Psychotherapy
2014, Vol. 51, No. 2, 224–245

© 2013 American Psychological Association
0033-3204/14/$12.00 DOI: 10.1037/a0033815

A Unified Protocol for the Transdiagnostic Psychodynamic Treatment of Anxiety Disorders: An Evidence-Based Approach

Falk Leichsenring
Justus-Liebig-University Giessen

Simone Salzer
Georg-August-University Goettingen

Although there is evidence for the efficacy of psychodynamic therapy (PDT) in anxiety disorders, results are not yet satisfactory, for example, if rates of remission and response are considered. To address this problem, a unified psychodynamic protocol for anxiety disorders (UPP-ANXIETY) is proposed that integrates the treatment principles of those methods of PDT that have proven to be efficacious in anxiety disorders. In addition, this protocol is transdiagnostic, implying that is it is applicable to various forms of anxiety disorders and related disorders (generalized anxiety disorder, social phobia, panic disorders, avoidant personality disorder). Based on supportive-expressive therapy, the UPP-ANXIETY represents an integrated form of psychodynamic therapy that allows for a flexible use of empirically supported treatment principles. UPP-ANXIETY encompasses the following 9 treatment principles (modules): (1) socializing the patient for psychotherapy, (2) motivating and setting treatment goals, (3) establishing a secure helping alliance, (4) identifying the core conflict underlying anxiety, (5) focusing on the warded-off wish/affect, (6) modifying underlying internalized object relations, (7) changing underlying defenses and avoidance, (8) modifying underlying response of self, and (9) termination and relapse prevention. Some principles are regarded as core components to be used in every treatment (principles 3–8). A unified protocol for the psychodynamic treatment of anxiety disorders has several advantages, that is (1) integrating the most effective treatment principles of empirically supported psychodynamic treatments for anxiety disorders can be expected to further improve the efficacy of PDT; (2) using a unified protocol in efficacy studies has the potential to enhance the evidence-based status of PDT by aggregating the evidence; (3) a unified protocol will facilitate both training in PDT and transfer of research to clinical practice; and (4) thus, a unified protocol can be expected to have a significant impact on the health care system. We are planning to test the UPP-ANXIETY in a multicenter randomized controlled trial.

Keywords: anxiety disorder, empirically supported treatments, unified protocol, transdiagnostic

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

Anxiety is a central concept of psychoanalytic and psychodynamic theory and therapy. In his first "toxic theory" of anxiety, S. Freud (1895) regarded anxiety as a result of repressed or nondischarged libido. According to this theory, repression leads to anxiety (Zerbe, 1990). In his second (signal) theory of anxiety, however, S. Freud (1926) assumed that the ego responds to threats associated with impulses of the id with a signal of anxiety. Defense mechanisms are used to reduce anxiety by rendering the impulse unconscious. Accordingly, anxiety leads to repression (Zerbe, 1990). In Freud's second theory of anxiety the symptom is regarded as a compromise between the threatening impulse and the defense: the impulse is included in the symptom but distorted in such a way that it is no longer threatening—the "vicissitudes of instincts" (S. Freud, 1915). In terms of the structural model of psychoanalysis (S. Freud, 1923) a psychological symptom is based on an unresolved conflict between the id (sexual or aggressive impulses) on the one hand and the super ego (internalized norms) or external reality on the other hand which is (suboptimally) solved by the ego by use of defense mechanisms. Other forms of conflicts and fears were described by object relations theory and self psychology (e.g., Klein, 1946; Kernberg, 1975, 1976; Kohut, 1977), for example, the fears of annihilation, persecution, separation, fusion and disintegration.

Anxiety disorders are characterized by the fact that anxiety itself has become the psychological symptom. With regard to the etiology of anxiety disorders, a complex interplay of psychological and biological factors is presently assumed (e.g., Gabbard, 1992; Miller, Taber, Gabbard, & Hurley, 2005). This is consistent with both S. Freud's (1894) discussion of anxiety neurosis and modern research (e.g., Gabbard, 1992; Miller et al., 2005). The psychodynamics of anxiety disorders have been discussed in a plethora of articles. This article does not aim to give a comprehensive review of this discussion. For the present context of evidence-based psychodynamic treatments of anxiety disorders, the contributions by

This article was published Online First December 30, 2013.

Falk Leichsenring, Clinic of Psychosomatics and Psychotherapy, Justus-Liebig-University Giessen, Giessen, Germany; Simone Salzer, Clinic of Psychosomatic Medicine and Psychotherapy, University Medicine, Georg-August-University Goettingen, Goettingen, Germany.

We thank Prof. Dr. Sven Olaf Hoffmann (Hamburg) and Prof. Dr. Karl König (Goettingen) for helpful comments.

Correspondence concerning this article should be addressed to Falk Leichsenring, Clinic of Psychosomatics and Psychotherapy, University of Giessen, Ludwigstrasse 76, 35392 Giessen, Germany. E-mail: Falk.Leichsenring@psycho.med.uni-giessen.de

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

Gabbard (1992, 2000), Crits-Christoph et al. (1995), Busch, Milrod and Singer (1999), Busch et al. (1991), Shear et al. (1993), or Milrod et al. (1997) are specifically relevant. In the following, we will discuss the psychodynamics of the most common forms of anxiety disorders that is social anxiety disorder or social phobia, generalized anxiety disorder and panic disorder.

The psychodynamics of social anxiety disorder (SAD) or social phobia were recently reviewed by Leichsenring, Beutel, and Leibing (2007) from the perspectives of ego psychology, object relations theory, self psychology, and attachment theory. From the perspective of self psychology, Hoffmann, (2003) regarded a disturbed self-concept as a central component of SAD. A disturbed self-concept is associated with disturbances in self-perception, self-esteem, and unrealistic devaluations or idealizations of the self. Gabbard (1992, 2000) and Gilbert (2001) stressed the experiences of shame in SAD. According to Gabbard (1992), shame experiences in SAD result from the wish to be in the center of attention and receive affirming responses from others and the (anticipated) response from disapproving parental figures. To avoid these imagined humiliations or embarrassments, patients with SAD avoid situations where they risk these responses from others. Thus, from an object-relational perspective, SAD can be regarded as the result of an identification with the aggressor (Hoffmann, 2003). Empirical studies confirmed that patients with SAD are characterized by a low self-esteem and high levels of self-criticism and shame (e.g., Cox et al., 2004; Hirsch et al., 2003; Lutwak & Ferrari, 1997). An insecure attachment was reported for many patients with anxiety disorders (Bowlby, 1988) and specifically for patients with SAD (Vertue, 2003). An insecure attachment may lead to social anxieties and avoidance and may inhibit a curious approach to the world. Gabbard (1992) emphasized the importance of separation anxiety in SAD, that is, the fear of being abandoned or losing the caregiver's love when moving toward autonomy. To avoid such catastrophic cutoffs, patients with SAD avoid connecting with people in the outside world.

For generalized anxiety disorder (GAD) S. Freud's (1894) original description in his paper on "anxiety neurosis" is surprisingly up-to-date with regard to the current concept of GAD: a mounting process of worrying is currently regarded as characterized of GAD which was described by Freud as a "fearful expectation." Crits-Christoph et al. (1995) emphasized that this fearful expectation (worrying) often refers to interpersonal relationships. Research suggests that also many patients with GAD show an insecure attachment (Crits-Christoph et al., 1995) or have experienced traumatic events (Borkovec, 1994). Borkovec (1994) assumes that the permanent process of worrying serves a defensive function, that is to avoid even more threatening experiences such as traumatic experiences.

For panic disorder (PD), an interplay between psychological and biological factors has been discussed, for example, by Gabbard (1992, 2000), Miller et al. (2005) and Shear et al. (1993). An inborn neurophysiological irritability is assumed to predispose early fearfulness (Busch et al., 1991; Gabbard, 1992; Shear et al., 1993). A parental behavior that increases fearfulness leads to unresolved conflicts between dependence and independence and to disturbed object relations (Shear et al., 1993). These factors predispose to fears of being trapped, suffocated, and unable to escape and/or feeling alone and helpless (fearful dependency, Busch et al., 1991; Shear et al., 1993). A panic attack is usually triggered by conscious and unconscious fantasies of catastrophic dangers associated with negative feelings (Busch et al., 1991; Shear et al., 1993). Thus, although perceived by the patients in this way, panic attacks do not really come "out of the blue" (Busch et al., 1991). For patients with agoraphobia Bowlby (1973) regarded an insecure attachment as the central characteristic. For this reason Bowlby considered agoraphobia as a "pseudo phobia," as the underlying fear does not refer to libidinal or aggressive impulses, but to losing protection. For this reason patients with agoraphobia are assumed to permanently search for security giving objects (Bowlby, 1973).

Based on these concepts, psychodynamic treatments for the different forms of anxiety disorders have been developed. Specific forms of PDT have proven to be effective in anxiety disorders (Leichsenring, Klein & Salzer, in press a, b). For proving the efficacy of a treatment randomized controlled trials (RCTs) are regarded as the "gold standard" (e.g., Canadian Task Force on the Periodic Health Examination, 1979; Chambless & Hollon, 1998; Cook, Guyatt, Laupacis, Sacket, & Goldberg, 1995; Guyatt et al., 1995; Higgins & Green, 2009; Nathan & Gorman, 2002) implying that RCTs provide the highest level of evidence. A critical discussion of the RCT methodology was given, for example, by Persons and Silberschatz (1998); Roth and Parry (1997), Westen et al., (2004) or Leichsenring (2004). Although it is true that fewer RCTs exist for psychodynamic psychotherapy (PDT) as compared with cognitive–behavioral therapy (CBT), the available evidence suggests that PDT is effective in anxiety disorders as well. Reviews for the evidence of PDT in anxiety disorders were recently given by Slavin-Mulford and Hilsenroth (2012) and Leichsenring, Klein and Salzer (in press a, b). At present, eight RCTs are available testing the efficacy of different forms of PDT in anxiety disorders (see Table 1). The study characteristics are given in Table 1. According to these studies, evidence for PDT is available for PD with and without agoraphobia (Milrod et al., 2007; Wiborg & Dahl, 1996), SAD (Bögels et al., 2003; Knijnik et al., 2004; Knijnik et al., 2008, 2009; Leichsenring et al., 2013), and GAD (Crits-Christoph et al., 2005; Leichsenring et al., 2009; Salzer et al., 2011). Applying the criteria of evidence-based medicine reported above (e.g., Cook et al., 1995; Guyatt et al., 1995; Higgins & Green, 2009), the treatment concepts used in these (and only these) studies can be regarded as evidence-based, that is they have proven to be efficacious in RCTs. Outcome for PDT in anxiety disorders, however, is not yet satisfactory (Leichsenring, Klein & Salzer, in press, a, b; Leichsenring, Salzer et al., 2009; Leichsenring et al., 2013). This is evident, for example, if the rates of response and remission are considered. In a recent large-scale RCT ($n = 495$) comparing PDT and CBT in SAD, we found rates for response and remission of 52% and 26% for PDT (CBT: 60%, 36%). Accordingly, a considerable proportion of patients did not sufficiently benefit from PDT or CBT. Thus, improving the psychodynamic treatment of anxiety disorders is required. It is of note that this is true for CBT as well: A historical review showed that the efficacy of CBT for anxiety disorders has not increased over the years (Öst, 2008). Öst (2008) indeed reported a significant decrease in effect sizes from the 1980s to the present. Furthermore, a substantial proportion of patients do not sufficiently benefit from the various CBT treatments, and the percentage of nonresponders does not appear to have decreased over time (Öst, 2008).

As one approach to address this problem, research in CBT is moving from single-disorder focused approaches toward transdi-

Table 1
Randomized Controlled Studies of Psychodynamic Psychotherapy (PDT) in Anxiety Disorders

Study	Disorder	*n* (PDT)	Comparison group	Concept of PDT	Treatment duration
Bögels et al., 2003	Social phobia	22	CBT, $n = 27$	Malan (1976)	36
Crits-Christoph et al., 2005	Generalized anxiety disorder	15	Supportive therapy, $n = 16$	Luborsky (1984); Crits-Christoph et al. (1995)	16 sessions
Knijnik et al., 2004	Social Phobia	15	Credible placebo control group, $n = 15$	Malan (1976)	12 sessions
Knijnik et al., 2008, 2009	Social Phobia	28	Clonazepam, $n = 23$	Malan (1976)	12 90-minute sessions
Leichsenring, Salzer et al., 2009, 2011	Generalized anxiety disorder	28	CBT, $n = 29$	Luborsky (1984); Crits-Christoph et al. (1995); Leichsenring et al. (2005)	30
Leichsenring et al., 2013	Social Phobia	207	Cognitive therapy, $n = 209$ Waiting list, $n = 79$	Luborsky (1984); Leichsenring, Beutel, Leibing (2007)	Up to 30
Milrod et al., 2007	Panic disorder	26	CBT (applied relaxation), $n = 23$	Milrod et al. (1997)	24 sessions
Wiborg & Dahl, 1996	Panic disorder	20	Clomipramine, $n = 20$	Wiborg & Dahl, (1996)	15 sessions (15 weeks)

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

agnostic and modular treatments (e.g., Barlow et al., 2004: McHugh et al., 2009; Farchione et al., 2012; Wilamowska et al., 2010). Unified CBT-based treatment protocols have been developed aiming at integrating the most effective treatment components of CBT. Barlow et al. (2008; Wilamowska et al., 2010), for example, have developed a unified CBT-based treatment protocol for "emotional disorders" that uses a modular format and aims to target the core processes underlying emotional disorders.

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., 2005) and improvements in comorbid conditions when treating a principal disorder (e.g., Barlow et al., 2004; McHugh et al., 2009; Norton & Phillip, 2008).

For PDT, however, unified protocols that integrate principals of empirically supported treatments do not yet exist. This is true for anxiety disorders, but for other mental disorders as well: The available evidence for PDT in specific mental disorders comes from RCTs that used different treatment concepts (Leichsenring, Klein & Salzer, in press, a, b). With a very few exceptions, there are no two RCTs in which the same treatment concept was applied in the same mental disorder (Leichsenring, Klein & Salzer, in press a, b). This also implies a serious problem with regard to the status of evidence of PDT: The evidence for PDT is "scattered" between the different forms of PDT, not only for anxiety disorders, but for other mental disorders as well (Leichsenring, Klein & Salzer, in press a). It was for this very reason that short-term psychodynamic therapy was judged as only "possibly efficacious" by Chambless and Hollon (1998). To be judged as "efficacious" at least two RCTs are required in which the same treatment was effectively applied in the same mental disorder (Chambless & Hollon, 1998).

Unified protocols for the psychodynamic treatment of mental disorders would have several advantages, that is (1) integrating the most effective treatment principles of the empirically supported treatments, they can be expected to further improve the efficacy of PDT; (2) using unified protocols in efficacy studies will enhance the status of evidence of PDT by aggregating the evidence; (3) unified protocols will facilitate both training in PDT and transfer of research to clinical practice; (4) thus, they can be expected to have a significant impact on the health care system.

For these reasons we have developed a unified protocol for the psychodynamic treatment of anxiety disorders. The term "unified" in the title of the protocol refers to several aspects that are integrated ("unified"): (a) different treatment principles used by different empirically supported methods of PDT in (b) various types of anxiety disorders (see Table 1) were integrated within a unified protocol for (c) a diagnostic class of anxiety disorders, thus (d) contributing to "unifying" the evidence of PDT and enhancing the evidence-based status of PDT.

