The new transdiagnostic cognitive behavioral treatments: Commentary for clinicians and clinical researchers

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ABSTRACT

Recognition of the limitations of the current categorical diagnostic system and increased understanding of commonalities across clinical problems associated with negative emotion, including anxiety and depression, has led to the development of transdiagnostic psychological interventions. This new approach holds promise in shifting our emphasis from diagnostic categories to treating core constructs that cut across disorders. This paper identifies some of the similarities and differences across various cognitive-behavioral transdiagnostic protocols and key challenges in assessment and case conceptualization for clinicians wishing to use this approach. Some key needs in the research literature that would be particularly helpful to clinicians are also identified.

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1. Introduction

As the first author embarked on graduate school, his father, a practicing psychologist with more than 30 years of clinical experience, told him that the classification of mental health problems in the dominant paradigm, then the Diagnostic and Statistical Manual of Mental Disorders, IV-TR (APA, 2000), was at the place where classification of species was prior to Linnaeus, when people categorized creatures into “animals with tails and animals without” (J. Meidlinger, personal communication, March 22, 2011). While there is a certain degree of hyperbole in the statement, one does not need to engage in clinical practice or conduct research for very long before the limitations of our diagnostic system becoming apparent.

A number of theorists and researchers have identified problems in the current categorical diagnostic system (e.g., Brown et al., 1998; Watson, 2005; Widiger & Samuel, 2005). Three common critiques are (a) high comorbidity, (b) loss of important information that does not fit a category, and (c) lack of support for distinctiveness of the categories. There is substantial comorbidity across psychiatric disorders, with nearly half of all individuals with one disorder also meeting criteria for a second (Kessler et al., 2005). Additionally, these diagnoses have significant overlap in symptoms and criteria, a factor that is indicative of the lack of true categorical boundaries. While these overlapping symptoms can be seen as the reason for the high comorbidity, it has been argued that both the symptom overlap and the comorbidity are actually the product of shared underlying processes, which produce varying symptom manifestations (e.g., Krueger & Markon, 2006).

Secondly, in categorical classification systems such as the DSM, information that is clinically relevant may also be lost or ignored if it fails to meet criteria for a specific diagnosis (e.g., Widiger & Samuel, 2005). This issue is pervasive in clinical practice where it is not unusual to see individuals with subclinical but relevant diagnoses such as an individual with social anxiety disorder that has panic-like reactions to interoceptive stimuli or an individual diagnosed with generalized anxiety disorder who has some intrusive thoughts and safety behaviors that resemble obsessive-compulsive disorder.

Finally, analyses of the structure of the current diagnostic scheme typically indicate greater commonality across anxiety-related and unipolar depressive disorders than should be the case for exclusive categories (e.g., Brown et al., 1998; Brown, 2007). These models tend to indicate two higher order factors labeled positive and negative affect. While this does not negate the utility of the diagnostic scheme, it does indicate that the categories may be constructs of convenience rather than objective categories. This is further bolstered by evidence indicating shared risk factors (e.g., Hettema, Neale, Myers, Prescott, & Kendler, 2005; Kendler et al., 2011; Kendler, Prescott, Myers, & Neale, 2003) and maintaining processes (e.g., Clark, 1999; Hayes, Wilson, Gifford, Follette, & Strosahl, 1996) broadly across diagnostic categories.

This focus on artificially bounded diagnoses has resulted in a tendency for research programs to be siloed around them, hindering generalization of research findings across disorders that may share common mechanisms. Social anxiety disorder, for instance,
was once termed the “forgotten anxiety disorder” (Turner & Beidel, 1989) because intervention research lagged behind other anxiety-related diagnoses in spite of the fact that similar exposure-based treatment is broadly effective for it (e.g., Acarturk, Cuijpers, van Straten, & de Graaf, 2009). Transdiagnostic treatments offer a potent means of addressing many of these criticisms while also offering treatments that may be more easily disseminated. These treatments approach psychopathology through constructs shared across diagnosis, using common treatment components to address them. As will be seen below, the nature and approach of these treatments vary however.

2. What are transdiagnostic treatments

2.1. Transdiagnostic language

One issue when examining the literature on transdiagnostic treatments is that researchers lack a shared language to discuss these treatments and the terms used are often inexact. We bring this up in order to be open about the limitations of the language we use and define them as much as we are able. Both the umbrella term “transdiagnostic” and the treatment targets themselves are key examples of this issue. The term transdiagnostic implies a reliance on the present diagnostic system, which, as detailed above, may lack validity and utility. While the published treatment protocols encourage diagnostic assessment in order to obtain information in sufficient breadth, some encourage a treatment approach that may be equally well-defined as adiagnostic. We use the term transdiagnostic with these limitations in mind.

