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A Case of Premature Termination in a Treatment for Generalized Anxiety Disorder

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In this paper we present a case of failure in an integrative treatment for generalized anxiety disorder (GAD) combining cognitive-behavioral therapy, an empirically supported treatment for GAD, and interpersonal-emotional processing therapy. The client of focus dropped out of treatment after the 8th session. Based on our analysis of this case, we discuss the participant, technical and relationship factors that were likely implicated in this case of premature termination in both of the cognitive-behavioral and interpersonal-emotional processing segments that comprised the treatment. Implications for practice, training, and future research are also discussed.

One of the goals that clinicians and researchers share is to improve treatment. Not all of these attempts, however, work well for every client. Importantly, it may be that, in the pursuit of our ultimate goal of helping clients make positive changes, we can learn as much by studying cases of failure as we do by studying successes. In this paper, we present a failure case, or more precisely, a case of premature termination, in a treatment that was designed to improve upon the effectiveness of a gold-standard treatment for generalized anxiety disorder (GAD). We begin by outlining the integrative treatment approach used in the present case, followed by a description of the client and the technical and relationship factors that may have contributed to the client dropping out of treatment. We then discuss the clinical, training, and research implications of our findings for this case. It is important to note that because this client terminated treatment prematurely, we have no objective data on her response to the eight sessions of treatment that she received and we are assuming that her premature termination indicates that she did not benefit from the treatment.

Treatment Approach

Cognitive behavioral therapy (CBT) for GAD has been found to produce significant improvement. Studies also show that CBT generates greater improvement in GAD than no treatment, analytic psychotherapy, pill placebo, nondirective therapy, and placebo therapy (Borkovec & Ruscio, 2001). Despite its general efficacy, however, there is significant room for improvement of CBT, due to a failure to demonstrate sustained reduction in symptoms of GAD (Westen & Morrison, 2001). Meta-analyses also show that after treatment a marked percentage of clients continue to experience clinically significant levels of anxious symptoms (Borkovec & Ruscio).

It is important to note that no standard definition of response and nonresponse exists for empirically supported treatments (ESTs) for GAD. Researchers have operationalized their own definitions, often using different outcome measures. For example, one way to define response is to examine effect size, yet even these tend to vary within and across measures and from study to study. Nevertheless, meta-analyses suggest that, on average, about 50% of clients with GAD achieve high endstate functioning (Borkovec & Ruscio, 2001). In the present case, we have defined nonresponse by premature, unilateral termination. As such, we have conceptualized this as a case for whom the treatment failed because it did not provide her with an opportunity to receive full benefit.

One hypothesis for the limitation of CBT's impact is that such protocols for GAD have not included techniques to address important factors associated with the maintenance of this disorder, such as interpersonal problems and emotional processing avoidance. Both emotional processing avoidance and interpersonal problems are prevalent in persons with GAD, and researchers have provided well-developed models for their roles in the maintenance of worry and GAD (Borkovec, Alcaine, & Behar, 2004; Newman & Erickson, 2010). However, Borkovec, Newman, Pincus, and Lytle (2002) found that CBT for GAD failed to make a significant change in six of eight scales on the Inventory of Interpersonal Problems (IIP-Client; Horowitz,

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Rosenberg, Baer, Ureno, & Villasenor, 1988) at posttreatment, and most clients continued to score at least one standard deviation above normative levels on at least one IIP-C subscale. This study also found that pretreatment interpersonal problems (Dominant/Hostile, Intrusive/Needy, Vindictive/Self-Centered) predicted negative CBT outcome. Moreover, interpersonal problems not successfully treated by CBT at postassessment were predictive of failure to maintain follow-up gains. Such evidence points to the necessity of including therapy techniques to specifically address patterns of interpersonal problems, including the client's contribution to maintaining maladaptive ways of relating with others.

Similar to its failure to address interpersonal problems, CBT for GAD has failed to include interventions that target emotional processing avoidance and discomfort (Newman, Castonguay, Borkovec, & Molnar, 2004). In a study by Borkovec and Costello (1993), the level of emotional processing was found to be significantly lower in CBT than in a reflective listening condition. This finding is consistent with some process research literature suggesting that "CBT attempts to control or reduce patients' feelings" (Blagys & Hilsenroth, 2000, p. 172). Interestingly, studies have also found that higher levels of emotional experiencing were associated with a positive outcome in CBT (e.g., Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996).

Taken together, these basic and applied findings suggest that adding techniques specifically designed to help GAD clients deeply experience and process uncomfortable emotions may help them to reduce their chronic worrying. Within a CBT framework, such an intervention can be viewed as a means for exposure to feared stimuli (i.e., feared emotional processing), and within an interpersonal framework, emotional deepening can be viewed as a means for identifying interpersonal needs.

It should be noted that although it is common in standard CBT for GAD to address interpersonal issues, this is typically done in an *intrapersonal* way. That is, the client is engaged in cognitive restructuring regarding worries about others, as well as the way that others affect the client. Typically, CBT manuals for GAD do not address interpersonal issues in terms of teaching the client interpersonal skills and/or providing clients with feedback about their impact on others, including the therapist. This has also been the case regarding the therapeutic relationship. CBT protocols typically do not include a manualized intervention that explicates how to repair an alliance rupture, and/or how to address relationship dissatisfaction of the client toward the therapist or a negative impact that the client is having on the therapist (with the exception of some forms of CBT, such as dialectical behavior therapy [DBT]). Further, inappropriate interpersonal behavior on the part of the client toward the therapist has not been conceptualized in traditional CBT manuals as a subset of interpersonal behavior exhibited toward others. Although it may be common to elicit feedback about the therapeutic process, this specific elicitation is rarely explicitly manualized in CBT for GAD.

