Published in final edited form as:

Cogn Behav Pract. 2013 August ; 20(3): 282–300. doi:10.1016/j.cbpra.2013.02.001.

Emotion Regulation Therapy for Generalized Anxiety Disorder

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Abstract

Despite the success of cognitive behavioral therapies (CBT) for emotional disorders, a sizable subgroup of patients with complex clinical presentations, such as patients with generalized anxiety disorder, fails to evidence adequate treatment response. Emotion Regulation Therapy (ERT) integrates facets of traditional and contemporary CBTs, mindfulness, and emotion-focused interventions within a framework that reflects basic and translational findings in affect science. Specifically, ERT is a mechanism-targeted intervention focusing on patterns of motivational dysfunction while cultivating emotion regulation skills. Open and randomized controlled psychotherapy trials have demonstrated considerable preliminary evidence for the utility of this approach as well as for the underlying proposed mechanisms. This article provides an illustration of ERT through the case of “William.” In particular, this article includes a case-conceptualization of William from an ERT perspective while describing the flow and progression of the ERT treatment approach.

Keywords

cognitive behavior therapy; emotion regulation; generalized anxiety disorder; mindfulness

Individuals with generalized anxiety disorder (GAD) frequently live by the maxim that “most miseries lie in anticipation” (Balzac, 1897). Their lives are marked by strong emotional experiences often discussed as emotionality, intensity, or distress and that are particularly characterized by cautiousness that favors protection over promotion (Chorpita,

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Contains Video¹

¹Video patients/clients are portrayed by actors.

Albano, & Barlow, 1998; Klenk, Strauman, & Higgins, 2011; Woody & Rachman, 1994); they are often self-conscious about the interpersonal relationships and the events in their lives (Przeworski et al., 2011), and they tend to worry and persevere as a way to manage this emotional distress (Borkovec, Alcaine, & Behar, 2004). Emotion Regulation Therapy (ERT; Mennin & Fresco, 2009) represents our effort to better understand and reduce the suffering caused by GAD, particularly when it is accompanied by co-occurring depression. The ERT model melds principles from traditional and contemporary cognitive behavioral treatments (e.g., skills training and exposure) with basic and translational findings from affect science to identify targets of treatment in terms of core disruptions of normative cognitive, emotional, and motivational systems. Contrasting a client's difficulties with what we understand as normative functioning allows us to generate theory-driven hypotheses that form the basis of our case conceptualization and treatment planning (e.g., Sanislow et al., 2010).

Affect Science Approach to Emotion Function and Dysfunction

Drawing from a perspective that emphasizes the analysis of emotions from normative to disordered functioning, ERT delineates three main facets of basic emotional functioning: (a) *motivational mechanisms*, reflecting the functional and directional properties of an emotional response tendency; (b) *regulatory mechanisms*, reflecting the altering of response trajectories to be more congruent with contextual demands and constraints as well as one's personal values or goals, and (c) contextual *learning mechanisms*, reflecting, optimally, the promotion of broad and flexible behavioral repertoires. We offer both a normative account and our perspective for how these processes become dysfunctional in GAD.

Normative and Disordered Motivational Mechanisms

Emotions are functional and integrally tied to our motivations (Keltner & Gross, 1999), serving as signals to us that there is something important to which we must attend and, possibly, to take action (Frijda, 1986). Further, our actions and preparation for actions are guided by the motivational salience of stimuli that signal perceived threats/safety cues (i.e., security focus) in the face of gains/losses (i.e., reward focus; Gray & McNaughton, 2000; Higgins, 1997). One of the core premises of the ERT model is that the basic, primary directive of all organisms is to bring balance to our lives in terms of seeking safety and avoiding threat while engaging reward and minimizing loss. As we increasingly become creatures of habit over the course of our lives, we remain organisms pushed and pulled by these very basic motivations of security and reward (Mennin & Fresco, 2009; in press). Our well-ingrained behavioral repertoires are, in fact, shaped and sculpted to a large degree by these fundamental motivations.

In contrast to this normative functional response, individuals with GAD evidence heightened subjective emotional intensity (Mennin, Heimberg, Turk, & Fresco, 2005) as well as strong motivational impulses for security, protection, and control (Klenk et al., 2011). They inordinately focus on issues of personal safety and security following life experiences that reinforce beliefs concerning their sense of security in the world (Cassidy, Lichtenstein-Phelps, & Sibrava, 2009). As a result, individuals with GAD complicate their ability to make

beneficial life choices that can be informed not only by security concerns but also reward possibilities. Although more rigorous experimental and biobehavioral research is needed, preliminary findings support a role for both motivational dysfunction (i.e., Campbell-Sills, Liverant, & Brown, 2004) and subjective emotional intensity (i.e., Mennin, Haloway, Fresco, & Moore, & Heimberg, 2007) in the distress disorders.

Normative and Disordered Emotion Regulation

Although emotions serve adaptive functions, their presence is not always functional. Similarly, in some contexts, the absence of emotions may be dysfunctional. Thus, emotions are part of a larger self-regulation system that allows us to flexibly respond to events in our lives in accordance with both personal goals/values and situational factors (Keltner & Gross, 1999; Wilson & Murrell, 2004). This regulation reflects coordination across numerous biological and behavioral systems involved in the emotional response that help us fine tune this response to situations that arise in our lives. In some instances, the optimal tuning in a given situation results in the accentuation (i.e., up-regulation) of the emotional salience of the situation; in other instances, toning down (i.e., dampening) the emotional aspects of the situation is warranted (Gross & Thompson, 2007).

Emotional processes also unfold over time, and thus, emotion regulation is best conceptualized as temporally congruent with the unfolding of emotional responses (cf. Davidson, 1998). Building upon Gross' temporal model of emotion regulation (for an extensive review; see Gross & Thompson, 2007), we argue that emotional dysfunction in GAD can occur at varying points of an unfolding emotional response and these points become increasingly more elaborative over a given emotional trajectory. Elaboration essentially refers to the degree of verbal mediation required to engage a particular capacity (Baddeley, 2012). Greater elaboration requires greater mental effort and therefore can result in greater cognitive resource depletion (Joorman, Nee, Berman, Jonides, & Gotlib, 2010; MacNamara & Hajcak, 2010; Muraven & Baumeister, 2000).

Optimal emotion regulation may begin with engaging less elaborative capacities first, followed by capacities with increasing elaboration as needed. Less elaborative capacities, which are relatively less verbal, primarily involve *attentional flexibility*, or the ability to rapidly shift, sustain, or broaden one's attention from one stimulus to another as per contextual demands. When these less elaborative and less depleting capacities are not capable of producing an adaptive response to the current situation, we can draw upon more elaborative and more verbally mediated capacities, including the promotion of *acceptance and allowance* (Hayes, Strosahl, & Wilson, 1999), which we define as the ability to sustain one's awareness of emotionally laden information and maintain it in working memory, *meta-cognitive distancing and decentering* (Fresco, Segal, Buis, & Kennedy, 2007; Liberman & Trope, 2008; Safran & Segal, 1990), or the ability to gain perspective in time and space from emotionally laden information so as to gain clarity around the motivational and emotional signals, and *cognitive change*, or the ability to change a situation's meaning in a way that alters its emotional impact (Gross & Thompson, 2007).

In contrast to these adaptive emotion-regulation capacities, individuals with GAD utilize a series of maladaptive emotion-regulation strategies that also vary in their degree of

elaboration. Specifically, they *respond reactively* to the arising of intense emotions that signal strong pulls for security. These *reactive responses* are usually manifested in rigid and circumscribed ways to gain a greater sense of control, including making the sense of threat and danger go away or escaping or dampening the intensity of the emotional experience. The less elaborative maladaptive strategies include *attentional rigidity* by either fixating or avoiding both interoceptive and exteroceptive emotional stimuli (Mogg & Bradley, 2005). GAD with and without major depressive disorder (MDD) is characterized by a failure to spontaneously regulate emotional conflict by shifting attention in response to a motivationally salient emotional stimulus (Etkin, Prater, Hoeft, Menon, & Schatzberg, 2010; Etkin & Schatzberg, 2011). Each day, we are confronted with the simultaneous occurrence of emotionally conflicting information that may perturb our goal-directed behavior—requiring us to attend to, consider, and possibly inform our actions before completing the task at hand.

