

CHAPTER 2

EMOTION AND THE ACCEPTANCE-BASED APPROACHES TO THE ANXIETY DISORDERS

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Recent years have seen an eruption of interest and subsequent research on what are now being termed, acceptance-based behavioral treatments (Orsillo, Roemer, & Holowka, 2005). Approaches such as dialectical behavior therapy (DBT; Linehan, 1993a), acceptance and commitment therapy (ACT; S. C. Hayes, Strosahl, & Wilson, 1999), and mindfulness-based cognitive therapy (MBCT; Segal, Williams, & Teasdale, 2002) have expanded the boundaries of the cognitive-behavioral paradigm considerably. These approaches have offered novel solutions to vexing problems (e.g., relapse, poor outcome in functionality, and life satisfaction) in personality disorders (Linehan, 1993a), depression (Segal et al. 2002), and, particularly, anxiety disorders (Eifert & Forsyth, 2005; S. C. Hayes et al., 1999; Roemer & Orsillo, 2005). Cognitive-behavioral approaches to the anxiety disorders have historically demonstrated considerable efficacy (see Chambless & Gillis, 1993), but it has become increasingly clear that for more complex, chronic, and refractory presentations of these conditions, further intervention may be required to instill a lasting sense of change, functionality, and life satisfaction (Newman, 2000).

A significant common thread in the acceptance-based approaches may be the notion that a flexible approach to one's experiences brings with it a sense of health and well-being, even when sometimes those experiences are painful. Indeed, the unwillingness to stay in contact with certain aspects of experience (i.e., *experiential avoidance*; Hayes et al., 1999) and rigidity and pejorative judgment in responses to these experiences (as opposed to a state of *mindfulness*; Kabat-Zinn, 1990) have been proposed to be key factors in the maintenance of emotional dysfunction. Implicit in the acceptance-based conceptualizations of health and disorder is the notion that experiences characterized by strong emotions often challenge an individual's sense of efficacy in responding to internal and external stimuli (as would be expected by life's challenges). However, psychopathology occurs when individuals further their problems by attempting to avoid this emotional pain.

Thus, emotion is not purely detrimental in these approaches and is often seen as an important aspect of effective, healthy functioning. This inclusion of emotion factors in both the understanding of psychological disorders and the process of treatment is novel and contrasts with traditional cognitive-behavioral approaches, which often downplayed the role of emotion factors in functionality (Greenberg & Safran, 1987). Although slower to emerge in the clinical psychological literature, the importance of emotion has been embraced within numerous fields of psychology, including development (e.g., Eisenberg, Fabes, Guthrie, & Reiser, 2000), cognition (e.g., Gray, in press), social interaction (e.g., Lopes, Brackett, Nezlek, Schütz, Sellin, & Salovey, 2004), abilities and expertise (e.g., Mayer, Caruso, & Salovey, 1999), and neurobiological function (e.g., LeDoux, 1995).

These investigators have drawn from emotion theory (see Ekman & Davidson, 1994, for a discussion), which holds that emotions are not solely disruptive entities that impede functioning and success. Rather, these theorists define emotion as adaptive, goal-defining aspects of experience that help aid in decision making concerning movement toward or away from particular actions or plans (e.g., Frijda, 1986). In addition, the manner in which individuals are able to manage emotional experience to conform adaptively to a given context may also be important to mental health (Gross & Muñoz, 1995).

Although acceptance-based approaches have incorporated emotions in their conceptualizations of health and well-being, the functional value of emotions and the role of regulation are not always explicitly stated (but see Linehan, 1993b). Further, the evocation of emotion within the therapeutic context is also not consistently incorporated. In contrast, experiential therapies based on the historical traditions of client-centered, gestalt, and existential therapies have explicitly incorporated a functional view

of emotions and the need for their evocation as a central component of their interventions (see Greenberg & Van Balen, 1998). However, these approaches have traditionally not been as committed to empiricism. More recently (e.g., Greenberg, 2002), the experiential paradigm has strengthened connections to basic and applied research endeavors and is more focused on matching particular interventions to specific problem areas. As a result, these experiential approaches may have increasing relevance for acceptance-based approaches to the anxiety disorders.

Acceptance-based behavioral approaches may be further enhanced by their explicit incorporation of emotion theory, basic research on emotions, attention to the role of emotions in psychopathology, and emotion-focused interventions that effectively elicit emotional states capable of being addressed within a therapeutic context. This chapter aims to (1) illustrate the relevance of basic research on emotion to clinical psychological endeavors; (2) argue for the importance of examining different facets of disruption and dysregulation in emotions as central factors in the anxiety disorders; and (3) review how the traditions of cognitive-behavioral and experiential orientations have evolved into the increasingly congruent approaches of acceptance-based behavioral approaches and emotion-focused therapy, respectively; and (4) demonstrate how this convergence, lessons from basic affective sciences and the nexus between emotions and psychopathology can inform acceptance-based behavioral treatments for anxiety disorders.

EMOTIONS AND THEIR REGULATION

Conceptual and biological theories underlying basic affective sciences argue that emotion is not a passive entity but, rather, an integral component of activating, shaping, and processing experience. It both contributes to and is affected by cognitive and behavioral systems. Contemporary approaches suggest that the key to the functions of emotion may lie in its adaptive value. Frijda (1986) argues that emotions are cues for readiness for action that work to establish, maintain, or disrupt a relationship with particular internal and external environments that signify importance to the person. This is not a drive-like response but, instead, represents a stimulus-sensitive behavioral potential to act (Greenberg, 2002).

Emotion serves an information function to notify individuals of the relevance of their concerns, needs, or goals in a given moment. In this manner, motivation and personal goal attainment are essential aspects of the function of emotions. Goals can be both innate (e.g., attachment, self-protection) and learned (e.g., specific beliefs about how to obtain relatedness or financial security) in origin (Greenberg & Safran, 1987). As a result

of these conceptualizations, some theorists have argued that emotional and motivational systems should be viewed as unitary (e.g., Lang, Bradley, & Cuthbert, 1998). In the moment, emotions can give immediate salience to goals such that a given course of action can be deemed appropriate. In addition, emotions can give the motivational force to translate this potential for action into movement (Greenberg & Safran, 1987). Efran, Lukens, and Lukens (1990) explain that, because 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.

