11

Cognitive-Behavioral Assimilative Integration

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The three authors of this chapter define themselves, with more or less conviction, as cognitive-behavior therapists. Operationally, this means that we believe that distressing behaviors, cognitions, and emotions should be primary targets of our interventions. We also assume 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 further believe that a fruitful clinical strategy is to identify the determinants of clients' difficulties by conducting comprehensive functional analyses and case formulations that are grounded in known empirical knowledge.

However, while it is clear to us 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 writing of leading figures in cognitive-behavioral therapy (CBT), our clinical experience has suggested that the traditional techniques of this orientation 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-CBT" interventions has raised the question of how best to incorporate techniques 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.

THE INTEGRATIVE APPROACH

Our integrative approach is based on the assumption that clients' 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 most techniques associated with particular orientations are idiosyncratic manifestations of common principles. These principles include the fostering of positive expectations toward therapy, the increase in awareness about self and others, the establishment of a therapeutic alliance, the facilitation of new and/or corrective experiences, and the generalization of therapeutic change in the client's daily life. More about principles of change can be found in Eubanks and Goldfried (Chapter 4, this volume).

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 believe that a fruitful way to improve CBT's efficacy is 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 (e.g., Coyne & Gotlib, 1983; Goldfried & Castonguay, 1993; Robins & Hayes, 1993). There is convincing evidence that cognitive-behavioral therapists focus less on interpersonal experience than do psychodynamic-interpersonal (PI) therapists (e.g., Blagys & Hilsenroth, 2000). In addition, while one preliminary study found that CBT therapists tended to focus more on interpersonal issues than intrapersonal issues (Kerr et al., 1992), the reverse was found in two later studies (Castonguay et al., 1995; Castonguay, Hayes et al., 1998). More importantly, interpersonal focus in CBT has been found to be unrelated to client's improvement in two studies (Castonguay, Hayes et al., 1998; Kerr et al., 1992).

Moreover, one study found that the therapist's focus on interpersonal cognitions is negatively related to outcome in cognitive therapy (Hayes, Castonguay, & Goldfried, 1996). By contrast, evidence suggests that when PI therapists focus on interpersonal issues, such focus is positively linked with outcome (Castonguay, Hayes, et al., 1998; Kerr et al., 1992). Furthermore, process studies 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.

Emotional Deepening

Prominent authors in the field have criticized CBT for approaching emotions as phenomena to be controlled rather than 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, whereas PI therapists view good sessions as involving an increase in emotional experiencing. Recent studies lend very strong support for the notion that PI focuses more than CBT on the expression of patients' emotions. As noted by Blagys and Hilsenroth (2000, p. 172), these empirical findings also

> 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 et al., 1998). Indeed, a recent meta-analysis of 42 studies ($N = 925$) found that patient affective experiencing and expression in session was robustly associated with and predictive of ($d = .85$) favorable outcomes in psychotherapy (Peluso & Freud, 2018). That was the case with all types of psychotherapy, including CBT (Ablon & Jones, 1998, 1999; Coombs, Coleman, & Jones, 2002; Jones & Pulos, 1993).

The decision to emphasize both 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 are implicitly or explicitly embedded in our understanding of who we are. In addition, core schemas 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) 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. Safran's model has provided us with a conceptual framework accounting for and addressing interpersonal and emotional dimensions of human functioning when, as cognitive-behavioral 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 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

The main efforts described in this chapter to increase the effectiveness of CBT have evolved via the development and empirical testing of treatments for depression (Castonguay et al., 2004) and generalized anxiety disorders (GAD; Newman et al., 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. Numerous studies have demonstrated that this treatment leads to statistically and clinically significant change in the short and long term (Borkovec & Ruscio, 2001). As summarized in an overview of both psychopharmacological and psychosocial treatments for mental disorders, "[r]ecent studies suggest that CBT approaches are most successful for generalized anxiety disorder" (Nathan & Gorman, 2015, page xxi). Yet, there is also evidence that a substantial number of clients with GAD still show clinical symptoms after CBT (Borkovec & Ruscio, 2001; Borkovec & Whisman, 1996).

The evolution of integrative therapy for GAD had its origins in the seminal work of Thomas Borkovec, especially the basic and therapy outcome research on GAD he conducted 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 suggested that a therapeutic focus solely on intrapersonal processes proves insufficient.

