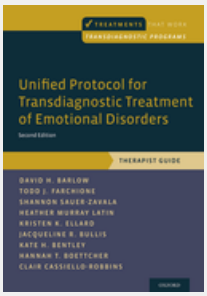

Unified Protocol for Transdiagnostic Treatment of Emotional Disorders: Therapist Guide (2 edn)

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Module 7: Emotion Exposures: (Corresponds to Chapter 11 of the UP Workbook)

Chapter:

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Overview

The primary focus of this module is *Emotion Exposures*. These are exercises designed specifically to provoke strong emotional responses so that patients can put into practice the skills they have developed thus far in therapy. Following a brief introduction to the concept of *Emotion Exposures* and the rationale for engaging in these exercises, you will assist your patient to gradually confront internal and external stimuli that produce intense emotional reactions while helping them modify their responses to those emotions. You will help your patient incorporate the skills learned in therapy (e.g., present-focused awareness, nonjudgment, cognitive reappraisal) into their exposure practice and address any emotion avoidance (or other behaviors) that may impede treatment progress.

Module 7: Emotion Exposures: (Corresponds to Chapter 11 of the UP Workbook)

Therapist Note

At least two sessions should be dedicated to this module, though for many patients it may be beneficial to devote several sessions to practicing Emotion Exposures, if possible. This module brings together all of the skills learned in treatment and provides patients with an opportunity to consolidate learning.

(p. 144) Module Goals

- Help patients gain an understanding of the purpose of *Emotion Exposures*
- Assist patients in developing a fear and avoidance hierarchy and how to design effective *Emotion Exposure* exercises
- Help patients to repeatedly practice confronting intense emotions through *Emotion Exposure* exercises

Materials Needed

- **Emotion Induction Exercise Materials** (patient-specific)
- **Emotion Exposure Hierarchy** located in UP workbook Chapter 12
- **Record of Emotion Exposure Practice Form** located at the end of UP workbook Chapter 12

Homework Review

Following a review of your patient's **Anxiety** and **Depression Scales** (as well as **Positive and Other Emotion Scales**, as applicable) and **Progress Record,** as well as any additional forms that may have been assigned for further progress, review the **Physical Sensation Practice Form**. Was your patient able to practice the physical symptom induction exercises that were assigned? As noted in the previous chapter, there are a number of reasons why patients might have difficulty completing these exercises at home (even if they were able to complete them during your treatment session). Work with your patient to identify specific reasons the exercises may not have been completed and collaboratively develop a plan for addressing these difficulties. You can also work with them on completing the exercises in-session as *Emotion Exposures* (see following discussion).

(p. 145) Emotion Exposures

The remainder of treatment focuses on exposure to internal and external stimuli that may produce strong or intense emotional reactions. We refer to these exposures as *Emotion Exposures* because the primary focus of the exposure is not the specific situation, image, or activity but rather the emotion itself. This part of treatment will likely be the most difficult for patients but is an opportunity for them to put the skills they have learned into practice (such as nonjudgmental, present-focused awareness; identifying automatic thoughts; and countering emotional behaviors), so that once treatment is finished, they will be confident in their ability to handle future emotional experiences as they unfold. It is very important that patients commit

sufficient time and effort during this last part of treatment, because this is often where many patients see the most significant changes occur.

Therapist Note

The goal of the Emotion Exposures is not immediate reduction in the emotional response. Rather, the goal is for patients to learn something new as a result of the experience. Consistent with a focus on emotions and emotion regulation, conceptually all exposures are directed toward patients experiencing their emotions fully (which means reducing patterns of avoidance) and implementing new responses. Tolerance of emotions is a critical learning goal of Emotion Exposures.

With regards to changing how patients experience and respond to their emotions, *Emotion Exposures* are important for the following reasons:

1. Interpretations and appraisals about the dangerousness of situations (whether they are internal or external in nature) begin to change, and newer, more adaptive interpretations and appraisals begin to emerge.
2. Avoidance, and subsequent impairment, are reversed.
3. Emotional behaviors can be recognized and modified.

(p. 146) Overall, patients come away with new, nondistressing associations about the emotion-producing situation or the emotion itself. For example, for a patient with posttraumatic stress disorder:

■ *Old association*: Situation (revisiting the place where trauma occurred) is associated with response (flashback, panic attack) and meaning ("I will be attacked again," I won't be able to handle it").

■ *New association*: Revisiting the place where trauma occurred does not lead to traumatic event(s) recurring and patient is able to tolerate strong emotions without escaping.

Similarly, for a patient with depression:

■ *Old association:* Situation (going out with friends or family) is associated with response (fatigue, low mood, urge to focus on negative feelings) and meaning ("This is pointless," "I won't ever be happy," "I can't stand feeling this way").

