


# Maladaptive Coping Strategies in Anxiety Disorders and Obsessive-Compulsive Disorder: Transdiagnostic Perspective

Anksiyete Bozuklukları ve Obsesif-Kompulsif Bozuklukta Uyumsuz Baş Etme Stratejileri: Transdiagnostik Perspektif

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## ABSTRACT

Anxiety disorders and obsessive-compulsive disorder constitute a significant burden at both individual and societal levels, owing to their high prevalence rates and substantial functional impairment. One of the central factors in the chronification of these disorders is the use of maladaptive coping strategies that individuals develop in an attempt to manage their symptoms. This study examines the maladaptive coping strategies observed in panic disorder, social anxiety disorder, generalized anxiety disorder, and obsessive-compulsive disorder from a transdiagnostic perspective. It further aims to situate these strategies within the Research Domain Criteria framework, which shares conceptual coherence with the transdiagnostic approach. The reviewed literature indicates that although maladaptive coping strategies reduce anxiety in the short term, they serve to maintain psychopathology over the long term through negative reinforcement cycles. Transdiagnostic analysis reveals that threat appraisal and interpretation biases, intolerance of uncertainty, perseverative cognition, and emotional avoidance emerge as shared mechanisms across disorders. Maladaptive coping strategies may be conceptualized not merely as disorder-specific clinical presentations, but as distinct phenotypic expressions of underlying transdiagnostic mechanisms. The findings of this review are expected to contribute to the identification of maladaptive coping strategies and to inform the development of transdiagnostic treatment protocols.

**Keywords:** Maladaptive coping strategies, avoidance behavior, perseverative cognition, psychopathology

## ÖZ

Anksiyete bozuklukları ve obsesif kompulsif bozukluk, yaygınlık oranları ve belirgin işlev kayıpları nedeniyle bireysel ve toplumsal düzeyde önemli bir yük oluşturmaktadır. Bu bozuklukların süregenleşmesindeki en önemli noktalardan biri, bireylerin semptomlarla baş etmek amacıyla geliştirdiği uyumsuz baş etme stratejileridir. Bu çalışma, panik bozukluk, sosyal anksiyete bozukluğu, yaygın anksiyete bozukluğu ve obsesif-kompulsif bozuklukta gözlemlenen uyumsuz baş etme stratejilerini; transdiagnostik perspektiften incelemektedir. Ayrıca bu yaklaşımla kavramsal bütünlük taşıyan Research Domain Criteria çerçevesinde uyumsuz baş etme stratejilerini incelemeyi amaçlamaktadır. Gözden geçirilen literatür, uyumsuz baş etme stratejilerinin kısa vadede anksiyeteyi azaltmakla birlikte negatif pekiştirme döngüleri aracılığıyla psikopatolojiyi uzun vadede sürdürdüğünü ortaya koymaktadır. Bu stratejilerin transdiagnostik açıdan değerlendirilmesi; tehdit algısı ve yorumlama önyargıları, belirsizlik intoleransı, perseveratif biliş ve duygusal kaçınmanın bozukluklar arası ortak mekanizmalar olarak öne çıktığını göstermektedir. Uyumsuz baş etme stratejileri, bozukluğa özgü klinik tablolar olmanın ötesinde, transdiagnostik mekanizmaların farklı fenotipik ifadeleri olarak kavramsallaştırılabilir. Bu gözden geçirmenin bulguları, hem uyumsuz baş etme stratejilerinin belirlenmesi bağlı transdiagnostik tedavi protokollerinin geliştirilmesine katkıda bulunacaktır.

**Anahtar sözcükler:** Uyumsuz baş etme stratejileri, kaçınma davranışı, perseveratif biliş, psikopatoloji

## Introduction

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Anxiety disorders are among the most prevalent mental disorders worldwide. Lifetime prevalence rates have been reported as approximately 3–5% for panic disorder (PD), 12% for social anxiety disorder (SAD), 5–6% for generalized anxiety disorder (GAD), and 2–3% for obsessive-compulsive disorder (OCD) (Kessler et al. 2005, Ruscio et al. 2010).

