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## SunCloud Health Continuing Education Series

**Transdiagnostic, integrated care for people with complex co-occurring disorders.**

# One Client, Many Models: Integrating CPT, TF-CBT and RO DBT Through a Transdiagnostic Lens

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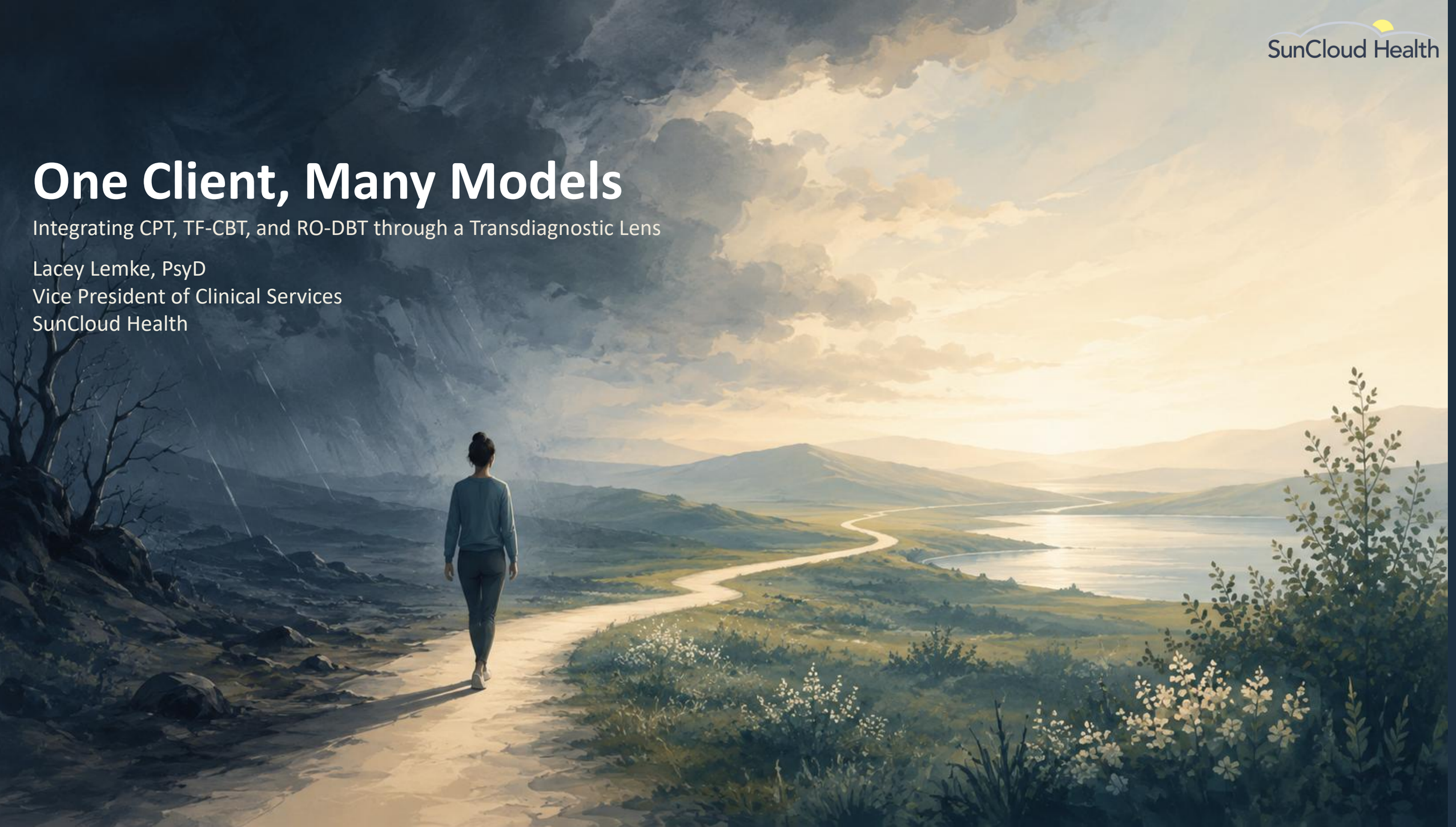
VP of Clinical Services



# One Client, Many Models

Integrating CPT, TF-CBT, and RO-DBT through a Transdiagnostic Lens

Lacey Lemke, PsyD
Vice President of Clinical Services
SunCloud Health

# Learning Objectives

Define a transdiagnostic, mechanism-based case conceptualization.

Compare the core targets of CPT, TF-CBT, and RO-DBT.

Identify where trauma processing, emotion regulation, and overcontrol interventions overlap and diverge.

Use sequencing questions to determine what to treat first, next, and later.

Apply an integrated formulation to a complex case presentation.

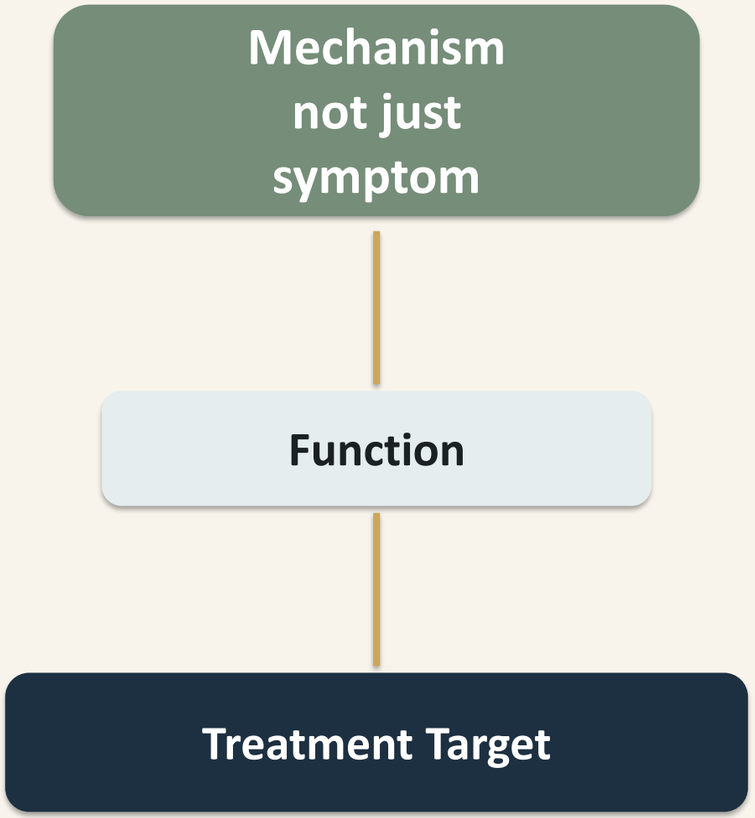
Barlow et al., 2017; Cohen et al., 2017; Lynch, 2018; Resick et al., 2024

# The Clinical Problem: Real Clients Are Messy

Most clients do not arrive with a single, tidy diagnosis.

Higher-acuity care often includes trauma, shame, anxiety, eating disorder symptoms, substance use, self-harm, perfectionism, and relational disconnection.

Treatment planning becomes difficult when each diagnosis points toward a different protocol.



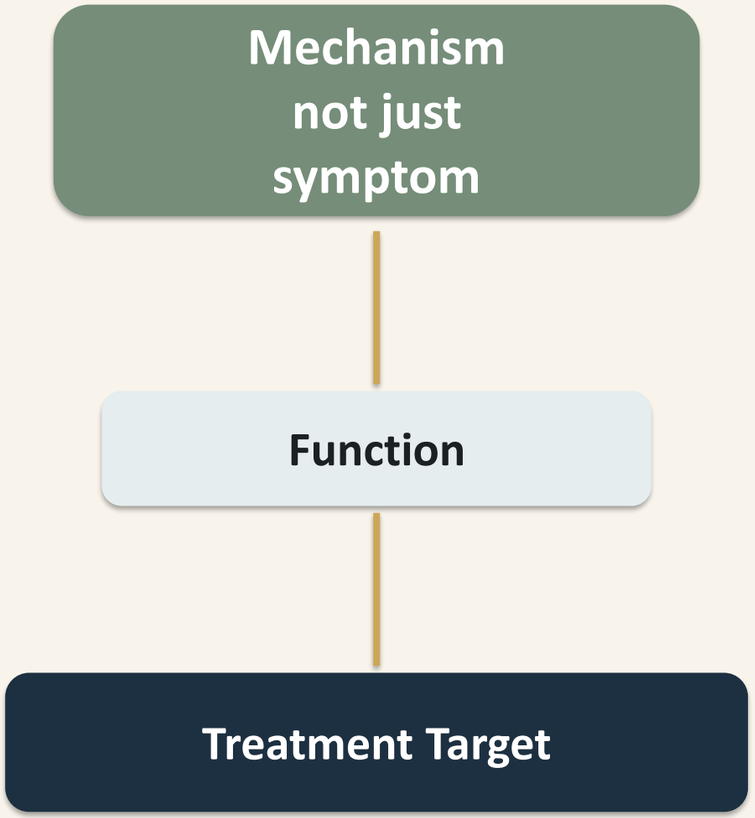

Barlow et al., 2017; Barlow et al., 2020

# From Diagnosis-Driven to Mechanism-Driven Care

Diagnosis-driven question: “Which disorder does this client have?”

