Psychodynamic-Interpersonal Treatment of Generalized Anxiety Disorder

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Roemer and Orsillo's proposed integration of acceptance-based techniques with cognitive-behavioral treatments for generalized anxiety disorder (GAD) focuses on worry as a form of avoidance. In a psychodynamic-interpersonal approach to GAD, this avoidance is conceptualized in terms of defense mechanisms. The interpersonal determinants of the avoided feelings are addressed through formulation and interpretation of core conflictual relationship themes. Because GAD is a chronic, refractory disorder involving multiple elements, it is likely that treatment of GAD will ultimately necessitate therapist implementation of a broad array of techniques originating out of the cognitive, behavioral, interpersonal, psychodynamic, and acceptance literatures.

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Roemer and Orsillo (this issue) make a credible case for the integration of acceptance-based treatment techniques into cognitive-behavioral therapy (CBT) for generalized anxiety disorder (GAD). Only approximately 50% of GAD patients achieve clinically significant change with CBT (Chambless & Gillis, 1993), suggesting that additional treatment techniques need to be tested to improve response rates. The rationale for testing acceptance-based techniques rests primarily on Borkovec's (1994) conceptualization and on emerging empirical support (Borkovec & Roemer, 1995) suggesting that worry, the central feature of GAD, is a form of avoidance, distracting individuals with GAD from more emotionally upsetting topics and/or memories. This rationale, taken together with promising preliminary results of studies of acceptance-based treatments of other patient problems (Strosahl, Hayes, Bergan, & Romano, 1998), provides a strong justification for further development and testing of the integrated package described by Roemer and Orsillo. It should be noted that acceptance of feelings is already part of the Beck and Emery (1985) treatment approach that has been the basis for the majority of the randomized clinical trials of CBT for GAD (see Beck & Emery, 1985, pp. 233–239). Presumably, the Roemer and Orsillo approach extends beyond the acceptance-oriented techniques described by Beck and Emery (1985).

My colleagues and I have been developing and testing a psychodynamic-interpersonal treatment for GAD (Crits-Christoph, Connolly, Azarian, Crits-Christoph, & Shappell, 1996; Crits-Christoph, Crits-Christoph, Wolf-Palacio, Fichter, & Rudick, 1995). In this commentary I present the background for a psychodynamic perspective on GAD, followed by a summary of our supportive-expressive psychodynamic model and comparisons between our conceptualization and that offered by Roemer and Orsillo (this issue).

PSYCHODYNAMIC CONCEPTUALIZATION OF WORRY AND ANXIETY

In psychodynamic terms, the use of worry as a way to avoid thinking about other troubling issues would be labeled a defense mechanism. This notion can be traced historically to Freud's signal theory of anxiety (see Compton, 1972) that postulated that defenses are activated in order to avoid thinking about more difficult, conflictual, or traumatic events or feelings. In this signal theory, a small amount of anxiety from a perceived danger "signals" the ego to be alert to the threat. Defense mechanisms are activated to keep the threat out of awareness so that it does not become overly traumatic. Treatment focused on insight about the perceived danger, so that the patient can see that the danger is not as great as what he or she imagines. A direct comparison here is evident with acceptance-based treatment: removing the strategies used to avoid feelings allows for a reduction in anxiety.

However, psychodynamic perspectives on worry and anxiety have looked beyond the avoidance (defense) to other determinants of excessive levels of anxiety. In formulating theories of anxiety, a number of psychodynamic theorists focused on the impact of human interpersonal relations on psychological growth. Horney (1950), for example, suggested relationships that hindered psychological growth in children (e.g., caretakers who are dominating, overprotective, overexacting, indifferent, etc.) lead

