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Cognitive Behavioral Therapy for Anxiety and Depression: Possibilities and Limitations of a Transdiagnostic Perspective

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Abstract. In the last several years, a number of researchers have developed a transdiagnostic or unified group cognitive behavioral therapy (CBT) that is provided to a diagnostically heterogeneous group consisting of individuals with various anxiety disorders and/or depression. This article provides a review of recent developments within this transdiagnostic perspective to CBT. Three approaches to transdiagnostic CBT are considered that vary in their theoretical emphasis. At this time, the unified protocol for emotional disorders offers the most cogent theory-driven transdiagnostic treatment approach, although its efficacy has yet to be demonstrated. The advantages and challenges of transdiagnostic CBT are reviewed, and the article concludes with a proposal that future research on transdiagnostic CBT would be better served if viewed as complementary rather than antagonist to well-established manualized disorder-specific CBT for the anxiety disorders and depression. *Key words:* transdiagnostic; cognitive behavioral therapy; emotional disorders; anxiety; depression.

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Over the last two decades, cognitive behavioral researchers have focused more on psychological constructs that are unique or specific to disorders rather than constructs that are shared across diverse psychological conditions. An example is the key role that cognitive-content specificity plays in Beck's cognitive theory of psychopathology. The hypothesis states that "each psychological disorder has a distinct cognitive profile that is evident in the content and orientation of the negative cognitions and processing bias associated with the disorder" (D.A. Clark, Beck, & Alford, 1999, p. 127). In a similar fashion, disorder-specific manualized cognitive behavioral treatment protocols have been developed, empirically evaluated, and promoted for specific anxiety disorders like panic disorder, social phobia, obsessive-compulsive disorder (OCD), and posttraumatic stress

disorder. Much of this research and treatment emphasis on disorder-related specificity was spurred on by the widespread adoption of the *Diagnostic and Statistical Manual of Mental Disorders* (fourth edition, text revision; American Psychiatric Association, 2000), which, of course, emphasizes the differentiation of psychiatric disturbance.

In recent years, we have seen evidence that the research pendulum is beginning to swing in the opposite direction, with a growing focus on psychological processes that are common across disorders and a renewed interest in treatment strategies that might be more broadly effective across diverse conditions. Referred to as transdiagnostic treatment, it has been defined as "a therapy that is made available to individuals with a wide range of diagnoses, and that does not rely on knowledge of these diagnoses to operate effectively"

(Mansell, Harvey, Watkins, & Shafran, 2009, p. 14). Transdiagnostic treatment is characterized by (a) a focus on cognitive, behavioral, and physiological processes that are shared or common across diverse disorders (i.e. so-called unified factors), (b) absence of diagnostic assessment, and (c) adoption of a convergent or integrative scientific approach (Mansell et al., 2009). A transdiagnostic perspective was first proposed by Fairburn, Cooper, and Shafran (2003) for the eating disorders and then advanced by Barlow's unified treatment protocol for anxiety and depression (Allen, McHugh, & Barlow, 2008; Barlow, Allen, & Choate, 2004), as well as by publication of an edited book (Harvey, Watkins, Mansell, & Shafran, 2004) and special issues on the topic in the *Journal of Cognitive Psychotherapy* and *International Journal of Cognitive Therapy*.

The present article discusses three aspects to the transdiagnostic perspective for anxiety and depression. First, what is meant by transdiagnostic CBT? Second, what are the advantages and disadvantages of the transdiagnostic approach? What challenges face the future development of this perspective? Finally, how can the transdiagnostic approach be reconciled with the current disorder-focused zeitgeist in CBT?

Defining transdiagnostic CBT

Three approaches to transdiagnostic CBT are evident in the literature. The first takes a more atheoretical, pragmatic perspective that could be labeled *transdiagnostic practice*. Therapeutic elements from various disorder-specific treatment protocols are brought together and offered to diagnostically mixed samples, normally in a group setting. There is no attempt to necessarily target common psychological processes, nor is the transdiagnostic treatment developed from a unified theory of emotional disorders. Instead, the goal is to determine whether a group format of well-established CBT strategies can be used effectively in a diagnostically heterogeneous sample. This predominantly clinical approach is apparent in some of the outcome studies showing that CBT for anxiety or depression can be effective in diagnostically mixed groups (e.g. Erickson, 2003; McEvoy & Nathan,

2007). In these studies, therapeutic ingredients known to be effective in disorder-specific CBT (e.g. psychoeducation, exposure, cognitive restructuring) are used more generically without direct reference to individuals' distinct symptom presentation. It may be assumed that common psychological processes are impacted, but these are not explicitly targeted. Sometimes, though, this pragmatic approach is informed by theory that identifies the unified factors in disorders. Norton's transdiagnostic treatment, for example, does have theory-driven elements, with the first nine sessions devoted to psychoeducation, self-monitoring, cognitive restructuring, and exposure (i.e. elements derived from disorder-specific CBT) and the final three sessions shifting focus to daily life issues that involve the common factors of uncontrollability, unpredictability, and threat (Norton, 2008; Norton, Hayes, & Hope, 2004).