For reasons described above, two of the present authors developed (in collaboration with Thomas Borkovec) a treatment that added interpersonal and emotional processing interventions (I/EP) to CBT. As detailed elsewhere (Newman et al., 2004), the conceptual basis for the addition of these components was derived, in large part, from Safran and Segal's (1990) expansion of cognitive therapy. Initial pilot testing of this protocol demonstrated its feasibility, with large effect sizes and promising results (Newman, Castonguay, Borkovec, Fisher, & Nordberg, 2008). Specifically, results showed that the integrative therapy (CBT plus I/EP) significantly decreased GAD symptomotology, with maintenance of gains up to 1 year following treatment. In addition, comparisons with the extant literature suggested that the effect size for this new GAD treatment was higher than the average effect size of CBT for GAD. However, more recent findings have demonstrated equivalence with CBT (Newman et al., in press). In sum, while it is premature to make a definitive comparative statement, data suggest that this new treatment is at least as effective as traditional CBT.

The treatment design, for scientific reasons, involved a separate and sequential combination of two distinct therapeutic segments (i.e., 50 minutes of CBT, followed by 50 minutes of I/EP). Using an additive design, our most recent randomized clinical trial (RCT) compared 50 minutes of CBT, followed by 50 minutes of I/EP to 50 minutes of CBT, followed by 50 minutes of supportive listening (SL). The full treatment lasted for 14 sessions (Newman et al., 2008; Newman et al., in press). With regard to the optimal sequence of therapeutic segments in clinical practice, we would also recommend a standard application using CBT followed by I/EP in this domain.

Description of the Treatment

CBT

Clients received CBT during the first 50 minutes of each of the 2-hour sessions. These techniques targeted intrapersonal aspects of anxious experience and included methods from the most comprehensive CBT protocol previously developed and tested at Penn State University (Borkovec et al., 2002): Training in self-monitoring of environmental, somatic, active, imaginal, and thought (especially worry) cues that trigger anxiety spirals with special emphasis on increasingly early cue detection; formal progressive relaxation (Bernstein & Borkovec, 1973); training in cue-controlled and differential

relaxation; self-control coping desensitization (Goldfried, 1995); and cognitive therapy (based on Beck & Emery, 1985) involving identification and challenging of automatic thoughts and assumptions underlying the threatening nature of events or anxiety cues.

Interpersonal/Emotional Processing Segment

Clients in the integrative treatment condition received I/EP interventions during the second 50 minutes of each session. This segment was specifically designed to address interpersonal difficulties and failures in accessing primary emotions involved in the generation of anxiety and worry. Specifically, the goals of this portion of therapy are as follows: (a) identification of interpersonal needs, past and current patterns of interpersonal behavior (including negative impacts on others) that attempt to satisfy those needs, and emotional experience that underlies all of these; (b) generation of more effective interpersonal behavior to better satisfy the needs; and (c) processing and deepening of avoided emotion associated with all therapeutic content. In order to achieve these goals, therapy was guided by eight principles, including emphasis on clients' phenomenological experience; therapists' use of their emotional experience to identify interpersonal markers; use of the therapeutic relationship to explore affective processes and interpersonal patterns (including clients' negative impact on others); generalization of therapeutic change via exploration of between-session events and provision of homework experiments; detection of alliance ruptures and provision of emotionally corrective experience in their resolution; processing and open communication of patients' affective experiencing in relation to past, current, and in-session interpersonal relationships; and use of skills-training methods (e.g., assertion, problem-solving, communication training, role-playing) to provide more effective interpersonal behaviors to satisfy needs.

As mentioned above, the aim of this paper is to provide a case illustration of a client who terminated treatment prematurely and to identify factors that may have interfered with change in therapy. First, we briefly describe our method of case analysis. We then provide some basic demographic information about the client, followed by a description of various idiosyncratic and common psychological factors that may have contributed to difficulties with the implementation of specific treatment segments for this case. Finally, we explore the technical and relationship factors that may have also contributed to premature termination.

Method of Case Analysis

The content of the present case study was based on multiple sources of information. First, the authors reviewed the available pretreatment data for this case. Second, the first two authors viewed all of the videotaped treatment sessions over a 6-week period. Extensive process notes were taken while viewing the tapes, which were ultimately compared and discussed, using a method similar to Comprehensive Process Analysis (CPA), developed by Elliott (1993). Third, the therapist who provided the treatment in this case was interviewed by the second author. The therapist also viewed several videotaped segments of the treatment to aid in his recall of the treatment process.

Case Information[1]

The client was a married, Caucasian female living with her husband and teenage son. She turned 40 during the course of treatment. She was employed full-time as an educational administrator, and although this was a new field for her, she was in many respects successful. She agreed to participate in the treatment research study and reported a wish to improve her "stress management." At the initial assessment period, the client met criteria for GAD (Clinician's Severity Rating [CSR] of 5 on an 8-point scale), social phobia (CSR of 4 or moderate), and depressive personality disorder based on the Anxiety Disorders Interview Schedule (ADIS-IV; Brown, Dinardo, & Barlow, 1996) and the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II; First, Gibbon, Spitzer, Williams, & Benjamin, 1997). She reported excessive worry across a number of situations, relationships, and activities, as well as concern about being judged by others. The client dropped out of treatment after attending the first eight psychotherapy sessions, totaling approximately 16 hours of psychotherapy (8 hours of CBT and 8 hours of I/EP).