On the other hand, evidence has indicated, both then and now, that interpersonal as well as intrapersonal processes are likely involved in the origins and maintenance of GAD (Newman & Erickson, 2010). Specifically, worry is most closely associated with social-evaluative fears (Borkovec et al., 1983) and interpersonal topics (Roemer, Molina, & Borkovec, 1997). In addition, social phobia is the most common comorbid diagnosis among GAD clients (Brown & Barlow, 1992). GAD clients also report elevated levels of attachment problems with their primary caregivers in childhood (Cassidy, 1995; Newman, Shin, & Zuellig, 2016; Schut et al., 1997), suggesting potential interpersonal problems with others. Moreover, several studies have found that a majority of GAD clients report interpersonal problems related to being intrusive, cold, exploitable and nonassertive that likely cause difficulties for them in their current relationships (Przeworski et al., 2011; Salzer et al., 2008). More recent studies also suggest that whereas hostile interpersonal problems of GAD individuals are reported by significant others, those with GAD tend to report more affiliative problems (Erickson et al., 2016; Shin & Newman, 2017) and that those with GAD under- or overestimate their hostile impact (Erickson & Newman, 2007). Dimensions of interpersonal problems also significantly predict posttherapy and follow-up clinical improvement (Borkovec et al., 2002; Newman et al., 2017; Salzer et al., 2011).

To address interpersonal difficulties experienced by several clients with GAD, the integrative approach added interpersonal and experiential techniques to CBT based, in part, on Safran and Segal's (1990) work. Despite the incorporation of techniques from different theoretical orientations, Borkovec was comfortable with the fact that empirical knowledge allowed such techniques to be used from within CBT. 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 (e.g., 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 empirical advances were made concerning GAD and the emotional process in general. Specifically, evidence has indicated that GAD clients largely ignore some of their emotions and indeed may be fearful of many of them, including positive ones (Borkovec, Alcaine, & Behar, 2004). These findings suggested that worry, the cardinal symptom of GAD, may actually serve the role of cognitive avoidance of affect. 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, our assimilative intervention involves a sequential application of two "pure" forms of therapy. Specifically, 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 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 research could not only provide evidence that CBT can be improved but also that such incremental improvement might be causally attributable to the added interventions. Such an additive design is one of the few process research designs that can adequately address a major question that drives science: Causality (Borkovec & Castonguay, 1998).

The concern with internal validity comes at a price of external validity. This integrative treatment, the way it has been 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., a 1-hour session involving a more permeable implementation of the two treatments).

However, we should mention that during the studies described later in this chapter, our therapists and clients did not find it onerous to work within a particular orientation for 50 minutes and then shift to a different treatment approach for another 50 minutes (with the exception of having to schedule a 2-hour appointment every week). In fact, our therapists frequently mentioned that the sequential structure helped them to focus on the tasks specific to each segment and had 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 predict that CBT 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. On the other hand, we would assume that this assimilative approach might not be relevant or sufficient to adequately address a number of clinical problems, such as psychotic diagnoses and severe substance dependence.

We have no evidence to suggest that the addition or removal of psychoactive medication can be either beneficial or detrimental when implementing this approach. In the two studies that we conducted thus far (see later discussion), we did not exclude clients who were currently using a stable dose of medication for anxiety as long as they consented (and their prescribing physician approved) to maintain their dose constant during the treatment. In general, however, we do believe that the use or increase of psychotropic medication to reduce anxiety has the risk of reducing the client's full exposure to both internal and interpersonal triggers of his or her worry—and thus may potentially interfere with the corrective mechanism assumed to underlie both CBT and the interpersonal/emotional components of the integrative approach.

ASSESSMENT AND FORMULATION

Because the GAD treatment was developed and used in the context of clinical trials, the clients were assessed by two independent administrations of a semi-structured interview—the Albany Anxiety Disorder Interview Schedule - IV (ADIS; Brown, DiNardo, & Barlow, 1994). The ADIS determined whether an individual suffered from the clinical disorder targeted by the treatment and identified the specific content of the client's worries. Moreover, it systematically assessed comorbid conditions that were likely to influence case formulation. For instance, knowing that a client also struggled with social phobia helped determine intervention targets (e.g., social skills) when addressing interpersonal issues.