It is an advantage that PDT shows several characteristics that facilitate the development of a unified psychodynamic protocol—not only for anxiety disorders, but for other mental disorders as well. They will be discussed in the following.

Psychodynamic Psychotherapy Is Transdiagnostic in Origin

Compared with CBT, psychodynamic psychotherapy is traditionally not tailored to single mental disorders or specific symptoms. It focuses on core underlying processes of disorders, that is on unresolved conflicts (e.g., Davanloo, 1980; Gabbard, 2000; Luborsky, 1984; Malan, 1976) or structural deficits (defined as impairments of ego-functions; Bellak, Hurvich & Gediman, 1973; Killingmo, 1989), for example, affect regulation, mentalization, internalized object relations, or insecure attachment (e.g., Bateman & Fonagy, 2009; Clarkin et al., 2007). Thus, PDT is transdiagnostic in origin. Consistent with this approach, methods of manual-guided PDT have been developed that are "universal" in nature, that is they do not focus on specific mental disorders (e.g., Davanloo, 1980; Luborsky, 1984; Malan, 1976; McCullough-Vaillant, 1997; McCullough et al., 2003). This implies on the other hand, however, that these concepts do not include treatment principles tailored to the treatment of specific mental disorders. This may limit their efficacy in specific mental disorders, as well as their comparative efficacy, for example, compared with CBT. Thus, by its transdiagnostic orientation PDT has tended to neglect disorder-specific treatment needs. In other words: It has been "too" transdiagnostic or universal. There is evidence from several studies carried out by CBT researchers that PDT was inferior to CBT if CBT was specifically tailored to the disorder under study, but PDT

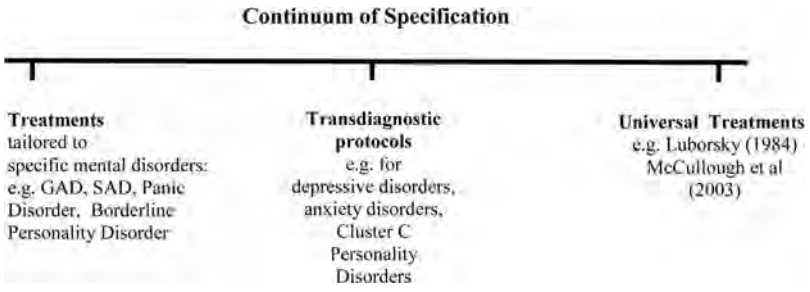


Figure 1. The specification of treatments with regard to mental disorders: a continuum.[1]

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

was not (Durham et al., 1994; Emmelkamp et al., 2006). The unfavorable implications for the scientific status of psychodynamic therapy are evident. From a methodological perspective, this inequality in treatment integrity constitutes a serious shortcoming of these studies as they do not warrant a fair comparison between treatments (Leichsenring & Leibing, 2007; Leichsenring, Klein & Salzer, in press a, b; Leichsenring et al., 2011).

Some of the universal treatment concepts listed above were later specifically tailored to the treatment of classes of diagnoses or single disorders. Luborsky's universal concept of supportive-expressive (SE) therapy, for example, has been adapted to the treatment of the most common mental disorders by integrating disorder-specific treatment elements (Barber & Crits-Christoph, 1995; Leichsenring, Salzer et al., 2009; Leichsenring et al., 2007; Leichsenring, Hoyer et al., 2009; Leichsenring et al., 2013). In Figure 1, the idea of a continuum is presented describing the specificity of psychotherapy with regard to targeting specific mental disorders.

Being transdiagnostic in origin and focusing on underlying core conflicts rather than on specific symptoms, implies that by using a unified transdiagnostic protocol PDT is playing on home grounds which may be an advantage compared with other approaches—with a unified protocol, PDT goes "back to the roots."

Psychodynamic Treatment Manuals Have a Modular Format

Furthermore, treatment manuals for PDT typically have a modular format allowing for a flexible use. This is especially true for the available manual-guided psychodynamic treatments for anxiety disorders (e.g., Busch et al., 1999; Crits-Christoph et al., 1995; Leichsenring et al., 2007; Leichsenring et al., 2005; Wöller et al., 2012). By the modular format, both the course of treatment and individual differences between patients can be taken into account, for example, patient motivation or severity of pathology. The modular format also allows the "dose" of each treatment element to be adapted to each individual patient's needs.

Manual-Guided Methods of PDT for Anxiety Disorders Have Core Treatment Principles in Common

The available evidence-based forms of PDT for anxiety disorders (see Table 1) have several core principles in common that outweigh the differences between the treatments. This applies to the treatment of PD with and without agoraphobia (Milrod et al., 2007; Wiborg & Dahl, 1996), GAD (Crits-Christoph et al., 1996; Crits-Christoph et al., 2006; Leichsenring, Salzer et al., 2009; Salzer et al., 2011) and SAD (Bögels et al., 2003; Knijnik et al., 2004; Knijnik et al., 2009; Leichsenring et al., 2013). These common treatment principles suggest to unify the psychodynamic treatment of anxiety disorders.

Toward a Unified Psychodynamic Protocol for Anxiety Disorders

For the reasons given above, we have developed a unified modular method of PDT for anxiety disorders by identifying and integrating common core principles of the empirically supported psychodynamic treatments for anxiety disorders (see Table 1). We are planning to test this unified psychodynamic protocol for the treatment of anxiety disorders in a multicenter randomized controlled trial. In this article, we will present the concept and the treatment principles of UPP-ANXIETY.

As will be described in more detail below, the UPP-ANXIETY includes both supportive principles (e.g., establishing a helping alliance, setting treatment goals) and expressive (insight-oriented) principles (e.g., focusing on unresolved core conflictual relationship themes associated with symptoms of anxiety), which target the core processes underlying anxiety disorders. The UPP-ANXIETY is consistent with several empirically supported concepts of PDT, in particular with

- the concept of a supportive-expressive continuum of psychodynamic interventions (Gabbard, 2000; Luborsky, 1984; Schlesinger, 1969; Wallerstein, 1989),
- Luborsky's (1984) model of supportive-expressive (SE) therapy, and
- the distinctive features of PDT as identified by Blagys and Hilsenroth (2000), that is, focus on wishes and fantasies, on affects and the expression of patients' emotions, on past and present relationships including the therapeutic relationship, on defense and resistance, and on patterns of patient's experiences.

Although based on Luborsky's model, the model of SE therapy has been expanded and consolidated within the UPP-ANXIETY

[1] Another dimension refers to the fact whether a protocol is unified or not, that is whether it explicitly integrates effective treatment components of different approaches. A treatment may be transdiagnostic without being unified in this sense.

by integrating treatment principles of other models of PDT that have proven to be effective, for example, by elements of the models by Milrod et al. (2007; Busch et al., 1999), McCullough et al. (2003) or Leichsenring et al. (2007).

A Unified Psychodynamic Protocol for Anxiety Disorders: Modules and Treatment Principles

In the following, we will discuss both general principles and specific modules of UPP-ANXIETY. To apply UPP-ANXIETY, a training in psychodynamic therapy is required.

General Principles

Some general principles of the UPP-ANXIETY which are consistent with available concepts and research of short-term psychodynamic therapy can be summarized as follows:

- The treatment is conducted in a face-to face position;
- Regression is restricted (e.g., by setting goals);
- In identifying and working through the focus of treatment, the therapist adopts a more active stance than in classical psychoanalysis or long-term psychodynamic psychotherapy (e.g., Luborsky, 1984);
- The use of more interpretive or supportive interventions depends on the patient's needs (Gabbard, 2004; Luborsky, 1984; Schlesinger, 1969; Wallerstein, 1989). The interventions are as expressive as possible and as supportive as necessary (Leichsenring et al., 2007). A clear delineation of supportive versus expressive interventions, however, is not possible (Schlesinger, 1969; Luborsky, 1984). It is the patient who decides whether an intervention is supportive (Schlesinger, 1983, cited from Luborsky, 1984, p. 72);
- Although the focus of UPP-ANXIETY is on conflict pathology, structural ("deficit") pathology defined as impairments in ego-functions (e.g., Bellak et al., 1973; McCullough-Vaillant, 1997; Killingmo, 1989) are not necessarily a contraindication. As emphasized by Luborsky (1984) the supportive-expressive continuum of psychodynamic interventions allows for more supportive interventions in case of more severe psychopathology or acute crisis. Such interventions were described, for example, by Kohut (1971, 1977); Blanck and Blanck (1974); Killingmo (1989) or more recently by Leichsenring et al. (2010).
- Although transference interpretations which include the therapist may be used, the emphasis is on the patient's maladaptive interpersonal patterns, as experienced in current relationships outside therapy—the role of transference interpretation will be discussed below in more detail;
- To foster the transfer to everyday situations, the therapist puts a strong emphasis on working through not only *within* sessions but also *between* the sessions (Leichsenring et al., 2007; Stricker, 2006);
- UPP-ANXIETY for anxiety disorders encompasses up to 25 sessions which is analogous to the studies by Leichsenring, Salzer et al. (2009) and Leichsenring et al. (2013);
- When termination is being considered, therapist and patient will review what they have done (Luborsky, 1984, p. 66). The three final sessions are carried out as booster sessions to prevent relapse (Crits-Christoph et al., 1995; Leichsenring et al., 2009; Leichsenring et al., 2013).

Indications for the UPP-ANXIETY

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

- Generalized anxiety disorder (GAD, *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition [*DSM–V*] 300.02),
- Panic disorder (PD, *DSM–V* 300.01)
- Agoraphobia (AP, *DSM–V* 300.22)
- Social anxiety disorder (SAD, *DSM–V* 300.23)

Specific phobia (*DSM–V* 300.29) is covered by the UPP-ANXIETY as well, but simple forms may rather be treated by CBT.

As an advantage, by focusing on the underlying processes, the UPP-ANXIETY may also be used to treat

- Separation anxiety disorder (*DSM–V* 309.21)
- Other specified anxiety disorder (*DSM–V* 300.09),
- Unspecified anxiety disorder (*DSM–V* 300.00),
- Adjustment disorder with anxiety (*DSM–V* 309.24),
- Subdefinitional threshold variations of anxiety disorders.

However, it should be noted that evidence for PDT in these disorders is not yet available. This applies, for example, to the new *DSM–V* category of separation anxiety disorders in adults.

Furthermore, we expect the UPP-ANXIETY to also improve comorbid mental disorders of anxiety disorders, for example, depressive disorders which often occur as a consequence of anxiety disorders.

Avoidant personality disorder (AVPD, *DSM–V* 301.82) shows a high phenomenological overlap and comorbidity with SAD and other anxiety disorders (Friborg et al., 2012). In a study by Emmelkamp et al. (2006), PDT based on the models by Malan (1976) and Luborsky (1984) was reported to be inferior to CBT. However, there are some indications that PDT was not as carefully implemented and specifically tailored to the treatment of AVPD as CBT (Leichsenring & Leibing, 2007). Further evidence from RCTs on PDT in AVPD is not available. The affect phobia model by McCullough et al. (2003) has proven to be effective in several RCTs on the treatment of Cluster C personality disorders which encompass AVPD (Abbass et al., 2008; Hellerstein et al., 1998; Svartberg et al., 2004; Winston et al., 1994). Results, however, were not reported separately for AVPD. The evidence for the model by McCullough et al. for the efficacy in Cluster C personality disorders in general, however, may justify the inclusion of treatment principles of this model in the UPP-ANXIETY with regard to the treatment of AVPD. Unfortunately, the model by McCullough et al. (2003) has not yet been tested in anxiety disorders; thus, there is no evidence for its efficacy in anxiety disorders.[2]

The UPP-ANXIETY does not include the treatment of obsessive–compulsive disorder or posttraumatic stress disorder for the following reasons: There is no evidence for PDT in obsessive–compulsive disorder. The evidence for PDT in posttraumatic stress disorder is scarce (Leichsenring, Klein & Salzer, in press, a, b). Furthermore these patients show specific treatment needs (e.g., Wöller et al., 2012). In *DSM–V* obsessive–compulsive disorder

[2] It is true, however, that the Cluster C personality sample by Svartberg et al. (2004) included a considerable proportion of patients with comorbid anxiety disorders. Again, the data of these patients were not analyzed separately, thus it is not clear to what extent the model by McCullough et al. (2003) is effective in anxiety disorders. For this reason, this study may provide only indirect evidence for the efficacy of the applied treatment model in anxiety disorders.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

and posttraumatic stress disorder are no longer regarded as anxiety disorders.

Empirical Support and Levels of Evidence for Process-Outcome Research

In the following, we will list principles of treatments (modules) that we identified as common in those psychodynamic treatments of anxiety disorders that have proven to be efficacious in RCTs (see Table 1). Regardless of their limitations, RCTs provide the highest level of evidence if the efficacy of a treatment under controlled experimental conditions is to be addressed (e.g., Chambles & Hollon, 1998; Leichsenring, 2004). For this question of research, RCTs are a necessary condition (Leichsenring, 2004; Palmer, Nascimento & Fonagy, 2013). However, RCTs are not sufficient, if other questions of research are to be addressed, for example, mechanisms of change or effectiveness under the conditions of clinical practice (Leichsenring, 2004; Palmer, Nascimento & Fonagy, 2013). If the effectiveness under the conditions of clinical practice is addressed, non-RCTs may be required (Leichsenring, 2004). Furthermore, RCTs can show that a treatment works, but not how it works. To examine the latter question, process-outcome research is required. Thus, the results of RCTs need to be complemented by other forms of evidence, for example, by effectiveness studies or process-outcome studies (e.g., Leichsenring, 2004; Palmer et al., 2013). RCTs are best seen as a part of a research cycle (Roth & Parry, 1997; Palmer et al., 2013, p. 152).

The treatment concepts used in the RCTs listed in Table 1 are complex packages encompassing several treatment components. This is true for many treatments of other theoretical orientation as well, for example, for CBT. For this reason, the studies listed in Table 1 provide evidence for these complex treatments as a whole, not necessarily for individual treatment elements. Where available, we therefore additionally included results of process-outcome research. However, not only evidence for efficacy, but also evidence of process-outcome relations may be more or less stringent. In the following, we will propose a systematic approach for classifying different levels of evidence for process-outcome relationships (see Table 2). To our knowledge, such a classification has not yet been proposed. We will specifically refer to anxiety disorders, but the considerations apply to process-outcome relationships in other mental disorders as well.

