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ORIGINAL PAPER

Emotion regulation therapy: An integrative approach to treatment-resistant anxiety disorders

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Abstract Cognitive-behavioral, psychodynamic, and experiential approaches have historically been characterized by differing definitions of emotions and beliefs concerning their role in psychopathological process and treatment. However, given recent advances in the basic psychological sciences of emotion and emotion regulation, theoretical orientations are converging on similar viewpoints as to the functional role of emotions in conceptualizing and treating of a variety of disorders. One such area where emotions and their regulation may play a significant role is in chronic, complex, and treatment-resistant forms of anxiety disorders such as generalized anxiety disorder (GAD). A review of the historical approaches to emotions in the major theoretical orientations is presented. Following this, a model of emotion disruption and dysregulation is presented as it relates to anxiety disorders and GAD, in particular. Finally, a new treatment for GAD, emotion regulation therapy, aimed at ameliorating dysfunctional affective processes, is described.

Keywords Anxiety disorders · Generalized anxiety disorder · Emotion regulation · Psychotherapy integration

In recent years, there has been an invigorated interest in the role of emotions in both the understanding of psychological disorders and the process of treatment. For a long period, differing viewpoints for what constituted an emotional experience divided many of the major theoretical orientations. Defining what emotion is and what it does has not proved to be a simple task given its common terminological usage but lack of consensus in operational definition. As a result, for many years, there was little consensus on both definition of emotion and its centrality in clinical psychological phenomenon.

Interestingly, largely due to advances in understanding basic and pathological emotional processes, theoretical orientations have been converging in emphasizing the importance of emotion. As a result, similarities across perspectives have become more apparent as they highlight the functional perspective of emotion in psychotherapy and mental health. A functional perspective states that emotions are adaptive, goal-defining aspects of experience that help aid in decision making concerning movement towards or away from particular actions or plans (e.g., Frijda, 1986). Efran, Lukens, and Lukens (1990) explain that, since emotion serves this function, it is in a continuous but changing state at all times. One may feel "emotional" at a given time but emotion systems are constantly present, responding to environmental and internally generated cues. In addition, the manner in which individuals are able to manage emotional experience to conform adaptively to a given context also appears to be important to mental health (Gross & Munoz, 1995). As such, a number of approaches have incorporated components of emotion regulation into interventions for a variety of psychopathological conditions (e.g, borderline personality disorder; Linehan, 1993).

One such area where emotions and their regulation may play a significant role is in the anxiety disorders. Attention to anxiety disorders has increased exponentially in the past 20 years. A great deal of evidence has demonstrated the utility of current conceptualizations and treatments for disorders such as panic disorder and social anxiety disorder (see Barlow, 2002, for a review). However, for some chronic and complex (e.g., highly comorbid) forms of anxiety disorders,

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difficulties in understanding and treating these conditions remain. For instance, GAD has received less theoretical attention compared to other anxiety disorders (Dugas, 2000) and has been found to have a poorer long-term response to treatment (Borkovec & Ruscio, 2001). Understanding of how emotional experience becomes dysfunctional and engenders dysregulation may aid in furthering both conceptualizations and treatments of complicated anxiety disorders such as GAD.

This paper aims to (1) demonstrate how views regarding emotion have been considered and evolved across the three main theoretical orientations of psychotherapy; (2) present a model for improving understanding of complex anxiety disorders such as GAD through delineating the role of emotion-related deficits; and (3) describe a developing integrative treatment, emotion regulation therapy (ERT), that is influenced by these theoretical traditions, their approaches to affective processes, and basic research on emotion and its regulation for the refractory anxiety disorder, GAD.

Emotion in the major theoretical approaches

The cognitive-behavioral perspective

Cognitive-behavioral conceptualizations have typically underplayed the importance of emotion variables (L. S. Greenberg & Safran, 1987; Samoilov & Goldfried, 2000). In addition, cognitive-behavioral treatments have also been found to be characterized by less emotional activation within sessions (e.g., Goldfried, Castonguay, Hayes, Drodz, & Shapiro, 1997). Skinner considered emotions to be largely inaccessible to observation and control. Skinner (1953) directly attacks the notion of emotion as a causal entity in *Science and Human Behavior* within a chapter on emotion that includes a heading entitled "Emotions are not Causes." He states "'emotions' are excellent examples of the fictional causes to which we commonly attribute behavior" (p. 160). As such, the subjective nature of emotional experience was a troublesome topic of study for early behaviorists, and inquiry into the phenomenon of emotions was clearly disparaged (Pritchard, 1976). Following early behavioral theory, some theorists attempted to combine learning theory with notions of drives that included emotional phenomena (Dollard & Miller, 1950). These positions were often criticized for attempting to incorporate psychoanalytic concepts into a learning framework. However, some behavior theorists did eventually incorporate internal processes into their formulations (e.g., Bandura, 1971). The resulting theories were an attempt to bring the concept of mind back into psychological science such that subjective experience would, once again, become an acceptable object of inquiry.

