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Delivering Transdiagnostic Treatment Over Telehealth During the COVID–19 Pandemic: Application of the Unified Protocol

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The COVID-19 pandemic has necessitated an abrupt transition to remote delivery of psychology services at a time when patients and practicing clinicians are experiencing an increase in life stressors (e.g., job loss, social isolation, need to adapt to telehealth practice), which can exacerbate mental health concerns and contribute to clinician burnout. Because the COVID-19 pandemic is affecting diverse individuals in myriad ways, these circumstances can elicit a wide range of emotions and emotional responses. Thus, treatment during this time must be able to address heterogeneous presenting problems while placing minimal burden on clinicians who are adjusting to continuously changing circumstances. Transdiagnostic, emotion-focused, cognitive behavioral treatments (CBT), such as the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (UP), may be particularly well suited to address the challenges faced by practicing psychologists, and their patients, in the current COVID-19 pandemic. This paper discusses the applicability and adaptability of transdiagnostic treatments to telehealth, focusing primarily on the UP in the context of the COVID-19 pandemic. Further, while many CBT skills (e.g., mindfulness) can be easily translated to tele-delivery, other skills, such as exposure, can be more difficult to implement remotely, especially in the midst of a pandemic. Thus, this paper also provides practical suggestions for clinicians with regard to implementing the UP remotely.

THE coronavirus disease 2019 (COVID-19) pandemic is an ongoing global health crisis that has substantially impacted the health and welfare of billions of people around the world. Rapid disease proliferation without clear scientific knowledge about underlying mechanisms, prognosis, or efficacious treatments has prompted worldwide governmental efforts to significantly limit viral transmission. Because COVID-19 is widely believed to transmit orally through airborne viral particles, physical or "social" distancing (i.e., staying at least 6 feet apart in physical space from others) has been implemented as a preventive measure in most parts of the world. In the United States, widespread efforts to curtail in-person social interactions have led to state and local governmental mandates requiring physical distancing, the wearing of facial masks, and the closure of businesses and schools. News and social media provide ubiquitous daily reminders of rising death tolls, unemployment, business closures,

and the migration of education to online platforms. Individuals also have reduced access to community resources and social support. Disparities in health care related to COVID-19 have been observed in Black and Hispanic Americans (Hooper et al., 2020; Yancy, 2020) and racial or ethnic minorities in other parts of the world (Townsend et al., 2020). Additionally, members of these communities are more likely to work in settings that are high risk for contracting the virus and more likely to have comorbid medical conditions associated with worse health outcomes (Ali et al., 2020; Tai et al., 2020). Making matters worse, national, state, and local guidelines on how to best stay safe and healthy have been changing regularly.

The numerous stressors accompanying the pandemic are putting adults at higher risk for developing mental health problems, such as depressive and anxiety disorders. Preliminary data from China indicate high rates of depression and anxiety among the general population (Huang & Zhao, 2020) and health care workers (Huang & Zhao, 2020; Liu et al., 2020) in response to the COVID-19 pandemic, and mental health surveys from past pandemics paint a similar

picture (Chong et al., 2004; Wheaton et al., 2012; Wu et al., 2009; Yip et al., 2010). Researchers have even begun to investigate the possibility of an emergent COVID-19 stress syndromal response, characterized by a combination of symptoms not specific to any one psychiatric disorder (e.g., traumatic stress symptoms, fear of contamination, fear of contracting the virus, xenophobia; Taylor et al., 2020).

Further, the pandemic is exacerbating existing health disparities experienced by communities of color and other underserved groups, and this is happening in the context of increased reporting of police brutality and the murders of individuals like George Floyd and Breonna Taylor. Taken together, accumulating evidence suggests many individuals are likely to experience heterogeneous mental health concerns in the coming months and years. Given the myriad emotional problems expected in the years following COVID-19, it is reasonable to expect that psychological services will be needed more than ever.

Because the scope and breadth of anticipated COVID-19-related mental health problems is broad (i.e., affecting millions of people) and heterogeneous (i.e., including problems such as depression, anxiety, substance use, etc.), and because time, money, and other resources may be acutely constrained during a pandemic, it is important to consider ways to optimize mental health services with a population health approach in mind (Evans & Bufka, 2020). At a macro level, frameworks are needed to drive system implementation of services (Kaslow et al., 2020). This includes implementation of value-based models of care delivery, such as integrated and collaborative care models, designed to reduce costs while enhancing quality of care. For psychologists, social workers, licensed professional counselors, and other behavioral health clinicians providing psychotherapeutic services outside primary care or other medical settings, the pandemic presents an array of challenges to the use of conventional treatments. A primary overarching challenge is the need to address the mental health needs of the population responding to a pandemic while simultaneously replacing traditional face-to-face psychotherapy with remotely delivered telehealth (also referred to as telepsychology) approaches.

One way to address these challenges is with evidence-based, time-limited, transdiagnostic (i.e., able to address problems across diagnostic boundaries) interventions using telehealth platforms. In this paper, we begin by describing the rationale for the application of transdiagnostic treatment principles to the emotional sequelae associated with the COVID-19 pandemic and focus on a prominent treatment, the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (Barlow et al., 2018a). This treatment approach is conducive to value-based models of care that emphasize quality outcomes and decreased cost of care (Southward et al., 2020). We review the application of this protocol in detail in order to provide practical suggestions for psychologists with regard to implementing this intervention in the context of the COVID-19 pandemic and via telehealth platforms.

Transdiagnostic, emotion-focused, cognitive behavioral treatments (CBTs) may be particularly well suited to address the challenges faced by practicing psychologists, and their patients, in the current COVID-19 pandemic. Rather than focusing on specific diagnoses or symptoms, transdiagnostic models of emotional problems focus on higher-order factors shared by these problems. Thus, they allow practicing psychologists to efficiently deliver evidence-based interventions to address a wide range of problems and diverse patient populations. The need for mental health services is predicted to continue increasing in the coming months at a time when many community mental health centers are facing financial crisis and are unsure if they will continue to operate (Wan, 2020). Thus, efficient, broadly applicable, evidence-based treatments are more needed than ever.

One such transdiagnostic model is the model of emotional disorders put forth by Barlow and colleagues (Barlow et al., 2004). This model highlights the widely accepted notion that emotions are inherently functional and adaptive. However, problems managing emotions can develop when individuals (a) experience emotions frequently and intensely, (b) perceive these emotional experiences as aversive or uncontrollable, and (c) engage in efforts to escape or avoid the experience of emotions (Sauer-Zavala & Barlow (2014)). These avoidance-based emotion regulation strategies typically reduce the intensity of an emotion in the short term but paradoxically maintain problems with emotional functioning in the long term (Campbell-Sills & Barlow, 2007). This model is particularly applicable during the current pandemic because it focuses on the experience of *any* strong emotion, making it relevant to the wide range of emotional problems individuals are having at this time (e.g., sadness, fear, anxiety, anger; Ilyushina, 2020; Wang et al., 2020). Moreover, it is a useful framework for addressing any clinically

significant problems related to emotional dysregulation (e.g., substance misuse), even if those problems do not meet full criteria for a diagnosable disorder.

The Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (UP; Barlow et al., 2018a, 2018b) is an evidence-based transdiagnostic, emotion-focused, cognitive-behavioral treatment that intervenes directly on the components of the previously described model of emotional disorders. In contrast to traditional psychotherapies that target one diagnosis at a time (e.g., major depressive disorder), the UP integrates evidence-based treatment principles and applies them across diagnostic boundaries. Accumulating evidence supports the UP's ability to target heterogeneous emotional disorders including anxiety, depressive, and related disorders (e.g., obsessive–compulsive, trauma-related, and somatic symptom disorders), as well as problems with emotional functioning that are not described as diagnoses in DSM-5, such as dysregulated anger (Cassiello-Robbins, Southward, Tirpak, & Sauer-Zavala, 2020), or problems that often occur alongside emotional disorders (e.g., substance misuse, insomnia, self-injurious behavior; Barlow & Farchione, 2018). The flexible nature of this treatment allows the therapist to consider each patient and their emotional experience in their unique context (i.e., factors such as race, sexual orientation, etc., that may influence the patient's experience). Further, the UP is 16 sessions (with shorter adaptations available), includes routine outcome monitoring using standardized, transdiagnostic assessments, and contains evidence-based principles of change, making it ideal for health care settings where treatment must be delivered efficiently and effectively to provide maximum benefit to the greatest number of patients. Finally, given its transdiagnostic nature, the UP is ideal to disseminate to community settings as providers only need to be trained in one treatment to be able to effectively address a wide range of presenting problems. For these reasons, and since a growing number of studies and conceptual pieces are considering important cultural and other adaptations of the UP (Cassiello-Robbins et al., 2020), we believe the UP is an excellent example of a treatment likely to be helpful to numerous individuals struggling emotionally during the COVID-19 pandemic. However, it is important to acknowledge other evidence-based, transdiagnostic and process-based cognitive-behavioral treatment approaches exist (e.g., Hayes & Hofmann, 2017). We do not intend to suggest those treatments are any less useful during this time; rather, we choose to focus on the UP given its growing evidence base, the likely ease with which it can be disseminated (Cassiello-Robbins et al., 2020), and its explicit focus on a wide range of emotional experiences which, in our opinions, make it particularly applicable to COVID-19-related mental health concerns.

The overarching goal of the UP is to encourage patients to adopt a willing and accepting attitude toward the experience of strong emotions. To this end, the UP teaches patients cognitive-behavioral skills to facilitate their ability to regulate emotions effectively. The UP consists of eight distinct modules or skills that are taught to patients: motivation enhancement, emotion psychoeducation, mindful emotion awareness, cognitive flexibility, changing emotional behaviors, awareness and tolerance of physical sensations, emotion exposure, and relapse prevention. Thus, this treatment contains many common skills taught across evidence-based psychological treatments. Psychoeducation about the utility and adaptive nature of all emotions—including negatively valanced emotions—is introduced early in treatment and thus provides an opportunity for discussion of emotions as allies in our response to the COVID-19 pandemic and other distressing experiences (e.g., racial injustice). Later modules focus on targeting maladaptive cognitive and behavioral responses to emotions that lead to emotional disorders. Taken together, skills taught in this treatment are well poised to help a wide range of individuals manage the emotional sequelae associated with the COVID-19 pandemic. In addition, the UP has been adapted for use with children and adolescents (e.g., Ehrenreich et al., 2009; Ehrenreich-May et al., 2018), and it also has been translated into several languages. Moreover, a detailed guide to diverse clinical and cross-cultural applications of the UP is available (Barlow & Farchione, 2018), and descriptions of additional cross-cultural adaptations of the UP are accumulating (Cassiello-Robbins et al., 2020).

Delivering the UP via Telecommunication Technologies During COVID–19

As outlined in the American Psychological Association's "Guidelines for the Practice of Telepsychology" (2013), "telecommunication technologies include but are not limited to telephone, mobile devices, interactive videoconferencing, email, chat, text, and Internet (e.g., self-help websites, blogs, and social media)" (p. 792). Moreover, the APA telepsychology guidelines highlight that "[d]ifferent technologies may be used

in various combinations and for different purposes during the provision of telepsychology services" (p. 792). Delivery of treatment via these technologies can improve access to care for patients from underserved communities who may not be able to regularly attend in-person sessions due to concerns such as caregiving responsibilities, inconsistent or restrictive work schedules, or difficulties with transportation. Given the range of technologies used by psychologists and other mental health providers, the diversity among patients with regard to access to various technologies, and the recent decision to cover telephone-only services for Medicare recipients (https://www.apa.org/news/-press/releases/2020/05/phone-only-telehealth-medi-care), we will discuss delivering the UP directly via interactive videoconferencing and via telephone alone.

In their recommendations regarding the delivery of evidence-based psychotherapies remotely, Gros et al. (2013) surveyed telehealth experts and suggested that clinicians address the following: treatment site considerations, communication style adjustments, and treatment protocol adjustments, which are defined in Table 1. For additional information on treatment site and communication considerations, we direct readers to the American Psychological Association's "Guidelines for the Practice of Telepsychology" (2013). Regarding protocol adjustments to the UP, we provide an initial discussion of general considerations, followed by a discussion of each module in brief. We include clinical examples to help guide providers in delivering UP content remotely, and we provide considerations specific to the current COVID-19 pandemic.

General Considerations

Many of the skills taught in the UP translate easily to telepsychology with little to no modification beyond the logistics of using a web- or phone-based platform to conduct sessions or share homework forms and readings. However, delivering the UP via telepsychology will require some level of additional preparation on the part of the clinician. As is the case in many cognitive-behavioral treatments, every UP session begins by delivering and briefly reviewing routine outcome assessments of anxiety, depression, and any other emotions that are relevant to track progress over the course of treatment. These outcome assessments typically include the Overall Anxiety Severity and Impairment Scale (OASIS; Norman et al., 2006), the Overall Depression Severity and Impairment Scale (ODSIS, Bentley et al., 2014), and a parallel scale that assesses other relevant emotions (e.g., anger; unpublished). Each of these assessment measures is included in the UP patient workbook (Barlow et al., 2018b), and the workbook is available for purchase. However, not all patients are able to afford the workbook. In these cases, clinicians who work for organizations that subscribe to Oxford Clinical Psychology may be able to access the workbook online and provide patients the UP materials they will need. Clinicians who do not have access to Oxford Clinical Psychology may be able to scan and email or physically mail materials to patients. Although many routine outcome assessments can be delivered orally by a clinician, it is important to recognize that the emotion measures included in the UP workbook are more difficult to administer orally because the response options are lengthy and vary item to item. Therefore, when delivering the UP remotely it is probably best to ensure patients have their own copies of the measures so that they can more easily share their scores each week. A related and noteworthy part of the UP involves the patient sharing progress on these measures with the clinician by plotting scores on a progress record (provided in the UP patient workbook). Clinicians who do not have access to video and therefore cannot ask patients to show them a visual

Table 1
Telehealth Considerations Defined by Gros et al. (2013)

Construct	Description
Treatment site considerations	Coordinating set up and maintenance of clinician and patient workspaces (e.g., technology, privacy)
Communication style adjustments	Changes to use of body language, hand gestures, microexpressions, etc. as these are difficult to perceive in telehealth.
Treatment protocol adjustments	Changes to treatment protocols given geographic distance from patients (e.g., self-report questionnaires, handouts, exposure practices). This term also encompasses identifying things such as intoxication, avoidance, etc. that are usually apparent during in-person visits.

of their scores over time should consider keeping their own progress record of the patient's scores to have as a quick visual aid.

