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Review article

Towards an evidence-based unified psychodynamic protocol for emotional disorders

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ABSTRACT

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

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

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

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

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

1. Introduction

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

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

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

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

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

2. Method

2.1. Definition of psychodynamic psychotherapy

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

2.2. Inclusion criteria and study selection

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

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

3. Results

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

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

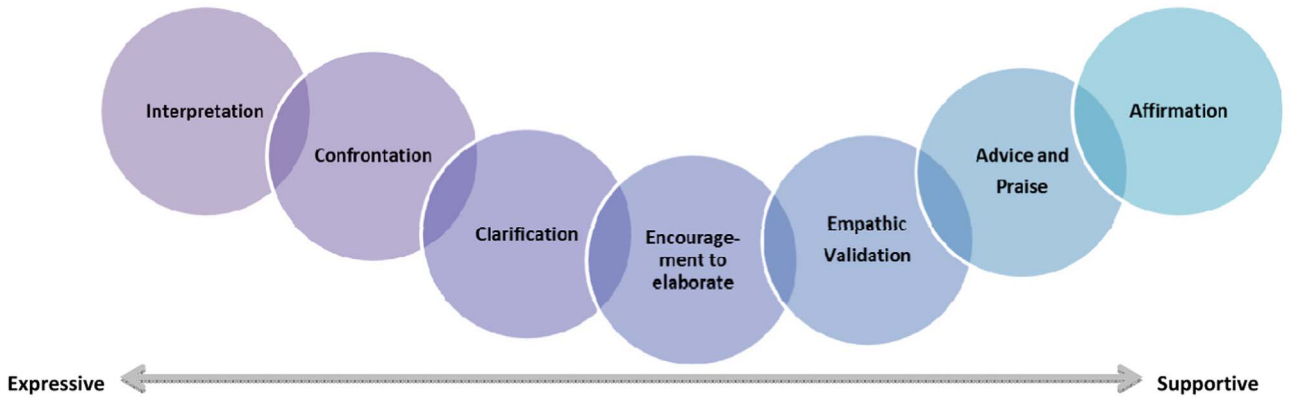

Fig. 1. The expressive-supportive continuum of psychodynamic interventions according to (Gabbard, 2000, p. 96).