

# Review

## CONCEPTUAL BACKGROUND, DEVELOPMENT, AND PRELIMINARY DATA FROM THE UNIFIED PROTOCOL FOR TRANSDIAGNOSTIC TREATMENT OF EMOTIONAL DISORDERS

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*Anxiety and mood disorders are common, chronic, costly, and characterized by high comorbidity. The development of cognitive behavioral approaches to treating anxiety and mood disorders has left us with highly efficacious treatments that are increasingly widely accepted. The proliferation of treatment manuals targeting single disorders, sometimes with trivial differences among them, leaves the mental health professional with no clear way to choose one manual over another and little chance of ever becoming familiar with most of them, let alone trained to competence in their delivery. Deepening understanding of the nature of emotional disorders reveals that commonalities in etiology and latent structures among these disorders supersedes differences. Based on empirical evidence from the domains of learning, emotional development and regulation, and cognitive science, we have distilled a set of psychological procedures that comprise a unified intervention for emotional disorders. The Unified Protocol (UP) is a transdiagnostic, emotion-focused cognitive behavioral treatment, which emphasizes the adaptive, functional nature of emotions, and seeks to identify and correct maladaptive attempts to regulate emotional experiences, thereby facilitating appropriate processing and extinction of excessive emotional responding to both internal (somatic) and external cues. The treatment components of the UP are briefly outlined. Theory and rationale supporting this new approach are described along with some preliminary evidence supporting its efficacy. Implications for the treatment of emotional disorders using the UP are discussed. Depression and Anxiety 27:882–890, 2010. © 2010 Wiley-Liss, Inc.*

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**Key words:** *anxiety disorders; treatment; Unified Protocol*

### INTRODUCTION

In the 1960s, psychological approaches to treating emotional disorders began to be derived from basic psychological science, specifically from theories and data pertaining to learning, emotional development and regulation and, somewhat later, cognitive science. By the 1980s, investigators began to focus on mechanisms of action and theories of behavior change. In considering exposure procedures, it was clear that “exposure” was simply a dry theoretical description of a process, with no heuristic value. Various theoretical

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accounts of fear reduction began to be investigated, such as habituation and extinction as well as more cognitively based accounts that targeted constructs, such as cognitive schemas, self-efficacy, and emotional processing. These theories of behavior change and increased knowledge of psychopathology led directly to new interventions. For instance, in our work with the treatment of panic disorder with agoraphobia (PD/A), interoceptive exposure was developed as an adjunct to situational exposure based on the recognition that the context of anxiety and fear was internal as well external.<sup>[1]</sup> In addition to exposure-based procedures, cognitive therapy, first developed to treat depression, became a staple among treatments for anxiety disorders.<sup>[2,3]</sup> Research on outcomes of individual cognitive behavioral therapy (CBT) protocols targeting specific anxiety, mood, and related disorders began to appear.<sup>[4]</sup> It soon became apparent that meaningful research studying these new treatments required the generation of detailed individual therapeutic manuals necessary to specify and manipulate an independent variable. Psychotherapeutic treatments were thus increasingly characterized by individual protocols that contained specific strategies, such as cognitive restructuring, coping skills, and situational and interoceptive exposure procedures, with each protocol tailored to target specific DSM defined disorders. These treatments were then tested empirically and found efficacious in a variety of delivery formats, uses, and settings.<sup>[5–11]</sup> It is fair to say that these findings have had a substantial impact in that public health authorities have allocated billions of dollars for training and dissemination of these treatments.<sup>[12]</sup>

Nevertheless, a number of significant limitations to current treatments exist. There are still a considerable number of patients who do not respond well to current psychological treatments, and the reasons for their lack of response are not yet known. The proliferation of manualized treatments has added another layer of complexity. Multiple manuals and protocols have been developed for each *DSM-IV* disorder, many of them with their own flavors or twists, but most of them reflecting the “copycat” phenomena present in pharmacological development. For example, more than 15 published manuals exist for panic disorder alone, most with only trivial alterations (and no empirical support justifying these changes), and it is sometimes difficult to choose among them. In addition, because the protocols are somewhat complex, dissemination of even one treatment protocol to providers is an obstacle to delivery of evidence-based treatment.<sup>[12,13]</sup> When a clinician completes the required months of training, they are certified to treat only one diagnostic category (e.g., PD/A, posttraumatic stress disorder [PTSD]) with uncertain abilities to treat or even address common patterns of accompanying comorbidity (e.g., depression, obsessive-compulsive disorder [OCD]). Thus, there are far too many published manuals targeting single disorders, no good way to choose

among them, and little chance of even becoming familiar with most of them, let alone trained to competence. This state of affairs is substantially diminishing the public health significance of the current evidence-based psychological treatments.

