Available online at www.sciencedirect.com
ScienceDirect
Cognitive and Behavioral Practice 14 (2007) 36–45
Cognitive and Behavioral Practice
www.elsevier.com/locate/cabp

Emotional Schemas and Resistance to Change in Anxiety Disorders

Robert L. Leahy
The American Institute for Cognitive Therapy

Cognitive-behavioral treatment for all anxiety disorders involves exposure to feared situations and feared emotions. Dropout from therapy is a continued problem for final treatment effectiveness. A meta-emotional model of fear of negative emotions (and anxious sensations and thoughts) is advanced that can be used as a transdiagnostic treatment model for anxiety disorders. According to this model, anxious individuals hold theories of anxiety that interfere with effective treatment. Specific treatment recommendations are developed from this model to counter roadblocks in cognitive-behavioral therapy of the various anxiety disorders.

Although there is considerable evidence that cognitive-behavioral therapy is highly effective in the treatment of anxiety disorders, many prospective patients do not complete the recommended course of treatment (Leung & Heimberg, 1996; van Minnen, Arntz, & Keijsers, 2002; Vogel, Stiles, & Gotestam, 2004). Since CBT requires continued exposure with response prevention for anxiety-provoking behavior, patients understandably may be reluctant to continue in treatment—or, if they do continue, they may be reluctant to comply with direct exposure. Indeed, effective exposure necessitates the activation of sufficient fear (Foa & Kozak, 1986). Each of the anxiety disorders that I will discuss—panic disorder, generalized anxiety disorder, obsessive-compulsive disorder, social anxiety disorder, and posttraumatic stress disorder—is characterized by a fear of the consequences of one's own anxiety or sensations. It is proposed here that each anxiety disorder consists of a theory of emotional dysregulation that underpins resistance to engage in exposure.

All of us have experiences of uncomfortable or unpleasant emotions—such as sadness, anxiety, fear, or anger—but not everyone develops a diagnosable psychiatric disorder. Anxiety disorders have been linked to early temperamental differences, anxiety sensitivity, hypervigilance for threat, and other cognitive dispositions. It is proposed here that noncompliance in CBT for anxiety disorders is partly related to the role of emotional avoidance and fear of anxiety. Exposure implies emotional dysregulation to the anxious patient.

1077-7229/07/36–45$1.00/0

Emotional Schemas

The role of emotional processing in anxiety disorders has been a focus of a number of studies. Of specific interest has been the construct of "alexithymia"—that is, the difficulty in labeling or identifying one's own emotions. Alexithymia has been viewed as a "meta-emotional" deficit reflecting difficulties recalling emotions or identifying the situations that give rise to emotions (Taylor, Bagby, & Parker, 1997). Overall levels of anxiety are positively related to alexithymia (Culhane & Watson, 2003; Eizaguirre, Saenz de Cabezon, Alda, Olariaga, & Juaniz, 2004). In a study of 85 combat veterans, alexithymia was predictive of PTSD (Monson, Price, Rodriguez, Ripley, & Warner, 2004), while in another study alexithymia was found to be essentially a *symptom* (that is, emotional numbing) characteristic of PTSD (Badura, 2003). Alexithymia is related to maladaptive coping with anxiety, such as drinking (Stewart, Zvolensky, & Eifert, 2002) and the search for perfectionism (Lundh, Johnsson, Sundqvist, & Olsson, 2002).

Although recognizing, labeling, and differentiating emotions are part of an essential first-step in emotional processing, individuals also differ in their interpretations and strategies of their own emotions once they recognize they have an emotion. I have proposed a model of emotional schemas that identifies a set of interpretative processes and strategies that are activated once an "unpleasant" emotion is experienced (Leahy, 2001b, 2003a). Once an emotion is activated, the first step is to attend to the emotion. This first step can include both noticing the emotion and labeling the emotion, a process underlying alexithymia. Of course, more than one emotion may be activated, thus adding further to the complexity of this first step. The next step can involve emotional and cognitive avoidance of the emotion, as

reflected by dissociation, bingeing, or alcohol consumption. For example, individuals with social anxiety disorder rely on alcohol or drugs to manage their emotions so that their emotional arousal will be diminished, thereby decreasing the likelihood that they will be humiliated because they might appear anxious. Similarly, individuals with PTSD also rely on alcohol and drugs to reduce the emotional impact of their intrusive images.

Each of the anxiety disorders entails emotional schemas (interpretations and strategies) of the sensations, emotions or intrusive thoughts and images that are experienced. Negative emotional strategies and interpretations include validation ("Other people understand the way I feel"), comprehensibility ("My emotions don't make sense to me"), guilt and shame ("I shouldn't have these feelings" or "I don't want anyone to know I feel this way"), simplistic thoughts ("I should not have mixed feelings"), higher values ("My feelings reflect my higher values"), control ("I am afraid my feelings will go out of control"), rationality ("I should be logical and rational—not emotional"), duration ("My feelings will last a long time"), consensus ("Other people have the same feelings"), acceptance ("I can accept the feelings I have"), rumination ("I sit and dwell about how bad I feel"), expression ("I can allow myself to cry"), blame ("Other people cause me to feel this way"). The emotional schema model is shown in Figure 1.