Best evidence of process-outcome research (level A) is provided for the UPP-ANXIETY by research relating treatment elements to outcome in patients with anxiety disorders for those models of PDT which were shown to be efficacious in anxiety disorders by RCTs (see Table 2). Process outcome relations may be studies in the RCT itself or in subsequent studies in patients with anxiety disorders. For these subsequent studies, RCTs are not required. Evidence in a broader sense comes from process-outcome research on models of PDT supported by RCTs (in anxiety disorders) where the evidence from process-outcome research is not specific to anxiety disorders (level B). This applies, for example, to process-outcome research on Luborsky's SE therapy by Crits-Christoph and Luborsky et al. (1990) relating changes of the CCRT to outcome, to the study by Crits-Christoph et al. (1988) on purity of CCRT interpretation or by the study by Connolly Gibbons et al. (2009) examining mechanisms of change in SE therapy and other forms of therapy in patient samples with heterogeneous disorders. Unfortunately, this form of evidence—process-outcome research on treatments empirically supported by RCTs in anxiety disorders—is not always available. Researchers may decide to include less stringent forms of evidence for process-outcome relations (see Table 2). This applies to two further types of evidence, RCTs of the respective treatment in other mental disorders than the disorder in question (levels C and D) and evidence from non-RCTs (levels E and F). In the first case, process outcome research carried out in these studies is not specific to anxiety disorders or another specific disorder in question (level D). For anxiety disorders, this applies, for example, to the RCTs testing the model by McCullough et al. (2003) in cluster C personality disorders (e.g., Abbass et al., 2008; Hellerstein et al., 1998; Svartberg et al., 2004; Winston et al., 1994). Process outcome research carried out in these studies refers to psychodynamic treatment principles that have proven to be associated with outcome in cluster C personality disorders (e.g., Ulvenes et al., 2012). Thus, evidence is more indirect as is not clear whether it is valid for anxiety disorder (level D). Future process-outcome research on this model, however, may be carried out in anxiety disorders, for example, in a new RCT leading to level A evidence or in subgroups of patients with anxiety disorders included in the sample of the original RCT (level C): The sample of the Svartberg et al. (2004) study, for example, included a considerable proportion of patients with anxiety disorders. This allows for process-outcome research in patients with anxiety disorders for whom the primary diagnosis was a cluster C personality disorder. Thus, this evidence does not refer to patients with the primary diagnosis of an anxiety disorder, but to comorbid anxiety disorders in patients with cluster C personality disorders (level C, Table 2). To further broaden the evidence base, researchers may decide to include process-outcome research on models of PDT supported by other forms of evidence (e.g., effectiveness research). In many cases, this form of evidence is more indirect and should be cautiously taken into account, at least for two reasons: (1) in some of these studies specific types of PDT were applied that have not yet been shown to be efficacious in RCTs (level E). This is true, for example, for the open study by Slavin-Mulford et al. (2011), which reported results for process-outcome relations in anxiety disorders. While an open study like this can show that specific PDT treatment elements are associated with significant prepost changes or with the proportion of clinically significant improvement, the treatment model employed has yet to be tested in an RCT. Therefore, whether or not this treatment model would produce changes that exceed those of control conditions such as

Table 2
Levels of Evidence for Process-Outcome Research in Anxiety Disorders

Process-outcome research*	RCT in anxiety disorders available	RCT in non-anxiety disorders available	Non-RCT
Anxiety Disorders	A	C[a]	E
Non-Anxiety Disorders	B	D	F

* Significant relationships between treatment components and outcome are required in each of the eight cases to provide evidence.
[a] This applies, for example, to process outcome research in patients with comorbid anxiety disorders for whom the primary diagnosis is not an anxiety disorder.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

treatment as usual or alternative psychotherapy conditions is not known. Thus, the treatment components associated with outcome may only enhance the outcome to an extent that is not superior, for example, to an alternative psychotherapeutic condition; (2) open studies may not exclusively refer to the disorder in question (e.g., anxiety disorders). This is true for, example, for the study by Falkenström et al. (2013) on therapeutic alliance. Thus, it is not clear whether the results provided by these studies are specific to anxiety disorders (level F). When we add this kind of process-outcome research in the following, we therefore ask the readers to be aware of this limitation. As a general conclusion, future research is required to further test the relationship of specific treatment elements to treatment outcome. We believe this research should primarily address process-outcome relations for models of PDT that have previously been shown to be efficacious in RCTs. This is another way to identify "empirically supported change processes" (Ablon, Katzenstein & Levy, 2006). To put it short and simple: before we study how a treatment works we need to show that it works.

The Nine Modules of the UPP-ANXIETY

The nine modules encompassed by the UPP-ANXIETY can be summarized as follows (see Table 3). Core principles that are regarded as essential for every treatment using the UPP-ANXIETY are marked by [C]. The first three modules have a strong supportive component whereas the modules 4–8 are more insight-oriented (expressive). In Figure 2, the modules are presented as cycles illustrating the cyclic process of psychotherapy and the interrelation of the modules.

If we list effective treatment principles in the following, this does not imply that the UPP-ANXIETY is a puzzle of treatment modules. Being more than the sum of its parts, the UPP-ANXIETY represents an integrated psychodynamic treatment, a whole, based on SE therapy. As noted above, an advanced or completed psychodynamic training is required to apply the UPP-ANXIETY.

1. Socializing the Patient for Psychotherapy—the Socialization Interview

Description. As suggested by Luborsky (1984), a socialization interview is conducted at the beginning of the treatment to prepare the patient (see Table 3). It follows the principles outlined by Orne and Wender (1968). The therapist informs the patient about the adaptive function of anxiety (signal anxiety), about his or her anxiety disorder and the planned treatment. The patient is given a rationale allowing for a first orientation with regard to his or her disorder and the planned treatment. We have described the required procedures in detail for the treatment of SAD (Leichsenring et al., 2007).

Evidence. A socialization interview was used as an integral part of the psychodynamic treatment of GAD (Leichsenring et al., 2009; Salzer et al., 2011) and SAD (Leichsenring et al., 2013). The treatments have proven to be efficacious. Based on Luborsky's SE therapy, Gibbons et al. (2012) recently presented a psychodynamic treatment for depression encompassing a "socialization focused component" comparable to our approach. The treatment by Gibbons et al. (2012) yielded effect sizes in favor of the approach as compared with a treatment as usual comparison condition.

2. Motivating, Addressing Ambivalence, and Setting Treatment Goals

Description. After the socialization interview, the therapist clarifies the patients' motivation for treatment. For patients with anxiety disorders, the UPP-ANXIETY puts a specific emphasis on the ambivalence and resistance to change, classical concepts of the psychodynamic approach (for a review of the different forms of resistance from a psychodynamic view see, e.g., Sandler et al., 2002, pp. 99–119). To address avoidance and ambivalence, the psychodynamic techniques for analyzing resistance are used (e.g., Greenson, 1967; Gabbard, 2000). Taking an empathic position, the therapist confronts, clarifies, and interprets the patients' ambivalence between changing and remaining, their avoidance behavior and resistance to change. Conveying to the patient that he or she understands the patient's motives, the therapist positions him- or herself on the side of anxiety and resistance. Referring to a patient with SAD, the therapist may say, for example: "If you avoid meeting other people, they cannot humiliate you . . . . So by avoiding other people, you protect yourself. That's helpful to you." An intervention for GAD may be the following: "Worrying about your children prevents anything bad happening to them. What's wrong with that?" Doing so will lead to a discussion of benefits and costs of anxiety and avoidance and of remaining the same or changing. As neither ambivalence nor resistance will ever disappear completely, they will have to be addressed empathically again and again during the course of treatment (see below module 7 "changing underlying defenses and avoidance" and module 8 "changing response of self"). If the initial ambivalence has been sufficiently worked through, treatment goals are discussed, that is the changes the patient wants to achieve. In case the patient seeks only relief from anxiety symptoms, the therapist may also need to enhance his or her motivation for psychodynamic treatment (Crits-Christoph et al., 1995; Leichsenring et al., 2007). Realistic treatment goals are discussed and set that do not only refer to symptom reduction, but also to gaining insight in the psychodynamics underlying the symptoms and interpersonal relationships (Crits-Christoph et al., 1995; Leichsenring et al., 2007). If a patient only wants to get rid of his symptoms, the therapist may say, for example: "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 are related to your panic attacks?"

Goals serve several functions (Luborsky, 1984, p. 63). During the course of treatment goals provide a marker for both the therapist and the patient of whether the patient has made some progress or not (Luborsky, 1984; Schlesinger, 1977). By conveying support for the patient's wish to achieve the goals, also establishing a helping alliance (see below module 3) is facilitated. Luborsky (1984, p. 82) gave the following example for an intervention: "When you started treatment, you made your goal to reduce your anxiety. You see, in fact, we are working together to achieve that." Furthermore, setting goals serves as a modulator or brake on regression (Luborsky, 1984).

Evidence. Setting goals and focusing on the helping alliance is an integral part of Luborsky's SE therapy (SET) that has proven to be effective in PDT based on SET in GAD and SAD (Crits-Christoph et al., 2005; Leichsenring et al., 2009; Leichsenring et al., 2013; Salzer et al., 2011). Setting goals and addressing the patient's ambivalence and doubts is also an integral part of the "socialization focused component" of the model by Gibbons et al.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

Table 3
Modules of a Unified Psychodynamic Protocol for Anxiety Disorders (UPP-ANXIETY)

Module	Content
1	Socializing the patient for psychotherapy – the socialization interview
	The therapist informs the patient about the adaptive function of anxiety (signal anxiety), about his or her anxiety disorder and the planned treatment. 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. Practical arrangements for the treatment are made (e.g., duration of treatment and sessions, arrangements for vacations and cancelled sessions). Thus, the patient is given a rationale allowing for a first orientation regarding the disorder and the treatment.
2	Motivating, addressing ambivalence, and setting treatment goals
	Taking an empathic position, the therapist confronts, clarifies, and interprets the patient's ambivalence between changing and remaining, their avoidance behavior, and resistance to change. 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?").
	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're related to your panic attacks?")
3 [C]	Establishing a secure helping alliance
	A secure helping alliance is fostered by expressing empathy, explaining the treatment process, setting treatment goals, supporting the patient in achieving the goals, monitoring the process by reference to goals, acknowledging that a goal has been reached, focusing on the common work between patient and therapist (e.g., "When you started treatment, you made your goal to reduce your panic attacks. They seem to have decreased. You see, in fact, we are working together to achieve this."), and conveying that the patient begins to deal with the problems in the same way the therapist does.
4 [C]	Identifying underlying core conflicts: wishes (affects), object relations, and defenses
	By use of patient narratives, the Core Conflicual Relationship Theme (CCRT) associated with the symptoms of anxiety is identified (wish, response of others, response of self). To facilitate identification of the CCRT, the therapist conducts a relationship episode interview (REP, Luborsky, 1990, p. 103): "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, and (3) what happened in the end. Tell me at least ten of these events." The CCRT is that pattern of W, RO, and RS that occurs most often. Discuss the CCRT as his/her "anxiety formula" that explains his/her symptoms of anxiety. The CCRT serves as the focus of treatment. The therapist relates the components of the CCRT to the patient's symptoms of anxiety, for a patient with SAD, for example: "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)."
5 [C]	Focusing on the warded-off affect – experiencing the wish component of the CCRT
	The CCRT includes a wish (impulse or affect) that triggers anxiety and is therefore warded off. The UPP-ANXIETY puts a specific focus on guiding the patient to experiencing this painful affect. 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 would happen if you do so? What would you do, what would 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 [C]	Modifying underlying internalized object relations – the RO component of the CCRT
	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 boss that you are angry with him. How would he react if you do so?").
7 [C]	Changing underlying defenses and avoidance – the maladaptive RS components of the CCRT: encouraging the patient to give up avoidance
	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 a 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, also 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. Both before and after confronting the feared situation, the therapist discusses confronting the feared situation carefully with the patient. 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 (e.g., "We set as a goal that 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.").
8 [C]	Modifying response of self – the adaptive RS component of the CCRT: Fostering more adaptive responses
	The therapist actively fosters the development of more adaptive responses from the self (RS). To foster an internalized encouraging dialogue, the therapist may say, for example: "We have learnt that your anxiety formula makes you anxious. However, is there anything that you can say to yourself that would encourage you?" The therapist encourages the patient to repeatedly activate the encouraging dialogue in everyday situations in order to make it habitual and to foster internalization.
	Several techniques may be applied to address a disturbed self-concept or a lack of self-esteem. For some patients it may be helpful to use the intervention of perspective changes ("How do you feel about another person in your shoes?"). As another intervention the therapist could ask the patient to imagine watching himself acting on a stage while sitting in the audience (stage paradigm). Kohut′s (1977) interventions often took the form of recognition of how hard it must have been for the patient to tolerate his parents′ constant undermining of his self-esteem.

(*table continues*)

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

Table 3 (*continued*)

Module	Content
9	Termination and Relapse Prevention In UPP-ANXIETY supporting patients with anxiety 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."). Furthermore, when termination is being considered, therapist and patient will review what they have done. When symptoms recur during the termination phase, the CCRT is often activated by both the anticipated loss of the therapist and by the anticipation that the wishes inherent in the CCRT will be not fulfilled. To patients who fear to lose the gains without the continued presence of the therapist, he or she may say the following (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 was based on the patient's own activities. 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.

(2012) successfully applied in the treatment of depression. Further evidence for addressing ambivalence early in treatment of anxiety disorders comes from studies of motivational interviewing (Westra, 2012). Adding three to four sessions of motivational interviewing to CBT has proven to enhance the outcome of CBT in anxiety disorders (Westra & Dozois, 2008; Westra et al., 2009). Westra (2012, p. 74) sees motivational interviewing "as a type of conflict resolution," without, however, citing any psychodynamic research. Taking the results by Westra et al. (2009) into account, empathically focusing on patient's ambivalence, avoidance, and resistance to change by use of psychodynamic techniques can be expected to further enhance the efficacy of PDT and to reduce the rate of nonresponders and drop-outs. Research on the contribution of a helping alliance to outcome will be presented in the following.

3. Establishing a Secure Helping Alliance [C]

Description. S. Freud (1913, p. 139) emphasized that only after establishing a "proper rapport," the successfully carrying out of the psychotherapeutic work can begin. This aspect of the patient's relationship to the therapist has been variously referred to as the "therapeutic alliance," "working alliance," or "treatment alliance"—a review of this concept was given, for example, by Sandler et al. (2002).

Within his concept of SE therapy, Luborsky (1984) emphasized the establishment of a secure helping alliance as one of the most important supportive treatment elements. He described several principles that foster the establishment of a helping alliance. These principles encompass, among others, supporting the patient in the

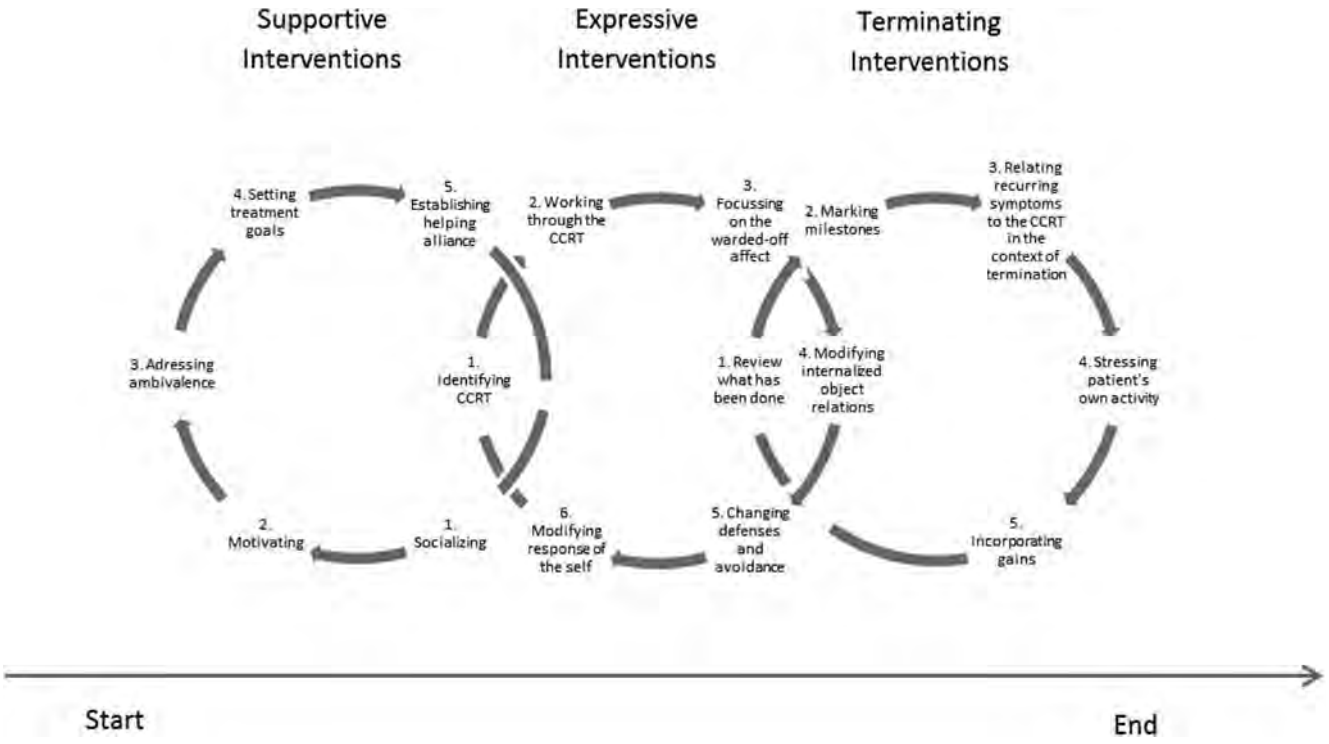


Figure 2. The modules of UPP-ANXIETY illustrated as therapeutic cycles.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

achievement of his or her goals; developing an affinity with the patient, helping the patient to maintain vital defenses and activities, communication of a realistic hope to achieve the treatment goals, recognition that the patient has made some progress toward the goals, encouraging a "we bond," conveying recognition of the patient's growing ability to use the tools of treatment as the therapist does (Luborsky, 1984, pp. 82–88). Crits-Christoph et al. (2006) described several additional techniques that are helpful to foster the development of a helping alliance, for example, regularly examining the patients motivation for and involvement in the psychotherapeutic process, monitoring and discussion raptures of the therapeutic bond in an accepting climate. The treatment for depression based on SE therapy by Gibbons et al. (2012) explicitly encompasses a "supportive alliance building component" using the techniques developed by Crits-Christoph et al. (2006). As many patients with anxiety disorders suffer from an insecure attachment (Eng et al., 2001), a secure helping alliance provides a corrective emotional experience (e.g., Crits-Christoph et al., 1995).