The comorbidity present in this case warrants further consideration. Personality disorders commonly co-occur with GAD; on average, approximately 60% of those with GAD have a co-occurring personality disorder (Sanderson, Wetzler, Beck, & Betz, 1994). The client's depressive personality contributed significantly to her pessimistic thought style. Indeed, the client occasionally viewed her frustration and disappointment as "just the way things were destined to be." Additionally, social phobia is the most commonly comorbid anxiety disorder with GAD. In our experience, the specific comorbidity tends to influence the content of clients' worries. For the present client, she worried most frequently about interpersonal relationships and social interactions involving her family and coworkers. As with all clients, this information was integrated into the client's initial case conceptualization and influenced the treatment plan

[1] Details about the case have been modified to protect the identity of the client.

insofar as the intended focus of worry topics in the CBT segment (e.g., concerns about social interactions), and current relationship difficulties in I/EP (e.g., interactions with specific family members and coworkers).

The client described growing up in an abusive home with an alcoholic father and provided some indication of domestic violence. She reported that her mother would frequently focus her anger on the client's younger brother, occasionally using physical violence. During one session, she reported that her brother had a bedwetting problem as a child, and she recalled racing out of the house to the bus stop every morning to avoid hearing her mother scream at him. The client endorsed a great sense of guilt in recalling this experience and frequently brought up her difficulties in relating to her brother and parents. For example, she reported that her brother currently suffers from mental health problems, including substance abuse, and he frequently asks her for financial assistance.

Although the client reported at the first session that things seemed to be improving for her in recent weeks, she described several areas in her life that she had found problematic and unsatisfying. For instance, she reported experiencing significant marital problems and disclosed that she had been considering divorce for some time. She explained that divorce did not seem to be a viable option because of the perceived strain that it would place on her son and the financial pressure and reduction in quality of life that she would experience as a single adult. She contemplated waiting until her son graduated from high school before pursuing the option of divorce, but continued to experience ambivalence around this issue. She also described several concerns related to her son, such as the consequences of her son getting pulled into arguments with her husband, and the realization that he was becoming more independent. Additionally, the client reported that her son had been spending more time with her husband, which caused some envy as well as worry that her son would "turn out more like him."

Over the course of treatment there were several issues that the client presented which likely influenced her decision to terminate prematurely. Among these concerns were skepticism about the usefulness of therapy, occasional lack of compliance with assigned homework, uncertainty about readiness for change, and above all, discomfort with and difficulty tolerating emotional experience. Consistent with findings from experimental and self-report studies on GAD (Llera & Newman, 2010; Mennin, Heimberg, Turk, & Fresco, 2005), reticence to experience emotion was one difficulty that appeared to permeate and fuel several of these other issues. We will briefly detail these concerns and explore their potential contributions to the treatment dropout.

First, the client repeatedly expressed doubts about the usefulness of treatment, specifically as it pertained to the tasks and goals of I/EP. Although she appreciated the relaxation and aspects of cognitive restructuring in the CBT segment, she often questioned the rationale for exploring areas of interpersonal dissatisfaction in her life and the associated negative emotions. While beginning to express disappointment over her unsatisfying marriage, for instance, the client occasionally interrupted her own process to point out that it was not helpful to feel bad about these things because, at 40 years of age, she had "already made [her] choices" in life. Despite the therapist's attempts to explain the benefits of emotional processing, and the client's own acknowledgment that the rationale made logical sense, she continued to worry that this would only make her feel worse about her life and potentially make rash decisions. Although she was able to get in touch with many negative emotions over the course of the 8 weeks and she appeared to attain some insight as a consequence (based on the client's own self-report), she often began the subsequent session by once again questioning the helpfulness of psychotherapy.

Reluctance to fully engage in treatment was also observed in the CBT segment. Despite her apparent agreement with the CBT rationale as well as tasks and goals for treatment, the client inconsistently complied with between-session homework assignments. The beginning of each CBT segment was devoted to reviewing homework from the previous week, and she often stated that she "sort of tried" to work on these tasks. For example, she was asked to practice self-monitoring and early cue detection dozens of times each day, yet she frequently reported forgetting to do this and was not sure that the suggested frequency was feasible.

In addition, the client exhibited inconsistent readiness for change over the course of the 8 weeks. At times she seemed ready to acknowledge the myriad problems in her life (e.g., family, work, unsatisfying marriage); at others, she compared her life favorably to others and argued that she really didn't need treatment at this time. This could be conceptualized as a fluctuation between the *precontemplation* and *contemplation* stages of change in psychotherapy, where precontemplation refers to the stage in which individuals do not recognize themselves as having a problem, and consequently, they are less willing to make life changes (Prochaska & DiClemente, 1982). Questions around the need for change appeared to impact the process of therapy, and were perhaps employed as a strategy to escape the anxiety associated with facing previously avoided negative emotional material. As noted above, there were times when the client more explicitly expressed her concerns about experiencing negative emotions.

