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Interpersonal and Emotion-focused Processing Psychotherapy

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Introduction

Over the last 30 years, many studies have documented the limited effectiveness of cognitive-behavioral therapy (CBT) for generalized anxiety disorder (GAD) (e.g., Borkovec & Ruscio, 2001). Concurrently, a new literature began to emerge indicating that two important mechanisms, interpersonal problems and avoidance of emotional processing, were neglected in GAD treatments (see Newman, Castonguay, Borkovec, & Molnar, 2004). As such, our research group at Penn State University endeavored to create a new treatment that, while being based on CBT, incorporated interventions aimed at fostering and correcting maladaptive interpersonal problems, as well as facilitating the awareness and deepening of emotions linked to clients' interpersonal needs.

Safran and Segal (1990) offer an approach to interpersonal and emotional difficulties within a CBT framework. Safran argues that "interpersonal schemata" – internal models of relationships based on prior interactions with caregivers – create self-fulfilling prophecies as persons express and reaffirm these internal representations in their current relationships. Emotions, according to Safran and Segal (1990), are an integral part of interpersonal schemas. Specifically, interpersonal schemas are encoded via cognitive, but also affective and expressive pathways (we react to others affectively and behaviorally, in large part based on whether or not they confirm our wishes and/or fears). Emotions, therefore, can provide information about an individual's needs (fulfilled or unfulfilled). As such, the exploration of clients' emotions, including those related to their relationships with therapists, can shed light on clients' interpersonal needs, wishes, and fears. Safran and Segal (1990) thus provided us with a framework for the unification of cognitive, interpersonal (past and current), and emotional issues into a cohesive model of functioning and change, which in turn guided our integration of techniques derived from diverse orientations.

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However, in many ways, the integrative treatment developed by our group is different than the approach offered by Safran. First, we modified Safran's model to address GAD clients' needs (described in the organization and rationale section below). Second, Safran and Segal emphasize the concurrent focus on cognitive, interpersonal, and affective dimensions. In contrast, our treatment introduced CBT and non-CBT techniques in two separate segments for theoretical and conceptual reasons detailed later.

This chapter will first detail the interpersonal and emotional literature present at the time of the treatment's development. Next, we will discuss the treatment protocol and therapeutic rationale. The findings of the integrative treatment will then be explored and reinterpreted based upon an updated view of current emotional and interpersonal processing literature.

Interpersonal Issues Present in GAD

In the 1990s, it was increasingly recognized that interpersonal difficulties were highly prevalent in GAD. In fact, persons with GAD worry about interpersonal matters more than anything else (Roemer, Molina, & Borkovec, 1997). Of the Axis I disorders, GAD's most commonly comorbid disorder is social phobia (Barlow, 2002), and almost half of GAD persons have a personality disorder which is defined by chronic maladaptive relationship patterns (Sanderson, Wetzler, Beck, & Betz, 1994). Persons with GAD also tend to display more interpersonal discomfort and fall into extremes on the interpersonal circumplex (Przeworski et al., 2011). These findings suggest that interpersonal dynamics may influence the initiation and continuation of GAD.

Attachment styles also appear to influence one's core views of self and the habitual ways in which one relates with others (Safran & Segal, 1990). Research showed that persons with GAD held unresolved negative feelings, such as anger and vulnerability toward their caregivers (Cassidy, 1995). However, standard CBT did not generally spend much time addressing early issues, instead tending to focus primarily on the "here and now" (Goldfried, Castonguay, Hayes, Drozd, & Shapiro, 1997). Interestingly, however, studies have found that an exploration of the past (including relationships with attachment figures) is associated with positive change in CBT (Hayes, Castonguay, & Goldfried, 1996).

Notably, relationship issues predict negative outcomes in GAD. Borkovec and colleagues (2002) found that unaddressed interpersonal deficits lead to a failure to sustain therapy advances. Similarly, comorbidity with personality disorders predicted minimal effectiveness of CBT (Durham, Allan, & Hackett, 1997). As unaddressed interpersonal deficits impair therapy gains, our research group reasoned that it might be beneficial to integrate interpersonal deficits and developmental origins within CBT for GAD.

