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Review article

# Towards an evidence-based unified psychodynamic protocol for emotional disorders

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ABSTRACT

*Background:* In psychotherapy research unified, transdiagnostic and modular treatments have emerged. This is true for both cognitive-behavioral therapy and psychodynamic therapy. Recently, two unified psychodynamic protocols were presented, one for anxiety disorders, another for depressive disorders. Integrating the treatment principles for these two highly prevalent disorder groups into one protocol for "emotional disorders" may be useful for both clinical practice and training in psychotherapy.

*Methods:* After updating the evidence for psychodynamic therapy in anxiety and depressive disorders in terms of randomized controlled trials (RCTs) by a systematic search, the treatment elements applied in those RCTs providing evidence for the efficacy of psychodynamic therapy in depressive or anxiety disorders were reviewed and compared.

*Results:* Twenty-seven RCTs for anxiety or depressive disorders were identified. A review revealed a high overlap between the principles used for the psychodynamic treatment of anxiety and depressive disorders, reflecting the transdiagnostic nature of psychodynamic therapy. The overlap suggested to integrate the identified treatment principles into one **u**nified **p**sychodynamic **p**rotocol for "emotional disorders" (UPP-EMO). As a result, seven treatment principles or modules were distilled which can be flexibly applied depending on the patient´s symptoms and needs. In addition, a separate module addresses diagnostic assessment. Across modules, a focus on resources has been included.

*Limitations:* Despite being based on RCTs, UPP-EMO has not yet been examined in an RCT - which is planned as a next step.

*Conclusions:* As psychodynamic therapy is transdiagnostic in origin focusing on core underlying processes of mental disorders, acceptability of UPP-EMO among psychodynamic psychotherapists is likely to be high.

## 1. Introduction

Anxiety and depressive disorders represent a significant public health concern due to their prevalence, impairment, chronicity and associated economic consequences (Kessler et al., 2012; Wittchen et al., 2011). With 12-month prevalence rates of 22.2% and 7.1%, a considerable proportion of the general population is affected (Kessler et al., 2012). In Europe, 61.5 million subjects suffer from anxiety disorders and 30.3 million subjects from major depressive disorder (Wittchen et al., 2011). In a representative survey on the utilization of outpatient psychotherapy, 85% of the patients reported depressive symptoms and 63% symptoms of anxiety as the reasons for starting a psychotherapy - multiple reasons were possible (Albani et al., 2010).

Anxiety and depressive disorders can be efficaciously treated by both psychotherapy and pharmacotherapy (Barlow et al., 2015; Craighead et al., 2015; Driessen et al., 2015; Keefe et al., 2014; Kimmel et al., 2015; Prendes-Alvarez et al., 2015).

In psychotherapy research there is a tendency to move from single-disorder focused approaches towards transdiagnostic and modular treatments (e.g. Barlow et al., 2004; Farchione et al., 2012; McHugh et al., 2009; Norton, 2012; Schmidt, 2012). The rationale for transdiagnostic treatments focuses on similarities among disorders, particularly in a similar class of diagnoses (e.g. anxiety disorders) including high rates of comorbidity (e.g. Kessler et al., 2012) and improvements in comorbid conditions when treating a principal disorder (e.g. Barlow et al., 2004; Farchione et al., 2012; Norton et al., 2013). For these reasons, unified CBT-based treatment protocols have been developed aiming at integrating the most effective treatment components of CBT. Barlow et al. (2004), for example, have developed a unified CBT-based treatment protocol for “emotional disorders” (i.e. depressive and

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anxiety disorders) that uses a modular format and aims at targeting the core processes underlying emotional disorders.

For psychodynamic therapy, two unified protocols were recently developed, one for anxiety disorders (Leichsenring and Salzer, 2014), and another for depressive disorders (Leichsenring and Schauenburg, 2014). Due to both the high prevalence of anxiety and depressive disorders and the high overlap between these disorders in terms of comorbidity (e.g. Alonso et al., 2004), a unified psychodynamic protocol covering both anxiety and depressive disorders ("emotional disorders") can be expected to be quite useful in both clinical practice and training in psychodynamic psychotherapy. For these reasons, integrating the treatment principles used in psychodynamic therapy of anxiety disorders (Leichsenring and Salzer, 2014) and depressive disorders (Leichsenring and Schauenburg, 2014) into one unified protocol for "emotional disorders" would be a next useful step – which is analogous to the procedure by Barlow et al. (2004) for CBT.

## 2. Method

### 2.1. Definition of psychodynamic psychotherapy

Psychodynamic psychotherapy serves as an umbrella concept encompassing treatments that operate on a continuum of supportive-interpretive psychotherapeutic interventions (Fig. 1, Gunderson and Gabbard, 1999; Luborsky, 1984; Wallerstein, 2002). Interpretive interventions (e.g. interpretation) aim to enhance the patient's insight concerning repetitive conflicts sustaining his or her problems, e.g. depression or anxiety (Gabbard, 2004). The establishment of a (helping) therapeutic alliance is regarded as an important element of the supportive components of psychodynamic therapy (Luborsky, 1984). Specific supportive interventions aim to strengthen abilities (ego-functions, Bellak, Hurvich, and Gediman, 1973) that are temporarily not accessible to a patient due to acute stress (e.g. traumatic events) or that have not been sufficiently developed especially in patients with more severe impairment of personality functioning (e.g. regulation of self-esteem or assertiveness in depression). Modern variants of psychodynamic therapy are manual-guided and specifically tailored to the respective disorder (e.g. Leichsenring et al., 2015b).

### 2.2. Inclusion criteria and study selection

In order to identify treatment principles of empirically-supported psychodynamic treatments, a search for randomized controlled trials (RCTs) of psychodynamic therapy in anxiety and depressive disorders was carried out, updating the reviews by Leichsenring and Salzer (2014) and Leichsenring and Schauenburg (2014). We applied the following inclusion criteria for study selection: (a) RCT, (b) psychodynamic therapy meeting the above definition (Gabbard, 2004), (c) use of treatment manuals or manual-like guidelines, (d) treatment of a depressive or anxiety disorder, (e) use of standardized instruments in making diagnosis, (f) reliable and valid measures for outcome, (g) adult patients (≥18 years), (h) psychodynamic therapy had to be superior to waiting list, treatment as usual, or alternative treatment or no differences in outcome to a treatment established in efficacy were found (e.g. Chambles and Hollon, 1998). Studies combining psychodynamic therapy with pharmacotherapy or treatment as usual were not included except for treatment arms examining psychodynamic therapy alone. As recent meta-analyses (Abbass and Driessen, 2010; Driessen et al., 2010, 2015) reported lower effect sizes for psychodynamic group treatments of depression, we did not include studies employing psychodynamic therapy in groups in the treatment of depression.

We collected studies of psychodynamic therapy that were published between 1970 and May 2017 by use of a computerized search of MEDLINE and PsycINFO. The following search terms were used: (psychodynamic OR psychoanalytic* OR dynamic) and (therap* OR psychotherap* OR treatment*) and (RCT* OR trial* OR random*) and ("mood disorder*" OR "affective disorder*" OR depress*) respectively (anxiety OR phob* OR panic). Manual searches in articles and textbooks were performed. In addition, we communicated with experts in the field and searched a published and regularly updated electronic list of all previously identified RCTs of PDT (https://www.researchgate.net/publication/317335876_C).

## 3. Results

### 3.1. Evidence-based psychodynamic treatments of depressive and anxiety disorders: an update

Leichsenring and Salzer (2014) and Leichsenring and Schauenburg (2014) identified and included 8 RCTs on anxiety disorders (Bogels et al., 2014; Knijnik et al., 2008; Knijnik, 2004; Leichsenring et al., 2013; Leichsenring et al., 2009; Milrod et al., 2007; Wiborg and Dahl, 1996) and 14 RCTs on depressive disorders (Barkham et al., 1996; Beutel et al., 2014; Connolly Gibbons et al., 2012; Cooper et al., 2003; de Jonghe et al., 2004; Driessen et al., 2013; Gallagher-Thompson and Steffen, 1994; Johansson et al., 2013, 2012; Knekt et al., 2008; Maina et al., 2005; Salminen et al., 2008; Shapiro et al., 1994; Thompson et al., 1987). The updated search identified four further studies fulfilling the inclusion criteria, three for depressive disorders (Ajilchi et al., 2016; Connolly Gibbons et al., 2016; Town et al., 2017), and one for anxiety disorders (Milrod et al., 2015). The treatment models used in these four newly identified studies were those by Milrod et al. (1997), Luborsky (1984) and Davanloo (2000). Studies using these concepts and their treatment principles were already included in the unified protocol for anxiety disorders (Milrod et al., 2007) and depressive disorders (Connolly Gibbons et al., 2012). Thus, the treatment elements of these concepts are already included in the unified protocols for anxiety and depressive disorders (Leichsenring and Salzer, 2014;

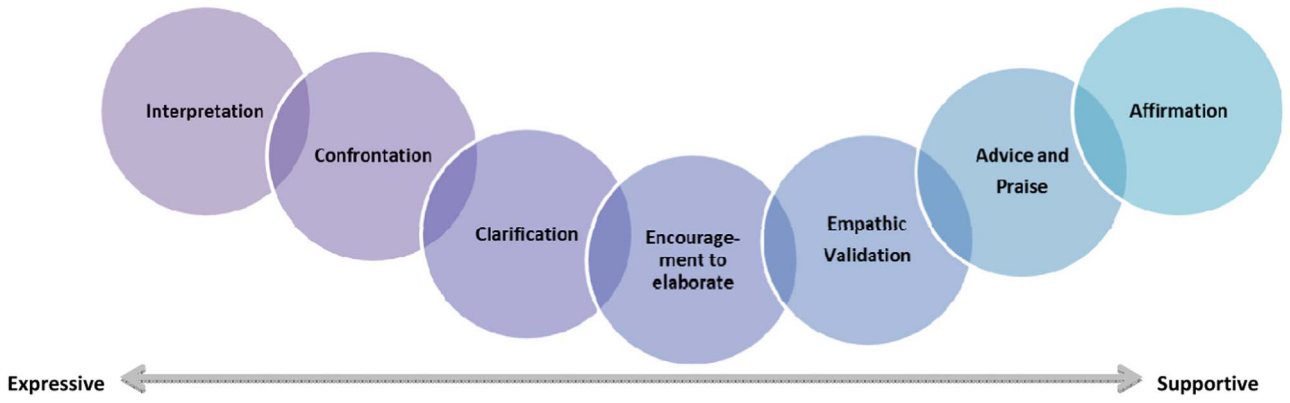


**Fig. 1.** The expressive-supportive continuum of psychodynamic interventions according to (Gabbard, 2000, p. 96).

**Table 1**
Randomized controlled trials providing evidence for short-term psychodynamic psychotherapy (STPP) in anxiety disorders and depressive disorders.

| Study | Disorder | Sample size (N) | Concept of STPP/Treatment elements | Treatment Duration |
|---|---|---|---|---|
| **Anxiety Disorders** | | | | |
| Bögels et al., 2014 | Social anxiety disorder | STPP: 22<br>CBT: 27 | Malan (1976)<br>*STPP:* Focus on two triangles:<br>(1) 'Triangle of conflict'<br>(a) Forbidden thoughts, feelings and wishes which<br>(b) cause anxiety, and<br>(c) Result in defensive mechanisms such as avoidance<br>(2) Triangle of<br>(a) Parents/caretakers,<br>(b) Important others, and<br>(c) The therapist.<br>Treatment:<br>(a) Early phase: definition of a focus (symptoms, conflicts or crisis)<br>(b) Middle phase: addressing the focus by interpretation and clarification<br>(c) Terminal phase: discussion of termination, review of progress, consolidation of gains | 36 sessions |
| Crits-Christoph et al., 2005 | Generalized anxiety disorder | STPP: 15<br>Supportive therapy: 16 | Luborsky (1984); Crits-Christoph et al. (1995)<br>*Supportive-expressive therapy:*<br>(a) Focus on core conflictual relationship theme<br>(b) Focus on helping alliance<br>(c) Interpretive and supportive interventions<br>(d) Specific modifications for dealing with generalized anxiety (interpretation of primitive wishes common in GAD patients, interpretation of resistances and defenses common in GAD patients, and working with issues related to past traumas) | 16 sessions |
| Knijnik et al., 2004 | Social anxiety disorder | STPP: 15<br>Credible placebo control group: 15 | Malan (1976)<br>*Psychodynamic group therapy:*<br>Phase I: two individual interviews to obtain a psychiatric and developmental history and to conceptualize each patient's focus<br>Phase II: 12 group sessions<br>(a) Sessions 1–3 (address group formation, ensuring patients' agreement to focus exclusively on the treatment of generalized social anxiety disorder and focus formulation)<br>(b) Sessions 4–10 (connection between symptoms and conflicts is investigated)<br>(c) Sessions 11–12 (discuss issues related to treatment termination)<br>Active therapist addressing conflicts and transference emerging in the<br>group and similarities in social problems | 12 sessions |
| Knijnik et al., 2008, Knijnik et al., 2009 | Social anxiety disorder | STPP: 28<br>Clona-zepam: 23 | Malan (1976), see above | 12 sessions |
| Leichsenring et al., 2009; Salzer et al., 2011 | Generalized anxiety disorder | STPP: 28<br>CBT: 29 | Luborsky (1984); Crits-Christoph et al. (1995), Leichsenring et al. (2005)<br>*Short-term STPP based on supportive-expressive therapy:*<br>(a) Focus on core conflictual relationship theme<br>(b) Focus on helping alliance<br>(c) Interpretive and supportive interventions<br>(d) Specific interventions dealing with generalized anxiety | Up to 30 sessions |
| Leichsenring et al., 2013 ; 2014 | Social anxiety disorder | STPP: 207<br>CBT: 209<br>WL: 79 | Luborsky (1984); Leichsenring, Beutel, Leibing (2007)<br>*Short-term STPP based on supportive-expressive therapy:*<br>(a) Focus on core conflictual relationship theme<br>(b) Focus on helping alliance<br>(c) Interpretive and supportive interventions<br>(d) Specific interventions dealing with social fears (e.g. patients are encouraged to confront rather than to avoid the situation they fear) | Up to 30 sessions |

(*continued on next page*)

