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Cognitive-Behavioral Assimilative Integration

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The educational and cultural backgrounds of the authors vary considerably. How frequently is a chapter written by a French Canadian, a Jewish woman from New Jersey, an ex-seminarian from the Midwest, a German-born living in Switzerland, and an Asian American born and raised in the Philippines? Nonetheless, each of us defines himself or herself, with more or less conviction, as a cognitive behavior therapist. Operationally, this means that we believe that distressing behaviors, cognitions, and emotions should be primary targets of our interventions. Severe social anxiety, frequent panic attacks, and chronic insomnia, to name a few specific impairments, deserve our clinical attention. We also agree that both situational (e.g., external contingencies) and intrapersonal (e.g., inaccurate cognitions) factors are involved in the etiology and/or maintenance of our clients' impairments. As cognitive behavior therapists, we also believe that a fruitful strategy to identify the determinants of clients' difficulties is to conduct comprehensive functional analyses that are grounded in known empirical knowledge.

Although we believe that psychotherapy can reduce clients' impairments, we are convinced that cure is not a possibility. Even after successful therapy, the difficulties of life will likely continue to trigger vulnerabilities that are linked to years of complex learning, implicit meaning structures, biological processes, and genetic predispositions. In our opinion, the ultimate goal of therapy is to facilitate the acquisition of coping skills (emotional, cognitive, and behavioral) that will help clients cope with life's stressful demands.

Along with the theoretical writings of leading figures in cognitive-behavioral therapy (CBT), however, our clinical experience has suggested that traditional cognitive-behavioral therapy techniques are not always sufficient to treat clients' distress and to help them develop better ways of dealing with life's difficulties. On more than one occasion, we have found it helpful to let clients talk extensively about

early relationships with their parents, to encourage them to experience and "stay with" painful feelings, or to draw links between what is taking place in the therapy relationship and what has occurred in their interpersonal relationships outside of therapy.

The beneficial use of what many would consider non-cognitive-behavioral therapy (non-CBT) methods has raised the question of how best to incorporate methods derived from (or consistent with) humanistic, psychodynamic, interpersonal, or systemic approaches into our CBT practice. The integrative approach described in this chapter represents our effort to improve the efficacy of CBT via a systematic and theoretically cohesive assimilation of treatment procedures typically associated with other psychotherapy orientations.

EXPANDING COGNITIVE-BEHAVIORAL THERAPY

Our integrative approach is based on the assumption that clinical improvement is due in part to principles of change that cut across different forms of therapy (Castonguay, 2000). As described by Goldfried (1980; Goldfried & Padawer, 1982), we believe that several techniques associated with particular orientations are idiosyncratic manifestations of common principles. These principles include the acquisition of a new perspective of self, the establishment of a therapeutic alliance, the facilitation of new or corrective experiences, and generalization of therapeutic change to the client's daily life. Thus, from a clinical standpoint, our approach is based on the premise that the repertoire of interventions of a particular orientation (e.g., CBT) can be increased by adding techniques that reflect general principles of intervention while allowing this specific approach to address more directly or adequately certain dimensions of human functioning. Based on research findings, as well as on conceptual critiques and modifications of CBT, we concluded that the most fruitful way to improve CBT's efficacy was to add techniques aimed at facilitating interpersonal functioning and emotional deepening.

Interpersonal Focus

Several authors have criticized CBT (and especially cognitive therapy) for not paying sufficient attention to interpersonal factors involved in psychopathology (Coyne & Gotlib, 1983; Goldfried & Castonguay, 1993; Robins & Hayes, 1993). As demonstrated by Blagys and Hilsenroth (2000), there is convincing evidence that cognitive-behavioral therapists focus less on interpersonal experience than psychodynamic-interpersonal (PI) therapists. In addition, while one preliminary study found that CBT therapists tended to focus more on interpersonal issues than intrapersonal issues (Kerr, Goldfried, Hayes, Castonguay, & Goldsamt, 1992), the reverse was found in two later studies (Castonguay, Hayes, Goldfried, & DeRubeis, 1995; Castonguay, Hayes, Goldfried, Drozd, Schut, & Shapiro, 1998). More importantly, interpersonal focus in CBT has been found to be unrelated to client's improvement in two studies (Castonguay et al., 1998; Kerr et al., 1992). Moreover, one study found that the therapist focus on interpersonal cognitions negatively related to outcome in cognitive therapy (Hayes, Castonguay, & Goldfried, 1996). By contrast, evidence suggests that when psychodynamic-interpersonal therapists focus on interpersonal issues, such focus is positively linked with outcome (Castonguay et al., 1998; Kerr et al., 1992).

Furthermore, process studies also suggest that clients do improve when cognitive behavior therapists focus on the kinds of interpersonal issues typically emphasized in psychodynamic treatment. For instance, Hayes et al. (1996) found a positive relationship between the therapist's focus on early attachment patterns and client's improvement in CBT. Other studies (Ablon & Jones, 1998; Jones & Pulos, 1993) also found that the therapist's connections between the therapeutic relationship and other relationships were among a set of psychodynamic techniques positively related to therapeutic change in CBT. Taken together, these

findings suggest that adding techniques from the psychodynamic and interpersonal traditions to address client's maladaptive relationship patterns might increase the therapeutic impact of CBT.

Qualitative findings have also suggested that certain ways of dealing with problems in the therapeutic relationship observed in CBT may impede its efficacy. Castonguay, Goldfried, Wiser, Raue, & Hayes (1996) find that when confronted with alliance ruptures, cognitive therapists frequently increased their focus on cognitive therapy rationale or techniques. Rather than resolving the alliance difficulties, however, such interventions seemed to exacerbate them. These findings suggest that integrating new strategies to address alliance difficulties, such as the ones proposed by Burns (1989) and Safran and Segal (1990), might also improve the efficacy of CBT.

Emotional Deepening

Prominent authors in the field have criticized CBT for approaching emotions as phenomena to be controlled rather than being experienced (e.g., Mahoney, 1980). One study (Wiser & Goldfried, 1993) provided evidence to suggest that cognitive-behavior therapists see the reduction of emotional experiencing as a significant event during the session. Summarizing the empirical literature, Blagys and Hilsenroth (2000) concluded that "recent studies lend very strong support for the notion that PI focuses more than CBT therapy on the expression of patients emotions" (p. 172). They also added that current findings

> support the notion that PI therapy attempts to evoke the expression of patients' emotion while CB therapy attempts to control or reduce patients' feelings. The propensity of PI therapy to focus on affect not only conveys a greater emphasis on cathartic expression, but also a greater focus on emotional insight and a greater encouragement to identify, stay with and/or accept emotions.

