Perspective

Movement towards transdiagnostic psychotherapeutic practices for the affective disorders

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ABSTRACT

Evidence-based cognitive behavioural therapy (CBT) practices were first developed in the 1960s. Over the decades, refinements and alternative symptom foci resulted in the development of several CBT protocols/manuals for each of the many disorders, especially in the affective disorders. Although shown to be effective in highly trained providers, the proliferation of CBT protocols also has shown to demonstrate challenges in dissemination and implementation efforts due to the sheer number of CBT protocols and their related training requirements (eg, 6 months per protocol) and their related cost (eg, over US$2000 each; lost days/hours at work). To address these concerns, newer transdiagnostic CBT protocols have been developed to reduce the number of disorder-specific CBT protocols needed to treat patients with affective disorders. Transdiagnostic treatments are based on the notion that various disorder-specific CBT protocols contain important but overlapping treatment components that can be distilled into a single treatment and therefore address the symptoms and comorbidities across all of the disorders at once. 3 examples of transdiagnostic treatments include group CBT of anxiety, unified protocol for transdiagnostic treatment for emotional disorders and transdiagnostic behaviour therapy. Each transdiagnostic protocol is designed for a different set of disorders, contains a varied amount of CBT treatment components and is tested in different types of samples. However, together, these 3 transdiagnostic psychotherapies represent the future of CBT practice.

Initial practices of behaviour therapy began as a deviation of common psychotherapy practices to address specific types of psychopathology in the early 1960s. Systematic desensitisation was one of the best examples of this trend, in which a specific set of behavioural techniques was used as a translation of the basic sciences of learning theory to psychotherapeutic practices.[1] From the mid-1960s to the early 1980s, these initial practices were further investigated, refined and applied to new psychiatric disorders, resulting in the development of some of the common evidence-based practices of today (eg, situational exposures).[2] However, several disorders and groups of symptoms still lacked effective techniques, suggesting that additional developments were needed.[3]

Over the next two decades, extensive research was completed on the mechanisms of action, theories of behaviour change and cognitive models of each of the separate affective disorders.[2] This research was complemented by refinements in the third edition of the Diagnostic and Statistical Manual to improve the validity and reliability of the psychiatric disorders.[4] Together, this research led to the identification and development of additional evidence-based techniques (eg, interoceptive exposures) as well as research on the initial manualised protocols for affective disorders.[5 6] In the 2000s, the initial developments of cognitive behavioural therapy (CBT) practices were followed by an explosion of new disorder-specific manualised protocols, each of which contained many of the same evidence-based CBT practices as presented in table 1. With the continued research on and refinement of these new practices, there are now several evidence-based manuals for each of the primary affective disorders, including panic disorder (PD), social anxiety disorder (SOC), generalised anxiety disorder (GAD), specific phobia (SP), obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD), major depressive disorder (MDD) and persistent depressive disorder (PDD).

Although the benefits of these programmes are clear, a number of limitations have been identified through the dissemination and implementation efforts of these practices. One of the most significant limitations is the sheer number of different CBT manuals. Standard workshops for disorder-specific, evidence-based psychotherapies typically involve a substantial time and monetary commitment from providers (table 2). In addition, indirect costs also can be a significant hurdle for providers and facilities (eg, loss of revenue during training activities). Only a small number of workshops are available per year and typically require out-of-town travel, representing a significant burden on providers, especially if training is needed for more than one disorder (eg, 6–12-month commitment per treatment per disorder), and these types of trainings are only available for specific disorders. In fact, Dr David Barlow—one of the leaders in the development and dissemination of CBT—has argued that, ‘unless these treatments become more ‘user-friendly’ as recommended (by a recent NIMH task force), it is unlikely that most non-research clinicians will have a sufficient understanding of, or access to these empirically supported techniques for the affective disorders.’[2]

Table 1 Overlapping components of common CBT protocols of depressive/anxiety disorders

