Review Psikiyatride Güncel Yaklaşımlar-Current Approaches in Psychiatry 2023; 15(1):12-28
doi: 10.18863/pgy.1064590

Transdiagnostic Cognitive Behavioral Psychotherapy: Unified Protocol as an Example

Ötetanısal (Transdiyagnostik) Bilişsel Davranışçı Psikoterapi: Bütünleşik Protokol Örneği

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ABSTRACT

The fact that there are many limitations of the current classification systems led to the emergence of transdiagnostic approaches (TA) that focus on the common psychopathological processes underlying disorders rather than categorical diagnoses. TA focuses on the underlying common psychopathological processes in the emergence and persistence of mental disorders. Thus, even if the disorders are categorically diagnosed differently, it can be determined how they overlap or separate with each other. TA aims to treat mental disorders using these aspects. TA has a flexible and modular structure that can be easily integrated into cognitive behavioral therapies. The rest of this review will focus on the Unified Protocol (UP), one of the most popular TA examples. The main purpose of the UP is to enable patients to recognize their feelings and give more adaptive reactions to their negative emotions. Accordingly, UP consists of eight modules. The modules can usually be completed in a total of 11 - 17 weeks. Each 50 to 60-minute individual session is held once a week. If necessary, changes can be made to the number or the frequency of sessions allocated to modules. The goals of each module of the UP and the treatment approaches towards these goals allow a very clearly defined approach. For this reason, there is a need for a detailed evaluation, conceptualization and treatment plan before the UP is put into practice. We hope that mental health professionals from Turkey will contribute to the developments in the UP.
Keywords: Cognitive behavioral therapy, modular approach, transdiagnostic approach, unified protocol

ÖZ

Kategorik sınıflandırmaya imkân veren yaklaşımların pek çok kısıtlılığının olması, tanılardan ziyade tanıların altında yatan ortak psikopatolojik süreçlere odaklanan ve kesitsel yerine boylamsal (uzunlamasına) değerlendirmeyi vurgulayan ötetanısal (transdiyagnostik, tanılarötesi) yaklaşımların (ÖY) öne çıkmasına yol açmıştır. ÖY ruhsal bozuklukların ortaya çıkmasında ve sürmesinde altta yatan ortak psikopatolojik süreçlere odaklanır. Böylelikle kategorik açıdan bozukluklar farklı şekilde tanı alsa dahi birbirleriyle ne açıdan örtüştükleri ya da ayrıştıkları tespit edilebilir. ÖY, bu yönleri kullanarak ruhsal bozuklukları tedavi etmeyi amaçlar. ÖY, bilişsel davranışçı terapilerin işleyişine kolaylıkla entegre edilebilecek esnek ve modüler bir yapıya sahiptir. Bu gözden geçirme yazısının geri kalan kısmında en popüler ÖY örneklerinden biri olan Bütünleşik Protokol (BP) üzerinde durulacaktır. BP'de temel amaç hastaların duygularını tanımaları ve olumsuz nitelikteki duygularına daha işlevsel tepkiler vermelerini sağlamaktır. Bu doğrultuda BP sekiz modülden oluşur. Modüller genellikle haftada bir sıklıkta, her biri 50 – 60 dakika süren bireysel görüşmeler ile toplam 11 – 17 hafta içerisinde tamamlanabilir. Gereklilik olması halinde modüllere ayrılan oturum sayılarında veya oturumların sıklığında değişiklik yapılabilir. BP'nin her bir modülü hedefleri ve bu hedeflere dönük tedavi yaklaşımları son derece net bir şekilde belirlenmiş bir yaklaşıma imkân verir. Bu nedenle BP'nin uygulamaya geçirilmesinden önce detaylı bir değerlendirme, olgu kavramsallaştırması ve tedavi planı ortaya çıkarma gereği vardır. BP konusundaki gelişmelere Türkiye'den ruh sağlığı ve hastalıkları uzmanları ve çalışanlarının da katkı yapması ümit edilmektedir.
Anahtar sözcükler: Bilişsel davranışçı terapi, bütünleşik protokol, modüler yaklaşım, ötetanısal yaklaşım

Introduction

Although efforts to classify mental disorders go back thousands of years, it has come to the fore to classify mental disorders within defined taxonomies, especially in the last fifty years (Kendler 2009). Today, the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM 5) (American Psychiatric Association 2013) and the World Health Organization's International Classification of Diseases (ICD-10) (World Health Organization 1992) are used as the basis for the classification of mental disorders. However, the many limitations of these approaches that allow categorical classification have led to the emergence of transdiagnostic

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Received: 28.01.2022 | **Accepted:** 26.05.2022

approaches (TA), which focus on the common psychopathological processes underlying diagnoses rather than diagnoses per se, and emphasize longitudinal rather than cross-sectional assessment, especially in the last thirty years (Sauer-Zavala et al. 2017a).

The shortcomings of the current categorical and diagnostic classification systems were grouped under seven headings in a recent review (Dalgleish et al. 2020):

1. The biopsychosocial and psychopathological processes underlying mental disorders are transdiagnostic (Kendler 2012).
2. Symptom clusters of mental disorders form a dimensional phenomenon that is continuous from normal to pathological rather than cross-sectionally categorizing the disorder as present or absent (Haslam et al. 2012). Moreover, many people with mental disorders present with symptoms below the threshold values required for diagnosis (Kotov et al. 2018).
3. There is a markedly high rate of comorbidity among mental disorders, and the differentiating features of different disorders are limited (Kessler et al. 2005, van Loo and Romeijn 2015).
4. There may be significant differences between symptom clusters in people diagnosed with the same mental disorder. In fact, 16,400 different symptom profiles can be created for the diagnosis of major depressive disorder based on DSM (Fried and Nesse 2015). There are 636,120 different possibilities for the diagnosis of post-traumatic stress disorder (Galatzer-Levy and Bryant 2013).
5. Categorical classification of mental disorders leads to the omission of many symptom clusters, which are actually a part of the disorder but are not included in the diagnostic criteria. As a matter of fact, according to the DSM, 52 different depression symptoms can be assessed with 280 different clinical measurment tools (Santor et al. 2006) that can be used in people diagnosed with major depressive disorder. It has been reported that only 12% of all symptoms may be assessed by the seven most widely used measurment tools (Fried 2017).
6. The phenomena of mental disorders may vary over time and may cause individuals to switch from one diagnostic category to another (Wittchen et al. 2008, Fichter et al. 2010).
7. The practice of clinicians in real life is based on the individual conceptualizations of the people who present to them rather than on diagnosis-specific treatment interventions, thus allowing an eclectic approach to the treatment of complex phenomena such as comorbidity or the presence of sub-threshold symptoms.

In addition to the points summarized above, considering the stigma brought by the diagnosis of mental disorders, the additional burden and lack of experience caused by the new clinicians learning the treatment protocol specific to each disorder, etc. it will be better understood why TA might replace traditional approaches specific to the disorder (Batmaz 2018). On the other hand, it seems difficult in today's conditions to abandon the existing diagnostic classification systems and switch to radical TA-based classification and treatment interventions. As a matter of fact, taking these discussions into account in the relevant literature, it is recommended to practice TA by both staying within categorical diagnoses (“soft” approach), and by completely ignoring categorical diagnoses (“hard” approach) (Dalgleish et al. 2020).

Transdiagnostic Approach

TA focuses on the underlying common psychopathological processes in the onset and maintenance of mental disorders. Thus, even if these disorders are diagnosed differently from a categorical point of view, it can be determined how they overlap with or diverge from each other. TA aims to treat mental disorders by using these aspects (Batmaz 2018). TA has a flexible and modular structure that can be easily integrated into the process of cognitive behavioral therapies (CBT) (Mansell et al. 2012, Barlow and Farchione 2018).

CBT-based TA is based on detecting and intervening in the common psychopathological processes underlying mental disorders. It is known that these processes have been increasingly identified and chosen as a treatment target, thanks to research in recent years. Primarily, selective attention to external and internal stimuli, attentional avoidance or attention to safety, explicit selective memory, recurrent memories, interpretational and expectancy biases, emotional reasoning, repetitive negative thinking style, positive and negative metacognitive beliefs, avoidance behaviors, safety-seeking behaviors and experiential avoidance have been reported as definite transdiagnostic cognitive and behavioral processes (Harvey et al. 2004, Oğuz and Batmaz 2020). It has been suggested that implicit selective memory, overgeneral memory, avoidant encoding and retrieval, attribution bias, mental heuristics, covariation bias, confirmation bias, thought suppression, and

inadequately perceived safety cues are possible transdiagnostic processes (Harvey et al. 2004). . In addition, intolerance to uncertainty, impulsivity associated with emotional reactivity, perfectionism, neuroticism, emotion regulation strategies, anxiety sensitivity, alexithymia, thought-action fusion, self-esteem, anhedonia, shame, obsessive beliefs, interpretation of intrusions, thought suppression, problem-solving skills, re-appraisal, self-criticism, and delaying instant gratification for a long-term reward are also counted among the transdiagnostic psychological processes (Mansell et al. 2008, Oğuz and Batmaz 2020).

