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Intimacy is a Transdiagnostic Problem for Cognitive Behavior Therapy: Functional Analytical Psychotherapy is a solution

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Abstract

Problems with intimacy and interpersonal issues are exhibited across most psychiatric disorders. However, most of the targets in Cognitive Behavioral Therapy are primarily intrapersonal in nature, with few directly involved in interpersonal functioning and effective intimacy. Functional Analytic Psychotherapy (FAP) provides a behavioral basis for working on intimacy and interpersonal functioning. The current paper describes how intimacy concerns are addressed by FAP and provides evidence for the need to assess and understand the role of intimacy across a number of disorders. There are several justifications for support for including attempts to measure intimacy and design treatments to increase clients' effectiveness in intimacy. In conclusion, there appears to be a need to empirically determine the extent to which intimacy should be a therapeutic target of interest across many psychiatric disorders and FAP may be an important part of therapeutic change in these areas.

Keywords

Functional analytic psychotherapy, intimacy, interpersonal functioning, transdiagnostic

The purpose of this paper is to highlight some current trends in transdiagnostic approaches to cognitive behavioral therapy (CBT) and how these trends relate to the constructs of intimacy and interpersonal functioning. We will define aspects of intimacy, introduce how Functional Analytic Psychotherapy may aid in developing effective intimacy and interpersonal functioning, and underscore the importance of intimacy across a range of disorders and clinical presentations. We aim to make the case that explicitly addressing intimacy and interpersonal functioning is essential for the holistic long-term well-being of those suffering from psychiatric disorders, and for CBT practitioners, using a behaviorally based treatment such as FAP will enhance these efforts.

The term interpersonal functioning comprises a wide range of topics, such as social skills, social cognition, intimacy, and connectedness. Intimacy is a core part of interpersonal functioning as, broadly speaking, it is the quality of close connection between individuals and the ongoing process of promoting and maintaining this quality. Researchers have conceptualized in a number of different ways. Jamieson (2011) viewed intimacy as something experienced emotionally, cognitively, and behaviorally, and may include sharing feelings of mutual love, sharing a similar worldview and sharing common life experiences. Others have considered intimacy a form of social cognition (i.e., intrapersonal processes such as encoding, storing, and retrieving information about one's own species) that is essentially interpersonal (Sharp, Fonagy, & Goodyer, 2008). Still others have defined intimacy a process of increasing reciprocity of self-disclosure in which individuals experiences their innermost self-validated, understood, and cared for by the other (Reis & Shaver, 1988).

Given the behavioral context of this paper, we chose a definition of intimacy by Cordova and Scott (2001) to use throughout this paper, that lends itself to behavioral analytic theory. In this view intimacy develops from a historical collection of events "in which behavior vulnerable to interpersonal punishment is reinforced by the response of another person" (p. 75). These events consist of a number of types of overt and covert behaviors including: sharing private thoughts and feelings or self-disclosure consisting of either unpleasant feelings (e.g., sadness, embarrassments, failures, etc.) or more "positive" sentiments (e.g., love, attraction, closeness, gratitude, hope, etc.); sharing memories and secrets; physical closeness (e.g., sex, hugging, acts of physical comfort, etc.); and subjective states (e.g., warmth, closeness, and loving). Thus by this definition, intimate behavior incurs risk that may leave one vulnerable to aversive experiences of shame, humiliation, embarrassment, or rejection. The willingness to engage in the process of intimacy as defined by Cordova and Scott promotes accessibility to gains in experiences of feeling validated, understood, and cared for (Reiss & Patrick, 1996).

Although there are therapeutic approaches that target increasing intimate behaviors through individual or couples modalities (e.g., Emotion-Focused Therapy; Greenberg & Watson, 2004; Johnson, 2004), few have roots in the cognitive-behavioral tradition. Integrative behavioral couple therapy is one exception (Christensen, Jacobson, & Babcock, 1995); however it is designed to be of use in couples therapy, leaving somewhat of a void in CBT for working on intimacy in individual therapy. Functional Analytic Psychotherapy (FAP; Tsai, Kohlenberg, Kanter, Kohlenberg, Follette, & Callaghan, 2009) may help address this void, as it is a behaviorally based therapy that works with in-session behavioral change to promote functional interpersonal skills and intimacy outside of the session.

