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Therapy focused on the reduction of threat perception (TFRTP) based on the PAMTA and ACT model to decrease pathological worry

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ABSTRACT

Worry is a complex process of great adaptive utility for the human being, which is possible due to the capacity for anticipation and language. According to the PAMTA model (Perception of future threat, Activation, Motivation, Thought and Action), it reduces the probability that we are affected by different threats or mitigate their effects if they occur. However, dysfunctions are frequently observed in the worry process that is associated with different disorders, such as social anxiety, depression and, especially, generalized anxiety disorder. In the present work, the Therapy focused on

the reduction of threat perception (TFRTP) is described as an intervention proposal for pathological worry based on the PAMTA model, which sequentially describes different steps to carry out the worry process in an adaptive way and points out different aspects that can make it dysfunctional. Likewise, different proposed acceptance and commitment therapy (ACT) strategies are used. The most novel aspects of the proposed treatment are: 1) it provides a guide to worry adaptively, 2) it places particular emphasis on reducing the perception of threat, in which strategies such as cognitive implosion and radiating circumference are used, and 3) The use of ACT to cope with cognitive fusion and promote psychological flexibility. Finally, some aspects of the intervention are discussed, and the need for further studies to study the efficacy of TFRTP is pointed out.

Keywords: Anxiety; stress; worry; treatment; acceptance and commitment therapy; generalized anxiety disorder.

Resumen

La preocupación es un proceso complejo de gran utilidad adaptativa para el ser humano, el cual es posible debido a la capacidad de anticipación y del lenguaje. Según el modelo PAMPA (Percepción de futura amenaza, Activación, Motivación, Pensamiento y Acción) reduce la probabilidad de que estemos afectados por diferentes amenazas o paliemos los efectos de estas en caso de presentarse. Pero, frecuentemente, se observan disfunciones en el proceso de preocupación que se asocian a diferentes

trastornos, como, por ejemplo, ansiedad social, depresión, y sobre todo el trastorno de ansiedad generalizada. En el presente trabajo se describe la Terapia centrada en la reducción de la percepción de amenaza (TCRPA) una propuesta de intervención para la preocupación patológica basada en el modelo PAMPA, el cual describe secuencialmente diferentes pasos para realizar el proceso de la preocupación de forma adaptativa y señala diferentes aspectos que lo pueden hacer disfuncional. Asimismo, se utilizan diferentes estrategias propuestas de la terapia de aceptación y compromiso (ACT). Los aspectos más novedosos del tratamiento propuesto son 1) proporciona una guía para preocuparse de forma adaptativa, 2) pone especial énfasis en la reducción de la percepción de amenaza, en el cual se utilizan estrategias como la implosión cognitiva y la circunferencia radiada y 3) el uso de la ACT para hacer frente a la fusión cognitiva y favorecer la flexibilidad psicológica. Finalmente, se discuten algunos aspectos de la intervención y se señala la necesidad de realizar estudios posteriores para estudiar la eficacia de la TCRPA.

Palabras clave: Ansiedad; estrés; preocupación; tratamiento; terapia de aceptación y compromiso; trastorno de ansiedad generalizada.

Worry is a frequent and characteristic human phenomenon (Borkovec et al., 1998). Tallis et al. (1994) reported that 38% of people admit to worrying daily, and up to 72% worry at least once a month. However, when worry becomes excessive, uncontrollable, and chronically present and is accompanied by

elevated levels of discomfort, it may meet the criteria for generalized anxiety disorder (GAD) (APA, 2013), although it can also be used to prevent anxiety from being able to achieve anxiety disorder. However, it is also observed in other disorders, such as social anxiety, panic disorders, depression, etc. (Starcevic et al., 2007). Different explanatory models of GAD have been developed (see a review in Velázquez-Díaz et al., 2016); however, no explanatory models of functional concern have been proposed, except the PAMPA model (Future perception Threat, Activation, Motivation, Thought, and Action) (Padrós et al., 2019), which offers a conceptual understanding of the PAMPA model.

Concern from the PAMPA model (Padrós et al., 2019) is conceived as a complex mechanism that evolved from fear and involved an internal linguistic-verbal activity (Borkovec & Lyonfields, 1993). Note that language is a fundamental aspect of Acceptance and Commitment Therapy (ACT) by Hayes et al. (1999).

The following is a brief description of the PAMPA Concern Model, which consists of four basic steps and four additional steps that are only carried out in some cases (Padrós et al., 2019).

