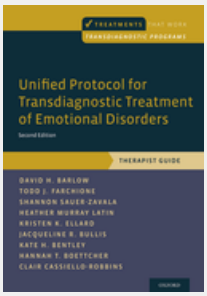

Unified Protocol for Transdiagnostic Treatment of Emotional Disorders: Therapist Guide (2 edn)

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Additional Information for Therapists

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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.

(p. 22) 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 (p. 23) 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 (p. 24) 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).

(p. 25) 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 (p. 26) 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 (p. 27) 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 (p. 28) 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 (p. 29) 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. (p. 30)