FUNCTIONAL ANALYTIC PSYCHOTHERAPY

FAP is deeply rooted in behavioral principles and will be briefly summarized in the following paragraphs. It employs a "here and now" approach to address clinically relevant behaviors (CRBs), which are interpersonal behaviors the client displays inside of the session that may be problematic and parallel to problematic behaviors occurring outside of the session. A first step in FAP is to identify the interpersonal behaviors that are interfering with the client progressing outside of the session and then to identify how these behaviors present inside of the session (or to evoke these behaviors if they are not present). Next, a therapist needs to understand the function that the client's behaviors serve in order to determine whether a behavior is problematic or an improvement. For example, a client who questions the validity of a homework assignment may do so in the service of being assertive (i.e., an improvement for a non-assertive person) or being disagreeable (i.e., a life-interfering behavior). The function of the behavior is particularly important as the FAP therapist will want to reinforce behaviors during the session that improve interpersonal functioning and ignore or punish behaviors that inhibit functioning. In addition, recognizing any small improvement in a behavior may allow a therapist to shape the client to toward a larger goal.

FAP emphasizes reinforcing functional behavior and highlights the importance of immediacy and providing natural versus contrived reinforcers. In contrast to contrived or manufactured rewards, natural reinforcers given within the session should resemble what is typical and reliable in daily encounters. In an example of trying to promote more intimate behaviors, (i.e., disclosure of information subject to punishment) by a client, a therapist may respond to an improvement in this area by genuinely expressing how they feel in reaction to the behavior, with words such as feeling closer to the client and a tone that is warm and encouraging. In contrast, contrived reinforcement may range from handing the client a piece of candy to objectively and unemotionally stating that this new behavior will serve them well in the outside world. In some situations the difference between natural and contrived reinforcement may be more subtle, but pairing this with the practice of immediately reinforcing steps toward goal behaviors is supported by decades of research in behaviorism (cf. Baruch et al., 2009).

FAP's view on intimacy is shaped by three themes, namely that intimacy issues are clinically important, intimacy involves a mutual exposing of the self, and intimacy involves connecting emotionally to others (Kohlenberg, Kohlenberg, & Tsai, 2009). In general, the process of therapy is an intimate sharing by the client; in order to fit in with a FAP model for increasing intimacy, the therapist must engage in this process actively as well. While this does not mean a therapist will reveal every personal detail about their life, it does mean that a genuine investment of caring and experiencing are required in order for mutual emotion connection to occur. Therefore a therapist using FAP will strive to connect emotionally, in an intimate manner, to clients in need of increasing intimate behaviors outside of the session.

Once it is determined that a client may have a goal of increased intimacy, the in-session work will be directed by FAP's five rules (Tsai, Kohlenberg, Kanter, & Waltz, 2009). Rule 1 states that the therapist be aware of all CRBs in session that are examples of out of session behaviors, including both problematic behaviors (referred to as CRB1s) and improvements (known as CRB2s). Although the topography and function of each client with non-functional intimacy behaviors will differ, a CRB1 might be to avoid the risk of feeling vulnerable by avoiding personal disclosure and sharing emotions. For this example, CRB2s would be to share intimate thoughts, feelings, and fears. Rule 2 encourages evocation of CRBs. During the course of therapy, a therapist may need to increase the frequency of situations that bring about CRBs in order to provide the client and therapist an opportunity to block avoidance of intimate behaviors and naturally reinforce progress toward intimacy. Rule 3 states CRB2s should be naturally reinforced (as was described earlier). Rule 4 requires the therapist to be aware of their impact on the client. Part of this involves evaluating whether the therapist's actions are serving as reinforcers (e.g., by an increase in CRB2s) and to adjust accordingly if necessary. Finally, Rule 5 is to promote interpretation and generalization about the issues. A client should begin to understand and discuss how their reinforcement history maintained problematic behavior, what might be changing in therapy, and to begin to practice within-session changes in out-of-session relationships.

Perhaps it appears as though the case has been made for increasing intimacy and using FAP in the service of that goal. However, given the lack of emphasis on intimacy in CBT therapeutic targets of interest, it appears as though there is a need to recognize this more formally. Therefore, we shall turn our attention to the current trends in CBT, the need for CBT to attend to intimacy across many disorders, and how FAP can be part of that solution.

CURRENT TRENDS IN COGNITIVE BEHAVIORAL THERAPY

Despite the importance of intimacy in interpersonal functioning, many of our current approaches in cognitive behavioral therapy (CBT) do not seem to emphasize it as a target of treatment. CBT has traditionally focused on treatment techniques designed for each specific disorder. In this approach, a model of symptom development and maintenance is identified and key maintenance processes are highlighted and targeted, which are thought to be unique to the disorder in question. However, Mansell and colleagues (Mansell, Harvey, Watkins, & Shafran, 2009) note that transdiagnostic approaches claim to have identified core targets for change across similar conditions (i.e., safety-seeking behaviors for anxiety disorders [Norton & Philip, 2008] and avoidance behavior for mood disorders [Jacobson, Martell, & Dimidjian, 2001]) or universal processes (e.g., experiential avoidance; Hayes et al., 1996, or distress tolerance; Zvolensky, Bernstein, & Vujanovic, 2011; attention, memory, reasoning, thought, behavior; Harvey, Watkins, Mansell, & Shafran, 2004) thought to maintain or contribute to most diagnostic disorders. From this research, a number of CBT-based therapeutic approaches and protocols have been developed with a transdiagnostic focus (Barlow, Allen, & Choate, 2004; Fairburn, Cooper, & Shafran, 2003; Hayes, Strosahl, & Wilson, 1999; Norton & Phillip, 2008). Each of these has different, albeit similar, targets for treatment depending on the groups of disorders (i.e., those thought to share similar processes for change)