The assessment also involved a number of questionnaires that the therapists used to identify negative cognitions that may reflect

and contribute to the client's worry and anxiety (i.e., Dysfunctional Attitude Scale; Beck et al., 1991), as well as to better understand the client's relationship patterns (e.g., Inventory of Interpersonal Problems; Alden, Wiggins, & Pincus, 1990). The daily monitoring of clients' anxiety and the systematic monitoring of their relationships also helped therapists conduct functional analyses of clients' problematic reactions.

During treatment, the information derived by such an extensive assessment was used to construct case formulations, which in turn guided an idiographic application of the CBT and I/EP techniques. In CBT, therapists developed 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) of such reaction that could be replaced by more adaptive responses? In I/EP, the case formulations were centered around the following questions: What are the clients' most central interpersonal schema (i.e., core views of self in relation to 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 there 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 (including CBT and I/EP). However, the ways in 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 that can trigger images of negative events, which can 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 or 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. Clients are informed 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 the 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 in which 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 this integrative treatment is the *provision of a new perspective*. By offering an explanation of the etiology and maintenance of GAD symptoms, the rationales described earlier intrinsically serve this principle. As described in the next section, each segment of the treatment 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. While implementing 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 recognize multiple types of determinants involved in their difficulties, as well as 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 testing 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 made by paying attention to the interaction with the therapist during I/EP segments, as well as between the client and others in his or her daily life.

Interestingly, while 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 in each 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 they help them 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 this 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 the integrative treatment, therapists pay careful attention to the development and maintenance of a positive therapeutic relationship. There is, of course, a good reason for this, as different aspects of the therapeutic relationship stand as robust predictors of change in psychotherapy (Norcross, 2011). 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 a theoretical and clinical difference in how the relationship plays a role in the process of change underlying the two segments of this 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, then it is 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 the interpersonal and emotional processing segment of the intervention. A good relationship is viewed as necessary 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 change process. Therapists use what takes place during the session to help clients gain awareness of, and change, their maladaptive patterns of interpersonal interaction. Therapists, in other words, not only attempt to build a positive relationship in I/EP but also work with the relationship to deepen authentic emotions 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.

METHODS AND TECHNIQUES

Although some principles of change cut across the two segments of this integrative treatment for GAD, the techniques used to implement these principles differ. Before describing these various techniques, however, it is important to mention that the stance of the therapist in both segments is fairly directive. Specifically, therapists ensure that the session is in line with the respective goals of each segment. While focusing on different aspects 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) with ones that are more effective and less maladaptive. 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.

Cognitive-Behavioral Work

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 (Newman, 2002)

Self-Monitoring and Early Cue Detection

Clients are taught to identify their earliest reactions to perceived threats and 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 signs of anxious responding by describing typical worry and anxiety experiences 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 also 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 attend to and process immediately available experiences, both in the environment and internally. The goal is to help clients 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, stimulus control is used to reduce the amount of time spent worrying and to decrease the habit strength of worrying. For example, 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. One way to attenuate the sympathetic nervous system 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 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 and noticeable 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* is aimed at reducing muscle tension and sympathetic activation via systematic tensing and releasing various muscle groups. *Meditational techniques* can be combined with relaxation to facilitate the client's shift away from anxiety-provoking cues and toward pleasant internal stimuli.

At the end of each relaxation practice session, the client can be instructed to focus on a meaningful, pleasant internal stimulus (an image, a word) that is associated with safety, comfort, security, love, and/or tranquility. A related technique, *guided imagery*, can be used to deepen the relaxation by leading the patient through a sequence of tranquil and pleasant images.

The use of *applied relaxation* allows the client to cultivate a more relaxed life style and to cope adaptively with perceived threats as they occur in day-to-day living. It is applied on a moment-to-moment basis during the course of the day whenever clients recognize early cues of anxiety (and, eventually, any time clients are aware of the absence of a calm or tranquil state), and it is intended to shift attention away from tension/anxiety and toward relaxation. The therapist helps 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 (Goldfried, 1971) 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 him- or herself in a situation in which he or she detects anxiety cues. Second, the therapist repeatedly guides the client through imagining successfully applying relaxation techniques in that situation. In the course of therapy, self-control desensitization 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 this coping skill 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

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 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, special emphasis is placed on the creation of multiple perspectives for any given situation 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, instead of only the negatively biased information.

Behavioral experiments are also use 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 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 client also learns to be fully immersed in his or her present reality, to process environmental information as needed, and to be confident that he or she can 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 little 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 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.