The terms for treatment targets are similarly fraught with difficulty. Some transdiagnostic treatments (e.g., Norton 2012) target “anxiety disorders” but changes in DSM-5 to remove some disorders from this grouping limit the utility of this label (APA, 2013). Developers of these treatments are now stuck with defining treatment targets as anxiety disorders, obsessive-compulsive disorder, posttraumatic stress disorder, and illness anxiety disorder. Similarly, in defining the scope of the Unified Protocol (UP; Barlow et al., 2010) the authors argue that DSM-IV-TR anxiety disorders and unipolar depression fall under the higher order category of “emotional disorders” with subsequent publications arguing that borderline personality disorder also falls under this umbrella (Sauer-Zavala & Barlow, 2014; Sauer-Zavala, Bentley, & Wilner, 2016). Certain technical boundaries are placed on this definition by the authors but any such boundaries are difficult to define (should intermittent explosive disorder be an emotional disorder?). The complexity of these applications is emblematic of the deficits in present diagnostic system and also the difficulty of retrofitting a transdiagnostic dimensional system to a categorical system. This problem will likely be resolved as research on psychopathology continues to move beyond DSM categories and can further inform appropriate treatment targets.

2.2. Transdiagnostic treatments

A number of prominent transdiagnostic treatments have arisen in the past decade, most prominently the UP (Barlow et al., 2010) and Transdiagnostic Cognitive Behavioral Group Therapy (TGCBT; Norton, 2012). These treatments have largely shown themselves to be effective relative to waitlist controls (e.g., Farchione et al., 2012; Norton & Hope, 2005), other transdiagnostic treatments (e.g., relaxation; Norton, 2011), and some preliminary evidence indicates they are as effective as diagnosis-specific treatment (Norton & Barrera, 2012). While past discussion of divisions of these treatments have focused on treatment origins, dividing them into theory- and pragmatically-derived treatments (Clark & Taylor, 2009), from a practical perspective that may be especially relevant to clinicians, the treatments can be divided into two groups based on implementation. The division then is between integrative treatments that focus on the implementation of a single unified process across pathology (e.g., Gros, 2014; Norton, 2012; Schmidt et al., 2012) and modular, mechanism-focused treatments that use a discrete set of treatment mechanisms that are implemented across disorders (e.g., Barlow et al., 2010).

While there are a number of different transdiagnostic treatments they are, at their core, quite similar. For all of these treatments (e.g., Barlow et al., 2010; Gros, 2014; Norton 2012; Schmidt et al., 2012) it is arguable that the core active treatment component is decreasing behavioral and experiential avoidance (e.g., Gros, 2014; Norton, 2012) or what the UP refers to as emotion-driven behaviors (Ellard, Fairholme, Boisseau, Farchione, & Barlow, 2010). In fact, this core piece is consistent not only across transdiagnostic treatments but also across disorder-specific cognitive behavioral treatments (CBT; e.g., Barlow and Craske, 2007; Hope, Heimberg, & Turk, 2010) and acceptance and commitment therapies (e.g., Hayes-Skelton, Orsillo, & Roemer, 2013). As with many disorder-specific CBT interventions, many of the transdiagnostic treatments also include one or more emotion–regulation strategies, such as cognitive restructuring (e.g., Norton, 2012) and/or mindfulness (e.g., Barlow et al., 2010) for example. Such commonalities across approaches may help facilitate training in transdiagnostic approaches if clinicians have disorder-specific treatment experience.

Although the core of these treatments is similar, the implementation of that core differs substantially in ways that may be clinically meaningful for clients. The integrative treatments typically focus on a single set of procedures that are repeatedly implemented across various situations or experiences that are relevant to the client. Norton (2012) combines exposure with cognitive restructuring. Other protocols focus more exclusively on reducing avoidance (Gros, 2014; Schmidt et al., 2012). This singular structure offers some advantages. The model for treatment is notably simpler, which may make it easier for clinicians and clients to understand and internalize. This simplicity may be increasingly important to consider when working with clients with cognitive deficits that may impact learning, memory, and application of skills (e.g., attentional problems, memory deficits, low IQ).

Alternatively, the mechanistic/modular treatments such as the UP offer a broader array treatment tools (e.g., cognitive restructuring and mindfulness; Barlow et al., 2010). While this may be more complicated for clients to internalize and apply, it also offers different means of approaching behavioral change and may address a broader range of underlying constructs. This may offer some benefit when clients are struggling to make progress as it allows the therapist to shift approaches to emphasize what is effective for each client.

