Mental health:
Transdiagnostic perspective

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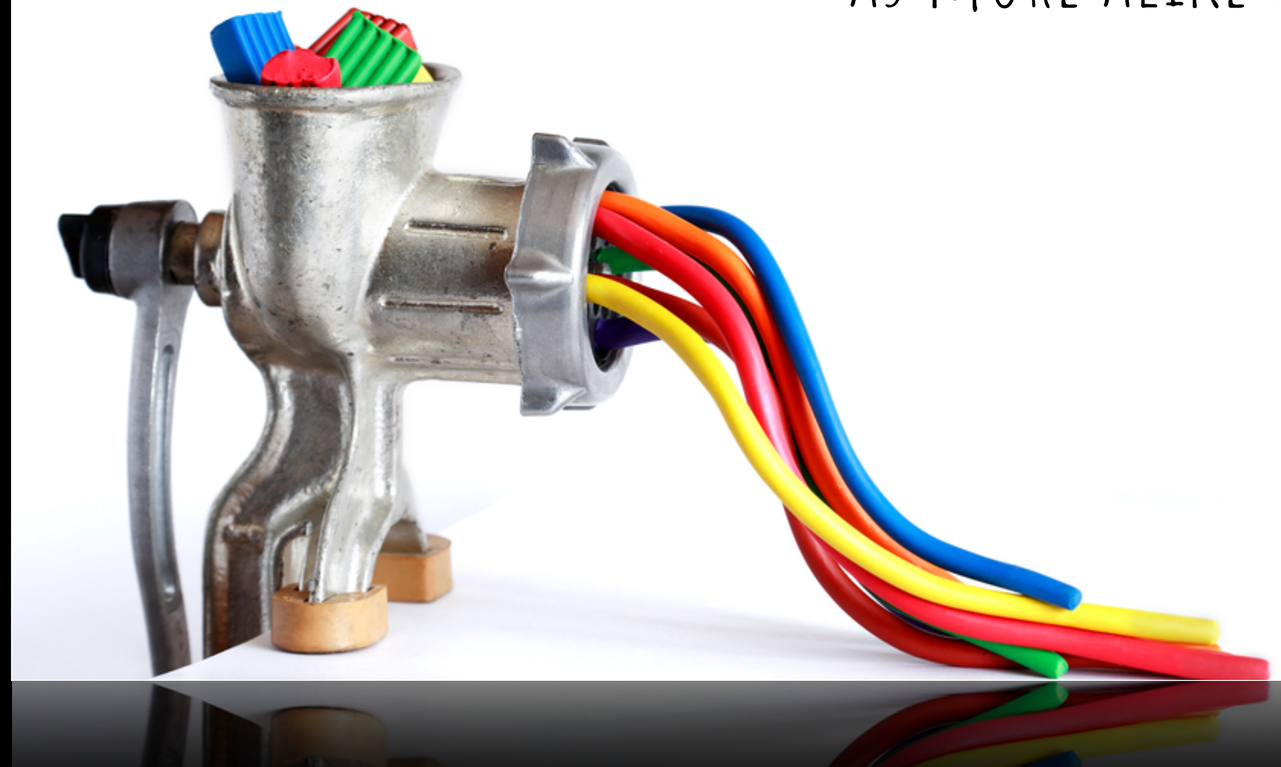
Main Idea: Mental disorders are seen as

- a collection of few crucial psychological processes
- not separate psychiatric categories
- as more alike than different



- Background: Why transdiagnostic?
    - Focus on common characteristics, not differences
- Transdiagnostic mechanisms
    - Identify few active ingredients
- How might transdiagnostic perspective influence our views on mental health?
    - Links to psychodynamic and humanistic psychologies?

What is transdiagnostic?

Psychological, biological, social processes that …

1) … are observed in clinical populations
2) … are observed in at least 4 different diagnostic categories
3) … help to explain the presentation of the diagnosis
4) … are also observed in the general population

Transdiagnostic psychiatry: a systematic review

What is transdiagnostic?