1) Perception of future threat: According to the PAMPA model, worry begins when the person foresees that a circumstance may negatively affect them in the future (although frequently the person is not aware), that is, “they perceive a possible future threat.”

1b) Threat detection: refers to the variability observed in people's ability to identify threats. People who present pathological worry frequently, in an uncontrollable, maladaptive way, and it causes them discomfort.

2) Physiological activation/Increased motivation: refers to the activation of the physiological response, which varies depending on the severity and the probability of occurrence of given to the possible threat, as well as the perceived control (evaluated in the second instance and only in some occasions). At the same time, it affects the motivation to think and act to reduce the probability of the potential threat appearing.

2b) Perceived control: this aspect can significantly reduce the activation and motivation to worry. So, the person frequently assesses the elements available to him to face the potential threat; if the person perceives that he has the elements to face the possible threat to a large extent, the worry and associated anxiety cease.

3) Focusing on what to do: In this phase, the person must consider and plan possible actions.

3b) Metacognitions about the phenomenon of worry: The person may have beliefs about the worry process, which can be positive, such as, for example, "the more time I spend worrying, the more likely I will be to find a solution," or harmful, such as, "the more time I spend worrying, the more likely I will be to find a solution." For example, “If I worry too much, I can get sick.”

4) Action: This phase can affect the external environment since the person carries out specific actions to reduce the risk of being affected by the threat or

alleviate its effects (for example, going to a medical consultation to reduce the risk of the effects of a possible disease).

4b) Evaluation of the effectiveness of the action: in this additional phase, people can evaluate the results of their actions. It is also possible that they evaluate their level of conviction regarding the decisions made.

The conceptualization of worry from the PAMPA model (Padrós et al., 2019) differs from the perspective of others who conceive it as a mechanism related to problem-solving (e.g., Davey, 1994). The association of worry with problem-solving has even given rise to problem-solving therapy (D'Zurilla and Nezu, 2006), widely used to treat depression and anxiety (Zhang et al., 2018). In fact, according to Wells (1999), several patients with GAD maintain the belief that worry is a problem-solving mechanism, which is considered a positive metacognition related to the etiology and maintenance of GAD. However, the concern from the PAMPA model (Padrós et al., 2019) is conceived from an evolutionary perspective. Therefore, it is emphasized that the valuation of actions considers probabilities so that it is considered a behavior effective even though sometimes it does not have positive results. For example, using a seat belt to reduce the risk of severe consequences in the event of an accident is considered an effective and adaptive action, even though a percentage of people have died after a traffic accident with their seat belts fastened. This conceptualization of worry is fundamental (and is emphasized in Psychoeducation, the first component of the intervention proposal) since it favors the acceptance that in most circumstances, the control we exercise is relative, and it is impossible to predict with certainty the outcome. This aspect is essential because it facilitates tolerance to uncertainty and reduces self-demand.

Furthermore, the PAMPA model (Padrós et al., 2019) implicitly implies the idea that in various circumstances, people will suffer the consequences of adverse events, so it is important to accept the idea that suffering is natural, frequent and inevitable, a fundamental element of ACT (Hayes et al., 1999).

One of the fundamental elements of ACT is the fusion between thoughts (internal language) and experiences, which is conceived as a phenomenon that hinders flexibility and adaptive functioning (Hayes, 2004). So, the anxious thought (derived from worry) "fuses" with the feeling of anxiety, with the result that the simple act of having a thought causes a high level of anxiety. It has been reported that people with GAD symptoms show higher levels of negative reactivity towards their own emotions and perceive their worries as dangerous (Lee et al., 2010; Mennin et al., 2005). Therefore, according to Hayes-Skelton et al. (2015), people with GAD tend to make significant efforts to avoid (with the aim of controlling) said thoughts or sensations, which, paradoxically, increases reactivity, fusions and the frequency of the thoughts and sensations that they want to avoid.

So, GAD is partially maintained through fusion. In that case, it is suggested to use decentering, which refers to the ability to observe thoughts and feelings as objective events in the mind rather than personally identifying with them (Safran and Segal, 1990). Decentering is closely related to the concept of cognitive defusion, which is described as a process that alters the relational response and, therefore, the meaning of thoughts through a change of context so that connections between words or specific phrases and subsequent behavior are weakened (see Blackledge, 2007, for a comprehensive theoretical review of defusion). For all these reasons, in this work an intervention proposal is made considering elements of the PAMPA model and ACT.