Many studies have been published on the effectiveness of TA due to high rates of comorbidity, heterogeneous symptom clusters, and limited effectiveness of diagnostic-specific methods (Dalgleish et al. 2020). Recent meta-analyses and review articles show that TA is at least as effective as disorder-specific psychotherapies in depressive disorders and anxiety disorders, and that even superior results may be obtained in depression and quality of life with TA rather than disorder-specific psychotherapies. Efficacy is also seen in children and adolescents, but it may still be too early to recommend TA instead of disorder-specific treatments. The effectiveness of TA might be reported higher than it actually is due to the low level of quality and methodological problems in some of the studies. Therefore, more research is needed in this area (Reinholt and Krogh 2014, Ewing et al. 2015, Newby et al. 2015, Andersen et al. 2016, Garcia-Es calera et al. 2016, Newby et al. 2016, Pearl and Norton 2016, Pasarelu et al. 2017, Sakiris and Berle 2019, Oğuz and Batmaz 2020).

In clinical practice, TA can be roughly divided into two groups (Dalgleish et al. 2020):

1. Modular Approaches: Modular approaches consist of evidence-based functional units, each of which works on its own, can be used in line with the needs of the patient or the order of use can be changed. Implementing psychotherapy in modules is more difficult as it requires a customized algorithm according to the needs of each patient, but has a higher agreement in terms of the overlap of the patient's complaints at presentation and the therapy offered.
2. Universal Approaches: Universal approaches have the same content for all patients and allow the use of therapeutic techniques that cover as wide a range of diagnoses as possible. The fact that clinicians do not need to choose between techniques enables these approaches to be disseminated through trainings and to be learned and applied more easily.

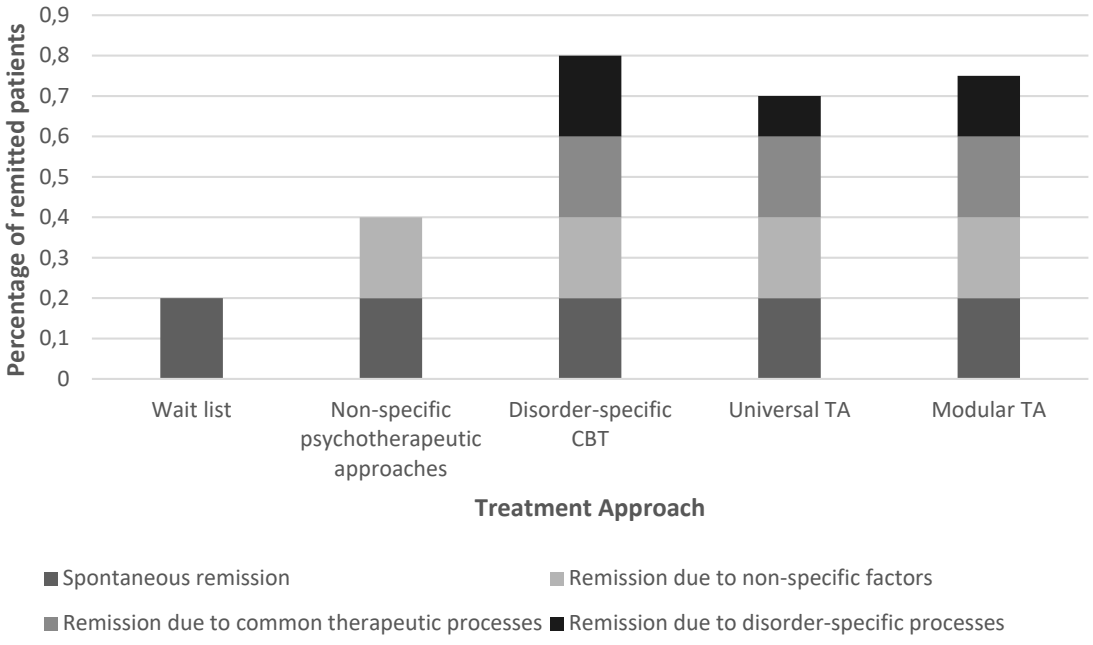

Figure 1. Expected percentage of remitted patients under control conditions, disorder-specific CBT and TA groups in primary mental disorders.
CBT, cognitive behavioral therapy; TA, transdiagnostic approach. Adapted from Dalgleish et al. (2020).

Both groups have their own advantages and disadvantages. Depending on the conditions of the patients to whom TA will be applied or the clinicians who will administer TA, the choice of approaches in these two groups may be prioritized. On the other hand, what can be considered as a successful outcome after TA practices gains importance. As it is known, a significant part of the effectiveness after psychotherapy practices is attributed to

common factors that are valid for almost all psychotherapies, such as the recovery expectations of the patients, the order that the structured and programmed therapy sessions bring to the patient's life, and the establishment of a therapeutic bond and relationship between the patient and the therapist (Norcross and Wampold 2011). From the point of view of CBT, whatever the diagnostic categorical equivalent is, the techniques that therapists will apply are actually shaping according to the consequences of behaviors, stimulus control, shaping, self-management, reducing arousal, coping and emotion regulation, problem solving, exposure strategies, behavioral activation, interpersonal communication skills. It corresponds to some common therapeutic processes such as cognitive reappraisal, changing core beliefs, cognitive defusion, acceptance, clarification of values, non-judgmental awareness, and crisis intervention (Hayes and Hofmann 2018). Disorder-specific CBT approaches suggest that beyond the common factors and common therapeutic processes outlined right here, they offer content (diagnosis-specific processes) tailored to patients' reasons for presentation. When the effectiveness of TA comes to the fore, it should be considered how much of an impact all the factors listed here have on the success of the therapy outcome. This is presented in Figure 1 and Figure 2 (Dalgleish et al. 2020):

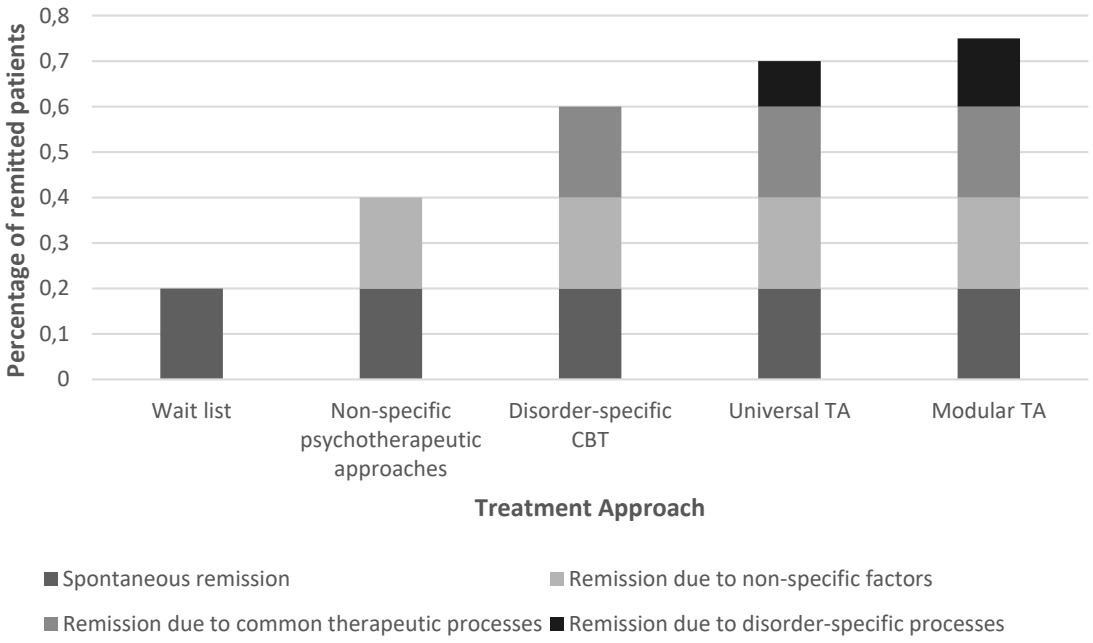

Figure 1. Expected percentage of remitted patients under control conditions, disorder-specific CBT and TA groups in comorbid mental disorders.

CBT, cognitive behavioral therapy; TA, transdiagnostic approach. Adapted from Dalgleish et al. (2020).