2.3. Assessment

The advent of transdiagnostic treatments requires parallel innovation in assessment of psychopathology and clinical outcomes. This includes some substantive theoretical work examining the underpinnings of transdiagnostic treatments and some general recommendations across the various treatment modalities for approaching both initial assessment and treatment monitoring. Four relevant frameworks are described below: focusing variably on symptoms, treatment targets, underlying processes, and underlying constructs.

Brown and Barlow (2009) proposed a symptom-focused dimensional classification system for mood and anxiety disorders based on a number of empirically supported constructs. These dimensions include: anxiety/neuroticism/behavioral inhibition;
behavioral activation/positive affect; unipolar depression; mania; somatic anxiety; panic and related autonomic surges; intrusive cognitions; social evaluations; past trauma; behavioral and interoceptive avoidance; and cognitive and emotional avoidance. An assessment tool based on existing measures is being developed (Rosellini & Brown, 2014). While both the model and the assessment approach are promising in terms of their ability to offer a more nuanced and useful examination of clients’ presenting problems, this model and assessment approach are still largely based on adding a dimensional scheme to existing categorical diagnoses. This symptom focus may miss underlying processes or constructs that are relevant to the symptom profiles.

A similar, but much simpler treatment-focused heuristic, was developed by Gros (2014) as the basis for his transdiagnostic behavior therapy protocol. In this protocol negative emotions are conceptualized as being the product of four types of avoidance: situations, interoceptive cues, thoughts, or positive emotions and treatment follows an individualized plan of exposures to these avoidance areas. While this treatment protocol is still in the early stages of gaining empirical support, this heuristic of categories of avoidance is a useful one to consider when assessing and determining treatment across many transdiagnostic protocols.

Other researchers have proposed moving to a more process driven approach (e.g., Harvey, Watkins, Mansell, & Shafran, 2004; Mansell, Harvey, Watkins, & Shafran, 2009). They argue that diagnosis is unnecessary for transdiagnostic treatment and, as such, assessment should focus on underlying processes rather than diagnosis. The authors identify 12 possible transdiagnostic processes (e.g., interpretational bias, explicit selective memory) across 5 domains (i.e., attention, memory, reasoning, thought, and behavior). Such models are still relatively early in their development but may prove useful in guiding treatment in the future.

Another interesting developing area has been in the examination of transdiagnostic constructs that may underlie pathology across disorders. Several, among many, promising ones include anxiety sensitivity (e.g., Boswell et al., 2013; Carleton, Sharpe, & Asmundson, 2007), distress tolerance (e.g., Wolitzky-Taylor et al., 2015; Zvolensky, Vujanovic, Bernstein, & Leyro, 2010), rumination (e.g., Hsu et al., 2015; Spinhowen, Drost, van Hemert, & Penninx, 2015) and intolerance of uncertainty (e.g., Carleton et al., 2007; McEvoy & Mahoney, 2012). Recent work on modeling the relationship between these factors and disorders has indicated that both anxiety sensitivity and intolerance of uncertainty contributed significant information to hierarchical models including negative affect (Norton & Mehta, 2007; Paulus, Tolkovsky et al., 2015). These construct-focused models offer some promise towards providing finer-grained understanding as well as providing clinically useful information as constructs may be linked to treatment approaches (e.g., anxiety sensitivity responding to interoceptive exposure).

While it is too early in the research to guess how all (or none) of these frameworks will inform our future changes in our understanding of diagnosis, it is our opinion that all of these approaches offer substantial strengths. Rather than reflecting conflicting viewpoints, the differences in these reflect different levels of analysis. As such, we feel all of these may be useful when assessing and conceptualizing cases transdiagnostically.

2.4. Intake assessment

Both the UP (Barlow et al., 2010, p. 5–6) and Norton (2012, p. 47) recommend that treatment begin with a standard biopsychosocial assessment including some form of diagnostic interview, whether unstructured or structured. These structured interviews include a variety of assessments such as the Anxiety Disorders Interview Schedule for the DSM-5 (Brown & Barlow, 2014), the Structured Clinical Interview for the DSM-5 (First, Williams, Karg, & Spitzer, 2016), or the Mini International Neuropsychiatric Interview (Sheehan et al., 1997). These structured assessments offer opportunity to assess both the presenting problem, broader stressors, and, importantly, subclinical problems that may be beneficial if addressed in treatment. Of these instruments it is notable that the ADIS-5 is the only one that offers dimensional rating scales, which may be of particular use for including subclinical diagnoses when preparing for transdiagnostic treatment. Regardless of the instrument chosen, it is important to continue to maintain a transdiagnostic perspective while conducting diagnostic assessment.