Emotions are also adaptive because they serve a communication function. Facial expressions are clear indicators of emotional experience (Ekman, 1993). The expression of emotion, especially in facial expression, may aid individuals in understanding their own emotions (Ekman, 1993). In addition, research has supported the role of emotions as social signals (Campos, Mumme, Kermoian, & Campos, 1994). Expression of emotion has also been found to be tension relieving (Pennebaker, 1993) and essential to emotional and physical health (Kennedy-Moore & Watson, 1999). Pennebaker and colleagues have shown the ameliorative effects of emotional disclosure on autonomic nervous system activity, immune functioning, and physical and emotional health (e.g., Pennebaker, 1993). Campos and colleagues (1994) have also illustrated the importance of conceptualizing emotion in a relational context. They explain that emotions can provide signals for others to maintain or change their behavior.

Frijda (1986, p. 401) explains that “people not only have emotions, they also handle them.” Emotion regulation, as a field of study, examines how individuals influence, control, experience, and express their emotions (Gross, 1998). Related constructs such as *mood regulation* (Parkinson, Totterdell, Briner, & Reynolds, 1996) and *affect regulation* (G. J. Taylor, Bagby, Parker, & Alexander 1997; Westen, Muderrisoglu, Fowler, Shedler, & Koren, 1997) encompass similar definitions (but see Ekman & Davidson, 1994, for a discussion of the differences between emotion, affect, and mood). Emotion regulation was first addressed in the developmental literature (e.g., Campos et al, 1994) but has also been examined in adults (e.g., Gross, 1998). More recently, investigators in both the developmental and adulthood emotion regulation fields have jointly presented this construct in a life-span perspective (e.g., Levenson & Izard, 1999).

Historically, the term *emotion regulation* has often been construed as denoting the reduction or control of emotion. However, more contemporary definitions of emotion regulation recognize that many control efforts are dysregulatory and that the allowance and accentuation of emotion can also be regulatory. Thompson (1990) has stressed the importance of not only

restraint of emotion but also its maintenance and enhancement. Needs to diminish emotional arousal in order to work effectively or contain one's anger in a public setting are aspects of emotion regulation. However, investigators have more recently argued for the importance of accentuating both *positive and negative* emotional experiences to gain a greater understanding of motivation and goal pursuit (see Bonnano, 2001). For example, a person who is feeling "numb" may listen to a sad piece of music to help identify his or her feelings and become "unstuck." In addition, communication with others is often encouraged when one feels negatively in order to "work through" these emotions. It may also be more adaptive when one is in a "bad mood" with no clear precipitant to not attempt to control this experience but rather to allow its presence and let emotional experiences shift more naturally as a regulatory action. This broader view of emotion regulation as incorporating the allowance and benefit of emotional experience is quite consistent with acceptance-based approaches.

Effective regulation of emotions can involve regulation of emotions by an external regulator *or* the regulation of an external source *by* emotion (Dodge and Garber, 1991). Essential to the definition of emotion regulation is that activity in a given response domain may serve to magnify or modulate activation in another response domain. From this notion, it may be assumed that emotion regulation is both regulated by and is a regulator of other processes such as cognition. Cicchetti, Ackerman, and Izard (1995) have stressed that a central component of emotion regulation is the intercoordination of the emotions and cognitive systems. Gross (1998), citing Solomon (1976), likens emotion regulation to a harmonious relationship between reason and the passions. In this manner, cognition about emotion is essential to the regulation of emotion. However, emotional regulation also describes the ability for the cognitive system to gain information from the emotion system (Cicchetti et al., 1995).

Recent explorations of the biological underpinnings of emotion have illustrated the need for such a view (e.g., Damasio, 1994; Davidson, Jackson, & Kalin, 2000; LeDoux, 1996). This research has shown a relational interdependence of emotion and cognition through depiction of multiple connections between limbic cortices and the neocortex. These connections include pathways originating in the thalamus and extending to the amygdala that may demonstrate early processing to signal emotional response. In addition, the amygdala has pathways to the neocortex, which suggests that emotional responses can signal higher order cognitive processing as well as modulate sensory activity. Finally, the neocortex has been found to have fibers leading back to the amygdala that could be interpreted as cognitive feedback to further influence the emotional response. Damasio (1994) explains the importance of such cognitive-emotional findings. He

states that emotional input provides a unique contribution to reason such that what we consider to be “rationality” could not exist without such an influence.

Recent models of the beneficial role of emotions have stressed that individuals differ in their ability to utilize emotions effectively. Salovey, Mayer, and colleagues (e.g., Mayer, Salovey, Caruso, in press) theorize that people differ in their ability to attend to, process, and act as a result of their emotions, which they have called *emotional intelligence*. Emotional intelligence may be demonstrated at four different levels: (1) perception, appraisal, and expression of emotion; (2) emotion’s facilitative effect on thinking; (3) understanding and analyzing emotions/employing emotional knowledge; and (4) reflective regulation of emotions to promote emotional and intellectual growth. Thus, someone who is able to recognize emotion experiences, understand their meaning, utilize their informational value, and manage this experience according to contextual demands would be expected to respond more effectively to life’s demands. Research supports the benefits of emotional intelligence and implicates the fourth regulatory factor as being central to functional outcome (e.g., Lopes et al., 2004).