Not unsurprisingly, interpersonal deficits often are manifested in the therapeutic relationship (Beck, Freeman, Davis, & Associates, 2003). However, in the 1990s treatment manuals for CBT did not focus frequently and systematically on the connection between the ways clients related with others and how they interacted with therapists (Goldfried et al., 1997). Furthermore, findings suggested that strategies emphasized in cognitive therapy to deal with problems in the therapeutic relationship

may not resolve them and, at times, may exacerbate them (Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996). Our treatment focused on specific relationship dynamics that occurred, but had gone unaddressed (or appeared to have been addressed unsuccessfully) within traditional CBT for GAD.

Emotional Issues in GAD

Near the development of our integrative treatment, research emerged that suggested worry is used to avoid emotional processing. Specifically, this literature advocated that persons with GAD employ worry to avoid some aspects of initial reactivity to emotions, and that this avoidance is reinforced by alleviating short-term distress (Borkovec, Alcaine, & Behar, 2004). We thus concluded from this research that emotional processing was crucial to extinguish fear.

Tying both emotional and interpersonal issues that are insufficiently or inadequately addressed in traditional CBT for GAD, our research group's integrative treatment utilizes techniques that help to increase the awareness, expression, and deepening of emotions that are interpersonally relevant. Our first goal was to help clients to become aware of their needs and their maladaptive relationship patterns (in their past and current relationships, as well as in the therapeutic relationship) that prevented them from fulfilling those needs. Our second goal was to provide corrective experiences inside and outside of the session so that clients changed their views of selves and others, as well as developed more successful ways to have their interpersonal needs met. Throughout this process, however, avoidance was identified and worked with.

Organization and Rationale for the Integrative Therapy

As mentioned earlier, the integrative therapy was developed to determine whether CBT could be enhanced for GAD by adding interpersonal and emotional components (Newman et al., 2004). Methodologically, the most controlled way to answer this question was through an additive design. Thus, the integrative treatment was broken into two 55-minute segments: a CBT component and a subsequent interpersonal/emotional processing (I/EP) component. As described in detail below, our research group compared CBT + I/EP against a CBT segment followed by a supportive listening (SL) segment (providing self-reflection, introspection, acceptance, and support through empathic statements). We decided to use supportive listening to control for the time in therapy and to capture the influence of common factors within the therapeutic relationship. Accordingly, if CBT + I/EP led to greater outcomes, then it would provide evidence for an added benefit beyond that found in CBT.

The CBT component of the therapy was adapted from protocols used in previous studies (Borkovec et al., 2002). It was principally composed of an initial therapy rationale, self-monitoring and early cue detection, homework assignments, and review of homework (including results of daily self-monitoring and early identification of anxiety cues), progressive and applied relaxation training, cognitive therapy, and self-control desensitization (Newman, 2000).

Within the CBT component, clients initially engage in self-monitoring and early identification of environmental, somatic, affective, imaginal, and thought (especially worry) cues, which would then be targeted in the treatment. Next, clients were taught progressive and applied relaxation techniques to help them maintain a more relaxed state.

Cognitive therapy was conducted according to Beck, Emery, and Greenberg (1985). Clients were taught the associations between their thoughts and feelings, identifying maladaptive thought processes and substituting more accurate and adaptive thoughts. Clients were also asked about positive beliefs that could be maintaining these worries (e.g., "expect the worst, and you'll be prepared"). Therapists conducted a functional analysis of the behavior, exposing to them the costs of worrying (e.g., lack of sleep, fatigue, depression).

The last CBT component was self-control desensitization, in which clients first engaged in relaxation training. Once relaxed, clients imagined themselves in a situation that typically triggered worry. Clients then signaled the therapist when they noticed their anxiety increasing. At this point, clients continued to imagine themselves in the situation but attempted to relax away their anxiety, while imagining themselves coping successfully with the situation. Then the clients stopped imagining the situation and focused only on relaxation. This process was repeated multiple times with the same situation until it no longer generated anxiety.