Beyond directly impairing quality of life, maladaptive coping strategies play a decisive role in the chronification of these disorders, increasing their individual and social burden. Chronic course stems not only from the disorder itself but also from the individual's coping behaviors. The longer the period without treatment, the more these maladaptive patterns become entrenched, thereby negatively affecting the efficacy of early intervention and treatment (Salkovskis 1991).

Understanding the role of maladaptive coping behaviors in psychopathology predates modern cognitive models, tracing back to the early period of behavioral learning theory. Mowrer (1939, 1960) proposed a two-stage learning model to explain anxiety and avoidance behaviors. In the first stage, an initially neutral stimulus acquires a fear response through classical conditioning by being experienced concurrently with perceived danger. In the second stage, avoidance behavior directed toward this conditioned fear stimulus is negatively reinforced by reducing anxiety, thereby maintaining the disorder. Mowrer's formulation offered the first account of why avoidance becomes a self-perpetuating cycle – because the individual never comes into contact with the feared stimulus, the fear response cannot be extinguished (Mowrer, 1939, 1960). This negative reinforcement cycle continues to form the foundation of the maintenance mechanisms of all avoidance-based anxiety disorders (Craske et al. 2014). Lazarus and Folkman (1984) defined coping as the cognitive and behavioral efforts used by an individual to manage internal and external demands that tax their resources. They divided coping strategies into two main categories: problem-focused coping, which aims to directly manage or alter the stressor, and emotion-focused coping, which aims to regulate the negative emotional response to stress. Carver and colleagues (1989) further divided this theoretical framework into functional and dysfunctional coping behaviors. These models constituted the forerunners of the processes later conceptualized as emotion regulation difficulties in contemporary transdiagnostic approaches.

Although the explanatory power of the two-factor theory is significant, Rachman (1976, 1977) argued, based on clinical observations and research, that many cases could not be explained by "conditioning" alone. Rachman (1980) developed the concept of emotional processing, addressing the integrated processes of the processing and extinction of fear responses. This approach posits that because of avoidance, emotional processing is not completed, and fear therefore does not extinguish. This conceptual foundation directly contributed to Foa and Kozak's (1986) emotional processing theory. Foa and Kozak's (1986) emotional processing theory identified two essential conditions for the modification of fear structures: (a) activation of the fear structure and (b) access to corrective information. Escape behavior disrupts the second condition – the individual activates the fear construct but is unable to complete the corrective experience. Avoidance, by contrast, prevents both conditions from the outset, creating a more fundamental clinical obstacle and preserving the dysfunctional structure of the fear construct.

From the mid-1980s onward, Salkovskis (1985) focused on maintenance mechanisms by addressing the role of catastrophic appraisals of obsessive thoughts and the neutralization responses to those appraisals in OCD. This approach moved beyond a purely behavioral framework and marked a turning point by integrating the concept of avoidance into the processes of cognitive appraisal and meaning attribution. Salkovskis (1991) further elaborated this conceptual framework by defining "safety behaviors" – behaviors performed while in contact with perceived threat, intended to prevent that threat from materializing. Conceptually distinct from passive avoidance, these behaviors are active strategies employed while contact with danger continues. They prevent the disconfirmation of beliefs that the feared threat will not occur. This formulation is not limited to OCD; it has been integrated into the cognitive-behavioral models of all anxiety disorders – including PD, SAD, and GAD – and has become one of the core building blocks of contemporary transdiagnostic models.

Mowrer's negative reinforcement model, Rachman's emotional processing framework, Lazarus and Folkman's coping definitions, and Salkovskis's safety behavior formulation together constitute the foundation of contemporary transdiagnostic anxiety models. This conceptual framework is essential for understanding the historical roots of the transdiagnostic approach examined in this review. The aim of this review article is to examine maladaptive coping strategies that emerge in anxiety disorders and obsessive-compulsive disorder within a transdiagnostic framework. The central question addressed is whether maladaptive coping strategies are specific to particular disorders or whether they share common features across different diagnoses. To this end, the following are examined: escape, avoidance, safety-seeking behaviors, compulsive neutralization, rumination, and perseverative cognitive processes. Particular attention is given to how threat perception biases, intolerance of uncertainty, and emotional avoidance manifest across different clinical presentations. The purpose is to investigate whether symptoms that appear superficially distinct share a common psychopathological basis, and whether these strategies exhibit a transdiagnostic structure.

