (at least in the short term). Without deliberate exposure to feared emotions, opportunities for extinction of fear are precluded; as a consequence, worry is much more likely to persist (as the only way, albeit inefficient and costly, to reduce emotional pain). Thus the incorporation of experiential techniques designed to facilitate emotional processing may directly address a major underlying mechanism maintaining GAD symptomatology.

The importance of emotional processing to therapeutic change is highlighted by Safran and Segal (1990) who suggest that interpersonal schemata are coded, at least in part, in affective or expressive/motor form. Thus it is important to work with clients in an "emotionally alive fashion." Similarly, Foa and Kozak's (1986) neobehavioristic theory of emotional processing, originally developed to explain underlying mechanisms of action of exposure for fears, can be extended to explain the usefulness of therapy for interpersonal issues. For example, Safran and Greenberg (1991) note that interpersonal schemata are most amenable to modification by exposure to corrective experiences when related emotions are activated. Furthermore, experiencing emotions increases clients' awareness of needs about which they were previously unaware (Greenberg & Safran, 1987) and can guide them in choosing new behaviors to meet these needs, as well as behaviors to abandon.

In order to facilitate emotional processing, the present integrative treatment makes use of various techniques that help clients increase their awareness, experience, and expression of interpersonally relevant primary emotions. These techniques are aimed at creating an affective context to facilitate the assessment and challenge of clients' core perceptions of self and others.

STRUCTURE AND RATIONALE OF INTEGRATIVE THERAPY FOR GAD

As mentioned earlier, each session of the integrative treatment is composed of two separated components: a CBT segment of 55 minutes, followed by an Interpersonal/Emotional processing (I/EP) segment of 55 minutes. The decision to divide these components in this manner was based on empirical and theoretical considerations. The primary goal of our research is to determine whether the efficacy of CBT can be improved for GAD (Newman, Castonguay, Borkovec, & Schut, 1999b). Methodologically, the most appropriate strategy to test this question is an additive design (Borkovec & Castonguay, 1998). Thus we are currently comparing CBT + I/EP to a treatment protocol of the same length that is composed of a CBT segment and a supportive listening (SL) segment (the SL segment controls for time in therapy and common factors such as the therapeutic relationship). If CBT + I/EP leads to greater improvement than CBT + SL, it will provide evidence that the I/EP techniques add a therapeutic benefit above and beyond CBT.

The CBT component of the integrative protocol has been previously tested by Borkovec and Costello (1993) and Borkovec, Newman, Pincus, and Lytle (2002). Because CBT treatments are fully described elsewhere in this book, the rest of this chapter is devoted to the I/EP techniques (see also Borkovec & Newman, 1998, and Newman, 2000a, for additional information on our approach to CBT).

Although I/EP involves techniques not typically associated with CBT, it rests on a conceptualization that is perfectly compatible with CBT. In both the CBT and the I/EP segments of treatment, maladaptive symptoms of GAD are viewed as arising from overlearning of bad habits. The bad habits addressed in CBT are associated with clients' searching for threats in their environment and trying to control them via worrying. In I/EP, clients are told that they have overlearned the bad habit of avoiding painful emotion. Furthermore, they may be so busy trying to avoid what they fear from others that they fail to actively pursue their interpersonal needs. Ironically, although avoidance of emotion and some maladaptive relationship patterns may be motivated by a desire to anticipate and avoid danger, clients often create situations that are more likely to lead to negative outcomes. In particular, their approach to protecting themselves from the negative reactions of others has been to avoid letting others know who they are and what they feel. However, rather than making them more likeable, this approach makes them hard to connect with, and they may appear cold and uninterested in others.

The solution in both of these therapy segments is to replace maladaptive habits with new, more adaptive habits. The techniques used in the two segments, however, are substantively different. Whereas in the CBT segment therapists apply techniques that make use of the clients' current

strengths (e.g., ability to analyze situations cognitively and critically, desire to control their negative responses to situations and to feel less anxious), in the I/EP segment therapists attempt to address clients' deficits (e.g., inability to get in touch with and process emotion, discomfort with interpersonal vulnerability and spontaneity).

Much of I/EP involves attempting to expose clients to feared emotions, to feared critical feedback about their impact on others, and to their fear of being vulnerable to other people by showing who they really are. Clients are encouraged to try things that may help them confront their immediate fears and to become aware of how their avoidance of negative emotions in the short term comes at a great cost in terms of a restricted lifestyle in which their needs are not met in the long term. Furthermore, we attempt to help them shift their attentional focus away from anticipating danger and toward openness, spontaneity, and vulnerability to others, as well as toward more empathic attention to the needs of others.

Thus our conceptualization is consistent with most CBT models. What is added in I/EP is the recognition of dangers (painful affect, interpersonal fears) as well as learned habits to cope with these threats (avoidance of emotion, maladaptive ways of relating with others) that have not been typically identified in traditional CBT. In addition, many I/EP techniques are based on mechanisms of change underlying most CBT procedures for anxiety: exposure, modeling, and skills training. Furthermore, the target of intervention in I/EP is based on a functional analysis. Indeed, therapists always specify interpersonal behaviors that should be changed or acquired, interpersonal situations within which such behaviors take place or fail to take place, short- and long-term impacts of such behaviors, and the functions the behaviors have served in clients' lives. Therapists gather this evidence from their emotional responses to clients, from clients' self-reports, and from clients' in-session behavior and emotional responses.