■ *New association*: The social interaction is reinforcing. It does not lead to increased low mood or an urge to focus on the emotion, nor does not elicit negative thoughts about the situation.

Introduction to In-Session Emotion Exposures

In-session *Emotion Exposures* help patients learn how to conduct *Emotion Exposures* while processing emotions immediately with the therapist. Though not always feasible, in-session exposures should be conducted whenever possible. When you conduct an exposure with our patient, you are better able to give corrective feedback and clear instruction, provide participant modeling, and facilitate your patient's tolerance of emotions during the exercise.

The particular exposure tasks will vary from patient to patient. The **Emotion Exposure Hierarchy** in the UP workbook can be used to get an idea of the types of situations that tend to trigger uncomfortable emotions for many patients and the situations that are most often avoided. Several types of *Emotion Exposure* exercises are detailed in the UP workbook and are also described here. These include situation-based, imaginal, and physical sensation *Emotion Exposures*. All of these exercises can be used to assist patients in practicing skills they have learned during the course of treatment.

(p. 147) Situation-based Emotion Exposures

Situation-based Emotion Exposures involve entering situations that are likely to provoke intense emotional reactions (and/or the patient may currently be avoiding). For example, a patient with panic disorder and agoraphobia who avoids taking public transportation might intentionally go on the subway.

Imaginal Emotion Exposures

Imaginal Emotion Exposures involve confronting distressing thoughts, worries, or memories. This type of exposure works well for fears/concerns that cannot be confronted in real life (or at the present time) and/or for individuals who are concerned that worrying or thinking about something will lead to increased emotion or make it more likely that feared outcomes will occur. For example, a patient with obsessive-compulsive disorder who engages in excessive checking rituals to ensure they do not leave the stove on and burn down the house might be asked to imagine this worst-case scenario playing out. Similarly, a patient with generalized anxiety disorder who worries excessively about the health of her loved ones might imagine these significant others dying, including her worst fears of what her life would be like afterwards.

Physical Sensation Emotion Exposures

Physical Sensation Emotion Exposures involve confronting uncomfortable physical sensations that may be contributing to strong emotions. For example, for a patient with social anxiety, you might focus on having the patient elicit distressing, intense physical sensations that typically arise while giving a presentation (e.g., heart racing, flushed face, sweaty palms) via symptom-induction exercises. Note that interoceptive exposures can be combined with situational and/or imaginal exposures to enhance the intensity of emotion experienced. For example, you might ask a patient to run up several flights of stairs to induce uncomfortable physical sensations before entering an anxiety-producing conversation with a confederate. (p. 148)

Therapist Note

When designing exposures, it is important to consider that uncomfortable or aversive emotions can be negative or positive in valence. For example, a patient struggling with recurrent worry and tension may find it difficult to fully engage in a pleasurable activity and "leave their worries behind." The experience of positive emotions may evoke anxiety about "being caught off guard." Similarly, a patient struggling with obsessive doubts may find it difficult to enjoy dinner out with friends. Allowing themselves to be fully present in the moment without retreating into engagement with intrusive thoughts may be particularly anxiety provoking. Therefore, it may be important to design Emotion Exposures around both negative and positive emotional experiences.

Conducting In-Session Emotion Exposures

Once the specific *Emotion Exposure* task has been identified, spend time with your patient preparing for the exposure by engaging in some or all of the following steps before attempting a task:

1. Agree upon a specific task that will be completed (usually drawn from the **Emotion Exposure Hierarchy**).
2. Discuss anxious or negative thoughts occurring prior to initiating the task, or those that are expected to occur during the task, and consider other interpretations.
3. Remind your patient of the importance of using *Mindful Emotion Awareness* during the exposure.
4. Identify emotional behaviors that are likely to interfere with the exposure. Relatedly, it may also be helpful to set behavioral goals for the exposure (e.g., make eye contact in a social situation; remain in an anxiety-provoking environment for at least five minutes; refrain from asking for reassurance).

You should structure the task in a way that best permits new learning to occur. This typically involves some level of clarification of what it is that your patient is most worried about, or anticipates happening, so that the exposure can then be directed toward challenging those negative outcome expectancies. If what your patient is most concerned (p. 149) about is the emotional response itself, then the corrective learning is about their ability to tolerate certain emotional responses or sustained levels of distress. With all *Emotion Exposures*, it is extremely important for you to "catch" any moments where your patient is avoiding their emotions, such as changing the topic, "breaking" the role of the exposure, distracting themselves, and so on. As soon as you notice these maladaptive emotional responses, help make your patient aware that

they are avoiding the full emotional experience and then redirect their attention back to the emotion.