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to a lack of confidence in self and others, which generates feelings of isolation and helplessness, leaving the child with a "basic anxiety." Sullivan (1953) articulated another interpersonal-psychodynamic theory of anxiety that postulated that anticipated disapproval from the primary caregiver early in life is a contributing factor. Other facets of early interpersonal experiences were highlighted by Fairbairn (1952), who emphasized the anxiety-producing conflict between the child's feelings of dependency on the primary caregiver and a fear of being engulfed and loss of identity, and Klein (1975), who linked anxiety to the infant's fear of not being able to evoke the primary caregiver when needed. In all of these models, internalized representations of self and others are activated later in life and impact ongoing interpersonal relationships and generate anxiety. Whether this general anxiety overlaps with the modern *DSM-IV* diagnosis of GAD is not clear. Nevertheless, these early theories informed our formulation of a brief, focal psychodynamic-interpersonal therapy for GAD. As mentioned by Roemer and Orsillo (this issue), Borkovec (1999) has also recently integrated strategies for modifying interpersonal problems into CBT for GAD.

SUPPORTIVE-EXPRESSIVE PSYCHODYNAMIC THERAPY OF GAD

The rationale for the development of an interpersonally oriented psychodynamic treatment for GAD was derived not only from the historical interest in anxiety within psychodynamic camps, but also from the emerging empirical literature suggesting a link between interpersonal factors and GAD. For example, Borkovec, Robinson, Pruzinsky, and DePree (1983) found that worry was associated with high levels of interpersonal concerns. Lichtenstein and Cassidy (1991) reported that, using retrospective recall methods, significantly more insecure attachment to primary caregivers was found in GAD subjects compared to non-GAD subjects. GAD subjects reported greater enmeshment and role reversal (i.e., the child taking on parental responsibilities), as well as greater preoccupying anger and oscillating feelings toward the caregiver. In addition, GAD subjects felt more rejected as children by the primary caregiver than did non-GAD subjects.

Drawing on the above historical psychodynamic literature on defenses and early developmental factors in anxiety, together with recent studies on worry as avoidance and interpersonal factors in GAD, our supportive-expressive (SE) model of GAD hypothesizes that a set of dangerous or traumatic interpersonal experiences leads to a set of basic wishes/desires, expectations, beliefs, and feelings about oneself and other people. Typically, these wishes/desires involve obtaining love, stability, or protection from others and are connected to fears that others may abandon, abuse, disappoint, or criticize. The anxiety connected to these interpersonal desires and beliefs is strong—so strong that the person with GAD avoids thinking about the desires, feelings, and memories that have contributed to the fears. One way of avoiding thinking about these desires, feelings, and memories is to become overly cognitively concerned (worried) with certain current events in life. Unlike classical psychoanalytic theory, our SE model does not restrict the development of GAD to early childhood events. Interpersonal traumas and stresses can occur at any phase of life, although a prolonged period of insecure attachment during childhood is likely to generate rather powerful expectations about others that continue into adulthood.

Once established, the set of interpersonal desires, beliefs, and feelings become part of cyclical feedback systems by recreating the type of perceived circumstances that originally generated anxiety. The SE model operationalizes these repetitive, cyclical relationship patterns in terms of the core conflictual relationship theme (CCRT), which consists of three components: the wish or desire, the perceived or expected response from the other person, and the response of the self. The primary expressive (exploratory) task of the therapist in SE treatment is to formulate a CCRT for each patient and use this formulation to guide interventions. The primary supportive task of the therapist in SE treatment is to establish and maintain a positive therapeutic alliance.

Within this model, the anxiety in GAD has multiple sources. Most basic is the persistent fear of not obtaining what one needs in relationships. The worry component of anxiety, as mentioned, is assumed to be a defensive response. Other anxiety symptoms, such as somatic symptoms, can also be a defensive response (i.e., focus on bodily symptoms as a way of avoiding emotions). Life events also add "realistic" anxiety at times to the mix of fears and defenses that are being brought from past relationships into current relationships.

Summarizing, our SE model has several overlapping features to the integrated acceptance-based approach proposed by Roemer and Orsillo (this issue). Most notably is the conceptualization of worry as avoidance (defense). As

mentioned, a focus on interpersonal patterns, the main element of SE treatment, has also been integrated into CBT (Borkovec, 1999). To the extent that such interpersonal patterns are not part of the treatment focus within the Roemer and Orsillo model, this represents a significant point of departure of the models.