We have found that these negative emotional schemas are related to depression, anxiety, PTSD, metacognitive aspects of worry, alcohol abuse, marital discord, and personality disorders (Leahy, 2001a, 2002a,2002b, 2003b; Leahy & Kaplan, 2004) Of interest in the current paper is the relation between emotional schemas and specific anxiety disorders. For example, individuals with panic disorder are expected to believe that their sensations and emotions are not comprehensible, will go out of control, will last a long time, are not experienced by others, cannot be accepted, and cannot be expressed. Indeed, CBT addresses many of these interpretations by using bibliotherapy, explanation of the nature of panic disorder, setting up experiments, and testing specific predictions. Similarly, the treatment of OCD entails addressing the patient's beliefs in thought-action fusion (loss of control), responsibility for neutralizing intrusions (control and guilt), and the personal implication of intrusions (guilt and shame) (Clark, 2004). These cognitive elements of OCD are also "emotional schemas" in that they constitute a rule-book that these individuals use for handling "unwanted" thoughts, images, and emotions.

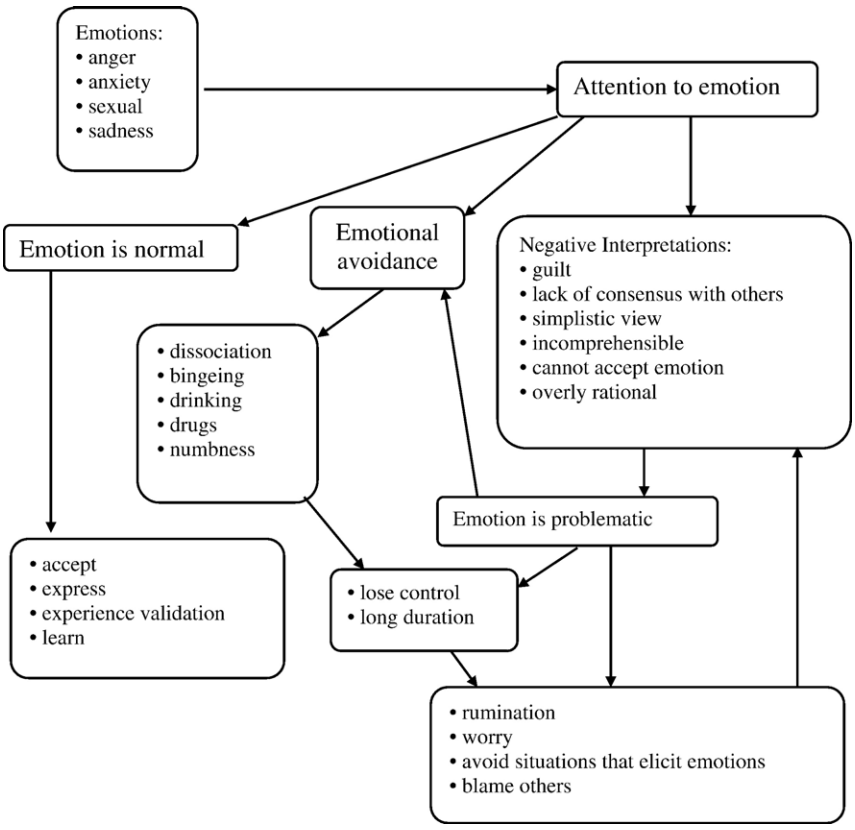

Figure 1. Model of emotional schemas.

Each anxiety disorder is based on the individual's *theory of mind*—specifically, a theory about the meaning, danger, and control of anxiety and the thoughts, images, and sensations related to anxiety. The meta-emotional and meta-cognitive model outlined here attempts to directly address these theories of anxiety in a manner consistent with other meta-cognitive models of treatment (Papageorgiou & Wells, 2001; Wells & Carter, 2001). These dimensions include beliefs about control, duration, shame, uniqueness, personal implication, validation, expression, and the role of rumination and other strategies. Specific interventions based on the emotional schema model are described below.

The Solution Is the Problem

Each anxiety disorder may be characterized as a set of rules that are employed to avoid the negative effects of anxious arousal, thoughts, or sensations. These strategies or solutions include hypervigilance for emotion, attempts to suppress, escape, avoidance, and the use of safety behaviors. For example, individuals with social anxiety disorder are hypervigilant for any signs of their own arousal or signs of negative evaluation from others, they attempt to suppress or hide their arousal from others, they often escape from or avoid situations that elicit their anxiety, and they rely on safety behaviors (overpreparing, clutching furniture, lowering their eye-gaze, misusing alcohol) in order to prevent others from detecting their anxiety (Rodebaugh, Holaway, & Heimberg, 2004). Each of these "solutions" *constitutes* social anxiety—*thereby making the solution the problem.*

Similarly, individuals with generalized anxiety disorder (GAD) are hypervigilant for any thoughts about potential mistakes or bad outcomes, they engage in safety behaviors (such as overpreparing, "what-iffing"), they attempt to eliminate their worries by searching for perfect solutions in order to eliminate uncertainty, and they may procrastinate or avoid situations that may trigger their worry. Again, these solutions actually constitute GAD.

Each anxiety disorder is an attempt to eliminate anxiety because of the individual's negative interpretation of anxious thoughts, sensations, or arousal. These interpretations and strategies—which I call "emotional schemas"—are impediments to CBT, since prolonged exposure to anxiety is in conflict with the individual's theory of how anxiety should be handled (Leahy, 2003a). Indeed, the therapist is asking the patient to abandon the solutions in order to discover that the problem will disappear once the solutions are relinquished. Thus, CBT may seem counterintuitive to the anxious patient.