The client's fear of and ambivalence toward the emotional experiencing focus of I/EP posed a significant challenge for the treatment and therapist. When guided to reflect on emotional situations, the client often reacted with dubiousness and discomfort with this process, occasionally exclaiming "I can't do this." She described herself as "a very emotional person" who needed to work hard to prevent her emotions from "taking over," sometimes expressing the fear that if she began to cry, she would never stop. Although this issue proved difficult for the emotional processing component of the treatment, it is not unique to the task of treating persons with GAD. Unfortunately, this mode represents a common struggle for many individuals with anxiety disorders such as GAD (see Llera & Newman, 2010; Mennin et al., 2005; Roemer, Salters, Raffa, & Orsillo, 2005; Turk, Heimberg, Luterek, Mennin, & Fresco, 2005), and for this client, the therapist found it challenging to effectively address this, as detailed below.

In sum, there were several client characteristics—some unique to the client and others common to GAD—that posed challenges to the treatment. We would like to emphasize that in describing the above difficulties, it is not our intention to place sole responsibility for premature termination on the client. Although client factors surely impact therapeutic process and outcome, the way in which a therapist handles these factors also contributes to ultimate outcome. Further, some of the client factors that present challenges to therapists may be the very features that are bringing the client to treatment. In the next section, we address the ways in which these issues likely interacted with problems in treatment implementation.

Treatment Factors Accounting for Dropout

In this section, we discuss treatment factors that might have contributed to premature termination in this case. We divide this section into two parts. First, we address problems in the use and implementation of interventions in both CBT and I/EP segments (technical factors). Second, we address problems related to the working alliance (relationship factors). In both parts, we provide some insight into the therapist's perspective of these issues. It is important to mention that in both CBT and I/EP, our measures of adherence do not dictate the specific time-points in therapy for the delivery of any of the techniques. Therapists are trained to introduce or focus on any specific technique at time points that seem appropriate and helpful for any one client. The goal is simply that over the course of the 14 sessions, all techniques have been introduced. In addition, much of what we note about the therapist is out of character. This particular therapist was usually quite diligent, perceptive, in tune with most clients, and task-oriented. Therefore, we suspect that the combination of this therapist with this particular client may have led to some of the noted problems, and we attempt to explore these factors.

Technical Factors

CBT

As described above, CBT for GAD involves a series of interventions aimed at increasing client awareness of somatic and cognitive cues of worry and anxiety, teaching and practicing stimulus control, self-control coping desensitization, and relaxation methods, and teaching clients to confront and replace distorted thoughts. Importantly, the relative emphasis of these different interventions for each client is left to the discretion of the therapist. In our experience, treatment failure can occur due to a number of factors, such as providing an inadequate rationale of these tasks and how they relate to the client's problems and goals for treatment, and introducing interventions at a point in time when another intervention might be more helpful. Of course, implementation problems can contribute to negative outcome.

Self-monitoring is a core component of CBT and is often one of the first areas of focus in treatment. Such is the case in CBT for GAD where clients are instructed to frequently monitor their experience and begin to detect early cues in the worry process (e.g., tension in the neck and shoulders). Effective implementation occurs when the client is able to self-monitor frequently throughout the days and weeks, and this itself becomes an automatic, learned process (Newman, 2000). Clients are occasionally surprised by how frequently they are instructed to monitor their experience (thoughts, sensations, emotions) and some have difficulty following through with the task to fully realize its potential impact. As mentioned, in the present case the client often reported that she "sort of tried" self-monitoring throughout the week yet frequently forgot and was not sure that the suggested frequency was feasible. Although this may have been due to an insufficiently explicated rationale, the therapist did not spend a lot of time working with the client to make the practice seem more helpful and reasonable. Additionally, he explicitly intended to practice monitoring with the client throughout one of the early sessions, yet did not follow through with this.

Upon reflection, the therapist reported that he perhaps overnormalized the client's struggles to complete the between-session activities, given the pull to empathize with her busy schedule. In addition, the therapist speculated that his reticence may have been due to a desire to avoid conflict with this client. He explained that the client's uncertainty about therapy caused him to take a more careful stance with such issues, perhaps to the detriment of the treatment. In this particular case, these

tendencies may have gotten in the way of a more direct and thorough discussion of the importance of engaging in all aspects of the treatment, including homework assignments. In reference to the self-monitoring practice in session, the therapist reported that this was an issue of time management, rather than a conscious decision on his part.

Relaxation methods are another crucial component of CBT for GAD (Newman & Borkovec, 2002). Clients are instructed to practice diaphragmatic breathing, progressive muscle relaxation, and applied relaxation between sessions. In this case, diaphragmatic breathing was introduced at the end of the first session and the client was instructed to practice this throughout the week. At the beginning of Session 2, the therapist checked in with the client regarding whether or not she had practiced breathing and if she had noticed anything. The client reported that she had indeed been able to practice and found it extremely helpful. She reported, with noticeable positive affect, observing a big difference between diaphragmatic breathing and how she usually breathes. The therapist responded matter-of-factly that this was good, yet seemed to have failed to appropriately seize upon/reinforce this accomplishment. Additionally, although the therapist indicated that he would be introducing progressive muscle relaxation (PMR) early in the treatment, he did not begin to formally introduce this intervention until the end of the Session 5, and was unable to complete the first in-session practice due to time constraints. Given the client's positive experience with diaphragmatic breathing, it was surprising that the therapist postponed the introduction of PMR until so late in the treatment.