Interpersonal/Emotional Processing

I/EP has been added to CBT so that therapists can address 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. Although the focus of interventions and the techniques used differ from CBT, the general goal is the same: 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 are. By trying to confront their immediate fear, clients become aware of how their avoidance of negative emotions in the short term comes at a great cost 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 client's interpersonal history. Responses to open-ended questions about relationships with past and current significant others provide 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, 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.

It is assumed that clients' maladaptive patterns of relating are likely to be repeated in the therapeutic relationship. As such, an important task for the therapist 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—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 clients to become aware, own, or deepen their emotional experiences.

Once hooked, the therapist stops acting in ways that are consistent with the client's expectations. Instead, he or she is ask to explore what is taking place in the relationship 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's self-disclosure immediately leads clients to being open to their own emotional experience.

With 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 therapist's 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 meta-communicating (Kiesler, 1996)—can provide the client with a unique corrective experience (Alexander & French, 1946; Goldfried, 1980).

Similar techniques of meta-communication 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 in no way suggests that clients are always responsible for alliance problems. Such strains in the alliance can be caused or exacerbated by the therapist's less than adequate level of engagement, attention, empathy, warmth, tact, or attunement to the client's needs. The therapist may frustrate the client's desire to be helped by not using an effective technique, by failing to competently execute a perfectly adequate intervention, or by being blinded by his or her own interpersonal schema and its accompanying emotion. Thus a therapist may avoid dealing with core therapeutic issues because of his or her own fears of hurting the client or because of personal frustration or annoyance (Wolf, Goldfried, & Muran, 2017). From a cognitive-interpersonal perspective (Safran & Segal, 1990), alliance ruptures can be expected when two individuals are involved in a complex, demanding, and emotionally meaningful relationship such as therapy.

Accordingly, 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 et al., 1990). Therapists are asked to attend to the markers of alliance ruptures during both the CBT and I/EP segments but, because of the additive research design noted earlier, these markers are only addressed during the I/EP segment which has an interpersonal focus.

Attempts are made to repair the alliance by following three steps (Burns, 1989; Safran & Segal, 1990). 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 believes that the client feels understood, the therapist should then recognize and comment on his or her own contribution to their relationship difficulty. His 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 own experiences can lead to the client's openness 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 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, such connections with outside interpersonal events frequently help clients gain a deeper awareness of their rigid constructions of relationships and maladaptive ways of relating.

Therapists also ask clients to monitor and record between sessions events taking place 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 help clients to identify what they need and what they actually get from others (McCullough, 2005; McCullough & Schramm, Chapter 14, this volume). 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

Helping the client to experience, deepen, and express his or her emotions is aimed in part at extinguishing fear and avoidance (including worry as a cognitive avoidance response) of emotion. As mentioned earlier, 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 (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 later.

Emotions are an important source of information for what we need in life (Grawe, 2002; Greenberg & Safran, 1987). 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, Rice, & Elliott, (1996), therapists 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 sadness 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 a significant other—are dealt with in 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 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 occur 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 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.

DIVERSITY CONSIDERATIONS

Our integrative approach was developed and used in the context of clinical trials. One of the limitations of these trials (which are described later) is that they have involved a very large majority of Caucasian clients. As a consequence, we have no observations and evidence to rely on to make reliable statements and inferences about whether our approach applies to underrepresented ethnic and racial populations. It thus remains an open question as to whether procedural modifications (cultural adaptations) should be made to the treatment to optimize its impact for clients of non-Caucasian identity and whether some elements of our current treatment are particularly attuned to or unresponsive to the needs of a diversity of client populations. Needless to say, future investigations of this integrative approach, within and/or outside of our own research program, should pay close attention to these and other crucial diversity considerations. At the same time, as with most approaches to psychotherapy, our treatment entails personalization and making use of client goals, strengths, and limitations to tailor our approach to individual needs.

CASE EXAMPLE

The following case was chosen because it illustrates the major thrust of our assimilative 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" is a female, Caucasian undergraduate seen within the context of an National Institute of Mental Health (NIMH)-funded study aimed at providing preliminary evidence for the feasibility and impact of the CBT + I/EP treatment for GAD (this study is presented in 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 received 2 months of psychotherapy for an interpersonal problem. 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 any mental health problems in her immediate family but that she would characterize her mother as a worrier.

Wendy was treated by a Caucasian male psychologist who was primarily trained in CBT. In addition to his full-time private practice, the therapist had served as a therapist in several CBT trials (e.g., Borkovec & Costello, 1993; Borkovec et al., 2002).

