



TREATMENTS THAT WORK
TRANSDIAGNOSTIC PROGRAMS


Unified Protocol for Transdiagnostic Treatment of Emotional Disorders

Second Edition

THERAPIST GUIDE

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OXFORD



**Unified Protocol
for Transdiagnostic
Treatment of Emotional
Disorders**

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Stunning developments in healthcare have taken place over the last several years, but many of our widely accepted interventions and strategies in mental health and behavioral medicine have been brought into question by research evidence as not only lacking benefit, but perhaps, inducing harm (Barlow, 2010). Other strategies have been proven effective using the best current standards of evidence, resulting in broad-based recommendations to make these practices more available to the public (McHugh & Barlow, 2010). Several recent developments are behind this revolution. First, we have arrived at a much deeper understanding of pathology, both psychological and physical, which has led to the development of new, more precisely targeted interventions. Second, our research methodologies have improved substantially, such that we have reduced threats to internal and external validity, making the outcomes more directly applicable to clinical situations. Third, governments around the world and healthcare systems and policymakers have decided that the quality of care should improve, that it should be evidence based, and that it is in the public's interest to ensure that this happens (Barlow, 2004; Institute of Medicine, 2001, 2015; McHugh & Barlow, 2010).

Of course, the major stumbling block for clinicians everywhere is the accessibility of newly developed evidence-based psychological interventions. Workshops and books can go only so far in acquainting responsible and conscientious practitioners with the latest behavioral healthcare practices and their applicability to individual patients. This series, *Treatments That Work*, is devoted to communicating these exciting new interventions to clinicians on the frontlines of practice.

The manuals and workbooks in this series contain step-by-step detailed procedures for assessing and treating specific problems

and diagnoses. But this series also goes beyond the books and manuals by providing ancillary materials that will approximate the supervisory process in assisting practitioners in the implementation of these procedures in their practice.

In our emerging healthcare system, the growing consensus is that evidence-based practice offers the most responsible course of action for the mental health professional. All behavioral healthcare clinicians deeply desire to provide the best possible care for their patients. In this series, our aim is to close the dissemination and information gap and make that possible.

A leading development in evidence-based treatment programs based on the most up-to-date research and clinical evaluation is found in unified, transdiagnostic interventions for disorders that share common features and respond to common therapeutic procedures. Deepening understanding of the nature of psychological disorders reveals that commonalities in etiology and latent structures among many classes of disorders supersede differences, and many disorders in a class look very similar in terms of behavioral problems and brain function. Indeed, most people with one disorder or problem typically have another problem or comorbid disorder, often from the same class of disorders. Thinking of these disorders or problems as related, or on a “spectrum,” is the approach now taken by leading therapists and by the authors of the *DSM-5*.

This volume, *Unified Protocol for Transdiagnostic Treatment of Emotional Disorders*, inaugurates a new collection of books published as part of the *Treatments That Work* series, TTW: Transdiagnostic Programs, established to reflect and respond to the growing acknowledgement in our field of the importance of the spectrum approach to mental health treatment. This book is designed to address emotional disorders. Generally, this group of disorders includes all of the anxiety and mood (depressive) disorders such as panic disorder with or without agoraphobia, social anxiety disorder, generalized anxiety disorder, post-traumatic stress disorder, obsessive-compulsive

disorder and depression. The program is also designed to address closely related “emotional disorders” such as health anxiety, the experience of dissociation (feelings of unreality), and alcohol or substance abuse associated with substantial negative affect such as anxiety and depression. What all of these disorders have in common, based on recent research findings, is excessive or inappropriate emotional responding accompanied by a sense that one’s emotions are careening out of control.

In this fully updated and revised second edition of the *Unified Protocol*, treatment procedures have been further elucidated and more guidance is provided to practitioners on how to present key treatment concepts. Chapters brand new to this updated edition introduce functional assessment and describe how to provide the UP in a group format, while patient materials have been revised, streamlined, and made more user-friendly.

The development of the *Unified Protocol for Transdiagnostic Treatment of Emotional Disorders* began with the distillation of key principles from traditional empirically supported cognitive behavioral treatments (CBT; e.g., Barlow & Craske, 2006) integrated with advances in research on emotion regulation and dysregulation (e.g., Fairholme, Boisseau, Ellard, Ehrenreich, & Barlow, 2010). It is important to note that the UP continues to emphasize the fundamental principles of traditional CBT as applied to emotional disorders such as extinction learning, through the prevention of cognitive and behavioral avoidance strategies, behavioral, emotional and interoceptive exposure, and the encouragement of cognitive flexibility.

This program is not generally recommended for a specific phobia, if that is the sole problem unaccompanied by other emotional disorders. Other books in this series can deal more efficiently with that problem (see Craske, Antony, & Barlow, 2006).

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References

- Barlow, D. H. (2004). Psychological treatments. *American Psychologist*, *59*, 869–878.
- Barlow, D. H. (2010). Negative effects from psychological treatments: A perspective. *American Psychologist*, *65*(2), 13–20.
- Barlow, D. H. & Craske, M. G. (2006). *Mastery of your anxiety and panic (4th ed): Therapist guide*. New York: Oxford University Press.
- Craske, M. G., Antony, M. M., & Barlow, D. H. (2006). *Mastering your fears and phobias (2nd ed): Therapist guide*. New York: Oxford University Press.
- Fairholme, C. P., Boisseau, C. L., Ellard, K. K., Ehrenreich, J. T., & Barlow, D. H. (2010). Emotions, emotion regulation, and psychological treatment: A unified perspective. In A. M. Kring & D. M. Sloan (Eds.), *Emotion regulation and psychopathology: A transdiagnostic approach to etiology and treatment*. (pp. 283–309). New York: Guilford Press.
- Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Washington, DC: National Academy Press.
- Institute of Medicine (IOM). (2015). *Psychosocial interventions for mental and substance use disorders: A framework for establishing evidence-based standards*. Washington, DC: National Academies Press.
- McHugh, R. K., & Barlow, D. H. (2010). Dissemination and implementation of evidence-based psychological interventions: A review of current efforts. *American Psychologist*, *65*(2), 73–84.

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✓ PART I

Background for Therapists

“Human infirmity in moderating and checking the emotions I name bondage: for, when a man is a prey to his emotions, he is not his own master, but lies at the mercy of fortune: so much so, that he is often compelled, while seeing that which is better for him, to follow that which is worse”

—Baruch Spinoza, *Ethics*

Over the last several decades, many advances have been made in the psychological treatment of anxiety and mood disorders. In fact, effective treatments have emerged for the most common mental health conditions (e.g., Mastery of Your Anxiety and Panic for panic disorder, Managing Social Anxiety for social anxiety disorder; Barlow & Craske, 2007; Hope, Heimberg, & Turk, 2006). These individual protocols have narrowly focused on addressing the discrete symptoms associated with a given disorder (e.g., panic attacks, fears of social evaluation). However, more recent conceptualizations of these common conditions emphasize their similarities rather than their differences. Specifically, research suggests that there is considerable overlap in symptoms across disorders; for example, worry occurs in all of the anxiety disorders, though the focus may vary across conditions (e.g., worry about safety of loved ones in generalized anxiety disorder, worry about having another panic attack in panic disorder). Additionally, there appears to be a broad treatment response when targeting one disorder that often generalizes across other disorders. Finally, there are extremely high rates of comorbidity for the range of anxiety and depressive disorders (estimates as high as 75%; Brown, Campbell, Lehman, Grisham, & Mancill, 2001), suggesting that patients do not fit neatly into the diagnostic boxes the field has created for them. Taken together, this

evidence suggests that there may be a common set of vulnerabilities contributing to the development of anxiety, depressive, and related disorders that can become a more efficient focus of treatment than the diverse symptoms themselves.

Specifically, research converges on three core vulnerabilities that put an individual at risk to develop many common mental health conditions. First, there is evidence to suggest that anxiety, depressive, and related disorders are characterized by high levels of negative affect. In other words, individuals with these disorders have a temperamental propensity to experience negative emotions frequently and intensely, referred to as neuroticism (Barlow, Sauer-Zavala, Carl, Bullis, & Ellard, 2014). Second, individuals with these common conditions tend to view their emotional experiences negatively (e.g., “it’s weak to feel this way,” “no one else is reacting like this,” “these physical sensations are terrible”). Finally, aversive reactions to emotions when they occur, in turn, lead to efforts to avoid and suppress them. Individuals with anxiety and depressive disorders often rely on maladaptive regulation strategies that backfire (Purdon, 1999), maintaining high levels of negative affect and contributing to the persistence of symptoms. Given the role of emotional experiences in the development and maintenance of the full range of anxiety, depressive, and related disorders, we refer to these conditions as “emotional disorders” to emphasize this common feature. For more information on the nature of emotional disorders, see Barlow, Sauer-Zavala, Carl, Bullis, and Ellard (2014).

Thus, cutting-edge research lends support for a unified approach that considers these commonalities and is applicable to a range of emotional disorders. Based on these advances, we developed a treatment applicable to all anxiety and unipolar depressive disorders, and potentially other disorders with strong emotional components (e.g., eating disorders, borderline personality disorder). The Unified Protocol (UP) for the Transdiagnostic Treatment of Emotional Disorders addresses neuroticism by targeting the aversive, avoidant reactions to emotions that, while providing relief in the short term, increase the likelihood of future negative emotions and maintains disorder symptoms. The strategies included in this treatment are largely based on common principles found in existing empirically supported psychological treatments—namely, fostering mindful awareness, reevaluating

automatic cognitive appraisals, changing action tendencies associated with the disordered emotions, and utilizing exposure procedures. It is important to note, however, that the focus of these core skills has been adjusted to specifically address core negative responses to emotional experiences, described in detail in the following chapter.

Advantages of a Unified, Transdiagnostic Approach

Mechanistically transdiagnostic interventions, like the UP, confer several practical advantages for patients and clinicians (Sauer-Zavala et al., 2017). First, as noted previously, rates of co-occurrence across the emotional disorders is quite high, and single-disorder protocols (SDPs; i.e., interventions that focus on the symptoms of one disorder) are not equipped to handle comorbid conditions. In contrast, by targeting the core emotional processes that maintain symptoms across disorders, the UP can simultaneously address co-occurring conditions. Additionally, the field's emphasis on SDPs has created a training burden, as therapists must familiarize themselves with a separate treatment for nearly every disorder. Again, the UP eliminates this burden as therapists need only learn one intervention in order to provide evidence-based care to most common conditions.

Efficacy of the UP

The UP has now garnered strong empirical support for its use with a range of emotional disorders. First, in a small randomized controlled trial ($N = 37$), the UP was found to significantly reduce symptoms for a range of anxiety disorders compared to a wait-list control group, with patients continuing to improve even 18 months after treatment (Bullis, Fortune, Farchione, & Barlow, 2014; Farchione et al., 2012).

Based on these promising results, we then conducted a larger, randomized trial ($N = 223$) comparing the UP to gold-standard, evidence-based protocols designed to treat the diagnosis-specific symptoms (i.e., SDPs) of generalized anxiety disorder, social anxiety disorder, obsessive compulsive disorder, and panic disorder. Results indicated that emotional disorder symptoms improved similarly for UP and SDPs, with

both groups demonstrating significant reductions in the severity of the principal diagnosis posttreatment, with the UP evidencing significantly less attrition than the SDPs. With regard to comorbid conditions, 62% of patients treated with the UP no longer met diagnostic criteria for *any* emotional disorder, and these improvements were largely maintained one year later. Overall, these results suggest that the transdiagnostic UP approach is just as good at addressing the primary disorder as the targeted protocol designed explicitly for that condition. Given the practical advantages of the UP (described previously), these results lend support for the widespread dissemination of the UP.

There is also preliminary data to suggest that the UP can be successfully applied to other diagnoses that are characterized by the emotional disorder vulnerabilities described earlier. Specifically, there is evidence to support the use of the UP for emotional disorder patients with co-occurring alcohol abuse or dependence diagnosis (Ciraulo et al., 2013), unipolar depressive disorders (Boswell, Anderson, & Barlow, 2014), bipolar disorder (Ellard, Deckersbach, Sylvia, Nierenberg, & Barlow, 2012), borderline personality disorder (Sauer-Zavala, Bentley, & Wilner, 2016), and posttraumatic stress disorder (Gallagher, 2017).

Given the UP's focus on addressing core processes, we have also studied the UP's ability to change dimensions of temperament in the scope of the randomized control trials mentioned previously (Carl, Gallagher, Sauer-Zavala, Bentley, & Barlow, 2014). Results revealed that the UP, compared to the wait-list group, indeed produces small to moderate changes in neuroticism from pre- to posttreatment. Significantly, these changes in temperament are related to improvements in functional impairment and quality of life (Carl et al., 2014). These results underscore the potential importance of factoring in changes in temperament when considering treatment outcome.

Furthermore, based on the relative advantages of group treatment to individual treatment (e.g., ability to treat more patients, reduced stigma associated with seeking treatment, opportunity to learn from other group members), we have studied the efficacy of the UP delivered in a group format, which happens to be where the protocol originated (Barlow, Allen, & Choate, 2004). Results indicated moderate to strong effects on anxiety and depressive symptoms, functional impairment,

quality of life, and emotion regulation skills. Additionally, patients who received the UP in a group format reported comparable levels of satisfaction to those who received individual administration (Bullis et al., 2015).

Purpose of This Therapist Guide

This book was developed to provide mental health providers with guidance on administration of the UP. This guide is based on our research related to the development of this protocol for over a decade, on our clinical experience administering this treatment to countless individuals with emotional disorders, and on the feedback we have received from other practitioners whom we have trained and others who use the UP regularly in their clinical practice. Clinical vignettes are provided to illustrate common issues that tend to arise in the administration of the protocol and ways to resolve them. However, for more detailed case examples covering a range of emotional disorders, please see our recent publication designed specifically for that purpose (Barlow & Farchione, 2017).

The first four chapters of this guide provide introductory and background information about the treatment program. Subsequent chapters provide step-by-step instructions for facilitating treatment and conducting sessions. Each of these chapters corresponds to a chapter in the UP (patient) workbook. Please note that in this guide we intentionally use the terms *therapist*, *clinician*, and *practitioner* interchangeably to describe treatment providers.

Basic Principles Underlying the Treatment Procedures

The Unified Protocol (UP) is based on traditional cognitive-behavioral principles. However, its particular emphasis on the way individuals experience and respond to their emotions is unique in that it brings emotional processes to the forefront, making them available to fundamental psychological mechanisms of change. These mechanisms not only change behavior, including responses to emotional experience, but also change brain function and create new learning and memories (Craske & Mystkowski, 2006; Monfils, Cowansage, Klann, & LeDoux, 2009). The main premise of this treatment is that individuals with emotional disorders use emotion regulation strategies—namely attempts to avoid or dampen the intensity of uncomfortable emotions—which ultimately backfire and contribute to the maintenance of their symptoms. Thus, the UP is an emotion-focused treatment approach; that is, the treatment is designed to help patients learn how to confront and experience uncomfortable emotions and learn how to respond to their emotions in more adaptive ways. By modifying patients' emotion regulation habits, this treatment aims to reduce the intensity and incidence of interfering and overwhelming emotional experiences and improve functioning. It is important, however, to understand that the UP does not attempt to eliminate uncomfortable emotions. On the contrary, the emphasis is on bringing emotions back to a functional level, so that even uncomfortable emotions can be appreciated as adaptive and helpful.

Early chapters of the UP workbook help patients develop a greater understanding of emotions. Patients learn about emotions, including

why they occur and how they are adaptive, and are presented with a three-component model of emotion that helps them develop a greater understanding of the interaction of thoughts, physical sensations, and behaviors in generating internal emotional experiences. In addition, patients are taught to track their emotional experiences in accordance with this model. This process assists patients with gaining a greater awareness of their emotional experiences (including the triggers and short- and long-term consequences of behavior) and helps them take a more objective view of their emotions, rather than simply getting “caught up” in their emotional response. This increased understanding and awareness of emotion transitions to *the first core skill of the UP, mindful emotion awareness, which involves the practice of nonjudgmental, present-focused attention toward emotional experiences*. This mindful awareness building is seen as an important fundamental skill serving to enhance acquisition of subsequent treatment concepts. As such, the UP emphasizes the adaptive, functional nature of emotions and helps facilitate greater tolerance of emotions.

Challenging automatic thoughts related to external threats (e.g., being late) and internal threats (e.g., physical sensations leading to a heart attack) and increasing cognitive flexibility comprise the second core skill in the UP. We adapted existing cognitive interventions, as innovated by Aaron T. Beck (Beck, 1972; Beck, Rush, Shaw, & Emery, 1979), to focus on two fundamental misappraisals: (1) overestimating the likelihood of a negative event happening (“probability overestimation”) and (2) exaggerating the consequences of that negative event if it did happen and underestimating the ability to cope (“catastrophizing”) (Barlow & Craske, 2000; Zinbarg, Craske, & Barlow, 2006). Also, unlike some other cognitive therapies, the emphasis of the UP is not on eliminating or replacing negative thoughts with more adaptive or realistic interpretations but rather on increasing cognitive flexibility as an adaptive emotion regulation strategy. Patients are encouraged to use reappraisal strategies not only before but also during and after emotionally laden situations. In addition, the UP emphasizes the dynamic interaction between cognitions and both physical sensations and behaviors as an important component of emerging emotional experiences. Although cognitive reappraisal could theoretically be used as a standalone treatment procedure, our experience is that it is

particularly important for assisting patients to change behaviors and face challenging, emotionally provoking situations later in treatment.

A third core skill in the UP is identifying and modifying problematic action tendencies, or emotional behaviors. Inclusion of this strategy is consistent with theories and evidence from emotion science that indicate that focusing on and modifying these actions can be an effective means of emotion regulation. As Izard pointed out in 1971, “the individual learns to act his way into a new way of feeling” (p. 410). The idea of reducing patterns of avoidance is introduced early in treatment, during the initial discussion on the nature of emotions, and is then discussed in greater detail in the second half of the program.

Increasing awareness and tolerance of physical sensations through interoceptive exposures represents a fourth core skill in the UP. All patients, regardless of their diagnosis, are asked to engage in a series of interoceptive exercises designed to evoke physical sensations analogous to those typically associated with the emotions they find uncomfortable. We first placed an emphasis on interoceptive exposures as applied to the treatment of panic disorder (Barlow, 1988; Barlow & Cerny, 1988), in which physical sensations serve as both a direct trigger and a specific focus of anxiety. However, in the UP, interoceptive exposures are applied across diagnoses, whether or not physical sensations represent a specific trigger for the patient’s emotional response. This serves not only to increase the patient’s awareness of physical sensations as a core component of emotional experiences but also increases tolerance of these sensations, which in turn reduces the contribution of physical sensations to emotion aversion and avoidance. Through interoceptive exposure exercises, patients begin to recognize the role of physical sensations in emotional experiences, identifying ways in which these somatic sensations might influence thoughts and behaviors, as well as how thoughts and behaviors can serve to intensify these somatic sensations—all while challenging expectations about their ability to cope when experiencing strong physical symptoms.

These core treatment concepts are brought together in the final phase of the UP through engagement in emotion exercises, a fifth core component of the UP. These exercises emphasize the elicitation of and exposure

to emotional experiences in both situational and internal contexts. Consistent with other cognitive behavioral therapies utilizing exposure, the exposure exercises occur in a graduated “step-wise” fashion, so that patients confront less difficult (and less emotionally provoking) situations before systematically moving on to situations that elicit more intense emotions. However, it is important to communicate that there is no necessary reason for conducting exposures in this way. More difficult situations may produce higher intensity emotions that may be more difficult for patients to tolerate, but it does make the emotions more dangerous. With all exposures, the focus is on confronting the situation fully, so patterns of avoidance and other safety behaviors are identified and then efforts are made to reduce or eliminate these behaviors during the exposure exercises to best facilitate new learning and the creation of new memories. In this way, the tendency to engage in avoidance behaviors or emotional suppression is replaced with more adaptive approach tendencies.

Description of Treatment Modules

Based upon the five core skills just discussed, the UP consists of five core treatment modules that target key aspects of problematic emotional processing, specifically aversive reactions to emotions that lead to avoidant coping strategies (see Box 2.1): (1) mindful emotion awareness,

Box 2.1 UP Modules

Module 1: Setting Goals and Maintaining Motivation

Module 2: Understanding Emotions

Module 3: Mindful Emotion Awareness

Module 4: Cognitive Flexibility

Module 5: Countering Emotional Behaviors

Module 6: Understanding and Confronting Physical Sensations

Module 7: Emotion Exposures

Module 8: Recognizing Accomplishments and Looking to the Future

Note: Core modules are in bold.

(2) cognitive flexibility, (3) countering emotional behaviors, (4) recognizing and confronting physical sensations, and (5) emotion exposures. Based upon traditional cognitive-behavioral therapy approaches, these modules are anchored within the three-component model of emotion (thoughts, physical sensations, and behaviors) with an emphasis upon increasing awareness of the interaction among these components, as well as the function of emotions and behaviors within the context of present moment experience. Placing unfolding emotional experiences within the context of present moment awareness allows the patient to identify patterns of emotion regulation strategies being employed that are inconsistent or incompatible with ongoing situational or motivational demands. Thus, the UP moves away from targeting disorder-specific symptoms and toward targeting underlying mechanisms that exist along the full “neurotic spectrum” (Barlow, 2002; Krueger, Watson, & Barlow, 2005; Brown & Barlow, 2009). The five core modules are preceded by an introductory module that includes treatment exercises for enhancing motivation. A final module consists of reviewing progress over treatment and developing relapse prevention strategies. As the treatment proceeds, thoughts, physical feelings, and behaviors are each explored in detail, focusing specifically on elucidating dysfunctional emotion regulation strategies that the patient has developed over time within each of these domains and teaching more adaptive emotion regulation skills.

The modules build upon one another and were designed to proceed sequentially. However, flexibility was built into the UP by allowing each of the modules to be completed within a range of sessions, thus allowing for extra time to be devoted to certain modules in accordance with individual patient needs. For example, individuals with excessive, uncontrollable worry might benefit from an extended focus on mindful emotion awareness (Module 3), whereas individuals with repetitive compulsive behaviors might benefit from prolonged practice and attention to emotional behaviors (Module 5). Further, a common use of additional time is to extend Module 7 (Emotion Exposures) as needed, as this module provides an opportunity to practice all treatment skills simultaneously.

Following is a basic description of the UP treatment modules. We recommend that each patient complete all of the treatment modules, if

possible, even if the module may not initially appear to be directly relevant to the presenting problem. For instance, some patients do not report experiencing significant sensitivity to physical sensations, and so, on the surface, interoceptive exposures may not appear indicated. However, it has been our experience that many of these patients still report some benefit from engaging in these procedures, giving them the opportunity to recognize physical sensations as an important component of emotional experiences. For each module, we provide a recommended duration. Again, flexibility in the number of sessions dedicated to each module provides the therapist with some freedom in how much the treatment procedures are emphasized for a particular patient.

Module 1: Setting Goals and Maintaining Motivation

- *Duration: 1 session*
- *Corresponding Therapist Guide Chapter: 6*
- *Corresponding Workbook Chapter: 4*

This module focuses on increasing the patient's readiness and motivation for behavior change and fostering the patient's self-efficacy, or belief in his or her ability to successfully achieve change. To enhance motivation, patients are given the opportunity to weigh the pros and cons of making changes during treatment. They are also given the opportunity to articulate goals for treatment, with a focus on making their goals more concrete and identifying possible steps for achieving their treatment goals. This module was incorporated into the UP based on research conducted by Westra and colleagues illustrating the efficacy of such techniques as an adjunct in the treatment of anxiety disorders (Westra & Dozois, 2006; Westra, Arkowitz, & Dozois, 2009; Westra, Constantino, & Antony, 2016) and is based heavily on the principles and techniques used in Motivational Interviewing (Miller & Rollnick, 2002, 2012).

Module 2: Understanding Emotions

- *Duration: 1–2 sessions*
- *Corresponding Therapist Guide Chapter: 7*
- *Corresponding Workbook Chapters: 5 and 6*

This module provides patients with psychoeducation on the nature and function of emotions and the concept of learned responses. In addition to discussing the function of anxiety, this module covers many other emotions including anger, sadness, guilt, and fear, as well as positive emotions. Patients should begin to understand that their emotions serve a functional and adaptive role of providing information about the environment that informs and motivates behavior. During this module, patients also develop greater awareness of their own patterns of emotional responding, including potential maintaining factors of such experiences (e.g., common triggers and/or environmental contingencies), by beginning to monitor and track these experiences.

Module 3: Mindful Emotion Awareness

- *Duration: 1–2 sessions*
- *Corresponding Therapist Guide Chapter: 8*
- *Corresponding Workbook Chapter: 7*

The goal of Module 3 is for patients to learn and begin to apply present-focused, nonjudgmental attention to their emotional experiences. Specifically, this module serves to cultivate an attitude of curious and willing observation, facilitating the ability to “watch” the interaction between their thoughts, feelings, and behaviors during an emotional experience. Teaching of these concepts occurs in the context of three in-session exercises. First, patients are led in a guided meditation that prompts them to apply mindful attention to each component of an emotional experience; patients are then encouraged to practice this meditation for homework as a way to gain an understanding of what this type of attention feels like. Next, patients are asked to identify and listen to an emotion-eliciting song to practice applying nonjudgmental, present-focused awareness in the context of a strong emotion. Finally, patients are taught a “real-life” application of these formal meditation exercises called “anchoring in the present.” Here, they are encouraged to observe the three components of an emotional response and ask themselves whether their reaction is relevant to the demands of the present moment. After this module, patients’ understanding of their emotions should be sufficient to utilize strategies covered in subsequent modules.

Module 4: Cognitive Flexibility

- *Duration: 1–2 sessions*
- *Corresponding Therapist Guide Chapter: 9*
- *Corresponding Workbook Chapter: 8*

The primary purpose of Module 4 is to encourage flexible thinking using principles originated by Beck (1976) and modified in our setting over the decades (e.g., Barlow & Craske, 1988). In this session, patients come to understand how their thoughts influence their emotional reactions. Automatic interpretations happen quickly while in the moment and are most often negative. *Core* automatic thoughts are more generalizable cognitions patients have about themselves, for instance “I am a disappointment,” and these may shape many emotional responses. Automatic thoughts cause the patient to exclude other, potentially more appropriate perspectives on the situation. These thoughts are considered “thinking traps” if the patient has difficulty viewing the situation in another way. Two thinking traps common to all emotional disorders (and the only two that are taught in the UP, reflecting our longstanding approach) are “jumping to conclusions,” or the tendency to assume a negative outcome is very likely to occur, and “thinking the worst,” or thinking the outcome will be disastrous or that one is unable to cope with the outcome. The patient is taught to identify these biases and encouraged to be more flexible in their thinking by using reappraisal strategies.

Module 5: Countering Emotional Behaviors

- *Duration: 1–2 sessions*
- *Corresponding Therapist Guide Chapter: 10*
- *Corresponding Workbook Chapter: 9*

This module focuses on the behavioral component of an emotional experience. In this part of the treatment, you will assist patients in identifying behavioral patterns that function to avoid negative

emotions. In order to generate an encompassing list of emotional behaviors, patients are encouraged to consider several behavioral categories. These include emotion-driven behaviors that serve to dampen the experience of emotions once they are present (e.g., escaping a crowded area when feeling anxious, harming oneself when feeling overwhelmed), overt avoidance (e.g., refraining from air travel or attending parties), subtle behavioral avoidance (e.g., limiting eye contact, procrastinating), cognitive avoidance (e.g., distraction, thought suppression), and safety signals (e.g., carrying a lucky charm). Here, the consequences of these behaviors (i.e., reduction of distress in the short term but maintenance of it in the long term) is highlighted once again. After the patient identifies his or her patterns of emotional behaviors, the therapist encourages the use of alternative actions in which emotions (and the situations that provoke them) are approached, rather than avoided.

Module 6: Understanding and Confronting Physical Sensations

- *Duration: 1 session*
- *Corresponding Therapist Guide Chapter: 11*
- *Corresponding Workbook Chapter: 10*

This module focuses on increasing awareness of the role of physical sensations in emotional experiences. You will conduct a series of interoceptive exposure exercises designed to evoke physical sensations analogous to those typically associated with the experience of strong emotions (e.g., running in place to induce elevated heart rate, spinning in a chair to induce dizziness). The purpose of these exercises is to develop an increased tolerance of these sensations, in order to reduce the impact of strong physical symptoms on emotion aversion and avoidance. This module also allows the patient to begin to identify how physical sensations influence thoughts and behaviors, as well as how thoughts and behaviors can influence physical sensations.

Module 7: Emotion Exposures

- *Duration: 2 sessions minimum. Many therapists find it beneficial to devote several sessions to practicing emotion exposures, if possible. This intervention provides an opportunity to consolidate learning from previous modules and is where many patients see the most progress.*
- *Corresponding Therapist Guide Chapter: 12*
- *Corresponding Workbook Chapter: 11*

This module focuses on exposure to both internal (including physical sensations) and external emotional triggers, which provides patients with opportunities to increase their tolerance of emotions and allows for new contextual learning to occur. The focus of the exposures is on the emotional experience that arises and can take the form of in-session, imaginal, and in vivo exposures. You will help your patient design an Emotion Exposure Hierarchy that contains a range of situations so that exposures can proceed in a graded fashion for the remainder of treatment.

Module 8: Recognizing Accomplishments and Looking to the Future

- *Duration: 1 session*
- *Corresponding Therapist Guide Chapter: 14*
- *Corresponding Workbook Chapter: 13*

Treatment in the protocol concludes with a general review of treatment concepts and a discussion of the patient's progress. In this module, you will help your patient identify ways to maintain treatment gains and anticipate future difficulties and encourage them to use treatment techniques to make further progress in achieving short-term and long-term goals.

Outline of the Treatment Procedures

All of the treatment modules can be completed in as few as nine sessions but typically one or more of the modules will require more than

one session, extending the total length of treatment to between 12 to 16 sessions. Sessions are approximately 50 to 60 minutes in duration. Sessions are typically conducted weekly, although toward the end of treatment, after initiating Module 7, you may elect to hold sessions at two-week intervals to allow patients more time to experience and practice overcoming residual problems.

Table 2.1 provides an example of how you may wish to work through the chapters in the UP workbook. Again, the number of sessions for each of the primary UP modules, and thus the total number of treatment sessions, will vary from patient to patient, at your discretion. For example, a patient who worries constantly and has difficulty “staying in the moment” may spend more time developing awareness skills, whereas a patient suffering primarily from obsessive thoughts and compulsive behaviors may benefit from spending more time on the later treatment modules, as those are more directly focused on countering avoidance of feared situations and modifying maladaptive action tendencies.

Table 2.1 Sample Program Outline

Treatment Week(s) and Module	Workbook Chapter(s)	Therapist Guide Chapter(s)
Week 1 Introduction	Chapter 1: What are Emotional Disorders? Chapter 2: About this Treatment Chapter 3: Learning to Record Your Experiences	Chapter 5: Functional Assessment and Introduction to Treatment
Week 2 Module 1	Chapter 4: Setting Goals and Maintaining Motivation	Chapter 6: Setting Goals and Maintaining Motivation
Weeks 3 and 4 Module 2	Chapter 5: Understanding Your Emotions—What is an Emotion? Chapter 6: Understanding Your Emotions—Following the ARC	Chapter 7: Understanding Emotions

(continued)

Table 2.1 Continued

Treatment Week(s) and Module	Workbook Chapter(s)	Therapist Guide Chapter(s)
Weeks 5 and 6 Module 3	Chapter 7: Mindful Emotion Awareness	Chapter 8: Mindful Emotion Awareness
Weeks 7 and 8 Module 4	Chapter 8: Cognitive Flexibility	Chapter 9: Cognitive Flexibility
Weeks 9 and 10 Module 5	Chapter 9: Countering Emotional Behaviors	Chapter 10: Countering Emotional Behaviors
Week 11 Module 6	Chapter 10: Understanding and Confronting Physical Sensations	Chapter 11: Understanding and Confronting Physical Sensations
Weeks 12 through 15 Module 7	Chapter 11: Putting it into Practice—Emotion Exposures	Chapter 12: Emotion Exposures
	Chapter 12: The Role of Medication in the Treatment of Emotional Disorders	Chapter 13: Medications for Anxiety, Depression, and Related Emotional Disorders
Week 16 Module 8	Chapter 13: Moving UP from Here: Recognizing Accomplishments and Looking to Your Future	Chapter 14: Recognizing Accomplishments and Looking to the Future

Assessment and Monitoring

You may wish to screen patients for the presence of emotional disorder(s) using the Anxiety and Related Disorders Interview Schedule for DSM-5 (ADIS-5; Brown & Barlow, 2014), which was designed for this purpose. This semi-structured, diagnostic clinical interview focuses on DSM-5 diagnoses of anxiety disorders and their accompanying mood states, somatic symptom disorders, and substance and alcohol use. The information derived from the interview allows clinicians to determine differential diagnoses and gain a clear understanding of the nature and severity of each diagnosis. The ADIS-5 is available from Oxford University Press. Of course, a medical evaluation is also recommended to rule out medical conditions that may account for or exacerbate presenting symptomatology.