**Table 1** (*continued*)

| Study | Disorder | Sample size (N) | Concept of STPP/Treatment elements | Treatment Duration |
|---|---|---|---|---|
| **Anxiety Disorders** | | | | |
| Milrod et al., 2007 | Panic disorder | STPP: 26<br>Applied relaxation: 23 | Milrod et al. (1997)<br>*Panic-focused STPP:*<br>Uncover unconscious meanings of panic symptoms<br>Phase I: acute panic<br>(1) Exploration of circumstances/feelings surrounding panic onset<br>(2) Exploration of personal meanings of panic symptoms<br>(3) Exploration of feelings/content of panic episodes<br>Phase II: panic vulnerability<br>(1) Addressing the transference<br>(2) Working through – demonstration that the same conflict emerges in many settings<br>Phase III: termination<br>Addressing patient reaction to termination | 24 sessions |
| Milrod et al., 2015 | Panic disorder | STPP: 81<br>CBT: 81<br>Applied relaxation: 39 | Milrod et al. (1997), see above | 19-24 sessions |
| Wiborg and Dahl, 1996 | Panic disorder | STPP: 20<br>Clomipramine: 20 | Wiborg and Dahl, (1996)<br>*Brief dynamic psychotherapy:*<br>(a) Help patient develop insight into the origins and determinants of his or her dysfunctional patterns<br>(b) Acquisition of more adaptive patterns of interpersonal relatedness<br>(c) Focus on identification and working through of dysfunctional patterns as they emerge in the past, present and transference<br>(d) All technical elements of STPP are included (clarification, confrontation, interpretation of resistance, defensive styles and isolated affects) | 15 sessions |
| **Depressive Disorders** | | | | |
| Ajilchi et al 2016 | Major Depression | STPP: 16<br>wait list: 16 | Davanloo (2000), Abbass (2015) (a) evaluation of psychic capacities (unconscious anxiety and defensive patterns) and capacity to respond to treatment (b) building capacities to tolerate anxiety and experiences through graded emotion activation and reflection (c) mobilization of unprocessed emotions about traumatic events (d) recapitulation to encourage emotional awareness and weaken emotional avoidance (e) focusing on grief, buried rage and guilt related to attachment trauma | Mean = 15 sessions |
| Barkham et al.,1996 | Major Depression | STPP: 18<br>CBT: 18 | Shapiro and Firth (1985)<br>*Psychodynamic-interpersonal therapy:*<br>(a) focus on interpersonal relationships<br>(b) focus on relationship to therapist to understand interpersonal problems (link),<br>(c) conversational model (negotiation, language of mutuality, use of metaphor, focus on here and now, offering hypotheses) | 8 vs. 16 sessions |
| Beutel et al., 2014 | MDD or minor depressive disorder in breast cancer opatients | STPP: 78<br>TAU: 79 | Luborsky (1984)<br>*STPP based on supportive-expressive therapy:*<br>(a) focus on CCRT<br>(b) interpretive and supportive interventions<br>(c) specific interventions dealing with life-threatening disease | 20-25 sessions |
| Connolly Gibbons et al., 2012 | MDD or minor depressive disorder<br>HAMD ≥ 14 | STPP: 21<br>TAU: 19 | Luborsky (1984); Connolly Gibbons et al. (2012)<br>*Supportive-expressive therapy:*<br>(a) focus on CCRT<br>(b) supportive alliance building component<br>(c) socialization-focused component<br>(d) education focused component<br>(e) cultural sensitivity component | 12 sessions |
| Connolly Gibbons et al., 2016 | MDD | STPP: 118<br>CBT: 119 | Luborsky (1984); Book (1998)<br>*Supportive-expressive therapy:*<br>(a) focus on CCRT<br>(b) supportive alliance building component<br>(c) socialization-focused component | 16 sessions |
| Cooper et al., 2003 | Maternal depression (MDD) | STPP: 50<br>Counselling: 48<br>CBT: 43<br>Primary Care: 52 | Cramer et al. (1990)<br>*STPP:*<br>exploring the mother´s representation of and relationship to her infant taking her own attachment history into account | 10 sessions |

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**Table 1** (*continued*)

| Study | Disorder | Sample size (N) | Concept of STPP/Treatment elements | Treatment Duration |
|---|---|---|---|---|
| **Anxiety Disorders** | | | | |
| de Jonghe et al., 2004 | MDD | STPP: 106<br>STPP + Pharmacotherapy: 85 | de Jonghe et al. (1994)<br>*Psychoanalytic supportive psychotherapy:*<br>(a) focus on actual relationships<br>(b) supportive attitude (e.g. empathic, accepting, affirmative, active)<br>(c) systematic use of supportive interventions (e.g. reducing anxiety, reassuring, encouraging, advising, modeling, confronting, clarifying, reframing symptoms as problem-solving attempts)<br>(d) defenses are respected<br>(e) interpretation is used cautiously<br>(f) transference is used, but not interpreted | 16 sessions |
| Driessen et al., 2013 | Major Depression<br>HAMD ≥ 14 | STPP: 177<br>CBT: 164 | de Jonghe (1994), see above | 16 sessions |
| Gallagher-Thompson and Steffen, 1994 | Major, minor or intermittent depressionin caregivers | STPP: 30<br>CBT: 36 | Mann (1973), Rose and DelMaestro, 1990<br>*Brief relational/insight psychotherapy:*<br>(a) conflicts over dependence and independence reactivated by caregiving situation<br>(b) focus on this conflict | 16-20 sessions |
| Johansson et al., 2012 | Major Depression | STPP: 46<br>Structured Support:46 | Silverberg (2005)<br>*Internet-guided self-help:*<br>9 modules<br>(1) introduction to the treatment and the concept by Silverberg<br>(2) techniques how to discover unconscious patterns<br>(3) understanding the pattern<br>(4) techniques to break unhelpful patterns<br>(5) preventing relapse to old patterns<br>(6) applying obtained knowledge in working life<br>(7) applying obtained knowledge in personal relationships<br>(8) relationship between unconscious patterns and depression<br>(9) summary and advice for future | 10 weeks |
| Johansson et al., 2013[a] | Depressive and anxiety disorders | STPP: 50<br>Support: 50 | McCullough et al. (2003); Frederick (2009)<br>Internet-guided self-help:<br>8 modules<br>(1) introduction to affect phobia model<br>(2) explanation of the problem<br>(3) mindfulness practiceJohannson<br>(4) defence restructuring<br>(5) anxiety regulation<br>(6) affect experiencing<br>(7) affect expression and self/other restructuring<br>(8) summary and advice for continued work | 10 weeks |
| Knekt et al., 2008[a] | Depressive and anxiety disorders § | LTPP: 128<br>(Mood Disorder: 113)<br>STPP: 101 (Mood Disorder: 79)<br>Solution-focused therapy, SFT, 97 (Mood Disorder: 84) | Malan (1979); Sifneos (1978)<br>*Short-term STPP:*<br>(a) focus on intra-psychic and interpersonal conflicts<br>(b) transference-based<br>(c) actively creating alliance<br>(d) use of confrontation, clarification, interpretation | LTPP: 232 sessions<br>STPP: 18.5 sessions<br>SFT: 9.8 sessions |
| Maina et al., 2005 | Dysthymic disorder, Depressive disorder NOS, adjustment disorder with depressed mood | STPP: 10<br>Supportive Therapy:10<br>Waiting List: 10 | Malan (1979)<br>*Short-term STPP:*<br>(a) early phase: definition of a focus (symptoms, conflicts, or crisis)<br>(b) middle phase: addressing the focus<br>(c) terminal phase: discussion of termination, review of progress, consolidation of gains.<br>Goal: insight into repetitive conflicts and trauma underlying and sustaining the patient´s problems;<br>Techniques: interpretation, clarification | 15-30 sessions<br>M = 19.6 |
| Salminen et al., 2008 | Major Depression | STPP: 26<br>Fluoxetine: 25 | Malan (1979); Mann (1973)<br>*Short-term STPP:*<br>(a) formulation of psychodynamic focus<br>(b) active therapist<br>(c) early Connolly Gibbonstransference interpretation<br>(d) working through termination Use of confrontation, clarification, interpretation. | 16 sessions |
| Shapiro et al., 1994, Shapiro et al., 1995[b] | Major Depression | STPP: 58<br>CBT: 59 | Shapiro and Firth (1985), see above | 8 vs. 16 sessions |

(*continued on next page*)

**Table 1** (*continued*)

| Study | Disorder | Sample size (N) | Concept of STPP/Treatment elements | Treatment Duration |
|---|---|---|---|---|
| **Anxiety Disorders** | | | | |
| Thompson et al. 1987; Gallagher-Thompson et al.,1990 | Major Depression in elders (60 or above) | STPP: 24<br>BT: 25; CBT: 27;<br>waiting list: 19 | Horowitz and Kaltreider (1979)<br>*Short-term STPP:*<br>(a) establishing a working alliance<br>(b) focus on central conflicts, developmental problems, defensive styles making subjects vulnerable to this particular stress experience<br>(c) use of clarification and interpretation<br>(d) reappraisal of serious life event<br>(e) revisions of the inner model of self and world<br>(f) supportive interventions<br>(g) termination: working through approaching loss of therapist, relating it to stress event (e.g. loss). | 16-20 sessions |
| Town et al,. 2017 | Treatment resistant MDD | STPP: 30<br>TAU: 30 | Davanloo (2000), Abbass (2015)<br>For components see Ajilchi et al 2016 above | 20 sessions |

Note.
HAMD: Hamilton Rating Scale for Depression.
LTPP: long-term psychodynamic therapy.
STPP: short-term psychodynamic therapy.
[a] The results were separately evaluated for patients with depressive and anxiety disorders.
[b] In the study by Shapiro et al. (1994) dose-effect relationship was observed with PDT of 8 sessions showing less improvement than CBT and PDT of 16 sessions being equivalent to 16-session CBT (Table 2). In a replication study carried out in an applied setting, the 16 session conditions of both CBT and PDT were superior to the 8 session-conditions of CBT and PDT on some measures at some assessments.

Leichsenring and Schauenburg, 2014).

The twenty-six studies included in this review are listed in Table 1.

In a first step, we reviewed the treatment elements used in these RCTs as described in the included articles. For each study, these elements are listed in Table 1. When abstracting from model-specific language, we found a high degree of overlap in basic treatment elements between studies (Table 1), including

- a focus on the (unconscious) conflicts or
- on structural deficits in ego-functions underlying the symptoms of anxiety or depression,
- an emphasis on establishing a supportive alliance between patient and therapist,
- the use of interpretive interventions in order to address (unconscious) conflicts (e.g. interpretation),
- the use of specific supportive elements in the case of impaired ego-functions (e.g. encouraging, affirming, advising, reassuring, calming, respect of vital defenses),
- a focus on termination and relapse prevention.

This does not imply that the methods listed in Table 1 share all treatment components, but rather that many components are used by several approaches – with some components being more prominent in some approaches than in others. On the other hand, some components were used only by specific approaches (Table 1). The supportive-expressive approach by Connolly Gibbons et al. (2012) for depression, for example, is the only one to include an education-focused component and a cultural sensitivity component. Furthermore, transference interpretations (an explicit interpretation of the patient´s ongoing relationship with the therapist) are not included by all but only by some of the approaches listed in Table 1. They were explicitly included, for example, in the studies using Malan´s or Davanloos's approach (e.g. Davanloo, 2000; Malan, 1976) or in the studies by Milrod et al. (Milrod et al., 2015, 2007) or Salminen et al. (2008), whereas transference is considered, but not interpreted in de Jonghe´s approach (de Jonghe, 1994).

Like psychodynamic interventions in general, the evidence-based treatments listed in Table 1 can be situated on a supportive-expressive continuum (Fig. 1), with some treatment concepts putting more emphasis on supportive techniques (e.g. deJonghe's approach, 1994) whereas others put a stronger focus on expressive (insight-oriented) aspects (e.g. studies using Malan's approach, 1976). However, the differences between the listed psychodynamic approaches are rather gradual in nature with regard to being more supportive or more expressive.

Thus, despite some specific differences, there is a high overlap and consistency between the treatment components of the empirically-supported psychodynamic treatments for depressive and anxiety disorders.[1] The high overlap between empirically supported methods of STPP in anxiety and depressive disorders highlights that psychodynamic therapy is transdiagnostic in origin, primarily focusing on conflicts and structural deficits underlying these problems rather than on symptoms or categories of mental disorders - being transdiagnostic is a great advantage facilitating an integration of treatment principles.

Thus, the empirically supported psychodynamic models for the treatment of depressive disorders and of anxiety disorders (Table 1) have most principles in common, suggesting to integrate these principles into one protocol for "emotional disorders". In an analogous way Barlow et al. (2004) developed a CBT protocol for "emotional disorders".

In the following, the principles for the psychodynamic treatment of anxiety and depressive disorders listed in Table 1 will be discussed and integrated into one unified protocol for emotional disorders (UPP-EMO).

### 3.2. General principles of a Unified Psychodynamic Protocol for Emotional Disorders

Consistent with the treatments listed in Table 1, UPP-EMO has a modular format allowing for flexible application and adapting the sequence and “dosage” of each treatment element to the individual

[1] The unified protocol for anxiety disorders (Leichsenring and Salzer, 2014) and the unified protocol for depressive disorders (Leichsenring and Schauenburg, 2014) are based on the treatment principles for anxiety or depressive disorders listed in Table 1. Thus, these protocols overlap to a high degree as well. Both protocols include a socialization interview, modules for addressing motivation, ambivalence and setting treatment goals, for establishing a secure alliance, for supportive interventions, for identifying and working-through core conflicts, and for termination and relapse prevention. The unified protocol for depression includes two additional modules, one on educating and empowering the patient and another on cultural-sensitivity components (Leichsenring and Schauenburg, 2014).

patient´s needs. By the modular format, both the course of treatment and the individual patient and his or her disorder can be taken into account, e.g. problems in patient motivation or in severity of pathology. Some modules are regarded as core modules and should be used in every treatment though possibly with varying emphasis. For applying UPP-EMO, therapists need to be trained in psychodynamic therapy. Some general principles of UPP-EMO can be summarized as follows:

- consistent with the RCTs fulfilling the inclusion criteria (Table 1), UPP-EMO constitutes a method of short-term psychodynamic therapy (STPP), encompassing up to 24 sessions;
- the treatment is conducted in a face-to face position;
- regression is generally restricted (e.g. by setting goals, or avoiding longer periods of silence (Luborsky, 1984, 1995);
- both in identifying and working through the focus of treatment and in the application of supportive elements, the therapist adopts a more active stance than in classical psychoanalysis or long-term psychodynamic psychotherapy (Leichsenring and Salzer, 2014; Luborsky, 1984, 1995);
- in order to foster the transfer of treatment gains to everyday situations, the therapist is recommended to put a strong emphasis on working through, i.e. reflecting on newly gained insight and testing new behaviors not only *within* sessions but also *between* the sessions (Leichsenring and Salzer, 2014; Leichsenring et al., 2013; Leichsenring and Schauenburg, 2014; Stricker, 2006);
- the use of more interpretive or supportive interventions depends on the patient´s capacity and needs (Connolly Gibbons et al., 2012; Luborsky, 1984, 1995);
- research on transference interpretations has shown that in STPP high levels of transference interpretations were negatively associated with outcome in more severely disturbed patients (Ogrodniczuk et al., 1999; Piper et al., 1991). Thus, UPP-EMO puts the emphasis on the patient´s maladaptive interpersonal patterns as experienced in current relationships outside therapy. If transference interpretations including the therapeutic relationship are made as emphasized in intensive short-term dynamic therapy (Abbass, 2015; Davanloo, 2000), they should be carefully applied taking the quality of the patient´s object relations into account (Connolly et al., 1999; Gabbard, 2006; Levy and Scala, 2012). In more severely disturbed patients, they should be avoided.
- In psychodynamic therapy patient resources are hardly systematically taken into account (Priebe et al., 2014; Wöller, 2015). Focusing on resources, however, may enhance treatment outcome especially in anxiety disorders, as suggested by research on CBT (Fluckiger et al., 2016; Willutzki et al., 2004). Across the various treatment modules UPP-EMO puts an explicit focus on resources (Table 2).