When Figure 1 and Figure 2 are examined, the following conclusions can be reached regarding how TA-based applications can be evaluated (Dalgleish et al. 2020):

1. In comparisons of TA to disorder-specific CBT, the efficacy of TA is likely to be lower in primary mental disorders. Considering comorbid mental disorders, although it is thought that TA will be more advantageous, the effect size of this difference will probably be small.
2. Comparative studies should focus on comorbid diagnoses as well as primary mental disorders in order to demonstrate that TA is more effective. In addition, research designs showing that TA is not less effective than disorder-specific CBT in terms of primary mental disorders, but more effective in terms of comorbid mental disorders should be emphasized.
3. TA should not be evaluated only with effectiveness comparisons, it should also be remembered that it has advantages such as ease of training and dissemination, thus increasing access to treatment and, consequently, creating a cost-effective service delivery opportunity. Research is needed to test these aspects as well.

As it can be understood even as far as it is tried to be summarized, the fact that TA is increasingly being translated to clinical practice and is the subject of research remains up-to-date. The remainder of this review will focus on the Unified Protocol (UP), one of the most popular examples of TA.

Unified Protocol

UP first appeared in the chapter titled "The Process of Fear and Anxiety Reduction: Affective Therapy" in Barlow's 1988 book Anxiety and Its Disorders (Barlow 1988). In the aforementioned section, Barlow was talking about transdiagnostic change targets based on emotion theory and aiming to address a wide range of emotional disorders (depression and anxiety-related disorders). Among these goals, action tendencies (behaviors driven by emotions), a sense of loss of control over stressors in life (neuroticism), and negative attentional biases (schemas that focus on internal, emotionally charged and negative self-evaluation) were listed (Barlow 1988, Kennedy and Barlow 2018). However, this approach, which did not attract much attention at that time, was brought up again in a new article published in 2004 (Barlow et al. 2004). In the light of the increasing number of new DSM diagnoses, the authors of the article argued for the necessity of an approach that focused on the common principles underlying the change and that formed the basis of the ideas they expressed nearly two decades ago (Barlow et al. 2004). As a result of research on how such an approach is possible, UP, which is applied in its current form, was developed.

The prominent reasons for the implementation of a unified approach for emotional disorders can be roughly grouped under four headings (Kennedy and Barlow 2018):

1. There are many common aspects among emotional disorders. In this context, both the commonality of neurobiological mechanisms, the improvement in comorbidities and high comorbidity rates should be considered even if treatment is given for a single mental disorder. For example, in patients diagnosed with a primary anxiety disorder, over 75% of those are diagnosed with another anxiety disorder or depressive disorder throughout their lives (Brown et al. 2001). Similarly, it has been shown that the diagnosis of comorbid mental disorders significantly disappeared after treatment in patients receiving CBT for panic disorder (Brown et al. 1995). It is known that a similar situation is also obtained in the context of response to antidepressant drugs, other than psychotherapies (Gorman 2007). From a neurobiological point of view, numerous studies have shown that some conditions such as excessive excitability in limbic structures and limited inhibitory controls of cortical structures (for example, increased bottom-up processing and dysregulation in cortical inhibition of the amygdala and high levels of neuroticism) are effective in the emergence of emotional disorders (Kennedy and Barlow 2018).

2. Emotional disorders have a hierarchical structure. Numerous and repeated studies have shown that there are two underlying (latent) temperament dimensions of emotional disorders. These temperament dimensions are named as neuroticism (negative affect, behavioral inhibition, emotional instability) and extraversion (positive affect, behavioral activation) (Gray 1982, Clark and Watson 1991, Brown et al. 1998, Barlow 2002). It has been suggested that emotional disorders originate from these two core dimensions at the top of the hierarchy, and that different levels of neuroticism or extraversion together cause different diagnostic manifestations.

3. Negative reactions to emotional experiences can also magnify the problems. People with emotional disorders not only have higher levels of neuroticism, they also react more negatively to their own emotional experiences, have more difficulty accepting them and make an effort to change these experiences (Kennedy and Barlow 2018). Negative interpretation of emotions as summarized here can also be seen in panic disorder, obsessive compulsive disorder, generalized anxiety disorder and social anxiety disorder (Rachman and da Silva 1978, Clark 1986, Newman and Llera 2011, Barlow et al. 2014).

4. There are transdiagnostic processes that play a role in the emergence of emotional disorders and their persistence. Among these processes, experiential avoidance, anxiety sensitivity, lack of adequate non-judgmental awareness, negative evaluations and attributions especially related to the feeling of uncontrollability, suppression of emotions, repetitive negative thinking (rumination) can be counted (Beck 1976, Kabat-Zinn 1982, Wegner et al. 1987, Nolen-Hoeksema 1991, Reiss 1991, Hayes et al. 1996). UP includes treatment targets that will cover all these transdiagnostic processes. For example, a goal-oriented approach is possible, such as interoceptive training for increased anxiety sensitivity, emotionally driven behaviors for experiential avoidance, and prevention of emotional avoidance (Kennedy and Barlow 2018).

Considering these reasons, UP was first prepared as a treatment guideline in 2011 (Barlow et al. 2011). Later, this guideline was updated in 2018 (Barlow et al. 2018). The researchers designed the guidelines both to guide therapists and as workbooks that patients can use during their therapy. Thus, for each session, the therapist has a standardized set of content, agenda items and techniques, while the patients have at their disposal a helpful resource that runs parallel to these sessions and highlights important parts of the process and includes exercises

for homework. Such an organization not only plays a facilitating role for therapists new to clinical practice, but also ensures that all therapy sessions are of the same standard. The main purpose in UP is to enable patients to recognize their emotions and give more functional responses to their negative emotions. Accordingly, the UP consists of eight modules (Table 1).

Table 1. Modules in the Unified Protocol

No	Module	Duration	Type
1	Goal setting and motivation	1 session	Optional
2	Understanding emotions	1 – 2 sessions	Optional
3	Mindful emotion awareness	1 – 2 sessions	Core
4	Cognitive flexibility	1 – 2 sessions	Core
5	Countering emotionally driven behavior	1 – 2 sessions	Core
6	Understanding and confronting bodily sensations	1 session	Core
7	Emotion exposures	4 – 6 sessions	Core
8	Recogizing achievements and looking ahead	1 session	Optional

Modules can be completed in a total of 11-17 weeks, with individual sessions lasting 50-60 minutes each, usually once a week. If necessary, the number of sessions allocated to modules or the frequency of sessions can be changed. Below is a summary about each module (Barlow et al. 2018, Kennedy and Barlow 2018):

Module 1 – Setting Goals and Enhancing Motivation: In this module, the awareness that people can make a change in themselves is revealed by using motivational interviewing techniques. The primary aim of the module is to support the participation of people as much as possible during the treatment and to return to the techniques for increasing motivation again when necessary. The second aim of the module is to set concrete targets for the expected results from the treatment. In line with these two purposes, the main techniques used in this module are decision making balance and treatment goal setting exercises.

Module 2 – Understanding Emotions: In this module, individuals are given psychoeducation about emotions (anxiety, anger, sadness, fear, etc.) and their functions (an adaptive role by providing information about what is going on around and taking appropriate actions for the person). Psychoeducation focuses on the cognitive, physiological and behavioral components of emotions and the interaction of these components with each other. In this way, it is aimed to better understand emotions by making use of basic CBT techniques and based on one's own experiences. UP uses the Antecedent-Response-Consequence (ARC) conceptualization for this purpose. Antecedents are triggering situations and events associated with the emergence of emotions; responses are cognitive, physiological and behavioral components of the resulting emotions; consequences are conceptualized as the short- and long-term effects of emotional responses. In this process, the therapist lays the groundwork for the exercises to be done in the next modules, especially by emphasizing the effect of negative reinforcement on the continuation of these disturbing feelings.

Module 3 – Mindful Emotion Awareness: This module is included in UP to enable individuals to develop an objective, present-day, non-judgmental perspective on their emotional experience. It is aimed that people realize the factors that are effective in the emergence of their emotions. In this direction, individuals are taught to distinguish between primary emotions and reactions to these emotions, based on their own experiences, and especially to notice their subjective, judgmental and negative biased evaluations in their reactions.

Module 4 – Cognitive Flexibility: This module originates from basic CBT approaches and demonstrates how people's biased assessments of situations affect their emotional responses. As in traditional CBT approaches, cognitive distortions (thinking errors) are handled in UP, and ways to reevaluate situations in a more flexible and different way are shown. UP specifically focuses on cognitive distortions such as catastrophizing (believing that the worst consequences of what can happen will happen) and exaggerating the probability (believing that things will happen with a much higher probability than they actually are).