During in-session exposures, it is important to be directive and confident and to encourage patients to continue with the exposure despite experiencing intense and uncomfortable emotions. Be careful not to reinforce your patient's perceived inability to tolerate negative emotions, and try not to collude with your patient in engaging in patterns of avoidance, or accommodating emotional behaviors, as noted earlier. Also, it is important that you do not suggest to your patient that a particular situation may be too difficult or too distressing. Therefore, early on it may be best to choose activities toward the middle of your patient's hierarchy so that they are likely to succeed. This will allow them to gain a sense of mastery over an aversive experience while simultaneously becoming more tolerant of their emotions. Over time, you will help your patient gradually and systematically work up the hierarchy.

After the exposure is completed, spend at least 10 minutes processing it with your patient. The **Record of Emotion Exposure Practice Form** can be used for this purpose. Work with your patient to identify and explore emotions they experienced during the task within the three-component model. Further, ask them to consider what they learned by engaging in the exposure and what they could do to make their next exposure more effective. This discussion will help you to identify emotional behaviors that may need to be addressed in later exposures. This will also help identify ways to increase the level of difficulty of future exposures and make them more effective overall. Finally, outline the accomplishments your patient made and provide positive reinforcement for completing (or at least attempting) the task.

(p. 150) Moving Emotion Exposures into the Real World

A crucial factor in the success of treatment lies in your patient's continued practice of *Emotion Exposures* outside of session. Moving exposures into the real world is important for several reasons. First, it allows them to directly apply the skills they have learned in treatment to the context of their daily lives. Second, practicing in vivo exposures allows them to develop a sense of autonomy or agency in their own treatment, facilitating the transition away from you and toward independence. Finally, the actual time spent in therapy represents less than 1% of your patient's waking hours; therefore, in order to truly learn skills presented in therapy, it is essential that they continue to practice skills outside of session.

You and your patient will work together to design *Emotion Exposures* that can be practiced outside of the therapy session. Again, the **Emotion Exposure Hierarchy** in the UP workbook can be used to identify possible *Emotion Exposures*. For example, a patient struggling with panic symptoms may take a crowded subway to work. A patient struggling with social phobia may purposely engage in a conversation with an unfamiliar coworker. A patient who fears dogs after having been bitten may visit an animal shelter and practice petting the animals. Or a person with intrusive and distressing thoughts may write down their most feared thoughts and read them aloud daily.

Homework Review

■ Ask your patient to practice *Emotion Exposures* repeatedly (we recommend at least three times per week) and record their practice on the **Record of Emotion Exposure Practice Form** in the UP workbook. As treatment progresses, exposures should increase in difficulty and your patient should be encouraged to take more responsibility for designing exposures. Spend time processing exposures practiced over the week at the start of the following session, paying particular attention to any patterns of emotional avoidance or obstacles that

may have stood in the way of successful completion of exposures. As noted, a patient should always receive positive reinforcement for any attempt at an exposure, and you and your patient (p. 151) should work together toward making exposures optimally effective and continually increasing their difficulty.

■ 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**.

Case Vignettes

Case Vignette #1

In the following case vignette, the therapist clarifies the intended purpose of *Emotion Exposures* and provides guidance on how to most effectively complete these tasks.

P: I conducted the *Emotion Exposure* we had discussed. I rode the subway for the entire time I was supposed to, but my fear never became less. I was terrified.

T: That's great!

P: How's that great!? I felt awful. I didn't like being scared. I kept thinking it was going to get better but it never did.

T: The point of the *Emotion Exposures* is not to be able to do them without any fear. It's really about how you experience and respond to your fear that's most important. We purposely selected that situation because we knew it would bring up uncomfortable emotion. We wanted you to learn a couple of things. First, as we discussed, it was important for you to expose yourself to this particular situation for you to see that what you thought was going to happen didn't actually happen. In fact, it turned out much better than you thought it would. Second, we wanted you to work toward developing a greater tolerance of your emotions, in this case fear. The important point here is that despite feeling afraid, you stayed the entire time.

P: Do you think it will be better next time? I mean, will I eventually be less afraid?

T: It's likely that by continuing to ride the subway, the fear will gradually begin to decrease. But that depends on whether you attempt to (p. 152) avoid your emotions in that situation or do something to make the situation less frightening.

P: Why does that matter again?

T: Well, as we've discussed, engaging in avoidance prevents you from really learning that the situation is not dangerous. In this case, you were afraid that your fear might become so intense that you would lose control of yourself . . . that you might go crazy.

P: Definitely. So you're saying that if I just allow my fear to be there, and don't do anything to avoid, that eventually it will diminish?