Interestingly, a number of studies have found that the client's emotional experience in CBT is positively linked with outcome (Castonguay et al., 1996; Castonguay, Pincus, Agras, & Hines, 1998). Processes and techniques related to emotional exploration were components of different sets of therapeutic factors found to be positively linked with outcome either in CBT (Ablon & Jones, 1998; Jones & Pulos, 1993) or across CBT and interpersonal therapy (Ablon & Jones, 1999; Coombs, Colema, & Jones, 2002). Although not all studies have found emotional experience to be predictive of outcome (Hayes & Strauss, 1998), as a whole, research suggest that adding techniques that facilitate client experience and expression of emotions may also improve the effectiveness of CBT.

Our decision to emphasize interpersonal and emotional issues when attempting to improve CBT has also been influenced by Safran's expansion of cognitive therapy (Safran, 1998; Safran & Segal, 1990). Although endorsing the concept of schema, Safran has argued that such mental representation of self is intrinsically interpersonal. Relationships with others, according to Safran, are embedded in our understanding of who we are. In addition, core schema are not purely cognitive. Rather, they are cognitive-affective structures, or "hot" cognitions. The interpersonal and emotional nature of our core schema reflect the fact that our views of self are deeply shaped by our relationships with significant others. The ways we perceive and treat ourselves are based on the way important others (past and current) have viewed and treated us. Within this context, an emotionally immediate exploration of the clients' problematic relationships with important others (parents, spouse, therapist him/herself) provides a unique opportunity to better understand their interpersonal needs and fears, as well as to correct their maladaptive schema of self and others and their behavioral relationship patterns. In sum, Safran's model provided us with a conceptual framework accounting for and addressing interpersonal and emotional dimensions of human functioning when, as cognitive therapists, we attempt to provide a new perspective of self, to facilitate positive experience, foster more adaptive ways of dealing with

reality, and to enhance or repair our therapeutic alliances.

Having described the empirical and theoretical bases of our integrative approach, we now turn to a more pragmatic question: How do we actually combine traditional CBT techniques with interpersonally and emotionally focused interventions that are derived from (or consistent with) interpersonal, psychodynamic, and humanistic orientations?

APPLICABILITY AND STRUCTURE

Our efforts to increase the effectiveness of CBT has evolved via the development and empirical testing of treatments for depression (Castonguay et al., 2004) and generalized anxiety disorders (GAD) (Newman, Castonguay, Borkovec, & Molnar, 2004). Because it is the most comprehensive of the two, the GAD treatment will be the main focus of this chapter.

CBT includes multiple techniques that directly address situational and intrapersonal factors involved in the etiology or maintenance of GAD. Previous studies have demonstrated that this treatment leads to statistically and clinically significant change in the short- and long-term and has an impact on both GAD specific symptoms and comorbid conditions. CBT has been found to be superior to no-treatment, nondirective therapy, psychodynamic therapy, and pharmacotherapy (Borkovec & Ruscio, 2001). A recent review of outcome studies on GAD concluded that "the most successful psychosocial treatments combine relaxation exercises and cognitive therapy with the goal of bringing the worry process itself under the patient's control" (Barlow, Raffa, & Cohen, 2002, p. 326). In fact, CBT-oriented treatment currently stands as the only form of psychotherapy meeting criteria for empirically supported treatment for GAD (DeRubies & Crits-Chirstoph, 1998).

The evolution of our integrative therapy for GAD and its incorporation of interpersonal and experiential techniques had its origins in empirical results that were emerging during the third author's conduct of basic and therapy outcome research on GAD from 1984 to 1995 (Borkovec, 1996). The fact that many clients in these earlier therapy trials were not returned to normal levels of anxiety by the end of treatment (Borkovec & Whisman, 1996) suggested that a therapeutic focus soley on intrapersonal processes may be insufficient. On the other hand, considerable evidence indicated that interpersonal processes were likely involved in the origins and maintenance of GAD. For instance, worry was most closely associated with social-evaluative fears (Borkovec, Robinson, Pruzinsky, & DePree, 1983) and interpersonal topics (Roemer, Molina, & Borkovec, 1997). GAD clients also reported elevated levels of role-reversed relationships with their primary caregivers in childhood (Cassidy, 1995; Schut et al., 1997), suggesting an understandable etiological basis for their world view as a dangerous place for both themselves and their parents. Moreover, a majority of GAD clients fall into an overly nurturing and intrusive interpersonal style that caused difficulties for them in their current relationships, possibly based on their childhood history of taking care of others (Pincus & Borkovec, 1994). Dimensions of interpersonal problems also significantly predicted posttherapy and follow-up clinical improvement (Borkovec, Newman, Pincus, & Lytle, 2002).

On the basis of this accumulating evidence, Borkovec decided that the next therapy investigation needed to test whether adding techniques that targeted interpersonal functioning could increase improvement rates generated by CBT. With the arrival of the first and second authors at Penn State and due to their expertise in interpersonal methods, he invited them to join future therapy projects and to make suggestions on how best to develop the envisioned interpersonal therapy element. The therapy element that was eventually added to CBT was created by the second author. Based in part on Safran and Segal's (1990) work, this element combines techniques derived from both interpersonal and experiential therapies.

Despite the incorporation of techniques from different theoretical orientations, the third author was comfortable with the fact that exist-

ing empirical knowledge allowed such techniques to be used from within a cognitive-behavioral perspective. Interpersonal therapy can be viewed from within CBT as an approach that examines, and then attempts to modify by emotionally focused and interpersonally focused methods, the cause-and-effect links that exist among (a) environmental events, (b) the client's cognitive, affective, behavioral, and interpersonal processes, and (c) the consequences of the client's interpersonal behaviors. Moreover, the use of the therapeutic relationship to provide feedback to the client about his or her interpersonal effect on the therapist is fully in line with CBT principles of change (Kohlenberg & Tsai, 1991).

Finally, the use of emotional deepening techniques (prescribed in both experiential and interpersonal therapies) turned out to fit the behavioral learning view quite well, once recent discoveries were made concerning GAD and emotional process in general. Specifically, evidence now suggests that GAD clients largely ignore their emotions and indeed may be fearful of many of them, including positive ones. These findings suggest that worry, the cardinal symptom of GAD, may actually serve the role of cognitive avoidance of affect (Borkovec, Alcaine, Behar, 2004). From a CBT perspective, therefore, emotional deepening techniques can be used as exposure methods for the sake of full emotional processing of fear (Foa & Kozak, 1986).