SPECIFIC I/EP TECHNIQUES

I/EP techniques can be classified into two major categories: addressing problematic relationship patterns and facilitating emotional deepening.

Addressing Problematic Relationship Patterns

Exploring Past and Current Relationships

Early in I/EP, clients are asked about people with whom they have had intimate relationships, familial links, and important friendships. Therapists avoid focusing on developmental issues until they have fully explored cur-

rent interpersonal problems, especially if these problems are manifested in the therapeutic relationship. This is based on our observation that clients with GAD often talk about the past to avoid talking about their immediate feelings. It is easy indeed for these clients to engage in storytelling about what happened in their lives, and quite difficult for them to be "present-focused" and in touch with feelings in the here and now of the therapy session. Such an intellectual description, in effect, may serve the same role that worry plays. By "remaining in their heads," such clients avoid experiencing painful emotion.

On the other hand, clients will frequently draw a connection between their current affective experience (with the therapist or a current significant person) and an earlier moment in their lives when therapists facilitate the exploration of feelings associated with a current interpersonal event. Such an emotionally immediate connection (especially when a client makes it, rather than having it pointed out by a therapist) can become a powerful way to understand why patterns of relating with others may have been realistic and functional in the past but have become archaic and maladaptive.

Once a therapist has gathered general information about a client's interpersonal relationships (which takes one or two sessions), the therapist chooses a person who seems important to the client and explores in more depth the client's relationship with this individual. Because persons with GAD are more apt to focus on a description of the other individual than to describe the relationship, the manner in which the therapist asks the client about the relationship is important. Even a directive such as "Tell me about your relationship with John" tends not to elicit the relevant information from GAD individuals. In our experience, if asked about the general state of any one relationship, a person with GAD may either deny difficulties or blame current relationship problems on the other person.

This point is illustrated by the case of Clark, a 55-year-old professor. When Clark started treatment, he was in the midst of intense conflict with his ex-wife and was estranged from his two children. Clark initially represented himself as a victim of his ex-wife and children, and he attempted to illustrate this point by describing instances where they had treated him badly. In one of these scenarios, he reported that his son and daughter had ignored him. He had visited them to celebrate the combination of his daughter's graduation and Father's Day, and to attend a reception hosted by his ex-wife for his daughter.

Rather than accept Clark's characterization that he was blameless in his problems with his children, the therapist asked him to talk about a specific interaction that took place during this visit, in which he was left feeling as though he did not really get what he wanted or needed. The therapist instructed him to do this in a blow-by-blow manner (i.e., "What did you do, and then what did he do, and then what did you do?"). To guide

Clark in responding to this request (and to redirect him when he wandered off topic), the therapist used a chart that we have developed to explore the interpersonal situations (see Figure 13.1).

After Clark had described an interaction with his son, the therapist asked him what emotion he felt and he replied that he had felt angry. Then the therapist asked what he needed or wanted from his son and what he was afraid might happen. As demonstrated in the following vignette, the therapist then tried to determine whether Clark did something or failed to do something that decreased the probability of getting his needs met.

CLARK: I decided that I wanted to have lunch with my son for Father's Day, so I called him up to find out whether he was free.

THERAPIST: When exactly did you make this phone call?

CLARK: When I got into town.

THERAPIST: So tell me exactly what you said to him when you called him.

CLARK: I said that I thought it would be fun if we had lunch on Saturday. Then he said, "Mom already planned a special Father's Day lunch with Grandpa, so I can't make it, but I would like to stop by before then to give you your Father's Day gift."

THERAPIST: And what did you say to that?

CLARK: I said, "Well I really wanted to have lunch, but I guess that would be better than nothing."

THERAPIST: Then what happened?

CLARK: We said goodbye. However, I thought about what happened over and over until he stopped by, and the more I thought about it, the an-

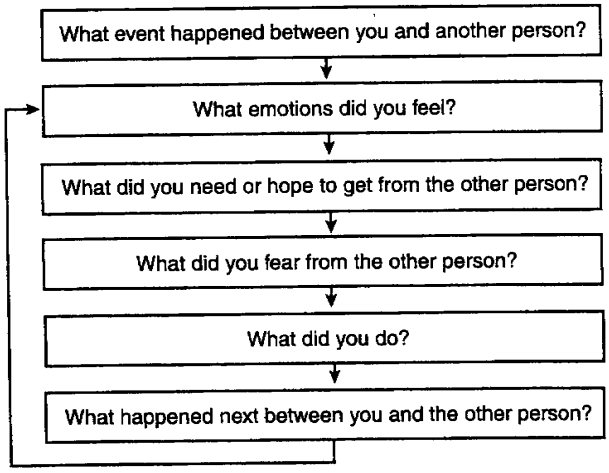

FIGURE 13.1. I/EP interpersonal exploration chart.

grier I got. I mean, I'm his father, so don't I deserve to be honored on Father's Day?

THERAPIST: When was the next time you spoke with him?

CLARK: When he came by to give me my Fathers Day gift later that day, but by that time I really didn't want to see him. When he handed the gift to me, I said, "Why don't you get the hell out of here and go figure out who your father really is!" Then I called my daughter to tell her I would not attend her graduation reception, because I would not get to spend the kind of time with her that I had expected.