A number of additional standardized self-report inventories can provide useful information for case formulation and treatment planning, as well as to evaluate therapeutic change. This might include disorder-specific measures such as the self-report version of the Yale-Brown Obsessive Compulsive Scale (Goodman et al., 1989) for obsessive compulsive disorder, the self-report version of the Panic Disorder Severity Scale (adapted from Shear et al., 1997) for panic disorder with and without agoraphobia, the Penn State Worry Questionnaire (Meyer, Miller, Metzger, & Borkovec, 1990) for generalized anxiety disorder, and the Social Interaction Anxiety Scale (Mattick & Clarke, 1998) for social anxiety disorder. Of course, there are many other good measures available that could be utilized in place of these.

For measures that cut across emotional disorders, we have used the Beck Depression Inventory-II (Beck, Steer, & Brown, 1996) and Beck Anxiety Inventory (Beck, Epstein, Brown, & Steer, 1988; Beck & Steer, 1990; Steer, Ranieri, Beck, & Clark, 1993) as general measures of depressive and anxious symptoms, respectively. Another briefer option is the 21-item version of the Depression Anxiety Stress Scales (Lovibond & Lovibond, 1995), which assesses symptoms of depression, anxiety, and panic. Additionally, we recommend using the two non-diagnosis-specific measures of anxiety and depression provided in the UP workbook. These measures, the Overall Anxiety Severity and Impairment Scale (OASIS; Norman, Cissell, Means-Christensen, & Stein, 2006; referred to as the Anxiety Scale in the UP workbook and the remainder of this guide) and Overall Depression Severity and Impairment Scale (Bentley, Gallagher, Carl, & Barlow, 2014; referred to as the Depression Scale in the UP workbook and the remainder of this guide), a measure we adapted from the OASIS to assess symptoms of depression, were developed as continuous measures of anxiety- and depression-related symptom severity and impairment that could be used across disorders and in patients with multiple disorders.

You may also find it valuable to examine functional impairment and quality of life. A number of reliable and well-validated measures exist specifically for this purpose, including the Work and Social Adjustment Scale (modification of scale introduced by Hafner & Marks, 1976), the RAND 36-item Short-Form Health Survey (Hays, Sherbourne, & Mazel, 1993), and the Quality of Life Inventory (Frisch et al., 1992).

Medication

Many patients presenting to treatment for emotional difficulties will already be on psychotropic medications. In our experience, patients presenting to our clinic are typically taking low doses of high potency benzodiazepines (such as Xanax or Klonopin) or antidepressants (such as SSRIs like Paxil or Prozac), SNRIs (such as Effexor), and, to a lesser extent, tricyclic antidepressants. Issues surrounding the combination of medications with cognitive-behavioral therapy (CBT) treatments are

not fully understood, and the most effective ways to combine medications and CBT has yet to be empirically tested. Thus, we do not recommend that patients discontinue medications before initiating treatment with the UP. Rather, we suggest that they continue on a stable dose of their current medications while going through the program.

Unless clinically necessary, we discourage patients from increasing dosages of medications, and from beginning new medications, during the course of treatment. When patients begin new medication regimens during treatment, it can be difficult to determine whether changes in treatment (either positive or negative) should be attributed to the medication (or side effects of the medication), the treatment, or a combination of the two. This can become confusing for the therapist and frustrating for the patient and may ultimately lead to poorer treatment outcome. In addition, certain medications such as benzodiazepines, when taken regularly, may have a number of negative effects. They may lessen motivation to practice the skills learned in treatment and can dampen the intensity of emotions, making it difficult for patients to reap the full benefit of the exposures at the end of this program. If used to attempt to reduce emotional intensity (such as at the height of a panic attack), medications can also serve to reinforce maladaptive emotional responding (i.e., avoidance or escape of unwanted emotions) through negative reinforcement (i.e., short-term distress reduction). For some patients, medications can become safety signals that may interfere with their ability to correct misappraisals of danger. Also, consistent with the concept of state dependent learning, skills learned under the influence of the drug may not generalize to times when the drug is not present. Most of these problems are associated with high-potency benzodiazepines and do not seem to occur with antidepressant medications. Finally, patients may attribute changes in treatment to any medication, thus making it difficult for them to gain a sense of efficacy in confronting feared situations. In turn, this may limit their ability to reduce or discontinue medications once treatment has been completed.

Who Will Benefit From the UP Program?

As noted, the UP was developed to assist people suffering from the full range of emotional disorders. The most common emotional

disorders are anxiety disorders and unipolar depression. Our randomized controlled trials of the UP have focused primarily on the treatment of patients suffering from DSM-IV and DSM-5 diagnoses of panic disorder with and without agoraphobia, obsessive-compulsive disorder, generalized anxiety disorder, and social phobia; however, the UP has also been used successfully in open trials to treat posttraumatic stress disorder, agoraphobia without history of panic disorder, specific phobia, hypochondriasis, bipolar disorder, borderline personality disorder, and major depressive disorder. Further, as noted in Chapter 1, an early version of the UP (developed shortly after initial inception of the protocol in 2004) was shown to facilitate abstinence from alcohol consumption in individuals with comorbid alcohol use and anxiety disorders, as compared to a control treatment condition (Ciraulo et al., 2013). We would also expect the UP to be useful in treating clinical symptoms of anxiety and depression in patients who may not meet full definitional clinical criteria for an anxiety or depressive disorder and who would then be categorized as having an *other-specified* or *unspecified* anxiety (or depressive) disorder (formerly called *not otherwise specified*, or NOS), as well as individuals who are subthreshold on severity criteria but at risk for full disorder status.

What If Other Emotional Problems Are Present?

Currently the evidence strongly suggests considerable overlap among the various anxiety and mood disorders. At the diagnostic level, this is most evident in the high rates of current and lifetime comorbidity (e.g., Brown, Campbell, Lehman, Grisham, & Mancill, 2001; Kessler et al., 1996, 1998). So it is not at all uncommon for people with one anxiety or mood disorder to exhibit features of other disorders. The presence of additional problems, however, does not preclude treatment with the UP. In fact, unlike single-disorder protocols, the UP was developed in large part to address the clinical reality of comorbidity and can be used to treat co-occurring disorders simultaneously. This position is consistent with our research findings, which support the efficacy of the UP in simultaneously addressing additional problems in treatment (Barlow et al., 2017; Ellard et al., 2010; Farchione et al., 2012).

Who Should Administer the Program?

Treatment concepts and techniques are presented in sufficient detail in the UP workbook so that most mental health professionals should be able to guide its implementation with their patients. However, we do have some recommendations for minimal requirements. We believe it is important that therapists are familiar with the basic principles of cognitive-behavioral interventions. Further, therapists should have a good understanding of the principles underlying the specific treatment procedures presented in the UP workbook. This knowledge will put therapists in the best position to adapt material to suit the needs of each patient and overcome difficulties in treatment should they arise. We also recommend that therapists become familiar with the nature of emotional disorders; some basic information is presented in Chapter 1 of this guide with a recommendation for further reading. Finally, the Unified Protocol Institute provides in-depth training on the delivery of the UP, including certification programs. See www.unifiedprotocol.com for more information.

Benefits of Using a Workbook

The first “revolution” in the development of effective psychological treatments has been the “manualization” of treatments during the past fifteen to twenty years. These structured programs were written in sufficient detail to provide adequate instruction for therapists to administer them in the fashion that they were proven effective. The same holds for the UP, although this protocol focuses more on the administration of potent and empirically supported therapeutic procedures, as opposed to providing specific instruction on the treatment of symptoms related to a particular diagnosis or disorder. This does not imply that therapeutic skills are no longer required to achieve optimal outcomes. In fact, these skills are invaluable as the patient proceeds with the program.

The second stage of this “revolution” is creating a rendition of the structured program that is appropriate for direct distribution to patients who are working under therapeutic supervision (i.e., a patient workbook). The UP workbook strives to be a good example of a scientifically sound guide written at the patient’s level, which can be a valuable supplement

to programs delivered by professionals from a number of disciplines. There are several advantages to this as described in the sections that follow.

Self-Paced Progress

The availability of the UP workbook allows patients to move at their own individual pace. Some patients may wish to move more quickly through the program, by scheduling more frequent sessions, while others may choose to move more slowly, due to conflicting demands such as work and travel schedules. Having the UP workbook available between irregularly scheduled sessions for patient review or rereading can be quite beneficial, although we find that most patients receive maximum benefit when sessions are held with some regularity.

Ready Reference

While patients may seem to have a good understanding of material during the session, it is common for them to forget the important points, or to become confused, after leaving. One of the greatest benefits of the UP workbook is that it provides an opportunity for review of treatment concepts, explanations, and instructions between sessions. Further, it provides an immediate reference for patients when they are experiencing strong emotions. This can be important for the learning process, since going back to the information and using the skills “in the moment” can facilitate a greater understanding of the treatment concepts and a better appreciation for how these procedures can effectively be applied.

Availability to Family Members and Friends

Research at our center has shown that there is a significant benefit to having family members, especially spouses or other partners, be aware of and (sometimes under therapeutic direction) involved in treatment (e.g., Barlow, O'Brien, & Last, 1984; Cerny, Barlow, Craske, & Himadi, 1987). For example, in one study of patients with panic

disorder with agoraphobia, patients whose partners were included in treatment did better at a two-year follow-up than did those patients whose partners were not included. Similarly, research by Chambless and Steketee (1999) has shown that greater levels of hostility expressed toward the patient by relatives prior to the start of therapy predicted poorer treatment response. Nonhostile criticism, or being critical of specific behaviors, without devaluing, on the other hand, predicted better treatment response. A more recent study by Zinbarg, Lee, and Yoon (2007) produced identical results.

Family participation appears to be beneficial in several ways. First, when family members become more familiar with the nature of the disorder and the rationale underlying treatment, they can be helpful in overcoming avoidance behaviors. Second, having this understanding can also help family members stop behaviors of their own that may be detrimental to the treatment, such as unwittingly accommodating the patient's patterns of avoidance. Third, providing information to family members may help correct misconceptions regarding emotional disorders and, in doing so, reduce hostility and foster greater empathy, understanding, and compassion. Of course, some patients prefer that their spouse or family members be relatively uninformed about their problem and uninvolved in their treatment program. In these cases, you may wish to speak with the patient to identify any concerns they might have about sharing the problem with loved ones and to discuss the possible advantages (and disadvantages) of sharing more openly. Although we have generally found it beneficial to involve family members and friends, either initially or throughout the entire treatment, there may occasionally be times when it would be inappropriate to do so (e.g., severe marital discord). In these cases, we do not encourage the significant other's involvement.

Referencing the Manual After the Program Ends

The UP workbook will help patients to deal effectively with emotional difficulties after treatment is over. As most patients will reexperience their symptoms at some point following treatment, usually under times of increased stress, they may find it helpful to refer back to the UP workbook for information on managing their symptoms and hopefully

prevent their symptoms from escalating into a full-blown relapse. Chapter 13 of the UP workbook specifically outlines ways for patients to maintain progress and prevent relapse. For many, the UP workbook may also assist them in making further gains once treatment has ended. As they move forward with new challenges, and continue to work on meeting their goals for treatment, they may very well find continued meaning in the UP workbook material and ultimately develop a greater understanding of the treatment concepts.

Reading Assignments

Some therapists prefer that patients read the UP workbook chapter(s) before the session, so that the therapist can elaborate on issues and tasks, as well as answer questions. Other therapists prefer that patients read each chapter after the session is over, to review and consolidate the points covered in-session. We usually follow the latter strategy and assign the relevant UP workbook chapter(s) after each session.

Full Workbook versus Installments

Some therapists might prefer distributing chapters from the UP workbook in installments, as opposed to supplying it in its entirety at the start of treatment. This prevents patients from skipping ahead and encourages a more organized approach to learning the treatment procedures. However, a potential downside in asking patients to piece the UP workbook together over time is that individual chapters are more likely to be misplaced. If this occurs, patients may end up with incomplete workbooks at the end of treatment, making it difficult for them to use the workbook as a reference during the later parts of treatment or after treatment has ended. Also, some patients find it useful to read ahead in order to gain a greater understanding of how earlier concepts may relate to later procedures and to provide them with a more general overview of the treatment program. In general, the more time patients spend looking at the UP workbook and thinking about the treatment concepts, the deeper their understanding of the treatment procedures

and the greater their benefit. During the session, if patients mention material that they have read in future chapters, you can simply redirect their attention to the current material and immediate assignments. Nevertheless, we do not discourage therapists from distributing the UP workbooks in installments if preferred.

Session Structure

Consistent with most cognitive-behavioral treatment protocols, sessions typically begin with a review of the homework assigned in the previous session. This provides you with an opportunity to briefly review the previous session's content and link that content to what the patient experienced during the week since your last meeting. You should also use the homework review to assess your patient's progress and to inform the material covered in session. Following the homework review, you will present key concepts and conduct in-session exercises to assist your patient with understanding the treatment skills. This didactic instruction and interactive skill-building forms the main work for the session. At the end of each treatment session, you will help your patient consolidate what he or she has learned. Ask your patients to summarize the main take-home points or messages from the session, and ask if they had a negative reaction to anything about the session. Finally, you will negotiate the specific homework to be completed before the next session.

The Therapist's Role

Ideally, your role should be one of a collaborator rather than an "authority." We often reflect to patients that we are experts in cognitive-behavioral therapy, they are experts in their own experience, and treatment is a matter of combining the expertise of both parties. Both you and your patient must work together throughout treatment to design

the most effective treatment plan possible. Changing patterns of behavior is difficult and patients will need to give feedback regarding what is helpful and what is not, so that the most effective treatment plan possible can be devised and implemented. It probably goes without saying, but it is important to gain a thorough understanding of the issues the patient brings to treatment and work to establish good rapport; these are both crucial parts of providing a strong foundation from which to introduce treatment concepts and successfully carry out some of the more challenging treatment exercises in future sessions.

Homework and Out of Session Practice

Homework and practice assignments will be assigned each week to reinforce the concepts learned from that session and to practice new skills. Research has found that completion of homework facilitates the practicing of skills learned in treatment and is necessary in order to maximize the benefits of treatment. Thus, it is important to convey to patients the following:

1. Attending sessions and listening to the concepts sets the stage for change.
2. Application and practice of the concepts in “real life” are what will lead to noticeable, lasting changes.
3. Every week, patients will be given papers from the UP workbook to record assignments, and these should be brought to the following session to facilitate discussion about problems, setbacks, or obstacles.
4. Monitoring patient progress by charting changes in anxiety and depression (and other emotions) on the **Progress Record** from the UP workbook will help patients gauge their progress through treatment. Monitoring records can serve as both a powerful motivator and an important source of discussion during sessions, such as normalizing a patient’s feeling that they have “backtracked” by reminding them that progress does not occur in a linear fashion.

At the end of each session, we recommend to patients that they read the UP workbook chapters relevant to the material that was just discussed

in session in order to reinforce concepts. Further, as you work through the treatment modules, you can have patients continue with homework from previous modules, if the additional practice is warranted. For instance, once your patient is introduced to the concept of mindful emotion awareness in Module 3, he or she can continue to practice these skills for the remainder of the treatment, if clinically indicated.

Homework Review

Beginning with the second session (or following the initial assignment of monitoring homework), it is a good idea to begin each session with a review of your patient's homework. Beginning each session this way serves three important functions:

1. Routinely starting the session with homework review reinforces the important role homework plays in the ultimate success of this program. If your patient is having difficulty complying with homework, address the issue right away, helping them identify obstacles to homework compliance and designing a plan they can stick to.
2. Reviewing homework allows you to correct any misconceptions or misunderstandings about the previous session's concepts, and provides an opportunity for your patient to ask any questions or voice any concerns.
3. Reviewing homework provides you with a rich source of information about your patient's ongoing experiences, which can be drawn upon when illustrating subsequent concepts.

Patient Commitment

In order for this treatment to be effective, it is expected that patients will commit to and make time for the sessions each week. Urge patients to make the treatment sessions and homework a high priority. Remind them that treatment lasts for a relatively short period of time, and making it a priority will allow them to reap the full benefits of the program and give them the opportunity to successfully achieve their treatment goals.

Dealing with Patient Ambivalence and Resistance

Maximizing patient motivation and engagement throughout treatment is essential for promoting meaningful, lasting change. Homework compliance and engagement in treatment are consistently associated with treatment response and improved treatment outcomes. However, one of the most common difficulties that arises when working with patients is ambivalence about engaging in treatment procedures, including the completion of homework assignments. This can be challenging. When patients do not readily comply with treatment procedures, therapists may assume that the patient lacks motivation for change. However, it is important to appreciate that in treatment we are asking patients to engage in the very tasks that they have had difficulty with in the past, and to confront physical sensations and other situations that are likely to produce intense, uncomfortable emotions. Module 1 was specifically designed to help patients resolve ambivalence about change and ultimately foster motivation to engage in treatment. It includes two exercises, adapted from Miller and Rollnick (2002), for enhancing motivation at the beginning of treatment (see Chapter 6).

Additional Reading on Motivation Enhancement

- Arkowitz, H., Westra, H. A., Miller, W. R., & Rollnick, S. (2017). *Motivational interviewing in the treatment of psychological problems, second edition*. New York: Guilford Press.
- Miller, W. R., & Rollnick, S. (2012). *Motivational interviewing: Helping people change*. Guilford Press.
- Rosengren, D. B. (2009). *Building motivational interviewing skills: A practitioner workbook*. New York: Guilford Press.

Providing the Treatment

(Corresponds to Chapters 1–3 of the UP Workbook)

Overview

This initial treatment session is designed to provide a review of your patient's presenting problems and diagnoses, if assigned, within the context of the emotional disorder framework. This is an opportunity to start identifying how your patient's experience fits into a transdiagnostic model emphasizing frequent strong emotions and aversive, avoidant responses to these emotions. This session also provides patients with an introduction to the treatment protocol.

Module Goals

- Gain a better understanding of your patient's difficulties, conceptualized within a transdiagnostic framework, including
 - Experiences of uncomfortable emotions,
 - Aversive reactions/negative beliefs about emotional experiences,
 - Efforts to avoid or escape uncomfortable emotions.
- Introduce patients to the treatment program and procedures, including the nature and importance of ongoing assessment and homework completion.

- **Unified Protocol Case Conceptualization Worksheet** located at the end of this chapter.
- **Anxiety Scale, Depression Scale, Other Emotion Scale, Positive Emotion Scale, Progress Record** located in UP workbook Chapter 3.

Review of Patient's Presenting Complaints

Treatment with the UP begins with a brief review of your patient's presenting concerns or diagnoses. In many cases, these have already been identified or assigned during an intake process; if not, the functional assessment conducted in this introductory session can serve the purpose of gathering details that would otherwise be collected during intake procedures. In this session, you will conduct an initial functional assessment of the nature of the presenting symptoms, within the trans-diagnostic framework upon which the Unified Protocol was developed. Although this is typically a continuous process unfolding across early treatment sessions, it begins by asking patients to provide a description of their presenting concerns. This description can also be useful in providing a rationale for using the UP, and you may wish to refer back to specific examples when discussing primary treatment components.

Presenting Treatment Rationale while Conducting Functional Assessment

It has been our experience that presenting the rationale for using the UP is a natural opportunity to build a functional conceptualization of the patient's difficulties. For this reason, we recommend describing the characteristics of an emotional disorder and, over the course of this conversation, evaluating the extent to which these features are present in your patient's emotional experiences. What follows is a description of the essential parts of such a discussion. We recommend filling out the **Unified Protocol Case Conceptualization Worksheet**, found at the end of this chapter, during or after this discussion, for your benefit in constructing an initial case formulation.

Describing the Rationale for the UP

We begin by providing a basic rationale for the UP. In this and the following suggestions of language to use with patients, we encourage you to draw upon the patient's identified problems to illustrate the points being made.

Prior to when this treatment (the UP) was developed, clinicians and researchers noticed that, more often than not, people presented for help with multiple areas of difficulty. So, for instance, someone reporting difficulties with anxiety might also be struggling with depression. We also noticed it was not uncommon for patients treated for one disorder to return at a later point in time for help with another problem. On the flip side, some patients getting treated for one problem actually report experiencing some improvement in other difficulties as well! Researchers wanted to understand why these different mental health difficulties commonly co-occurred and why addressing one area of difficulty sometimes helped with other areas. They collected lots of data about symptoms of different psychological problems and found that these disorders, at their core, were very similar—they all shared several common characteristics. We refer to this similar group of disorders as emotional disorders.

Frequent, Tense, Unwanted Emotions

Next, highlight the first common feature of emotional disorders by saying something such as the following:

So what is an emotional disorder anyway? I'll answer that by describing the major features of these disorders, and you can let me know whether you feel like they apply to you. First, people at risk for emotional disorders experience emotions more strongly, intensely, and frequently than the average person. This characteristic exists on a continuum—some people are low on this characteristic, others are higher. Some people at one end of the continuum seem like they are not fazed by anything—everything just rolls off their back. And then there are people at the other

end of the continuum, who are just more affected by things, are more emotional, or take longer to calm down. Where would you put yourself on the continuum?

In this discussion, most patients will identify themselves as the type of person who tends to have more frequent and intense emotional experiences. You can then reflect how this is unsurprising (e.g., “That make a lot of sense—most people who want to work on anxiety or depression would say the same thing”), and perhaps point out how this is not inherently a problem (e.g., “And that’s not necessarily a bad thing! Lots of people value being in touch with their emotions, and I wouldn’t be a very good therapist if I wasn’t. But at the same time, it can be tough to feel like your emotions are running your life.”).

If your patient does not consider themselves the type of person to have frequent and intense emotions, this does not impede the discussion either. It is possible that they are so good at avoiding situations that might provoke unwanted emotions that they do not experience strong emotions all that often. Or, it may simply be that their problematic emotions are not extremely frequent (e.g., only in response to low frequency events like air travel). Either way, it is the other major features of emotional disorders—aversion to and avoidance of strong emotions—that are essential to the maintenance of these disorders.

At this point, you will most likely begin constructing an idiographic case conceptualization by identifying the specific emotions that are arising for your patient. Endeavor to not only assess the emotions consistent with the presenting disorders (e.g., anxiety for someone presenting with an anxiety disorder) but the full range of negative emotional experiences: anxiety, sadness, anger, fear, guilt, embarrassment, and shame. Ask about the frequency of these emotions, how intense they find them, how long they last, and how often they believe their emotions are stronger than the context of the particular situation may call for (e.g., getting very sad upon experiencing a small setback or disappointment).

Negative Reactions to or Beliefs About Unwanted Emotions

Next, explore aversive reactions to emotional experiences by setting the stage with something similar to the following:

Let's talk about another characteristic that's important to emotional disorders. In fact, this feature is even more important than experiencing frequent or intense emotions. We find that individuals with emotional disorders are prone to having a negative reaction to these emotional experiences when they occur. Many people with emotional disorders start to notice an unwanted emotion arising and automatically think things like, "I hate these feelings," "I'm falling apart" or "I shouldn't be feeling this way." Responses like this make the ebbs and flows of our emotional life seem even more distressing; when we are hard on ourselves for feeling the way we feel, we generally feel even worse. Does any of that resonate with you?

Throughout this conversation, try to evaluate the degree to which patients find their emotions aversive, unwanted, dangerous, or bad (e.g., shameful, stupid, reflective of poor character). Patients may describe aversion to overall emotional experiences or to one part of their experience. A patient presenting with generalized anxiety disorder, for example, may find their worries to be very distressing, while a socially anxious individual might be most upset by their voice trembling or blushing during social interactions. In this discussion and indeed throughout the entire course of treatment, take note of negative judgments patients make about their emotional experiences or of themselves for having such emotions. Examples of such include *"This is dangerous," "I can't handle feeling this bad," "This means I'm out of control," or "I'm just being stupid (by feeling this way)."* Note that patients will often identify situations, not emotions, as aversive. Yet this distinction will be important to make over the course of treatment. For instance, abstaining from sex after a sexual trauma may reflect aversion to the sense of fear and vulnerability associated with sexual situations, not opposition to sex itself. As another example, avoidance of loud sounds in an individual who has combat-related posttraumatic stress disorder may reflect an effort to

avoid the frustration, anxiety, or shame associated with being startled by loud noises, not an explicit belief that these noises are dangerous.

Note that not all strong emotions are accompanied by aversive reactions, and it is important to refrain from characterizing all reactions to emotions as contributing to the emotional disorder cycle. An individual may very well acknowledge, contextualize, and tolerate strong, even painful, emotions without expecting them to last forever—a healthy reaction! For example, a patient might say, “It makes sense I would feel anxious when reminded of what I experienced while in combat,” or “I really wanted a job that I didn’t get, but this disappointment will only motivate me to keep looking for another opportunity.”

It is also important to remain aware that the patient may be experiencing aversive reactions to positive emotions. Often, patients do not consider this among their presenting problems and may even be unaware of such reactions. For some individuals, though, aversive reactions to positive emotions is important to case formulation because, much like aversion to negative emotions, they maintain maladaptive habits of avoidant coping. For example, feeling joyful might be followed by worry that the circumstances will change, that they do not deserve to feel good, or that they will feel even worse when the experience passes. Some patients describe feeling calm as paradoxically uncomfortable because it triggers worries about letting down one’s guard, being irresponsible, or forgetting something. Feeling love or affection for a partner may lead to fears about abandonment or concerns about ruining the relationship. Similarly, feelings of hopefulness may be met with worry about disappointment.

As you explore aversive reactions to emotions, you may also help your patient identify the effects this aversion has on the emotional experiences themselves—making them feel even more intense, threatening, or difficult to deal with. You may have the patient describe what happens when they evaluate their emotions negatively, in order to illustrate how aversive reactions prolong unwanted emotions and send the message that they are intolerable. For example, worrying about having a panic attack when experiencing shortness of breath may lead to physiological arousal that intensifies this feeling. This “snowball effect” provides justification for targeting aversive reactions to emotion in the UP.

Efforts to Avoid, Escape from, or Control Emotions

Next, it is important to assess for the presence of avoidant emotional behaviors. This includes any strategy whose primary function it is to minimize the degree a patient comes into contact with or remains in contact with an unwanted emotion. Examples of behaviors constituting avoidance include the following:

1. Overt situational avoidance (e.g., declining to take the bus in agoraphobia or to shake hands in contamination-based obsessive-compulsive disorder).
2. Emotion-driven behaviors (e.g., excusing oneself from a meeting when feeling socially anxious).
3. Subtle behavioral avoidance (i.e., efforts to minimize engagement with uncomfortable emotions or their components; e.g., rushing through a stressful task, restricting use of caffeine).
4. Cognitive avoidance (e.g., distracting oneself, attempting to engage in thought suppression).
5. Use of safety signals (e.g., only going out with one's spouse, carrying medication at all times).

We do not recommend describing all of these variations on avoidant coping during the first session; instead, we mention them here to draw your attention to the diversity of strategies that fall under this umbrella. Often the most salient example of avoidant coping—which is sufficient for illustrating this vulnerability to patients—is overt situational avoidance or escape. Note that avoidant coping, like aversion, may be directed at a single component of an unwanted emotion, such as a thought (e.g., avoiding religious material for fear that it might trigger blasphemous intrusive thoughts) or a physical sensation (e.g., avoiding walking up the stairs quickly due to anxiety about elevated heart rate). To facilitate a discussion of emotion avoidance, you might use language such as the following:

The last major feature of emotional disorders is the one we'll be focusing our efforts on changing, because it's what makes the biggest difference in the course of emotions over time, and that's the tendency to engage in avoidant coping, which means trying hard to dampen or escape emotions rather than tolerating and accepting them. It makes a lot of sense that

you'd want to avoid your emotions, since we just talked about how bad they can feel. But avoidance isn't an effective strategy in the long term, and we'll spend a lot of time talking about why that is. For now, though, let's think about how this applies to you. Some examples of avoidant coping might be refusing to do things that make you anxious, withdrawing from others when you feel sad, avoiding situations that might remind you of unpleasant memories, drinking to calm down, procrastinating on a task that might stress you out, or just not making eye contact during a serious conversation with a boss. Can you think of some examples of how you avoid strong emotions or how you try to stop feeling strong emotions once they begin?

Following this discussion, summarize the features of emotional disorders by reminding patients that you will be targeting each of the features just described: the experience of frequent, intense unwanted emotions; aversive reactions or negative beliefs about emotions; and efforts to avoid emotions.

Importance of Cultural Factors

It is essential to understand that a patient's sociocultural background may affect their presentation. For example, somatic complaints are often more prominent in Latino individuals' understanding of anxiety compared to European Americans (e.g., Varela & Hensley-Maloney, 2009). Consider, too, the impact of culture in determining whether a behavior is adaptive or maladaptive relative to a patient's context. For example, many patients with social anxiety find it difficult to be assertive, and they may engage in exposure tasks that challenge them to be assertive. On the other hand, patients whose cultures have strong collectivist values (e.g., China, Japan) may act in ways that European Americans would not consider to be assertive. This could be independent of social anxiety or, alternatively, exacerbate existing social anxiety. Factors such as these may influence the behavioral responses or "alternative actions" that are most effective for a given patient within their cultural context. Therefore, it can be helpful to gain an understanding of your patient's perspectives on the behaviors they wish to increase or decrease and to thoughtfully consider the functional triggers, consequences, and

maintaining mechanisms of each behavior in evaluating the degree to which it contributes to emotion aversion and avoidance (Boettcher & Conklin, 2017).

Looking Ahead: Ongoing Functional Assessment and Transdiagnostic Case Conceptualization

Assessment should continue throughout treatment as opportunities for assessing emotional disorder features will only be enriched as treatment continues. Not all patients arrive with the insight required to report on emotional experiences, particularly before coming to understand the function and nature of emotions. Thus, it is important to remain vigilant for other opportunities for case conceptualization and assessment later in treatment. We discuss examples of this in more detail in Barlow and Farchione (2017).

Troubleshooting: Questions to Assist with Functional Assessment

A number of factors can make functional assessment challenging, including high comorbidity, low insight, symptoms being maintained by unclear contingencies, and high emotionality on the part of the patient. Box 5.1 present examples of questions to guide the discussion, particularly if the descriptions of emotional disorder features do not appear to resonate with the patient. These questions are designed such that if the patient answers in the affirmative, you would then ask additional questions to clarify further.

Introducing the Patient to the Program

Following this discussion on emotional disorders and functional assessment of the patient's presenting problems, you will provide an introduction of the treatment program and overview of treatment components. This is deliberately conducted right after the description of emotional disorders so that you can draw your patient's attention to how the UP seeks to change aversive responses and avoidant coping in response to unwanted emotions.

Box 5.1 Questions to Assist with Functional Assessment

Questions to Assess for Experiences of Negative Emotion that are Frequent or Intense

- Does it seem like you feel sad/anxious/frustrated more than other people?
- Is it hard for you to stop thinking about things that upset, anger, or embarrass you?
- Do you consider yourself a worrier?
- Do you have trouble controlling your temper?
- Have other people observed that your emotions seem more intense than others in response to situations?
- Does it take you longer than other people to calm down when you get upset?
- Does it seem like you feel things more intensely than other people?

Questions to Assess for Negative Reactions to or Beliefs about Unwanted Emotions

- Do you beat yourself up for feeling certain ways, like giving yourself a hard time for getting upset about something?
- Do you get frustrated thinking that your emotions are irrational?
- When you start to feel nervous, do you often worry it's going to escalate into even more anxiety?
- When you start to feel down, do you feel like it's going to ruin your whole day?
- Do you sometimes wish you could get rid of negative emotions altogether?
- Are there parts of your thoughts/feelings/symptoms that scare you?
- Do your emotions feel uncontrollable at times?