A similar consideration applies to the worksheets used throughout treatment to facilitate skills practice. Use of the worksheets is key to both help patients learn and implement skills, as well as for the clinician to review inter-session practice. Therefore, it is important to ensure patients have access to these worksheets and can show the clinician completed worksheets. There are many ways to accomplish this goal. First, patients who purchase the UP workbook, or who receive the worksheets via email from the clinician, can complete worksheets by hand and either (a) scan/take pictures of them and send them via email in the case of phone-only services, (b) hold them up and show them to the clinician if video is being used, or (c) use screen sharing to share the worksheet with the clinician. Creative solutions can ensure homework is still completed and reviewed with the clinician. However, additional problem solving may be needed at the outset of treatment, or during the transition to telepsychology for established patients, to make sure inter-session practice is still emphasized and occurring when services are not being delivered in person. Finally, although not ideal due to the extra time it will require, for telephone-only services, the patient can also read worksheet responses to the clinician and the clinician can take down notes.

Beyond tracking symptoms and inter-session practice, telepsychology (especially over the telephone) can necessitate flexibility in other ways, especially for patients from underresourced communities. For example, patients may have difficulty finding private spaces in which to conduct therapy sessions, especially if there are many people in their home (e.g., multigenerational homes). Patients may also be hesitant to allow the therapist to see parts of their home due to clutter or privacy concerns. Therefore, the therapist will want to work with the patient at the outset of treatment to discuss where sessions will take place and help the patient find a space in which they will be comfortable engaging in treatment. When the home is not a viable option, some patients may opt to conduct sessions in their cars, which often receive Wi-Fi if parked near the home. It is important for therapists to recognize that Wi-Fi interference may occur due to multiple people using the Wi-Fi network, outages, etc., and thus represents another domain where flexibility is needed.

In order to conduct treatment remotely and ensure equitable access to treatment, therapists should think about whether any typically "essential" requirements for therapy can be relaxed. For example, therapists might consider allowing minimal distractions, such as people walking by in the background (as long as the patient is comfortable), setting a threshold for allowable levels of Wi-Fi interference, or being more lenient about absences or requests to reschedule. Taken together, these considerations may result in treatment progressing at a slower pace than it would in traditional outpatient settings, and the patient and therapist may want to discuss this possibility at the outset of treatment to develop clear expectations about the pace of treatment. Additionally, the therapist may want to consider which components are critical to deliver within each session, with the acknowledgment that there may not be time to get through the usual content. When delivering treatment flexibly as outlined here, it is also important to discuss HIPAA compliance with patients and to review how to share materials in a confidential way. Thus, additional preparation may be needed at the outset of treatment to help patients access HIPAA-compliant means of sharing information (e.g., confidential email platforms) and teach patients to use these tools if they are not technologically savvy.

Providing treatment via telepsychology can also make is more difficult for clinicians to identify and address behaviors in which a patient engages that might interfere with treatment. This is especially true of subtle avoidance behaviors. Examples of such behaviors include not completing homework assignments, or making jokes or hostile remarks in session (detectible to the clinician via nonverbal cues) instead of answering questions or fully engaging. Most clinicians familiar with delivering cognitive-behavioral therapies are well versed in identifying and targeting these behaviors, which often function to avoid difficult emotions brought up in therapy. In the context of telepsychology, some avoidance/interfering behaviors may emerge but are likely to be more difficult for the clinician to identify. For example, when treatment is conducted on a computer, patients may have additional web pages open and be distracting themselves during session (e.g., reading the news, responding to email), or in the case of telepsychology conducted over the telephone, the patient may keep their eyes open during an imaginal exposure activity even though they were instructed to close their eyes. It also is important to differentiate maladaptive avoidance behaviors from life stressors, and thus for therapists to practice cognitive flexibility (a UP module discussed in detail later) themselves. For example, a patient may reschedule sessions due to maladaptive avoidance, or due to changing childcare needs. Additionally, patients' environments may naturally be more distracting than the typical clinician's office (e.g., pets, children, roommates may be nearby). Therefore, as is recommended when delivering any psychological treat-

ment remotely, it is important to discuss with patients early on how to minimize distractions during session as well as how therapy-interfering behaviors will be collaboratively identified and addressed, and for clinicians to accept that there is only so much they can control.

Finally, there are clinical considerations beyond logistics. Patients may have begun treatment before the COVID-19 pandemic started or may just be initiating therapy now and their goals for treatment may or may not be related to the pandemic. Even if a patient's goals are not related to managing emotions related to COVID-19, it may be helpful for clinicians to be prepared with COVID-19-related examples for each module given the pervasive nature of these circumstances. Additionally, patients whose concern about the pandemic is impairing their functioning (e.g., obsessing and ritualizing about the possibility of contamination, uncontrollable worry, extreme avoidance), or those who are not taking the pandemic seriously enough, may present to treatment. It is likely both of these presentations are driven by strong emotions and the UP is well poised to target either presentation by helping the patient assess their emotional response and use skills to engage in more effective responses when needed. As we review each module below, we will highlight COVID-19 related considerations for its delivery.

Module 1: Motivation Enhancement

The COVID-19 pandemic might affect motivation for treatment in several ways. Patients might be less motivated to engage in treatment because their symptoms are exacerbated by the pandemic (e.g., by social isolation, limited physical movement), resulting in increased avoidance. On the other hand, some patients might find their symptoms are improving because they are having fewer contacts with stressful situations (e.g., social interactions, leaving the house). Additionally, the pandemic might shift patients' goals. Indeed, even for established patients it may be worthwhile to assess whether COVID-19 has changed their goals or motivation for treatment. For example, patients who recently lost their jobs might now have the goal of finding a job, which takes priority over previously discussed goals.

The goal of this module is to increase a patient's motivation for treatment and readiness to change. First, overarching emotion-related problems are discussed and then specific goals are identified. Patients are encouraged to develop several goals, and progress made towards goals is revisited throughout treatment. The second element of this module is a decisional balance worksheet to help patients identify the pros/cons of changing versus staying the same.

For patients whose symptoms are worsening during the pandemic, motivation can be enhanced by discussing how the skills taught in treatment can remediate symptoms, even in the context of the limited circumstances associated with COVID-19. For example, skills might help facilitate social interactions or engagement in valued activities. For patients whose symptoms are lessening during the pandemic, the therapist might suggest the patient use this opportunity to bolster their skills and build resilience to help them prepare for how they want to manage as COVID-related restrictions are reduced. Clinicians might also benefit from explicitly reassessing goals for established patients in order to ascertain any change in goals necessitated by the pandemic.

The processes in Module 1 are easily accomplished via telepsychology as they predominantly involve discussion and the completion of worksheets. This module also presents an opportunity to identify and discuss any behaviors or situations that may interfere with treatment via telepsychology (e.g., responding to emails, getting ill, or taking care of an ill loved one). The decisional balance can be completed in anticipation of, and in order to plan for, these behaviors.