Clark told the therapist that his role as father was not being acknowledged adequately, since he had received the same invitation to his daughter's graduation reception that everyone else had. Even though his daughter reminded him that she was hoping she could see him at her reception, this was not good enough. In the end he felt dishonored and discounted.

The therapist's goal was to help Clark to become aware of his role in these problematic interactions. In this instance, the therapist noted how he had waited until the last minute to invite his son to lunch, and how some of his angry behaviors toward his children served to push them away from him. As noted earlier, such problematic behaviors are often a result of clients' misguided attempts to avoid what they fear. However, some attempts to avoid a feared reaction may actually evoke that reaction. Specifically, Clark feared that his children would not value him. Because of this fear, he made plans with his children at the last minute and did not communicate directly to them how important it was for him to see them. His behavior contributed to his children's unavailability, which he interpreted as evidence that they did not value him. He then pushed his children away even further by yelling at his son and refusing to attend his daughter's graduation. Interpersonal events such as these are what the therapist hopes to target in I/EP.

Teaching Clients Alternative Ways to Handle Interpersonal Interactions

Once identified, problematic relationship patterns become the target of direct intervention. Thus, after examining the ways in which clients have created or exacerbated an interpersonal problem, therapists and clients work on (most typically via role plays) alternative ways of relating with others.

Of course, such skills training interventions are consistent with a CBT model. However, social skills' training has never been part of Borkovec's CBT protocol for GAD, because the goal of this protocol was to directly target GAD symptomatology (i.e., worrisome thinking and muscular tension). On the other hand, social skills interventions are perfectly in line

with the I/EP focus on interpersonal issues, as well as with it's emphasis on learning as the basis of both the etiology and treatment of GAD.

Social skills training targets a deficit frequently observed in individuals suffering from GAD. In our experience, when asked to generate specific ways that they could have handled their relationship problems differently, persons with GAD often come up with extreme, "all-or-none" solutions (e.g., "I could either yell at him, or I could say nothing"). Most likely because of a fear of being vulnerable, clients often do not even consider the option of talking to others in a way that would help them understand what the clients are feeling.

In doing role plays, therapists first encourage clients to play themselves and to attempt to recapture what they said as well as how they said it. Once therapists have a sense of what the clients did, they assume the clients' role and ask the clients to assume the role of the person with whom they were interacting. Clients, who are playing the role of the other, are asked to imagine how they would have been impacted in the interaction, as if in the other person's shoes. Such a reverse role play often elucidates for clients the impact they had on the other person. We have found it important to emphasize that clients pay attention to the impact that therapists (who are playing the role of the client) have on them, rather than to use the role play as an opportunity to feel vindicated and understood by their therapists.

In the following role play, the therapist attempted to make Mindy (a college student with GAD) aware of her impact on her friend Ellen. In particular, Mindy realized that even though she was not meeting Ellen's needs, she nonetheless expected Ellen to meet her needs:

MINDY: Ellen told me she thought I went home too often. When she said this I laughed and said, "Thanks for your opinion!"

THERAPIST: What did you feel?

MINDY: Criticized.

THERAPIST: Sounds like your friends wish they could see you more often.

MINDY: I don't feel like they are hearing me, though.

THERAPIST: I wonder how well you are hearing them. They are saying they enjoy your friendship, yet you feel like you are not being heard.

MINDY: I'm often told I'm sensitive. But I feel condemned by them. I just feel like ending the friendship.

THERAPIST: Let's do a role play where I am you and you are Ellen. Try to imagine what she was feeling.

MINDY: OK. (*As Ellen*) You go home too often and spend too much time with John [Mindy's boyfriend]. I feel like I am second best to John.

THERAPIST: (*As Mindy*) Thanks for your opinion!

MINDY: (as Ellen) I guess I really miss spending time with you. I am going to graduate soon, and we won't have as many chances to spend time together.

THERAPIST: How did you feel as Ellen?

MINDY: I don't like being Ellen.

THERAPIST: What does Ellen need from you?

MINDY: She wants to spend more time with me. But I don't want to spend time with her if she is going to be critical of me and condemn me.

THERAPIST: Do you think your response to her got you what you needed?

MINDY: I guess not.

THERAPIST: How did it feel as Ellen to hear your response?

MINDY: Bad. I didn't feel like Mindy cared about what I wanted.

THERAPIST: Seems like your friends have needs they are not getting met, and that if you consider their needs, maybe you will get more of what you want.

Once maladaptive relationship patterns have been identified, and clients have learned to respond in ways that can have a better impact, homework is assigned so that clients can apply new responses outside of therapy. As is commonly done in CBT, I/EP therapists always follow up to determine whether clients did the assignment and how it went. For Mindy, the homework was to listen actively to others in order to understand better what they needed from her.

At one point, Mindy noted that whenever her boyfriend, John, was not attending fully to her, she interpreted his silence as meaning that he was going to leave her. Her fear initially prevented her from realizing that there could be an alternative explanation. The therapist set up a role play in which Mindy played the role of John. In this role, Mindy recreated a recent episode in which she talked at length about events in her life, and while she was talking, she expected John to be totally attentive to her feelings. However, the role play helped her realize that she did not give John much space to talk about himself—that his silence was actually the price she had to pay for her to have "the stage," and that she was "guilty" of what she accused him of (i.e., not being attentive to the other's needs). As highlighted by the following transcript, she then tried to be more attentive to John:

MINDY: I told John how excited I was about us getting engaged and moving close to my family when we graduate, and he didn't say anything. He hasn't been professing his love to me like he did when we first started dating.