The structure of the GAD treatment is unique. Rather than involving a simultaneous blend of theoretically diverse intervention, it involves a sequential application of two "pure" form of therapy. Specifically, our therapists are trained to conduct a 50-minute segment of CBT, which is immediately followed by a 50-minute segment of Interpersonal/Emotional Processing (I/EP) therapy (Newman et al., 2004).

This structure of our integrative therapy has been dictated by a specific scientific purpose. If this treatment combination (CBT+I/EP) can be shown to be superior to the combination of CBT and a supportive listening (SL) condition (CBT+SL), then our research would not only provide evidence that CBT can be improved but also that such incremental improvement is causally attributable to the added interventions. Such an additive design is one of the few designs that can adequately address a major question that drives science: Causality (Borkovec & Castonguay, 1998).

Our concern with internal validity, however, comes at a price of external validity. Our integrative treatment, the way it is currently structured, is not easily transportable to the clinical setting. Effectiveness research will hopefully be conducted to assess the feasibility and impact of a treatment structure more in sync with the way psychotherapy is typically conducted (e.g., 1-hour session involving a more permeable implementation of the two treatments). We should mention, however, that with the exception of scheduling a 2-hour appointment every week, our therapists and clients have not found it onerous to work within a particular orientation for 50 minutes and then shift to a different treatment approach for another 50 minutes. In fact, our therapist have frequently mentioned that the sequential structure has helped them to focus on the tasks specific to each segment and has on many occasions prevented them from prematurely shifting to an "off-task" intervention.

Although we have developed the integrative approach specifically for GAD, we believe that it could be applied to other clinical problems. We would predict that many CBT protocols may be improved by adopting parts of our treatment when targeting any problems for which the etiology and maintenance involve interpersonal difficulties or the avoidance of painful emotions.

ASSESSMENT AND FORMULATION

Because our GAD treatment has been developed and used in the context of clinical trials, the clients treated by our therapists have been assessed by two independent administrations of a semistructured interview—the Albany Anxiety Disorder Interview Schedule–IV (ADIS; Brown, DiNardo, & Barlow, 1994). The ADIS allows us to determine whether an individual

suffers from the clinical disorder targeted by our treatment and identifies the specific content of the client's worries. Moreover, it allows us to systematically assess comorbid conditions that are likely to influence case formulation. For instance, knowing that a client also struggles with social phobia helps us to determine our intervention targets (e.g., social skills) when addressing interpersonal issues.

Our assessment also involves a number of questionnaires and self-monitoring instruments. For example, the therapists use the Dysfunctional Attitude Scale (DAS; Beck, Brown, Steer, & Weissman, 1991) to identify the negative cognitions that may reflect and contribute to the client's worry and anxiety. Therapists also review the client's scores, obtained at pretreatment, on the Inventory of Interpersonal Problem–Circomplex (IIP-C; Alden, Wiggins, & Pincus, 1990), the Inventory of Adult Attachment (IIA; Lichtenstein & Cassidy, 1991), and the Structured Clinical Interview for DSM-IV Axis II (SCID-II; First, Spitzer, Gibbon, Williams, & Benjamin, 1994). Along with the gathering of interpersonal history information during sessions, as well as the observation of the client's behavior toward them, therapists use these pretreatment scores to understand the client's relationship patterns. The daily monitoring of clients' anxiety, as well as the systematic monitoring of their relationships, also help therapists conduct functional analyses of clients' problematic reactions.

The information derived by such an extensive assessment is use to construct case formulation, which in turns guides an ideographic application of the CBT and I/EP techniques. In CBT, therapists built their case formulations around the following questions: What are the early cues (situational and internal) of the client's anxiety reaction? What are the maladaptive elements (cognitive, imaginal, physiological) if such reaction that could be replaced by more adaptive responses? In I/EP, the case formulations are centered around the following questions: What are the clients' most central interpersonal schema (i.e., core views of self in relation with others)? What do clients want and fear from others? What do they do to get their needs met? What is the impact they have on others? Are their specific emotions that they are avoiding and that might tell them what they want from others?

PROCESSES OF CHANGE

We assume that a substantial part of the process of change can be attributed to general principles that cut across different forms of psychotherapy and, needless to say, operate in both segments (CBT and I/EP) of our integrative approach. In line with Goldfried's model (1980; Goldfried & Padawer, 1982), however, the ways by which these principles were implemented vary from one segment to another.

Early in therapy, therapists work toward *creating positive expectations* for the clients. This is accomplished by providing a rationale explaining factors that might have contributed to their difficulties, as well as a description of techniques that will be used to address these factors. In CBT, the rationale focuses on situational and intrapersonal issues. Specifically, clients are informed that their experiences of uncontrollable worry and anxiety are learned responses to threat cues, which involve maladaptive and habitual interactions among cognitive, behavioral, and physiological systems. For example, GAD patients frequently have a preattentive bias to indications of danger, which can trigger images of negative events. These, in turn, lead to defensive somatic reactions. As one component in the spiraling intensification of anxiety, such somatic responses can result in greater attention to physiological activity, which can interfere with a client's attention to (and realistic appraisal of) external reality and further increase his/her internal response of worry and rumination. The goal of CBT is to identify early cues that indicate that an anxiety spiral is beginning and to help the client replace these maladaptive reactions with adaptive coping responses.

In the I/EP segment, the rationale focuses on both interpersonal and emotional issues. We inform clients that chronically anxious individuals frequently develop interpersonal styles that contribute to their anxiety. Therapists tell their clients that when they interact

with others, anxious people tend to focus more on avoiding what they fear rather than trying to get what they need. Unfortunately, attempts to avoid what one fears sometimes lead to specific—and anxiety provoking—reactions from others that one tried to avoid (e.g., being extra-attentive to another's need in order to not be ignored can lead the other to move away from the relationship because he or she is feeling intruded upon). The attention to what they fear has become such an automatic focus for chronically anxious persons that they are frequently unaware of many of their interpersonal needs. Clients are informed that one way to become aware of what they need from others is to explore their emotions. Accordingly, the goal of I/EP is to help clients become aware of, and then change, the maladaptive ways they interact with others, including the therapist. By exploring and owning emotions that are triggered by their relationship difficulties, clients will increase their abilities to get what they want and better deal with what they fear from others.