Questions to Assess for Avoidant Efforts to Control or Change Emotions

- Do you tend to avoid or put off doing things that make you anxious?
- Do you tend to avoid situations where you think you'll be uncomfortable?
- Do you avoid doing things when you're in a bad mood or feeling down?
- Do you try not to think about the things that make you upset?
- Do you sometimes cope with uncomfortable emotions by distracting yourself?
- Are there things you wish you could do but don't because you're concerned about feeling a strong emotion, like anxiety, sadness, or frustration?
- Do you try to do things to get rid of your negative emotions?
- Do you try to do things to prevent yourself from feeling certain emotions?

As noted in Part I of this guide, the goals of this treatment program are to help patients learn to better understand and tolerate their emotional experiences, to ground them within the current context in which they are occurring, and to counter maladaptive strategies for managing uncomfortable emotional experiences. When introducing the treatment program to patients, we have found it helpful to clearly convey the idea that the goal is *not* to eliminate the emotions of fear, anxiety, sadness, anger, and so on. In fact, eliminating these emotions would not be very helpful because emotions provide us with a lot of important information when they are occurring in a functional, adaptive manner. Instead, this treatment focuses on bringing a greater awareness and understanding of the ways in which emotional experiences and responses to these experiences are contributing to symptoms. This treatment will also help patients become aware of the full range of experiences that elicit uncomfortable emotions, which may include both negative *and* positive events, and help them to learn more adaptive ways of responding to emotional triggers.

After communicating this, proceed to a more detailed description of treatment components with an emphasis on how these components will specifically help your patients in overcoming their emotional difficulties (which you explored earlier in the session). Using information contained in Chapters 1 and 4 of this guide, help your patient understand the primary goals of treatment and provide an overview of the core treatment skills that the patient will learn during treatment. The following is an example of how you might preview the remainder of the treatment. We recommend incorporating patient-relevant examples, if possible (e.g., “The cognitive exercises will be a chance to start expanding your perspective on going to staff meetings, so they don’t always have to feel so stressful.”)

Now that we’ve talked about the rationale for this treatment, let me tell you what you can expect going forward. Next week we’ll work together to identify your own personal reasons for making changes in treatment and also acknowledge what challenges might arise. We’ll also set specific goals to guide our progress. Then, we’ll explore what’s helpful about emotions, start breaking down your emotions into their parts, and work on putting your emotional experience in the context of triggers

and consequences. Next, I'll teach you some skills for relating to your emotions in a more accepting way. Our next move is work on targeting different parts of your emotions one by one: your thoughts, the physical feelings you have when you're having a strong emotion, and emotional behaviors. We'll learn a skill called "cognitive flexibility" in order to become more balanced in the way you think about emotional situations. In terms of behaviors, we'll start practicing behaviors that let you approach your emotions rather than avoiding or escaping them. Then we'll work on increasing your tolerance of physical sensations that might be making your emotions feel harder to deal with. After these skills are learned, we'll spend most of our time putting them into practice in real-life situations that we'll design to purposely experience strong emotions and practice coping with them in healthy ways. These are called "emotion exposures," and they let you learn important lessons about your ability to handle emotions without avoiding them. This is also the best way to really develop the accepting and willing attitude toward emotions that we've been talking about. Throughout, you'll be practicing the skills we learn between our meetings. At the end, we'll develop a plan to continue practicing while "being your own therapist," until the skills we've worked on start coming naturally to you.

Finally, Session 1 concludes with a discussion of material from Chapter 4 of this guide and Chapter 3 of the UP workbook. Specifically, you should provide an introduction to the general format of treatment (e.g., weekly, 50- to 60-minute individual sessions) and procedures, including the nature and importance of ongoing assessment and intersession practice. As part of this discussion, you will introduce the Anxiety Scale; the Depression Scale; the optional Other Emotion Scale for tracking emotions such as guilt, anger, and shame; and the optional Positive Emotion Scale. These brief, five-item questionnaires ask about the severity and functional impairment associated with strong emotions in the past week. You will also introduce the Progress Record to keep ongoing records of emotional experiences and to track progress over the course of treatment. These tracking forms can be found in Chapter 3 of the UP workbook.

An important point to highlight as part of this discussion is the distinction between subjective and objective monitoring. You might point

out that it is easy to get into the habit of describing one's emotions in judgmental, subjective terms ("That panic attack was horrible and it lasted forever!"). Not only does this contribute to seeing emotions as threatening, but it often obscures important information about an emotional experience (e.g., the fact that uncomfortable emotions wax and wane rather than maintaining a maximum level of distress indefinitely). Therefore, you should encourage your patient to start thinking about their emotional experiences from an objective standpoint. The Anxiety Scale, Depression Scale, and optional Other Emotion and Positive Emotion scales provide a means for doing this by asking patients to reflect on how much their emotions have actually gotten in the way of day-to-day life over the course of a week, rather than simply at times of high distress when patients tend to pay the most attention to emotions. Furthermore, tracking each of these forms on the Progress Record serves as a reminder that progress is not necessarily linear, which can help maintain motivation for skills practice even when a patient is experiencing an uptick in symptoms or finds the exercises to be particularly challenging.

Worksheet 5.1: UP Case Conceptualization Worksheet

UP Case Formulation

Patient: _____

PRESENTING PROBLEMS:

STRONG UNCOMFORTABLE
EMOTIONS:

AVERSIVE REACTIONS:

AVOIDANT COPING

SITUATIONAL AVOIDANCE/ESCAPE:

SUBTLE BEHAVIORAL AVOIDANCE:

COGNITIVE AVOIDANCE:

SAFETY SIGNALS:

TREATMENT PLAN: FOCUS / APPLICATION OF CORE MODULES

MODULE 3:

MODULE 4:

MODULE 5:

MODULE 6:

MODULE 7:

Worksheet 5.2: UP Case Conceptualization Worksheet

UP Case Formulation

Patient: _____

PRESENTING PROBLEMS:

- Trouble finishing work assignments on time
- "Overthinking" interactions with coworkers
- Anxiety when presenting at meetings
- Unhappy with social circle

STRONG UNCOMFORTABLE EMOTIONS:

- Anxiety about interactions, work
- Fear of embarrassment when presenting
- Sadness about lack of friends

AVERSIVE REACTIONS:

- "Can't get anything done when I'm stressed at work"
- Fearful of blushing
- "It's stupid to feel bad because it's my fault I don't have friends"

AVOIDANT COPING

SITUATIONAL AVOIDANCE/ESCAPE: Turn down opportunity to lead meeting, leave work events early, reluctant to reach out to old friends

SUBTLE BEHAVIORAL AVOIDANCE: Procrastinate on work assignments, poor eye contact when talking to coworkers, rush through presentations

COGNITIVE AVOIDANCE: Start watching TV when think about being lonely, take a nap avoid thinking about upcoming presentation

SAFETY SIGNALS: Only socializes with sister present

TREATMENT PLAN: FOCUS / APPLICATION OF CORE MODULES

MODULE 3: Practice nonjudgment about having few friends, anchor in the present when worried about work at home

MODULE 4: Decatastrophize making a mistake at work, reframe likelihood of being rejected by old friends

MODULE 5: Practice alternative actions (e.g. talk slowly when presenting)

MODULE 6: Exposure to blushing (pinching cheeks, drinking hot beverage, wearing heavy coat) - later combine this with public speaking exposure

MODULE 7: Emotion exposure: Call old friend, give speech at work, start work assignment immediately

Module 1: Setting Goals and Maintaining Motivation

(Corresponds to Chapter 4 of the UP Workbook)

Overview

The purpose of this module is to maximize the patient's readiness for change and increase motivation to engage in treatment. It was designed to help patients clarify their goals for treatment and to explore the benefits and costs of changing and remaining the same. This module provides two exercises for enhancing the motivation necessary in initiating this type of treatment program and can be reviewed as needed throughout the course of treatment.

Module Goals

- Discuss the importance of motivation to treatment outcome
- Help patients identify concrete goals to achieve during treatment
- Assist patients to set manageable steps to reach treatment goals
- Help patients explore the benefits and costs of changing and remaining the same

Materials Needed

- **Treatment Goals Form** located at the end of UP workbook Chapter 4
- **Decisional Balance Form** located at the end of UP workbook Chapter 4
- **Anxiety Scale, Depression Scale, Other Emotion Scale** (optional), and **Positive Emotion Scale** (optional) located in UP workbook Chapter 3

Motivation and Commitment

As discussed briefly in Chapter 4 of this guide, motivation and commitment are essential for patients beginning a course of cognitive-behavioral treatment. We find that it makes sense to discuss motivation for treatment shortly after presenting an overview of the skills, as many patients experience uncertainty about their ability to complete the program effectively when considering all of the exercises planned for treatment. Therefore, we typically begin the discussion of motivation by validating that many patients find the prospect of treatment to be daunting. We then inform them that some of the biggest determinants of successful treatment outcomes are ongoing motivation for change and engagement with the program. We let patients know that motivation is expected to wax and wane throughout treatment and that we have found attention to motivation from the beginning to be the most effective way to preemptively deal with fluctuations down the road.

You can assist your patient in increasing readiness and motivation for behavior change through two motivational exercises. First, we utilize a **Treatment Goal Setting Exercise** in which patients have the opportunity to articulate goals for treatment and are guided toward making their goals more concrete, followed by a **Decisional Balance Exercise** in which patients weigh the pros and cons of changing and for staying the same.

Clarifying Top Problems and Setting Treatment Goals

Building on information collected during the functional assessment in session 1 (Chapter 5), you will help your patient clarify the top problem areas they would like to target in treatment. Some patients will enter treatment with a clear idea of how their emotional experiences lead to significant problems in their life, though many patients start the treatment process with a vague understanding of their problems and related change they would like to accomplish in the treatment process. Clarifying top problem areas (see **Treatment Goals Form** in Chapter 4 of the UP workbook) will provide both you and your patient with a better idea of problem areas to focus on in treatment. Given the diversity in top problems amongst patients, clarifying the problems will also facilitate personalization of the treatment.

Once top problem areas have been identified, begin to discuss setting concrete and realistic treatment goals. This activity will enhance your patient's belief in their ability to successfully achieve the desired change, also known as *self-efficacy*. Research has consistently shown that one of the most effective ways to achieve successful behavior change is through goal setting. "Goals" refer to future states or events that an individual is interested in making happen or hoping to prevent from happening. Goals related to top problem areas may include "feeling less anxious" or "making more friends." By assisting your patient in setting specific, concrete, and manageable goals for behavior change, you are greatly improving their chances of successfully changing. While "feeling less anxious" is a popular goal, this goal is diffuse and difficult to measure. Ask your patient to identify measurable behaviors or experiences that reflect what "feeling less anxious" would look like to them. Concrete behavioral goals may include "participating in work meetings" or "submitting five job applications." This discussion will also facilitate setting realistic expectations for treatment. For instance, goal setting is an opportunity to shape the patient's expectations regarding experiencing emotions. Many patients seek treatment to eliminate uncomfortable emotional experiences. Given that humans are programmed to experience a range of emotions

(see Chapter 7 in this guide for details regarding the function of emotions), this goal is not only unrealistic but also inconsistent with the treatment approach. Realistic and attainable goals may include “learning to tolerate intense emotional experiences while giving a presentation.” Given that the nature of emotions has yet to be discussed, focus on goals that are consistent with the treatment rationale. An example of a completed **Treatment Goals Form** can be found on p. 166 in Appendix B of the UP workbook.

By clarifying top problem areas and treatment goals in the beginning of the treatment, and checking in on these goals as treatment progresses, your patient will have a more objective understanding of treatment gains made during the course of treatment. In addition, the rationale for the treatment approach can be directly connected to your patient’s top problem areas and related goals. Revisiting the treatment goals throughout the course of treatment will also provide a clear focus and structure to the therapy session.

Therapist Note

*Some of your patient’s goals might be achievable in a matter of hours (“going to the gym tonight”), whereas others might take longer to accomplish (“making more friends”), and some might be things that patients will always be working toward. Everyone has goals that are achievable in these different time frames. Research has shown that setting specific, concrete, and manageable goals for behavior change greatly improves individuals’ chances of successfully changing. Thus, the goal of “going to the gym tonight” is much more likely to lead to successful behavior change than the goal of “feeling more satisfied in life.” We’ve found that it can be helpful for patients to identify their larger goals for treatment and then come up with more concrete manageable steps to achieving those goals by completing the **Treatment Goals Form** in the UP workbook. We typically recommend that you guide your patient through choosing and breaking down at least one primary treatment goal in session. Then, the generation and breaking down of additional goals may be assigned for homework and discussed briefly at the beginning of a subsequent session.*

Building Motivation—Decisional Balance Worksheet

This exercise was designed to help patients directly address ambivalence for change by exploring the pros and cons of both staying the same and changing (see **Decisional Balance Form** from Chapter 4 of the UP workbook). Once they have been given a sense of what treatment entails, it can be overwhelming to consider actually completing treatment, which naturally triggers ambivalence. Even the most highly motivated patients can be expected to experience fluctuations in their levels of motivation over the course of treatment. The very nature of emotional disorders suggests at least some ambivalence about changing responses to anxious and depressive symptoms, as the patient is at least partially aware of how the symptoms have negatively affected their life. However, changing these responses on the patient's own has been difficult, if not impossible. For example, a patient with obsessive-compulsive disorder might recognize that their compulsive behavior is excessive and at the same time believe that not engaging in the compulsion makes it more likely that a feared outcome or catastrophic consequence (the content of the obsession) will occur. Alternatively, a patient with generalized anxiety disorder might feel very distressed about worry but also believe that worry offers some control over their anxiety. As mentioned previously, this ambivalence is a natural part of the process of behavior change. One way to help resolve some of this ambivalence is to help your patient push the balance of the scales toward behavior change by amplifying the discrepancy between their current situation and their ideal or desired situation. Miller and Rollnick (2002) aptly described this process as “developing discrepancy.” Essentially, if an individual views their current behavior as conflicting with important personal goals or values, the chances of modifying the behavior increase.

Using the **Decisional Balance Form**, help your patient identify pros and cons of changing, as well as for staying the same. As noted in the clinical vignette, some patients will struggle with identifying “cons” associated with changing their behavior. After all, they are coming to therapy in order to make a change in their life. However, it is important to help them identify potential sources of ambivalence and to develop discrepancy between the patient's life, currently, and how they would like it to be. If done properly, this exercise can lead naturally into a “call

to arms” type discussion that offers the UP, and your patient’s commitment to making a change, as a means for achieving the short- and long-term goals your patient identified and for developing a more desired situation in general. An example of a completed **Decisional Balance Form** can be found on p. 167 in Appendix B of the UP workbook.

Therapist Note

Some patients will be eager to jump into the treatment components that they perceive as more helpful or skill based. Particularly when motivation is high at the beginning of treatment, it can be helpful to provide a strong rationale for spending time evaluating the pros and cons of change. Investing time at the beginning of treatment discussing cons of treatment often alerts you to the types of barriers that may become problematic later in treatment. In addition, by having this conversation early on, your patient is aware of the fluidity of motivation and may be more willing to discuss problems as they arise in treatment.

Homework

- Identify additional goals on the **Treatment Goals Form** or steps for achieving goals for treatment goals identified but not discussed in session.
- Instruct the patient to begin monitoring progress by completing the **Anxiety and Depression Scales** (as well as **Other Emotions** and **Positive Emotions Scales**, if they are using them).

Case Vignettes

Case Vignette #1

In the following case vignettes, T represents the therapist and P represents the patient. The following is a therapist/patient dialogue where the therapist is working with the patient to set and break down a primary goal for treatment.

P: Well, I would really like to make more friends.

T: Okay, great. So, what would it look like when you’ve achieved this concrete goal? What kinds of things would you be doing?

- P: Hmm, I guess I'd be in contact with people more using social media, maybe go out more with people from work, have friends over for dinner or maybe throw a party at my place, and not stay home on Saturday nights anymore when people ask me to do things.
- T: Okay, those are some specific goals that you can work toward over the course of treatment. What are some manageable steps you can take to reach those goals?
- P: I'm not sure. I guess I could ask for someone's phone number or social media user name?
- T: That sounds like a good idea. What can you do before that, to help make that step easier?
- P: Well, I guess I could start by making small talk with people at work or the gym.

Case Vignette #2

The following is a therapist/patient dialogue where the therapist is working with the patient to complete the **Decisional Balance Form** by exploring the pros and cons for making a behavior change (i.e., engaging in treatment).

Part 1

- T: Okay, now let's look at some of the pros for staying the same. What did you come up with?
- P: I left it blank. I don't really think there are any benefits to staying the same.
- T: It's not uncommon to feel that way. However, what do you think has held you back from changing this before you came in for treatment?
- P: Well, changing on my own was just so much work.
- T: Changing one's behavior is really hard work, especially when it's something we've done for so many years. It sounds like one of your pros for staying the same might be that it's easier to stay the same. What is another benefit for staying the same?

Part 2

T: What are some of the cons for staying the same?

P: Well, the way things are kind of stinks. I mean, I can't do a lot of the things I want to, like travel or go out with friends.

T: So, some of the cons include being unable to travel and unable to go out with friends. What else were you able to come up with?

P: Mainly just that—all of the things that I can't do because of my panic.

T: You mentioned that one of the benefits for staying the same was that it was easier. How much work is it for you to try and manage your panic now?

P: It's a lot of work. In fact, it's pretty exhausting to constantly be on guard for situations that are going to make me panic.

T: It sounds like staying the same requires quite a lot of energy and effort on your part as well.

Troubleshooting

When reviewing the **Treatment Goals Form** with patients it is important to make sure that the goals they have identified are reasonable and achievable. Patients will sometimes have problems identifying concrete steps toward the larger goals they have identified. Make sure that the steps they have listed in the “*Taking the Necessary Steps*” column of the worksheet are in fact manageable. This is illustrated in Case Vignette #1 where the therapist responded to a common difficulty by helping the patient to generate intermediate steps that she could work toward to achieve her ultimate goal of making more friends. In addition to modeling the problem-solving or goal-setting process for the patient, the therapist also helped to enhance the patient's self-efficacy by reinforcing her problem-solving attempts.

When reviewing the **Decisional Balance Form** with patients, it is important to ensure that they have honestly explored the pros and cons for both changing and staying the same. As illustrated in Part 1 of Case Vignette #2, one difficulty that comes up is that patients will sometimes leave blank the cons for changing or the pros for staying the same. However, it is important to recognize that there *are* benefits

to staying the same, and identifying these potential obstacles early in treatment will allow the patient to be aware of them as treatment progresses. Once you have reviewed potential benefits for staying the same, launch a review of the cons for staying the same. You can also use any benefits your patient came up with to help them generate additional cons for staying the same. This is shown in Part 2 of Case Vignette #2, where the therapist was able to help the patient identify her own ambivalence and also to generate additional reasons against staying the same. This technique can be helpful for overcoming patient ambivalence and continuing to build motivation.

(Corresponds to Chapters 5 and 6 of the UP Workbook)

Overview

Module 2 provides psychoeducation on the functional, adaptive nature of emotions and assists patients in developing greater awareness of patterns of emotional responding, including potential maintaining factors (e.g., common triggers, environmental contingencies, and/or the maintaining role of avoidance). Patients will also learn how to monitor and track their emotions by focusing on three core components of their emotional experiences (thoughts, physical feelings, and behaviors).

Therapist Note

*You may choose to cover the content of Module 2 across two or more sessions. However, if you opt to cover this module in one session, the homework assignments in Chapter 6 of the UP workbook will be redundant with Chapter 5. In that case, assign the **Following Your ARC Form** to monitor emotional experiences, not the **Three-Component Model of Emotion Form**.*

Module Goals

- Help patients develop a more flexible, accurate understanding of emotions and their function

- Assist patients in developing greater awareness of emotions as they occur, particularly interactions between physical sensations, thoughts, and behaviors
- Help patients begin to identify triggers to emotional experiences, as well as their responses to these emotions and the short- and long-term consequences of these responses
- Help patients understand the ways in which emotional experiences influence ongoing and future behaviors

Materials Needed

- **Three-Component Model of Emotion Form** located at the end of UP workbook Chapter 5 (if module is conducted across two or more sessions)
- **Following Your ARC Form** located at the end of UP workbook Chapter 6
- **Anxiety Scale, Depression Scale, Other Emotion Scale** (optional), and **Positive Emotion Scale** (optional) located in UP workbook Chapter 3

Homework Review

As with all sessions to follow, we begin with a review of the patient's completed homework. You might begin by discussing your patient's experience monitoring emotions using the **Anxiety** and **Depression Scales** (as well as the **Other Emotions** and **Positive Emotions Scales**, if completed). Next, review any additional goals your patient has added to the **Treatment Goals Form** since the last session. If your patient did not rate his emotions using these scales, take a few minutes in session to collect and record the anxiety and depression ratings. Noncompliance with homework assignments is important to address early in treatment. Discuss barriers for completing the assignment(s) and brainstorm strategies to complete upcoming assignments. Also, reiterate the importance of homework in learning how to apply treatment strategies.

Emotions Are Adaptive

Many patients seek treatment with the goal of getting rid of their uncomfortable and unwanted negative emotions. While providing empathy for the distress they are experiencing, it is also necessary to describe the functional and adaptive nature of emotional experiences. This discussion provides the necessary foundation supporting the rationale for treatment. Remember, the overarching goal of this treatment model is to learn to better tolerate and adaptively respond to intense emotional experiences, rather than engaging in efforts to directly control, suppress, or avoid them. The psychoeducation included in this module will not only provide fundamental information about emotional experiences but will also increase “buy in” for the challenging treatment strategies that lie ahead.

When discussing the adaptive nature of emotions, it is important to communicate that emotions serve an important function, one that we should pay close attention to. The primary function emotions serve (e.g., fear, anxiety, depression, and anger) is to alert us to important external or internal events or situations and to motivate us to act in response. All emotions, positive and negative, are important and necessary at their core, even the ones we might view as uncomfortable or unpleasant. Patients will first learn to observe their emotional experiences and consider the function of the emotional experience.

To illustrate the adaptive, functional role of emotions, you may want to discuss with your patient in session the definitions and examples of emotions provided in Chapter 5 of the UP workbook. It is likely that patients do not view these emotions (fear, sadness, anxiety, anger, and guilt/shame) as serving particularly positive or functional roles in their own lives and may instead feel these emotions get in the way of their functioning. Also discuss the adaptive function of positive emotions (such as happiness, excitement, and pride). To illustrate the point that emotions serve an important and adaptive function, ask your patient whether he or she has ever had experiences when “negative” emotions have been helpful or useful.

Therapist Note

If your patient is having difficulty identifying instances when uncomfortable emotions have been adaptive in his or her own life, you may want to make the connection for the patient by reflecting examples of emotions the patient shared with you during the initial functional assessment.

Understanding Emotions—The Three-Component Model of Emotional Experiences

The first step to helping patients improve emotion regulation is to assist them in gaining awareness of their emotional response. Patients often experience emotions like a big “cloud” of intense feelings and find it difficult to determine what information (about the environment, situation, etc.) the emotions are trying to provide. Often this can lead to the perception that their emotions are uncontrollable, irrational, or occurring for no apparent reason. In turn, this may lead to increased attempts to directly suppress or stop these (seemingly senseless) emotions from occurring. Emotional experiences can actually be broken down into three main parts—what we think, how we physically feel, and what we do (or have the urge to do). By breaking emotions into smaller components, patients can more easily assess how their emotions occur in response to internal or external stimuli and, in turn, begin to experience their emotions as more manageable and less overwhelming. This psychoeducation also provides an opportunity to understand the causal interactions among parts of emotions and how these interactions may contribute to maintained emotion over the long term.

The three components of emotions are as follows:

1. *Thoughts*: The way we think about any given experience will color the way that experience is felt. To better understand the role thoughts have in an emotional experience, encourage your patient to identify thoughts during times of heightened emotions. The following questions may be helpful in getting your patient to think more about the types of thoughts they are experiencing during

- emotional experiences: “*What types of thoughts do you notice when you feel depressed or anxious?*” “*What about when you feel happy?*”
2. *Physical Sensations*: Each emotional state is associated with physical responses. To illustrate the role physical sensations have in emotional experiences, you may want to ask your patient the following questions: “*What physical sensations constitute feeling excited?*” “*What about when experiencing panic?*” “*Are there similar physical responses with different emotional states?*” “*What physical sensations are associated with depression or sadness?*” “*What about with fatigue, muscle tension, etc.?*”
 3. *Behaviors/Behavioral Urges*: Emotions serve to motivate a behavioral change. Behaviors are actions we engage in or have the urge to engage in as a response to the feeling state. Often, someone will respond to a feeling without thinking about it. This is because it seems like our bodies just “know” the best way to deal with these situations. To illustrate this component, you may want to offer your patient some examples. For instance, someone who is depressed may stay in bed all day or just watch television because the thought of getting out and “confronting” the day is too overwhelming. Or, someone who feels anxious in social settings and suddenly finds themselves in a crowd of people where they are expected to interact may quickly exit the situation to escape these frightening social encounters.

As you present these three components, it is also important to begin discussing how one component might influence another, often in a reciprocal fashion. Take the following example from a patient named John:

John reported having the following anxious and self-deprecating thoughts after participating in a conversation with his boss at work: “I acted like an idiot,” “I asked stupid questions,” “I should have had a better grasp of the material.” In helping John to identify the three components of his emotion in this particular situation, the therapist used thoughts John identified to help him also think about the other two components of the model. The therapist asked, “And when you were thinking this way, did you notice any changes in how you were feeling in your body?” In response, John reported experiencing a sudden rush of adrenaline while

replaying the interaction with his boss in his head, which resulted in an increase in body temperature and some mild feelings of unreality. In turn, these feelings provoked more negative thoughts, which then increased the physical response, and so on. After a short time, John was feeling “incredibly worked up and anxious.” At that point, he elected to stop participating in the conversation with his boss (a behavior), which made him feel a bit calmer (decreased his heart rate, a change in his physical response). Later, though, he thought “I’m a loser for not being able to have a simple conversation” (a cognition triggered by his behavior of withdrawing from the conversation).

Using the Three-Component Model of Emotion Form

During the treatment session, we have found it helpful to directly assist the patient in identifying the three components of their emotion using the **Three-Component Model of Emotion Form** from Chapter 5 of the UP workbook.

When using this form in session, you should carefully question your patient about each component separately while also discussing how the components interact to increase emotion. This increase in emotion can occur very quickly and is often described by patients as being automatic or habitual. One of our patients once described it as if their emotions were “going from zero to sixty.” Again, this may contribute to a patient’s experience of their emotions as being too intense or out of control. It may help to begin by asking, “What was the first thing you noticed?” or “What tipped you off that you were getting anxious?” pointing out that an emotional response may, subjectively, begin with a thought (e.g., “I’m not doing a good job”), a physical feeling (e.g., noticing shortness of breath), or a behavior (e.g., tapping one’s foot). It can be helpful to explain to patients that breaking their emotions down into the component parts will help them to gain a better understanding of how the emotion unfolds and why it is occurring. Also, this process of examination often leads to a discussion of how emotional responses can be adaptively modulated as they unfold (in real time), further establishing the rationale for subsequent treatment components.

Recognizing and Tracking Emotional Experiences—The ARC of Emotions

Another important step toward helping patients understand their own emotional experiences—and toward making their emotional experiences less intense or uncomfortable and more manageable—is by gaining a better understanding of when, where, and why they are occurring and how they are maintained. This means patients must begin to look more closely at their experiences by monitoring what is happening at the very moment it occurs, and taking note of what happened before and after.

Identifying the “ARC of emotions” is meant to introduce patients to the process of monitoring experiences with the goal of gaining a better understanding of what happens during an emotional experience. This will allow patients to work toward responding more adaptively and realistically. At this point in the treatment, your patient is not expected to change their emotional experiences, though this may occur with increased awareness and as a result of monitoring. Rather, the goal is to simply monitor emotional experiences and to become more aware of the context in which these experiences occur.

To illustrate the ARC of emotions, it is important to work through an example of short- and long-term consequences of emotional responses, such as the ones provided in Chapter 6 of the UP workbook. The following section discusses aspects of the ARC of emotions when introducing and applying the concepts related to tracking emotional experiences:

- Emotions do not just come out of nowhere, even though sometimes it might feel like they do. Every emotional experience is triggered by some event or situation, which causes a person to react and respond. In turn, these responses have consequences. Sometimes it is difficult to identify these triggers, but with repeated practice they can be identified.
- The “As” (in the acronym ARC), or *antecedents*, are the events or situations that trigger emotional experiences. Triggers can be either something that has just happened, something that happened much earlier in the day, or even something that occurred the week before. To illustrate this point, you may want to refer

to the examples in Chapter 5 of the UP workbook. For instance, if the woman who receives the text message from her friend cancelling their dinner plans had an argument or was rejected by a loved one in the morning, it could influence the way she thinks about and approaches the situation with her friend. She may be more likely to assume that she is “lame” and that this appraisal is indeed shared by her friend and the cause of the cancellation. She may not have reacted in the same way if the argument earlier in the morning had not occurred. The “A” in this case would be both immediate and distal—for example, receiving the text from her friend (proximal) and the argument with a loved one earlier in the day (distal). When working with patients with posttraumatic stress, it can be helpful to point out that some antecedents may be far in the past (e.g., experiencing a life-threatening situation), which we would consider to be an antecedent if it potentiates later experiences of emotions (e.g., fearing for one’s safety in similar environments).

Therapist Note

For patients experiencing intrusive, unwanted thoughts or images, it can be helpful to conceptualize the intrusive thought or images as the antecedent and identify the response and consequence to that intrusive thought, as described later. For example, a patient may report intense shame when experiencing intrusive sexual images. He may respond to the unwanted images by having thoughts that “I’m a terrible person,” and notice physical sensations of increased muscle tension, and engage in behavioral strategies such as replacing unwanted thoughts with pleasant thoughts. Help your patient examine the short-term consequences of this response as well as the long-term consequences.

- The “Rs,” or *responses*, to emotional experiences include all of the responses that occur across the three main components of emotional experiences: thoughts, physical sensations, and behaviors. As mentioned previously, patients may have difficulty initially identifying their responses in all three domains, so you may remind them that these responses reflect the three-component model.

- The “Cs,” or *consequences* of emotional responses, are both short term *and* long term. It is essential to help your patient understand how short- and long-term consequences are often quite different. In the case of patients with emotional disorders, the short-term consequences of emotional behaviors are often negatively reinforcing (i.e., they lead to an immediate reduction in uncomfortable emotions), causing the patient to engage in similar behaviors in the future. For example, when someone leaves a party early because they are experiencing a great deal of social anxiety, this response results in an immediate reduction in anxiety, which reinforces this behavior in the future. Similarly, indulging in an urge to check for someone who has intrusive doubting thoughts causes immediate relief from the anxiety caused by the doubt. However, in both these cases, long-term consequences are also evident. In the first scenario, a pattern of leaving parties early, or not attending at all, results in feelings of loneliness and isolation. In the second scenario, engaging in checking behaviors reinforces the belief that doubting thoughts must be neutralized by checking, which can develop into an intrusive, time-consuming behavior, prolonging the time it takes to leave the house by several minutes.

It is important for patients to see both of these consequences of their responses—the short-term positive effect and the long-term detrimental effect—as they are often in conflict with one another and represent a poignant example of the disconnect between the lives patients would like to lead and the lives they are leading in service of managing their emotional distress.

Therapist Note

It is not necessary to change any emotion avoidance behaviors that your patient might be engaging in at this stage of treatment. You will discuss ways to change emotional behaviors in more detail later. Rather, it may be best to simply reflect to patients that the short-term consequence of these strategies is a reduction in intense emotions in the moment. You may also wish to begin to develop discrepancy for patients by suggesting that these strategies have not been very effective thus far, especially in the long term. For example, you could ask: “How effective has that strategy been?” or “Is that working for you?”

Understanding Emotions and Behaviors: Learned Responses

The concepts in the preceding section of this chapter (and in the prior chapter) should provide your patient with a better understanding of how emotional experiences unfold, the importance of increasing awareness of how emotions are triggered, how triggers influence responses, and what the short- and long-term consequences of these responses are. This next section expands upon the discussion of the consequences (or “Cs”) of the ways in which the patient responds to emotional situations or events by introducing the concept of learned responses. There are three main points that you may want to present when discussing learned behaviors:

We Learn from Our Experiences

The triggers of our emotions, and what happens when we experience them, tend to leave a lasting impression. What we learn will influence how we experience a similar situation in the future.

