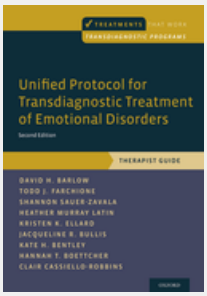

Unified Protocol for Transdiagnostic Treatment of Emotional Disorders: Therapist Guide (2 edn)

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 2: Understanding Emotions: (Corresponds to Chapters 5 and 6 of the UP Workbook)

Chapter:

(p. 63) Module 2: Understanding Emotions: (Corresponds to Chapters 5 and 6 of the UP Workbook)

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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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).

Module 2: Understanding Emotions: (Corresponds to Chapters 5 and 6 of the UP Workbook)

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

(p. 64) ■ 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.

(p. 65) Psychoeducation—The Nature of Emotions

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. **(p. 66)**

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 (p. 67) 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 (p. 68) 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.

(p. 69) **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 (p. 70) 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.

(p. 71) ■ 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?"

(p. 72) 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 (p. 73) 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.

(p. 74) 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.

(p. 75) 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. 76)

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.

(p. 77) 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. (p. 78)

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. (p. 79)

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 (p. 80) 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.