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Using Flexible Clinical Processes in the Unified Protocol for the Treatment of Emotional Disorders in Adolescence

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The purpose of this manuscript is to highlight the *Unified Protocol for the Treatment of Emotional Disorders in Adolescents* (UP-A) as an exemplar model of a principle-based, flexible treatment for adolescents with either depressive or anxiety disorders. The theoretical basis, mechanism of change, and research support for three of the UP-A's guiding treatment principles are presented. Verbal exchanges between UP-A therapists and adolescent clients are shared to demonstrate clinical processes related to UP-A techniques that follow such guiding principles. The benefits of this approach to treatment are discussed, including reduction in the number of evidence-based treatment manuals to be learned, administered, and supervised. The UP-A has demonstrated positive outcomes, yet further examination of clinical process variables is warranted. These clinical process variables and additional future directions for the UP-A are addressed.

Keywords: adolescents, treatment, clinical process, emotion, disorders

Disseminating evidence-based treatments (EBTs) into "real world" settings is a great advancement for clinical psychology, yet maintaining fidelity at community sites can be timely, costly, and cumbersome (McHugh, Murray, & Barlow, 2009). Inevitably, some level of EBT flexibility must occur within the context of varied clinical settings and across providers to meet the needs of complex clinical presentations embedded within multiple family, school, and community systems. Existent limitations of EBTs and related dissemination efforts have led to development of transdiagnostic and principle-based treatments (Barlow, Allen, & Choate, 2004).

The *Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders* (UP; Barlow et al., 2010) was developed based on theory and research on learning, emotion development and regulation, cognitive science, and EBT techniques across existent protocols for anxiety and mood disorders. This literature supports a unified treatment approach with studies showing similarities across emotional disorders including common characteristics between disorders (e.g., Brown, 2007), high rates of current and lifetime comorbidity (e.g., Brown, Campbell, Lehman, Grisham, & Mancill, 2001), improvements in comorbid anxiety and mood disorders that were not specifically targeted in treatment (e.g., Borkovec, Abel, & Newman, 1995; Brown, Antony, & Barlow, 1995), and a shared biological vulnerability that leads to the development of emotional disorders generally (e.g., Barlow, 2002).

The UP was originally developed for adults with emotional disorder symptoms by emphasizing five core treatment principles: (1) becoming mindful through awareness of emotional experience; (2) reappraising rigid, emotion-laden appraisal and attributions; (3) identifying and preventing emotional avoidance and maladaptive emotion-driven behaviors; (4) increasing emotional awareness and identifying the role of physical sensations in emotional experiences; and (5) facilitating exposure to both interoceptive and situational clues associated (Barlow et al., 2010). Importantly, the UP has demonstrated positive treatment effects across heterogeneous clinical samples in both open and randomized control trials (e.g., Ellard, Fairholme, Boisseau, Farchione, & Barlow, 2010; Farchione et al., 2012).

The UP was adapted for an adolescent population, through substantial developmental modifications and addition of parent-directed content, and is known as the *Unified Protocol for the Treatment of Emotional Disorders in Adolescents* (UP-A) (Ehrenreich et al., 2008). The UP-A is useful for adolescents with any primary anxiety or depressive disorder (or their cooccurrence) and is a flexible, principle-based intervention with five required and three optional modules based on the principles above. The number of sessions is not fixed per se; however, a minimum of 8 and maximum of 21 treatment sessions are recommended to adequately present and practice techniques related to the core principles. An initial case series and open trial demonstrated positive results (Ehrenreich, Goldstein, Wright, & Barlow, 2009; Trosper, Buzzella, Bennett, & Ehrenreich, 2009).

The UP-A potentially reduces the number of EBT manuals to be learned and applied for individual depressive or anxiety disorders into shared principles and techniques that can be applied universally for adolescents with emotional disorders. This allows for flexibility in administration, creating a unique clinical process for the adolescent client as well as clinician. Below, the theoretical

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basis, mechanism of change, and research support for each UP-A principle will be presented, along with an illustrative verbal exchange between a client and therapist[1] that occurred in the use of UP-A, highlighting the clinical process when using flexible techniques associated with each principle.