The second approach can be termed *transdiagnostic theory*. In this perspective, there is an attempt to specify a conceptual framework that delineates the common or unifying psychological constructs, disorder-specific constructs, and their functional relation in the maintenance of emotional disturbance. Research within this tradition recognizes that what is similar across disorders is greater than what differentiates them. However, at the same time, it is acknowledged that any theory must also explain the existence of different disorders. Mansell et al. argued that certain cognitive processes like attentional bias, self-focused attention, thought suppression, selective recall, and avoidance and safety-seeking are common constructs across disorders, whereas individuals' current concerns, dysfunctional thought or belief content, or the presence of varying degrees of transdiagnostic processes might account for disorder specificity (Mansell, Harvey, Watkins, & Shafran, 2008; Mansell et al., 2009). Another well-recognized theoretical approach that can be considered transdiagnostic is L. A. Clark and Watson's (1991) tripartite model of anxiety and depression. Various refinements have been introduced over the years (e.g. Watson, 2005), but the basic argument is that a tendency to experience negative emotion (i.e. negative affectivity) is a general,

nonspecific mood–personality disposition common to anxiety and depression, whereas low positive affect (i.e. lack of pleasurable engagement) is specific to depression and physiological hyperarousal is specific to most anxiety states but especially panic disorder. Even though rarely specified, research on common and specific elements of the latent structure of emotional disorders could provide a conceptual basis for the development of transdiagnostic treatment.

The third perspective to transdiagnostic treatment is a more recent development that takes a strong theory-driven approach in the construction of a unified treatment protocol for all emotional disorders. This approach is most clearly illustrated by the unified protocol (UP) for emotional disorders described by Barlow et al. (Allen et al., 2008; Barlow et al., 2004), which builds an intervention strategy on the known commonalities between anxiety and depression. Based on the concept of generalized psychological vulnerabilities, such as a sense of uncontrollability, which are critical in the etiology of emotional disorders as well as the presence of a common latent symptom structure in the form of high negative affect, three broad change principles are proposed: (a) need to alter emotion-based misappraisals of critical life experiences, (b) prevention of avoidance of negative emotion triggers, and (c) modification of emotion-driven behaviors (Allen et al., 2008). UP consists of four treatment components: (a) psychoeducation about the persistence of emotional disturbance; (b) change in the faulty appraisals of the probability and consequences of negative experiences (i.e., cognitive restructuring); (c) prevention of emotional avoidance in terms of reliance on cognitive or behavioral avoidance strategies, or excessive safety-seeking; and (d) modification of emotion-driven behaviors that are specific reactive behaviors associated with particular emotions such as hypervigilance in anxiety or withdrawal in depression (Allen et al., 2008). Initial open trials on the efficacy of UP are still in progress, so its effectiveness is largely unknown at this time. However, UP provides an excellent example of fresh insights and innovation that occurs when a theory-driven approach is adopted for transdiagnostic treatment.

Advantages and disadvantages of transdiagnostic CBT

There are many practical reasons for advocating transdiagnostic CBT, which have been discussed in various review articles (see special issues of *Journal of Cognitive Psychotherapy* and the *International Journal of Cognitive Therapy*). First dissemination of multiple manualized disorder-specific CBT is time-consuming, costly, and inefficient. Having a single transdiagnostic CBT that is applicable to a broader range of disorders might increase the adoption rate of evidence-based CBT by mental health practitioners and improve access and availability of effective psychological treatment in the health care sector. Second, in most countries, there is growing concern about the escalating costs of health care. Transdiagnostic CBT is usually offered in a group format and so is a more economical treatment approach than individual standard CBT. Third, transdiagnostic CBT is particularly well suited to general community mental health or rural settings where a diagnostically heterogeneous clientele is serviced and the base rates for specific diagnoses may be low.

A fourth advantage of transdiagnostic CBT is that it might improve treatment acceptance rates if offered before a course of disorder-specific individualized CBT. A significant number of individuals with anxiety, in particular, refuse treatment, and many patients terminate prematurely before they achieve significant symptom improvement. Transdiagnostic CBT, with its broader focus on common processes, may be less threatening and thus more acceptable to individuals reluctant to commit to therapy. Fifth, transdiagnostic CBT could be used to address residual symptoms that often remain even after a successful course of standard CBT. Group transdiagnostic CBT could be offered concurrent with or immediately after disorder-focused standard CBT as a relapse prevention program, which also has a positive effect on residual symptoms. Sixth, transdiagnostic CBT could be used when individuals show high comorbidity for anxiety and depression. By targeting shared symptoms, the treatment might be more likely to have a greater impact on both conditions compared with a disorder-focused approach. Finally, transdiagnostic CBT might offer new insights into the

development of prevention programs by targeting unified psychological processes and common change principles that might be more effective in preventing new occurrences of anxious or depressive episodes (Dozois, Seeds, & Collins, 2009).