## COMMONALITIES IN EMOTIONAL DISORDERS

Empirical conceptions of the anxiety and mood disorders are emerging that emphasize their commonalities rather than their differences.<sup>[14–16]</sup> Major developments in at least four areas support these conceptions.

## COMORBIDITY AND OVERLAP AMONG DISORDERS

First, studies of phenomenology and nosology, with a particular focus on comorbidity, suggest considerable overlap among disorders. At the diagnostic level, this is most evident in high rates of current and lifetime comorbidity.<sup>[17–22]</sup> In a study of 1,127 patients presenting at our clinic, 55% of patients with a principal anxiety disorder had at least one additional anxiety or mood disorder at the time of assessment, and this rate increased to 76% when lifetime diagnoses were considered.<sup>[18]</sup> Further evidence for the overlap among anxiety and mood disorders emerges from observations that psychological treatments for a given anxiety disorder produce improvement, sometimes significant improvement in at least some additional comorbid anxiety or mood disorders that are not specifically addressed, based on the assessment immediately post-treatment.<sup>[23–26]</sup> But these outcomes are uneven and may not be durable in all instances,<sup>[24]</sup> perhaps because cross-cutting unified treatment principles were not utilized. In any case, whether this broad-based improvement, short term or long term, represents the generalization of elements of treatment to independent facets of both disorders or a way of effectively addressing “core” features of emotional disorders is not significant to our purpose here. In both cases, the efficiency of a unified treatment approach would be suggested. More importantly, one intriguing explanation is that this pattern of comorbidity argues for the existence of what has been called earlier a “general neurotic syndrome.”<sup>[16,27–30]</sup> Under this conceptualization, heterogeneity in the expression of emotional disorder symptoms (e.g., individual differences in the prominence of social anxiety, panic attacks, anhedonia, etc.) is regarded as phenotypic variation in the manifestation of a broader syndrome.

## EVIDENCE OF DISORDER OVERLAP FROM AFFECTIVE NEUROSCIENCE

Second, recent research from affective neuroscience lends support to the potential existence of a broader based, more fundamental syndrome. Some findings

from this literature suggest hyperexcitability of limbic structures, coupled with disrupted or limited inhibitory control by cortical structures, may distinguish individuals with anxiety and mood disorders from healthy controls, and may be one possible explanation for the increased intensity and frequency of negative emotional experience among individuals with anxiety and mood disorders.<sup>[31–34]</sup> Several recent studies seem to support the idea that increased “bottom up” processing through amygdala overactivation, coupled with dysregulation of cortical inhibition of amygdala responses, may be characteristic across these disorders, as evidenced in studies of social anxiety disorder (SAD),<sup>[35–37]</sup> post-traumatic stress disorder (PTSD),<sup>[38]</sup> generalized anxiety disorder (GAD),<sup>[39,40]</sup> specific phobia,<sup>[41,42]</sup> and depression.<sup>[43,44]</sup> In addition, increased amygdala activation has been found to distinguish individuals high in the personality dimension of neuroticism,<sup>[45]</sup> which may represent a unifying diathesis for anxiety and mood disorders (see below). Exaggerated amygdala responses have also been linked to a functional polymorphism in the promoter region of the serotonin transporter gene (5HTTPR), linking the presence of the s/s genotype (presence of two short alleles) to greater magnitude of amygdala responses to emotional stimuli,<sup>[46,47]</sup> and reductions in positive connectivity between the amygdala and ventromedial prefrontal cortex.<sup>[48]</sup> This suggests more intense limbic responses and less efficient regulatory feedback between cortical and limbic structures. Further, the presence of this s/s allele functional polymorphism has been found to be associated with neuroticism and trait anxiety.<sup>[49]</sup> Time will tell whether these commonalities better account for the nature of emotional disorders than unique neurobiological factors associated with single DSM diagnoses.<sup>[50]</sup>

## LATENT STRUCTURE OF EMOTIONAL DISORDERS

Third, another thread of evidence emerges from quantitative approaches using structural equation modeling to examine the full range of anxiety and mood disorders without the constraints of artificial categories, given their strong relationship and potential overlap.<sup>[29,51–53]</sup> We have been studying this question for the last 10 years<sup>[15,16,29,54]</sup> and have confirmed, with some modifications, the tripartite model of emotional disorders first proposed by Clark and Watson,<sup>[52]</sup> which places emphasis on dimensions corresponding to broader biologically and environmentally based constructs of temperament and personality (e.g., neuroticism/negative affectivity).<sup>[55]</sup>