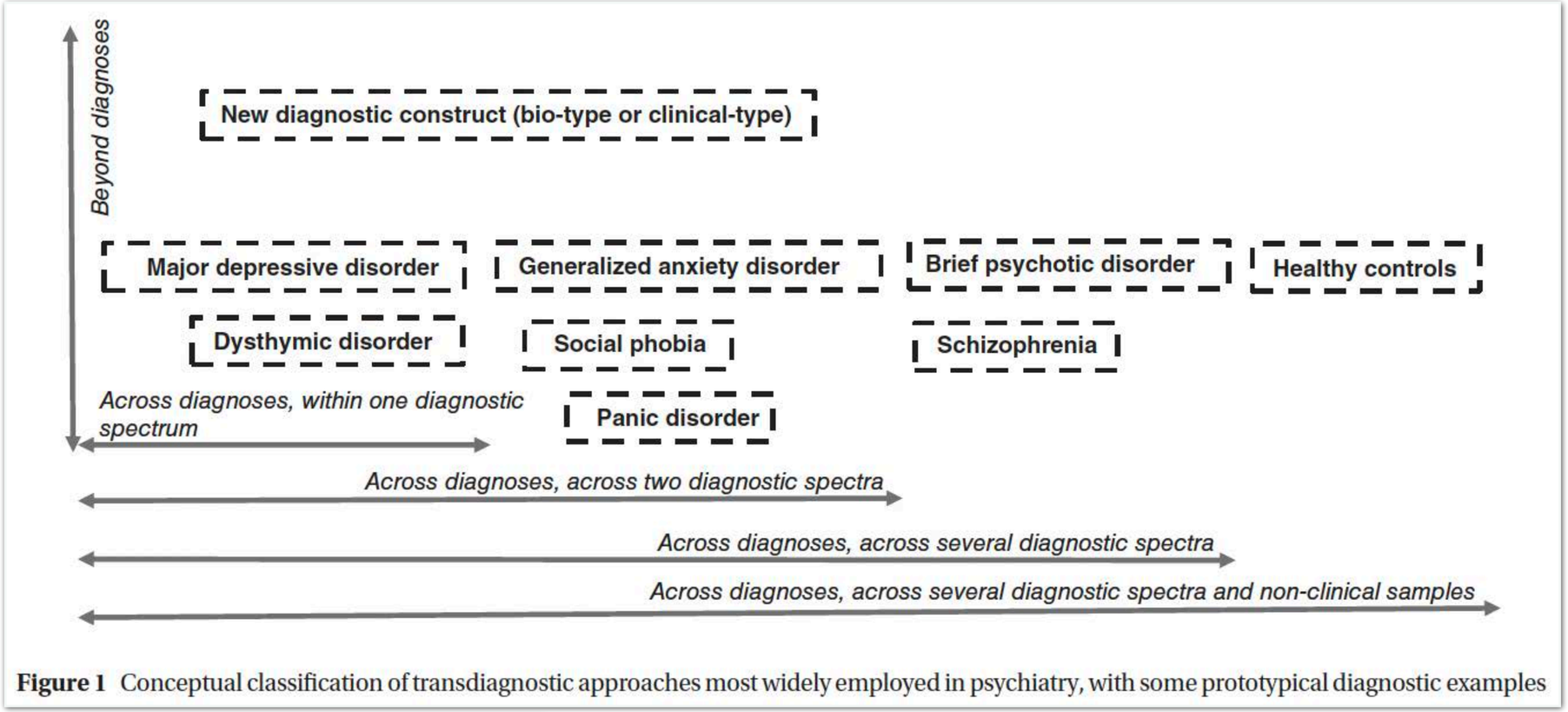
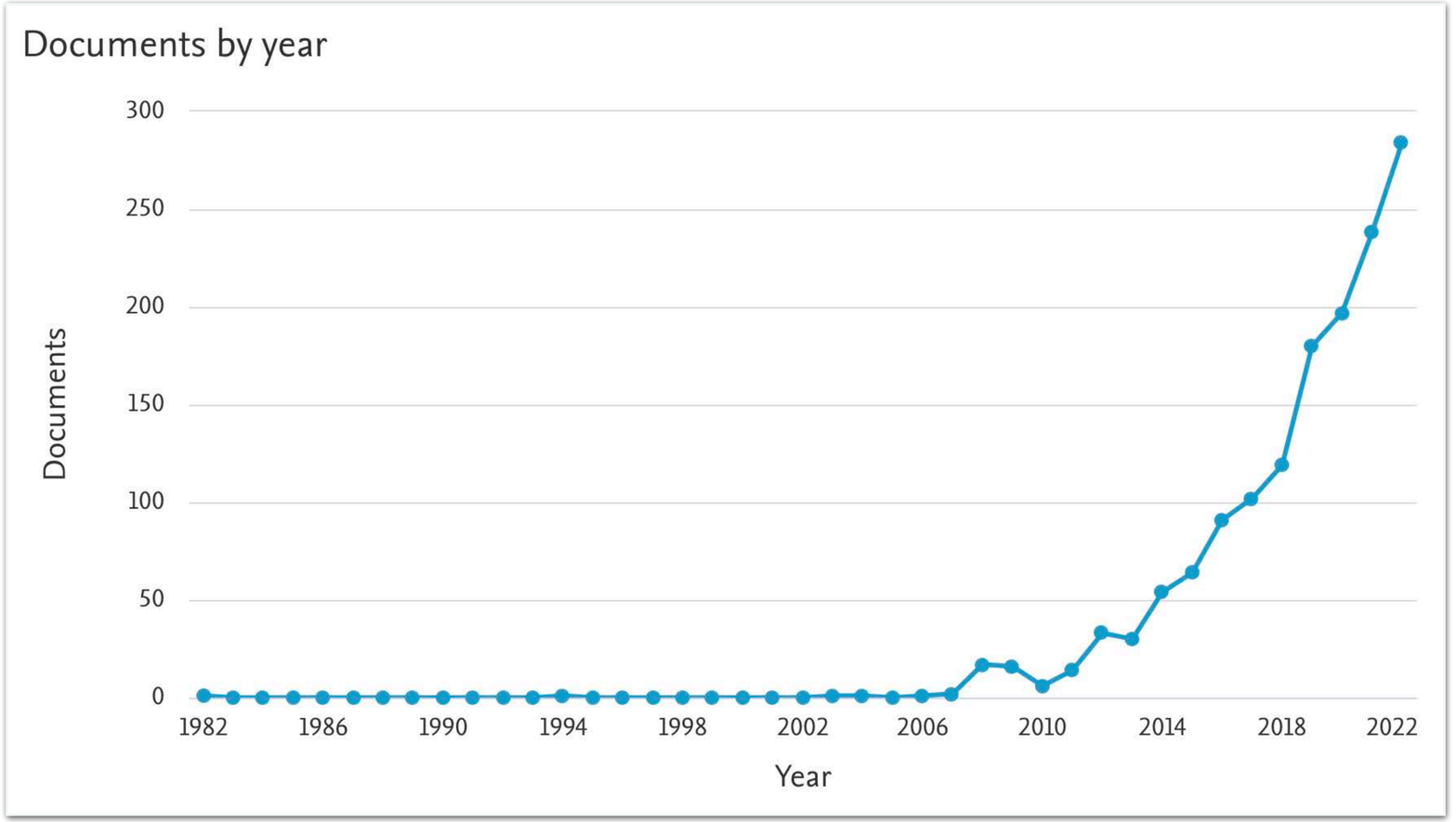


Figure 1 Conceptual classification of transdiagnostic approaches most widely employed in psychiatry, with some prototypical diagnostic examples

Transdiagnostic psychiatry: a systematic review

"Transdiagnostic" in article titles

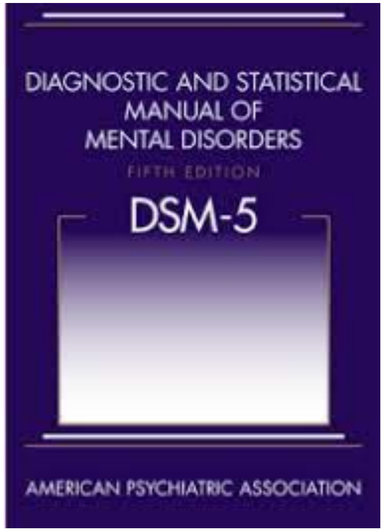


Comorbidity as the starting point:

- Different diagnostic categories overlap considerably with each other

Even the same symptom may apply to many categories

In total, we identified 628 distinct symptoms: 397 symptoms (63.2%) were unique to a single diagnosis, whereas 231 symptoms (36.8%) repeated across multiple diagnoses a total of 1022 times (median 3 times per symptom; range 2-22).