Protocol and disorder	Evidence-based treatment components
CBT for PD	Relaxation training, cognitive restructuring, situational exposures, interoceptive exposures, relapse prevention
CBT for SOC	Cognitive restructuring, situational exposures, interoceptive exposures, relapse prevention
Exposure with response prevention for OCD	Cognitive restructuring, situational exposures, imaginal exposures, response prevention, relapse prevention
Prolonged exposure for PTSD	Relaxation training, cognitive restructuring, situational exposures, behavioural activation, imaginal exposures, relapse prevention
Cognitive processing therapy for PTSD	Cognitive restructuring, imaginal exposures, relapse prevention
CBT for specific phobia	Situational exposures, relapse prevention
CBT for GAD	Relaxation training, cognitive restructuring, imaginal exposures, situational exposures, response prevention, problem-solving, relapse prevention
CBT for MDD/DD	Cognitive restructuring, behavioural activation, problem-solving, relapse prevention

Only hallmark protocols were detailed due to the large number of protocols available for each disorder. All exposure/activation techniques are presented to shades of red. CBT, cognitive behavioural therapy; DD, depressive disorder; GAD, generalised anxiety disorder; MDD, major depressive disorder; OCD, obsessive-compulsive disorder; PD, panic disorder; PTSD, post-traumatic stress disorder; SOC, social anxiety disorder.

Table 2 Direct costs training in evidence-based psychotherapy

Training component	Cost	Time
Workshop registration	US$1100	4 days
Estimated travel (flight and airport cost)	US$500	2 days
Estimated hotel (city)	US$120×4=US $500	–
Estimated meals (not covered in training)	US$50×4=US$200	–
Supporting manual and patient workbook	US$50	–
Weekly post-training supervision/consultation	–	6 months
Single training total direct costs	US$2350	
Trainings across disorders	US$2350×8=US $18 800	4 years (without overlap)

Workshop registration is based on published price for prolonged exposure for post-traumatic stress disorder.

Similar concerns have been expressed by the Department of Veteran Affairs (DVA) leadership involved in CBT dissemination efforts.[7]

Given the intensive requirements of disorder-specific treatments, providers who wish to competently provide CBT for the affective disorders and their comorbidities must complete the following steps: (1) choose from among the many evidence-based CBTs that are available to treat each of these affective disorders; (2) identify and attend comprehensive trainings in the intervention, including multiple-day workshop trainings, ongoing supervision and case consultation; (3) develop an understanding through these trainings and their own independent research about how to address comorbidities, including choosing the primary disorder to target in a non-arbitrary, informed fashion; and (4) efficiently recreate the structure of treatment for patients with comorbidities (eg, comorbid PTSD and PD) to ensure that they are delivering treatment with satisfactory fidelity and effectiveness without simply doubling the length of treatment and fully implementing multiple CBT protocols. The latter two steps must be accomplished without direct training, as these issues are typically not addressed in training workshops for disorder-specific CBTs. Each of these steps must be repeated for each separate disorder-specific treatment to be learnt and mastered.

In contrast to the lengthy training necessary for the disorder-specific CBT protocols, a shift to a transdiagnostic CBT protocol for affective disorders would eliminate much of the unnecessary procedures, time commitment and financial burdens. Transdiagnostic treatments are based on the notion that various disorder-specific CBT protocols contain important but overlapping treatment components that can be distilled into a single treatment and therefore address the symptoms and comorbidities across all of the disorders at once.[8] This notion is most true of the affective disorders in which a large number of overlapping symptoms and related components of CBT exist. As presented in table 1, CBT for SOC, PD, GAD and SP, Exposure with Response Prevention for OCD, and Prolonged Exposure for PTSD all contain situational/behavioural exposures as an essential, if not primary, component of treatment.[9] Similar behavioural components exist in CBT for MDD and PDD as well (behavioural activation).[9] As described above, these techniques are based on the same theories, guided by the same principles and thus are nearly identical across each of the disorder-specific protocols. The transdiagnostic approach to the affective disorders represents a major shift in philosophy regarding application of evidence-based psychotherapy to specific symptoms after decades of developing scores of disorder-specific treatments. This approach aims to simplify treatment of the affective disorders by combining the shared/overlapping treatment components into a single treatment for the entire class of disorders. Transdiagnostic treatments would greatly reduce the training burden on providers as only one protocol would be needed for the affective disorders, rather than separate protocols for each separate disorder. In addition, since transdiagnostic treatments are designed to address multiple affective disorders at once, they most likely are able to address the needs of patients with comorbidities without requiring providers to successfully identify and implement multiple treatment protocols or decide the order to best target comorbid affective disorders.