Principle One: Reappraising Antecedent Cognitions

This UP-A principle involves addressing negativistic or threat-related cognitions *before* engaging in an emotionally evocative experience. The theoretical basis for this principle comes from Beck's (1972) "cognitive triad" in which depressed individuals maintain negative beliefs about their own self, the world, and the future. Similarly, clients maintain anxiety due to the influence of internal sensations and emotions on cognition. Importantly, this principle differs from other cognitive restructuring strategies as it emphasizes use of such techniques in the antecedent condition. There is evidence to suggest that reappraisal before an emotional event can reduce the subjective, negative emotion later (e.g., Sloan & Telch, 2002). Thus, the mechanism of change is such that if the client can reappraise thoughts before the emotional event, he or she has a greater ability to alter thoughts and modify subsequent emotional responding. Techniques consistent with this principle include identifying "thinking traps" or core beliefs and conducting "detective thinking," which largely invoke the overall use of flexibility in evaluating negative or threat-related cognitions, rather than dogged adherence to initial, automatic thoughts. These strategies involve helping the client identify cognitive errors (i.e., ignoring the positive, thinking the worst, jumping to conclusions) that may be subjective, unrealistic, or inaccurate and guiding the client in gathering evidence regarding the realistic nature of their cognitions.

The clinical process for this principle must be flexible, as it is dependent on the number of and specific thinking traps expressed by the adolescent, the style of "gathering evidence," and the adolescent's ability to explore cognitions. Thus, as the process unfolds, a therapist makes clinical decisions such as whether to expand the number of sessions needed or the way in which he or she guides the client to develop evidence. Therapists may ask the adolescent directly to come up with evidence in a simple straightforward dialogue. However, additional questions can be asked to help the client gather evidence, such as in the conversation below between the UP-A therapist and a 16-year-old male with generalized anxiety disorder:

T: One way to get out of "thinking traps" is to use detective thinking. So, what does a detective do?

C: Umm . . . solves mysteries and finds out what happened in a situation.

T: Yeah, they solve mysteries. They gather evidence and look for clues. Sometimes we can think of our thinking traps as mysteries. We can use detective strategies like gathering evidence to work through that thinking trap.

C: Okay.

T: So, we will practice detective thinking in session and I'll have you practice it for homework. But, it's really important that we use detective thinking before you get in the situation when the emotion gets too big and before we get really into the thinking trap. Why do you think that is?

C: Because it might be harder to like, find reason if you are sucked into the trap. Once you are in the trap, I don't want to say you are panicking, but you have all these negative thoughts and it's hard to think positive or reasonably.

T: Right, when we are in the height of the emotion, we have automatic thinking and the emotion we are experiencing can color the way we think. If we can use detective thinking before the emotion, we will be better at applying the detective skills. I know emotional experiences will happen that you can't predict and you will need to use it during or after. But let's break it down now so that in the future, you are better prepared to get out of the thinking trap when it happens. Okay, so let's give this a try. Let's think of a thinking trap you've had this week.

C: Umm. (Pauses). Probably . . . magical thinking.

T: So, what's the thought?

C: Well, I guess my thought is that if I don't text my mom, she can get hurt in a car accident.

T: Okay. So, now let's try to gather some information, or clues, about how accurate this thought is. Do you know for 100% certainty that your mom will get in an accident if you don't text her?

C: No.

T: Okay and what is the evidence you have for this fear?

C: Well, one in five people get into car accidents.

T: So, you have some statistics about the chance that car accidents can happen. All right, let's try to get more information. Let's look at the past. What has happened in the past? Have you ever wanted to text your mom but couldn't?

C: Yeah.

T: And did she get in an accident? What happened in those situations?

C: Well . . . actually . . . my mom was completely fine. Nothing happened, no car accidents.

T: That's good to know. There is some additional evidence. Well, how can you be sure you know the answer of what will happen to your mom?

C: Well, I mean . . . no one can predict it.

T: And how much do you feel that your mom will get into an accident if you don't text? What is the likelihood that this will happen?

C: I mean, it feels like it will definitely happen, but it's actually not that much of a chance . . . I guess it seems like a low percentage.

T: Well, you said earlier that one in every five people get in a car accident, but that is sometime in their life, right? That is not the statistic for every individual each time he or she goes driving.