Module 2: Psychoeducation

The second module focuses on the provision of psychoeducation about the adaptive nature of emotions and teaches patients to monitor their emotional experiences. This module begins with a discussion about the purpose of emotions in general (e.g., to provide information and motivate behavioral responses) as well as the function of specific emotions (see Appendix A). Often, and depending on the patient's gender or cultural context, they have received information suggesting certain emotions are "bad" or inappropriate for them. Therefore, this discussion is extremely important to help patients build an accepting attitude toward the experience of all emotions, including those they find particularly uncomfortable.

After reviewing the nature of emotions, two skills are introduced to break down emotional experiences into their component parts: the three-component model and the Antecedent-Response-Consequence (ARC) model. The purpose of the three-component model is to help patients understand how thoughts, physical sensations, and behaviors occur and interact during emotional experiences, and it often helps overwhelming emotional experiences begin to seem more manageable. The ARC model builds on the three-component model by putting the emotional experience in context. Patients are taught to identify the antecedents (A) to strong emotions, to continue to

use the three-component model to characterize their response (R), and to then evaluate the short- and long-term consequences of the various elements of their response (C). Often, patients will find they engage in responses designed to suppress or avoid strong emotions, especially when the consequences are helpful in the short term but problematic in the long term. Maladaptive elements of an emotional response tend to reduce emotional intensity in the short term but lead to difficulty with emotion regulation and goal attainment in the long term.

As discussed in Module 1, the main considerations of delivering this module remotely revolve around completing worksheets collaboratively while delivering treatment remotely. If completing this module over the telephone alone, the clinician may want to refer to and use the example three-component models and ARC form provided in the UP workbook to structure initial conversation about these topics, followed by collaboratively working through patient-specific examples next.

As noted previously, the psychoeducation provided in this module is extremely relevant to the COVID-19 pandemic as individuals adjust to rapidly changing circumstances and experience a range of emotions about the virus and the pandemic (Wang et al., 2020). This module can help validate the intense emotions that individuals may be experiencing in response to the impacts of COVID-19 (e.g., increased relational conflict due to multiple family members now needing to live in the same residence), exacerbation of preexisting health conditions, closed schools and childcare centers, and managing health care under continuously changing circumstances (see Appendix A). Efforts can be made to use COVID-19-related examples to illustrate how emotions that seem problematic in one context are extremely adaptive right now (e.g., although intense anxiety may lead us to worry excessively or avoid trauma-related reminders, it also leads us to make sure we are engaging in physical distancing and avoiding touching our faces). Additionally, this module can validate the unique difficulties associated with managing COVID-19, a major stressor that is long-lasting and global in scale.

Further, this module can encourage patients to attend to their emotions in an effort to better understand their needs and foster resilience. Discussing the adaptive nature of emotions can help patients recognize and acknowledge instances in which their emotions were helpful to them, allowing them to build on existing strengths. By teaching patients to monitor their emotional experiences and break them down into three components (thoughts, physical sensations, and behaviors), clinicians encourage patients to label their experiences, a strategy shown to reduce emotional

intensity (Moyal et al., 2014). The ARC model provides a heuristic by which patients can evaluate their behavior and determine whether it serves their long-term interests. For example, a patient who is feeling ill might avoid making a doctor's appointment because they feel anxious about leaving the house. While avoiding the doctor might reduce feelings of anxiety in the short term, this avoidance will likely have undesirable long-term consequences not only because it elongates the patient's period of illness, but also because it puts the patient at risk of worse depression and anxiety down the road. Evaluation of the consequences of behavior or other elements of an emotional response in this manner can help patients identify behaviors that are in line with their long-term goals and build motivation towards acting in line with those goals. This skill is very valuable since effective coping strategies can change over time, and since it will be helpful for patients to consider a future beyond the current pandemic.

Module 3: Mindful Emotion Awareness

The third module introduces mindful emotion awareness and provides several exercises to help patients practice taking a mindful stance toward the experience of strong emotions. Psychoeducation for this skill focuses on the importance of being nonjudgmental and present-focused when it comes to noticing, examining, and experiencing emotions. A key mechanism of this module involves increasing the patient's ability to objectively observe the various components of their emotional experiences as they unfold in order to evaluate whether their response is effective or in need of adjustment. Further, objective awareness can facilitate recognition of the transient nature of strong emotions and difficult experiences. Patients complete three exercises to facilitate applying nonjudgmental, present-focused attention to their emotional experiences. First, they complete a guided meditation exercise, which guides the patient through focusing on their thoughts, physical sensations, and overall emotional experiences while providing reminders to remain present-focused and nonjudgmental. Second, patients bring up strong emotions purposefully using personally relevant music as a mood induction in order to practice mindfulness in the context of a strong emotion. Third, patients learn a skill called "anchoring in the present." This skill consists of four steps to help patients observe and respond to emotions as they occur in day-to-day life: (1) use a cue, such a breathing, to ground oneself in the present, (2) observe thoughts, physical sensations, and behaviors (or behavioral urges), (3) consider whether the response is in line with the current circumstances or whether it is a reac-

tion to a past concern or future-oriented worry, and (4) bring the response back in line with the needs of the present moment. This skill can help patients interrupt intense or ongoing emotional experiences (step 1) and engage in objective observation of the components of their response (step 2). After making these observations, the patient can consider whether this response is in line with the demands of the present moment and then engage in skills learned in treatment (e.g., more in-depth mindfulness practice, shift thoughts to focus on the present, cognitive flexibility, alternative actions) as needed (steps 3 and 4).

For many patients, meditation activities can be emotion-provoking and they will request to stop early. Managing this distress remotely can be challenging. When a clinician knows this is likely to be a problem, it can be helpful to provide a rationale for completing the exercise without escaping early and problem-solving around how to do so. When this distress is unexpected, clinicians will have to choose whether to stop the exercise or not, the same as they do during in-person sessions. In a telepsychology context, clinicians may be more likely to stop the exercise because patients can abruptly end the session in a way they cannot during in-person sessions. However, clinicians are encouraged to ask patients to complete the exercise in order to prevent avoidance of unpleasant emotions associated with meditation specifically, and emotional awareness more generally. Accordingly, problem-solving prior to these exercises may include a plan for what will happen if the patient has the urge to end the exercise prematurely or chooses to hang up the phone or end the video visit.

During the current COVID-19 pandemic, the anchoring exercise may be particularly useful. Because this skill is brief and can be conducted in the context of a patient's day-to-day life, it may be more feasible for patients to utilize anchoring. This skill is often described as the "real life" mindfulness skill because it is the most practical skill to use in day-to-day situations (i.e., it would be impractical to do a mindful emotion awareness meditation in the midst of teaching a class). However, many patients' lives have changed dramatically as a result of the current pandemic. Their perception of a response in line with the demands of the present moment (step 3) is likely quite different from what it would be outside the context of a pandemic. Still, patients can be helped to recognize that some responses are likely to be more helpful than others. It may be useful to have patients create a list of things that need to be done every day while their lives take place primarily in their homes, as well as a list of things they anticipate needing to do once COVID-19-related restrictions are lifted. This way, the home-specific list provides guidance on things that can be practiced now, whereas the other list reminds the patient that the material in this treatment will also apply to life beyond the COVID-19 pandemic. However, it is important this list is used in the spirit of mindfulness and not as a tool to avoid emotions. That is, use of this skill should still facilitate nonjudgmental, present-focused awareness of emotions as opposed to using "to do" lists as a distraction.