THERAPY FOCUSED ON REDUCING THREAT PERCEPTION (TCRPA) BASED ON THE PAMPA AND ACT MODEL

The proposed intervention consists of 5 components. Depending on the alterations detected in each patient's worry process, more or less emphasis is placed on one or the other.

The first component is Psychoeducation about worry. Psychoeducation about worry explains what worry is and its usefulness, emphasizing that it is a fundamental mental process and that it is essential to distinguish between thoughts, emotions, and oneself. Exercises can be used to promote cognitive defusion, such as “the lemon exercise” or “distinguishing thoughts as thoughts” (Wilson and Luciano, 2002).

On the other hand, an explanation of worry is extracted from the PAMPA model (Padrós et al., 2019), which implicitly implies an adaptive functioning pattern of worry (see Annex 1). It is noted that it is essential to spend a (relatively brief) time worrying about possible future threats since prolonged worry is ineffective.

Particular emphasis is placed on the frequent conceptualization of worry as a problem-solving mechanism. It is explained that this meaning of concern lacks theoretical and empirical support and can be harmful. Worry is explained as a complex mechanism that begins from perceiving one or more possible future threats and not as a problem-solving mechanism. Note that the word “problem” refers to obstacles that stand in the way of achieving an objective and invites us to think that a correct solution can be found. It is important to

note that frequently, the objects that cause concern can hardly be considered problems (e.g., the imminent death of a loved one, the loss of job status or employment, the fear of abandonment by the partner, or that he or she will be unfaithful to each other) many others), and it is more accurate to conceive them as potential threats. Although frequently, the person does not consciously perceive that they are facing a threat. This event occurs in the case of a job promotion, where the underlying threat could be discomfort in self-image if the promotion is not achieved. Likewise, the relationship between fear and worry is highlighted, as well as the fundamental difference in the severity of the potential damage and the immediacy of the perceived threat of fear. It is emphasized that in both mechanisms, individuals are motivated to act; in the case of fear, the behavior is poorly elaborated but very fast (flight, fight, or freezing), and in the case of worry, the motivation is less; it lasts longer, in time and the behavior is highly elaborate (thought, imagination, anticipation, etc.) and is carried out over a relatively long time from several minutes to months (depending on the perceived threat). It is reported that fear, under natural conditions, has great adaptive utility, but it is only effective in a percentage of cases.

In some cases, actions derived from fear are insufficient, and the individual dies. So, it is a strategy of great adaptive value due to the high percentage of successes. However, like any natural mechanism, it is fallible, and its effectiveness is influenced by elements that the individual does not control. Similarly, it happens with worry; it is an excellent strategy evolved from fear, and in a high percentage of cases, it is very effective but sterile in others. It is emphasized that, in most cases, after using worry, uncertainty remains regarding what may happen, and this, adding to being reasonable, cannot be

eliminated. The person must learn to tolerate it. It can use, for example, the metaphors “The blanket on the grass” or “The waves on the beach” (Wilson and Luciano, 2002).

It is also recommended to administer an instrument for evaluating pathological concerns at the beginning of treatment, such as the PSWQ by Meyer et al. (1990); the reduced version of 8 items can be used (Padrós-Blázquez et al., 2018). Likewise, it is recommended to administer some anxiety, depression, or scale specific to the disorder that the patient is presenting in order to evaluate the severity and effects of the therapy at the end of treatment. Usually, 2 or 3 one-hour sessions are required to carry out the first component.

The second component is the reduction of threat perception. It is the most innovative aspect of the present intervention proposal. The relevance of this component is emphasized since if one learns to reduce the perception of threat, the anxiety (arousal) significantly decreases, and the person is in better conditions to think effectively. The inverted “U” association between performance and arousal proposed by Yerkes and Dodson (1908) is explained.

The hedonic treadmill model (Brickman and Cambell, 1971) is explained, which indicates that subjective well-being tends to be stable so that after experiencing important events, both positive and negative, it tends to return to its initial state. The model has received support from studies in which it has been observed that lottery winners and accident victims, after some time (approximately 3-5 years), tend to restore the level of satisfaction before the event (Brickman et al., 1978).