**Table 2**
Resources in psychodynamic therapy of emotional disorders.

By focusing on patient resources, the efficacy of already empirically supported treatments may be further improved, especially in anxiety disorders (Fluckiger et al., 2016; Willutzki et al., 2004). For this reason, UPP-EMO puts an explicit focus on resource activation.

We recommend the therapist to generally adopt a resource-oriented perspective across the various treatment modules - focusing on resources is not regarded as a specific method or another module but rather as a perspective or a therapeutic attitude that may be adopted when using each of the modules.

During the biographical interview usually carried out before starting a psychodynamic therapy, for example, the therapist is recommended to explore exceptions (de Shazer, 1985), that is situations in which the patients was less anxious or depressive or in which he or she was able to use an impaired ego-function (e.g. mentalization or affect regulation) more effectively. These exceptions demonstrate to the patient that he or she “can” (i.e. use the respective ego-function). Furthermore they may allow exploring the conditions which enable the patient to function on a higher level. The therapist and the patient may examine how he or she can go on like this.

- We have conceptualized the UPP-EMO as a form of short-term psychodynamic psychotherapy. However, with some modifications the modules described below may also be useful in long-term psychodynamic psychotherapy of depressive and anxiety disorders.
- In specific populations, interventions specific to the population may be used, e.g. interventions dealing with life-threatening disease in depressed breast cancer patients (Beutel et al., 2014) or exploring the mother's representation of and relationship to her infant taking her own attachment history into account in maternal depression (Cooper et al., 2003).
- No treatment component is unique to UPP-EMO. However, the whole is more than the sum of its constituent parts.
- Caveat: If we list treatment principles in the following, this does not imply that the UPP-EMO is a puzzle of treatment modules. Being more than the sum of its parts, the UPP- EMO represents an integrated psychodynamic treatment, a whole, based on the supportive-expressive continuum of psychodynamic interventions

### 3.3. A Unified Psychodynamic Protocol for Emotional Disorders: modules and treatment principles

In the following, the treatment principles included in UPP-EMO will be presented as modules. These modules are interrelated with each other as displayed by Fig. 2, presenting the modules in cycles illustrating the cyclic process of psychotherapy and the interrelation of the modules within UPP-EMO.

### 3.4. Module 1: diagnostic assessment

Before starting the treatment, a diagnostic assessment is carried out, both on a phenomenological (e.g. DSM-5, ICD-10,) and a psychodynamic level. From a psychodynamic perspective, the treatment of a specific mental disorder (e.g. depression, agoraphobia) depends on the underlying psychodynamic features (e.g. conflicts, defenses, personality organization), which may vary considerably within one category of psychiatric disorder (Kernberg, 1996). These psychodynamic factors may affect treatment outcome and may have a greater impact on outcome than the phenomenological DSM categories (Piper et al., 2001). For assessing psychodynamic characteristics several methods may be used, for example the structural interview according to Kernberg (1981) or the method of Operationalized Psychodynamic Diagnosis (OPD Task Force, 2008). Some models of STPP used in depressive disorders (Table 1) put a specific focus on the applied defense mechanisms and the capacity to tolerate anxiety (Abbass, 2015; Davanloo, 2000). In case of suicidality a careful evaluation is required to assess the risk of an actual suicide. A trial therapy may be carried out so long as the patient makes an honest commitment not to act on these impulses (Abbass, 2015). If the patient is not able or willing to make such a commitment, emergency services or hospitalization are required.

For some patients with severe anxiety or depression, at least initially, concomitant pharmacotherapy may be considered as a treatment option.

### 3.5. Module 2: Preparing the patient for psychotherapy – the socialization interview

Several studies listed in Table 1 include a socialization interview carried out at the beginning of the treatment to make the patient familiar with the principles of the approach. For this reason, we included the socialization interview into UPP-EMO. It follows the principles outlined by Orne and Wender (1968), Luborsky et al. (1995), Book (1998) and Connolly et al. (2012), giving the patient a rationale allowing for a first orientation with regard to the disorder and the planned treatment (Connolly et al., 2012). The socialization interview encompasses a general and a disorder-specific part. In anxiety-disorders, for example, the patient is informed that confronting the feared

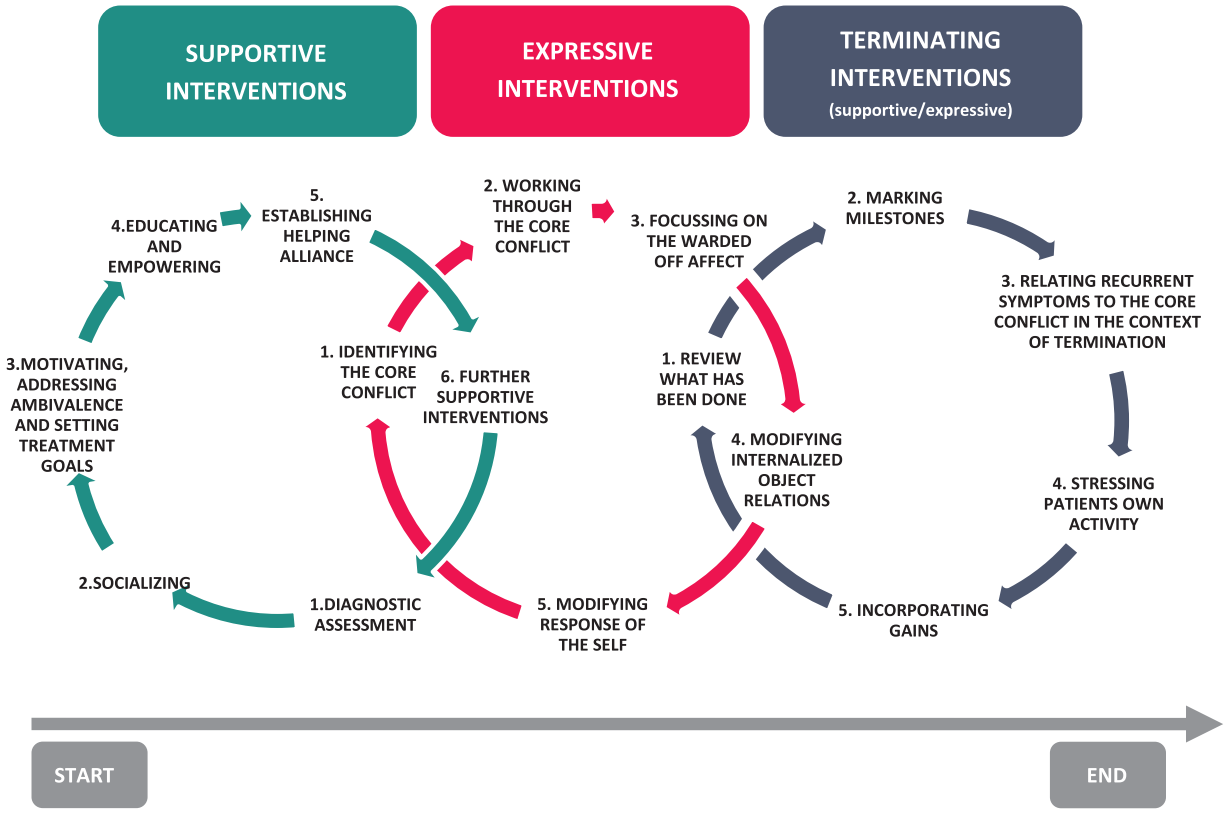


**Fig. 2.** The modules included in the unified protocol for emotional disorders and their interrelations.

situation is necessary for treatment success, emphasizing the patient´s active contribution to treatment progress. A more detailed description of the socialization interview is given in Table 3. The initial interview applied in the studies using intensive short-term dynamic therapy uses a more confronting style addressing vagueness, avoidance and feelings (in the current situation, transference and the past) to assess unconscious anxiety, the capacity to tolerate anxiety and main defense mechanisms (Ajilchi et al., 2016; Davanloo, 2000; Town et al., 2017).

### 3.6. Module 3: motivating, addressing ambivalence and setting treatment goals

Addressing the patient´s motivation and setting treatment goals is regarded as important for patients with mental disorders in general (Luborsky, 1984) and for patients with depressive disorders (Connolly et al., 2012; Leichsenring and Schauenburg, 2014) and anxiety disorders (Leichsenring and Salzer, 2014) in particular. Specific evidence for addressing existing ambivalence early in treatment comes from studies of motivational interviewing showing that motivational interviewing enhances treatment outcome (Westra et al., 2009). Consistent with these approaches UPP-EMO puts a specific emphasis on the ambivalence and resistance and on clarifying the patient's motivation for treatment. A description of techniques and examples for interventions are given in Table 3.

If initial ambivalence has been sufficiently worked through, treatment goals are discussed. Realistic treatment goals are discussed and set that do not only refer to symptom reduction, but also to gaining insight in the motivations and fears underlying the symptoms and the difficulties in interpersonal relationships (Table 3) (Crits-Christoph et al., 1995a; Leichsenring and Salzer, 2014; Leichsenring and Schauenburg, 2014). In case that the patient seeks only relief from depressive or anxiety symptoms, the therapist may need to enhance the patient´s motivation for getting insight (Crits-Christoph et al., 1995b; Leichsenring et al., 2007).

As emphasized by Luborsky (1984, p. 63) goals serve several functions.

- They provide a marker for both the therapist and the patient of whether the patient has made some progress or not (Luborsky, 1984; Schlesinger, 1977)
- Setting goals also modulates or brakes regression, which is particularly important for patients who are afraid of dependency and for suspicious patients (Luborsky, 1984).
- By conveying support for the patient´s wish to achieve the goals, also establishing a helping alliance (see below) is facilitated.
- From a resource perspective goals focus on solutions rather than on problems (Tables 2, 3) (de Shazer, 1985; Willutzki et al., 2004). Instead of saying, for example, “I am afraid of giving a presentation” or “I cannot get out of bed in the morning to start work”, goals may be "In this semester, I will give at least two presentations" or "This month, I will not get out of bed later than 8 o'clock."

### 3.7. Module 4: educating and empowering the patient

Based on psychoeducational approaches, Connolly et al. implemented an "education-focused component" in their treatment approach for depression (Connolly et al., 2012). A major aim is to empower the patient to become an active participant in the treatment. Thus, a focus is on patient resources. In order to achieve this, the therapist pays attention to legal, medical and family crises. A more detailed description is given in Table 3. We included this module in UPP-EMO. It may be specifically relevant for the treatment of depressive patients.

**Table 3**
Modules of a unified psychodynamic protocol for emotional disorders (anxiety and depressive disorders, UPP-EMO).

| Module | |
|---|---|
| 1 | **Diagnostic Assessment**<br>Before starting the treatment, a diagnostic assessment is carried out, both on a phenomenological (e.g. DSM − 5, ICD − 10,) and a psychodynamic level. For assessing psychodynamic characteristics several methods may be used, for example the structural interview according to Kernberg (1981) or the method of Operationalized Psychodynamic Diagnosis (OPD Task Force, 2008). Some models of STPP used in depressive disorders (Table 1) put a specific focus on the applied defense mechanisms and the capacity to tolerate anxiety (Abbass, 2015; Davanloo, 2000). |
| 2 | **Socializing the patient for psychotherapy – the socialization interview**<br>The therapist informs the patient about his or her anxiety or depressive disorder and the planned treatment. Also practical arrangements for the treatment are made (e.g. duration of treatment and sessions, arrangements for vacations and cancelled sessions). In the socialization interview, the treatment process is explained to the patient emphasizing his or her active role necessary for a successful treatment. The therapist's role is explained as well. To depressive patients, Luborsky et al. (1995, p. 20) suggested to say, for example: "You are about to start psychotherapy for your depression and other problems. It will help you to know how psychotherapy works. The basic plan is that you tell what you have to tell about yourself, about events, and about the treatment. I will listen and respond whenever it is likely to be helpful". Thus, the patient is given a rationale allowing for a first orientation regarding the disorder and the treatment. By focusing on the patients´ active role, they will later be able to attribute the progress to their own activities, which is important for an enduring improvement after end of therapy. Thus, the patient's activities may be regarded as an important resource.<br>In anxiety disorders, the adaptive function of anxiety (signal anxiety) is explained. Furthermore, self-exposure to the feared situation is described as necessary for treatment success (Leichsenring and Salzer, 2014; Leichsenring and Steinert, 2016; Leichsenring and Steinert, 2015) - which is consistent with recommendations by Freud (1917, p. 166) Freud, p. 166) (1917) In addition, the patient is informed that confronting the feared situation will be carefully planned along with the therapist, carried out stepwise starting with less difficult situations, first in fantasy and finally in reality. The patient is also informed that his or her experiences made during self-exposure are important and will be carefully discussed with the therapist. |
| 3 | **Motivating, addressing ambivalence and setting treatment goals**<br>Taking an empathic position, the therapist confronts, clarifies and interprets the patients´ ambivalence between changing and remaining, their avoidance behavior and resistance to change. From a resource-oriented perspective, the therapist is recommended to discuss the patient´s symptoms as a solution of a problem (Luborsky, 1984), thus emphasizing the patient´s abilities. Conveying to the patient that he/she understands the patient´s motives, the therapist positions him- or herself on the side of anxiety and resistance (e.g. “If you avoid meeting other people, they cannot humiliate you…. So by avoiding other people, you protect yourself. That´s helpful to you.” or “Worrying about your children prevents anything bad happening to them. What´s wrong with that?”). Ambivalence may also be addressed by open questions: "What´s good about staying in bed all day?" or "What problem do you solve by staying in bed all day?" Doing so will lead to a discussion of benefits and costs of the patient´s symptoms and remaining the same or changing. Conveying to the patient that the therapist understands the patient´s motives, the therapist positions him- or herself on the side of anxiety and resistance to change. As a consequence, the patient may move on the side of changing. The patient´s wish for change is another resource that may be activated in this way.<br>Realistic treatment goals are discussed and set that do not only refer to symptom reduction, but also to interpersonal relationships, e.g. “You told me that you would like to get rid of your panic attacks. I see that this is important to you. However, you also told me that there are some problems in your interpersonal relations. Maybe we can examine whether they related to your panic attacks?”<br>From a **resource perspective** goals focus on solutions rather than on problems (Willutzki et al., 2004). The therapist may ask the patient, for example, “Please imagine that you have reached the end of therapy and most of your problems are gone. How do you feel? What has changed?” |
| 4 | **Module 3: Educating and empowering the patient** A major aim is to empower the patient to be an active participant in the treatment (Connolly Gibbons et al., 2012). The therapist is instructed to pay immediate attention to legal, medical and family crises and to provide the patient with information to avoid further life crises without detracting from the discussion of relationship conflicts. Once the current stressors are stabilized, the therapist returns to addressing the relationship patterns associated with the crisis (Connolly Gibbons et al., 2012). |
| 5 | **Supportive Interventions** |
| 5.1 [C] | **Establishing a secure helping alliance**<br>The establishment of a secure helping alliance is regarded as a central treatment element (Davanloo, 1992; Luborsky, 1984) and was consistently shown to be significantly associated with favourable treatment outcome (Horvath et al., 2011). Luborsky and Crits-Christoph described several principles that foster a secure helping alliance (Crits-Christoph et al., 2006; Luborsky, 1984, p.82–88), that is<br>• expressing empathy,<br>• explaining the treatment process,<br>• setting treatment goals,<br>• supporting the patient in achieving the goals,<br>• monitoring the process by reference to goals,<br>• recognition that the patient has made some progress toward the goals,<br>• focusing on the common work between patient and therapist, this encouraging a "we bond" (e.g. “When you started treatment, you made your goal to reduce your panic attacks/depression/xxx. They seem to have decreased. You see, in fact, we are working together to achieve this”),<br>• monitoring and discussing ruptures of the bond in an accepting climate (Crits-Christoph et al., 2006),<br>• regularly examining the patient´s motivation for treatment.<br>• conveying recognition of the patient´s growing ability to use the tools of treatment as the therapist does.<br>By internalizing the therapist as a helpful person, an enduring improvement is warranted and an important resource is acquired. As many patients with anxiety and depressive disorders suffer from insecure attachment representations (Bifulco, Moran, Ball, and Bernazzani, 2002; Vertue, 2003), a secure supportive alliance also may provide a corrective emotional experience. Thus, the therapeutic relationship represents an important interpersonal resource. |
| 5.2 | **Specific Supportive Interventions**<br>Specific supportive interventions may be required in some patients and/or in some therapeutic situations, e.g. reducing anxiety, reassuring, encouraging, advising, or modeling (de Jonghe, 1994; Driessen et al., 2013). For a panic disorder Busch, p. 239) et al. (1999) gave the following example for an intervention: “We know that your internist has reassured you that there is nothing wrong with your heart, so we need to understand more why you still have the fear that you´re dying of a heart attack.” The therapist may also reframe symptoms as problem-solving attempts, help the patient to maintain vital defenses and activities or foster the patient´s ability to reflect on their own and others´ thoughts and feelings (mentalization). Depending on the patient´s capacities and needs, the therapist oscillates between supportive and expressive interventions, that is between working on structural deficits (e.g. Blanck and Blanck, 1974, Kohut, 1971 or Leichsenring et al., 2016 or on conflicts (e.g. McCullough Vaillant, 1997, p. 44–45), see module 5).<br>From a resource-oriented perspective, the therapists explores exceptions, conditions which enabled the patient to use specific ego-functions that are presently impaired (Wöller, 2015). |