FUNCTIONAL EMOTIONS AND THE ANXIETY DISORDERS

If high levels of emotion regulation are associated with productivity and positive emotional health, then low levels of emotion regulation should have the converse effect. Cicchetti et al. (1995) divide emotional regulation problems into two categories. The first involves difficulties in modulation of emotional experience and/or expression; the second involves frequent or automatic attempts to control or suppress emotional experience or expression. In the first scenario, the person experiences emotions with great intensity but is unable to adequately modulate the experience (e.g., self-soothe, inhibit emotional expression). In the second scenario, the person engages in control strategies in an effort to prevent emotion from being experienced. One way in which this may occur is that the person may attend to cognitive information at the expense of emotional experience. By decreasing attention to emotional experience, emotion is avoided or blunted, thereby reducing ability to benefit from its possible information value. Thus, modulation of emotion can be effective in certain contexts but not all forms of management are adaptive (e.g., attempts to control, constrain, or suppress emotion in order to avoid this experience). Berenbaum, Raghavan, Le, Vernon, and Gomez (2003) propose a similar dichotomy in their discussion of two emotional regulation disturbances, which they term *emotional hyperreactivity* and *hyporeactivity*. These characteristics of emotional

dysregulation can be conceptualized as the antitheses of emotional intelligence.

The relationship of emotional deficits and dysregulation with psychopathology has received increasing attention (e.g., Berenbaum et al., 2003; Gross & Muñoz, 1995; Kring & Bachorowski, 1999). However, little is known regarding the specific nature of the maladaptive emotional experiences that may underlie these disorders. 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 anxiety and mood disorders. 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.

In a multisample factor analytic study, we have obtained a solution that confirms these four factors from a number of commonly used measures of emotional ability and dysfunction (Holaway, Mennin, Fresco, & Heimberg, 2004). Exploratory and confirmatory factor analytic methods corroborated this four-factor model. Further, these four factors correspond quite well as antitheses to the emotional intelligence abilities described by Salovey and colleagues (Mayer et al., *in press*) above. Moreover, these four factors were found to have unique patterns of prediction to generalized anxiety disorder (GAD), social anxiety disorder (SAD), and depression. All psychopathologies showed a relationship with at least one of the components of the model but only GAD demonstrated a relationship with all four factors (Holaway et al., 2004). Similarly, a composite variable encompassing these four factors has been found to contribute to the prediction of GAD beyond the predictive contributions of worry, anxiety, and depression (Mennin, Heimberg, Turk, & Fresco, *in press*).

Following the theoretical approaches of Thompson (1990) and Gross (1998), Rottenberg and Gross (2003) caution that, when looking at the relationship between emotion dysregulation and psychopathology, investigators need to recognize that regulation occurs dynamically throughout different points in the emotion-generative process. As such, it may be that the four factors of the emotion dysregulation model are related in a rapid temporal manner. Although the temporal relationship among these factors has not yet been substantiated by research, one might hypothesize that individuals with certain anxiety disorders may frequently experience strong negative affect and have emotional reactions that occur intensely, easily, and quickly (i.e., heightened emotional intensity). These individuals may react strongly to situations that are not evocative to most other people. A number of anxiety psychopathologies may also involve a difficulty in

identifying primary emotions such as anger, sadness, fear, disgust, and joy and instead experience their emotions as undifferentiated, confusing, and overwhelming (i.e., poor understanding of emotions), particularly when these individuals are in the midst of an intense emotional state. Given strong emotional responses and a poor understanding of them, anxious individuals may experience emotions as aversive and become anxious when they occur (i.e., negative reactivity to emotions). Associated reactions may include rigid hypervigilance or avoidance of threatening information and activation of negative beliefs about emotions. Finally, given this aversive state, individuals with anxiety disorders might attempt to manage their emotional responses. However, these individuals may have difficulty knowing when or how to enhance or diminish their emotional experience in a manner that is appropriate to the environmental context (i.e., maladaptive emotional management). For instance, one may need to contain one's feelings of inadequacy due to a co-worker's comments during a business meeting but in a different context, such as a romantic relationship, discussion of feeling hurt may be beneficial.

Specific findings in the anxiety disorders support aspects of this emotion dysregulation model, although the temporal unfolding described above has not been examined yet. Mennin and colleagues (in press, Studies 1 & 2) found that individuals with GAD rated their emotional experiences as significantly more intense than other individuals. This factor appears to be more specific to GAD as it has differentiated individuals with GAD from those with other anxiety disorders such as SAD (Turk, Heimberg, Luterek, Mennin, & Fresco, 2005) and obsessive compulsive disorder (OCD; Holaway & Heimberg, 2003).

Consistent with the notion in the model that individuals with anxiety disorders have poor understanding of their emotions, individuals with either GAD or SAD have reported more difficulty than control participants in identifying, describing, and clarifying the motivational content of emotions than controls (Mennin et al., in press; Studies 1 & 2; Turk et al., 2005). 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). Deficits in emotional understanding have also been reported in a number of other anxiety disorders such as panic disorder (Parker, Taylor, Bagby, & Acklin, 1993) and childhood sexual abuse-related posttraumatic stress disorder (PTSD; Cloitre, Scarvalone, & Difede, 1997). Understanding one's emotions predicts active coping and positive attributions (Gohm & Clore, 2002). In addition, firefighter trainees who reported greater clarity of their emotions were more able to effectively manage a series of live-fire exercises (evidenced by clearer thinking and fewer instances of "blanking out")

than those with lower levels of clarity (Gohm, Baumann, & Sniezek, 2001). Finally, Feldman-Barrett, Gross, Conner Christensen, and Benvenuto (2001) found that individuals were more likely to effectively regulate their intense emotional experiences when they could differentiate the emotions being experienced.