Another principle of change underlying each segment of our integrative treatment is the *provision of a new perspective*. By offering an explanation of the etiology and maintenance of GAD symptoms, the rationales described above intrinsically serve this principle. As described in the next section, each segment of the protocol includes additional procedures to foster a new understanding such as (a) helping the client challenge inaccurate thoughts, cognitive errors, and maladaptive attitudes, (b) experiencing and expressing previously implicit emotions and meanings, and (c) exploring wishes and fears about others, interpersonal schemas, and maladaptive relationship patterns. Though serving the same general principle of change, these interventions focus on different dimensions of human functioning (i.e., cognitive, emotional, interpersonal). Our clinical observations suggest that clients are able to recognize multiple types of determinants involved in their difficulties, as well as to establish meaningful connections among them. For example, they realize that some of their ways of thinking, at times, parallel their ways of relating with others or that being more open about their emotions will help them to become less rigid about their appraisal of themselves.

Several of the techniques described later in this chapter directly serve the principles of *corrective experience* and *continued test with reality*. For example, relaxation and self-control desensitization techniques are used during CBT segments and between sessions to help the client to learn and rehearse new, more adaptive coping responses to anxiety-provoking cues. Similarly, attempts at fostering new and more meaningful ways of relating with others are done by paying attention to interaction with the therapist during I/EP segments, as well as between the client and others in his or her daily life.

Interestingly, though different techniques are used to foster these two principles of change, some of the techniques are based on the same learning processes. For instance, exposure in CBT is designed to help the client gain control over his or her anxiety. In I/EP, it is aimed at helping the client to stay with and own his or her painful emotions. In both situations, the mastery of previously intolerable situations is experienced as a positive corrective event. Modeling and problem-solving skills are also involved in the techniques used in each specific segment to correct maladaptive responses, learn more adaptive reactions, and implement them in situations outside the sessions. For example, such learning processes are at play when therapists help clients to react more adaptively to anxiety provoking cues or when therapists help clients to find better ways to get what they want from others.

Finally, as in all forms of psychotherapy, the use of the *therapeutic relationship* reflects a core principle of change in our integrative treatment. The ways in which therapists attend to the working alliance in each of the segment are described in the next section.

THERAPY RELATIONSHIP

In both segments of our protocol, therapists pay careful attention to the development and maintenance of a positive therapeutic alliance. There is, of course, a good reason for this. The

quality of the therapeutic alliance currently stands as one of the most robust predictors of change in psychotherapy (Constantino, Castonguay, & Schut, 2001). Thus, during the whole course of the treatment, therapists make all possible efforts to be empathic, warm, and supportive toward their clients and to foster mutual agreement on the goals and tasks of therapy.

However, there is an important difference about the role of the relationship in the process of change in the two segments of our integrative therapy. In the CBT segment, the relationship is primarily viewed as a precondition for change. Therapists, in other words, adopt a supportive attitude mainly to build the client's trust in the treatment rationale and procedures, as well as to foster the client's willingness to do what he or she needs to do to develop better coping skills. It is assumed that if a good therapeutic bond (based on mutual respect and affection for each other) is created, that if the therapist genuinely understands the client's subjective experience, if he or she is flexible and tactful in the use of the prescribed technique, and if he or she encourages and reinforces the client's engagement in the treatment task, that it is then likely that the client will face what he or she had avoided in the past and will implement, during and between sessions, new ways of reacting to anxiety cues.

The same assumption is held in I/EP. A good relationship is viewed as a necessary condition for the client's engagement in the demanding and anxiety-provoking tasks prescribed in this therapy segment. In this segment, however, the therapeutic relationship is also used as a direct mechanism of change. Therapists use what takes place during the session to help client's gain awareness of, and change, their maladaptive patterns of interpersonal interaction. Therapists, in other words, not only attempt to built a positive relationship in I/EP but also to work with the relationship to identify and deepen authentic primary emotion and to modify interpersonal habits that have contributed to clients' anxiety.

In addition, specific techniques are included in I/EP to deal with alliance ruptures. Although therapists are asked to pay attention to markers of alliance ruptures in both the CBT and I/EP segments, these markers are addressed only during the I/EP portion of therapy.

METHODS AND TECHNIQUES

Although some principles of change cut across the two segments of our integrative treatment for GAD, the techniques used to implement these principles differ. Before describing these techniques, however, it is important to indicate that the stance of the therapist in both segments is fairly directive. Specifically, therapists must remain actively involved in making sure that the focus of the session is in line with the respective goals of each segment. While focusing on different dimensions of functioning in each segment, therapists help clients to be more cognizant of what they perceive as dangers (e.g., specific external events, internal images, negative emotions, interpersonal issues) and to replace their earlier coping responses (e.g., catastrophizing, scanning physiological reactions, avoidance of emotion, engaging in fear-reducing interpersonal behaviors). Helping clients to develop new skills to deal with anxiety requires that the therapist be task-oriented and directive, irrespective of the stimuli feared and the skills to be taught.

CBT

The CBT segment is primarily aimed at modifying and reducing internal responses to specific threats. Following is a brief overview of standard methods employed in the CBT segment to achieve this therapeutic task (Borkovec & Sharpless, 2004; Newman, 2002)

Self-Monitoring and Early Cue Detection

Clients are taught to identify their earliest reactions to perceived threats, their reactions to these early reactions, as well as the spiraling chain of internal events (attention, thoughts, images, bodily sensations, emotions, and behaviors) that then occur. Clients can begin to discover early components of anxious responding by describing typical worry and anxiety ex-

periences and/or imagining situations involving different components of their anxiety responses. Therapists can also help clients detect early cues of anxiety by asking them to intentionally worry about a personal concern. Therapists are also asked to pay great attention to noticeable shifts in the clients' affective states as they occur during the therapy session. Immediately pointing out such a shift can sharpen the client's own early cue detection. In addition to these in-session experiences, the client is asked to self-monitor his or her worrying and anxiety responses on a daily basis. As sessions progress, clients are increasingly asked to pay attention to and process all immediately available experiences, both in the environment and internally. The goal is to help clients to shift attention to present-moment reality and away from the illusions of the future and of the past that their worrying and rumination create.

Stimulus Control Methods

Once clients have learned to detect early cues for anxiety, a stimulus control method is used to reduce the amount of time spent worrying and to decrease the habit strength of worrying. Specifically, clients are instructed to postpone any early-detected worrying during the day to a fixed period of worrying—30 minutes at the same time and in the same place every day, during which they can engage in problem solving about the worry or apply cognitive restructuring skills to it. Such a deliberate postponement of worry enables clients to refocus attention to the present environment and the task at hand.

