In Review

New Psychotherapies for Mood and Anxiety Disorders

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Objective: To discuss psychotherapies for depression and anxiety that have emerged in recent years and to evaluate their current level of empirical support.

Method: An electronic and a manual literature search of psychotherapies for mood and anxiety disorders were conducted.

Results: Five new therapies for mood disorders and 3 interventions for posttraumatic stress disorder with co-occurring substance abuse met criteria for inclusion in this review. Fewer psychotherapies have been developed for other anxiety disorders. Although research for some of the psychotherapies has demonstrated superiority to usual care, none have firmly established efficacy or specific benefits over other established psychotherapies.

Conclusions: A plurality of the new psychotherapies introduced and established in the past 5 years have been different assimilations of previously established cognitive-behavioural, interpersonal, or psychodynamic models. While initial results are promising for some, more rigorous efficacy trials and replications are necessary before conclusions can be drawn regarding their relative benefits.

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Clinical Implications

- Many of the reviewed therapies include cognitive, behavioural, interpersonal, and psychodynamic therapies.
- As research on most new psychotherapies is in the early stages, further research is necessary before most of these psychotherapies are disseminated.
- Little advancement has been made in achieving substantially better treatment outcomes for patients with mood and anxiety disorders.

Limitations

- Applications of established treatments to additional disorders were not addressed.
- Minimal modifications to previously established interventions were not included in this review.
- Many of the psychotherapies reviewed were introduced too recently to have fully established efficacy.

Key Words: *new psychotherapies, depression, anxiety*

In recent years, it has become evident that the clinical response rates for current evidence-based psychotherapies are limited.[1,2] A recent meta-analysis[1] estimated rates of improvement at 54% for depression, 63% for panic disorder, and 52% for GAD. Thus a recent focus in the psychotherapy literature has been the development of alternatives or enhancements to established treatments to improve clinical outcomes. In our paper, we describe treatments for prevalent adult mood and anxiety disorders[3] that have been introduced or tested for efficacy in the past 5 years.

Determining criteria for designation of psychotherapies as new is challenging. New psychotherapies often have long gestation periods. The first article to describe a new therapy may occur 10 to 15 years before a definitive efficacy trial is published, and, in the interim, the treatment may become well known. In addition, some new interventions represent less of a significant departure from established psychotherapies than refinements or integrations of established interventions. Similarly, some psychotherapies that are efficacious for one

disorder are then tested, with little modification, for additional disorders and cannot be considered novel. A comprehensive discussion of the entire literature on new developments in psychotherapy is beyond the scope of this article. In the current review, we will identify psychotherapies that include novel interventions or strategies, or represent notable modifications of established psychotherapies, and evaluate their current level of empirical support.

Method

Literature Search

We conducted a computer search of PsycINFO and MEDLINE, using the key words that included the name of each disorder and psychotherapy, psychosocial treatment, and the names of specific psychotherapies known to have been developed in the last 5 years. Additionally, we searched high-quality, high-impact journals that publish psychosocial treatment-efficacy research *(The Journal of the American Medical Association, The American Journal of Psychiatry, Psychotherapy and Psychosomatics, Journal of Clinical and Consulting Psychology, Archives of General Psychiatry, The British Journal of Psychiatry: The Journal of Mental Science,* and *The Canadian Journal of Psychiatry)*. Finally, we manually reviewed prior meta-analyses and reviews.[4–7]

Abbreviations used in this article

ABP	affect-focused body psychotherapy
ACT	acceptance and commitment therapy
AD	antidepressant
BA	behavioural activation
BD	bipolar disorder
CBT	cognitive-behavioural therapy
CT	cognitive therapy
GAD	generalized personality disorder
ICM	intensive clinical management
IPSRT	interpersonal and social rhythm therapy
IPT	interpersonal psychotherapy
MDD	major depressive disorder
PFPP	panic-focused psychodynamic psychotherapy
PPT	positive psychotherapy
PTSD	posttraumatic stress disorder
RCT	randomized controlled trial
SS	seeking safety
SST	self-system therapy
SUD	substance use disorder
TARGET	Trauma Adaptive Recovery Group Education and Therapy
TAU	treatment as usual
TREM	Trauma Recovery and Empowerment Model

Criteria for Inclusion in the Current Review

In the current review, new psychotherapies were defined as introduced and studied within the past 5 years, or as notable psychotherapeutic models that were introduced earlier (generally in the past decade), but for which research emerged within the past 5 years. Refinements or integrations of established psychotherapies were included if they differed significantly from earlier models, or if they were modified specifically for the treatment of a particular disorder. For example, in recent years, researchers have been studying the application of IPT,[8] originally studied for the treatment of MDD, to anxiety disorders, with little modification.[9–11] However, IPT was modified significantly to address the symptoms of BD.[12] Thus we will discuss the modification for BD, but not for anxiety disorders.