Because of deficits in less elaborative emotion regulation, individuals with GAD often resort to a variety of highly elaborative, depleting, and generally maladaptive ways of responding to emotional stimuli. These elaborative responses include worry, rumination, and self-criticism. Worry serves as a regulatory strategy aimed at reducing distress that arises from conflicting emotional and motivational states (e.g., Borkovec et al., 2004; Mennin & Fresco, 2009; Newman & Llera, 2011). Similarly, rumination represents another perseverative cognitive process (e.g., Fresco, Frankel, Mennin, Turk, & Heimberg, 2002; Segerstrom, Tsao, Alden, & Craske, 2000; Watkins, 2008) closely related to depression (Nolen-Hoeksema, Wisco, & Lyubomirsky, 2008). Self-critical thinking commonly arises to provoke perfectionistic responses or, conversely, to further demoralize one into inactivity (Antony, Purdon, Huta, & Swinson, 1998; Marshall, Zuroff, McBride, & Bagby, 2008; Sturman & Mongrain, 2010). Although topographically different from one another, these responses are functionally similar in their attempts to diminish arousal by enveloping it in elaborative self-conscious processing. In addition, individuals with GAD also use further behavioral methods such as physical avoidance (Michelson, Lee, Orsillo, & Roemer, 2011), reassurance seeking (Cougle et al., 2012), and compulsive behaviors (Schut, Castonguay, & Borkovec, 2001) to reduce distressing emotions. These methods become negatively reinforced through the illusory correlation that they were able to ward off negative outcomes (when these outcomes were unlikely to occur, regardless of these strategies). The increases in the usage of these strategies are problematic for a number of reasons. First, these elaborative responses are depleting and require an expenditure of resources to employ (Muraven & Baumeister, 2000). Second, increasing the elaboration reduces clarity in receiving, processing, and optimally responding to the emotion (Schultz, Izard, Ackerman, & Youngstrom, 2001).

Normative and Disordered Contextual Learning

Behavioral flexibility and versatility are adaptive, health protective, and offer survival value (Brosschot & Thayer, 2004; Hayes, Strosahl, & Wilson, 2011; Thayer & Lane, 2002; Wilson & Murrell, 2004). Providing the contextually appropriate behavioral response may be the difference between life and death and between love and loss. The adaptive emotion-regulation capacities described above provide a foundation for behavioral flexibility in that

they will likely help us size up our situation with maximal clarity so that we can engage the event with the most adaptive behavioral response. Similarly, considerable evidence now shows that positive emotions (e.g., joy or interest) can broaden our array of thoughts and actions and build new approaches through the generation of enduring personal resources (Fredrickson, 2001). Thus, appropriate balancing of the emotions that arise in our lives facilitates being maximally prepared to respond adaptively to the conditions we face in our daily lives.

Individuals with the disordered emotion-regulation profile we have described often exhibit impoverished and inflexible repertoires of behavior in response to the conditions in their lives. These patterns of behavior further serve the function of promoting escape, avoidance, or inactivity (e.g., Ferster, 1973). Several lines of evidence and reason offer an explanation for how deficits in emotion regulation culminate in inflexible behavioral repertoires. First, one consequence of attentional and interoceptive rigidity is a diminishment or obfuscation of access to potentially salient information (Schultz et al., 2001). Rather, individuals myopically focus only on certain aspects, and thereby may miss cues that would beget more adaptive responses. Similarly, elaborative regulation deficits represent maladaptive compensatory strategies that can deplete and promote diminished clarity in our emotional understanding. For example, worry encourages avoidance of emotional processing (Borkovec, 1994; Newman & Llera, 2011) and results in increased ability to be conditioned to threat (Otto et al., 2007), greater stimulus generalization (Lissek et al., 2010), and diminished ability to discriminate stimuli and learning contingencies (Salters-Pedneault et al., 2008). Similarly, rumination decreases the likelihood of new reward-based learning and obfuscates focusing on purposeful action (Bar, 2009; Joorman & Tran, 2009). The net effect is a diminishment in access and attainment of reward (e.g., limited meaningful actions, weaker instrumental behavior, poorer social networks that negatively impact quality of life), yet these narrowed behavioral repertoires gain in habit strength in our patients (via negative reinforcement) and minimize the possibility of a meaningful, flexible, and broadly defined life.

Benefits in Contrast to Standard CBT for GAD

ERT is our effort to simultaneously remain true to CBT core principles while also incorporating theory and evidence from the burgeoning basic and translational science of emotions in hopes of improving our understanding and treatment of GAD while also aligning with NIMH priorities such as the research domain criteria (Sanislow et al., 2010). Thus, we view ERT as a member of the *family of CBTs* and as *one* way to understand and implement the principles common to many of the successful CBT packages (Butler, Chapman, Forman, & Beck, 2006; Hollon, Stewart, & Strunk, 2006). Successful traditional CBTs share the components of psychoeducation, self-monitoring, relaxation training, cognitive reframing, problem solving, and exposure. More recent advances in CBT packages—for example, dialectical behavior therapy (Linehan, 1993), acceptance and commitment therapy (Hayes et al., 1999), mindfulness-based cognitive therapy (Segal, Williams, & Teasdale, 2002), behavioral activation (Jacobson, Martell, & Dimidjian, 2001), acceptance-based behavioral therapy (Hayes-Skelton, Orsillo, & Roemer, this issue; Roemer, Orsillo, & Salters-Pedneault, 2008), and the unified protocol (Ellard et al., 2010)—have increasingly

incorporated an emphasis on present-moment focus (mindfulness), decreasing control strategies, emotional exposure, and increasing behavioral action congruent with personal values. However, all of these components reflect two overarching principles that typify CBT. First, CBT works by teaching clients skills to overcome deficits in emotional and cognitive processing. Second, as clients show some facility with new skills, treatment then focuses on creating opportunities for exposure and new learning to extinguish fear/anxiety responses while increasing approach behavior and reward activation.

Although traditional CBT has been successful, meta-analytic findings indicate that compared to other anxiety and mood disorders, effect sizes are somewhat smaller in GAD (Borkovec & Ruscio, 2001; Gould, Otto, Pollack, & Yap, 1997, Mitte, 2005) and patients with GAD may be less likely to achieve high end-state functioning (Borkovec & Ruscio, 2001). In hopes of improving treatment efficacy for all emotional disorders, including GAD, the NIMH has promoted two initiatives to accelerate the payoff from basic and translational research into treatment application and to identify factors that promote or diminish the effectiveness of evidence-based treatments. First, the Research Domain Criteria (RDoC; Sanislow et al., 2010) aims to delineate normative functioning at different levels of inquiry so that these normative findings can be contrasted with disordered subgroups to identify mechanistic regions of interest that may in turn become the targets of treatment development. The second initiative is treatment personalization as a means of deliberately studying the factors that predict who will benefit from a given treatment and then to systematically determine ways of optimizing care so that more patients and clients enjoy the benefits. While creating linkage to the family of CBTs, ERT deliberately seeks to integrate findings from basic and translational affect science while also simultaneously being responsive to the emerging priorities of NIMH. The net effect is an integrated, mechanism-targeted CBT that strives to improve the acute and enduring treatment efficacy for patients suffering from GAD, especially when their clinical presentation is accompanied with co-occurring depression.