## **Maladaptive Coping Strategies in a Transdiagnostic Context**

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### **Escape, Avoidance, and Safety-Seeking Behaviors**

Escape and avoidance behaviors constitute one of the most deeply rooted conceptual pairs in learning theory and clinical psychology. The fundamental distinction lies in the temporal relationship between the behavior and the threatening stimulus: escape refers to the act of actively terminating contact with a feared stimulus, whereas avoidance describes a behavioral pattern aimed at preventing any encounter with the stimulus from the outset (Salkovskis 1991). It is essential to distinguish between escape and avoidance, terms that are frequently used interchangeably in the literature. Escape refers to behaviors carried out with the purpose of leaving a situation upon encountering a feared stimulus or circumstance. Avoidance, by contrast, refers to behaviors aimed at keeping distance from a stimulus or situation perceived as threatening from the very beginning (Salkovskis 1991).

Although safety behaviors share certain similarities with avoidance, they constitute a distinct conceptual category. They have been defined as behaviors performed during a state of anxiety in order to prevent a perceived threat from materializing. Unlike avoidance, these behaviors are carried out while contact with the danger continues. For example, a panic disorder patient who carries medication out of fear of having a heart attack is exhibiting a safety behavior, not an active avoidance behavior (Salkovskis, 1991). The meta-analysis by Aldao and colleagues (2010) demonstrated that avoidance shows a strong positive correlation with the severity of psychopathology. In particular, the combination of behavioral avoidance, suppression, and rumination emerges as the strongest predictor of psychopathological symptomatology. This meta-analytic finding supports the view that avoidance should be treated not merely as an ordinary symptom in treatment, but as a direct intervention target.

Although traditional categorical classification systems facilitate diagnosis, their contribution to understanding the factors that maintain disorders has remained limited. The high comorbidity rates, the presence of shared psychological mechanisms, and the similarities in treatment responses gave rise to a need for alternative conceptual frameworks that go beyond the categorical approach. The concept of the transdiagnostic approach emerged from this need. This approach aims to examine the psychological mechanisms and processes that are common across various diagnostic categories. It conceptualizes mental disorders not as separate disease categories, but as different manifestations of shared underlying constructs. Gaining a systematic foundation through the work of Harvey and colleagues (2004), this approach questions the functioning of multidimensional mechanisms across multiple disorders. The transdiagnostic approach examines processes such as threat perception, intolerance of uncertainty, emotional avoidance, and perseverative cognitions. To understand the details of these processes, it is also necessary to briefly discuss the Research Domain Criteria (RDoC) and "network analysis." RDoC examines transdiagnostically defined processes at a more fundamental level – for example, it addresses threat perception within the Negative Valence Systems and cognitive control within the Cognitive Systems. In other words, while RDoC seeks to answer the question of which mental and neurological systems these

common processes rely upon, "network analysis" seeks to answer how these processes and symptoms clinically influence one another. The focus here is not on individual symptoms but on the relationships they form with one another.

For instance, an increase in threat perception strengthens intolerance of uncertainty, which in turn increases emotional avoidance; avoidance then prevents threat perception from being evaluated realistically, causing these processes to form a mutually reinforcing vicious cycle. For this reason, RDoC and network analysis have been treated as concepts that complement the transdiagnostic approach (Insel et al. 2010). RDoC were published by the National Institute of Mental Health (NIMH) in 2010. They aim to classify psychopathological processes dimensionally, based on the interaction between neurobiology, behavior, and environment (Insel et al. 2010).

RDoC has six main categories (Cuthbert 2022):

1. Negative Valence Systems: Acute threat (fear); encompasses responses to negative stimuli in the brain in the face of a perceived danger.
2. Positive Valence Systems: Covers reward-seeking, reward anticipation, and motivational processes.
3. Cognitive Systems: Covers processing functions such as attention, memory, and perception. Executive functions are central to this domain.
4. Systems for Social Processes: Covers social-cognitive processes such as attachment and social communication.
5. Sensorimotor Systems: Motor behavior, motor learning, and sensorimotor integration.
6. Arousal and Regulatory Systems: Covers regulatory processes such as the sleep-wake cycle, arousal level, and biological rhythms.