C: Yeah, I guess you're right. Otherwise, I would see every fifth car in an accident!

T: Right . . . that would be scary! Driving would be very dangerous if that were true. Knowing that the true likelihood if you don't call is very low, then what is the most realistic outcome?

[1] We have adhered to the American Psychological Association's ethical standards in the treatment of clients. All clients have been de-identified and have provided informed consent for their clinical interactions to be used for this purpose.

C: I guess if I don't text her and don't hear from her, then I'll have to wait to see her at the end of the school day. I guess she will probably be okay.

T: All right. That seems like a more accurate thought than what we started with. But, we don't want to act like nothing bad ever happens, right? We discussed before that sometimes unfortunate things happen. Do you think you could cope if your mom did get in an accident?

C: Yeah, if she was okay.

T: So, if she did get an accident but no one was harmed, it might be scary and inconvenient but it sounds like you could deal with it.

C: Yeah, I wouldn't like it, but I guess I could handle it.

Principle Two: Identifying and Preventing Emotional Avoidance

The purpose of this UP-A principle is to assist the adolescent client in identifying how he or she may be avoiding intense emotions and to help prevent emotional avoidance. Much like a client with a phobia is "exposed" to the feared stimulus (e.g., spiders, vomit, airplanes) or a client with depression is "exposed" to positive events (e.g., scheduling and engaging in positive activities) to increase behavioral activation, this principle involves "exposing" clients to emotions generally. The theoretical basis comes from research showing that individuals, including those with emotional disorders, attempt to avoid unexpected, distressing emotional experiences by suppressing or withholding their emotions (e.g., Roemer, Litz, Orsillo, & Wagner, 2001). Importantly, there is some evidence that clinical techniques used to avoid negative sensations and emotional experiences (e.g., breathing control, relaxation, suppression, cognitive rehearsal, safety signals) may be counterproductive and lead to indices of lower functioning, including greater heart rate and distress (e.g., Schmidt et al., 2000). Thus, rather than suppress negative emotions, the UP-A promotes generalized emotion exposures that encourage the client to accept a range of emotions felt in the current state, even less preferred ones, versus becoming distressed, angry, or disappointed (e.g., nonjudgmental awareness).

For many adolescents, being focused in the present is not a process with which they are typically familiar or comfortable. Some may display uncomfortable laughter, ask more questions than usual, and talk to delay or avoid general emotions that might be felt in the present. Occasionally, the client may express they are "not good" at this technique due to frequently distracting sensations or thoughts. It is helpful to anticipate these reactions, exercise patience, avoid delays, and allow time for practice. Below is a conversation in which the UP-A clinician introduces this concept and its purpose with a 17-year-old female with a primary diagnosis of social phobia and both comorbid generalized anxiety disorder and major depressive disorder:

T: Today I wanted to introduce a new skill called nonjudgmental awareness. It means being present in the moment and accepting our emotions as they come without trying to judge them or react to them. Have you ever been in a situation, like taking the SAT or an important test, and you notice that you're nervous and think, "Oh no, I can't be nervous!"

C: Yeah.

T: And just telling yourself to stop being nervous, does that decrease or increase your anxiety?

C: Actually, it doesn't help at all. I feel bad when I start to feel anxious and it gets worse.

T: Okay. Or when people notice you are upset and say, "Just calm down! Just stop being anxious."

C: (Gasps) . . . I get really annoyed when people say that to me!

T: Okay, so, it probably doesn't help the anxiety then, right? So, sometimes when we are feeling an intense emotion, we often judge ourselves for having this emotion, especially sadness, anxiety, or anger, or what people like to think of as "bad emotions." Sometimes we think we shouldn't have these feelings. As you mentioned, it doesn't help because by judging our emotions, we can make them more intense and harder to work through. It doesn't necessarily mean feeling good about the emotion or saying, "Wow, I feel anxious, that's great!" Instead, it involves learning to accept the emotion by being present in the moment and examining how you are feeling without putting any kinda judgment on that. Does that make sense?

C: Yeah, it makes sense.