Elemental psychopathology: Distilling constituent symptoms and patterns of repetition in the diagnostic criteria of the DSM-5

Miriam K. Forbes[1], Bryan Neo[1], Omid Mohamed Nezami[2], Eiko I. Fried[3], Katherine Faure[1], Brier Michelsen[1], Maddison Twose[1], and Mark Dras[2]

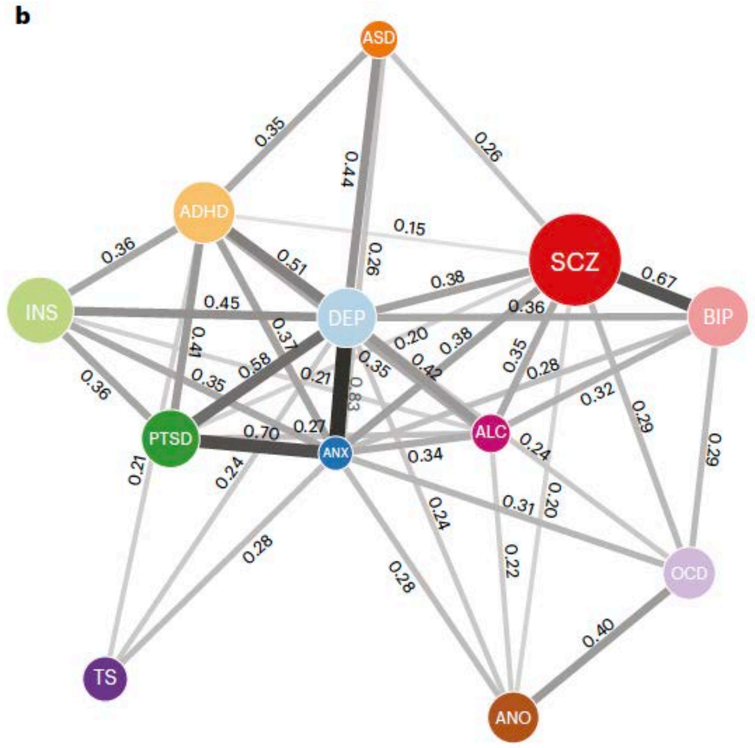
Table 2. Top 15 most non-specific symptoms based on highest frequency and repetition across multiple classes of psychopathology

Symptom	Number of diagnoses
*Insomnia	22
*Difficulty concentrating	17
*Hypersomnia/sleepiness	17
Irritable mood	16
*Psychomotor agitation	16
*Depressed mood	15
*Psychomotor retardation	14
Hallucinations	14
*Fatigue	12
*Increased appetite	12
Anxiety	12
Restlessness	10
*Weight loss	10
Euphoria	10
*Decreased appetite	10

Note. Sorted by the number of diagnoses in which the symptom occurs.
* Denotes symptoms that are part of the diagnostic criteria for major depressive disorder.
Table S2 expands on this list to include all symptoms that repeat across chapters.

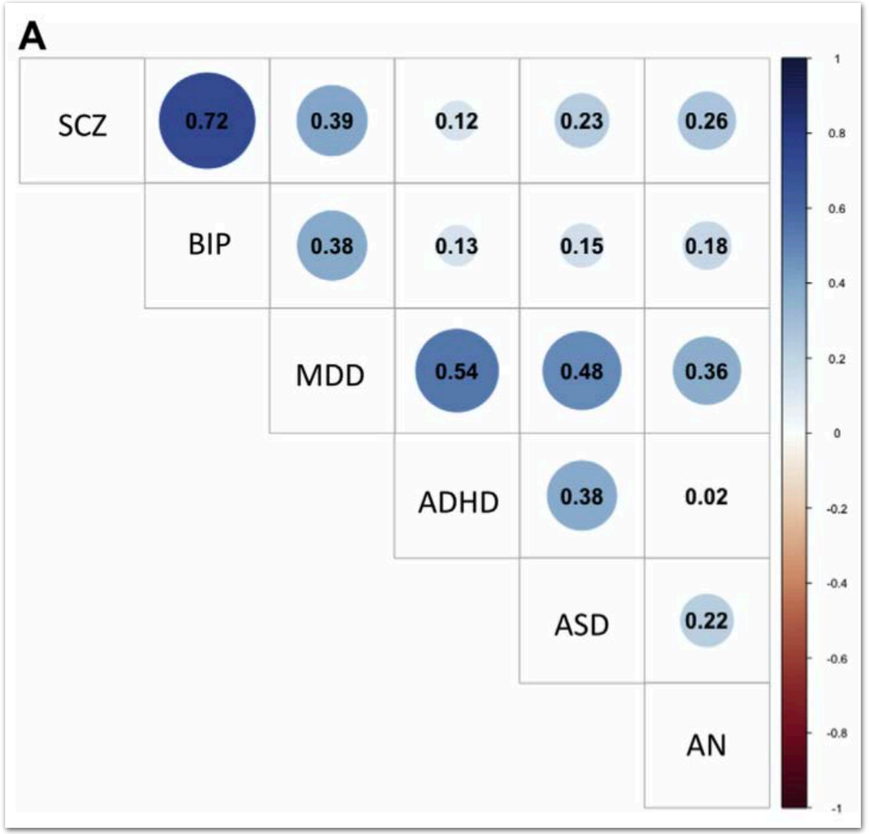
COMORBIDITY ORIGINATES ALREADY AT THE GENETIC LEVEL:

Exploring the genetic overlap between twelve psychiatric disorders



Like previous studies[40], we mainly observed overlap among pairs of psychiatric disorders, suggesting that genetic overlap could be largely pair specific.