## Network Analysis

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Another multidimensional approach that has come to the fore in mental health research in recent years is "network" analysis. It offers a new perspective for understanding mental disorders, drawing on both neuroscientific and statistical methods. In the traditional view, disorders such as depression, anxiety, or OCD are treated as independent and separate categories. Borsboom and Cramer (2013) argued that this view is inadequate. According to them, a symptom that emerges in a person – for example, a sleep disturbance – is not isolated. It triggers other symptoms, which in turn lay the groundwork for further symptoms. In other words, symptoms are causally connected, and these relationships form a network. Within this network, certain symptoms play a particularly influential role. Maladaptive coping strategies such as avoidance behaviors and repetitive negative thinking (perseverative cognition) are identified as the central nodes of the network. A central node is the point that exerts the greatest influence on the rest of the network. The critical importance of these nodes also explains why several disorders persist simultaneously: avoidance can simultaneously feed anxiety, depression, and OCD. A study by Robinaugh and colleagues (2020) comprehensively examined the contributions of network theory to psychopathology research and also addressed its methodological limitations. McNally (2021) emphasized that network analysis results do not yet allow for direct causal inferences of the type "this triggers that" between two variables. Furthermore, the degree to which the network structure remains consistent across different samples – that is, the stability of the network – remains an important open question. This approach should therefore be considered with a critical eye.

## Maladaptive Coping Behaviors in Mental Disorders and Transdiagnostic Assessment

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### Obsessive-Compulsive Disorder

In OCD, avoidance encompasses keeping distance from stimuli that trigger obsessional thoughts. These avoidance behaviors can broaden over time, significantly restricting the individual's functioning (Rachman

2002).

### **Compulsive Neutralization**

Compulsive neutralization is one of the maladaptive coping strategies aimed at reducing the distress triggered by obsessions or preventing a feared event from occurring. Although neutralization attempts provide short-term relief, they serve to maintain the cycle in the long run. Foa and Kozak (1986), within the framework of emotional processing theory, argued that compulsions are behaviors that prevent the correction of the fear network. In cognitive explanations of OCD (e.g. Salkovskis's Responsibility Model, 1985; Rachman's Cognitive Approach), cognitive structures such as the overestimation of danger, excessive responsibility-taking, thought-action fusion, perfectionism, and intolerance of uncertainty are reported to play an important role in the development and maintenance of OCD (Rachman 2002).

### **Excessive Reassurance-Seeking**

Reassurance-seeking occupies a special place among the maintaining mechanisms of OCD. Like compulsions, seeking reassurance from others produces a short-term reduction in anxiety. However, in the long run, it increases both obsessional doubt and dependence on reassurance-seeking.

### **Thought Suppression**

Wegner and colleagues (1987) termed this "ironic processes." They demonstrated that conscious attempts to suppress unwanted thoughts can paradoxically increase the frequency of those very thoughts. In the context of OCD, thought suppression is a commonly used strategy for eliminating distressing obsessions.

### **Transdiagnostic Assessment**

From a transdiagnostic perspective, the maladaptive coping strategies observed in OCD (obsessional avoidance, compulsive neutralization, reassurance-seeking, and thought suppression) are not unique to this disorder alone; they also appear as different clinical manifestations of similar mechanisms in other diagnoses. The short-term distress-reducing function of compulsions overlaps with the safety behaviors seen in panic disorder and the avoidance patterns seen in social anxiety disorder (Abramowitz et al. 2009). Intolerance of uncertainty is also found in both OCD and other anxiety disorders. Carleton's (2016) review demonstrates that excessive threat perception in the face of uncertainty plays a role in maintaining not only OCD but also SAD, GAD, and PD. The repetitive, difficult-to-control, and negatively valenced thought structure shared by obsessional rumination in OCD, worry in GAD, and post-event processing in SAD is explained by Ehrling and Watkins's (2008) concept of perseverative cognition. These commonalities suggest that it may be more appropriate to conceptualize OCD not as an isolated diagnostic category but as part of a broader transdiagnostic psychopathology (Harvey et al. 2004). In OCD, perseverative cognition manifests as obsessional rumination and mental neutralization. The repetitive and involuntary character of obsessive thoughts reflects the uncontrollable dimension of perseverative cognition. Within the framework of Salkovskis's (1985) responsibility model, interpreting obsessional content through the attribution of excessive responsibility increases ruminative control attempts, thereby reinforcing the perseverative cycle.