Evaluation of Efficacy

In evaluating the empirical status of each psychotherapy, we were guided by the following standards for efficacy, effectiveness, and specificity,[13] although we recognize that newer psychotherapies are unlikely to have met all of these standards. To be fully established as an efficacious and specific treatment,[13] efficacy, relative to an adequate control group or comparison treatment, in a large-scale randomized trial should be demonstrated. Replication, ideally by a different research group, should occur. The specific benefits of the psychotherapy should be established through comparison with an established psychotherapy. Before widespread implementation, the new treatment should also be demonstrated to be effective (again, compared with a control group or alternative active treatment) in a large-scale study that includes the types of patients, providers, and settings that would be typical for the application of the treatment in routine practice.

New Psychotherapies for Mood Disorders

Major Depressive Disorder

In the past 5 years, the new psychotherapies that have been introduced and studied for depression have generally fallen within a cognitive or behavioural framework. Each has been modified in clinically meaningful ways, through novel interventions or emphasis on different constructs. Thus a typical session for these newer variations should be easily distinguishable from more established cognitive-behavioural psychotherapies.

Acceptance and Commitment Therapy

ACT[14–16] is a behavioural psychotherapy that departs from traditional behavioural models by positing that people learn and relate events within situationally or historically defined contexts. ACT targets 2 processes by which problematic behaviours and distressing emotions are maintained. The first is experiential avoidance, in which people attempt to alter negative experiences by changing their form, frequency, or the contexts in which they occur. The second process is cognitive fusion, a process by which behaviours are

determined more by verbal networks than by experienced environmental consequences. A precursor to the full ACT model (called comprehensive distancing[17,18]) placed less emphasis on the identification and clarification of values than the current model and did not include exercises to help patients identify or act in ways consistent with their central values.

A recent randomized study[19] was conducted at a university student clinic at which 99 students with depression or anxiety disorders received ACT or standard CT for an average of 15 sessions. The average age of participants, 28 years, was younger than that of samples in other clinical trials for depression. Although rates of specific disorders were not described, the authors noted that 33% of the sample had a depressive disorder.[19] No significant differences in outcomes were found, and 61% of the total were considered recovered from their depressive symptoms. This study[19] did not target MDD or analyze results separately for different diagnoses. Earlier studies that targeted depression[17,18] used small, female samples and tested comprehensive distancing rather than ACT. Thus research will be necessary to further examine the efficacy and effectiveness of ACT for MDD.

Behavioural Activation

A new and expanded model of BA[20] was recently developed and tested. In contrast to earlier BA interventions,[21] the expanded model emphasizes idiographic functional analysis for the understanding of depressive behaviour and makes use of contextual interventions to change these behaviours. BA focuses on the role of contextual changes associated with decreased access to reinforcers in the development and maintenance of depressive symptoms. The model places emphasis on identifying and changing patterns of avoidance and withdrawal, and seeks to promote engagement with reinforcing activities and contexts that are consistent with a person's long-term goals.

The expanded version of BA has been tested in one clinical trial. A large (n = 241), methodologically rigorous randomized comparison of 16 weeks of BA, CT, and ADs for MDD was recently completed.[20] BA outperformed CT (by 76% and 48% for response or remission, respectively) and produced similar outcomes when compared with ADs among a severely depressed subset of patients (n = 138). These findings appeared largely to be due to extreme nonresponse by a subset of patients who received CT,[20] and, if replicated, may indicate that some patients with long histories of depression may benefit more from attention to behavioural interventions.[22] Statistically significant differences were not found between the 3 treatments among the less severely depressed patients.[20] Both CT and BA reduced the risk of recurrence by about 63% relative to medication withdrawal over a 2-year follow-up.[23] If these findings are replicated by an independent research group, they could have implications for the dissemination of evidence-based psychotherapies, as some have posited that training to competence in BA may be easier than in CT.[24]