We Learn to Do Things to Avoid Potentially Feeling Bad

Learning how to avoid objects and situations that have caused us harm or made us feel bad in the past, or have the potential to do so in the future, is generally a reasonable and adaptive strategy for survival. Consider using the following example (or create your own) as part of your discussion regarding learned behaviors:

A small rabbit is hopping about in the forest while searching for food. Suddenly, and unexpectedly, it comes upon a hungry fox hiding behind a tree. In reaction to this unexpected (and certainly unwanted) confrontation, the rabbit quickly takes off in the opposite direction. Running for its life, it puts as much distance between itself and the fox as possible.

The next day, the rabbit is again foraging for food in the same area as the day before. But, unlike the previous day, the rabbit goes nowhere near the tree where it previously came upon the fox. And every day since that

day, the rabbit continues to avoid that tree despite never coming across the fox again.

Put simply, we learn to do things that make us feel good and avoid things that have the potential to make us feel bad or harm us in some way. In the example, the rabbit's fear response is entirely adaptive—it narrowly escaped what could have otherwise been a very bad situation. Avoiding situations is also adaptive under some circumstances, but it can lead to learned behaviors that are excessive or incongruent with the current context or inconsistent with our goals. Once patterns of avoidance have been established, they can be difficult to break. In the preceding example, avoidance of the tree where the rabbit came upon the fox serves the animal well, as it definitely does not want to run into the fox again. But this may be less adaptive (or nonadaptive) under other circumstances, or when the threat is no longer present.

The difficulty associated with changing avoidance behaviors may be due, at least in part, to the fact that avoidance limits new learning. If, for instance, a person avoids going into a situation that previously caused a significant fear reaction, they will never be able to challenge existing thoughts regarding the dangerousness of the situation or their ability to cope with a feared outcome and, thus, the fear (and avoidance) is likely to continue. They also fail to learn an important lesson regarding the emotion itself—intense or distressing emotions will eventually abate and fade away once it is clear that the situation has changed (and, in the case of fear, the threat is no longer present or the outcome is tolerable).

We Learn to Do Things to Manage Intense and Distressing Emotions

Although engaging in avoidance (and other emotional behaviors) may seem adaptive due to a short-term reduction in the intensity of strong emotions, it can lead to a vicious cycle in which the behaviors become more ingrained, counterproductive, and out of line with the true context in which the behavior is occurring.

As will become clear in discussing the other key points, and which you may choose to emphasize, people generally form behavioral habits based on short-term consequences more so than long-term consequences. (That's why it is easier to get into the habit of eating junk food, which is immediately gratifying, and more difficult to get into the habit of going to the gym, where the positive consequence is delayed.) In the context of strong emotions, this explains why avoidance is such a common habit and so difficult to break. Changing the cycle of avoidance will therefore require a willingness to feel more distress in the short term—and, for some patients, a leap of faith in trusting that prioritizing long-term consequences will pay off.

Emotional behaviors that serve to suppress or escape emotions are maintained through a basic process of negative reinforcement. Because these behaviors reduce intense or distressing emotions (i.e., removal of something bad), they are more likely to occur again in the future. Unfortunately, the emotional response and associated maladaptive behaviors will be maintained and are likely to occur at an intensity that is similar, if not greater, than it was previously in the same context as no new competing learning has occurred.

Patients will often recognize that their emotional behaviors seem irrational, given the true danger associated with a situation. They might say something like, “I know rationally it's not dangerous, but I avoid it anyway” or “Even though I know nothing bad is going to happen, I just want to get out of the situation.” The idea of the learned response can help patients to understand why they are engaging in behaviors that may otherwise seem “irrational.”

Therapist Note

It is a good idea to make sure patients have a very clear understanding of the difficulties associated with avoiding uncomfortable emotions and why trying to push away uncomfortable feelings may not be the best solution. It is important that patients begin thinking about these concepts and begin to increase their awareness of how patterns of learned behaviors are functioning in their daily lives, particularly with regards to managing distressing emotions.

Homework

- Ask your patient to complete the **Three-Component Model Form** in Chapter 5 of the UP workbook by selecting at least one emotional experience that occurs during the course of the week and breaking it down into thoughts, physical sensations, and behaviors. This form will help the patient build awareness of their emotional experiences, breaking down experiences in order to help them feel less overwhelming and unmanageable.
- Have your patient use the **Following Your ARC Form** to identify both short- and long-term consequences of their responses to emotionally distressing situations or events, as well as any patterns of learned behavior.
- Instruct your patient to continue monitoring weekly emotional experiences by completing the **Anxiety and Depression Scales** (as well as the **Other Emotion** and **Positive Emotions Scales**, if they are using them) and using the **Progress Record** to chart the ratings.

Therapist Note

*If this module is completed in one session, we recommend only assigning the **Following Your ARC Form** for homework.*

Case Vignettes

The following vignettes provide therapist/patient dialogues where the therapist is working with the patient to understand the adaptive and functional nature of the emotional experience of anxiety.

Case Vignette #1

P: I guess I can see where anxiety can help you prepare for something, but when I'm anxious I just get so stressed out I don't feel like I can get anything done at all!

T: Can you give me an example?

- P: Like last week, when I had to get ready for this job interview. I needed to find out more information about the company, and I probably should have practiced what I was going to say in the interview, but instead I just got so stressed out that I shut down and couldn't do anything.
- T: So the anxiety about the interview motivated you to want to prepare by researching the company and practicing what you might say in the interview, but it also caused you to feel stressed. Did you feel tense?
- P: Yes, my shoulders and neck get really tight and stiff.
- T: And what happened when you "shut down?"
- P: I just started worrying about whether I would come across as smart enough, or if I would seem like I knew what I was talking about, or if I would just blow the whole thing. And then I just got overwhelmed and couldn't think at all.
- T: So you had some thoughts about what might happen—some doubts, some worries?
- P: Yes.
- T: And what did you end up doing?
- P: Nothing. I felt paralyzed. In the end I was cramming for the interview the night before, by just reading things off of their website. I didn't feel prepared at all.
- T: So you reacted to your anxiety by procrastinating and not doing anything until the last minute. It sounds like you also reacted by worrying a lot and having a lot of doubting thoughts and by getting physically tense. So whereas that initial anxiety prompted you to want to research and prepare for the interview, a whole bunch of other thoughts, feelings, and behaviors kicked in as well. We will talk more about these other responses during a later session, but for now let me ask you this: Do you think that initial experience of anxiety that gave you the idea to prepare for the interview by researching the company and practicing was a good thing or a bad thing?
- P: Well, I guess *that* part of it was a good thing, but then it just made me stressed out and overwhelmed.
- T: So, at its core, the anxiety served a good purpose, even though it ended up triggering an uncomfortable experience for you. How that occurs is something we'll be focusing on throughout this program.

Case Vignette #2

- P: I guess I hear what you're saying, but I don't want to feel these things. I'm tired of being anxious and sad; that's what I came to you for!
- T: That's right. No one wants to struggle or suffer through life, and that's what brought you here—to try and end your struggles. But as much as you don't like feeling sad or anxious, can you think of a time those emotions may have actually been helpful for you? Did you ever lose or break a favorite toy when you were a kid?
- P: I don't know, I guess. I do remember one time I dropped my favorite action figure down a storm drain.
- T: Can you remember how you felt about it?
- P: Well, I obviously got really upset. I was only like six or seven. I remember I ran home crying.
- T: So you felt pretty sad. What happened when you got home? Was anyone there to greet you?
- P: My mom was there.
- T: Do you remember how she responded?
- P: Well, she probably gave me a big hug. I remember she tried to help me fish it out with my dad's fishing rod, but it didn't work.
- T: So it sounds like your sadness motivated your mother to comfort you, and to help you cope in some way, by helping you try and get your action figure back?
- P: I guess I never thought about it that way, but yes.

Case Vignette #3

In the following vignette, the therapist assists the patient with identifying the ARC of his emotional experience.

- P: How do I know what the "A" is? I don't always know why I feel anxious or irritable, sometimes I just do.
- T: Can you give me an example?
- P: Well, like the other morning, I just woke up not feeling "right" and I'm not sure why.
- T: Can you remember what was happening that morning?
- P: It was Saturday, so nothing was really going on. I'm not sure.

T: Can you remember what happened when you woke up? Did you get up right away, or did you lie in bed for a while?

P: I didn't get up right away; I stayed in bed for a while after I woke up.

T: Can you recall what you were doing when you stayed in bed, besides lying there?

P: Hmm, I'm not sure. I guess I was thinking a little about work. I had a meeting the day before, and I was sort of replaying it in my mind.

T: Do you remember any specific thoughts you had about the meeting?

P: I was wondering if something I said might have been misinterpreted by my coworker. I guess I was a little worried that something might happen when I get back to work on Monday.

T: So you were worrying about the outcome of your meeting the day before? Anything else?

P: I guess I was also wondering whether I should call my friend to make plans for the day, or if it was going to be too late to get hold of him.

T: How did those thoughts make you feel?

P: I guess I started to feel isolated, and started to beat up on myself.

T: What did you do next?

P: I didn't call my friend and stayed in bed.

T: So, in this situation, if your "R" or response was negative thoughts about yourself, feelings of anxiousness and loneliness, and deciding to stay in bed, what do you think the "A" might have been?

P: I guess thinking about how I did in the meeting the day before.

T: Right! In this situation, you were ruminating about your performance, and worrying about the implications of your performance, which caused you to feel anxious and self-critical, leading to more negative thoughts about yourself, and driving you to stay home rather than call your friend. So, in this case, waking up ruminating and worrying served as a powerful trigger, or the "A."

Case Vignette #4

The following vignette illustrates how learned behavioral responses can have long-term negative consequences.

P: I don't see what's so bad about leaving a situation if it makes me feel better.

- T: So you've left situations in the past, rather than staying and feeling bad?
- P: Yes.
- T: And how did that make you feel, when you left?
- P: It got rid of my anxiety!
- T: Right! Sounds like a pretty effective strategy, at least in the short term. This is what we mean by learned behavior—it seems to work, so you learn to do it again the next time. What about long-term consequences? Are these situations you would like to be able to stay in?
- P: Sometimes. Like my sister's graduation party—I really wanted to be there for her, but I didn't know her friends, and I was too uncomfortable, so I didn't stay.
- T: Did you want to stay?
- P: Yes! For my sister—I felt like I really let her down. I wanted to be there for her.
- T: So whereas the short-term consequence of leaving the party was to get rid of your anxiety, it sounds like there were some other, long-term consequences as well?
- P: Yes. I feel like I really disappointed her, and I feel like I missed out on her important day.

Troubleshooting

Even though some patients may be able to see how emotions, even negative ones, can be adaptive, they may find it difficult to identify any time in their own lives when negative emotions were useful or helpful to them. If your patient is having difficulty identifying instances when uncomfortable emotions were adaptive, you may want to make the connection for them by reflecting examples of emotions they shared with you during the initial functional assessment. As shown in Case Vignette #1, using a concrete example from the patient's own experience and walking the patient through this example piece by piece can help them to identify ways in which the initial emotional response may actually have been adaptive. It is not important at this stage in treatment to emphasize the distinction between adaptive and maladaptive aspects of your patient's experience, nor is it important to identify their

specific thoughts, feelings, or behaviors that may have been maladaptive reactions. At this stage, the primary goal is to help your patient deconstruct their experience in order to identify at what point the emotional response may have been functional and adaptive.

For those patients who feel like their emotions just “happen” to them, or come out of nowhere, it can be difficult to identify emotional triggers. Help these patients identify their emotional triggers by taking examples from their own lives and working through them to make them more concrete and specific. For example, if a patient reports feeling “bad” on a certain day, help them to identify more concrete examples of their experience by asking what they were doing at a specific time, or to recount any exchanges they may have had that day with others. Use one of these more specific scenarios to map out the ARC of the patient’s experience. Remember, the “As” can be something that happened much earlier in the day, or even earlier in the week, and can be something external or internal (e.g., feeling tired after a bad night’s sleep). Have your patient describe the experience in detail, and work backwards with them to reconstruct the experience until you are able to identify the ARCs.

Similarly, some patients find it very difficult to identify the consequences of their experience. Ask patients to identify their responses to the emotional trigger and how their responses made them feel immediately after. Most often, patients will respond that their actions had a positive effect, such as relieving their anxiety. It is important to acknowledge this initial, often positive result, as this is the key to better understanding learned responses and reinforcement. Additionally, because the result is often so positive, it is difficult for some patients to take a step further and identify ways in which these learned responses are negative, or at the very least serve to perpetuate their symptoms. Sometimes, by identifying what the patient values (such as being a supportive sister in Case Vignette #4), the patient is able to identify how his response to his emotions detracts from pursuing this value in the long-term. These concepts are important for your patients to understand, as they serve to both explain why the lure to engage in emotion avoidance is so strong and illustrate why this approach is not necessarily working for them.

(Corresponds to Chapter 7 of
the UP Workbook)

Overview

The purpose of Module 3 is to introduce patients to cultivating a non-judgmental, present-focused stance toward their emotional experiences. The previous module asked patients to monitor to how their emotions unfold over time. This module builds upon that work by encouraging them to incorporate mindful awareness that moves beyond simply paying attention to these experiences. The principles of mindfulness are very consistent with the overall goal of the UP—to develop a more open, approach-oriented relationship with emotions.

Therapist Note

This module is best administered across two or more sessions. The first session is generally spent providing psychoeducation on the definition of Mindful Emotion Awareness, followed by an in-session meditation exercise that allows patients to experience the principles of mindfulness first-hand. In the second session of this module, following a week of daily meditation practice, patients are asked to practice applying mindful awareness in the context of induced emotion. They are also provided with steps for how to apply the principles of Mindful Emotion Awareness to daily emotional experiences occurring in real time. An alternative session structure for this module can be seen in the Troubleshooting section at the end of this chapter.

Module Goals

- Help patients learn how to observe their emotional experiences in an objective, nonjudgmental way
- Work with patients to develop skills to observe emotional experiences within the context of the present moment
- Assist patients to apply *Mindful Emotion Awareness* to daily emotional experiences

Materials Needed

- Music file or CD
- Headphones, computer with speakers, or stereo
- **Mindful Emotion Awareness Form** located at the end of UP workbook Chapter 7

Homework Review

As with previous sessions, we typically begin with a review of the patient's homework. In this case, one or more **Following Your ARC Form(s)** should have been completed. Start by asking your patient to describe some of the antecedents that triggered emotional experiences over the past week, encouraging them to identify patterns. You can help patients see similarities amongst their antecedents; for example, you might say something like: "It looks like some of your triggers occur at home with your family and others happen at work. Although they may seem different on the surface, they are all characterized by feeling backed into a corner by quick deadlines."

The amount of session time spent on the "R" part of the **Following Your ARC Form** will depend on whether you presented the two Understanding Your Emotions UP workbook chapters (Chapter 5—What is an Emotion? and Chapter 6—Following Your ARC) across one or two sessions. If you covered both chapters in one session, you may want to spend a bit more time helping patients understand how

their thoughts, physical sensations, and behaviors influence each other. On the other hand, if you spread the material in these chapters across two sessions, you will have likely reviewed this information in sufficient detail during the homework review of your previous session (using the **Three-Component Model Form**). In this case, we generally spend less time reviewing the “R” on the **Following Your ARC Form**. The final part of the **Following Your ARC Form** to review with your patient is the identification of consequences that occur as a result of their emotional responses. Encourage them to examine both short-term and long-term consequences. This part of the homework emphasizes the rationale for this treatment—short-term strategies that push away emotions are, in fact, leading to *even more* difficult emotions in the long run. This concept is essential for establishing “buy-in” for this treatment program. If your patient is having any difficulty completing the **Following Your ARC Form**, you may want to review the key concepts from the past two sessions.

Introduction to Mindful Emotion Awareness

In this module you will be introducing the concept of *Mindful Emotion Awareness*. The previous module (Understanding Your Emotions) was focused on how emotional experiences unfold over time, including antecedents; interactions between thoughts, physical sensations, and behaviors (collectively referred to as the emotional response); and consequences. This module will build upon this work by discussing a particular quality of awareness that the patient can apply to their emotional experiences. *Mindful Emotion Awareness* refers to approaching emotions in a nonjudgmental, present-focused way. This is an important skill for the patient to acquire early on in treatment and will facilitate acquisition of later treatment concepts.

Nonjudgmental Emotion Awareness

Very often, patients react to their emotions with an evaluative, critical, or judgmental tone. Patients who experience emotional disorders often judge themselves simply for having emotional reactions to situations in

their lives. This might involve telling themselves “I shouldn’t be feeling this way” or “No one else is reacting like this.” Patients also judge themselves for not feeling their emotions as strongly as they would like (“Why am I not happier about this—there must be something wrong with me,” “I should be angrier about this problem—I’m so weak”). They mistakenly believe that beating themselves up for having a particular emotional response (or lack thereof) will prompt them to feel the way they think they “should.” Here, it is important for you to highlight how this approach to managing emotions does not work. For instance, you might remind your patient that emotions are normal, natural, and hard-wired into us, so it is actually impossible to change our emotions completely when the situation calls for them.

Another way that patients can be judgmental is to have a negative reaction to specific parts of their emotional experiences; in other words, patients might believe that the thoughts, physical sensations, and behaviors that they experience are bad in some way. For example, patients with panic disorder are likely telling themselves that their racing hearts and flushing face are too uncomfortable to cope with. Or patients with obsessive-compulsive disorder might believe that having thoughts about something bad happening to a loved one (e.g., getting into a car accident) means this event is more likely to occur. Other patients might think that they’re more likely to do something out of control if they are feeling a particular emotion (like anger).

Therapist Note

You may want to illustrate the consequences of judgmental responses to emotions by guiding patients through a hypothetical, universal example. For instance, we often ask patients to imagine what emotions they might experience prior to giving a presentation. Most patients indicate that they’d be feeling at least somewhat nervous. Then, we ask them to imagine what would happen next if they responded to this nervousness judgmentally (e.g., “It’s stupid to feel this way over a little presentation,” “No one else reacts like this”). Again, most patients are able to articulate that putting pressure on themselves to feel different actually increases their anxiety and may also generate additional emotions (e.g., feeling guilty, angry at themselves). Finally, after using this generic example to illustrate the consequences of negatively judging emotional experiences,

we ask patients to provide personal examples of times when judgmental reactions may have influenced their own emotions.

In contrast, nonjudgmental awareness means accepting emotional experiences as they are, instead of labeling them as problematic and immediately trying to push them away. It is important to point out to your patients that accepting emotions does not mean resigning oneself to feel uncomfortable. Instead, encourage your patients to recognize that their emotions, even the difficult ones, are trying to tell them something. The goal here is to help patients move past their knee-jerk reaction to immediately change how they are feeling, allowing them to respond to their emotions in a more thoughtful way.

Therapist Note

To illustrate a nonjudgmental approach to emotional experiences, it may be helpful to ask your patient to imagine how she would respond to a friend who revealed that he was experiencing a particularly uncomfortable emotion, such as sadness. Often it is much easier to provide a compassionate response to our friends than to ourselves.

You can also provide patients with a template of the language they can use to be nonjudgmental of their emotional responses. For example, you might guide patients toward: “Given my experiences, it makes sense I’m feeling this way.” You can, of course, tailor this language to fit your patient’s personal situation (e.g., “It makes sense that you become more anxious when people raise their voices, given that you grew up in a home with domestic violence”).

Present-Focused Emotion Awareness

In addition to emphasizing the importance of taking a nonjudgmental stance on emotional experiences, mindfulness also includes grounding oneself in the present moment. Oftentimes, emotional reactions are based upon memories and associations with past situations and/or anticipation over potential future consequences. Patients may not be paying enough attention to the current context in which their emotions are occurring and thus are missing out on valuable corrective

information. For example, a patient with panic disorder who is experiencing dizziness may be focusing on the fact that the last time she had these physical sensations, she experienced a full-blown panic attack (past). She might also be focusing on the impending panic attack she believes will “inevitably” follow the physical sensations (future). The patient is *not* focusing on potentially corrective information occurring in the here and now: namely, that she is not currently having a panic attack. Similarly, a patient with generalized anxiety disorder may be so focused on a potentially catastrophic future outcome, such as becoming destitute and alone, that he misses the fact that at that moment he is neither destitute nor alone and has actually been surviving quite well. Likewise, a patient with depression might compare her current experience to better times (past) or anticipate that she will not have a good time attending a social event (future) and decide not to go. Focusing on the demands of the present moment may make an emotional situation feel more manageable. Additionally, present-moment awareness can be used to bring more attention to positive emotions.

Therapist Note

Here you may return to the example provided earlier to illustrate the consequences of judgmental reactions to emotions; however, in this instance we emphasize how focusing on the past and the future can influence an emotional response. Using the example of giving a presentation, we ask our patients: “What would happen to your nervousness if you started to think about the ways you messed up (e.g., lost train of thought, froze) the last time you gave a speech?” “What would happen to your nervousness if you started to predict all the ways this upcoming presentation could go wrong (e.g., people will be bored)?” Again, patients are generally able to understand that focusing on the past and/or future (rather than the demands of the situation right in front of them) can impact the intensity of the emotions they are experiencing.

Of course, it is important for you to emphasize that we learn significant information from our past experiences and that focusing on the present does not simply mean discounting what has happened before. Similarly, preparing for challenges that may come up in the future can also be quite useful and adaptive. Instead, we are encouraging patients to refrain from exclusively focusing on the past or the future *at the*

expense of (or ignoring) what is right in front of them, particularly in emotional situations.

Practicing Mindful Emotion Awareness

Mindful Emotion Awareness is a skill best understood through experience. Although patients can readily recognize the theoretical advantages of *Mindful Emotion Awareness*, it is necessary to put these concepts (nonjudgment and present-focus) into practice in order to really grasp them. This module includes three exercises aimed at helping patients cultivate a mindful stance toward their emotions. First, we include a brief guided meditation exercise (*Mindful Emotion Awareness Meditation*) that is designed for patients to “get their feet wet” with what mindfulness means; we recommend having patients begin by completing this exercise while they are in a neutral mood (or close to it) as it is difficult to learn any new skill when feeling very strong emotions. The second exercise is a *Mindful Mood Induction*, in which music is used to bring on an emotional state. It is more difficult to be nonjudgmental and present-focused when feeling a strong emotion, so this exercise allows patients to practice this skill in a controlled, emotional context. Finally, the ultimate goal of this skill is to respond mindfully when emotions come up in day-to-day life. The last exercise in this module, called *Anchoring in the Present*, provides patients with step-by-step instructions to apply the mindful attention they’ve been practicing as emotions come up naturally.

Therapist Note

In order to help patients understand how the three exercises included in this module fit together, we often use the analogy of building a muscle. The first exercise, the Mindful Emotion Awareness Meditation, can be described as a “five-pound weight”—a bit of resistance because it is a new “move,” but a good place to start. The Mindful Mood Induction adds a bit more resistance because it is more difficult to be present-focused and nonjudgmental when experiencing an emotional response—we call this exercise our “10-pound weight.” Finally, Anchoring in the Present is what we’ve been training for—it’s the real-world application of all this practice.

Mindful Emotion Awareness Meditation

As noted, the first experiential exercise in this module is the *Mindful Emotion Awareness Meditation*. The purpose of this exercise is to help patients get a better idea of what nonjudgmental, present-focused attention feels like. After defining *Mindful Emotion Awareness*, we generally lead patients through a guided meditation following the script provided in the UP workbook. We ask patients to follow the instructions in the script as this will help them to approach their emotional experiences in an objective, present-focused way. After completing the meditation, it is important to process the exercise with your patient.

Therapist Note

The guided meditation exercise provided in the UP workbook encourages patients to apply present-focused, nonjudgmental awareness to the three components of an emotional experience—thoughts, physical sensations, and behaviors/behavioral urges. The following are tips for describing how to mindfully attend to each component, as well as emotions more broadly. We usually incorporate these points into the discussion that follows the guided meditation.

- *Thoughts: Remind patients that their thoughts are not facts. Encourage them to notice thoughts that come up during the exercise without taking them at face value and subsequently feeling compelled to respond to them. To illustrate this point, we ask patients to articulate the difference between telling yourself “I’m stupid” versus “I’m having a thought that I’m stupid.” The latter is more debatable, whereas the former feels more like the truth.*
- *Physical Sensations: Patients often use judgmental language to describe the physical sensations associated with emotional experiences (e.g., “This is terrible,” “I’m choking,” “My heart shouldn’t be racing”). We ask them to use more neutral language to describe how they’re feeling (e.g., “I feel a tightness in my chest,” “My heart rate has increased a bit”) that is akin to a scientist recording objective data (or “facts” about the situation). Physical sensations also tend to draw future-oriented appraisals (e.g., “This feeling is going to get worse,” “I’m going to feel this way forever”). Here, we encourage patients to focus on what they are feeling in this very moment, emphasizing*

that forecasting negative outcomes in the future will almost certainly intensify the physical sensations they are feeling now.

- *Behaviors/Behavioral Urges: We encourage patients to take note of any behaviors or urges to act they experience during the meditation. Often behaviors are designed to dampen the experience of emotions (discontinuing the practice, deep breathing to eliminate fast heart rate). We ask patients to observe these urges without acting on them as a means to explore what happens when they do not immediately push emotional experiences away.*
- *Emotions: The meditation script compares emotions to waves—the intensity builds and crests, only to come back down again. For many of our patients, completing this exercise is the first time they have sat still with their emotions long enough to see this process unfold. Following the meditation, we ask our patients if their emotions stayed at the same intensity throughout the entire practice. Typically, there are fluctuations, allowing patients to see that they need not engage in knee-jerk avoidant responses in order to see relief from emotional experiences.*

The homework following this first session is daily practice with the meditation exercise; patients can download the audio file from our website (<http://www.oup.com/us/ttw>) or you can record yourself reading the script and email it to them directly. Patients are asked to record their experience with this practice on the **Mindful Emotion Awareness Form**. They are instructed to note their observations of thoughts, physical sensations, and behaviors/behavioral urges (tying it back to the three-component model), as well as to rate the extent to which they were able to maintain their attention in the present moment, in a non-judgmental manner. Importantly, we emphasize that we are only asking patients to commit to a week of daily practice; the meditation is a great way to experience the concept of mindful attention, but our ultimate goal is to apply nonjudgmental, present-focused awareness to emotional experiences as they unfold in real time. We find that pitching the meditation as a short-term exercise makes it seem less daunting for individuals who might think they will need to complete this exercise daily for the rest of their lives in order to see the benefit. Of course, if patients enjoy the meditation, we encourage them to continue to use it.

Mindful Mood Induction

Once your patient has had the opportunity to practice present-focused, nonjudgmental awareness using the *Mindful Emotion Awareness Meditation* (we typically recommend a week of daily practice), it is useful to employ this same skill in the context of an emotional experience. We find that listening to music is a useful way to bring up manageable emotional experiences in session. You should encourage your patients to choose songs that are particularly meaningful for them, as well as to experiment with a variety of songs that may bring up different emotions. Often patients have personally-relevant songs downloaded on their phones already, but if they do not, many songs are freely available on YouTube or streaming services and can be played on your computer. If your patient has difficulty choosing a piece of music, you can offer her the suggestions on the list available for download from the Treatments *ThatWork*[™] website at <http://www.oup.com/us/ttw>. As you listen to each piece of music, encourage your patients to try to remain nonjudgmental (“It makes sense that I’d think about my ex while listening to this song”) and remind them to refrain from getting carried away by the past or the future (“That was a long time ago—I’ve made changes to my life since being with them”). If patients get carried away by their emotional experience, you can remind them to use their breath to help anchor them back to the present moment. At the conclusion of the music, assist patients in eliciting thoughts, feelings, or other reactions, helping them observe these reactions in objective, nonjudgmental ways. In addition to songs, we have also used emotionally provoking movie clips (typically downloaded from YouTube) and/or images.

In the week following the session in which the *Mindful Mood Induction* is introduced, we encourage participants to listen to songs that bring up strong emotions several more times as a means to get more practice approaching emotions in a nonjudgmental, present-focused manner.

Anchoring in the Present

The final exercise in this module involves encouraging your patients to incorporate the principles learned from the *Mindful Emotion Awareness Meditation* and the *Mindful Mood Induction* into their daily lives. This

skill is called *Anchoring in the Present*, and the goal is for patients to “slow down” and notice their emotions in the present moment, as the emotion starts to build; instead of just responding reflexively, we ask them to deliberately choose a response that is consistent with the present moment, rather than being driven by the past or the future.

In the UP workbook, we outline four steps for *Anchoring in the Present*. The first step for the patient is to pick a cue that they can use to pull their attention back to the present when they are feeling emotional. The breath is a useful cue because it is with us wherever we go, but any concrete sensation will work (e.g., the feeling of one’s feet on the floor). The next step is for patients to look at their emotional response in a nonjudgmental manner. This is called doing a “three-point check” and reminds patients to take stock of their thoughts, physical sensations, and behaviors. Once they become more aware of their emotional response, we can then ask them to consider whether it is consistent with the demands of the present moment. In other words, we ask our patients to determine if their emotion fits with what is going on right now, in the present moment. If they find that the intensity of their emotion is being driven by thoughts about the past or worries about the future, the last step is to ask them to adjust their response to be more in line with what is happening in the “here and now.” For homework, we ask patients to use the steps for *Anchoring in the Present* whenever they feel an emotional response starting to build.

Therapist Note

It can be helpful to provide an example of how patients can use Anchoring in the Present. For instance, we often describe a person who is worried about finding a parking space well before they leave their house for an important appointment. This person’s thoughts are likely to be future oriented (e.g., “There won’t be any street parking. I’m going to be late or even miss my appointment”). These worries may be associated with racing heart and muscle tension and behaviors like pacing while mentally reviewing all the metered spots near the appointment and what they might do if parking is unavailable. We ask our patients to consider whether this response is consistent with the demands of the present moment and, if not, what they could do instead. Patients are usually able to reflect that they are not really able to know what the parking situation will be until they get to their destination and therefore should

probably refocus on tasks that need to be done around the house (e.g., having lunch, doing laundry).

One of our patients began referring to this skill as doing a “real-time threat assessment.” He had watched a lot of law enforcement TV shows and felt that this phrase, pulled from these programs, really captured what he was doing when Anchoring in the Present. In essence, we are indeed asking patients to check in with what is going around them to assess whether their emotions are reflecting a true threat or a false alarm. We liked this phrasing so much that we began using it with more of our patients.

Homework

The three exercises described previously can be practiced using the **Mindful Emotion Awareness Form** found at the end of Chapter 7 of the UP workbook. An example of a completed **Mindful Emotion Awareness Form** can be found on p. 171 in Appendix B in the UP workbook. As noted already (see the *Therapist Note* near the start of this chapter), this module is typically conducted in two sessions, and assignments pertaining to each session are as follows:

- *Week 1 Homework:* The patient is asked to practice the guided *Mindful Emotion Awareness Meditation* once a day and record their reactions on the **Mindful Emotion Awareness Form**.
- *Week 2 Homework:* The patient is asked to practice the *Mindful Mood Induction* and record their experiences on the **Mindful Emotion Awareness Form**. The same form is also used to practice the *Anchoring in the Present* skill that should be completed anytime an emotional experience is starting to build. Finally, if the patient would like to continue the *Mindful Emotion Awareness Meditation*, they can continue to record their responses on the **Mindful Emotion Awareness Form**.
- Instruct your patient to continue monitoring progress by completing the **Anxiety and Depression Scales** (as well as **Other Emotion and Positive Emotions Scales**, if they are using them) and charting their scores on the **Progress Record**.

Case Vignette #1

The following is a therapist/patient dialogue where the therapist addresses the patient's concerns regarding *Mindful Emotion Awareness*.

- P: This feels a little “new age-y.” I’m not really into that sort of thing.
- T: You’re right—mindfulness meditation has its roots in practices like Buddhism and that can feel uncomfortable to some people. Keep in mind that I’m not asking you to become a Buddhist, or even a formal meditator. Instead, I’m trying to pull out the principles from mindfulness that help people cope better with their emotions. Doing these formal mindfulness exercises now allows you to practice what it feels like to observe your emotions in a nonjudgmental and present-focused way. Many people find this to be a helpful tool for coping with uncomfortable emotional experiences when they come up naturally.

Case Vignette #2

In the following therapist/patient dialogue, the therapist tries to address the patient's concerns about being more in the present with her emotional experiences.