The third component of this emotion regulation model, that individuals with anxiety disorders may react negatively to their emotions with fear and anxiety, has been demonstrated in a number of studies. Leahy (2002) found that both depression and anxiety were associated with viewing one's emotions as incomprehensible, uncontrollable, different than others' emotions, and characterized by guilt. However, whereas depression was more associated with expectations of long mood duration, anxiety was more likely to be associated with lack of acceptance of emotions. Chambless and colleagues have extended the construct of anxiety sensitivity (see S. Taylor, 1999, for a review) to address not only fear of anxiety but also a more generalized tendency to fear emotions (including fear of anxiety, sadness, anger, and positive emotions) and have associated this reactivity to emotions to panic (Williams, Chambless, & Ahrens, 1997; Berg, Shapiro, Chambless, & Ahrens, 1998). Individuals with GAD have 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). Persons with GAD also reported greater fear of sadness than persons with SAD (Turk et al., 2005), and fear of negative emotions was significantly and uniquely associated with severity of GAD, controlling for degree of worry (Roemer, Salters, Raffa, & Orsillo, 2005). Further, negative reactivity to one's emotions, measured 3 months after the events of September 11, 2001, mediated the relationship between GAD (measured September 10, 2001) and increases in anxiety/mood symptoms and functional impairment 1 year later in young adults directly exposed to the World Trade Center collapse (Farach, Mennin, Smith, & Mandelbaum, 2005).

The final component of the emotion regulation model involves maladaptive regulatory responses including both difficulties in managing emotional experiences and the usage of control strategies to avoid emotions (Cicchetti et al., 1995). Individuals with GAD have difficulty soothing themselves following a negative mood. In particular, they demonstrated lower trait (Mennin et al., in press; Studies 1 & 2) and state levels (following an experimental mood induction; Mennin et al., in press; Study 3) of returning negative moods to a euthymic baseline state than controls. There are numerous strategies for managing emotional experiences (Parkinson et al., 1996), with some being more adaptive to a given context and some inevitably leading to greater dysfunction. Given their high level of emotional

intensity, difficulty understanding, and reactivity to emotions, individuals with GAD, if unable to soothe negative moods, may turn to a number of maladaptive methods for managing aversively perceived emotional experiences.

Maladaptive management is likely not specific to GAD, however. Indeed, individuals with SAD endorsed a similar level of poor ability to manage emotions as did individuals with GAD (Turk et al., 2005). Future research will be necessary to determine if there are specific microbehavioral differences that may distinguish disorders even though poor emotional management is likely to be a general factor in many forms of psychopathology.

More work is clearly necessary to determine exactly how these factors relate to each other. They may occur in the temporal manner hypothesized by this emotion dysregulation model. However, it is likely also possible that poor management of emotions increases emotional intensity. Indeed, attempts to suppress or avoid emotions have been found to increase emotional intensity (e.g., Gross & Levenson, 1997). One compelling study (Lynch, Robins, Morse, & MorKrause, 2001) has examined the relationship between heightened emotional intensity and dysregulation in both clinical and nonclinical samples. In particular, these investigators examined affect intensity and emotional inhibition (in particular, maladaptive management strategies of thought and expressive suppression) in distress levels (i.e., hopelessness and depressive symptoms). Using structural equation modeling, emotional inhibition was found to mediate the relationship between affect intensity and psychological distress in both samples. The authors concluded that emotional inhibition may be a particularly negative management strategy that leads to dysfunction, especially when emotions are experienced intensely. This study provides an elegant example of how dysfunctional emotional processes may begin at one point of a spectrum (i.e., intense emotional experience) but lead to another point (i.e., inhibition of emotion). Likely, this is a feedback loop and causes subsequent increases in intensity, as well. From this viewpoint, dysregulation arises from a lack of homeostasis rather than dysfunction in one particular component in isolation from other processes. This conceptualization of dysregulation is quite consistent with an acceptance-based approach that would implicate control efforts as leading to increases in the unpleasant intensification of anxiety and other emotions.

EVOLVING THERAPEUTIC APPROACHES TO EMOTION

A functional account of emotions and their regulation may also have implications for treatment. The evolution of traditional behavioral and cognitive

approaches to acceptance-based models represents a unique period in clinical psychology for not only the incorporation of a more central role for emotion but also for the integration of other intervention approaches that have traditionally comprised emotion elements. This section reviews the historical development of views of emotion from the more traditional cognitive-behavioral approaches to the acceptance-based behavioral approaches. Further, experiential interventions are reviewed as this treatment paradigm has typically utilized functional viewpoints of emotion and has more recently been developed in a manner that is increasingly congruent with behavioral approaches.

Acceptance-based models that stress the importance of the allowance of emotional experience may be further strengthened by the explicit incorporation of the functional role of emotions, the view of acceptance as congruent with a regulatory approach (utilizing a wider view of regulation including elevating, diminishing, and allowing emotions), and the need for in session evocation of emotion to focus on phenomenologically relevant emotional patterns that are difficult to address through typical verbal methods. To this end, an integrative approach is suggested that can be incorporated into acceptance-based approaches and an example of such a treatment for anxiety disorders is provided.

TRADITIONAL COGNITIVE-BEHAVIORAL PERSPECTIVE

Cognitive-behavioral conceptualizations have historically underplayed the importance of emotion variables (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, Drozd, & Shapiro, 1997). The marginalization of emotion in this approach has its origins in the early behaviorist tradition. Behaviorists originally sought to understand human behavior solely through the examination of observable data. Watson and Skinner considered emotions to be disruptive biological responses and inaccessible to observation and control (Samoilov & Greenberg, 2000). 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).

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 that "'emotions' are excellent examples of the fictional causes to which we commonly attribute behavior" (p. 160). As a result of this belief, Skinner sought to redefine emotion in an operant conditioning framework. Holland and Skinner (1961) argued that mental disorders arise as a result of environmental events that

serve to reinforce maladaptive actions. Certain external operants, Skinner argued, were more likely to increase the probability of emission of “emotional” behavior. Power and Dalgleish (1997) point out the circularity in this view of emotion. They give the example of a person afraid of a bear. They explain that Skinner’s theory would require that a fearful event involving a bear be present for the person to be afraid. However, they question how the bear can be considered a fearful stimulus. They state that “Skinner must resort to saying that it is a fearful event because it gives rise to fear and therein lies the circularity of the Skinnerian theory of emotions” (p. 36). Furthermore, Lyons (1980) points out that some emotions do not typically exhibit external operant properties (e.g., grief).