Positive Psychotherapy

Instead of directly targeting symptoms of depression, PPT[25] was developed to foster engagement, meaning, and positive emotion. Patients work with their therapist to identify signature strengths and find practical ways of using these strengths more often through a series of exercises. Clients are coached to refocus their attention and memory to positive aspects of their lives with the goal of developing a more balanced view of their negative experiences. PPT appears to overlap in some sense with CT. However, discussions of problems and symptoms are minimized in PPT sessions in favour of efforts to strengthen existing positive aspects, rather than to reinterpret the negative aspects. Although PPT may be used alone for mild levels of depression, the developers intend it as an adjunct to established therapies for moderate-to-severe levels of unipolar depression.[25]

Two small pilot studies have been conducted to examine the efficacy of PPT.[25] The first study compared group PPT to eclectic, client-centered psychotherapy (TAU) for 40 mildly-to-moderately depressed students (diagnosed using an unstructured diagnostic interview) in a university clinic and found significant differences in symptom reduction. A second study (n = 46) randomized students diagnosed with MDD to individual PPT or TAU, and compared these 2 groups to a matched comparison group of patients who received TAU with medications. Significantly more patients who received PPT met criteria for remission by the end of treatment. Additional research that is adequately powered to detect between-group differences and conducted with more representative samples is needed. A larger clinical trial is ongoing.

Self-System Therapy

SST[26] was designed to translate the principles of regulatory focus theory[27] into an intervention for examining and modifying a person's goals and strategies for pursuing them. The model purports that depression is a result of a chronic failure to attain personal goals owing to a disorder in motivation and goal pursuit. People whose socialization histories did not include consistent emphasis on promotion goals (advancement, achievement, or growth) would have difficulty pursuing such goals in adulthood. The goals of SST are to improve self-regulation to attain personal goals. The 20- to 25-session treatment uses strategies from CT, IPT, and BA to define the patient's goals, identify activities that will facilitate these goals, clarify barriers to progress, and develop a plan to attain these goals.

One RCT, comparing SST with CT for 45 patients with depression,[28] has been conducted to date. The treatment developers hypothesized that patients with a poor promotion socialization history would show greater improvements with SST than with CT. Because the inclusion criteria allowed patients with various affective disorders to participate, not all of the patients had MDD, and the sample was less depressed than samples in other clinical trials. Treatment length was not standardized for either treatment. Although there were no

significant differences in depression outcomes between the 2 treatments for the overall sample, the outcomes for patients with problematic self-regulation were significantly better if they received SST. It remains to be seen whether SST is more efficacious than established treatments for a particular subgroup of depressed patients.

Bipolar Disorder

Interpersonal and Social Rhythm Therapy

Only one treatment, IPSRT,[29] was identified as new under the criteria for inclusion in this review. IPSRT is a form of IPT developed specifically for BD, and it includes several elements not found in the original IPT model. IPSRT is intended to provide insight into the relation between mood and interpersonal events, stabilize endogenous circadian rhythms by stabilizing daily routines and sleep cycles, and address interpersonal problems related to grief, role transitions, role disputes, and interpersonal deficits.[29] In the initial phase, the clinician takes a history of the illness and of interpersonal functioning, provides psychoeducation about the disorder, and identifies interpersonal problem areas. In the intermediate phase, the clinician works with the patient to manage symptoms, implement social rhythm stabilization strategies, and address interpersonal problem areas. In the preventative phase, treatment goals are solidified and potential threats to continued stability are identified. In the termination phase, treatment successes and areas of continued vulnerability are reviewed.