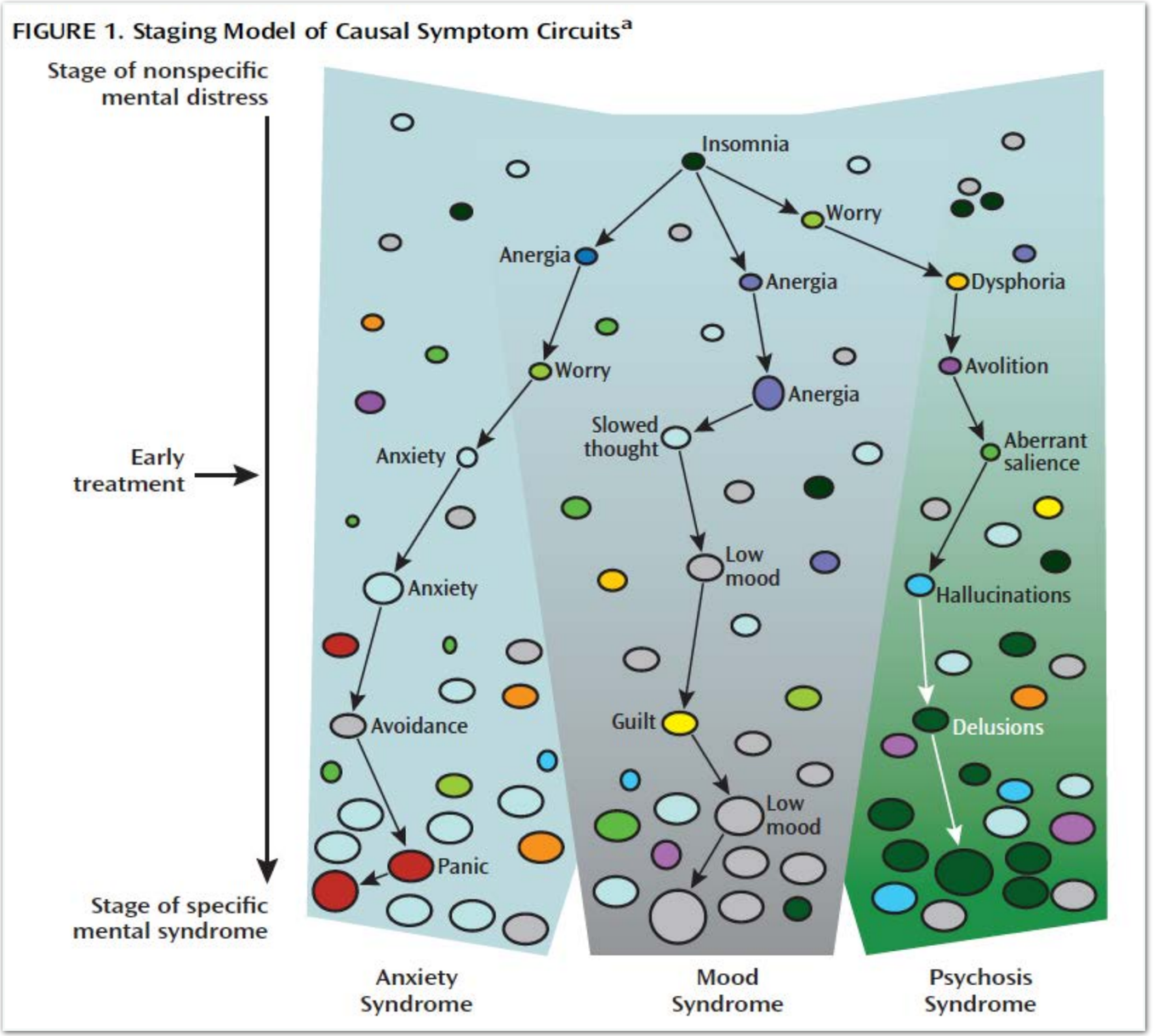
Risk in Relatives, Heritability, SNP-Based Heritability, and Genetic Correlations in Psychiatric Disorders: A Review



Developmental perspective

The earliest expressions of psychopathology are a nonspecific, mixed bag of affective dysregulation, aberrant salience, motivational alterations, anxiety states, and other early symptoms.

The Dynamics of Subthreshold Psychopathology: Implications for Diagnosis and Treatment