Following early theorizing, some behaviorists began to argue for the importance of emotions. The noted behaviorist, Mowrer (1960) stated, “The emotions are of quite extraordinary importance in the total economy of living organisms and do not deserve being put into opposition with ‘intelligence.’ The emotions are, it seems, themselves a high order of intelligence” (p. 308). Other behavioral theorists attempted to combine learning theory with notions of drive that included emotional phenomena (e.g., Dollard & Miller, 1950). These positions were often criticized for incorporating psychoanalytic concepts into a learning framework. However, some behavior theorists did eventually incorporate internal processes into their formulations (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 1950s (e.g., Neisser, 1967). The information processing framework emphasized cognitive phenomena through delineation of an information processing system. 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, & Greenberg, 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 (Greenberg & Safran, 1987). Fancher (1995) argues that cognitively oriented theorists do not ignore emotion. Rather, he explains that cognitions in cognitive-behavioral practice are only examined as they relate to emotional phenomena. So, in this sense, emotion is essential to a cognitive-behavioral approach.

In foundational 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 by autonomic or “physiological” components (e.g., rapid heart beat, shortness of breath). 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, extended 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. Although many cognitive-behavioral interventions for anxiety disorders discuss the adaptive value of emotions in psychoeducational components early in treatment, the active ingredients of treatment often still characterize emotion in disruptive terms. Further, other emotions besides anxiety are not typically considered to be integral to understanding and treating anxiety disorders.

Although some investigators have questioned examining factors beyond cognition (e.g., Alloy, 1991), emotion in cognitive-behavioral theory has recently been increasingly brought to the forefront. Barlow (2002) has developed a perspective on anxiety and mood disorders that is based on emotion theory. He explains that these disorders are primarily *emotional disorders* and, as such, involve dysfunction in emotional processes, not limited solely to anxiety or fear. He cites a number of empirical investigations that have examined the hierarchical structure of anxiety and mood pathology. Investigators such as Clark and Watson (1991), Brown, Chorpita, and Barlow (1998), and Zinbarg and Barlow (1996) have shown that a higher order factor of negative affect is common to anxiety and mood symptomatology. Further, behavioral accounts of anxiety disorders have also begun to incorporate the importance of emotions as automatic, interoceptive cues to fear (Bouton, Mineka, & Barlow, 2001). Friman, Hayes, and Wilson (1998) have argued that anxiety and emotions, in general, as concepts should not be avoided by radical behavior analytic theorists solely because of difficulties in operational definition. Rather, they need to be studied as they are central to the experience of humans but, according to a modern behavioral framework, need to be understood as they relate to our actions to master, control, or accentuate these internal events rather than as instigating entities in themselves.

ACCEPTANCE-BASED BEHAVIORAL PERSPECTIVES

A number of recent cognitive and behavioral interventions have begun to emphasize emotional phenomena. Acceptance-based behavioral approaches have been at the forefront of this movement (Cordova,

Jacobson, & Christensen, 1998; S. C. Hayes et al., 1999; Kohlenberg & Tsai, 1991; Linehan, 1993a; Segal et al., 2002). These approaches share a focus on the allowance of emotional experiences, even those that are negative or painful. DBT (Linehan, 1993a), MBCT (Segal et al., 2002), and ACT (S. C. Hayes et al., 1999) are some of the most popular acceptance-based approaches and have clear implications for the anxiety disorders. Indeed, treatments that integrate these different acceptance-based approaches have demonstrated initial efficacy for GAD (Roemer & Orsillo, 2005).

DBT has been widely accepted and is considered a first-line treatment for borderline personality disorder. The treatment involves both group-based skills training and individual sessions wherein these skills are applied to address patient's ongoing conflicts. Following an orientation phase that involves education about the disorder and building the therapeutic relationship, there are four stages to DBT intervention. The first stage targets crisis-oriented and other problematic behaviors such as suicidal acts, parasuicidal behaviors, and substance use. This stage also involves behavioral management skills training that focus on mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. The second stage encourages the patient to utilize these skills during exposure exercises aimed at confronting difficult and traumatic life experiences. The third stage involves patients learning life skills to improve employment, living, and relational aspects of their lives. The final stage focuses on a process level concerning the value in accepting personal struggles and managing them, when necessary (in order to encourage the patient to continue to use these skills after treatment).

Anxiety disorders would be expected to be relevant to a DBT framework given that components of the treatment target worry and anxious responding (see Gratz, Tull, & Wagner, 2005, for a discussion of how DBT mindfulness skills might be applied to the treatment of anxiety disorders). However, it is unclear how efficacious this package would be for individuals with anxiety disorders who do not have severe personality psychopathology. DBT has demonstrated efficacy in individuals with individuals with borderline personality disorder, suicidal and parasuicidal behaviors (including but not limited to those with borderline personality disorder), and, more recently, eating disorders (S. C. Hayes, Masuda, Bissett, Luoma, & Guerrero, *in press*). As a package, DBT has not yet demonstrated efficacy for the anxiety disorders. However, elements of DBT have been incorporated with success into treatments for GAD (Roemer & Orsillo, 2005) and PTSD (Cloitre, Koenen, Cohen, & Han, 2002).

Linehan (1993a, 1993b) was one of the first investigators to incorporate a functional viewpoint of emotions (beyond just fear) into a cognitive-behavioral treatment package. Her model of borderline personality

disorder emphasizes the joint roles of a heritable tendency to react intensely to environmental stimuli coupled with an invalidating context. This developmental environmental influence typically involves dismissive, punitive, critical, or neglectful reactions to strong emotional displays. These early emotional experiences are often already quite intense and painful and the disavowal of this experience by caregivers often leads these individuals to pursue stronger means of communicating or controlling these emotions. Linehan argues that borderline personality disorder then develops as a result of this invalidated reactivity to one's own emotional experience, which, in turn, generates a number of maladaptive methods for managing emotions that serve to reinforce this emotional intensity.