As described above, the supportive-expressive continuum of psychodynamic interventions allows for more supportive interventions in case of more severe psychopathology or acute crisis (Luborsky (1984). For patients with high levels of anxiety, more supportive interventions may be initially required. For patients with PD, for example, it may be necessary to calm the patient by reassurance or conveying a first understanding of the psychological significance of the symptoms showing the patient that he or she is able to gain control through psychological understanding (Busch et al., 1999). Busch et al. (1999, p. 239) give 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." A model for oscillation between conflict pathology and deficit pathology was presented by McCullough-Vaillant (1997, pp. 44–45).

Evidence. As demonstrated by a large number of studies, a helping alliance is significantly associated with treatment outcome (e.g., Horvath et al., 2011). It can be regarded as a common factor in psychotherapy (Flückiger et al., 2012). Crits-Christoph et al. (2006) showed that therapists can be trained in the use of techniques fostering a helping alliance. The treatment by Gibbons et al. (2012) for depression explicitly encompassing a "supportive alliance building component" yielded favorable results compared with a treatment as usual condition. A recent study by Falkenström et al. (2013) provided evidence for a reciprocal causal relationship in which the alliance predicts subsequent change in symptoms while prior symptom change also affected the alliance. As a limitation for the present context, this study does not specifically refer to anxiety disorders. In addition, the study did not include a control group. Furthermore, results were evaluated across different forms of treatment (e.g., psychodynamic, CBT, interpersonal and others). Thus, they are not specific to PDT. For patients with cocaine dependence, Barber et al. (2008) found a complex and nonlinear relationship between strong alliance and treatment outcome for SE therapy. Strong alliance combined with low levels of adherence to SE therapy was associated with better outcome than moderate or high levels. It is unknown, however, whether these results are possibly specific to cocaine dependence and do not generalize to other mental disorders. A recent study by Ulvenes et al. (2012) using the data of the RCT by Svartberg et al. (2004) on the treatment of Cluster C personality disorders showed that the relationship between therapeutic action, bond (as a component of the alliance) and outcome was different for PDT and CBT. Whereas for CBT avoidance of affect was positively related to both the formation of the bond and symptom reduction, avoidance of affect suppressed the relationship of bond to symptom reduction and also negatively influenced symptom reduction in PDT. These results are also relevant for focusing on the affect in PDT and will be discussed again later (module 5: Focusing on the warded-off affect—experiencing the wish component of the CCRT). Thus, although the bond is a common factor and an important component of the alliance, it appears to work differently in PDT and CBT (Ulvenes et al., 2012). In PDT, a focus on affect was related to symptom reduction, even if focusing on affect decrease the bond (Ulvenes et al., 2012). Thus, in PDT a focus away from affect may improve the bond, but not the outcome. To benefit, the patients need to talk about and experience difficult feelings, even if that means that the bond is not as strong for periods.[3] Further research on the role of the alliance for treatment outcome is presently carried out for the already mentioned RCT on SAD (Leichsenring et al., 2009; Leichsenring et al., 2013).

4. Identifying the Underlying Core Conflict: Wishes, Object Relations and Defenses [C]

Description. As described above, the concept of conflict plays a central role in psychodynamic theory and therapy. According to Freud's second (signal) theory of anxiety (S. Freud, 1926), the formation of psychological symptoms is based on an unresolved conflict between libidinal or aggressive impulses and the superego (suboptimally) resolved by the ego using defense mechanisms. Luborsky (1984) has operationalized Freud's idea of symptom formation by his concept of the core conflictual relationship theme (CCRT). A CCRT consists of three components, a wish (W), a response from the others (RO), and a response of the self (RS). The RS component is complex, including both defense mechanisms and the patient's symptoms (Luborsky, 1984). Including the patient's wishes and anticipated responses from the object, the CCRT also represents the patient's transference potential (Luborsky, 1984). Thus, the CCRT method is also a method to operationalize the concept of transference (Freud's "sterotype plates," S. Freud, 1912; Luborsky, 1984). Malan's (1979) triangle of conflict is another model to conceptualize the relationship between impulses, anxiety and defenses. 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).

[3] We thank one of the anonymous reviewers for pointing this out. For psychoanalysis, Greenson (1967) emphasized the dialectical relationship between therapeutic alliance and transference interpretation stressing that each transference interpretation is a blow against the working alliance as the patient and the therapist do not encounter as two adults working together on the same level. As will be described below more in detail, the UPP-ANXIETY puts the emphasis on patient's maladaptive interpersonal patterns as experienced in current relationships outside therapy (Connolly et al., 1998). For this reason, the conflict between transference interpretations (including the therapist) and the maintenance of a helping alliance is not grave in the UPP-ANXIETY.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

Malan's (1979) triangle of person. Malan's triangle of conflict and person are compatible with Luborsky's CCRT approach.

Consistent with these concepts, the UPP-ANXIETY focuses on the conflicts underlying the symptoms of anxiety. Following the principles described by Luborsky (1984), the CCRT associated with the symptoms of anxiety is identified (and worked through). To facilitate identification of the CCRT, the therapist conducts a relationship episode interview (REP, Table 3) as described by Luborsky (1990). In the UPP-ANXIETY the CCRT is discussed with the patient as his or her "anxiety formula" which allows him or her to explain and understand their pattern of anxiety reactions thus providing a sense of control (Leichsenring et al., 2007; Leichsenring et al., 2013). For a patient with SAD, the CCRT may be described in the following way (e.g., Gabbard, 1992; Leichsenring et al., 2007): "I wish to be affirmed by others (W). However, the 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)." The symptoms of anxiety (RS) are interpreted and discussed with the patient as a problem–solution or coping attempt (Luborsky, 1984, p. 114). The therapist may refer to the discussion of the benefits and costs of the patient's anxiety and avoidance during module 2. For patients with SAD it is also important to focus on the affect of shame associated with the wish to expose oneself (Gabbard, 1992; Hoffmann, 2003; Leichsenring et al., 2007). For patients with PD who usually experience their panic attacks as coming "out of the blue," it is of particular importance to explore the situation when the symptoms of panic occurred for the first time (Busch et al., 1999; Milrod et al., 2007). A careful exploration of this situation allows the identification of the conflicts that are related to PD. These conflicts are often related to problems around separation and individuation and to dangers experienced from aggressive impulses (Busch et al., 1999; Milrod et al., 2007). For PD, other authors have stressed conflicts between the need for approval and the fear of punishment for self-assertiveness (Wiborg & Dahl, p. 691).[4] However, we do not assume that there is one CCRT that is specific to either SAD, PD or GAD (Crits-Christoph et al., 1995; Leichsenring et al., 2007).

Once the CCRT is identified, it serves as the focus of treatment. The therapist relates the components of the CCRT to the patient's symptoms of anxiety. 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 . . ."; Luborsky, 1984; Leichsenring et al., 2007).

The therapist repeatedly works through the CCRT in current and past relationships, including the relationship with the therapist (Luborsky, 1984; Menninger & Holzman, 1973; Crits-Christoph et al., 1995; Leichsenring, Salzer et al., 2009; Leichsenring et al., 2007; Leichsenring et al., 2013)—Malan's triangle of person. Working through the CCRT constitutes the expressive (insight-oriented) element of the UPP-ANXIETY. As emphasized by Luborsky (1984) this form of gaining insight has not only a cognitive, but also an emotional component—working through the CCRT includes the dynamics, that is the defenses and the warded-off affects (also Crits-Christoph et al., 1995, pp. 56–57).

The UPP-ANXIETY specifically emphasizes the process of working through, including both the therapist and the patient activity. Not only within but also between sessions, patients are asked to work on their anxiety formula, that is to monitor their emotions including their bodily components (see also module 5) and to identify the components of the CCRT that lead to anxiety. We have described this procedure in detail for the treatment of SAD (Leichsenring et al., 2007). By working on their anxiety formula, the patients are expected to achieve a better understanding and awareness of their anxiety reactions and a sense of control.

Evidence. The concept of the CCRT is among the best studied concepts of psychodynamic therapy—for a review, see, for example, Leichsenring and Leibing (2007). With regard to anxiety disorders, there is evidence from RCTs that methods of PDT focusing on the CCRT are efficacious in anxiety disorders (Crits-Christoph et al., 2005; Leichsenring et al., 2009; Leichsenring et al., 2013; Salzer et al., 2011). The treatment for depression based on SE therapy by Gibbons et al. (2012) encompassing an "expressive relationship focused component" yielded favorable results compared with a treatment as usual. Further evidence for focusing on the CCRT comes from process-outcome research. As shown by Crits-Christoph and Luborsky (1990) for SE therapy in general, changes in the (pervasiveness of the) CCRT were significantly associated with treatment outcome. Furthermore, the accuracy of interpretation of the CCRT was significantly associated with outcome (Crits-Christoph et al., 1988). The competent delivery of expressive (interpretative) techniques was shown to be significantly associated with outcome in depressive patients (Barber, Crits-Christoph & Luborsky, 1996). Across different mental disorders, change in self-understanding was shown to be significantly associated with changes in anxiety (and depression) not only in SE-based therapy, but also in CBT, especially with additional changes during the follow-up period (Connolly Gibbons et al., 2009). As expected, self-understanding changed significantly more in PDT than in CBT (Connolly Gibbons et al., 2009). In a recent open trial of PDT in anxiety disorders, identification of recurrent patterns in actions, feelings or experiences by use of the CCRT method was significantly associated with outcome (Slavin-Mulford, Hilsenroth, Weinberger & Gold, 2011). This was also true for suggesting alternative ways to understand experiences not previously recognized by the patient (Slavin-Mulford et al., 2011). The latter result may be of particular relevance with regard to identification and working through of the patient's anxiety formula. Limitations of open studies were discussed above. For anxiety disorders, future research on the role of working on the CCRT is presently carried out for the already mentioned multicenter RCT on SAD (Leichsenring et al., 2009; Leichsenring et al., 2013).

As described in the following, the UPP-ANXIETY 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).

[4] As recently stressed by Hoffmann (2012), aggression may not only trigger anxiety, but can be used to protect against anxiety, for example, in borderline personality disorder or (sexual) exhibitionism.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

5. Focusing on the Warded-Off Affect—Experiencing the Wish Component of the CCRT [C]

Description. 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, 1977).

As a central component, the CCRT 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. The UPP-ANXIETY puts a specific focus on guiding the patient to experiencing this painful affect. Here often negative affects such as anger, guilt, or shame are involved (Shear et al., 1993). Focusing on the warded-off affect is consistent with Luborsky's SE therapy. As noted above, insight into the CCRT is not restricted to cognitive processes, but also includes working through the defenses and the warded-off affects (also Crits-Christoph et al., 1995, pp. 56–57). McCullough et al. (2003) seem to put an even stronger emphasis on this procedure. Here, the UPP-ANXIETY follows the principles outlined by McCullough et al. (2003) that have proven to be effective in Cluster C personality disorders. Having established a secure therapeutic alliance, patients are encouraged to repeatedly experience the avoided affect, first in sensu, then in real relationships (McCullough & Osborn, 2004). As stressed by McCullough and Osborn (2004) it is important that also the bodily components of the affect are include here (McCullough & 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 the UPP-ANXIETY and in PDT 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—for a discussion of these different forms of affects (affects related to the id, the ego, or the superego) see, for example, Jacobson (1953). Furthermore, the patient's sense of control is increased. A theoretical discussion on the regulation of affects and impulses from an ego-psychological perspective was given by Bellak et al. (1973). Focusing on the warded-off affect, a therapist may say to a patent with a PD: *"You are afraid to tell your boss that you are angry with him because you are afraid of losing control. What would happen if you do so?"* 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). Furthermore, 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).

Evidence. Identifying and working on the wish component is an integral part of the form of PDT based on SE therapy we applied in GAD and SAD (Leichsenring et al., 2009; Leichsenring et al., 2013; Salzer et al., 2011). According to studies by Crits-Christoph and Luborsky (1990), changes in the wish component of the CCRT were significantly associated with outcome. Additional evidence comes from the studies that effectively used the McCullough model of affect phobia in Cluster C personality disorders that put a specific focus on the warded-off affect (Abbass et al., 2008; Hellerstein et al., 1998; Svartberg et al., 2004; Winston et al., 1994). A recent study by Ulvenes et al. (2012) using the Svartberg et al. (2004) data on Cluster C personality disorders specifically corroborated for the model by McCullough that focusing on affects is associated with improved outcome in PDT, but not in CBT. For these data Schanche et al. (2011) showed that across treatments an increase in the experience of activating affects and decrease in inhibitory affects was associated with an increase of self-compassion which was positively related to outcome. For an open trial including patients with Cluster C personality disorders, Town et al. (2012) reported that the therapist's use of confrontation, clarification, and support compared with questions, self-disclosure, and information interventions was followed by higher levels of immediate affect experiencing. Confronting either the visceral experience of affect or a patient's defenses against feelings led to the highest levels of immediate affect experiencing. In a meta-analysis, focusing on affect was shown to be significantly related to outcome in short-term psychodynamic therapy (Diener, Hilsenroth & Weinberger, 2007). Further evidence for improving the outcome of psychotherapy by focusing on affects comes from research on emotion-focused therapy in depression, including both outcome (e.g., Goldmann, Greeenberg & Angus, 2006) and process research (e.g., Goldman, Greenberg & Pos, 2005; Pos et al., 2003). As mentioned above, future research on the role of working on the components of the CCRT is presently carried out for the multicenter RCT on SAD (Leichsenring et al., 2009; Leichsenring et al., 2013).