(*continued on next page*)

**Table 3** (*continued*)

| Module | |
|---|---|
| 6 [C] | **Identifying and working through underlying core conflicts: wishes (affects), object relations and defenses**<br>By use of patient narratives, the core conflict associated with the symptoms of anxiety or depression is identified (wish, response of others, response of self).<br>To facilitate identification of the core conflict, the therapist may conduct a relationship episode interview (REP, Luborsky, 1990, p. 103) using the following instruction: "Please tell me some events involving you and another person. Each one should be a specific event. Some should be old and some current incidents. For each one, please tell me (1) who the other person was, (2) what he/she did and what you did, (3) and what happened in the end. Tell me at least ten of these events." The core conflict is that pattern of W, RO and RS that occurs most often.<br>Discuss the core conflict as his/her "**anxiety formula**" /"**depression formula**" that explains his/her symptoms of anxiety. The core conflict serves as the focus of treatment. The therapist relates the components of the core conflict to the patient´s symptoms of anxiety, for a patient with, for example, social anxiety disorder: "As we have seen, you are not only afraid of exposing yourself (RS), but you sometimes wish to be in the center of attention and to be affirmed by others (W). However, you are afraid that they will humiliate you (RO)." To a depressed patient, the therapist may say referring to interactions with some people the patient just described (Luborsky, 1995, p. 27): "In these interactions, you clearly felt you couldn´t get the respect and understanding you needed and so you ended up feeling unloved and began to feel depressed."<br>Again, exceptions may be helpful to understand the patient's psychodynamics. Willutzki and Teismann (2013), for example, described a patient with social anxiety disorder who recalled meeting two friends when she felt a little bit sick. In this situation she felt less socially anxious. Exploring the situation showed that she had allowed herself to make a mistake and put the focus of her attention rather on the others than on what she said. From a psychodynamic view, being ill seems to have reduced the influence of a critical introject or super-ego ("If I am ill, I do not have to be perfect.").<br>Having identified the core conflict, the therapist repeatedly works it through with a focus on current relationships (Luborsky, 1984; Menninger and Holzman, 1973). In UPP-EMO. the therapist is recommended to develop written formulations along with the patient and to ask the patient to work with these formulations also between the sessions (fostering transfer and the process of working-through). |
| 6.1 **[C]** | **Focusing on the warded-off affect – experiencing the wish component of the conflict**<br>The core conflict includes a wish (impulse or affect) that triggers anxiety and is therefore warded off. The UPP-EMO puts a specific focus on guiding the patient to gradually experiencing this painful affect (Davanloo, 1992). Here often negative affects such as anger, guilt or shame are involved (e.g. "You are afraid of telling your boss that you are angry with him because you are afraid of losing control. What will happen if you do so? What will you and what will he do?"). The psychodynamic techniques of clarifying affects can be used here, e.g. "You were ´upset´ ? Could you try to describe this feeling more precisely?" |
| 6.2 **[C]** | **Modifying underlying internalized object relations – the RO component of the conflict**<br>The therapist clarifies what the patient expects to happen in object relations if he expresses his wish (worst case scenario), e.g. "You are afraid to tell your mother that you will not come at Christmas this year. How would she react if you do so?" |
| 6.3 **[C]** | **Changing underlying defenses and avoidance – the maladaptive RS components of the core conflict: encouraging the patient to give up avoidance**<br>The therapist stresses the adaptive and evolutionarily meaningful function of anxiety and shows the patient that anxiety and avoidance are attempts to protect against more unpleasant feelings (e.g. "You regularly experience attacks of panic when you are in conflict with your mother. Maybe getting anxious is easier for you to stand than being in conflict with her."). In the socialization interview, the costs of avoidance were discussed and the patient was informed that in the middle part of the treatment he or she will be called on to confront rather than to avoid the situation they fear. In addition to behavioral avoidance discussed below, avoidance of affects needs to be specifically addressed (Abbass, 2015; Davanloo, 1992)<br>**Focusing on avoidance**: Encouraging the patient to give up avoidance and to confront the feared situation was described by Freud (1919) as an indispensable treatment element for patients with anxiety disorders and obsessive compulsive disorder. Based on the RCTs listed in Table 1 and consistent with the recommendations given by Freud (1919), UPP-EMO puts a specific focus on addressing the patient´s avoidance behavior. Patients are called on to confront rather than to avoid the situation they fear. It is important for the therapist to discuss confronting the feared situation carefully with the patient both before and afterwards. The therapist asks the patient to have a close look at what is happening during confrontation including both his/her own reactions and the reactions of others. This is important for two reasons, to strengthen the observing ego and to collect material to be discussed later with the therapist. Thus, encouraging the patient to confront the feared situation must not be mistaken as encouraging him or her to jump in at the deep end. Otherwise the patient´s fearful expectations may be confirmed. Confronting the feared situation is carefully planned, carried out stepwise starting with less difficult situations, first in fantasy and finally in reality. The therapist may say, for example: "We set as a goal that you want to lose your fear of giving presentations. Thus, you need to stop avoiding it, you need to do it. We will carefully play through this situation in fantasy here and discuss your experiences after you have done it." For patients with deficits in social skills it may be necessary to anticipate the social situation and to run it through in fantasy (Freud´s "Probehandeln", Freud, 1900) before exposing oneself to the feared situation. |
| 6.4 **[C]** | **Modifying response of self – the adaptive RS component of the CCRT: Fostering more adaptive responses**<br>The therapist actively fosters the development of more adaptive responses from the self. In order to foster an **internalized encouraging dialogue**, the therapist may say, for example:<br>"We have learnt that your anxiety (or depression) formula makes you anxious (depressive). Is there anything that you can say to yourself that would encourage you? Do you remember anything you said to yourself that made you feel less anxious?" The therapist encourages the patient to repeatedly activate the encouraging dialogue in everyday situations in order to make it habitual and to foster internalization. In this way, it may become an important resource for the patient. |
| 7 | **Cultural sensitivity component**<br>Cultural influences may have an impact on the therapeutic work. (Connolly Gibbons et al., 2012) included an explicit cultural sensitivity component in their treatment approach for depression. They emphasized four concepts that can aid therapists to specifically address the role of culture in the therapeutic process:<br>• being aware of both one´s own cultural background;<br>• being familiar with the patient´s cultural background;<br>• acknowledging and exploring the existing cultural differences, and distinguishing between what is normal versus impaired within the patient´s ethno-cultural context. |
| 8 | **Termination and Relapse Prevention**<br>In UPP-EMO supporting patients with anxiety or depressive disorders to prevent relapse is regarded as an important treatment element. Therapists are recommended, for example, to remind the patient when termination will take place. He or she should also mark treatment phases (arrival at a goal) so that they can serve as milestones (e.g. "It was a kind of breakthrough when you told your mother that you will not be at home on Christmas.").<br>Furthermore, when termination is being considered, the therapist and the patient will review what they have done. When symptoms recur during the termination phase, the core conflict is often activated by both the anticipated loss of the therapist and by the anticipation that the wishes inherent in the core conflict will be not fulfilled. To patients who fear to lose the gains without the continued presence of the therapist, he or she may say (Luborsky, 1984, p. 28, 155): "You believe that the gains you have made are not part of you but depend on my presence….. You seem to forget that the gains you have made are based on your own work. You used the same tools to solve your problems that I used during our sessions. And you can go on doing so after the end of treatment." Thus, the therapist stresses that the reduction of anxiety or depression was based on the patient´s own activities and the patient can go on doing so.<br>In addition, the final three sessions are carried out as booster sessions at two-week intervals to monitor and support the patient´s improvements. |

Note. [C]: Core Principle.

### 3.8. Module 5: supportive interventions

#### 3.8.1. Establishing a secure alliance [C][2]

In psychodynamic therapy the establishment of a secure helping alliance is regarded as a central treatment element (Luborsky, 1984) and was consistently shown to be significantly associated with favourable treatment outcome (Horvath et al., 2011; Zilcha-Mano, 2017). Based on the included RCTs (Table 1) UPP-EMO puts a particular emphasis on establishing a secure alliance. Luborsky described several principles that foster the establishment of the helping alliance (Table 3). Crits-Christoph et al. (2006) presented several additional helpful techniques to this effect, e.g. regularly examining the patients motivation for and involvement in the psychotherapeutic process, monitoring and discussing ruptures of the therapeutic bond in an accepting climate, and the use of a conversational style. As shown by Crits-Christoph et al. (2006) therapists can be trained in these techniques.

#### 3.8.2. Specific supportive interventions

The supportive-expressive continuum of psychodynamic interventions allows for additional supportive interventions in the case of either more severe psychopathology or acute crisis (Luborsky, 1984). For patients with more severe depression or anxiety supportive interventions may be required like reassuring or encouraging (Busch et al., 1999; de Jonghe, 1994; Driessen et al., 2013). Some examples for such interventions are given in Table 3. Depending on the patient´s capacities and needs, the therapist oscillates between supportive and expressive (interpretive) interventions, that is between working on structural deficits (e.g. Blanck and Blanck, 1974, Kohut, 1971 or Leichsenring et al., 2010 or on unconscious conflicts (e.g. McCullough Vaillant, 1997, p. 44–45), see module 5).

#### 3.8.3. Module 6: Identifying and working through the core conflict: wishes, internalized object relations and defenses [C]

The concept of conflict plays a central role in psychodynamic theory and therapy. This is true for anxiety disorders (Leichsenring and Salzer, 2014) and depressive disorders (Leichsenring and Schauenburg, 2014) as well. According to Freud´s second (signal) theory of anxiety (Freud, 1926), the formation of psychological symptoms is based on an unresolved conflict between libidinal or aggressive impulses and the super-ego (sub-optimally) resolved by the ego using defense mechanisms. Patient's symptoms are regarded as a compromise between the patient´s impulses and the specific defense mechanisms he or she applies. Luborsky (1984) has operationalized Freud´s model of symptom formation by his concept of the core conflictual relationship theme (CCRT). A core conflict consists of three components, a wish (W), a response from the others (RO) and a response of the self (RS). The response of self component is complex, including both defense mechanisms and the resulting symptoms (Luborsky, 1984). The core conflict also represents the patient´s transference potential, since it includes the patient's wishes and anticipated responses from the object (Luborsky, 1984). Thus, the CCRT method is also a method to operationalize the concept of transference - Freud´s "stereotype plates" (Freud, 1912; Luborsky, 1984). However, Luborsky´s model is not the only attempt to understand the development of the patient´s symptoms. Malan´s triangle of conflict is another model to conceptualize the relationship between impulses, anxiety and defenses (Malan, 1979). It is used in Davanloo's concept of intensive short-term dynamic therapy as well (Abbass, 2015; Davanloo, 1992). An impulse or feeling (Malan´s "feeling pole", F), for example, anger or sexual desire, triggers anxiety, guilt or shame ("anxiety pole", A) and leads to defenses ("defense pole", D). These patterns began with past persons (P), are maintained with current persons (C) and often include the therapist (T) – Malan's triangle of person (Malan, 1979). Malan's triangle of conflict and person are compatible with Luborsky's CCRT approach. This is also true for the concept of the interpersonal-affective focus (IPAF) recently presented by Lemma, Target, and Fonagy (2011) and for the relationship axis of the Operationalized Psychodynamic Diagnostics system (OPD, Schauenburg and Grande, 2011). As these concepts are compatible with each other, clinicians may choose the concept they are most familiar with.

Consistent with the focus on conflicts in the RCTs listed in Table 1, UPP-EMO focuses on the conflicts underlying the symptoms of anxiety or depression. To facilitate identification of the core conflict, the therapist may conduct a relationship episode interview (REP, Table 3) as described by Luborsky (1990).

In the unified protocols for anxiety and depressive disorders (Leichsenring and Salzer, 2014; Leichsenring and Schauenburg, 2014) we proposed to discuss the CCRT with the patient as his or her "anxiety formula" or "depression formula", respectively (Leichsenring and Salzer, 2014; Leichsenring and Schauenburg, 2014) which allows him or her understand their pattern of anxiety or depressive reactions, thus providing a sense of control. An increasing sense of control can be seen as a step towards the formulation by Freud (1917, p. 143) according to which the ego again becomes the "master in its own house". In UPP-EMO, depending on the patient´s disorder, we propose to use the terms "anxiety formula" or "depression formula" as well.