Mechanism-driven question: “What is maintaining suffering across presentations?”

Clinical integration becomes safer and more precise when it targets mechanisms rather than symptoms alone.



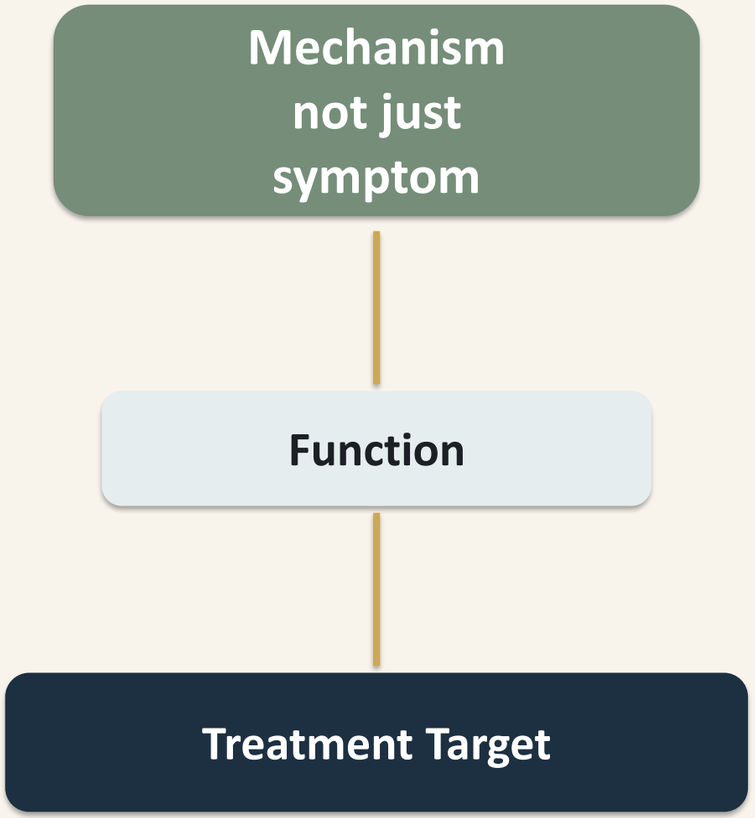

Barlow et al., 2017; Barlow et al., 2020

# What “Transdiagnostic” Means Here

A transdiagnostic lens identifies processes that cut across disorders.

It does not erase diagnosis; it adds an organizing layer underneath diagnosis.

Shared processes include avoidance, threat sensitivity, shame, cognitive rigidity, emotional inhibition, perfectionism, and social disconnection.




Barlow et al., 2017; Barlow et al., 2020

# Shared Maintaining Mechanisms

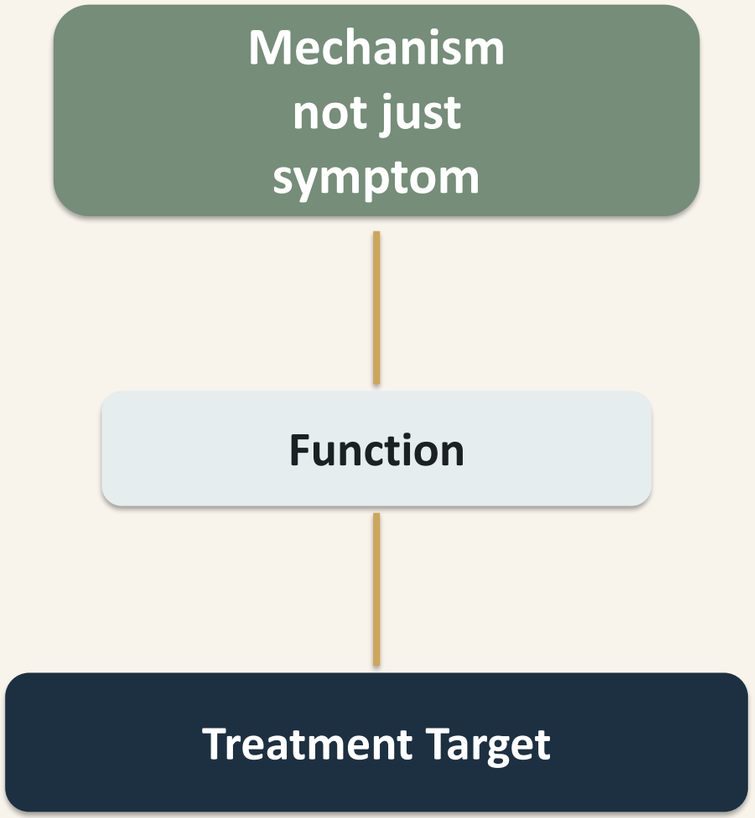
Avoidance reduces distress short-term and maintains symptoms long-term.

Threat sensitivity narrows attention toward danger, certainty, and control.

Shame increases secrecy, self-attack, and withdrawal.

Cognitive rigidity turns trauma meanings into rules for living.

Emotional inhibition limits corrective relational experience.




Barlow et al., 2017; Barlow et al., 2020

# A Mechanism Loop Common in Complex Presentations

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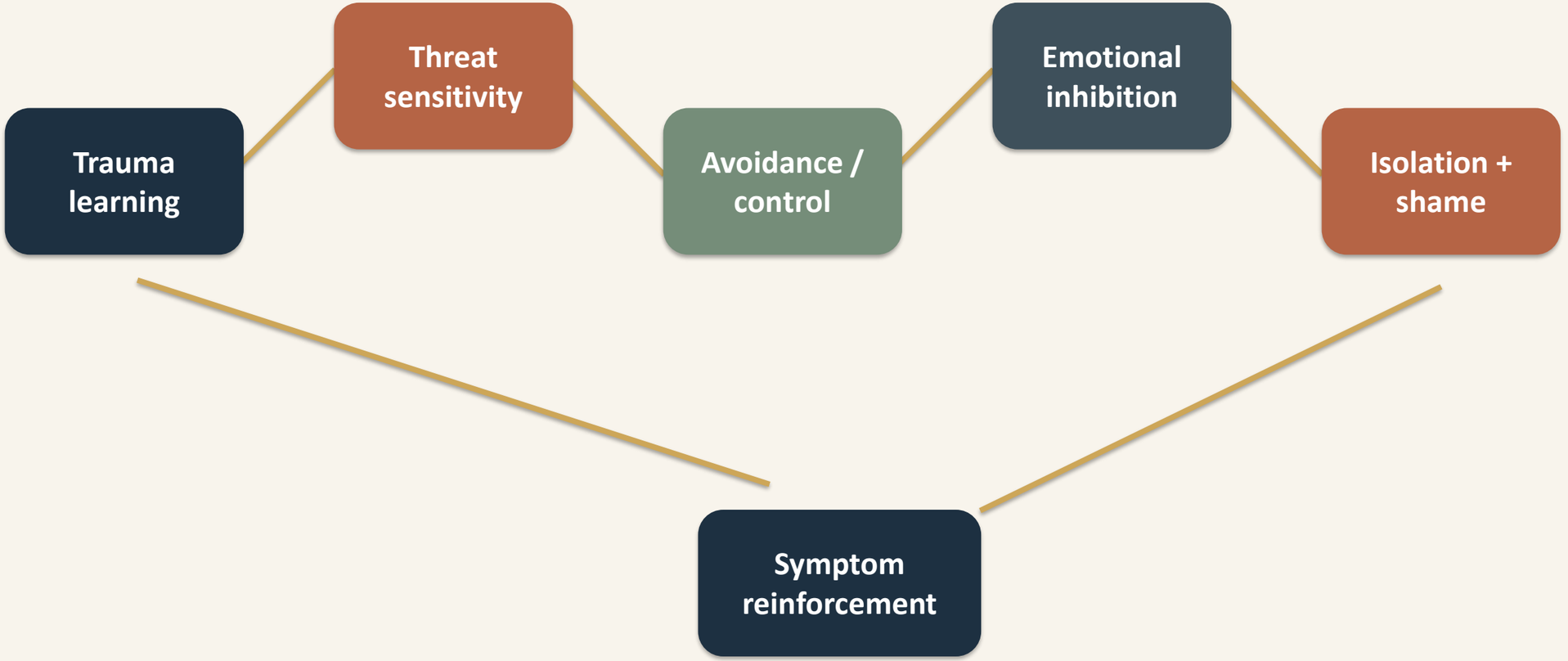


**Clinical implication: intervene where the loop is most movable today.**

Cloitre et al., 2019; Barlow et al., 2020; Lynch, 2018

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Part I: Trauma-Focused Models
CPT and TF-CBT as complementary trauma pathways

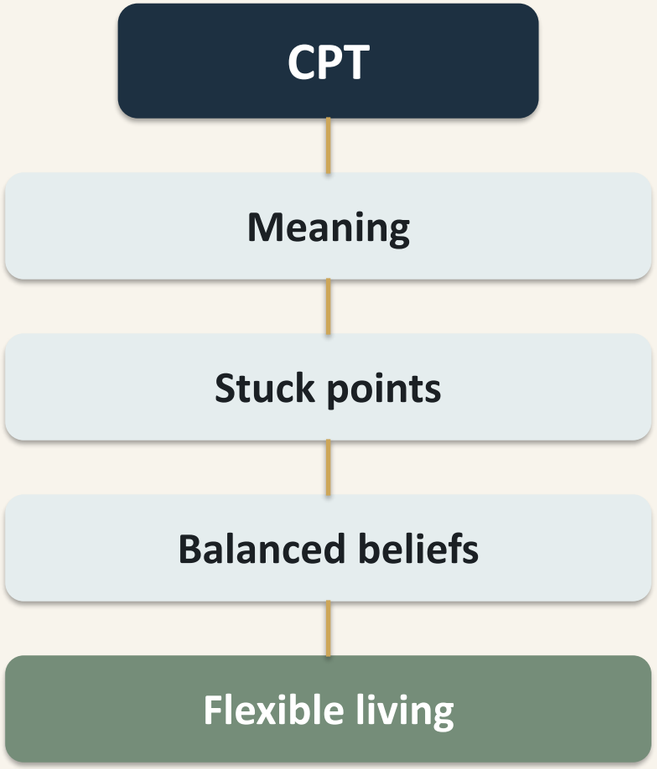
# Cognitive Processing Therapy: Core Frame

CPT lens: trauma-related meaning, stuck points, and balanced accommodation

CPT is a trauma-focused cognitive therapy for PTSD and related difficulties.