To date, IPSRT has been tested in 3 studies with adults, 2 of which were RCTs. A large ($n = 175$), methodologically rigorous randomized clinical trial compared pharmacotherapy with either IPSRT or a medication management protocol, ICM, followed by a maintenance phase in which participants received IPSRT or ICM. People diagnosed with BD I or schizoaffective disorder, manic type, participated in the study. Treatment with IPSRT during the acute phase resulted in a longer survival time without a new affective episode, regardless of the maintenance strategy, and patients who received IPSRT were more likely to remain well over a 2-year follow-up.[13]

Miklowitz et al[30,31] randomized 300 patients with BD to a 3-session psychoeducation condition (collaborative care) or 1 of 3 intensive psychotherapies (CBT, IPSRT, or family-focused therapy). The psychotherapies resulted in significantly better relationship functioning and life satisfaction at the end of a 9-month acute phase and significantly higher rates of recovery at the end of a 12-month follow-up.[30,31] Differences between the 3 psychotherapies were not significant, although the study was not adequately powered to detect such differences.

New Psychotherapies for Anxiety Disorders

Posttraumatic Stress Disorder

Recently, owing to the high incidence of co-occurring SUDs and the challenges to treatment in the context of substance abuse or dependence, 3 interventions designed to address PTSD and substance abuse or dependence have been introduced and tested. Each includes multiple modules and components, which are intended to develop skills for coping with cravings and PTSD symptoms.

Seeking Safety

SS[32] is a structured treatment package consisting of 24 modules, evenly divided between cognitive, behavioural, and interpersonal coping skills. Skills that are relevant to both disorders, such as identifying and fighting triggers, asking for help, and setting boundaries, are taught and practiced in each session. The intervention includes weekly individualized commitments to practicing the skills discussed in each module. The primary emphasis of the treatment is patient safety, defined as abstinence from all substances, reduction in self-destructive behaviour, establishment of a support network, and self-protection from dangers associated with the disorders. SS was developed to be used in group or individual formats, although most of the research to date has examined group interventions.

SS has been examined in 13 studies. Preliminary research yielded promising decreases in PTSD symptoms and substance use, compared with usual care conditions.[32–34] However, the findings of more recent large-scale studies, including 2 fairly rigorous RCTs,[35,36] have not been as favourable. One of them compared SS with TAU, and found significantly greater reduction in PTSD symptoms, but more substance use, among SS patients.[35]

The largest (n = 353) study was a hybrid efficacy–effectiveness comparison of a 12-session modification of SS plus standard substance abuse treatment (TAU) to a Women's Health Education Group plus TAU for women with PTSD (or subthreshold PTSD) and substance abuse.[36] Treatments were implemented in nonresearch settings with TAU varying somewhat by site. Rolling admission into treatment groups was permitted, and less stringent inclusion and exclusion criteria were employed. Neither PTSD nor substance use outcomes differed between the 2 active treatments, although both produced significant reductions in symptoms. Secondary analyses indicated that SS patients had greater reductions in high-risk sexual behaviours.[37] As the active psychotherapies or psychoeducation interventions were not compared with a no-treatment control or TAU, it is difficult to draw conclusions regarding the relative efficacy of either combined treatment to standard care.

Trauma Recovery and Empowerment Model

TREM[38] is a 33-session, manualized group treatment designed to address the emotional and interpersonal consequences of physical or sexual abuse for women. The

treatment uses a supportive, skill-building curriculum that allows members to acknowledge the impact of abuse while focusing on the development of techniques for mastery and enhancing existing strengths and coping skills. The intervention focuses on empowerment, trauma education, and skills-building in 11 different areas.

TREM has been the subject of 2 studies, 1 of which also included a comparison to SS. In a quasi-experimental study involving 170 women,[39] participants who received a 24-session modification of TREM in addition to standard care were compared with those who received standard care in a residential substance abuse setting. Participants were eligible if they had a diagnosis of current substance abuse, a history of trauma, and a current Axis I or II disorder. Participants who received the TREM intervention experienced significantly greater improvements in trauma-related symptoms at the 12-month outcome assessment; however, group differences were not found in substance abuse outcomes. The results of this study[39] must be interpreted with caution, as not all of the participants met full criteria for PTSD, and the study was not randomized.

A large (n = 2026) multisite, quasi-experimental study of multicomponent treatment models for women with histories of trauma and SUD compared SS, TREM, and usual care (in outpatient mental health settings).[40] Usual care was not standardized across sites, although, at each site, an integrated, trauma-informed approach was used. As in the previously described study,[39] not all participants were diagnosed with PTSD, and participants were not randomized. Neither approach outperformed the usual care condition, but some benefits were found in PTSD and mental health symptom reduction when the data for SS and TREM were aggregated and compared with usual care.[40] As with the previously described study, methodological considerations limit the interpretability of the results. More rigorous study will be necessary to investigate the efficacy of TREM. In addition, although research indicates that both SS and TREM produce significant symptom change, no research has demonstrated benefits for a specific combined treatment package, and neither treatment has been compared with established treatments for PTSD or substance abuse alone.