T: Okay, good. The first step is to allow yourself to fully experience the emotion while you are having it. Instead of trying to stop being anxious . . . just let yourself feel it. Not thinking about the future, not even 5 minutes from now, or the past. So, if it's the night before the exam, instead of saying, "Oh no . . . I can't be nervous tomorrow for my test," you would just allow yourself to notice the nervousness and then stay with that emotion you are having without judging or changing it. You let it come and pass on its own. All right, well because you said this happened to you before, when you were taking the SAT, were you anxious the whole time?

C: No, I don't think so.

T: What happened to the anxiety?

C: I guess after a while, it just went down.

T: Yeah, this true of all emotions, even if intense, they will eventually go down on their own.

T: All right, let's practice an exercise in nonjudgmental awareness. In this exercise, let's focus on your breathing. But, you could focus on any sensation you wanted like the sound of waves or how your skin feels when a light breeze is blowing. Move your chair out, get comfortable. Close your eyes or leave them open. However you want . . . .

C: Is this like yoga or something?

T: Sort of, except our goal is not really relaxation or exercise. It's to be present and not judge what we feel. (Speaking softly and slowly). Okay, so notice your breath coming in. Notice how your stomach is going up as you breathe in and how it goes down as you breathe out. I want you try to put all your attention on your breath. (Long pause). You may be noticing other things going on . . . hearing people in the hallway or thinking about what you are doing when you get home.

C: (Chuckles). How did you know?

T: (Speaking softly). When you notice your mind wander from focusing on breathing, just accept it and then let your mind go gently back to focusing on your breath. Breathing in and breathing out. (Pauses). Pay attention to how the breath feels through your nostrils as you breathe in and how it feels a little warmer as you breathe out. Let your stomach move up as you breathe in and down as you breathe out. (Pauses and quiets voice). If you have any thoughts, that's okay too, just go back to noticing your breath. Notice how your lungs feel when you take in a deep breath in

(pause) . . . and then release it out. Any tension you feel, I imagine you are just breathing it out. (Therapist remains quiet for 3 min).

T: Whenever you are ready, open your eyes and bring your attention back to us.

C: Wow, oh gosh, I'm tired.

T: How was it? What was that like for you?

C: That was nice, it was very relaxing.

T: Did your attention wander at any point?

C: Yeah. I tried to focus on breathing but I did hear people talking and then I also had thoughts that my breathing feels weird.

T: That happens. Just notice that you are having a thought or hearing a conversation. It's okay to acknowledge that and then bring the attention back to the present breathing or whatever you have chosen to focus on. Remember you don't want to judge the thoughts. Fully experience what you think or feel in the moment. Okay, let's practice again.

Principle Three: Modifying Behavioral Action Tendencies

In contrast to the first two, the third principle is applied when the client is in the height of an emotional experience. The mechanism behind this "opposite action" principle involves encouraging clients to reduce behaviors consistent with their experience of fear, depression, and anxiety (e.g., avoidance, withdrawal, reassurance seeking, safety behaviors, ruminating) and encouraging the client to take an alternative opposite action to promote engaged coping with the heightened emotional state (Barlow, 1988). An example of this mechanism at work is the tendency for clients with depression to display inaction (e.g., lethargy, passivity); however, Jacobson, Martel, and Dimidjian (2001) discovered that having the client engage in "behavioral activation" reduced depressive symptoms. In addition to behavioral activation, two other techniques representative of this principle are interoceptive and situational exposures. Interoceptive exposures involve creating physiological sensations in the body similar to those experienced as part of anxiety, as opposed to trying to avoid the sensations. For example, having a client breathe through a tiny coffee straw will evoke sensations similar to being unable to breathe and a panicked sensation. The therapist helps the client recognize that sensations build but eventually decrease and can be tolerated without use of avoidant coping techniques. This emerging understanding and confidence that sensations are harmless and tolerable prepares the client for sensations that will likely occur during situational exposures when the opposite action is taken (e.g., allowing exposure to the feared object or event rather than avoid).

Encouraging a client to engage in the opposite behavior from their "default" behavioral responding may invoke unexpected changes in rapport, enthusiasm, mood, and attendance. It is important for therapists to anticipate this possibility and make attempts to communicate to parents and adolescents that despite any changes, the goal will continue to commit to attendance and effort in producing the opposite behavior. Below is a conversation between a UP-A therapist and 17-year-old female with a primary diagnosis of generalized anxiety disorder and comorbid obsessive compulsive disorder and major depressive disorder, as the therapist conducts a situational exposure and explains its importance:

T: Today, I want to start taking steps toward doing things that you used to or still avoid doing. So for example, I know you are really, really afraid of spiders.