They are offered a sequenced process to reduce the perception of threat: the first step is identifying the threat; sometimes, it takes work. For example, a patient says, “I feel nervous and stressed about my wedding.” Then she is asked: Really, what are you afraid of? It may be fear of commitment, that the ceremony will not go “well” (then the specific threat is that the food, the place, the chosen dress will not be to a guest's liking, etc.). When the person identifies what they fear, it is often reduced considerably. To promote understanding of the lately explained, in horror films, it is frequently used as a resource to increase fear in the viewer that the “monster” appears partially or very briefly on the screen because, at the moment in which the image of the monster remains clearly visible for a long time (no matter how well done the special effects are), it is observed that the viewer's fear is reduced.

Below are two strategies for reducing the perception of threat. The radiated circumference technique or awareness of the human reaction to events that affect people's well-being. It is explained that the relevant aspects of a person's satisfaction can be distributed based on importance in a radiated circumference (the portions are more significant depending on the relevance that each person grants). It is noted that the distribution is different depending on each person, but what is usual and adaptive is that it includes different areas. The values questionnaire can be used (Wilson et al., 2010) so the patient knows what is relevant to his life. It is also said that when something affects us, it typically does so in one or two important areas but rarely in all. Although usually, people amplify the relevance of the area that is affected, functioning in a way analogous to pain (when something hurts, we do not keep in mind that in all other parts of the body, we do not experience pain), which informs us of an abnormal situation in our body that must be attended to, after

informing us it is no longer helpful, and that is why painkillers are administered.

Regarding the functioning of concerns, we do not have sedatives. Therefore, it is essential to become aware of the relevance of the other areas (the figures of the radiated circumferences of satisfaction that appear in Annex 2 are used). The patient is suggested to ask himself: In what areas would it affect me if the feared event were to occur? The importance of keeping the perspective that different domains affect our level of satisfaction is highlighted. Likewise, you are asked to ask yourself: How will it affect me in 5, 10, or 20 years if this threat has affected me? The person then notices that most effects have dissipated or significantly been minimized over time.

Cognitive exposure is then applied, asking the patient to write: What is the worst that can happen? The concept of cognitive defusion is recalled, and it is vital to remember that thoughts, images, etc., are creations of the mind (Assaz et al., 2018). “The board metaphor” or “the observer exercise” (Wilson and Luciano, 2002) can be used to facilitate the process. It is emphasized that the perception of a possible future threat is a thought unrelated to the probabilities of the feared event coming true. Although in most concerns, patients do not identify serious consequences, they are invited to think about the worst thing that can happen to them in life, what we call cognitive implosion, such as their death, that of a loved one, or suffering from A severe illness. The patient is asked to imagine what will happen after a period of two or three years, 5 and up to 10 after their death, that of a loved one, or if they suffer from a disabling chronic illness. The client is asked to explain what he believes happens when he dies. If he is a believer, different religions propose optimistic outcomes. If the person is an atheist, the therapist explains to the patient that the brain stops

working; therefore, they cannot feel or think anything. Emphasis is placed on the little relevance of oneself, one's own species, and even life; it is explained that the human species will probably disappear from the planet in the future, and it is even possible that that of every living system, just as happens with the other known planets. It is recommended to talk for as long as necessary until the person does not show any fear about it. The ideal (and this is discussed with the patient) is that they accept the inconsequentiality of their existence and that of their loved ones (at least the "earthly" ones).

Regarding terminal and/or painful diseases, it is reported that in most cases, the existing analgesics alleviate, to a large extent, the pain experienced. It should be emphasized that we are continually exposed to possible threats, whether we are aware of them or not. The adaptive thing is not to try to control these possible events because it cannot be done; therefore, what must be learned is to tolerate uncertainty, an aspect that has been pointed out as fundamental in the GAD (Dugas et al., 2001; Dugas et al. al., 2005). This aspect is critical in those who, in phase 2b (perceived control), express a great desire (almost need) to perceive that possible future events are under their control.

Likewise, the "epitaph" or "funeral" exercise can be suggested (Wilson and Luciano, 2002).