Research Findings

To date, the efficacy of ERT has been demonstrated in a recently concluded NIMH-funded open trial (OT; $N = 19$) and a randomized clinical trial (RCT; $N = 60$; Mennin & Fresco, 2011; Mennin, Fresco, Heimberg, & Ciesla, 2012). ERT was very well tolerated by clients, as evidenced by low rates of attrition in the course of treatment. For instance, 18 of 19 OT patients and 26 of 30 RCT patients completed all 20 sessions of treatment. In terms of clinical outcomes, OT patients evidenced reductions in both clinician-assessed and self-report measures of GAD severity, worry, trait anxious, and depression symptoms and corresponding improvements in quality of life with within-subject effect sizes well exceeding conventions for large effects (Cohen's d s = 1.5 to 4.5). These gains were maintained for 9 months following the end of treatment. The RCT patients receiving immediate ERT, as compared to a modified attention control condition, evidenced significantly greater reductions in GAD severity, worry, trait anxious, and depression symptoms and corresponding improvements in functionality and quality of life with between-subject effect sizes in the medium to large range ($d = .50$ to 2.0). These gains were maintained for 9 months following the end of treatment. In addition, these effect size

estimates also take into account patients who dropped out of treatment and do not just reflect the treatment completers. Finally, not surprisingly given comorbidity rates (Kessler et al., 2005; Kessler, Chiu, Demler, & Walters, 2005), a sizable subgroup of GAD patients with comorbid MDD ($N = 30$) were enrolled and treated. Within-subject effect sizes in both clinician-assessed and self-report measures of GAD severity, worry, trait anxious, and depression symptoms and corresponding improvements in functionality and quality of life were comparable to the overall trial findings—thereby suggesting that MDD comorbidity did not interfere with treatment efficacy (Cohen's $d = 1.5$ to 4.0). Further, depression-related outcomes such as rumination and anhedonia were reduced considerably (Cohen's $d = 1.5$ to 2.0).

Application of the ERT Model to the Clinical Case Conceptualization

Specific Assessment Strategies

When determining the appropriateness of a case for ERT, a combination of nomothetic and idiographic assessment techniques is utilized. Although like most behavior therapists we view diagnostic categorizations as less relevant, we begin with a lifetime diagnostic interview such as the Structured Clinical Interview for DSM-IV (First et al., 2002) or Anxiety Disorders Interview Schedule–Lifetime, Fourth Edition (Di Nardo, Brown, & Barlow, 1994) to determine the presence of a GAD diagnosis as well as other current and lifetime Axis I conditions. At intake and before each session, clients also complete self-report measures assessing worry (Stöber & Bittencourt, 1998), GAD (GAD-7; Spitzer, Kroenke, Williams, & Lowe, 2006) and depression symptoms (Beck Depression Inventory-II; Beck, Steer, & Brown, 1996). From intake and throughout therapy, we also encourage therapists to develop and to continually evaluate a more ideographically derived, ERT-consistent case formulation that is revisited in each phase of treatment (cf. Persons & Fresco, 2008). There is no unitary assessment device, but from initial intake and throughout each phase of treatment, therapists render a clinical impression for the degree to which clients endorse intense emotions and narrowing their focus on security to the exclusion of reward (i.e., motivational mechanisms); engage in rigid and reactive responses in service of escaping or avoiding intense emotions (i.e., regulatory mechanisms); and, in turn, diminish their pursuit of potentially rewarding or enhancing experiences (i.e., contextual learning mechanisms). In addition to monitoring these aspects of the ERT psychopathology model, therapists also track and revise their impressions as to the degree to which clients demonstrate mindful awareness of emotions and motivations, demonstrate a capacity to regulate their emotions, and to articulate and pursue a life that is compatible with their personal values.

Translation of William's Case Presentation to the ERT Model—Beginning with the available nomothetic information about William (see Robichaud, this issue), we learn that he has met diagnostic criteria for GAD for a number of years and in the past has achieved short-lasting but nondurable benefit from antidepressant medication treatment. The clinical interview also revealed that, in recent years, William has experienced intermittent sad mood with hopelessness and melancholy, as well as increased social isolation above and beyond the impairment he attributes to his GAD. This additional difficulty approximates the

diagnostic criteria for dysthymic disorder and appears to have arisen well after he met diagnostic criteria for GAD. Finally, in the recent past, William endorsed experiencing some panic attacks that were cued by events at his work, and thus, did not conform to a diagnosis of panic disorder.

According to our ERT psychopathology model, GAD patients like William manifest deficits in emotion generation characterized by the tendency towards strong emotional responses mediated by motivational salience to perceived threats/safety cues (i.e., security system) in the face of reward gains/losses (i.e., reward system). They may focus inordinately on the cues that denote threat or danger to the exclusion of cues signaling safety and/or opportunities for reward. In other instances, individuals with GAD may be motivationally paralyzed by the simultaneous pulls for high threat and high reward such that they are nearly incapable of taking behavioral action. Both kinds of emotion generation deficits are apparent in William. For instance, at times of heightened stress, William has described feeling intense anxiety that nearly pushed him to a “nervous breakdown” (e.g., birth of his daughter coupled with work responsibilities) and increasing frequency of panic attacks (e.g., cued by office turmoil and additional responsibilities at work). At these times, William's focus appears to narrow on actual or perceived dangers, which ultimately undermines other important aspects of his experiences or relationships. Similarly, William at times is nearly incapable of making a decision when he feels simultaneously pulled by reward and threat motivations. For example, he agonizes over the decision of where to vacation with the family or what to order for dinner at a restaurant for fear of making a bad decision that he might later regret. From an ERT perspective, William appears to be in the throes of an intense motivational conflict given the simultaneous pulls of reward and threat engendered by the particular situation.

Within the ERT model, patients like William also commonly evidence deficits in emotion regulation characterized by early, less elaborative deficits, including rigidity in attentional responses to exteroceptive and interoceptive emotional stimuli. Although less clearly in evidence, William likely experiences difficulties responding to the arising of positive emotions (e.g., joy, curiosity, interest, or contentment), leading to reward motivations becoming diminished, neglected, and infrequently acted upon. Similarly, within the ERT framework, GAD patients like William also commonly experience deficits, in more elaborative emotion regulation characterized by increased use of poor compensatory strategies (e.g., worry) and inability to implement adaptive strategies (e.g., reappraisal) that are more efficient at inhibition. There are also clear signs that William suffers deficits in elaborative emotion-regulation capacities. In particular, he engages in a variety of reactive responses that likely provide short-term escape or relief from the emotional signals in his life, but are largely depleting. The arising of emotion results in engaging in reactive responses in rigid and circumscribed ways to gain a greater sense of control over one's situation. In the case of William, he frequently worries and seeks the reassurance of others in his life. Although topographically different, an ERT perspective views worry and reassurance seeking as two kinds of reactive responses as they are actions emitted by GAD patients late in the emotion generative process, often in service of gaining security. In addition to worry and reassurance seeking, William oftentimes appears to be highly self-critical, which further heaps on the distress that he experiences in his life.

Within the ERT framework, the cumulative effect of emotion generation deficits in the form of intense emotional and motivational pulls coupled by deficits in emotion-regulation strategies often result in narrowed behavioral repertoires characterized by the inability to develop new learning repertoires (lack of opportunity for extinction or reward activation) to promote valued life directions. In essence, our access and apprehension of our emotions and motivations becomes diffuse and cloudy, which in turn results in a narrowed behavioral repertoire largely focused on escape and avoidance learning as well as interference of reward learning. William clearly shows signs of behaviorally constricting his life in ways that serve an avoidance function. For example, he is prone to procrastination as a way of delaying making choices that would commit him to a path or cause any sort of criticism among loved ones and co-workers alike. He also socially isolates himself, especially in activities that require spontaneity—instead favoring planned and scripted activities that are more controlled and predictable. All these efforts to dull or rid himself of the immediacy of this emotional upheaval may offer temporary relief or a sense of regained control, but in the long run, perpetuate the fatigue, deplete resources, while accentuating a deep sense of regret for lost opportunities. Finally, the initial ERT formulation also strives to elucidate the degree to which clients manifest any adaptive emotion-regulation capacities such as mindful somatic and emotional awareness, adaptive elaborative emotion-regulation capacities, and proactively engaging values-informed actions in one's life. The information provided does not suggest that William is presently proficient in these capacities.