But assuming an interpersonal element is captured in the Roemer and Orsillo (this issue) model, or could be easily added based upon Borkovec's modification of CBT for GAD, what are the differences in treatment methods between an integrated CBT package that incorporates a focus on both cognitive avoidance and interpersonal issues and our brief, focal SE psychodynamic treatment? To a large extent, the differences reduce to an issue of emphasis. Within the context of a brief (e.g., 12–20 session) treatment, only so much time can be devoted to discussion of interpersonal issues within a CBT treatment that might also involve setting a session agenda, teaching relaxation skills, monitoring automatic thoughts, examining evidence for patient's beliefs, generating alternative interpretations, and other CBT and acceptance-oriented techniques.

In typical psychodynamic therapy, and in our SE therapy in particular, the assumption is that extensive amount of therapy session time is needed to allow patients to recount their interpersonal experiences in detail—their memories, feelings, and understandings of the events that transpired between people. The unfolding of this material is thought to be best accomplished at the patient's pace, although the therapist remains relatively active within a brief therapy model and encourages the elicitation of specific narratives about interactions with other people. In general, however, the process of SE therapy is less structured than CBT.

In addition, the therapist within SE is less directive compared to CBT. Traditional psychoanalytic therapy would avoid directive techniques almost completely based on the concern that the use of such techniques would confound the therapeutic relationship, making it difficult to sort out patient transference reactions to the therapist from an authority figure role that has been created. SE therapy has a greater tolerance for some degree of integration of directive techniques and moves away from the "blank screen" stereotype of psychoanalytic therapy. Nevertheless, once a patient is placed in an ongoing passive role as a function of being taught several different skills (e.g., relaxation therapy, mindfulness exercises, monitoring techniques, problem-solving methods) and a large amount of psychoeducational material over many sessions, some patients may not view therapy as a place to discuss their ongoing interpersonal dilemmas that are causing distress. If a balance can be achieved between the didactic and skills teaching elements and the elicitation and discussion of interpersonal material, this concern would be lessened.

ACCEPTANCE OF PSYCHODYNAMIC CONTRIBUTIONS

Given the conceptual overlap between psychodynamic models and evolving cognitive-behavioral models of GAD, it is noteworthy that there appears to be little interest among cognitive-behaviorists in recognizing or discussing this overlap. Borrowing from the concepts of acceptance therapy, I can hypothesize that there are frequently learned negative emotions connected to a psychodynamic perspective. Despite the accumulation of numerous clinical trials demonstrating the efficacy of brief dynamic therapy (see meta-analysis by Anderson & Lambert, 1999), psychodynamic theories and therapies, often equated erroneously with psychoanalysis, are associated with a nonscientific orientation, and psychodynamic therapy becomes something to avoid. For example, in discussing the role of forms of acceptance in a variety of treatments, Hayes, Wilson, Gifford, Follette, and Strosahl (1996) displayed an openness to how acceptance cuts across different theoretical orientations, but also used the type of subtle negative language, the effects of which are so well described within the acceptance therapy model, to characterize noncognitive behavioral approaches:

Interestingly, many of the less empirically oriented treatment strategies have long emphasized forms of acceptance from psychoanalysis . . . to logotherapy . . . to Alcoholics Anonymous. . . . Some empirical clinicians may be worried by this overlap between the more and less empirical sides of psychology, but it could be very healthy for the field if dimensions can be found that cross these boundaries without a loss in scientific integrity. (p. 1163)

I commend Hayes et al. (1996) and others who are willing to no longer avoid the rich clinical and fledgling empirical literature on psychodynamic therapy. As an empirical clinician who draws from the psychodynamic research and clinical literature, I would like to provide some reassurance that crossing these boundaries won't necessarily lead to one's loss of scientific integrity, and the expected nega-

tive reactions from colleagues that I presume is connected to this step.