The "cognitive revolution" in clinical psychology was a response to the rapid growth of information processing research that began in the late 1950's (e.g., Neisser, 1967). Emotional phenomena were explicitly de-emphasized in cognitive science due to the complexity and subtlety involved in the fuzzy category of emotion (Gardner, 1985). Classical cognitive therapy (e.g., Beck & Emery, 1985) has approached emotion as a byproduct of cognition. Affect is viewed only as an *outcome* of cognitive activity. As a result, emotion is often relegated to dependent variable status in cognitive-behavioral research examining emotional dysfunction (L. S. Greenberg & Safran, 1987).

In classic cognitive-behavioral approaches to the anxiety disorders, anxiety as an emotion was clearly seen as integral to the disorder but rarely was characterized beyond a dysfunctional effect of other phenomena (e.g., behavior or cognitions) and usually characterized only by autonomic or "physiological" components (e.g., rapid heart beat, shortness of breath; Lang, 1985). Early models of emotional processing viewed anxiety in strictly disruptive terms with mental health being defined as the reduction of this emotion (Rachman, 1980). Foa and Kozak (1986), in their seminal article on emotion processing, began to extend the cognitive-behavioral definition of emotions, stating the importance of eliciting emotional arousal and its associated meaning elements while confronting feared stimuli. This viewpoint emphasized the importance of emotional experience but did not explicitly discuss functional aspects of emotion. Rather, emotion was still viewed solely in disruptive terms. Further, other emotions besides anxiety were not considered to be integral to understanding and treating anxiety disorders.

Although some investigators have focused solely on cognitive factors, emotion in cognitive-behavioral theory has recently been increasingly brought to the forefront (Samoilov & Goldfried, 2000). Barlow (2002) has developed a theory of anxiety and mood disorders that is based in emotion theory. He cites a number of empirical investigations that have found that a higher order factor of negative affect is common to anxiety and mood symptomatology (e.g., Zinbarg & Barlow, 1996). Other theorists have now examined anxiety in more complex emotional terms, emphasizing relations between emotions such as fear of anxiety or *anxiety sensitivity* (Taylor, 1999) and, more recently, fear of a number of evocative emotional experiences (e.g., sadness, anger, elation; Williams, Chambless, & Ahrens, 1997).

In addition, a number of recent cognitive and behavioral interventions have begun to emphasize emotional phenomena. Emotion has received the most attention in the acceptance-based behavioral therapies (e.g., Hayes, Strosahl, & Wilson, 1999; Linehan, 1993), which focus on the allowance and acceptance of emotional experiences; even those that are negative or painful. Linehan (1993) was one of the first investigators to incorporate this approach to emotion

into a cognitive-behavioral treatment package. The resulting, empirically informed treatment, Dialectical Behavior Therapy (DBT) has been widely accepted and is considered a first-line treatment for borderline personality disorder.

Mindfulness-based meditation procedures (Kabat-Zinn, 1990; also one component of DBT) aid clients in becoming more flexibly and non-judgmentally aware. When "mindful," one is able to step back, gain perspective and, in the case of emotional allowance, permit feelings to emerge that can provide direction. These techniques have gained a great deal of popularity recently in treating anxiety (Roemer & Orsillo, in press) and depression (Segal, Williams, & Teasdale, 2002), likely because of their compatibility with behavioral models (Orsillo, Roemer, Block-Lerner & Tull, 2004). In addition to DBT and mindfulness approaches, another acceptance-based approach that has gained popularity is Acceptance and Commitment Therapy (ACT) developed by Hayes and colleagues (Hayes et al., 1999), which aims to reduce emotional avoidance by facilitating experiential openness. This is largely accomplished through the process of acceptance, which refers to allowance of your internal experience without trying to alter or change it. ACT has shown promise as an intervention for anxiety disorders (e.g., Eifert & Forsyth, 2005).

The psychoanalytic perspective

In contrast to the de-emphasis of emotion in cognitive-behavioral traditions, psychoanalytic theories classically have focused centrally on affective variables but have held deterministic beliefs regarding the manner in which emotion is experienced and expressed. Emotion, from a classical viewpoint, is experienced as a result of drive and instinctual energy forces. Freud viewed emotions in terms of the hydraulic concept of energy that was prevalent during the period in which he wrote (e.g., Freud, 1912/1959). In this view, affect is a product of non-social and non-cognitive instinctual impulses. In the process of classical psychoanalysis, the analyzed undergoes a *catharsis*, wherein emotions associated with dammed up instinctual energy are released, allowing the system to return to normal functioning (Efran et al., 1990). Here, emotions are seen as episodic releases of energy rather than consistent aspects of experience. Affective experience occurs only as a result of non-conscious instinctual impulses that have little to do with external occurrences (e.g., relationships) or the person's perceptions of those occurrences.