It also is important to note that at this time, patients may be engaging in more worry or rumination than usual. For example, many patients are spending increased time viewing news and doing research about COVID-19, the economy, or disaster preparation. Anchoring can help patients re-orient their behavior away from activities that are likely to increase emotional intensity over the long term (e.g., worry, rumination) and engage in more adaptive activities like exercising that help them stay healthy.

Module 4: Cognitive Flexibility

The cognitive flexibility module zeros in on the relationship between thoughts and emotions, and it teaches patients how to identify problematic automatic thoughts and develop alternative appraisals for thoughts that serve as "thinking traps" (i.e., increase the intensity of strong emotions). Although this module shares many elements with traditional cognitive reappraisal, it differs in several ways. First, whereas many models of cognitive therapy encourage patients to learn about and recognize a variety of unhelpful automatic thoughts, the UP highlights the importance of monitoring just two types of unhelpful automatic thoughts: probability overestimation (i.e., expecting the worst outcome) and catastrophizing (i.e., assuming one won't be able to cope with the outcome). Given the myriad stressors we all are facing in the midst of the COVID-19 pandemic, learning to identify two specific types of unhelpful automatic thoughts, rather than an entire list, may enhance efficiency during telephone or video visits, and feasibility of practice in the real world. At the core of this skill is a contextualistic and pragmatic approach to examining the "truth" of thoughts (Pepper, 1942), wherein the primary goal is to consider whether a thought is helpful or not. Most important, the UP focuses on increasing cognitive flexibility by encouraging patients to develop alternative appraisals as a strategy for not getting "trapped" in particular ways of thinking without privileging a specific thought as "correct." Moreover, patients can be encouraged to think flexibly about their emotions (e.g., thinking flexibly about anxiety might include acknowledging that while it has led to problems in

some contexts, it can lead to desirable/helpful outcomes in other contexts).

Teaching this skill via telepsychology requires many of the considerations raised in previous modules. In the context of the COVID-19 pandemic, patients may notice an increase in negative automatic thoughts attributable to the ongoing stressors they are experiencing. Interestingly, given the unprecedented and uncertain nature of the situation, it is difficult to describe how accurate or inaccurate a COVID-19-related thought is because there is limited scientific information about the risk factors, mechanisms, course, and prognosis of COVID-19. Cognitive flexibility can be particularly useful in this circumstance because it emphasizes the generation of alternative appraisals over accuracy of these appraisals. Thus, patients are encouraged to consider other possible outcomes. Since intolerance of uncertainty is an important, transdiagnostic maintaining factor across the emotional disorders (Boswell et al., 2013; Mahoney & McEvoy, 2012), focusing less on discussing whether thoughts are "correct" or "accurate," and more on whether they are helpful/ the only way of interpreting a situation, seems more useful in the context of a situation characterized by uncertainty. Indeed, preliminary data suggest the UP leads to greater tolerance of uncertainty among patients (Khakpoor et al., 2019). In addition, as part of generating alternative appraisals for catastrophizing thoughts (e.g., "I won't be able to cope if I cannot pay my rent"), patients are encouraged to think through the worst-case scenario and how they would handle it. As circumstances change frequently during the COVID-19 pandemic, this skill can be helpful as a way for patients to plan ahead, and to remember they can cope with ongoing or new challenging situations.

Module 5: Countering Emotional Behaviors

In Module 5, patients identify behavioral repertoires that are ineffective over the long-term and work to change these behaviors using alternative actions. Although all emotions are naturally associated with behaviors that serve an adaptive function (i.e., action tendencies), these behaviors are not always effective. The key to identifying ineffective emotional behaviors is that they provide short-term negatively reinforced relief from strong unpleasant emotions at a cost to an individual's long-term goals and well-being (this concept is first introduced in Module 2). Patients and clinicians work collaboratively to identify behaviors that fall into this pattern. To facilitate this discussion, five categories of ineffective emotional behavior that cut across

specific diagnoses are presented: overt avoidance, subtle behavioral avoidance, cognitive avoidance, safety signals, and emotion-driven behaviors (Wilamowska et al., 2010; see Table 2 for the five categories and COVID-19 examples). After identifying these behaviors, patients are encouraged to plan to engage in alternative actions prior to the next session. Whereas ineffective emotional behaviors function to reduce the intensity of strong emotions, alternative actions involve staying in contact with the emotion in its full intensity. Patients are likely to find this very difficult in the short term, but it makes coping with strong emotions easier in the long term.

To facilitate identification of ineffective emotional behaviors, Table 10.1 from the UP clinician manual may be used to provide common examples of emotional behaviors. Showing patients examples from this table often helps them generate additional personal examples. When delivering the UP via video or telephone only, we recommend sharing a list of the items included in this table via email or mail. In addition, we recommend that you add COVID-19-relevant examples to each category. For example, overt avoidance, which consists of outright avoidance of emotion-provoking stimuli, might include avoiding talking about the pandemic, avoiding going to the doctor, or avoiding people one assumes to be more likely to have COVID-19. Alternative actions to this avoidance might include talking about the pandemic, attending scheduled doctor's appointments, and specifically talking to people from a group being stigmatized. As another example, subtle behavioral avoidance, which is engagement in behaviors that prevent fully experiencing an emotion, might include avoiding the use of certain words (e.g., "COVID"). In this case, an alternative action is to specifically use the avoided words. Additional examples are available in Table 2.

Patients are likely seeing an increase in ineffective behaviors in response to strong emotions elicited by the COVID-19 pandemic. For example, Clay and Parker (2020) noted stress is often associated with increased alcohol use and expressed concern about increased alcohol use as individuals maintain physical distancing. Since the identification of alternative actions may be challenging if patients are required to stay at home or limited in where they can travel, we also have included COVID-19-relevant ideas for alternative actions in Table 2. If these examples are not relevant to your patient, it is important to remember that an alternative action is a behavior that keeps the patient in contact with the emotion they are avoiding with an emotional behavior.