Module 5 – Countering Emotional Behaviors: Strategies for avoiding emotions are covered in this module, preventing people from fully experiencing negative emotions and seeing what the consequences will be in situations that make people feel distressed. In addition, it is emphasized that since it cannot be seen that negative expectations are not confirmed, it cannot be understood that the anxiety that arises as an emotional reaction will also go away. Another issue discussed in this module is that people learn adaptive emotion regulation skills. In line with all this content, the module works on how to recognize and change emotional avoidance (implicit behavioral avoidance, cognitive avoidance, safety signs) and emotions-driven behaviors (action tendencies).

Module 6 – Understanding and Confronting Bodily Sensations: This module is on recognizing and enduring bodily sensations. For this purpose, exercises that reveal bodily sensations (interoceptive) (for example, hyperventilation, turning the chair quickly, running in place) are used. The goal after repeated exercises is to shake the person's belief that bodily sensations are harmful.

Module 7 – Emotion Exposures: This module is the most time consuming module of UP. The aim here is to give the opportunity to perform emotional exposures prepared specifically for the individual both during and between sessions. The point to be considered during these exercises is that the exposures are not directed to situations, but to the negative emotions that arise in those situations. Exposures can take various forms, depending on individual needs. Examples of exposures include watching a distressing movie for depressive symptoms, remembering a past traumatic experience for PTSD symptoms, or taking an elevator up a few floors for specific phobia symptoms. In this module, internal cues that were detected in the previous module and that were noticed to trigger bodily sensations are also utilized. The ultimate goal of emotional habituation is to replace assessments of how dangerous situations are with more adaptive ones, to prevent emotional avoidance, to replace emotion-driven behaviors with others, and to quench the anxiety response to intense emotional responses.

Module 8 – Recognizing Achievements and Looking Ahead: The final session covers the outline of the treatment and the person's progress throughout the entire therapy process. If sufficient progress has not been made, possible reasons for this are investigated. In addition, a kind of relapse prevention strategy is created by discussing how to deal with difficult situations that will inevitably be encountered again due to the nature of life, by using these learned skills.

Table 2 summarizes the contents of the UP modules.

Table 2. Contents of Unified Protocol modules

No	Summary	Primary Goal	Key Theme
1	Motivation	Increasing treatment motivation Setting concrete goals	Balance of decision making Treatment goal setting
2	Psychoeducation	Information about emotions and their functions Triggers of emotions, components of emotions, and effects of emotional responses The role of negative reinforcement	Antecedent-Response-Consequence (ARC) conceptualization
3	Mindfulness	Recognizing emotional experiences without judgment Understanding bias in emotional responses	Primary emotions Reactions to emotions
4	Cognitive interventions	Understanding cognitive distortions and changing biases	Catastrophizing Overestimation of probability
5	Avoidance	Avoidances and recognizing their effects	Emotional avoidance Behaviors driven by emotions
6	Bodily sensations	Ability to withstand bodily sensations	Interoceptive exposure
7	Exposure	Changing the perception of danger Prevention of emotional avoidance Modifying emotional responses so that they don't cause anxiety	Exposure Internal cues
8	Relapse prevention	Teaching relapse prevention strategies	Outline of treatment Progress level

Each module of UP allows for a very clearly defined approach to goals and treatment approaches to these goals. Therefore, before the implementation of UP, there is a need for a detailed assessment, case conceptualization and treatment plan. Boettcher and Conklin have prepared a comprehensive guide on this subject (Boettcher and Conkin 2018):

1. The characteristics of emotional disorders are shared with the patient, and after the patient shares his/her own experiences, it is determined to what extent they overlap with the defined emotional disorders. Some key points that should be emphasized when explaining emotional disorders to the patient should include:
    a. Some people feel certain emotions more frequently and intensely than the average of the society. The frequency and intensity of emotions can be thought of as on a spectrum. Some people may be at one end of the spectrum, while others may be on the other. The patient should be asked where he sees himself in this spectrum.

b. The frequency and severity of the emotions are as important as the reactions of the people to their emotions. Some people describe some of the emotions they feel as bad, dangerous, permanent, distressing, etc. and they may criticize and blame themselves for experiencing such feelings. It should be investigated whether the patient has ever behaved or evaluated his feelings in this way.

c. One of the main reasons for the persistence of negative emotions is trying to suppress or avoid them, rather than relying on or accepting them. After the patient is given examples of different ways of avoiding emotions, it should be noted which of these coping methods he or she uses.

2. Details of each of the disturbing emotions expressed by the patient, such as their severity, frequency, how long they last, and how insurmountable they are compared to the difficulties they face, are recorded.

3. They are asked how much they find their feelings undesirable, bad or disturbing. At this stage, all components of emotions (thoughts, bodily sensations, etc.) can be evaluated from the same perspective.

4. During the whole treatment process, we are alert to the judgments people make about their feelings. Recognizing these and being able to intervene when necessary is one of the parts of the treatment.

5. It is clarified whether what people describe as disturbing is really the situation they are in or the emotional reactions that occur in those situations. Making this distinction is one of the important points of treatment. Table 3 gives examples of disturbing reactions to certain emotional experiences.

Table 3. Examples of disturbing responses to emotional experiences

Diagnosis	**Situation**	**Response**
Depressive Disorder	Waking up in the morning feeling bad	"I'm going to have a terrible day." "It is incomprehensible that I feel this way when nothing is going wrong in my life." "I can't accept not feeling completely well."
Test Anxiety	Worrying before the exam	"If I continue to worry, I will not be able to give myself to the exam and I will get a bad grade." "Why do I keep worrying so much about such trivial matters?"
Social Anxiety Disorder	Shaking before public speaking	"Everyone will notice how anxious I am." "How can I get promoted if I can't even make a simple speech?"
Obsessive Compulsive Disorder	Thoughts of harming a child come to mind	"Only a murderer can think of things that way." "What kind of parent am I?"
Panic Disorder	Feeling palpitations while getting on a crowded bus	"If my heart beats a little faster, I should get off the bus immediately." "How weak I am for having panic attacks. I should have gotten away with it by now."
Borderline Personality Disorder	Fear of partner's abandonment	"I cannot stand on my own."

Adapted from Boettcher and Conklin (2018)

6. Periods when people do not find their emotions disturbing should also be determined. Because these periods show that people can actually withstand their emotions, they know that their emotions are temporary, and they think that they are understandable considering the conditions they are in. One of the goals to be achieved in treatment is to be able to realize this in the face of other negative emotional experiences.

7. Some people may also find their positive emotional experiences disturbing. For example, the fact that they are feeling good right now may be disturbed by the fear that a moment will come when they will lose it. This situation should not be overlooked either.

8. It should be focused on how the disturbing reactions of people to their emotions affect them. Thus, it is aimed to understand the role of such reactions in the continuation of emotions.

9. Individuals' coping strategies related to avoidance should be questioned. These coping strategies include overt behavioral avoidance (for example, not traveling by bus due to agoraphobia), escape (for example, leaving the environment in a situation that raises social anxiety), implicit behavioral avoidance (for example, reducing caffeine consumption), cognitive avoidance (for example, distraction), or safety signs. Table 4 contains some examples of emotional avoidance.

10. Not all avoidance-related coping strategies need to be identified in the case conceptualization in the first session. Deficiencies here may be updated as necessary as therapy progresses or as new information is

obtained from the patient. It should also be noted that different components of emotion may come to the fore in these coping ways. For example, an obsessive-compulsive disorder patient may avoid worshiping because of intrusive thoughts that blaspheme his religious beliefs, while a panic disorder patient may give up running because it causes an increase in heart rate.

Table 4. Examples of emotional avoidance

Emotional response	Avoidance behavior
Worry	Perfectionism Procrastination Avoiding situations with adverse consequences Making overly detailed preparations for the future Frequent calls to relatives to make sure they are safe
Public anxiety	Avoidance of eye contact Leaving a party early Not attending meetings Avoid expressing your own opinions
Physical sensations	Using sedatives Avoiding caffeine Not exercising Keeping water with them constantly
Fear of not getting out	Getting off the subway when feeling uncomfortable Sitting near the exit Using back roads to avoid getting stuck in traffic Not taking the elevator
Body shape	Restricting calorie intake Hiding photos Doing excessive amounts of exercise Purging
Fear of abandonment	Frequent phone calls to check where their partner is Ending relationships early Seeking reassurance that they won't be abandoned Threatening to hurt oneself if abandoned
Sadness	Sleeping Watching tv Binge eating Alcohol use Self-harm
Anger	Not saying that you disagree Leaving the environment Drinking alcohol without going into uncomfortable environments Not expressing uncomfortable behaviors
Guilt	Blaming others Changing subject if feelings of guilt arise
Shame	Staying away from people one has done wrong Changing subject if feelings of shame arise

Adapted from Boettcher and Conklin (2018).