Wendy felt very comfortable during the CBT segments. 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 segments proved 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 therapist'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. While 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 believe 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 with 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 met the real her. She thought that she was doing everything he wanted her to do, including self-disclosing.

Wendy was also expecting significant 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.

Wendy's 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. 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 a formative 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 helped 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 connections.

At the same time, Wendy 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 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.

After completing the 14 sessions prescribed by the treatment (plus an additional "booster" session planned in the research study), Wendy was followed-up for 2 years. At pre-therapy, her GAD severity level was 6; by follow-up it was 1. Also, the client demonstrated clinically significant change and high end-state functioning (i.e., her

score was within the range of a normative sample) on all six of GAD-associated symptoms (e.g., self-reported worry, self-reported trait anxiety, assessor-rated severity of GAD, and self-reported diary measure of worry). She showed at least 20% change and was within the range of a normative sample on all measures.

OUTCOME RESEARCH

This 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 its outcome would suggest improvement over traditional CBT for GAD (Newman et al., 2008).

Eighteen clients with GAD received the CBT + I/EP described earlier. 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 while therapists focused more on interpersonal issues in I/EP than in CBT, they focused more on intrapersonal issues in CBT than in I/EP (Castonguay et al., 2002). In addition, both self-report (client and therapist) and observation 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 et al., 1999, 2001), which is consistent with its focus on building skills and increasing self-efficacy.

The outcome findings obtained in this open trial were promising. Pre-/posttreatment effect sizes indeed appeared to be superior to those obtained by previous studies conducted with traditional CBT. In fact, the average within-participant effect size from previous CBT studies was 2.44, whereas our pilot study obtained a 3.5 effect size.

Based on these preliminary findings, we conducted a second NIMH-funded study (Newman et al., 2011). In this randomized clinical trial, 83 GAD clients were assigned to either CBT + I/EP or CBT + SL (i.e., supportive listening). As previously mentioned, such an additive design was adopted not only to assess whether our integrative treatment was superior to traditional CBT, but also to determine, if this was the case, whether the improvement was specifically due to the addition of specific components (i.e., interpersonal focus and emotional deepening techniques). Contrary to our prediction, however, the analyses showed no statistically significant difference between the integrative and the CBT + SL conditions (Newman et al., 2011).

Because the integrative treatment showed higher percentages of clients having reached clinically significant change on almost all outcome scores, it is possible that the lack of statistical difference was due to the study's relatively small sample size. Another interpretation, more empirically and clinically sound in our view, is that the analyses of main effects (i.e., the comparisons of the two conditions) might have actually masked more nuanced but real differences. Inasmuch as CBT has been repeatedly shown to be efficacious for a substantial number of GAD clients, it may be that adding components to CBT may increase it efficacy for some clients but not for others.

To test this possibility, secondary analyses were conducted to assess the moderating impact of clients' attachment problems (Newman et al., 2015). The findings of these analyses revealed that clients with one particular type of attachment style (i.e., dismissive) benefitted significantly more from the integrative therapy than the CBT + SL condition, both at the end of therapy and at follow-up assessments. In contrast, clients with a primary angry attachment style showed the reverse results—but only at posttreatment. Because dismissively attached individuals tend to avoid both emotion and intimacy, it makes sense, conceptually and clinically, that they might gain more from a treatment that helps them to recognize their affective needs and to develop interpersonal

connections. In contrast, an emphasis on emotional deepening may have interfered with improvement (at least in the short term) of angrily attached individuals, who tend to be emotionally reactive.

These results suggest that, although it is legitimate and important to investigate whether integrative therapies achieve better outcomes than pure forms of therapy, it may be more fruitful to examine for whom such treatments are more appropriate than traditional approaches. These findings have also clinical implications as they suggest that while some clients may benefit more from an integrative therapy, others may improve less—in least in the short term—than they would have if they had received a pure form of therapy. In our effort to improve therapy, and especially with the current emphasis on harmful effects (Castonguay et al., 2010), it is thus crucial to recognize an obvious reality: clients matters.

