Disclosures

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  - American Psychological Association
  - National Institute of Mental Health
  - University of Nebraska–Lincoln
  - University of Houston

- Royalties received from:
  - Anti-Anxiety Workbook (Guilford)
  - Group Cognitive-Behavioral Therapy for Anxiety: A Transdiagnostic Treatment Manual (Guilford)
Transdiagnostic Models of Emotional Disorders

- Proposes that different anxiety (and related) disorders reflect predominantly morphological variations vs ontological differences


Transdiagnostic CBT for Emotional Disorders

- Intervention applicable across anxiety (and related) diagnoses, broadly targeting distorted cognitions and stimulus disengagement

Why Transdiagnostic CBT?

1. Match with theoretical models

2. Practical constraints
Evolution of Anxiety Diagnoses

DSM (in theory)

Anxiety Disorders
- Panic Disorders
- Social Phobia
- GAD

Obs-Comp Disorders
- OCD

Depressive Disorders
- MDD
- PDD

Trauma Disorders
- PTSD

- Panic Disorder
- Social Phobia
- GAD

- Panic Disorder
- Social Phobia
- GAD
- Obsessive-Compulsive Disorder
- Post-Traumatic Stress Disorder
- Major Depressive Disorder
- Pediatric Depressive Disorder
DSM (in reality)

Negative Affect Disorder

Depressive Disorders

Anxiety Disorders

Obs-Comp Disorders

Trauma Disorders

Prev. / Contin.
Comorbidity
Genetics
Neurobiology
Learning
Cognition
Development

Transdiagnostic CBT for Anxiety (and Emotional Disorders)

- Designed for use with groups of clients experiencing a range of NA Disorders


... and several others unpublished ...
Why Transdiagnostic CBT?

1. Match with theoretical models

2. Practical constraints

 Practical Constraints
History of Transdiagnostic CBT for Anxiety

- Scopus Database: “Transdiagnostic and Anxiety” *(Accessed: 03/03/2017)*
History of Transdiagnostic CBT for Anxiety

- Special Issues and Sections:
  - 2017 (vol. 46) – *Journal of Anxiety Disorders* (Guest Ed.: P.J. Norton)
  - 2012 (vol. 31) – *Clinical Psychology Review* (Guest Ed. W. Mansell)
  - 2009 (vol. 23) – *Journal of Cognitive Psychotherapy* (Guest Eds.: S. Taylor & D.A. Clark)
  - 2008 (vol. 1) – *International Journal of Cognitive Therapy* (Guest Ed.: W. Mansell)

Does tCBT work?
Nebraska Pilot Trial

- 23 patients meeting DSM-IV criteria for a primary diagnosis of any Anxiety Disorder

  - Inclusion Criteria:
    - Age 19 or older
    - Ability to read and communicate in English
    - Accept possibility of randomization to delayed-treatment condition
    - No evidence of dementia or neurocognitive conditions
    - No suicidality, significant substance abuse, or other condition requiring immediate intervention


Diagnostic Measures

<table>
<thead>
<tr>
<th>Condition</th>
<th>Immediate</th>
<th>Delayed</th>
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</thead>
<tbody>
<tr>
<td>Clin. sig. Yes</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Anx. Dx at Pre-treatment? No</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

\[ \chi^2 (1) = 10.24, p = .001 \]
Diagnostic Measures

CSR of Primary Diagnosis

![Bar Chart](image)

Pre-Tx vs. Post-Tx
- Immediate
- Delayed

\[ F (1,15) = 7.55, p = .015 \]

Unified Protocol

- Open trial of Unified Protocol \([n = 15 \text{ (GAD, SAD, OCD, PDA)}]\)

F-SET

• RCT (vs. waitlist) of F-SET \([n = 96 \ (GAD, SAD, PD/A)]\)

<table>
<thead>
<tr>
<th></th>
<th>F-SET</th>
<th>Wait-list</th>
<th>Treatment x Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety and Depression at Baseline and Posttreatment by Treatment Condition</td>
<td></td>
<td></td>
<td></td>
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<tr>
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</tbody>
</table>