The treatment's second portion, I/EP, is consistent with a cognitive-behavioral framework. Within the CBT segment, therapy attempts to reduce the practice of constantly attempting to anticipate and control potential future threats. The I/EP segment seeks to remedy clients' maladaptive behavioral patterns of both avoiding unpleasant emotions and others' negative evaluations. The I/EP rationale suggests that attempts to avoid feared negative emotions and interpersonal situations can paradoxically elicit the negative outcomes that they sought to avoid. For example, to avoid being hurt or rejected, persons with GAD may not express their own view or emotions in an attempt to make themselves appear more likable. Yet, this approach may lead to diminished bonds with others, as persons with GAD may often seem cold and uncaring.

The techniques within the CBT and I/EP segments are functionally different. In the CBT portion, therapy emphasizes clients' cognitive strengths (e.g., the ability to analyze situations cognitively, desire to learn to control their negative emotional responses). In contrast, I/EP attempts to address inadequacies, such as a difficulty processing emotions along with a discomfort surrounding vulnerability in relationships. I/EP invokes exposure to feared emotions, negative reactions about how they affect others, and vulnerability of showing their emotions to others. In the I/EP segment, therapists provide psychoeducation regarding how avoidance of emotions in the short term paradoxically causes negative outcomes in the long term as their needs go unmet in relationships. I/EP deemphasizes the need to anticipate danger and concentrates on honesty, spontaneity, and vulnerability toward others.

I/EP utilizes mechanisms of change in CBT, such as exposure, modeling, and skills training. I/EP adds to CBT content by including painful emotions and interpersonal fears, in addition to addressing maladaptive coping behaviors like emotional avoidance and being closed off toward others. Also consistent with a CBT framework, the I/EP

segment targets behaviors identified from a functional analysis, including: (1) what relational behaviors should be altered, (2) identification of interpersonal circumstances that elicit and fail to elicit intended interpersonal consequences, (3) immediate and lasting impacts of these interpersonal behaviors, and (4) the purpose of the behaviors within the clients' lives.

Interpersonal/Emotional Processing (I/EP) Techniques

This section will describe I/EP's interventions that (1) address current and past relationship behavior outside of the context of the client–therapist relationship; (2) focus on ways of changing relationship dynamics within the client–therapist relationship; and (3) facilitate emotional processing.

I/EP explores connections between wants, needs, fears, and behavior in the context of step-by-step relationship examinations. I/EP therapists ask specific questions about the client's interpersonal events to assess the client's feelings (e.g., wishes and fears), client's actions, and the result of the interpersonal interactions. These questions attempt to increase clients' awareness of their interpersonal behaviors, relationship needs, and emotions. Specifically, I/EP attempts to allow clients to realize that their actions are not leading to their desired consequences.

After identifying how clients contribute to negative interpersonal consequences, I/EP directly targets these behaviors. Therapists and clients develop alternative ways of relating to others, often within the context of role plays. These clients rarely consider expressing their feelings in a nonaggressive way and often engage in a pattern of avoidance to minimize their discomfort. Thus, role plays and therapists' refusal to permit avoidance (by redirecting) are important techniques within this therapy.

After discovering how they affect others and how they might interact differently, clients receive homework to practice their new response patterns in their actual relationships. In a subsequent session, therapists ask clients about the outcome of the interpersonal interaction and reexplore any difficulties within therapy to see if there might be better ways of satisfying the client's needs. Additionally, clients are encouraged to act directly and openly when responding to ambiguous meanings, rather than assume negative meanings from these unclear transactions.

In addition to exploring clients' relationships with others, I/EP posits that maladaptive interpersonal transactions are often repeated within the client–therapist relationship. Within I/EP, therapists often find it difficult to realize when they have been "hooked" or pulled into the client's maladaptive behavior patterns (Safran & Segal, 1990). Accordingly, therapists are encouraged to track signs for ways in which they have been hooked. These hooks include disengagement, along with loquacious and abstract descriptions from the client, rather than exploring how the client interacted and/or what the client wants or fears in a relationship.

In addition to identifying hooks, therapists attempt to notice ways in which clients may have a negative impact on them. Modeling good communication, therapists attempt to provide direct feedback to clients about these negative impacts by describing how the client made them feel. After giving the feedback, therapists then explore

clients' feelings. Therapists also discuss how they feel when clients react differently in these situations.

