Need for Transdiagnostic Cognitive Behavior Therapy in Indian Psychiatric Setting

Sir,

Cognitive behavior therapy (CBT) has been the treatment of choice for several psychiatric disorders including mood disorders, anxiety disorders, psychotic disorders, substance abuse disorders, eating disorders, and personality disorders.[1] It has been found to be as efficacious as other therapeutic modules and has more enduring effects than medication.[2] The efficacy of CBT has been established in India as well specifically with respect to common mental disorders.[3] However, despite its benefits, not everyone has access to these therapies owing to a tremendous treatment gap (0.03 psychologists per 100,000 population).[4] Further, CBT comes to a standstill in the case of rampant comorbidities within psychiatric disorders.[5]

Comorbidity is a very common phenomenon in psychiatry also seen to be prevalent in Indian setting[6] and leads to low quality of life and increased suicide risk. About 21% of people who fulfill criteria for one mental disorder meet the criteria for three or more comorbid disorders.[7]

With comorbidity, dawns several problems with employing CBT. There is not enough literature regarding how therapists should go about determining the sequence of treatment for comorbid disorders, to employ strategies that limit comorbid disorders from interfering with the treatment of primary disorders, deliver the treatment protocols in a manner that benefit comorbid disorders, and ensuring long-lasting effects of CBT on these disorders. This brings us to the question of how to address comorbidity in psychiatric disorders.

High comorbidity levels and emergence of shared features across different disorders has led to the advent of transdiagnostic CBT (TCBT). TCBT represents a shift of emphasis from disorder specific CBT to an across disorder CBT. It is a therapy applicable to the shared underlying principles across disorders without adhering to a diagnosis.[8] Fairburn and Harrison[9] and Norton's[10] work in the area of eating disorders and anxiety disorders, respectively, have paved the path to use TCBT in the treatment of psychiatric disorders.

Several advantages to TCBT have further added to its commencement as a suitable therapy for comorbid disorders. These benefits include spending less time diagnosing a client and selecting the treatment of choice as well as avoiding stigma attached to diagnostic labels and saves therapist time and cost due to its applicability in group-based treatments. Its capacity to apply in groups makes for an easier accessibility and much larger dissemination.

Despite its advantages, the therapist should exercise certain cautions to TCBT. As TCBT caters to comorbid disorders, at times, the therapists make the mistake of trying to do too much at once which should be guarded against. Comorbidity gives way to complexity and hence the treatment may take longer than it does for a single disorder. Further, not many randomized controlled trials have been done in the realm of TCBT so far, and much research is needed to solidify the results. Moreover, TCBT utilizes several therapeutic approaches at once and at times, they may cancel out the effects of one another which require special attention by the therapist in order to avoid such circumstances. In a group setting, TCBT may dilute group cohesiveness due to different presentations by each client and may thus increase the drop-out rates. However, this has been refuted by some studies[10] which show no impact of diagnostically different groups on group cohesion or outcomes.

Conclusively, TCBT appears as a promising alternative to CBT, especially in cases of comorbidity and has special significance in a limited resource country like India where there is less accessibility to psychotherapy treatments owing to a skewed ratio of client versus therapist population although more research is warranted in this regard.

Financial support and sponsorship
Nil.

Conflicts of interest
There are no conflicts of interest.

Pragya Sharma, Manju Mehta[1]
Department of Clinical Psychology, Dr. Ram Manohar Lohia Hospital, [1]Department of Clinical Psychology, Holy Family Hospital, New Delhi, India

Address for correspondence: Pragya Sharma, Room number 14, Department of Clinical Psychology, Dr. Ram Manohar Lohia Hospital, Park Street, New Delhi-110001, India.
E-mail: pragya.cp@gmail.com

REFERENCES

1. Roth A, Fonagy P. What Works for Whom? A Critical Review of Psychotherapy Research. New York: Guilford Publications; 2013.
2. Otto MW, Wisniewski SR. CBT for treatment resistant depression. Lancet 2013;381:352-3.
3. Kushwaha V, Chadda RK, Mehta M. Psychotherapeutic intervention in somatisation disorder: Results of a controlled study from India. Psychol Health Med 2013;18:445-50.
4. Isaac M. Mental health services in South Asia: Past, present and future. South Asian J Psychiatry 2011;2:4-12.
5. Stewart RE, Chambless DL. Cognitive-behavioral therapy for adult anxiety disorders in clinical practice: A meta-analysis of effectiveness studies. J Consult Clin Psychol 2009;77:595-606.
6. Kar N, Bastia BK. Post-traumatic stress disorder, depression and generalised anxiety disorder in adolescents after a natural disaster: A study of comorbidity. Clin Pract Epidemiol Ment Health 2006;2:17.
7. Andrews G, Slade T, Issakidis C. Deconstructing current comorbidity: Data from the Australian National Survey of Mental Health and Well-Being. Br J Psychiatry 2002;181:306-14.
8. McEvoy PM, Shand F. The effect of comorbid substance use disorders on treatment outcome for anxiety disorders. J Anxiety Disord 2008;22:1087-98.
9. Fairburn CG, Harrison PJ. Eating disorders. Lancet 2003;361:407-16.
10. Norton PJ. An open trial of a transdiagnostic cognitive-behavioral group therapy for anxiety disorder. Behav Ther 2008;39:242-50.

Access this article online

Website: www.ijpm.info

DOI: 10.4103/0253-7176.183090

Quick Response Code

How to cite this article: Sharma P, Mehta M. Need for transdiagnostic cognitive behavior therapy in indian psychiatric setting. Indian J Psychol Med 2016;38:273-4.