DBT incorporates a functional emotional approach involving both acceptance elements that illustrate the adaptive importance of emotions and change elements that highlight the importance of emotion management (Linehan, 1993a, 1993b). A central component of DBT is the inclusion of interventions meant to increase identification, understanding, and management of emotions, especially those that may become disruptive. This is accomplished particularly through the emotion regulation modules of the treatment. Patients learn to understand what compels them to use these poor methods of controlling their emotions and, instead, learn more functional ways to approach and manage their emotional experience. An adaptive view of emotions is also reflected in the mindfulness component (i.e., flexible reactions to one's internal experiences), the distress tolerance component (i.e., importance of allowing painful reactions), and the interpersonal component (i.e., understanding how needs get expressed within a relational context). Given that emotion regulation components have recently been further emphasized in DBT (see McMain, Korma, & Dimeff, 2001) and that the package is currently being update to incorporate recent advances in emotion research (Linehan, 2004), it is likely that this intervention will be quite relevant to improving treatments for the anxiety disorders.

Mindfulness interventions have also been incorporated into a number of acceptance-based behavioral treatments including DBT (Linehan, 1993b) and MBCT (Segal et al., 2002). Mindfulness refers to a process of purposeful, flexible, nonjudgmental awareness of the present moment (Kabat-Zinn, 1990). Mindfulness is derived from a spiritual, Buddhist tradition (Nhat Hahn, 1976) but has been adapted for western usage. Kabat-Zinn (1990) has derived an approach to mental and physical distress using mindfulness. Mindfulness-based stress reduction (MBSR) includes a formalized meditation practice component to aid individuals in remaining in a present oriented, nonjudgmental state. Acceptance-based behavioral approaches have built upon Kabat-Zinn's foundational contributions, retaining much

of the same conceptual framework. Some approaches also retained a formalized meditation component (i.e., daily sitting meditation process, e.g., Segal et al., 2002); whereas others incorporate more flexible applications of mindfulness practice (Linehan, 1993b; Roemer & Orsillo, 2005). Mindfulness has been applied to a number of conditions including borderline personality disorder (Linehan, 1993a), depression (Segal et al., 2002), and substance disorders (Marlatt, 1994). Mindfulness interventions have demonstrated efficacy for anxiety disorders in both purer formats (Kabat-Zinn et al., 1992) and as a component of an acceptance-based behavioral treatment for GAD (Roemer & Orsillo, 2005).

It is currently unclear as to what mechanisms are involved in mindfulness or how this process specifically relates to psychopathology (S. C. Hayes, 2002). However, a number of mindfulness-based interventions encourage an attendance to internal experiences including emotions (Baer, 2003). When “mindful,” one is able to step back, gain perspective, and allow current feelings or permit feelings to emerge. Although focus has largely been on the allowance aspects of the mindfulness process, emotions are often an integral aspect of this emergent experience. Bishop and colleagues (2004) have argued that mindfulness involves a “decentered” stance toward emotions such that one is able to create distance with the emotional experience, decrease emotional reactivity, and promote a more rapid return to baseline quiescence. Emotions, even negative and painful ones, are seen as important aspects of experience and, thus, should be allowed and noticed. In MBCT, Segal and colleagues (2002) devote a part of their fifth session to reading and discussing *The Guest House* (see Block-Lerner, Salters-Pedneault, & Tull, 2005), a poem by the 13th-century Sufi poet, Rumi, which stresses the importance of welcoming unwanted feelings. However, the functional and informational value of emotions is not explicitly stressed. The key element is the allowance of their rise and passage without attempts to avoid or control this experience (Segal et al., 2002).

Roemer and Orsillo (2003) state that inherent in the mindfulness process are emotion-regulating properties. Distress may not be decreased (and is sometimes increased) by mindfulness but through the component processes of decentering and nonjudgementalness, emotions are seen in a greater context and are, thus, more able to be recovered from. A. M. Hayes and Feldman (2004) argue that mindfulness interventions can be quite consistent with an emotion regulatory framework. They suggest that mindfulness may provide a balance of extreme emotional responses such as avoidance (i.e., overregulation) or overengagement (i.e., underregulation), such that one is able to have greater clarity in the meaning of his or her emotions. In addition, they argue that mindfulness can be used not only

to notice and allow a broader experience of emotions but also to transform destructive emotions. They view this process as similar to exposure in that one needs to allow emotional experiences, even distressing arousal, in order to generate greater meaning and restore a more balanced emotional state. These authors review preliminary evidence that mindfulness has been found to be associated with clarity of feelings and perceived ability to repair one's mood, both essential precursors to effective emotion regulation. However, given that a functional view of emotions is not explicitly delineated in mindfulness practices, one would expect some distinction between this construct and emotion variables. Indeed, a recent investigation demonstrates that a broad range of emotion regulation deficits show a unique relationship with GAD beyond mindfulness deficits (Salters-Pedneault, Roemer, & Mennin, 2005).

In addition to DBT and other mindfulness-based approaches, another acceptance-based approach that has gained popularity is ACT developed by S. C. Hayes and colleagues (1999). The premise of psychopathology in ACT lies in the unwillingness to allow internal experiences including, but not limited to, emotions (as well as thoughts, memories, and sensations). These internal events are constrained, suppressed, and avoided and it is this inability to allow this experience that is considered to be where psychopathologies such as anxiety disorders arise. This dysfunctional process has been termed *experiential avoidance* and is the primary target of ACT interventions. These interventions aim to reduce emotional avoidance by facilitating the process of *acceptance*, which refers to allowance of your internal experience without trying to alter or change it (S. C. Hayes et al., 1999). However, this engagement of experience is not an end itself but rather is theorized to allow greater flexibility to both internal and external possibilities and to promote behavioral action in accordance with one's values (S. C. Hayes et al., 1999). In this sense, as its name suggests, ACT encourages both actions that promote acceptance but also actions that promote change. This is similar to Linehan's emphasis on the dialectic between acceptance and change. This change is typically in a behavioral form (as thoughts and feelings are not responsive to mental command, as per ACT theory) and involves incremental acts toward valued goals (S. C. Hayes et al., in press).