Relaxation Methods

As part of the natural response to perceived threats ("fight or flight"), anxiety reactions are closely associated with the activation of the sympathetic nervous system (SNC). One way to attenuate the SNC at the early detection of anxious responding is by activating the parasympathetic system through learning and repeatedly using applied relaxation methods (Bernstein, Borkovec, & Hazlett-Stevens, 2000).

Multiple relaxation methods are taught in order to encourage flexibility in the use of coping resources and to find those that are most helpful for clients in different situations or in response to different internal cues. Slowed, paced, *diaphragmatic breathing* is an ideal starting point to provide the client with an immediate, noticeable, and positive effect of treatment and to teach him or her ways to reach a rapid relaxation response that is easy to learn and readily applicable in daily living. The client is instructed to slow-down breathing and to shift it from the chest to the stomach by letting the diaphragm rise and fall without expanding the chest. *Progressive muscle relaxation* (PMR) is aimed at reducing muscle tension and sympathetic activation via systematic tensing and releasing various muscle groups. *Meditational techniques* can be combined with PMR to facilitate the client's ability to shift away from anxiety-provoking cues and toward pleasant, internal stimuli. At the end of each PMR practice session, the client can be instructed to focus on a meaningful, pleasant internal stimulus (an image, a word, etc.) that is associated with safety, comfort, security, love, and/or tranquility. A related technique, *guided imagery*, can be used to further deepen the relaxation by leading the patient through a sequence of tranquil and pleasant images. The use of *applied relaxation* allows the clients to cultivate a more relaxed lifestyle and to cope adaptively with perceived threats as they occur in day-to-day living. It is applied on a moment-to-moment basis whenever clients recognize early cues of anxiety (and, eventually, any time clients are aware of the absence of a calm or tranquil state) and is intended to shift attention away from tension/anxiety toward relaxation. Therapist help clients to acquire and practice this coping skill during the session by frequently asking them to apply the relaxation response whenever therapists or clients observe signs of increased anxiety.

Self-Control Desensitization

Self-control desensitization (SCD) involves the rehearsal of relaxation responses (and, later in

therapy, cognitive perspective shifts) while imagining frequently occurring anxiety-provoking situations (both environmental cues and internal cues). First, the client is asked to imagine himself or herself in a situation in which he or she detects anxiety cues. The therapist then repeatedly guides the client through imagining himself or herself successfully applying relaxation techniques in that situation. In the course of therapy, SCD is practiced with several sets of anxiety cues in order to generalize this adaptive coping response to various situations. Clients are also asked to include SCD at the end of their daily relaxation practice. Finally, in the course of cognitive therapy (described next), images of the most likely outcomes for worrisome topics are created, and these are to be imagined vividly as soon a worry is detected.

Cognitive Therapy

From a CBT perspective, clients' inaccurate perceptions are important components of their worry and anxious experiences. As such, numerous cognitive techniques are used to help them develop cognitions that more closely correspond with the available environmental information. Clients are first instructed to observe their environment, as well as to monitor the content of their anxious thoughts on a daily basis. Clients' inaccurate perceptions and/or interpretations are then challenged by diverse methods, such the search for evidence to support and reject clients' cognitions, the generation of alternative perspectives, and the identification of core beliefs (or nonadaptive attitudes) underlying many of their specific inaccurate thoughts and negative images. Because worry frequently involves an exaggeration of the negative implications of specific events, the cognitive technique of decatastrophizing (i.e., a step-by-step analysis of what it is that the client fears might happen, including the probability of each of these steps and the client's coping resources to deal with them) is particularly useful for GAD clients. Perhaps differing from some CBT approaches, we place special emphasis on the creation of multiple perspectives for any given situation in order to maximize flexibility in thinking.

Clients also complete a Worry Outcome Diary, wherein they write down (a) their worries when detected, (b) what they fear will happen, and (c) the actual outcome once it occurs. The purpose of this information is to help clients to build a new history of evidence of the way things actually are and to facilitate their processing of all available information from their environments, not just the negative biased information.

Behavioral experiments are also used to test unrealistic cognitions, as well as to provide additional exposure to feared situations and opportunities to practice applied relaxation and perspective shifts. On the basis of the data collected in these analytic and behavioral exercises, the clients learn to treat their perceptions as hypotheses and revise inaccurate predictions or assumptions involved in the spiraling intensification of their anxiety. By learning to pay less attention to negative environmental cues and by focusing less on the past or the future, the clients also learn to be fully immersed in their present reality, to process environmental information as needed, and to be confident that they will be able to deal with smaller or bigger challenges to come. Indeed, the eventual goal in therapy is to move from inaccurate expectations about the future, to relatively more accurate expectations, and ultimately to no expectations at all. Such expectancy-free living is our cognitive therapy method for contributing to the goal of living in the present moment, wherein there can be no anxiety or depression.

Finally, clients are encouraged increasingly to make use of intrinsically motivated behaviors for approaching worrisome or anxiety-provoking situations and for taking an active approach to daily living in general in order to maximize joy in life. Thus, drawing from the values that clients hold near and dear to their hearts, the therapist helps them to create emotional and cognitive sets reflective of those values and facilitative of a true, whole-organism approach to each life situation that they are about to enter.

I/EP

I/EP has been added to CBT so that therapists can address the clients' problematic relationships and facilitate emotional deepening. Briefly put, the goals pursued in this segment are to facilitate clients' identification of interpersonal needs, fears, and schemas and to help them develop behaviors that will better satisfy their personal needs. Though the focus of interventions and the techniques used differ from CBT, the general goal is the same. Essentially, therapists attempt to help clients to live in the present—to focus on their immediate experience with others. Rather than paying attention to the past or the future (the bad things that happened and/or could happen), clients learn to focus on what they currently want from others, as well as on what others want from them. A greater awareness of their contributions to maladaptive patterns of relating and the acquisition of new social skills will also help clients to reduce their negative impact on others.

As in the CBT segment, I/EP directly targets the GAD clients' tendency to avoid. Clients are encouraged to expose themselves to feared emotions, feared critical feedback about their impact on others, and their fear of being vulnerable to other people by showing who they really are. By trying things that may help them confront their immediate fear, clients 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. The therapist also helps clients to shift their attentional focus away from danger anticipation and toward openness, spontaneity, and vulnerability with others as well as toward a greater empathic attention to the needs of others.

Exploring and Changing Interpersonal Functioning

Early in the I/EP segment, the task of the therapist is to get a sense of the clients' interpersonal history. Open-ended questions about relationships with past and current significant others are aimed at providing the therapist with a general understanding of clients' perceptions of their interpersonal needs and fears, as well as their typical attempts to deal with them. As early as in the second or third session, however, the primary focus of treatment shifts away from a description of these past and/or current relationships to an exploration, in an emotionally immediate way, of the therapeutic relationship.