Pursuant to this, we would offer two recommendations attached to the use of these instruments. The first of these is that, regardless of whether the instrument examines disorders dimensionally, the assessor approaches them in this manner, noting significant subclinical symptoms. While there are no formal assessments designed to accomplish this, keeping a conceptual framework in mind such as Brown and Barlow’s (2009) or Gros’ (2014) during assessment can help guide practical, treatment-focused questions. In our opinion, there is a great deal of clinical utility in knowing subclinical diagnoses of clients (e.g., if a client with PTSD has panic-like symptoms). This is particularly true in a transdiagnostic treatment, where a major strength is that subclinical but impairing diagnoses can be readily included in treatment.

The second recommendation we would make is to view the DSM categories based more on their functional analytic core. This is a practice that many cognitive-behavioral clinicians and researchers do implicitly but it is useful to define explicitly as well. The DSM criteria for panic disorder are an excellent example of this. The criteria in the DSM contain no reference to interoceptive sensitivity, however a great deal of research supports this being the core fear of panic disorder (e.g., McNally, 2002; Taylor, Koch, & McNally, 1992). Because of this, clinicians and researchers often conceptualize the disorder as a disorder of interoceptive sensitivity and associated escape/avoidance responses and, in assessing panic disorder, often explicitly elicit information regarding these constructs from clients. Because the transdiagnostic treatments free clinicians from the need to have diagnosis define treatment in the way that it did for disorder-specific treatments, the functional analytic perspective has more utility and should be pursued.

3. Idiographic case formulation

3.1. Diagnostically driven case formulation

Traditionally case conceptualization has stemmed from generally accepted models of disorder-specific pathology. In this vein, the conceptualization for an individual with social anxiety disorder may be built using the cognitive behavioral model proposed by Rapee and Heimberg (1997) and inserting idiographic information as applicable into the component pieces. While this is tenable for individuals with only a single disorder, when there are multiple diagnoses it becomes increasingly difficult to merge multiple models into a single useful whole. Furthermore, individuals with multiple diagnoses may be substantially different than individuals with one of their constituent diagnoses (Norton & Chase, 2015). Thus, idiographic case formulation that integrates all presenting problems may be more appropriate.

3.2. Idiographic transdiagnostic case formulation

Idiographic case formulation involves the development of a hypothesized mechanism that underlies the presenting problem(s) (e.g., Haynes, O’Brien, & Kahalomula, 2011; Kuyken, Padesky, & Dudley, 2009; Persons, 2008). A case can be formulated at multiple levels. For example, an overall case formulation will include
all of the presenting clinical issues as well as overall background of the client. Cases can also be formulated around a particular problem such as procrastination or inability to maintain employment or a particular situation such as an argument with family member last weekend. Case formulation is most useful when the hypothesized mechanism can be evaluated empirically and it leads to a plan for intervention. In an evidence-based context, case formulation includes consideration of research on psychopathology for given diagnoses or presenting problems. For example, a formulation for panic attacks will include interoceptive conditioning and catastrophic misinterpretation of physical sensations while recognizing ideographic considerations—“I fear I am having a heart attack. My father died of a heart attack at about my age.”

Ideographic case formulation, especially as described by Persons (2008) fits well in a transdiagnostic context because it involves integrating information across all diagnoses to have a global understanding of the context and presenting problem(s). Thus, the clinician may consider the following problem list—depressed mood, underemployed, few friends, relationship problems, social anxiety—and determine that avoidance of challenging situations (new people/situations, conflict) is a common mechanism, perhaps driven by dysfunctional cognition or lack of reinforcement due to poor social skills. (The cognition vs. social skills deficit could be distinguished with further assessment.) Avoidance behavior, dysfunctional cognition, and poor social skills are all evidence-based mechanisms (e.g., Heimberg et al., 1998; Herbert et al., 2005; Mattick, Peters, & Clarke, 1989) for the various presenting problems though that research has often been tied to particular diagnoses. The particular disorders that present are less relevant here as the clinician looks for interventions that target these mechanisms. The advantage of transdiagnostic treatment packages is that the clinician need not cobble together interventions from several protocols. Rather there is an integrated treatment already available.

If all clients receive all of the interventions in a transdiagnostic treatment, then one could argue that ideographic case formulation is not necessary. However, we propose that it is especially useful in this context for two reasons. First, all of the current transdiagnostic interventions allow for flexibility to tailor the treatment to the individual client. Case formulation can help guide those decisions. Second, the formulation can help the client understand how various problems might be related and increase motivation to engage in treatment that will be more broadly helpful than it might appear on the surface.