THERAPIST: How did you respond to his silence?

MINDY: At first I was scared, but then I thought about how I don't always hear people. So I tried to understand his feelings and to talk to him about them.

THERAPIST: What did you say?

MINDY: I said, "Don't you want to get engaged any more? How come you don't tell me how much you love me any more?" He said he wanted to get engaged, but it was hard for him to think about living so far away from his parents. He said, "Imagine how you would feel if you had to live far away from your family," and then I realized that it would be hard for John to live hundreds of miles away from his own family when I got to live so close to mine.

THERAPIST: Sounds like it was important for John that you understand where he was coming from.

MINDY: Yeah. I want to hear him. He may leave me if he doesn't feel supported by me.

Communicating directly and less defensively allowed Mindy to develop empathy for John and to understand further how her focus on self was actually increasing the likelihood that John would not feel understood in the relationship. Interestingly, the relief that Mindy experienced after directly asking John what he was feeling negatively reinforced her more adaptive behavior of trying to understand his needs. Such negative reinforcement made it likely that she would engage in this behavior with others, thereby increasing the probability of having her own needs met in relationships.

Making Use of the Client–Therapist Relationship

The interpersonal component of I/EP is founded on the idea that clients' maladaptive patterns of relating are often repeated in the therapeutic relationship. This is consistent with Safran and Segal's (1990) suggestion that successful therapy often requires therapists to be "hooked" into clients' maladaptive ways of relating to others (i.e., to be pulled by clients into behaving consistently with the clients' expectations). Thus, in I/EP therapists try to identify when and how they have been participating in clients' interpersonal schemata. Once therapists identify that they have been hooked, they need to act in ways that oppose clients' expectations of them, thereby disconfirming clients' cognitive–interpersonal schemata. The goal is to help clients gain awareness of their maladaptive ways of relating and any rigid construals of interpersonal relationships that may underlie these patterns. Such awareness helps them identify their contribu-

tion to their interpersonal difficulties, as well as the needs that motivated their behaviors (e.g., what they were trying to gain or were afraid to lose as a result of the interaction). Once the needs are identified, concrete behavioral strategies can teach clients better ways to satisfy them.

It is often difficult for I/EP therapists to recognize when they have been hooked in a way that enables clients' interpersonal or emotional avoidance. Among the indicators that therapists have been hooked are therapists' impression that therapy isn't going anywhere, that they feel emotionally detached from certain clients, and the sense that they are persistently frustrated or feeling helpless with the clients. To deal with such issues, therapists make notes after each session about things they may have done, intentionally or unintentionally, to contribute to clients' enactment of interpersonal and/or emotional avoidance. In addition, therapists attempt to adopt the attitude of a participant-observer (Sullivan, 1953). By taking some distance from the interaction, they can identify markers as they are unfolding. Therapists have reported, for example, allowing clients to provide irrelevant background information, to tell long tangential stories, to change the topic, and to provide only abstract descriptions of events and/or feelings. Another example is a therapist and client becoming engaged in an analysis of why something happened, why the client had a particular feeling, or why another person acted a certain way. The focus on "why" is an indication that the client is avoiding being emotionally present.

Although clients' ways of relating can pull therapists into patterns of avoidance, therapists have their own vulnerabilities with regard to being hooked. For example, the impulse to try to make clients feel better quickly, rather than to help them stay with painful emotions. Other issues have included therapists' discomfort with clients' anger when it is directed at them, or bringing humor into the room when clients are talking about a difficult experience. It is important for therapists to identify and change negative ways that they may act on those issues.

As a means to identify clients' maladaptive interaction patterns that may be manifested in the therapeutic relationship, and to determine quickly when they may have been hooked, therapists continually check in on their own emotions, with particular awareness of how the clients' behaviors would affect them if they had a friendship with the clients rather than a therapeutic relationship. By doing this, therapists become more sensitive to clients' behaviors that might be ignored or excused in the therapy context, but that may be creating problems for the clients outside therapy. Checking in on their feelings requires therapists to take a step back from the ongoing interaction and to adopt the attitude of a participant-observer (Sullivan, 1953).

Once therapists become aware of clients' negative impact, they are encouraged to address this issue in an open and nondefensive manner,

thereby modeling the communication style that clients are encouraged to use. A helpful way of presenting the information can be "I feel _____ when you do _____ (e.g., "I feel pushed away, when you don't answer my questions"). After providing feedback, therapists invite clients to talk about their affective responses to such feedback (e.g., "How do you feel about what I just said to you?"). Clients' ability and willingness (or lack thereof) to examine their own emotional responses following such feedback (e.g., being hurt or angry), as well as their behavioral responses to these emotions (e.g., changing the subject), provide unique opportunities for therapists to observe clients' openness to their affective experiences. These moments in therapy also inform therapists about clients' ability and willingness to accept and respond positively to others' self-disclosure—and, reciprocally, to allow themselves to be open and vulnerable with another person.