11. An approach compatible with the socio-cultural level of the individuals is required in all assessments. It should be kept in mind that cultural diversity may cause differences in both emotional responses and coping styles associated with avoidance. When necessary, appropriate adaptations should be made to the patient. UP attaches great importance to cultural differences and therefore offers a detailed approach to the problems that may be encountered (Ametaj et al. 2018).

12. UP advocates that assessment should not be limited to a single session and should be continued in other modules as necessary. In particular, psychoeducation, non-judgmental awareness, cognitive intervention and avoidance modules are the sessions in which the missing points can be identified and reinforced during the evaluation sessions.

13. During the therapy, it is recommended to monitor the depression and anxiety levels on a weekly basis. In this way, an idea about the course of treatment can be obtained.

14. UP aims to ensure that case conceptualization does not vary from therapist to therapist through standardized questions during the evaluation of emotional disorders. Some of the standard questions are given in Table 5.

Table 5. Questions that can be used in the evaluation of emotional disorders	
Frequency and severity of negative emotions	Do you feel more sad/anxious/angry than other people? Do you have trouble coping with thinking about things that make you sad, anxious, or angry? Do you see yourself as a worrier? Do you have trouble controlling your anger? Do other people around you tell you that your feelings are more intense than others in an event that has happened to you? Does it take more time for you to calm down when you are bored with something? Do you think you experience your emotions more intensely than others?
Negative reactions or beliefs to disturbing emotions	Do you get angry or criticize yourself for feeling certain emotions? Do you get angry with yourself thinking that your feelings have no logical explanation? When you notice that you are feeling nervous, do you worry that it will get worse? Do you believe that when you feel sad it will ruin your whole day? Do you ever want to get rid of your negative emotions completely? Do you find any of your thoughts, feelings, or symptoms frightening? Do you sometimes feel that you are not in control of your emotions?
Avoidance behaviors to control or change emotions	Do you stop or postpone doing things that worry you? Do you avoid certain situations because you think you will feel uncomfortable? Do you stop doing your work when you feel bad? Do you try not to think about things that bother you? Do you divert your attention in other directions to deal with your troubling emotions? Are there things you want to do but don't do because you'll feel anxious/sad/angry if you do? Is there anything you do to get rid of your negative emotions? Is there anything you do to avoid certain feelings?
Adapted from Boettcher and Conklin (2018).	

15. After the necessary information for the evaluation is obtained, it will be useful to present this information in a case conceptualization suitable for UP so that the treatment can be planned with the patient. For this purpose, a form containing the following five titles can be used for each case:

    a. Problem areas at the time of presentation: The question areas that the patient is in search of treatment are listed.

    b. Feelings that cause discomfort: Based on the questions at the evaluation stage, the feelings that cause discomfort for the patient in terms of frequency and severity are determined.

    c. Negative reactions to emotions: Negative reactions to emotions or negative beliefs about emotions that are revealed during the evaluation phase are listed.

    d. Coping ways related to avoidance: Coping strategies that are determined during the assessment and include all types of emotional avoidance are included.

    e. Places of modules in practice: Considering the contents and focal points of the modules, a roadmap is drawn up on how the patient can benefit from them in relation to their problem areas.

Figure 2 shows an example of UP-specific case conceptualization:

Studies on Unified Protocol

There has been a significant increase in the frequency of studies on UP recently. When a PubMed-based search is performed with the keywords "Unified Protocol" in the literature, 170 publications are found as of the beginning of April 2020. More than 80% of these publications were published in the last ten years, and more than 60% in the last five years. The number of publications published since 2019 corresponds to one fifth of all publications. Some of the studies on UP can be grouped under the following headings:

1. Efficacy studies: UP is effective in primary depressive and anxiety disorders and comorbid conditions (Farchione et al. 2012, Maia et al. 2013, Carl et al. 2014, de Ornelas Maia et al. 2015, Ito et al. 2016, Varkovitzky et al. 2018, Sauer-Zavala et al. 2020), its effectiveness has been preserved in the long term (Bullis et al. 2014), and it has been shown to increase the quality of life (Gallagher et al. 2013, de Ornelas Maia et al. 2017). As a matter of fact, in a recent meta-analysis, it is stated that UP is effective in emotional disorders, and the decrease in the severity of the disorders corresponds to a large effect size, and the change in emotion regulation skills corresponds to a medium effect size (Sakiris and Berle 2019).

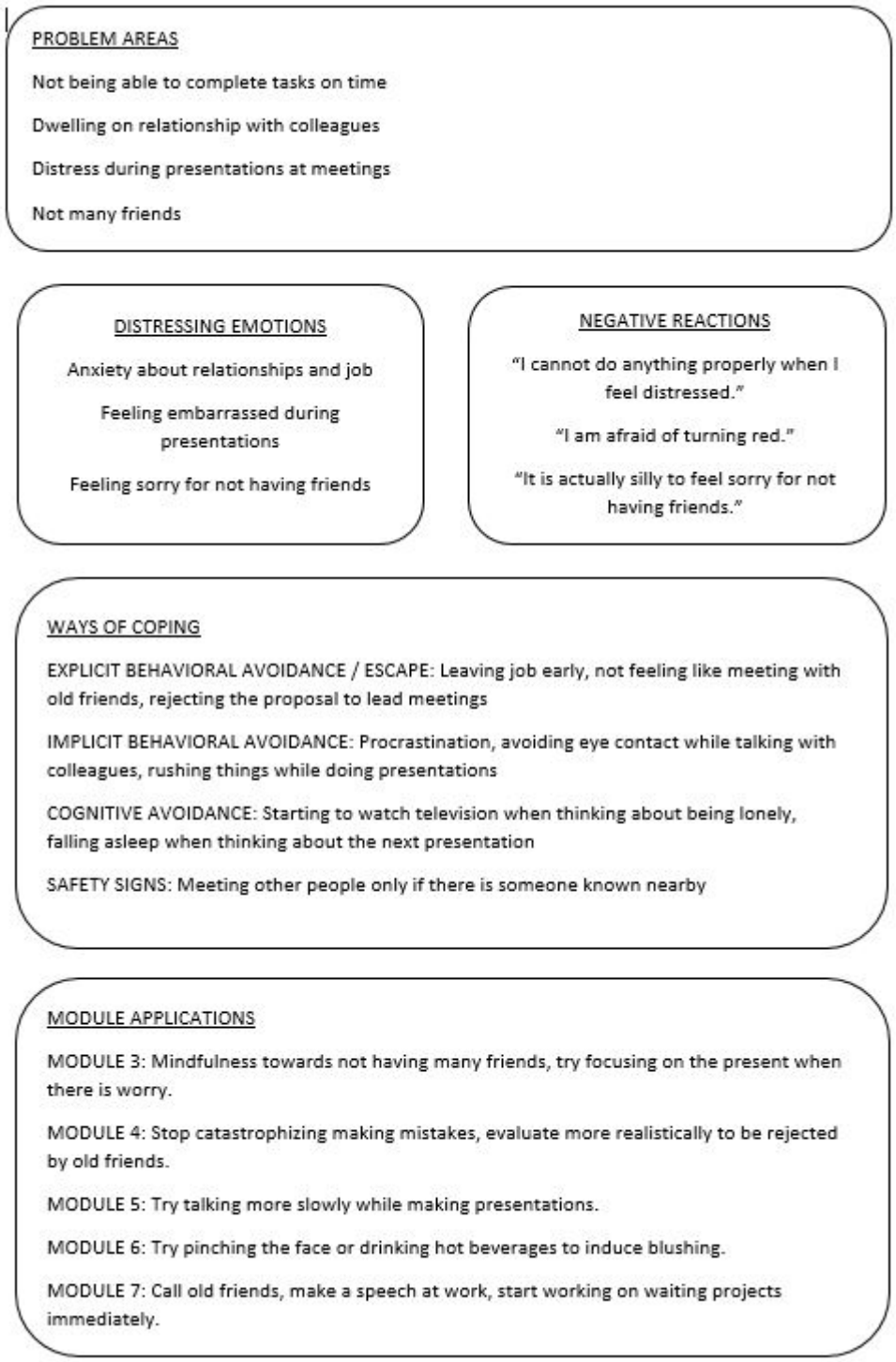

Figure 2. An example of a case conceptualization according to the Unified Protocol. (Boettcher and Conkin (2018)).

2. Comparative studies: When compared with protocols based on a single diagnosis, it has been shown that UP can be at least as effective as them (Barlow et al. 2017, Cassiello-Robbins et al. 2018, Steele et al. 2018).
3. Studies on the mode of action: In studies on how UP works, the role of the frequency of negative emotions and the relationship people have with these emotions (Sauer-Zavala et al. 2012), and that improving emotion regulation skills may have a mediating role in improvement (Khakpoor et al. 2019), the order of implementation of the modules can be changed by taking into account the strengths and needs of the patients (Sauer-Zavala et al. 2019), each module can be effective in gaining the skills expected from him/her,

especially psychoeducation and opposing the behaviors guided by emotions can have a wider impact (Sauer-Zavala et al. 2019). -Zavala et al. 2017b) have been reported.