Two genetically based core dimensions of temperament have been posited as instrumental in the etiology and course of the emotional disorders: *neuroticism/negative affectivity* and *extraversion/positive affectivity*. Extensive evidence indicates these constructs are strongly heritable<sup>[56–60]</sup> and relatively stable over

time.<sup>[61–63]</sup> Whereas neuroticism/negative affect is relevant to the full range of emotional disorders, the contribution of extraversion/positive affect seems to be more specific to unipolar depression, SAD, agoraphobia, and mania, with depression, SAD, and agoraphobia associated with low extraversion/positive affect and mania with high extraversion/positive affect.<sup>[15,29,63–66]</sup> Although the theoretical frameworks were developed independently (cf. references<sup>[67,68]</sup>), neuroticism/negative affect and extraversion/positive affect are closely related to Gray's<sup>[69]</sup> constructs of behavioral inhibition and behavioral activation, respectively, at both the conceptual and empirical levels.<sup>[62,70–72]</sup> A substantial literature underscores the roles of these constructs in accounting for the onset, overlap, and maintenance of anxiety and depression.<sup>[15,29,62,73]</sup> For instance, in a large sample of outpatients, Brown et al.<sup>[29]</sup> found that virtually all the considerable covariance among latent variables corresponding to the *DSM-IV* constructs of unipolar depression (DEP), SAD, GAD, OCD, and PD/A was explained by the higher order dimensions of negative affect and positive affect (bipolar depression was not included). Although the results were consistent with the notion of neuroticism/negative affect as a broadly relevant dimension of vulnerability, results indicated the *DSM-IV* disorders were differentially related to negative affect, with DEP and GAD evidencing the strongest associations.<sup>[15,29]</sup> In accord with a reformulated hierarchical model of anxiety and depression,<sup>[29]</sup> and consistent with the results reported above, positive affect was predictive of DEP and SAD only. These findings have recently been extended by our research team, but require further extension to emotional disorders comorbid with psychotic or externalizing disorders.<sup>[15,16,74]</sup>

## ETIOLOGY

Fourth, current conceptual models assert that dimensions of temperament do not act alone in determining the etiology, course, and complications of emotional disorders.<sup>[14,65,75,76]</sup> For instance, we<sup>[14,77,78]</sup> have formulated a triple vulnerability model of emotional disorders, which draws from and integrates the rich literatures of genetics, personality, cognitive science, neuroscience, and emotion and learning theories. This model specifies the existence of a generalized biological vulnerability to experience anxiety consisting of a well-established genetic contribution to this diathesis accounting for approximately 30–50% of the variance. In addition, a generalized psychological vulnerability emerges from early childhood experience characterized by a stressful unpredictable environment and/or the influence of specific parenting styles described in detail in the attachment theory literature that inhibit the development of effective coping procedures and the emergence of self-efficacy.

These early experiences lead to a general sense of unpredictability and uncontrollability over life events that, along with elevated sympathetic nervous system arousal, form the core of the process of anxiety.<sup>[14]</sup> If these two generalized or diatheses line up, the individual is at increased risk for experiencing generalized anxiety and/or depression in the context of triggering stressful events.<sup>[51,78]</sup> But a third diatheses, referred to as a specific psychological vulnerability, comes into play in the form of learning a particular focus for anxiety, or learning that some situations, objects, or internal somatic states are potentially dangerous even if objectively they are not. These early learning experiences can be as straightforward as watching parents model severe fears of specific objects or situations, such as small animals (e.g., as in specific phobia), or more subtle, such as experiencing heightened attention from caregivers to the potential danger of experiencing unexplained somatic sensations (e.g., as in PD/A or hypochondriasis). We have proposed that these specific foci of anxiety represent the disorder-specific symptoms that may be trivial variations in the manifestation of a broader underlying syndrome.

One may notice that the two generalized vulnerabilities, biological and psychological, describe a more stable disposition to experience anxiety, and thus could be considered more accurately as a temperament. Indeed, we consider anxiety in this regard as simply the expression of the temperament of neuroticism/behavioral inhibition (N/BI) with the addition, in many cases, of a specific focus (or several specific foci) dictated by the learning experiences that comprise the third vulnerability. Evidence for this relationship, presented in detail elsewhere, provides somewhat less support at present for the third (specific) vulnerability than for the two generalized vulnerabilities.<sup>[14,78]</sup> If this is the case, a unified treatment approach that moves beyond disorder-specific symptoms and targets common underlying vulnerabilities may lead to more enduring treatment effects.