Does it work equally for different Anxiety Disorder diagnoses?
• Treatment-only no-control trial
• 52 participants with any anxiety disorder
  – Including comorbid diagnoses
    • 32 with Social Anxiety Disorder
    • 25 with Panic Disorder/Agoraphobia
    • 16 with GAD
    • 6 with Specific Phobia
    • 2 with OCD


• Weekly anxiety ratings (STAI) measures given to all group attendees
• Analyzed individual change using Mixed-effect Regression Modeling
Unified Protocol

- Open trial of Unified Protocol \([n = 15]\)
  - Primary diagnoses (GAD=3, SAD=5, OCD=3, PDA=2, GAD+Ag=1, GAD+SAD=1)
  - Comorbid diagnoses (GAD=3, SAD=3, OCD=1, PDA=2, MDD=2, Dys=1, SpPh=1 Hypoch=1, ADNOS=1)

Table 4

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>N</th>
<th>Pre-Tx Mean</th>
<th>SD</th>
<th>Post-Tx Mean</th>
<th>SD</th>
<th>df</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>GAD</td>
<td>5</td>
<td>5.17</td>
<td>0.75</td>
<td>3.00</td>
<td>1.79</td>
<td>1</td>
<td>9.45*</td>
</tr>
<tr>
<td>SAD</td>
<td>9</td>
<td>5.22</td>
<td>0.83</td>
<td>3.00</td>
<td>1.73</td>
<td>1</td>
<td>18.18**</td>
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<tr>
<td>OCD</td>
<td>4</td>
<td>6.90</td>
<td>0.62</td>
<td>2.75</td>
<td>1.28</td>
<td>1</td>
<td>14.47</td>
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<tr>
<td>FDA</td>
<td>4</td>
<td>4.75</td>
<td>0.96</td>
<td>3.00</td>
<td>1.63</td>
<td>1</td>
<td>13.26*</td>
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<tr>
<td>DEF</td>
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<td>4.50</td>
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<td>2.25</td>
<td>2.06</td>
<td>1</td>
<td>6.84</td>
</tr>
</tbody>
</table>

*p<.05, **p<.01.

Does it work as well as traditional Diagnosis-Specific CBT?

Comparative Outcome Trial - Dx-Specific

- **RCT comparing**
  - transdiagnostic CBT
    - \( n = 23; \) Panic: 5, Social: 12, GAD: 6
  - diagnosis-specific CBT
    - \( n = 23; \) Panic: 6, Social: 13, GAD: 4

- Barlow & Craske *Mastery of your Anxiety and Panic*
- Heimberg *Cognitive-Behavioral Group Therapy for Social Phobia*
- Dugas & Robichaud *Cognitive-Behavioral Treatment for Generalized Anxiety Disorder*

Comparative Outcome Trial - Dx-Specific

- Treatment Effects replicated those from Norton & Hope (2005), Norton (2008), and Norton (2012b)

Transdiagnostic vs. Diagnosis-Specific CBT

- Meta-Analytic review of 67 clinical trials ($n = 3872$) of tCBT or dxCBT

  - tCBT:
    - $g = 1.059, (.876-1.242)$

  - dxCBT:
    - $g = 0.951, (.874-1.027)$

Summary of Efficacy Evidence

- It works
  - It works equally across diagnoses

- It works as well as other treatments
  — Supported by meta-analyses

What effect does it have on comorbid diagnoses?
Comorbidity in Anxiety & Depression

- Comorbidity – the presence of two or more diagnoses
  - Over 60% comorbidity rates
    - Majority will have a 2\textsuperscript{nd} (or more) anxiety or depressive diagnoses
  - Average = 2.1 diagnoses

Comorbidity is usually ignored

Most treatment approaches:

1. Treat principal diagnosis first

   **THEN**

2. Treat comorbid diagnoses sequentially, as necessary
Treatment of Primary Diagnosis

Sequential Treatment

For the remaining ≈ 60%

- 12-16 weeks of CBT for Primary Diagnosis
  - Plus

- 12-16 weeks of CBT for Comorbid Diagnosis
  - Plus?