Guided by Safran and Segal's (1990) integration of interpersonal therapy constructs (e.g., Sullivan, 1953), we assume that clients' maladaptive patterns of relating are likely to be repeated in the therapeutic relationship. As such, an important task of therapists is to identify when and how they have been participating in clients' interpersonal schemata. Safran and Segal (1990) have suggested that therapists actually *need* to be "hooked" into clients' maladaptive ways of relating to others—to be pulled by clients into behaving consistently with clients' expectations—in order to help them change the way they interact with others. Adopting an attitude of a participant-observer (Sullivan, 1953), therapists pay constant attention to signs of having been hooked, such as a feeling of being emotionally detached from the client, or the realization of having frequently let the client tell long tangential stories. Another indicator of therapists being hooked is when they and/or their clients are trying to find out *why* clients are reacting (or not reacting) in a particular way, instead of helping the client to become aware, own, or deepen their emotional experience.

Once hooked, the therapist stops acting in ways that are consistent with the client's expectations. Instead, he or she is asked to explore what is taking place in the relationship in order to help the client gain awareness of his or her maladaptive ways of relating, as well as the rigid construal of interpersonal relationships that underlies these patterns. Such exploration first requires the therapist to disclose, in an open and nondefensive manner, his or her reaction to what transpired in the relationship, such as saying "I feel pushed away, when you don't answer my questions." In some cases, the therapist self-disclosure immediately leads clients to being open to their own emotional ex-

perience. With our GAD clients, however, we have rarely observed such an ability or willingness to be vulnerable with another person. What is typically required is gentle but repeated invitations for the client to identify, experience, and express emotions triggered by the therapist's self-disclosure and/or the event that preceded it. The therapists' role is then to empathize with and validate the affective experiences expressed by the client, as well as to share his or her own reactions to the client's self-disclosures, such as saying "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 and communicate whether clients' responses to their openness help them feel understood by clients.

When used with warmth and support, these interventions can help the client become aware of his or her impact on another person. In addition, such an exploration of the therapeutic relationship allows the therapist to model an open communication style. By disconfirming the validity of the client cognitive-interpersonal schema (i.e., "It is dangerous to openly communicate with others), this way of working with the therapeutic relationship—of metacommunicating (Kiesler, 1996)—can provide the client with a unique corrective experience (Alexander & French, 1946; Goldfried, 1980).

Similar techniques of metacommunication are also used in I/EP to repair alliance ruptures. In fact, the enactment of client interpersonal schema during sessions, as when the client walls off the therapist or pulls for his or her hostility, will at times create alliance ruptures. This, however, in no way suggests that clients are always responsible for alliance problems. Such alliance tears can be caused or exacerbated by the therapist's less than adequate level of engagement, attention, empathy, warmth, tact, or attunement to the client needs. The therapist may frustrate the client's desire to be helped by not using the most appropriate technique, by failing to use competently a perfectly adequate intervention, or by being blinded by his or her own interpersonal schema (avoiding core therapeutic issues because of his or her own fears of hurting the client or being hurt by outbursts of anger). From a cognitive-interpersonal perspective (Safran & Segal, 1990), alliance ruptures are events that can be expected when two individuals are involved in a complex, demanding, and emotionally meaningful relationship such as therapy.

Accordingly, our therapists are trained to recognize markers of alliance ruptures, such as clients' overt expressions of dissatisfaction, indirect expressions of hostility, disagreements about the goals or tasks of therapy, overly compliant behavior, evasive behavior, and self-esteem–boosting maneuvers (Safran, Crocker, McMain, & Murray, 1990). Therapists are asked to attend to markers of alliance ruptures during both the CBT and I/EP segments, but these markers can only be addressed during the I/EP segment because, for our additive design study, the protocols could not allow therapeutic work on interpersonal behaviors during CBT segments.

Based on the contributions of Burns (1989) and Safran (Safran & Segal, 1990), attempts are made to repair the alliance by following three steps. First, therapists invite clients to talk about their negative reactions (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?"). Second, the therapist empathizes with the client's perception and emotions and invites him or her to express additional emotions and thoughts about what was unhelpful or invalidating in the treatment. When the therapist has the sense that the client feels understood, the therapist should then recognize and comment on his or her own contribution to their relationship difficulty. This last step, elegantly captured by Burns (1989) as a "disarming" technique, requires the therapist to find some truth in the client's reaction, even when the reaction may seem unreasonable. The use of this technique is based on the assumption that the therapist has invariably contributed in some way to the lack of synchrony between client and therapist. It is also based on the assumption that the therapist's openness to his or her experiences can lead to the client's open-

ness to his or her experience, which may in turn help them to exit an unproductive cul-de-sac in their relationship (Castonguay, 1996).

Contrary to the client's expectation, he or she learns that being emotionally vulnerable can lead to stronger and safer relationships. The client also learns that when "living in the moment" (such as when experiencing and exploring in an emotionally immediate way what is taking place in a relationship), he or she ceases to pay attention to the past and the future. Worries and ruminations dissipate as one becomes real and present with others.

In addition to paying attention to the therapeutic relationship, therapists also help clients to draw links between interaction patterns observed in the session and patterns in clients' past or current relationships with significant others. Therapists, however, are reminded that such connections are sometimes drawn (by the client or themselves) as a way to avoid processing negative events taking place in the therapeutic relationship. Such defensive maneuvers may prevent the client from fully experiencing his or her emotions and further reinforce long-standing avoidance strategies (e.g., intellectualizing or "staying in his or her head" as opposed to being open and vulnerable with another person). When part of an emotionally immediate exploration of the client's experience, however, such connections with outside interpersonal events frequently helps clients gain a deeper awareness of their rigid constructions of relationships and maladaptive ways of relating with others.

Therapists also ask clients to monitor and record events taking place between sessions with significant others. Specifically, clients are asked to describe specific interactions and to take note of the emotions they felt during these interactions, what they wanted and feared from the other person, what they did, and what happened next. Such functional analyses of intrapersonal and interpersonal factors frequently helps clients to identify what they need and what they actually get from others (McCullough, 2005). In particular, these analyses reveal the negative impacts that some of the client's behaviors have on others. When indicated, behavioral strategies (e.g., social skills training) are then used to teach clients better ways to satisfy their interpersonal needs.

