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COMMENTARY

Applying Transdiagnostic Approaches to Treatments With Children and Adolescents: Innovative Models That Are Ready for More Systematic Evaluation

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Comorbidity has become a well-established aspect of adolescent psychopathology, with the majority of adolescents entering treatment having more than one psychiatric condition. When this occurs, which disorder should be treated first? Should disorders be treated separately or simultaneously? Answers to basic service-delivery questions such as these are currently unknown. The co-occurrence of disorders complicates the conceptualization and provision of treatment and is generally associated with higher dropout, lower recovery, and poorer maintenance of gains. Little is known regarding effective treatment delivery for comorbid conditions, however, because individuals with comorbidity have often been excluded from clinical trials.

After many years of focus on the development and evaluation of disorder-specific interventions, evidence-based treatments, many of which are forms of cognitive-behavioral therapy (CBT), exist for the most common disorders of childhood and adolescence. The pendulum now appears to be swinging towards the identification of common processes that bridge numerous diagnostic categories. This work is fairly new and, to date, has been limited to a small group of clinical researchers in adult psychotherapy (e.g., Barlow, Allen, & Choate, 2004; Hayes, Wilson, Strosahl, Gifford, & Follette, 1996). Research is emerging to support the transdiagnostic approach for adults, but very little has been available for children and adolescents. The authors in this special section are to be commended for beginning to address this major gap in our understanding of psychotherapy research. Each article in this special section wrestles with various challenges involved in treatment integration and with tackling more complicated client populations. The clients in these case studies are actually not unusually complex; they are just described in greater detail. Previous randomized controlled trials (RCTs) evaluating disorder-specific interventions have been conducted with many clients just like this; that research, however, has tended to focus exclusively or primarily on one aspect of their psychological situation. For major categories of disorder, standard treatment research (one disorder treated by a single intervention) may be reaching a point of diminishing returns. The new focus on expanded concepts of psychopathology and intervention illustrated in this section provides an innovative and potentially valuable method of continuing progress in intervention research.

Strengths of the Transdiagnostic Approach

The most important positive feature of a transdiagnostic approach is that it provides a method of addressing comorbidity, allowing multiple forms of pathology to be conceptualized and treated within a single, unified framework. If this goal can be achieved, it would represent a major advantage for dissemination. The current implicit recommendation provided by the research community for intervening with youth who have comorbid conditions is that evidence-based treatments aimed at each of the presenting disorders be provided. How treatment for these disorders is prioritized is not specified. Of concern, research currently being conducted by my colleagues and me with comorbid depressed/substance-abusing adolescents suggests that there is a fairly limited window of opportunity to engage a family into treatment (Rohde, Waldron, Turner, Brody, & Jorgensen, May, 2010). Therefore, the provision of treatments in a sequential manner may not be feasible due to high attrition for the second treatment in a sequenced approach. The second option (i.e., simultaneously providing empirically support treatments) may avoid the attrition problem with sequenced care but results in its own complexities. Most importantly, it is not clear what treatment rationale is provided to the child and his or her parents. Chu, Merson, Zandberg, and

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Areizaga (2012-this issue) review different approaches to intervening with comorbid youth, noting that a "mix-and-match" approach is confusing to clients and lacks the coherent rationale that may be a core essential feature of effective treatment. Many years ago, it was theorized that the provision of a clear and compelling rationale for treatment is an "essential ingredient" of effective treatment for depression (Zeiss, Lewinsohn, & Muñoz, 1979). Presumably, this need for a treatment rationale applies to other psychiatric conditions. The rationale is shared with the client (and parents, in child/adolescent psychotherapy) and provides a structure that guides clients to the belief that change in the factors included in the model will result in symptomatic recovery. Perhaps the most novel and significant benefit of transdiagnostic models is that they provide compelling models for change across conditions.

A related benefit of the transdiagnostic approach is that it potentially simplifies treatment for both the client and therapist, although this goal of simplification is not always clearly espoused (as will be discussed later). A simplified model would greatly facilitate dissemination. The current situation in which clinicians are expected to master a large array of disorder-specific treatment manuals that have some degree of empirical support is unwieldy and undoubtedly contributes to the gap between researchers and clinicians. A simplified and unified model could improve the quality of care provided to a larger proportion of the treatment population, as the majority of clients (either children/adolescents or adults) do not receive a full dose of evidence-based disorder-specific treatment.

The appeal of transdiagnostic interventions is very clear—the availability of efficient and effective evidence-based approaches for treating multiple problems within a single protocol would satisfy a great need in public health. It addresses a major criticism made by clinicians that manualized interventions are not applicable to the complex situations seen in routine practice.