Description of the ERT Protocol Using the Case Example of William

Clinical Considerations

As noted above, the ERT model adopts the affect science perspective that, although not always productive in every given moment, emotions are adaptive and have survival value in that they are powerful signals for both approach and avoidance motivations. However, because of deficits in flexibly attending to these emotional states, individuals suffering from GAD instead utilize a preponderance of more elaborative maladaptive reactive responses (i.e., worry, rumination, self-criticism). By the time they apprehend and respond to their emotions, the emotion itself has intensified and they must resort to a much more effortful, elaborative, and depleting response for an emotion that is no longer just the pure and clear signal of a motivation state. The kind of elaboration that patients with GAD are likely to engage imbues the emotional signal with negative beliefs about emotion, self-criticism for having the emotions, worry about the meaning of the emotions, and recruitment of memories of past difficulties. Lost in this negative cognitive elaboration is the initial motivational information conveyed by the arising emotion. In other words, our clients come to treatment engaging their emotions very late in the emotion generative stream, and their only recourse are highly reactive and ultimately ineffective reactive responses. The goal of ERT is to teach clients to improve attendance to their motivational states and learn alternatives to reactive responses including worry, rumination, self-criticism, compulsive behaviors, and reassurance seeking. To accomplish this goal, clients progress through ERT first by learning skills to increase mindful awareness of emotional and motivational states; learning skills to increase adaptive emotion regulatory congruent with contextual demands (“counteractive” as an alternative to reactive response focused regulation); and increasing values-informed

behavioral actions that strike a balance between security and reward motivational pulls (“proactive” regulation akin to antecedent-focused regulation; Gross & Thompson, 2007).

Outline of a Phase-by-Phase ERT Treatment Protocol for William

ERT as a treatment protocol, in its current form, consists of 16 weekly sessions and 18 hours of direct care. Sessions 10 through 13 consist of 90 minutes in length. The remaining sessions consist of 60 minutes in length. ERT is divided into four phases, each focusing on a different facet of treatment. Each phase corresponds to the mechanistic targets outlined above. Figure 1 summarizes each treatment process and its target mechanisms. The general flow of ERT sessions consists of brief agenda setting, review of homework, mindfulness practice and skills implementation, discussion of ERT principles, discussion and demonstration of new ERT skills, and assigning of homework. Sessions 10 to 15 typically include in-session exposure exercises and out-of-session exposure exercises conducted in the ensuing week.

Phase I: Awareness Skills Training—The first phase of ERT (Sessions 1 to 3) seeks to break the cycle of reactive responding that typifies patients with GAD. The overarching theme for Phase I is to promote awareness of somatic and emotional cues. Building upon this theme, Phase I is based on three core principles: increasing understanding of emotions and underlying motivations via psychoeducation and contextualizing historical and concurrent events within the ERT model; improving cue detection to better identify antecedents and consequences (cues) associated with emotions, motivational pulls, and reactive responses; increasing mindful awareness to cultivate attentional flexibility, interoceptive awareness, and superior emotional conflict monitoring and adaptation.

At the outset of treatment, William would first be introduced to a psychoeducational ERT model that explains normative emotion generation and regulation, how this normative experience and expression of emotion can be thwarted by historical and proximal factors, and how the course of GAD might affect one's life. William would be encouraged to tell his particular life story through the lens of an ERT perspective as a way of beginning to demonstrate an understanding of the ERT model so that the therapist can begin to normalize and contextualize his experiences. By the same token, this discussion of normative emotion would also serve the purpose of inviting William to begin adopting a more open perspective on his emotional experiences with the goal of more clearly hearing the motivational message that is being conveyed with the arising of emotions. Three exercises conducted during Phase I of ERT further solidify and contextualize the rationale for adopting this more open perspective with respect to one's emotions and to recognize they way we are swayed by our emotions and motivations. First, William would be asked to undertake a security history writing exercise. Clients are asked to spend 15 minutes a day for 2 days writing first about the historical basis for a “security-first” orientation. That is, events in their life that promoted an orientation towards favoring security over reward in their lives. The second day, clients write about more contemporary factors that result in a security-first orientation towards their lives. This exercise is useful in terms of rapport building, providing idiographic material from the client's life, and in assessing a client's understanding of the important ERT concepts of security and reward motivations. Essentially, clients construct a narrative of their lives

from an ERT lens. With respect to William, there is a rich narrative in his early life to create linkage to the ERT model. We know that William is the eldest of three sons from a loving family, whose parents he characterizes as irresponsible and flaky. As a result, William was thrust into the role as the responsible adult in the family, often serving in that capacity for his younger siblings. This way of relating within his family has essentially translated into the role he plays in all his relationships throughout his adult life (e.g., husband, father, bank manager). William clearly sees his early life successes as well as the subsequent distress and suffering tied to this tendency to worry and seek reassurance in all things. Seeing threat and possible danger in most facets of his life, responding reactively with worry, reassurance seeking, perfectionism, and self-criticism, and emitting a narrow set of behavioral responses (e.g., social isolation, indecision, procrastination) all relate back to his early life experiences.

In the course of Phase I, William would also become acquainted with two important metaphoric concepts that provide a rationale for observing and informing our emotions closer to their origin in the temporal unfolding of emotion and as well as with greater emotional granularity and clarity (i.e., better differentiation of each emotion even when multiple emotions are present). The first of these concepts is the snowball metaphor, and this idea is carried forward through the remainder of ERT. Clients are asked to first picture a white fluffy snowball comprised of pristine snow without any dirt or blemishes. Then clients are asked to picture this snowball rolling down a hill, and in the course of its travel, it picks up dirt and twigs and becomes hard and icy. In effect, the snowball's fall down the hill has obscured the primacy and purity of the original snowball with extra and unwanted elements. The travel of the snowball down the hill is akin to the unfolding of our emotional experience, particularly when, in the aftermath of failures, one engages in increasingly more elaborative and maladaptive emotion regulation. The emotional and motivational signals at the arising of the emotional unfolding become obscured. Also, the effort to trace back the origins of the emotion is made more effortful by the extra mass of the snowball and the challenge of rolling something up a steep incline. Painting a picture of this once pristine snowball invites clients such as William to see the value in apprehending emotions and the corresponding motivation pulls closer to their source. Essentially, the temporal model of emotion regulation conveyed to clients in ERT is that less effort is required when emotions are handled via less elaborative capacities first and as needed, with elaborative strategies. There is value in seeking to notice and respond to emotions closer to their arising in the temporal unfolding.

The second conceptual exercise utilized in Phase I is called the orchestra metaphor and is intended to invite clients such as William to experience their emotions with greater granularity and clarity. Clients are asked to imagine a musical orchestra where each of the instruments represents a different emotion. The composition they are playing represents the motivational pulls in our lives. Ideally, the composition of the orchestra is harmonious and the music moves us to take some action in our lives. However, for individuals with GAD, the "anxiety tuba" ends up drowning the rest of the orchestra. The more nuanced and complete message is replaced by the cacophony of a tuba. ERT clients are encouraged to listen to the orchestral piece in a way where each and every part of the orchestra can be heard and discerned for its contribution to the orchestra composition.