6. Modifying Underlying Internalized Object Relations—the RO Component of the CCRT [C]

Description. From the very beginning of psychodynamic theory and therapy, object relations have played a central role for understanding the development of intrapsychic structures of self-regulation (e.g., the superego), but also for the development of psychopathology (e.g., Freud's concept of the Oedipus complex). The internalization of object relations is a central psychodynamic concept: Experiences with external objects are internalized in form of object representations and corresponding self representations and affects (e.g., Kernberg, 1976). In object relations theory, self psychology, and attachment theory, object relations play a major role. In patients with anxiety disorders the symptoms of anxiety are assumed to be closely related to specific object and self representations (e.g., Gabbard, 1992; Shear et al., 1993; Vertue, 2003).

In the UPP-ANXIETY, the therapist focuses on all components of the CCRT including the RO component. He or she clarifies what the patient expects to happen in object relations (RO) if he expresses his wish (worst case scenario). To do so, the therapist may say, for example: "You are afraid of telling your mother that you will not be at home on Christmas. How would she react if you do

so?" This part of the work refers to the RO component of the CCRT or the anxiety (A) component of Malan's (1979) triangle of conflicts. 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).

Evidence. Evidence comes from studies that applied the CCRT concept in the treatment of anxiety disorders (Crits-Christoph et al., 2005; Leichsenring et al., 2009; Leichsenring et al., 2013). Crits-Christoph and Luborsky (1990) showed that changes in the RO component of the CCRT are significantly related to outcome.

The therapeutic handling of the RO component of the CCRT is related to the question of transference interpretation. In studies of short-term psychodynamic psychotherapy, transference interpretations were negatively associated with outcome in more severely disturbed patients (Piper et al., 1991; Ogrodniczuk et al., 1999). In a study of long-term psychodynamic psychotherapy, however, transference interpretations were positively associated with outcome (Høglend et al., 2006, 2008). Further analyses showed that the impact of transference interpretation on psychodynamic functioning was more positive within the context of a weak therapeutic alliance for patients with low quality of object relations (Høglend et al., 2011). For patients with more mature object relations and high alliance, a negative effect of transference work was reported. Furthermore, women benefitted significantly more from transference interpretations than men (Ulberg et al., 2012).

For the UPP-ANXIETY, we have drawn the following conclusions: As a form of short-term psychodynamic psychotherapy, the UPP-ANXIETY puts the emphasis on patient's maladaptive interpersonal patterns as experienced in current relationships outside therapy (Connolly et al., 1998). If transference interpretations are made that include the therapeutic relationship, they should be carefully applied taking the quality of the patient's object relations into account (Gabbard, 2006; Levy & Scala, 2012; Piper et al., 1991; Ogrodniczuk et al., 1999). In more severely disturbed patients, they should be avoided.

7. Changing Underlying Defenses and Avoidance (the Maladaptive RS Components of the CCRT): Encouraging the Patient to Give Up Avoidance [C]

Description. To be sociable, human beings need to regulate their impulses and affects. According to psychodynamic thinking, defense mechanisms are used for that purpose (S. Freud, 1926; A. Freud, 1936). From the perspective of ego psychology, defense mechanisms are regarded as ego functions (e.g., Bellak, Hurvich & Gediman, 1973). Defenses may have both adaptive and maladaptive effects (e.g., Bellak, Hurvich & Gediman, 1973). They may help the subject to protect against threatening impulses or affects, but may also lead to psychological symptoms (see above). Within psychotherapy, defense mechanisms may appear as a form of resistance to be worked through (e.g., Sandler et al., 2002). S. Freud (1914) related the concept of working through initially to the work on defense mechanisms and resistance. With regard to psychoanalytic technique, Wilhelm Reich (1933) was among the first psychoanalysts who emphasized to focus on analyzing resistance before interpreting libidinal or aggressive impulses (also Fenichel, 1941). Techniques to analyze resistance (e.g., confrontation, clarification, interpretation) have been described, for example, by Reich (1933); Fenichel (1941); Greenson (1967) and more recently by McCullough et al. (2003). Reich also described the contribution of habitual defense mechanisms to forming a subject's personality, a concept later elaborated by other authors (Reich, 1929, 1933; also A. Freud, 1936; Kernberg, 1970, 1994).

Within UPP-ANXIETY changing underlying defenses and avoidance, that is the maladaptive RS components of the CCRT are given specific attention (Module 7). 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., Luborsky, 1984; McCullough et al., 2003; see also modules 1, 2, and 6 in Table 3).[5] Beside the adaptive function, the therapist points out the maladaptive functions of defenses. Especially in AVPD defenses are egosyntonic and a part of the personality structure, that is the subject does not experience them as a problem but as "normal" and uses them habitually. For this purpose, the therapist points out the costs of habitual avoidance and defense, thus making them egodystonic, that is a "problem" to the patient (e.g., "Avoiding people you do not know protects you against being criticized. On the other hand, you told me that you often feel lonely/miss being affirmed by others. Apparently, this is the price you are paying for being safe."). In AVPD, working through habitual defenses and avoidance in this way is of particular importance. In patients with GAD, it is important for the therapist to focus on the defensive function of worrying, for example, "By worrying all the time that something terrible will happen to your husband you seem to avoid facing the conflicts existing between you and him"). In SAD this especially applies to avoidance of social contacts, in PD to the defensive function of panic attacks that serve to protect against more threatening impulses and wishes (e.g., of separation, "You experienced your first panic attack when you thought of leaving your parents and move to another city. As we have found out, you were afraid your mother would not survive if you leave her"). The benefits and costs of defenses and avoidance are discussed as described above. In general, the well-known psychodynamic techniques of confronting, clarifying and interpreting are used here. McCullough et al. (2003, pp. 119–123) presented several examples for each of these techniques, for example, 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] feeling of grief [F] that are an inevitable part of the break up with your lover [C]."[6]

Within the UPP-ANXIETY, we regard it as essential that the therapist also encourages the patient to try out new behavior and to express (avoided) feelings more appropriately. As stressed by Shear et al. (1993, p. 863) for PD, avoidance of real life experi-

[5] On a theoretical level, it is of interest that avoidance has not been included among the defense mechanisms of the Defensive Functioning Scale proposed for further study in *DSM–IV* (pp. 751–753). In contrast, Bellak et al. (1973, p. 465) rated avoidance as a defense mechanism (found e.g., in free-floating anxiety, agoraphobia or claustrophobia) on level 3 of their 7-point defensive functioning scale (1 = *worst*, 7 = *best*).

[6] 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).

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

ments impairs learning about predictability of threats and interferes with realistic self-confidence in coping with threats and reduces the sense of controllability. Following the recommendations by S. Freud (1919) for patients with agoraphobia, the UPP-ANXIETY puts a specific focus on addressing the patient's avoidance behavior.[7] 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 afterward. The therapist asks the patient to have a close look at what is happening during confrontation including both his or 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. For patients with deficits in social skills, for example, it may be necessary to anticipate the social situation and to run it through in fantasy (Freud's "Probehandeln"; S. Freud, 1900) before exposing oneself to the feared situation. As a next step after confrontation, the therapist relates the experiences the patient made during confrontation to the CCRT and its components. Thus, the patient's experiences are used to work on his or her conflicts (CCRT). This is a crucial difference to exposure as used in CBT and follows the recommendations by S. Freud (1919). We have described this procedure in detail in our manual for the treatment of SAD (Leichsenring et al., 2007) applied in a large randomized controlled trial (Leichsenring et al., 2013). 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 SAD, the treatment sessions themselves encompass a form of exposing oneself, that is to the therapist.

Evidence. As for the wish and the RO component of the CCRT, changes in the RS component of the CCRT were shown to be significantly associated with outcome (Crits-Christoph & Luborsky, 1990). Evidence for anxiety disorders comes from the above mentioned studies on GAD and SAD in which the CCRT was used as a focus of treatment (Crits-Christoph et al., 2005; Leichsenring et al., 2009; Leichsenring et al., 2013; Salzer et al., 2011). Further evidence comes from RCTs which used the affect phobia model by McCullough et al. (2003) in the treatment of Cluster C personality disorders (Abbass et al., 2008; Hellerstein et al., 1998; Svartberg et al., 2004; Winston et al., 1994). For the Cluster C personality disorders sample of the Svartberg et al. (2004) study, Johansen et al. (2011) reported that change in overall defensive functioning during treatment predicted change in symptom distress from pretreatment to 2 years after treatment.

Connolly Gibbons et al. (2009) found that reductions of discrepancies between one's actual self image and one's ideal self image and between one's actual self image and one's ought-to-be self-image were significantly associated with reduction of anxiety and improvements in quality of life across diverse psychotherapies including SE therapy and diverse mental disorders. The authors also reported that improvements in compensatory skills were associated with reduction of anxiety (and depression), not only with improvements at the end of therapy, but also with improvements during the follow-up period (Connolly Gibbons et al., 2009). Both changes in the self-image and in compensatory may be related to changes in the RS component of the CCRT. For a naturalistic study of long-term psychodynamic psychotherapy in patients with chronic or recurrent depressive or anxiety disorders and/or personality disorders, Bond and Perry (2004) reported that change in defense style significantly predicted outcome beyond initial symptom level. A higher level of defensive functioning was also predictive of a better self-reported therapeutic alliance. As a limitation for the present context, these results are not specific to anxiety disorders and refer to long-term psychodynamic psychotherapy.

8. Modifying Response of Self—the Adaptive RS Component of the CCRT: Fostering More Adaptive Responses [C]

Description. The self response component of the CCRT includes both maladaptive and adaptive responses from the self.[8] Working through the self-defeating aspects of the RS lays the groundwork for developing new RS and new behaviors (e.g., Crits-Christoph et al., 1995).

In the UPP-ANXIETY the therapist actively fosters 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 on two aspects, that is (a) fostering an internalized encouraging dialogue and (b) improving the patient's self-esteem.

Fostering an internalized encouraging dialogue. From an object relational perspective, the patients symptoms are maintained by inner dialogues associated with pathogenic internalized object relations. As described by Kernberg (1976), internalized object relations encompass an object representation, a corresponding self representation, and a corresponding affect connecting them. 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 therapy we recommend the therapist to actively foster the development of an internalized encouraging dialogue (Hoffman, 2003). Following Hoffman (2003), we have described the implied procedures in detail for the treatment of SAD (Leichsenring et al., 2007). The therapist may say, for example: "We have learnt that your anxiety formula makes you anxious. However, is there anything that you can say to yourself that would encourage you?" 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 GAD, PD, 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"). Activating an internalized encouraging dialogue is especially helpful when confronting an anxiety-provoking situation (Leichsenring et al., 2007). The therapist encourages the patient to repeatedly activate the encouraging dialogue in everyday situations to foster internalization. Supporting the patient to establish a helpful inner dialogue can be expected to foster the internalization of a good and constant object that has

[7] 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.

[8] In Malan's (1979) triangle of conflicts modified by McCullough and Osborne (2004, p. 844), the adaptive responses from the self are assigned to the F pole (adaptive impulse/feeling).

an appreciating (Kohut, 1971), directing (König, 1997, p. 94) or calming (Bowlby, 1973; Busch et al., 1999) function.

Improving patient's self-esteem. From an ego psychological perspective, regulation of self-esteem is regarded as an ego function (Bellak, Hurvich and Gediman, 1973). From both an object relational and a self psychological perspective, regulation of self-esteem is closely related to the quality of internalized objects (e.g., Kernberg, 1975; Kohut, 1971).

As reported above, many patients with anxiety disorders suffer from a disturbed self-concept and a lack of self-esteem (e.g., Cox et al., 2004; Henning et al., 2007; Shear et al., 1993). In patients with SAD, for example, the process of transmuting internalization (Kohut, 1971) seems to have been impaired in a special way, that is by an identification with the aggressor (Hoffmann, 2003; Leichsenring et al., 2007). Several techniques may be applied to address a disturbed self-concept or a lack of self-esteem. For some patients it may be helpful to use the intervention called perspective changes (McCullough & Osborn, 2004, p. 850): The patient "needs to imagine that other people in his life feel care or compassion for him before he can experience positive feeling for himself." McCullough and Osborn (2004, p. 850) suggested, for example, the following intervention: "Whose eyes lit when they saw you?" As another intervention the therapist could ask the patient: "How do you feel about another person in your shoes?" Analogous to changing perspectives Hoffmann (2003) suggested asking the patient to imagine watching himself acting on a stage while sitting in the audience (Leichsenring et al., 2007). Addressing a disturbed self-esteem, Luborsky (1984, p. 75, 76) referred to Kohut (1977) whose interventions often took the form of recognition of how hard it must have been for the patient to tolerate his parents' constant undermining of his self-esteem. For patients with SAD, Hoffmann (2003) also recommended no longer allowing the patient to devalue him- or herself within the session, and to actively stop him or her when doing so (Leichsenring et al., 2007). We have described various procedures to address a disturbed self-concept in more detail (Leichsenring et al., 2007).

The UPP-ANXIETY has been developed to treat anxiety disorders, but not to primarily treat severe disturbances of the self as they are characteristic, for example, for patients with narcissistic personality disorder or borderline personality disorder.

Evidence. Procedures to foster an internalized encouraging dialogue and to improve the patient's self-esteem described above were applied in a randomized controlled trial of PDT based on SE therapy in SAD which proved to be efficacious (Leichsenring et al., 2013). Further evidence comes from the studies on Cluster C personality disorders (Abbass et al., 2008; Hellerstein et al., 1998; Svartberg et al., 2004; Winston et al., 1994). In process–outcome research changes in self-understanding, views of the self, and compensatory skills were shown to be significantly associated across mental disorders with changes in anxiety (and depression) in both SE based therapy and CBT (Connolly Gibbons et al., 2009). Changes in self-understanding and compensatory skills were associated with additional changes during the follow-up period, suggesting that changes in self-understanding and compensatory skills may produce subsequent changes in outcome rather than covarying with them (Connolly Gibbons et al., 2009). As an unexpected result, psychodynamic psychotherapy based on SE therapy produced as much change in compensatory skills as CBT (Connolly Gibbons et al., 2009). Further research on changes of the self is presently carried out for the data of the RCT on SAD (Leichsenring et al., 2009; Leichsenring et al., 2013).

9. Termination and Relapse Prevention

Description. In the UPP-ANXIETY supporting patients to prevent relapse is regarded as an important treatment element. As described by Luborsky (1984) for SE therapy, termination of therapy is regarded as a particularly important step. He stressed both patient and therapist activities. In his manual, Luborsky (1984) formulated several principles with regard to termination (for details see Luborsky, 1984, pp. 142–158). For the UPP-ANXIETY, we follow Luborsky's recommendations (1984). Therapists are recommended, for example, to remind the patient when termination will take place or mark treatment phases (arrival at a goal) so that they can serve as milestones. Furthermore, when termination is being considered, therapist and patient will review what they have done (Luborsky, 1984, p. 66). When symptoms recur during the termination phase, the CCRT is often activated by both the anticipated loss of the therapist and by the anticipation that the wishes inherent in the CCRT (e.g., security, guidance, closeness, care, acceptance, appreciation etc.) will not be fulfilled (Luborsky, 1984). The therapist interprets the resurgence of symptoms of anxiety and relates them to the CCRT (Luborsky, 1984). 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) the following: "You believe that the gains you have made are not part of you but depend on my presence." He or she may go on: "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." These procedures foster incorporating the gains (Luborsky, 1984, p. 26): "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." By internalization, the patient incorporates the therapist as a helpful person and learns to use the tools applied by the therapist also in the absence of the therapist.