C: Do not make me touch a spider!

T: That is not the first thing we would do. We won't start with something you never do and that is the hardest because you might become so overwhelmed and may want to avoid it even more. We want to take something low on our list of fears and do that first. We will take small steps so that you feel success with things that make you feel a little nervous.

C: Well, I don't know if I could do anything involving spiders.

T: I understand it feels that way. So, if you had to touch a giant, hairy, live tarantula, what would you do?

C: Run out of the room and never come back!

T: Okay, but what if instead, you had to touch a fake, plastic spider? On a zero to eight scale, how scary would that be?"

C: Oh, well that would be a zero.

(Therapist pulls out a plastic spider and gently tosses it to the client).

C: Eww . . . okay, okay it's a two. This is gross-looking!

T: What's gross about it? Anything about it that makes you not want to touch it?

C: Its legs are creepy . . . the whole thing is freaky. Look at its eyes!

T: Yes, so this is exactly what we want to do when we face our fears. I want you to keep looking at it. Look at whatever you think is the grossest parts and tell me about it. Tell me when your anxiety level is down to a zero and let me know if it goes up or down.

C: Everything on it is hideous . . . the legs are nasty.

T: All right, then see if you can push those creepy legs onto your arm. Whatever makes it the scariest . . . try doing that.

C: (Client moves spider up to arm). Ughh . . . it's a three now. I don't want it on my arm. It's a four now, it's getting worse!

T: That's okay . . . it's when you want to take it off, that is when you need to keep it on and face it. We have to stick with it.

C: I hate when spiders twirl. If I close my eyes and blur them, this spider looks real. Like if it twirled down from the ceiling and landed on my hair, it would be an eight!

T: Does that make the number go up?

C: Yes! Now I'm a six!

T: Well then, let's imagine it's real. I like that you are putting it in realistic situations. That's a great way to face it and become comfortable with what's uncomfortable.

(Therapist waits silently for a few minutes). What is your level, now?

C: A three.

T: Okay. We'll keep waiting. (Silence for 2 min).

C: I think I'm a one . . . do I just wait until zero?

T: Yes, a zero or for several minutes more. I will let you know when. I want you to become best friends with that spider! (After three more minutes). Okay, I'll have the spider back now. Good job sticking with it. Let's think about how your anxiety changed over time. Depending on what you did with the spider or what you imagined it doing, it seemed like the anxiety changed. But, even if you made him as scary as possible, did it stay at a six or higher?

C: No, it went down.

T: What had to happen for it to go down?

C: I had to touch the spider for a long time.

T: Yeah. Sometimes when our emotion is at its highest, we feel the only way to make it go down is to get rid of what is scary or avoid it or even distract ourselves. But is that the only way to make it go down?

C: Uh no . . . I guess not. I guess, become friends with the fear?

T: Yes, that's one way of saying it. Sometimes I call it riding the wave . . . our emotion goes up and even to an eight sometimes. But, do you think it will stay there forever?

C: Probably not.

T: Right, we have to be surfers . . . ride the wave up and wait for it to come back down. Sometimes it can take a long time, but just try to feel it rather than push it away. Next time, the anxiety won't go up as high. Our bodies can't stay in a state of high anxiety so it will naturally go down on its own. Although it is definitely faster to leave the room or squish the spider, why would that be a bad idea even if it makes you go from a six to a zero?

C: I don't know. That sounds like a better idea to me, though!

T: Well, just like you did today, if you stay for enough time, you will get more comfortable. But, if we avoid, the brain learns that the thing or situation was not safe. It tells us that avoiding was a good coping strategy, so your brain will want you to avoid next time too. If you avoid it once, it's much harder to stick it out next time and you will want to escape faster. Plus, if you begin to escape things in life, you could miss out on some really fun stuff.

C: It's hard though.

T: You're right, it isn't easy. It's hard at first, but as you get better at it, you become less afraid and realize you can do it. You did a great job of waiting it out today.