Trauma Adaptive Recovery Group Education and Therapy

TARGET[41] is a 12-session, trauma-focused, present-centred, emotion self-regulation model for concurrent treatment of PTSD and SUDs. It consists of 3 parts: education about PTSD as a biological change in response to trauma; teaching of skills for managing traumatic stress, which complement skills used in SUD treatments for coping with cravings; and an experiential exercise to facilitate the processing of emotionally charged memories through a nonverbal, creative arts modality. Unlike TREM and SS, which do not include exposure, exposure work is optional in the TARGET intervention.

To date, the effectiveness of TARGET has been assessed in one study, which took place in community-based outpatient clinic. The study included 213 men and women with a trauma history, SUD, and an additional Axis I diagnosis who were randomized to TARGET or TAU. Findings for one of the primary outcome analyses, sobriety self-efficacy, approached statistical significance, but differences were not found between groups for PTSD symptoms. Secondary analyses revealed differential effects for some demographic subgroups.[42] Consequently, modifications may be necessary to address the needs of minority patients.

Panic Disorder

Panic-Focused Psychodynamic Psychotherapy

Few developments in psychotherapies for panic disorder have emerged recently, other than the integration of technology into established psychotherapies. However, a twice-weekly, 24-session PFPP was developed. The intervention targets core conflicts about anger recognition, ambivalent feelings about autonomy, and fears of loss or abandonment commonly found in panic disorder. Over the course of the sessions, therapists work to uncover unconscious meanings to panic symptoms, understand and change the core conflicts.

Three studies,[43–45] 2 of which were RCTs, have examined PFPP. Most recently, 49 adults with primary Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, panic disorder were assigned to either 12 weeks of twice-weekly sessions of PFPP or applied relaxation training.[45] Patients who received PFPP experienced a significantly higher decrease in panic severity than the applied relaxation group (73%, compared with 39%), and greater reduction in functional impairment and depressive symptoms. One potential limitation of this trial is the use of applied relaxation training, which has been found to be less effective than CBT, as a comparison treatment. These preliminary results suggest that PFPP may be an efficacious intervention for panic disorder; however, further comparison to approaches such as CBT that incorporate homework and exposure strategies is warranted. A larger clinical trial is currently in progress.

Generalized Anxiety Disorder

Affect-Focused Body Psychotherapy

Only one psychotherapy, ABP,[46] has emerged as a new treatment for GAD in recent years. ABP is based on a treatment that was originally applied to chronic pain, but its application to GAD is the first study that evaluates its efficacy for an Axis I disorder. Based in part in psychodynamic theory, ABP integrates bodily techniques and the exploration of affect into a psychodynamic frame of reference. Clinicians focus on developing an understanding of the information latent in affects and increasing the tolerance for anxiety and previously withheld affect. As the bodily interventions allow the patient to focus on whatever the body tells him or her, the treatment includes a mindfulness component.

ABP has been examined in an RCT with 61 patients diagnosed with GAD, most of whom were also diagnosed with an Axis II disorder.[46] Patients were randomized into ABP or TAU. Fewer than one-half of the TAU patients received psychotherapy, while others visited the doctor or had unspecified intermittent therapeutic contact. ABP patients were seen for an average of 37 sessions over 1 year, and treatment length for the TAU condition varied. Although patients in the ABP condition experienced significantly greater reductions in general psychiatric symptoms as measured by 1 of 3 self-reports used to assess outcomes, differences in anxiety were not significant between the 2 groups. The methodological limitations associated with this study,[46] including the use of self-report measures, heterogeneous sample, differences in TAU, and variable treatment length, limit the conclusions that can be drawn from it.

Other Anxiety Disorders

Novel treatments for social anxiety disorder and obsessive–compulsive disorders have not emerged in the past 5 years. ACT, described more fully in the depression section above, has been investigated in very small open trials for each disorder[47,48]; however, given the preliminary nature of these studies, more rigorous clinical trials will be necessary to determine whether it is an efficacious and viable alternative to more established psychotherapies for these disorders.