The core clinical target is how trauma alters beliefs about self, others, and the world.

CPT asks: What meanings did the client make from what happened, and how are those meanings maintaining symptoms now?




Resick, Monson, & Chard, 2017/2024; APA, 2017; VA National Center for PTSD, 2026

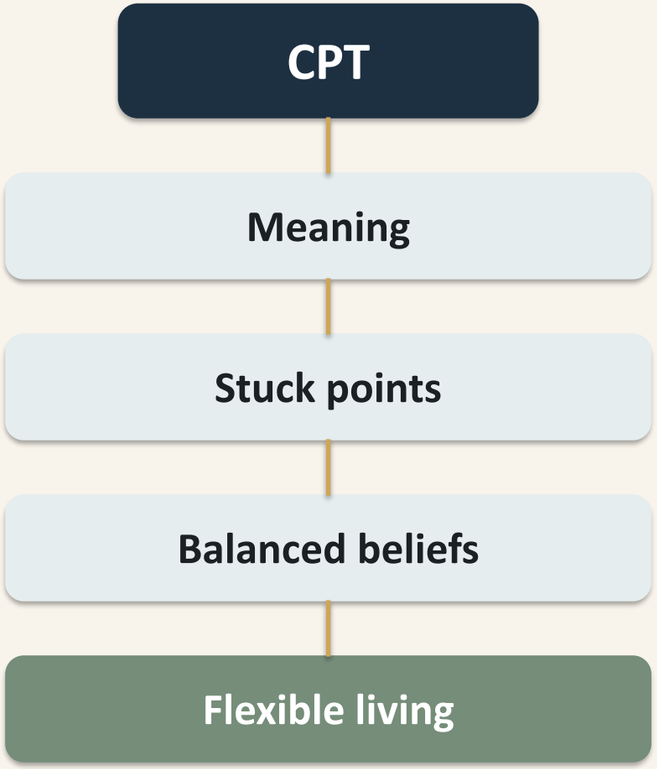
# CPT Stuck Points

CPT lens: trauma-related meaning, stuck points, and balanced accommodation

Stuck points are concise beliefs that keep the client trapped in trauma-related meaning.

They often sound absolute: “I should have known,” “I cannot trust anyone,” “I am damaged,” “If I relax, something bad will happen.”

Stuck points may involve self-blame, danger, trust, power/control, esteem, or intimacy.




Resick, Monson, & Chard, 2017/2024; APA, 2017; VA National Center for PTSD, 2026

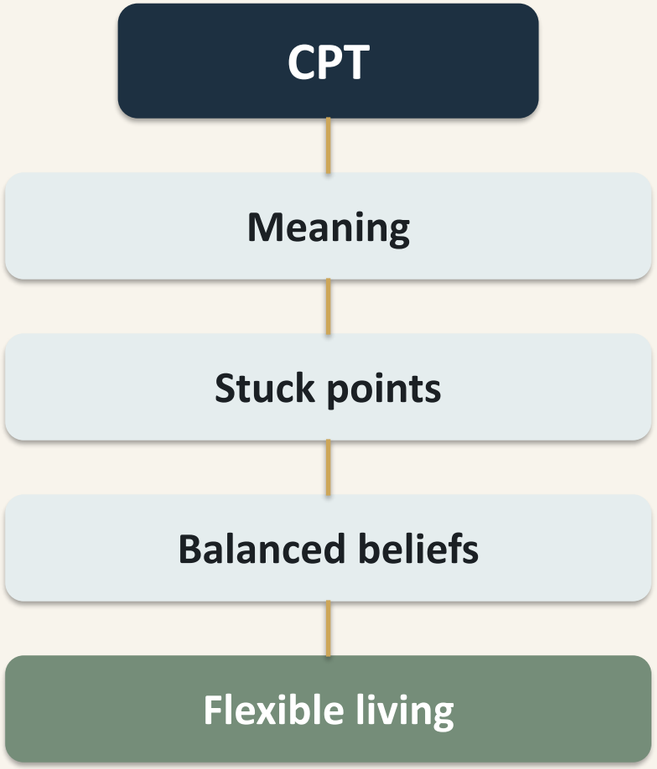
# Assimilation, Accommodation, Overaccommodation

CPT lens: trauma-related meaning, stuck points, and balanced accommodation

Assimilation: altering the memory to fit prior beliefs, often through self-blame.

Overaccommodation: broad, rigid rule-making after trauma.

Accommodation: balanced belief change that integrates the trauma without letting it define the entire self or world.




Resick, Monson, & Chard, 2017/2024; APA, 2017; VA National Center for PTSD, 2026

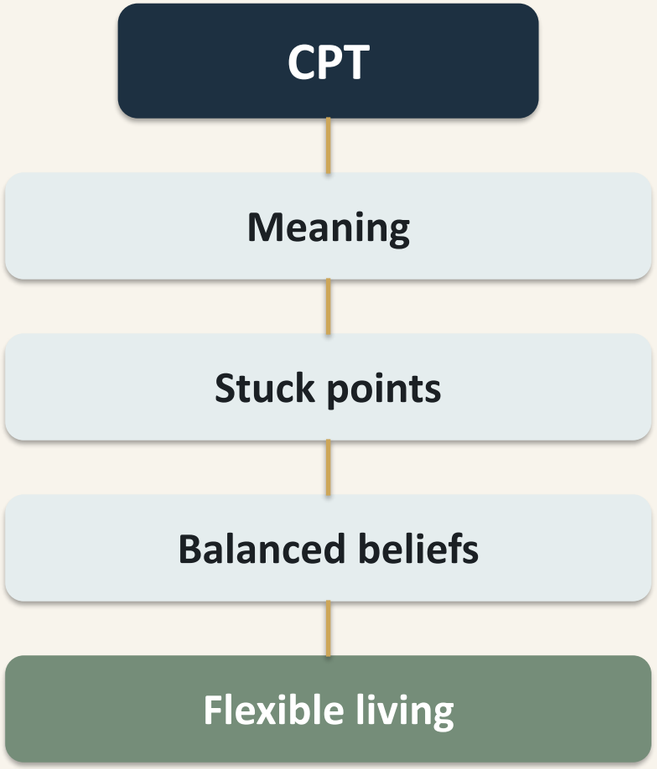
# CPT Through a Transdiagnostic Lens

CPT lens: trauma-related meaning, stuck points, and balanced accommodation

CPT targets cognitive rigidity, shame, guilt, threat appraisals, and meaning-making.

These mechanisms cut across PTSD, eating disorders, depression, anxiety, and relational avoidance.

CPT may be especially useful when trauma beliefs are the organizing center of the presentation.




Resick, Monson, & Chard, 2017/2024; APA, 2017; VA National Center for PTSD, 2026

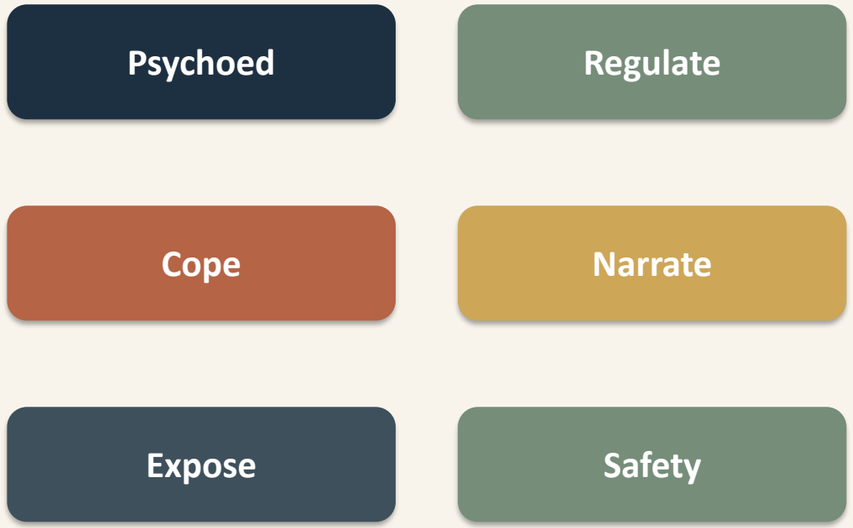
# TF-CBT: Core Frame

TF-CBT lens: regulation, narration, exposure, and safety

TF-CBT is a structured, phase- and component-based trauma treatment, originally developed for children and adolescents.