In this case, the therapist described himself as focusing more on cognitive interventions and perhaps getting somewhat "stuck" on these at times, possibly interfering with the implementation of relaxation training. Nevertheless, the therapist perceived the client as finding the cognitive interventions helpful, which was likely based on the ease with which she was able to identify, and use the language to report, distorted thinking styles. The relative emphasis of different cognitive and behavioral components with a given client raises important empirical and clinical issues. It is also important to note that the therapist intended to focus more on relaxation training in future sessions. Because of premature termination, however, he did not have this opportunity.

As noted, cognitive therapy is an important treatment component, and this represented a significant focus of treatment in the present case. Although the client seemed willing and able to engage in cognitive therapy tasks (e.g., frequently reviewed cognitive distortion handouts and began to use the language—"That's a *should*"), as previously stated, the therapist may have focused on cognitive techniques to the detriment of other important treatment components (e.g., relaxation methods). In addition, there were problems in the implementation of some cognitive techniques. For example, early on in treatment the client reported being in a car accident, for which she was at fault. To her and the therapist's surprise, she described handling the incident well and experiencing minimal anxiety, even when angrily confronted by the other driver. However, the client did report becoming significantly anxious when it occurred to her that she would have to explain this to her husband, and then described becoming incredibly anxious when he arrived on the scene. Rather than focusing on what may have been the more salient issue (e.g., thoughts about interacting with her husband), the therapist chose to focus on the accident itself.

When asked about this episode, the therapist felt that there were two processes underlying this decision. First, he described experiencing conflict over what content to focus on due to the multifaceted nature of this situation. He explained that he decided to focus on the client's thoughts as they related to her competency in this situation (i.e., driving) because he perceived the accident to be an aspect of the client's concern as well as the most straightforward opportunity to demonstrate cognitive restructuring at that point in the treatment. The therapist also noted that he may have been overly focused on teaching techniques, possibly at the cost of missing the most relevant aspects of the situation for the client (i.e., impact of husband's judgment). Although this may have stemmed from a desire to effectively impact change, it ultimately lost the thread of the client's actual anxiety experience. This incident underscores the importance, and the challenges therein, of ascertaining the most salient elements of topics brought in by our clients.

I/EP

As described earlier, the I/EP segment aims to facilitate the client's identification of interpersonal needs, fears, and behaviors, and to help the client develop behaviors that will better satisfy personal needs. Further, this segment aims to use the client's impact on the therapist to provide feedback on behaviors that may not be working for her outside of therapy. Additionally, clients are encouraged to expose themselves to feared emotions, feared critical feedback about their impact on others, and their fear of vulnerability.

In attempting to *explore and change the client's interpersonal functioning*, the focus of this segment was frequently on her family. With the aid of the therapist, the client identified interpersonal situations that caused her to become anxious or angry; however, the exploration process rarely evolved in a useful way and the client and therapist frequently seemed to be at a standstill. For

example, the client would begin to offer specific details about a situation, to which the therapist would respond by requesting her to report a feeling. Occasionally the client would be able to respond with an emotion, yet would continue to describe the interpersonal situation, to which the therapist would again respond by requesting her to report a feeling. When the client had difficulty with this, the therapist would reiterate the treatment rationale. In other instances the reverse process would occur—the client would describe a feeling in response to her husband or son, and the therapist would switch the focus to interpersonal dynamics, often wondering about the client's potential impact on others. The client would often become confused by these questions, which further disrupted emotional deepening. Although exploring the client's impact on important others is a core component of the treatment, the therapist's timing seemed to cause the client to become defensive.

Importantly, the difficulties that emerged in facilitating the client's emotional exposure and deepening were most likely related to the client's existing beliefs about the nature and usefulness of emotional experiencing. However, current literature suggests that difficulties with emotional processing may be the sine qua non of GAD, and, thus, working with clients to address these problems is *the* task of the I/EP treatment. In the current case, the client would at times comply with treatment goals and engage in emotional deepening, but often returned the next week voicing the same anxieties that she would be harmed by such activity. Although this may have reflected the client's vacillation between precontemplation and contemplation stages of change, it may have also interacted with the therapist's own self-consciousness about his performance.[2] We explore this dynamic further when discussing relationship factors affecting treatment.

In addition to occasionally disrupting emotional deepening (e.g., *evocative unfolding*) by asking a question about a thought or interpersonal situation, for example, the therapist did not implement certain prescribed emotion-focused interventions, such as two-chair techniques for *self-evaluative splits* (i.e., *One part of me feels x, but another part of me feels y*). Although the therapist was able to pick up on some emotional markers (e.g., pointing out shifts based on nonverbal behavior), he failed to address several important internal conflicts experienced by the client, the most salient being her concern regarding the helpfulness of emotional experiencing. However, it is possible that the client's repeated reluctance to engage in emotional processing left the therapist doubtful that this client would be willing to engage in experiential exercises toward this goal, and that he was waiting to gain a footing in simple descriptions of her emotions before moving toward these exercises wherein the purpose was further deepening.

Given that disrupted emotional processing is a key pathogenic factor in GAD, we see this as a central focus of the treatment. However, addressing these issues can be one of the more alarming aspects of treatment for the GAD client, and perhaps this therapist held back out of a hesitancy to push an already resistant client. Again, due to the early withdrawal, the therapist was unable to continue in these efforts.

