roundly recognized as a robust contributor to, and potential potentiator of, supervision's unfolding process and outcome[7,8].

Sixth, the primary trans-theoretically applicable components of psychotherapy supervision are case conceptualization, teaching/instruction, modeling, providing feedback, asking reflection-purposed stimulus questions, and discussion[8].

Seventh, conceptual contributions and empirical study identify the earliest period of therapist development as being the most troubling, a time of particularly heightened supervisee vulnerability[9]. Beginning therapists tend to have limited skills, lack a sense of therapist identity, feel like an impostor, and can question their very fitness to serve. Heightened supervisor sensitivity to and support of the vulnerable supervisee may be most crucial at this pivotal juncture. According to the International Study of Development of Psychotherapists, a beginning supervision experience characterized by *healing involvement* is developmentally critical[9].

Eighth, supervision has increasingly become a multi-culturally minded endeavor. All supervision in some respects is a triadic multicultural relationship. Thus, such variables as gender, race/ethnicity, sexual orientation and religion/spirituality, readily affecting the treatment experience, also readily affect the supervision experience. Supervisors ideally strive to understand the myriad ways in which that is so and make the multicultural an integral part of the supervision process[1,4].

Ninth, supervision research has advanced considerably since its inception in the late 1950s. Data across a host of studies indicate that supervision works, at least for supervisees, contributing to such positive outcomes as enhanced treatment knowledge, skill development/enhancement, and heightened self-awareness[9]. But supervision's impact on patients, referred to as the real effectiveness acid test, has yet to be definitively investigated and remains a most pressing accountability issue. Other identified limitations of supervision research (e.g., small sample sizes, over-reliance on self-report measures) also require redress going forward[9].

Tenth, psychotherapy supervision's significance as a vital educational practice is internationally recognized more so now than at any time in its 100 year history[4]. Supervision has gone global, a reality that seemingly will become even more heartily evident in the years and decades ahead.

No longer viewed as an ancillary, expendable practice, psychotherapy supervision's time has come. It is now rightly recognized as one of the key signature pedagogies of the mental health disciplines, educational *sine qua non* for, and grand facilitator of the psychotherapist development process. Just as "there is nothing so practical as a good theory", there is nothing so positively practice affecting as a good psychotherapy supervisor.

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The unified protocol for transdiagnostic treatment of emotional disorders

Broadly defined, the fields of psychotherapy and psychopathology have been with us for well over 100 years, but in recent decades substantial paradigm shifts have occurred. In particular, classification of mental disorders shifted from a global set of descriptors based almost entirely on theoretical conceptions to a more atheoretical empirically derived and more narrowly construed set of criteria, resulting in a substantial increase in the total number of disorders.

Paradigm shifts such as this often produce a substantial surge in research, which was indeed soon evident. In addition to ramping up research on neurobiological and cognitive bases of various disorders, these new more precise descriptions of psychopathology led to operational definitions of disorders as dependent variables. This development resulted in well-defined clinical trials typically evaluating either drugs or very specific psychological treatments targeted to the main features of each disorder[1].

These outcomes were seen as positive by most clinical scientists and, in the years following, enabled a closer look at commonalities among disorders, differences that define the disorders, and response to treatment. This was particularly true for a class of disorders we have come to refer to as "emotional disorders"[2], comprising anxiety, depressive, and related disorders that constitute what used to be called the "neurotic spectrum". Clinical scientists came to discover common neurobiological mechanisms underlying emotional disorders, and a hierarchical structure with dimensions of temperament at the top of the hierarchy, specifically neuroticism or negative affect and extraversion or positive affect[3].

Based on this research, we developed a single "transdiagnostic" treatment that no longer focuses directly on what we now regard as trivial symptomatic differences among disorders such as panic disorder, generalized anxiety disorder, obsessive-compulsive disorder, and depression, but rather targets their shared temperamental core[4]. Thus, the term "transdiagnostic" does not, in our view, simply refer to a treatment thought to be applicable across a wide range of psychopathology, as was true for old "schools" of psychotherapy, but rather to an intervention that tar-

gets specific psychopathological mechanisms (e.g., neuroticism) shared across a defined class of disorders[2].