In addition, the final three sessions are carried out as booster sessions at 2-week intervals. In the booster sessions, a specific focus is put on the maintenance of gains. We have already used booster sessions in our previous treatment studies of GAD and SAD (Leichsenring, Salzer et al., 2009; Leichsenring et al., 2013; Salzer et al., 2011). Our experiences are consistent with those reported by Crits-Christoph et al. (1995): The positive effects of the booster sessions outweigh any potential interference with the working through of termination. The therapist uses the booster sessions to monitor and support the patient's improvements with regard to his or her anxiety disorder. If symptoms recur, the patient is informed that this does not imply relapse. The therapist relates recurrence of symptoms to the CCRT and to the loss of the therapist (Luborsky, 1984). The therapist encourages and supports the patient's own activities in working on his or her problems including his or her self exposure. He or she stresses the patient's own contribution to progress.

Evidence. These procedures were applied in RCTs on GAD and social anxiety disorder, which provided evidence for the

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

applied methods of PDT (Crits-Christoph et al., 2005; Leichsenring et al., 2009; Salzer et al., 2011; Leichsenring et al., 2013). For CBT, the effectiveness of booster sessions has been demonstrated for child and adolescents with mood and anxiety disorders (Gearing et al., 2013). However, future research on the methodology of booster sessions is required, including identifying the factors associated with change and the maintenance of outcome (e.g., Whisman, 1990).

Concluding Remarks

Within the UPP, the nine modules described above are used in a flexible way depending on the patient's needs and on the course of the treatment. This applies to the dose, the timing, and the sequence of the modules. Some modules are regarded as core modules and should be used in every treatment though with varying emphasis. We do not claim that there is a treatment component that is unique to the unified protocol. However, the whole is more than the sum of its constituent parts.

We have conceptualized the UPP-ANXIETY as a form of short-term psychodynamic psychotherapy. However, with some modifications the modules described above may also be useful in long-term psychodynamic psychotherapy of anxiety disorders.

Following the classification of transdiagnostic approaches by Mansell et al. (2009), the unified psychodynamic protocol for anxiety disorders may be classified as a "limited range, multiprocess approach," expressing that in a (limited) range of disorders (anxiety disorders) wider than traditional models (e.g., SAD or PD or GAD)[9] a range of maintaining psychodynamic processes (e.g., the CCRT pattern and its components) are implicated—in contrast, single process approaches assume one common underlying process (Mansell et al., 2009).

It may be of interest to compare our unified psychodynamic protocol with unified CBT protocols. In general, it may be an advantage of PDT that both historically and conceptually PDT has always been transdiagnostic, sometimes, however, neglecting the disorder-specific treatment needs. Furthermore, PDT focuses on core underlying processes of the disorder, not on specific symptoms. In addition, psychodynamic treatment manuals are usually less structured, have a more modular format, and allow for a more flexible use. Thus, for both psychodynamic researchers and practitioners a unified transdiagnostic protocol as proposed here is consistent with their usual conceptual and clinical approach. This may constitute a difference to CBT.

The unified CBT protocols by McEvoy et al. (2007), Garcia (2003), Erickson et al. (2007), and Schmidt et al. (2012) include some common components, that is psychoeducation, cognitive restructuring, exposure, relaxation training, and relapse prevention—classical CBT interventions. The protocol by Barlow et al. (2004) for "emotional disorders" seems to go beyond these classical CBT components by additionally including some more innovative modules. For this reason, it may be of specific interest to compare the Barlow et al. protocol with UPP-ANXIETY. There seem to be some similarities, but also some clear differences—some of these differences were already emphasized above. As a first difference, the Barlow et al. protocol has a wider range of application by including both anxiety disorders and depressive disorders. UPP-ANXIETY does not claim to also cover depressive disorders. Using another theoretical language, the Barlow et al. protocol—and some of the other CBT protocols listed above—stress some treatment principles that are regarded as important by the UPP-ANXIETY as well: The modules on motivation enhancement, psychoeducation, and relapse prevention (e.g., Wilamowska et al., 2010) emphasize motivating the patient and explaining his or her disorder and the treatment rationale and prevention of relapse (modules 1, 2, 9). From a psychodynamic view and in a psychodynamic language, these targets are addressed by the first two modules of UPP-ANXIETY (Module 1: Socializing the patient for psychotherapy—the socialization interview: Module 2: Motivating, addressing ambivalence and setting treatment goals) and in the final module (Module 9: Termination and Relapse Prevention). Thus, these procedures of beginning and ending a psychotherapy seem to be important for both CBT and PDT and possibly for any form of short-term psychotherapy irrespective of its theoretical orientation.[10] As a difference, UPP-ANXIETY puts a strong focus on establishing a helping alliance (module 3), a principle not explicitly listed by Wilamowska et al. (2010). With regard to the core underlying processes of anxiety disorders, the UPP-ANXIETY focuses on unresolved conflicts (CCRT), the applied defense mechanisms, the warded-off affect, internalized object relations, and response of the self, that is on classic concepts of psychodynamic theory and therapy (modules 4–8). From the perspective of CBT, Wilamowska et al. (2010) focus on cognitive reappraisal, emotion awareness, emotion driven behaviors (EDB) and emotional avoidance awareness, and tolerance of physical sensations and interoceptive and situational exposure (modules 3–7). Some of these modules are classical cognitive–behavioral treatment elements, for example, cognitive reappraisal which is not included in UPP-ANXIETY but by the other unified CBT protocols listed above (McEvoy et al., 2007; Garcia, 2003; Erickson et al., 2007; Schmidt et al., 2012). For some other modules of the Barlow et al. protocol, however, there may be some overlap with some of the modules of UPP-ANXIETY—if the differences implied by another theoretical language are "subtracted." Both the Barlow et al. protocol and the UPP-ANXIETY put a specific focus on experiencing affects. Crucial differences between the cognitive–behavioral emotional awareness training, and the UPP-ANXIETY module 5 (Focusing on the warded-off affect—experiencing the wish component of the CCRT) were already discussed above: UPP-ANXIETY focuses on the **warded-off** affect (the F [feeling] component of Malan's triangle of conflicts, Malan, 1979). Furthermore, as another difference, UPP-ANXIETY does not make use of exposure as it is applied in CBT and in the unified CBT protocols: The therapist does not accompany the patient during confrontation. In UPP-ANXIETY patients are encouraged to self-expose to the feared situation and the experiences made during exposure are used by the therapist to work on the underlying CCRT, which is consistent with the recommendations by S.

[9] In contrast, the methods by Luborsky (1984) and McCullough et al. (2003), for example, represent universal approaches referring to all or to the majority of mental disorders.

[10] This is surprisingly consistent with S. Freud's (1913) statement that both in psychoanalysis and in chess only the opening and the closing moves of the game allow for an exhaustive systematic description. 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.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

Freud (1919). 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., 2011). For this module, the authors state (Wilamowska et al., 2011, p. 886)

> that "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., A. Freud, 1936; Kernberg, 1994), Wilamowska et al., (2011, p. 886) go on by discriminating "adaptive" and "maladaptive" aspects of emotional avoidance. It does not come as a surprise that Wilamowska et al. (2011, p. 886) 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." This is the classic psychodynamic work on defense and resistance as described above (Reich, 1929, 1933; Fenichel, 1941; A. Freud, 1936; Kernberg, 1970, 1994) 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-ANXIETY in particular, especially with the UPP-ANXIETY modules 7 ("changing underlying defenses and avoidance; the maladaptive RS components of the CCRT") and 8 ("modifying response of self—the adaptive RS component of the CCRT: Fostering more adaptive responses"). Apparently, a treatment concept has been integrated into the unified protocol by Barlow et al. (2004; Wilamowska et al., 2011) that has a psychodynamic origin.

We have addressed similarities and differences between unified CBT protocols and the UPP-ANXIETY from a conceptual perspective. However, an empirical approach is required to identify the real overlaps and differences between psychodynamic and CBT protocols, that is to study what the therapists actually do and where they differ. In our study comparing CT and PDT in SAD, the two approaches could be clearly discriminated by masked raters (Leichsenring et al., 2013). In this context it is of interest that CT therapists used more interventions regarded as psychodynamic than vice versa (Leichsenring et al., 2013).

Discussion

Anxiety disorders represent a significant public health concern because of their prevalence, impairment, chronicity, and associated economic impact (Gustavsson et al., 2011; Grant et al., 2005; Kessler et al., 2005; Alonso et al., 2004). This is true for SAD, PD, and GAD. Complex and highly comorbid mental disorders are difficult to treat by the use of manual-guided treatments that are tailored to single mental disorders. In this article, we presented principles of a unified protocol for the psychodynamic treatment of anxiety disorders. These principles are based on those methods of PDT that have proven to be effective in RCTs. A unified transdiagnostic psychodynamic treatment for anxiety disorders has several advantages. In particular, it has the potential to accomplish the following

- enhance the efficacy of PDT in anxiety disorders by integrating treatment principles of empirically supported methods of psychodynamic therapy;
- facilitate translation of research into clinical practice of mental health professionals—for one unified protocol this is easier than for different protocol for various disorders;
- facilitate training for practitioners and dissemination of treatment approaches relative to training in several distinct single-disorder treatments;
- be more cost efficient;
- and have an impact on the public health system.

Thus, a unified transdiagnostic psychodynamic treatment for anxiety disorders addresses priorities put forward by NIMH (Insel, 2009), such as innovative methods, translational research, impact on public health, and facilitating dissemination of cost-effective treatments.

For CBT, some evidence exists that a transdiagnostic approach is effective (e.g., Norton & Philipp, 2008; Farchione et al., 2012; Schmidt et al., 2012; Norton, 2012).

Also for PDT some evidence is available to support a transdiagnostic approach: (a) consistent with the traditionally universal approach of PDT, several RCTs exist in which manual-guided PDT has proven to be effective in samples of heterogeneous disorders (e.g., Guthrie et al., 1999; Guthrie et al., 2001; Piper et al., 1990; Shefler et al., 1995; Bressi et al., 2010); (b) further evidence for a transdiagnostic approach in PDT is provided by several RCTs mentioned above which adapted the (universal) affect phobia model by McCullough et al. (2003) to the treatment of Cluster C personality disorders (Abbass et al., 2008; Hellerstein et al., 1998; Svartberg et al., 2004; Winston et al., 1994) which constitute a broader class of diagnoses—as noted above, unfortunately, evidence for this approach does not yet exist for anxiety disorders; (c) for anxiety disorders, several studies have tailored Luborsky's universal model of SE therapy to the treatment of anxiety disorders and provided evidence for this approach in GAD and SAD (Crits-Christoph et al., 1996; Crits-Christoph et al., 2005; Leichsenring, Salzer et al., 2009; Salzer et al., 2011; Leichsenring et al., 2013).

Thus, there is already some relevant evidence to support a transdiagnostic approach for PDT in general and for anxiety disorders in particular. However, a unified and empirically supported protocol for the psychodynamic treatment of anxiety disorders has not yet been developed and applied. As noted above, we are planning to test the UPP-ANXIETY in a RCT.

By a UPP-ANXIETY we not only aim to enhance the efficacy of PDT in anxiety disorders, but also to facilitate training and dissemination of empirically supported psychodynamic approaches. As PDT traditionally focuses on core underlying processes of disorders and tends to have a modular and transdiagnostic format, acceptability of UPP-ANXIETY among psychodynamic psychotherapists in clinical practice is likely to be high.

Evidence is emerging that PDT is effective in specific mental disorders (e.g., Leichsenring, Klein & Salzer, in press, a). At present, however, the existence of diverse manual-guided psychodynamic approaches for a specific mental disorder has a severe disadvantage if the criteria for empirically supported treatments put forward by Chambless and Hollon (1998) are applied: The evidence that is available for one approach only refers to the specific method of PDT applied in the respective study. This

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

applies, for example, to the studies by Clarkin et al. (2007) and Bateman and Fonagy (2009), providing evidence for different methods of PDT in the treatment of borderline personality disorder. Thus, the available evidence is scattered between different approaches. If unified protocols are used in the future, evidence provided by different studies will be in support of the respective unified protocol. Thus, the unified protocol approach has the potential to strengthen the scientific and political position of psychodynamic psychotherapy in general. For this reason, developing unified psychodynamic protocols for other classes of diagnoses would be of interest, especially for depressive disorders, personality disorders or somatoform disorders. For that purpose, however, the so-called 'narcissism of small differences' needs to be overcome. Some CBT researchers were able to overcome this problem. We hope that psychodynamic researchers will be able to do so as well.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

References

Abbass, A. A., Sheldon, A., Gyra, J., & Kalpin, A. (2008). Intensive short-term dynamic psychotherapy for *DSM–IV* personality disorders: A randomized controlled trial. *Journal of Nervous and Mental Disease, 196,* 211–216.

Ablon, J. S., Levy, R. A., & Katzenstein, T. (2006). Beyond brand names of psychotherapy: Identifying empirically supported change processes. *Psychotherapy: Theory, Research, Practice, Training, 43,* 216–231.

Alonso, J., Angermeyer, M. C., Bernert, S., Bruffaerts, R., Brugha, T. S., Bryson, H., . . . Vollebergh, W. A. (2004). Prevalence of mental disorders in Europe: Results from the European Study of the Epidemiology of Mental Disorders (ESEMeD) project. *Acta Psychiatrica Scandinavia, 109,* 21–27.

Barber, J., & Crits-Christoph, P. (1995). *Dynamic therapies for psychiatric disorders (Axis I)* New York, NY: Basic Books.

Barber, J., Crits-Chrustoph, P., & Luborsky, L. (1996). The effects of adherence and competence on patient outcome in brief dynamic therapy. *Journal of Consulting and Clinical Psychology, 64,* 619–622.

Barber, J. P., Gallop, R., Crits-Christoph, P., Barrett, M. S., Klostermann, S., McCarthy, K. S., & Sharpless, B. A. (2008). The role of the alliance and the techniques in predicting outcome of supportive-expressive dynamic therapy for cocaine dependence. *Psychoanalytic Psychology, 25,* 461–82.

Barlow, D. H., Allen, L. B., & Choate, M. L. (2004). Toward a unified treatment for emotional disorders. *Behavior Therapy, 35,* 205–230.

Bateman, A., & Fonagy, P. (2009). Randomized controlled trial of outpatient mentalization-based treatment versus structured clinical management for borderline personality disorder. *American Journal of Psychiatry, 166,* 1355–1364.

Bellak, L., Hurvich, M., & Gediman, H. K. (1973). *Ego functions in schizophrenics, neurotics, and normals: A systematic study of conceptual, diagnostic, and therapeutic aspects*. New York, NY: Wiley.

Blagys, M., & Hilsenroth, M. J. (2000). Distinctive features of short-term psychodynamic-interpersonal psychotherapy: A review of the comparative psychotherapy process literature. *Clinical Psycholigie: Science & Practice, 7,* 167–188.

Blanck, G., & Blanck, R. (1974). *Ego psychology: Theory and practice*. New York, NY: Columbia University Press.

Bögels, S. W. P., & Sallerts, S. (2003, September). *Analytic psychotherapy versus cognitive-behavioral therapy for social phobia.* Paper presented at the European Congress for Cognitive and Behavioural Therapies, Prague, Czech Republic.