### **Panic Disorder**

PD is defined as a clinical condition characterized by unexpected panic attacks, avoidance behaviors related to these attacks, and the resulting significant impairment in quality of life. Clark's cognitive model (1986) is an important reference for understanding panic disorder. This model proposes that panic attacks originate from the catastrophic misinterpretation of bodily sensations, and that this interpretation triggers anxiety, intensifies the sensations, and creates a vicious cycle.

### **Avoidance and Agoraphobic Behaviors**

When avoidance behavior becomes pervasive in PD, it develops into agoraphobia. Individuals avoid places and situations in which they believe a panic attack might occur or from which escape might be difficult.

These avoidance behaviors impair quality of life and, over time, lead to agoraphobia.

### **Safety Behaviors**

According to Salkovskis (1991), common safety behaviors observed in panic disorder include carrying anxiolytic medication, checking the location of exits in enclosed spaces in advance, sitting down to prevent dizziness, avoiding physical activity, and keeping a trusted person constantly nearby. These behaviors give rise to distorted attributions such as "Nothing bad happened because I took my safety precaution," which ultimately leads to chronification of the disorder. Within the framework of Clark's (1995) cognitive model, engaging in safety-seeking behaviors prevents cognitive change and reinforces the catastrophic interpretation. For this reason, eliminating safety-seeking behaviors has become an important component of cognitive-behavioral treatment protocols.

### **Bodily Hypervigilance and Selective Attention**

Interoceptive hypervigilance – excessive attention to bodily symptoms – is frequently observed in panic disorder. Although the continuous monitoring of ordinary bodily sensations interpreted as signals of potential danger is not a direct avoidance behavior, it contributes to the perpetuation of the panic cycle (Cisler and Koster 2010).

### **Transdiagnostic Assessment**

Although the maladaptive coping strategies identified in PD (agoraphobic avoidance, safety behaviors, and bodily hypervigilance) may appear specific to this disorder, these mechanisms are shown to be operative in other disorders as well, across different threat contexts. Clark's (1986) catastrophic misinterpretation model is similarly directed toward social situations in SAD, ambiguous future scenarios in GAD, and obsessional content in OCD (Cisler and Koster 2010). Safety behaviors – by producing protective attributions and preventing the disconfirmation of feared scenarios – constitute a core maintenance mechanism that is valid across all four disorders. Selective attention to bodily signals closely resembles self-focused attention in SAD: both involve the monitoring of internal stimuli and feed the avoidance cycle. The evaluation by Bouton and colleagues (2001) within a learning theory framework demonstrates that the conditioning and negative reinforcement principles underlying agoraphobia are applicable not only to PD but to all avoidance-based disorders. Perseverative cognition in PD operates through two main mechanisms. The first consists of cognitive processes following panic attacks: the individual's repeated retrospective analysis of the experienced attack reinforces the catastrophic interpretation and feeds anticipatory anxiety about future panic attacks. Evaluated within the framework of Clark's (1986) cognitive model, this perseverative processing functions as a cognitive schema activation that strengthens the interpretation of bodily sensations as dangerous. The second mechanism is related to anticipatory anxiety. The recurrent processing of scenarios involving worry about panic attacks – regarding the likelihood of future attacks and their catastrophic consequences – reflects the core patterns of perseverative cognition. Within the framework of the perseverative cognition hypothesis of Brosschot and colleagues (2006), this process sustains activation of the autonomic nervous system and, by feeding interoceptive hypervigilance (excessive attention to bodily signals), perpetuates the vicious cycle.

### **Social Anxiety Disorder**

SAD is characterized by fear of negative evaluation by others during social performance or interaction, and by the marked anxiety this fear generates. According to Clark and Wells (1995), individuals with SAD direct their attention inward rather than outward in social situations – focusing on their own bodily sensations and mental images. The individual then resorts to maladaptive coping strategies in order to escape from this state. As a result, the individual is unable to genuinely confront the feared social situation, causing the threat perception to be maintained and strengthened rather than extinguished.