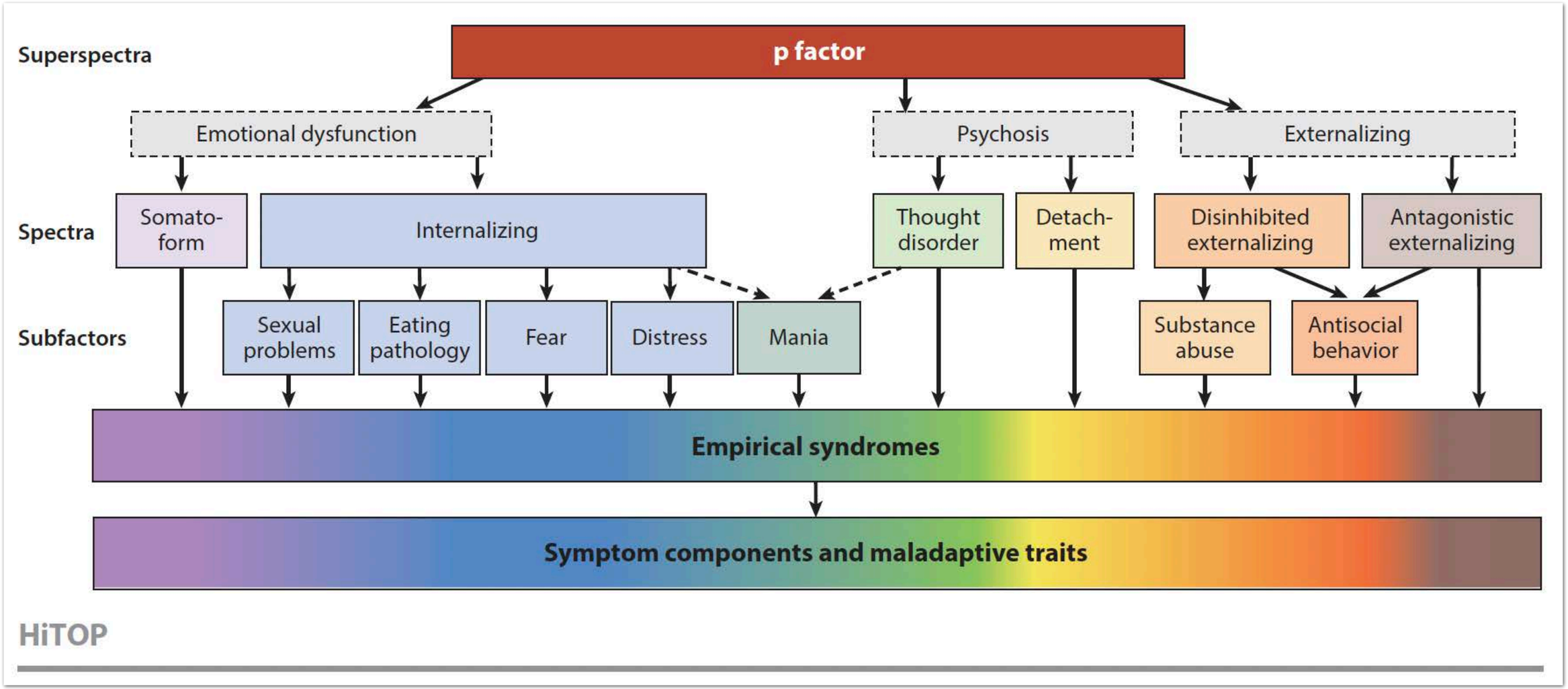
In contrast to assumptions of diagnosis-specific research and clinical protocols, we found evidence that virtually no one gets and keeps 1 pure diagnosis type.

Mental disorder life histories are better described by age of onset, duration, and diversity of disorder than by any particular diagnosis.

Longitudinal Assessment of Mental Health Disorders and Comorbidities Across 4 Decades Among Participants in the Dunedin Birth Cohort Study

Annual Review of Clinical Psychology

The Hierarchical Taxonomy of Psychopathology (HiTOP): A Quantitative Nosology Based on Consensus of Evidence



Example: Personality disorders in the forthcoming ICD-11

Current ICD-10: Categories

F60 Specific personality disorders
F60.0 Paranoid personality disorder
F60.1 Schizoid personality disorder
F60.2 Antisocial personality disorder
F60.3 Borderline personality disorder
F60.4 Histrionic personality disorder
F60.5 Obsessive-Compulsive personality disorder
F60.6 Avoidant personality disorder
F60.7 Dependent personality disorder
F60.8 Other specific personality disorders
F60.81 Narcissistic personality disorder
F60.89 Other specific personality disorder
F60.9 Personality disorder, unspecified

Example: Personality disorders in the forthcoming ICD-11

Mild personality disorder

There are notable problems in many interpersonal relationships and the performance of expected occupational and social roles, but some relationships are maintained and/or some roles carried out.

Moderate personality disorder

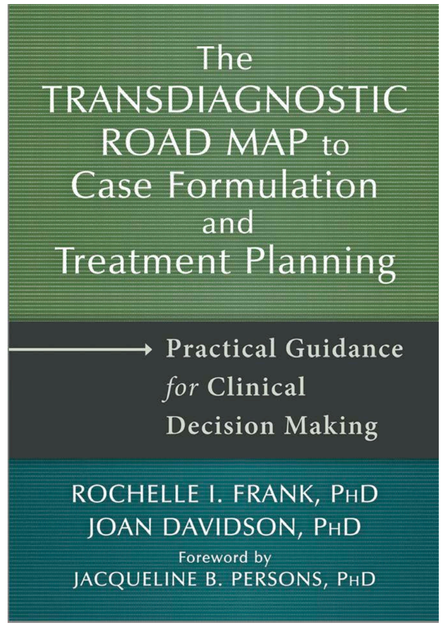
There are marked problems in most interpersonal relationships and in the performance of expected occupational and social roles across a wide range of situations that are sufficiently extensive that most are compromised to some degree.

Severe personality disorder

There are severe problems in interpersonal functioning affecting all areas of life. The individual's general social dysfunction is profound and the ability and/or willingness to perform expected occupational and social roles is absent or severely compromised

Toward a Transdiagnostic Road Map

Current trends within the scientific community are shifting away from a symptom-based, disorder-specific approach that prescribes different treatment interventions for separate disorders. Instead, there is increasing interest in and support for an approach that focuses on the common psychological processes underlying topographical descriptions of different disorders that contribute to the etiology and/or maintenance of psychopathology (e.g., Egan et al., 2011; Egan et al., 2013; Ehring & Watkins, 2008). This transdiagnostic perspective is particularly salient in addressing psychiatric comorbidities and is based on distilling principles of treatment rather than developing new therapy prototypes (Barlow et al., 2004; S. C. Hayes et al., 1996). More importantly, perhaps, a transdiagnostic perspective constitutes the basis of a functional approach to treatment that transcends the limits of categorical classification, such as that in the *Diagnostic and Statistical Manual of Mental Disorders*



Consider the diagnosis of anorexia nervosa ...