In summary, the considerable overlap among anxiety and mood disorders, as evidenced by high rates of diagnostic comorbidity, some generalization of treatment response, common patterns of neural activation, quantitative approaches highlighting temperamental dimensions, and similar etiological processes suggests that commonalities among anxiety and mood disorders may supercede differences.<sup>[14,78]</sup> If this is the case, then a unified treatment protocol cutting across current diagnostic categories to address core features of the anxiety disorders and mood disorders could be a more parsimonious and, perhaps, powerful option than current single diagnosis treatment protocols.

## PROTOCOL DEVELOPMENT

The development of the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders (UP) began with the distillation of key principles from

traditional empirically supported CBT treatments,<sup>[1,2,79]</sup> integrated with the advances in research on emotion regulation and dysregulation.<sup>[80–84]</sup> It is important to note that the UP continues to emphasize the fundamental principles of traditional CBT as applied to emotional disorders, such as extinction learning, through the prevention of cognitive and behavioral avoidance strategies, behavioral, emotional and interoceptive exposure, and the identification and modification of maladaptive cognitions.

Although it has roots in traditional cognitive behavioral principles, the UP is unique in the particular emphasis placed on the way individuals with emotional disorders experience and respond to their emotions. For example, the UP expands on the traditional practices used for patients with panic disorder via interoceptive exposure,<sup>[77,84]</sup> to include exposure to and confrontation of the somatic aspects of uncomfortable emotions and teaches patients to respond to those emotions more adaptively. This is done in addition to traditional strategies focusing on external contextual cues associated with the emotional disorder (e.g., performance demands in SAD, worry triggers in GAD). By focusing on the patient's particular emotional experience, the UP emphasizes the adaptive functional nature of emotions, facilitates greater tolerance of intense emotions, and seeks to identify and correct maladaptive attempts to regulate emotional experiences.

## COMPONENTS OF TREATMENT

Currently, the UP consists of eight modules with five of these modules forming the core components of treatment (see Table 1). The modular focus allows various portions of the treatment to be expanded or shortened as appropriate for a given patient. The following is a basic description of the modules:

The first treatment module, *Motivation Enhancement*, focuses on increasing the patient's readiness and motivation for behavior change and fostering the patient's self-efficacy or belief in his or her ability to successfully achieve change. Patients complete a "Decisional Balance" exercise weighing the pros and

**TABLE 1. Modules of the unified protocol for transdiagnostic treatment of emotional disorders**

Module	Title
1	Motivation Enhancement
2	Psychoeducation and Treatment Rationale
3	Emotion Awareness Training <sup>a</sup>
4	Cognitive Reappraisal <sup>a</sup>
5	Emotion Driven Behaviors and Emotional Avoidance <sup>a</sup>
6	Awareness and Tolerance of Physical Sensations <sup>a</sup>
7	Interoceptive and Situational Exposure <sup>a</sup>
8	Relapse Prevention

<sup>a</sup>Indicates core UP module.

cons of changing versus staying the same. Patients also articulate goals for treatment, with a focus on making goals more concrete, and identify possible steps for achieving their treatment goals. This module was incorporated into the UP based on research conducted by Westra et al., illustrating the efficacy of such techniques as an adjunct in the treatment of anxiety disorders,<sup>[85]</sup> and is based heavily in the principles and techniques used in Motivational Interviewing.<sup>[86]</sup> Although the UP typically dedicates one session to motivation enhancement, therapists continue to use these strategies throughout the course of treatment as necessary in order to maintain motivation for behavior change.

The second module, *Psychoeducation and Treatment Rationale*, focuses on educating patients about the adaptive nature of emotions and the main components of an emotional experience (physiological, cognitive, and behavioral), with a specific focus on why the full range of negative and positive emotions are both necessary and functional. In addition, an introduction to the concept of Emotion Driven Behaviors (EDBs) (i.e., action tendencies or motivated behavioral responses that are an integral part of the emotion (e.g., fear-escape; anxiety-vigilance)) is provided, highlighting their adaptive function. Finally, patients are introduced to monitoring their emotional experiences by identifying antecedents; cognitive, behavioral, and physiological responses; and short- and long-term consequences of these responses. The aim of this module is to help foster a greater acceptance of the adaptive, functional nature of emotions and increase the patient's awareness of their own patterns of emotional responding.