It is also clear that therapists matters. Research findings have indicated that some therapists are better than others, and that, inversely, other therapists are less effective than the majority of practitioners (Castonguay & Hill, 2017). These findings have led us to explore whether the main effects presented earlier did not also mask other subtle differences. Preliminary analyses conducted on the randomized controlled trial (RCT) revealed that the clients of one of the therapists showed poorer outcomes than the clients of the other two therapists involved in the study (Youn et al., 2017). Furthermore, when new analyses were conducted on the outcome data with the first therapist removed, results showed significant differences in the predicted directions between the two conditions compared. In other words, these findings suggest that there was a therapist effect and that this effect may have hidden real and predicted advantages of the integrative therapy over CBT.

Based on these findings, intense (both quantitative and qualitative) analyses were conducted on videotaped sessions involving three clients: a client who failed to benefit from the integrative treatment and who was seen by the less effective therapist, and two clients who responded to treatment and were treated, respectively, by one of the other two therapists. The results indicated that the less effective therapist committed two types of errors. One type were errors of omission, when, for example, the therapist failed to use (as a response to clear markers of interventions) prescribed social skills training to help his client to be more assertive in her interpersonal relationships. The second type of mistake were ones of commission. These took the form of relational problems, as manifested by the therapist's frequent interruptions of the client disclosure. These errors were also technical in nature. In the I/EP segment, in particular, therapists repeatedly used interpretations when working with client worries. Rather than exploring and deepening the client's emotion that may have triggered such worry, the therapist's interpretations replaced one type of thought with another—essentially encouraging the client to "stay in her head." In doing so, the therapist appeared to reinforce the client's cognitive avoidance of emotion, which the I/EP segment was specifically aimed at correcting.

Taken together, the studies conducted thus far on the integrative therapy of GAD suggest that this treatment is promising but that understanding its helpful impact requires a complex interaction of client, therapist, relational, and technical variables—which most certainly mirrors what therapists encounter in routine practice.

Preliminary outcome studies on an integrative treatment for depression have also been conducted. In this treatment, only one of the components of the I/EP package is added to traditional CBT. Specifically, alliance ruptures are addressed in cognitive therapy. Conducted with inexperienced therapists (graduate students), the findings of the first pilot study showed that this integrative cognitive treatment (ICT) was superior to a waiting-list condition (Castonguay et al., 2004). 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 et al., 1961), for example, was twice that estimated in a meta-analysis of control studies comparing cognitive therapy (CT) and wait-list or placebo condition (Gloaguen et al., 1998).

In a subsequent pilot study, Constantino and colleagues (2008) examined the efficacy of ICT by comparing it to CT. The findings showed that ICT patients evidenced greater posttreatment improvement regarding depressiveness and global symptomatology (with small to medium effects), and ICT patients displayed more clinically significant change than did CT patients. Furthermore, ICT clients also showed higher alliance and empathy scores across treatment than CT clients. Because they have been conducted with small samples of depressed clients ($N = 21$ and 22, respectively), the results of these two studies should be considered with caution. Taken together, however, they provide preliminary support for the potential viability and effectiveness of integrating rupture–repair interventions into a standard CT for depression.

Further support for the enhancement of CBT via an assimilation of theoretically "foreign" interventions toward the therapeutic relationship comes from empirical studies on Brief Relational Therapy (BRT; Safran & Muran, 2000). Based on Safran's seminal contribution on the exploration and repair of alliance ruptures, BRT shares strong conceptual and clinical roots with the I/EP segment of the integrative therapy for GAD and even stronger (foundational) links with ICT for depression. In a study with a sample of personality-disordered clients, Muran, Safran, Samstag, and Winston (2005) found that BRT was as effective as CBT and short-term dynamic therapy on outcome measures, but more successful at retaining clients in therapy. In a more recent study aimed at improving interpersonal interactions between clients and therapists in CBT for outpatients with comorbid with Axis I and II disorders, Muran, Safran, Eubanks, and Gorman (2018) trained novice therapists in a two-step protocol. First, therapists were trained to fidelity standards in CBT, and, subsequently (after either 8 or 16 sessions), therapists underwent alliance-focused training (AFT) that draws on the same principles as BRT. The results of this training provide further support to supplementing CBT with alliance-focused components.

Although not the main focus of this chapter, several other ways of enhancing CBT in line with principles of assimilative integration have been developed (Castonguay et al., 2015). These approaches vary by diagnostic specificity and theoretical background, as well as by relative research support. Two diagnosis-specific approaches with strong interpersonal components are the cognitive-behavioral analysis system of psychotherapy for patients with chronic depression (CBASP; McCullough & Schramm, Chapter 14, this volume) and the dialectic behavior therapy for patients with borderline personality disorder (DBT; Heard & Linehan, 1993; Chapter 12, this volume).