Regarding intrusive worries, it is explained that when people make efforts not to have a specific thought or image, a paradoxical increase in its frequency is observed (Jiménez-Ros et al., 2015). It is proposed to carry out the experiment known as "white bear quickly" (Wegner et al., 1987). In the homework assignments, the patient is instructed, in agreement with the therapist, to make

a list of the concerns they have and specifically identify the threat, using a pencil and paper, and then use the strategies described to reduce the perception of the threat (supported by Annex 2). The technique of scheduling a worry time is used as proposed in some treatments (Costello and Borkovec, 1992; Leahy et al., 2000), where patients are asked to dedicate 10 to 30 minutes daily (it is mandatory explains that staying focused on the same thought for a long time is not effective, on the other hand, the rest of the day you should tell yourself as a self-instruction that "it is not time now" and focus on the activities you do, or the sensations you perceive, etc.), preferably at a fixed time when you know you will not have distractions. It would help if you worked on concerns as indicated in Annex 2. In subsequent sessions (usually between 4 and 6), the tasks completed are reviewed and corrected. Once the patient identifies the threat and appropriately reduces the perception of its impact, they move on to the third component.

The third component is activation reduction. Diaphragmatic breathing is usually explained and trained in a single session. The application of the second component can be carried out together. In cases where the person has a high degree of activation, other exercises, such as relaxation, meditation, etc., can be proposed, which have shown efficacy in reducing physiological anxiety (e.g., Chen et al., 2016).

The fourth component is a guide for action and decision-making. This component offers strategies to carry out actions that reduce the probability of the threatening event occurring or mitigate the effects if it occurs. In this phase, the patient must ask themselves: What can I do? What options do I have to reduce the likelihood that I will be affected by the future threat I perceive or mitigate its effects if it does affect me? You can seek support from

others or use the brainstorming technique proposed by Dugas and Koerner (2005).

In many cases, several actions can be taken (e.g., someone who fears a traffic accident can go to the mechanic to check their car, wear a seat belt, drive at low speed, etc.). However, Sometimes the actions are incompatible (e.g., Do I study Law or History? Should I separate from my partner or not?); in such cases, it is suggested to make a list of positive and negative aspects that can be related to each option. , as appears in Annex 3. The patient must evaluate the positive and negative aspects and decide. Between sessions, during the worry time, the patient is asked to work on his worries in writing and in a limited time (always starting with reducing threat perception). Frequently, in two or three sessions, the patient performs the activity adequately, and the fifth and final component can be accessed.

The fifth component is the reduction of discomfort when decisions are made with a low level of conviction. Psychoeducation is carried out regarding decision-making, where the patient is informed that we are continually making decisions, although in most cases, we are unaware of them. The patient is asked a hypothetical question: Would you rather have your arm cut off or be given a bicycle? The patient smiles and says clearly the bicycle. Then he is asked: What degree of conviction do you have regarding the decision made, where a “0” is no conviction and a “100” is absolute conviction? The patient says 100. Subsequently, he is asked: What do you prefer to be cut? An arm (the dominant one) or a leg? Or you can ask a child: What would you prefer if someone gave you a bicycle rather than a self-driving car? You are informed that there are people who, when faced with these questions, may decide with high conviction, for example, due to their lifestyle or because they have very

marked preferences (in the case of a professional soccer player or someone with a great love for playing soccer or a professional violinist or a person who likes to play the violin, or in the case of the question to the child, he/she, they may be very fond of or eager to have a bicycle or a self-driving car). However, many people will make these decisions with a low level of conviction (close to "0").

It is explained to the patient that the objective when deciding with a low level of conviction is not to eliminate the doubt but to tolerate the discomfort associated with it. It is emphasized that these types of decisions are relatively frequent and expected. Many people have difficulty tolerating doubt, especially students with excellent grades since they tend to think that there is one correct option (or solution) and the other alternatives are wrong. Some people make a fallacious association because, in the academic field, in most situations in which they have had doubts, there is only one correct option (e.g., the correct way to write a word, a mathematical problem, etc.) and transfer the nature of the decisions to other areas. Nevertheless, there is no correct solution or option (e.g., whether or not to change jobs, the destination of a trip, etc.). Likewise, in Psychoeducation, the limitations (intellectual, knowledge, etc.) of every human being are emphasized, and it is reported that doubting is a natural, frequent, adaptive process and that, even though it is associated with a certain discomfort, it allows us to improve and be more tolerant. Annex 4 offers a series of slogans that may be useful to tolerate the discomfort derived from deciding with a low level of conviction (which includes the strategies worked on in component 2 to reduce the threat), which means "making a mistake" or regretting having made a decision).

Finally, it is recommended that the PSWQ applies the questionnaire by Meyer et al. (1990) and an anxiety and depression scale, or a specific scale to the disorder that the patient has presented, be administered at the end of treatment to evaluate the effectiveness of the intervention. Patients usually require between 2 or 3 sessions to manage it properly, but many sessions should be extended until the person adequately carries out the entire worry process (the 5 components).

