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SPECIAL SERIES

Translating Transdiagnostic Approaches to Children and Adolescents

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Introduction

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Transdiagnostic interventions make use of eclectic treatment strategies to address multiple diagnostic problem sets linked by common underlying etiological or maintaining mechanisms. A good transdiagnostic treatment relies on strategies with empirical support and is flexible enough to accommodate diverse problems. As such, transdiagnostic treatments have numerous potential advantages over traditional approaches, including increased efficiency, practicality, efficaciousness, and effectiveness. Translation of transdiagnostic therapies to youth populations is in its nascent stages. This introduction reviews the special series in adaptations of transdiagnostic treatments to youth population. It will define transdiagnostic therapies, discuss potential advantages of such an approach, and then review each of the special series articles.

Transdiagnostic interventions have been gaining support in the adult literature as an efficient and effective approach for treating multiple problems within a single protocol (e.g., Barlow, Allen, & Choate, 2004; Fairburn, Cooper, & Shafran, 2003). A good transdiagnostic approach draws from a unifying theoretical model that explains disparate conditions via common mechanisms. Its treatment strategies are also flexible enough to accommodate diverse problems. As such, initial trials have proved successful in adult populations (e.g., Barlow et al., 2004; Fairburn et al., 2003). However, evidence regarding the relevance and effectiveness of transdiagnostic approaches for children, adolescents, and families is still emerging. High comorbidity rates, shifting symptom profiles over time, and complex family contexts all complicate "treatment as usual" for youth populations and make a transdiagnostic approach appealing (Chu, Colognori, Weissman, & Bannon, 2009). This special series will review recent developments in transdiagnostic treatments for youth psychological disorders with an eye toward clinical descriptions that distinguish this novel approach from traditional methods of managing co-occurring and overlapping clinical problems.

Keywords: transdiagnostic treatment; child and adolescent

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Defining Transdiagnostic Therapies

No single definition captures all "transdiagnostic" treatments or theories. Many have developed out of an attempt to manage the pervasive comorbidity that frequently occurs across disorders (Angold, Costello, & Erkanli, 1999). The traditional evidence-based treatment approach promotes disorder-specific protocols that prioritize a single primary clinical problem. The implication is that clinicians treat comorbid problems separately, in a sequential manner, or through some combination of empirically supported strategies. However, the decision rules by which a clinician chooses among these strategies are not well supported. Transdiagnostic treatments, on the other hand, present a consolidated set of interventions aimed to efficiently and effectively treat multiple disorders or problem sets simultaneously. Transdiagnostic treatments are developed through an understanding of clinical science and knowledge of how candidate disorders relate based on shared etiology, structural commonalities, or similar maintaining processes among disorders. Treatment strategies are then chosen that specifically target these common etiological or maintaining mechanisms.

This focus on a small set of "core psychopathology" (Fairburn et al., 2003) promises a number of advantages, including increased efficiency, practicality, and effectiveness of our evidence-based treatments, particularly as they are performed in everyday clinical practice (Barlow et al., 2004; Harvey, Watkins, Mansell, & Shafran, 2004). Targeting mechanisms that underlie multiple syndromes

can be more efficient and increase the chances that gains are generalized. Instead of addressing one symptom set at a time, the clinician can focus on a core set of related processes that underlie presenting symptoms. Clients learn strategies that can be applied across problems which can improve generalizability and may improve treatment acceptability because several problems are addressed simultaneously. Ultimately, this approach may require therapists to learn and apply fewer treatment components by using a pared-down set of treatment interventions known to address targeted mechanisms. In principle, this could reduce the number of treatment components clinicians have to learn, shrink the number of treatment manuals clinicians must know, and reduce the diversity of specialized skills therapists have to maintain through continuing education. Such simplicity could facilitate training and dissemination of evidence-based treatments.

The scope and focus of each transdiagnostic treatment varies. Some focus on naturally related (yet still diverse) clinical disorders. Barlow et al.'s (2004) Unified Protocol for Emotional Disorders has established itself primarily for anxiety and depression, and Fairburn et al.'s (2003) intervention addresses core pathology among multiple adult eating disorders. Still others attempt to apply a universal structure to a broader swath of disorders. For example, Harvey and colleagues (2004) have reviewed the role that basic cognitive and behavioral processes play in contributing to nearly all DSM-IV diagnoses.

Transdiagnostic interventions are particularly relevant for youth populations where comorbidity is more the rule than the exception. Receiving a diagnosis of one clinical disorder significantly increases the odds of having a second disorder, and this relationship holds whether the primary diagnosis is internalizing or externalizing in nature (Angold et al., 1999). Based on this data, some have made compelling arguments that dimensional symptom profiles capture youth pathology better than categorical systems (Achenbach, 1995). A focus on core mechanisms may help unify categorical versus dimensional debates by focusing on the underlying processes that give rise to multiple symptom and diagnostic profiles. Furthermore, a transdiagnostic approach may help take into account the greater complexity of interpersonal systems that impact youth. Parents, siblings, school, and broader community networks all influence youth functioning to a greater degree than in adults. Transdiagnostic conceptualizations may help look for unifying interpersonal and systems processes across disorders (e.g., multisystemic therapy) that impact functioning as much as individual cognitive, behavioral, emotional processes.