Support has also been gained for *schema therapy* (Young, Klosko, & Weishaar, 2003), which was created to treat patients with challenging interpersonal problems by integrating principles of CBT with object relations theory and gestalt therapy. Developed in the United Kingdom, cognitive analytic therapy (Ryle et al., 2014) integrates psychodynamic therapy with CBT principles in a brief, user-friendly relational therapy and has received empirical evidence for its effectiveness for the treatment of a range of clinical disorders. Other assimilative treatments have focused on specific dimensions of psychological functioning, such as resistance, emotional processing, or outcome expectation. For example, responsively integrating motivational interviewing (MI) to address emerging patient resistance to standard CBT for GAD has been shown to outperform CBT alone on long-term worry and distress reduction (Westra, Constantino, & Antony, 2016). Furthermore, and consistent with MI's target, MI-CBT versus CBT patients experienced less during-treatment resistance, which mediated the superior treatment effect (Constantino et al., 2019; Westra & Constantino, Chapter 13, this volume).

Built to enhance cognitive-emotional processing in the depressed client, exposure-based cognitive therapy (EBCT) systematically integrates principles of exposure therapy for anxiety disorders with interventions of emotion-focused therapy (Hayes et al., 2005, 2015). At this time, evidence for the efficacy of EBCT has been obtained in an RCT and two pilot trials (grosse Holtforth et al., 2011, 2019; Hayes et al., 2005). Assimilating strategies for

increasing patients' positive outcome expectations (identified by Goldfried [1980] as a general principle of change) has also been shown to improve CBT for depression in a small pilot trial (see Constantino, 2012).

FUTURE DIRECTIONS

CBT is by far the psychotherapy that has received the most research support, so it is encouraging, both from a scientific and a clinical perspective, that several attempts have been made to improve it based on the integration of complementary constructs and techniques derived from other traditions. More is needed, however, to expand and solidify the empirical bases of these CBT-assimilative treatments. We have envisaged a number of future directions for our own integrative efforts—directions that we believe might also prove beneficial for the other CBT assimilations briefly mentioned in this chapter.

Based on the moderating findings reported earlier, it is clinically relevant to assess experimentally whether or not integrative therapy is superior to CBT with particular clients suffering from GAD. These moderating variables may be associated with attachment problems and/or other individual differences. With these specific clients and/or with GAD individuals in general, the next empirical steps should also include the investigation of our own integrative treatment at different sites, with different investigators, and with more diverse ethnic clients. Moreover, it would be useful to conduct investigations in more naturalistic settings in order to investigate the effectiveness of the integrative treatment. 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. It would also be interesting to examine 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 also be done on the less comprehensive protocol that has begun to be tested on depression. In particular, studies with large sample sizes comparing ICT and CT are required before it can be confidently asserted that adding techniques to repair alliance ruptures improves the efficacy of CT for depression. As with GAD, future research should not be restricted to efficacy studies. For example, plans are being made 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.

We plan to continue to develop and test treatment methods that might improve the effectiveness of therapy. In particular, we hope that the studies supporting the new model of worry and GAD proposed by one author of this chapter (i.e., contrast model; Newman & Llera, 2011) will provide fruitful heuristics for the potential improvement of CBT and other treatment approaches.

In addition to these research directions, we believe that clinical developments could be beneficial for most GAD clients and/or for specific types of individuals—such as ethnic/racial minority clients. In particular, we believe that the recent literature on therapist effects might provide insightful ways to improve our treatment (as well as many others) without imposing major changes in its general structure. We know that therapist effects explain between 5% and 8% of outcome variance (Barkham et al., 2017). Research has also identified a number of factors that explain why some therapists are better than others, such as the ability to establish a good working alliance, facilitative interpersonal skills, and deliberate practice (Wampold et al., 2017). Based primarily on clinical observations, clinical guidelines have been derived from those and other therapist factors with the goal of enhancing treatment outcomes (Castonguay & Hill, 2017). These guidelines address issues such as how to deal

with cultural microaggressions, how to regulate and use negative emotions for therapeutic purposes, and how to foster engagement during treatment. As we look to the future, we can and should assimilate, in clinically cohesive ways, many of these guidelines into our integrative efforts—in the same way that these efforts have integrated methods from diverse theoretical orientations.

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