A number of psychoanalytic theorists have challenged drive theory for its neglect of personal meanings of behavior and the importance of interpersonal relatedness, especially within an affective framework (J. R. Greenberg & Mitchell, 1983). In the past fifty years, contemporary psychoanalytic theory has developed beyond the confines of classical Freudian theory. Jung (1946) may have been one of the first psychoanalysts to discuss cognition and distinguish between thinking and feeling. He argued that whereas thinking evaluates experience along the dimension of true vs. false, feeling evaluates experience along a dimension of good vs. bad. Bowlby (1969) theorized that emotionally laden relationships are mentally represented in "working models" of self and primary attachment figures. These models are cognitive representations of the emotional security of the attachment relationship. Over time, these mental representations lead to expectations about the caregiver's involvement with the child and resulting reactions from the child. These working models, subsequently, affect the formation of new relationships as the child grows. Positive attachment experiences will lead to a rich working model of the effectiveness of relationships for the secure child. As a result, this child will grow to trust others and form effective relationships.

Erikson (1950) and Sullivan (1953), in different ways, both viewed emotional phenomena in the social context in which they develop. This position has been expanded by the object relations theorists who are often associated with a dialectical focus on a relational matrix and its components of the self, other and the self-other vortex (J. R. Greenberg & Mitchell, 1983). Relational theorists such as Fairbairn, Winnicott, and Klein have written extensively about the development of the person through one's interactions with others (for a review, see J. R. Greenberg & Mitchell, 1983). It is these interactions that form the need for relatedness. These theorists discuss the importance of the whole individual's experience including emotional and cognitive phenomena within the relational matrix. Russell (1998, p. 35) states, "thoughts, feelings, and acts all inform one another and require one another. Any feeling represents a press (however slight) towards some action, in other words, a wish. However, it requires thought to be consummated." Further, contemporary psychoanalytic theorists such as Epstein (1994) have argued for the need to incorporate both experiential, emotional systems and rational, analytic systems in conceptualizations of human functioning. Finally, Westen (1998) has presented a comprehensive framework for a psychoanalytically informed research program that stresses the importance of both cognitive and emotional factors and draws from cognitive science, neuroscience, *and* relational theories.

From a therapeutic standpoint, models of psychoanalytic intervention have also evolved to address more dynamic models of interpersonal relations and emotional experience. Treatments in these domains are briefer and have more specific targets of intervention. Some treatments in the short-term dynamic psychotherapy (STDP) approach focus on core relational themes that have unfolded from early to later development (Luborsky, 1984), whereas others specifically engage the therapeutic relationship as a microcosm for the client's patterns of relations (Safran & Muran, 2000). These

brief relational approaches have been applied recently to anxiety disorders with success (Crits-Christoph, Connolly Gibbons, & Crits-Christoph, 2004; Newman, Castonguay, Borkovec, & Molnar, 2004).

Other recent STDP approaches are more explicitly focused on emotional experience both in the context of interpersonal dyadic regulation (Fosha, 2000) and through an intrapersonal focus on defenses against feared emotional experiences or "affect phobias" (McCullough, Kuhn, Andrews, Kaplan, Wolf, & Hurley, 2003). Both approaches are based on the short-term psychodynamic models of Davenloo (1980) and Malan (1976) who pioneered a therapeutic style aimed at aiding clients in addressing defenses against emotional experiences. The approaches of Fosha (2000) and McCullough and colleagues (McCullough et al., 2003) are unique in the psychoanalytic literature for intervening on emotions directly and extend these earlier STDP models by incorporating a more explicit focus on emotions, which are seen as vital, adaptive and motivationally informative. These emotion-focused, STDP approaches draw not only from earlier psychoanalytic thought but also from the experiential tradition, which is reviewed in the next section.

Experiential perspective

Although psychoanalytic and cognitive-behavioral orientations are clearly divergent in a number of respects, both approaches, in their classical forms, originally viewed emotions in similarly dysfunctional terms, an entity needing to be reduced for functionality to occur. In contrast, the experiential approach has historically viewed humans in dynamic, interrelated terms incorporating the importance of emotion in adaptive functioning. *Experiential therapy* is an umbrella-term for modern approaches rooted in humanistic, gestalt, and existential traditions. Following a rise in interest in these orientations in the 1960s and 1970s, mainstream attention to these approaches diminished. However, the emergence of contemporary treatments (e.g., L. S. Greenberg, 2002) has revitalized an interest in these experiential orientations. These treatments are novel as they base their approaches on not only these historical traditions but also on basic research on emotion and affective neuroscience.