Alliance ruptures are another aspect that requires therapists to remain vigilant to the dynamics of the client–therapist relationship. Alliance ruptures can be viewed as a chance to redefine dysfunctional interpersonal schemas into more adaptive ways of thinking and behaving (Safran & Segal, 1990). Therapists in I/EP are trained to recognize the following signs of alliance ruptures: explicit expressions of discontent; implied communications of hostility; disagreement about the objectives of therapy; highly submissive behavior, evasion; and egotism.

Blaming clients for alliance ruptures may worsen their impact (Castonguay et al., 1996). Following steps adapted from humanistic and interpersonal therapies, therapists instead address alliance ruptures by discussing the problem, reflecting back clients' feelings, and acknowledging how they (the therapists) may have contributed to the relational difficulties (Castonguay et al., 2004). Once processed, therapists can try to link interpersonal behaviors observed in the session with interpersonal interactions that occur outside of the therapeutic relationship.

While addressing interpersonal functioning, I/EP also focuses on the facilitation of emotional processing, which is often inhibited by perpetual worry in those with GAD (see above). As such, facilitating emotional awareness and processing are therapeutic interventions intended to expose GAD clients to previously feared and avoided affect.

To help them track emotionality throughout each session, therapists are taught emotional markers, including changes in voice quality (e.g., the sound of sadness in the voice), slowing/quickening of conversational pace, and disruption/discontinuation of emotional expression. When markers of emotionality are observed, clients are encouraged by therapists to fully experience them.

In an effort to ensure that emotions were fully processed, therapists also looked for conflicting emotions, labeled as "internal conflicts" by humanistic therapists (Greenberg, Rice, & Elliott, 1996; Greenberg & Safran, 1989). Markers of internal conflicts were evidenced by clients' being "of two minds about something" (e.g., a part of them felt one way but another part of them felt completely differently). To address internal conflicts, clients are asked to engage in a two-chair exercise, which requires that they address and separately embody each emotion as if they were two distinct persons.

Another sign for a failure to engage in emotional processing is a problematic reaction to emotions. Markers for problematic reactions can include clients' surprise, confusion, or ambivalence regarding their own reaction (Greenberg et al., 1996; Greenberg & Safran, 1989). When clients have a problematic reaction, they imagine the situation unfolding and detail the events and their feelings at that time. Such reexperiencing can often allow persons to recognize previously buried emotions (Greenberg et al., 1996).

Along with emotions, clients may also hold unresolved feelings toward a third party, which is known as "unfinished business" (Greenberg et al., 1996). To deal with unfinished business, therapists use the empty-chair exercise (Greenberg et al., 1996), asking clients to imagine the third party sitting in an empty chair and to vocalize their negative or positive feelings toward the third party. After having acknowledged their emotions, clients may choose whether to act on them.

Outcomes from the Pilot and Randomized Controlled Trial of the Integrative Treatment

To date, we have conducted two studies to test our interpersonal emotional processing therapy. In an initial pilot study of an open trial we demonstrated that the treatment protocol described above was feasible. The pilot study generated promising results, demonstrating a robust effect size of CBT + I/EP at the end of treatment ($d = 3.15$), which was also maintained at follow-up ($d = 2.97$) (Newman, Castonguay, Borkovec, Fisher, & Nordberg, 2008). This study also demonstrated that 77% of clients showed clinically significant change from the CBT + I/EP. The study also demonstrated that interpersonal issues were substantially decreased following treatment.

After these promising initial findings, our research group conducted a randomized controlled trial (RCT) comparing CBT + I/EP to CBT + SL (Newman et al., 2011). In the RCT, CBT + I/EP demonstrated excellent within-group changes at the end of treatment, which were maintained at a 2-year follow-up ($d = 1.90$). Moreover, 75% of persons in the CBT + I/EP no longer met criteria for GAD at the 2-year follow-up. Despite these successes, outcomes from the CBT + I/EP group were not significantly superior to the CBT + SL group outcomes. The lack of statistically significant differences between CBT + I/EP and CBT + SL may have been the result of limited power and errors with significance testing. The outcomes may also be explained by added therapeutic benefits from both the I/EP segments as well as the SL segments. We plan to follow up with analyses of individual differences that may moderate outcome.