It integrates coping skills, cognitive processing, trauma narrative, exposure, caregiver work, and safety enhancement.

The model is often summarized through PRACTICE.

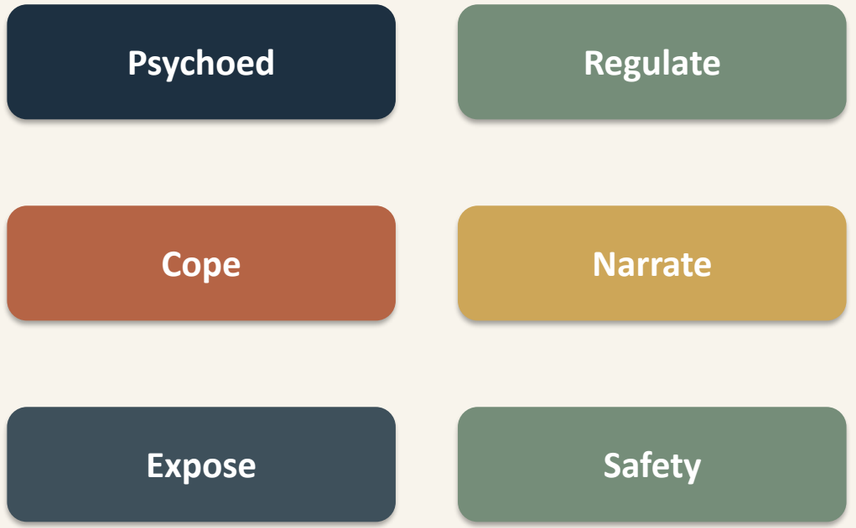



Cohen, Mannarino, & Deblinger, 2017; Cohen et al., 2015; de Arellano et al., 2014

# The PRACTICE Components

TF-CBT lens: regulation, narration, exposure, and safety

- Psychoeducation and parenting/caregiver support when appropriate.
- Relaxation and affective modulation.
- Cognitive coping and cognitive processing.
- Trauma narrative and gradual exposure to trauma reminders.
- Conjoint work, integration, and enhancing safety.




Cohen, Mannarino, & Deblinger, 2017; Cohen et al., 2015; de Arellano et al., 2014

# TF-CBT Mechanisms

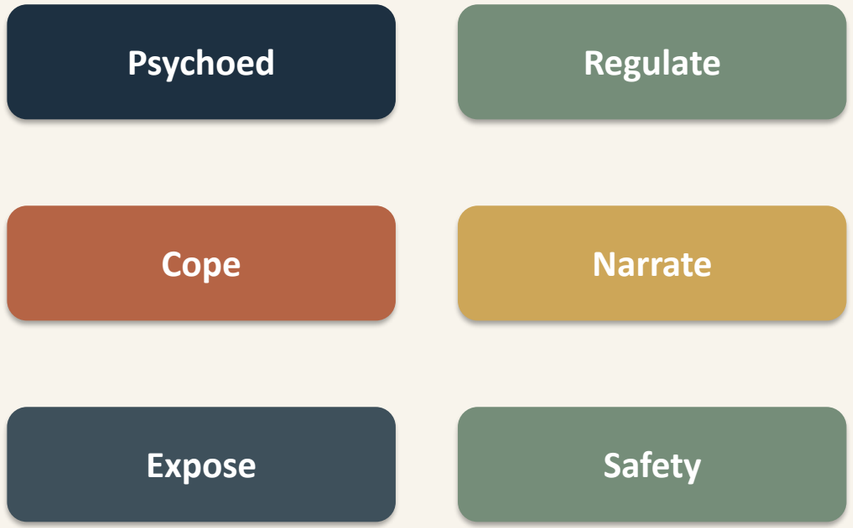
TF-CBT lens: regulation, narration, exposure, and safety

Reduces avoidance through graduated exposure and trauma narration.

Improves regulation through relaxation, affect modulation, and coping skills.

Supports cognitive change through developmentally appropriate processing.

Addresses family or system responses that may unintentionally maintain symptoms.




Cohen, Mannarino, & Deblinger, 2017; Cohen et al., 2015; de Arellano et al., 2014

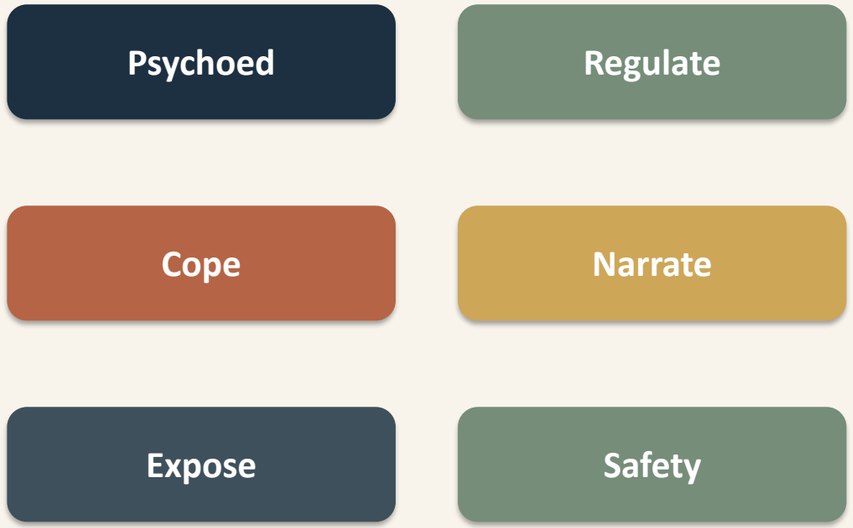
# TF-CBT Through a Transdiagnostic Lens

TF-CBT lens: regulation, narration, exposure, and safety

Targets avoidance, dysregulation, fear conditioning, trauma fragmentation, and safety learning.

Useful when stabilization and graded exposure are essential before deeper cognitive work.

Especially relevant when developmental level, caregiver context, or relational environment shapes symptom maintenance.




Cohen, Mannarino, & Deblinger, 2017; Cohen et al., 2015; de Arellano et al., 2014

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# Part II: RO-DBT and Overcontrol

When control protects — and then imprisons

# RO-DBT: Core Frame

RO-DBT lens: openness, flexibility, social connection

RO-DBT targets maladaptive overcontrol rather than undercontrol.

Psychological health is framed around openness, flexibility, and social connectedness.

The treatment gives special attention to social signaling and emotional loneliness.

Lynch, 2018; Lynch et al., 2015; Gilbert et al., 2023; ABCT, 2021

# What Overcontrol Looks Like Clinically

RO-DBT lens: openness, flexibility, social connection

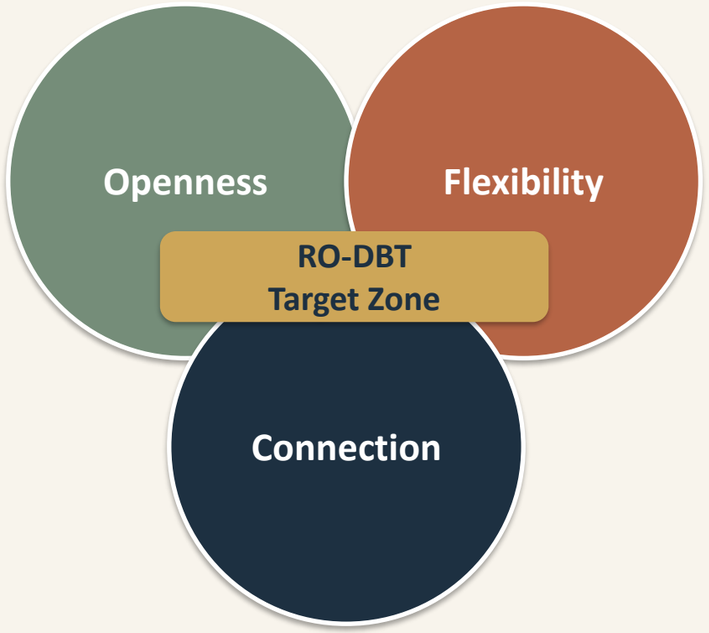
Perfectionism, high self-monitoring, and rule-governed behavior.

Emotional inhibition or flattened expression.

Risk aversion, guardedness, and difficulty receiving feedback.

Strong threat sensitivity masked by competence.

Chronic loneliness despite apparent functioning.




Lynch, 2018; Lynch et al., 2015; Gilbert et al., 2023; ABCT, 2021

# RO-DBT Mechanisms

RO-DBT lens: openness, flexibility, social connection

Low openness: difficulty taking in disconfirming feedback.

Low flexibility: rigid rules, routines, or values held too tightly.

Low social connectedness: social signaling patterns that unintentionally communicate distance.

Emotional loneliness: feeling unknown, unseen, or unreachable.