Emotion-Control Strategies and Resistance

Each of the anxiety disorders constitutes the individual's theory of how the anxiety can be controlled. Thus, the panic disordered patient believes that the best strategy is to avoid situations that elicit anxious arousal, direct attention toward internal sensations, interpret these as signs of impending physical catastrophe or mental breakdown, and look for signs of escape. The panic theory is that arousal is dangerous, that it will escalate and will last indefinitely. Individuals utilizing an OCD theory believe that they should watch for any intrusive thoughts, catch them early, suppress them, neutralize them through compulsions, and avoid situations that trigger these thoughts. Again, the fear is that anxiety will escalate out of control with exposure and that one is responsible for neutralizing obsessions.

Anxiety theories held by patients follow a Catch-22 logic: First, if there are breakthrough high escalations of anxiety, one should implement the emotion-control strategies even more forcefully; and, second, in the more likely case that emotions do not escalate to catastrophic levels, the patient will conclude that the strategies are working. An emotional schema approach to these "anxiety-theories" allows the therapist to identify the patient's idiosyncratic beliefs about the disorder, consider how these beliefs will interfere with compliance to exposure with response prevention, and modify these beliefs using cognitive, behavioral, and experiential techniques.

Anticipating Noncompliance

Identifying the Patients Theory of Anxiety

CBT addresses a number of the components of the emotional schema model in the treatment of each of the anxiety disorders. For example, CBT emphasizes psychoeducation (comprehensibility, consensus, guilt/shame), exposure (expression), and the prevention of neutralization, escape or the use of safety behaviors (acceptance, duration, control). It is proposed here that directly addressing the dimensions of emotional schemas prior to exposure will enhance compliance with treatment. For example, in the treatment of panic disorder and agoraphobia, patients can be given information and rational perspectives on the issues of "comprehensibility" (panic disorder is a genetically predisposed condition that was adaptive in the evolutionary primitive environment to enhance avoidance of situations that conferred danger—for example, open spaces, heights, closed spaces). Similarly, their guilt or shame can be reduced by indicating that panic is an automatic and adaptive response that means that their ancestors were more likely to survive—it is now the right response at the wrong time. Many patients with anxiety disorders believe that the intense experience of their anxiety will continue to rise with continued exposure—a question that can be directly addressed prior to exposure: "What do you think will happen with your anxiety if you do this? How long will it be at these high levels?" Abandoning safety behaviors or

escape can also be addressed: "You may believe that your anxiety will continue to rise unless you control it—have you ever given up trying to control it to see what happens?"

Strategies for Intervention

Treatment of each of the anxiety disorders will involve some degree of exposure, which requires the activation of emotional schemas. I review below a number of dimensions of emotional schemas that are relevant to noncompliance and fear of treatment.

Validation, Comprehensibility, and Consensus

A distinctive feature of CBT is socialization and psychoeducation of patients. The patient is viewed as part of a collaborative alliance in addressing the problems that are presented. In order to reduce noncompliance, the therapist can validate the difficulty of the anxiety disorder: "It must be very difficult to feel awkward and anxious around people" (social anxiety disorder) or "Your OCD has interfered in your daily life so much that you often have felt hopeless about ever getting better" (OCD). It is important to recognize that many patients not only wish to have their problems solved, but they also want to have their emotional struggle recognized and appreciated—they want to feel cared for. Validation is the first step in effective CBT.

Understanding the nature of the problem—and the solution—will help the patient gain a sense of control. Indeed, if the patient does not understand why the problem exists, it is hard to imagine how he or she will believe that the solution is worth the discomfort of exposure. Bibliotherapy or the use of patient information handouts help the patient "make sense" of the problem and, in fact, help the patient recognize that millions of other people have similar problems (see Leahy & Holland, 2000). Patient-interest groups, such as the OC Foundation or the National Alliance for the Mentally Ill, also reduce the sense that one is alone with the problem.

Acceptance and Expression

Accepting that one has anxiety symptoms (rather than struggling, ruminating, or feeling ashamed) is an important starting point for changing them. The individual who does not accept the symptom adds to the sense of danger, personal implication, shame, guilt, and loss of control. Acceptance is a core strategy of emotional processing in dialectical behavior therapy, acceptance and commitment therapy, and mindfulness training (Blackledge & Hayes, 2001; Linehan, 1993). Acceptance of an intrusion would eliminate the hypervigilance and suppression of the intrusion, which can allow the patient to test the belief that one must be on guard for internal states of anxiety. Similarly, acceptance of uncertainty can reduce the need to worry to find perfect solutions, dramatically reducing the symptoms of GAD (Dugas, Buhr, & Ladouceur, 2004).

Expression of emotion—allowing oneself to have an emotion—can allow the patient to test the beliefs that having anxiety will lead to escalation, loss of control, mental collapse, or physical danger. The patient's predictions about the consequences of expression can be elicited and set up as an experimental test of a theory of anxiety. It is essential that the exposure to having the emotion is extended, since short exposure without habituation runs the risk of sensitizing the patient to emotional experience. For example, the OCD patient's belief that the expression or experience of anxiety will rise and remain high cannot be disconfirmed without extensive and repeated exposure. Indeed, the short exposures that the patient may have experienced may have continued to confirm the belief that expression or acceptance simply makes things worse.