covered by the approach. Yet all these approaches emphasize intrapersonal processes.

For example, most of the aforementioned transdiagnostic procotols (Barlow et al., 2004; Fairburn et al., 2003; Norton & Phillip, 2008) emphasize psychoeducation, cognitive and behavioral techniques (e.g., reappraisal and exposure), and strategies for maintenance gains/relapse prevention. With regard to approaches targeting universal processes, distress tolerance has been implicated in a variety of psychiatric disorders (Zvolensky et al., 2011). Harvey and colleagues (2004) also list a number of universal processes (attention, memory, reasoning, thought, and behavior) implicated in a wide range of conditions. Additionally, targeting experiential avoidance (EA) with Acceptance and Commitment Therapy (ACT; Hayes et al., 1999) has produced the most research with favorable findings across a wide variety of disorders (Powers, Vording, & Emmelkamp, 2009). One aspect missing from almost all of these approaches is attention to interpersonal processes designed to increase intimate behaviors.

We, and many other researchers across therapeutic approaches, believe that interpersonal functioning, and perhaps especially intimate behaviors, play an important role in many disorders, despite the fact that most Axis I conditions' diagnostic criteria remain free of the specific mention of intimacy. We aim to highlight how intimacy may influence individuals across a wide range of disorders (using Major Depression, Obsessive Compulsive Disorder, and Trichotillomania as primary examples) in an attempt to show that it is deserving of future research, a needed target of treatment for CBT, and that FAP may be useful in ameliorating these problems. What is envisioned by this paper is that intimate behaviors generalize to become humane treatment targets with specific CBT therapeutic techniques to further increase treatment effectiveness.

INTIMACY IN CLINICAL CONDITIONS

Intimacy itself appears to play a key role in the development, maintenance, or long-term recovery from a number of disorders. However, a brief overview of the most recent DSM (Fourth edition – revised; APA, 2000) reveals that, aside from Personality Disorders, there is an absence of indication of specific aspects of intimacy as a symptom of disorders. While most conditions require impairment in one or more important areas in life (which may include intimacy), difficulties associated with intimacy are unique in that it has great potential for improvement in the therapeutic context because of the interpersonal nature of therapy, since it can be directly observed and attended to in real time. A discussion of the factors that influence the development and maintenance of interpersonal functioning (including intimacy), as well as clinical presentations of interpersonal difficulties and treatment implications will follow. The difficulties in intimacy are often associated with research on attachment, and functionally may be related to EA (i.e., to avoid negative consequences). We believe that many intimacy problems may result from "poor" attachment and/or a pattern of avoidance, however, we will suggest that other areas may also contribute to a dearth of intimacy.

A vast array of literature exists looking at difficulties related to intimacy as a result of one's attachment style. Attachment difficulties have been implicated as a major risk factor for psychopathology overall (Mikulincer & Shaver, 2012) and are associated with a range of disorders such as depression (Catanzaro & Wei, 2010), clinically significant anxiety (Bosmans, Braet, & Van Vlierberghe, 2010), obsessive-compulsive disorder (Doron, Moulding, Kyrios, et al., 2009), post-traumatic stress disorder (Ein-Dor, Doron, Solomon, et al., 2010), suicidal tendencies (Gormley & McNiel, 2010), and eating disorders (Illing, Tasca, Balfour, et al., 2010). In addition, FAP supports the notion that attachment is a relevant concept, useful in the conceptualization of client difficulties (Kohlenberg et al., 2009).