A small number of transdiagnostic treatment approaches have been developed for the affective disorders.[10 11] For the purposes of this paper, three in-person transdiagnostic approaches with supporting evidence will be reviewed briefly. Each transdiagnostic approach has strengths and weaknesses.

The first published transdiagnostic psychotherapy was transdiagnostic group CBT of anxiety (T-GCBT).[12] The treatment involves 12 weekly 2-hour group sessions for patients with anxiety disorders. The primary treatment components of T-GCBT are cognitive and exposure therapies. T-GCBT has received the most support in the literature among the transdiagnostic treatments and has been shown to be equally effective as relaxation therapy and disorder-specific psychotherapies across the anxiety disorders.[12 13] However, there also are some limitations to T-GCBT. T-GCBT only covers the Diagnostic and Statistical Manual of Mental Disorders 5 anxiety disorders. In addition, T-GCBT includes a large cognitive therapy component prior to exposure therapy, an approach that has received criticism in the more recent literature.[14] More specifically, use of cognitive therapy prior to exposure therapy is said to reduce the efficacy of exposure practices, which are the most efficacious in the treatment of anxiety disorders.

Perhaps the most well-known transdiagnostic psychotherapy is the unified protocol for transdiagnostic treatment for emotional disorders (UP).[15] The treatment involves up to 18 weekly 1-hour individual sessions for patients with anxiety disorders, although it has been hypothesised to aid other disorder categories as well. The UP includes at least the four primary treatment components of psychoeducation about emotions, alteration of antecedent cognitive misappraisals, prevention of emotional avoidance and modification of emotion driven behaviours.[16] Additional treatment components have been presented elsewhere as well.[17] The initial findings are promising for the UP in patients with anxiety disorders, including an open trial and a wait-list control trial.[16 17] Similar concerns are present for the UP as was listed for T-GCBT, including the limited scope to the anxiety disorders (thus far) and the use of cognitive therapy prior to exposure therapy. The ease of dissemination also may be of concern for the UP given the requirement to learn four-to-six separate number of evidence-based treatment components present in its protocol.[15]

A third, newer transdiagnostic protocol developed is transdiagnostic behaviour therapy (TBT), which was developed within the DVA for use with veterans.[18] TBT involves 12 weekly 1-hour individual sessions for patients with affective disorders, including PTSD and MDD. TBT includes only one primary treatment component, exposure therapy, and therefore is not subject to the same concerns regarding cognitive therapy and may be easier to disseminate.[19] The initial findings for TBT are promising across disorders; however, no randomised controlled trials (RCTs) have been completed for TBT as yet.[20] In addition, TBT has only been investigated in veteran samples, limiting its generalisation to civilian samples. Ongoing research on TBT will answer and may address these limitations.

Together, these three transdiagnostic psychotherapies represent the future of CBT practice. Over time, CBT has fluctuated from too little to too many protocols. These transdiagnostic approaches may aid in reducing the number of protocols by shifting from disorder-specific and disorder-category-specific. More research is needed on these treatments prior to the field shifting to them; however, larger RCTs are ongoing, hopefully supplying further support for their use compared to the many disorder-specific approaches.[20]

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