In the third module, and the first core module, *Emotion Awareness Training*, the focus is on helping patients develop a greater objective awareness of their emotional experiences through monitoring the interaction between thoughts, feelings, and behaviors while anchoring this awareness within the current context in which their emotions occur. Placing unfolding emotional experiences, within the context of present-moment experiences, allows patients to identify patterns of responses and/or emotion regulation strategies being employed that are inconsistent or incompatible with ongoing situational or motivational demands. This is often difficult for patients initially, because many are distracted by past experiences or potential upcoming stressors. Therefore, in order to foster emotion awareness, the UP utilizes an adaptation of mindfulness exercises from Segal et al.<sup>[87]</sup> as well as brief, daily exercises designed to condition present-focused awareness. In addition, consistent with the UPs focus on emotional responding, idiosyncratic emotion induction exercises (such as playing meaningful music in session or viewing personal emotive photographs) are used with the intention of practicing present-focused awareness in the context of an ongoing emotional experience. During these emotion exposures, the therapist works with the patient to identify

thoughts, feelings, and behaviors that arise in reaction to their emotions, and encourage patients to allow these emotional reactions to occur (accept them) without ascribing judgmental attributions (e.g., "This makes me feel uncomfortable").

In the fourth module, and second core module, *Cognitive Reappraisal*, patients develop an understanding of how they interpret or appraise situations and how their appraisals influence patterns of emotional responding, with an emphasis on the ways in which cognitions interact with behaviors and physiological sensations in ongoing emotional experiences. The aim of this module is to foster flexible thinking by teaching patients to generate numerous alternative attributions and appraisals when faced with intense emotional experiences. The concepts of appraisal and reappraisal are introduced in session, by having the patient describe the actions depicted in a scene from an ambiguous picture. Although the patient's initial interpretation is often negative, more flexible alternative appraisals are subsequently elicited with the goal of highlighting that generating different "takes" on a situation is always possible. Over the course of treatment, appraisals are elicited and reappraisal is practiced by reviewing the patient's self-monitoring forms in session.

In the fifth module, and third core module, *Emotion Driven Behaviors and Emotion Avoidance*, 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 tuning out), or by use of safety signals (something that a patient may keep with them at all times that confers an irrational sense of safety during intense emotional experiences). Emotion driven behaviors (EDBs) are the behavioral components of an emotion that can be adaptive (e.g., flight/fight response in life-threatening situations), but can easily become maladaptive when they occur indiscriminately or are employed in inappropriate circumstances (e.g., flight/fight response in social situations). As such, another important goal of this phase is to aid patients in identifying maladaptive EDBs and teaching them to develop more adaptive behavioral responses to intense emotions.

In the sixth module, and fourth core module, *Awareness and Tolerance of Physical Sensations*, all patients engage in a series of interoceptive exercises designed to evoke physical sensations analogous to those typically associated with anxiety and distress. Interoceptive exposures are applied across diagnoses, whether or not physical sensations represent a specific focus of the patient's anxiety, as a way to increase the patient's awareness of the role of physical sensations as a core component of emotional experiences, as well as increase tolerance of these sensations. Through these exercises, patients begin to recognize the ways in which somatic sensations might influence thoughts and

behaviors, as well as how thoughts and behaviors can serve to intensify these sensations.

In the seventh module, and the final core module, *Interoceptive* and *Situational Exposure*, patients increase their tolerance of intense or uncomfortable emotions through exposure to both internal and external emotional triggers. Continued engagement in interoceptive exposure allows patients to identify and tolerate uncomfortable physiological sensations that often accompany and can serve as internal triggers for emotional experiences. Through situational exposures, patients are gradually introduced to situations and experiences that they had been avoiding earlier and that serve as external triggers for emotional experiences. In this sense, exposure to situational experiences serves as an external context to provoke intense emotional experiences. Through repeated exposure to both internal and external cues, patients ultimately increase their tolerance for intense and uncomfortable emotional experiences.

In the last module, *Relapse Prevention*, treatment principles are reviewed, and it is emphasized that the return of anxiety and mood disturbances does not mean the patient has relapsed. Instead, patients are reminded of the natural vacillation of emotions and how they can employ the skills learned in therapy to navigate through these experiences in an adaptive way.