ICD-10 diagnostic criteria for anorexia nervosa (F 50.0) (2)

- Actual body weight at least 15% below expected weight, or body mass index 17.5 or less (in adults).
- Weight loss is caused by the avoidance of high-calorie foods and at least one of the following:
  - Self-induced vomiting
  - Self-induced purging
  - Excessive exercise
  - Use of appetite suppressants and/or diuretics
- Distorted body image as a specific psychological disorder
- Endocrine disorder, manifest in the female as amenorrhea and in the male as a loss of libido
- If onset is prepubertal, the puberty in boys and girls may be delayed (growth ceases; in girls the breasts do not develop)

... And the different psychological mechanisms associated with anorexia:

Clinical Perfectionism

This is seen as an example of a dysfunctional system for self-evaluation much like the "core psychopathology" of eating disorders. In essence, clinical perfectionism refers to the overevaluation of the striving for, and achievement of, personally demanding standards, despite adverse consequences. When present, these demanding standards are applied to eating, weight, and shape and their control thereby intensifying aspects of the eating disorder.

Mood Intolerance

This is defined as either an inability to tolerate intense mood states or a particular sensitivity to such states. In those with mood intolerance, binge eating, vomiting, and driven exercising are further maintained by their role as means of modulating or controlling such moods. Mood intolerance is now included in the core theory and treatment as "events and associated mood change" (see Fig. 14.1).

Core Low Self-Esteem

This creates hopelessness about the capacity to change, thereby undermining patients' compliance with treatment and results in patients pursuing achievement in valued domains, in this case control over eating, shape, and weight, with particular determination.

Emotion regulation

In sum, many studies identified lack of skills and strategies required to adaptively and effectively regulate negative affect (i.e., poorer emotional awareness and clarity, nonacceptance, difficulties with re-appraisal, and with problem-solving) as being associated with eating pathology. On the other hand, individuals with disordered eating may have a greater vulnerability to use maladaptive ER strategies (i.e., rumination, avoidance of emotions, and suppression).

Interpersonal Difficulties

These difficulties are seen as contributing further to the maintenance of disorder. Examples include family tensions intensifying resistance to eating, especially in younger patients; certain interpersonal environments (both occupational and familial) magnifying concerns about controlling eating, shape, and weight; adverse interpersonal events

Social skills

people with ED had attachment insecurity ($d = 1.31$), perceived low parental care ($d = .51$), appraised high parental overprotection ($d = 0.29$), impaired facial emotion recognition ($d = .44$) and facial communication ($d = 2.10$), increased facial avoidance ($d = .52$), reduced agency ($d = .39$), negative self-evaluation ($d = 2.27$), alexithymia ($d = .66$), poor understanding of mental states ($d = 1.07$) and sensitivity to social dominance ($d = 1.08$). There is less evidence for problems with production and reception of non-facial communication, animacy and action.

Functional perspective:

– What function does the mechanism serve?

– How is the mechanism dysfunctional in mental disorders?

Some candidates for trans diagnostic mechanisms:

- Experiential avoidance
- Cognitive flexibility
- Emotional sensitivity & regulation

Experiential avoidance

the phenomenon that occurs when a person is unwilling to remain in contact with particular private experiences (e.g., bodily sensations, emotions, thoughts, memories, behavioral predispositions) and takes steps to alter the form or frequency of these events and the contexts that occasion them, even when doing so creates harm

Lack of psychological flexibility

ability to flexibly adapt responses, in order to meet situational demands and personal goals, which could be the key contribution that flexibility makes to well-being.

flexibility is defined as "despite an individual having formed a particular cognitive/behavioral pattern of responding to a specific situation they are able to disengage from this initial pattern if the initial pattern of responding is no longer effective for the specific situation."

Table 2
Unweighted mean effect sizes for 10 cognitive functions across disorder categories.

	Executive Functions					Attention	Memory		Processing speed	Visuospatial Abilities	Unweighted Mean ES
	Set Shifting	Response Inhibition	Working Memory	Fluency	Planning		Verbal Memory	Non-Verbal Memory			
Eating Disorders	0.27	0.29	0.26	0.13	0.43	0.25	0.42	0.42	0.27	0.40	0.31
Tourette Syndrome	–	0.33	–	–	–	–	–	–	–	–	0.33
Panic Disorder	0.31	–	0.29	0.43	0.29	–	0.55	0.31	0.08	0.38	0.33
Gambling	–	0.57	–	–	–	0.12	–	–	0.33	–	0.34
Substance Abuse	0.38	0.41	0.49	0.29	0.72	0.29	0.48	0.47	0.29	0.48	0.43
ADHD	0.50	0.48	0.41	0.57	0.39	0.54	0.53	0.20	0.36	0.31	0.43
ASD	0.65	0.49	0.40	0.44	0.27	–	–	–	–	–	0.45
OCD	0.42	0.49	0.33	0.38	0.59	0.48	0.38	0.75	0.48	0.40	0.47
PTSD	–	–	0.50	0.43	–	–	0.65	0.31	0.59	0.38	0.48
Depression	0.62	0.83	0.38	0.54	0.45	0.55	0.44	0.53	0.50	0.57	0.54
Personality Disorders	0.28	0.51	0.33	0.39	0.84	0.40	0.45	1.59	0.47	0.41	0.57
Bipolar Disorders	0.64	0.66	0.56	0.62	0.60	0.61	0.71	0.57	0.68	0.33	0.60
Schizophrenia	0.80	0.65	0.82	0.93	0.86	0.78	1.02	0.85	0.96	0.76	0.84
Unweighted Mean ES	0.49	0.52	0.43	0.47	0.54	0.45	0.56	0.60	0.46	0.44	0.47

ADHD = Attention Deficit/Hyperactivity Disorder; ASD = Autism Spectrum Disorder; OCD = Obsessive-Compulsive Disorder; PTSD = Post-Traumatic Stress Disorder.