Bond, M., & Perry, J. C. (2004). Long-term changes in defense styles with psychodynamic psychotherapy for depressive, anxiety and personality disorders. *American Journal of Psychiatry, 161,* 1665–1671.

Borkovec, T. D. (1994). The nature, function and origin of worry. In G. C. L. Davey & F. Tallis (Eds.), *Worrying: Perspectives on theory, assessment and treatment*. New York, NY: Wiley.

Bowlby, J. (1973). *Attachment and loss. Vol 2: Separation: Anxiety and anger*. New York, NY: Basic Books.

Bowlby, J. (1988). *A secure base: Clinical applications of attachment theory*. London, UK: Routledge.

Bressi, C., Porcellana, M., Marinaccio, P. M., Nocito, E. P., & Magri, L. (2010). Short-term psychodynamic psychotherapy versus treatment as usual for depressive and anxiety disorders: A randomized clinical trial of efficacy. *Journal of Nervous and Mental Disease, 198,* 647–652.

Busch, F., Cooper, A. M., Klerman, G. L., Penzer, R. J., Shapiro, T., & Shear, M. K. (1991). Neurophysiological, cognitive-behavioral, and psychoanalytic approaches to panic disorder: Toward an integration. *Psychoanalytic Inquiry, 11,* 316–332.

Busch, F. N., Milrod, B. L., & Singer, M. B. (1999). Theory and technique in psychodynamic tetment of panic disorder. *Journal of Psychotherapy Practice and Research, 8,* 234–242.

Canadian Task Force on the Periodic Health Examination. (1979). The periodic health examination. *Canadian Medical Association Journal, 121,* 1193–1254.

Chambless, D. L., & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychoogyl, 66,* 7–18.

Clarkin, J. F., Levy, K. N., Lenzenweger, M. F., & Kernberg, O. F. (2007). Evaluating three treatments for borderline personality disorder: A multiwave study. *American Journal of Psychiatry, 16,* 922–928.

Connolly, M. B., Crits-Christoph, P., Shappell, S., Barber, J. P., Luborsky, L., & Shaffer, C. (1998). Relation of transference interpretation to outcome in the early sessions of brief supportive-expressive psychotherapy. *Psychotherapy Research, 9,* 485–495.

Connolly Gibbons, M. B., Crits-Christoph, P., Barber, J. P., Wiltsey Stirman, S., Gallop, R., Goldstein, L. A., . . . Ring-Kurtz, S. (2009). Unique and common mechanisms of change across cognitive and dynamic psychotherapies. *Journal of Consulting and Clinical Psychology, 77,* 801–813.

Cook, D., Guyatt, G. H., Laupacis, A., Sacket, D. L., & Goldberg, R. J. (1995). Clinical recommendations using levels of evidence for antithrombotic agents. *Chest, 108* (4 Suppl), 227S–230S.

Cox, B. J., Fleet, C., & Stein, M. B. (2004). Self-criticism and social phobia in the US national comorbidity survey. *Journal of Affective Disorders, 82,* 227–234.

Crits-Christoph, P., Connolly, M. B., Azarian, K., Crits-Christoph, K., & Shappell, S. (1996). An open trial of brief supportive-expressive psychotherapy in the treatment of generalized anxiety disorder. *Psychotherapy, 33,* 418–430.

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. *Psychotherapy Research, 16,* 268–281.

Crits-Christoph, P., Connolly Gibbons, M. B., 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., Cooper, A., & Luborsky, L. (1988). The accuracy of therapists' interpretations and outcome of dynamic psychotherapy. *Journal of Consulting and Clinical Psychology, 56,* 490–495.

Crits-Christoph, P., Crits-Christoph, K., Wolfpalacio, D., Fichter, M., & Rudick, D. (1995). Supportive-expressive dynamic psychotherapy for generalized anxiety disorder. In J. P. Barber & P. Crits-Christoph (Eds.), *Dynamic therapies for psychiatric disorders: Axis* (pp. 43–83). New York, NY: Basic Books.

Crits-Christoph, P., & Luborsky, L. (1990). Changes in the CCRT perva-

sivenss during psychotherapy. In: L. Luborsky and P. Cris-Christoph (Eds.) *Understanding transference*, 133–146. New York, NY: Basic Books.

Davanloo, H. (1980). *Short-term dynamic psychotherapy*. New York, NY: Jason Aronson.

Diener, M. J., Hilsenroth, M. J., & Weinberger, J. (2007). Therapist affect focus and patient outcomes in psychodynamic psychotherapy: A meta-analysis. *American Journal of Psychiatry, 164,* 936–941.

Durham, R. C., Murphy, T., Allan, T., Richard, K., Treliving, L. R., & Fenton, G. W. (1994). Cognitive therapy, analytic psychotherapy and anxiety management training for generalized anxiety disorder. *British Journal of Psychiatry, 165,* 315–323.

Emmelkamp, P., Benner, A., Kuipers, A., Feiertag, G. A., Koster, H. C., & van Appelddorn, F. J. (2006). Comparison of brief dynamic and cognitive-behavioral therapies in avoidant personality disorder. *British Journal of Psychiatry, 189,* 60–64.

Eng, W., Heimberg, R. G., Hart, T., Schneider, F. R., & Liebowitz, M. R. (2001). Attachment in individuals with social anxiety disorder. *Emotion, 1,* 365–380.

Erickson, D. H., Janeck, A., & Tallman, K. (2007). Cognitive-behavioral group for patients with various anxiety disorders. *Psychiatric Services, 58,* 1205–1211.

Falkenström, F., Granström, F., & Holmqvist, R. (2013). Therapeutic Alliance Predicts Symptomatic Improvement Session by Session. *Journal of Counseling Psycholology, 60,* 317–328.

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. *Behavior Therapy, 43,* 666–678.

Fenichel, O. (1941). *Problems of psychoanalytic technique*. Albany, NY: The Psychoanalytic Quarterly, Inc.

Flückiger, C., Del Re, A. C., Wampold, B. E., Symonds, D., & Horvath, A. O. (2012). How central is the alliance in psychotherapy? A multilevel longitudinal meta-analysis. *Journal of Counseling Psychology, 59,* 10–17.

Freud, A. (1936). *The ego and the mechansism of defense*. New York: International Universities.

Freud, S. (1894). On the grounds for detaching a particular syndrome from neurasthenia under the description anxiety neurosis. In J. Strachey (Ed.), *The standard ed. of the complete psychological works of Sigmund Freud* (Vol. 3, pp. 85–117). London, UK: Hogarth.

Freud, S. (1895). Project for a scientific psychology. In J. Strachey (Ed.), *The standard ed. of the complete psychological works of Sigmund Freud,* Vol *1,* 281–397. London, UK: Hogarth.

Freud, S. (1900). The interpretation of dreams. In J. Strachey (Ed.), *The standard ed. of the complete psychological works of Sigmund Freud* (Vol. 4, pp. 1–338). London, UK: Hogarth.

Freud, S. (1912). The dynamics of transference. In J. Strachey (Ed.), *The standard ed. of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 97–108). London, UK: Hogarth.

Freud, S. (1913). On beginning the treatment. (further recommendations on the technique of psychoanalysis). In J. Strachey (Ed.) *The standard ed. of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 123–144). London, UK: Hogarth.

Freud, S. (1914). Remembering, repeating and working through. In J. Strachey (Ed.), *The standard ed. of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 147–156). London, UK: Hogarth.

Freud, S. (1915). Instincts and their vicissitudes. In J. Strachey (Ed.), *The standard ed. of the complete psychological works of Sigmund Freud* (Vol. 14, pp. 117–140). London, UK: Hogarth.

Freud, S. (1919). Lines of advance in psych-analytic therapy. In J. Strachey (Ed.), *The standard ed. of the complete psychological works of Sigmund Freud* (Vol. 17, pp. 159–168). London, UK: Hogarth.

Freud, S. (1923). The ego and the id. In J. Strachey (Ed.), *The standard ed. of the complete psychological works of Sigmund Freud* (Vol. 19, pp. 12–66). London, UK: Hogarth.

Freud, S. (1926). Inhibitions, symptoms and anxiety. In J. Strachey (Ed.), *The standard ed. of the complete psychological works of Sigmund Freud* (Vol. 20, pp. 12–66). London, UK: Hogarth Press.

Friborg, O., Martinussen, M., Kaiser, S., Overgård, K. T., & Rosenvinge, J. H. (2012). Comorbidity of personality disorders in anxiety disorders: A meta-analysis of 30 years of reearch. *Journal of Affective Disorders*. doi:10.1016/j.jad.2012.07.004

Gabbard, G. O. (1992). Psychodynamics of panic disorder and social phobia. *Bulletin of the Menninger Clinic, 56,* A3–A13.

Gabbard, G. O. (2000). *Psychodynamic psychiatry in clinical practice*. Washington, DC: American Psychiatric Press.

Gabbard, G. O. (2004). *Long-term psychodynamic psychotherapy*. Washington, DC: American Psychiatric Publishing, Inc.

Gabbard, G. O. (2006). *Editorial. When is transference work useful in dynamic psychotherapy? American Journal of Psychiatry, 163,* 1667–1669.

Garcia, M. S. (2004). Effectiveness of cognitive-behaviopral grup therapy in patients with anxiety disorders. *Psychology in Spain, 8,* 89–97.

Gearing, R. E., Schwalbe, C. S. J., Lee, R., & Hoagwood, K. E. (2013). The effectiveness of bosster sessions in CBT treatment for child and adolescent mood and anxiety disorders. *Depression and Anxiety*. doi:10.1002/da.22118

Gibbons, M. B., Thompson, S. M., Scott, K., Schauble, L. A., Mooney, T., Thompson, D., Green, P., MacArthur, M. J., & 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.

Gilbert, P. (2001). Evolution and social anxiety. The role of attraction, social competition, and social hierarchies. *Psychiatric Clinics of North America, 24,* 723–751.

Goldman, R. N., Greenberg, L. S., & Angus, L. (2006). The effects of adding emotion-focused interventions to the client-centered relationship conditions in the treatment of depression. *Psychotherapy Research, 16,* 537–549.

Goldman, R. N., Greenberg, L. S., & Pos, A. E. (2005). Depth of emotional experience and outcome. *Psychotherapy Research, 15,* 248–260.

Grant, B. F., Hasin, D. S., Blanco, C., Stinson, F. S., Chou, S. P., Goldstein, R. B., . . . Huang, B. (2005). The epidemiology of social anxiety disorder in the United States: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Journal of Clinincal Psychiatry, 66,* 1351–1361.

Greenson, R. R. (1967). *The techniques and practice of psychoanalysis*. New York, NY: International Universities Press.

Gustavsson, A., Svensson, M., Jacobi, F., Allgulander, C., Alonso, J., Beghi, E., . . . Olesen, J. (2011). Costs of disorders of the brain in Europe 2010. *European Neuropsychopharmacology, 21,* 718–779.

Guthrie, E., Kapur, N., Mackway-Jones, K., Chew-Graham, C., Moorey, J., Mendel, E., . . . Tomenson, B. (2001). Randomised controlled trial of brief psychological intervention after deliberate self poisoning. *British Medical Journal, 323,* 135–138.

Guthrie, E., Moorey, J., Margison, F., Barker, H., Palmer, S., McGrath, G. . . . Creed, F. (1999). Cost-effectiveness of brief psychodynamic-interpersonal therapy in high utilizers of psychiatric services. *Archives of General Psychiatry, 56,* 519–526.

Guyatt, G., Sacket, D. L., Sinclair, J. C., Hayward, R., Cook, D. J., & Cook, R. (1995). User's guides to the medical literature. IX. A method for grading health care recommendations. *Journal of the American Medical Association, 274,* 1800–1804.

Hellerstein, D. J., Rosenthal, R. N., Pinsker, H., Wallner Samstag, L., Muran, J. C., & Winston, A. (1998). A randomized prospective study

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

comparing supportive and dynamic therapies. Outcome and alliance. *Journal of Psychotherapy Research and Practice, 7,* 261–271.

Henning, E. R., Turk, C. L., Mennin, D. S., Fresco, D. M., & Heimberg, R. G. (2000). Impairment and quality of life in individuals with generalized anxiety disorder. *Depression and Anxiety, 24,* 342–349.

Higgins, J. P., & Green, S. (2009). *Cochrane handbook for systematic reviews of interventions*. New York, NY: Wiley.

Hirsch, C. R., Clark, D. M., Mathews, A., & Williams, R. (2003). Self-images play a causal role in social phobia. *Behavior Research and Therapy, 41,* 909–921.

Hoffmann, S. O. (2003). Soziale Ängste: Die psychodynamische Perspektive in Konzeptbildung und Behandlungsansätzen [Social anxieties: The psychodynamic perspective in conceptualization and treatment approaches.]. *Psychotherapie im Dialog, 4,* 32–41.

Hoffmann, S. O. (2012, in press). Menschliche "Angstbeisser". Zur Abwehr von Ängsten durch aggressives Verhalten. [Human "Angstbeisser". The defense against anxiety by aggressive behavior]. *Persönlichkeitsstörungen – Therapie und Therapie*.

Høglend, P., Amlo, S., Marble, A., Bøgwald, K. P., Sørbye, O., Sjaastad, M. C., & Heyerdahl, O. (2006). Analysis of the patient-therapist relationship in dynamic psychotherapy: An experimental study of transference interpretations. *American Journal of Psychiatry, 163,* 1739–1746.

Høglend, P., Bøgwald, K. P., Amlo, S., Marble, A., Ulberg, R., Sjaastad, M. C., . . . Johansson, P. (2008). Transference interpretations in dynamic psychotherapy: Do they really yield sustained effects? *American Journal of Psychiatry, 165,* 763–771.

Høglend, P., Hersoug, A. G., Bøgwald, K. P., Amlo, S., Marble, A., Sørbye, Ø., . . . Crits-Christoph, P. (2011). Effects of transference work in the context of therapeutic alliance and quality of object relations. *Journal of Consulting and Clinical Psychology, 79,* 697–706.

Horvath, A. O., Del Re, A. C., & Fluckiger, C. (2011). Alliance in individual therapy. *Psychotherapy, 48,* 9–10.

Insel, T. R. (2009). Translating scientific opportunity into public health impact: A strategic plan for research on mental illness. *Archives of General Psychiatry, 66,* 128–133.

Jacobson, E. (1953). The affects and their pleasure-unpleasure qualities in relation to the psychic discharge process. In R. Loewenstein (Ed.), *Drives, affects, behavior*. New York, NY: International Universities Press.

Johansen, P. Ø., Krebs, T. S., Svartberg, M., Stiles, T. C., & Holen, A. (2011). Change in defense mechanisms during short-term dynamic and cognitive therapy in patients with cluster C personality disorders. *Journal of Nervous and Mental Disease, 199,* 712–715.

Kernberg, O. F. (1970). Psychoanalytic classification of character pathology. *Journal of the American Psychoanalytic Association, 18,* 800–822.

Kernberg, O. F. (1975). *Borderline conditions and pathological narcissism*. New York, NY: Aronson.

Kernberg, O. F. (1976). *Object relations theory and clinical psychoanalysis*. New York, NY: Aronson.

Kernberg, P. (1994). Mechanisms of Defense. Development and research perspectives. *Bulletin of the Menninger Clinic, 58,* 55–87.

Kessler, R. C., Chiu, W. T., Demler, O., Merikangas, K. R., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month *DSM–IV* disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62,* 617–627.

Killingmo, B. (1989). Conflict and defecit: Implications for technique. *International Journal of Psychoanalysis, 70,* 65–79.