For a patient with social anxiety disorder, the CCRT according to Luborsky may be described in the following way (e.g. Gabbard, 1992 ; Leichsenring et al., 2007): "I wish to be affirmed by others (**W**). However, others will humiliate me (**RO**). I feel ashamed and become afraid of being together with others, so I have decided to avoid exposing myself (**RS**, symptoms of social phobia)." For a depressed patient, the CCRT may be, for example: "I want to be respected (or understood) (**W**). However, the others do not respect (understand) me (**RO**). I feel unloved and depressed (**RS**, symptoms of depression)." For patients with depressive disorders, the following core conflict was identified as most representative: a strong wish to feel close to others, the perception of rejection and possible dislike, and feelings of helplessness and disappointment (Vanheule et al., 2006). Consistent with empirical data (Vanheule et al., 2006) however, we do not assume that there is just one core conflict specific to all patients with depressive disorders or an anxiety disorder (Crits-Christoph et al., 1995a; Leichsenring and Salzer, 2014; Leichsenring and Schauenburg, 2014).

In UPP-EMO the symptoms of anxiety or depression (RS) are interpreted and discussed with the patient as a problem-solution or coping attempt, that is a way to deal with a conflict (Luborsky, 1984, p. 114). By doing so the therapist emphasizes the patient's resources. He or she may refer to the discussion of the benefits and costs of the patient´s anxiety and depression during module 2.

Once the core conflict is identified, it serves as the focus of treatment: The therapist relates the components of the core conflict to the patient´s symptoms. For the example given above, the therapist could do so by an expressive intervention in the following way: "As we have seen, you are not only afraid of exposing yourself (RS), but you sometimes wish to be in the center of attention and to be affirmed by others (W). However, you are afraid that they will humiliate you (RO)." The intervention also includes a supportive component as it refers to the common work between patient and therapist ("As we have seen ...", Leichsenring et al., 2007; Luborsky, 1984).

#### 3.8.4. Working through

During the course of treatment the therapist repeatedly works through the core conflict in current and past relationships including the relationship with the therapist (Luborsky, 1984) – Malan´s triangle of persons (Malan, 1979). Working through the core conflict constitutes the expressive (insight-oriented) element of the UPP-EMO. As noted by Luborsky (1984) this form of gaining insight has not only a cognitive, but also an emotional component - working through the core conflict

[2] [C]: Core Principle.

includes the dynamics, that is the defenses and the warded-off affects (Crits-Christoph et al., 1995a). As in the unified protocols for both anxiety disorders and depressive disorders (Leichsenring and Salzer, 2014; Leichsenring and Schauenburg, 2014), the process of working through is specifically emphasized in UPP-EMO including both the therapist and the patient activity. For this purpose, we proposed to use written formulations of these conflicts (e.g. Leichsenring et al., 2015a; Leichsenring et al., 2013) to guide both the patient and the therapist in working through the relationship between the patient´s wishes, his or her expected responses from others and the responses from the self, including the symptoms. These written formulations are developed along with the patient in a collaborative effort. They are modified until both the patient and the therapist agree with them (Leichsenring et al., 2015a).

Furthermore, not only within but also between sessions, patients are asked to work on their anxiety or depression formula, that is to monitor their emotions including their bodily components (see also module 5.1) and to identify the components of the core conflict that lead to anxiety or depression (Leichsenring and Salzer, 2014; Leichsenring and Schauenburg, 2014). Again, a particular emphasis is put on the patient´s own activity.

As we will describe in the following, UPP-EMO puts a specific focus on each component of the CCRT, that is on the wish (W), the response of the objects (RO) and the response from the self (RS).

*3.8.5. Focusing on the warded-off affect: experiencing the wish component of the conflict [C]*

The concept of a wish (impulse or affect) that is unacceptable to the subject plays a central role in psychodynamic theory and therapy. In terms of drive psychology, both libidinal and aggressive impulses are included here. Object relations theory, self psychology and attachment theory have amplified the spectrum of wishes by calling attention to wishes for symbiosis, separation and individuation (Mahler et al., 1975), attachment (Bowlby, 1973) or affirmation (Kohut, 1971).

As a central component, the core conflict includes a wish (impulse or affect) that triggers anxiety and is therefore warded off – the impulses/feelings component (F) in Malan's (1979) triangle of conflict model used in several RCTs listed in Table 1. Here often negative affects such as anger, guilt or shame are involved (Shear et al., 1993). UPP-EMO puts a specific emphasis on experiencing the warded-off affect which is consistent with Davanloo´s model of intensive short-term dynamic psychotherapy (Abbass, 2015; Davanloo, 2000), the affect phobia model by McCullough et al. (2003) and the unified protocols for anxiety and depressive disorders (Leichsenring and Salzer, 2014; Leichsenring and Schauenburg, 2014).

Having established a secure therapeutic alliance, the therapist is recommended to encourage patients to repeatedly experience the avoided affect (Abbass, 2015; Davanloo, 1992). Specifically intensive short-term dynamic psychotherapy emphasizes graded emotion activation and reflection for building capacities to tolerate anxiety and experiences (Abbass, 2015; Ajilchi et al., 2016; Davanloo, 2000; Town et al., 2017). In order to gradually lead the patient to experiencing the avoided affect, this may be done first in sensu, then in real relationships. (McCullough and Osborn, 2004). It is important that also the somatic components of the affect are included here (Abbass, 2015; McCullough and Osborn, 2004). - Focusing on the warded-off affect implies a crucial difference to desensitization in CBT, where the symptoms of anxiety are desensitized (the A [anxiety] component on Malan's triangle of conflicts, Malan, 1979), not the threatening, that is warded-off affect (the F [feeling] component in Malan´s triangle of conflict).

In UPP-EMO – and in psychodynamic therapy in general – , focusing on the warded-off affect aims at increasing the patient´s tolerance of the warded-off affect or impulse, improving awareness and perception of this affect and to better integrate the avoided impulse into the patient´s conscious experience (Abbass, 2015; Davanloo, 1992). Thus, the patient´s sense of control is increased. Focusing on the warded-off affect, a therapist may say, for example, to a patient with a panic disorder (Leichsenring and Salzer, 2014) : “You are afraid to tell your boss that you are angry with him because you are afraid of losing control. What will happen if you do so?” Fear of losing control over feelings was also emphasized by Davanloo (1992).

The psychodynamic techniques of clarifying affects can be used here. If a patient, for example, tells the therapist that he was “upset” when he talked to his boss, he or she could say: “You were ´upset´? Could you try to describe more precisely what you experienced?” (affect clarification). A very similar way of confronting and clarifying affects is used in intensive short-term dynamic therapy, for example to address vagueness and avoidance (Abbass, 2015; Davanloo, 1992). If the patient says that he is angry, to further clarify the affect the therapist may ask (Davanloo, 1992, p. 59): "How do you experience your anger?" The therapist should be aware of the fact, that the patient is not familiar with these possibly alarming feelings of rage, anger or sexual desire. The patient may need to find adequate (functional) ways to express the affect that had been warded off for so long. The therapist may support the patient by anticipating and discussing possible ways of adequately expressing the affect – a new functional response of self (RS component of the CCRT, F pole of Malan´s triangle of conflict).

*3.8.6. Modifying underlying internalized object relations: the response of others component of the core conflict [C]*

The conflicts underlying symptoms of depression or anxiety (Table 1) include an internalized object relation, that is the response of others component in Luborsky's CCRT model or (Luborsky, 1984, 1995) or the anxiety (A) component in Malan's (1979) triangle of conflicts.

UPP-EMO focuses on all components of the core conflict including the response of other components. He or she clarifies what the patient expects to happen in object relations if he expresses his wish (worst case scenario). In order to do so, the therapist may say, for example: “You are afraid of telling your mother that you will not be home for Christmas. How would she react if you do so?” The aim is to improve the patient's reality testing ability, but also to allow for corrective emotional experiences with others including the therapist: others do not necessarily respond as expected (changing transference expectations).

*3.8.7. Changing underlying defenses and encouraging the patient to give up avoidance [C]*

Consistent with the studies listed in Table 1, for example those based on Luborsky´s model of supportive-expressive therapy (Crits-Christoph et al., 1995a; Luborsky, 1984, 1995), therapists using UPP-EMO are recommended to stress the adaptive and evolutionarily meaningful function of anxiety and to show the patient that anxiety and avoidance are attempts to protect against more unpleasant feelings. Beside the adaptive function, the therapist points out the maladaptive functions of defenses (Leichsenring and Salzer, 2014; Leichsenring and Schauenburg, 2014). The therapist takes up again the discussion of benefits and costs of defenses and avoidance described above (Module 2). In general, the well-known psychodynamic techniques of confronting, clarifying and interpreting are used here. McCullough et al. (2003, p. 119–123) presented several examples for each of these techniques, e.g. for confronting defenses (“When situations like this come up, you talk a lot about what you **think** [D], but you seem to avoid talking about how you **feel** [F]) or for interpreting defenses (”I wonder if spending all the time at work [D] might be a way of avoiding the virtually unbearable [A] fweelings of grief [F] that are an inevitable part of the break up with your lover [C].”[3] Intensive short-term dynamic therapy puts a specific focus on assessing and addressing the

[3] D refers to the defensive pole of Malan´s triangle of conflicts, F to the feeling pole, A to the anxiety pole and C to a current person in Malan´s triangle of person (McCullough et al., 2003).

various defense mechanisms (Abbass, 2015, p. 11–26)

*3.8.7.1. Focusing on avoidance*. Following the recommendations given by Freud (1919) for patients with agoraphobia (and obsessive-compulsive disorder), UPP-EMO puts a specific focus on addressing the patient´s avoidance behavior (Leichsenring and Salzer, 2014; Leichsenring and Steinert, 2016; Leichsenring & Steinert, in press).[4] As stressed by Shear et al. (1993, p. 863) for panic disorder, avoidance of real life experiments impairs learning about predictability of threats and interferes with realistic self-confidence in coping with threats and reduces the sense of controllability. For this reason, patients are called on to confront rather than to avoid the situation they fear. Confronting the feared situation is carefully planned, carried out stepwise starting with less difficult situations, first in fantasy and finally in reality. As the next step after confrontation, the therapist relates the experiences the patient made during confrontation to the core conflict and its components. Thus, the patient´s experiences are used to work on his or her core conflicts. **This is a crucial difference to exposure as used in CBT and follows the recommendations by** Freud (1919). We have described this procedure in detail in our manual for the treatment of social anxiety disorder (Leichsenring et al., 2007) applied in a large randomized controlled trial (Leichsenring et al., 2013, 2014). **Furthermore, the therapist will not accompany the patient during exposure. This is another crucial difference to exposure in CBT.** For some patients, especially for those with social anxiety disorder, the treatment sessions themselves encompass a form of exposure, that is to the therapist.

*3.8.8. Modifying response of self – fostering more adaptive responses [C]*

Focusing on the conflicts associated with the symptoms of depression or anxiety which is regarded as necessary in most RCTs listed in Table 1 also implies working through the self-defeating aspects of the self response. - The self response component of the core conflict includes both maladaptive and adaptive responses from the self.[5] Working through the self-defeating aspects of the self response lays the groundwork for developing new responses of the self and new behaviors (Crits-Christoph et al., 1995a). Thus, UPP-EMO recommends the therapist to actively foster the development of more adaptive responses from the self (RS). For this purpose, he or she takes a more active stance than in classical psychoanalysis. Emphasis is put, for example, on fostering an internalized encouraging dialogue. As described by Kernberg (1976), internalized object relations encompass an object representation, a corresponding self representation and a corresponding affect connecting them. From an object relational perspective, the patients symptoms are maintained by inner dialogues associated with pathogenic internalized object relations. In long-term psychotherapy, the patient has the chance of making corrective emotional experiences especially with the therapist. Thus, an alternative (benign) object can be internalized. In short-term psychodynamic therapy we recommend the therapist to actively foster the development of an internalized encouraging dialogue (Hoffmann, 2003; Leichsenring and Salzer, 2014; Leichsenring and Schauenburg, 2014). Following Hoffmann (2003), we have described the implied procedures in detail for the treatment of social anxiety disorder (Leichsenring et al., 2007). The therapist is recommended to use first indications of the patient of encouraging him- or herself, that is exceptions, situations when the patient was not anxious or mastered the feared situations, indicating resources (de Shazer, 1985; Willutzki and Teismann, 2013). The therapist may say, for example: “We have learnt that your anxiety formula makes you anxious. Is there anything that you can say to yourself that would encourage you? Do you remember anything you said to yourself that made you feel less anxious?” For some patients it is something the therapist has said to him or her. These patients “take” the therapist with them (internalization). For patients with generalized anxiety disorder, panic disorder or agoraphobia, the inner dialogue may have a more calming tone and function (“I know that I will not die of a heart attack. I am just angry”). For depressive patients, it may focus on self-esteem (“If I don't get this job, it does not mean that I am worthless.”). Activating an internalized encouraging dialogue is especially helpful when confronting an anxiety-provoking situation (Leichsenring et al., 2007; Leichsenring and Salzer, 2014). The therapist encourages the patient to repeatedly activate the encouraging dialogue in everyday situations in order to make it habitual and to foster internalization (Leichsenring and Salzer, 2014; Leichsenring and Schauenburg, 2014; Leichsenring & Steinert, in press; Steinert, Schauenburg, Dinger, and Leichsenring, 2015). In this way, the internalized dialogue may become a resource for the patient. Supporting the patient to establish a helpful inner dialogue can be expected to foster the internalization of a good and constant object that has an appreciating (Kohut, 1971), directing (König, 2015) or calming (Bowlby, 1973; Busch et al., 1999) function.

### 3.9. Module 7: cultural sensitivity component

Cultural influences may have an impact on the therapeutic work. Connolly et al. included an explicit cultural sensitivity component in their treatment approach for depression (Connolly et al., 2012) They emphasized four concepts that can aid therapists to specifically address the role of culture in the therapeutic process. They are described in Table 3. A cultural sensitivity component is not only relevant to depressed patients, but to patients with anxiety disorders and other mental disorders as well.

### 3.10. Module 8: termination and relapse prevention

In many of the RCTs providing evidence for the efficacy of STPP in anxiety and depressive disorders termination of therapy is regarded as a particularly important step (Table 1). This is consistent with recommendations for STPP in general . Thus, similar to the unified protocols for anxiety and depressive disorders particular (Leichsenring and Salzer, 2014; Leichsenring and Schauenburg, 2014), UPP-EMO puts a particular emphasis on termination. Luborsky, p. 26) (1984) described the importance of termination in the following way: “The patient must be able to say to himself or herself, at least by the end phase of the treatment, that what has been learned during its course will remain, even though the schedule of face-to-face psychotherapy sessions will come to an end. However, what has been learned and the impression of the helping relationship will stay alive.” – that is become a resource for the patient. Luborsky put particular emphasis on both patient and therapist activities. He formulated several principles pertaining to termination (Luborsky, 1984, p. 142–158) For UPP-EMO we follow the recommendations by Luborsky and Connolly Gibbons et al. (2012). Examples for interventions are given in Table 3.