One common client reaction to therapists' feedback is to explain how doing what they did helps them (e.g., "I changed the subject because talking about my emotions made me uncomfortable"). Clients often seem to feel that if they provide a reason for their behavior, the behavior becomes acceptable. However, the actual reason for their behavior may be to avoid painful emotion. Furthermore, justification does not mitigate the negative impact of the behavior. When clients do express an emotion (which may require repeated but gentle invitations), therapists' immediate task is to empathize with and validate their affective experiences. Therapists are then asked to share their own reactions to clients' self-disclosures (e.g., "Of course you would want to avoid a topic that made you uncomfortable. However, not answering my question also has an impact on me and makes me feel as though what I am asking for, isn't important"). Therapists are also encouraged to observe whether clients' responses to their openness help them feel understood by clients.

In addition to paying attention to the therapeutic relationship, therapists try to facilitate links between interaction patterns observed in the session and patterns in clients' past or current relationships outside the session. However, therapists try not to make such connections until they have fully processed any negative feelings that may have emerged in the therapeutic relationship. As illustrated in the following example, when clients and therapists are open to their own experience (and that of each other) during the session, the exploration of the here-and-now situation and of outside (past and present) relationships can have a synergistic and beneficial impact.

To return to the case of Mindy, it became apparent that she sometimes felt the same negative emotions toward the therapist that she had been feeling with her friends. The following segment occurred immediately after the therapist asked Mindy how she felt.

MINDY: I don't like this hour as much, because you hear about my bad qualities—like how I don't like to be with my friends because I feel anxious, and like they are being critical of me.

THERAPIST: I feel like I know more about who you are when you share more with me, instead of saying "Mmm-hmm" to everything I say. That sounds like you are saying, "I'm not bad. I'm not bad." I don't feel like I know you at all or what you are feeling when you are always the good student.

MINDY: I would form negative opinions of someone who told me about their bad qualities.

THERAPIST: Close your eyes and try to get in touch with what you are feeling in your body about sharing bad parts of yourself with me.

MINDY: My fists are clenched. I don't like this. I'm scared I'll find out more bad things about myself.

THERAPIST: What have you found out about yourself?

MINDY: I need control. I don't like being with my friends. I'm angry. I don't want this to be me!

THERAPIST: It is hard to be with others when you can't control what they will do and how they will see you. It seems like how you feel with your friends is similar to how you feel with me, wanting to be viewed positively by me.

MINDY: (*Speaking in a very distant way*) There could be elements of that that would be applicable.

THERAPIST: Check your body.

MINDY: I'm afraid. I'm surprised you don't know me, because I feel with you like I feel with my friends, so maybe they don't know me either. I tried to figure out how to be more vulnerable with people and hear them, but it's like getting on a horse that I fell off of, only the horse is much taller now.

THERAPIST: It's a struggle to let yourself be vulnerable.

MINDY: I've been hurt when I've let myself be vulnerable. I feel sad, and I need to put the suit on [Mindy's way of describing her false self].

THERAPIST: It seems hard for you to allow all of what you feel.

MINDY: I keep my feelings to myself, but I still have them. When I was younger, I had a best friend, Rick. I told him I liked a guy in my school, and he told the guy how I felt. I didn't think my friend would betray my secret.

THERAPIST: (*Pulling up a chair*) Tell Rick how you feel.

MINDY: (*Speaking to the empty chair*) It's your fault that I turned into the suit person. I mean, I know it isn't fair to blame you for all of it.

THERAPIST: Slow down—stay with what you are feeling.

MINDY: I feel empty. (*Mindy relaxes her muscles, becomes visibly sad, and begins to cry freely.*)

THERAPIST: It's nice to meet you, Mindy [referring to the fact that Mindy has revealed her "true self"].

MINDY: Really?

THERAPIST: Yes, it is really nice to meet you.

MINDY: How do I fix it?

THERAPIST: Feel it and let it teach you what you want.

(Mindy sits with sadness.)

THERAPIST: When threat is all you pay attention to, relief is all you can ever have, but you can feel even more when you are not trying to escape. What did you find out today about yourself?

MINDY: I want to be myself with my friends instead of avoiding them. I'm ready for whatever they say to me.

THERAPIST: You learned about who you were when you took a risk with me.

Another aspect of the therapeutic relationship that is targeted in I/EP has to do with alliance ruptures. In line with Safran's model, the emergence of therapeutic ruptures in I/EP is viewed as an opportunity to disconfirm clients' maladaptive interpersonal schemata and to help them gain more realistic perceptions of themselves and others, as well as more adaptive ways of behaving. Using markers developed by Safran, Crocker, McMain, and Murray (1990), therapists are trained to identify such ruptures. These markers include clients' overt expressions of dissatisfaction; indirect expressions of hostility (e.g., sarcasm, passive-aggressive behavior); disagreement about the goals or tasks of therapy; overly compliant behavior; evasive behavior (e.g., constant confusion, skipping from topic to topic, never really answering a direct question, arriving late); and self-esteem-boosting maneuvers (e.g., self-justifying or self-aggrandizing).

One type of alliance rupture frequently observed with clients who have GAD happens when they begin to address questions posed by therapists but then move to a totally different topic. Another type occurs when clients suggest that before therapists can understand their answers, they must first give therapists some background information. These behaviors can be in-session manifestations of an overlearned pattern of avoidance. Such noncompliance is often a response to therapists' attempts to facilitate emotionally immediate exploration of significant interpersonal issues related to the therapeutic relationship or a significant outside relationship.