Facilitating Emotional Deepening

In the I/EP segment, helping the client to experience, deepen, and express his or her emotion is aimed in part at extinguishing fear and avoidance (including worry as a cognitive avoidance response) of emotion. As mentioned above, basic research has suggested that when individuals with GAD worry, they do so in part to avoid painful events (future bad outcomes or distressing emotions). As such, worry is maintained, at least in part, by its negative reinforcement quality (e.g., suppression of somatic aspects of anxiety or the eventual nonoccurrence of low-probability, but feared, negative events). By exposing the client to his or her emotional experience, he or she learns that although some emotions can be painful, they are not dangerous (e.g., sadness and anger over another's betrayal). As such, the safety of the therapeutic relationship provides clients with yet another unique opportunity for corrective experiences. Indeed, if the experience with and exploration of feeling repeatedly fails to be intolerable, they learn that there is nothing to fear from their emotional experience. And when there is nothing to fear, there is no reason to avoid. Worry, as a consequence, loses its reinforcing impact, and clients begin to gain access to primary affects that can motivate and direct adaptive behaviors, as described below.

Emotions are an important source of information for what we need in life. As such, emotional deepening is also used in I/EP to help clients better understand what they need from others. Guided by the work of Greenberg and his colleagues (Greenberg, Rice, & Elliott, 1996; Greenberg & Safran, 1987), therapists are trained to track markers of emotionality in order to decide when to use techniques aimed at deepening feelings. Examples of such markers are 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 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. For example, "What just happened? You were allowing yourself to cry, and you quickly moved away from your feeling."

When markers of a *self-evaluative split*—internal conflict experienced by clients—are observed, clients are invited to take part in a two-chair exercise. In the exercise, clients distinguish the two parts of themselves—as though they were two separate people—and then embody each one separately and repeatedly as one part speaks to the other until clients have gained greater insight into their feelings and their own needs in the internal conflict.

In contrast, markers of *unfinished business*—unresolved feelings toward another person—are dealt within an empty-chair exercise. Here, the client expresses his or her feelings while imagining another person sitting across in an empty chair.

The technique of "systematic evocative unfolding" (Greenberg et al., 1996) is also used to address markers of *problematic reactions*—when clients experience surprise or confusion about one of their own reactions. Clients are asked to close their eyes and imagine themselves back in the situation that evoked the reaction and play the scene in slow motion in their imagination. They are asked to vividly remember every aspect of the scene, describe in detail the events and their feelings during the situation, and to pay attention to every internal cue as they repeatedly describe the situation. By reexperiencing fine-grained details and their reactions to them, clients can better express and own the emotions that first surprised them, as well as gain access to previously implicit emotions.

Therapists also encourage clients to focus on and own their emotions as they go on in their day-to-day lives. It is indeed important to help clients generalize the corrective experiences of expressing feelings in the safe environment of the therapy session to interpersonal relationships outside of therapy. Continued attention to clients' experience and behavior in the real world may well be crucial to help them overcome their fear of vulnerability and achieve a lasting change in their habitual avoidance of emotion.

CASE EXAMPLE

The following case was chosen because it illustrates the major thrust of our integrative treatment. It demonstrates how the addition of specific techniques to CBT allows therapists to work with material not directly or adequately addressed in traditional CBT. As such, the case description will mostly focus on the I/EP segment of the therapy.

Wendy was a White undergraduate seen within the context of a National Institute of Mental Health (NIMH)-funded study aimed at providing preliminary evidence for the feasibility and impact of our integrative CBT+I/EP treatment for GAD (this study is presented in more detail in the next section). Although Wendy's primary diagnosis was GAD, she was also diagnosed with comorbid social phobia, obsessive compulsive disorder, and a specific phobia. She reported that she had previously sought psychotherapy for an interpersonal problem and that this therapy lasted 2 months. She was not currently taking any medications nor had she taken any psychiatric medications in the past. In terms of her GAD symptoms, she reported that the current bout of GAD had been chronically ongoing for 7 years. She reported that she was not aware of any formal diagnoses of mental health problems in her immediate family but that she would characterize her mother as a worrier.

Wendy was treated by a White male psychologist, who was primarily trained in CBT. In addition to his full-time private practice, the therapist had served as a protocol therapist in several previous CBT studies.

Wendy felt very comfortable during the CBT segment. She took the therapist's directives to heart and actively complied with the therapeutic tasks prescribed during and between sessions. On the other hand, the I/EP segment was much more difficult for her, at least initially. She was reluctant to reveal herself, expressing minimal emotion and, when she did, only in response to the thera-

pist's persistent requests. Although she wanted to please the therapist, he felt discounted by her lack of authentic interpersonal and emotional behavior toward him, probably due to her fear of being vulnerable. Though she tried hard to understand and follow the therapist's instructions (as the perfect client that she wanted to be—and felt that she could be in CBT), the therapist did not feel that she wanted to connect with him or allow herself to be emotionally close during the I/EP segment.

What was happening during therapy paralleled what had been taking place in Wendy's interpersonal relationships. Early on in I/EP, she reported that she felt that she had to be perfect with others. Her view of relationships was that she felt obligated to take care of others' happiness. Not surprisingly, she felt burdened by what she perceived to be the expectations of others, became angry when friends asked her to socialize because it was taking time away from her studies, and frequently avoided being with them.

As therapy progressed, it became clear that she had a hard time being empathic to others. In part, because her attention was on her own behavior (her attempt to please others), she did not fully listen to others. She was so focused on her fear of failure in meeting their needs that she had little energy left to listen to the needs they actually expressed. She thus found herself trapped in an unfortunate paradox: She spent so much time trying to do everything for others that she feet burdened by others and thus discarded them.

At the same time she was surprised to learn that she did not meet their needs. For example, when she asked the therapist after several sessions whether he liked her, she was quite surprised by his reply that he did not know whether he liked her or not, because he had not yet really met the real her. She thought that she was doing everything he wanted her to do, including self-disclosing.

She was also expecting important others in her life, including her boyfriend, to have a similar view of relationships. Specifically, she expected others to be vigilant and attentive to her needs. She expressed considerable frustration at the fact that her boyfriend was not always anticipating what she wanted from him. As therapy helped her to focus on her interpersonal needs, she became aware that she had difficulty being spontaneous with others. One of her first realizations was that she felt angry at others. This led her to be more assertive with her boyfriend, but it also made it more difficult for her to be vulnerable, as well as to be attentive to his needs.

