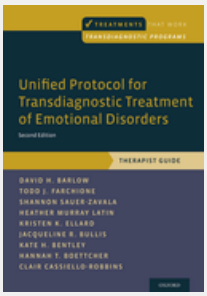

Unified Protocol for Transdiagnostic Treatment of Emotional Disorders: Therapist Guide (2 edn)

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Session 1: Functional Assessment and Introduction to Treatment: (Corresponds to Chapters 1–3 of the UP Workbook)

Chapter:

(p. 37) Session 1: Functional Assessment and Introduction to Treatment: (Corresponds to Chapters 1–3 of the UP Workbook)

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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.

Session 1: Functional Assessment and Introduction to Treatment: (Corresponds to Chapters 1–3 of the UP Workbook)

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.

(p. 38) Materials Needed

- **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 transdiagnostic 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.

(p. 39) 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 (p. 40) *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).

(p. 41) **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 (p. 42) 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.

(p. 43) **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 (p. 44) *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 (p. 45) 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.

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?

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. (p. 46)

(p. 47) 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 (p. 48) 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 **(p. 49)** 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.

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