Lynch, 2018; Lynch et al., 2015; Gilbert et al., 2023; ABCT, 2021

# Social Signaling: Why It Matters

RO-DBT lens: openness, flexibility, social connection

Facial expression, vocal tone, posture, eye contact, and timing shape relational safety.

Overcontrolled clients may signal distance even when they desire connection.

Therapy can explicitly teach warmer, more flexible social signaling.

Lynch, 2018; Lynch et al., 2015; Gilbert et al., 2023; ABCT, 2021

# Trauma + Overcontrol

RO-DBT lens: openness, flexibility, social connection

Trauma can teach: vulnerability is dangerous, emotions are unsafe, mistakes are costly, and control prevents harm.

Overcontrol may begin as an adaptive survival strategy.

Treatment must honor the function of control before asking the client to loosen it.

Lynch, 2018; Lynch et al., 2015; Gilbert et al., 2023; ABCT, 2021

# RO-DBT Through a Transdiagnostic Lens

RO-DBT lens: openness, flexibility, social connection

Targets emotional inhibition, perfectionism, rigidity, threat sensitivity, and interpersonal disconnection.

Relevant across anorexia nervosa, chronic depression, OCD traits, anxiety, PTSD, and personality presentations.

Especially useful when symptoms are maintained by constriction rather than chaos.

Lynch, 2018; Lynch et al., 2015; Gilbert et al., 2023; ABCT, 2021

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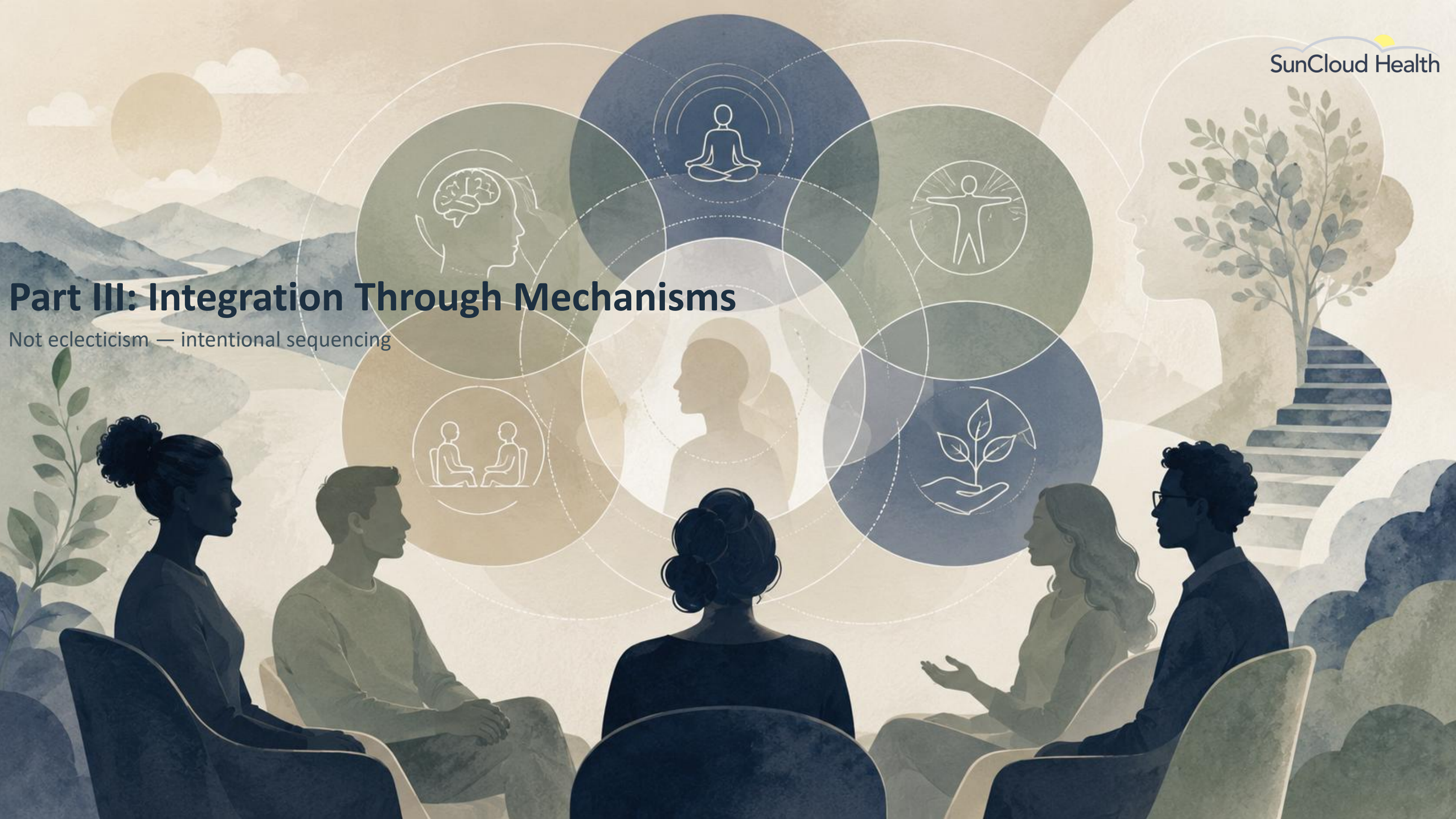

# Part III: Integration Through Mechanisms

Not eclecticism — intentional sequencing

# Model Comparison: What Each Adds

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| CPT | TF-CBT | RO-DBT |
| --- | --- | --- |
| Trauma-related meaning<br>Stuck points<br>Cognitive rigidity<br>Shame and self-blame | Stabilization<br>Affect regulation<br>Narrative/exposure<br>Safety and systems | Overcontrol<br>Emotional inhibition<br>Social signaling<br>Loneliness |

**Clinical integration asks: Which mechanism is most maintaining suffering today?**

Resick et al., 2024; Cohen et al., 2017; Lynch, 2018

# Where the Models Overlap

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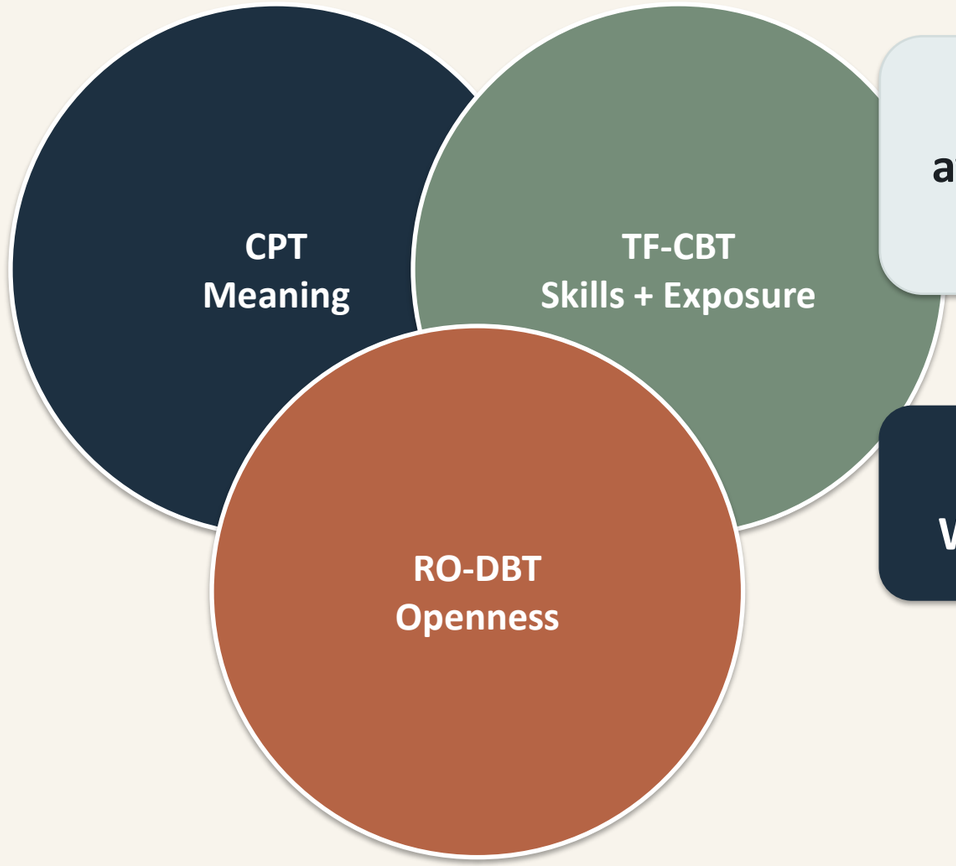



**Shared targets:**
**avoidance • shame • rigidity • safety learning**

**Key question:**
**Which pathway unlocks movement?**

Barlow et al., 2020; Cloitre et al., 2019

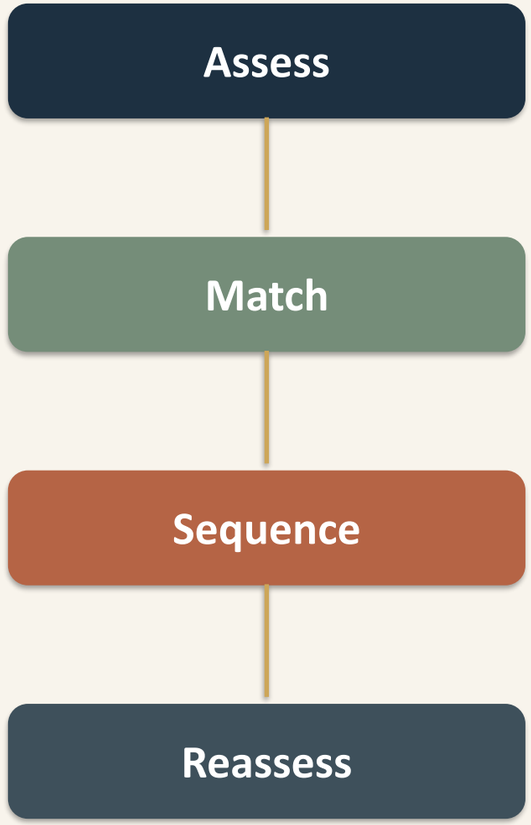
# The Sequencing Principle

Clinical sequencing translates mechanism into timing

Do not ask: “Which model do I like best?”