GAD is refractory disorder not well treated by either current psychosocial or psychopharmacological methods. Patients with GAD present with a variety of symptom patterns, life stresses, coping styles, and interpersonal concerns. Although some commonalities might be found in GAD patients across these domains, to achieve high levels of treatment success, clinicians need to be prepared to address the diversity that is apparent across individuals as well. It may be that different GAD theorists and investigators have been chipping away at isolated aspects of this diversity. Ultimately, a treatment package that flexibly integrates across cognitive, behavioral, psychodyamic/interpersonal, and acceptance-based models may be needed, or a method developed for determining whether to focus treatment in one domain or the other.

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REFERENCES

Anderson, E., & Lambert, M. (1995). Short-term dynamically oriented psychotherapy: A review and meta-analysis. *Clinical Psychology Review, 15,* 503–514.

Beck, A. T., & Emery, G. (1985). *Anxiety disorders and phobias: A cognitive perspective*. New York: Basic Books.

Borkovec, T. D. (1994). The nature, functions, and origins of worry. In G. Davey & F. Tallis (Eds.), *Worrying: Perspectives on theory, assessment, and treatment* (pp. 5–33). Sussex, UK: Wiley.

Borkovec, T. D. (1999, June). *The nature and psychosocial treatment of generalized anxiety disorder.* Paper presented at the annual meeting of the American Psychological Society, Denver, CO.

Borkovec, T. D., Robinson, E., Pruzinsky T., & DePree, J. A. (1983). Preliminary exploration of worry: Some 39 characteristics and processes. *Behavior Research and Therapy, 21,* 9–16.

Borkovec, T. D., & Roemer, L. (1995). Perceived functions of worry among generalized anxiety disorder subjects: distraction from more emotionally distressing topics? *Journal of Behavior Therapy & Experimental Psychiatry, 26,* 25–30.

Chambless, D. L., & Gillis, M. M. (1993). Cognitive therapy of anxiety disorders. *Journal of Consulting and Clinical Psychology, 61,* 248–60.

Compton, A. (1972). A study of the psychoanalytic theory of anxiety: I. The development of Freud's theory of anxiety. *Journal of the American Psychoanalytic Association, 20,* 3–44.

Crits-Christoph, P., Connolly, M. B., Azarian, K., Crits-Christoph, K., & Shappell, S. (1996). An open trial of brief supportive-expressive psychotherapy in the treatment of generalized anxiety disorder. *Psychotherapy, 33,* 418–430.

Crits-Christoph, P., Crits-Christoph, K., Wolf-Palacio, D., Fichter, M., & Rudick, D. (1995). Supportive-expressive dynamic psychotherapy for generalized anxiety disorder. In J. P. Barber & P. Crits-Christoph (Eds.), *Dynamic Therapies for Psychiatric Disorders: Axis I* (pp. 43–83). New York: Basic Books.

Fairbairn, W. R. D. (1952). *An object-relations theory of the personality.* New York: Basic Books.

Hayes, S. C., Wilson, K. G., Gifford, E. V., Follette, V. M., & Strosahl, K. (1996). Experiential avoidance and behavioral disorders: A functional dimensional approach to diagnosis and treatment. *Journal of Consulting and Clinical Psychology, 64,* 1152–1168.

Horney, K. (1950). *Neurosis and human growth: The struggle toward self-realization*. New York: Norton.

Klein, M. (1975). *Love, guilt, and reparation and other works 1921–1945.* New York: Delacorte Press/Seymour Lawrence.

Lichtenstein, J., & Cassidy, J. (1991, April). *The inventory of adult attachment (INVAA): Validation of a new measure*. Paper presented at the Society for Research in Child Development, Seattle.

Strosahl, K. D., Hayes, S. C., Bergan, J., & Romano, P. (1998). Assessing the field effectiveness of Acceptance and Commitment Therapy: An example of the manipulated training research method. *Behavior Therapy, 29,* 35–64.

Sullivan, H. S. (1953). *The interpersonal theory of psychiatry.* New York: Norton.

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