The C Factor: Cognitive dysfunction as a transdiagnostic dimension in psychopathology

Amitai Abramovitch [a,*], Tatiana Short [a], Avraham Schweiger [b]

Emotional sensitivity & regulation

Anxiety sensitivity

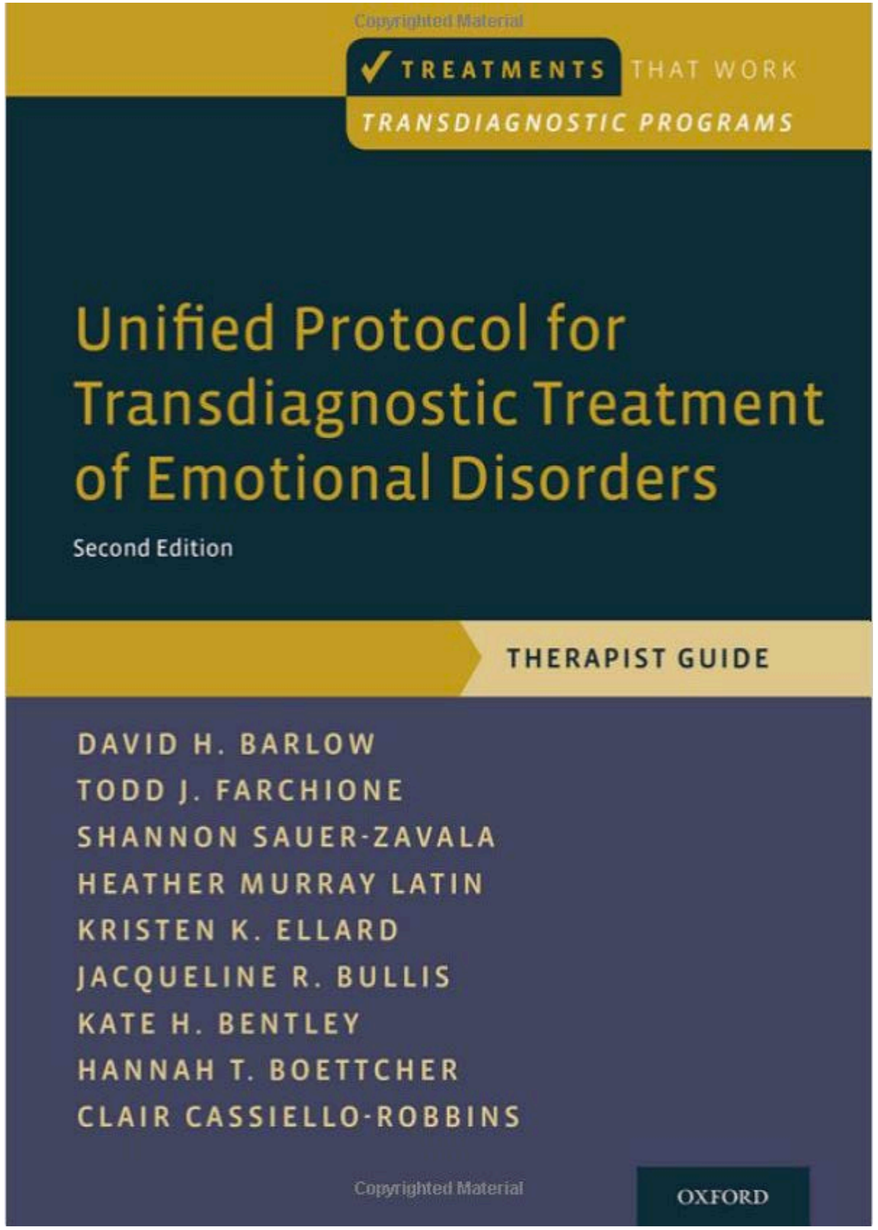
fear of anxiety-related sensations due to the belief that these sensations are harmful

Distress intolerance

perceived inability to fully experience unpleasant, aversive or uncomfortable emotions, accompanied by a desperate need to escape the uncomfortable emotions

Intolerance to uncertainty

incapacity to endure the aversive response triggered by lack of sufficient information, sustained by perception of uncertainty



While the Unified Protocol (UP) is based on traditional cognitive-behavioral principles, its particular emphasis on the way individuals with emotional disorders experience and respond to their emotions is unique in bringing implicit cognitive and emotional processes to the forefront and making them available to fundamental psychological mechanisms of change.

Thus, the UP is an emotion-focused treatment approach; that is, the treatment is designed to help patients learn how to confront and experience uncomfortable emotions, and to respond to their emotions in more adaptive ways. By modifying patients' emotion regulation habits, this treatment aims to reduce the intensity and incidence of maladaptive emotional experiences and improve functioning. It is important, however, to understand that the UP does not attempt to eliminate uncomfortable emotions altogether. Rather, the emphasis is on bringing emotions back to a functional level, so that even uncomfortable emotions can be adaptive and helpful.

Table 1. UP core modules

Topic name	Session	Main topics covered	Relevance for neuroticism
Mindful Emotion Awareness	4–6	Nonjudgmental awareness of thoughts, feelings, behaviors; Increasing present-focused attention toward emotional experiences; practice applying these skills in response to emotional experiences as they occur by anchoring in the present	Observing emotions nonjudgmentally allows patients to learn they are temporary, perhaps decreasing automatic emotional avoidance that exacerbates negative emotionality in the long term
Cognitive Flexibility	5–8	Reciprocal relationship between thoughts and emotions; strategies for questioning negative first impressions; generating alternative appraisals of emotion-eliciting situations	Directly challenging cognitions about emotions (i.e. 'I'm weak to feel this way) may also decrease emotional avoidance, preventing rebound effects
Countering Emotional Behaviors	6–10	Emotions are associated with urges to engage in behaviors which may/may not be helpful in the short/long term; examples of unhelpful emotional behaviors for different emotions; engaging in alternative actions can lead to different emotional consequences	Deliberately engaging in behaviors that approach emotions, rather than avoid them, demonstrates to patients that emotions are not dangerous – again, reducing habitual avoidant coping
Tolerating Physical Sensations	7–11	Psychoeducation on the role that physical sensations play in emotional experiences is provided, patients engage in interoceptive exposures (e.g. breathing through a thin straw, hyperventilating) designed to deliberate bring on the physical sensations that are similar to what they experience in the context of strong emotions	Physical sensations contribute to the overall intensity of a subjective emotional experience and our appraisals of these sensations (i.e. 'a racing heart is dangerous') may increase the urgency to avoid emotional experiences
Emotion Exposures	8–15	Deliberately creating opportunities to face strong emotions in order facilitate new learning about emotions themselves (e.g. that they don't last forever, that they can be tolerated); practicing previous skills in the context of an emotional experience	The goal of emotion exposures is to extinguish distress in response to emotional experiences, themselves, decreased aversive reactivity may reduce reliance on avoidant coping that ultimately exacerbates the frequency/intensity of emotional experiences

Broader influence?