L. S. Greenberg and colleagues (L. S. Greenberg & Van Balen, 1998; Watson, Greenberg, & Lietaer, 1998) review the contributions of client-centered, humanistic, gestalt, and existential traditions in the shaping of modern experiential therapy. The role of emotions figures prominently in the original formulations of these orientations. Carl Roger's client-centered approach was groundbreaking in its primary focus on the phenomenological experience of the client. The ability of the therapist to engage this experience of the client in an empathic, non-judgmental manner and reflect this back to the client was considered by Rogers to be the essential component of client-centered therapy. Rogers considered dysfunction to arise from an unwillingness to remain aware of all aspects of experiences, particularly those that have growth potential (Rogers, 1959). Rogers argued that clients grow as a function of their ability to become more aware of their emotional reactions in their experience, become more accepting of them, and increase understanding of their importance in engaging in experiences congruent with their needs.

Gestalt therapy, developed by Fritz Perls (1969), historically has also explicitly focused on emotional processes in its approach to therapeutic change. Central to this orientation is the notion that life experiences are not static but are, rather, evolving continuously. Further, one's ability to engage this unfolding of experience and create meaning from it is directly related to their ability to functional effectively (Watson et al., 1998). In gestalt therapy, exercises are used to generate a focus upon the present moment experience of needs, feelings, sensations and motor behaviors. From this awareness of experience, clients are able to create meaning of this experience, become more active in determining where they would like these experiences to progress towards, and become more tolerant of when these goals are unable to be realized. Insight into what is impeding their ability to gain this awareness and action related to their emotions occurs through a process of discovery rather than interpretation. Rather than discussing challenges to experiencing at an intellectual level, exercises are conducted in which clients enact conflicts in self or dialogues with others with which they have unresolved feelings (Watson et al., 1998).

Inherent in the tradition of existential approaches is the acceptance of emotional experience as an integral aspect of living (e.g., May, 1960). In existential theory, individuals are conflicted with the knowledge of death, isolation, freedom, and meaninglessness (Watson et al., 1998). Health is seen as the ability to accept the anxiety that accompanies the knowledge of these negative forces and to not resort to trying to ignore, suppress, or control this reality of the finitude of experience. Yalom (1980) stresses the importance of immediate affective experience, especially within the therapeutic context, in assisting clients to accept all aspects of experience and to create meaning, even in the face of uncertainty.

Contemporary experiential approaches build upon the foundational views of emotions inherent in client-centered, gestalt, and existential traditions. Gendlin (1996), in his focusing-oriented psychotherapy, has stressed the importance of awareness of the immediate affective experience, especially as it relates to bodily sensations. Gendlin argues that the *felt sense* of bodily sensations provide individuals with a tacit form of knowledge of our reactions to both internal and external events. In this treatment, individuals learn to identify these sensations and gain a better understanding of their implicit meanings. Greenberg (e.g., 2002; this issue) has developed emotion-focused therapy, which he considers

a "process-experiential therapy," since it focuses on the temporal unfolding of an emotional episode and all of its constituent components. Greenberg draws heavily from the empathic tone of client-centered therapy and the experiential exercises of gestalt therapy. The goal of emotion-focused therapy is to bring emotions and their associated motivational elements into active awareness (Watson et al., 1998).

L. S. Greenberg and Safran (1987) have distinguished among types of emotion including those that are reflective of core emotional reactions (which he terms *primary emotions*; these can be adaptive or maladaptive), that are reactions to other emotions (which he terms *secondary emotions*; these are largely maladaptive), and that are only evoked strategically to gain a desired outcome (which he terms *instrumental emotions*; these are often manipulative). Primary emotional reactions refer to biologically adaptive emotional responses that provide information about action tendencies, associated meanings and motivation for behavior. These responses include what have been termed the "basic emotions" such as fear, joy, anger, and sadness. Adaptive primary emotions are integral to understanding our goals and making decisions and, hence, their exploration is encouraged in Greenberg's treatment. This is accomplished through acceptance of emotional experiences, adaptive utilization of this experience to create meaning, and the transformation of maladaptive emotional states to more productive, emotional ones that aid in effective decision making and adaptive action engagement (L. S. Greenberg, 2002; this issue).

Although the experiential traditions have incorporated fundamental views of emotions since their inception, many of the historical foundations of the experiential approach were originally empirically untested and unconnected to other literatures on the process of emotion, disorder, and interpersonal relations. However, this has changed considerably in contemporary experiential therapy. First, L. S. Greenberg has developed his approach largely from basic findings concerning the functional role of emotions and their neurobiological substrates. Also, L. S. Greenberg and colleagues have found positive therapeutic outcome for EFT and have demonstrated that depth of experiencing emotions in session is a key factor in treatment success (for a review, see Whelton, 2004). Recently, in line with current trends in emotion research, L. S. Greenberg has begun to stress not only the experience of emotions but also the need for their management and regulation (L. S. Greenberg, 2002; this issue). Finally, experiential traditions originally eschewed the concept of disorder. However, recently, experiential therapists have delineated their approaches to specific disorder populations such as depression (Pos & Greenberg, 2003) and anxiety disorders (Wolfe & Sigel, 1998), thus increasing ability to determine specificity of different experiential therapeutic processes for different forms of psychopathological conditions.

