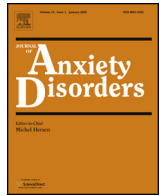




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The new transdiagnostic cognitive behavioral treatments: Commentary for clinicians and clinical researchers

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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 construct 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., Hetttema, 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,

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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 varies 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 adiabatic. 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 varyingly 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;



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با سلام ☐ متأسفانه
مشکلی در فرایند
اجرای درخواست شما
رخ داده است ☐

همکاران ما در حال تلاش برای رفع این

مشکل هستند ☐

لطفاً درخواست خود را در ساعات دیگری

مجدداً تکرار فرمایید و اگر باز هم با این

مشکل رو به رو شدید، از طریق فرم تماس

با ما به واحد پشتیبانی اطلاع دهید ☐

برای یافتن مطلب مورد نظر خود می

توانید از روش های جستجوی زیر استفاده

فرمایید :

جستجو در میان موضوعات

برای جستجو در میان موضوعات، به محض این که عبارت خود را در فیلد زیر بنویسید، موضوع های مرتبط در درخت سمت چپ با رنگ متمایزی مشخص می شوند.

جستجو ...

جستجو در میان مقالات

اگر موضوع مورد نظر شما در لیست موضوعات اصلی وجود نداشت، با استفاده از فیلد زیر می توانید آن را در بین کل مقاله های سایت جستجو فرمایید.

جستجو ...

جستجو

لیست
درختی
موضوعات

- الگوریتم های هیوریستیک + <
- بازاریابی و مدیریت بازار + <
- حسابداری و حسابرسی + <
- روش های آماری + <
- سازمان و مدیریت + <
- سیستم های اطلاعاتی + <
- علوم اقتصادی + <
- مدیریت استراتژیک + <
- مدیریت امور فرهنگی + <
- مدیریت تولید + <
- مدیریت دولتی + <
- مدیریت رفتار سازمانی + <
- مدیریت مالی + <
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تماس با واحد پشتیبانی

همکاران ما در واحد پشتیبانی آمادگی دارند تمامی درخواست های شما عزیزان را بررسی نموده و در اسرع وقت رسیدگی نمایند.

پیگیری خرید مقاله

پس از خرید هر مقاله، یک کد رهگیری منحصر به فرد به شما تقدیم خواهد شد که با استفاده از آن می توانید وضعیت خرید خود را پیگیری فرمایید.

کد رهگیری

ارسال

پیگیری سفارش ترجمه

با ثبت کد رهگیری پرداخت، می توانید سفارش خود را پیگیری نموده و به محض اتمام ترجمه، فایل ترجمه مقاله خود را دانلود نمایید □

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