Broader influence?

Psychotherapy was then broadly "transdiagnostic," driven and informed by a focus on hypothesized neurotic conflicts (ie, core emotional issues). The contribution of Barlow and colleagues[2] documents the efficacy of an "emotion-focused" transdiagnostic cognitive behavioral therapy (CBT) for multiple anxiety disorders, the "Unified Protocol" that brings us full circle to when there were fewer diagnostic entities, a more unified view of psychopathology, and a more singular psychotherapeutic approach.

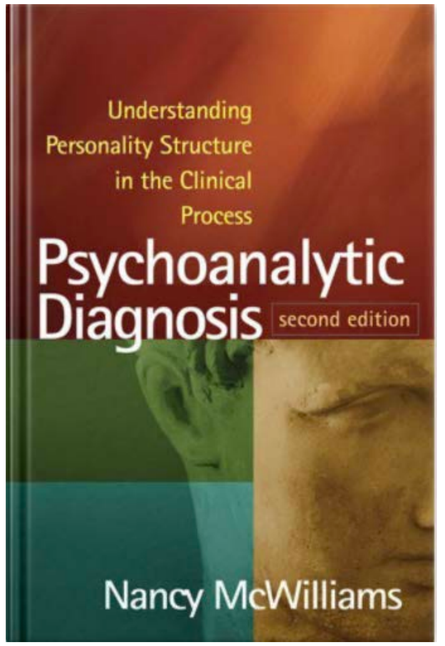
It unintentionally moves the field, at least partially, in the direction of more emotion-focused relational (IPT) and psychodynamically oriented treatments at a time when these treatments are being increasingly validated[3,7] and when many psychotherapists still identify with this tradition in terms of their orientation and practice.

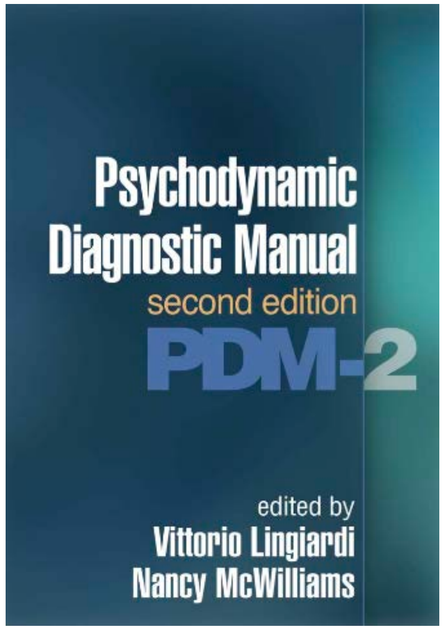
Transdiagnostic Cognitive Behavioral Therapy and the Return of the Repressed

Peter Roy-Byrne, MD

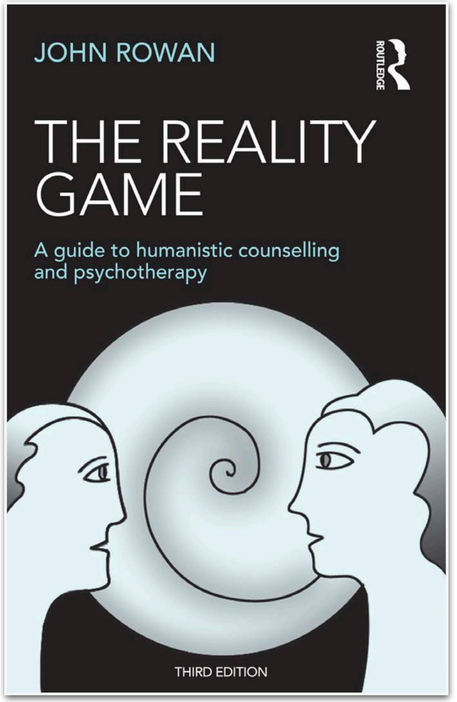
TABLE 5.2. Features Distinguishing Levels of Personality Organization

	Psychotic	Borderline	Neurotic
Level of identity integration	Severely disturbed	Marked identity diffusion	Relatively integrated
Predominant level of defenses	Primary defense mechanisms (projection, splitting)	Primary defense mechanisms (splitting, projective identification)	Secondary defense mechanisms (repression, rationalization, reaction formation)
Capacity for reality testing	May be seriously disturbed (prone to delusions, hallucinations)	Relatively intact, may be temporarily disturbed, particularly in high arousal conditions	Intact
Quality of object relations and self/other representations	Serious disturbances in object relations and (threatening) disintegration of self and object representations	Troubled interpersonal relationships, often marked by chaos, idealization–denigration, instability of self and other representations	Relationships may be characterized by more subtle conflicts around autonomy/relatedness, integration of love and aggression
Capacity for self-observation	Severely disturbed	Often severely disturbed	Relatively intact
Nature of primary conflicts	Existential (life, death, identity)	Relational	Conflicts around autonomy/relatedness (e.g., guilt, shame, sexual intimacy)





Human beings do have problems, but when it comes to psychotherapy, they are not isolable separate problems that can be treated like a disease or a faulty component or a blocked pipe. They are problems connected with being that person. This is why one label can never be enough to tell us what to do about a person. One of the main characteristics of our approach is a refusal to label people in any firm or final way. Of course we have tentative ideas as to what is basically wrong with any client, but as George Kelly once said: 'The client does not ordinarily sit cooped up in a nosological pigeonhole, he proceeds along his way'



Summary:

– Mental health problems overlap with each other

– Aim to identify functional psychological mechanisms that underlie

– Symptoms are still important, but only as indicators of underlying problems

– Mental disorders are seen on a spectrum of normal–to–dysfunctional psychological mechanisms