3.3. Treatment monitoring

Across CBT treatment protocols there has been a consistent emphasis on ongoing and continuous assessment. This ongoing assessment serves a variety of purposes, including tracking progress and determining when to terminate treatment, providing clients some objective feedback on progress, and assisting in the hypothesis testing that is at the core of scientist-practitioner model. Tracking progress and outcome in treatment using disorder-specific measures (e.g., Social Phobia Scale (Heimberg, Mueller, Holt, Hope, & Liebowitz, 1992)) creates methodological problems in both transdiagnostic research (Gros, 2014) and in clinical practice. For example, a given measure may not be equally relevant across all participants. Clinicians have more flexibility to choose the most relevant measure but, as discussed below, the assessment burden is high if multiple measures are needed. Two approaches to assessment will be described below, both of which use standardized measures.

3.4. Traditional measures of psychopathology

While not ideal in a treatment study, disorder-specific measures are still a viable option in individual or group treatment in clinical settings. However it requires specific tailoring to match the client’s symptom profile. This can be done simply either by selecting measures that match the diagnoses of the client or by selecting measures that match the hypothesized constructs underlying the client’s diagnostic profile. These two approaches may often yield the same results but a focus on underlying constructs may prove more parsimonious in a diagnostically complex case. A client meeting criteria for generalized anxiety disorder, obsessive-compulsive disorder, and panic disorder may receive three measures using diagnosis as a guide, while a conceptualization-based monitoring plan may conclude that a construct such as intolerance of uncertainty underlies the client’s pathology and is sufficient for monitoring.

This approach is somewhat cumbersome in terms of the requirements on the clinician and may be burdensome on the client. Also, in some settings it is helpful to have a uniform measure across clients to allow aggregation of data for program evaluation. The alternative is to default to well-validated but broader measures of distress. In this role, treatment studies tend to have used the Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996), the Beck Anxiety Inventory (BAI; Beck & Steer, 1990), the Depression Anxiety and Stress Scales-21 item version (DASS-21; Henry & Crawford, 2005), or the State Trait Anxiety Inventory (STAI; Spielberger, 1983). While it is beyond the scope of this paper to review the merits of these measures in depth, they all have their own strengths and are fully appropriate for a wide variety of clients. The broadest and most inclusive of these measures is the DASS-21, the only one of the measures above that provides indices of both depression and anxiety. As such, it may be the simplest of the existing measures in cases where there is a need to standardize measurement across clients. For this reason we have used a modified version of the DASS-21 that includes two items assessing suicidal ideation in our clinic. Of course, there are other more general measures such as the Kessler 10 (K-10; Kessler et al., 2002) or the Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983) which could be appropriate for assessing progress with transdiagnostic treatments but these have tended not to be used in the studies evaluating the treatments to date.

3.5. Measures of functioning

To a certain extent the evaluation of treatment outcome is contingent on changes in a client’s daily functioning. Assessments of functioning have seen significant use in research examining physical health problems (e.g., Von Korff et al., 2005; Yellen, Cella, Webster, Bladowski, & Kaplan, 1997) and research on severe mental illness (e.g., Harding, Brooks, Ashikaga, Strauss, & Breier, 1987; Saavedra, Lopez, Gonzalez, Arias, & Crawford, 2015). Functional measures are appealing because they rely heavily on behavioral indicators, which are often more reliable indicators of change. Unfortunately, many of these measures are focused on medical impairment and have significant ceilings when applied to individuals with anxiety and depression typically seen in outpatient setting. The World Health Organization Disability Assessment Schedule (WHODAS 2.0; Ustun, Kostanjsek, Chatterji, & Rehm, 2010), for instance, assesses number of abilities that one would expect either to not be impaired in almost all mental health clients (e.g., “Standing up from sitting down”) or impaired in only a select group of mental health clients (e.g., “Eating”).

There are at least two measures of functioning that have seen use in transdiagnostic treatment studies including the clinician-rated Work and Social Adjustment Scale (WSAS; Mundt, Marks, Shear, & Greist, 2002) and the self-report Illness Intrusiveness Rating Scale (IIRS; Devins et al., 1983). These measures provide useful infor-
mation relevant to the evaluation of treatments and can usefully supplement more subjective measures.