However, given that other factors influence the level of intimacy in addition to attachment (e.g., reinforcement and punishment in interpersonal relationships other than early attachment figures, experience of trauma, interference of symptoms from psychological conditions, lack of social skills, etc.), we cite evidence from the attachment literature as a contributor to intimacy difficulties rather than focusing solely on attachment. From a behavioral perspective this distinction is important for both treatment and research as our recommendations will suggest targeting behaviors in the service of increasing intimacy rather changing an attachment style. Mansfield and Cordova (2007) have produced a behavioral analytic account of attachment, in which they "frame attachment behavior specifically as a behavioral class shaped by its operant function of obtaining nurturance" (pg. 394), that may be useful as a model for change via FAP. In their account nurturance-seeking behaviors are intimate (e.g., bids for closeness, comfort, caretaking, etc.) and may have been responded to in one of three manners: reinforced, punished, or ignored. The type and ratio of the responses (i.e., schedules of reinforcement) determine the "attachment repertoire" and how one will respond to potential attachment figures. The authors conclude that attachment (i.e., nurturance) histories cannot be eliminated, but clients can be given new learning opportunities through healthy "responsive intimate relationships" (pg. 4.08) to shape one into a more "secure" attachment style (Mansfield & Cordova).

While problems with intimacy may be related to attachment, these same difficulties could also be associated with EA. For example, people who have been punished (or even not reinforced) for previous intimate behaviors may try to escape or avoid these actions, in accordance with the definition of EA (Hayes et al., 1996). EA of intimacy may also develop in response psychological symptoms such as those associated with Post-Traumatic Stress Disorder (e.g., avoidance behaviors in response to trauma related symptoms and lack of emotional involvement and expression; Erbes, Polusny, MacDermid, & Compton, 2008). While these may be an important reasons for refraining from intimate behaviors and we would expect there to be a strong correlation between EA and a lack of intimacy, we believe that there are still other reasons for a lack of intimacy (i.e., a lack of interest, awareness or skills of how to be intimate) that are not functionally due to a fear of intimacy. We do believe that attempts to reduce EA through ACT can be successfully combined with FAP, and others have written on this topic as well (Kohlenberg & Callaghan, 2010).

Major Depression. While many of the studies that examine interpersonal functioning in relation to depression do not always use the term intimacy, it appears as though psychosocial factors in general and intimacy in particular may play a key role the development, maintenance, and successful recovery from depression. Psychosocial factors are a major vulnerability for depression. Generally speaking, relationship dissatisfaction and depression are highly related (Whisman, 2001) and depression severity is correlated with social-interpersonal dysfunction (cf. Vittengl, Clark, & Jarrett, 2004). Also, poor psychosocial functioning predicts a recurrence of Major Depressive Disorder (MDD) (Vittengl, Clark, & Jarrett, 2009).

When examining risk factors for the onset of MDD, researchers have found that a lack of intimacy significantly increased the risk of MDD (Hällström, 1986). A review across a number of studies examining risk factors for depression (i.e., the Brown and Harris Vulnerability factors) found that lack of intimacy was more strongly associated with depression than other factors (i.e., parental loss, employment status, and number of children) and increased the risk for onset (Patten, 1991). More broadly speaking, interpersonal constructs such as excessive reassurance-seeking (Potthoff, Holohan, & Joiner, 1995; Prinstein, Borelli, Cheah, Simon, & Aikins, 2005), insecure attachment orientation (Bottonari, Roberts, Kelly, Kashdan, & Ciesla, 2007; Hankin, Kassel, & Abela, 2005), maladaptive interpersonal stress responses (Flynn & Rudolph, 2008), and ineffective interpersonal problem solving (Davila, Hammen, Burge, Paley, & Daley, 1995) have been linked to increased risk for depression. Some of these interpersonal vulnerabilities to depression have been found in studies of children (Abela, Hankin, Haigh, Adams, Vinokuroff, & Trayhern, 2005) and adolescents (Prinstein et al., 2005).

The role of intimacy in the development and maintenance of depression may differ based on gender. For example, one study examining attachment style and depression found that in depressed women, the avoidance of intimacy due to a fear of rejection in significant relationships was related to depression severity, however, males did not show a significant relationship between intimacy and depression (Reis & Grenyer, 2004). While the exact reasons why fear of intimacy may not relate to depression in men as strongly as it does women may not be known, Thomas Joiner's recent book on loneliness may account for this finding (2011). Joiner posited that men undervalue relationships compared to women and are much less likely to replenish lost relationships and thus display higher levels of loneliness later in life. Therefore, intimacy still may play a key role for depression in men, although men may not fear intimacy as much as they undervalue it compared to women.

Additional evidence for the importance of interpersonal functioning and intimacy comes from the treatment literature. It should be noted that many treatments highlight interpersonal functioning as a target of change, (i.e., FAP; Tsai et al., 2008; Dynamic Interpersonal Therapy; Lemma, Target, & Fonagy, 2011) and some are empirically validated for treating major depression (i.e., Interpersonal Therapy [IPT]; Klerman, Weissman, Rounseville, & Chevron, 1984). Along with the studies showing favorable results for IPT (Elkin et al., 1995; Goldfried et al., 1997) other studies have highlighted the importance of addressing interpersonal functioning to improve treatment outcome or maintain gains from CBT treatments.