Although we recognize that alliance ruptures can be the result, at

least in part, of clients' avoidance patterns, I/EP therapists are trained not to focus on possible avoidance behavior as they begin addressing such ruptures. This is based on research evidence (Castonguay et al., 1996; Piper et al., 1999) suggesting that assigning responsibility for alliance ruptures to clients may actually exacerbate them. Instead, therapists use techniques that are consistent with strategies used in humanistic and interpersonal therapies. These techniques involve three steps (Castonguay et al., in press).

First, a therapist explicitly communicates that he or she has noticed the client's negative reaction and invites the client to talk about it (e.g., "I have a sense that you aren't as engaged as you have been in other sessions. Is that how you are feeling?"). The second step is to reflect back the client's perception and emotions, and then to invite the client to express additional emotions and thoughts about unhelpful or invalidating events that have taken place in the treatment. This step continues until the therapist has the sense that the client feels understood.

The third step is accomplished by using the technique of "disarming" (Burns, 1989). Using this technique, the therapist finds some truth in the client's reaction, even when the reaction may seem unreasonable. The assumption underlying this technique is that even when a treatment obstacle seems related to the client's difficulties (such as the overlearned coping device of emotional avoidance), it is always the case that the therapist has contributed in some fashion to the lack of synchrony between the two participants. The therapist's openness to his or her experiences and recognition of his or her own contribution to a relationship problem often facilitate the client and therapist to step out of an unproductive process (Castonguay, 1996).

In a situation where a client has been evasive, for example, the therapist may say something like this: "I am sorry that my questions don't seem relevant to you. I realize now that I haven't always clearly explained the rationale of my approach to you." To clients who frequently change the topic, even after repeated attempts by therapists to refocus their attention to a specific issue, therapists might say something such as this: "I am afraid that I have been pressuring you to talk about something that might not be important to you, or that you might not be ready to talk about now."

The positive impact of Burns's disarming technique is consistent with Carl Rogers's (1961) observation that openness of one person frequently leads to openness by another. It is our experience that therapists' explicit and nondefensive recognition of their contribution to alliance problems is often followed by clients' recognition of their own role (e.g., "I appreciate your saying that. I guess I did feel some pressure, but I think I avoid talking about these things, even though I should talk about them").

It is also important to note that not addressing an alliance rupture is a

frequent manifestation of being hooked. Following the steps described above is a difficult task, since it frequently involves inviting a client to talk about negative feelings toward the therapy and/or the therapist him- or herself. However, avoiding alliance ruptures is likely to be another way for therapists to mimic how other people in clients' lives may respond to them. In contrast, actively addressing and resolving problems in the therapeutic relationship is likely to provide clients with are important corrective experiences (Safran & Segal, 1990). In particular, it shows clients how being open and vulnerable about their emotions can be a way to get closer to another person. Contrary to the habit of avoidance typically used by GAD individuals, such vulnerability (and exposure to fear) can actually, and paradoxically, be the best strategy for them to have their worries decrease and get their interpersonal needs met.

Facilitating Emotional Deepening

An important element of I/EP is the facilitation of emotional experience. Emotional awareness and deepening are used to facilitate exposure to previously avoided affect and, conversely, to achieve the extinction of a learned (i.e., negatively reinforced) habit of cognitive avoidance (i.e., worry). The use of emotional processing techniques is also based on Greenberg and Safran's view that emotion provides information about a person's needs.

Thus therapists are asked to track markers of emotionality. Examples include changes in voice quality, the sound of tears in the voice, and a slowing or quickening of conversational pace. When such markers are noted, clients are encouraged to stay with their emotions and to allow themselves to fully experience them. Therapists also need to pay attention to moments of emotional disruption or disengagement. When clients stop emoting and/or being attentive to their affective experience, therapists invite them to focus on their immediate experience (e.g., "What just happened? You were allowing yourself to cry, and you quickly moved away from your feeling").

Our clinical observation matches basic science findings that clients with GAD are incredibly avoidant of, and uncomfortable with, their emotions. One common problem is that when asked what they are feeling, clients describe what they are thinking. Thus an early step in therapy may be to teach the difference between thoughts/observations and feelings. Our therapists use the phrase "You are going into your head" as a way to help clients notice when they are moving away from their affective experience and are instead focused on thoughts. We sometimes find that even requiring clients to put words to their affective experience can move them away from the initial feeling. Therefore, therapists will at times tell clients to stay with their current feelings.

We have also observed that the emotion most commonly described by clients with GAD is frustration or anger. In part, we believe this is because frustration and anger are the emotions that make these clients feel least vulnerable to others. I/EP therapists therefore explore the possibility that beneath the frustration, clients also experience other feelings. This is illustrated in the following segment, where Marie described running into her friend Gail, who said she felt bad for Fran (one of Marie's ex-roommates):

THERAPIST: How did you respond?

MARIE: I laughed and told her I have problems of my own. It's not my problem that Fran lacks social skills and nobody wants to room with her.

THERAPIST: How did you feel?

MARIE: I was pissed that Gail wasn't supportive of me.

THERAPIST: Let's slow this down, so you have a chance to feel that anger. What did you want from Gail?

MARIE: I wanted sympathy. I wanted support.