3.6. Assessment recommendations

While there are a large number of potential options for initial and ongoing assessment it is difficult to establish clear rules in the absence of any established research in the area. With that caveat in mind, our general clinical approach has been as follows. We typically recommend using some form of structured interview, simply because it offers the broadest picture of the clinical problems a client may have. We always then recommend building an idio- graphic case conceptualization around this information, including both information from diagnoses that meet diagnostic threshold (e.g., for an individual with social anxiety this may include information such as marked anxiety in situations, avoidance of group social contact, diminished enjoyment of social interaction etc.) and information from subthreshold problems (e.g., anxiety regarding the safety of loved ones) to build a model of treatment targets. This idiosyncratic model should be informed by more nomothetic models of psychopathology (e.g., Rape & Heimberg, 1997) as is applicable to the individual case. We recommend that the ongoing assessment focus on a parsimonious attempt to capture this idiosyncratic model. For many cases this may be no different than is current typi- cal practice, using standardized symptom-focused measures. While not typically used in treatment research, we would argue that some of the process-focused measures discussed above (e.g., rumination, anxiety sensitivity, distress tolerance) may better capture links across multiple diagnoses for some individuals. For instance, an individual with panic disorder, illness anxiety disorder, and posttraumatic stress disorder may be best monitored using a measure of anxiety sensitivity given the role that interoceptive sensitiv- ity plays in all these disorders (e.g., McNally, 2002; Taylor, 2003). Similarly, a measure of rumination may be a good choice for an indi- vidual who presents with rumintive depression and social anxiety characterized by post-interaction rumination.

4. Considerations for treatment format

4.1. Individual and group formats

For most psychological treatments, the default format of treat- ment administration has been weekly individual therapy sessions or weekly group therapy sessions. While many transdiagnostic treatments have been only formally evaluated in randomized con- trolled trials in either group (e.g., Gros, 2014; Norton & Hope, 2005) or individual (Farchione et al., 2012; Schmidt et al., 2012) format, there are some indications that both the UP (Bullis et al., 2015) and TCBT (Paulus & Norton, 2016) can and have been success- fully administered in the alternate format. In our opinion, there are no clear reasons to expect that these treatments could not be translated across treatment formats and remain efficacious.

There are, however, considerations when selecting treatment format for clients. Individual format may be more appropriate for clients with complexity that may be difficult to address in a group context or who may be disruptive to group process, although Norton (2012, p. 36) argues that disruptive clients tend to self-correct. Additionally, Norton recommends that clients for whom the nature of their anxiety is particularly difficult to disclo- se or address in front of others (e.g., sexual obsessions, sexual trauma) should be placed in individual treatment. Beyond this, however, Norton offers few limitations on inclusion in transdiagnos- tic groups.

Research indicates that diagnostic heterogeneity in transdiagnos- tic groups does not impact outcome (Chamberlain & Norton, 2013). Anecdotally, clients in transdiagnostic groups tend to recog- nize more similarities in their problems than do clinicians trained in diagnosis-driven treatment. There is some evidence that eth- nic/racial differences may have some impact on group cohesion and outcome. Paulus, Hayes-Skelton, Norton (2015) found that very diverse groups, in which no two individuals shared a racial/ethnic identity, group outcomes were lower. These findings were not present for any other segment of their sample, including diverse groups where any two or more individuals shared an ethnic or racial identity. Following their recommendations, in groups where no individuals share an ethnic/racial identity, multicultural issues should be addressed more directly and openly throughout the group.

4.2. Transdiagnostic or diagnosis specific treatment

At present, there is little empirical data to guide a clinician or client in choosing between transdiagnostic versus disorder-specific approaches. While this is an important research question, it is also important practically to consider the availability of specific treat- ments. Dissemination has historically been one of the most difficult part of implementing empirically supported treatments (Barlow, Leveitt, & Bufka, 1999; McHugh & Barlow, 2010). One of the major benefits of transdiagnostic treatments may be that they simplify dissemination by requiring training on fewer protocols (McHugh, Murray, & Barlow, 2009).

As discussed above, the validity of the DSM diagnostic system has been seriously challenged but this is not to say that disorder-specific treatments are not effective. A large body of treatment outcome literature shows that they most certainly are helpful for many people (e.g., Barlow, Craske, Cerny, & Klosko, 1989; Jacobson, Martell, & Dmidjian, 2001; Ledley et al., 2009). It may be that the mechanisms of action are through constructs related to but not distinct from a particular disorder (e.g., anxiety sensitivity in panic disorder [McNally, 2002]) but it may be close enough that it is effective for a majority of clients meeting criteria for the disorder. One important challenge for researchers is to determine whether cer- tain cases are better treated with a disorder specific treatment both clarifying treatment as applied to the current diagnostic scheme as well as identifying underlying constructs.

Schmidt et al. (2012) argue that the utility of transdiagnostic treatments is “...likely to be where these treatments offer clear advantages over existing CBT protocols.” Where this advantage lies is likely to be in treating individuals who have multiple disorders that provide substantial impairment, individuals who fit poorly in to present diagnostic categories, or individuals whose primary diagnosis is exacerbated by or interlinked with a secondary diag- nosis (e.g., an individual with primary social anxiety disorder and panic disorder who has panic attacks in social contexts). Disorder- specific treatments may have an advantage in treating individuals with only a single diagnosis or individuals with a primary diag- nosis that should be the principle focus of treatment. Newby, Mewton, & Andrews (this issue) found some early but tantalizing results in their study comparing transdiagnostic internet-based CBT to disorder specific internet-based CBT for comorbid depres- sion and generalized anxiety disorder. This study suggested small differences in favor of transdiagnostic treatment for the comorbid condition. While this is a single study focused on two diagnoses, it provides some early evidence that transdiagnostic treatments may be more effective in treating comorbid diagnoses. More research is needed to determine when and if a transdiagnostic approach leads to superior clinical outcomes.