- P: I don't like to sit still—it makes me more anxious.
- T: Tell me more—what happens when you sit still?
- P: I don't know—I just feel like I should be doing something. I feel like if I stop thinking about everything I need to do, my whole day will fall apart. I'm also afraid I'll start thinking about things I'd really rather not think about.
- T: So by sitting still and focusing on the present, you're afraid you will be losing control of things that are supposed to happen today and that you might start thinking about things that have happened in the past?
- P: Yeah, and that just makes me even more anxious.
- T: Tell me what you are thinking about the things you need to do later today.

P: Well, I'm worried that I'll be late for my doctor's appointment and that I won't get the car back to my husband in time this afternoon. If I don't get him the car, he will be late for his meeting, and that would be really bad.

T: And where are you right now?

P: I'm here in this office.

T: Are you running late right now?

P: No, unless we run over.

T: Are we running over?

P: Well, not right now.

T: So, you are not late for anything at the moment, but you are focusing on the possibility that you might be late later on. How does focusing on the possibility you might be late later on make you feel?

P: Anxious!

T: And what about the information that right now, in this moment, you are not running late?

P: Well, much less anxious. But I still could run late later!

T: Does thinking about being late later, or noticing that you are not late now, change what is going to happen in three hours' time?

P: I don't know—it depends on what happens later!

T: Right! The thing is, you have no way of knowing exactly what may happen later. You may hit traffic or your doctor's appointment might run over. Or, alternatively, you might find the roads are clear and your appointment only lasts 15 minutes instead of the scheduled 30 minutes. In other words, you just don't know. The only thing you do know for sure is that you are in this office right now, and at the moment you are not late for anything. This means that the only thing that is different about worrying about the future as opposed to paying attention to the present moment is that one makes you really anxious and the other makes you less anxious. How does worrying about being late later this afternoon make you feel physically?

P: Agitated, tense, stressed out!

T: And what about the thought that you are not late right now?

P: Well, a little less tense.

T: So, sitting still and observing your experience in the present moment doesn't mean trying to pretend you are not worried about what is going to happen later in the day or trying not to think about memories from the past. Instead, sitting still and observing your

experience means noticing in an objective, curious way that your thoughts are focused on potential negative events that may or may not happen in the future. It also allows you to notice that these thoughts also make you feel tense and anxious and lead to urges to stop the practice.

Case Vignette #3

In the following vignette, the therapist addresses the patient's perception that they are not able to successfully practice *Mindful Emotion Awareness*.

P: I don't think I'm doing this right. I can't focus, and I can't stop thinking!

T: There is no right or wrong way to practice *Mindful Emotion Awareness*. The goal here is to notice our own experiences—so if you *notice* that you have a lot of thoughts moving through your mind, then you *are* doing it right! Now, we just need you to practice going easier on yourself for when you catch your mind wandering. You have a lot going on right now, so it's natural that you're thinking about lots of topics. If you notice that you're getting carried away by a particular topic—maybe pulled to the past or the future—try to anchor yourself back to the present. You might find your thoughts carry you away a hundred times, but you can also anchor yourself one hundred times—eventually it gets easier to stay in the present. Again, the very fact that you notice yourself getting carried off by your thoughts means you *are* successfully observing your experience.

Troubleshooting

Some patients may be resistant to the idea of *Mindful Emotion Awareness*, finding it difficult or even “hokey,” as illustrated in Case Vignette #1. Others may find the skill unsatisfying, as observing their experience nonjudgmentally may not feel like “doing enough” to address their symptoms. In this case, it is important to reiterate the

rationale behind practicing nonjudgmental, present-focused awareness, to be sure patients fully understand. In the UP, *Mindful Emotion Awareness* is a foundational skill that will enhance the patient's ability to proceed through the remainder of treatment. Being able to observe their experience objectively will give them the room to make deliberate changes in how they respond to their thoughts, physical sensations, and behaviors using subsequent skills.

Sometimes patients with certain symptoms (e.g., trauma-related disorders, severe panic disorder) or particular comorbidities (e.g., chronic pain) experience a lot of difficulty completing the *Mindful Emotion Awareness Meditation*. Given the nature of their symptoms, there is rarely a time when they are in a neutral enough mood to use this exercise as a way to get a baseline for what mindful attention feels like. In these cases, we usually start with the *Mindful Mood Induction* or another concrete stimulus (e.g., seated meditation where they focus on the noise in the room, walking meditation). We work up to bringing the focus of the meditation to internal emotional stimuli, with the ultimate goal of being to sit still with their emotional experiences. You should use your conceptualization of your case to determine which exercise might be most neutral to demonstrate the skill, with the goal of moving onto ones that may elicit more discomfort.

On a related note, if patients are unable or unwilling to close their eyes during the *Mindful Emotion Awareness Meditation* or *Mindful Mood Induction*, it can be helpful to ask them to pick a spot on the floor or the wall in front of them to focus their gaze.

(Corresponds to Chapter 8 of the UP Workbook)

Overview

Module 4 focuses on one very important component of emotional experiences: thoughts. Specifically, you will work with your patient to develop a greater awareness of how their thoughts (or interpretations) influence their emotions, to learn to identify their negative thinking patterns, and to increase flexibility in interpreting different situations. The concepts introduced in this chapter are aimed to facilitate patients' ability to approach emotion-provoking situations and respond to their emotions in more helpful, adaptive ways.

Therapist Note

This module is generally administered over two or more sessions. The first session is typically spent discussing the role of thoughts in emotional experiences, followed by introducing the concept of automatic thinking patterns and presenting two common "thinking traps." The second session is usually dedicated to practicing a skill for generating alternative thoughts or interpretations about emotion-provoking situations. Patients are provided a list of specific questions to help them come up with alternative, ideally more adaptive and present-focused, interpretations. The troubleshooting section contains instructions for addressing core automatic thoughts (i.e., core beliefs), which can be useful if patients are having difficulty using the Cognitive Flexibility skill, and other commonly encountered roadblocks.

Module Goals

- Explain the reciprocal relationship between thoughts and emotions
- Introduce the concept of automatic thoughts
- Introduce and help patients identify common thinking traps
- Introduce and help patients increase flexibility in thinking

Materials Needed

- **Ambiguous Picture** (Figure 8.2) in UP workbook Chapter 8
- **Practicing Cognitive Flexibility Form** located at the end of UP workbook Chapter 8
- **Downward Arrow Form** (as needed) located at the end of UP workbook Chapter 8

Homework Review

As with all treatment sessions, we generally begin with reviewing the homework. In this case, focus on your patient's **Mindful Emotion Awareness Form(s)**. Was your patient able to practice nonjudgmental and present-focused awareness through formal *Mindful Emotion Awareness Meditation*, *Mindful Mood Induction*, and daily-life *Anchoring in the Present* exercises? Was he or she able to note any thoughts, physical sensations, and behaviors/behavioral urges that arose during these exercises? If your patient had difficulty completing or became frustrated during these exercises, normalize that *Mindful Emotion Awareness* can be a difficult skill to develop. It often requires repeated practice over an extended period of time. If patients seem to be struggling with mindful awareness of *emotions* specifically, it may be helpful to help them practice this skill by engaging in an in-session exercise where they engage in an everyday task less likely to elicit intense emotions (e.g., eating a snack, drinking a cup of tea). The aim here is to focus on the *sensory* experience of that task (e.g., what is the smell, what does it taste like, what is the texture). This can help give your patient a better sense of

what to strive for in terms of practicing nonjudgmental and present-focused awareness of his or her *emotional* experiences.

Introduction to Cognitive Flexibility

In this module, you will introduce the concept of *Cognitive Flexibility*. The previous chapter was focused on developing mindful awareness of emotional experiences. Patients practiced attending to all aspects of their emotions (including thoughts, physical sensations, and behaviors) in a nonjudgmental and present-focused manner. The skill presented in this chapter targets one very important component of every emotional experience: thoughts. A specific skill for coping with automatic, negative thinking patterns will be introduced. This skill is aimed at helping patients become more flexible in their thoughts (or interpretations) about and during emotion-provoking situations. *Cognitive Flexibility* will help your patient be better able to approach strong emotions and respond more adaptively to them, thereby decreasing the frequency and intensity of negative emotions over time.

The Importance of Thoughts

Our thoughts (or interpretations) tend to help determine the kinds of emotions experienced in response to a given situation. By emphasizing that how we think about (or interpret) situations influences our feeling or mood states, the rationale for teaching a skill dedicated to patterns of thinking becomes clear. When discussing this point, we have found it helpful to ask patients to come up with an example or two from their lives of when how they thought about or interpreted a situation influenced how they felt. This discussion also offers you the opportunity to model nonjudgmental awareness and acceptance of feelings, by validating the patient's emotional reactions (e.g., "Of course you would feel Y if you interpreted the situation that way"; "it is natural to feel Y if X were true").

Therapist Note

If your patient is having trouble coming up with a personally relevant example of his emotional state influencing his interpretations of a situation, you could ask him to consider the following scenario: He is walking down the street and sees an old friend he hasn't seen in a while. He waves to this person, but she does not wave back. If the patient were to think, "She just ignored me," how would this interpretation make him feel? Probably sad, guilty, embarrassed, or lonely. But what about, "She must not have seen me"? Probably more neutral.

Emotions can also influence the kinds of thoughts we have (or interpretations we make) in a given situation. We have similarly found it useful to ask patients to describe how moods or feelings might lead them to appraise differently a recent situation they encountered (e.g., "If you felt Y, how do you think you would interpret that situation?"). You could also consider asking your patient to discuss how different types of emotions (i.e., fear, anxiety, sadness, anger) might influence their thoughts or interpretations. We have found this discussion to further assist patients in understanding how their feelings or mood states can help determine how they think about (or interpret) situations. This discussion often leads nicely into introducing the next key concept: *automatic thinking patterns*.

Therapist Note

If your patient has difficulty coming up with his own example, consider providing the same example of waving to an old friend on the street. You could ask your patient to imagine that right before seeing this friend, he had just received some very bad news—like having failed a big test or being let go from his job—so he was feeling sad, anxious, or angry. While feeling this way, how would he be likely to interpret his friend not waving back? Probably in a negative way, like this person was ignoring him or it means something negative about their friendship or his own self-worth, which would of course intensify his negative feelings. But what if he had just received some very good news—how would feeling more joyful affect his interpretation of the person not waving back? Maybe he would be a bit more likely to believe (or at least consider) a more neutral possibility, like the friend not seeing him or it really not being a big deal.

Automatic Thinking Patterns

There are almost always many different ways that one can interpret a given situation or event. In every situation, there are a large number of different aspects (or stimuli) that a person can attend to or focus on. This is the way the human mind works—serving as a filter by focusing on certain aspects of a situation and assigning meaning to those aspects, in order to increase the efficiency and speed of response to a given situation. Experiences from the past also help us interpret current situations, and then these interpretations are used to project what might happen in the future. It is important to convey that this type of *automatic thinking* often happens without awareness.

Ambiguous Picture Exercise

The *Ambiguous Picture Exercise* can be used to show *automatic thinking* in action. First, present the ambiguous picture (Figure 8.2 in the UP workbook) to your patient. After approximately 10 seconds, put the picture away and ask for the patient's initial interpretation of what is happening in the scene. After identifying the initial (or automatic) interpretation, consider asking your patient to try to name the specific aspects of the picture (such as a particular object or facial expression) that may have led them to this automatic interpretation. You may also consider asking whether a past memory or experience may have influenced their initial interpretation of the picture. Once you've spent some time discussing their first interpretation, return the image to your patient and ask them to try generating alternative interpretations about what might be happening in the picture.

Therapist Note

During the Ambiguous Picture Exercise, encourage patients to generate as many alternate interpretations as possible, even if some seem less plausible. Some patients have trouble with this. It can be helpful to validate that coming up with alternatives can be difficult at first, but that, with practice, it gets easier and can become "second nature." You also may choose to note that there is no right answer and that the purpose of the exercise is not to change interpretations so that they are

more “appropriate” or “better.” Nor is the purpose to come up with the “right” interpretation. Rather, the purpose is to show that despite the speed with which we generate initial interpretations, other interpretations are possible.

The main point to emphasize with the *Ambiguous Picture Exercise* is that we tend to interpret situations in our lives quickly and at times, even without conscious awareness. This process generally happens as a result of honing in on specific aspects of the situation, and filtering out other parts. Once we have landed on our first interpretation, it can be difficult to step back and see other possibilities, and this is especially true when experiencing intense emotion. However, there are almost *always* other possible interpretations of a given situation.

Therapist Note

The Ambiguous Picture Exercise can also be used to show the point discussed in the previous section—how we think affects how we feel, and vice versa. This can be accomplished by asking patients to describe how various interpretations would trigger certain feeling states (e.g., “How would/did interpretation X make you feel?”) and how certain feelings might influence their interpretations (e.g., “How would/did feeling X [anxious, sad, angry, neutral, joyful] influence your interpretations?”).

Automatic thinking helps us filter our experiences and respond to situations quickly and efficiently. In some situations, it is adaptive to focus on a few key salient pieces of information and exclude additional information or evidence so that we can respond quickly. Over time, individuals often develop a particular way or style of appraising situations. Research has found that individuals with emotional disorders are more likely to latch onto negative, more pessimistic interpretations. It can be useful to use your patient’s initial interpretation of the ambiguous picture to illustrate this point, or you can use a personally relevant patient example discussed in the previous section. This point sets the stage for the next key concept: *thinking traps*.

Latching onto a single interpretation (or type of interpretation) about a situation or event repeatedly can create a powerful heuristic and start to exclude other ways of thinking about or interpreting a situation or event. Although filtering out unnecessary information is adaptive and helpful, it can become problematic when a person continues to filter out additional information and exclude other possible, more realistic interpretations of a situation. Such filtering may lead to increased negative emotions and, in turn, to more negative and judgmental thoughts about oneself and the world. Thus, both automatic thoughts and emotions maintain this cycle—our thoughts influence how we feel, and our feelings influence the future interpretations we make.

Two common automatic thinking patterns (or *thinking traps*) often found in individuals with emotional disorders are *jumping to conclusions* (or *probability overestimation*) and *thinking the worst* (or *catastrophizing*). It can be helpful to use examples from the patient's daily life to identify possible thinking traps. Looking at their previously completed **Following Your ARC Forms** to identify possible thinking traps is often a good place to start. Try to elicit specific examples of interpretations that may be rigid or problematic in that the interpretation or thought focuses on one aspect or interpretation of a situation that may not be helpful in the long term. We have also found it useful to try and ascertain the automatic interpretations patients may have that are adaptive—ones that filter out truly unnecessary information and focus on motivating patients to deal with a specific problem or task. However, we tend to spend the most time discussing the automatic thoughts that get in the way of functioning.

Therapist Note

“Jumping to conclusions” happens when patients jump to the conclusion (or overestimate the probability) that a negative outcome will occur, even with little or no evidence. They may also ignore evidence to suggest a different possibility. “Thinking the worst” is when patients automatically predict that the worst possible scenario is going to happen, and if/when it does happen, they will be unable to cope with it. Although there is a distinction between these two thinking traps, we tend to emphasize that most negative automatic thoughts can be considered both types of

traps, and it is not all that important to determine whether a particular thought is one trap or the other.

The problem with thinking traps is that they prevent us from acknowledging a range of different interpretations or considering the context in which something occurs. By repeatedly falling into thinking traps, we are more likely to respond in maladaptive, avoidant ways to the experience of negative emotion. Over time, this maintains the cycle of frequent and intense negative emotion and emotional disorder symptoms. After introducing thinking traps, ask your patients to try to begin noticing when they might be falling into a thinking trap in their daily lives.

Therapist Note

It is common for patients to judge or blame themselves for the automatic interpretations they make. This can create a barrier to generating flexibility in thinking because the more they blame themselves, the more negative affect they experience in response to the thoughts and, in turn, the more negative thoughts they have. It is important to help patients practice being aware of automatic thoughts in a nonjudgmental way, noticing the thought and allowing it to pass through their mind (consistent with practicing Mindful Emotion Awareness), rather than holding onto it as the only way of considering the situation and “running” with that interpretation. The point is to be aware of the thinking trap and consider it within the context of the emotion being experienced, not as the only truth but as one way of thinking about the situation.

Practicing Cognitive Flexibility

Thinking traps maintain problematic emotional response cycles by decreasing our flexibility in thinking. The problem with these ways of thinking is not that they are “bad” or “wrong” but rather that they are limiting in that they represent only one possible interpretation of the situation. Thus, the goal of *Cognitive Flexibility* is to increase flexibility in appraising situations, *not* to replace bad thoughts or “fix” faulty ways of thinking. One way out of these thinking traps is to pay attention

to interpretations and evaluate them not as “truths” but as one possible way to look at the situation. Instead of automatically thinking that the worst scenario is going to happen and about one’s inability to cope, it is important to begin to introduce and consider other interpretations. Thoughts about the worst scenario can still be there, but they can “coexist” with other possible assessments of the situation. The goal is to allow flexibility in our thoughts and for alternate interpretations of emotionally provocative situations that are anchored in the present situation and take the current context into consideration.

Therapist Note

It is important to emphasize that the purpose of this Cognitive Flexibility skill is not to eliminate all thoughts related to negative thoughts, nor is it to “punish” patients for having negative interpretations. Cognitive Flexibility is useful for helping the patient gain some perspective on thoughts, so that negative, automatic thoughts do not further feed the problematic emotional response cycle. Thinking more flexibly about and during emotional situations is also a helpful way to facilitate later emotion exposures by allowing for different assessments of the emotions when they are experienced. Helping patients to practice realistically assessing automatic interpretations will provide some motivation when faced with completing a difficult emotion exposure.

Cognitive Flexibility involves coming up with other interpretations of emotion-provoking situations or experiences. This is a useful strategy for helping to break problematic emotional response cycles and can also be an effective way to change the way an emotion or event is experienced. Learning to generate more, realistic, and evidence-based interpretations of emotional situations facilitates adaptive, nonavoidant responding to intense emotions.

In this treatment, we use a series of questions (presented in Chapter 8 of the UP workbook) to assist patients in generating alternative interpretations. Examples of such questions include, “Could there be any other explanations? Even if X was true, could I cope with it? Is my negative automatic thought driven by the intense emotions I’m experiencing?” The questions are designed to be broadly applicable across both types of thinking traps. We generally encourage patients, especially as they

are just learning the *Cognitive Flexibility* skill, to utilize all the questions when attempting to generate alternative perspectives on emotion-provoking situations. Patients also may benefit from entering this list of questions in their cell phone or taking a picture of them, which can facilitate use in daily life.

Therapist Note

We have also found it useful to encourage patients to work toward increased flexibility in their thoughts about emotions themselves. Many of our patients tend to have negative, judgmental, and/or catastrophic interpretations of the experience of emotion. Thoughts like “Feeling anxious is terrible” or “I can’t handle feeling this way” are very common. To assist the patient in considering alternatives, you might ask them to reflect on how emotions can be functional, as was discussed in Module 2 (“Anxiety can help me prepare for important things” or “Being sad after a loss is normal—feeling this way now will help me move on later”). The same questions presented in the UP workbook can also be useful with these thoughts. Generating other interpretations about what it means to experience emotions, even the negative ones, will help your patient approach their emotions and respond in more adaptive ways—the main goal of this treatment.

Homework

- Ask your patient to use the **Practicing Cognitive Flexibility Form** to monitor their automatic thoughts and thinking traps. They will note the situation or trigger for the automatic thought, the automatic thought itself, and whether they fell into a thinking trap. Once you have covered the *Cognitive Flexibility* skill in-session (typically during the second session of Module 4), your patient should use the final (fourth) column to record other possible interpretations. We generally encourage patients to generate at least one alternative interpretation for every situation, although coming up with additional alternatives can be helpful as well. The list of questions for generating alternative interpretations is included at the top of the form to facilitate this process. The **Practicing Cognitive Flexibility Form** can be assigned for homework after each Module 4 session, as

long as thinking traps have been introduced. When assigning and reviewing this homework, it can be helpful to remind your patient that the goal is not to “believe” a new interpretation but rather to allow it to coexist with the automatic negative thought. Neither of the interpretations is necessarily correct—they are each examples of a range of possible interpretations. An example of a completed version of this form can be found on p. 172 in Appendix B of the UP workbook.

- Instruct your patient to continue monitoring progress by completing the **Anxiety** and **Depression Scales** (as well as **Other Emotion** and **Positive Emotions Scales**, if they are using them) and charting their scores on the **Progress Record**.
- Finally, you can ask your patient to continue practicing skills introduced in the previous module, as needed. For example, it may be helpful for them to continue practicing *Anchoring in the Present* using the **Mindful Emotion Awareness Form**. Although the main focus of the homework should be practicing the *Cognitive Flexibility* skill learned in this chapter, you should feel free to assign one or two worksheets from previous chapters if extra practice would be of benefit.

Case Vignettes

Case Vignette #1

In the following vignette, the patient is having difficulty identifying her thoughts.

- P: I don't know. I didn't think anything. I mean, I just had to escape. I had to get out of there right away!
- T: What do you remember thinking while you were standing in front of everyone?
- P: I was thinking about the presentation I was supposed to give.
- T: Were you making any specific predictions about how it might go? Or did you have any concerns about what might happen?
- P: Well, I was pretty sure it was going to go badly, just like the last time I tried to give a presentation. I was really concerned that the audience would see how anxious I was and think that I didn't know what I was talking about.

Case Vignette #2

In this vignette, the therapist helps the patient think more flexibly about a possible undesirable scenario.

T: You mentioned that you are afraid that you won't meet the expectations that your new supervisor has for you. If they don't give you a good review, what are you concerned will happen?

P: I'll lose my job.

T: If you lose your job, what are you concerned would happen next?

P: It would be completely devastating for me. I'd have let my family down again, and I wouldn't know how to handle that. My depression would get worse.

T: So your biggest concern is that if you don't meet your new supervisor's expectations, you will be let go from your job, which will leave you devastated and unable to cope. Is this correct?

P: Yeah, I guess that's it.

T: Okay. Have you ever received a negative review before?

P: Yeah. Not many times, but it has happened before. [pause] Three times, I think.

T: Were you let go any of these times?

P: Once. Two years ago. That was awful.

T: So you've gotten a negative review three times before and were let go once. Based on this evidence, is there a *chance* you may not lose your job now?

P: Yeah, I mean, I'm not *certain* it will happen. But if it does, I don't know what I'll do.

T: I understand. Let's talk a little bit about the one time you were let go. How did you feel?

P: I was so upset. I hadn't seen it coming. That was the toughest part—being blind-sided.

T: That must have been difficult. Can you be more specific about the emotions you experienced?

P: Well, at first I was angry. And really sad because it was like I'd failed. I hadn't been at the job for long, so it was like I had disappointed my supervisor, and myself.

T: Of course you felt sad. It is always hard when we lose something important to us, especially when we think that we could've done

- something to prevent it. How would you say you were able to cope with this situation then?
- P: Well, the first few weeks were terrible. I got really down on myself and basically didn't leave the house or see anyone, which didn't help.
- T: And after that?
- P: After those first few weeks? I guess I coped okay. I mean, I started applying for jobs and did get one eventually. I also had a friend who had recently lost his job too, so it was good having someone else in the same boat as me. We supported each other.
- T: So despite losing something you really cared about, it sounds like you were able to cope pretty well. In fact, after a tough first few weeks, you turned things around fairly quick.
- P: Yeah, I guess so.
- T: Also, is there anything different about the situation you're in now that might make coping a bit easier this time around, if you do lose your job again?
- P: Maybe. I mean, I already got a heads-up that my review isn't going to be positive. So it wouldn't exactly come out of nowhere, like it did before.
- T: How could this be helpful for you?
- P: I guess I could plan ahead a bit. Like start to look for other openings online, and update my resume.
- T: Good! Is there anything else you have going for you now that could help you cope?
- P: [pause] Well, I'm learning coping skills for my depression, which I guess should help. I also have more money saved, so I *could* survive for a while even if I'm unemployed.
- T: Okay. So even in the case that you are let go, is it possible that it won't be as devastating as you had initially assumed?
- P: I guess not. I mean, it's happened before and I'm still standing. I could live through it.

Troubleshooting

As described in Case Vignette #1, some patients can have difficulty identifying their thoughts. Often times, these individuals will become so focused on the intensity of the emotion in the moment that they will

effectively “ignore” the events or moments that preceded their reaction. In cases like these, it can be helpful for the therapist to help guide the patient “back in time” to before they entered the situation or when they had just entered the situation to help them begin to identify their automatic thoughts. In Case Vignette #1, the therapist helped the patient to identify what kinds of thoughts she was having prior to the situation (e.g., giving a presentation) and her response in the situation itself (e.g., intense urge to escape). In cases like this, patients will likely benefit from additional focus on and practice with identifying their automatic thoughts, before moving on to the *Cognitive Flexibility* skill.

For some patients experiencing intrusive cognitions (e.g., obsessions or worry), the evaluation of risk or determining the actual probability of the feared outcome can become problematic itself. In these situations, it is helpful to ask the patient to redirect from evaluating probabilities to evaluating the consequences or implications of the event itself. For example, a patient with obsessive-compulsive disorder may think that because they have intrusive and disturbing thoughts, they are a terrible person. In this case, it can be most helpful to focus primarily on generating other interpretations about what the unwanted thoughts mean about them as a person. In addition to redirecting these individuals to evaluate the consequences associated with the feared event itself, it can also be useful to establish a time limit for patients to use the flexibility skill to help ensure they do not get stuck in a cognitive avoidance cycle.

Another potential roadblock that arises for many of our patients is that considering other perspectives in certain emotion-provoking situations does not seem to “help.” Individuals may report that although they can come up with other possibilities, they do not find them very (or even remotely) believable. This is especially true when their emotions are intense. You may also observe that, for some patients, there is a disconnect between the intensity of their emotional response and their interpretation of a given situation. For example, if a patient described avoiding an important social event and the thought related to this was “I may not have anything interesting to say,” there is a disconnect between the relatively extreme behavior (avoidance) and the relatively mild cognition. In these cases, it can be helpful to identify the patient’s *core automatic thought* (i.e., core belief) that is driving the emotional response, not merely the surface-level cognitions that are often more easily accessible.

Therapist Note

This treatment differentiates core automatic thoughts from surface-level automatic thoughts in that core automatic thoughts are not specific to one situation or event. Common core automatic thoughts about the self include “I’m incompetent,” “I’m a failure,” “I’m unlovable,” “I’m bad,” “I’m worthless,” and “I’ll be alone forever.” Common core automatic thoughts about the world are “The world is a dangerous place,” or “At the end of the day, I have no control over what happens to me.” When these core automatic thoughts are activated, patients are likely to find it more difficult to think flexibly and resist the urge to engage in avoidant, maladaptive responses to emotion.

When helping patients identify their core automatic thoughts, the *Downward Arrow* strategy can be useful. This involves starting with a surface-level automatic thought, and asking your patient questions such as “What would happen if this were true?” and “What would it mean about you if this were true (or if this did happen)?” Two examples of completed **Downward Arrow Forms** can be found on pp. 173–174 in Appendix B of the UP workbook.

Once the core automatic thought(s) have been identified, you may decide to work with your patient on becoming more flexible with their core automatic thoughts. This can involve using the same list of questions from Chapter 8 of the UP workbook to come up with more balanced or neutral alternatives (e.g., “I’m okay,” “I have value,” “I’m good enough,” and “I am successful sometimes”). We generally try to stay away from overly positive and therefore unrealistic thoughts (e.g., “I am always successful”). We have also found that encouraging patients to begin looking for evidence that supports their new, more balanced core thoughts can help them strengthen these more adaptive cognitions about the self and the world. Thinking flexibly here is key, as it is expected that the patient will continue to notice negative events—while *also* being on the lookout for positive or more neutral things. Suggesting that the patient write down two or three pieces of observed evidence to support their new core thought each day can facilitate this process.

(Corresponds to Chapter 9 of
the UP Workbook)

Overview

Module 5 focuses on the behavioral component of the emotional response and begins by reviewing the role of *emotional behaviors* (i.e., behaviors that are used to control strong emotions) in the development and maintenance of maladaptive emotional responding. In this module, you will help your patient identify relevant emotional behaviors and then work with them to develop and engage in *Alternative Actions*. Over time, it is expected that these *Alternative Actions* will help remediate cognitive and behavioral patterns contributing to the frequent occurrence of strong negative affect and maintaining your patient's distress in response to their experience of strong emotions.

Module Goals

- Introduce the concept of emotional behaviors
- Review types of emotional behaviors
- Help patients identify their own emotional behaviors
- Demonstrate and discuss the paradoxical effects of emotional behaviors and provide a rationale for countering them
- Help patients develop *Alternative Actions* to their emotional behaviors

Materials Needed

- **List of Emotional Behaviors Form** located at the end of UP workbook Chapter 9
- **Countering Emotional Behaviors Form** located at the end of UP workbook Chapter 9

Homework Review

As with all the treatment sessions conducted thus far, we usually begin by reviewing the patient's homework. In this case, focus on the patient's **Cognitive Flexibility Form(s)**. Did your patient identify automatic appraisals and work to evaluate them more flexibly? If relevant, did they note any core beliefs and work on challenging them as well? Should your patient express difficulty with these exercises, it can be helpful to remind them that this skill will continue to improve with practice. If your patient describes difficulties believing the alternate appraisal, remind them that the act of generating the new appraisal is what is most important—in fact, that is what encourages the cognitive flexibility! As always, if a patient is having trouble completing their homework, it can be helpful to remind them about the importance of homework and problem-solve with them to address any barriers to homework completion.

Discussion of Emotional Behaviors

The focus of this module is on understanding emotional behaviors, a term that refers to the behaviors a patient engages in to manage strong emotions. As such, this portion of treatment zeros in on the behavioral component of the Three-Component Model of Emotions (described in Chapter 7 of this guide). At this point in treatment, familiarity with this model as well as mindful awareness of all aspects of an emotional experience will likely mean that patients are already conscious of many of their own behaviors. Thus, this module provides an opportunity to expand their knowledge of how behaviors influence emotional

experiences and to explore ways of countering the behaviors that do not serve them well in the long term.

When reviewing the role of behaviors in emotional experiences, it can be helpful to begin by explaining that there are several ways in which behaviors can influence emotions. To start, every emotion has behaviors that are naturally associated with it; sometimes these behaviors are referred to as the action tendencies associated with a given emotion. For example, anxiety might motivate preparation or avoidance of threatening stimuli, and sadness tends to prompt withdrawal. It can be helpful to remind patients that these behaviors generally serve an adaptive function by allowing us to respond quickly to our environment. For example, feeling anxious before a presentation prompts practice to ensure a good talk. Feeling anxious when walking alone in the woods might prompt avoidance of potentially dangerous situations (e.g., going off the trail, being attacked by a bear). Withdrawing when sad can help an individual process a loss. The UP workbook contains more examples of behaviors that are naturally associated with a variety of emotions.

Therapist Note

Just as you reviewed several emotions in Chapter 7 when discussing the adaptive nature of emotions, it can be helpful to take a similar approach here. Discussing the adaptive nature of behaviors that are “hardwired” to occur with each emotion can serve as a useful reminder that a lot of behaviors in which the patient is engaging make sense and serve them well. As detailed in this chapter, what we want to do is start to evaluate behaviors in context to identify the ones that are maintaining your patient’s emotional difficulties.

However, the same behaviors that are adaptive under some circumstances may be less adaptive in others and may, in fact, contribute to the development and maintenance of an emotional disorder. For example, a threatening situation might elicit anger and fear, which would motivate an individual to engage in behaviors that are designed to be protective. In this case, these emotions might result in behaviors linked to the act of fighting, fleeing, or both. These behaviors would be entirely adaptive if there was a threat present that could objectively result in a considerable degree of harm (e.g., someone is about to be

mugged). However, if a true threat is not present and the person is in fact experiencing a “false alarm,” then the behaviors would likely be less adaptive. That is, it may be that the level of anger and subsequent response is not justified by what is actually happening in the situation (e.g., your patient’s boss is trying to give them constructive feedback). At this point in the discussion, it can be helpful to revisit the concept of short-term and long-term consequences of emotional behaviors. Remember, these behaviors tend to reduce distress in the short term but often cause more problems in the long term. These problems can include the perception that emotions are difficult to cope with and necessitate avoidance, thus maintaining the pattern of maladaptive emotional responding, which is at the core of the emotional disorder itself.