It is also important to recognize that the emotional and interpersonal literature in connection to GAD has expanded greatly in the past 15 years, and suggests new directions regarding treatment of interpersonal issues and avoidance of emotional processing in GAD. Based on these research advances, we believe that an integrative treatment of CBT + I/EP would likely be enhanced by the incorporation of recent empirical evidence. The next section will focus on current findings with respect to interpersonal and emotional processing in GAD, which will be followed by a description of future directions for the I/EP therapy.

Current Emotional Processing Research in GAD

As opposed to the previous view of GAD as a disorder characterized primarily and specifically by the avoidance of emotion, current research suggests that (1) GAD is a disorder of emotional hypperreactivity and (2) what individuals with GAD seek to avoid is not emotion *per se*, but a contrast between euthymic affect and a negative emotional experience (Newman & Llera, 2011). Persons with GAD tend to react with greater emotionality than controls to emotional disclosures by a confederate and they have greater difficulty recovering from negative mood states (Erickson & Newman, 2007).

Worry appears to be the root of the connection between GAD and emotion. Replicated findings support the contention that worry contributes to a reduced likelihood of emotional processing. At odds with the I/EP treatment rationale, evidence now suggests that worry neither attempts nor succeeds at enabling emotional avoidance

(Newman & Llera, 2011). Instead, recent research suggests that worry evokes and sustains negative emotionality.

Based on these findings, Newman and Llera developed a new model of GAD: the Contrast Avoidance model. This model posits that persons with GAD use perseverative thinking to emotionally prepare for the worst possible outcome. According to this theory, those with GAD prefer to experience sustained negative emotion than to experience the sharp shift in emotion that would occur if they were in a neutral or relaxed state and their feared outcome came true (Newman & Llera, 2011). This model suggests that those with GAD are more sensitive to the experience of contrasting emotions and/or shifting from a neutral to a negative emotion than those without GAD. This model was influenced by the theory of affective contrast (Bacon, Rood, & Washburn, 1914), which states that unpleasant emotions are even more distressing when preceded by a positive emotional state and less distressing if preceded by a negative emotional state. The Contrast Avoidance model of GAD has received empirical support, as will be discussed below.

Worry predicts sustained negative emotionality and pervasive physiological activation. For both persons with and without GAD, worry inductions lead to greater self-reported and physiological emotionality, both within and across persons (when compared to relaxation and neutral inductions) (Llera & Newman, 2011). For example, worries are related to increased cardiovascular activity, which is part of the sympathetic nervous system (SNS) (Llera & Newman, 2010). Such SNS activation is related to heightened levels of arousal and has been implicated in the flight or fight response (Lehnart et al., 2005).

In fact, rather than lead to avoidance of negative emotionality, studies suggest that worry sustains negative emotionality. For instance, ambulatory physiological monitoring has shown that worry led to elevated activation that extended into sleep and that worry in the evening predicted elevated cortisol the following morning (Brosschot, Van Dijk, & Thayer, 2007).

According to the Contrast Avoidance model, persons with GAD engage in perseverative worry to avoid experiencing contrasts from positive to negative emotions (Newman & Llera, 2011). Persons with GAD fear this emotional contrast and prefer to consider all negative outcomes so that they can avoid a negative emotional shift. Consistent with this theory, those with GAD reported that worry immediately before a negative emotion induction was significantly more helpful than neutral or relaxation experiences in coping with the emotional impact of the induction (Llera & Newman, 2011). However, the opposite was true for those without GAD. Healthy controls reported that relaxation or neutral inductions prior to the negative emotion induction helped them feel better able to cope with the impact of the induction compared to worry (Llera & Newman, 2011). Thus, those with GAD use worry as a purposeful and regulatory strategy to maintain negative emotionality.

Interpersonal Processes in GAD

Similar to research on emotional processes in GAD (and consistent with it), the interpersonal literature regarding GAD has changed markedly over the past 15 years.