### **Behavioral Avoidance**

Avoidance behaviors in SAD are highly diverse. Avoiding social gatherings, conversations, interactions with

authority figures, eating in public, and performance-demanding situations are among the foremost examples. More subtly, avoidance can manifest as avoiding eye contact, adopting a silent role in conversation, leaving social events early, and limiting voluntary participation. These subtle avoidance patterns have a high likelihood of being overlooked during clinical assessment and therefore require careful inquiry.

### **Safety-Seeking Behaviors**

In Clark and Wells's (1995) model, safety behaviors are defined as strategies applied while in contact with social situations, aimed at preventing negative evaluation. These behaviors include excessive preparation, rehearsing speech, choosing "safe" topics, making efforts to avoid drawing attention to symptoms (blushing, sweating), and physical concealment (e.g., standing at the periphery). These strategies reinforce existing beliefs by eliminating the possibility of verifying whether the feared catastrophe occurs.

### **Post-Event Processing**

Post-event processing (PEP) is the process of meticulously analyzing one's own performance after a social interaction has ended. This process involves selective focus on negative outcomes and reinforces social anxiety. Post-event processing frequently overlaps with the concept of rumination, yet carries its own distinct content in terms of social context and performance evaluation (Clark and Wells, 1995).

### **Excessive Reassurance-Seeking and Approval-Seeking**

In SAD, the search for reassurance may manifest as seeking approval from others or requesting retrospective confirmation of one's performance. Reassurance-seeking behaviors initiated especially by questions such as "How did I come across?" or "Was it good enough?" reinforce self-referential biases in interpreting social cues (Rapee and Heimberg, 1997).

### **Transdiagnostic Assessment**

When the coping patterns that appear specific to SAD (social avoidance, safety behaviors, and PEP) are examined, it becomes clear that they are the unique reflections of transdiagnostic processes in the social context. Post-event processing, together with worry in GAD and obsessional rumination in OCD, forms a shared categorical structure within Ehrling and Watkins's (2008) perseverative cognition framework. The mechanism of self-focused attention shows structural similarities to interoceptive hyperarousal in PD. Both processes involve the monitoring of internally perceived stimuli that are appraised as threatening — social performance cues in SAD and bodily sensations in PD (Clark & Wells, 1995; Clark, 1986). The uncertainty generated by the fear of negative judgment overlaps with the intolerance of uncertainty that lies at the heart of GAD. In the social context, intolerance of uncertainty creates the ground for potential criticism to be perceived as unbearable (Carleton, 2016). According to Salkovskis (1991), the negative reinforcement cycle sustained by safety behaviors and avoidance in SAD is analogous to that in OCD and PD. These structural commonalities position SAD not as an isolated diagnostic category, but as a dimension of broader transdiagnostic psychopathology driven by threat perception, emotional avoidance, and perseverative cognition (Harvey et al., 2004).

## **Generalized Anxiety Disorder**

GAD is characterized by excessive, difficult-to-control, and pervasive worry across multiple life domains, accompanied by somatic symptoms. Among the theoretical explanations for GAD, the intolerance of uncertainty model developed by Dugas and colleagues (1998) and the metacognitive model developed by Wells (2009) stand out.

### **Worry and Perseverative Cognition**

Worry, a defining feature of GAD, involves the recurrent processing of scenarios involving potential danger. Borkovec and Roemer (1995) proposed that worry serves in part as a function of avoidance of more distressing imaginal or emotional processing. Ehrling and Watkins's (2008) analysis indicated that worry

and rumination may function as a maintenance mechanism not only for GAD but for many disorders. Nolen-Hoeksema and colleagues (2008) emphasized the importance of this construct by focusing on the function of rumination in depressive disorders.

### **Intolerance of Uncertainty**

According to the model of Dugas and colleagues (1998), intolerance of uncertainty constitutes the central cognitive feature of GAD. In this context, avoidance takes two forms: avoidance of ambiguous decisions and situations (behavioral avoidance), and attempting to gain control over possible negative outcomes through worry itself (cognitive avoidance).