Discussion

Our brief overview of selected new psychotherapies raises questions about: the nature of new psychotherapies in relation to previous psychotherapies; the clinical applicability of such new psychotherapies based on available empirical evidence; implications of such new psychotherapies for training and dissemination; and directions for future research. We address each of these questions here, with examples drawn from the types of new psychotherapies contained in our brief review.

What makes a new psychotherapy new? Many of the psychotherapies that have been studied in recent years can be characterized more as refinements or extensions of existing therapeutic models (cognitive-behavioural, interpersonal, or psychodynamic), rather than as significant departures from established psychotherapies. The refinements and modifications to these therapies generally represent efforts to apply existing models to additional disorders, often by bringing together several techniques that were previously used in other separate contexts. Thus, in many ways, the new psychotherapies are not really new. For example, IPSRT is a new psychotherapy for BD that largely uses the techniques of IPT but also adds stabilization of daily routines and sleep cycles. This careful attention to cues for circadian rhythms (for example, mealtime and bedtime) borrows from cognitive-behavioural treatments for insomnia that also address such cues. However, this is not to say that such a repackaging and refinement is not an advancement that may lead to substantially better clinical outcomes in certain new contexts.

One psychotherapy that is more than a repackaging is PPT. While the goals of PPT (for example, self-actualization and positive mental health) have long been addressed in the mental health and psychotherapy literature,[49,50] many of the specific interventions used in PPT are novel. For example, homework assignments in PPT can include writing a story illustrating one's character strengths or giving one's time in a way that calls on one's signature strengths to serve something much larger than the self.[25]

The clinical applicability of these new psychotherapies should ultimately be based on available empirical evidence. In general, it is too early to tell whether these new psychotherapies will succeed, as most of them have not yet been examined in adequately powered, methodologically rigorous studies. Among the 4 psychotherapies (BA, SS, IPSRT, and PFPP) that have been tested in adequately powered, high-quality clinical trials, only BA has demonstrated superiority to an established, first-line psychotherapy for a subset of patients. As none of the treatments reviewed have firmly established efficacy or specificity, more rigorous relative efficacy trials and replications are necessary before conclusions can be drawn regarding their relative benefits.

The advent of new psychotherapies raises the issue of when to disseminate these treatments and how best to train therapists in the new methods. Historically, new psychotherapies were disseminated regardless of the extent of their empirical support. The rise of behavioural, and later cognitive, treatments was in part anchored in the concept that decisions about what to practice—and, therefore, train and disseminate—needed to be based on scientific evidence about effectiveness. Despite this current widespread belief, new psychotherapies are still often disseminated before their efficacy is firmly established. For challenging clinical phenomena for which no empirically supported treatment has emerged, practising clinicians are eager for clinical guidance and may seek promising or innovative approaches before they are fully investigated. Similarly, new treatments might generate widespread interest if they yield comparable results to an established psychotherapy in preliminary research, particularly if their therapeutic models are well received by clinicians. Given the substantial amount of time required to secure funding and conduct large clinical trials, it is not surprising that individual clinicians would make such decisions when working with nonresponsive or challenging patients. Further, developers of new psychotherapies can reap substantial financial rewards through books, workshops, and training institutes. Thus clinician demand, the length of time required to establish efficacy, and financial incentives can work against waiting for definitive tests of efficacy and effectiveness to disseminate a new psychotherapy. Given the clinical implications of disseminating ineffective treatments, the expense of providing adequate training, and challenges related to the implementation of new therapeutic models, we recommend that strong empirical support be established before large-scale implementation.

Insufficient data are available regarding implications for treatment matching. Adequate tests of moderators have not yet been conducted for most of these treatments. However, some interventions (for example, SFT, SS, TARGET, and TREM) are being developed specifically for segments of the larger population diagnosed with a particular disorder. By focusing on a subgroup within a disorder, such new psychotherapies are implicitly addressing treatment moderation: the new treatment is expected to be especially effective for one type of patient and, by inference, not for another type of patient. Thus clinical ideas about moderators of treatment effectiveness have been a driving force behind the development of new psychotherapies.