Relationship Factors

CBT

Regardless of the specific treatment, therapists should make all possible efforts to be empathic, warm, and supportive toward clients and foster mutual agreement on the goals and tasks of therapy (Castonguay, Constantino, & Holtforth, 2006). As described elsewhere (Castonguay, Constantino, McAleavey, & Goldfried, 2010), a positive working alliance is considered to be a precondition for successful implementation of CBT interventions and positive outcome. A bond should exist between client and therapist, and the therapist should understand the client's subjective experience, demonstrate flexible and tactful use of interventions, and provide reinforcement for client engagement in tasks.

There were a number of issues observed during the CBT segment of treatment that suggested a strong alliance was not fully developed and/or maintained. Starting at Session 1, the client reported beginning to feel better and questioned the appropriateness of treatment ("Some things have already resolved; I'm wondering how much of this I need."). This attitude toward treatment and its interaction with the technical problems outlined above may have had a negative impact on client engagement. As such, there seemed to be a lack of clear agreement and commitment to treatment tasks and goals. Although seemingly minor in the moment, the therapist's response to the client's description of being helped by diaphragmatic breathing mentioned above also represents a missed opportunity for providing reinforcement for client engagement in tasks.

I/EP

Similar to the CBT segment, the client had concerns about the usefulness of emotional experiencing, and specifically questioned the focus of the I/EP segment. In

[2] With regard to readiness for change and premature termination, it is important to note that this client was self-referred via advertisement to this treatment study. Nevertheless, there is no existing empirical evidence to suggest that self-referred clients differ significantly from professionally referred clients in their readiness for change. Conversely, statistical equivalence between these referral groups on other potentially relevant pretreatment characteristics has been demonstrated (e.g., Marks, Kenwright, McDonough, Whittaker, & Mataix Cols, 2004).

contrast to CBT, however, the therapeutic relationship is a specific focus of intervention in I/EP. Therapists are instructed to identify and repair alliance ruptures, and use their own here-and-now experience of the relationship to identify difficulties and to foster corrective experiences, including (but not restricted to) the repair of alliance ruptures.

There were several alliance ruptures in the I/EP segment. This occurred in the context of the exchanges outlined above regarding the exploration of client interpersonal functioning and emotional deepening. When the client had difficulty with what the therapist was asking, the exchange read something like: "You are doing X, and I would like you to do Y," to which the client would become frustrated and respond, "I don't know what you want from me." Rather than use prescribed techniques (Safran, Muran, & Samstag, 1994) when confronted with alliance ruptures, the therapist increased his focus on the treatment rationale or techniques ("How does that make you feel?"), which seemed to exacerbate, rather than resolve such alliance difficulties. In addition, when therapists disclose their reactions to the relationship, they must do so in a nondefensive manner. In his attempt to address perceived ruptures, the therapist occasionally came across as defensive, characterized by a tendency to repetitively emphasize the treatment rationale, which only served to increase the client's own defensiveness.

In the current case, we believe that this experienced therapist may have become unnerved due to the pressure to elicit change in a client who vacillated between endorsing the value of particular techniques and a strong reluctance to engage in these techniques. He appeared conflicted between wanting to empathize with her struggles and a strong desire for her to overcome them. When asked about this, the therapist explained that he was feeling as though the client was neither improving nor engaging in the treatment in the ways that he would have hoped, and he felt that he should have been able to help the client but was having difficulty figuring out how to do so. In the I/EP segment, he experienced an inability to "gain a footing," which left him feeling de-skilled. In a way, the therapist began to experience the same hopelessness and irritability likely experienced by the client. He reported that given the client's frequently voiced concerns with aspects of the treatment, he seemed to lose sight of what she actually needed, which led him to become "more self-conscious about his performance" and more "dogged" in his adherence to the treatment protocol. In turn, this made it difficult to meet the client where she was.

Research Implications

Several research implications can be distilled from our analysis of this client who dropped out of treatment. First, we believe that this case highlights the difficulty of working with particularly avoidant clients. In GAD, some clients may be less aware of the function that avoidance serves in maintaining their anxiety, while other clients report being quite aware of the role that worry plays in their daily functioning. That is, some clients cling to worry as a way to maintain a sense of control over themselves and their environment. Immediate experience is clearly perceived as threatening, which presents a significant obstacle to a treatment that is focused on exposing clients to their emotions and facilitating emotional deepening. Consequently, we believe that this case further illustrates the importance of understanding how beliefs about worry and experiential avoidance impact treatment compliance and outcome. In fact, a recent study conducted by Hayes, Orsillo, and Roemer (2010) found that an increase in GAD clients' acceptance of internal experiences was related to positive outcome. Future research should continue to examine whether variability in emotional/experiential avoidance assessed at pretreatment (or repeatedly across treatment) predicts treatment retention and/or response, using measures such as the Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004). If higher levels of avoidance negatively impact treatment compliance, as presumably was the case with the present client, then therapists can assess for this prior to (or throughout) treatment and possibly incorporate specific interventions to address this in order to facilitate client engagement.

Relatedly, this case highlights the importance of client engagement. The client was clearly ambivalent about therapy—its tasks, goals, and likelihood of having a positive impact. One aspect of engagement, readiness for change, appears to be an important pretreatment factor that is likely to predict subsequent engagement and treatment outcome. Once a client enters therapy, however, her/his level of engagement is likely to interact with therapeutic tasks and goals as well as the characteristics of the therapist. For example, this case may provide an illustration of how a therapist's timing with a particular client, or lack thereof, can contribute to reduced client engagement.