Ask: “What must shift first so the next intervention can work?”

Sequencing is a clinical safety issue, not simply a preference.




Cloitre et al., 2019; Lynch, 2018; Resick et al., 2024

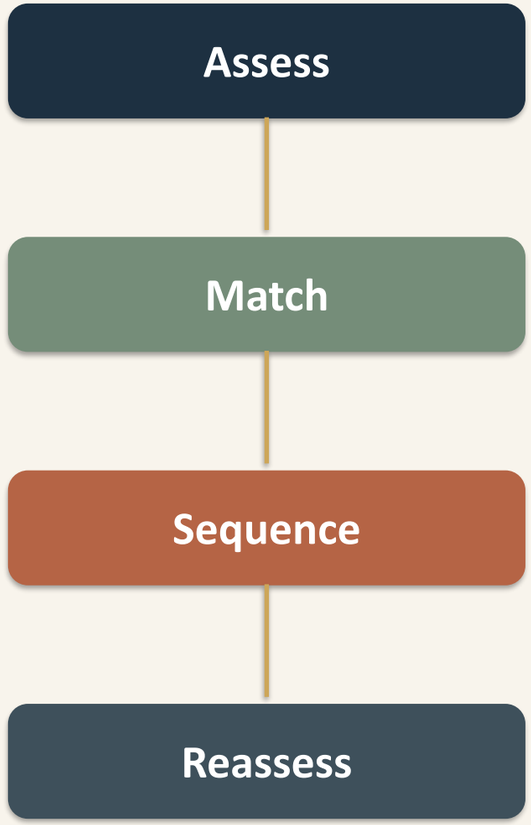
# Decision Point 1: Can the Client Access Emotion?

Clinical sequencing translates mechanism into timing

If the client cannot feel, name, or express affect, trauma work may become intellectualized.

RO-DBT may help build emotional openness and social signaling first.

TF-CBT affect modulation may help if the issue is dysregulation rather than inhibition.




Cloitre et al., 2019; Lynch, 2018; Resick et al., 2024

# Decision Point 2: Is Avoidance Primarily Cognitive, Emotional, Behavioral, or Relational?

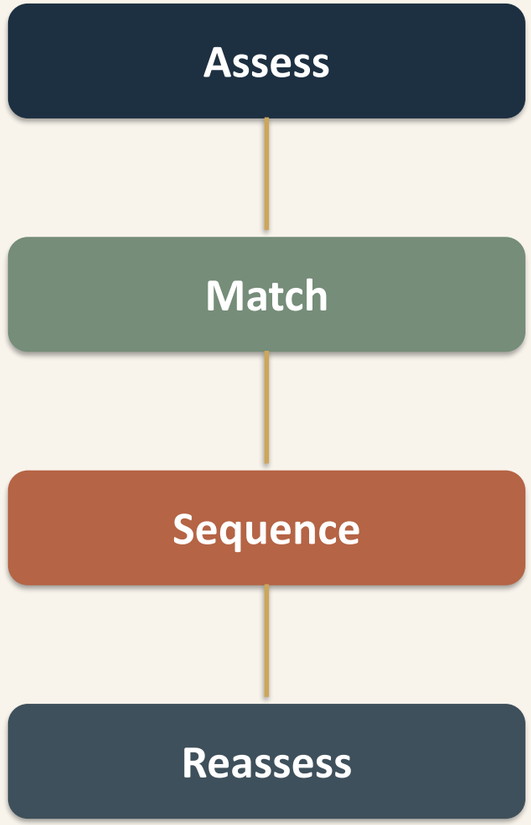
Clinical sequencing translates mechanism into timing

Cognitive avoidance: stuck point work may be central.

Emotional avoidance: affect modulation or RO-DBT openness may be needed.

Behavioral avoidance: exposure-based work may be central.

Relational avoidance: social signaling and alliance work may come first.




Cloitre et al., 2019; Lynch, 2018; Resick et al., 2024

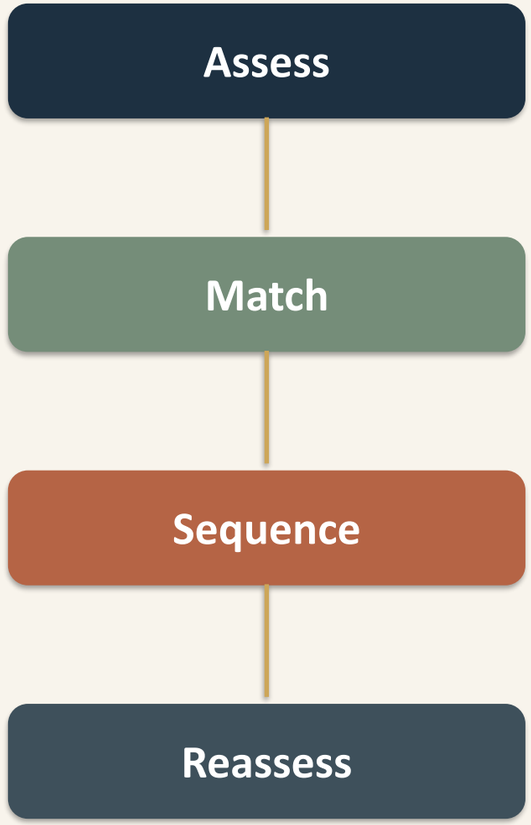
# Decision Point 3: What Is the Function of Control?

Clinical sequencing translates mechanism into timing

Control may reduce threat, shame, uncertainty, body distress, grief, or relational risk.

Before loosening control, identify what the client believes control prevents.

Interventions should respect the protective function while expanding flexibility.




Cloitre et al., 2019; Lynch, 2018; Resick et al., 2024

# Decision Point 4: What Does the Alliance Need?

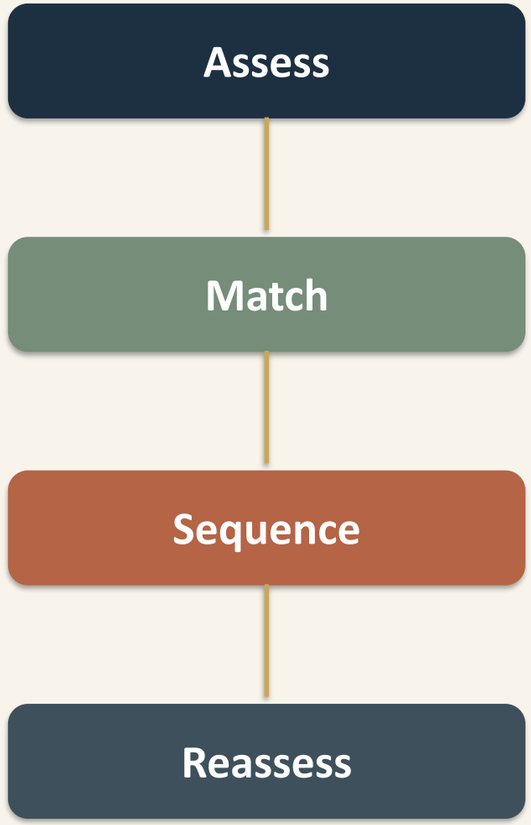
Clinical sequencing translates mechanism into timing

Overcontrolled clients may need warmth, playfulness, and explicit social signaling.

Highly traumatized clients may need predictability and choice.

Shame-prone clients may need careful pacing and nonjudgmental curiosity.

The model must be delivered through the relationship.