An alternative to the development of new psychotherapies for increasingly narrowly defined populations is the development of approaches that would apply broadly across many disorders. Such approaches, if found to be effective with a broad set of disorders, have the potential to be implemented more easily than different, highly specific approaches for different disorders. The applications of IPT and ACT to multiple disorders without significant modifications, and a recent unified treatment model for depression and anxiety,[51,52] follow this method. These models are consistent with the view that many disorders stem from an underlying common diathesis, and propose a more simplified and distilled approach to treatment.

In the quest for new and better psychotherapies, it is also important to consider the role of common factors. Most existing psychotherapies include the elements of a positive therapeutic alliance, a new corrective emotional experience that allows the patient to experience past problems in new and more benign ways, positive expectations for change, therapist empathy and positive regard, and provision of an explanation for understanding the cause or maintenance of a problem. Empirical evidence exists supporting the role of these factors in relation to psychotherapy outcome.[53] Efforts should be made to design research to investigate the role of common, compared with specific, factors when comparing new psychotherapies to established treatments,[54] particularly when there is overlap between the therapeutic models. An alternative strategy to developing new psychotherapies would be to create and test therapy models that attempt to maximize one or more of these common factors, as has been done for the alliance.[55]

The above discussion makes clear several directions for future research. Basic efficacy and effectiveness studies are still needed for many of the new psychotherapies. Rather than assuming that a new psychotherapy is appropriate only for a specialized subpopulation, this hypothesis should be tested in studies of moderators of treatment effectiveness or patient–treatment matching designs. Combining some of the new treatments with existing psychosocial treatments or medications is also likely to be a fruitful direction for research. For example, adding in PPT interventions to treatment (whether psychodynamic or cognitive-behavioural) may be useful, especially as a second phase of treatment occurring after major psychiatric symptoms have been alleviated and functioning is improved. To combine quite different approaches, some long-held beliefs about treatment may need to be changed, such as the need for a psychodynamic therapist to remain relatively neutral and to not be directive. Alternatively, treatment models that rely on 2 therapists, each skilled in administering their respective techniques, could be developed to address these concerns. The use of more than one clinician may be particularly needed if it is difficult for a single clinician to learn multiple approaches and feel fully committed to each of them.

Although we remain optimistic that additional research will advance our knowledge of the clinical usefulness of new psychotherapies, there is also an impression that there has been relatively little advancement in the past decade in achieving substantially better treatment outcomes for patients with mood and anxiety disorders. Is there some process (for example, the nature of training in graduate school, the allegiance to existing schools of therapy, and funding opportunities) that is restricting the development of truly innovative new approaches that would potentially be breakthroughs? Are there inherent restrictions on how much certain behavioural problems, or certain people, can change?[56] Does the uniqueness of each person's past experiences and current circumstances require sophisticated approaches that use a range of techniques depending on the person? We hope further research on new psychotherapies provide some answers to these questions.

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Résumé : Nouvelles psychothérapies pour les troubles de l'humeur et anxieux

Objectif : Discuter des psychothérapies pour la dépression et l'anxiété qui ont fait leur apparition ces dernières années et évaluer le niveau actuel de leur soutien empirique.

Méthode : Une recherche documentaire électronique et manuelle des psychothérapies pour les troubles de l'humeur et anxieux a été menée.

Résultats : Cinq nouvelles thérapies pour les troubles de l'humeur et 3 interventions pour le trouble de stress post-traumatique avec abus de substances co-occurrent satisfaisaient aux critères d'inclusion pour cette étude. Un moins grand nombre de psychothérapies ont été mises au point pour d'autres troubles anxieux. Bien que la recherche pour certaines des psychothérapies ait démontré une supériorité sur les soins habituels, aucune n'a prouvé fermement une efficacité ou des avantages spécifiques par rapport aux autres psychothérapies établies.

Conclusions : Une pluralité des nouvelles psychothérapies introduites et établies dans les 5 dernières années constituent différentes assimilations de modèles cognitivo-comportementaux, interpersonnels ou psychodynamiques établis antérieurement. Bien que les premiers résultats soient prometteurs pour certaines, des essais d'efficacité plus rigoureux sont nécessaires avant de pouvoir tirer des conclusions quant à leurs avantages relatifs.