In the present case, the therapist manifested a lack of timing (i.e., implementing specific interventions at the appropriate point or moment) in several ways. There were moments when he seemed to be strongly adhering to an aspect of the treatment protocol that wasn't working with this client, such as when he continued to ask about emotion when the client was frustrated with him. Other manifestations of a lack of timing included focusing on material that was less salient to the client, refocusing in a way that removed the client from her experience, or failing to adequately reinforce positive experiences in treatment. Although we believe that a lack of timing has

deleterious effects on client improvement, we theorize that the totality of its impact is probably best captured by its interaction with client engagement. That is, a lack of timing will likely diminish the client's level of engagement, and vice versa. As such, the relationship between timing and engagement should be a focus of future research. For example, attempts could be made to model the temporal relationship between timing and engagement in session. These factors might be best captured by process measures that assess moment-to-moment interpersonal behavior, such as the Structural Analysis of Social Behavior (SASB; Benjamin, 1996). Threshold autoregressive models could be used to analyze these dyadic interactions over time (Hamaker, Zhang, & van der Maas, 2009). Based on the results of this analysis, therapists could be trained in methods to decrease the likelihood that they will be thrown off by repeated treatment avoidance on the part of the client (e.g., taking a particular interpersonal stance or attending to specific information), and its effect on client engagement could be studied.

Although not synonymous, decrements in timing and engagement may also be symptoms of a poor working alliance. Although the working alliance has been shown to be a consistent predictor of outcome across a number of treatment approaches and disorders (Castonguay et al., 2006), there is a relatively limited empirical knowledge related to principles guiding the detection and repair of alliance ruptures. In the present case, the client expressed a lack of agreement on tasks and goals through inconsistent homework compliance as well as her explicit dislike for emotional processing. In the latter case, the therapist responded in a way that created a nonproductive therapeutic interaction. Although this is an anticipated effect of some of the work in I/EP (it is not always easy for clients to hear that they have an impact on others and are also contributing their problems), it can be difficult to deliver these interventions with optimal timing in the heat of the session. As such, it will be important for us to learn more about the nature of these transactions, the timing of interventions, and their interaction with client characteristics. This will likely require complementary approaches of both qualitative and quantitative research.

One could argue that, traditionally, timing has been indirectly assessed by measuring competence at the session level. However, directly capturing these in-session processes would likely require intensive process coding. Timing is a difficult dimension to measure because it is necessarily relative to something (e.g., a client utterance, a process marker). Further, there are no right or wrong responses; such things tend to be a judgment call in the moment. Although it will be important to separate process from outcome, it will probably be necessary to link assessments of timing to specific, identifiable in-session or postsession impacts, which can either be coded by observers or gathered through self-report immediately after the session.

An additional research question emerges regarding individual differences and responsiveness to CBT. In the present case, the client seemed to benefit from relaxation training, yet the therapist chose to focus more on cognitive therapy interventions. Indeed, applied relaxation and cognitive therapy were both elements of the CBT intervention under investigation; however, one wonders about the alternative outcome of this case (e.g., staying in the treatment) had the therapist focused more on applied relaxation earlier in the treatment. Research aimed at identifying individual difference variables that might explain differential responsiveness to components of CBT could be quite informative and aid in clinical decision making (e.g., Which interventions should be the primary focus *for this client*? In what order should these interventions be introduced *for this client*?; Newman, Crits-Christoph, Connelly Gibbons, & Erickson, 2006).

Clinical and Training Implications

This case presents some important clinical and training implications. First and foremost, we believe that this case illustrates a core difficulty in working with individuals who engage in emotional processing avoidance. Although there is evidence that reduced avoidance may be an important predictor of change, and many clients understand the rationale for exposure interventions that target this (including the present case), avoidance (and the negative reinforcement it serves) can be a deeply entrenched coping strategy. There are, however, strategies that have been devised to address this issue, with several of these featured in the I/EP protocol described in this paper (see Newman et al., 2004, for a more comprehensive discussion).

In the present case, client emotional deepening might have been facilitated by a greater focus on helping the client stay with her emotional experience. Interrupting client exposure prematurely may reinforce avoidance, which can not only result in a lack of effect, but can also cause harm (Castonguay, Boswell, Constantino, Goldfried, & Hill, 2010). In order to facilitate the activation of core structures and emotional processing, it is important for clients to stay with their experience until it has diminished naturally (Foa & Kozak, 1986). In the present case, the therapist appeared to be pulled to connect the client's emotion with her perceptions of specific interpersonal transactions. Although such connections are important, this might have been done prematurely. By the therapist's own report, given some of the difficulties he was experiencing with this case, he was feeling pressured to effectively deliver the treatment

and make an impact. This speaks to the importance of patience and following through with a particular process, which is crucial in the case of emotional processing. Beginning therapists and trainees may feel pressure to address too much (or too many things) in a given moment, yet sometimes it is better to thoroughly facilitate a single process.