### **Reassurance-Seeking and Control Efforts**

In GAD, reassurance-seeking may manifest as gathering information about the source of anxiety, seeking approval from experts, or requesting confirmation from one's close circle. This behavior reduces discomfort with uncertainty in the short term; however, in the long term, it prevents the development of tolerance for uncertainty and thus perpetuates the cycle. In Wells's metacognitive model (2009), these behaviors are linked to cycles of Type I worry (worrying about events and believing this to be useful) and Type II worry (worrying about worry).

### **Cognitive Suppression and Distraction**

Another coping strategy frequently observed in GAD is the use of distraction to reduce anxious thoughts. Given that worry already functions partly as cognitive avoidance, the paradoxical effects of suppression attempts become particularly significant. The meta-analysis by Aldao and colleagues (2010) demonstrated that maladaptive emotion regulation strategies such as suppression and worry/rumination are consistently and positively associated with symptoms of anxiety and depression, and that this association is stronger than that observed for other emotion regulation strategies.

### **Transdiagnostic Assessment**

From a transdiagnostic perspective, the maladaptive coping strategies identified in GAD (worry, reassurance-seeking, intolerance of uncertainty, and cognitive suppression) reflect the typical presentation of this disorder. Borkovec and Roemer (1995) proposed that worry serves the function of avoidance of intense emotions. This cognitive avoidance function overlaps with compulsive neutralization in OCD and safety behaviors in SAD. According to Dugas and colleagues' (1998) model, intolerance of uncertainty is of central importance for GAD, while Carleton (2016) demonstrated that this construct also plays a maintaining role in SAD, OCD, and PD. As defined in Wells's (2009) metacognitive model, Type II worry (worry about worry) shows a structural resemblance to the processes that reinforce the threat value of obsessions in OCD. The manner in which reassurance-seeking behavior perpetuates the cycle directly overlaps with the compulsive reassurance-seeking mechanism observed in OCD. The findings of the meta-analysis by Aldao and colleagues (2010) demonstrate a strong and consistent relationship between cognitive suppression and perseverative cognition across anxiety and mood symptoms. These findings suggest that the strategies described are not merely characteristic of GAD but are transdiagnostic maintenance mechanisms applicable across the entire diagnostic spectrum. The worry cycle described by Borkovec and Roemer (1995) reflects the core features of perseverative cognition. The recurrent verbal processing of future threats serves an emotional avoidance function; while providing short-term relief, it maintains the anxiety cycle in the long run. According to Wells's (2009) metacognitive model, Type II worry in GAD (worry about worry) demonstrates that perseverative cognition is reproduced even at the metacognitive level.

## **Transdiagnostic Common Mechanisms in OCD and Anxiety Disorders**

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### **Threat Perception and Interpretation Biases**

Overestimation of danger and attentional and interpretation biases toward threatening information appear

to constitute the shared cognitive foundation of the four disorders examined. In PD, this bias is directed toward bodily sensations; in SAD, toward social evaluation signals; in GAD, toward information containing uncertainty; and in OCD, toward obsessional content. The work of Cisler and Koster (2010) identified the functional role of attentional biases in maintaining anxiety disorders.

### **Negative Reinforcement Cycles and Avoidance**

Negative reinforcement cycles constitute the common functional denominator of maladaptive coping strategies across all the disorders examined. The short-term reduction in anxiety achieved through avoidance behavior, safety-seeking, or compulsions reinforces these strategies and prevents the threatening aspects of the stimulus from being evaluated (Craske et al., 2014).

### **Intolerance of Uncertainty**

It has become increasingly apparent that intolerance of uncertainty is not specific to GAD alone but also plays a functional role in SAD, OCD, and PD. It manifests as doubt-related uncertainty in OCD ("Did I check enough?"), social evaluation-related uncertainty in SAD ("What did they think?"), and bodily sensation-related uncertainty in PD ("What does this mean?"). Although the model developed by Dugas and colleagues (1998) was primarily built around GAD, it is clearly observable in other anxiety disorders as well.

