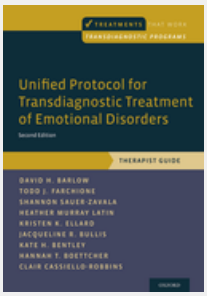

Unified Protocol for Transdiagnostic Treatment of Emotional Disorders: Therapist Guide (2 edn)

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Using the UP in a Group Format

Chapter: (p. 171) Using the UP in a Group Format

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Introduction

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

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

line of research, this chapter will share some preliminary insights into using the UP in a group format.

Benefits of a Group Format

One of the biggest benefits of using the UP in a group setting is that it is efficient, because one practitioner can deliver the treatment to a group (p. 172) of individuals at the same time. For example, it would take one practitioner a total of 96 hours to do 16 sessions of the UP with six different patients. In comparison, one practitioner could treat all six patients at the same time in a group format. We have successfully delivered the UP in a group setting using 12 two-hour sessions. By delivering the UP in a group format, a practitioner could treat six patients in only 25% of the time it would take to treat the same number of patients on an individual basis.

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

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

Recommendations for Using the UP in a Group Format

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

(p. 173) Structure

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

Table 15.1 Outline of UP Content Delivered by Session

Session	Content
1	Introduction and treatment rationale; motivation enhancement strategies; treatment goal setting (UP Module 1).

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

In an individual format, homework review is often limited to 10 to 15 minutes, with the remainder of the session spent on the introduction of new material. However, in a group format, it may be necessary to allocate more time to ensure adequate comprehension of concepts and skills across all members of the group. We found it helpful to make (p. 174) copies of group members' completed homework forms each week so that the group leader could then review them in between sessions. In doing so, it was possible to identify group members who were reporting a strong grasp of the material during session but were demonstrating difficulty applying treatment concepts during homework practice outside of session. By spending more time on homework review, group leaders were better able to gauge comprehension and to provide corrective feedback as necessary. In addition, this created an expectation that every group member would participate in homework review instead of asking for a few group members to volunteer an example from their homework practice.

Treatment Rationale

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

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

We have asked a small number of patients who have received the UP in a group format to provide feedback on their impressions of the group after they completed it. Patients generally reported that the treatment approach made sense to them, and they were satisfied with it. Most patients seemed to feel positively about the diversity of diagnoses and symptoms within the group. For example, one patient stated that she (p. 175) found "it was very helpful to hear the experiences of others" because "it [was] nice to be able to have a variety and understand that issues always come to a common center." However, another patient reported that he sometimes had trouble relating to other people's problems in the group and found it most helpful when the group leader gave him instruction that was specific to his experiences.

Flexible Application of the Unified Model

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

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

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

T: What happened?

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

T: So what did you do? (p. 176)

P: Oh, I totally lost it. I was swearing and yelling at her, asking her how many times she needs me to explain to her that we can't be spending money like we used to until I get another job.

T: It sounds like you were really upset. How did it feel to yell at her?

P: I mean, I feel terrible about it now. I completely overreacted.

T: But how did it feel in the moment?

P: I guess it felt good in the moment—it felt like I was showing her how unacceptable her behavior was.

T: Did it work?

P: No, it totally backfired. She hasn't spoken to me for the past three days. I also saw more shopping bags in her car this morning. She probably went shopping just to spite me.

T: If we think about the ARC of emotions, what were the triggers or antecedents?

P: Well, I guess I've been more worried about money since I was laid off, even though we have a substantial savings.

T: And what about the job interview you had earlier that day; how did it go?

P: It was a total waste of time. It turns out the company doesn't even know if there will be an opening available. So I guess that put me in a bad mood before I even got home.

T: Okay, so it sounds like there were some things that contributed to your reaction. It also seems like yelling at your wife felt good in the moment, and maybe helped you to feel more in control, but in the long term only made the situation worse. Does anyone have any ideas for alternative behaviors that he could use instead of lashing out in anger?

Emotion Exposures in a Group Format

How to conduct emotion exposures efficiently and effectively in a diagnostically diverse group remains an important area for future research. Because our center is also a training clinic, we ran our UP groups with three group leaders, which allowed us to assign one group leader to every two group members to plan and execute personally relevant exposures. After the exposures were completed, the group would reconvene to debrief on what was learned from the exposure and to plan what **(p. 177)** exposures each group member would complete for homework. Once a group member demonstrated mastery completing emotion exposures, group leader(s) considered allowing that individual to conduct their emotion exposure independently so that other group members who needed more guidance could receive more individual coaching from a group leader. Alternatively, group members in need of more assistance were paired with a group member who was excelling at emotion exposures to support each other, with the group leader taking a more passive role. **(p. 178)**