While GAD has been consistently marked by its association with personality disorders and maladaptive interpersonal processes (Newman & Erickson, 2010), the literature has recently evolved in regard to its explanation of GAD's etiology. Specifically, the development and maintenance of this disorder appears to be determined, at least in part, by interpersonal cognitions and problematic behaviors (Newman & Erickson, 2010).

Regarding interpersonal cognitions, compared to those without GAD, persons with GAD are also more likely to consider others' behavior as attacking, ignoring, or controlling. In addition, worry predicts higher levels of perceived coldness based on others' interpersonal behavior, which is independent of co-occurring social anxiety or depression (Erickson, Newman, & Abelson, 2010). This interpersonal cognitive bias toward threat may help to preserve negative affective states and avoid unanticipated negative emotional shifts.

Such interpersonal bias toward threat may fuel the maladaptive interpersonal behaviors seen in GAD. Persons with GAD are more likely to be intrusive, exploitable, nonassertive, and cold (Przeworski et al., 2011). Moreover, GAD has been found to be strongly associated with being separated or divorced, fewer intimate relationships, and lower marital satisfaction (Whisman, Sheldon, & Goering, 2000). Additional studies further suggest that interpersonal problems may play a role in the exacerbation or maintenance of GAD symptoms (Durham et al., 1997), Thus, evidence suggests that GAD leads to interpersonal issues, and these interpersonal issues perpetuate GAD.

In line with the Contrast Avoidance model, persons with GAD may instrumentally use unpleasant behaviors toward others as a means to avoid associated sharp shifts in negative emotion. Specifically, Newman and colleagues (Newman, Llera, Erickson, Przeworski, & Castonguay, 2013) argue that it is possible that persons with GAD may behave maladaptively toward others to avoid negative emotional contrasts (preferring to experience lasting distress to ensure that they are emotionally prepared for a negative outcome). The avoidance of an emotional contrast could also be responsible for interpersonal conflicts, hostility, and coldness seen in GAD. Likewise, the use of warm and compliant interpersonal behavior from persons with GAD may be a means to limit hostile responses from others.

Although there has been an increasing awareness of interpersonal problems and emotional reactivity associated with GAD, none of the newly developed treatments, including the treatment described in this chapter, has demonstrated superiority to standard CBT in addressing these problems (see Newman et al., 2013, for more details). In the next section, we will concentrate on future treatment foci that may lead to greater efficacy by incorporating the Contrast Avoidance model to explain interpersonal and emotional functioning.

Future Directions for Interpersonal and Emotional Processing Psychotherapies

As mentioned above, CBT combined with I/EP proved to be effective in reducing symptomatology for clients with GAD; however, it was not significantly more effective than CBT combined with supportive listening. We suggest that a way to enhance

the efficacy of this therapy is to specifically target a fear of emotional contrasts and associated interpersonal behaviors. The implications of the Contrast Avoidance model are that past treatments have targeted worry patterns, but these treatments may not have targeted the underlying fears that propel the worry.

This might be accomplished via exposure to emotional contrasts, paired with relaxation. Such emotional contrast exposure could be elicited by outside or personalized images, sound clips, videos, or thoughts, wherein positive or neutral emotional inductions would be immediately followed by a negative emotional induction. For example, immediately before a negative emotion induction, clients could engage in relaxation. Repeatedly pairing this exposure, with relaxation, would be conducted in order to achieve habituation to emotional contrasts. As relaxation is seen as an opposing process to worry, this would discourage the use of worry as a defensive practice. Since interpersonal issues in GAD may be motivated by fear of negative emotional shifts, targeting interpersonal behavior that avoids emotional contrasts may increase the efficacy of the treatment.

Conclusion

GAD has been consistently associated with a number of interpersonal and emotional issues. Our treatment was the first attempt to incorporate interpersonal and emotional issues into a CBT regime. Although the therapy was only partially effective, we suggest that the recent emotional and interpersonal literature may inform how best to enhance the integrated therapy. Thus, we recommend that future therapies address avoidance of negative emotional contrasts to better treat the underlying issues of interpersonal and emotional difficulties.

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