In Phase I, beyond psychoeducation, clients such as William would learn skills designed to promote early cue detection as well as the cultivation of mindful awareness. The ability to detect sensorimotor cues early on in their arising is regarded as an adaptive capacity that can result from practicing self-monitoring—one of the most tried-and-true techniques to emerge from CBT (Norcross & Goldfried, 2005). After learning the psychoeducational model of normative emotions and the tendency towards reactive responding (e.g., snowball metaphor), clients learn how to “Catch Yourself Reacting” (CYR), which is akin to the self-monitoring or chain analysis practices common in many CBT packages. Over the course of Phase I, this practice begins as a simple ABC exercise where clients attempt to identify the triggers of their emotions, the actual emotions themselves (e.g., fear, anxiety, disgust, etc.), and the intensity of each emotion they listed. In later sessions, the amount of information clients monitor and record becomes more complex such that in the second CYR form, clients also record their concurrent levels of security and reward motivation pulls as two independent ratings made on 100-point scales. By the end of Phase I, clients also record their internal and external responses to the arising of emotions and motivations (e.g., worry, self-criticism, reassurance seeking, etc.) Completing CYRs outside of session and reviewing them as part of homework is one of the mainstays throughout ERT. As a way of illustrating the CYR approach in ERT, we offer the reader a video of an actor who is portraying a patient¹ with GAD reviewing a CYR with her therapist (see Video 1).

Both the snowball and orchestra metaphors, along with the CYR work that is initiated in Phase I, fit well with the available case data on William. For instance, he has a hard time “enjoying the present moment” because of his focus on the many security-oriented difficulties that have resulted in increasing social isolation and have also caused strain in his marriage. He is almost constantly in a state of distress that leads to a diminishment of the potentially enjoyable moments, frequent irritability with family and co-workers, and on some occasions, worry-induced panic attacks. These kinds of examples typify and offer personalized accounts of taking a security-first approach (i.e., anxiety tuba), not attending mindfully to one's experience (i.e., dirty snowball), and, in turn, provide a powerful rationale and motivation towards improving one's cue detection (i.e., CYR).

The final component of ERT Phase I is training mindfulness exercises designed to promote single-pointed and flexible attention with a particular emphasis on less elaborate, less linguistic processing of one's experience. For example, in Session 1, clients are taught diaphragmatic breathing as a brief, less elaborate practice that gathers one's attention onto sensations in the body (cf. Roemer & Orsillo, 2009). Clients are then encouraged to practice diaphragmatic breathing each day in the ensuing week. In Session 2, clients learn a practice adapted from the body scan work common in MBSR (Kabat-Zinn, 1990) and MBCT (Segal

¹“Joan,” the client portrayed in this article's series of videos, is a 28-year-old, married woman suffering from GAD with comorbid major depressive disorder. She and her husband have been married for 2 years and dated for 6 years prior to their marriage. Joan works in pharmaceutical sales, a career she chose for practical reasons (e.g., good salary), but does not find the work intellectually interesting. Joan's husband is pursuing a Ph.D. in philosophy and has 2 years left before they will move to allow him to pursue his career. The prospect of giving up this job, which is their only source of income at the time, is causing anxiety for Joan. The other big stressor in Joan's life right now pertains to her husband's family. All the members of his family have graduate degrees and they hold advanced education in high esteem. Joan feels as though she is viewed more critically because she chose not to pursue a graduate degree after obtaining a B.A. in chemistry so that she could financially support her boyfriend/husband and herself. Finally, Joan and her husband frequently quarrel about finances and she typically must assume the role as the financially responsible member of the family as well as serving as the breadwinner.

et al., 2002) coupled with an awareness-based progressive muscle relaxation approach, which has been effectively utilized in the treatment of GAD (Borkovec et al., 2002; Roemer & Orsillo). The mindful awareness exercises in Phase I progress to mindfulness of senses where clients are encouraged to bring a beginner's mind (i.e., an attitude of openness, eagerness, and lack of preconceptions; Suzuki, 1970) to their experience with liked and disliked stimuli in their daily lives. Finally, clients practice a mindfulness of emotions exercise where they bring to mind a situation possessed of conflicting emotions and motivations (i.e., simultaneous security and reward pulls), and they are invited to sit with the experience until they can hold and more clearly delineate the emotions and motivational pulls in the situation. These mindfulness exercises are first practiced in-session and then are assigned as out-of-session homework with the goal of practicing at least 6 out of 7 days each week. Finally, given the considerable efficacy in the GAD literature for recall relaxation procedures (e.g., Borkovec & Sharpless, 2004), clients are encouraged to build up a regular practice of body scan and progressive muscle relaxation but also on-the-spot implementation of recall relaxation as a way of promoting greater flexibility in musculature response during periods of physical tension.

Combined with self-monitoring and cue-detection skills, introduced in Phase I, William seems especially well suited to the mindful attention skills. We know that he frequently complains of muscle tension and sleep difficulties that are the by-products of the distress burden in his life. Teaching William to bring a more focused, flexible attention to both interoceptive and exteroceptive stimuli, ideally with less elaboration, judgment, and recrimination, will likely facilitate better cue detection and may in fact produce some immediate relief from the tension and distress. ERT walks a fine line with clients in introducing these skills for the sake of relieving distress. We mention to clients that these practices may produce some relief now, but the importance of these practices is the skill or capacity that is cultivated over the long term.

Phase II: Regulation Skills Training—With the combination of psychoeducation, improved early cue detection, and mindful awareness, clients begin developing an alternative to the reactive responding that has been commonplace in their lives. Phase II of ERT (Sessions 4 through 8) aims to build upon this foundation by teaching clients to approach their lives “counteractively” instead of reactively by learning regulation of emotion skills. The overarching theme of Phase II is the “Courage to be Counteractive.” Clients learn that the word *courage* derives from the French word *coeur*, which translates into English as heart. Similarly, clients are taught that *mindfulness* comes from the native language of Buddhism, which made no distinction between the concepts of mind and heart (cf. Kabat-Zinn, 2005). An ERT therapist might convey this to a client as “there is no mind without heart; there is no heart without mind.” One of the problems caused by GAD is that this inherent connection between head and heart has been severed. For example, when people with GAD worry about situations, they can often believe that they are taking their problems head-on. However, facing life “head-on” is overlooking one's heart, one's emotional and motivational side. Likewise, many people with GAD seek the reassurance of others when they are awash in powerful emotions. Reassurance seeking is an example of responding to life with heart but not head. We are better able to face life when we cultivate a balance of head and heart. We

position ourselves to achieve this balance with the courage to face life with willingness and to utilize mindfulness skills. Finding this balance and responding to life with a balance of head and heart is the basis of responding counteractively rather than reactively. There is ample evidence that William struggles both with less elaborative skills, but so too in harnessing more elaborative capacities. For instance, we know that in hopes of dampening unpredictability and retaining control over situations in his life, William frequently holds onto tasks and responsibilities as long as possible, often turning his work in late for fear of being judged critically. He also attempts to minimize unpredictability by imposing as much routine into his life as possible and frequently declining invitations for impromptu events that might be enjoyable. These examples reflect behavioral manifestations of more elaborative reactive responses that are a focus of Phase II. Similarly, by his own account, William utilizes worry, distraction, and self-criticism to respond reactively in a cognitive manner to the arising of strong security pulls in his life.

With this invitation, William would be introduced to concepts, exercises, and practices aimed at helping him mindfully regulate emotional and motivational signals in his life. The three main components of Phase II are acceptance and allowance, cognitive distancing (decentering), and cognitive change (reframing). In contrast to Phase I, which provided rationale and training to promote less elaborative capacities associated with focused attention, attentional and interoceptive flexibility and conflict adaptation, Phase II is comparatively more elaborative in the concepts taught and practiced with clients. This transition from less elaborative to more elaborative is perhaps most apparent in the mindfulness practices that are introduced in Phase II—particularly in terms of the objects of mind that become the focus of one's attention and nonjudgmental awareness. These practices are increasingly conceptual, symbolic, and mediated by language. Finally, whereas the mindfulness practices introduced in Phase I and the outset of Phase II are seen as “off-line” exercises, which are meant to be practiced at a specified time each day, toward the end of Phase II and through the rest of ERT, clients are taught, and then encouraged to deploy, brief, on-the-spot versions of the off-line practices, which are intended to help them to mindfully manage the arising of difficult emotions without resorting to the kinds of reactive responses that are more habitually utilized by individuals with GAD.