ACT has been applied to myriad of psychopathologies (see S. C. Hayes et al., in press). Avoidant properties of anxiety are central to the conceptualizations of psychopathology in ACT. As such, it is not surprising that the treatment has been applied to a number of anxiety disorders in its complete form (see Eifert & Forsyth, 2005; Orsillo, Roemer, Block-Lerner, LeJeune, & Herbert, 2004; Twohig, Masuda, Varra, & Hayes, 2005) and as a component of other acceptance-based approaches (Roemer & Orsillo,

2005). These treatments have shown promise (e.g., Block & Wulfert, 2002; Orsillo, Roemer, & Barlow, 2003; but randomized controlled trial data are not yet published).

The view of emotions in ACT is based, in part, on the radical behavioral approaches mentioned in the previous section (Friman et al., 1998). Similar to mindfulness approaches, emotions are not directly considered functional entities that hold informational value but are still thought to be an integral aspect of adaptive experience. As such, emotions are not seen as purely disruptive nor are they diminished in ACT (in contrast to traditional cognitive-behavioral approaches; S. C. Hayes et al., 1999). Psychopathology, in this approach, does not arise from emotions but rather from our attempts to avoid the experience of these emotions (and other internal events). As such, effective living characterized by acceptance of emotional experiences is the goal of ACT rather than explicit regulation of emotions (either to diminish or amplify; Blackledge & Hayes, 2001; S. C. Hayes et al., 1999). A. M. Hayes and Feldman (2004), however, have argued that experiential acceptance can be considered as a form of emotion regulation in that it affects change in the qualities of emotional experience, which may facilitate valued action (see Zvolensky, Feldner, Leen-Feldner & Yartz, 2005, for further discussion of acceptance and mindfulness within an emotion regulation framework). In contrast to a focus on emotions directly, assessment of emotional experiences as markers of experiential avoidance or acceptance is encouraged in ACT. S. C. Hayes and colleagues (1999) and Orsillo, Roemer, Block-Lerner, and Tull (2004) have distinguished between “clean” or “clear” emotions and “dirty” or “muddled” emotions. The former types of emotions refer to initial emotional responses to a stimulus. In contrast, the latter types of emotions refer to emotions that overlay clearer emotions because we try to avoid them or because they are clouded by insomnia, perseverative thought (e.g., worry, rumination), or a conditioned response due to associations with past experience. This conceptualization is quite similar to the notion of primary and secondary distinctions outlined in Greenberg’s (2002) model of emotions in psychotherapy (reviewed in the following section).

The emphasis on experiential acceptance in ACT may appear to be in conflict with models that suggest that regulation of emotions should include management or alteration of emotional experience. Within ACT, clients are encouraged not to *require* that their emotional experience changes in order to do the things that matter to them, and they are helped to see how, in their own experience, efforts at experiential control have been ineffective. However, accepting responses toward one’s emotions may in fact serve to modulate them (perhaps by minimizing “dirty” emotions), as noted by A. M. Hayes and Feldman (2004). Linehan (1993a) notes the

importance of seeing the dialectic between acceptance and change, rather than engaging exclusively in one versus the other.

EXPERIENTIAL PERSPECTIVE

Experiential approaches have 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., Greenberg, 2002) has revitalized an interest in these experiential orientations. These treatments are novel as they base their approaches not only on these historical traditions but also on basic research on emotion and affective neuroscience.

Greenberg and colleagues (Watson, Greenberg, & Lietaer, 1998; Greenberg & Van Balen, 1998) have reviewed 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, nonjudgmental 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 believed that an important aspect of this awareness was the allowance of a full range of potential emotions that may be involved in that experience. Rogers argued that clients change from therapy as a function of their ability to become more aware of the emotional reactions in their experience, to accept them, and to understand their importance in engaging in experiences congruent with their needs.

Gestalt therapy, developed by Fritz Perls, 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 his or her ability to function 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 toward, 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 whom they have unresolved feelings (Watson et al., 1998).

Acceptance of emotional experience as an integral aspect of living is inherent in the tradition of existential approaches (e.g., May, 1977). 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 provides individuals with an implicit knowledge of our reactions to both internal and external events. In this treatment, individuals learn to identify these sensations and gain a better understanding about their implicit meanings. Greenberg (2002) has developed emotion-focused therapy, which he considers a “process-experiential therapy,” because 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). Using modified gestalt procedures, emotions are enacted within session to address concerns related to unexpressed relational conflicts and conflicts between aspects of self or experience (Greenberg, Rice, & Elliott, 1996). However, not every emotion is considered functional or is the target of experience encouraging interventions. Greenberg distinguishes among types of emotion to determine core emotional reactions (which he terms *primary emotions*; these can be adaptive or maladaptive), which are secondary reactions (which he terms *secondary emotions*; these are largely maladaptive),

and which are only evoked strategically to gain a desired outcome (which he terms *instrumental emotions*; these are often manipulative).

Primary adaptive emotional reactions refer to biologically adaptive emotional responses that provide information about action tendencies, associated meanings and motivation for behavior (Greenberg, 2002). These responses include what have been termed the *basic emotions* such as fear, joy, anger, and sadness (Plutchik, 1990). 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 ones that aid in effective decision making and adaptive action engagement (Greenberg, 2002).

Although the experiential traditions have incorporated fundamental views of emotion 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, Greenberg has developed his approach largely from basic findings concerning the functional role of emotions and their neurobiological substrates. The investigators have shown through a number of studies that depth of experiencing emotions in session is related to positive therapeutic outcome (see Whelton, 2004). Recently, in line with current trends in emotion research, Greenberg (2002) has begun to stress not only the experience of emotions but also the need for their management and regulation. 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, Goldman, & Korman, 2003) and anxiety disorders (Wolfe & Sigl, 1998), thus increasing ability to determine specificity of different experiential therapeutic processes for different forms of psychopathological conditions.