Conclusions

This article describes therapy focused on reducing threat perception based on the PAMPA and ACT models to reduce pathological worry. This is distinguished by focusing on reducing the perception of threat since the PAMPA model indicates that worry begins when consciously or unconsciously perceiving a possible future threat. If this component is managed well, Anxiety levels are greatly reduced. The description of novel techniques, such as radiated circumference and cognitive implosion, stands out.

It is important to note that in Psychoeducation, it is emphasized that worry does not solve problems if the probabilities of being affected by a possible threat are not reduced (and usually not eliminated) (it helps to increase tolerance to uncertainty, a fundamental aspect for Dugas et al. (2005) in the TAG). Likewise, it offers a well-founded perspective of what worry is and how it affects patients' metacognition (a very relevant aspect in GAD, according to Wells (1999).

The fourth component is similar to the one proposed in problem-solving described by D'Zurilla and Nezu (2006). However, the fifth component is also

novel, first because it indicates that doubting is usually the most reasonable thing to do; it also emphasizes the adaptive value of doubt in Psychoeducation and, subsequently, because it offers strategies to tolerate the discomfort derived from doubt and doubt decision making with a low level of conviction. We think it can be handy for managing obsessions or for personalities with obsessive-compulsive traits, frequently associated with anxiety disorders and especially with GAD (Citkowska-Kisielewska et al., 2020).

One of the possible difficulties that the therapist may encounter is in the case of suicide risk and severe depressive symptoms. Note that the use of techniques such as cognitive implosion can increase the acquired capacity for suicide, a fundamental element for committing suicide according to the Interpersonal Psychological Theory of Suicide (González-Betanzos et al., 2023). In this case, it would be advisable to first address the suicidal ideation and considerably reduce the depressive symptoms and then begin the treatment outlined here. Among other strategies, it is suggested that the life script technique be used to guide and increase hope. of people (Padrós-Blázquez, 2021).

Finally, it should be noted that this treatment has yet to be tested in clinical trials. Future research must study the effectiveness of therapy focused on reducing the perception of threat based on the PAMPA and ACT model to reduce pathological worry.

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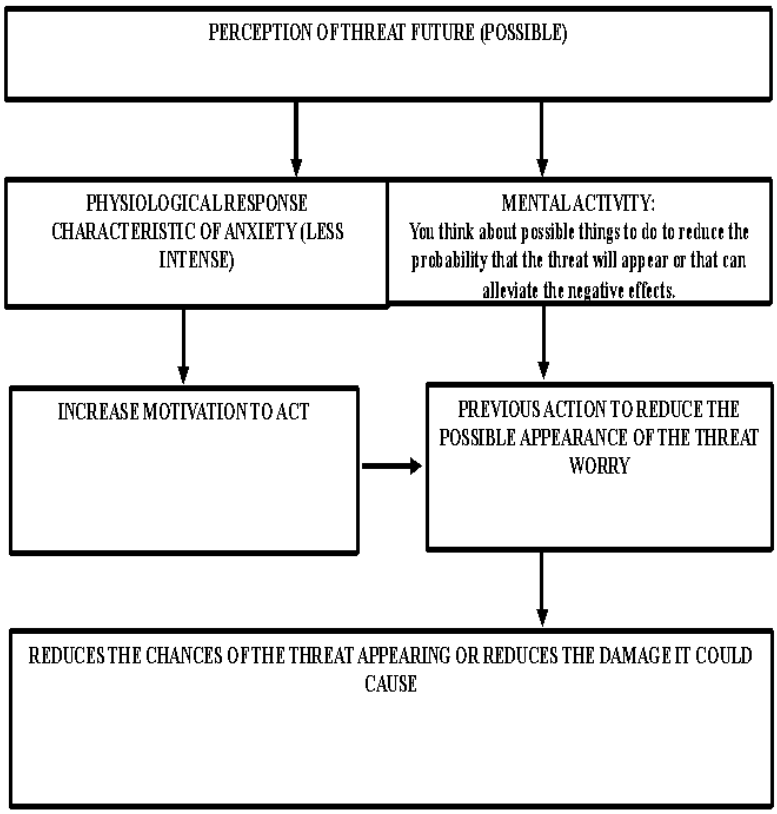
APPENDIX 1. WHAT IS WORRY?