After this initial introduction, work with your patient to identify the emotional behaviors that are most relevant to them and occur most frequently. To facilitate this discussion, it can be helpful to review the different types of emotional behaviors (described in Chapter 9 of the UP workbook) one by one and ask patients to generate examples from their lives. Patients can write these examples on the **List of Emotional Behaviors Form**. Table 9.2 in the UP workbook defines each type of emotional behavior and provides additional examples. The definitions are included here as well:

- *Emotion-driven behaviors (EDB)*: Behaviors **driven** by strong emotions that are designed to reduce the intensity of that emotion.
- *Overt avoidance*: Outright avoidance of situations, people, and so on that bring up strong emotions.
- *Subtle behavioral avoidance*: Behaviors that prevent fully experiencing an emotion when outright avoidance is not an option.
- *Cognitive avoidance*: Cognitive strategies that are used to avoid thinking about something that is distressing.
- *Safety signals*: Items that are used to feel more comfortable and/or keep an emotion from becoming overwhelming.

Therapist Note

In the previous edition of this treatment manual, we distinguished between emotion avoidance and emotion-driven behaviors (EDBs). Emotion avoidance (which is comprised of overt avoidance, subtle

behavioral avoidance, cognitive avoidance, and safety signals) can be thought of as strategies an individual might use to prevent the onset of a strong emotion. On the other hand, EDBs can be thought of as behaviors accompanying strong emotions that one is already experiencing. It can sometimes be helpful to consider emotional behaviors in a temporal fashion, and you might find it useful to think about the subtle differences between these types of emotional behaviors when considering the function of a patient's behavioral response. However, it is not essential to make this distinction and may be confusing to some patients.

Table 10.1 lists examples of emotional behaviors associated with different emotions and the type of emotional behavior that it might represent. Remember, these concepts apply to all emotions, so it can be helpful to consider the full range of emotions when exploring your patient's behaviors.

In addition to the emotional behaviors described in the UP workbook, you should be aware of the potential avoidance of somatic sensations associated with emotions. This avoidance is quite common across emotional disorders, since these sensations may trigger intense affect. For example, some patients avoid coffee or exercise because these trigger an increase in heart rate, which is often a somatic sensation associated with anxiety. Avoidance of somatic sensations is discussed in more detail in relation to Module 6 (covered in Chapter 11 of this guide).

It is also relevant to note that these concepts apply to positive emotions as well as negative ones. For instance, patients suffering from depression often report difficulty in allowing themselves to feel positive emotions. Additionally, patients with emotional disorders sometimes indicate reticence to experience positive emotions because they are “waiting for the other shoe to drop” or for something bad to come along that will take away their positive emotions. Thus, they might apply any of the aforementioned behaviors to the experience of positive emotions as a way to avoid potential disappointment.

Table 10.1 Examples of Emotional Behaviors

Emotion-Driven Behaviors Behaviors driven by strong emotions that are designed to reduce the intensity of that emotion	
Checking behavior (i.e., locks, stove, etc.)	Asking for reassurance
Self-injurious behaviors	Yelling or hitting someone
Insulting someone	Leaving a situation when feeling anxious or frightened
Apologizing excessively	Calling a relative repeatedly to check on their safety
Drinking alcohol or using other substances	Excessively engaging in pleasurable activities
Overt Avoidance Outright avoidance of situations, people, etc. that bring up strong emotions	
Walking instead of using public transit due to fears of having a panic attack	Avoiding crowded areas
Not attending a party to avoid anxiety in social situations	Avoiding exercise and other forms of physiological arousal
Declining offers to see friends	Refusing to drive during “rush hour”
Avoiding pleasurable activities	Staying in bed or frequently napping
Subtle Behavioral Avoidance Behaviors that prevent fully experiencing an emotion when outright avoidance isn't an option	
Texting at a party to avoid small talk	Not drinking caffeine
Perfectionism	Restricting food intake
Avoiding eye contact	Excessive planning
Procrastination (avoiding emotionally salient tasks)	Making comments that undercut the enjoyment of a situation
Making snide comments	Speaking in a low tone of voice

Table 10.1 Continued

Cognitive Avoidance	
Cognitive strategies that are used to avoid thinking about something that is distressing	
Distraction (e.g., reading, listening to music, watching television)	Worry/Rumination
Trying to push away “bad” thoughts that bring up emotions (thought suppression)	Forcing self to “think positive”
Reassuring self that everything is okay	Dissociation

Safety Signals	
Items that are used to feel more comfortable and/or keep an emotion from becoming overwhelming	
Carrying “good luck” charms to feel comfortable	Carrying items like water bottles, medication, or cell phones “just in case”
Bringing a “safety person” to an uncomfortable situation	Carrying self-defense items
Stockpiling water, food, and other supplies in case of an emergency	Having reading materials/prayer books on hand

Understanding the Role of Behaviors in the Maintenance of Emotional Disorders

It is important for patients to understand how maladaptive emotional behaviors can contribute to the maintenance of their emotional difficulties. When a patient engages in an emotional behavior that produces relief from the experience of intense emotions, however briefly, that behavior is reinforced. The next time the patient enters a situation that brings up a strong emotion, they will feel a pull to do something similar, as it has “worked” (and was reinforced) in the past (i.e., reduces the intensity of the emotion). Although these behaviors make them feel better (or less bad) in the moment, they can also strengthen beliefs that

the emotion is dangerous and that the patient is unable to cope. Thus, the next time the patient experiences that emotion, or another intense emotion, they will be even more likely to engage in the (previously reinforced) emotional behavior, thus maintaining the pattern of maladaptive emotional responding.

Therapist Note

Helping patients understand that emotional behaviors are learned and reinforced over time can lend insight into why they might continue to engage in such behaviors despite their negative consequences. This insight is integral to treatment because it can aid patients in taking a nonjudgmental stance on their behaviors, increasing their willingness to change.

For example, consider a patient who storms out of their boss' office after having a difficult conversation. Leaving the office early (i.e., escaping) might help them "calm down" and feel less upset in the short term (i.e., reduce the intensity of their emotion). However, feeling less upset reinforces the escape behavior in that context, and possibly in other similar situations as well, which in the long term could cause interpersonal problems and interfere with the development or use of more appropriate (and ultimately more effective) social behaviors, such as being assertive.

Demonstration of Emotion Avoidance

The UP workbook provides a specific exercise to demonstrate the paradoxical effects of emotional behaviors, specifically thought suppression. This exercise is adapted from an experiment conducted by Professors Daniel Wegner and David Schneider on mental control and thought suppression (Wegner, Schneider, Carter, & White, 1987). In that experiment, study participants were asked to think of anything but a white bear, a task that highlighted how it is nearly impossible *not* to think of something. In the UP, patients are asked to try not to think about a situation or a memory that is particularly embarrassing for them. For the first minute they are asked to focus on

that memory and then rate how successful they were at doing so. For the second minute, they are instructed to think about *anything* other than that memory and then again rate their success in doing so. Most patients find it remarkably more difficult to avoid the memory than to focus on it.

We have found this exercise to be helpful in illustrating the idea that attempts to suppress thoughts (and emotions) are generally unsuccessful. In fact, suppression may actually increase the frequency and intensity of the very thoughts and emotions the individual is trying to stop. You can point out to patients that while they may have been able to avoid thinking about the memory or situation for at least a period of time, to be sure they were not thinking of the memory (which was the purpose of the task), they would need to occasionally “check” to make sure thoughts about the memory or situation were not in their mind. This very process then involves thinking about the memory or situation and thus ensures they will have to think about it at some level.

Some patients will say that they were able to completely avoid focusing on the memory. In these cases, patients often put a lot of effort into avoiding it, perhaps by distracting themselves (e.g., counting ceiling tiles, making lists, singing songs in their heads). Here, it is helpful to point out how much effort it took these patients to avoid the memory and that as soon as they ceased these efforts—which would be difficult to sustain in the “real world”—the memory would return, thus demonstrating that suppression of the memory is still an inefficient strategy.

Breaking the Cycle of Unhelpful Emotional Behaviors

After discussing various emotional behaviors and the functions they may serve, this is a good point to introduce the idea of *Alternative Actions*. This is the skill that patients will use to break the cycle of unhelpful behaviors. By *Alternative Action*, we mean engaging in an action that is different, and often opposite, to what a patient typically does when experiencing a strong emotion.

When it comes to identifying Alternative Actions, it is important to stress to patients that they should work toward *doing* something different. Patients are often tempted to simply say “I will just stop doing [the emotional behavior].” However, it is often very difficult to go from doing something to doing nothing, especially when experiencing an uncomfortable emotion. In our experience, patients find it is much easier to go from doing something to doing something else. The UP workbook contains a table with many suggestions for *Alternative Actions* to emotional behaviors. Table 10.2 is an abbreviated version of the *Alternative Action* table included in the UP workbook.

Therapist Note

*Identifying an emotional behavior and understanding its function (i.e., emotion avoidance and suppression of an emotional response) is paramount to developing an effective Alternative Action. We encourage you to take time to discuss your patient’s emotional behaviors at this level, possibly even using examples from previous **Three-Component Tracking Forms** that were completed by your patient during treatment.*

Changing how we behave can change how we feel. For example, imagine a patient is invited out to dinner by a friend and needs to decline because they have conflicting plans but feels guilty about doing so. As they talk to their friend, they might start to feel physical sensations such as shakiness, trembling, and elevated heart rate. They might also think “I’m a bad friend for turning down this invitation.” These sensations and thoughts could prompt them to apologize excessively. In the short term, this behavior might reduce the intensity of their guilt. But in the long term, it reinforces the idea that the patient did something wrong by declining and might also annoy their friend! On the other hand, if the patient uses an *Alternative Action* and simply explains that they have conflicting plans, they might notice that they feel uncomfortable in the moment but less guilty in the long term and when a similar situation arises in the future. Engaging in *Alternative Actions* typically has different short-term and long-term consequences than emotional behaviors. These new actions tend to be more difficult in the short term but reduce emotional intensity in the long term and can also help patients feel proud of their ability to cope.

Therapist Note

Three-Component models (Chapter 7) can provide a helpful way to illustrate how emotional behaviors can feed into the cycle of unhelpful emotions. The previous example paragraph might be drawn in a model to illustrate the interaction of behaviors with the other components (thoughts and physical sensations) in the patient's experience.

Table 10.2 Examples of Alternate Actions for Emotional Behaviors

Emotion	Emotional Behavior(s)	Alternative Action(s)
Fear	Escape/avoid people or places Pick fights Make threats	Stay in the situation, approach Speak calmly Give compliments
Sadness	Withdraw from friends Avoid enjoyable activities Listen to sad music	Call friends, make plans to go out Make plans to do something fun Listen to upbeat music
Anxiety	Overprepare Avoid Seek reassurance	Set a time limit on how long to prepare, engage in a pleasant activity Face the situation Resist reassurance seeking by talking about something else
Anger	Fight Yell Break things	Taking a break before responding, go for a walk Talk in an even tone Move slowly, put items down gently
Guilt/Shame	Withdraw Avoid eye contact Speak softly	Contact others Make eye contact Use a full voice

Homework

- Your patient should use the **List of Emotional Behaviors Form** from the UP workbook to identify additional emotional behaviors that were not discussed in session.
- Have your patient begin using the **Countering Emotional Behaviors Form** to work on changing emotional behaviors (both avoidance and EDBs) in response to emotions and situations that arise.
- Instruct your patient to continue monitoring progress by completing the **Anxiety and Depression Scales** (as well as **Other Emotion and Positive Emotions Scales**, if they are using them) and charting their scores on the **Progress Record**.
- In preparation for *Emotion Exposures* (Chapter 12), it may be helpful to encourage patients to begin entering situations that may provoke difficult emotions. This could include talking to a friend about a difficult topic, watching a distressing television show or movie, or other similar activities. Patients do not yet need to elicit emotions that are personally relevant per se. It is most important that they begin to practice *Emotion Exposures* that are only mildly threatening to get a sense of what it is like to do these activities. Instruct patients to practice being aware of their emotional experience in these situations, including automatic thoughts and emotional behaviors.

Case Vignettes

Case Vignette #1

In the following vignette, the therapist helps the patient identify the function of a specific emotional behavior and subsequently develop an *Alternative Action*.

p: Typically, when I get ready to give a talk, I spend a lot of time preparing. I guess I'm avoiding the possibility of making a mistake . . . but isn't that a good thing? I mean, I know a lot of people who do that. Maybe my anxiety is actually helping me here. I just want to do a good job.

- T: That's a really good point. I agree that avoidance can sometimes be adaptive, and I can see why you might not want to make too many mistakes during an important talk. But do you think that the amount of time you spend preparing is reasonable, given the importance of the talks? After the talk is over, do you look back and wonder whether you needed to prepare as much as you did?
- P: I see where you're coming from. No . . . I probably don't need to prepare as much as I do. Some of the talks are more important than others, but I think I prepare for everything the same way. And even for the important talks, I tend to go a little overboard.
- T: Do you have a sense of why you prepare so much?
- P: Like we talked about last week, I guess I get worried about doing a good job. . . . I get scared that I'll get anxious, my mind will go blank, and I won't be able to continue.
- T: I think we can agree that going into a big talk without any preparation at all is probably not the best strategy. But at this point, it seems like the function of your behavior is primarily to avoid an outcome which is not likely to occur. That is, you may be overpreparing in order to avoid feeling anxious in that situation. You're afraid that your anxiety will significantly interfere with your performance.
- P: I would agree with that.
- T: But I wonder if you have data to support that idea? You said yourself that even when you get anxious during a talk, you still do well. And last week we also agreed that even if you didn't do a good job, it would be okay in the end . . . that you would be able to handle it. So in this situation, I wonder if the overpreparing is not very adaptive for you. It may prevent you from challenging some of the ideas you have about experiencing anxiety in that situation, which wouldn't make the situation any easier in the future.
- P: Good point, doc. Maybe I should only prepare when the talk is really important and even then, I could try to keep it more reasonable. There's a part of me that knows I would do just fine, even if I didn't prepare.

Case Vignette #2

In the following vignette, a patient has some difficulty recognizing what she believes is a personal preference is actually an emotional

behavior. She is assisted by the therapist, who encourages her to think about the function of her behavior and how it might relate to her anxiety and worry.

P: Last night it was really hot outside, and my husband wanted to open the windows in our bedroom. He got upset with me because I wouldn't let him.

T: Why didn't you want to open the windows?

P: The noises outside make it hard for me to sleep. In the morning, the birds are always chirping. Sometimes they wake me up.

T: That makes sense. I wonder why your husband got so upset.

P: He thinks it's related to my anxiety. He says I'm paranoid.

T: Why does he think you're being paranoid?

P: Remember I told you that a couple of years ago our apartment got broken into. Well, after that, I got really anxious about someone breaking in again, especially at night. Since then, I haven't really wanted to leave the windows open.

T: So you close your windows at night to prevent someone from breaking in while you and your husband are sleeping?

P: Well, also because of the bird noises . . . but yeah, I guess the fear of someone breaking in is the main thing. I know it's not very likely. We live on the third floor. But I get so anxious when we leave them open at night. . . . I really have trouble sleeping unless they're closed and locked.

T: It's hard to know sometimes whether we're engaging in a behavior out of personal preference and when it might actually be an example of avoidance. How do you think we might tease that out in this situation?

P: Well, I guess I wasn't too concerned about locking (or even closing) the windows at night before the house was broken into. And when I'm sleeping in another place, I'm much less concerned about it, even if there's noise outside. So I guess I'm mostly avoiding the possibility of someone breaking into our house again . . . even though it's unlikely this will happen.

Differentiating Adaptive and Nonadaptive Behaviors

In the beginning of this module, we introduced the concept of action tendencies, and patients are reminded that emotions, as well as associated behaviors, are often adaptive. Sometimes patients find it difficult to tell when a behavior is adaptive and when it is interfering, as seen in Case Vignette #1. In these cases, the therapist will most likely find it beneficial to work with the patient to collaboratively define what constitutes adaptive versus nonadaptive behaviors, taking into consideration the patient's expectations of their own behavior, the specific context in which the behavior occurs, and the consequences with which it is associated. The ability to recognize when, and under what circumstances, a behavior should be considered adaptive versus nonadaptive is essential to behavioral change, and helping patients develop this discrimination ability is an important part of treatment. As a general rule, behaviors are less adaptive when they fall into the aforementioned pattern of reducing distress in the short term but maintaining it in the long term.

Differentiating Between the Various Types of Emotional Behaviors

For some patients, the distinction between types of emotional behaviors (i.e., overt avoidance, subtle behavioral avoidance, cognitive avoidance, safety signals, and EDBs) can be confusing. While these categories are meant to provide a heuristic to help patients examine their own behavior and identify those that do not serve them, there is no need to get hung up on these subtle distinctions. Instead, focus on helping patients understand the *function* of emotional behaviors (i.e., to get away from strong emotions) and the role of these behaviors in maintaining emotional disorders, then work toward implementing *Alternative Actions*.

Seeing Emotional Behaviors as Personal Preferences

As seen in Case Vignette #2, some patients have difficulty recognizing a behavior as an emotional behavior even though it appears to be one. Often, a patient will claim that an emotional behavior is a personal preference. In Case Vignette #2, the patient states that she prefers to sleep with the windows closed and locked due to the noise outside. However, she acknowledges that she is also worried someone will break into her house if the windows are open; thus, it appears this behavior serves an emotionally avoidant function, allowing her to avoid the anxiety she would experience were the windows open. While patients may see some behaviors as simply reflecting personal preferences, as opposed to emotional behaviors, the therapist should work with the patient to respectfully consider the possibility that these “preferences” may in fact reflect an underlying fear of internal or external stimuli. Once again, a discussion of short-term and long-term consequences of various behaviors can help to parse preferences apart from emotional behaviors.

Patients Say Their Emotional Behaviors Make Them Feel Worse

Even though we commonly state that emotional behaviors make individuals feel better in the short term, some patients will find this description inconsistent with their experience, claiming that their emotional behaviors only make them feel worse in both the short and long term. In these cases, the emotional behavior is often the “lesser of two evils.” While the emotional behavior does not feel good, it feels less bad than if the patient were to resist engaging in it altogether. For example, worry can be very unpleasant while it is occurring and also interfering in the long term. However, it can also feel like problem-solving, in that someone might feel guilty for “ignoring” the topic of concern were they to resist worrying. So even though the worry is unpleasant, it would feel *even worse* not to do it. In these cases, it is not that the emotional behavior feels good but that it feels *less bad* than the alternative.

Trouble Brainstorming Alternative Actions

Sometimes patients experience difficulty thinking of *Alternative Actions*. When this issue arises, encourage them to think of the most extreme *Alternative Action* possible and then scale it back to a behavior that is feasible and that they are willing to do. For example, take a patient who avoids all interactions with women for fear of offending them and one of his emotional behaviors is to get off the train if a woman stands next to him. The most extreme opposite action might be to walk up to a strange woman on the train, stand next to her, and talk to her. However, the patient might not be willing to do that. Thus, a more feasible action might be to stand next to the woman without talking.

Therapist Note

It can be particularly difficult to think of an Alternative Action for worry and rumination. For these behaviors we recommend the use of Mindful Emotion Awareness as the Alternative Action. Present-focused awareness is inherently inconsistent with ruminations about the past or worries about the future. Another potential opposite action for worry can be problem-solving, that is, making a list of concrete steps to address the problem and then following through on them step by step. Mindfulness is also important in problem-solving as Anchoring in the Present can provide a helpful framework through which patients can enact their plan.

*(Corresponds to Chapter 10 of
the UP Workbook)*

Overview

This chapter focuses on *interoceptive exposure*, or exposure to physical sensations that are associated with (and can sometimes trigger) intense emotions. The exercises described in the UP workbook are designed to assist patients in gaining further awareness of physical sensations that are part of an emotional reaction. Further, these exercises, and continued exposures focused on physical sensations, are expected to help patients learn to tolerate and think differently about the sensations and provide an opportunity to break the conditioned association between the sensations and strong emotions such as fear, anxiety, and sadness.

Module Goals

- Increase patients' understanding of the role that physical sensations play in determining their emotional responses
- Help patients identify internal physical sensations associated with their emotions
- Repeatedly engage in exercises designed to help patients become more aware of their physical sensations and increase tolerance of these symptoms

Materials Needed

- **Physical Sensation Test Form** located in UP workbook Chapter 11
- Thin straw or coffee stirrer
- Stopwatch, timer, or clock with a second hand
- Any other materials that may be relevant to patient's specific physiological reactivity (e.g., space heater, wrist weights, belt for tightening around waist)
- **Physical Sensation Practice Form** located at the end of UP workbook Chapter 11

Homework Review

Before starting this chapter, review the **Countering Emotional Behaviors Form**, as well as any additional forms that may have been assigned for further practice. At this point, patients may have been able to identify *Alternative Actions* to their emotional behaviors but may be having difficulty implementing these new responses. You may wish to work with your patient in examining the specific reasons they were unable to move forward with engaging in the new behaviors. You may find it useful to help patients identify and challenge outcome expectancies regarding what they believe will happen if they do not engage in their current emotional behaviors. For instance, a patient may believe that if they do not engage in a particular emotional behavior that the emotion will increase in intensity or that it will be experienced indefinitely. Addressing these concerns will help your patient to see their emotional behaviors as being nonadaptive and essentially “clear the path” for new *Alternative Actions*.

Physical Sensations and the Emotional Response

In the same way that patients learn to recognize thoughts and behaviors as part of the emotional response, it is important for them to have a good understanding of how physical sensations can also contribute to emotions. Here we emphasize that, depending on how patients think about and experience these physical sensations, they can contribute

to the emotional experience: they may be an important part of what makes the emotion hard to tolerate. For instance, take a person—giving a speech in front of a large audience—who begins experiencing an increased heart rate, sweaty palms, lightheadedness, and slight feelings of unreality. If these sensations are viewed as a threat to that person's ability to continue with the speech, they are likely to experience an intensification of the emotional response (including the physical sensations), which, in turn, will cause the person to become even more concerned about the sensations and so on. If, on the other hand, the person giving the speech interprets the sensations as a normal reaction that sometimes occurs in high-pressure situations and does not believe that the sensations significantly interfere with their performance, or was accepting of this possible interference, it is more likely that the person would be able to focus their attention on the speech, and, after a short period of time, the symptoms would diminish on their own.

In talking about physical sensations you may want to emphasize the role that interpretation can play in changing how the patient experiences those sensations. We present this idea by noting that the context in which the physical sensations occur can influence our interpretation and level of acceptance of those sensations. So, for example, playgrounds are designed specifically to induce strong physical sensations—dizziness, racing heart, shortness of breath, and so on—and in fact, that's what makes them fun for kids! Similarly, amusement park rides are designed to elicit similar physical sensations in adults. Yet when these very same sensations arise in an anxious adult, or in a context where they may not be expected, they are interpreted very differently. Likewise, you might point out how the very same physical sensation may be associated with different emotions depending on the context—such as flushing being associated with pride, embarrassment, or anger, depending on the thoughts it accompanies. This illustrates that physical sensations are not *inherently* threatening; rather, it is our interpretations of these sensations that make them feel that way.

Therapist Note

As many practitioners are aware, interoceptive exposure has traditionally been applied in the treatment of panic disorder, in which specific concerns about the consequences of physical experiences are central to

the psychopathology. However, having conducted interoceptive exposure with patients with a wide range of diagnoses, we believe strongly that this intervention can benefit any patient who experiences noticeable physical sensations as part of their strong uncomfortable emotions—which is to say almost all patients, even if they do not initially identify fear of physical sensations as a problem. We believe this because, as mentioned, physical sensations are part of what convinces a patient that they cannot handle an unwanted emotion. For example, a depressed patient may feel less willing to engage in behavioral activation when experiencing the physical heaviness that accompanies low mood. A patient with obsessive-compulsive disorder may report that their intrusive thoughts feel more true and threatening when accompanied by physical arousal. Socially anxious patients might find that blushing or sweating increases the likelihood of negative appraisals arising during a social interaction. Patients with generalized anxiety often feel greater urges to engage in avoidant emotional behaviors (e.g., procrastination) when worries are accompanied by unwanted physical sensations such as elevated heart rate or muscle tension. In each of these cases, the process is the same: Concerns about the physical sensations heighten aversion to the emotional experience, which increases the pressure to suppress the physical sensations to cope.

The initial discussion on the role of physical sensations in the emotional response provides patients with justification for conducting exercises designed to increase the flexibility of their interpretations of physical sensations. Then take the opportunity to identify the physical sensations that most frequently arise during emotional experiences, looking back at previous examples of **Three-Component Model of Emotions** or **Following Your ARC Forms** if necessary. Next, proceed to a discussion of avoidance of physical sensations and the value of conducting exposures to these sensations.

Avoidance of Physical Sensations

Avoidance of physical sensations is common in patients suffering from panic disorder. However, in our experience, patients with other anxious and depressive symptoms also exhibit some level of avoidance of physical sensations. More obvious avoidance includes avoiding activities, such

as physical exercise; arguments with friends; thrilling movies; or sexual relations, which elicit strong physical sensations. Patients may avoid substances that naturally produce physical sensations, such as caffeinated beverages, chocolate, energy drinks, and even over-the-counter medications. Avoidance also includes distracting oneself from thoughts about physical sensations. Of course, avoidance precludes new learning about one's ability to tolerate physical sensations in the context of a strong emotion and instead maintains the vigilance for and acute sensitivity to such sensations. Therefore, the majority of this module is devoted to helping the patient repeatedly confront physical sensations, so the patient can increase their tolerance of these sensations and learn that these are not harmful.

Over the course of a number of such practices, anxiety over the symptoms eventually declines. Having patients systematically face their feared sensations is very different from how they may have experienced these sensations in the past, as those experiences were most likely accompanied by significant fear and avoidance. In this case, patients will work toward embracing, rather than avoiding, the physical sensations that typify their uncomfortable emotional experiences. Here is an example of how you might describe interoceptive exposure to a patient, drawing on conversations from the previous module on emotional behaviors:

As we've been talking about throughout this treatment, we're working on building a more accepting, willing attitude toward emotions and their parts. We just spoke about how interpretations of physical sensations really color how they feel to us, and that shows up when we think about some of the three-component models and ARCs of emotion that you made before. Remember how you pointed out that you feel muscle tension all over when you're worrying about your family, and this makes you feel like you should just call them so you can relax? But we figured out in the last session that calling your family is an emotional behavior that can contribute to you staying anxious over the long term. So ideally, the feelings of muscle tension wouldn't be adding to that urge to call your family as soon as you have a worry thought. Keeping that in mind, we're going to work on building up a more tolerant attitude toward your physical feelings of tension and other sensations that come up when you're emotional. Just as we've been working on practicing Alternative Actions to counter

emotional behaviors, we're going to practice an Alternative Action to how you typically respond to feeling muscle tension. Instead of immediately doing something to make yourself feel more comfortable, we'll actually practice bringing on muscle tension on purpose, then not doing anything at all—just tolerating the sensation and the distress it brings up, and watching it change on its own. We will do this over and over again until you feel more used to the sensations, until you are no longer worried that they will lead to negative consequences or be intolerable.

Symptom-Induction Exercises

Prior to engaging in interoceptive exposure, it is essential to identify those exercises that are likely to elicit the physical sensations most resembling those that arise in the context of strong emotion and that are at least moderately distressing for each individual patient. Instructions for administration of these exercises are found in the UP workbook but generally involve performing the exercise at full force for 60 seconds. A number of specific exercises are described in the UP workbook, but you should be creative in trying to develop exercises that will be most relevant, given the patient's presenting symptoms. The **Physical Sensation Test Form** can be used to assess the patient's response to these exercises in session. After each exercise, patients are asked to rate the distress associated with the symptoms and the similarity of those symptoms to those that typically occur as part of an emotional response. Each of these items is rated on a 0 to 10-point scale, with 0 = *none*, 5 = *moderate*, and 10 = *extreme*. Based on the results of this assessment, several exercises can be selected for additional practice in-session or given to the patient as homework.

The symptom-induction exercises are to be performed in a way that elicits sensations as strongly as possible. Although patients may only be able to engage in the exercises for a short period of time initially, the length of exposure gradually can be extended. However, it is important that the sensations are fully induced and that the patient continues with exposure beyond the point that the sensations are initially experienced, as terminating the exercises on first noticing the sensations will reinforce fear of the symptoms. The present-focused awareness skills

developed earlier in treatment should also be brought to bear during the exercises. You should instruct your patient to focus on their sensations while conducting the exercises, not to distract from them. If your patient notices certain thoughts occurring during the exercises, they should not engage in cognitive reappraisal at this point but rather should simply notice them as part of the experience. All forms of avoidance (e.g., distraction, minimal symptom induction, the presence of safety signals) should be prevented in order for patients to obtain the most benefits from the exposures.

Therapist Note

Before conducting the symptom-induction exercises, it is important to fully assess for any medical conditions that would render these exercises harmful for the patient and to consult, as appropriate, with the patient's medical professional. It is also important to differentiate psychological distress from true potential for harm. For example, a patient diagnosed with panic disorder who fears having a heart attack while running in place (in the absence of any physical heart condition) is different from a patient who could be put at risk for cardiac arrest due to a documented medical condition.

Repeated Exposures

After identifying exercises that elicit physical sensations most similar to your patient's naturally occurring symptoms, it is important to identify the feared consequences associated with the sensations. Examples of feared consequences might include passing out, throwing up, dying, having a heart attack, having a full-blown panic attack, losing control, feeling distressed for a very long time, or being unable to do other things following the exercises. These consequences are important to identify because the object of interoceptive exposure (and emotion exposure generally) is to violate expectations about the meaning or consequences of the experience. After identifying feared consequences, you should ask your patient to engage in the exercises repeatedly, in session and as homework. Ideally, your patient will practice first in your office so that you can assist with troubleshooting, particularly keeping an eye out for subtle avoidance (e.g., stopping prematurely, not engaging

fully, distracting). The duration of interoceptive exposure trials can be lengthened gradually in order to teach your patient about their ability to cope with progressively more “difficult” exercises, particularly if distress decreases rapidly with initial practice.

Following research recommendations for administering interoceptive exposure (e.g., Deacon et al., 2013), we recommend conducting the same exercise repeatedly with no breaks between trials—the patient only waits long enough to provide ratings of distress and similarity. The exercises should continue until your patient no longer expects their feared consequences to occur. To assess this, you may choose to ask your patient to make ratings of expectancy (e.g., “I think there is a 40% chance straw breathing will cause me to lose control”), although this is not a formal part of the recordkeeping. It is likely, though not guaranteed or required, that distress will decrease across trials. If a patient is experiencing decreasing distress, a good rule of thumb is to continue until distress does not get above 3 out of 10. However, the most important thing is to change expectations and interpretations about experiencing physical sensations and to create a willingness to experience these sensations, whether or not they are distressing.

Homework

- Ask your patient to repeatedly engage in physical sensation exposures following the instructions on the **Physical Sensation Practice Form**. This form can be used to help conduct symptom induction exercises at home. Assign three brief physical sensation exposure exercises, to be agreed upon between you and your patient in-session.
- Instruct your patient to continue monitoring progress by completing the **Anxiety and Depression Scales** (as well as **Other Emotion and Positive Emotions Scales**, if they are using them) and charting their scores on the **Progress Record**.

Case Vignette #1

In the following two vignettes, the therapist provides an explanation for why hyperventilation can contribute to the physical sensations that the patient feels and explains that the exercise is unlikely to result in fainting (which this patient is particularly concerned about).

P: Why does hyperventilating cause all those physical sensations I feel?

T: That's a good question. Without going into too much detail, hyperventilation essentially leads to low levels of carbon dioxide in the blood. This causes many of the symptoms you may feel if you hyperventilate. For instance, low carbon dioxide levels cause the brain's blood vessels to constrict, resulting in a slight reduction of blood flow to the brain, which results in feelings of lightheadedness. Breathing slowly, or just allowing your body to regulate itself, will bring the balance of oxygen and carbon dioxide back to normal, and the physical symptoms will naturally diminish.

Case Vignette #2

P: Won't I faint if I do the hyperventilation exercise?

T: The short answer is no. At least, it would be highly unlikely, unless you're especially prone to fainting. When people faint, it's usually due to a sudden drop in blood pressure and/ or heart rate. This is not what happens during hyperventilation. It's possible to pass out from hyperventilating, but that typically occurs when people hyperventilate for long periods of time and/or you hold your breath immediately afterwards. Our exercise is not really long enough to cause this to happen. It is, however, likely to produce some physical sensations that may be slightly uncomfortable, including lightheadedness, increased heart rate, and tingling in your hands and face. Those are normal sensations and do not necessarily mean that you're going to faint.