The first aspect of responding counteractively, which is likely quite familiar to most CBT practitioners, is acceptance and allowance. Building upon the improved cue detection and mindful awareness cultivated in Phase I, the implementation of acceptance and allowance in ERT is meant to engender a willingness to be “all in” with one's experience. This courageousness to be counteractive in ERT is also accomplished through off-line and on-the-spot practices. The off-line practice is called Clearing the Air and involves an in-session imaginal exercise designed to invite clients to remain in contact with all sensations, whether they are emotional, tactile, cognitive, etc., that arise in pursuit of a difficult-to-achieve but motivationally enhancing action—in effect, a personally salient approach-avoidance conflict. This exercise is based on a meditation practice sometimes referred to as *open presence* (Halifax, 2009; Ricard, 2006), where one's attention is not anchored in the breath or body, but instead, promotes attending to and allowing of exteroceptive and interoceptive sensations that arise without judgment or narrative. The on-the-spot version of this exercise is called the Three-Minute Breathing Space, which is drawn from MBCT (Segal et al., 2002). This

practice is intended to help clients gather themselves in an event when the demands of the situation are resulting in pulls to respond reactively. Much like in MBCT, the breathing space is meant to help clients allow an emotional experience to unfold so that they can notice and glean the emotional and motivational aspects of the experience.

The second component in ERT Phase II is to cultivate decentering, which involves metacognitive awareness and distancing so that clients can engage an emotional situation with clarity and, in turn, provide a more effective behavioral response. Decentering is often defined as “relating to negative experiences as mental events in a wider context or field of awareness rather than simply being [one's] emotions, or identifying personally with negative thoughts and feelings” (Teasdale et al., 2002, p. 276). In ERT, we emphasize the aspect of decentering that allows one to see motivational pulls and emotions arising, and create healthy distance from them, so as not to be automatically pulled to action. Decentering essentially promotes perspective-taking, thereby allowing one to deliberately respond “counteractively” instead of mindlessly responding reactively. ERT strives to cultivate decentering through two off-line mindfulness practices as well as their corresponding on-the-spot versions. The first practice, familiar to practitioners of MBSR, is the mountain meditation. In this guided practice, clients are invited to internalize a living breathing mountain to provide solidity and permanence to their lives in contrast to the transient emotion upheavals, which are represented as the weather on the mountain (Kabat-Zinn, 1994). This practice helps develop a decentered perspective through the lens of time—helping clients to tell themselves, “This too shall pass.” After practicing the mountain meditation in an off-line manner, clients then learn their first on-the-spot exercise, Invoking the Mountain, which is a brief version of the mountain meditation, designed to be utilized in either planned or impromptu moments that pull for a security-first response to help sustain or regain a decentered stance in that moment.

The other main decentering exercise, Gaining an Observer's Distance, focuses on mental spatial distance. This practice, which draws in part from the Observer You exercise in ACT (Hayes et al., 1999), is designed to teach clients to bring situations to mind and then to granulize the constituent parts of the situation by placing them externally on objects in the room. This off-line practice is an invitation to create healthy distance in the mind's eye so that these products of mind are more readily observable and can inform our deliberate actions from a decentered perspective. For example, one recent ERT client and his therapist developed a way to gain distance by imaginably grabbing the jumble of thoughts and feelings that characterized the client's experience and imaginably tossing them against the wall so that the pattern they form could be examined from a more distanced, decentered perspective. This practice also has a corresponding on-the-spot skill, Bringing It With You, where clients imaginably place products of their mind on objects that they ordinarily carry in their daily lives. One of our clients actually carried around a shoehorn he crafted, which he used to “pry” himself away from his products of mind to promote better observation and nonjudgment. In the case of William, one situation that causes him distress is making decisions such as selecting a vacation destination or even choosing a restaurant. Clearing the air might be a helpful exercise, allowing him to lay out the various thoughts and feelings that arise in his mind so that they can be examined in their entirety instead of simply privileging the ones associated with security.

The final component of Phase II is cognitive change, which involves helping clients to reframe one's evaluation of an event so as to alter its emotional significance (Gross, 2002). All of these brief, on-the-spot skills are derived from the longer, off-line practices and are designed to help clients obtain temporary relief from emotional intensity, facilitate a restoration of emotional clarity, and promote effective action. For example, clients are encouraged to adopt a courageous perspective wherein they can address security-driven responses and provide alternative statements that reflect their strength in the face of uncertainty. Clients are also encouraged to adopt a self-compassionate reappraisal stance wherein they can imagine telling a very caring, interested, compassionate individual about their difficult thoughts and feelings and reminding themselves of their strengths and coping ability (Gilbert, 2010; Segal et al., 2002). Noticing one's self-critical thoughts is encouraged: "softening" them when they arise is accomplished through the invoking of alternative, self-validating statements. These courageous and compassionate statements are typically written down on the back of an index card or business card and carried with the patient in a pocket or put on a smartphone set as a recurrent reminder. After committing these statements "to heart," clients are then encouraged to simply tap their pocket or bag containing the written statement or smartphone to quickly regain this sense of perspective.

The less elaborative skills in Phase I and the more elaborative off-line skills introduced in Phase II, coupled with their on-the-spot counterparts, may be particularly beneficial to the case of William, whose GAD is especially marked by difficulties with muscle tension, reactive responses including worry, self-criticism, and reassurance seeking, and behavioral withdrawal, perfectionism, and procrastination. For instance, William would be encouraged to utilize acceptance, decentering, and reframing skills to help him view his life from this more expansive perspective as a means of deemphasizing the salience of threat and distress. Similarly, each of the on-line practices would be taught to William and tailored to his particular presentation. For instance, given the prominence of muscle tension, William may find relief with recall relaxation. In addition, worry and self-criticism may be addressed by articulating courageous and self-compassionate self-statements. This combination of off-line and on-the-spot skills would ideally help William achieve and maintain a more balanced and decentered perspective in relation to the challenges in his life and prepare him for the work ahead in Phase III.

Finally, the CYR exercise is elaborated upon so that, in addition to triggers, emotions, motivations and responses, clients also record their implementation of on-the-spot skills and the impact that those skills had on the situation. Therapists and clients review CYR entries each week, with an emphasis on reviewing instances where clients evidenced success implementing their ERT skills to manage a situation as well as instances where clients had difficulty. Here, clients may have neglected to use their skills, or the outcome of the situation was not favorable despite the effort put forth by the client. On these occasions, therapists may choose to conduct a "do-over" with the client. This activity resembles both the cognitive rehearsal task, which is described in traditional cognitive therapy of depression (Beck, Rush, Shaw, & Emery, 1979), and evocative unfolding in experiential therapy (Elliott, Watson, Goldman, & Greenberg, 2004). In ERT, imagery of a difficult situation is evoked and once the activity is in mind, clients engage their counteractive skills to regain a decentered perspective, identification of any emotions or motivational pulls, and then to

articulate some actions they could take. The CYR “do-over” essentially represents a therapist-supervised opportunity to shape and solidify the counteractive skills that clients have been practicing throughout ERT. In this second ERT video, we see an example of the “do-over” exercise (see Video 2).

Phase III: Experiential Exposure to Promote New Contextual Learning—

In Phase III, which consists of Sessions 9 to 13, patients such as William continue to increase their capacity for “counteractive” strategies that can be engaged in response to arising emotional states but also begin to work on becoming more “proactive.” Taking a proactive stance involves making choices to broaden one's behavioral repertoire and, thus, essentially involves exposure to potentially rewarding but often risky experiences. Exposure therapies typically focus on fear-evoking cues (cf. Foa & Kozak, 1986). However, recent empirical and theoretical advances support a broader focus on various emotions and disorders beyond fear as well as an expansion of the goal of emotional processing from reducing emotions to the creation of new personal meanings through facilitated attention to the motivational information conveyed through emotion. (cf. Greenberg, 2002; Teasdale, 1999). In this regard, new meanings occur from the utilization of emotional information rather than its mere reduction. Indeed, modern learning theory suggests that exposure is effective, not because previously associated emotional meanings are unlearned or erased, but because new emotional meanings are strengthened (Bouton, Mineka, & Barlow, 2001; Craske et al., 2008). Relatedly, the promotion of new, rewarding behaviors is a central treatment goal for behavioral activation therapy (e.g., Jacobson et al., 2001), which has demonstrated efficacy for depression.

