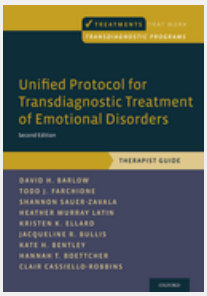

Unified Protocol for Transdiagnostic Treatment of Emotional Disorders: Therapist Guide (2 edn)

David H. Barlow, Todd J. Farchione, Shannon Sauer-Zavala, Heather Murray Latin, Kristen K. Ellard, Jacqueline R. Bullis, Kate H. Bentley, Hannah T. Boettcher, and Clair Cassiello-Robbins

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Module 5: Countering Emotional Behaviors: (Corresponds to Chapter 9 of the UP Workbook)

Chapter:

Author(s):

David H. Barlow, Todd J. Farchione, Shannon Sauer-Zavala, Heather Murray Latin, Kristen K. Ellard, Jacqueline R. Bullis, Kate H. Bentley, Hannah T. Boettcher, and Clair Cassiello-Robbins

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Module 5: Countering Emotional Behaviors: (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

(p. 114) 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 (p. 115) 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 (p. 116) 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.

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.

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
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

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. (p. 118)

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 (p. 117) 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.*

(p. 119) 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 (p. 120) 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 **(p. 121)** 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.

(p. 122) 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.

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	Taking a break before responding, go for a walk
	Yell Break things	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

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.

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(p. 124) **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. **(p. 125)**

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 **(p. 126)** 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.

(p. 127) Troubleshooting

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*.

(p. 128) **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.

(p. 129) **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.

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