Overview of the Special Series

The current special series reviews the latest in clinical applications of transdiagnostic therapies for youth disorders. Each paper provides its own working definition of "transdiagnostic therapy," describes a transdiagnostic treatment approach, and then briefly reviews its supporting theoretical and empirical evidence. The authors provide a case example so that readers can evaluate how this approach differs from traditional cognitive behavioral methods for addressing comorbidity. Each author also discusses the strengths and limits of their approach and the developmental issues that were considered in its development and delivery.

Chu, Merson, Zandberg, and Areizaga (2012–this issue) provide an overview of evidence-based approaches to managing comorbidity in youth populations. These approaches include using "flexibility within fidelity" in single-target treatments (the most common form of empirically supported treatment), modular-based treatments that guide adaptation through a sequence of decision rules, and transdiagnostic treatments that focus on core underlying mechanisms. The authors present two case studies to illustrate how a clinician might address comorbidity in two single-target treatments: the anxiety-focused Coping Cat protocol and the depression-focused Primary and Secondary Control Enhancement Treatment. Individual Behavioral Activation Therapy is then introduced to describe how co-occurring anxiety/depression with significant school refusal and somaticizing symptoms can be addressed by targeting core avoidance processes. The three cases highlight the similarities and differences among these approaches.

Loeb, Lock, Greif, and Le Grange (2012–this issue) describe a family-based treatment that has demonstrated empirical support in treating multiple eating disorders in teens (anorexia nervosa, bulimia nervosa, eating disorders–not otherwise specified). The Maudsley approach maintains an atheoretical framework when considering the etiology of eating disorders, but their treatment approach identifies common family processes that maintain the disorder, including the secrecy, blame, and internalization of the illness that occurs in families where a member has an eating disorder. The Maudsley approach borrows from an eclectic set of treatment interventions, including a broad range of family modalities and exposure-based exercises. The treatment makes use of evidence-based learning theory and interventions but is distinctive from traditional cognitive-behavioral therapy in its focus on family processes. The authors provide an illustrative case study that highlights these differences, and describes how family processes can be used transdiagnostically.

Racer and Dishion (2012–this issue) take the broadest stance of the series and review disordered attention processes that extend across internalizing and externalizing problems in youth. The authors provide an accessible description of the multifaceted attention process and how it

affects the clinical phenomena that clinicians see. They discuss the evidence for how executive attention can mediate or moderate development of both antisocial behaviors and depression, but that unique relationships between specific attention processes and certain disorders do exist. Although it may appear daunting for the local clinician to address disordered attention processes, the authors review available assessment tools and then describe several innovative computer-based programs that target core attention processes. The authors review how attention training programs can be used as a primary or supplemental treatment tool (e.g., as pretraining for other clinical problem) and also provide useful information about where to find attention training programs, their feasibility, and their pros and cons.

The next two papers describe how a single transdiagnostic protocol can be developed across problem sets while adhering to a central framework and set of therapeutic tools. Ehrenreich-May and Bilek (2012–this issue) describe the adaptation of the Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders in Youth (UP-Y; Ehrenreich, Goldstein, Wright, & Barlow, 2009), which itself was an adaptation from the adult version, into a group designed for youth and parents. This group focuses on co-occurring anxiety and depression like UP-Y, but it also integrates specific parenting lessons to encourage youth independence, consistency in parenting, and empathy of youth emotional expression. Allen, Tsao, Seidman, Ehrenreich-May, and Zeltzer (2012–this issue) then adapt the UP-Y to address chronic pain that can co-occur with anxiety and depression in pediatric settings. The authors take time to define pain as its own multidimensional construct consisting of sensory and affective components. They promote an emotion regulation framework that builds on the experiential avoidance foundation of UP-Y.

Weersing, Rozenman, Maher-Bridge, and Campo (2012–this issue) describe a second approach to treating anxiety and depression in outpatient and pediatric settings. The authors describe a toolbox of modular-based interventions representing a common set of psychoeducational, behavioral, and exposure strategies that can be tailored to the setting and client population. For example, anxiety and depression in outpatient settings are treated using six modules over 12 sessions and prioritize in-session activation exercises. Comorbid internalizing symptoms with irritable bowel syndrome calls for a modified six modules over 6 sessions and emphasizes take-home practice. The variations reflect the differences in flexibility, session limit, and session duration allowed in outpatient versus medical settings. The flexibility of a toolbox allows clinicians to use empirically supported interventions while meeting individual needs of clients.

Rohde (2012–this issue) concludes the series by discussing the strengths and limitations of the transdiagnostic approach. Rohde reflects on the progress and promise of the transdiagnostic approach and offers a cogent critique of the issues that remain. For example, the novelty of transdiagnostic treatments has been questioned. If traditional manual-based therapies have encouraged "flexibility within fidelity" and recognizes individual adaptation is important, how does the transdiagnostic approach offer something unique?

Together, these papers represent a transition in thinking about how we conceptualize and treat overlapping problem sets. The development of any new technology will prompt welcomed critique as the field wrestles with questions of scientific validity and clinical relevance. This further discussion will ideally lead to refined versions of both transdiagnostic and traditional CBT interventions. As it stands, these papers illustrate the possibilities that exist when evidence-based treatment protocols are extended to target a diversity of treatment populations, symptom and dysfunction profiles, and etiological and maintaining mechanisms.

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