THERAPIST: What did you fear?

MARIE: Conflict. I didn't want to get upset. I mean, the whole world has been ganging up on me. University housing messed up again, and I have to move out for a second time. And she feels bad for Fran? What about me?

THERAPIST: Try to slow down.

MARIE: I feel like if I get it all off my chest, then I'll feel relief.

THERAPIST: You don't allow your feelings to sink in when you talk about this so quickly. Often anger isn't the first emotion, but it covers up another emotion. Do you think there was a feeling underneath the anger?

MARIE: (*Speaking while laughing*) Maybe hurt was under the anger. I'm angry at the world. (*Smiling*) I needed someone to understand me.

THERAPIST: There is that smile again, but this doesn't really make you happy. Could you have responded in a different way to Gail? How about, "Gail, I've been through a lot with all of this moving. I feel like I need support and understanding about what it has been like to go through all of this."

MARIE: I kind of want her to mysteriously know what I need without my having to ask, and to ask if I am OK.

THERAPIST: What stopped you from asking for what you want?

MARIE: I feel bad, as if I'll hurt someone and they won't like me. I'm scared

I'll be alone if I ask for what I need. I feel sad because I want to be allowed to feel what I'm feeling. (*Marie goes off on a tangent.*)

THERAPIST: I feel a little lost, like I'm running to keep up.

MARIE: I don't want to slow down. I can get hurt and do damage. If I bring up feelings from the past it will hurt me twice.

THERAPIST: I feel like there is an urgency right now.

MARIE: I felt like there was an urgency with Gail.

THERAPIST: I can't absorb what you say when you talk so quickly. You're telling me you are scared and angry, but I don't feel like you are connected to those feelings.

MARIE: I'm afraid if I let my feelings in that they won't go away.

In addition to general markers of underlying emotionality, I/EP therapists pay attention to markers of what humanistic therapists label "internal conflicts," "unfinished business," and "problematic reactions" (Greenberg, Rice, & Elliott, 1996; Greenberg & Safran, 1987). In each of these instances, experiential techniques are employed to help clients to get in touch with, own, and deepen previously unprocessed emotions.

Markers for internal conflicts are usually expressions by clients that they are "of two minds" about something (e.g., "A part of me wants to leave my husband, but another part of me can't imagine life without him"). Once a client has acknowledged an internal conflict, a therapist asks the client to take part in a two-chair exercise wherein the client distinguishes the two parts of the self—as though they were two separate people—and then embodies each one separately. It can often be helpful for the client to label each of the parts.

One of our clients, Sara, experienced a persistent conflict between the facade that she felt she needed to show others and her true feelings, which she felt she should discount. She labeled the facade "outside Sara" and her needs and wishes "inside Sara." The therapist placed two chairs facing one-another and had Sara first take the role of "outside Sara" and talk about her feelings to "inside Sara." After a time, the therapist had her switch chairs and roles, this time being "inside Sara" telling "outside Sara" how she felt. She was then asked to switch roles multiple times. Eventually she realized that she spent a great deal of time trying to repress "inside Sara." Nonetheless, her true feelings often leaked out eventually. She also realized that "outside Sara" sometimes operated on avoidance of fear. Therefore, she worked on finding a better balance between showing the side of her that she believed others wanted to see and allowing her own needs to come through.

Unfinished business refers to a client's unresolved feelings toward another person (who may still be alive or may have passed away). The pri-

mary intervention to deal with this is an empty-chair exercise (Greenberg et al., 1996). In this exercise, the client expresses his or her feelings toward the other person, who is imagined sitting across from the client in an empty chair. Interestingly, unresolved feelings are not always negative. We have often found that clients with GAD regret never having told someone how much they value them. One client had a father who was terminally ill. After much exploration, she realized that she was trying to show her father through her actions how important he was to her, but had never expressed what she felt. The therapist recognized that it was important for this client to process what her father meant to her. She was asked to imagine her father in the empty chair and to tell him how she felt about him. She spent several sessions getting in touch with her feelings and eventually told her father how she felt, which brought them closer together.

Markers for a problematic reaction include clients' surprise, confusion, or ambivalence about a particular reaction of theirs. When such markers are observed, clients are asked to close their eyes and imagine themselves back in the situation that evoked the reaction. It is helpful for clients to play the scene in slow motion, to vividly imagine every aspect of the scene, and to describe in detail the events and their feelings during the situation. The key is to help clients pay attention to every internal cue as they repeatedly describe the situation. By reexperiencing fine-grained details and their reactions to them, clients can express and own the emotions that first surprised them. Clients will frequently gain access to previously implicit emotions as a result of this technique, appropriately called "systematic evocative unfolding" (Greenberg et al., 1996). This technique is also used when clients do not seem to know what they felt in a particular instance.