A recent study analyzing the data from the NIMH Treatment of Depression Collaborative Research Program found that although Cognitive Therapy (CT) and IPT had similar outcomes, therapist's attending to interpersonal relationship themes significantly improved outcome for IPT, but *reduced* outcome for CT (Crits-Christoph, Gibbons, Temes, Elkin, & Gallop, 2010). The authors concluded that different mechanisms of change may exist for each treatment, but also speculated that adding interpersonal aspects to CT may improve treatment. A few studies have demonstrated these findings, as interventions that addressed the interpersonal and developmental domains were associated with greater improvement in CT (Hayes, Castonguay, & Goldfried, 1996), greater use of psychodynamic techniques in CT was associated with relatively more favorable outcomes (Jones & Pulos, 1993), and adding FAP to CT increased relationship satisfaction over CT alone (Kohlenberg, Kanter, Bolling, Parker, & Tsai, 2002). The last study is of particular importance for this paper as the therapists' focus on ideographically relevant CRBs was significantly greater in the FAP + CT condition than CT alone, providing clear evidence for FAP's utility in treating depression.

Finally, it is thought that a reduction in depressive symptoms is necessary for improving psychosocial functioning. A recent study found support for this, and also reported findings that may have additional implications for addressing psychosocial functioning in treatment. In a sample of clients receiving CT for MDD, an increase in psychosocial functioning and a decrease in depressive symptoms occurred, with a large inter-correlation between the two changes. Although the magnitude of change in depressive symptoms showed greater improvement than psychosocial change, the change in psychosocial functioning predicted a change in depressive symptoms *better* than a change in depressive symptoms predicted a change in psychosocial functioning (Dunn, Vittengl, Clark, Carmody, Thase, & Jarrett, 2011). Thus, improvements in psychosocial functioning may contribute to the reduction of depressive symptoms, suggesting that these are a worthy treatment target.

Other studies have shown that although successful treatment of depression with CT has resulted in an improvement in most social-interpersonal areas, patients' relationships with significant others improved less than other areas, and these gains were only moderately related to changes in depressive symptoms (Vittengl et al., 2004). In a longitudinal study of depressed individuals, despite a significant reduction in depressive symptoms over time, the social functioning of the depressed patients did not improve over the course of the follow-up period (Gotlib & Lee, 1989). Therefore, additional techniques may be needed to enhance treatment to help ameliorate social functioning and intimacy.

A review of the literature on depression yields a few findings relevant to this paper. Interpersonal vulnerabilities, including a lack of intimacy, may be risk factors for depression and the amount of interpersonal dysfunction is related to depression relapse. In addition, treatment targeting only symptom reduction may benefit from additional techniques to increase intimacy

and interpersonal functioning. Finally, FAP has been used to enhance the effectiveness of CT.

Obsessive-Compulsive Disorder. The quality and ability of interpersonal skills and intimacy is understudied in obsessive compulsive disorder (OCD), but current literature suggests impairments in a number of areas across the course of the disorder. In general, those with OCD typically report low self-esteem, dissatisfaction with social functioning, and avoidance of activities and contact with other people (Sorenson, Kirkeby, & Thomsen, 2004). Symptoms may influence one's ability to engage in appropriate intimate behaviors as many hide their thoughts and rituals to avoid being rejected, feared, or distrusted by others (Newth & Rachman, 2001), thus reducing emotional intimacy with partners. Some symptom presentations may elicit more avoidance of sharing obsessions than others such as sexual obsessions (i.e., doubting one's sexual orientation or being fearful of thoughts related to pedophilia; Grant et al., 2006) or other morally repugnant thoughts (i.e., indirectly or directly harming a loved one, being blasphemous, etc.; Rachman, 2003). Proneness to feelings of shame is directly correlated to symptom severity, and changes in shame correspond with changes in severity as well (Fergus, Valentiner, McGrath, & Jencius, 2010). In relationships, individuals with OCD demonstrate difficulties in many types of intimacy (e.g., social, sexual, emotional, recreational, and intellectual) and self-disclosure, and many of these constructs are significantly correlated with severity of obsessions (Abbey, Clopton, & Humphreys, 2007).

Evidence also exists for reduced quality of significant relationships. About half of the marriages involving someone with OCD reported significant marital distress before treatment (Riggs, Hiss, & Foa, 1992). In couples with an OCD individual, there is sexual dissatisfaction and an avoidance of sexual activity (Staebler, Pollard, & Merkel, 1993). In a meta-analysis assessing domains of quality of life, the social domain was more affected than any other area, including physical or mental health (Olatunji, Cisler, & Tolin, 2007). Interestingly, despite all the difficulties in interpersonal functioning in OCD, every other type of anxiety disorder (excluding specific phobias) demonstrated more impairment than OCD in the social area (Olatunji et al.). Finally, family members often react to OCD behaviors with elevated levels of criticism, anger, and hostility due to accommodations of symptoms and perceived burden (cf. Steketee & Van Noppen, 2003).