Duration and Temporal Variability

A common misconception that anxious individuals have is that their intense anxiety will rise uncontrollably unless they escape or neutralize. The obsessive-compulsive individual believes that the intense anxiety will escalate and last indefinitely—requiring immediate neutralization—and the patient with panic disorder believes that the intense panic attacks will also last indefinitely. This belief can be addressed directly prior to exposure: "Many people with anxiety problems believe that their anxious arousal will escalate beyond control and will last indefinitely unless they escape from the situation. This belief has maintained and reinforced your anxiety—since you seldom stay long enough to find out that your anxiety will naturally decline on its own—even if you do absolutely nothing to make it decline." The question of duration of anxiety can be addressed by asking the patient what has happened after every increase in anxiety—has the anxiety decreased? This is similar to the dialectical behavior therapy view that reality (including emotions) is *impermanent*. If emotions or arousal are impermanent, then there is less to fear.

Control and Globalization Beliefs

Anxious individuals believe that their sensations, intrusive thoughts or images, or anxious arousal must be controlled or dire consequences will ensue. Since control is often immediately implemented (in panic, by escaping; in OCD, by neutralizing; and in social anxiety disorder, either by hiding, avoiding, or by escaping), the individual does not have the opportunity to disconfirm the belief that control needs to be taken. Control beliefs underlie the reliance on safety behaviors that serve to neutralize or "protect" the anxious individual from losing control (Salkovskis, Clark, Hackmann, Wells, & Gelder, 1999). If

the patient continues to believe that the safety behaviors are necessary, then exposure is compromised (Wells, 1997). The purpose of exposure is to disconfirm the patient's belief that giving up control (neutralization, avoidance, or escape) will result in catastrophe. Indeed, practicing the symptom (anxiety or physical sensations) without struggling to gain control confirms the belief that anxiety can be tolerated—and, therefore, does not need to be controlled.

These beliefs about controllability increase the sense of lack of control as intrusive thoughts and images cannot be eliminated and anxious arousal is not amenable to willful affirmations (Wegner, 1989; Wegner & Zanakos, 1994). Simply, the more the patient tries to control intrusive thoughts and "unpleasant" emotions, the more uncontrollable and frightening they appear. The therapist can point out that illusions of needing and manifesting control have maintained the anxiety disorder by requiring the impossible (control of the uncontrollable; see Hayes, Luoma, Bond, Masuda, & Lillis, 2006). In fact, "uncontrollability" can be viewed as a phobic problem in itself—that is, the fear of losing control. This can be addressed directly through experiments in losing control ("Try going crazy") or mindfulness exercises that refocus to being an observer rather than someone who controls and judges anxious arousal (Roemer & Orsillo, 2002). Similarly, relinquishing control can also be manifested by attentional training and reduced vigilance (see Bogels & Mansell, 2004; Wells, 1997)—setting up the experiment of intentionally redirecting attention elsewhere to see what happens with the anxiety ("If I don't control, does it escalate?"). The use of mindfulness may engage a metacognitive mode of processing and increase flexibility in response to threat (Toneatto, 2002; Wells, 2002) that allows the patient to detach from the experience while observing it. In this sense, metacognitive, acceptance and mindfulness models of emotional avoidance complement one another.

Related to the sense of control is the degree of helplessness and hopelessness about the symptoms that reoccur. In addition, beliefs about the self ("I am a neurotic") that are global and stable may also demoralize anxious individuals who consider treatment. Dunmore, Clark, and Ehlers (1999) found that longer-term outcome for patients with PTSD was affected by appraisal of symptoms, perceived negative responses of others, and beliefs in permanent change. Thus, the interpretation of controllability, global personal inference, and shame are important components of the maintenance of symptoms (Ehlers & Clark, 2000; Ehlers et al., 1998). The belief that one's symptoms are part of a larger pattern of incompetence or insanity also undermines effective outcome (Steil & Ehlers, 2000). The therapist can address these global beliefs by asking the patient to consider the anxiety disorder as a "limited and specific vulnerability." For example, the patient can list all of the behaviors, thoughts, feelings, and relationships where the anxiety disorder is not disabling. Compartmentalizing the problem allows the patient to feel less overwhelmed and more hopeful of change.

Shame

The sense of humiliation that accompanies many anxiety disorders makes it difficult for some patients to pursue treatment. For example, a male patient who believed that his continued PTSD was a sign of weakness and failure delayed seeking treatment, since treatment was further evidence that he was "not a man"—an example consistent with the predictors of poor outcome for traumatized patients (Clohessy & Ehlers, 1999). Individuals with OCD may feel guilt about their intrusive images and thoughts, making them reluctant to engage in exposure. Indeed, the shame that accompanies these intrusive thoughts and urges may inhibit the patient from either disclosing these thoughts or in continuing in treatment (Gilbert & Andrews, 1998). Patients with OCD or PTSD who experience shame about their intrusive thoughts, images, and avoidance may be encouraged to know that shame is a common core feature of the disorder. We have found it useful to tell patients directly that intrusive thoughts and images often evoke shame in patients because of their perfectionistic standards for their emotions and thoughts. Indeed, the shame that accompanies these intrusions makes them more disturbing and, thus, adds to their personal significance and to the attention given them. If the individual were not ashamed of these mental and emotional phenomena—and recognized that a vast majority of nonclinical individuals have similar thoughts and images—then the shame can be reduced.

Shame, of course, is a central component of social anxiety disorder, as the individual attempts to hide the anxiety symptoms from other people. The patient can be asked exactly what is predicted should someone know that he or she is anxious and then to test these predictions by disclosing the anxiety to several friends. Further, the shame can be reduced by having the patient canvas other people about their psychological problems. We have found that this often reduces the shame—and increases the consensus and validation—because many friends or family members will acknowledge specific phobias, obsessions, or other problems.