Consistent with other researchers, we additionally recommend carrying out the final sessions as booster sessions e.g. at two-week intervals (Crits-Christoph et al., 1995a; Leichsenring and Salzer, 2014; Leichsenring and Schauenburg, 2014; Luborsky, 1995). In these last sessions, a specific focus is put on the maintenance of gains (Table 3). If symptoms recur, the patient is informed that this does not imply relapse (dealing with relapse). The therapist relates recurrence of symptoms to the core conflict and to the loss of the therapist (Luborsky, 1984). The therapist stresses again the patient´s own contribution to his or her progress (Leichsenring and Salzer, 2014; Luborsky, 1984). The therapist emphasizes that some relapse is "normal", he or she may compare it with learning to ride a bicycle or to ski. Even if you fall sometimes, it is important to go on.

[4] Thus, encouraging the patient to give up avoidance and to confront the feared situation was described by Freud as an indispensable treatment element long before it was used by CBT.

[5] In Malan´s triangle of conflicts (Malan, 1979) modified by McCullough and Osborn, p. 884) (2004) the adaptive responses from the self are assigned to the F pole (adaptive impulse/feeling).

#### 3.10.1. Future modules

The efficacy of UPP-EMO may be enhanced in the future by including further modules, provided that they are consistent with the procedures of UPP-EMO and that they will be supported by evidence from RCTs. Some promising candidates are

(1) focusing on mentalization (Lemma et al., 2010),
(2) focusing on patients at risk for non-response by giving feedback on patient progress (Lambert et al., 2002; Shimokawa et al., 2010),
(3) maintenance treatment and
(4) treatment options for non-responders (Leichsenring et al., 2015a).

#### 3.10.2. Indications for UPP-EMO

Taking the available evidence into account (Table 1), UPP-EMO addresses the treatment of

- major depressive disorder (DSM-5 296. XX),
- generalized anxiety disorder (DSM-5 300.02),
- panic disorder (DSM-5 300.01)
- agoraphobia (DSM-5 300.22),
- social anxiety disorder (DSM-5 300.23).

Furthermore, we expect UPP-EMO to also improve comorbid mental disorders, e.g. anxiety disorders in depressive disorders and vice versa. Specific phobia (DSM-5 300.29) is in principle covered by UPP-EMO as well, but at present no evidence for STPP in simple phobia exists - simple forms of phobia may rather be treated by CBT. As an advantage, by focusing on the underlying processes, UPP-EMO may also be used to treat

- separation anxiety disorder (DSM-5 309.21)
- other specified anxiety disorder ( DSM-5 300.09),
- unspecified anxiety disorder ( DSM-5 300.00),
- adjustment disorder with anxiety (DSM-5, 309.24),
- sub-definitional threshold variations of anxiety and depressive disorders.

It is of note however, that evidence for psychodynamic therapy in these five conditions is not yet available. Furthermore, UPP-EMO does not include the treatment of post-traumatic stress disorder. These patients show specific treatment needs (e.g. Wöller, Leichsenring, Leweke, and Kruse, 2012). For obsessive-compulsive disorder (OCD), a new psychodynamic treatment protocol was recently developed (Leichsenring and Steinert, 2016; Leichsenring & Steinert, in press). Focusing on both the conflicts underlying symptoms of OCD and using supportive interventions, it is consistent with UPP-EMO with regard to the applied treatment principles (Leichsenring and Steinert, 2016; Leichsenring & Steinert, in press). We are about to test this protocol in an RCT, but at present no evidence for psychodynamic therapy in obsessive-compulsive disorder is available.

## 4. Discussion

Due to the high prevalence of anxiety and depressive disorders and the frequent use of CBT and psychodynamic therapy in clinical practice (Cook et al., 2010; Norcross and Rogan, 2013), the existence of both a cognitive-behavioral (Barlow et al., 2004) and a psychodynamic protocol for emotional disorders may facilitate the treatment of many patients. In addition, compared to several single disorder approaches, unified protocols may facilitate the transfer of research results to clinical practice and the training of therapists.

### 4.1. Limitations

UPP-EMO is based on RCTs showing that STPP is efficacious in depressive or anxiety disorders. As a limitation however, UPP-EMO has not yet been examined in an RCT - which is planned as a next step. This is true for the Barlow protocol in so far as it has only been studied in anxiety disorders, but not yet in depressive disorders (Barlow et al., 2017; Wilamowska et al., 2010). For therapists the specific protocols for STPP in depressive and anxiety disorderes (Table 1) may have the advantage that they provide a more specific and familiar frame. The question whether UPP EMO is as efficacious as the specific models needs to be addressed empirically. For anxiety disorders, Barlow et al. (2017) recently showed that their CBT UP for emotional disorders was as efficacious as single-disorder models. However, this study was not sufficiently powered to demonstrate equivalence if an equivalence margin below 0.40 is used.(Leichsenring et al., 2015c)

It may be of specific interest to compare UPP-EMO with the unified Barlow et al. protocol (UP) for emotional disorders (Barlow et al., 2004). There seem to be some similarities, but also some clear differences – some of these differences were already emphasized above. The protocol by Barlow et al. includes the following modules: (1) motivation enhancement, (2) psychoeducation and treatment rationale, (3) emotion awareness training, (4) cognitive reappraisal, (5) emotion driven behaviors and emotional avoidance, (6) awareness and tolerance of physical sensations, (7) interceptive and situational exposure, and (8) relapse prevention. Using another theoretical language, the Barlow et al. protocol stresses some treatment principles that are regarded as important by the UPP-EMO as well. This is true for the modules on motivation enhancement, psychoeducation and relapse prevention (modules 1, 2, 8 by Wilamowska et al.). From a psychodynamic perspective, these targets are addressed by the first two modules of UPP-EMO (socialization; addressing ambivalence) and in the final module 7 (termination and relapse prevention). Thus, these procedures of beginning and ending psychotherapy seem to be important for both CBT and psychodynamic therapy and possibly for any form of short-term psychotherapy irrespective of its theoretical orientation.[6] As a difference, UPP-EMO puts a strong focus on establishing a helping alliance (module 4), a principle not explicitly listed by Wilamowska et al. (2010). This is consistent with the strong emphasis psychodynamic therapy puts on the therapeutic relationship. Furthermore, regarding the core underlying processes of anxiety and depressive disorders, UPP-EMO focuses on unresolved conflicts, structural deficits, defense mechanisms, the warded-off affect, internalized object relations and response of the self, that is on classic concepts of psychodynamic theory and therapy (UPP-EMO modules 4, 5). From the perspective of CBT, Wilamowska et al. (2010) focus on cognitive reappraisal, emotion awareness, emotion driven behaviors (EDB) and emotional avoidance, and on tolerance of physical sensations and interoceptive and situational exposure (modules 3–7). Some of these modules are classical cognitive-behavioral treatment elements, e.g. cognitive reappraisal which is not included in UPP-EMO. For other modules of the Barlow et al. protocol however, there may be some overlap with some of the modules of UPP-EMO - if the differences implied by another theoretical language are “subtracted”. Both the Barlow et al. protocol and UPP-EMO put a specific focus an experiencing affects. Crucial differences between the cognitive-behavioral emotional awareness training, and the UPP-EMO module 5.1 (focusing on the warded-off affect) were already discussed above: UPP-EMO focuses on the **warded-off** affect (the F [feeling ] component of Malan´s triangle of conflicts (Malan, 1979). Furthermore, as another difference, UPP-EMO does not make use of exposure in the way as it is applied in CBT: The therapist does not accompany the patient during confrontation. In UPP-EMO patients are encouraged to confront the feared situation; the experiences made during exposure are used by the therapist to work on the underlying

[6] This is surprisingly consistent with Freud´s statement that both in psychoanalysis and in chess only the opening and the closing moves of the game allow for an exhaustive systematic description (Freud, 1913.). – By the use of (unified) treatment manuals, however, we try to define core treatment procedures to be used after the opening moves, allowing, however, for some improvisation, that is for a flexible use.

conflict, which is consistent to the recommendations by Freud (1919) – that is they are used in another way than in CBT. The Barlow et al. protocol includes a further module called “Emotion Driven Behaviors and Emotional Avoidance” (module 5). As far as this module is presented by Wilamowska et al. (2010) it seems to be closely related to the psychodynamic concepts of defense and defense mechanisms, though described in a cognitive-behavioral language (Wilamowska et al., 2010). For this module, the authors state (Wilamowska et al., 2010, p. 886): “ … the goal is to identify specific behaviors that prevent full exposure to (and processing of) strong emotions. Emotion avoidance can occur through subtle behavioral avoidance (e.g. procrastination), cognitive avoidance (e.g. daydreaming …) or by use of safety signals (something that a patient may keep with them at all times that confers an irrational belief of safety during intense emotional experiences.”). Consistent with the psychodynamic approach on defense mechanisms (e.g. Freud, 1936; Kernberg, 1994). Wilamowska, p. 886) et al. (2010) go on by discriminating “adaptive” and “maladaptive” aspects of emotional avoidance. It does not come as a surprise that Wilamowska, p. 886) et al. (2010) then conclude: “… another important goal of this phase it to aid patients in identifying maladaptive EDBs [Emotion Driven Behaviors] and teaching them to develop more adaptive behavioral responses to intense emotions” - the classic psychodynamic work on defense and resistance as described above (e.g. also Fenichel, 1941; Freud, 1936; Kernberg, 1976; Reich, 1933), formulated in a cognitive-behavioral language. Module 5 of the Barlow et al. protocol clearly overlaps with psychodynamic concepts in general and with the UPP-EMO in particular, especially with the UPP-EMO modules 5.3 (“changing underlying defenses and avoidance”) and 5.4 (“modifying response of self ... fostering more adaptive responses”). It was for this reason that Roy-Byrne (2017) commented on the study by Barlow et al. (2017) as "transdiagnostic cognitive-behavioral therapy and the return of the repressed "

However, an empirical study is required to identify the real overlaps and differences between psychodynamic and CBT protocols. – In our studies comparing CBT and short-term psychodynamic therapy in generalized anxiety disorder and social anxiety disorder, the two approaches could be clearly discriminated by blind raters (Leichsenring et al., 2013, 2009).

As psychodynamic therapy traditionally focuses on core underlying processes of disorders and tends to have a modular and transdiagnostic format, acceptability of UPP-EMO among psychodynamic psychotherapists in clinical practice is likely to be high.

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## References

Abbass, A., 2015. Reaching Through Resisiance: Advanced Psychotherapy Techniques. Seven Leaves Press, Kansas.
Abbass, A., Driessen, E., 2010. The efficacy of short-term psychodynamic psychotherapy for depression: a summary of recent findings. Acta Psychiatr. Scand. 121, 398–399.
Ajilchi, B., Nejati, V., Town, J.M., Wilson, R., Abbass, A., 2016. Effects of intensive short-term dynamic psychotherapy on depressive symptoms and executive functioning in major depression. J. Nerv. Ment. Dis. 204 (7), 500–505. http://dx.doi.org/10.1097/NMD.0000000000000518.
Albani, C., Blaser, G., Geyer, M., Schmutzer, G., Brähler, E., 2010. Outpatient psychotherapy in Germany from the patient perspective: Part 1: health care situation. Psychotherapeut 55, 503–514.
Alonso, J., et al., 2004. 12-Month comorbidity and associated factors in Europe: results from the European Study of the Epidemiology of Mental Disorders (ESEMeD) project. Acta Psychiatr. Scand. Suppl 420, 28–37.
Barkham, M., Rees, A., Shapiro, D.A., Stiles, W.B., Agnew, R.M., Halstead, J., Harrington, V.M., 1996. Outcomes of time-limited psychotherapy in applied settings: replicating the Second Sheffield Psychotherapy Project. J. Consult. Clin. Psychol. 64 (5), 1079–1085.
Barlow, D.H., Allen, L.B., Choate, M.L., 2004. Toward a unified treatment for emotional disorders. Behav. Ther. 35, 205–230.
Barlow, D.H., Conklin, L.R., Bentley, K.H., 2015. Psychological treatments for panic disorder, phobias, and social and generalized anxiety disorder. In: Nathan, P.E., Gorman, J.M. (Eds.), A Guide to Treatments That Work, 4th ed. Oxford University Press, New York, pp. 409–461.
Barlow, D.H., Farchione, T.J., Bullis, J.R., Gallagher, M.W., Murray-Latin, H., Sauer-Zavala, S., Cassiello-Robbins, C., 2017. The unified protocol for transdiagnostic treatment of emotional disorders compared with diagnosis-specific protocols for anxiety disorders: a randomized clinical trial. JAMA Psychiatry. http://dx.doi.org/10.1001/jamapsychiatry.2017.2164.
Bellak, L., Hurvich, M., Gediman, H.K., 1973. Ego functions in schizophrenics, neurotics, and normals: a systematic study of conceptual, diagnostic, and therapeutic aspects. Wiley, New York.
Beutel, M.E., Weissflog, G., Leuteritz, K., Wiltink, J., Haselbacher, A., Ruckes, C., Brahler, E., 2014. Efficacy of short-term psychodynamic psychotherapy (STPP) with depressed breast cancer patients: results of a randomized controlled multicenter trial. Ann. Oncol. 25 (2), 378–384. http://dx.doi.org/10.1093/annonc/mdt526.
Bifulco, A., Moran, P.M., Ball, C., Bernazzani, O., 2002. Adult attachment style I: its relationship to clinical depression. [research support, non-U.S. gov't]. Social. Psychiatry Psychiatr. Epidemiol. 37 (2), 50–59.
Blanck, G., Blanck, R., 1974. Ego Psychology: Theory and Practice New York Columbia. University Press.
Bogels, S.M., Wijts, P., Oort, F.J., Sallaerts, S.J., 2014. Psychodynamic psychotherapy versus cognitive behavior therapy for social anxiety disorder: an efficacy and partial effectiveness trial (Comparative Study Randomized Controlled Trial). Depress Anxiety 31 (5), 363–373. http://dx.doi.org/10.1002/da.22246.
Book, H.E., 1998. How to Practice Brief Psychodynamic Therapy. American Psychological Association, Washington, D.C.
Bowlby, J., 1973. Attachment and Loss Separation: Anxiety and Anger. 2 Basic Books, New York.
Busch, F.N., Milrod, B.L., Singer, M.B., 1999. Theory and technique in psychodynamic treatment of panic disorder. J. Psychother. Pract. Res. 8, 234–242.
Chambles, D.L., Hollon, S.D., 1998. Defining empirically supported therapies. J. Consult Clin. Psychol. 66, 7–18.
Connolly, M.B., Crits-Christoph, P., Shappell, S., Barber, J.P., Luborsky, L., Shaffer, C., 1999. Relation of transference interpretation to outcome in the early sessions of brief supportive-expressive psychotherapy. Psychother. Res. 9, 485–495.
Connolly Gibbons, M.B., Thompson, S.M., Scott, K., Schauble, L.A., Mooney, T., Thompson, D., Crits-Christoph, P., 2012. Supportive-expressive dynamic psychotherapy in the community mental health system: a pilot effectiveness trial for the treatment of depression. Psychotherapy 49, 303–316.
Connolly Gibbons, M.B., Gallop, R., Thompson, D., Luther, D., Crits-Christoph, K., Jacobs, J., Crits-Christoph, P., 2016. Comparative effectiveness of cognitive therapy and dynamic psychotherapy for major depressive disorder in a community mental health setting: a randomized clinical noninferiority trial. JAMA Psychiatry. http://dx.doi.org/10.1001/jamapsychiatry.2016.1720.
Cook, J.M., Biyanova, T., Elhai, J., Schnurr, P.P., 2010. What do psychotherapists really do in practice ? An internet study of over 2.000 practitioners. Psychother.: Theory Res. Pract., Train. 47, 260–267.
Cooper, P.J., Murray, L., Wilson, A., Romaniuk, H., 2003. Controlled trial of the short- and long-term effect of psychological treatment of post-partum depression. I. Impact on maternal mood. Br. J. Psychiatry 182, 412–419.
Craighead, W.E., Johnson, B.N., Carey, S., Dunlop, B.W., 2015. Psychosocial treatments for major depressive disorder. In: P.E., N., Gorman, J.M. (Eds.), A Guide to Treatments that Work. Oxford University Press, New York, pp. 381–408.
Cramer, B., Robert-Tissot, C., Stern, D., 1990. Outcome evaluation in brief mother-infant psychotherpy: a preliminary report. Infantt M. Health J. 2, 278–300.
Crits-Christoph, P., Crits-Christoph, K., Wolf-Palacio, D., Fichter, M., Rudick, D., 1995a. Brief supportive-expressive dynamic psychotherapy for generalized anxiety disorder. In: Barber, J.P., Crits-Christoph, P. (Eds.), Dynamic Therapies for Psychiatric Disorders: Axis I. Basic Books, New York, pp. 43–83.
Crits-Christoph, P., Crits-Christoph, K., Wolfpalacio, D., Fichter, M., Rudick, D., 1995b. Supportive-expressive dynamic psychotherapy for generalized anxiety disorder. In: Barber, J.P., Crits-Christoph, P. (Eds.), Dynamic Therapies for Psychiatric Disorders:

Axis I. Basic Books, New York, pp. 43–83.
Crits-Christoph, P., Connolly, MB, Gibbons, MB, Narducci J, Schamberger, M, Gallop, R. , 2005. Interpersonal problems and the outcome of interpersonally oriented psychodynamic treatment of GAD. *Psychotherapy: Theory/ Research/ Practice/Training, 42*, 211-224.
Crits-Christoph, P., Connolly Gibbons, M.B., Crits-Christoph, K., Narducci, J., Schamberger, M., Gallop, R., 2006. Can therapists be trained to improve their alliances? A preliminary study of alliance-fostering psychotherapy. Psychother. Res. 16, 268–281.
Davanloo, H., 1992. A method of short-term dynamic psychotherapy. In: Davanloo, H. (Ed.), Short-term Dynamic Psychotherapy. Jason Aronson, Northvale, pp. 43–71.
Davanloo, H., 2000. Intensive Short-term Dynamic Psychotherapy: Selected Papers of Habib Davanloo. Wiley, Chichester.
Driessen, E., Cuijpers, P., de Maat, S.C., Abbass, A.A., de Jonghe, F., Dekker, J.J., 2010. The efficacy of short-term psychodynamic psychotherapy for depression: a meta-analysis. Clin. Psychol. Rev. 30 (1), 25–36 (doi: S0272-7358)(09)(00116-0)(pii) (10.1016/j.cpr.2009.08.010).
Driessen, E., Van, H.L., Don, F.J., Peen, J., Kool, S., Westra, D., Dekker, J.J.M., 2013. The efficacy of cognitive-behavioral therapy and psychodynamic therapy in the outpatient treatment of major depression: a randomized clinical trial. Am. J. Psychiatry 170, 1041–1050.
Driessen, E., Hegelmaier, L.M., Abbass, A.A., Barber, J.P., Dekker, J.J., Van, H.L., Cuijpers, P., 2015. The efficacy of short-term psychodynamic psychotherapy for depression: a meta-analysis update. Clin. Psychol. Rev. 42, 1–15. http://dx.doi.org/10.1016/j.cpr.2015.07.004.
Farchione, T.J., Fairholme, C.P., Ellard, K.K., Boisseau, C.L., Thompson-Hollands, J., Carl, J.R., Barlow, D.H., 2012. Unified protocol for transdiagnostic treatment of emotional disorders: a randomized controlled trial (Randomized Controlled Trial Research Support, N.I.H., Extramural). Behav. Ther. 43 (3), 666–678. http://dx.doi.org/10.1016/j.beth.2012.01.001.
Fenichel, O., 1941. Problems of Psychoanalytic Technique. The Psychoanalytic Quarterly, Inc., New York, Albany.
Fluckiger, C., Forrer, L., Schnider, B., Battig, I., Bodenmann, G., Zinbarg, R.E., 2016. A single-blinded, randomized clinical trial of how to implement an evidence-based treatment for generalized anxiety disorder [IMPLEMENT]–effects of three different strategies of implementation (Research Support, Non-U.S. Gov't). EBioMedicine 3, 163–171. http://dx.doi.org/10.1016/j.ebiom.2015.11.049.
Frederick, R.J., 2009. Living like you mean it: use the wisdom and power of your emotions to get the life you really want. Jossey-Bass, San Francisco.
Freud, A., 1936. The Ego and the Mechanisms of Defense. International Universities Press, New York.
Freud, S., 1900. The Interpretation of Dreams. Part I, Standard Edition 4. Hogarth Press, London, pp. 1–338.
Freud, S., 1912. The Dynamics of Transference. Standard Edition 12. Hogarth Press, London, pp. 97–108.
Freud, S., 1913. On Beginning the Treatment (Further Recommendations on the Technique of Psychoanalysis), Standard edition. 12. Hogarth Press, London, pp. 123–144.
Freud, S., 1917. A Difficulty in the Path of Psychoanalysis, Standard edition. 17. Hogarth Press, London, pp. 137–144.
Freud, S., 1919. Lines of advance in psycho-analytic therapy. Standard Edition 17. Hogarth Press, London, pp. 159–168.
Freud, S., 1926. Inhibitions, symptoms and anxiety. In: Strachey, J. (Ed.), The Standard Edition of the Complete Psychological Works of Sigmund Freud 20. Hogarth, London, pp. 12–66.
Gabbard, G.O., 1992. Psychodynamics of panic disorder and social phobia. Bull. Menn. Clin. 56 (Suppl. A), A3–A13.
Gabbard, G.O., 2000. Psychodynamic Psychiatry in Clinical Practice, 3rd ed. American Psychiatric Press, Washington, DC.
Gabbard, G.O., 2004. Long-term Psychodynamic Psychotherapy. American Psychiatric Publishing, Washingtopn, DC.
Gabbard, G.O., 2006. Editorial. when is transference work useful in dynamic psychotherapy? . *Am. J. Psychiatry* 163, 1667–1669.
Gallagher-Thompson, D., Hanley-Peterson, P., Thompson, L.W., 1990. Maintenance of gains versus relapse following brief psychotherapy for depression. J. Consulting Clinical Psychology 58 (3), 371–374.
Gallagher-Thompson, D., Steffen, A.M., 1994. Comparative effects of cognitive-behavioral and brief psychodynamic psychotherapies for depressed family caregivers. J. Consult. Clin. Psychol. 62, 543–549.
Gunderson, J.G., Gabbard, G.O., 1999. Making the case for psychoanalytic therapies in the current psychiatric environment. J. Am. Psychoanal. Assoc. 47, 679–704.
Hoffmann, S.O., 2003. Soziale Ängste: die psychodynamische Perspektive in Konzeptbildung und Behandlungsansätzen. [Social anxieties: the psychodynamic perspective in conceptualization and treatment approaches]. Psychother. Im. Dialog 4, 32–41.
Horvath, A.O., Del Re, A.C., Fluckiger, C., 2011. Alliance in individual therapy. Psychotherapy 48 (9-1).
Horowitz, M., Kaltreider, N., 1979. Brief therapy of the stress response syndrome. Psychiatric Clinics North. Am. 2, 365–377.
Johansson, R., Ekbladh, S., Hebert, A., Lindstrom, M., Moller, S., Petitt, E., Andersson, G., 2012. Psychodynamic guided self-help for adult depression through the internet: a randomised controlled trial. PLoS One 7 (5), e38021. http://dx.doi.org/10.1371/journal.pone.0038021. (PONE-D-12-06905)(pii).
Johansson, R., Björklund, M., Hornborg, C., Karlsson, S., Hesser, H., Ljotsson, B., Andersson, G., 2013. Affect-focused psychodynamic psychotherapy for depression and anxiety through the Internet: a randomized controlled trial. PeerJ 102, 1–22.
de Jonghe, F., 1994. Psychoanalytic supportive psychotherapy. J. Am. Psychoanal. Assoc. 42, 421–446.
de Jonghe, F., Hendricksen, M., van Aalst, G., Kool, S., Peen, V., Van, R., Dekker, J., 2004. Psychotherapy alone and combined with pharmacotherapy in the treatment of depression (Clinical Trial Randomized Controlled Trial). Br. J. Psychiatry 185, 37–45.
Keefe, J.R., McCarthy, K.S., Dinger, U., Zilcha-Mano, S., Barber, J.P., 2014. A meta-analytic review of psychodynamic therapies for anxiety disorders. Clin. Psychol. Rev. 34 (4), 309–323. http://dx.doi.org/10.1016/j.cpr.2014.03.004.
Kernberg, O., 1996. A psychoanalytic model for the classification of personality disorders. In: Achenheil, B.B.M., Engel, R., Ermann, M., Nedopil, N. (Eds.), Implications of Psychopharmacology to Psychiatry. Springer, New York.
Kernberg, O.F., 1976. Object Relations Theory and Clinical Psychoanalysis. Aronson, New York.
Kernberg, O.F., 1981. Structural interviewing. Psychiatr. Clin. North Am. 4, 169–195.
Kernberg, P., 1994. Mechanisms of defense. Development and research perspectives. Bull. Menn. Clin. 58, 55–87.
Kessler, R.C., Petukhova, M., Sampson, N.A., Zaslavsky, A.M., Wittchen, H.U., 2012. Twelve-month and lifetime prevalence and lifetime morbid risk of anxiety and mood disorders in the United States. Int J. Methods Psychiatr. Res 21, 169–184.
Kimmel, R.J., Roy-Byrne, P.P., Cowley, D.S., 2015. Pharmacological treatments for panic disorder, generalized anxiety disorder, specific phobia, and social social anxiety disorder. In: Nathan, P.E., J.M., G. (Eds.), A Guide to Treatments that Work. Oxford University Press, New York, pp. 463–505.
Knekt, P., Lindfors, O., Harkanen, T., Valikoski, M., Virtala, E., Laaksonen, M.A., Renlund, C., 2008. Randomized trial on the effectiveness of long-and short-term psychodynamic psychotherapy and solution-focused therapy on psychiatric symptoms during a 3-year follow-up. Psychol. Med. 38, 689–703.
Knijnik, D.Z., Kapczinski, F., Chachamovich, E., Margis, R., Eizirik, C.L., 2004. Psychodynamic group treatment for generalized social phobia. Rev. Bras. Psiquiatr 26, 77–81.
Knijnik, D.Z., Blanco, C., Salum, G.A., Moraes, C.U., Mombach, C., Almeida, E., Eizirik, C.L., 2008. A pilot study of clonazepam versus psychodynamic group therapy plus clonazepam in the treatment of generalized social anxiety disorder. Eur. Psychiatry 23, 567–574.
Knijnik, D.Z., Salum Jr., G.A., Blanco, C., Moraes, C., Hauck, S., Mombach, C.K., Eizirik, C.L., 2009. Defense style changes with the addition of psychodynamic group therapy to clonazepam in social anxiety disorder. J. Nerv. Ment. Dis. 197 (7), 547–551.
Kohut, H., 1971. The Analysis of the Self. International Universities Press, New York.
König, K., 2015. Anxiety and Personality. The Concept of a Directing Object and its Applications. Karnac, London.
Lambert, M., Whipple, J., Vermeersch, D., Smart, D., Hawkins, E., Nielsen, S., Goates, M., 2002. Enhancing psychotherapy outcomes via providing feedback on client progress: a replication. Clin. Psychol. Psychother. 9, 91–103.
Salzer, S., Winkelbach, C., Leweke, F., Leibing, E., Leichsenring, F., 2011. Long-term effects of short-term psychodynamic psychotherapy and cognitive-behavioral therapy in generalized anxiety disorder: 12-month follow-up. Canadian J. Psychiatry 56, 503–508.
Leichsenring, F., Salzer, S., 2014. A unified protocol for the transdiagnostic psychodynamic treatment of anxiety disorders: an evidence-based approach. Psychotherapy 51 (2), 224–245. http://dx.doi.org/10.1037/a0033815.
Leichsenring, F., Schauenburg, H., 2014. Empirically supported methods of short-term psychodynamic therapy in depression – towards an evidence-based unified protocol. J. Affect Disord. 169C, 128–143. http://dx.doi.org/10.1016/j.jad.2014.08.007.
Leichsenring, F., Steinert, C., 2015. . Short-term psychodynamic therapy of obsessive-compulsive disorder: a manual-guided approach - treating the "inhibited rebel" Bull. Menninger Clin. (in press).
Leichsenring, F., Steinert, C., 2016. Psychodynamic therapy of obsessive-compulsive disorder: principles of a manual-guided approach. World Psychiatry 15, 293–294.
Leichsenring, F., Beutel, M.E., Leibing, E., 2007. Psychodynamic psychotherapy for social phobia: a treatment manual based on supportive-expressive therapy. Bull. Menn. Clin. 71 (1), 56–83.
Leichsenring, F., Salzer, S., Jaeger, U., Kachele, H., Kreische, R., Leweke, F., Leibing, E., 2009. Short-term psychodynamic psychotherapy and cognitive-behavioral therapy in generalized anxiety disorder: a randomized, controlled trial. Am. J. Psychiatry 166 (8), 875–881. http://dx.doi.org/10.1176/appi.ajp.2009.09030441.
Leichsenring, F., Masuhr, O., Jaeger, U., Dally, A., Streeck, U., 2010. The effectiveness of psychoanalytic-interactional psychotherapy in borderline personality disorder. Bull. Menn. Clin. 74 (3), 206–218. http://dx.doi.org/10.1521/bumc.2010.74.3.206.
Leichsenring, F., Salzer, S., Beutel, M.E., Herpertz, S., Hiller, W., Hoyer, J., Leibing, E., 2013. Psychodynamic therapy and cognitive-behavioral therapy in social anxiety disorder: a multicenter randomized controlled trial. Am. J. Psychiatry 170, 759–767.
Leichsenring, F., Salzer, S., Beutel, M.E., Herpertz, S., Hiller, W., Hoyer, J., Leibing, E., 2014. Long-term outcome of psychodynamic therapy and cognitive-behavioral therapy in social anxiety disorder. Am. J. Psychiatry 171 (10), 1074–1082. http://dx.doi.org/10.1176/appi.ajp.2014.13111514.
Leichsenring, F., Leweke, F., Klein, S., Steinert, C., 2015b. The empirical status of psychodynamic psychotherapy - an update: bambi's alive and kicking. [Review]. Psychother. Psychosom. 84 (3), 129–148. http://dx.doi.org/10.1159/000376584.
Leichsenring, F., Luyten, P., Hilsenroth, M.J., Abbass, A., Barber, J.P., Keefe, J.R., Steinert, C., 2015c. Psychodynamic therapy meets evidence-based medicine: a systematic review using updated criteria. Lancet Psychiatry 2 (7), 648–660. http://dx.doi.org/10.1016/S2215-0366(15)00155-8.
Leichsenring, F., Beutel, M., Salzer, S., Haselbacher, A., Wiltink, J., 2015a. Psychodynamic therapy of social phobia [Psychodynamische Therapie der sozialen Phobie]. Göttingen: Hogrefe.
Leichsenring, F., Masuhr, O., Jaeger, U., Rabung, S., Dally, A., Dumpelmann, M., Streeck,