Table 2
Emotional Behaviors, Alternative Actions, and COVID-19-Relevant Examples

Type of Emotional Behavior	Description	COVID-19 Example	Alternative Action
Overt avoidance	Outright avoidance of situations, people, etc. that bring up strong emotions	Avoiding talking about the pandemic	Discuss the pandemic
		Avoiding engaging with a member of a group of people being unfairly stigmatized as likely to have COVID-19	Plan to talk to an individual from a group stigmatized for being likely to have COVID-19
Subtle behavioral avoidance	Behaviors that prevent fully experiencing an emotion when outright avoidance isn't an option	Avoiding turning on your computer's camera during a virtual meeting	Turn your computer camera on
Cognitive avoidance	Anything you might do to keep your mind off something that is distressing	Rumination Worry Distraction	Mindful emotional awareness
Safety signals	Items or people that help us feel more comfortable and/or keep an emotion from becoming overwhelming	Carrying guns	Leave guns at home/ in gun safes
		Only leaving the house if someone can accompany you	Leave the house alone
		Carrying medication	Leave medication at home
Emotion-driven behavior	Behaviors driven by strong emotions that are designed to reduce the intensity of that emotion	Panic buying	Make a list of what you need and only buy those items
		Substance use	Exercise
		Watching news excessively	Turn off news, engage in another activity
		Refusing to wear mask	Follow guidelines for your area
		Yelling at someone who is not wearing a mask in public	Talk in an even tone and recommend they consider wearing a mask the next time they go out

Module 6: Awareness and Tolerance of Physical Sensations

This module focuses on interoceptive exposure, or exposure to uncomfortable physical sensations. A guide for conducting these exposures is beyond the scope of this paper and interested readers are pointed to Boettcher et al. (2016). In brief, this module begins by providing psychoeducation about the role of physical sensations in *all* emotional experiences. This psychoeducation can include discussion of how these physical responses are often useful (e.g., autonomic increase in response to a threat facilitates fight or flight) to reduce the perception of these sensations as threatening. Additionally, it is important to discuss how interpretation of these sensations can artificially

amplify strong emotions (e.g., assuming you're having a panic attack when your heart rate increases will make your heart rate increase further).

Next, the patient and clinician conduct symptom-induction exercises in which they complete activities designed to bring up strong physical sensations including breathing through a thin straw, running in place, and hyperventilating. The purpose of these exercises is to allow patients to experience physical sensations they typically avoid, notice how changes in physical sensations affect other parts of one's experience (e.g., hyperventilation can lead to the thought "I can't breathe," which can intensify autonomic arousal), and learn to cope with them. For example, patients may use mindful emotion awareness to remain non-judgmental of sensations or cognitive flexibility to ree-

valuate the danger posed by the sensations. Although clinicians using the UP are not directed to pursue fear/distress reduction, or habituation, as a result of interoceptive exposures (indeed, physical sensations like nausea are likely to always be unpleasant), this may be useful for some patients. Patients are encouraged to practice these exercises multiple times per day in order to build awareness and tolerance to sensations they would typically avoid. This type of exposure activity has most often been used in the treatment of panic disorder, but growing evidence suggests it is applicable to the range of emotional disorder presentations (e.g., Blakey & Abramowitz, 2017; Boettcher et al., 2016).

Interoceptive exposure is one of the least utilized cognitive-behavioral techniques by treatment providers (Hipol & Deacon, 2013). However, as clinicians transition to telepsychology, we encourage them to implement this intervention as consistent research supports its efficacy in reducing patients' fear and intolerance of physical sensations (Boettcher et al., 2016). Conducting these exposures via telepsychology can necessitate creativity to induce physical sensations. Usually, clinicians provide tools (e.g., straws) to induce physical sensations for the patient. However, because patients and clinicians are now separated, patients will need to use materials in their home to induce physical sensations. Additionally, an important element of these exposures is helping patients identify ways they may be avoiding experiencing the sensations fully. These can be obvious (e.g., stopping the exercise early) or subtle (e.g., "white knuckling" by counting seconds or not running full force). It may be more difficult to identify these avoidance efforts via video conferencing, and especially via telephone. Therefore, clinicians may find it beneficial talk to patients about the importance of observing efforts to engage in avoidance before starting the symptom induction exercises. In addition, clinicians who are using telephone only may want to choose in-session practice exercises that are easy to monitor in the absence of video feedback (e.g., it's relatively easy to tell when a patient is not hyperventilating at full force). It is beneficial to provide a strong rationale for identifying and reducing avoidance of the physical sensations and ensuring patients understand this rationale before proceeding. Interoceptive exposure can be very valuable, and, at the same time, clinicians want to be sure they do not accidentally reinforce avoidance because they were not able to observe it on the telepsychology platform.

It is imperative to note that the symptoms associated with COVID-19 involve physical sensations such as shortness of breath, fever, and fatigue. Most people are receiving messages via news outlets about being aware of the development of these symptoms, which may be increasing their interoceptive awareness and fear of physical sensations (which is not an entirely bad thing). Therefore, interoceptive exposure can help patients learn to manage the anxiety that may accompany physical sensations. For example, breathing through a straw can induce shortness of breath, and breathing through a straw repeatedly can lead to better tolerance of shortness of breath. If patients do not have straws they can hyperventilate or roll up paper into thin tubes. Heat can be experienced by running in place, wearing layers, or sitting in front of a heater, and fatigue can be induced by wearing something heavy (e.g., a backpack full of heavy books or weights). These exposures can also help patients learn to differentiate physical symptoms intensified by anxiety from other symptoms that require medical attention. By teaching patients awareness of physical sensations, as well as how these sensations interact with other parts of the three-component model, patients can learn to ascertain whether their physical symptoms are being exacerbated by their thoughts or behaviors as opposed to being indicative of illness.

Interoceptive exposure may also be a helpful tool to facilitate patients wearing masks in public. As public health guidelines and local government ordinances emphasize wearing masks to reduce transmission of COVID-19 in public settings, interoceptive exposure can build familiarity and comfort with the sensations associated with wearing a face mask, which can include shortness of breath and physical discomfort. Indeed, wearing a mask in session may be a useful interoceptive exposure in and of itself.

Patients, and clinicians alike, may be more resistant to using these exercises than usual precisely because they induce physical sensations similar to those experienced by patients with COVID-19. Regarding patient concerns, anticipating this resistance in advance can prepare clinicians to manage it if it presents in session. Depending on the patient, clinicians can use a decisional balance to help patients weight the pros/cons of engaging in versus avoiding interoceptive exposure.

Regarding clinician concerns, we recommend consulting with medical colleagues if you are working with a patient who recently has been exposed to—or is in the process of recovering from—COVID-19, or other medical illnesses, prior to conducting interoceptive exposures. Because it is unknown whether interoceptive exercises that temporarily increase heart rate or shortness of breath could exacerbate an existing COVID-19 illness, and because some patients with COVID-19 are asymptomatic, a medical provider may

recommend that a patient be tested for the novel coronavirus before interoceptive exposures are conducted. In these cases, interoceptive exposures that do not rely on respiratory processes can be used; examples include: spinning in circles (either standing or in a chair), drinking a lot of seltzer to feel uncomfortably full, holding one's arms out in a "T" to create muscle tension, wall sits, and wearing tight clothing.

Another concern clinicians may have is how to manage panic attacks remotely. If interoceptive exposures result in a panic attack, the clinician can use this as an opportunity to coach a patient through a panic attack in a couple of ways. One option is for the clinician to provide step-by-step instructions for managing the attack (e.g., ask the patient to describe their thoughts/physical feelings/behaviors, walk the patient through a mindfulness exercise, etc.). This is also an opportunity for the therapist to model how to handle the panic attack by remaining visibly calm and using a calm tone of voice when talking to the patient. If possible, the therapist might consider engaging with the patient and asking the patient to choose a skill to implement while having a panic attack (cognitive flexibility applied to interpretation of physical sensations).