In terms of sequencing disorder-specific and transdiagnostic treatments there is no clear empirical guidance for possible treat- ment outcomes or how to order treatments. In general, all of these CBT treatments, both disorder-specific and transdiagnostic, are
Based mostly on principles of behavioral activation and/or exposure. As such, they are often conceptually compatible with one another and, in clinical work, one would expect little difficulty shifting between them if the client finds the treatment rationale to be credible. If the client is a treatment non-responder, we think shifting to a conceptually similar treatment may be most beneficial if there is a clear rationale for the shift (e.g., the client needs to address anxiety across a number of diagnoses) based on research into the importance of treatment credibility (e.g., Safren, Heimberg, & Juster, 1997). In other cases where the client is a non-responder for unclear reasons, we feel it may be most beneficial to shift to an approach with a more dissimilar rationale such as acceptance and commitment therapy, as a similar treatment may lack credibility for that particular client. Research that addressed the sequencing of transdiagnostic and disorder-specific treatments across modalities as part of an overall evaluation of stepped care models (Bower & Gilbody, 2005) would be very useful.

5. Training considerations in transdiagnostic treatments

Training clinicians to effectively conduct transdiagnostic treatments may be influenced by a number of factors including therapist experiences and familiarity with CBT interventions in general. However, the limited research on training has not identified barriers to treatment. Gros, Szafranski, and Shead (2017) found that a four-hour seminar given to experienced clinicians was sufficient for them to be able to implement the treatment effectively. However, the prior training in and experience with similar exposure- and behavioral activation-based interventions was not assessed, a factor that may have facilitated learning. Norton, Little, and Wetterneck (2014) indicated that therapist experience did not predict outcome in implementation of TGCBT, however all therapists were supervised by an expert in the treatment, which may have mitigated any experience gap.

When training graduate students or clinicians with little CBT experience, one would expect the learning curve to be a little bit shallower and require ongoing supervision to aid in treatment implementation. Given the diversity of clients seen in transdiagnostic protocols, perhaps training should be extended until the therapist has seen a variety of cases. For example, Gros' (2014) four types of avoidance and exposure (or three if the treatment does not include depression) may again be a useful heuristic for determining the set of experiences a therapist needs before being fully trained in the treatment.

One factor we have observed in our experience in training on Norton's TGCBT is the difficulty that therapists have in shifting to a transdiagnostic conceptualization of cases. Therapists who have worked within a DSM system often struggle to implement treatment plans that cross cut diagnostic lines rather than treating co-morbid diagnoses sequentially. For example, for a client who meets criteria for both social anxiety disorder and obsessive-compulsive disorder, a therapist inexperienced in transdiagnostic approaches may tend to treat one disorder then the other rather than focus on a common construct such as “situations in which you cannot control the outcome.” In contrast, clients in transdiagnostic groups see many commonalities with each other, irrespective of diagnosis.

6. Research directions

While research into transdiagnostic treatments has made great strides in recent years, the field is still relatively new with important research domains that are still largely open for investigation. One of the most salient of these is basic research into the nature and structure of psychopathology. Although research has indicated that the present diagnostic system lacks validity, no established alternative has emerged from the competing models. Approaches focused on underlying process and constructs of psychopathology (e.g., Mansell et al., 2009; Paulus, Talkovsky et al., 2015) that lead to identification of maintenance processes and transdiagnostic constructs, rather than symptoms, seem most promising.

While it is beyond the scope of this paper to discuss them at length, there are a number of constructs that appear to be functionally important across disorders. These include constructs such as distress tolerance, intolerance of uncertainty, rumination, anxiety sensitivity, experiential avoidance, among many. While the research on many of these provides a sense of the breadth and depth of their importance, we know very little about how most of these cross-cutting constructs may relate to each other, how they may produce different clinical presentations, and how that may impact treatment.