Interpersonal changes are the targets in some OCD treatments (e.g., reducing accommodations provided by family members); however, most techniques focus on symptom reduction by reducing either the provision of accommodations (by the family members) or asking for them (by the client) rather than increasing intimacy. A change in symptoms alone is not sufficient to restore adequate interpersonal functioning. In one of the few studies to assess this area, in couples with marital distress prior to treatment, 58% still experienced marital distress even after post-treatment assessments revealed a reduction in symptoms (Riggs et al., 1992). Further, former OCD patients, who were treated during childhood, do not cope as well socially as age- and sex-matched controls, even with symptom remission (Thomsen, 1995). Finally, quality of life in interpersonal domains increases after treatment, but is lower, albeit not significantly, than healthy controls (Huppert, Simpson, Nissenson, Liebowitz, & Foa, 2009).

In summary, for individuals with OCD, there are a host of interpersonal difficulties including a lack of intimacy. While it is possible that individuals with OCD may be more intimate in expressing their fears, most probably have less experience with intimacy in other areas. In addition, despite successful treatment in childhood or as adults, interpersonal problems still remain after symptoms have abated.

Although to date there is little empirical evidence for FAP in OCD treatment, a few studies highlight the contribution FAP could make in this area. Kohlenberg and Vandeberghe (2007) added an interpersonal factor to the treatment of two individuals with OCD who had a sense of over-responsibility. In short, the therapist worked on increasing trust by taking on the responsibility of any negative consequences related to the OCD fears of the clients during CBT-oriented homework exercises. The additional interpersonal factor was deemed necessary in order to complete more challenging exposures and response prevention.

A final point of interest comes from a meta-analysis of therapist-assisted exposures versus self-controlled exposures. Abramowitz (1996) found that clients with OCD or GAD who participated in therapist-assisted exposures endorsed greater improvement than those who participated in self-controlled procedures. Although this is likely due to the therapist giving feedback on the proper implementation of the techniques, it may also result from interpersonal variables such as trust in the therapist.

Trichotillomania. Although there is a paucity of research on Trichotillomania (TTM) in general, there is evidence that indicates impairment in interpersonal functioning and intimacy. Most people with TTM are female and the symptoms typically result in altering one's appearance (most people with TTM pull from the scalp, eyebrows, or eyelashes, and have noticeable hair loss in these areas; Stein, Christenson, & Hollander, 1991), which is an important variable in women's self-esteem (Soriano, O'Sullivan, Baer, Phillips, McNally, & Jenike, 1996). Therefore, the effects of hair-pulling may affect one's desire for or confidence in interpersonal activities. In fact, some researchers consider many deficits in areas of intimacy to be part of etiology of TTM (Stemberger, Thomas, Mansueto, & Carter, 2000).

Impairment manifests itself in a number of ways. In one sample of 67 women with TTM, over 80% reported feeling depressed due to hair pulling and over 70% had significant feelings of shame, irritability, and low self-esteem (Stemberger et al., 2000). Additionally, 83% were secretive about their symptoms, and 87% felt unattractive. Avoidance of social activities occurred in most, while 35% avoided sexual intimacy as a direct result of pulling (Stemberger et al.). Another study showed similar results in 417 non-referred women with TTM (Wetterneck, Woods, Norberg, & Begotka, 2006). Over 40% reported that they refrained from close friendships at least 'some of the time' and approximately 86% reported that the quality of close friendships was reduced due to TTM during their lifetime. Furthermore, 42% of the sample reported that they refrained

from intimate relationships at least 'some of the time' and approximately 81% reported that the quality of intimate relationships had been negatively affected by TTM during their lifetime (Wetterneck et al.).

Interpersonal difficulties seem consistent across the lifetime for those with TTM. A cross-sectional study of functional impairment in women with TTM found that impairment in social functioning was present in children and increased with age, maintaining at a high level throughout adulthood (Flessner, Woods, Franklin, Keuthen, & Piacentini, 2009). The authors concluded that for children and adolescents, interventions should be tailored to improve peer interactions and that developing stronger friendships may be important. In addition, early interventions may have an important prophylactic function for reducing long-term functional impairment from TTM (Flessner et al.). Thus, the authors imply that even if TTM is treated early, the effects of interpersonal impairment may not dissipate.