Emotion regulation therapy (ERT) for GAD

Emotion dysregulation model

Despite its association with significant impairment and life dissatisfaction, increased health care utilization, increased health care costs and decreased productivity (Kessler, 2004), GAD remains an understudied (Dugas, 2000) and treatment-resistant (Borkovec & Ruscio, 2001) disorder. Cognitive-behavioral treatments for GAD, although efficacious, have not yet demonstrated that clients, following successful psychotherapy, have improved to a level of life quality and long-term functioning that is seen in other anxiety disorders.

One avenue for improving understanding and treatment of GAD is through delineation of the role of emotion dysfunction and dysregulation. Studies in this area, particularly those that have examined the avoidant function of worry (see Borkovec, Alcaine, & Behar, 2004, for a review) have begun to demonstrate the importance of emotion in the worry process. However, emotions may play a larger role in GAD than solely in their relationship to worry. In fact, emotion regulation deficits contribute to the prediction of GAD beyond the predictive contributions of worry, anxiety, and depression (Mennin et al., in press). My colleagues and I (for an introduction to this perspective, see Mennin, Heimberg, Turk, & Fresco, 2002; Mennin, Heimberg, Turk, & Carmin, 2004) have developed an emotion dysregulation model of GAD. In this model, emotion disruption and dysregulation may be reflected in (1) heightened intensity of emotions; (2) poor understanding of emotions; (3) negative reactivity to one's emotional state (e.g., fear of emotion); and (4) maladaptive emotional management responses.

Preliminary evidence provides support for this emotion dysregulation model in explaining dysfunctional processes in GAD (Mennin et al., in press). We found that individuals with GAD rated their emotional experiences as significantly more intense than other individuals. Consistent with our model, individuals with GAD had more difficulty than control participants identifying, describing, and clarifying the motivational content of emotions than controls (Mennin et al., in press; Studies 1 & 2). Further, individuals with GAD who underwent a negative mood induction had more difficulty understanding their reactions to their resultant emotional state than controls (Mennin et al., in press; Study 3). Individuals with GAD also reported greater fear of anxiety, sadness, anger, and positive emotions than controls, and fear of sadness and anxiety made unique contributions to the detection of GAD (Mennin et al., in press; Studies 1 & 2). The final component of the emotion regulation model of GAD involves maladaptive regulatory responses including difficulties in managing emotional experiences and the usage of control strategies to avoid emotions. Individuals

with GAD have difficulty soothing themselves following a negative mood. In particular, they demonstrated lower trait (Mennin et al., in press; Study 1 & 2) and state levels (following an experimental mood induction; Study 3) of returning negative moods to a euthymic baseline state than controls.

Taken together, these findings suggest that given a high level of emotional intensity and difficulty understanding emotions, individuals with GAD may react negatively to their emotions and have an inability to soothe resulting negative moods and turn to a number of maladaptive methods for managing aversively perceived emotional experiences, including, but not limited to, worry. This emotion regulation perspective builds upon the foundational work of Borkovec and his colleagues in their examination of worry in GAD (for a review, see Borkovec et al., 2004). Individuals with GAD may attempt to regulate their emotions by using worry to ineffectively and inappropriately control or suppress emotional experience. Worry may be viewed as a cognitive control strategy that individuals employ to reduce/control an aversive, uncertain emotional state. Borkovec and colleagues have provided considerable evidence that worry serves such an avoidance function in GAD (Borkovec et al., 2004).

Overview of ERT

ERT addresses the emotionally avoidant characteristics of individuals with GAD within a framework of emotion dysregulation (for a case study using this approach, see Mennin, 2004). This emotion regulation approach to GAD may offer additional strategies to bolster the efficacy of treatments for GAD. If we conceptualize persons with GAD as having difficulties in the modulation of emotion and as fixedly utilizing cognitive control strategies to avoid their intense emotional experiences, it follows that they may benefit from interventions that enhance their knowledge, acceptance, utilization, and management of emotions.

ERT for GAD integrates components of emotion focused treatments into a cognitive-behavioral framework. In particular, skills training elements related to adaptive regulation of emotions are included in ERT. In addition, emotion-focused techniques from the experiential tradition (see L. S. Greenberg, 2002) are utilized for the purpose of in-session emotion evocation. Some techniques are also drawn from the burgeoning area of emotion-focused brief psychodynamic therapy (see Fosha, 2000; McCullough et al., 2003) and relational interventions (Safran & Muran, 2000). Other integrative approaches to GAD have also been developed and, although they also have experiential components, are more clearly interpersonally-focused (see Newman et al., 2004). Taken together, ERT addresses cognitive factors (e.g., beliefs about threat and security), emotional factors (e.g., avoidance and management of emotional experience) and contextual factors (e.g., patterns of relating to others and the environment) that may contribute to maladaptive responses.