Associated with new models is the need to build evidence-based clinical assessment tools. As stated before, we posit that many clinicians presently use the diagnostic interview to elicit information about the constructs underlying diagnoses (e.g., intolerance of uncertainty, fear of negative evaluation) but movement should be made towards building standardized instruments for assessing these underlying factors explicitly, potentially based on the models gleaned from the more basic research into psychopathology detailed above. Ultimately, however, we recognize that much of the assessment that drives treatment is based more on functional analysis than it is on symptom or construct measures, which does not lend itself to standardization. So, while we would recommend that research move towards a new and deeper understanding of psychopathology, we would also recommend expanded training in functional analysis in graduate training for all mental health professionals.

The lack of assessment tools creates difficulty in research as well. It remains unclear what outcome measures should be in studies of transdiagnostic treatments. The current symptom/disorder specific measures are inadequate. Decades of psychotherapy research has focused on decreasing negative emotions with insufficient attention to assessing positive emotions. For both transdiagnostic and disorder-specific treatments we need to measure both negative and positive emotionality and functional impairment and quality of life as well as move towards assessing outcome using important latent constructs (e.g., anxiety sensitivity, intolerance of uncertainty) across mental health problems.

While the proposed research into new ways modeling the structure of psychopathology will likely lead to equally significant changes in transdiagnostic treatments, there are presently a number of important empirical questions to be answered about transdiagnostic treatments themselves. We do not yet have an understanding of the long term outcomes of transdiagnostic treatments or a fully developed sense of the differential impact of transdiagnostic CBT and disorder-specific CBT on both primary and secondary symptoms. Even the idea that they may be more easily disseminated and implemented has only limited research support.

While we expect that transdiagnostic treatments may gradually supplant many disorder-specific treatments, if for no reason other than ease of dissemination, we would caution researchers not to ignore disorder-specific treatments. While targeting diagnostic categories with limited validity creates a great deal of noise in the system, it should be recognized that there is also signal there. It is not difficult to imagine some shifting of treatment components from diagnostic targets (e.g., social anxiety disorder) to construct-based targets (e.g., overestimation of the cost of social failure) will occur as supporting evidence develops about what key constructs addressed in those treatments. Research examining the utility of adding optional diagnosis-specific (or, more appropriately, construct specific) modules for transdiagnostic treatments may prove...
useful, perhaps something similar to Chopita and Weisz (2009) approach to treating children.

7. Conclusions

Transdiagnostic treatments offer a number of appealing advantages to the mental health field. These include conceptual advantages such as better matching research-driven models of mental health problems, health care system advantages such as improved ease of dissemination, and basic clinical advantages such as improvements in the ability to address comorbidity.

While it has been argued that transdiagnostic treatments represent a niche treatment (Clark, 2009), the above factors indicate that transdiagnostic approaches represent the beginning of a paradigm shift in how we conceptualize and treat psychopathology.

With that said, these treatments still rely on the fundamental principles that behavioral treatments have used for decades. The core of all of these treatments is some combination of exposure and behavioral activation guided by functional analysis, often combined with an emotion-regulation strategy. They all have different components attached to this core and different ways of approaching this but they share significant commonalities. It has been argued, in fact, that this movement is a return to the past when behavior therapy did not use diagnosis to direct treatment (e.g., McManus, Shafran, & Cooper, 2010). This bears mentioning as many of these transdiagnostic treatments may resemble approaches that some behaviorally-trained clinicians already use in their work. As such, the transdiagnostic approach may be offering very little that is really new, especially when considering a history that predates DSM.

That said, these treatments approach psychopathology from a fundamentally different perspective than we have done as a field in recent decades. Implementing them effectively requires a significant effort on the part of the clinician to alter their clinical perspective and treatment approach from using a diagnosis-specific mechanism to reduce diagnosis-related symptoms to one centered around utilizing a broad process to improve an individual’s quality of life.

As a specific example of the shift in thinking, we can think of one case we would previously have treated as “a panicker” but that, using Norton’s (2012) treatment, we approached as an individual with a high need for control and heightened anxiety sensitivity, which resulted in both panic attacks and rigidity in other facets of the individual’s life. Exposures involved interoceptive exercises and cognitive restructuring centered on his belief that the individual needed to control symptoms of anxiety and exposures centered around other areas where his desire for control resulted in distress and impairment but were not associated with any diagnosis (e.g., excessive speeding and anger about being late). One of the unsung advantages of transdiagnostic treatments is not just that they treat comorbid diagnoses better but that they encourage treatment of underlying tendencies more broadly and potentially foster greater generalization of the skills learned.

While there is great promise in transdiagnostic treatments and great utility for clinicians, there are, as of yet, relatively few treatment studies and there are still substantial gaps in the broader research base underlying these treatments. It is also entirely possible that greater understanding of the cross-cutting constructs underlying psychopathology may yet point an entirely different direction for the best intervention. However, right now transdiagnostic approaches offer much to pique the curiosity of clinicians and researchers alike.

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