Despite these advances in conceptualizing exposure-based learning, GAD has remained a challenge to target with components of exposure therapy. Past attempts to incorporate exposure elements focused largely on the imaginal processing of an unfolding current worry (Hoyer & Gloster, 2009). However, unlike overt stimuli such as social interactions, trauma cues, or even physical sensations, the negative content in GAD can often be a moving target, changing with the focus of the week's worried outcomes. Drawing forward a central, recurring theme to the exposure can be a challenge. Consistent with an emotion regulation framework, some approaches (e.g., Ellard et al. 2010) have promoted exposure to emotional experiences themselves in order to increase acceptance of these experiences and diminish the need to utilize strategies such as worry as an attempt to escape feared emotional states. However, a focus on negative emotional exposures may do less to expose individuals to core schematic themes that certain emotions may convey. Further, they do not necessarily encourage proactive behavior towards desired outcomes. In other words, exposure may be most fruitful when it involves contexts that have recurrent themes such as threat (i.e., security) and that encourage enhancing one's life (i.e., reward).

Consistently, Newman and Llera (2011) demonstrated that worry is reinforced not by the reduction of emotions but by creating a fixed, invariable, and predictive defensive emotional state, which inevitably precludes emotional processing. As a result, individuals with GAD are likely to avoid a negative *contrast* that might produce a worsening negative emotional state. In other words, for example, what is feared is the contrast caused by a shift from being in a positive state to being in a negative state, which may disincline individuals with GAD to

engage a positive state if it means increased possibility for a negative state. As noted above, William demonstrates an aversion to situations that call for us to view things with nuance and thus with greater contrast. He much prefers situations that are predictable—even if that means predictably bad. Thus, the case of William fits well with this formulation. This conceptualization is also consistent with our emotion regulation model where individuals with GAD are considered to engage worry in order to address security motivations, which overshadow reward motivations. Further, it is consistent with behavioral activation theory for depression, which argues that depressed individuals withdraw to protect themselves from the aversion of loss and thus do not gain any new rewards that would help counteract their depression. Taken as a whole, these perspectives suggests that exposure to rewarding contexts that have the possibility of high risk may be most ameliorative for these patients.

In ERT, exposure to threat-reward contrasts is accomplished by focusing clients on their personal values, which represent a person's highest priorities and most cherished principles (Hayes et al., 1999; Hayes et al., 2011; Wilson & Murrell, 2004). Values-based exposure is derived from ACT (e.g., Hayes et al., 1999; Hayes et al., 2011) and involves turning a problem on its head: rather than exposing to feared outcomes, one is exposed to the way that she or he would like to be living and the expected arrival of perceived fears, disappointments, and judgments are treated as obstacles to being able to live a valued life. ERT expands values-based exposure to address not only “top-down” decisions about life goals but also “bottom-up” influences of security and reward motivational pulls as well as their interaction. For example, with respect to William, we see many instances of him being simultaneously pulled in a bottom-up fashion by both security and reward pulls—thereby leading to indecision and procrastination. In Phase III, clients experientially explore acting in accordance with their values and confronting any accompanying perceived obstacles that arise both within and between sessions. Specifically, Phase III sessions consist of three main exposure components to promote valued living: (a) imaginal action related to values-informed goals; (b) experiential dialogue tasks to explore perceived internal conflicts that impede engaging valued actions (Greenberg, 2002); and (c) planned between-session exercises wherein clients engage valued actions outside of session. Clients also utilize regulation skills to help facilitate engagement during the in-session experiential tasks and to facilitate valued action outside of session. One example from William's life that would likely be appropriate here pertains to his love of gardening. We know that William takes pride in his garden and yet gardening too has become quite a burden in terms of having to make the decisions about what flowers to plant as well as other decisions relevant to the garden. For this reason, William may avoid gardening altogether or only garden because he feels pressured by external pulls to do so. In ERT, a therapist would help William elucidate his values regarding gardening but do so by also exploring the experiential ways in which he is pulled both to make sure nothing bad happens to the garden (i.e., security) and wanting the garden to grow and represent an even more enhancing experience (i.e., reward). This dialectic between his “top-down” value and his “bottom up” motivational pulls can help William contextualize his gardening behavior and make more genuine choices for how to take action in this hobby.

Proactive valued action: ERT draws from ACT (Hayes et al., 1999; Hayes et al., 2011) in stressing the importance of *commitment*, involving a willingness to act in accordance with one's values despite whether strong security motivations and accompanying anxiety, worry, and distress are present. This willingness may also involve an allowance of reward (i.e., promotion) motivations to become more salient and to follow these motivations in the service of valued action. In ERT, commitment is considered to be proactive as it involves intentional actions towards goals that are reflective of stated values. However, outcome and goal achievement are not the purpose of engaging values (Hayes et al., 1999; Hayes et al., 2011; Wilson & Murrell, 2004). Rather, values are engaged to be more congruent with what matters most to the client and to open up to the opportunities that come with that flexibility. In the outset of Phase III, therapists and clients collaborate to identify cherished values in the domains (e.g., family, friends, relationships, work, personal care) where clients report discrepancies between the importance they place on this value and how consistently they have been living accordingly (Wilson & Murrell). Therapists then encourage clients to think about a salient value with a large discrepancy and how they want their actions to reflect this value *today*, even if it involves only a small action step.

Wilson and Murrell (2004) note that clients often have difficulty engaging in values work. Given that clients may still be committed to not experiencing their emotions and could utilize the skills in an avoidant manner, valued action is explored through systematic experiential exploration. By encouraging active exploration of valued actions, clients can form a better blueprint for how to live by their values and create new meaningful change. Specifically, imaginal exposure tasks that focus on engaging in *specific* valued actions are conducted to (a) provide the client with an experientially rich rehearsal of the steps that might be necessary to live by her or his values and (b) confront the emotional challenges that are likely to come up as the client imagines engagement of valued action. In this imagery exposure task, therapists help clients imagine each step involved in engaging this action while noting changes in motivational levels and encouraging utilization of skills to address difficulties in awareness and balancing of emotional responses. Utilizing imagery to consolidate skills and promote functional action is also congruent with interventions such as cognitive rehearsal (Beck et al., 1979). In response to William's desire to spend more quality time with his daughter, he may choose to imaginally engage a valued action of sharing an activity with her even at times he is fully feeling distressed by his finances.

Exploring conflict themes in obstacles to valued living: The second exposure component involves addressing perceived obstacles to taking valued action. Obstacles reflect the client's own internal struggle that holds her or him back from engaging in this valued action. In ERT, obstacles are approached via "conflict themes," including primarily (a) a *motivational conflict* (e.g., security motivations are blocking or interrupting reward efforts) and (b) *self-critical reactive responses to emotions* (i.e., judgmental negative beliefs about one's emotional responses and associated motivations). These conflict themes are addressed within session using an experiential dialogue task derived from emotion-focused therapy (i.e., "chair dialogues"; Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg, 2002). In ERT, the *motivational conflict* is most central to interrupting valued action and is addressed by encouraging clients to engage a dialogue between the part of themselves that is strongly

motivated to obtain security and the part that is motivated towards self-reliance to arrive at a more unified motivational stance that is conducive to valued action. Resolution comes from both sides being able to hear and acknowledge the needs of the other and an agreement to engage commitment to the valued action while allowing a place for a softened obstacle voice to be present without total control. The purpose of these tasks is to reduce negative emotional responses that are activated when obstacles reflecting these conflicts are perceived (i.e., exposure), generate a new perspective (i.e., new meaning) on these obstacles, and engage more adaptive emotions that are facilitative of valued action engagement. William might be encouraged to engage an imaginal dialogue between a security voice that commands him to make sure he is safe (e.g., make choices associated with minimal financial risk or health concerns) and a “values experienter” voice that wants to engage his life in meaningful ways such as sharing quality time with his daughter.

