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Current Definitions of "Transdiagnostic" in Treatment Development: A Search for Consensus

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Research in psychopathology has identified psychological processes that are relevant across a range of *Diagnostic and Statistical Manual* (DSM) mental disorders, and these efforts have begun to produce treatment principles and protocols that can be applied transdiagnostically. However, review of recent work suggests that there has been great variability in conceptions of the term "transdiagnostic" in the treatment development literature. We believe that there is value in arriving at a common understanding of the term "transdiagnostic." The purpose of the current paper is to outline three principal ways in which the term "transdiagnostic" is currently used, to delineate treatment approaches that fall into these three categories, and to consider potential advantages and disadvantages of each approach.

Keywords: transdiagnostic; treatment; mechanisms; psychopathology

In recent decades, classification of mental disorders has largely focused on differentiating psychopathology into thinly sliced categories, an approach exemplified by the *Diagnostic and Statistical Manual* (DSM; American Psychiatric Association, 1980, 2000, 2013). Emerging research, however, suggests that this "splitting" approach to diagnosis, while enhancing reliability, may come at the expense of validity (see: Barlow, Sauer-Zavala, Carl, Bullis, & Ellard, 2014). There is increasing evidence that some *DSM* disorders do not represent unique constructs and instead reflect relatively trivial variations in a common underlying syndrome (Brown & Barlow, 2009). Based on these findings, there has been a renewed interest in constructs that may be broadly applicable across classes of disorders, such as temperament, body image distortion, or anxiety sensitivity (Barlow et al., 2014; Boswell et al., 2013; Fairburn, Cooper, & Shafran, 2003). Grouping disorders based on shared characteristics is consistent with a more dimensional and functional basis for classification, with the National Institute of Mental Health's Research Domain Criteria (RDoC; Insel et al., 2010) representing one option. This trend is also captured by an upsurge in authors using the keyword "transdiagnostic" to characterize their articles. Of the 294 studies indexed by PsycINFO with this keyword as of this writing (June, 2016), more than three quarters were published in the last 5 years, with very few appearing prior to 2008. As the identification of constructs or processes that occur across diagnostic boundaries has blossomed, so too has interest in treatments that may be applicable to multiple disorders. Although the term "transdiagnostic" has been increasingly utilized to describe a variety of treatment approaches in recent years (e.g., Barlow et al., 2011a, b; Leichsenring & Salzer, 2014), there may be conceptual differences in

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the use of this term and in the manner in which transdiagnostic treatments lead to improvement across a range of disorders. The purpose of the current paper is to delineate various meanings of this term to facilitate understanding and future research.

In order to effectively categorize interventions that have recently been described as "transdiagnostic," it is necessary to establish a working definition of this term. Although no guidelines have been published with regard to what qualifies as a transdiagnostic intervention, several articles have proposed criteria for determining whether a *psychological process* can be considered "transdiagnostic." These criteria may represent a good starting point for drawing distinctions among "transdiagnostic" treatments. First, Mansell and colleagues (2009) set what they described as "arbitrary but challenging criteria" (p. 9) to determine whether a process could be considered transdiagnostic. Specifically, their criteria require that transdiagnostic processes be assessed in both clinical and nonclinical samples and be present in a minimum of four disorders. More recently, Harvey and colleagues (2011) have highlighted differences between constructs that are "descriptively transdiagnostic" (i.e., processes that are present in a range of diagnoses), which is consistent with Mansell et al.'s (2009) criteria, and those that are "mechanistically transdiagnostic" (i.e., processes that reflect a causal, functional mechanism for co-occurrence).

Whereas the designation "mechanistically transdiagnostic" implies that the construct in question is causally related to a range of psychopathology, the term "descriptively transdiagnostic" suggests only that a construct is present in multiple disorders, without regard to how or why. To illustrate the differences between Harvey et al.'s (2011) conceptions of "descriptively transdiagnostic" and "mechanistically transdiagnostic," constructs that fit these categories will be highlighted. First, consider low self-esteem, which can be found in a variety of disorders from schizophrenia to panic disorder (e.g., Glashouwer, Vroling, de Jong, Wolfe, & de Keijser, 2013; Holding, Tarrier, Gregg, & Barrowclough, 2013). Although low self-esteem may be descriptively transdiagnostic, there is no unifying theory to account for *how* low self-esteem contributes to the development and maintenance of these disorders. As such, it does not appear to be mechanistically transdiagnostic; therefore, specifically targeting low self-esteem in treatment may not lead directly to alleviation of specific psychopathological processes maintaining symptoms. Similarly, for many years, panic attacks were thought to be specific to panic disorder (APA, 1994; Barlow et al., 1986). However, panic attacks are now described as ubiquitous and potentially occurring in the context of any disorder (APA, 2013). Nevertheless, few would believe that panic attacks are functionally related to the onset or maintenance of a disorder such as schizophrenia or that targeting them in treatment would lead to substantial clinical improvement.

In contrast, mechanistically transdiagnostic constructs provide information regarding the development and maintenance of a class of disorders; in other words, they represent common or core vulnerabilities that put an individual at risk for more than one mental health diagnosis as similar underlying processes are driving symptoms across conditions. For example, overvaluation of shape and weight has been implicated as a core functional mechanism in the development and maintenance of symptoms across anorexia, bulimia, and eating disorders not otherwise specified (now called other-specified eating disorders or unspecified eating disorders in DSM-5; e.g., Fairburn, Peveler, Jones, Hope, & Doll, 1993; Wilson, Fairburn, Agras, Walsh, & Kraemer, 2002). Additionally, clear theoretical accounts have been proposed regarding how rumination, another example of a mechanistically transdiagnostic process, contributes to the development and maintenance of a range of emotional disorders (e.g., depression, anxiety, borderline personality disorder; Baer & Sauer, 2011; McLaughlin & Nolen-Hoeksema, 2011; Sauer-Zavala & Barlow, 2014). Specifically, Selby and colleagues (Selby & Joiner, 2009; Selby, Anestis, Bender, & Joiner, 2009; Selby & Joiner, 2013) proposed and tested the emotional cascade model, in which rumination is used as a strategy for coping with negative emotions, leading to increased levels of negative affect, followed by more rumination, and so on, until a physically potent behavior (e.g., nonsuicidal self-injury, substance use) occurs and serves to distract from negative thoughts and emotions. Whether rumination is a core mechanism or simply part of a larger system of vulnerabilities is unclear, but it is a transdiagnostic mechanism per Harvey et al.'s (2011) definition.

We believe there are advantages to exploring processes that are mechanistically transdiagnostic over those that are descriptively transdiagnostic. Reserving the term transdiagnostic to refer to underlying mechanisms that are relevant across a class of disorders may function to better inform treatment development, as strategies can be included that focus on these core deficits rather than targeting what may be more trivial disorder correlates. Continued identification of mechanistically transdiagnostic processes may lead to more efficient treatments because targeting underlying mechanisms has been shown to lead to clinical improvement