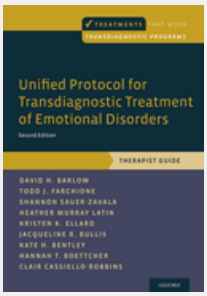

Unified Protocol for Transdiagnostic Treatment of Emotional Disorders: Therapist Guide (2 edn)

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Introduction to the Unified Protocol

Chapter: (p. 3) Introduction to the Unified Protocol

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> *"Human infirmity in moderating and checking the emotions I name bondage: for, when a man is a prey to his emotions, he is not his own master, but lies at the mercy of fortune: so much so, that he is often compelled, while seeing that which is better for him, to follow that which is worse"*
>
> —Baruch Spinoza, *Ethics*

Over the last several decades, many advances have been made in the psychological treatment of anxiety and mood disorders. In fact, effective treatments have emerged for the most common mental health conditions (e.g., Mastery of Your Anxiety and Panic for panic disorder, Managing Social Anxiety for social anxiety disorder; Barlow & Craske, 2007; Hope, Heimberg, & Turk, 2006). These individual protocols have narrowly focused on addressing the discrete symptoms associated with a given disorder (e.g., panic attacks, fears of social evaluation). However, more recent conceptualizations of these common conditions emphasize their similarities rather than their differences. Specifically, research suggests that there is considerable overlap in symptoms

across disorders; for example, worry occurs in all of the anxiety disorders, though the focus may vary across conditions (e.g., worry about safety of loved ones in generalized anxiety disorder, worry about having another panic attack in panic disorder). Additionally, there appears to be a broad treatment response when targeting one disorder that often generalizes across other disorders. Finally, there are extremely high rates of comorbidity for the range of anxiety and depressive disorders (estimates as high as 75%; Brown, Campbell, Lehman, Grisham, & Mancill, 2001), suggesting that patients do not fit neatly into the diagnostic boxes the field has created for them. Taken together, this (p. 4) evidence suggests that there may be a common set of vulnerabilities contributing to the development of anxiety, depressive, and related disorders that can become a more efficient focus of treatment than the diverse symptoms themselves.

Specifically, research converges on three core vulnerabilities that put an individual at risk to develop many common mental health conditions. First, there is evidence to suggest that anxiety, depressive, and related disorders are characterized by high levels of negative affect. In other words, individuals with these disorders have a temperamental propensity to experience negative emotions frequently and intensely, referred to as neuroticism (Barlow, Sauer-Zavala, Carl, Bullis, & Ellard, 2014). Second, individuals with these common conditions tend to view their emotional experiences negatively (e.g., “it’s weak to feel this way,” “no one else is reacting like this,” “these physical sensations are terrible”). Finally, aversive reactions to emotions when they occur, in turn, lead to efforts to avoid and suppress them. Individuals with anxiety and depressive disorders often rely on maladaptive regulation strategies that backfire (Purdon, 1999), maintaining high levels of negative affect and contributing to the persistence of symptoms. Given the role of emotional experiences in the development and maintenance of the full range of anxiety, depressive, and related disorders, we refer to these conditions as “emotional disorders” to emphasis this common feature. For more information on the nature of emotional disorders, see Barlow, Sauer-Zavala, Carl, Bullis, and Ellard (2014).

Thus, cutting-edge research lends support for a unified approach that considers these commonalities and is applicable to a range of emotional disorders. Based on these advances, we developed a treatment applicable to all anxiety and unipolar depressive disorders, and potentially other disorders with strong emotional components (e.g., eating disorders, borderline personality disorder). The Unified Protocol (UP) for the Transdiagnostic Treatment of Emotional Disorders addresses neuroticism by targeting the aversive, avoidant reactions to emotions that, while providing relief in the short term, increase the likelihood of future negative emotions and maintains disorder symptoms. The strategies included in this treatment are largely based on common principles found in existing empirically supported psychological treatments—namely, fostering mindful awareness, reevaluating (p. 5) automatic cognitive appraisals, changing action tendencies associated with the disordered emotions, and utilizing exposure procedures. It is important to note, however, that the focus of these core skills has been adjusted to specifically address core negative responses to emotional experiences, described in detail in the following chapter.