The goals of ERT are for individuals with GAD to become better able to (1) identify, differentiate, and describe their emotions, even in their most intense form; (2) increase both acceptance of affective experience and ability to adaptively manage emotions when necessary; (3) decrease use of worry and other emotional avoidance strategies; (4) increase ability to utilize emotional information in identifying needs, making decisions, guiding thinking, motivating behavior, and managing interpersonal relationships and other contextual demands. Achievement of these therapeutic goals should equip clients with the ability to effectively increase or decrease their attendance to emotional experience as is necessary to attain desired outcomes, tolerate distress and properly adapt to life's inevitable challenges.

ERT is still currently under development. As such, the treatment will likely be altered from its current form as lessons are learned from its ongoing implementation. Currently, ERT is administered over 20 sessions in a 16-week period. The first 4 weekly sessions (Phase I) focus on psychoeducation about GAD, functional patterns of worry and emotions in past and current situations, and self-monitoring of worry episodes. The following 4 weekly sessions focus on the development of somatic awareness and emotion regulation skills (Phase II). Given their centrality to the approach, the following 8 sessions occur twice-weekly, within a 4-week period. These intensive sessions focus on the application of skills during exposure to emotionally evocative themes (Phase III). The final 4 sessions are conducted weekly. These sessions focus on terminating the therapeutic relationship, relapse prevention, and future goals (Phase IV). Sessions are typically 50 to 60 minutes in length.

Phase 1: Psychoeducation, monitoring, and developmental history

In initial sessions, clients are introduced to the emotion regulation perspective on worry and GAD and to the format of ERT. Early sessions also focus on current worries and patterns of avoidance. Clients are asked about the domains of worry that are most pertinent and the contexts in which these typically arise. The therapist uses the client's anxious experiences to highlight examples of the functional relationship between worry and avoidance of emotion. Clients also begin to examine these episodes through out-of-session self-monitoring (recording thoughts, emotions, physical sensations, and behaviors that arise during the episode) and unstructured writing exercises, which are meant to increase awareness of anxiety-related themes through developing a narrative of these experiences. Both analytic (e.g., Leahy, 2002) and narrative (e.g., Pennebaker, 1997) approaches to writing assignments have been shown to have therapeutic

value and can provide different but convergent sources of emotional awareness.

In the next few sessions, proposed etiological factors are discussed in terms of the contributing role of both hereditary and developmental factors. Clients report as to whether other members have also been anxious. Clients also review the initial onset and developmental history of their worry and anxiety. Individuals with GAD commonly repeat lifelong patterns of behavior that reinforce their beliefs in the need to worry and avoid emotional experience. By examining the developmental origins of GAD, clients can gain a better understanding of how they came to have this condition and begin to recognize contributing patterns that they have repeated over time. Also, an implicit goal of these sessions is to build the therapeutic alliance by fostering an empathic connection through a validating stance taken by the therapist in response to the client's expression of life struggles. Allowing clients to present their narrative concerning their history with GAD is often crucial given that many clients with GAD feel strong needs to have their therapists hear their "story." The importance of validating emotional experience has been stressed in other approaches such as Linehan's DBT for borderline personality disorder (see Linehan, 1993).

Developmental factors are discussed in terms of the genesis of feelings of insecurity and belief in the need for threat preparedness. Individuals with GAD commonly develop a view of the world as threatening and are often vigilant to challenges to this sense of security. Research has shown that individuals with GAD retrospectively report insecure attachment relationships with their primary caregivers and, often, demonstrate similar dysfunctional interpersonal patterns in adulthood (e.g., role-reversed parenting in retrospective report and excessively nurturing in adulthood; see Borkovec et al., 2004). In session, discussion explores the maladaptive ways in which clients may have learned to view the world as unsafe and also how they currently seek to address their security needs. In particular, excessive needs for safety often make management of one' emotional life difficult and are typically related to the triggering of worry episodes throughout one's life. The therapist explains how the relationship between safety-seeking behaviors and emotional avoidance could be seen as a vicious circle wherein beliefs about insecurity and inability to cope can motivate avoidance of distressing emotions and cause emotional messages to become more intense. This intensity could, in turn, lead to the experience of emotion as even more aversive, confirming beliefs about inability to cope, leading to greater attempts to control the emotion with worry, leading the cycle to be repeated. Clients continue to self-monitor outside of session and are asked to pay attention to how their emotional responses lead them into a worry cycle and to take note of any recurrent themes that have arisen as the worry process was engaged (even if the superficial topic of worry constantly shifts). Fears of alienation, detachment, loss, and failure are common themes.