T: Again, it sort of depends on you. In general, I would suggest that you focus more on reducing patterns of avoidance and changing emotion-driven behaviors, rather than worrying so much about what happens to your fear. Now it's important to be aware of the emotional experience, and maybe you can even do a quick three-point check to notice your thoughts, feelings, and behaviors as the emotion unfolds. But then it's just about riding the

wave. I mean, actively do nothing. Just allow the emotion to be there and then notice what happens as a result. Are you losing your mind? Are you doing anything uncontrollable? If you don't do anything to avoid or escape, then you'll be in the best position to learn that your fear is not dangerous in this situation, and chances are the emotion will eventually diminish.

Case Vignette #2

In the following case vignette, the therapist helps the patient identify the anxious cognitions he experienced when attempting an *Emotion Exposure*.

P: I stayed at the meeting for a little while, but eventually I had to get out of there.

T: And why was that?

P: Well, I started feeling really upset. My vision got blurry and I was having trouble focusing on what my boss was saying.

T: So then what happened?

P: Well, I excused myself from the meeting and went outside to get some air. I really tried to stay but the feelings got so intense. I knew that if I just stayed a little longer, something bad might happen. **(p. 153)**

T: Why did you feel the need to protect yourself against those feelings? What are your thoughts about what could have happened if you stayed?

P: I was just concerned that I might say something stupid because I couldn't really focus properly . . . on account of the feelings I was having.

T: It looks like maybe we should take some time to look a little more closely at those thoughts.

Case Vignette #3

In the following case vignette, the therapist assists the patient in developing strategies for modifying her emotion-driven behaviors(EDBs) during an *Emotion Exposure*.

P: I keep leaving the situation too early, right when my emotion hits the peak. What do you think I should do to keep myself in it?

T: It's tough sometimes to go against our emotionally driven behaviors, especially when those behaviors have been reinforced so much in the past. I mean, at this point, you know that escaping from that situation will make you feel relieved. So it's hard not to do that. I think there are a couple of things you might do here. You could try choosing a situation that's a little further down on your hierarchy. Maybe choose something that's likely to be a little less frightening and that you feel you'll really be able to stay in. Also, you could purposely put yourself in a situation where escape is difficult, or ask a friend or family member to assist you with staying in the situation when you're feeling frightened. How does that sound?

P: That sounds pretty good. It helps when I have something to remind me to come back to the three components we talked about in the past. Maybe I'll just make out a little note card that I can fill in while I'm completing the exposure.

T: I like that idea. Also, remember that if you escape from a situation prematurely, you can always think about the situation a little when the emotions aren't as high and then try to go back into the situation as soon as possible.

(p. 154) Troubleshooting

Sometimes patients are not fully "on board" with the rationale for conducting *Emotion Exposures*, so they might choose "easy" exposures, or exposures that are not likely to provoke significant symptoms. In these cases, continuing to go through the exercises will not be helpful. If your patient is unwilling to face uncomfortable emotions, then the time should be spent revisiting prior treatment concepts to assist them in eventually engaging in *Emotion Exposures*. You may also find it useful to review your patient's responses to the two motivation enhancement exercises from Module 1 (Chapter 6).

As illustrated in Case Vignette #3, occasionally during *Emotion Exposures*, patients may escape from a situation if their emotions become too strong. If this happens, it should not be regarded as a failure. Rather, this can simply be presented as an opportunity for the patient to learn from it. Escape is a clear EDB that typically occurs in response to a fear reaction and is usually based on the prediction that continued endurance will result in some kind of negative outcome. For example, it is not uncommon for patients to believe that if they stay in the situation, their anxiety or fear will become so intense that the emotion will become out-of-control and they will be unable to function. In this case, you would help the patient evaluate this prediction in terms of the thinking traps of jumping to conclusions and thinking the worst. From there, the patient could be encouraged to reenter the situation as soon as possible.

Patients can sometimes be discouraged by the pace at which symptom reduction occurs. Also, it can be upsetting to patients when they notice a decrease in their emotional response to a situation over time, only to then reexperience strong and uncomfortable emotions in the same situation at a later point. In these cases, it can be important to remind the patient that learning is rarely linear and that, just like any other time of learning, some forgetting occurs over time. Also, learning tends to be fairly context-dependent, so changing things up even a little bit can sometimes cause a return of the symptoms that they thought had been completely diminished. The recurrence of their emotional response to these situations should not be taken as a failure or an indication that exposures do not work. Rather, it should be viewed as another (p. 155) opportunity to learn that they can tolerate their emotions and that the situation is not dangerous. These recurrences provide excellent learning opportunities and can actually help them generalize what they learned in one situation to other similar situations as well. Again, the goal of treatment is for patients to be less distressed by their emotions (and the situations that provoke them) and to respond more adaptively—the goal is not to prevent them from happening.