WORRY: It is a **mental activity** that begins when a (possible) **future threat** is **perceived** and that serves to make a **decision** and **act** (or take care of ourselves) in order to **reduce** the probability of its appearance or to **alleviate** the negative effects that it may cause. are derived.



APPENDIX 2. HOW TO REDUCE THE PERCEPTION OF THREAT?

- Schedule time to think (between 10 and 30 minutes)
- Write on paper and pencil.

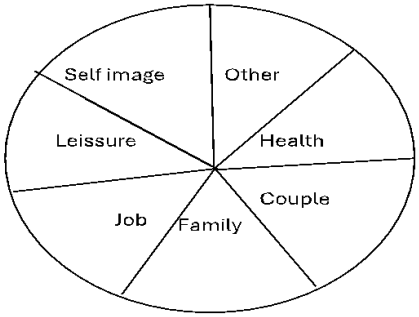
1) Ask yourself: What is the **specific threat,** I fear?

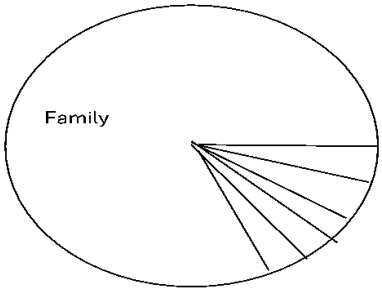
Describe (and imagine) what is the worst thing that could happen and remember the inconsequentiality of your own life.

2) Remember to keep in mind that lottery winners and those affected by serious accidents (paraplegics) after a period of time (months or a few years) express levels of satisfaction very similar to those they themselves had before the event.

Ask yourself: How will it affect me in 3, 5 or 10 years if this threat has affected me?

3) Ask yourself: In what area/s would it affect me? How would it reduce my quality of life? Use the radiated circumference of satisfaction to locate the relevant areas of your life. Remember that at first the area it affects is expanded and its relevance must be restored.





Appendix 3. HOW TO ACT TO REDUCE THE LIKELIHOOD OF THE APPEARANCE OF A THREAT OR ALLIGATE ITS EFFECTS IF IT HAPPENS?

- **Schedule time to think (between 10 and 30 minutes)**
- **Write on paper and pencil.**

Ask yourself: What options do I have?

1) You can talk to people you trust (in case they give you any ideas)

2) You can use the brainstorming technique

If you find yourself with incompatible options, ask yourself: What decision do I make?

1) Make a list of the positive and negative aspects of each of the options.

2) Assess each of the positive and negative aspects of each of the options.

OPTION 1		OPTION 2		OPTION 3	
+	-	+	-	+	-

Until the decision is made

* If you need important information to make the decision you anticipate you can or will get in the future, postpone worrying until you have the information.

APPENDIX 4. HOW CAN I REDUCE DISCOMFORT AFTER MAKING A DECISION WITH A LOW LEVEL OF CONVINCANCE?

*** REMEMBER TO DO IT IN TIME TO WORRY**

1) Keep in mind that these decisions will come up to you **on several occasions** in your life. They generate discomfort (because there is a lot of doubt), they **are normal,** and it happens to everyone at one time or another.

2) In most cases there **is no right or wrong option**.

3) Keep in mind that these situations arise **when one's preferences are not very marked**.

4) Keep in mind that **doubting is adaptive and allows us to improve and be more tolerant.**

MAKE USE OF SOME SLOGANS

When we decide, we always refer to the future, therefore, it is a forecast. **I CAN NEVER BE CERTAIN WHAT IS GOING TO HAPPEN!**

We have to make a decision. **DON'T DECIDE, IT'S A DECISION!**

On very few occasions we will know what would have happened if we had made a different decision. **I ONLY UNCOVER ONE PATH!**

We will always make a percentage of "errors" since we have important limitations (time, intelligence, knowledge...). **I WILL REGRET IT ON A PERCENTAGE OF OCCASIONS (IT'S NORMAL AND HEALTHY)!**

We almost always decide with the best possible intention. **I ALMOST ALWAYS SAY THE BEST I CAN!**

I try to do things better every time (I try to learn) and reduce the "error" percentage. **TOMORROW I WILL DO (OR WOULD DO) BETTER THAN TODAY!**

PLACE THE AREA OF DOUBT IN THE **RADIATED CIRCUMFERENCE OF SATISFACTION** AND USE THE TECHNIQUES OF WHAT HAS BEEN WORKED ON TO REDUCE THE PERCEPTION OF THREAT.

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