The last major benefit of the transdiagnostic approach is that it more directly targets the mechanisms or processes that need to be changed. Disorder-specific interventions are developed and evaluated to reduce symptoms of specific conditions, but the actual mechanism of change can vary widely for the same condition. As several of the authors in this section note, targeting mechanisms that underlie multiple syndromes could be much more time-efficient and successful, potentially increasing the likelihood that gains are generalized across conditions.

Limitations of the Transdiagnostic Approach

In spite of these very promising positive features, the transdiagnostic approach has at least two significant limitations. First, the model potentially complicates training for therapists. It is unclear whether clinicians need to learn these interventions, possibly in addition to the standard, disorder-specific evidence-based treatments. Do we need multiple interventions— existing interventions for clients with pure (noncomorbid) disorder and transdiagnostic approaches for clients who respond poorly to standard interventions? That approach complicates rather than simplifies training demands on busy mental health providers.

The second key drawback for these approaches involves limitations in our current understanding of core processes for psychopathology. Given that numerous common factors are potentially available (e.g., experiential avoidance, repetitive negative thinking, genetic processes, negative affect in the area of anxiety disorder/depression), the question is, Which factor is the "right" unifying construct? There is a tension between models being large enough to be inclusive versus being so big that they lose specific, valuable content and skills. These models require that the most powerful processes are identified and then assessed prior to treatment. These approaches, at least initially, will increase assessment demands unless the focus on diagnostic assessment is greatly simplified. We will need to create a new classification system based on cognitive and behavioral processes rather than (or to complement?) observable symptoms.

Does the labeling of a diagnosis help the client or contribute to stigma? Some disorders have high stigma, especially in children and adolescents, but clients may also find comfort in realizing they are not unique and that their problems have a label (although oftentimes the label provides no actual explanation for what caused the symptoms or what the treatment should be).

Progress and Promise of the Transdiagnostic Approach With Children and Adolescents

The transdiagnostic approach in this special series is applied most often to intervening with youth who experience anxious and depressive symptoms, sometimes in combination with chronic pain or other somatic conditions. Chu and colleagues (2012-this issue) provide a model for addressing internalizing disorders of depression and anxiety, with the unifying concept of avoidance. Ehrenreich-May and Bilek (2012-this issue) also address these conditions, using the concepts of avoidance and negative appraisals of threat. The model articulated by Allen, Tsao, Seidman, Ehrenreich-May, and Zeltzer (2012-this issue) incorporates chronic pain and internalizing symptoms, using an adaptation of the unified protocol discussed by Ehrenreich-May and Bilek. Weersing, Rozenman, Maher-Bredge, and Campo (2012-this issue) address these same conditions using an approach that focuses on exposure and behavioral activation, which were

selected based on a review of effective core techniques across empirically supported treatments for anxiety and depression. Currently, the most promise for transdiagnostic approach seems to apply for depression and anxiety disorders. This area has received the most attention and seems more ready for systematic evaluation.

Loeb, Lock, Greif, and le Grange (2012-this issue) cover variants of eating disorders, with the unifying concept of overevaluation of shape and weight. Although this article focuses on the most constrained range of conditions, the treatment of restricting, bingeing, and purging behaviors covers a broad range of behaviors in the realm of disordered eating, and having a unifying model would benefit both clients and practitioners. Racer and Dishion (2012-this issue) have the broadest reach, addressing the treatment of internalizing and externalizing problem behaviors with the unifying concept of attentional dysfunction. Attention is not conceptualized as the etiologic cause of disorders but moderates the association of known risk factors, in that the presence of strong executive attention can protect individuals from known risk factors for both internalizing (stress) and externalizing (deviant peers) risk factors. Attention (attention training specifically) is a unified concept for treatment rather than pathology, and improved attentional control would not be the sole treatment but would facilitate the delivery of other disorder-specific treatments. This article is novel because it proposes a unifying factor that has an impact on the effectiveness of treatment across a broad range of psychiatric conditions.

Issues That Remain

Perhaps the biggest challenge involves whether the transdiagnostic approach complements or replaces disorder-specific treatments. Intuitively, the appeal is that the whole system of treatment is simplified for both the clinician and the client, and the articles in this special section seem to propose that these transdiagnostic treatments can replace disorder-specific approaches. However, much of the writing on transdiagnostic treatments prior to this special section implies that both types of interventions would be taught and provided (Clark & Taylor, 2009, page 64). For example, in their discussion of conceptual foundations for a transdiagnostic approach to CBT (in adults), Mansell, Harvey, Watkins, and Shafran (2009) state, "We currently believe that there is no need to carry out transdiagnostic CBT when one would predict that disorder-specific treatment is equally efficient" (p. 16). Ideally, transdiagnostic interventions should or will be as effective as disorder-specific treatments for pure forms of disorder, too.