Cloitre et al., 2019; Lynch, 2018; Resick et al., 2024

# Integrated Treatment Sequencing Map

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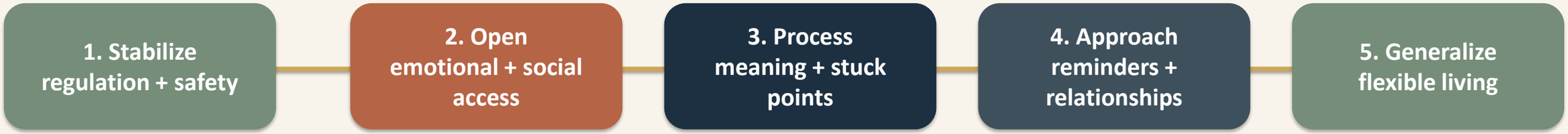


**This is not always linear. The clinician cycles back when risk, dysregulation, or constriction increases.**

Cohen et al., 2017; Lynch, 2018; Resick et al., 2024

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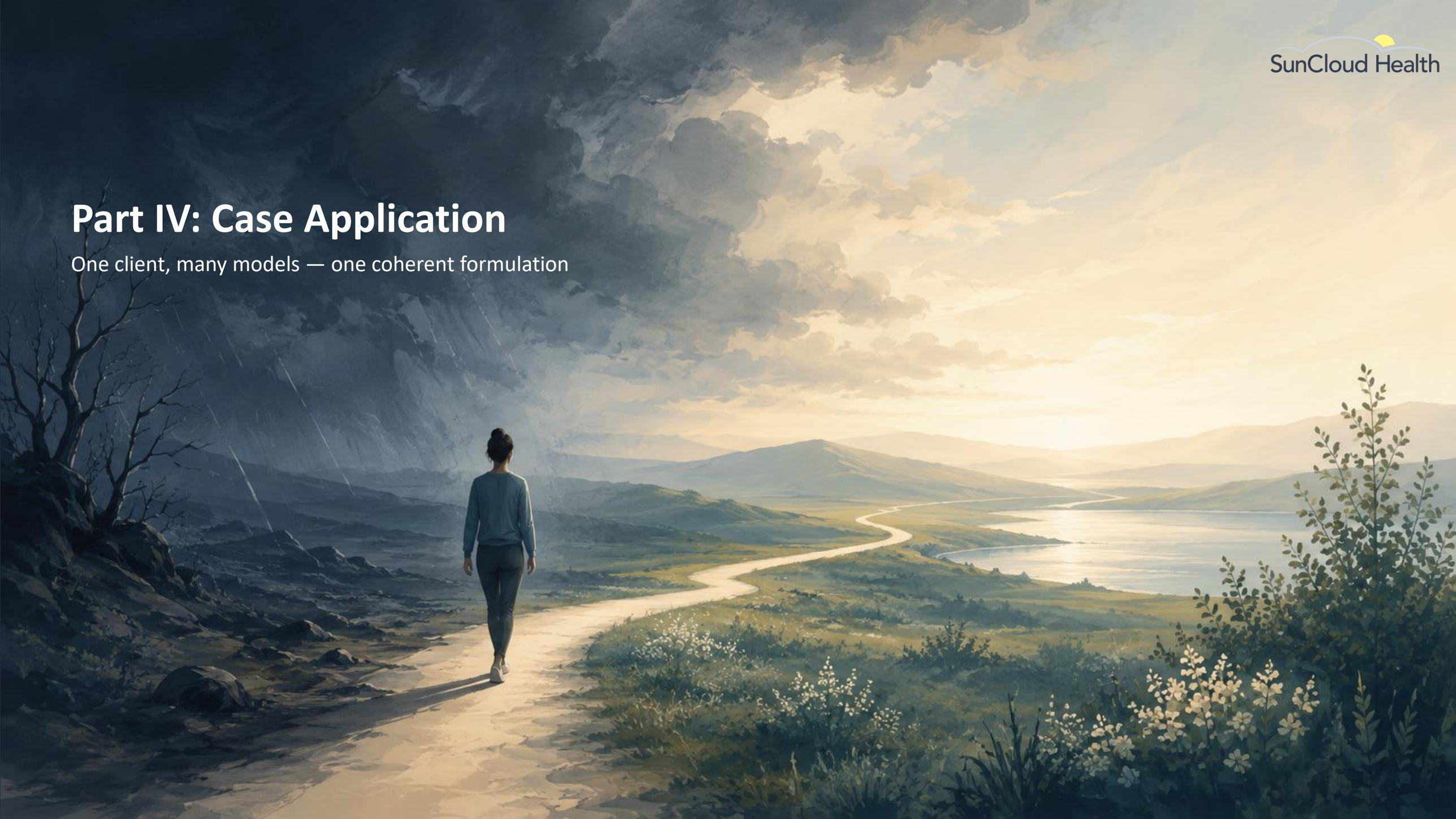
# Part IV: Case Application

One client, many models — one coherent formulation



# Case: “Amanda.”

Composite vignette for teaching and discussion

Amanda is a 27-year-old client in eating disorder treatment with restrictive behaviors, chronic anxiety, and childhood trauma history.

She is high-achieving, guarded, perfectionistic, and rarely appears dysregulated in session.

She reports feeling lonely, defective, and terrified of needing others.

Trauma reminders lead to increased restriction, overworking, and withdrawal.

**CPT**

**TF-CBT**

**RO-DBT**

**Mechanism formulation**

Teaching composite; treatment examples informed by Resick et al., Cohen et al., and Lynch

# Amanda’s Initial Formulation

Composite vignette for teaching and discussion

Trauma learning: vulnerability led to danger or humiliation.

Core stuck points: “Needing others is weakness”; “My body is unsafe”; “If I lose control, I will fall apart.”

Maintaining behaviors: restriction, emotional masking, perfectionism, withdrawal, overpreparation.

Short-term relief reinforces long-term isolation and shame.

**CPT**

**TF-CBT**

**RO-DBT**

**Mechanism formulation**

Teaching composite; treatment examples informed by Resick et al., Cohen et al., and Lynch

# What Not To Do First

Composite vignette for teaching and discussion

Do not assume her calm presentation means she is ready for intensive trauma processing.

Do not confront control without validating its protective history.

Do not focus only on cognitive insight while ignoring relational distance.

Do not interpret compliance as engagement.

**CPT**

**TF-CBT**

**RO-DBT**

**Mechanism formulation**

# Initial Treatment Priorities

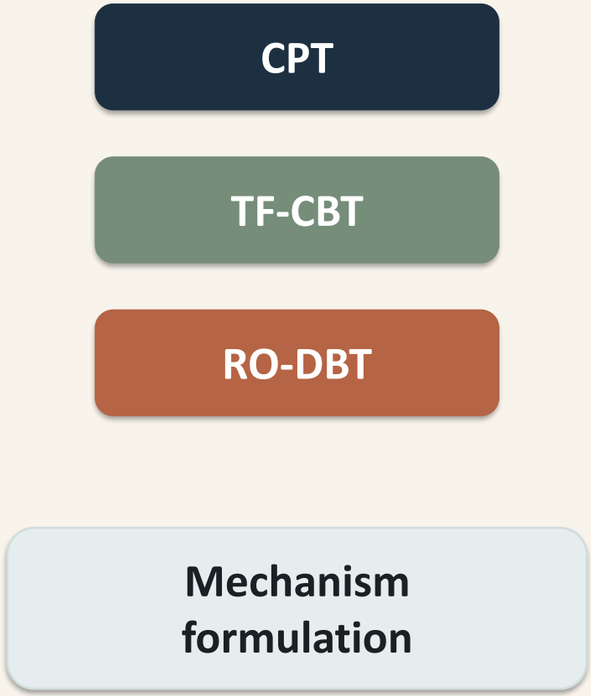
Composite vignette for teaching and discussion

Build alliance through predictability, warmth, and collaborative choice.

Use RO-DBT-informed work to increase openness, social signaling, and willingness to be emotionally seen.

Use TF-CBT-informed regulation skills to expand tolerance for trauma-linked affect.

Begin CPT-informed stuck point identification without rushing formal processing.



# Middle-Phase Integration

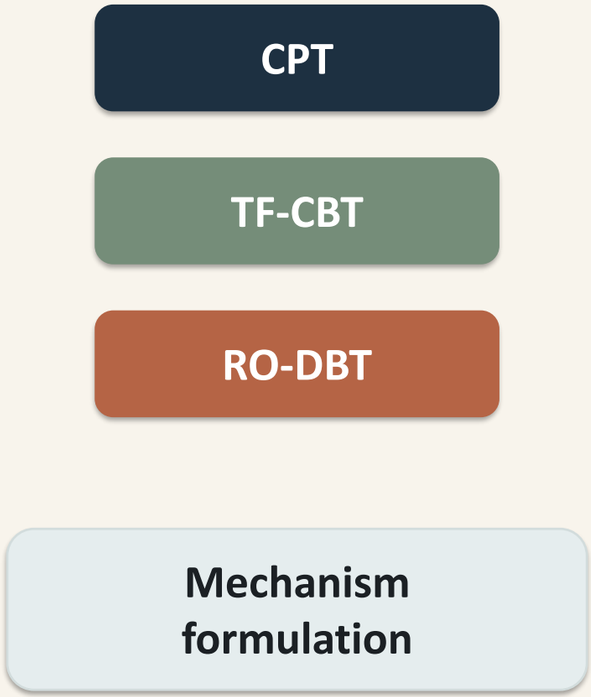
Composite vignette for teaching and discussion

CPT: challenge stuck points related to blame, defectiveness, safety, and control.

TF-CBT: use graduated exposure to trauma reminders and body-related triggers.

RO-DBT: practice vulnerability, flexible responding, and warmer social signaling.

Eating disorder behaviors are tracked as avoidance/control strategies, not isolated symptoms.