4. Studies in different diagnosis groups: Apart from emotional disorders that UP has determined as the main target, there are publications showing that it can also be used in different diagnostic categories such as body dysmorphic disorder (Mohajerin et al. 2019), bipolar disorder (Ellard et al. 2012, Ellard et al. 2017), self-harming and suicidal behaviors (Bentley 2017, Bentley et al. 2017), psychological needs of organ and tissue transplant patients (Fidel et al. 2015), functional bowel diseases (Mohsenabadi et al. 2018), personality disorders and temperament (Carl et al. 2014, Osma et al. 2018).
5. Studies in different age groups: UP can also be successfully applied in children and adolescents with a separately developed therapy guide and workbook (Ehrenreich et al. 2009, Trosper et al. 2009, Allen et al. 2012, Girio-Herrera and Ehrenreich- May 2014, Ehrenreich-May et al. 2017, Bentley et al. 2018, Eckhardt et al. 2019, Hawks et al. 2019, Kennedy et al. 2019).
6. Studies of different ways of administration: Apart from face-to-face and one-on-one meetings, UP can also be applied online (Tulbure et al. 2018) and in group format (Maia et al. 2013, Bullis et al. 2015, de Ornelas Maia et al. 2015, Laposa et al. et al. 2017, Reinholt et al. 2017, De Paul and Caver 2021).
7. Studies in different cultures: There are publications showing that UP can be applied in different cultures (Ito et al. 2016, Mohammadi et al. 2019).

When UP modules are examined, it is seen that they integrate many components from other TAs in their content. For example, in metacognitive therapy the relationship with internal experiences is deemed more important than the internal experiences per se and in therapy this relationship is targeted (Wells 2011), in emotional schema therapy the role of emotional schemas are emphasized in the maintenance of psychopathology (Leahy 2015), in dialectical behavior therapy emotion regulation skills are taught (Linehan 2014), or in acceptance and commitment therapy the positive aspect of mindfulness in all areas of life is emphasized (Hayes et al. 2011). These techniques have been incorporated into a conventional CBT framework so that patients with different problems might benefit from different approches. Evaluation of such a wide range of patients may cause the need for many scales both in clinical practice and in research. In order to overcome this difficulty, it may be helpful to use scales that collectively include at least some of the transdiagnostic processes in the evaluation phase. Such scales include Multidimensional Emotional Disorder Inventory (Rosselini et al. 2015), Cognitive and Behavioral Processes Scale (Patel et al. 2015, Oğuz and Batmaz 2020) or Cognitive Attention Syndrome-1 Scale (Gündüz et al. 2019, Nordahl and Wells 2019). For this purpose, the articles of Stanton et al., which include suggestions for scales that can be used in the assessment of psychopathology in TA, can also be consulted (Stanton et al. 2020).

Conclusion

TA is a treatment modality that has recently been in the interest of more clinicians and researchers. The advantages of focusing on the underlying processes rather than treating psychopathological symptoms as separate diagnostic categories are the main factors in the prevalence of TA. As one of the TA-based CBT options, UP is perhaps the most well-known in this area. It is thought that a review that includes this option in the Turkish literature can give an idea about the direction in which the field is progressing. Therefore, in this review, both TA in general and UP as a unique example are mentioned. It is hoped that psychiatrists and mental health professionals from Turkey will also contribute to developments in UP.

References

Allen LB, Tsao JC, Seidman LC, Ehrenreich-May J, Zeltzer LK (2012) A unified, transdiagnostic treatment for adolescents with chronic pain and comorbid anxiety and depression. Cogn Behav Pract, 19:56-67.

American Psychiatric Association (2013) Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5®). Arlington, American Psychiatric Pub.

Ametaj AA, Sarver NW, Anakwenze O, Ito M, Rattner-Castro M, Potluri S (2018) Cross-cultural applications of the Unified Protocol: Examples from Japan and Colombia. In Applications of the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders. (Eds DH Barlow, TJ Farchione):268-290. New York, Oxford University Press.

Andersen P, Toner P, Bland M, McMillan D (2016) Effectiveness of transdiagnostic cognitive behaviour therapy for anxiety and depression in adults: a systematic review and meta-analysis. Behav Cogn Psychother, 44:673-690.

Barlow DH (1988) Anxiety and its Disorders: The Nature and Treatment of Anxiety and Panic. New York, Guilford Press.

Barlow DH (2002) Anxiety and its Disorders: The Nature and Treatment of Anxiety and Panic 2nd ed. New York, Guilford Press.

Barlow DH, Allen LB, Choate ML (2004) Toward a unified treatment for emotional disorders. Behav Ther, 35:205-230.

Barlow DH, Farchione TJ, Bullis JR, Gallagher MW, Murray-Latin H, Sauer-Zavala S et al. (2017) The unified protocol for transdiagnostic treatment of emotional disorders compared with diagnosis-specific protocols for anxiety disorders: A randomized clinical trial. JAMA Psychiatry, 74:875-884.

Barlow DH, Farchione TJ, Fairholme CP, Ellard KK, Boisseau CL, Allen LB et al. (2011) Unified Protocol for Transdiagnostic Treatment of Emotional Disorders: Therapist guide. New York, Oxford University Press.

Barlow DH, Farchione TJ, Sauer-Zavala S, Latin H, Ellard KK, Bullis JR et al. (2018) Unified Protocol for Transdiagnostic Treatment of Emotional Disorders: Therapist guide, 2nd ed. New York, Oxford University Press.

Barlow DH, Sauer-Zavala S, Carl JR, Bullis JR, Ellard KK (2014) The nature, diagnosis, and treatment of neuroticism: Back to the future. Clin Psychol Sci, 2:344-365.

Barlow DH, Farchione TJ (2018) Applications of the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders. New York, Oxford University Press.

Batmaz S (2018) Ergen psikopatolojisine transdiyagnostik yaklaşım. In Ergenlik Dönemi ve Ruhsal Bozukluklar. (Ed T Bildik):74-83. Ankara, Türkiye Klinikleri.

Beck AT (1976) Cognitive Therapy and the Emotional Disorders. Madison, CT, International Universities Press.

Bentley KH (2017) Applying the Unified Protocol transdiagnostic treatment to nonsuicidal self-ınjury and co-occurring emotional disorders: a case ıllustration. J Clin Psychol, 73:547-558.

Bentley KH, Boettcher H, Bullis JR, Carl JR, Conklin LR, Sauer-Zavala S et al. (2018) Development of a single-session, transdiagnostic preventive intervention for young adults at risk for emotional disorders. Behav Modif, 42:781-805.

Bentley KH, Sauer-Zavala S, Cassiello-Robbins CF, Conklin LR, Vento S, Homer D (2017) Treating suicidal thoughts and behaviors within an emotional disorders framework: Acceptability and feasibility of the unified protocol in an inpatient setting. Behav Modif, 41:529-557.

Boettcher H, Conklin LR (2018) Transdiagnostic assessment and case formulation rationale and application with the unified protocol. In Applications of the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders. (Eds DH Barlow, TJ Farchione):17-37. New York, Oxford University Press.

Brown TA, Antony MM, Barlow DH (1995) Diagnostic comorbidity in panic disorder: Effect on treatment outcome and course of comorbid diagnoses following treatment. J Consult Clin Psychol, 63:408–418.

Brown TA, Campbell LA, Lehman CL, Grisham JR, Mancill RB (2001) Current and lifetime comorbidity of the DSM-IV anxiety and mood disorders in a large clinical sample. J Abnorm Psychol, 110:49–58.

Brown TA, Chorpita BF, Barlow DH (1998) Structural relationships among dimensions of the DSM-IV anxiety and mood disorders and dimensions of negative affect, positive affect, and autonomic arousal. J Abnorm Psychol, 107:179–192.

Bullis JR, Fortune MR, Farchione TJ, Barlow DH (2014) A preliminary investigation of the long-term outcome of the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders. Compr Psychiatry, 55:1920-1927.

Bullis JR, Sauer-Zavala S, Bentley KH, Thompson-Hollands J, Carl JR, Barlow DH (2015) The unified protocol for transdiagnostic treatment of emotional disorders: preliminary exploration of effectiveness for group delivery. Behav Modif, 39:295-321.

Carl JR, Gallagher MW, Sauer-Zavala SE, Bentley KH, Barlow DH (2014) A preliminary investigation of the effects of the unified protocol on temperament. Compr Psychiatry, 55:1426-1434.