Case Vignette #3

In the following case vignette, the therapist provides a rationale for why the patient should practice interoceptive exercises even if they do not feel particularly afraid of any physical sensations.

P: I don't think I'm really afraid of any physical sensations. Do you think we should still go through the exercises?

T: Yes, I do. Even if you're not afraid of physical sensations, the exercises will give you a chance to really focus on the sensations and build your awareness of this component of the emotional response. Then, when you experience a strong emotional reaction, you'll be better able to notice the physical reaction that occurs as part of the emotional response. We have also learned that these exercises can be helpful even if physical sensations are not what you're afraid of, because even in these cases, physical sensations are part of what makes emotions feel hard to tolerate.

Case Vignette #4

In the following case vignette, the therapist provides the patient with guidelines for deciding when to stop practicing the hyperventilation exercises.

P: Hyperventilating makes me feel lightheaded and tingly no matter how many times I do it. When should I stop doing it?

T: Do you feel distressed when you become lightheaded or tingly?

P: Not anymore, I was originally . . . it really bothered me . . . but now it's just uncomfortable. I don't like it too much, but it doesn't make me anxious or anything.

T: If you are no longer distressed by the sensations, there is no need to continue with the exercise. Remember, the exercises are not designed to eliminate the sensations but to lessen your distress about the sensations. You might want to come back to it from time to time, just to practice, but otherwise I think you can move on to another exercise.

The Exercises Are Not Distressing

Some patients do not report much distress during the symptom-induction exercises. There are a number of reasons why this might be. Some patients may need to engage in exercises that are different from those listed in the UP workbook. You should work collaboratively with your patient to identify any avoidance of physical sensations and then use that information to construct an exercise that is more likely to elicit strong physical sensations (and distress). The following are examples of physical exercises to try, which can also be found in the UP workbook:

- *To raise your heart rate:* Squats, push-ups, walking up and down stairs
- *To feel hot and sweaty:* Burpees or squat thrusts, sitting in front of a space heater, putting on a heavy coat indoors
- *To feel dizzy:* Roll your head from side to side, or sit with your head between your legs and then raise your head rapidly
- *To feel disoriented:* Look into a mirror with your face just a few inches away, stare at a bright lamp or pattern (e.g., window blinds) and then look away suddenly
- *To feel shaky:* Hold books or weights straight out to the sides of your body until your arms start to shake, or hold a plank position until your body starts to shake
- *To feel heavy or tired:* Wear wrist weights, ankle weights, or a heavy backpack while going about daily activities for five minutes
- *To feel nauseous or full:* Drink a large quantity of water and wear a tight belt.

The Patient Engages in Subtle Avoidance or Escape

You should also be aware that some patients discontinue the exercises before they fully experience physical sensations. They may terminate the exercises as soon as the sensations are felt or may not perform the exercise with the intensity needed to fully produce physical sensations. You should address such avoidance and help patients modify their

anxious beliefs regarding this situation. Even when patients do not report much distress when completing the exercises, they should still be asked to conduct them repeatedly to help facilitate greater awareness of the physical sensations when they occur in other contexts.

Problems Implementing Exercises at Home

Occasionally, patients report difficulty completing the symptom exercises at home. Often, this is because the perceived safety of the therapist, or the therapeutic environment, is no longer present. Patients become concerned that if they experience strong physical sensations, that they will not recover as easily from the experience, or that it may lead to more intense emotions. You should help your patient identify the perceived consequences and work with them to put things back into perspective (e.g., “What’s the worst that can happen?” “What has happened when you have had these sensations while alone in the past?”). A graduated approach can also be used. Patients could begin the exercises in the presence of a friend or family member, or even in your office with you out of the room. Next, the patient would practice alone.

Conditional Aversion to Physical Sensations

Sometimes patients only experience distress about the sensations when they are in certain situations but not others. Usually this is due to how the patient is thinking about the sensations within that particular context. For instance, having feelings of lightheadedness may be perceived as being much more dangerous if experienced while driving than in some other situation. You should examine the kind of thoughts that make the symptoms appear more dangerous in those situations. Remind your patient that, in reality, the symptoms are no more harmful in that situation than they are in other situations, including your office. Moreover, in some cases, concerns about physical sensations may not be intrinsic to physical arousal but rather related to another aspect of the experience (e.g., fear of judgment when visible physical symptoms arise in social situations). In these cases, it will also be important to combine interoceptive exposure with situational exposure in later sessions.

(Corresponds to Chapter 11 of the UP Workbook)

Overview

The primary focus of this module is *Emotion Exposures*. These are exercises designed specifically to provoke strong emotional responses so that patients can put into practice the skills they have developed thus far in therapy. Following a brief introduction to the concept of *Emotion Exposures* and the rationale for engaging in these exercises, you will assist your patient to gradually confront internal and external stimuli that produce intense emotional reactions while helping them modify their responses to those emotions. You will help your patient incorporate the skills learned in therapy (e.g., present-focused awareness, nonjudgment, cognitive reappraisal) into their exposure practice and address any emotion avoidance (or other behaviors) that may impede treatment progress.

Therapist Note

At least two sessions should be dedicated to this module, though for many patients it may be beneficial to devote several sessions to practicing Emotion Exposures, if possible. This module brings together all of the skills learned in treatment and provides patients with an opportunity to consolidate learning.

Module Goals

- Help patients gain an understanding of the purpose of *Emotion Exposures*
- Assist patients in developing a fear and avoidance hierarchy and how to design effective *Emotion Exposure* exercises
- Help patients to repeatedly practice confronting intense emotions through *Emotion Exposure* exercises

Materials Needed

- **Emotion Induction Exercise Materials** (patient-specific)
- **Emotion Exposure Hierarchy** located in UP workbook Chapter 12
- **Record of Emotion Exposure Practice Form** located at the end of UP workbook Chapter 12

Homework Review

Following a review of your patient's **Anxiety** and **Depression Scales** (as well as **Positive and Other Emotion Scales**, as applicable) and **Progress Record**, as well as any additional forms that may have been assigned for further progress, review the **Physical Sensation Practice Form**. Was your patient able to practice the physical symptom induction exercises that were assigned? As noted in the previous chapter, there are a number of reasons why patients might have difficulty completing these exercises at home (even if they were able to complete them during your treatment session). Work with your patient to identify specific reasons the exercises may not have been completed and collaboratively develop a plan for addressing these difficulties. You can also work with them on completing the exercises in-session as *Emotion Exposures* (see following discussion).

Emotion Exposures

The remainder of treatment focuses on exposure to internal and external stimuli that may produce strong or intense emotional reactions. We refer to these exposures as *Emotion Exposures* because the primary focus of the exposure is not the specific situation, image, or activity but rather the emotion itself. This part of treatment will likely be the most difficult for patients but is an opportunity for them to put the skills they have learned into practice (such as nonjudgmental, present-focused awareness; identifying automatic thoughts; and countering emotional behaviors), so that once treatment is finished, they will be confident in their ability to handle future emotional experiences as they unfold. It is very important that patients commit sufficient time and effort during this last part of treatment, because this is often where many patients see the most significant changes occur.

Therapist Note

The goal of the Emotion Exposures is not immediate reduction in the emotional response. Rather, the goal is for patients to learn something new as a result of the experience. Consistent with a focus on emotions and emotion regulation, conceptually all exposures are directed toward patients experiencing their emotions fully (which means reducing patterns of avoidance) and implementing new responses. Tolerance of emotions is a critical learning goal of Emotion Exposures.

With regards to changing how patients experience and respond to their emotions, *Emotion Exposures* are important for the following reasons:

1. Interpretations and appraisals about the dangerousness of situations (whether they are internal or external in nature) begin to change, and newer, more adaptive interpretations and appraisals begin to emerge.
2. Avoidance, and subsequent impairment, are reversed.
3. Emotional behaviors can be recognized and modified.

Overall, patients come away with new, nondistressing associations about the emotion-producing situation or the emotion itself. For example, for a patient with posttraumatic stress disorder:

- *Old association:* Situation (revisiting the place where trauma occurred) is associated with response (flashback, panic attack) and meaning (“I will be attacked again,” “I won’t be able to handle it”).
- *New association:* Revisiting the place where trauma occurred does not lead to traumatic event(s) recurring and patient is able to tolerate strong emotions without escaping.

Similarly, for a patient with depression:

- *Old association:* Situation (going out with friends or family) is associated with response (fatigue, low mood, urge to focus on negative feelings) and meaning (“This is pointless,” “I won’t ever be happy,” “I can’t stand feeling this way”).
- *New association:* The social interaction is reinforcing. It does not lead to increased low mood or an urge to focus on the emotion, nor does not elicit negative thoughts about the situation.

Introduction to In-Session Emotion Exposures

In-session *Emotion Exposures* help patients learn how to conduct *Emotion Exposures* while processing emotions immediately with the therapist. Though not always feasible, in-session exposures should be conducted whenever possible. When you conduct an exposure with our patient, you are better able to give corrective feedback and clear instruction, provide participant modeling, and facilitate your patient’s tolerance of emotions during the exercise.

The particular exposure tasks will vary from patient to patient. The **Emotion Exposure Hierarchy** in the UP workbook can be used to get an idea of the types of situations that tend to trigger uncomfortable emotions for many patients and the situations that are most often avoided. Several types of *Emotion Exposure* exercises are detailed in the UP workbook and are also described here. These include situation-based, imaginal, and physical sensation *Emotion Exposures*. All of these exercises can be used to assist patients in practicing skills they have learned during the course of treatment.

Situation-based Emotion Exposures

Situation-based Emotion Exposures involve entering situations that are likely to provoke intense emotional reactions (and/or the patient may currently be avoiding). For example, a patient with panic disorder and agoraphobia who avoids taking public transportation might intentionally go on the subway.

Imaginal Emotion Exposures

Imaginal Emotion Exposures involve confronting distressing thoughts, worries, or memories. This type of exposure works well for fears/concerns that cannot be confronted in real life (or at the present time) and/or for individuals who are concerned that worrying or thinking about something will lead to increased emotion or make it more likely that feared outcomes will occur. For example, a patient with obsessive-compulsive disorder who engages in excessive checking rituals to ensure they do not leave the stove on and burn down the house might be asked to imagine this worst-case scenario playing out. Similarly, a patient with generalized anxiety disorder who worries excessively about the health of her loved ones might imagine these significant others dying, including her worst fears of what her life would be like afterwards.

Physical Sensation Emotion Exposures

Physical Sensation Emotion Exposures involve confronting uncomfortable physical sensations that may be contributing to strong emotions. For example, for a patient with social anxiety, you might focus on having the patient elicit distressing, intense physical sensations that typically arise while giving a presentation (e.g., heart racing, flushed face, sweaty palms) via symptom-induction exercises. Note that interoceptive exposures can be combined with situational and/or imaginal exposures to enhance the intensity of emotion experienced. For example, you might ask a patient to run up several flights of stairs to induce uncomfortable physical sensations before entering an anxiety-producing conversation with a confederate.

Therapist Note

When designing exposures, it is important to consider that uncomfortable or aversive emotions can be negative or positive in valence. For example, a patient struggling with recurrent worry and tension may find it difficult to fully engage in a pleasurable activity and “leave their worries behind.” The experience of positive emotions may evoke anxiety about “being caught off guard.” Similarly, a patient struggling with obsessive doubts may find it difficult to enjoy dinner out with friends. Allowing themselves to be fully present in the moment without retreating into engagement with intrusive thoughts may be particularly anxiety provoking. Therefore, it may be important to design Emotion Exposures around both negative and positive emotional experiences.

Conducting In-Session Emotion Exposures

Once the specific *Emotion Exposure* task has been identified, spend time with your patient preparing for the exposure by engaging in some or all of the following steps before attempting a task:

1. Agree upon a specific task that will be completed (usually drawn from the **Emotion Exposure Hierarchy**).
2. Discuss anxious or negative thoughts occurring prior to initiating the task, or those that are expected to occur during the task, and consider other interpretations.
3. Remind your patient of the importance of using *Mindful Emotion Awareness* during the exposure.
4. Identify emotional behaviors that are likely to interfere with the exposure. Relatedly, it may also be helpful to set behavioral goals for the exposure (e.g., make eye contact in a social situation; remain in an anxiety-provoking environment for at least five minutes; refrain from asking for reassurance).

You should structure the task in a way that best permits new learning to occur. This typically involves some level of clarification of what it is that your patient is most worried about, or anticipates happening, so that the exposure can then be directed toward challenging those negative outcome expectancies. If what your patient is most concerned

about is the emotional response itself, then the corrective learning is about their ability to tolerate certain emotional responses or sustained levels of distress. With all *Emotion Exposures*, it is extremely important for you to “catch” any moments where your patient is avoiding their emotions, such as changing the topic, “breaking” the role of the exposure, distracting themselves, and so on. As soon as you notice these maladaptive emotional responses, help make your patient aware that they are avoiding the full emotional experience and then redirect their attention back to the emotion.

During in-session exposures, it is important to be directive and confident and to encourage patients to continue with the exposure despite experiencing intense and uncomfortable emotions. Be careful not to reinforce your patient’s perceived inability to tolerate negative emotions, and try not to collude with your patient in engaging in patterns of avoidance, or accommodating emotional behaviors, as noted earlier. Also, it is important that you do not suggest to your patient that a particular situation may be too difficult or too distressing. Therefore, early on it may be best to choose activities toward the middle of your patient’s hierarchy so that they are likely to succeed. This will allow them to gain a sense of mastery over an aversive experience while simultaneously becoming more tolerant of their emotions. Over time, you will help your patient gradually and systematically work up the hierarchy.

After the exposure is completed, spend at least 10 minutes processing it with your patient. The **Record of Emotion Exposure Practice Form** can be used for this purpose. Work with your patient to identify and explore emotions they experienced during the task within the three-component model. Further, ask them to consider what they learned by engaging in the exposure and what they could do to make their next exposure more effective. This discussion will help you to identify emotional behaviors that may need to be addressed in later exposures. This will also help identify ways to increase the level of difficulty of future exposures and make them more effective overall. Finally, outline the accomplishments your patient made and provide positive reinforcement for completing (or at least attempting) the task.

Moving Emotion Exposures into the Real World

A crucial factor in the success of treatment lies in your patient's continued practice of *Emotion Exposures* outside of session. Moving exposures into the real world is important for several reasons. First, it allows them to directly apply the skills they have learned in treatment to the context of their daily lives. Second, practicing in vivo exposures allows them to develop a sense of autonomy or agency in their own treatment, facilitating the transition away from you and toward independence. Finally, the actual time spent in therapy represents less than 1% of your patient's waking hours; therefore, in order to truly learn skills presented in therapy, it is essential that they continue to practice skills outside of session.

You and your patient will work together to design *Emotion Exposures* that can be practiced outside of the therapy session. Again, the **Emotion Exposure Hierarchy** in the UP workbook can be used to identify possible *Emotion Exposures*. For example, a patient struggling with panic symptoms may take a crowded subway to work. A patient struggling with social phobia may purposely engage in a conversation with an unfamiliar coworker. A patient who fears dogs after having been bitten may visit an animal shelter and practice petting the animals. Or a person with intrusive and distressing thoughts may write down their most feared thoughts and read them aloud daily.

Homework Review

- Ask your patient to practice *Emotion Exposures* repeatedly (we recommend at least three times per week) and record their practice on the **Record of Emotion Exposure Practice Form** in the UP workbook. As treatment progresses, exposures should increase in difficulty and your patient should be encouraged to take more responsibility for designing exposures. Spend time processing exposures practiced over the week at the start of the following session, paying particular attention to any patterns of emotional avoidance or obstacles that may have stood in the way of successful completion of exposures. As noted, a patient should always receive positive reinforcement for any attempt at an exposure, and you and your patient

should work together toward making exposures optimally effective and continually increasing their difficulty.

- Instruct your patient to continue monitoring progress by completing the **Anxiety and Depression Scales** (as well as **Other Emotion and Positive Emotions Scales**, if they are using them) and charting their scores on the **Progress Record**.

Case Vignettes

Case Vignette #1

In the following case vignette, the therapist clarifies the intended purpose of *Emotion Exposures* and provides guidance on how to most effectively complete these tasks.

P: I conducted the *Emotion Exposure* we had discussed. I rode the subway for the entire time I was supposed to, but my fear never became less. I was terrified.

T: That's great!

P: How's that great!? I felt awful. I didn't like being scared. I kept thinking it was going to get better but it never did.

T: The point of the *Emotion Exposures* is not to be able to do them without any fear. It's really about how you experience and respond to your fear that's most important. We purposely selected that situation because we knew it would bring up uncomfortable emotion. We wanted you to learn a couple of things. First, as we discussed, it was important for you to expose yourself to this particular situation for you to see that what you thought was going to happen didn't actually happen. In fact, it turned out much better than you thought it would. Second, we wanted you to work toward developing a greater tolerance of your emotions, in this case fear. The important point here is that despite feeling afraid, you stayed the entire time.

P: Do you think it will be better next time? I mean, will I eventually be less afraid?

T: It's likely that by continuing to ride the subway, the fear will gradually begin to decrease. But that depends on whether you attempt to

avoid your emotions in that situation or do something to make the situation less frightening.

P: Why does that matter again?

T: Well, as we've discussed, engaging in avoidance prevents you from really learning that the situation is not dangerous. In this case, you were afraid that your fear might become so intense that you would lose control of yourself . . . that you might go crazy.

P: Definitely. So you're saying that if I just allow my fear to be there, and don't do anything to avoid, that eventually it will diminish?

T: Again, it sort of depends on you. In general, I would suggest that you focus more on reducing patterns of avoidance and changing emotion-driven behaviors, rather than worrying so much about what happens to your fear. Now it's important to be aware of the emotional experience, and maybe you can even do a quick three-point check to notice your thoughts, feelings, and behaviors as the emotion unfolds. But then it's just about riding the wave. I mean, actively do nothing. Just allow the emotion to be there and then notice what happens as a result. Are you losing your mind? Are you doing anything uncontrollable? If you don't do anything to avoid or escape, then you'll be in the best position to learn that your fear is not dangerous in this situation, and chances are the emotion will eventually diminish.

Case Vignette #2

In the following case vignette, the therapist helps the patient identify the anxious cognitions he experienced when attempting an *Emotion Exposure*.

P: I stayed at the meeting for a little while, but eventually I had to get out of there.

T: And why was that?

P: Well, I started feeling really upset. My vision got blurry and I was having trouble focusing on what my boss was saying.

T: So then what happened?

P: Well, I excused myself from the meeting and went outside to get some air. I really tried to stay but the feelings got so intense. I knew that if I just stayed a little longer, something bad might happen.

- T: Why did you feel the need to protect yourself against those feelings? What are your thoughts about what could have happened if you stayed?
- P: I was just concerned that I might say something stupid because I couldn't really focus properly . . . on account of the feelings I was having.
- T: It looks like maybe we should take some time to look a little more closely at those thoughts.

Case Vignette #3

In the following case vignette, the therapist assists the patient in developing strategies for modifying her emotion-driven behaviors (EDBs) during an *Emotion Exposure*.

- P: I keep leaving the situation too early, right when my emotion hits the peak. What do you think I should do to keep myself in it?
- T: It's tough sometimes to go against our emotionally driven behaviors, especially when those behaviors have been reinforced so much in the past. I mean, at this point, you know that escaping from that situation will make you feel relieved. So it's hard not to do that. I think there are a couple of things you might do here. You could try choosing a situation that's a little further down on your hierarchy. Maybe choose something that's likely to be a little less frightening and that you feel you'll really be able to stay in. Also, you could purposely put yourself in a situation where escape is difficult, or ask a friend or family member to assist you with staying in the situation when you're feeling frightened. How does that sound?
- P: That sounds pretty good. It helps when I have something to remind me to come back to the three components we talked about in the past. Maybe I'll just make out a little note card that I can fill in while I'm completing the exposure.
- T: I like that idea. Also, remember that if you escape from a situation prematurely, you can always think about the situation a little when the emotions aren't as high and then try to go back into the situation as soon as possible.

Sometimes patients are not fully “on board” with the rationale for conducting *Emotion Exposures*, so they might choose “easy” exposures, or exposures that are not likely to provoke significant symptoms. In these cases, continuing to go through the exercises will not be helpful. If your patient is unwilling to face uncomfortable emotions, then the time should be spent revisiting prior treatment concepts to assist them in eventually engaging in *Emotion Exposures*. You may also find it useful to review your patient’s responses to the two motivation enhancement exercises from Module 1 (Chapter 6).

As illustrated in Case Vignette #3, occasionally during *Emotion Exposures*, patients may escape from a situation if their emotions become too strong. If this happens, it should not be regarded as a failure. Rather, this can simply be presented as an opportunity for the patient to learn from it. Escape is a clear EDB that typically occurs in response to a fear reaction and is usually based on the prediction that continued endurance will result in some kind of negative outcome. For example, it is not uncommon for patients to believe that if they stay in the situation, their anxiety or fear will become so intense that the emotion will become out-of-control and they will be unable to function. In this case, you would help the patient evaluate this prediction in terms of the thinking traps of jumping to conclusions and thinking the worst. From there, the patient could be encouraged to reenter the situation as soon as possible.

Patients can sometimes be discouraged by the pace at which symptom reduction occurs. Also, it can be upsetting to patients when they notice a decrease in their emotional response to a situation over time, only to then reexperience strong and uncomfortable emotions in the same situation at a later point. In these cases, it can be important to remind the patient that learning is rarely linear and that, just like any other time of learning, some forgetting occurs over time. Also, learning tends to be fairly context-dependent, so changing things up even a little bit can sometimes cause a return of the symptoms that they thought had been completely diminished. The recurrence of their emotional response to these situations should not be taken as a failure or an indication that exposures do not work. Rather, it should be viewed as another

opportunity to learn that they can tolerate their emotions and that the situation is not dangerous. These recurrences provide excellent learning opportunities and can actually help them generalize what they learned in one situation to other similar situations as well. Again, the goal of treatment is for patients to be less distressed by their emotions (and the situations that provoke them) and to respond more adaptively—the goal is not to prevent them from happening.

CHAPTER 13

Medications for Anxiety, Depression, and Related Emotional Disorders

(Corresponds to Chapter 12 of the UP Workbook)

Overview

This chapter provides information for the therapist and does not correspond to a particular therapy session. Discontinuation of medications is usually addressed toward the end of therapy when patients are beginning to feel better and more confident in their ability to manage their symptoms without medication. You may find the information in this chapter useful for discussing medications, including discontinuation, with your patient.

Session Goals

- Discuss reasons for medication use
- Review how medication use might affect treatment
- Provide information on how medications can be discontinued

Materials Needed

- **UP workbook** Tables 12.1 and 12.2, describing various types of medication and their most common side effects, if needed

Discussing Medication Issues

There is tremendous variability in the extent to which individuals use medication, psychological treatment (such as this program), or some combination of the two. In general, we do not really talk about medication as a more or less effective form of treatment but as more or less appropriate depending on the situation.

There are a number of medications that are often used in the treatment of emotional disorders including benzodiazepines, beta-blockers, selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), mood stabilizers, antipsychotic medications, and other sedatives. The mechanisms by which these medications act are largely unknown, and different medications tend to have different side effect profiles. The UP workbook offers a thorough review of commonly used medications as well as considerations regarding their side effects. During a discussion of these medications, we emphasize the importance of consulting a prescriber before making decisions.

Under ordinary circumstances, medications are likely to begin exerting beneficial effects in a shorter period of time than a psychological treatment program. This is especially true of the benzodiazepines and beta-blockers, which can be effective almost immediately. Antidepressant medication such as SSRIs and SNRIs, which are widely regarded as the first-choice medication treatments for most anxiety and mood disorders, can take longer (about four to six weeks) to be metabolized into the bloodstream and begin to exert their effects. Additionally, some of these medications, particularly SSRIs, SNRIs, and mood stabilizers, require a titration period. That is, the dosage of these medications is increased gradually over time until it is at a therapeutic level. This titration period can mean it takes a little longer for these medications' effects to begin.

Another consideration is that sometimes medications can lose some of their effectiveness when taken continuously over an extended period of time. In addition, there may be a greater risk of relapse when the medication is discontinued. The UP program may be beneficial for individuals who have achieved some relief from medication or who are hoping to prevent long-term use of such medications.

How Medications Can Affect UP Treatment

Medications can interact and sometimes even interfere with treatment procedures. For a number of disorders, in particular panic disorder, combination medication and cognitive-behavioral treatments have been shown to have poorer treatment outcomes over the long term than individual cognitive-behavioral treatments. This does not appear to be the case with depression, where combination treatment appears to be somewhat more effective than either treatment alone, at least in the short term.

Beyond overall treatment outcome, it is important to note that fast-acting medications, such as benzodiazepines, may interfere with exposures by either preventing levels of emotion from reaching peak intensity and/or by functioning as safety signals. In both cases, the use of these medications may prevent the new learning that naturally occurs during exposures. Further, reliance on them, like any safety signal, can reduce the patient's sense of self-efficacy and belief in their ability to cope with the experience of strong emotions. Case Vignette #1 in this chapter provides an example of a therapist talking to a patient about using medication as a safety signal.

A number of patients who come in for therapy mention going off of their medications as one of their treatment goals. Withdrawal or reduction in medication use must be undertaken under the direct supervision of a physician. This process can be accompanied by an increase in anxious or depressed mood as well as uncomfortable physical sensations. Such side effects are common, and the application of the techniques described in the UP is appropriate and can be helpful for patients. If withdrawal from medications is particularly difficult (as might often be the case when withdrawing from benzodiazepines), then the program described in the book *Stopping Anxiety Medication* (Otto & Pollack, 2009) from the Treatments That Work series might also be helpful (search for the title on www.oxfordclinicalpsych.com).

Case Vignette #1

In the following vignette, the therapist talks with a patient about using medication as a safety signal.

P: Can I take my medication with me during (or before I do) the exposure?

T: What makes you think you need to take your medication with you during the exposure?

P: I don't think I'll need them. I mean, I haven't taken them in months, but I want to have them in case my emotions get too intense.

T: Have you had any intense emotions over the past few months?

P: Yes, many times. Especially during some of the recent exposures we've been doing.

T: Okay, so in that last exposure, did you take your medication?

P: No, I didn't have it with me.

T: What happened to your emotions?

P: Well, they got really intense, but I guess they came back down on their own.

T: So if your emotions came back down on their own, what role do you think taking them into this exposure might play?

P: I guess they could actually be a safety signal and might prevent me from fully engaging in the exposure and may even prevent my emotions from coming down as quickly as they naturally would on their own.

Case Vignette #2

Here the therapist and patient discuss a commonly held belief regarding how medications work.

P: I thought that the medication was necessary to correct my chemical imbalance.

T: That is actually a commonly held belief. However, to date, there is no clear evidence of a specific chemical imbalance that is a primary cause of anxiety or depression. The question of how the medications

work isn't well understood, except that they do seem to reduce the intensity of the symptoms experienced. Regardless of how the medications work, it is still important to learn that you can cope with emotions, even if you do experience more intense symptoms.

Case Vignette #3

In this vignette, the therapist helps the patient with concerns about withdrawal from medication.

P: I'm afraid that my emotions are going to become even more severe when I stop taking the medication and I'll be right back where I started.

T: Specifically, what do you mean when you say that your emotions would become more severe?

P: You know, out of control like they were before I started this treatment.

T: Okay. How would you respond to those emotions now?

P: Well, I suppose I would try to apply the skills I've learned in treatment.

T: Great! What would that look like specifically?

P: Well, I guess first I would try to identify what I was feeling. Then I would practice being mindful and maybe try to think about things differently.

T: So it sounds like you've learned quite a bit about your emotions and how to respond to them effectively.

P: I guess I have.

T: Given how much you've learned, and that you've already changed how you experience and respond to your emotions once, how do you think you would respond even if your emotions did become more severe and intense?

P: Well, I guess I'd work through the treatment procedures again. If I've done it once, it must be easier the second time.

Perception that Medications Remedy a Chemical Imbalance

As illustrated in Case Vignette #2, patients often have preconceived notions about the nature of emotional disorders and the need for medications to correct chemical imbalances in their brain. These beliefs can increase patients' anxiety or apprehension about withdrawing from their medication. Brief psychoeducation about the research on the nature of emotional disorders can be helpful in allowing patients to make a more informed decision about continuing or withdrawing from their medication. In short, the causes of these disorders are complex and still largely unknown. There is likely a biological component to them (e.g., neurotransmitters, genes), but research suggests that the way individuals interpret and respond to events also constitutes a large vulnerability to the development of them. Programs such as the UP can target the latter vulnerability.

Concerns that Discontinuing Medications Will Result in More Severe Symptoms

Another common fear described by patients is that their emotions or symptoms will become more severe and intense once they discontinue medication and that they will be right back where they started before treatment. As illustrated in Case Vignette #3, it is helpful to point out to patients how much they have learned and how far they have come already. Even if they do have a recurrence of their symptoms, they have developed a new way of responding to them that they did not previously have. Thus, they will never really be right back where they started.

(Corresponds to Chapter 13 of the UP Workbook)

Overview

The purpose of this module is to evaluate the patient's progress and to plan for the future. You will also reinforce the skills learned in treatment, review key treatment concepts, and help patients develop strategies for preventing "relapse." Additionally, this chapter is used to address symptom recurrence and how patients can maintain treatment gains in the long term.

Module Goals

- Review key treatment concepts and skills for coping with emotions
- Evaluate treatment progress and areas for improvement
- Set short-term and long-term goals for maintaining treatment gains and for continued progress

Materials Needed

- **Treatment Goals Form** located at the end of UP workbook Chapter 4

- **Progress Evaluation Form** located at the end of UP workbook Chapter 13
- **Practice Plan** located at the end of UP workbook Chapter 13

Homework Review

Review your patient's continued progress with completing homework assignments. You may find it useful to compare changes on more recent assignments with homework completed earlier in treatment, to identify improvement that has occurred over the course of the program. Further, assessing your patient's ability to complete homework assignments during treatment is important for discussing short-term and long-term goals for maintaining treatment gains and for continued progress.

Review of Treatment Skills

This module begins with a review of treatment skills. As part of this review, you may find it helpful to present a scenario that is consistent with your patient's presenting symptoms and then ask them how they would respond adaptively to the emotions they are most likely to experience. Using an example that is personally relevant will help your patient more easily appreciate their ability to handle these situations now and in the future, thus promoting a greater sense of efficacy as treatment comes to an end.

Evaluating Progress

Help your patient evaluate their progress in treatment to this point. The **Treatment Goals Form** and **Progress Evaluation Form** from chapters 4 and 13 of the UP workbook, respectively, can be used to facilitate a discussion regarding treatment gains and to identify areas in need of further improvement. Also, use data from the monitoring records that were completed throughout the course of treatment. This helps eliminate the possibility that your patient will simply focus on how they feel now, in general, compared to how they remember feeling at the

beginning of treatment. We typically make graphs displaying a summary score for patients' weekly ratings on the **Anxiety and Depression Scales** and other scales if they were given. This provides a visual record of progress in treatment and can be used to generate discussion about treatment gains and to identify areas for improvement.

We have found it best to discuss change and improvement as a continuing process, consistent with learning any new set of responses and skills. Continued improvement following treatment is very typical, as patients have additional opportunity to practice and apply the skills they have learned.

It will also be important to assist your patient in understanding reasons for a lack of progress, when this occurs. Reasons might include initial error in diagnosis, difficulty understanding the treatment principles, the need for more time to practice the therapeutic strategies, unrealistic goals, and lack of motivation or opportunity for practice. Lack of progress should not be presented as a hopeless outcome. Instead, explore these possible reasons to determine the best course of action that can now be taken in order for your patient to progress. In this way, the end of treatment can actually be presented as an opportunity to engage in a “new phase” of development in which your patient can work toward overcoming prior obstacles and ultimately achieve greater gains.

Anticipating Future Difficulties

All patients will experience intense or uncomfortable emotions in the future, which often occur in response to life stressors. However, everyone experiences fluctuations in their emotional life—the ups and downs of everyday existence. Sometimes strong emotions can occur that may not appear to directly correlate with any overt stressors. This can be quite distressing to patients, and such experiences can serve as strong triggers for relapse. Throughout the course of treatment, patients have been developing a more detached, less judgmental stance toward their emotional experiences. As treatment is concluded and the focus turns to promoting skill generalization, it is essential to help patients bring this same nonjudgmental stance to bear on the inevitable ups and downs they will experience once treatment is terminated.