- 12-16 weeks of CBT for additional Comorbid Diagnoses?
Nebraska Pilot Trial

- 23 patients with a primary Anxiety Disorder
  - 18 had comorbid diagnoses (9 w/ multiple comorbid)
    - Comorbid MDD/Dys = 10
    - Comorbid PD = 5
    - Comorbid SAD = 5
    - Comorbid GAD = 3
    - Comorbid SpPh = 1
    - Comorbid Alcohol Abuse = 1
    - Comorbid PTSD = 1
    - Comorbid OCD = 1
    - Comorbid Anxiety NOS = 1


Diagnostic Measures

![Graphs showing changes in CSR of Primary Diagnosis and Comorbid Diagnoses pre- and post-treatment.](image)

\[ F_{(1,15)} = 7.55, p = .015 \]

\[ F_{(1,15)} = 7.80, p = .014 \]
Transdiagnostic CBT on Comorbidity


- **48 clients with comorbid diagnoses of clinical severity**
  - Clients with comorbidity showed a decline in the CSR ratings of their comorbid diagnoses of 3.06 units ($sd = 1.82$).
  - Majority ($n = 32; 66.7\%$) no longer met criteria for any clinically significant comorbid diagnosis at post-treatment.


Transdiagnostic CBT on Comorbidity

- **In benchmark studies, 40.07\% showed remission of comorbid diagnosis**

![Bar chart showing remission rates across studies](chart.png)

- Norton et al. (2013) 66.7\%
- Ellard et al. (2010) 64\% HESF
- Brown et al. (1999) 47.8\%
- Borkovec et al. (1999) 42.9\%
- Tsao et al. (1998) 37.1\%
- Tsao et al. (2002) 38.7\%
- Allen et al. (2010) 32.5\%
- Como (complete) 40.07\%
Transdiagnostic CBT on Comorbidity

DEPRESSION COMORBIDITY

42 Anxiety patients with comorbid Depression

Percent with comorbid Depression

Pre-Treatment: 100%
Post-Treatment: 28.60%


Summary of Efficacy Evidence

• It works better at treating the whole patient (primary and comorbid diagnoses)
Moving Forward

Brief tCBT Efficacy in Adults

- 5-session tCBT program for GAD, social phobia, and panic disorder in comparison to controls
  - Participants in tCBT experienced significantly less anxiety ($d = 2.01$) and depression ($d = 2.16$) than no-treatment controls
  - Change in avoidance strategies mediated the group changes in anxiety symptoms

tCBT Efficacy in Adolescents

• RCT comparing Unified Protocol to control (n = 51)
  – Mostly GAD, Social Phobia, and Depression

• Significantly greater improvement among those in UP compared to controls
  – Gains maintained at 3- and 6-month follow-up


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tCBT with Military Veterans - 1

• 48 military veterans completing group tCBT

• Significant reductions in anxiety and fear from pre- to post-treatment

• Reductions in anxiety and fear were predicted by changes in
  – Threat perceptions \(\rightarrow\) cognitive
  – Experiential avoidance \(\rightarrow\) behavioral

• Trained 28 mental health providers in tCBT

• 6 months after training, therapists rated perceived effectiveness of tCBT (1-5 scale):

- Depression = 3.8
- PTSD = 4.0
- GAD = 3.5
- Panic Disorder = 4.3
- Social Phobia = 4.0
- OCD = 4.7


Internet-Delivered tCBT

https://thiswayup.org.au/

• Large treatment effect sizes for depression and anxiety

- Anxiety: (tCBT = GAD) > MDD
- Depression: (tCBT = MDD) > GAD
- For comorbid GAD+MDD: tCBT > (MDD = GAD)

tCBT for Anxiety, Depression, and Substance Use

- Developed a combined tCBT + Substance Abuse treatment with 29 comorbid patients
  - Moderate, but not consistent, improvement in stress and anxiety scores
  - Significant decreases in alcohol use
  - No change in drug use


tCBT for Anxiety + Chronic Headache

- Combined tCBT with CBT for headache for 63 adolescents
  - RCT comparing combined treatment to “treatment as usual” (TAU)
  - Both groups improved, but significantly greater for combined treatment than TAU
    - Anxiety
    - Headache

Transdiagnostic Approaches to the Treatment of Anxiety and Emotional Disorders:

Peter J. Norton, Ph.D.