U., 2016. Psychoanalytic-interactional therapy versus psychodynamic therapy by experts for personality disorders: a randomized controlled efficacy-effectiveness study in cluster b personality disorders. [Research Support, Non-U.S. Gov't]. Psychother. Psychosom. 85 (2), 71–80. http://dx.doi.org/10.1159/000441731.
Lemma, A., Target, M., Fonagy, P., 2010. The developement of a brief psychodynamic protocol for depression: dynamic interpersonal therapy (DIT). Psychoanal. Psychol. 24, 329–346.
Lemma, A., Target, M., Fonagy, P., 2011. The development of a brief psychodynamic intervention (Dynamic Interpersonal Therapy) and its application to depression: a pilot study. Psychiatry 74, 41–48.
Levy, K.N., Scala, J.W., 2012. Transference, transference interpretations, and transference-focused psychotherapies. Psychotherapy 49, 391–403.
Luborsky, L., 1984. Principles of Psychoanalytic Psychotherapy. Manual for Supportive-expressive Treatment New York. Basic Books.
Luborsky, L., 1990. The relationship anecdotes paradigm (RAP) interview as a versatile source of narratives. In: Luborsky, L., Crits-Christoph, P. (Eds.), Understanding Transference. The CCRT Method. Basic Books, New York, pp. 102–113.
Luborsky, L., Mark, D., Hole, A.V., Popp, C., Goldsmith, B., Cacciola, J., 1995. Supportive-expressive psychotherapy of depression, a time-limited version. In: Barber, C.-C., J.P., P. (Eds.), Dynamic Therapies for Psychiatric Disorders. Axis I. Basic Books, New York, pp. 13–42.
Mahler, M.S., Pine, F., Bergmann, A., 1975. The psychological birth of the human infant: symbiosis and individuation. Basic Books, New York.
Maina, G., Forner, F., B, F., 2005. Randomized controlled trial comparing brief dynamic and supportive therapy with waiting list condition in minor depressive disorders. Psychother. Psychosom. 74, 3–50.
Malan, D.H., 1976. The frontier of brief psychotherapy: an example of the convergence of research. Plenum, New York.
Malan, D.H., 1979. Individual psychotherapy and the science of psychodynamics. Butterworth, London.
Mann, J., 1973. Time-limited psychotherapy. Harvard University Press, Cambridge MA.
McCullough, L., Kuhn, N., Andrews, S., Kaplan, A., Wolf, J., Hurley, C.L., 2003. Treating affect phobia: A manual for short-term dynamic psychotherapy. Guilford Press, New York.
McCullough, L., Osborn, K.A., 2004. Short-term dynamic psychotherapy goes to Hollywood: the treatment of performance anxiety in the cinema. J. Clin. Psychol. 60, 841–852.
McCullough Vaillant, L., 1997. Changing Character. Basic Books, New York.
McHugh, R.K., Murray, H.W., Barlow, D.H., 2009. Balancing fidelity and adaptation in the dissemination of empirically-supported treatments: the promise of transdiagnostic interventions. Behav. Res. Ther. 47, 946–953.
Menninger, K., Holzman, P.S., 1973. The Theory of Psychoanalytic Techniques, 2nd ed. Basic Books, New York.
Milrod, B., Busch, F., Cooper, A., Shapiro, T., 1997. Manual of panic-focused psychodynamic psychotherapy. American Psychiatric Press, Washington, D.C.
Milrod, B., Leon, A.C., Busch, F., Rudden, M., Schwalberg, M., Clarkin, J., Shear, M.K., 2007. A randomized controlled clinical trial of psychoanalytic psychotherapy for panic disorder (Case Reports Comparative Study, Randomized Controlled Trial, Research Support, N.I.H., Extramural, Research Support, Non-U.S. Gov't). Am. J. Psychiatry 164 (2), 265–272. http://dx.doi.org/10.1176/ajp.2007.164.2.265.
Milrod, B., Chambless, D.L., Gallop, R., Busch, F.N., Schwalberg, M., McCarthy, K.S., Barber, J.P., 2015. Psychotherapies for panic disorder: a tale of two sites. J. Clin. Psychiatry. http://dx.doi.org/10.4088/JCP.14m09507.
Norcross, J.C., Rogan, J.D., 2013. Psychologists conducting Psychotherapy in 2012: current practices and historical trends among Division 29 members. Psychotherapy 50 (4), 490–495. http://dx.doi.org/10.1037/a0033512.
Norton, P.J., 2012. A randomized clinical trial of transdiagnostic cognitve-behavioral treatments for anxiety disorder by comparison to relaxation training (Randomized Controlled Trial Research Support, N.I.H., Extramural). Behav. Ther. 43 (3), 506–517. http://dx.doi.org/10.1016/j.beth.2010.08.011.
Norton, P.J., Barrera, T.L., Mathew, A.R., et al., 2013. Effects of transdiagnostic CBT for anxiety disorders on comorbid diagnoses. Depress. Anxiety 30, 168–173.
Ogrodniczuk, J.S., Piper, W.E., Joyce, A.S., McCallum, M., 1999. Transference interpretations in short-term dynamic psychotherapy. J. Nerv. Ment. Dis. 187, 572–579.
Orne, M., Wender, P., 1968. Anticipatory socialization for psychotherapy: method and rationale. Am. J. Psychiatry 124, 1202–1212.
Piper, Mc.Callum, Joyce, Rosie, Ogrodniczuk, 2001. Patient personality and time-limited group psychotherapy for complicated grief. Int. J. Group Psychother. 51 (4), 525–552.
Piper, W.E., Azim, H.F.A., Joyce, A.S., McCallum, M., 1991. Transference interpretations, therapeutic alliance, and outcome in short-term individual psychotherapy. Arch. General. Psychiatry 48, 946–953.
Prendes-Alvarez, S., Schatzberg, A.F., Nemeroff, C.B., 2015. Pharmacological treatments for unipolar depression. In: P.E., N., Gorman, J.M. (Eds.), A Guide to Treatments That Work. Oxford University Press, New York, pp. 327–353.
Priebe, S., Omer, S., Giacco, D., Slade, M., 2014. Resource-oriented therapeutic models in psychiatry: conceptual review. Br. J. Psychiatry 204, 256–261. http://dx.doi.org/10.1192/bjp.bp.113.135038.
Reich, W., 1933. Character Analysis. Orgone Institute, New York, pp. 1945.
Rose, J.M., DelMaestro, S.G., 1990. Separation-individuation conflict as a model for understanding distressed caregivers: psychodynamic and cognitive case studies. *Gerontologist* 30, 693–697.
Roy-Byrne, P., 2017. Transdiagnostic cognitive-behavioral therapy and the return of the repressed. JAMA Psychiatry. http://dx.doi.org/10.1001/jamapsychiatry.2017.1982. (10.1001/jamapsychiatry.2017.1982).
Salminen, J.K., Karlsson, H., Hietala, J., Kajander, J., Aalto, S., Markkula, J., Toikka, T., 2008. Short-term psychodynamic psychotherapy and fluoxetine in major depressive disorder: a randomized comparative study. Psychother. Psychosom. 77 (6), 351–357 (doi: 000151388)(pii) (10.1159/000151388).
Schauenburg, H., Grande, T., 2011. Interview Measures of interpersonal functioning and quality of object relations. In: Horowitz, L., Strack, S. (Eds.), Handbook of Interpersonal Psychology, Theory, Research. Assessment and Therapeutic Interventions. John Wiley, Hoboken, New Jersey, pp. 343–356.
Schlesinger, H., 1977. The responsibility of the psychoanalyst for analytic and therapeutic change. In: the transactions of the Topeka psychoanalytic society, recorder Appelbaum, A. Bull. Menn. Clin. 41 (269-206).
Schmidt, N.B., 2012. Innovations in the treatment of anxiety psychopathology: introduction. Behav. Ther. 43 (3), 465–467. http://dx.doi.org/10.1016/j.beth.2012.03.003.
Shapiro, D.A., Firth, J.A., 1985. Exploratory therapy manual for the Sheffield Psychotherapy Project. SAPU Memo. 733 University of Sheffield, Sheffield, England.
Shapiro, D.A., Barkham, M., Rees, A., Hardy, G.E., Reynolds, S., Startup, M., 1994. Effects of treatment duration and severity of depression on the effectiveness of cognitive-behavioral and psychodynamic-interpersonal psychotherapy. J. Consult. Clin. Psychol. 62, 522–534.
de Shazer, S., 1985. Keys to Solution in Brief Therapy. Norton, New York.
Shear, M.K., Cooper, A.M., Klerman, G.L., Busch, F., Shapiro, T., 1993. A psychodynamic model of panic disorder. Am. J. Psychiatry 150, 859–866.
Shimokawa, K., Lambert, M.J., Smart, D.W., 2010. Enhancing treatment outcome of patients at risk of treatment failure: meta-analytic and mega-analytic review of a psychotherapy quality assurance system. J. Consult Clin. Psychol. 78, 298–311.
Silverberg, F., 2005. Make the leap: a practical guide to breaking the patterns that hold you back. Marlowe & Co.BK, New York.
Sifneos, P., 1978. Short-term anxiety provoking psychotherapy. In: In: Davanloo, H. (Ed.), Short-term dynamic psychotherapy Spectrum, New York, pp. 35–42.
Steinert, C., Schauenburg, H., Dinger, U., Leichsenring, F., 2015. Short-term psychodynamic therapy in depression - an evidence-based unified protocol. Psychother. Psychosom. Med Psychol. http://dx.doi.org/10.1055/s-0035-1559612.
Stricker, G., 2006. Using homework in psychodynamic psychotherapy. J. Psychother. Integr. 16, 219–237.
Task Force, O.P.D., 2008. Operationalized Psychodynamic Diagnosis OPD-2 - Manual for Diagnosis and Treatment Planning. Hogrefe & Huber, Göttingen.
Thompson, L.W., Gallagher, D., Breckenridge, J.S., 1987. Comparative effectiveness of psychotherapies for depressed elders. J. Consult. Clin. Psychol. 55, 385–390.
Town, J.M., Abbass, A., Stride, C., Bernier, D., 2017. A randomised controlled trial of Intensive short-term dynamic psychotherapy for treatment resistant depression: the Halifax depression study. J. Affect. Disord. 214, 15–25. http://dx.doi.org/10.1016/j.jad.2017.02.035.
Vanheule, S., Desmet, M., Rosseel, Y., Meganck, R., 2006. Core transference themes in depression. J. Affect Disord. 91, 71–75.
Vertue, F.M., 2003. From adaptive emotion to dysfunction: an attachment perspective on social anxiety disorder. Pers. Soc. Psychol. Rev. 7 (2), 170–191.
Wallerstein, R.S., 2002. Psychoanalytic treatments within psychiatry: an expanded view. Arch. Gen. Psychiatry 59, 499–500.
Westra, H.A., Arkowitz, H., Dozois, D.J., 2009. Adding a motivational interviewing pretreatment to cognitive behavioral therapy for generalized anxiety disorder: a preliminary randomized controlled trial. J. Anxiety Disord. 23, 1106–1117.
Wiborg, I.M., Dahl, A.A., 1996. Does brief dynamic psychotherapy reduce the relapse rate of panic disorder? Arch. General. Psychiatry 53, 689–694.
Wilamowska, Z.A., Thompson-Hollands, J., Fairholme, C.P., Ellard, K.K., Farchione, T.J., Barlow, D.H., 2010. Conceptual background, development, and preliminary data from the unified protocol for transdiagnostic treatment of emotional disorders. Depress Anxiety 27 (10), 882–890. http://dx.doi.org/10.1002/da.20735.
Willutzki, U., Teismann, T., 2013. Ressourcenaktivierung in der Psychotheraopie [Resource Activation in Psychotherapy. Hogrefe, Göttingen.
Willutzki, U., Neumann, B., Haas, H., Koban, C., Schulte, D., 2004. Zur Psychotherapie sozialer Ängste: Kognitive Verhaltenstherapie im Vergleich zu einem kombiniert ressourcenorientierten Vorgehen: Eine randomisierte kontrollierte Interventionsstudie [psychotherapy of social anxieties: cognitive-behavioral therapy compared to a combined ressources oriented approach: a randomized controlled intervention study]. Z. Klin. Psychol. Psychother. 33, 42–50.
Wittchen, H., Jacobi, F., Rehm, J., Gustavsson, A., Svensson, M., Jönsson, B., HC, S., 2011. The size and burden of mental disorders and other disorders of the brain in Europe 2010. Neuropsychopharmacology 21, 655–679.
Wöller, W., 2015. Tiefenpsychologisch-fundierte Psychotherapie als ressourcenbasierte integratives Verfahren [psychodynamic psychotherapy as a resource-based integrative method]. Psychodyn. Psychother. 14, 3–12.
Wöller, W., Leichsenring, F., Leweke, F., Kruse, J., 2012. Psychodynamic psychotherapy for posttraumatic stress disorder related to childhood abuse - principles for a treatment manual. Bull. Menn. Clin. 76, 69–93.
Zilcha-Mano, S., 2017. Is the alliance really therapeutic? Revisiting this question in light of recent methodological advances. Am. Psychol. 72 (4), 311–325. http://dx.doi.org/10.1037/a0040435.