The unified protocol for transdiagnostic treatment of emotional disorders (UP) is an emotion focused cognitive-behavioral intervention consisting of five "core" modules or components based on cognitive behavior therapy (CBT) elements of proven effectiveness that target negative emotionality and aversive reactions to emotions when they occur. These modules are preceded by an introductory session that reviews the patient's presenting symptoms and provides a therapeutic rationale, a module on motivational enhancement, and a module focusing on psychoeducation about emotions. A final module consists of relapse prevention[5].

As the treatment proceeds, the domains of thoughts, physical sensations, and behaviors are each explored in detail, focusing specifically on elucidating dysfunctional emotion regulation strategies that the patient has developed over time within each of these domains, and teaching patients more adaptive emotion regulation skills.

The UP has accrued substantial support for its efficacy in the treatment of anxiety and depression. In fact, a recent systematic review and meta-analysis examined 15 studies with a total of 1,244 participants and found large effect sizes across studies for symptoms of anxiety and depression when UP was delivered in both individual and group format[6].

Following two small open trials and an initial randomized controlled trial comparing the UP to a waitlist control condition, our group conducted a large randomized controlled equivalence trial (N=223) comparing the efficacy of the UP to established single-disorder protocols (SDPs) and a waitlist control condition. The UP was equally effective as SDPs in reducing symptom severity ratings across disorders, as well as decreasing symptoms of anxiety and depression, both at the end of treatment and at 6-month follow-up[7]. In addition, the UP condition exhibited lower rates of attrition over the course of the study.

Meanwhile, other researchers have examined the efficacy of the UP in both individual and group contexts globally, including countries in South America, Asia and Europe. In general, these studies have also found the UP to be efficacious in the treatment of emotional disorders. While all humans experience emotions, culture can impact the messages one receives about the experience and expression of emotions, and the relevance of emotion regulation. Given that the majority of research has been conducted in Europe and the US to date, further research in other global contexts is warranted.

As with any CBT, cultural competence is critical when using the UP. A promising recent pilot study conducted in Japan with the UP found significant reductions in symptoms of anxiety and depression that were large in magnitude[8]. The authors did not find any difference in emotion suppression from pre- to post-treatment, which they state is consistent with existing literature showing a lack of association between suppression and psychopathology in Japan, and may represent an important cultural difference to consider when delivering the UP. In another example, the UP has been adapted to fit the uniquely broad spectrum of cultures, education levels and backgrounds of victims of Colombia's armed conflict[9].

The UP has been translated into numerous languages, including Chinese, Dutch, German, Japanese, Korean and Spanish. An Internet-delivered version of the protocol has recently been developed.

In summary, the UP provides a transdiagnostic psychological treatment that targets shared underlying mechanisms of all emotional disorders, thereby offering a single treatment that can be used across the most common clinical presentations. This treatment is equally effective as gold-standard SDPs, but may confer additional benefits with regard to efficiency, dropout, and training therapists.

Given the unmet global demand for mental health care, combined with the lack of clinicians trained in evidence-based treatments, we believe that transdiagnostic treatments are the future of mental health care, and represent one approach to increasing access to evidence-based care and impacting global mental health.

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Can we help more?

Before you read this essay, you need the benefit of informed consent. Reading it could make you anxious, somewhat uncomfortable, and perhaps a bit provoked – in the sense of activating your intellect and triggering your social conscience. If acceptable, please read on.

If possible, ask someone to read this piece to you. Settle in to a relaxed, seated, upright position. If comfortable for you, close your eyes. Clear your mind. Focus on your breath… breathe in and out… breathe deeply. Settle down and get ready to imagine something important to the fields of medicine, psychiatry, be-