Cassiello-Robbins C, Sauer-Zavala S, Wilner JG, Bentley KH, Conklin LR, Farchione TJ et al. (2018) A preliminary examination of the effects of transdiagnostic versus single diagnosis protocols on anger during the treatment of anxiety disorders. J Nerv Ment Dis, 206:549-554.

Clark DM (1986) A cognitive approach to panic. Behav Res Ther, 24:461–470.

Clark LA, Watson D (1991) Tripartite model of anxiety and depression: Psychometric evidence and taxonomic implications. J Abnorm Psychol, 103:103–116.

Dalgleish T, Black M, Johnston D, Bevan A (2020) Transdiagnostic approaches to mental health problems: Current status and future directions. J Consult Clin Psychol, 88:179-195.

de Ornelas Maia ACC, Nardi AE, Cardoso A (2015) The utilization of unified protocols in behavioral cognitive therapy in transdiagnostic group subjects: A clinical trial. J Affect Disord, 172:179-183.

de Ornelas Maia ACC, Sanford J, Boettcher H, Nardi AE, Barlow D (2017) Improvement in quality of life and sexual functioning in a comorbid sample after the unified protocol transdiagnostic group treatment. J Psychiatr Res, 93:30-36.

De Paul NF, Caver KA (2021) A pilot study of a brief group adaptation of the Unified Protocol in integrated primary care. Psychol Serv, 18:416-425.

Eckhardt S, Martell C, Lowe KD, Le Grange D, Ehrenreich-May J (2019) An ARFID case report combining family-based treatment with the unified protocol for Transdiagnostic treatment of emotional disorders in children. J Eat Disord, 7:34.

Ehrenreich JT, Goldstein CR, Wright LR, Barlow DH (2009) Development of a unified protocol for the treatment of emotional disorders in youth. Child Fam Behav Ther, 31:20-37.

Ehrenreich-May J, Rosenfield D, Queen AH, Kennedy SM, Remmes CS, Barlow DH (2017) An initial waitlist-controlled trial of the unified protocol for the treatment of emotional disorders in adolescents. J Anxiety Disord, 46:46-55.

Ellard KK, Bernstein EE, Hearing C, Baek JH, Sylvia LG, Nierenberg AA et al. (2017) Transdiagnostic treatment of bipolar disorder and comorbid anxiety using the Unified Protocol for Emotional Disorders: A pilot feasibility and acceptability trial. J Affect Disord, 219:209-221.

Ellard KK, Deckersbach T, Sylvia LG, Nierenberg AA, Barlow DH (2012) Transdiagnostic treatment of bipolar disorder and comorbid anxiety with the unified protocol: a clinical replication series. Behav Modif, 36:482-508.

Ewing DL, Monsen JJ, Thompson EJ (2015) A meta-analysis of transdiagnostic cognitive behavioural therapy in the treatment of child and young person anxiety disorders. Behav Cogn Psychother, 43:562-77.

Farchione TJ, Fairholme CP, Ellard KK, Boisseau CL, Thompson-Hollands J, Carl JR et al. (2012) Unified protocol for transdiagnostic treatment of emotional disorders: a randomized controlled trial. Behav Ther, 43:666-678.

Fichter MM, Quadflieg N, Fischer UC, Kohlboeck G (2010) Twenty-five-year course and outcome in anxiety and depression in the Upper Bavarian Longitudinal Community Study. Acta Psychiatr Scand, 122:75–85.

Fidel SK, Alcántara AT, Castan EC, Costa GR, Diez CQ, Lligoña AG et al. (2015) Unified Protocol for psychiatric and psychological assessment of candidates for transplantation of organs and tissues, PSI-CAT. Rev Psiquiatr Salud Ment, 8:130-136.

Fried EI (2017) The 52 symptoms of major depression: Lack of content overlap among seven common depression scales. J Affect Disord, 208:191–197.

Fried EI, Nesse RM (2015) Depression is not a consistent syndrome: An investigation of unique symptom patterns in the STAR_D study. J Affect Disord, 172:96–102.

Galatzer-Levy IR, Bryant RA (2013) 636,120 ways to have posttraumatic stress disorder. Perspect Psychol Sci, 8:651–662.

Gallagher MW, Sauer-Zavala SE, Boswell JF, Carl JR, Bullis J, Farchione TJ et al. (2013) The impact of the unified protocol for emotional disorders on quality of life. Int J Cogn Ther, 6:57-72.

Garcia-Escalera J, Chorot P, Valiente RM (2016) Efficacy of transdiagnostic cognitive-behavioral therapy for anxiety and depression in adults, children and adolescents: A metaanalysis. Revista de Psicopatologia y Psicologia Clinica, 21:147-175.

Girio-Herrera E, Ehrenreich-May J (2014) Using flexible clinical processes in the Unified Protocol for the Treatment of Emotional Disorders in Adolescence. Psychotherapy (Chic), 51:117-122.

Gorman JM (2007) The Essential Guide to Psychiatric Drugs. 4th ed. New York, St. Martin's Griffin.

Gray JA (1982) The Neuropsychology of Anxiety. New York, Oxford University Press.

Gündüz A, Gündoğmuş İ, Sertçelik S, Engin BH, İşler A, Çipil A et al. (2019) Validity and reliability of Cognitive Attentional Syndrome-1 Questionnaire. Psychiatry Investig, 16:355-362.

Harvey AG, Watkins ER, Mansell W, Shafran R (2004) Cognitive Behavioural Processes Across Psychological Disorders: A Transdiagnostic Approach in Research and Treatment. Oxford, Oxford University Press.

Haslam N, Holland E, Kuppens P (2012) Categories versus dimensions in personality and psychopathology: A quantitative review of taxometric research. Psychol Med, 42:903–920.

Hawks JL, Kennedy SM, Holzman JB, Ehrenreich–May J (2019) Development and application of an ınnovative transdiagnostic treatment approach for pediatric ırritability. Behav Ther, 51:334-349.

Hayes SC, Hofmann SG (Eds.) (2018) Process-based CBT: The Science and Core Clinical Competencies of Cognitive Behavioral Therapy. Oakland, New Harbinger Publications.

Hayes SC, Strosahl KD, Wilson KG (2011) Acceptance and Commitment Therapy: The Process and Practice of Mindful Change. New York, Guilford Press.

Hayes SC, Wilson KG, Gifford EV, Follette VM, Strosahl K (1996) Experiential avoidance and behavioral disorders: A functional dimensional approach to diagnosis and treatment. J Consult Clin Psychol, 64:1152–1168.

Ito M, Horikoshi M, Kato N, Oe Y, Fujisato H, Nakajima S, ... Usuki M (2016) Transdiagnostic and transcultural: pilot study of unified protocol for depressive and anxiety disorders in Japan. Behav Ther, 47:416-430.

Kabat-Zinn J (1982) An outpatient program in behavioral medicine for chronic pain patients based on the practice of mindfulness meditation: Theoretical considerations and preliminary results. Gen Hosp Psychiatry, 4:33–47.

Kendler KS (2012) The dappled nature of causes of psychiatric illness: Replacing the organic-functional/hardware-software dichotomy with empirically based pluralism. Mol Psychiatry, 17:377–388.

Kennedy AK, Barlow DH (2018) The unified protocol for transdiagnostic treatment of emotional disorders. An introduction. In Applications of the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders. (Eds DH Barlow, TJ Farchione):1-16. New York, Oxford University Press.

Kennedy SM, Bilek EL, Ehrenreich-May J (2019) A randomized controlled pilot trial of the unified protocol for transdiagnostic treatment of emotional disorders in children. Behav Modif, 43:330-360.

Kessler RC, Chiu WT, Demler O, Merikangas KR, Walters EE (2005) Prevalence, severity, and comorbidity of 12-month DSM–IV disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry, 62:617–627.

Khakpoor S, Saed O, Armani Kian A (2019) Emotion regulation as the mediator of reductions in anxiety and depression in the Unified Protocol (UP) for transdiagnostic treatment of emotional disorders: double-blind randomized clinical trial. Trends Psychiatry Psychother, 41:227-236.

Kotov R, Krueger RF, Watson D. (2018) A paradigm shift in psychiatric classification: The hierarchical taxonomy of psychopathology (HiTOP). World Psychiatry, 17:24–25.

Laposa JM, Mancuso E, Abraham G, Loli-Dano L (2017) Unified protocol transdiagnostic treatment in group format: a preliminary investigation with anxious individuals. Behav Modif, 41:253-268.

Leahy RL (2015) Emotional Schema Therapy. New York, Guilford Publications.

Linehan M (2014) DBT Skills Training Manual. New York, Guilford Publications.