Guilt

A sense of responsibility to do something about an intrusive thought or image is a central feature of both OCD and GAD (Clark, 2004; Purdon & Clark, 1993, 1994; Wells, 2000). The individual believes that the occurrence of the intrusion and the possibility that one can take

action to neutralize constitutes an absolute responsibility to do something. Accordingly, anxious patients are driven by an impossible standard of responsibility that they believe will help avoid future regret. Acceptance of lack of control and the "reasonable person" criteria for responsibility are important antidotes to the perfectionistic standards used by individuals with OCD or GAD. Moreover, the belief that one should never regret anything also constitutes a demand for absolute certainty that drives patients toward anticipating every possible way that things can go badly (Dugas et al., 2004). The therapist can point out that responsibility is based on reasonable ability to know and control—and that "moral standards" are those that we would apply universally to enhance human dignity (Leahy, 2001b).

Clinical Interventions for Emotional Schemas

In the section to follow, I will provide specific interventions addressed to each emotional schema. Suggested clinical interventions for each of the 14 emotional schema dimensions are shown in Table 1.

Emotional Schemas: Specific Examples

Guilt. Let us assume that the patient is feeling guilty over her angry feelings toward her mother. If she can understand that her feelings make sense, given what her mother may have said, and that others would feel the same way, given the situation—then she may feel less guilty. Validating her angry feelings and pointing out to her that she does not always have to be logical and rational would also help her feel less guilty. As she recognizes that her feelings may be due to a specific interaction or a specific relationship, she may be able to compartmentalize her angry feelings and recognize that they will not last forever and that she will not lose control. Recognizing all of the foregoing should help her reduce her rumination.

Rumination. According to Nolen-Hoeksema's (2000) model of rumination and depression, the consequence of rumination is increased self-focus on negative feelings that increase access to negative cognitions, thereby maintaining these negative emotions. Rumination also reduces the opportunity to experience pleasurable activities. Nolen-Hoeksema and her colleagues have found that individuals ruminate because they view this process as a problem-solving strategy. When we apply this to emotions, we can see that the individual who has a simplistic view of feelings (e.g., "I should have only one emotion") would be perplexed and would be more likely to ruminate. Similarly, a belief that emotions are problematic and that one should always emphasize rationality and logic would lead someone to ruminate in order to get rid of the emotion. Rumination is reduced when the individual experiences validation and finds that others share similar feelings, thereby making his feelings comprehensible and, therefore, not requiring further rumination. Furthermore, by making feelings comprehensible and finding consensus, the individual is less likely to feel guilty and less likely to believe that she will lose control.

For example, the woman who is angry with her mother and who is ruminating about this can find validation from friends or her therapist and can learn that others would respond to mother in a similar way. Thus, her feelings make sense for her—she is not alone. This reduces her guilt. She may also learn that she can love her mother and be angry at her—learning to tolerate ambivalent feelings—and that she does not always have to be rational and logical. The tolerance of ambivalence and the recognition that her feelings make sense may help her recognize that her angry feelings or her confusion will not last indefinitely.

Control. The belief that one does not have control over feelings is related to higher anxiety in a number of studies. This is consistent with the cognitive model that suggests that anxious individuals believe that they will lose control of their worry, emotions, or behavior. How can the individual learn that he has control? (Or, paradoxically, how can he learn that giving up on control as a goal may result in feeling "more in control"?). Again, imagine the woman who is angry with her mother. She may fear that she will lose control and say something hurtful or that she may lose control and "break down." She can gain greater sense of control over her feelings by taking a less simplistic view—that one can love and be angry at the same person—thereby indicating that she does not have to eliminate one set of feelings. Similarly, she is less likely to feel the need to control all of her feelings if she can become less guilty over her feelings. She can learn that her feelings make sense or that she has a right to her feelings through validation and finding a consensus, thereby helping her understand that others, who have some control, understand her feelings and share her perspective. Her sense of control can be improved if she recognizes that she does not always have to be rational and fair and that she can accept her anger as part of being a family member.

Validation. We have found that validation is related to a number of emotional schemas: increased consensus, control, shorter duration, less guilt, less simplistic views, more acceptance, and less rumination (Leahy, 2001a). Again, imagine the woman who is angry with her mother. How can validation be helpful? By sharing her thoughts and feelings with others, and by feeling supported by them, she may learn that others share her feelings, that her reaction to her mother makes sense, that she can express her feelings without losing control, and that she can accept the way she is feeling at the present time. This may assist her in feeling less guilty. As her feelings become