Phase 2: Skills training in somatic awareness and adaptive emotion regulation

During the skills training phase of ERT, sessions focus on the development of (1) somatic awareness skills to increase flexible awareness of bodily reactions to emotions, (2) cognitive skills that involve identification of beliefs about threat and insecurity (including delineation of maladaptive actions taken in service of avoidance, defense, and control), (3) emotion skills aimed at increasing understanding of emotional experience and regulation, especially in the face of intense emotional experience, and (4) contextual skills that involve strategies for both getting needs met and regulating emotions as is appropriate for different life domains (e.g., in relationships and at work). These sessions included didactic aspects wherein the therapist provides information (verbal and reading materials) as to how to achieve these skills but also includes a number of exercises for clients to apply these skills to ongoing issues and conflicts. Further, between sessions, clients are encouraged to practice written and experiential exercises and began applying these skills to their everyday experiences.

In the initial sessions of this phase, clients work to increase awareness of bodily sensations, gain comfort with these sensations, and allow flexibility in responding to these sensations. This may not be a problem for many individuals with GAD in the abstract but may become more of a problem when they are in an emotionally reactive state characterized by a sense of threat. During these times, individuals with GAD may be less able to understand their emotions and know what has brought them to feel in this particular manner. Clients are also encouraged to maintain a focus on their bodies without disengaging or trying to control the experience. Body awareness in psychotherapy has taken a number of forms including mindfulness training (Kabat-Zinn, 1990; Linehan, 1993; Segal et al., 2002), focusing (Gendlin, 1996), and modified progressive muscle relaxation (PMR; Bernstein, Borkovec, & Hazlett-Stevens, 2000; Roemer & Orsillo, in press); a number of these techniques are used in this phase of ERT. In the case of PMR, the purpose is a departure from the traditional use of PMR, which has often been used to directly decrease the experience of anxiety. In this approach PMR is used to increase awareness and flexibility of muscular responses to perceived threat.

As clients learn to attend to physical reactions in a manner that encourages flexibility and discourages avoidance, sessions begin to focus more on skill development involving emotional, cognitive, and contextual factors. As discussed above, GAD clients may not have learned the basic emotional skills necessary to adaptively respond to

environmental demands. Clients who feel insecure and overwhelmed by their emotional experience may respond to challenges with extreme reactions of emotional disinhibition and overcontrol. Clients learn to identify cues as to when beliefs about insecurity are typically being activated and examine how these beliefs affect their ability to function adaptively. Clients also learn skills to identify, label, and differentiate among different emotional states. Because of their informational value, accessing adaptive primary emotions (L. S. Greenberg, 2002) is essential to positive affective change and regulation. Clients are given a list of emotions and their corresponding motivational information (a list adapted from Lazarus, 1991). Using this list and other aids, clients learn to identify, label, and differentiate various primary emotional experiences.

During this phase, clients work towards discovering needs that they consistently find important and determining how often these needs are met. Clients learn skills for increasing understanding of how these needs become salient through different emotional experiences. Skills related to effective expression of emotional experience are also taught to foster ability to meet needs in an interpersonal context. Finally, clients learn skills related to managing their emotional experience once it feels overwhelming and interruptive. These skills include those directed at self-soothing through increasing a personal sense of safety and decreasing emotional arousal as well as learning about contextual cues that help determine when to introspectively deepen attention to one's emotional experience and when this may be counterproductive. At the end of this phase, clients are encouraged to integrate these skills into an adaptive problem-solving orientation that incorporates emotional, cognitive, and contextual sources of information. This stance is similar to what Linehan (1993) calls the "wise mind" because of its flexible integration of both rational and emotional factors.

Phase 3: Thematic experiential exposure

These twice-weekly sessions are the core of ERT. By this point, clients will have learned the skills of somatic awareness and emotion regulation. In this phase, in-session exposure exercises (referred to as "thematic experiential exposure" exercises) are utilized to help clients actively engage emotions, attenuate the anxiety engendered by these emotions, and to use their increased understanding of their emotional reactions to inform their needs, goals, and plans for action. If treatment focused solely on learning new skills to tolerate and regulate emotions, clients could continue to avoid aversive emotions by thinking about problems and needs intellectually without exposing themselves to feared emotional experiences (and their associated core thematic meaning) or practicing using the adaptive information these emotional experiences provide.

Thematic experiential exposure exercises are aimed at raising awareness of emotions, encouraging acceptance of emotional experience, and fostering regulatory strategies to generate adaptive courses for action related to core thematic issues. Each of these exercises is used to induce emotional arousal, increase understanding about the nature of these conflicts, and develop adaptive plans of action. The therapist will also use relational therapeutic techniques (see Safran & Muran, 2000), such as reflecting the patient's concerns and monitoring his or her own emotional reactions to the client to increase the client's understanding of how patterns of behavior may be reinforced in a given context. By the end of this phase, clients will have multiple opportunities to actively test their beliefs about emotional arousal, use their skills of somatic awareness and emotion regulation to address these concerns, and generate new courses of action based on the integration of cognitive, emotional, and contextual sources of information. A number of techniques are used to help clients experience feared emotional themes. Interventions range from more experientially-focused exercises aimed at increasing attendance to emotions to both cognitive-behavioral and affect-focused psychodynamic exercises aimed at addressing defensive and avoidant behavior. At the end of this vital phase, clients will use a number of these exercises to actively test beliefs about insecurity, utilize skills of somatic awareness and emotion regulation to address these concerns, and generate new courses of action based on the integration of cognitive, emotional, and contextual sources of information.