Summary and Future Directions

The three principles illustrated in this manuscript and their respective techniques at the core of the UP-A are grounded in theory and research and provide an evidenced-based approach that maximizes the protocol's utility through a flexible clinical process. The study of clinical process variables often lags well behind the establishment of efficacy data for a new or novel treatment approach (Kendall, 2000). The UP-A has evidenced initially positive efficacy-related outcomes, but remains in its infancy and additional research is warranted. Therapeutic alliance, client involvement, client participation, and therapist behaviors have all demonstrated a relation with treatment outcomes for children and adolescents (Karver et al., 2008). Examining how these variables impact UP-A treatment outcome is an important future direction.

In addition to clinical process that occurs within sessions, the UP-A's flexible structure suggests a notable opportunity in the training and supervisory process. The UP-A provides clinicians and their supervisors with a reduced burden regarding the number of manuals one might need to learn, implement, and supervise for youth emotional disorders; thereby, potentially leading to enhanced clinician time and efficiency in delivering evidence-based care. Understanding how to flexibly guide therapists in using this manual, as well as exploring its cost- and time-saving impact are topics worthy of further exploration with notable implications for training, supervision, and treatment of adolescents with emotional disorders.

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Practice Review

This is an open invitation for authors to submit what Charlie Gelso developed and termed a *Practice Review* for possible publication in *Psychotherapy*. I want to continue this series as a step toward enhancing the value and relevance of scientific research on psychotherapy and related processes to practice.

The general aim of the *Practice Review* is to clarify, as much as the current state of knowledge permits, what empirically-derived findings in a given area imply for practice in that and related areas. In this type of review article, the reviewer begins the process with the intent of deriving implications for practice from the research and theory that is examined. Much like program evaluation research, the central question for the writer of a *Practice Review* may be phrased as: "Despite the near inevitability of at least somewhat mixed findings on virtually any topic, what is the most likely relationship between these variables, and what does that relationship imply for the practitioner?"

The above kind of question is based on an awareness that the practitioner must do his or her practice, despite the general lack of fully consistent research findings; and it will be useful in that practice if the *best available* knowledge were used. This, of course, is not to say that the reviewer may take a cavalier attitude toward drawing implications for practice. The reviewer needs to derive such implications with great care. At the same time, the *Practice Review* does not convey the same degree of scientific skepticism that is typical of the classical scholarly review. For example, in the traditional scholarly review, as in classical scholarly inquiry in general, one takes a very conservative attitude toward accepting results. Substantial evidence must accumulate before we may safely say a given finding is confirmed and valid. In the *Practice Review*, on the other hand, the investigator searches for the *most likely* conclusion, when all evidence is weighed, and then seeks to place that conclusion within the context of practice.

The process of relating a "most likely conclusion" or finding to practice is rarely if ever a straightforward or linear process. As but one example, the most likely conclusions about the role of duration of treatment in outcome is that, other things being equal, the longer the therapy (at least up to a certain point), the more positive the outcomes. What implications does this have for the practitioner? For implications to be drawn, this finding needs to be placed within the context of related findings, existing theory, and other factors (e.g., pragmatic ones) that help the practitioner conceptualize duration factors in his or her practice. Placing findings within contexts such as these may well modify the findings.

With these considerations in mind, the following guidelines are offered for those who write *Practice Reviews*:

1. Your set from the beginning should be to find out what are the most likely conclusions about the relationships under investigation.
2. In doing so, consider how particular findings may be integrated with related findings in your area of review.
3. Once the most likely conclusions are arrived at and placed in the context of related knowledge, discuss what these findings imply for the practitioner.
4. In relating findings to practice, show an appreciation of the likelihood that the findings-to-practice links will not be direct and clear cut. Rather, given findings ("facts") may relate to practice through their connection to theories, clinical wisdom, practical and political concerns, etc.
5. Although the refrain, "more research is needed," is virtually always valid, the practice review must not hide behind scientific equivocation. Rather, the approach ought to be that, although more research is surely needed, here is our best available knowledge and what it implies for practice.

Although the length of practice reviews should be dictated by the subject matter, such reviews generally should be limited to about 25 pages of text. Reviews of relatively narrow topics should naturally be much briefer. Authors are invited to contact me if they are considering writing such a review but have questions about the process. Email me at Psychotherapy@adelphi.edu.