Table 1
Emotional Schemas: Interventions

Dimensions	Interventions
Validation	Are there some people who accept and understand your feelings? Do you have arbitrary rules for validation? Do people have to agree with everything you say? Are you sharing your emotions with people who are critical? Do you accept and support other people who have these emotions? Do you have a double-standard? Why?
Comprehensibility	Do the emotions make sense to you? What could be some good reasons why you are sad, anxious, angry, etc.? What are you thinking (what images do you have) when you are sad, etc. What situations trigger these feelings? If someone else experienced this, what kinds of different feelings could they have? If you think your feelings don't make sense right now, what does this make you think? Are you afraid that you are going crazy, losing control? Are there things that happened to you as a kid (or at other times) that might account for why you feel this way?
Guilt and Shame vs. Legitimacy	What are the reasons that you think your emotions are not legitimate? Why shouldn't you have the feelings that you have? What are some reasons that your feelings make sense? Is it possible that others could have the same feelings in this situation? Can you see that having a feeling (like anger) is not the same as acting on it (for example, being hostile)? Why are certain emotions good and others are bad? If someone else had this feeling, would you think less of him? How do you know if an emotion is bad? What if you looked at feelings and emotions as experiences that tell you that something is bothering you—like a caution sign, a stop sign, or a flashing red light? How is anyone harmed by your emotions?
Simplicity vs. Complexity	Do you think that having mixed feelings is normal or abnormal? What does it mean to have mixed feelings about someone? Aren't people complicated and so you could have different, even conflicting, feelings? What is the disadvantage of demanding that you have only one feeling?
Relationship to Higher Values	Sometimes we feel sad, anxious, or angry because we are missing something that is important to us. Let's say you feel sad about a breakup in a relationship. Doesn't this mean that you have a higher value that's important to you—for example, closeness and intimacy? Doesn't this say something good about you? If you aspire to higher values, doesn't this mean that you will have to be disappointed at times? Would you want to be a cynic who values nothing? Are there other people who share your higher values? What advice would you give them if they were going through what you are going through?
Controllable/Tolerable vs. Chaotic/Overwhelming	Do you think that you have to control your feelings and get rid of the "negative" feelings? What do you think would happen if you couldn't get rid of that feeling entirely? Is it possible that trying to get rid of a feeling completely makes that feeling too important to you? Are you afraid that having a strong feeling is a sign of something worse? Going crazy? Losing complete control? Isn't there a difference between controlling your actions and controlling your feelings?
Numbness	Are there situations that trigger spacing out? No feelings? Are there situations that bother most people that don't bother you? Do people think that you are blunted or empty in your feeling? What kinds of strong feelings do you have? Do you ever notice having a strong feeling and then you try not to have it? Do you ever have the feeling like you are going to cry but you stop it? What do you fear would happen if you let go and let yourself have those feelings? What kinds of thoughts do you have when you have strong feelings? Do you ever drink or use drugs or binge on food to get rid of those strong feelings?
Rationality, Anti-emotional	Do you think you should always be logical and rational? What would you be concerned about if you were not rational/logical? Do you think that people who are rational or logical are "better" people? What's happened in the past when you haven't been logical/rational? Is it possible that some experiences are not logical/rational, but simply emotional? Is there a rational painting? Rational song? Can your emotions tell you about what is hurting? What needs to be changed? Are emotions an important source of need, desire, neglect, and rights? Do you know other people who are less rational than you, but who have a happier or fuller life?

Duration of Strong Feelings	Do you have fears that a strong feeling will last too long? Have you had strong feelings before? What happened? Did they end? Why did they end? Do strong feelings go up and down? If you had a strong feeling in our meeting, what do you think would happen? If you cried or felt really bad for few minutes, what would you think would happen? What would you gain by finding out that your strong feelings can be expressed and can go away?
Consensus with Others	Exactly what feelings do you have that you think other people don't have? If someone else had these feelings, what would you think of them? When you see very emotional plays or movies or read emotional novels or stories, why do they appeal to people? Do you think that people like to find out that other people have the same feelings? Are there other people who are sad, angry, or anxious? Is it normal to be upset, have fantasies, etc.? If you are ashamed of your feelings and don't tell people, do you think that this keeps you from finding out that others have the same feelings?
Acceptance or Inhibition	What will happen if you allow yourself to accept an emotion? Will you act on it (feeling-action fusion)? Do you fear that if you accept an emotion it won't go away? Or do you think that not accepting your emotions will motivate you to change? What are the negative consequences of inhibiting a feeling? Excessive use of attention and energy? Rebound effect? Does the emotion conflict with a belief about good-bad feelings? If you deny that something bothers you, how could you fix the problem?
Rumination vs. Instrumental Style	What are the advantages and disadvantages of focusing on how bad you feel? When you are focusing on how bad you feel, what kinds of things are you thinking and feeling? Do you sit and think, "What's wrong with me?" or "Why is this happening to me?" Do you focus on sadness, replaying in your mind the same things over and over? Do you sometimes think that if you keep thinking about it you will come up with a solution? Does your rumination (worry) make you worry that you can't control your worries? Try setting aside 30 minutes each day when you will intensely worry and set aside your worries until that time. Rephrase your worries into behaviors that you can carry out, problems that you can solve. Distract yourself by taking action or calling a friend and talking about something other than your worries. Exactly what do you predict will happen? Have your predictions proved false? When you are ruminating, you are chewing things over. Is there some "truth" or "reality" that you just refuse to accept?
Expression	If you expressed a feeling, would you "lose control"? Feel worse? How long would you feel worse? Can expressing a feeling help you clarify your thoughts and feelings? Conversely, if you only focus on expressing a feeling, will you overfocus on these feelings? Will you become self-absorbed? Are there things that you can do to distract yourself or solve problems?
Blaming Others	What did other people say or do that made you feel the way you do? What thoughts did you have that made you feel sad, angry, anxious, etc.? If you thought about this differently, what would you feel or think? Are your feelings dependent on what others think of you? Are you focused on getting approval, respect, appreciation, or fairness? What would be the advantage and disadvantage of not needing approval, etc.? What rewards does the other person currently control? Can you have rewarding experiences despite what they said, did, etc.? Is it possible that your feelings are a combination of what is happening to you and what you are thinking? What would you like to feel—angry, sad, curious, indifferent, accepting, challenged? What are the costs and benefits of these different feelings? What would you have to think in order to have each of these feelings, given the situation? What would you like to have happen? How can you be more assertive? Solve problems? What thoughts would you have to change?

more comprehensible, she may have a less simplistic view of the situation, since others may help her recognize the complexity of ambivalence. Consequently, she will ruminate less.