Klein, M. (1946). Notes on some schizoid mechanisms. *International Journal of Psychoanalysis, 27,* 99–110.

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. *European Psychiatry, 23,* 567–574.

Knijnik, D. Z., Kapczinski, F., Chachamovich, E., Margis, R., & Eizirik, C. L. (2004). Psychodynamic group treatment for generalized social phobia. *Revista Brasileira de Psiquiatria, 26,* 77–81.

Knijnik, D. Z., Salum, G. A., Blanco, C., Moraes, C., Hauck, S., Mombach, C., . . . Eizirik, C. L. (2009). Defense style changes with addition of psychodynamic group therapy to clonazepam insocial anxiety disorder. *Journal of Nervous and Mental Disease, 197,* 547–551.

Kohut, H. (1971). *The analysis of the self*. New York, NY: International Universities Press.

Kohut, H. (1977). *The restoration of the self*. New York, NY: International Universities Press.

König, K. (1997). *Self-analysis for analysts*. London and Bristol, PA: Jessica Kingsley Publishers.

Leichsenring, F. (2004). Randomized controlled vs. naturalistic studies. A new research agenda. *Bulletin of the Menninger Clinic, 68,* 137–151.

Leichsenring, F., Beutel, M., & Leibing, E. (2007). Psychodynamic psychotherapy for social phobia: A treatment manual based on supportive-expressive therapy. *Bulletin of the Menninger Clinic, 71,* 56–83.

Leichsenring, F., Hoyer, J., Beutel, M., Herpertz, S., Hiller, W., Irle, E., . . . Leibing, E. (2009). The Social Phobia Psychotherapy Research Network (SOPHO-NET) - The first multi-center randomized controlled trial of psychotherapy for social phobia: Rationale, methods and patient characteristics. *Psychotherapy and Psychosomatics, 78,* 35–41.

Leichsenring, F., Klein, S., & Salzer, S. (in press, a). The efficacy of psychodynamic psychotherapy in specific mental disorders – a 2013 update of empirical evidence. *Contemporary Psychoanalysis*.

Leichsenring, F., Klein, S., & Salzer, S. (in press, b). Evidence for psychodynamic therapy in anxiety disorders. In P. Emmelkamp & T. Ehring (Eds.), *International handbook of anxiety disorders: Theory, research, practice Vol II*. New York, NY: Wiley-Blackwell.

Leichsenring, F., & Leibing, E. (2007). Fair play please! Letter to the Ed. *British Journal of Psychiatry, 190,* 80.

Leichsenring, F., & Leibing, E. (2007). Supportive-expressive psychodynamic psychotherapy: An update. *Current Psychiatry Reviews, 3,* 57–66.

Leichsenring, F., Masuhr, O., Jaeger, U., Dally, A., & Streeck, U. (2010). The effectiveness of psychoanalytic-interactional psychotherapy (PIP) in borderline personality disorder. *Bulletin of the Menninger Clinic, 74,* 206–218.

Leichsenring, F., Salzer, S., Hilsenroth, M., Leibing, E., Leweke, F., & Rabung, S. (2011). Treatment integrity: An unresolved issue in psychotherapy research. *Current Psychiatry Reviews, 7,* 313–321.

Leichsenring, F., Salzer, S., Jager, U., Kächele, U., Kreische, R., Leweke, F., . . . Leibing, E. (2009). Short-term psychodynamic psychotherapy and cognitive-behavioral therapy in generalized anxiety disorder: A randomized controlled trial. *American Journal of Psychiatry, 166,* 875–881.

Leichsenring, F., Winkelbach, C., & Leibing, E. (2005). Psychoanalytically oriented focal therapy of generalized anxiety disorder – a manual [Psychoanalytisch orientierte Fokaltherapie der Generalisierten Angststörung – ein Manual]. *Psychotherapeut, 50,* 258–364.

Leichsenring, F., Salzer, S., Beutel, M., von Consbruch, K., Herpertz, S., Hiller, W., . . . Leibing, E. (2013). Psychodynamic therapy and cognitive therapy in social anxiety disorder – a multi-center randomized controlled trial. *American Journal of Psychiatry, 170,* 759–767.

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, NY: Basic Books.

Luborsky, L. (1990). The relationship anecdotes paradigm (RAP) interview as a versatile source of narratives. In L. Luborsky & P. Crits-Christoph (Eds.), *Understanding transference: The CCRT method* (pp. 102–113). New York, NY: Basic Books.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

Luborsky, L., Barber, J. P., & Crits-Christoph, P. (1990). Theory based research for understanding the process of dynamic psychotherapy, *Journal of Consulting and Clinical Psychology, 58,* 281–287.

Lutwak, N., & Ferrari, J. R. (1997). Understanding shame in adults: Retrospective perceptions of parental-bonding during childhood. *Journal of Nervous and Mental Disease, 185,* 595–598.

Mahler, M. S., Pine, F., & Bergmann, A. (1975). *The psychological birth of the human infant: Symbiosis and individuation*. New York, NY: Basic Books.

Malan, D. (1976). *The frontier of brief psychotherapy: An example of the convergence of research and clinical practice*. New York, NY: Plenum Press.

Malan, D. (1979). *Individual psychotherapy and the science of psychodynamics*. London, UK: Butterworth.

Mansell, W., Harvey, A., Watkins, E., & Shafran, R. (2009). Conceptual foundations of transdiagnostic approaches to CBT. *Journal of Cognitive Psychotherapy, 23,* 6–19.

McCullough, L., Kuhn, N., Andrews, S., Kaplan, A., Wolf, J., & Hurley, C. L. (2003). *Treating affect phobia. A manual for short-term dynamic psychotherapy*. New York, NY: Guilford Press.

McCullough, L., & Osborn, K. A. (2004). Sort term dynamic psychotherapy goes to Hollywood: The treatment of performance anxiety in the cinema. *Journal of Clinical Psychology, 60,* 841–852.

McCullough-Vaillant, L. (1997). *Changing character*. New York, NY: Basic Books.

McEvoy, P. M., & Nathan, P. (2007). Effectiveness of cognitive behaviour therapy for diagnostically heterogeneous groups: A benchmarking study. *Journal of Consulting and Clinical Psychology, 75,* 344–350.

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. *Behaviour Research and Therapy, 47,* 946–953.

Menninger, K., & Holzman, P. S. (1973). *The theory of psychoanalytic techniques* (2nd ed.). New York, NY: Basic Books.

Miller, L. A., Taber, K. H., Gabbard, G. O., & Hurley, R. A. (2005). Neural underpinning of fear and its modulation: implications for anxiety disorders. *Journal Neuropsychatry Clinical Neuroscience, 17,* 1–6.

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. *American Journal of Psychiatry, 164,* 265–272.

Milrod, B., Leon, A. C., Busch, F., Cooper, A., & Shapiro, T. (1997). *Manual of panic-focused psychodynamic psychotherapy*. Arlington, VA: American Psychiatric Publication.

Nathan, P. E., & Gorman, J. M. (Eds.). (2002). *A guide to treatments that work* (2nd ed.). New York, NY: Oxford University Press.

Norton, P. J. (2012). A randomized clinical trial of transdiagnostic cognitive-behavioral treatments for anxiety disorder by comparison to relaxation training. *Behavior Therapy, 43,* 506–517.

Norton, P. J., & Phillip, L. M. (2008). Transdiagnostic approaches to the treatment of anxiety disorders: A quantitative review. *Psychotherapy Theory, Research, Practice, Training, 45,* 214–226.

Ogrodniczuk, J. S., Piper, W. E., Joyce, A. S., & McCallum, M. (1999). Transference interpretations in short-term dynamic psychotherapy. *Journal of Nervous and Mental Disease, 187,* 571–578.

Orne, M., & Wender, P. (1968). Anticipatory socialization for psychotherapy: Method and rationale. *American Journal of Psychiatry, 124,* 1202–1212.

Öst, L.-G. (2008). Cognitive behavior therapy for anxiety disorders: 40 years of progress. *Nordic Journal of Psychiatry, 47,* 5–10.

Palmer, R., Nascimento, L. N., & Fonagy, P. (2013). The state of evidence for psychodynamic psychotherapy for children and adolescents. *Child and Adolescent Psychiatric Clinics of North America, 22,* 149–241.

Persons, J. B., & Silberschatz, G. (1998). Are results of randomized trials useful to psychotherapists? *Journal of Consulting and Clinical Psychology, 66,* 126–135.

Piper, W. E., Azim, H. F., Joyce, A. S., & McCallum, M. (1991). Transference interpretations, therapeutic alliance, and outcome in short-term individual psychotherapy. *Archives of General Psychiatry, 48,* 946–953.

Piper, W. E., Azim, H. F., McCallum, M., & Joyce, A. S. (1990). Patient suitability and outcome in short-term individual psychotherapy. *Journal of Consulting and Clinical Psychology, 58,* 475–481.

Pos, A. E., Greenberg, L. S., Goldman, R. N., & Korman, M. (2003). Emotional processing during experiential treatment of depression. *Journal of Consulting and Clinical Psychology, 71,* 1007–1016.

Reich, W. (1929). The genital character and the neurotic character. In R. Fliess (Ed.), *The psycho-analytic reader*. London, UK: Hogarth, 1950.

Reich, W. (1933). *Character analysis*. New York, NY: Orgone Institute, 1945.

Roth, A. D., & Parry, G. (1997). The implications of psychotherapy research for clinical practice and service development: Lessons and limitations. *Journal of Mental Health, 6,* 367–380.

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 Journal of Psychiatry, 56,* 503–508.

Sandler, J., Dare, C., & Holder, A. (2002). *The patient and the analyst.* London, UK: Karnac.

Schanche, E., Stiles, T. C., McCullough, L., Svartberg, M., & Nielsen, G. H. (2011). The relationship between activating affects, inhibitory affects, and self-compassion in patients with Cluster C personality disorders. *Psychotherapy, 48,* 293–303.

Schlesinger, H. (1969). Diagnosis and prescription for psychotherapy. *Bulletin of the Menninger Clinic, 33,* 269–278.

Schlesinger, H. (1977). The responsibility of the psychoanalyst for analytic and therapeutic change. In A. Appelbaum (recorder), *The transactions of the Topeka psychoanalytic society*. *Bulletin of the Menninger Clinic, 41,* 269–306.

Schlesinger, H. (1983). Personal communication to Lester Luborsky. Cited form Luborsky, L. (1984). *Principles of psychoanalytic psychotherapy. Manual for supportive-expressive treatmen* (p. *72*). New York, NY: Basic Books.

Schmidt, N. B., Buckner, J. D., Pusser, A., Woolaway-Bickel, K., Preston, J. L., & Norr, A. (2012). Randomized Controlles Trial of False Safty Behavior Elimination Therapy: A Unified Cognitive Behavioral Treatment for Anxiety Psychopathologie. *Behavior Therapy, 43,* 518–532.

Shear, M. K., Cooper, A. M., Klerman, G. L., Busch, F., & Shapiro, T. (1993). A psychodynamic model of panic disorder. *American Journal of Psychiatry, 150,* 859–866.

Shefler, G., Dasberg, H., & Ben-Shakar, G. (1995). A randomized controlled outcome and follow-up study of Mann's time limited psychotherapy. *Journal of Consulting and Clinical Psychology, 63,* 585–593.

Slavin-Mulford, J., & Hilsenroth, M. J. (2012). Evidence-based psychodynamic treatments for anxiety disorders; a review. In R. A. Levy, J. S. Ablon, & H. Kaechele, (Eds.), *Psychodynamic psychotherapy research: Evidence-based practice and practice-based evidence* (pp. 117–137). New York, NY: Springer Press.

Slavin-Mulford, M. A., Hilsenroth, M., Weinberger, J., & Gold, J. (2011). Therapeutic interventions relatd to outcome in psychodynamic psychotherapy for anxiety disorder patients. *Journal of Nervous and Mental Disease, 199,* 214–221.

Stricker, G. (2006). Using homework in psychodynamic psychotherapy. *Journal of Psychotherapy Integration, 16,* 219–237.

Svartberg, M., Stiles, T., & Seltzer, M. (2004). Randomized, controlled trial of the effectiveness of short-term dynamic psychotherapy and cognitive therapy for Cluster C personality disorders. *American Journal of Psychiatry, 161,* 810–817.

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

Town, J. M., Hardy, G. E., McCullough, L., & Stride, C. (2012). Patient affect experiencing following therapist interventions in short-term dynamic psychotherapy. *Psychotherapy Research, 22,* 208–219.

Ulberg, R., Høglend, P., Marble, A., & Johansson, P. (2012). Women respond more favorably to transference intervention than men: A randomized study of long-term effects. *Journal of Nervous and Mental Disease, 200,* 223–229.

Ulvenes, P. G., Berggraf, L., Hoffart, A., Stiles, T. C., Svartberg, M., McCullough, L., & Wampold, B. E. (2012). Different processes for different therapies: Therapist actions, therapeutic bond, and outcome. *Psychotherapy, 49,* 291–302.

Vertue, F. M. (2003). From adaptive emotion to dysfunction: An attachment perspective on social anxiety disorder. *Personality and Social Psychology Review, 7,* 170–191.

Wallerstein, R. (1989). The psychotherapy research project of the Menninger Foundation: An overview. *Journal of Consulting and Clinical Psychology, 57,* 195–205.

Westen, D., Novotny, C. M., & Thompson-Brenner, H. (2004). The empirical status of empirically supported psychotherapies: Assumptions, findings, and reporting in controlled clinical trials. *Psychological Bulletin, 130,* 631–663.

Westra, H. A. (2012). *Motivational interviewing in the treatment of anxiety*. New York: Guilford Press.

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. *Journal of Anxiety Disorders, 23,* 1106–1117.

Westra, H. A., & Dozois, D. J. A. (2008). Integrating motivational interviewing into the treatment of anxiety. In H. Arkowitz, H. A. Westra, W. R. Miller, & S. Rollnick (Eds.), *Motivational interviewing in the treatment of psychological problems* (pp. 26–56). New York, NY: The Guilford Press.

Whisman, M. A. (1990). The efficacy of booster maintenance sessions in behaviour therapy: Review and methodological critique. *Clinical Psychology Review, 10,* 155–170.

Wiborg, I. M., & Dahl, A. A. (1996). Does brief dynamic psychotherapy reduce the relapse rate of panic disorder? *Archives of 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. *Depression and Anxiety, 27,* 882–890.

Winston, A., Laikin, M., Pollack, J., Samstag, L. W., McCullough, L., & Muran, J. C. (1994). Short-term psychotherapy of personality disorders. *American Journal of Psychiatry, 151,* 190–194.

Wöller, W., Leichsenring, F., Leweke, F., & Kruse, J. (2012). Psychodynamic psychotherapy for posttraumatic stress disorder related to childhood abuse – principles for a treatment manual. *Bulletin of the Menninger Clinic, 76,* 69–93.

Zerbe, K. J. (1990). Through the storm: Psychoanalytic theory in the psychotherapy of the anxiety disorders. *Bulletin of the Menninger Clinic, 54,* 171A3–183.

Received December 21, 2012
Revision received May 7, 2013
Accepted May 14, 2013 ■

This document is copyrighted by the American Psychological Association or one of its allied publishers.
This article is intended solely for the personal use of the individual user and is not to be disseminated broadly.

E-Mail Notification of Your Latest Issue Online!

Would you like to know when the next issue of your favorite APA journal will be available online? This service is now available to you. Sign up at http://notify.apa.org/ and you will be notified by e-mail when issues of interest to you become available!