Based on a few studies in the area of TTM it appears as though interpersonal difficulties, many associated with different aspects of intimacy, are the norm. In addition, treatment administered early after onset may help stave off long-term effects of altering interpersonal behaviors. Given that many people wait years, or decades after onset to receive help, a remittance of hair-pulling symptoms may not result in an increase in intimate behaviors. These findings help demonstrate the importance of enhancing other behavioral treatments for TTM with FAP when assessing and treating individuals with longstanding hairpulling behaviors.

Other Clinical Areas of Interest. Although the length of this paper precludes the authors from addressing the area of intimacy in each psychiatric disorder, it is worth highlighting a few more findings from other areas of clinical interest. For example, although treatments like CBT seem effective for eating disorders such as Bulimia Nervosa (BN; Craighead & Agras, 1991), most of the treatment focuses on eating and bingeing behaviors, and their triggers, with little to do with interpersonal variables. Recent research on the use of IPT to treat BN indicates that it is about as effective as CBT in the long-term (Agras, Walsh, Fairburn, Wilson & Kraemer, 2000; Fairburn, Jones, Peveler, Hope & O'Connor, 1993) even though it does not directly address any of the maintaining mechanisms identified by CBT (Fairburn, 1997).

In the area of personality disorders, previous researchers have categorized intimacy as one of the three primary problems in self-other domains (along with an adaptive self-system and the ability to function effectively in society; Livesley & Jang, 2000). It is likely that personality variables and interpersonal functioning underlie most clinical states and the intensity of such difficulties may affect therapeutic outcome. Skodol and colleagues, in their work on the upcoming DSM 5, posit that personality disorders emphasize self-identity and self-direction but also the interpersonal factors empathy and intimacy (Skodol et al., 2011). In their view, intimacy is characterized as the depth and duration of positive connections with others; desire and capacity for closeness; and mutuality of regard reflected in interpersonal behavior. Although this definition is different from those reported earlier (e.g., it refers to an internal state, desire), it appears as though this proposed system will call for even more focus on assessing and increasing intimacy in clinical disorders, specifically with personality disorders. Therefore, we chose not to review the evidence for intimacy deficits in a representative personality disorder.

Finally, while "marital difficulties" is not a clinical diagnosis in the DSM, it is frequently a reason to attend therapy and intimacy often plays an important role. For example, almost a third of couples report marriages with absent and/or deficient intimacy. Further, couples with "absent and/or deficient" marital intimacy had a significantly higher proportion of spouses with symptoms of non-psychotic emotional illness (Waring, Patton, Neron, & Linker, 1986). Hence the stress of marital difficulties can cause clinical conditions as well as conversely exacerbate existing problems. For instance, concerning the treatment of OCD, high levels of hostility & criticism (expressed emotion) have been associated with poorer treatment outcome and relapse at follow up in adults with OCD (Chambless & Steketee, 1999). Helping develop a "culture of change" as has been proposed for OCD can help provide a zone of safety, support and compassion in which effective change can occur.

WHY IS INTIMATE BEHAVIOR NOT EXPLICITLY ADDRESSED IN CBT?

There are a number of reasons why many current CBT treatments do not explicitly address intimacy. First and foremost, intimacy and interpersonal functioning may be such an obvious outcome that it is not made explicit and that the natural outcome of any therapy is better relational functioning. Furthermore, intimacy may not be addressed because it is not a specific symptom in a disorder and cognitive behavioral theory, in general, does not implicate intimacy as a factor that leads to the development or maintenance of disorders. Many empirically supported treatments target only one condition and even those that are considered transdiagnostic may focus attention on mechanisms of change across disorders, but are still in the service of symptom reduction. Trying to measure and target intimacy would understandably be a separate research question. However, there are recent findings that show that clinically significant symptom change does not always result in a reliable improvement in functioning and that the latter can occur without the former being achieved (Karpenko, Owens, Evangelista, & Dodds, 2009). Therefore we believe that when symptom reduction is part of the goal of therapy, we could also be targeting intimacy and interpersonal functioning as well.

Perhaps intimacy is targeted through other CBT techniques indirectly. For example, teaching cognitive restructuring may help a client recognize and correct patterns and errors in thinking that are preventing connection and intimacy from occurring. Encouraging a person to develop a hierarchy of fears and participate in exposures could be applied to various social and more intimate situations. Targeting emotional avoidance could include situations involving intimacy. It appears that our field may have some tools to use to increase intimacy, but generally these tools are used in the service of symptom reduction.