I have outlined in Table 1 a variety of questions, interventions, and behavioral experiments that might be used to address the patient's underlying theory of anxiety regulation and the emotional schemas that may be an impediment to effective treatment.

Conclusions

Noncompliance—early dropout, unwillingness to engage in exposure, and low compliance with self-help homework—poses significant problems in the treatment of anxiety disorders. This is especially true with cognitive-behavioral treatments that require exposure with response prevention. I have suggested that the clinician might benefit by identifying the patient's theory of anxiety—and how anxiety is regulated—using a meta-emotional and meta-cognitive framework. The model described here is consistent with other models that target experiential avoidance and emotional processing as key factors in the efficacy of exposure and the treatment of anxiety (Blackledge & Hayes, 2001; Foa & Kozak, 1986; Mennin, Heimberg, et al., 2002). A specific value of the emotional schema model is that it directly addresses the patient's conceptualization and strategy for "difficult" emotions, providing the clinician with potentially helpful interventions.

The clinician needs to be mindful that exposure treatment may appear not only counterintuitive to the emotionally avoidant patient, but may activate strategies of escape and avoidance, such as noncompliance or premature dropout. The emotional schema model acknowledges that the patient's "motivational" problem may reflect more pervasive problematic views of "difficult" emotions. This model allows both clinician and patient to anticipate and address the roadblocks that can interfere with successful treatment. Indeed, these roadblocks, which constitute the solutions to the problem of anxiety, are themselves the anxiety disorder.

References

Badura, A. (2003). Theoretical and empirical exploration of the similarities between emotional numbing in posttraumatic stress disorder and alexithymia. *Journal of Anxiety Disorders, 17*, 349–360.

Blackledge, J. T., & Hayes, S. C. (2001). Emotion regulation in acceptance and commitment therapy. *Journal of Clinical Psychology, 57*, 243–255.

Bogels, S. M., & Mansell, W. (2004). Attention processes in the maintenance and treatment of social phobia: Hypervigilance, avoidance and self-focused attention. *Clinical Psychology Review, 24*, 827–856.

Clark, D. A. (Ed.). (2004). *Intrusive Thoughts in Clinical Disorders: Theory, Research, and Treatment*. New York: The Guilford Press.

Clohessy, S., & Ehlers, A. (1999). PTSD symptoms, response to intrusive memories and coping in ambulance service workers. *British Journal of Clinical Psychology, 38*, 251–265.

Culhane, S. E., & Watson, P. J. (2003). Alexithymia, irrational beliefs, and the rational-emotive explanation of emotional disturbance. *Journal of Rational-Emotive & Cognitive Behavior Therapy, 21*, 57–72.

Dugas, M. J., Buhr, K., & Ladouceur, R. (2004). The role of intolerance of uncertainty in the etiology and maintenance of generalized anxiety disorder. In R. G. Heimberg, C. L. Turk, & D. S. Mennin (Eds.), *Generalized Anxiety Disorder: Advances in Research and Practice* (pp. 143–163). New York: The Guilford Press.

Dunmore, E., Clark, D. M., & Ehlers, A. (1999). Cognitive factors involved in the onset and maintenance of posttraumatic stress disorder (PTSD) after physical or sexual assault. *Behaviour Research and Therapy, 37*, 809–829.

Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy, 38*, 319–345.

Ehlers, A., Clark, D. M., Dunmore, E., Jaycox, L., Meadows, E., & Foa, E. B. (1998). Predicting response to exposure treatment in PTSD: The role of mental defeat and alienation. *Journal of Traumatic Stress, 11*, 457–471.

Eizaguirre, A. E., Saenz de Cabezon, A. O., Alda, I. O. d., Olariaga, L. J., & Juaniz, M. (2004). Alexithymia and its relationships with anxiety and depression in eating disorders. *Personality & Individual Differences, 36*, 321–331.

Foa, E. B., & Kozak, M. J. (1986). Emotional processing of fear: Exposure to corrective information. *Psychological Bulletin, 99*, 20–35.

Gilbert, P., & Andrews, B. (Eds.). (1998). *Shame: Interpersonal behavior, Psychopathology, and Culture*. London: Oxford University Press.

Hayes, S. C., Luoma, J. B., Bond, F. W., Masuda, A., & Lillis, J. (2006). Acceptance and commitment therapy: Model, processes and outcomes. *Behaviour Research and Therapy, 44*, 1–25.

Leahy, R. L. (2001a, November). *Emotional schemas in cognitive therapy*. Paper presented at the annual meeting of the Association for Advancement of Behavior Therapy, Philadelphia, PA.

Leahy, R. L. (2001b). *Overcoming Resistance in Cognitive Therapy*. New York: The Guilford Press.

Leahy, R. L. (2002a). A model of emotional schemas. *Cognitive and Behavioral Practice, 9*, 177–190.

Leahy, R. L. (2002b, November). *A model of emotional schemas*. Paper presented at the annual meeting of the Association for Advancement of Behavior Therapy, Reno, NV.

Leahy, R. L. (2003a). Emotional schemas and resistance. In R. L. Leahy (Ed.), *Roadblocks in Cognitive-Behavioral Therapy: Transforming Challenges into Opportunities for Change* (pp. 91–115). New York: The Guilford Press.

Leahy, R. L. (2003b, September). *Metacognition, emotional schemas and personality disorders*. Paper presented at the European Association of Cognitive and Behavioral Psychotherapy, Prague, Czech Republic.