INTEGRATIVE PERSPECTIVE

Taken together, there appears to be a convergence between the developing cognitive-behavioral and experiential paradigms. A number of acceptance-based behavioral approaches have included a functional viewpoint of emotions (e.g., Linehan, 1993b; Roemer & Orsillo, 2005) or have incorporated a regulatory framework (e.g., A. M. Hayes, Beevers, Feldman, Laurenceau, & Perlman, in press; Linehan, 1993b). Further, the foundations of acceptance in some of these approaches are reported to have, in part,

been derived from Greenberg's experiential approach (S. C. Hayes et al., 1999; Linehan, 1993b). Greenberg (2002) has also stressed the importance of behaviorally oriented acceptance and mindfulness practices.

Given both this convergence in orientations and the findings that individuals with anxiety disorders have a number of deficits in emotional functioning, incorporation of principles of basic affective sciences, emotion regulatory frameworks, and modern experiential interventions into acceptance-based behavioral approaches to anxiety disorders may be beneficial. If emotion responses impart motivational information, then allowance of this experience is important not only because suppression or control are problematic but also because attending to emotional information may be essential for effective, valued actions. As such, acceptance-based behavioral interventions might, in addition to encouraging acceptance of emotional experience, also encourage individuals to attend to possible adaptive emotional elements that are present. Further, explicit evocation exercises from the experiential tradition may also be beneficial to increasing the salience of emotions within session. Finally, incorporating a regulatory framework may improve acceptance-based approaches by including interventions that not only encourage the acceptance of emotions but change elements when either modulation or accentuation of emotion experience is necessary according to a given context.

Thus, core acceptance and mindfulness techniques could be altered to include these more emotion-focused processes. For instance, during mindfulness exercises, compassionate understanding of one's emotions may become an important focal point. From this understanding, a client may learn more about what motivations and values are involved in the experience and through the flexibility engendered by the mindfulness exercise, she or he may become more able to choose actions congruent with these emotional needs. Conversely, experiential interventions could directly utilize mindfulness and acceptance strategies. By decreasing judgmental and inflexible emotional responses, clients can learn more from emotion eliciting exercises and utilize them to their fullest potential. Finally, an acceptance-based approach might also be supplemented by the training of regulation skills that involve strategies that promote both quiescence (e.g., calming and soothing) and accentuating emotional experience (e.g., Linehan, 1993b).

My colleagues and I have developed an approach to treating GAD that integrates elements of acceptance-based behavioral approaches with emotion focused and regulatory elements. Emotion regulation therapy (ERT; also see Huppert & Alley, 2005; Newman, Castonguay, Borkovec, & Molnar, 2004; Roemer & Orsillo, 2005, for other approaches that incorporate emotion elements in treating GAD) is based on our model of emotion dysregulation in psychopathology (see Mennin et al. 2002, 2003). Despite its

association with significant impairment and life dissatisfaction (e.g., Stein & Heimberg, 2004) and increased health care costs and utilization (e.g., Blazer, Hughes, & George, 1991), GAD remains an understudied (Dugas, 2000), misunderstood (Persons, Mennin, & Tucker, 2001), and treatment-resistant (Borkovec & Ruscio, 2001) disorder.

The goals of ERT are for individuals 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 emotional avoidance strategies (e.g., worry); and (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 integrates components of emotion-focused treatments into a cognitive-behavioral framework. In particular, skills training elements related to awareness of bodily reactions, acceptance, and adaptive regulation of emotions are included in ERT. Berenbaum and colleagues (2003) recommend the use of skills training for individuals with deficits in emotional understanding, especially before the use of exposure techniques with anxious individuals. Indeed, other treatments have demonstrated the efficacy and utility of providing skills training in emotion regulation to increase patients' ability to engage a later exposure component (Cloitre et al., 2002; Linehan, 1993b). In addition, emotion-focused techniques from the experiential tradition (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). These are included largely to examine how one's emotions and emotional management styles affect relationships and are affected by them.

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. Initial sessions of ERT (Phase I) focus on psychoeducation about the disorder, functional patterns of worry and emotions in past and current situations, and self-monitoring of worry and/or anxiety episodes. The following sessions focus on the development of somatic awareness and emotion regulation skills (Phase II). Phase III comprises the most essential

and intensive sessions of the treatment as they focus on the application of skills during exposure to emotionally evocative themes. The final sessions focus on terminating the therapeutic relationship, relapse prevention, and future goals (Phase IV).

Formalized outcome data for ERT are not yet available. Given that ERT is still currently under development and will likely be altered from its current form as lessons are learned from its ongoing implementation, it is unclear how this type of integrative approach will fare for GAD or other anxiety disorders. Some evidence is available that an integrative, acceptance-based behavioral approach that incorporates acceptance techniques, experiential techniques, and an emotion regulatory framework is effective for treating depression (A. M. Hayes et al., in press). However, further research is clearly necessary to determine whether an explicit emotion focus and integration of emotion-focused interventions is beneficial to the acceptance-based behavioral approaches.

CONCLUSIONS

Integrative, emotion-focused interventions might further our ability to use acceptance-based behavioral approaches to treat 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 such as ERT will need to be empirically evaluated, particularly in comparison to existing interventions. In particular, it will be important to determine when and if interventions aimed at changing emotional functioning are warranted. Another important goal of future research in this area will be to study the process of change in acceptance- and emotion-based 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 emotional acceptance or regulation abilities such as comfort with emotional experience, emotional acceptance, ability to self-soothe, and ability to use emotional information in decision making and action. These questions can only be answered through an examination of both treatment outcome and process.

On a more general level, the understanding of emotions and their management may provide a common language for understanding psychopathological phenomena and treatment process. 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 cognitive-behavioral clinicians to discuss emotional phenomena

as being an integral part of adaptive life experience. The acceptance-based approaches have widened the scope of cognitive-behavioral intervention. The advances made by these treatments as well as integration of basic affective science and experiential techniques are likely to provide us with a greater ability to treat anxiety disorders, even in their most chronic, complex, and treatment resistant forms.

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