Addressing patient expectations regarding the recurrence of symptoms is an effective strategy for preempting the likelihood of symptom recurrence from spiraling into full-blown syndrome relapse. Help patients understand that fluctuation of symptoms is natural and normal and does not mean they have relapsed. If your patient experiences a recurrence of symptoms, including anxiety, depression, and avoidance of internal and external stimuli, this is not a sign that underlying problems are resurfacing to uncontrollable levels or that treatment did not work. Instead, it means that there is a temporary reappearance of old habits that can be addressed in the same ways as learned through the UP workbook.

Continuing Practice

In an effort to promote continuing progress following the end of treatment, you may wish to work with your patient to identify areas for further practice. Using the **Practice Plan** from the UP workbook, work with your patient to generate a list of specific things they would like to practice in the coming weeks.

We also recommend that patients set aside time each week to review progress and develop or revise a plan for moving forward. This gives them an opportunity to take stock in what they have accomplished, which can be very motivating. Also, they are in a good position to notice any recurrence of their symptoms and to prevent maladaptive patterns of emotional responding from developing. This can be especially helpful immediately after the end of treatment, usually for several weeks, but could be continued indefinitely or for as long as your patient finds it useful.

Establishing Long-Term Goals

Now that treatment is ending, and as patients experience improvement in their functioning, they may begin planning for things they were previously unable to do because of their symptoms. Using the **Treatment Goals Form** and **Practice Plan** from chapters 4 and 13 of the UP workbook, respectively, work with your patient to set long-term goals and the steps needed to achieve those goals.

Ending Treatment

Patients frequently express concern about ending treatment. It is important to emphasize that patients now have the knowledge and necessary skills to manage and more effectively respond to their emotions.

Case Vignettes

In each of the following vignettes, the patient is coming to terms with the end of treatment.

Case Vignette #1

P: I feel like I've made some real progress, but I'm worried about stopping treatment. I guess I'm a little scared that if my symptoms come back, I won't remember what we talked about or how to apply the skills I've learned.

T: I agree that you've made some real progress in treatment, and I can understand why you might be nervous. But remember, over the course of treatment, you've been developing important skills for responding more adaptively to your emotions. I would say that you now have a good understanding of these skills, and if you continue to practice what you've learned, I imagine you'll become even better at applying these skills over time. I guess it's sort of like any class we may have taken. We don't simply forget everything we've learned just because the class is over. But in order to really retain that information, we may need to continue practicing it or at least revisit it from time to time.

Case Vignette #2

P: We're at our last session but I still feel anxious and sad sometimes. I get worried that things might get worse after treatment is over. I wish I was cured.

T: I can understand your concern. Ending treatment can be difficult. But remember, our work wasn't about eliminating your emotions. Feeling

anxious and sad sometimes is perfectly normal, as these emotions can be very adaptive under certain conditions. So I wouldn't equate being "cured" with not experiencing these emotions. In fact, thinking this way can get you into some real trouble. Just take one situation at a time and come back to the skills you've learned. As you come back to these skills, and continue to practice them, they'll become second nature. Over time, I think it will be even easier for you to experience your emotions and respond to them in adaptive ways.

Case Vignette #3

P: I know I need to keep doing *Emotion Exposures*, but I'm afraid that once I stop coming in for treatment, I won't be able to make any additional progress. I don't have anyone to help me review my progress or give me feedback on how to do things differently.

T: Do you mean you aren't sure how to set up the exposures properly on your own?

P: No, I definitely know how to set them up, and I've been pretty good about doing them over the past few weeks. I'm just not sure I have the discipline to make myself practice. Coming in here each week and talking with you has been very motivating for me.

T: I can see how coming in each week may have provided some structure and helped you stay on-task with completing the exposures. But I wonder if there might be some other ways to stay motivated. For instance, we talked about setting up your own weekly sessions to review your progress and develop a plan for completing exposures. You can even keep the same time you've been coming to treatment. What other things could you try?

P: Well, I guess I could ask my husband to help me stay motivated as well. Maybe I could even sit down with him and go over the progress I make each week. He's very supportive, and I'm sure he would be willing to help out.

T: I think that's a good idea. Also, some people find it useful to give themselves little rewards for completing their practices. You can do this for a little while, and then eventually the benefits from practicing become motivation enough to keep going.

P: I really like that idea! It's always good to get rewards.

Troubleshooting

Patients can feel discouraged at the end of treatment and sometimes minimize the improvements they have made. As previously noted, using data from the weekly tracking forms can help patients to more accurately evaluate their levels of change. If your patient discounts the improvements they have made, in favor of dwelling on the negative, you may find it helpful to point out these specific negative appraisals and then help them to consider the situation in other ways. For instance, you might emphasize that even though there is still room for improvement, they have worked hard to get to this point and have made considerable progress in addressing their symptoms. It may also be helpful for patients to think about treatment as more of an ongoing process that occurs even after the formal program has ended, as opposed to something that has a definitive end-point. In this way, the inability to achieve complete remission of symptoms by the end of treatment is not viewed as a failure, nor is it an indication that additional improvements cannot be made.

Sometimes major life crises occur toward the end of treatment. Depending on how the patient responds to the situation, they may actually regress a bit and feel as though they are “back at square one.” If this happens, acknowledge the setback, but remind them that this does not mean that all progress has been lost. Reviewing records kept throughout treatment can be encouraging. By reviewing these records together, you can help your patient recognize that they have made progress before and that they can certainly do it again.

As illustrated in Case Vignettes #1 and #3, some patients will feel they are not yet ready to end treatment or will express uncertainty about their ability to continue to progress or to maintain what they have achieved once treatment ends. Acknowledging that this uncertainty can feel frightening will assure patients that this is a normal reaction. Remind your patients that they have learned skills that can be applied without continued assistance from you and that essentially in learning these skills they have become their own therapist. It can also be encouraging to explicitly point out the work that the patient may have done on their own, such as practicing *Emotion Exposures*.

Introduction

Many practitioners and treatment centers contact us to ask about whether the UP can be used in a group format. The short answer is yes—it was always our goal in developing this treatment program that it could be used for both individual and group therapy. Our research group has spent over a decade developing, evaluating, and refining the UP for delivery in an individual format. The efficacy of the UP has been established through several clinical trials, so we are now beginning to explore how the UP can be most effectively delivered to a group of individuals.

The goal of this research is to determine from the perspective of both patients and practitioners what works or does not work well in a group so we can then provide specific instructions for how to best implement the UP in a group format. An additional goal is to identify which individual characteristics of a patient predict a positive response to the UP in a group format to inform practitioners' treatment selection decisions. Since we are still in the early stages of this line of research, this chapter will share some preliminary insights into using the UP in a group format.

Benefits of a Group Format

One of the biggest benefits of using the UP in a group setting is that it is efficient, because one practitioner can deliver the treatment to a group

of individuals at the same time. For example, it would take one practitioner a total of 96 hours to do 16 sessions of the UP with six different patients. In comparison, one practitioner could treat all six patients at the same time in a group format. We have successfully delivered the UP in a group setting using 12 two-hour sessions. By delivering the UP in a group format, a practitioner could treat six patients in only 25% of the time it would take to treat the same number of patients on an individual basis.

One problem that we have encountered at our center is that it can take a while to gather enough patients with the same diagnosis to run a group. However, using the UP in a group format means that people with many different diagnoses can participate in the same group. Offering a group treatment that can accept patients with a range of symptoms and disorders can significantly decrease the wait for treatment.

There are also benefits of using a treatment in a group format that are not specific to the UP. Many patients report that listening to others with similar problems helps to normalize their own experience and lessen stigma. A group setting can also inspire patients to push themselves harder. For example, a patient who is initially reluctant to complete an exposure can be motivated by the support of the group or by watching another group member successfully complete a challenging exposure.

Recommendations for Using the UP in a Group Format

Although we always intended for the UP to be a treatment that could be used in either an individual or group format, most of the studies we have done so far have been on how the UP works in an individual format. In other words, we know that the strategies taught in the UP are effective, but we are still learning the best way to teach them in a group format. Here we review some recommendations for how to adapt the UP for a group format based on our initial experiences using it with groups at our center.

Structure

Most of the diagnosis-specific treatment groups that are run at our center are 12 weeks long with two-hour sessions, so we chose to use the same structure for our first evaluations of the UP in a group format. Table 15.1 provides an example of how the UP can be delivered in 12 sessions, but future research is necessary to determine the optimal “dosage” (i.e., number and length of treatment sessions) of the UP for groups.

In an individual format, homework review is often limited to 10 to 15 minutes, with the remainder of the session spent on the introduction of new material. However, in a group format, it may be necessary to allocate more time to ensure adequate comprehension of concepts and skills across all members of the group. We found it helpful to make

Table 15.1 Outline of UP Content Delivered by Session

Session	Content
1	Introduction and treatment rationale; motivation enhancement strategies; treatment goal setting (UP Module 1).
2	Psychoeducation on adaptive function of emotions; three-component model of emotional experiences (UP Module 2).
3	Natural course of emotions and role of avoidance; mindful emotion awareness (UP Module 3).
4	Cognitive flexibility; thinking traps and countering questions; downward arrow (UP Module 4).
5	Identification of emotional avoidance strategies; rationale for replacing emotion-driven behaviors with alternative behaviors (UP Module 5).
6	Psychoeducation on interoceptive conditioning; symptom-induction test; interoceptive exercises (UP Module 6).
7–11	Exposure rationale; create and review individual hierarchies; situational emotion-focused exposures (UP Module 7).
12	Skill review; emphasis on continued implementation of exposures; review of progress and future goals; relapse prevention strategies (UP Module 8).

copies of group members' completed homework forms each week so that the group leader could then review them in between sessions. In doing so, it was possible to identify group members who were reporting a strong grasp of the material during session but were demonstrating difficulty applying treatment concepts during homework practice outside of session. By spending more time on homework review, group leaders were better able to gauge comprehension and to provide corrective feedback as necessary. In addition, this created an expectation that every group member would participate in homework review instead of asking for a few group members to volunteer an example from their homework practice.

Treatment Rationale

Studies have shown that patients' beliefs about a treatment are closely linked to how well the treatment works for them. That means that patients who believe they will benefit from a treatment and that the treatment makes sense to them do better in treatment. For these reasons, it is important to not only explain to patients how the UP works to reduce symptoms (as discussed in Chapter 5) but also why it makes sense to have a group of people who have different symptoms or diagnoses in the same group.

It is helpful to clarify that even though the UP is designed to treat a range of emotional disorders, it is not a "one-size-fits-all" treatment. Instead of focusing on specific symptoms, the UP targets the *processes* that cause those symptoms to occur. This unified model is then applied to each group member's specific experiences in a more personalized manner, rather than simply focusing on one set of symptoms. During each session, the group leader should look for opportunities to point out these similarities to the group.

We have asked a small number of patients who have received the UP in a group format to provide feedback on their impressions of the group after they completed it. Patients generally reported that the treatment approach made sense to them, and they were satisfied with it. Most patients seemed to feel positively about the diversity of diagnoses and symptoms within the group. For example, one patient stated that she

found “it was very helpful to hear the experiences of others” because “it [was] nice to be able to have a variety and understand that issues always come to a common center.” However, another patient reported that he sometimes had trouble relating to other people’s problems in the group and found it most helpful when the group leader gave him instruction that was specific to his experiences.

Flexible Application of the Unified Model

In a structured diagnosis-specific treatment group, patients can feel frustrated when they are struggling with symptoms or interpersonal stressors that are not the focus of the treatment protocol. For example, a patient may also be experiencing significant depression or preoccupation over a recent breakup that makes it more difficult to engage with group therapy for social anxiety. Relatedly, it is challenging for a group leader to be responsive to concerns that fall outside the scope of the treatment’s focus without alienating other group members by spending too much time on material that may not be applicable to the rest of the group.

With the UP, any situation in which someone experienced a strong emotion can be utilized to reinforce the treatment model for all group members. The following case vignette demonstrates how the unified model was able to accommodate a patient who would often come to group preoccupied with his most recent disagreement with his wife. Instead of telling the patient that his strained marriage was not an appropriate topic for discussion, the group leader was able to relate the patient’s experience to the ARC of emotions.

P: I just got in the worst fight with my wife last week. She’s not even speaking to me now.

T: What happened?

P: Well, I had just gotten home from yet another job interview, and I was bringing in the mail. I opened our credit card bill and I couldn’t believe it—my wife had spent all this money on a new dress for my brother’s wedding, even though she knows how tight things are right now.

T: So what did you do?

- P: Oh, I totally lost it. I was swearing and yelling at her, asking her how many times she needs me to explain to her that we can't be spending money like we used to until I get another job.
- T: It sounds like you were really upset. How did it feel to yell at her?
- P: I mean, I feel terrible about it now. I completely overreacted.
- T: But how did it feel in the moment?
- P: I guess it felt good in the moment—it felt like I was showing her how unacceptable her behavior was.
- T: Did it work?
- P: No, it totally backfired. She hasn't spoken to me for the past three days. I also saw more shopping bags in her car this morning. She probably went shopping just to spite me.
- T: If we think about the ARC of emotions, what were the triggers or antecedents?
- P: Well, I guess I've been more worried about money since I was laid off, even though we have a substantial savings.
- T: And what about the job interview you had earlier that day; how did it go?
- P: It was a total waste of time. It turns out the company doesn't even know if there will be an opening available. So I guess that put me in a bad mood before I even got home.
- T: Okay, so it sounds like there were some things that contributed to your reaction. It also seems like yelling at your wife felt good in the moment, and maybe helped you to feel more in control, but in the long term only made the situation worse. Does anyone have any ideas for alternative behaviors that he could use instead of lashing out in anger?

Emotion Exposures in a Group Format

How to conduct emotion exposures efficiently and effectively in a diagnostically diverse group remains an important area for future research. Because our center is also a training clinic, we ran our UP groups with three group leaders, which allowed us to assign one group leader to every two group members to plan and execute personally relevant exposures. After the exposures were completed, the group would reconvene to debrief on what was learned from the exposure and to plan what

exposures each group member would complete for homework. Once a group member demonstrated mastery completing emotion exposures, group leader(s) considered allowing that individual to conduct their emotion exposure independently so that other group members who needed more guidance could receive more individual coaching from a group leader. Alternatively, group members in need of more assistance were paired with a group member who was excelling at emotion exposures to support each other, with the group leader taking a more passive role.

Definitions of Key Terms

- **Anchoring in the present.** The act of pausing to nonjudgmentally observe experience in the present moment and deliberately choosing a response consistent with current needs, goals, or values.
- **Anxiety Scale.** Overall Anxiety Severity and Interference Scale (OASIS). Weekly monitoring questionnaire for anxiety.
- **ARC of emotion.** Antecedents—Response—Consequences of an emotional experience.
 - *Antecedents* are triggers, conditions, or situations that bring up certain emotions. They may be *proximal* (immediate) or *distal* (in the past).
 - The *response* is the three components of emotion—thoughts, physical sensations, and behaviors.
 - *Consequences* are the resulting effects of the emotional response, which may be short term or long term.
- **Automatic thoughts.** Thoughts that occur immediately and involuntarily in response to a situation.
- **Cognitive challenging.** An exercise designed to increase flexibility of thinking habits by using challenging questions to examine whether thoughts are realistic and helpful, then generating more useful appraisals.
- **Cognitive flexibility.** The practice of deliberately considering multiple interpretations or predictions about a situation, instead of assuming that the first thought is accurate.
- **Core automatic thoughts.** Also called *core beliefs*. Central beliefs that an individual maintains about themselves, others, and the world that come up involuntarily but that are not specific to any one situation.
- **Depression Scale.** Overall Depression Severity and Interference Scale (ODSIS). Weekly monitoring questionnaire for depression.

- **Emotion avoidance.** Things an individual may do to prevent uncomfortable emotions from happening or prevent them from getting stronger. This may include
 - Situational (overt) avoidance: Avoiding situations that trigger strong emotions.
 - Subtle behavioral avoidance: In an uncomfortable situation, doing things to avoid facing strong emotions (e.g., not making eye contact).
 - Cognitive avoidance: Avoiding thinking about things that will bring up uncomfortable emotion (e.g., distracting oneself during an anxiety-provoking situation).
 - Safety signals: Talismans, people, or other things that make a person feel “safer” in uncomfortable situations (e.g., carrying medication, only talking to strangers at a party when accompanied by a friend).
- **Emotion exposure.** An exercise designed to increase tolerance of uncomfortable emotions by entering situations likely to produce uncomfortable emotion without engaging in avoidance or escape.
- **Emotional behaviors.** Includes emotion avoidance and emotion-driven behaviors. Behaviors that are used to control strong emotions, which may be adaptive or maladaptive.
- **Emotional disorders.** Psychological disorders, such as anxiety or depression, characterized by (1) frequent, strong emotions, (2) negative reactions to these emotions, and (3) avoidance of emotional experiences. These difficulties cause interference in important areas of functioning.
- **Emotion-driven behaviors (EDBs).** Behaviors that occur in response to emotions. These behaviors can be hard to resist (or change) in the presence of strong emotions. EDBs can be helpful and adaptive (e.g., jumping out of the way of a car due to feeling fear), but they can also be maladaptive (e.g., leaving a party early because of anxiety, staying in bed when feeling tired and depressed).
- **Interoceptive.** Referring to physical sensations.
- **Jumping to conclusions.** Also called *probability overestimation*. Overestimating the likelihood of a negative outcome.
- **Mindful emotion awareness.** A way of paying attention to emotional experiences that emphasizes the importance of focusing on

the present (including how an individual is currently feeling) in a nonjudgmental way.

- **Objective monitoring.** Observing “just the facts” of an experience without evaluation or judgment.
- **Other Emotion Scale.** Weekly monitoring questionnaire for other emotions a patient may be struggling with, such as anger, shame, or jealousy.
- **Positive Emotion Scale.** Weekly monitoring questionnaire for positive emotions.
- **Present-focused nonjudgmental awareness.** Sometimes called *mindfulness*. A way of interacting with emotional experiences that involves observing components of the experience without trying to push emotions away or change them, and without judging oneself for the emotions that are present.
- **Progress record.** A chart for visually representing scores from the Anxiety Scale, Depression Scale, Other Emotion Scale, and Positive Emotion Scale.
- **Subjective monitoring.** Observing experiences in a way that adds evaluation or judgment; e.g., focusing on how awful one feels or criticizing oneself for feeling a certain way.
- **SUDS.** Subjective Units of Distress Scale. A way to measure uncomfortable emotion ranging from 0 (no discomfort) to 8 (extreme discomfort).
- **Thinking the worst.** Also called *catastrophizing*. Thinking that if a negative outcome does occur, it will be extremely bad or the person will be unable to cope with it.
- **Thinking traps.** Thinking habits in which people repeatedly interpret or predict situations in a negative way. Include *jumping to conclusions* and *thinking the worst*.
- **Three-component model of emotion.** The three parts of any emotional experience: thoughts (what one is thinking), physical sensations (what one is feeling), and behaviors (what one is doing).

References

- Barlow, D. H. (1988). *Anxiety and its disorders: The nature and treatment of anxiety and panic*. New York: Guilford Press.
- Barlow, D. H. (2002). *Anxiety and its disorders: The nature and treatment of anxiety and panic* (2nd ed.). New York: Guilford Press.
- Barlow, D. H., & Cerny, J. A. (1988). *Psychological treatment of panic*. New York: Guilford Press.
- Barlow, D. H., & Craske, M. G. (1988). *Mastery of your anxiety and panic*. Albany, NY: Graywind Publications.
- Barlow, D. H., & Craske, M. G. (2000). *Mastery of your anxiety and panic (MAP-3): Client workbook for anxiety and panic* (3rd ed.). San Antonio, TX: Graywind/Psychological Corporation.
- Barlow, D. H., & Craske, M. G. (2007). *Mastery of your anxiety and panic: Workbook* (4th ed.). New York: Oxford University Press.
- Barlow, D. H., & Farchione, T. J. (Eds.). (2017). *Applications of the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders*. New York, NY: Oxford University Press.
- Barlow, D. H., Allen, L. B., & Choate, M. L. (2004). Towards a unified treatment for emotional disorders. *Behavior Therapy, 35*, 205–230.
- Barlow, D. H., O'Brien, G. T., & Last, C. G. (1984). Couples treatment of agoraphobia. *Behavior Therapy, 15*, 41–58.
- Barlow, D. H., Sauer-Zavala, S., Carl, J. R., Bullis, J. R., & Ellard, K. K. (2014). The nature, diagnosis, and treatment of neuroticism: Back to the future. *Clinical Psychological Science, 2*(3), 344–365.
- Beck, A. T. (1972). *Depression: Causes and treatment*. Philadelphia: University of Pennsylvania Press.
- Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. Madison, CT: International Universities Press.
- Beck, A. T., Epstein, N., Brown, G., & Steer, R. A. (1988). An inventory for measuring clinical anxiety: Psychometric properties. *Journal of Consulting and Clinical Psychology, 56*, 893–897.
- Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford Press.

- Beck, A. T., & Steer, R. A. (1990). Beck self-concept test. *Psychological Assessment, 2*(2), 191–197.
- Beck, A. T., Steer, R. A., & Brown G. K. (1996). *Manual for the Beck Depression Inventory-II*. San Antonio, TX: Psychological Corporation.
- Bentley, K. H., Gallagher, M. W., Carl, J. R., & Barlow, D. H. (2014). Development and validation of the Overall Depression Severity and Impairment Scale. *Psychological Assessment, 26*(3), 815.
- Boettcher, H., & Conklin, L. R. (2017). Transdiagnostic Assessment and Case Formulation: Rationale and Application with the Unified Protocol. In D. H. Barlow & T. J. Farchione (Eds.), *Applications of the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders* (pp. 17–38). New York: NY: Oxford University Press.
- Boswell, J. F., Anderson, L. M., & Barlow, D. H. (2014). An idiographic analysis of change processes in the unified, transdiagnostic treatment of depression. *Journal of Consulting and Clinical Psychology, 82*, 1060–1071.
- Brown, T. A., & Barlow, D. H. (2009). A proposal for a dimensional classification system based on the shared features of the DSM-IV anxiety and mood disorders: Implications for assessment and treatment. *Psychological Assessment, 21*(3), 256–271.
- Brown, T. A., & Barlow, D. H. (2014). Anxiety and related disorders interview schedule for DSM-5 (ADIS-5). New York: Oxford University Press.
- Brown, T. A., Campbell, L. A., Lehman, C. L., Grisham, J. R., & Mancill, R. B. (2001). Current and lifetime comorbidity of the DSM-IV anxiety and mood disorders in a large clinical sample. *Journal of Abnormal Psychology, 110*, 49–58.
- Bullis, J. R., Fortune, M. R., Farchione, T. J., & Barlow, D. H. (2014). A preliminary investigation of the long-term outcome of the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders. *Comprehensive Psychiatry, 55*(8), 1920–1927.
- Bullis, J. R., Sauer-Zavala, S., Bentley, K. H., Thompson-Hollands, J., Carl, J. R., & Barlow, D. H. (2015). The unified protocol for transdiagnostic treatment of emotional disorders: preliminary exploration of effectiveness for group delivery. *Behavior Modification, 39*(2), 295–321.
- Carl, J. R., Gallagher, M. W., Sauer-Zavala, S. E., Bentley, K. H., & Barlow, D. H. (2014). A preliminary investigation of the effects of the unified protocol on temperament. *Comprehensive Psychiatry, 55*(6), 1426–1434.
- Cerny, J. A., Barlow, D. H., Craske, M. G., & Himadi, W. G. (1987). Couples treatment of agoraphobia: A two-year follow-up. *Behavior Therapy, 18*, 401–415.
- Chambless, D. L., & Steketee, G. (1999). Expressed emotion and behavior therapy outcome: A prospective study with obsessive-compulsive and

- agoraphobic outpatients. *Journal of Consulting and Clinical Psychology*, *67*, 658–665.
- Ciraulo, D. A., Barlow, D. H., Gulliver, S. B., Farchione, T., Morissette, S. B., Kamholz, B. W., . . . Knapp, C. M. (2013). The effects of venlafaxine and cognitive behavioral therapy alone and combined in the treatment of co-morbid alcohol use-anxiety disorders. *Behaviour Research and Therapy*, *51*(11), 729–735.
- Craske, M. G., & Mystkowski, J. L. (2006). Exposure therapy and extinction: Clinical studies. In M. G. Craske, D. Hermans, & D. Vansteenwegen (Eds.), *Fear and learning: Basic science to clinical application* (pp. 217–233). Washington, DC: APA Books.
- Deacon, B., Kemp, J. J., Dixon, L. J., Sy, J. T., Farrell, N. R., & Zhang, A. R. (2013). Maximizing the efficacy of interoceptive exposure by optimizing inhibitory learning: A randomized controlled trial. *Behaviour Research and Therapy*, *51*(9), 588–596.
- Ellard, K. K., Deckersbach, T., Sylvia, L. G., Nierenberg, A. A., & Barlow, D. H. (2012). Transdiagnostic treatment of bipolar disorder and comorbid anxiety with the Unified Protocol. *Behavior Modification*, *36*, 482–508.
- Ellard, K. K., Fairholme, C. P., Boisseau, C. L., Farchione, T. J., & Barlow, D. H. (2010). Unified protocol for the transdiagnostic treatment of emotional disorders: Protocol development and initial outcome data. *Cognitive and Behavioral Practice*, *17*, 88–101.
- Farchione, T. J., Fairholme, C. P., Ellard, K. K., Boisseau, C. L., Thompson-Hollands, J., Carl, J., . . . Barlow, D. H. (2012). Unified protocol for the transdiagnostic treatment of emotional disorders: A randomized controlled trial. *Behavior Therapy*, *43*, 666–678.
- Frisch, M. B., Cornell, J., & Villanueva, M. (1992). Clinical validation of the Quality of Life Inventory: A measure of life satisfaction for use in treatment planning and outcome assessment. *Psychological Assessment*, *4*(1), 92–101.
- Gallagher, M.W. (2017). The unified protocol for posttraumatic stress disorder: A clinical replication series. In D. H. Barlow & T. J. Farchione (Eds.), *Applications of the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders* (pp. 11–126). New York: Oxford University Press.
- Goodman, W. K., Price, L. H., Rasmussen, S. A., Mazure, C., Fleischmann, R. L., Hill, C., & Charney, D. S. (1989). The Yale-Brown Obsessive Compulsive Scale: I. Development, use, and reliability. *Archives of General Psychiatry*, *46*(11), 1006–1011.
- Hafner, R. J., & Marks, I. M. (1976). Exposure in vivo of agoraphobics: Contributions of diazepam, group exposure and anxiety evocation. *Psychological Medicine*, *6*, 71–88.

- Hays, R. D., Sherbourne, C. D., & Mazel, R. M. (1993). The Rand 36-item health survey 1.0. *Health Economics*, 2, 217–227.
- Hope, D. A., Heimberg, R. G., & Turk, C. L. (2006). *Managing social anxiety: A cognitive-behavioral therapy approach: Therapist guide*. New York: Oxford University Press.
- Izard, C. E. (1971). *The face of emotion*. New York: Appleton-Century-Crofts.
- Kessler, R. C., Nelson, C. B., McGonagle, K. A., Lui, J., Swartz, M., & Blazer, D. G. (1996). Comorbidity of DSM–III-R major depressive disorder in the general population: Results from the National Comorbidity Survey. *British Journal of Psychiatry*, 168, 17–30.
- Kessler, R. C., Stang, P. E., Wittchen, H. U., Ustan, T. B., Roy-Byrne, P. P., & Walters, E. E. (1998). Lifetime panic-depression comorbidity in the National Comorbidity Survey. *Archives of General Psychiatry*, 55, 801–808.
- Krueger, R. F., Watson, D., & Barlow, D. H. (2005). Introduction to the special section: Toward a dimensionally based taxonomy of psychopathology. *Journal of Abnormal Psychology*, 114, 491–493.
- Lovibond, P. F., & Lovibond, S. H. (1995). The structure of negative emotional states: Comparison of the Depression Anxiety Stress Scales (DASS) with the Beck Depression and Anxiety Inventories. *Behaviour Research and Therapy*, 33(3), 335–343.
- Mattick, R. P., & Clarke, J. C. (1998). Development and validation of measures of social phobia scrutiny fear and social interaction anxiety. *Behaviour Research and Therapy*, 36, 455–470.
- Meyer, T. J., Miller, M. L., Metzger, R. L., & Borkovec, T. D. (1990). Development and validation of the Penn State Worry Questionnaire. *Behaviour Research and Therapy*, 28, 487–495.
- Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). New York: Guilford Press.
- Miller, W. R., & Rollnick, S. (2012). *Motivational interviewing: Helping people change* (3rd ed.). New York: Guilford Press.
- Monfils, M. H., Cowansage, K. K., Klann, E., & LeDoux, J. E. (2009). Extinction-reconsolidation boundaries: Key to persistent attenuation of fear memories. *Science*, 324(5929), 951–955.
- Norman, S. B., Hami Cissell, S., Means-Christensen, A. J., & Stein, M. B. (2006). Development and validation of an Overall Anxiety Severity and Impairment Scale (OASIS). *Depression and Anxiety*, 23(4), 245–249.
- Otto, M. W., & Pollack, M. H. (2009). *Stopping anxiety medication: Therapist guide*. New York: Oxford University Press.

- Purdon, C. (1999). Thought suppression and psychopathology. *Behaviour Research and Therapy, 37*, 1029–1054. doi:10.1016/S0005-7967(98)00200-9
- Sauer-Zavala, S., Bentley, K. H., & Wilner, J. G. (2016). Transdiagnostic treatment of borderline personality disorder and comorbid disorders: A clinical replication series. *Journal of Personality Disorders, 30*, 35–51.
- Sauer-Zavala, S., Gutner, C., Farchione, T. J., Boettcher, H. B., Bullis, J. R., & Barlow, D. H. (2017). Current definitions of “transdiagnostic” in treatment development: A search for consensus. *Behavior Therapy, 48*, 128–138.
- Shear, M. K., Brown, T. A., Barlow, D. H., Money, R., Sholomskas, D. E., Woods, S. W., . . . Papp, L. A. (1997). Multicenter Collaborative Panic Disorder Severity Scale. *American Journal of Psychiatry, 154*, 1571–1575.
- Steer, R. A., Ranieri, W. F., Beck, A. T., & Clark, D. A. (1993). Further evidence for the validity of the Beck Anxiety Inventory with psychiatric outpatients. *Journal of Anxiety Disorders, 7*(3), 195–205.
- Varela, R. E., & Hensley-Maloney, L. (2009). The influence of culture on anxiety in Latino youth: A review. *Clinical Child and Family Psychology Review, 12*(3), 217–233.
- Wegner, D. M., Schneider, D. J., Carter, S. R., & White, T. L. (1987). The paradoxical effects of thought suppression. *Journal of Personality and Social Psychology, 53*, 5–13.
- Westra, H. A., Arkowitz, H., & Dozois, D. J. A. (2009). Adding a motivational interviewing pretreatment to cognitive behavioral therapy for generalized anxiety disorder: A preliminary randomized controlled trial. *Journal of Anxiety Disorders, 23*, 1011–1184.
- Westra, H. A., Constantino, M. J., & Antony, M. M. (2016). Integrating motivational interviewing with cognitive-behavioral therapy for severe generalized anxiety disorder: An allegiance-controlled randomized clinical trial. *Journal of Consulting and Clinical Psychology, 84*(9), 768–782.
- Westra, H. A., & Dozois, D. J. A. (2006). Preparing clients for cognitive behavioural therapy: A randomized pilot study of motivational interviewing for anxiety. *Cognitive Therapy and Research, 30*, 481–498.
- Zinbarg, R., Craske, M., & Barlow, D. H. (2006). *Therapist's guide for the mastery of your anxiety and worry program*, New York: Oxford University Press.
- Zinbarg, R., Lee, L. E., & Yoon, L. (2007). Dyadic predictors of outcome in a cognitive-behavioral program for patient generalized anxiety disorder in committed relationships: A “spoonful of sugar” and a dose of non-hostile criticism may help. *Behaviour Research and Therapy, 45*(4), 699–713.

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