Module 7: Emotion Exposure

Module 7 of the UP is emotion exposure. In general, exposure-based procedures involve repeated approach toward a feared (but safe) stimulus in order to decrease avoidance, facilitate habituation, and develop flexible and adaptive response repertoires to the feared stimulus. Robust evidence supports the use of exposure to target anxiety, trauma-related, and obsessive–compulsive related disorders (e.g., Hofmann & Smits, 2008), and exposure-based interventions are used across a wide range of complex and multidiagnostic patient presentations (e.g., Hayes & Hofman, 2018). Exposures that elicit strong emotions can be interoceptive (see Module 6), in vivo, or imaginal. In vivo exposure involves having patients approach situations or things they would typically avoid. For example, a patient with social anxiety might make small talk with a stranger or give a speech. Finally, imaginal exposure involves having a patient vividly imagine a scenario. In the UP, this exposure is used to have patients approach situations that cannot be created in vivo (e.g., losing a loved one).

Recent literature has differentiated habituation-based exposure from non-habituation-based exposure. In habituation-based exposure, the goal of the exposure activity is a reduction in distress. These exposures are predicated on the idea that fear reduction during or across exposures serves as an indicator of the patient's readiness to proceed to a more difficult exposure and is also necessary to produce long-lasting changes in a patient's perception of a feared stimulus as dangerous. On the other hand, non-habituation-based exposures do not consider fear reduction an indicator of exposure success or effectiveness. One such model, inhibitory learning, focuses on helping patients learn new associations with feared stimuli. Thus, patients approach situations they typically avoid in order to learn about them (i.e., Does a feared outcome occur? If so, can they manage, etc.). Although inhibitory learning likely contains elements of habituation, it importantly does not predicate exposure success on a reduction in fear. Instead, these exposures prioritize new learning about the danger of a given stimulus. Readers are referred to Craske et al. (2014) for a thorough description of inhibitory learning exposure, and to Abramowitz and Blakey (2020) for an ever broader discussion of theorized mechanisms of exposure.

Exposure can be, and often is, emotion-focused. That is, instead of focusing on specific stimuli that the patient avoids, exposure can focus on asking patients to approach and experience the *emotions* they typically avoid. For example, although typical exposure therapy models emphasize the importance of having patients approach specific situations, people, places, and things (e.g., having someone with Social Anxiety Disorder attend a crowded party), emotion-focused exposure therapy emphasizes the importance of having patients approach emotions, thereby deemphasizing the necessity for specific stimuli. Emotion exposure is predicated on the idea that patients avoid specific stimuli because they provoke strong emotions, and the emotions themselves are perceived as aversive, unacceptable, or uncontrollable. Therefore, when the patient avoids specific stimuli, what they also are avoiding is the associated emotion. The goal of emotion exposure is to help patients learn that (a) emotions are not dangerous, (b) strong emotions do not last forever, and (c) the experience of emotions can be tolerated/managed. This learning is meant to generalize to *any* stimuli that provoke a strong emotion.

Emotion exposure that is inherently based on inhibitory learning principles may be more practical during the current public health crisis. Because the emotions experienced during this pandemic are predominantly functional and adaptive, we do not necessarily want patients to habituate to them. Indeed, habituating to anxiety in some circumstances, for example, could lead to a relaxation of social distancing measures and spending time in crowded public spaces.

This behavior is neither helpful nor desirable during the COVID-19 crisis. At the same time, being paralyzed by anxiety is not helpful to a patient either. Inhibitory learning-based emotion exposure can help patients learn to experience and manage strong emotions in a way that reduces the perceived threat of the emotion while allowing the emotion to continue serving its adaptive function.

A growing literature supports the delivery of exposure-based interventions via telepsychology and provides excellent guidance for doing so (e.g., Acierno et al., 2017; Gros et al., 2011). As we stated previously, exposure often involves encouraging patients to approach situations, people, places, and things they typically avoid. However, current concerns associated with COVID-19 have restricted activities throughout the world. At a minimum, this involves physical distancing. In some places, patients may be living with shelter-in-place orders, unable to leave their homes except to procure food and medical supplies. These circumstances greatly limit the situations, people, places, and things with which our patients can interact. But this does not mean exposure therapy cannot continue and benefit patients. Emotion exposure provides greater flexibility than traditional exposure with regard to identifying stimuli to use as the focus of exposure. Indeed, anything that provokes a strong emotion can be used. Clinicians can work with their patients to identify the emotions they dislike or avoid and stimuli at home that provoke these emotions. For example, music is a reliable inducer of strong emotions. Many specific movies or topics of conversation can also produce strong emotions. Therefore, watching a film clip through a shared screen or listening to a piece of music are examples of potential in-session emotion exposures that can be feasibly conducted using telepsychology. As another example, many patients are engaging in excessive cleaning or worry about contamination. Exposure for these concerns might include limiting the amount of cleaning done after returning from an errand (e.g., washing one's hands for 20 seconds per CDC guidelines and then stopping). Another option is to expose oneself to concerns about contamination by reading about virus spread and then using alternative behaviors to counteract ineffective anxiety-driven behaviors. Additional examples include: conducting imaginal exposures about oneself (or a loved one) contracting COVID-19; imaginal exposures related to the uncertainty of the future (e.g., not knowing when/how life will go "back to normal"); and role-playing difficult conversations about COVID-related topics (e.g., asking someone to wear a mask or engage in social distancing, or declining an invitation).

Before conducting exposures, patients should identify any strategies they might use to avoid experiencing their emotions during the exposure and brainstorm how they can remain fully engaged (e.g., mindful emotion awareness, alternative actions). The goal of their exposure is to complete their identified activity while remaining in contact with their emotions in order to facilitate new learning about the unacceptability/intolerability of the emotion. Here it can be helpful to reiterate that the purpose of exposures is not to eliminate emotions but instead to learn how to tolerate and respond to them effectively. After the exposure, patients should debrief. The therapist and patient can discuss how they experience each of the three components of emotion and how these components interacted during the exposure. Additionally, it can be helpful to highlight how changing one component (e.g., engaging in an alternative behavior) affects the other components. Finally, and perhaps most important, therapists and patients should discuss what was learned by conducting the exposure. Did their feared outcome occur? If it did, how were they able to cope? In the context of the COVID-19 pandemic, strong emotions are inevitable and emotion exposure can help patients learn how to experience and manage these emotions without relying on ineffective emotion regulation strategies.

Module 8: Relapse Prevention

Once patients have learned the skills taught in treatment and can implement them independently, they are typically ready to end their course of treatment using the UP. The UP provides a relapse prevention module to help patients review their progress, make plans to continue utilizing their skills, and consider how to respond to relapses.

This module is simpler to deliver over telepsychology than many of the previous modules because most of it can be accomplished via conversation. However, there are several considerations that are specifically relevant to the COVID-19 pandemic. An important element of this module is planning for continued practice of UP skills. Consistent research demonstrates that using skills beyond treatment termination is associated with better outcomes (Bullis et al., 2014). Patients will want to consider how to practice skills in their current context as well as how they will do so when they return to work, can socialize, etc. Additionally, patients who complete treatment solely (or mostly) in the context of social distancing and stay-at-home orders will need to think about how these skills can apply when these orders are relaxed. Patients whose symptoms

have improved during the pandemic will especially want to think about how they will continue to practice skills proactively during the pandemic (e.g., actively soliciting social interactions). Patients might also benefit from extra conversation dedicated to generalization of skills beyond this pandemic. Additionally, it may be helpful to discuss the possibility of relapse. Returning to work settings or social interactions may prompt challenging situations and emotions that the patient did not experience during treatment. Thus, patients may feel they are worsening initially and should be prepared for this possibility, as well as how to use their skills to cope with it.