Advantages of a Unified, Transdiagnostic Approach

Mechanistically transdiagnostic interventions, like the UP, confer several practical advantages for patients and clinicians (Sauer-Zavala et al., 2017). First, as noted previously, rates of co-occurrence across the emotional disorders is quite high, and single-disorder protocols (SDPs; i.e., interventions that focus on the symptoms of one disorder) are not equipped to handle comorbid conditions. In contrast, by targeting the core emotional processes that maintain symptoms across disorders, the UP can simultaneously address co-occurring conditions. Additionally, the field’s emphasis on SDPs has created a training burden, as therapists must familiarize themselves with a separate treatment for nearly every disorder.

Again, the UP eliminates this burden as therapists need only learn one intervention in order to provide evidence-based care to most common conditions.

Efficacy of the UP

The UP has now garnered strong empirical support for its use with a range of emotional disorders. First, in a small randomized controlled trial (N = 37), the UP was found to significantly reduce symptoms for a range of anxiety disorders compared to a wait-list control group, with patients continuing to improve even 18 months after treatment (Bullis, Fortune, Farchione, & Barlow, 2014; Farchione et al., 2012).

Based on these promising results, we then conducted a larger, randomized trial (N = 223) comparing the UP to gold-standard, evidence-based protocols designed to treat the diagnosis-specific symptoms (i.e., SDPs) of generalized anxiety disorder, social anxiety disorder, obsessive compulsive disorder, and panic disorder. Results indicated that emotional disorder symptoms improved similarly for UP and SDPs, with (p. 6) both groups demonstrating significant reductions in the severity of the principal diagnosis posttreatment, with the UP evidencing significantly less attrition than the SDPs. With regard to comorbid conditions, 62% of patients treated with the UP no longer met diagnostic criteria for *any* emotional disorder, and these improvements were largely maintained one year later. Overall, these results suggest that the transdiagnostic UP approach is just as good at addressing the primary disorder as the targeted protocol designed explicitly for that condition. Given the practical advantages of the UP (described previously), these results lend support for the widespread dissemination of the UP.

There is also preliminary data to suggest that the UP can be successfully applied to other diagnoses that are characterized by the emotional disorder vulnerabilities described earlier. Specifically, there is evidence to support the use of the UP for emotional disorder patients with co-occurring alcohol abuse or dependence diagnosis (Ciraulo et al., 2013), unipolar depressive disorders (Boswell, Anderson, & Barlow, 2014), bipolar disorder (Ellard, Deckersbach, Sylvia, Nierenberg, & Barlow, 2012), borderline personality disorder (Sauer-Zavala, Bentley, & Wilner, 2016), and posttraumatic stress disorder (Gallagher, 2017).

Given the UP's focus on addressing core processes, we have also studied the UP's ability to change dimensions of temperament in the scope of the randomized control trials mentioned previously (Carl, Gallagher, Sauer-Zavala, Bentley, & Barlow, 2014). Results revealed that the UP, compared to the wait-list group, indeed produces small to moderate changes in neuroticism from pre- to posttreatment. Significantly, these changes in temperament are related to improvements in functional impairment and quality of life (Carl et al., 2014). These results underscore the potential importance of factoring in changes in temperament when considering treatment outcome.

Furthermore, based on the relative advantages of group treatment to individual treatment (e.g., ability to treat more patients, reduced stigma associated with seeking treatment, opportunity to learn from other group members), we have studied the efficacy of the UP delivered in a group format, which happens to be where the protocol originated (Barlow, Allen, & Choate, 2004). Results indicated moderate to strong effects on anxiety and depressive symptoms, functional impairment, (p. 7) quality of life, and emotion regulation skills. Additionally, patients who received the UP in a group format reported comparable levels of satisfaction to those who received individual administration (Bullis et al., 2015).

Purpose of This Therapist Guide

This book was developed to provide mental health providers with guidance on administration of the UP. This guide is based on our research related to the development of this protocol for over a decade, on our clinical experience administering this treatment to countless individuals with emotional disorders, and on the feedback we have received from other practitioners whom we have trained and others who use the UP regularly in their clinical practice. Clinical vignettes are provided to illustrate common issues that tend to arise in the administration of the protocol and ways to resolve them. However, for more detailed case examples covering a range of emotional disorders, please see our recent publication designed specifically for that purpose (Barlow & Farchione, 2017).

The first four chapters of this guide provide introductory and background information about the treatment program. Subsequent chapters provide step-by-step instructions for facilitating treatment and conducting sessions. Each of these chapters corresponds to a chapter in the UP (patient) workbook. Please note that in this guide we intentionally use the terms *therapist, clinician,* and *practitioner* interchangeably to describe treatment providers. **(p. 8)**