Given that the reports in this special section were case studies, an obvious gap in this area is the absence of RCTs. The key question involves the selection of a control condition, and both evidence-based disorder-specific interventions and treatment-as-usual (TAU) should be considered as informative comparison conditions. To my knowledge, no study, with either adults or children/adolescents, has directly compared the transdiagnostic and disorder-specific approach. Comparing a transdiagnostic approach to the current treatment(s) of choice seems essential, although the magnitude of differences in outcomes might be small, which would necessitate large samples to detect differences. However, perhaps the two approaches should be compared on client factors (satisfaction, attendance, therapeutic alliance) and therapist factors (satisfaction, sustainability) or even organizational adoption, in addition to symptom change and maintenance of gains. Data regarding a broad range of factors could inform which approach would be more easily disseminated.

The second approach is to compare these novel approaches to TAU. My sense is that clinicians in the real world are much more reactive to the current presenting problem than research clinicians providing treatment in RCTs and attempt to cover, albeit to a more superficial degree, all presenting problems. Both approaches—the research clinician rigorously providing a single intervention intentionally or unintentionally ignoring other problems versus the hypothetical "real-world" clinician providing breadth of care but not depth—may do clients a disservice. For example, therapists in the Treatment for Adolescents with Depression Study (TADS) were prohibited from incorporating exposure and response prevention interventions in their treatment of depressed adolescents (27% of whom had a current anxiety disorder), and anxiety was found to be general predictor of poor response to depression treatment (Curry et al., 2006). Craske et al. (2007) compared two treatment conditions, one in which research clinicians focused treatment exclusively on the primary diagnosis (panic disorder with or without agoraphobia) and the second, in which therapy was allowed to also treat the most serious comorbidity. They found that both conditions achieved significant reductions in panic disorder, but the targeted approach appeared to result in more complete remission and actually better outcomes for the comorbid conditions. This was only one study but suggests that treatment "straying" is not helpful. One potential benefit of the transdiagnostic approach is that it standardizes what therapists do when deviating from a disorder-specific intervention. If the transdiagnostic approach can provide repeated practice of a coherent set of skills, it may allow for the overlearning of skills that is needed for use of skills in times of distress; the approach would represent a significant advance over being exposed to a variety of skills with little time for true incorporation and integration.

One immediate recommendation for research in both transdiagnostic and disorder-specific treatments is increased assessment. Although it will increase the burden

on participants, research requires a thorough assessment, covering a broad range of disorders and the hypothesized mechanisms of disorder maintenance or intervention provided in these reports. In particular, we need to know the temporal precedence of conditions, as that information seems critical when making decisions about the focus of treatment. It's surprising that researchers and clinicians don't emphasize the importance of temporal precedence in the onset of comorbid disorders. To the degree that one disorder consistently precedes the other disorder, treating just the first disorder (with a disorder-specific evidence-based treatment) could prevent onset of the second condition. We need to know more about this aspect of epidemiology because temporal precedence may suggest that treating one disorder early and aggressively is sufficient.

The present articles are promising but obviously reflect just initial work in this important area. More theorizing and clinical work is needed to encompass a broader range of conditions, especially substance use disorders (SUD) when comorbid with either internalizing or externalizing disorders. For example, a pattern is emerging in which depression may not negatively impact the adolescent's ability to engage and initially benefit from SUD treatment but it predicts much greater risk of SUD relapse after treatment (e.g., Rowe, Liddle, Greenbaum, & Henderson, 2004).

Unfortunately, in their efforts to traverse multiple domains, "turf wars" between established research communities may be a significant threat to the adoption of a transdiagnostic approach. Thus, challenge may be "political" rather than empirical. The added benefit of these transdiagnostic treatments may be questioned. If traditional manual-based therapies have encouraged "flexibility within fidelity" and recognize that individual adaptation is important, how does the transdiagnostic approach offer something unique? Although the strategies of treatment proposed in these reports are not new (with the possible exception of attentional retraining discussed by Racer and Dishion, 2012-this issue), what is new and valuable in these approaches is the conceptualization of disorder and the process of change, and the potential streamlining of evidence-based care delivery. To the degree that these goals can be achieved, they will represent very valuable contributions to our research and treatment communities and the young people we serve.

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