Despite the promise of transdiagnostic CBT, there are significant challenges that face further research and development. One question concerns its efficacy. To date there are a few open trials showing that transdiagnostic CBT is more effective than a wait-list condition (e.g., Norton, 2008; Norton & Hope, 2005; see meta-analysis by Norton & Philipp, 2008). However, there have been no direct comparisons between transdiagnostic and disorder-focused CBT, so the incremental effectiveness of the transdiagnostic approach is unknown. Transdiagnostic CBT might be more effective when comparing diagnostically heterogeneous samples, but it would not be expected to beat disorder-specific treatment for diagnostically homogeneous groups. Second, most group transdiagnostic treatments are not pure but instead contain varying amounts of disorder-specific ingredients. How much of the effectiveness is attributable to modification of unified cognitive and behavioral processes is confounded by the inclusion of disorder-specific treatment ingredients.

A third question concerns who might benefit most from transdiagnostic CBT. Given its recent history, we have no data on

personal, demographic, or clinical characteristics associated with a good or poor outcome. For example, it has been suggested that transdiagnostic CBT may not be suitable for individuals with OCD or PTSD (Erickson, Janeck, & Tallman, 2009). It is also not known whether transdiagnostic CBT should be offered as an adjunct or alternative intervention to disorder-focused CBT. Finally, more research is needed on the commonalities of anxiety and depression that should be targeted for treatment and on the common therapeutic change mechanisms that are most effective. Despite some differences among researchers, there is a significant degree of consensus on the common processes in emotional disorders that should be targeted in a transdiagnostic treatment. Table 1 provides a summary of some unified and specific cognitive and behavioral processes in anxiety and depression that have appeared in the transdiagnostic literature.

Transdiagnostic CBT: a possible approach

There is much to commend a transdiagnostic approach to the treatment of emotional disorders. The well-established findings of shared processes and the overlapping clinical features of the anxiety disorders and depression as well as their high rates of diagnostic and symptom comorbidity provide a solid rationale for pursuing further

Table 1. *Summary of selected shared and specific cognitive and behavioral variables in the emotional disorders*

Shared (unified) variables	Disorder-specific variables
Repetitive negative thought	Personal current concerns
Self-absorption	Negative automatic thought content
Perceived uncontrollability	Hopelessness (negative future expectancy)
Faulty appraisals of personal negative experiences (i.e. cognitive errors, interpretation biases)	Type of internal or external triggers (i.e. contextual elements)
Attentional biases	Hypersensitivity to physiological arousal
Selective memory recall	Negative schematic content
Faulty meta-cognitive processing	Heightened anxiety sensitivity
Maladaptive mental control (e.g. thought suppression, worry)	Type of safety-seeking
Excessive control efforts	
Emotional reasoning (i.e. "It must be significant because I am so distressed")	
Heightened personal vulnerability (i.e. helplessness)	
Avoidance, procrastination	

development of transdiagnostic CBT. As discussed, the overwhelming demand for mental health services in the population is further impetus for the development of more efficient interventions that are applicable to a wider segment of the population. However, progress will be stifled if transdiagnostic CBT is pitted against our current disorder-focused treatments. It is unlikely that a broadly based intervention would ever outperform a specific treatment protocol tailored to the unique features of particular disorders. If transdiagnostic treatment must be superior to disorder-focused treatment in order to justify further efforts in this direction, then this research agenda is likely doomed to failure. We currently have very effective disorder-focused treatments for depression and the anxiety disorders that also have broader positive effects on comorbid conditions (e.g. Tsao, Lewin, & Craske, 1998).

A way forward in the development of transdiagnostic CBT is evident if we view transdiagnostic and disorder-focused treatment in an integrative and complementary fashion. It may be that the optimal treatment will be a combination of prior transdiagnostic group CBT followed by a few sessions of individual disorder-specific CBT. If development of the transdiagnostic and disorder-specific components of a treatment package were based on a conceptual framework of common and specific processes, this would increase the probability of creating a more efficient and effective intervention. The critical empirical question would be whether the combination package of group transdiagnostic plus individual disorder-specific CBT is significantly more effective than either treatment component alone. Once the efficacy of the combination CBT has been demonstrated, this could be followed by treatment process studies to determine inclusion and exclusion criteria (i.e. who benefits most and least from this more intensive treatment) as well as dismantling studies that could lead to further refinement of the treatment package.

Much work needs to be done before we will begin to understand the potential of a transdiagnostic perspective to CBT. The research to date represents the very first steps in this direction. However, our efforts will prove disappointing unless they are guided by a strong theoretical orientation and

recognition that transdiagnostic components must be viewed as complementary to well-established disorder-specific CBT.

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