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FEATURE ARTICLE:

CBT for Jealousy

By Robert L. Leahy

One of the most difficult issues in intimate relationships is the problem of jealousy. We know from research on domestic violence that jealousy is the leading cause of partner homicide. And we also see jealousy between friends, siblings, and co-workers. Despite the ubiquitous nature of jealousy and the difficult consequences that ensue there has been very little in the CBT literature that addresses this problem. So I decided to write a general audience book on the topic and just published *The Jealousy Cure: Learn to Trust, Overcome Possessiveness, and Save Your Relationship*. In this book I describe the evolutionary origins of jealousy, gender differences, the individual differences in vulnerability to jealousy and I offer an integrative CBT approach for coping with jealousy. This approach includes my Emotional Schema Therapy model, ACT, cognitive therapy, metacognitive therapy and mindfulness and is addressed both to the individual experiencing the jealousy and the person who is the "target" of jealousy.

The evolutionary psychologist, David Buss, described his own experience with jealousy. Buss noted that when he was in college he thought he didn't have a right to tell his girlfriend what she could do with her body—she should feel free to have sex with whomever she wished. But then he changed his mind when he got a girlfriend. Jealousy is a universal emotion—we find it in infants who are jealous of the attention that the mother shows to another infant, in animals (dogs being more jealous than cats), friends, siblings, coworkers and romantic partners. Jealousy is always about three people---the person feeling jealous, the desired partner and the external threat.

Two evolutionary models are relevant—the parental investment model and the competition for limited resources model. Parental investment implies that I am more invested in the offspring with whom I share genes and I would compete with others to protect my investment. Since the female always knows her genes are represented in the offspring she would be less jealous than men about sexual infidelity, but more jealous about emotional closeness since she might fear that the male partner will direct resources toward another

partner. This sex difference is supported by the research. Of course, both genders can feel jealous. The limited resource model accounts for jealousy between siblings, friends and coworkers since they compete for resources or relationships of value. There are individual differences in the vulnerability to jealousy. Jealousy is related to greater uncertainty in the relationship, the stage of the relationship in terms of commitment, one's perception of desirable alternatives for the self if the current relationship ends, attachment style, and prior history of abandonment or betrayal. And jealousy is not reducible to low self-esteem: you can feel jealous because you will not tolerate devious behavior that you find disrespectful.

I distinguish between jealous thoughts and feelings and the problematic coping strategies that are employed—such as interrogating, checking, stalking, and testing the partner. These are safety behaviors that may actually increase the jealousy and ironically alienate the partner one is trying to hold onto. We can use metacognitive, acceptance and mindfulness techniques to acknowledge and accept the feelings and thoughts, but also consider detaching from them and following valued action in the relationship. Building a life worth living that is independent of the relationship provides a sense that one is not desperately dependent on this one working out. I also suggest that we think of our intimate relationships as inevitably filled with ambivalence, disappointment (at times), and frustration and I offer the metaphor of The Relationship Room. In the Relationship Room we imagine our relationship as a large room filled with experiences, emotions, memories and possibilities and we make room for the jealousy, disappointments and annoyances that we may experience. Rather than endorse a model of what I call "emotional perfectionism" we can recognize that we or our partner can experience these feelings and that there is room to contain and accept them while focusing on the values that build connection. In addition, we need to be realistic that people may have different levels of commitment or demands for freedom and that it is up to us to decide if "enough is enough" and that our jealousy tells us that it is time to leave.

PROGRAM PROFILE:

Program for Anxiety and Traumatic Stress Studies (PATSS)

By Melissa Peskin

The Program for Anxiety and Traumatic Stress Studies (PATSS) is a specialized clinical research program within the Department of Psychiatry at Weill Cornell Medical College that focuses on trauma and its sequelae, including Posttraumatic Stress Disorder (PTSD), anxiety disorders, and depression. Led by JoAnn Difede, Ph.D., a pioneer in the use of virtual reality technology for World Trade Center and combat-related PTSD, the program aims to develop and test innovative treatments for PTSD, improve the effectiveness of existing treatments, and identify genetic, psychophysiological, and cognitive-emotional factors that influence the development of PTSD and predict treatment response.

Although our program began in 1994, PATSS greatly expanded following the events of September 11 with a psychological screening and treatment program for disaster relief workers at the World Trade Center site. Recognizing that not all patients would benefit from exposure therapy, the only PTSD treatment recommended by expert guidelines when the 9/11 attacks occurred, Dr. Difede, in conjunction with colleagues, developed virtual

World Trade Center, a computer simulation of the September 11 attacks in which patients are able to encounter and gain mastery of their trauma (Difede et al., 2007). By offering not only visual, but auditory, olfactory, and haptic sensory cues to facilitate emotional engagement and processing of the trauma memory, virtual reality exposure therapy aims to reach patients who are reluctant or unable to recount their traumatic experiences using traditional imaginal exposure.

In 2005, following the success of this early work with 9/11 survivors (Difede et al., 2014), PATSS began offering individual therapy and psychological health and wellness workshops to military service members, establishing a longstanding relationship with military personnel that has continued to this day. In 2017, we finished recruitment for a Department of Defense-funded multisite, randomized controlled trial (RCT) of virtual reality and imaginal exposure therapy with a cognitive enhancer for Iraq and Afghanistan veterans with combat related PTSD.

Our current research studies span a number of domains. First, we have recently initiated a multiyear Department of Defense-funded clinical trial for military personnel from any service era with PTSD due to military sexual trauma. In this RCT, we are evaluating the efficacy of exposure therapy, the gold standard treatment for PTSD (Institute of Medicine, 2008), compared to Interpersonal Psychotherapy, a time-limited, diagnosis-targeted treatment of demonstrated efficacy for mood and eating disorders (Weissman, Markowtiz, & Klerman, 2007) that has recently demonstrated noninferiority to Prolonged Exposure in an RCT for individuals with PTSD due to various traumas (Markowitz et al., 2015).

Given some of the challenges associated with engaging service members with military sexual trauma in treatment, we are also undertaking a pilot study to explore the feasibility of using an environmental manipulation to promote willingness to engage in treatment, increase positive attributions towards a potential therapist, and decrease anxiogenic responding in this population. Specifically, this pilot study will gather preliminary data to explore whether interacting with a therapy dog facilitates treatment engagement and perceptions of warmth, likability, and trustworthiness toward a potential therapist and is associated with reduced physiological arousal in service members with PTSD due to military sexual trauma.

In addition to our work with the military, we are also conducting a randomized controlled trial of a first-in-class vasopressin receptor antagonist medication for the treatment of PTSD due to any type of trauma. As has been widely recognized, PTSD includes symptoms related to interpersonal functioning: isolation, aggression, distrust, or a sense of distance between patients and people in their lives. Vasopressin is one of the key neural modulators of social behavior, and this medication is one of the first compounds shown to cross the blood-brain barrier and selectively antagonize V1a receptors in the brain, which are consistently linked to social behaviors in mammals. Ours is the first trial of any such compound for the treatment of PTSD. In this Phase IIa clinical trial, our goals are primarily to investigate safety and tolerability of the medication in this clinical population. As such, all of our participants are taking the experimental medication for half the study and a pill placebo for the other half. We are assessing patients for symptom levels and safety every two weeks during the 18-week study, and provide referrals to patients still experiencing PTSD symptoms following the study's end.

Through these and other clinical research endeavors, including those at the William Randolph Hurt Burn Center at New York Presbyterian, we strive to expand the range of effective treatment options for PTSD, in dialogue with other professionals specializing in the treatment of trauma and related conditions.

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