Leahy, R. L., & Holland, S. J. (2000). *Treatment Plans and Interventions for Depression and Anxiety Disorders*. New York: The Guilford Press.

Leahy, R. L., & Kaplan, D. (2004, November). *Emotional schemas and relationship adjustment*. Paper presented at the annual meeting of the Association for Advancement of Behavior Therapy, New Orleans, LA.

Leung, A. W., & Heimberg, R. G. (1996). Homework compliance, perceptions of control, and outcome of cognitive-behavioral treatment of social phobia. *Behaviour Research and Therapy, 34*(5-6), 423–432.

Linehan, M. M. (1993). *Cognitive-Behavioral Treatment of Borderline Personality Disorder*. New York: The Guilford Press.

Lundh, L. -G., Johnsson, A., Sundqvist, K., & Olsson, H. (2002). Alexithymia, memory of emotion, emotional awareness, and perfectionism. *Emotion, 2*, 361–379.

Mennin, D. S., Heimberg, R. G., Turk, C. L., & Fresco, D. M. (2002). Applying an emotion regulation framework to integrative approaches to generalized anxiety disorder. *Clinical Psychology: Science and Practice, 9*, 85–90.

Monson, C. M., Price, J. L., Rodriguez, B. F., Ripley, M. P., & Warner, R. A. (2004). Emotional deficits in military-related PTSD: An investigation of content and process disturbances. *Journal of Traumatic Stress, 17*, 275–279.

Nolen-Hoeksema, S. (2000). The role of rumination in depressive disorders and mixed anxiety/depressive symptoms. *Journal of Abnormal Psychology, 109*, 504–511.

Papageorgiou, C., & Wells, A. (2001). Metacognitive beliefs about rumination in major depression. *Cognitive and Behavioral Practice, 8*, 160–163.

Purdon, C., & Clark, D. A. (1993). Obsessive intrusive thoughts in nonclinical subjects: I. Content and relation with depressive, anxious and obsessional symptoms. *Behaviour Research and Therapy, 31*, 713–720.

Purdon, C., & Clark, D. A. (1994). Obsessive intrusive thoughts in nonclinical subjects: II. Cognitive appraisal, emotional response and thought control strategies. *Behaviour Research and Therapy, 32*, 403–410.

Rodebaugh, T. L., Holaway, R. M., & Heimberg, R. G. (2004). The treatment of social anxiety disorder. *Clinical Psychology Review, 24*, 883–908.

Roemer, L., & Orsillo, S. M. (2002). Expanding our conceptualization of and treatment for generalized anxiety disorder: Integrating mindfulness/acceptance-based approaches with existing cognitive-behavioral models. *Clinical Psychology: Science & Practice, 9*, 54–68.

Salkovskis, P. M., Clark, D. M., Hackmann, A., Wells, A., & Gelder, M. G. (1999). An experimental investigation of the role of safety-seeking behaviours in the maintenance of panic disorder with agoraphobia. *Behaviour Research and Therapy, 37*, 559–574.

Steil, R., & Ehlers, A. (2000). Dysfunctional meaning of posttraumatic intrusions in chronic PTSD. *Behaviour Research and Therapy, 38*, 537–558.

Stewart, S. H., Zvolensky, M. J., & Eifert, G. H. (2002). The relations of anxiety sensitivity, experiential avoidance, and alexithymic coping to young adults' motivations for drinking. *Behavior Modification, 26*, 274–296.

Taylor, G. J., Bagby, R., & Parker, J. D. A. (1997). *Disorders of Affect Regulation: Alexithymia in Medical and Psychiatric Illness*. New York: Cambridge University Press.

Toneatto, T. (2002). A metacognitive therapy for anxiety disorders: Buddhist psychology applied. *Cognitive and Behavioral Practice, 9*, 72–78.

van Minnen, A., Arntz, A., & Keijsers, G. P. J. (2002). Prolonged exposure in patients with chronic PTSD: Predictors of treatment outcome and dropout. *Behaviour Research and Therapy, 40*, 439–457.

Vogel, P. A., Stiles, T. C., & Gotestam, K. (2004). Adding cognitive therapy elements to exposure therapy for obsessive compulsive disorder: A controlled study. *Behavioural and Cognitive Psychotherapy, 32*, 275–290.

Wegner, D. M. (1989). *White Bears and Other Unwanted Thoughts: Suppression, Obsession, and the Psychology of Mental Control*. New York: Penguin.

Wegner, D. M., & Zanakos, S. (1994). Chronic thought suppression. *Journal of Personality, 62*, 615–640.

Wells, A. (1997). *Cognitive Therapy of Anxiety Disorders: A Practice Manual and Conceptual Guide*. New York: Wiley.

Wells, A. (2000). *Emotional Disorders and Metacognition: Innovative Cognitive Therapy*. New York: Wiley.

Wells, A. (2002). GAD, metacognition, and mindfulness: An information processing analysis. *Clinical Psychology: Science and Practice, 9*, 95–100.

Wells, A., & Carter, K. (2001). Further tests of a cognitive model of generalized anxiety disorder: Metacognitions and worry in GAD, panic disorder, social phobia, depression, and nonpatients. *Behavior Therapy, 32*, 85–102.

Address correspondence to Robert L. Leahy, Ph.D., American Institute for Cognitive Therapy, 136 East 57th St., Suite 1101, New York, NY 10022, USA; e-mail: AICT@aol.com.

Received: December 22, 2005
Accepted: August 8, 2006
Available online 4 January 2007