## PRELIMINARY DATA

The latest iteration of the UP was pilot tested in an open trial of 15 patients with heterogeneous anxiety and mood disorders, seeking treatment at our center. Outcomes of this trial are detailed in Ellard et al.<sup>[88]</sup> To determine the clinical significance of outcomes in this trial, we examined the proportion of individuals meeting criteria for treatment responder status and high end-state functioning, using a conservative adaptation of algorithms reported in other similar trials of CBT for anxiety.<sup>[88,89]</sup> Using this algorithm, 73% of patients achieved responder status, and 60% of patients achieved high end-state functioning. The response for comorbid disorders was also promising ( $N = 11$ ), with 64% of patients attaining both responder and high end-state functioning status. Data were available for 13 individuals at 6-month follow-up. Of these individuals, 85% achieved responder status and 69% achieved high end-state functioning on principal diagnoses (defined as the most interfering current diagnosis). Follow-up data for comorbid diagnoses ( $N = 11$ ) indicated 80% achieved responder status, with more than half achieving high end-state functioning on comorbid disorders. Further examination of clinically significant change using the reliable change index (RCI) approach<sup>[90]</sup> applied to measures in the same manner as our conservative algorithm<sup>[88]</sup> revealed that 93% had achieved significant RCI scores at acute posttreatment on principal diagnoses, and 56% had achieved significant RCI scores on comorbid

diagnoses. At 6-month follow-up, 92% had achieved significant RCI scores on principal diagnoses ( $N = 13$ ) and 80% showed significant RCI scores on comorbid diagnoses ( $N = 11$ ). Additionally, 62% of the 13 individuals, for whom follow-up data were available, demonstrated additional gains over the period between posttreatment and follow-up, with 23% evidencing significant RCI scores between posttreatment and follow-up. Finally, analyses of the effect of treatment on negative affect, as assessed by the negative affect subscale of the Positive and Negative Affect Schedule<sup>[91]</sup> revealed that by posttreatment 67% of patients had achieved scores within a normal range, as compared to only 27% at pretreatment. By 6-month follow-up, 82% of patients achieved scores within a normal range.

## SUMMARY AND CONCLUSIONS

Several converging factors underscore the promise of a unified transdiagnostic approach to the treatment of anxiety and mood disorders.

- (1) Extant treatment protocols for the full range of anxiety disorders contain a common set of procedures, such as cognitive reappraisal, prevention of avoidance, and exposure-based procedures, which differ only in the situations, cognitions, and behaviors that provide the context for the application of the procedures.<sup>[92,93]</sup>
- (2) Extensive comorbidity among anxiety and mood disorders might be better addressed through a treatment protocol that targets multiple disorders simultaneously, as well as anxiety disorder “not otherwise specified” (NOS) and subdefinitional threshold variations, by focusing on common underlying factors across the disorders.
- (3) A unified transdiagnostic treatment approach would facilitate dissemination and training by providing a single set of therapeutic principles rather than numerous diverse protocols. Such an approach would be more cost effective and may help to increase the availability of evidence-based treatments for anxiety and mood disorders, meeting a significant public health need.
- (4) The presence of considerable overlap and common factors among disorders, as evidenced through generalized treatment responses, common patterns of neural activation, the latent structure of anxiety and mood disorders, and common etiological variables, suggest common unifying factors present across the emotional disorders that may be amenable to a single set of therapeutic principles.

Others have noted the value of distilling transdiagnostic approaches to psychopathology. In addition to our own efforts,<sup>[92]</sup> Fairburn pioneered the concept of transdiagnostic protocols and developed a transdiagnostic protocol for eating disorders to address the fact

that a particularly large number of those patients meet NOS criteria.<sup>[94,95]</sup> Norton has proposed a somewhat similar set of transdiagnostic therapeutic principles to ours for the anxiety disorders.<sup>[96]</sup> Some investigators have also begun to consider the totality of extant evidence-based therapeutic principles and how they could be integrated in various ways to address the full range of psychopathology in a transdiagnostic manner.<sup>[97–99]</sup> As Mansell et al.<sup>[99]</sup> point out, the scientific principles of parsimony and pragmatism strongly support a transdiagnostic approach if it is feasible.

Furthering research into the efficacy and effectiveness of a unified transdiagnostic treatment for anxiety and mood disorders has the potential to address recent priorities outlined by the NIMH.<sup>[100]</sup> These priorities include using innovative approaches informed by translational research to increase the public health impact by facilitating broader dissemination of cost effective psychosocial treatments for anxiety and mood disorders. At present, we have begun a large noninferiority clinical trial designed to establish that the UP is at least as efficacious and established as single diagnosis protocols.

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