Conversely, if the client appears to have consistent difficulty engaging in prescribed therapeutic tasks to promote emotional processing (or any other process of change) or appears to be frustrated with the treatment and/or therapist, continuing to try to engage the client in that task may be counterproductive (e.g., Castonguay et al., 1996). In addition, during emotional processing interventions, clients may engage in subtle forms of cognitive avoidance, which disrupt the activation of relevant fear structures and can lead to negative effects (Foa & Rothbaum, 1998). It is important for the therapist to assess for these tendencies and attempt to address them; otherwise, treatment is likely to have minimal impact. In the present case, the client's modus operandi was cognitive avoidance, and she expressed concerns regarding the helpfulness of emotional experiencing. It might be necessary to assess for and address such tendencies before proceeding with specific interventions. Here, the therapist typically reintroduced the treatment rationale in response to the client's concerns. The therapist acknowledged that he began to feel stuck and pressured after several iterations of this exchange and that this interfered with his ability to remain as responsive as he might have otherwise been. Although we cannot be certain, an alternative approach may have been to step back and explore the client's beliefs and concerns about experiencing before moving forward with specific interventions that require the client to engage in such experiencing. Although the pull to move forward is understandable and there is always a risk of continually "spinning one's wheels," the potential consequences include a lack of engagement and/or premature termination.

This concern and conflict around emotional experiencing was indicative of a *self-evaluative split* within the client. Consistent with polarized thinking, the client believed that one was either at the mercy of her emotions or was in complete control. On some occasions she reported feeling as though she had a rich emotional experience that made her a more actualized person, on other occasions this rich emotional experience was viewed as threatening. Conversely, she reported that others view her as cold and unemotional, which she did not agree with or appreciate, yet also frequently remarked that it was adaptive for her to control her emotions and that she probably that she benefited from this approach. Such evaluative splits serve as important markers.

One method of addressing these splits and exploring and deepening related affect states is a two-chair procedure (Goldfried, 1995; Greenberg, 2002). Another self-evaluative split present in this case involved the client's guilt over helping her ill brother who, although was in need of help, frequently made objectively unreasonable requests. These interactions, which took place mostly over the telephone, caused her to experience a tremendous amount of pain as she recalled "abandoning him" as she fled to the bus while he was abused. However, at other times she expressed a great deal of anger toward her brother and defiantly rejected being responsible for his happiness. Clients are more likely to benefit from exploring both sides of this issue, including both thoughts and emotional experience. The therapist eventually recognized these as important conflicts and made them explicit with the client. However, due to the client dropping out of treatment, he was unable to follow-up with them. For beginning therapists and trainees who are interested in experiential forms of treatment such as I/EP, it is important to be mindful of and sensitive to indications of polarized thinking and self-evaluative splits. Markers of such splits can include subtle shifts and disruptions within the client (e.g., stopping mid-sentence or failing to complete a thought) as well as inconsistencies and contradictions in what they are reporting.

This case also illustrates the importance of focusing on material and examples that are most salient and affectively charged. In CBT, for example, clients and therapists work together to identify situations and examples to focus on when practicing cognitive and applied relaxation strategies. Although clients may still be able to get the gist of how to apply these strategies (thus increasing the capacity for generalization), even if the chosen scenario is not necessarily the most indicative of their anxiety, the impact of these interventions is likely to decrease. Such diminished impact may not only impede learning, but is also likely to negatively influence client engagement. If the client seems to be concerned with situation or person A and the therapist proceeds to focus on situation or person B, then the client will less likely be hooked by the intervention. A similar impact is likely to occur when positive client experiences are not adequately reinforced, particularly early in treatment. Needless to say, this exemplifies the importance of timing in CBT, which can be illustrated by choosing the right focus of intervention to address the client's emotionally immediate needs. We believe that it is important for beginning therapists and other trainees to understand that it is acceptable to ask the client if there is uncertainty about what is most important for the client at a given moment. Questions such as, "What about this situation was most concerning to you?" or "What did you imagine was the

worst possible outcome in this situation?" can help ensure that the therapist and client are on the right track when implementing CBT.

Finally, the implementation of a treatment such as the one under investigation is challenging for even the most experienced therapist. The therapist has many interventions at his or her disposal and is required to simultaneously attend to multiple domains of experience—cognitive, behavioral, affective, and interpersonal. This requires sophisticated decision making, and although basic and applied research indicates that these interventions can be helpful in the treatment of clients with GAD, there is still much to learn regarding optimal implementation. At the present time, we believe that all clinicians (including, but not limited to, therapists in training) continue to be served by a thorough understanding of the basic change principles underlying the interventions being employed.

Conclusion

The goal of this paper was to present a case of premature termination in a treatment protocol aimed to improve an already effective treatment for GAD. We described the client characteristics and treatment factors (intervention and relationship factors) in both segments (CBT and I/EP) that are part of an integrative treatment. We also distilled some important research, clinical, and training implications.

Our case analysis highlights the importance of considering client, therapist, relationship, and technical factors in both successful and unsuccessful treatment cases. Even with treatments that are designed to improve upon approaches that have already been shown to be effective, we cannot expect all clients to benefit. It may well be that new components are not necessary for all individuals. For example, this client might have benefited more if treatment had been focused less on some aspects of CBT (e.g., cognitive restructuring) and more on others (e.g., relaxation training). It may also be that irrespective of the specific components of the treatment, some core processes of change need to be applied, specifically, fostering client engagement and the timing with which interventions are implemented. Both the *what* and the *how* of intervention use with a particular client are crucial, which is another way of saying that participant, technical, and relationship variables are important.

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