Conclusion

In the challenging circumstances posed by the COVID-19 pandemic, transdiagnostic, emotion-focused, cognitive-behavioral treatments like the Unified Protocol may be particularly well suited to help people manage diverse emotional problems experienced during this time. As we have delineated in this paper, an emotional disorders framework that focuses on a range of emotions and problematic emotion regulation strategies may parsimoniously address many of the mental health concerns people experience in response to this crisis.

As a 12- to 16-session treatment, the UP may be too long for many patients or treatment settings. Indeed, in traditional face-to-face psychotherapy, the average number of sessions attended in community settings is fewer than 5 (Wolitzky-Taylor et al., 2015). As a modular treatment, the UP provides flexibility in terms of the number of sessions dedicated to each module. Additionally, recent work has begun to establish that the UP modules can be delivered in isolation and achieve their intended effects (i.e., delivering cognitive flexibility in isolation leads to improvement in patients' use of this skill) suggesting it is feasible to reorder treatment modules (Sauer-Zavala et al., 2017). Although this work is preliminary, it suggests modules can be reordered or delivered independently based on the needs of the patient. There are currently no evidence-based guidelines for selecting or reordering modules. One possible approach is to engage in collaborative decision making with the patient in order to choose the skill taught in a given session. A small implementation trial of the UP in a health care for the homeless facility indicated this approach may be acceptable to patients and providers (Sauer-Zavala et al., 2019).

Given the high volume of individuals in need of support, many psychologists are being called on to provide single session or very brief interventions. In these circumstances it is not feasible to teach all the components of the UP. We suggest that providing psychoeducation about the function of emotions in these situations may be particularly helpful. As a result of the COVID-19 pandemic, many individuals who do not usually struggle to manage their emotions may be confused by the strong emotions they are experiencing, as well as how aversive they find these emotions. Psychoeducation about emotions can be validating in this context to help these individuals understand the purpose of various emotions and realize the experience of strong emotions is not necessarily a bad thing. To this end, we have created the aforementioned handout that provides this psychoeducation and includes a brief mindfulness skill (Appendix A).

This paper focused on the UP as one example of a transdiagnostic, cognitive-behavioral treatment that may be particularly applicable to the COVID-19 pandemic. However, as we stated previously, the UP is not the only such treatment and it is important to acknowledge other evidence-based interventions that may be applicable at this time. Treatments in the broader family of CBTs, such as Acceptance and Commitment Therapy (Hayes, 2004), Dialectical Behavioral Therapy (Linehan, 2014), and individualized approaches using empirically supported transdiagnostic processes of change in CBTs (Hayes & Hofmann, 2017), also focus on managing the experience of strong emotions in a way that is effective for a wide range of presenting problems. These treatments may also be beneficial to patients during this time and should be considered as treatment options.

As the COVID-19 pandemic progresses, transdiagnostic treatments such as the Unified Protocol are well poised to meet the rising demand for mental health services. Effective emotion management will help individuals put their emotions in context, validate the experience of strong emotions, and engage in behaviors that are consistent with their values and effective for their long-term goals. To that end, we have provided suggestions for using an evidence-based psychological treatment, the UP, to help those who are suffering.

Appendix A. Understanding and Managing Emotions Elicited by the COVID–19 Pandemic

Emotions and COVID-19
- The COVID-19 pandemic is affecting people in a lot of different ways, which can elicit a range of strong emotions
- As we cope with COVID-19, it is crucial to remember that *emotions are our allies*
- Emotions help us communicate (with ourselves and other people) and they also help guide behavior. Different emotions provide different information

What Can We Learn from ANXIETY?
- Anxiety alerts us to unexpected changes or potential threats, like the disruption COVID-19 is bringing to our lives, and it helps us prepare to manage change or threats
- *Feeling anxious right now makes a lot of sense* and is quite helpful
- Anxiety occurs when our brain notices something new and possibly dangerous. Right now, a lot of things are changing and we are not always sure if we're safe
- Anxiety can motivate people to stay home and follow guidelines recommended by experts to protect personal and public health
- Not feeling or attending to anxiety in the current COVID-19 situation is actually more concerning because it can lead people to ignore important recommendations which puts themselves and others at risk (e.g., gathering in crowded places)

What Can We Learn from SADNESS?
- Sadness can signify the loss of something important, and it helps us slow down to recover
- *Feeling sad right now makes sense*, especially if you've lost a job, cannot engage in activities that are meaningful to you, or cannot connect with other people (like friends/family)
- Noticing you feel sad can help you take a step back, think about what is important to you, and find new, creative ways to meet your needs (e.g., setting up video calls with people you care about)

What Can We Learn from ANGER?
- Anger occurs when our goals are blocked, or when something seems unfair
- *Feeling angry right now makes sense* if you cannot do things you like to do or obtain supplies you need
- Anger can inspire us to find new solutions to problems (like exercising inside), or to advocate for ourselves and others to ensure that needs are being met and people are being treated fairly

What Can We Learn from GUILT?
- Guilt lets us know we may have done something wrong and alerts us to question our behavior
- Right now, people are *feeling guilty about a lot of things they may not have felt guilty about before* (like leaving home and risking spreading the new coronavirus to others), which can be confusing
- This guilt can be helpful because it tell us to slow down and ask ourselves whether we did something wrong. If we did, guilt motivates us to change our behavior. For example, we might begin following the recommendations of public health experts in order to protect the safety and wellbeing of others

What if emotions feel too strong or overwhelming? (See other side)

What Can You Do if Your Emotions Become Overwhelming?

Although emotions provide helpful information and it makes sense to be experiencing some or all of them in the context of a public health threat like COVID-19, they might also become overpowering and make it difficult to think about anything else, or do what we need or want to be doing.

If this happens, consider using a quick mindfulness tool:

Step 1

- Take a breath.

Step 2

- Observe what you are thinking, feeling physically, and doing right now. Be as specific as possible. Write it down.
- *What am I thinking right now?* _____
- *What do I feel in my body right now?* _____
- *What am I doing right now/what do I have the urge to do?* _____

Step 3

- Ask yourself if you are responding to the present moment, or a past concern/future-oriented worry
- *Am I resopnding to the present moment?* _____

Step 4

- If you are responding to a past concern/future-oriented worry, turn your attention to the present moment.
- Refocus your attention and do what is needed in the present moment.

**BONUS TIP: If you are finding that these steps are extra hard to do, pause and try to get distance from your thoughts by starting every sentence with "I am having the thought…"

This handout was authored by Rachel Ammirati, PhD, Clair Cassiello-Robbins, PhD, & M. Zachary Rosenthal, PhD, and is based on content from the second edition of The Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (Barlow et al., 2018a, 2018b).

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