Moreover it may be assumed that intimacy will improve once symptoms remit. While it seems rational that symptom remission may set a stage for intimacy to occur, it may not be all that is required to increase intimacy. For example, many of the afore-

mentioned disorders typically have an onset during adolescence through early adulthood. The severity of the symptoms may hinder normal interpersonal development and make it more difficult to recover if the symptoms do remit. In addition, individuals who have had chronic psychiatric conditions for years or decades may have long-standing behavioral patterns that do not change simply with symptom remission. Finally, as Cordova and Scott (2001) point out, increasing intimacy can create a snowball effect of intimate exchanges and eventually a boundary will be crossed and an intimate behavior will be punished. Thus, if a client did receive help for increasing intimacy in session without experiencing it in session, it may be punished too early and impede a client's effort. One way to avert this outcome would be to use FAP and practice in a safer environment to allow for better recovery after punishment occurred.

Yet another reason may have to do with the current trends in CBT listed above. Disorder specific treatments may not target intimacy as deficits in this area are not explicit symptoms in disorders. Transdiagnostic approaches contain modules for shared mechanisms of maintenance. Could a brief module be devised to improve intimacy, especially in cases where the client has no partner with which they could practice new skills? EA as a universal process may account for deficits in intimacy. However, are all deficits in intimacy due to avoidance or escape from private events or is a lack of intimacy also due to a lack of an appropriate behavioral repertoire? Even if many difficulties associated with intimacy are related to EA, some prominent researchers have suggested that individually tailored measures of EA are needed for specific problems (Hayes, 2003) and many ACT protocols differ in order to focus on needed areas based on the client's presentation.

Along with the aforementioned reasons, intimacy difficulties may not have enough empirical support to warrant highlighting in current treatment packages. The evidence presented earlier in this paper ties together a case for addressing intimacy in therapy, but most of the research did not directly target intimacy as a point of interest and often more general measures of interpersonal difficulties or quality of social life were used. Perhaps more work needs to be done to investigate the role of intimacy in the development, maintenance, and remission from various types of psychopathology.

FUTURE DIRECTIONS

A brief look at intimacy and related areas of interpersonal functioning across a number of clinical disorders gives us reason to believe that it is an important construct to explore in future research and treatment. Furthermore, the theoretical basis and early evidence for using FAP to address these issues seems both logical and needed. Along with identifying FAP as a solution for intimacy issues, a few others steps need to be taken in order to make progress in this area including deciding on an accepted definition for intimacy, developing appropriate measures of intimacy, and planning a strategy of research that will assess FAP's usefulness. A thorough discussion of these topics could be separate papers, therefore in closing we will give a few brief suggestions.

Most of the research we cited on intimacy contained different definitions and conceptualizations of the term, or the authors inferred (and in some cases the current authors made the inference) that intimacy was a target of interest based on related constructs of interpersonal functioning. Therefore, we suggest that a common definition be employed and specifically refer to the writings of Cordova and Scott (2001) who defined intimacy as "behavior vulnerable to interpersonal punishment by the response of another person: (p. 75) and to include events such as self-disclosure of negative and positive thoughts, memories, secrets, and feelings, and physical closeness.

After establishing the definition, we propose that intimacy should be studied as a potential universal process across a variety of mental health conditions. There is precedence for theorists outside of CBT to highlight the importance of intimacy and other interpersonal aspects as central to many areas of psychopathology (cf. Horowitz, 2004). Including intimacy will help to determine the extent to which empirical evidence supports these claims and influence how much time should be devoted to intimacy in CBT. To do this, the field needs a measure to identify and capture the various aspects of intimacy.

Once an appropriate measure is developed, we suggest that studies investigate the role of intimacy across multiple clinical populations. Cross-sectional studies examining intimacy and disorder severity may be the easiest to conduct. In addition to examining intimacy in relation to severity of symptoms, we also believe it would be helpful to examine the developmental onset of the condition and the length of interference as intimacy may be more affected when a condition interferes with normal development at earlier ages and when prolonged patterns of behavior, including refraining from intimacy, are established. Regarding the development of psychopathology, longitudinal studies examining intimacy at earlier stages of life would be allow researchers to determine if interventions were needed to prevent difficulties in this area and the development of patterns of disordered behavior. Obviously for treatment purposes, single-subject designs or controlled case studies may be ideal for piloting the efficacy of FAP for a variety of presentations as either a stand-along treatment, or an enhancement to other therapies. Finally, investigating intimacy's relationship to variables related to treatment (i.e., therapeutic alliance), symptom changes or variables that predict change and maintenance of gains would help assess the value of studying intimacy.

As a final note, along with developing an intimacy construct for research purposes and testing FAP in controlled designs, we urge practitioners of CBT and other therapies to consider integrating ideographic assessment and treatment plans that include intimacy as a component of therapy. Although this can be accomplished in a number of ways (e.g., Emotion Focused Therapy; Greenberg & Watson, 2006; MBT; Allen, Fonagy & Bateman, 2008; and FAP; Tsai et al.; 2008), we believe that if you are a CBT practitioner, integrating your current work with FAP principles may be the most parsimonious way to meet this goal.

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