Her interactions with her boyfriend led the therapist to focus on her impact on others, including on the therapist himself, which in turn led her to become more emotionally expressive. The therapist then used emotional deepening techniques to explore the origins of her fear of being vulnerable with others. Specifically, the therapist used a systematic evocation technique and allowed her to reexperience her feeling of being betrayed by another person when she was in high school. This incident appeared to play an important role in her fear of trusting others, of letting her guard down, of being herself, of not worrying about (and therefore being burden by) others. The use of an empty chair (where she expressed her feeling of being betrayed and hurt) in the same session allowed her to become aware that the price paid for not being herself was social isolation, loneliness, and sadness. She realized that she had missed her previous connection with others.

At the same time, she was genuinely surprised by the therapist's acceptance of her tears and sadness (of her vulnerability) expressed during the evocation of these memories: "You like me when I'm like this, really? This is what you were looking for?" Because the therapist's reaction to her first authentic emotional reaction in therapy was opposite to what she expected, it led to a significant corrective emotional experience.

In the following sessions, the client became more emotionally present, displayed a wider range of and more intense emotions, and began making numerous and adaptive changes in the way she was relating to others outside of therapy.

Wendy has now been followed up 2 years after therapy was completed. At pretherapy, her assessor severity level was 6 and by follow-up it was 1. Also, the client demonstrated clinically significant change and high endstate functioning (i.e., her score was within the range of a normative sample) on 6 of the 6 measures of GAD-associated symptoms (e.g., self-reported worry, self-reported trait anxiety, self-reported relaxation-induced anxiety, assessor-rated severity of GAD, observer-rated

anxiety symptoms, and self-reported diary measure of worry), demonstrating that she showed at least 20% change and was within the range of a normative sample on all measures.

EMPIRICAL RESEARCH

Our integrative treatment for GAD has been the object of two NIMH-funded clinical trials. The first was a preliminary study aimed at determining whether it could be implemented and if it outcome would suggest possible improvement over traditional CBT for GAD.

Eighteen adults meeting *DSM-IV* criteria for GAD received the CBT+I/EP described above. The treatment was delivered by three experienced therapists (one originally trained in CBT and two primarily trained as psychodynamic therapists). Numerous process findings and adherence checks suggested that what took place during each segment of therapy was consistent with the treatment manuals. An observer-rated measure of the therapist interventions, for example, showed that although therapists focused more on interpersonal issues (e.g., interpersonal pattern, general interactions with others) in I/EP than in CBT, they focused more on intrapersonal issues (e.g., the link between different aspect of functioning such as the impact of thoughts on feelings) in CBT than in I/EP (Castonguay et al., 2002). Also as predicted, both clients and therapists reported talking more about interpersonal matters such as the client's family and significant relationships in I/EP than in CBT, whereas talking more about matters related to work and anxiety triggers in CBT than in I/EP (Castonguay, Schut, Newman, & Borkovec, 1999). In addition, both self-report (client and therapist) and observe-measures showed that, as predicted, higher levels of negative emotions (e.g., sadness) were found in I/EP. For a number of positive emotions (e.g., confidence, joy), however, higher levels of intensity were found in CBT (Castonguay, Schut, Newman, & Borkoveck, 1999; Castonguay et al., 2001), which is consistent with its focus on building skills and increasing self-efficacy.

Although tentative, the outcome findings obtained in this open trial were promising. The effect sizes (reflecting differences between pre-treatment and post-treatment outcome measures) indeed appeared to be superior to those obtained by previous studies conducted with traditional CBT. In fact, whereas the average within participant effect size from previous CBT studies was 2.44, our pilot study obtained a 3.5 effect size (Newman, Castonguay & Borkovec, 2002).

Based on these preliminary findings, we have embarked on a randomized clinical trial. When completed, more than 70 GAD clients will have been assigned to either CBT+I/EP or CBT+SL. The use of such an additive design will permit us to determine specifically whether the addition of specific components (interpersonal focus and emotional deepening techniques) will lead to an improved outcome over traditional CBT package. Our early results suggest that I/EP does show some added benefit at 2-year follow-up with a significantly greater percentage of participants receiving the integrative therapy demonstrating high endstate functioning when compared to the CBT/SL condition (Newman, Castonguay, & Borkovec, 2002).

We have also conducted a preliminary outcome study on an integrative treatment for depression which we called integrative cognitive therapy (ICT; Castonguay et al., 2004). Here, only one of the components of the I/EP package was added to a traditional form of CBT. Specifically, alliance ruptures were addressed in cognitive therapy (CT) by using techniques described by Burns (1989) and Safran & Segal (1990). Although the integrative treatment was conducted by inexperienced therapists (graduate students), the findings showed that it was superior to a waiting-list condition. As a whole, the findings also compared favorably with findings of previous results obtained with traditional CT. The effect size obtained for the Beck Depressive Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), for example, was more than twice that estimated in a meta-analysis of control studies comparing CT and wait-list or placebo condition (Gloaguen, Cottraux, Cucherat, & Blackburn, 1998). Because

of its small *N* and the absence of a direct comparison with a traditional CT, however, these findings should be considered very cautiously.

FUTURE DIRECTIONS

We hope to expand our research program in a number of scientifically and clinically important directions. Based on preliminary analyses conducted on the current GAD trial, we have submitted a research proposal for a study investigating the impact of our integrative treatment at different sites and with more diverse ethnic clients. It is indeed important to determine whether potential improvement of the efficacy of CBT for GAD can be generalized to different treatment environments and diverse clinical populations. We also hope to eventually conduct investigations in more naturalistic settings in order to investigate the effectiveness of our protocol. Directly relevant to effectiveness is the question of whether it would be possible and advantageous to combine the techniques involved in the integrative treatment within the same sessions—as opposed to dividing them into different segments of therapy sessions.

We are also interested in determining whether the treatment developed for GAD can be applied successfully to other clinical problems. Depression, for instance, is likely to be an appropriate target, as many of the process findings and theoretical arguments that guided our selection of the techniques to be added to traditional CBT emerged from the depression literature.

Much more research should be done on the less comprehensive protocol that we have begun to test on depression. Several other studies—with large sample sizes, conducted at different sites, and involving direct comparisons between ICT and CT—are required before it can be confidentially asserted that adding techniques to repair alliance ruptures improves the efficacy of cognitive therapy for depression. As with the protocol for GAD, future research should not be restricted to efficacy studies. Funding is currently being pursued by members of our team to determine if training therapists to use alliance repair techniques in their day-to-day practice (irrespective of their theoretical orientation and across a variety of clinical populations) can improve their effectiveness.

Finally, we hope to continue using our clinical experience, the progress made in the theoretical and empirical literature, as well as the results of our current and future research to continue to develop and test treatment methods that might improve CBT, as well as to provide heuristics for the potential improvement of other treatment approaches.

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