Maia ACC, Braga AA, Nunes CA, Nardi AE, Silva AC (2013) Transdiagnostic treatment using a unified protocol: application for patients with a range of comorbid mood and anxiety disorders. Trends Psychiatry Psychother, 35:134-140.

Mansell W, Carey TA, Tai S (2012) A Transdiagnostic Approach to CBT Using Method of Levels Therapy. East Sussex, Routledge.

Mansell W, Harvey A, Watkins E, Shafran R (2008) Cognitive behavioural processes across psychological disorders: A review of the utility and validity of the transdiagnostic approach. Int J Cogn Ther, 1:181–191.

Mohajerin B, Bakhtiyar M, Olesnycky OS, Dolatshahi B, Motabi F (2019) Application of a transdiagnostic treatment for emotional disorders to body dysmorphic disorder: A randomized controlled trial. J Affect Disord, 245:637-644.

Mohammadi A, Soleimani M, Mohammadi MR, Abasi I, Foroughi AA (2019) Unified Protocol for transdiagnostic prevention of depression and anxiety in ıranian adolescents: protocol development and ınitial outcome data. Iran J Pychiatry, 14:171-178.

Mohsenabadi H, Zanjani Z, Shabani MJ, Arj A (2018) A randomized clinical trial of the Unified Protocol for Transdiagnostic treatment of emotional and gastrointestinal symptoms in patients with irritable bowel syndrome: evaluating efficacy and mechanism of change. J Psychosom Res, 113:8-15.

Newby JM, McKinnon A, Kuyken W, Gilbody S, Dalgleish T (2015) Systematic review and meta-analysis of transdiagnostic psychological treatments for anxiety and depressive disorders in adulthood. Clin Psychol Rev, 40:91-110.

Newby JM, Twomey C, Li S, Andrews G (2016) Transdiagnostic computerised cognitive behavioural therapy for depression and anxiety: A systematic review and meta-analysis. J Affect Disord, 199:30–41.

Newman MG, Llera SJ (2011) A novel theory of experiential avoidance in generalized anxiety disorder: A review and synthesis of research supporting a contrast avoidance model of worry. Clin Psychol Rev, 31:371–382.

Nolen-Hoeksema S (1991) Responses to depression and their effects on the duration of depressive episodes. J Abnorm Psychol, 100:569–582.

Norcross JC, Wampold BE (2011) Evidence-based therapy relationships: Research conclusions and clinical practices. Psychotherapy (Chic), 48:98–102.

Nordahl H, Wells A (2019) Measuring the cognitive attentional syndrome associated with emotional distress: psychometric properties of the CAS-1. Int J Cogn Ther, 12:292-306.

Oğuz G, Batmaz S (2020) Transdiyagnostik bilişsel davranışçı yaklaşıma göre psikopatolojik süreçlerin değerlendirilmesi: Bilişsel ve Davranışçı Süreçler Ölçeği'nin Türkçe sürümünün geçerliliği ve güvenilirliği. Journal of Cognitive-Behavioral Psychotherapy and Research, 9:173-186.

Osma J, Sánchez-Gómez A, Peris-Baquero Ó (2018) Applying the unified protocol to a single case of major depression with schizoid and depressive personality traits. Psicothema, 30:364-369.

Păsărelu CR, Andersson G, Bergman Nordgren L, Dobrean A (2017) Internet-delivered transdiagnostic and tailored cognitive behavioral therapy for anxiety and depression: a systematic review and meta-analysis of randomized controlled trials. Cogn Behav Ther, 46:1–28.

Patel T, Mansell W, Veale D (2015) The cognitive behavioural processes questionnaire: a preliminary analysis within student, mixed clinical and community samples and the identification of a core transdiagnostic process. Cognit Ther Res, 39:193-203.

Pearl SB, Norton PJ (2016) Transdiagnostic versus diagnosis specific cognitive behavioural therapies for anxiety: A meta-analysis. J Anxiety Disord, 46:11–24.

Rachman S, de Silva P (1978) Abnormal and normal obsessions. Behav Res Ther, 16:233–248.

Reinholt N, Aharoni R, Winding C, Rosenberg N, Rosenbaum B, Arnfred S (2017) Transdiagnostic group CBT for anxiety disorders: the unified protocol in mental health services. Cogn Behav Ther, 46:29-43.

Reinholt N, Krogh J (2014) Efficacy of transdiagnostic cognitive behaviour therapy for anxiety disorders: a systematic review and meta-analysis of published outcome studies. Cogn Behav Ther, 43:171-184.

Reiss S (1991) Expectancy model of fear, anxiety, and panic. Clin Psychol Rev, 11:141–153.

Rosellini AJ, Boettcher H, Brown TA, Barlow DH (2015) A transdiagnostic temperament-phenotype profile approach to emotional disorder classification: An update. J Exp Psychopathol, 2:110–128.

Sakiris N, Berle D (2019) A systematic review and meta-analysis of the unified protocol as a transdiagnostic emotion regulation based intervention. Clin Psychol Rev, 72: 101751.

Santor DA, Gregus M, Welch A (2006) Eight decades of measurement in depression. Measurement (Mahwah N J), 4:135–155.

Sauer-Zavala S, Bentley KH, Steele SJ, Tirpak JW, Ametaj AA, Nauphal M et al. (2020) Treating depressive disorders with the Unified Protocol: A preliminary randomized evaluation. J Affect Disord, 264:438-445.

Sauer-Zavala S, Boswell JF, Gallagher MW, Bentley KH, Ametaj A, Barlow DH (2012) The role of negative affectivity and negative reactivity to emotions in predicting outcomes in the unified protocol for the transdiagnostic treatment of emotional disorders. Behav Res Ther, 50:551-557.

Sauer-Zavala S, Cassiello-Robbins C, Ametaj AA, Wilner JG, Pagan D (2019) Transdiagnostic treatment personalization: The feasibility of ordering unified protocol modules according to patient strengths and weaknesses. Behav Modif, 43:518-543.

Sauer-Zavala S, Cassiello-Robbins C, Conklin LR, Bullis JR, Thompson-Hollands J, Kennedy KA (2017b) Isolating the unique effects of the unified protocol treatment modules using single case experimental design. Behav Modif, 41:286-307.

Sauer-Zavala S, Gutner CA, Farchione TJ, Boettcher HT, Bullis JR, Barlow DH (2017a) Current definitions of "transdiagnostic" in treatment development: A search for consensus. Behav Ther, 48:128–138.

Stanton K, McDonnell CG, Hayden EP, Watson D (2020) Transdiagnostic approaches to psychopathology measurement: Recommendations for measure selection, data analysis, and participant recruitment. J Abnorm Psychol, 129:21-28.

Steele SJ, Farchione TJ, Cassiello-Robbins C, Ametaj A, Sbi S, Sauer-Zavala S, Barlow DH (2018) Efficacy of the Unified Protocol for transdiagnostic treatment of comorbid psychopathology accompanying emotional disorders compared to treatments targeting single disorders. J Psychiatr Res, 104:211-216.

Trosper SE, Buzzella BA, Bennett SM, Ehrenreich JT (2009) Emotion regulation in youth with emotional disorders: Implications for a unified treatment approach. Clin Child Fam Psychol Rev, 12:234-254.

Tulbure BT, Rusu A, Sava FA, Sălăgean N, Farchione TJ (2018) A web-based transdiagnostic intervention for affective and mood disorders: randomized controlled trial. JMIR Ment Health, 5:e36.

van Loo HM, Romeijn JW (2015) Psychiatric comorbidity: Fact or artifact? Theor Med Bioeth, 36:41–60.

Varkovitzky RL, Sherrill AM, Reger GM (2018) Effectiveness of the unified protocol for Transdiagnostic treatment of emotional disorders among veterans with posttraumatic stress disorder: a pilot study. Behav Modif, 42:210-230.

Wegner DM, Schneider DJ, Carter SR, White TL (1987) The paradoxical effects of thought suppression. J Pers Soc Psychol, 53:5–13.

Wells A (2011) Metacognitive Therapy for Anxiety and Depression. New York, Guilford Press.

Wittchen HU, Nocon A, Beesdo K, Pine DS, Hofler M, Lieb R, Gloster AT (2008) Agoraphobia and panic. Prospective longitudinal relations suggest a rethinking of diagnostic concepts. Psychother Psychosom, 77:147–157.

WHO (1992) The ICD-10 Classification of Mental and Behavioural Disorders: Clinical Descriptions and Diagnostic Guidelines. Geneva, World Health Organization.

Authors Contributions: The author(s) have declared that they have made a significant scientific contribution to the study and have assisted in the preparation or revision of the manuscript
Peer-review: Externally peer-reviewed.
Conflict of Interest: No conflict of interest was declared.
Financial Disclosure: No financial support was declared for this study.