# Later-Phase Integration

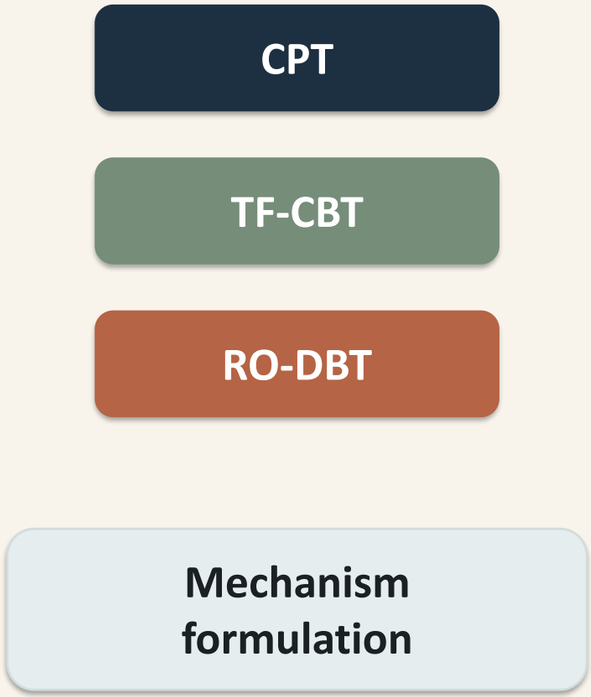
Composite vignette for teaching and discussion

Generalize flexible responding to relationships, meals, body distress, feedback, and uncertainty.

Use relapse prevention around shame spirals, trauma anniversaries, perfectionism, and isolation.

Strengthen identity beyond symptoms and control.

Continue practicing accommodation: trauma is part of the story, not the whole story.




Teaching composite; treatment examples informed by Resick et al., Cohen et al., and Lynch

# Tool: Integrated Mechanism Map

Step 1: Identify the presenting symptom.

Step 2: Ask what the symptom does for the client.

Step 3: Link the function to a maintaining mechanism.

Step 4: Select the model that best targets the mechanism.

Step 5: Reassess movement, not just insight.

Mechanism-based integration framework; Barlow et al., 2020; Cloitre et al., 2019

# Tool: Model-Matching Questions

CPT question: What belief keeps the trauma active?

TF-CBT question: What skill, exposure, or safety step is needed for tolerable approach?

RO-DBT question: Where is control blocking openness, flexibility, or connection?

Transdiagnostic question: What mechanism is most costly right now?

Mechanism-based integration framework; Barlow et al., 2020; Cloitre et al., 2019

# Tool: Fidelity Guardrails

Name whether you are delivering a full protocol or using model-informed interventions.

Do not mix interventions in ways that dilute the active ingredient.

Maintain informed consent about treatment rationale.

Use consultation and training when delivering formal protocols.

Document the mechanism, intervention, and client response.

Mechanism-based integration framework; Barlow et al., 2020; Cloitre et al., 2019

# Tool: Interdisciplinary Team Language

Instead of: “She is resistant.” Try: “Control is serving a safety function.”

Instead of: “He will not open up.” Try: “Emotional inhibition may be maintaining loneliness.”

Instead of: “She is noncompliant.” Try: “Avoidance is being negatively reinforced.”

Instead of: “He knows better.” Try: “Insight is not yet translating into flexible behavior.”

Mechanism-based integration framework; Barlow et al., 2020; Cloitre et al., 2019

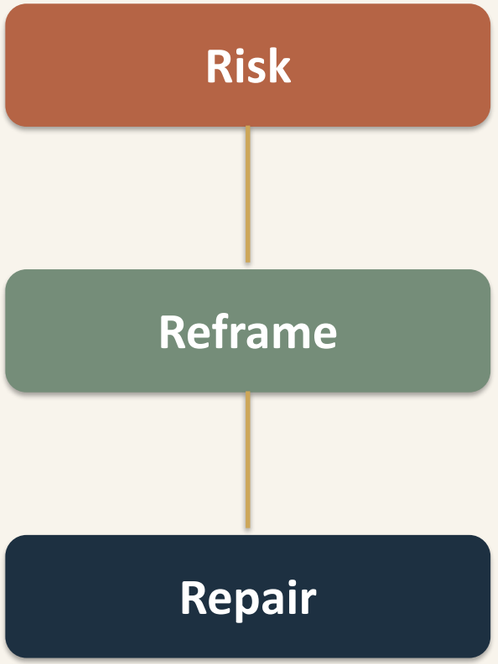
# Pitfall 1: Mistaking Overcontrol for Stability

The client appears calm, articulate, and compliant.

The treatment team assumes distress is low.

The client remains emotionally alone and increasingly rigid.

Corrective move: assess loneliness, inhibition, threat sensitivity, and social signaling.

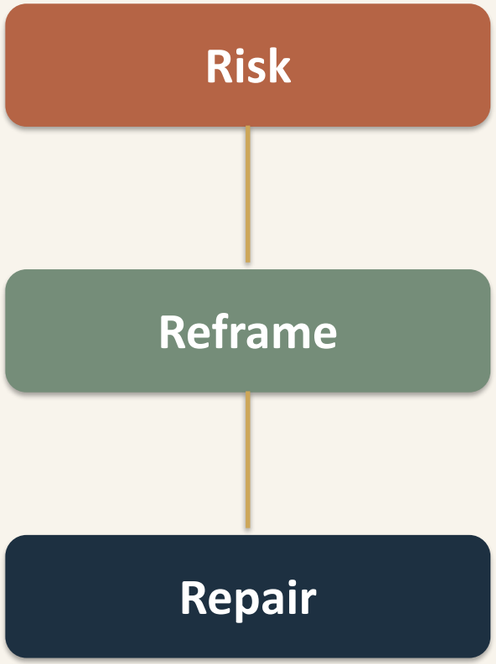


# Pitfall 2: Processing Trauma Before Capacity

Trauma processing can be helpful and evidence-based.

It can also overwhelm when skills, safety, or emotional access are insufficient.

Corrective move: pace trauma work according to arousal, alliance, readiness, and current coping function.

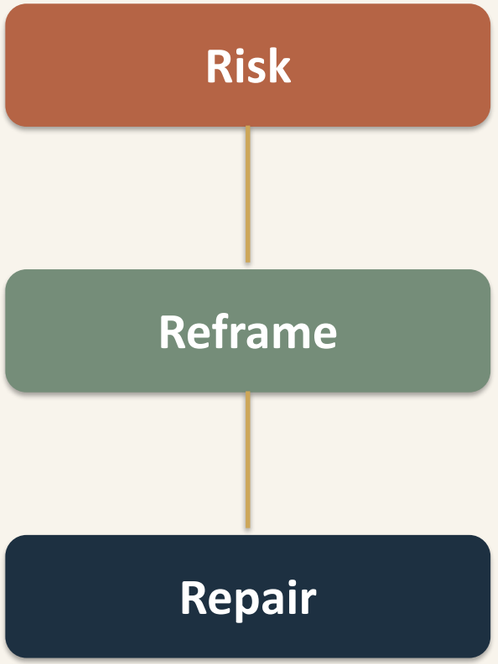


# Pitfall 3: Becoming Too Cognitive

Highly overcontrolled clients may excel at insight and worksheets.

Cognitive work can become another performance arena.

Corrective move: track emotional contact, relational vulnerability, body cues, and behavioral flexibility.



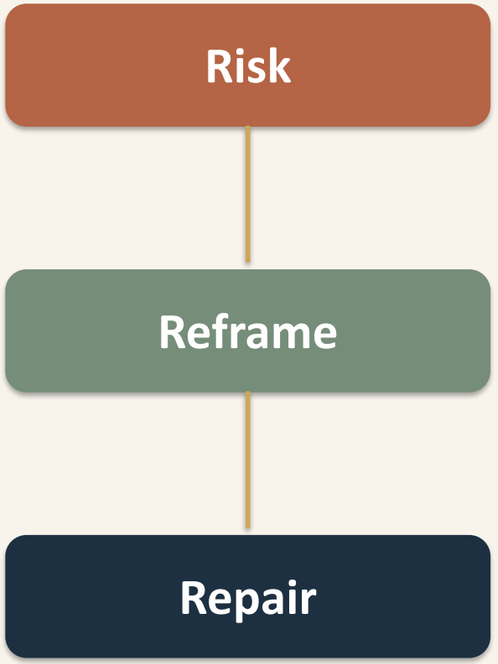
# Pitfall 4: Losing the Active Ingredient

Integration should preserve the core mechanism each model targets.

CPT without cognitive processing becomes generic CBT.

TF-CBT without graduated approach and safety becomes unstructured trauma discussion.

RO-DBT without social signaling and radical openness becomes generic skills training.



# Audience Reflection: 3-Minute Mechanism Drill

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Think of one complex client who feels hard to formulate.

Name one primary symptom that keeps repeating.

Ask: What does this symptom help the client avoid, control, reduce, express, or protect?

Choose the best model lens for the next intervention: CPT, TF-CBT, RO-DBT, or a sequenced combination.

Write one treatment target as a mechanism, not a diagnosis.

Example target:
Increase flexible approach to shame-linked body distress rather than relying on restriction and withdrawal.

# QUESTIONS

# Selected Academic References


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