As has been noted throughout this chapter, clients with GAD find emotional processing difficult, particularly the expression of vulnerable emotion in front of another person (i.e., the therapist). The expression of feeling provides a safe corrective experience, and is an important step in overcoming fear of vulnerability with others. Ultimately, however, such exposure will be of limited benefit if clients do not also change their habitual avoidance of emotion outside therapy. Because of their fear of emotions, clients with GAD may agree to be "pushed" toward emotionality during sessions, only to remain avoidant of their feelings between sessions. Homework is therefore assigned to encourage clients to focus on and stay with emotions outside of therapy. Because of a tendency to interpret instructions with an "all-or-none attitude" (e.g., "Either I shove my emotions aside, or I express whatever I happen to feel all the time"), clients are also told that the goal is to help them achieve a better balance between emotional expression and lack of expression. It is further emphasized that the goal of becoming aware of their feelings is not necessarily to stimulate emotional/cathartic expression. Clients are reminded that their

emotions are above everything else aspects of themselves that they need to accept, and that rather than attempting to avoid their feelings, they should see emotions as an important source of information for what they need in their lives. Once they have accepted their emotions, whether or not they act on them depends on the long-term costs and benefits of doing so.

RESEARCH

As noted earlier in this chapter, our integrative treatment (i.e., CBT + I/EP) is currently being compared to a control condition (i.e., CBT + SL) (Newman et al., 1999) to determine whether the addition of I/EP techniques can improve the efficacy of CBT, which is currently the only empirically supported therapy for GAD. Although it is too early to present the results of the study in progress, we have conducted a preliminary investigation of the integrative treatment (Newman et al., 1999). The first goal was to determine whether it would be possible to train therapists to conduct a treatment that required 55 minutes of CBT followed by 55 minutes of I/EP. The second goal was to conduct a preliminary examination, albeit limited, of the efficacy of the integrative treatment.

Eighteen individuals meeting *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (American Psychiatric Association, 1994) criteria for GAD received 15 sessions of CBT + I/EP. Three experienced therapists, two of them with a primarily psychodynamic background and the other originally trained in CBT, conducted the therapy. Therapists (one female and two males) were trained by Newman, Borkovec, and Castonguay and followed two treatment manuals, one for I/EP and one for CBT. They also received weekly individual supervision (by Newman and Borkovec) and group supervision (provided by Newman, Castonguay, and Borkovec).

Systematic adherence and quality checks revealed no major breaks in the treatment protocol and competent delivery of treatment (Newman et al., 1999). The two segments also did not differ in quality of alliance and credibility of the therapy (Borkovec, Newman, & Castonguay, 1998). Furthermore, analysis of outcome data suggested, although tentatively, that the integrative treatment can lead to greater therapeutic change then CBT. Indeed, the within-group effect sizes on commonly used anxiety outcome measures for CBT + I/EP compared favorably with those for a comprehensive CBT package (Borkovec et al., 2002) at posttreatment (2.87 vs. 2.16) and 1 year follow-up (2.74 vs. 1.93).

Although preliminary, these results suggest that I/EP techniques can be added to CBT, even if these techniques have been derived from different theoretical orientations. These results are also promising with regard

to the possibility of improving the efficacy of CBT for GAD. Of course, more definitive conclusions, especially with respect to outcome, must await the results of the current clinical trial.

CONCLUSION

As CBT therapists, we are aware of the therapeutic impact of CBT. However, we also recognize that CBT (like any other approach) has its weaknesses. Findings on the role of interpersonal, developmental, and emotional processing difficulties in the development and maintenance of GAD; on the clinical and conceptual limitations of CBT; and on the treatment process strongly suggest that the addition of I/EP techniques may be helpful to CBT for GAD. The addition of these techniques is also consistent with recent conceptual developments in CBT.

One may argue that because we conduct CBT and I/EP as distinct segments separated in time, we are not really doing integrative therapy. However, a number of treatments involving the sequential or concurrent use of different approaches have been described in the integrative literature (Glass, Victor, & Arnkoff, 1993). The key here is that although our therapy protocol uses techniques derived from divergent theoretical orientations, it is nonetheless based on a coherent theoretical framework. As described elsewhere, it represents a perfect example of one of the current trends in psychotherapy integration—that is, the improvement of effective therapies (in this case, CBT) by the assimilation of constructs and methods of other orientations (Castonguay et al., 2003). Furthermore, the use of different approaches (simultaneously or in succession) with the same patient has been recommended as relevant for future research on psychotherapy integration (Elkin, 1991). Whether the therapy would be improved by flexibly combining the techniques in one 2-hour block is, of course, an empirical question. However, given how difficult it is to keep therapists and clients focused on emotional processing and negative interpersonal patterns in I/EP, it would be even more difficult for therapists and clients not to get hooked into avoiding addressing these issues, without a specific block of time allotted for the delivery of these techniques. Furthermore, given how difficult it is for Clients with GAD to get in touch with and process emotions, anything less than a full therapy hour devoted to this process might diminish the efficacy of this intervention.

Finally, we would like to end this chapter by acknowledging that some psychotherapy approaches may have a lower direct cost than the ones that we have described (e.g., Newman, 1999; Newman, Consoli, & Taylor, 1997, 1999; Newman, Kenardy, Herman, & Taylor, 1997). However we would argue that although this integrative treatment requires more time than typical CBT protocols, it is likely to be more cost-effective. As dem-

onstrated by Newman (2000b), individuals with anxiety disorders who do not respond to CBT end up requiring a considerable amount of costly medical and psychological care. The present integrative protocol is specifically aimed at addressing factors that are predictive of nonresponse to CBT. As our research program progresses, we hope to show that the use of a more comprehensive treatment such as this one will, in the long run, be effective for a larger number of individuals by adequately addressing a larger number of variables involved in the etiology and maintenance of GAD (Newman, 2000b).

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