Engaging proactive valued action outside of session: Finally, valued action is promoted through between-session exercises that build upon the work conducted during the valued action exploration and obstacles confrontation exposure tasks. Clients are reminded that protection and avoidance will always preclude one being able to live in their most cherished ways. Thus, clients work to bring some of this struggle with them in the ensuing week by making choices to engage valued actions. Clients engage both planned (i.e., specific valued actions related to salient values explored in session and committed to in the presence of therapists) and spontaneous (i.e., any other valued actions clients notice themselves engaging in) valued actions outside of session (Hayes et al., 1999; Hayes et al., 2011). Further, clients are encouraged to utilize skills both proactively when they are planning to engage valued actions and counteractively when they notice themselves getting unexpectedly anxious and beginning to respond reactively with worry, reassurance seeking, self-criticism, or behavioral avoidance. Finally, external barriers (i.e., obstacles in the environment that are outside the client's control), which might have been deferred during exposure tasks, can also be addressed more actively in between-session exercises. Therapists can help clients problem-solve these obstacles or utilize skills such as acceptance to further facilitate valued action. In the case of William, he may be asked to pursue activities he can engage in with his daughter to deepen their connection to one another even during times of stress and/or while experiencing anxiety. In the third ERT video, we see an example of working with a valued action related to a relational value (see Video 3).

Phase IV: Consolidating Gains and Looking Ahead—In this final phase of ERT, which consists of Sessions 14 through 16, the focus shifts to consolidating gains and preparing for termination. Four main themes are discussed in these concluding sessions. First, clients are reminded of a message that has frequently been echoed throughout ERT. Specifically, experiencing emotions, even ones that are not especially welcome in our lives (e.g., fear, anxiety, sadness, anger), are a normal part of being human. Phase IV's second theme, “Surf the Wave,” attempts to emphasize for clients that life going forward will inevitably have moments of ups and downs and that we must prepare for how we will handle these moments so that lapses do not become full-blown relapses during difficult life periods (Dugas & Robichaud, 2007). Specifically, discussion focuses on ways to help prevent clients from becoming once again reliant on seeking security and responding reactively (e.g.,

excessive worry and behavioral avoidance) once therapy is terminated. Clients and therapists discuss how mindful awareness and regulation skills can continue to be utilized in service of responding to difficult events that might arise. Ability to tolerate possible future stressful and painful life circumstances is also further explored by reviewing skills and applying them to experiential exposure exercises that center on hypothetical situations related to core themes that may appear in the future. An open discussion of termination and “life after therapy” helps to fully address feelings associated with termination and the loss of the therapeutic relationship. The third theme of Phase IV is referred to as “Use It or Lose It.” Comparing it to exercise, or working out in a gymnasium, clients are strongly encouraged to keep up with their ERT skills practice and utilization. Much like the initiation of a workout plan, the training is hard work at first, but after a while, that muscle has a “memory” and the hard work at the beginning gets easier to maintain. Clients are invited to view their ERT skills practice in the same light and are cautioned against letting the fruits of their labor atrophy. The fourth theme in Phase IV, “Taking Larger Steps,” essentially represents an invitation to maintain a proactive perspective on their lives. In this discussion, therapists point out that by getting their lives back on the path to committed valued action, clients are likely to be inviting new and demanding challenges in their lives. If valued actions have been taken, clients have likely broadened their horizons by moving away from a limited focus on security. The goal here is to help the client see that pursuing a valued life is more balanced in terms of reward and security, albeit one that may come with new challenges, risk, successes, and failure. Therapists strive to help clients see this brave new world more so for the possibilities it may bring rather than the challenges it will impose on them. In the final example ERT video, we see a segment at the outset of Phase IV where the client and her therapist briefly review progress to an end point in treatment (see Video 4).

William After ERT

In many respects, William represents a prototypical ERT client—nomothetically, a client suffering from GAD with comorbid depression. From the lens of ERT, at the outset of treatment William is seen as an individual who manifests deficits in emotion regulation across the elaboration spectrum, which, in turn, has resulted in him responding reactively to the events in his life instead of proactively approaching the things that are most prized and valued by him. Although all ERT clients are conceptualized in terms of the degree to which their lives have been thrown into an imbalance of motivational pulls that favor security over reward, and also in terms of the reactive responses that they engage that serve to temporarily provide relief from the arising of intense emotions and motivational pulls, our manualized approach also includes idiographic case conceptualization so that it can be better tailored to the particular manner in which a given client has shown deviation from normative patterns of emotion regulation. In fact, case conceptualization is an iterative process (cf. Persons & Fresco, 2008) throughout each phase of ERT as clients are initially assessed in terms of reactive responding, giving way to counteractive responding with greater balancing of emotional signals and motivational pulls, and then in terms of proactively making a stand in their pursuit of valued actions. The overarching formulation as well as the process and flow of ERT is theoretically and nomothetically derived, but the process by which this formulation is applied to any given case, such as the case of William, is more idiographic and thus represents an attempt to harness existing strengths of the individual while providing

more intervention in areas that are seen as relative struggles. At the end of ERT, we aim to help clients reorient their lives proactively while having gained proficiency to counteract the arising of intense emotions and their motivational pulls in ways that do not derail their value-informed pursuits.

Future Directions

As compared to other mindfulness-informed CBTs (Ellard et al., 2010; Hayes et al., 1999; Hayes-Skelton et al., this issue; Jacobson et al., 2001; Linehan, 1993; Roemer, Orsillo, & Salters-Pedneault, 2008; Segal et al., 2002), ERT is a relative newcomer to the world of evidence-based treatments. Despite the success of CBT, a sizable subgroup of patients with complex clinical presentations such as GAD do not have adequate treatment response. To address these refractory conditions, there has been a growing interest in delineating core, empirically supported, intervention processes that directly target specific disorder mechanisms. ERT integrates traditional and contemporary CBT approaches within a framework that reflects basic and translational findings in affect science. To date, our findings are promising but preliminary (Mennin & Fresco, 2011; Mennin et al., 2012). Thus, we continue to refine our perspective as a mechanism-targeted intervention focusing on patterns of motivational dysfunction while cultivating regulation skills with varying degrees of verbal elaboration. We are optimistic that this approach will allow us to make a greater contribution to understanding the mechanisms by which CBTs provide their acute and enduring treatment effects, and possibly to improve the effect sizes above and beyond the already proven efficacious treatments. Some particular lines of research under way in our labs and clinics are experimental investigations examining lab studies of motivational responding and regulation normatively and in patient subgroups of GAD and MDD while monitoring indices in the central nervous system (i.e., EEG/ERP), the parasympathetic nervous system (i.e., tonic, phasic, and ambulatory heart rate variability), and neural circuits (e.g., fMRI assessment of implicit and explicit emotion regulation). We also continue to examine the degree to which these biobehavioral markers are associated with acute and enduring treatment change in the course of ERT. Concurrent with the pursuit of these research endeavors, work continues in demonstrating the efficacy of ERT among individuals with GAD and frequently cooccurring conditions such as major depressive disorder.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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Highlights

Introduces a model of conceptualizing anxiety and depression from a motivational and emotionregulation perspective

Describes emotion-regulation skills aimed to cultivate mindful awareness allowance, distancing/decentering, and reframing

Demonstrates application of these skills to emotion-based exposure exercises associated with meaningful behavioral actions

Describes strategies to build a plan to maintain gains and take bolder action despite the ending of the therapeutic relationship

Figure 1.

The ERT treatment model showing the conceptual progression of treatment.