Since the goal of the experiential exposures is to evoke emotions related to feared themes, therapists and clients use interventions that are most appropriate to the client and the contexts being addressed. Thematic experiential exposures utilize a number of techniques in order to promote acceptance of subjective emotional experience. For instance, emotion evocation techniques such as "chair dialogues" (L. S. Greenberg, 2002) involve actively engaging conflicts with representations of significant others (i.e., "empty chair technique") or between two opposing needs (i.e., "two-chair dialogue"). Often core fear experiences are difficult to address because fear of loss of security is too strong. In this case, a thematic experiential exposure that could be useful is a modified two-chair dialogue in which the client would have a dialogue between the part of herself that strongly needs security and the part that is motivated towards self-reliance and exploration in order to gain a more unified approach to meeting needs (L. S. Greenberg, personal communication). This could be achieved through a dialogue that encourages the "catastrophiser" (the part of oneself that is motivated towards always feeling secure) to frighten the less established, self-reliant self with catastrophic expectations. This is done to both evoke the core fear in this newer self and to encourage this voice, while in this fearful experience, to begin

to standup to the catastrophes by challenging or opposing them.

Classic cognitive and behavioral techniques of exposure can also be utilized within an ERT framework. If clients have difficulty attending to their emotional experience or remain in a worried state without engaging emotional experience, a derivative of the "downward arrow" technique (Beck, 1995) can be used. In this technique, the therapist does not try to stop the client from worrying or evoke emotion directly. Rather, the therapist asks the client about the feared consequences of the worry. Once these consequences are delineated, the therapist continues to ask the client about the consequences that she or he fears would arise. This process is continued until the clients' emotional arousal increases and the client has moved closer to core underlying themes. Other techniques that are commonly used are imagery exercises and role-playing.

Experiential exposure exercises occur in the context of the ongoing therapeutic alliance. Clients must feel comfortable confronting these themes without initiating security behaviors (e.g., worry). The therapist uses the alliance to reflect the client's concerns and monitor his or her own emotional reactions to the client in order to increase the client's understanding of how patterns of behavior may be reinforced in a given context. The therapist also aids the client in remaining in the experiential exposure by utilizing a number of communication tactics including empathic reflection, Socratic questioning, interpretation, and direct challenging of the client's verbal statements as well as non-verbal behaviors (e.g., client sighs).

Progress review, future goals/relapse prevention, and termination processing

In this final phase of ERT, sessions are typically returned to weekly meetings in preparation for termination. Initial goals are reviewed to determine if changes has occurred as well as continuing to address ongoing difficulties. Client and therapist discuss how to apply skills and promote emotional acceptance once therapy is terminated. Discussion often focuses on preventing clients from returning to old coping mechanisms (excessive worry and behavioral avoidance) once therapy was terminated. Client and therapist discuss how skills of emotional understanding and regulation can continue to be utilized in responding to events and making decisions. Ability to tolerate possible future stressful and painful life circumstances is also further explored by reviewing skills and applying them to experiential exposure exercises that center on hypothetical situations related to core themes that may arise in the future. An open discussion of termination and "life after therapy" is also discussed between client and therapist in order to fully address feelings associated with termination and the loss of the therapeutic relationship.

Conclusions

Integrative approaches such as ERT might further our ability to treat GAD and other refractory anxiety disorders. A treatment that focuses on improving emotion regulation deficits may also help to enhance client's overall sense of well-being and life quality. However, the efficacy of integrative approaches will need to be empirically evaluated, particularly in comparison to existing interventions. Another important goal of future research in this area will be to study the process of change in integrative, emotion-focused treatments of anxiety disorders. For instance, it will be important to determine if therapeutic change (i.e., symptom reduction, improvements in functioning and quality of life) occurs as a function of increases in specific emotion regulation abilities. These questions can only be answered through an examination of both treatment outcome and process. In addition, it will also be valuable to determine when and if interventions aimed at changing emotional functioning are warranted.

Utilizing an integrative, emotion-focused, approach provides a promising, novel direction for understanding the psychopathology and treatment of GAD and other treatment-resistant anxiety disorders. On a more general level, functional viewpoints of emotions appear to be providing a unique bridge between historically divergent areas of clinical psychology. Even 10 years ago, it would be unlikely for clinicians solidly ensconced in one theoretical viewpoint to have the terminological base or desire to converse with clinicians practicing from a different school of thought. The understanding of emotions and their management may provide a common language for understanding psychopathological phenomena and treatment process.

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