### **Perseverative Cognition**

In its broadest sense, perseverative cognition refers to repetitive and difficult-to-control thoughts focused on past negative experiences or future potential threats (Aktepe & Tolan, 2020; Erarslan İnceç, 2021; Einstein, 2014). Perseverative cognition is fundamentally composed of the components of rumination and worry. Rumination refers to an individual's repetitive thoughts related to past losses, failures, or injustices (Ingram, 1990; Trapnell & Campbell, 1999). Worry, by contrast, focuses on future uncertainties and potential threats (Aktepe & Tolan, 2020). Perseverative cognition can be summarized as the individual's inability to "disengage" from cognitively negative emotional content (Koster et al., 2011). Functioning as a "mental habit" and "avoidance strategy" at the cognitive level, this construct is characterized at the neuroscientific level by a loss of regulatory control of prefrontal regions (dlPFC) over the amygdala and dACC (Einstein, 2014; Özdel and Turkcapar, 2025).

Ehring and Watkins (2008) defined perseverative cognition – encompassing anxiety and rumination – as thinking that is difficult to control, repetitive, and negatively valenced. They proposed that this construct functions as a maintenance mechanism in anxiety and mood disorders. Worry in GAD, post-event processing in SAD, obsessional rumination in OCD, and "what if" scenarios in PD can all be regarded as typical manifestations of perseverative cognition. In their study examining rumination as a transdiagnostic factor, McLaughlin and Nolen-Hoeksema (2011) demonstrated this construct's association with symptoms of depression and anxiety.

The convergence of Brosschot and colleagues' (2006) perseverative cognition hypothesis, Watkins's (2008) repetitive negative thinking model, Nolen-Hoeksema's (1991, 2008) rumination theory, and Ottaviani and colleagues' (2016) neurophysiological research demonstrates that this construct has significant impact at both psychological and biological levels. The multifaceted relationships among cognitive mechanisms (rumination, worry, repetitive thinking, attentional biases), neuroscientific substrates, and psychopathology make perseverative cognition an important target for transdiagnostic research and intervention. Its maintaining function across anxiety disorders, depression, and panic disorder strengthens its positioning as a central target for transdiagnostic treatment protocols.

In Martin and Tesser's definition (according to control theory), perseverative cognition is triggered by discrepancies between an individual's current state and their desired goals (Martin and Tesser, 1989, 1996). When the individual is unable to resolve this discrepancy, repetitive thought patterns (pathological rumination) become entrenched (Watkins, 2008; Watkins and Nolen-Hoeksema, 2014).

In Wells's (2009) model, perseverative cognition is part of a construct called the "Cognitive Attentional Syndrome" (CAS). This syndrome is composed of a combination of worry, rumination, threat monitoring, and cognitive avoidance strategies. In this context, perseverative cognition functions as a form of cognitive avoidance aimed at reducing uncertainty or increasing the sense of control. Paradoxically, however, it increases anxiety and depression (Einstein, 2014; Flores et al., 2018).

The most salient cognitive feature of perseverative cognition is cognitive rigidity. Cognitive rigidity makes it more difficult to generate alternative solutions (Dağ and Gülüm, 2013; Hohl and Dolcos, 2024). Neuroscientific research suggests that perseverative cognition originates from a breakdown in coordination among brain networks and regions (Hohl and Dolcos, 2024). It has been observed that amygdala activity increases in the face of uncertainty and is sustained throughout perseverative thought processes (Einstein, 2014). The amygdala is thought to initiate emotional arousal by interpreting ambiguous stimuli as "threats." Furthermore, perseverative cognition is fundamentally grounded in the failure of the dorsolateral prefrontal cortex (dlPFC) and the medial prefrontal cortex (mPFC) to regulate bottom-up emotional signals (originating from the amygdala) through top-down control (Hohl and Dolcos, 2024). When the process is prolonged and uncertainty becomes chronic, amygdala activity may give way to the bed nucleus of the stria terminalis (BNST), which can lead to a persistent state of "hypervigilance" and anxiety sustained by perseverative cognition (Einstein, 2014).

<b>Mental Disorder</b>	<b>Avoidance Behaviors</b>	<b>Safety-Seeking</b>	<b>Cognitive Strategy</b>	<b>Transdiagnostic Commonality</b>
Panic Disorder	Avoiding physical activity; avoiding unsafe places/situations	Seeking a trusted person; carrying medication; identifying escape routes	Selective attention to bodily signals; catastrophic misinterpretation	Threat perception; negative reinforcement; intolerance of uncertainty
Social Anxiety Disorder	Avoiding social settings; avoiding eye contact; staying silent	Excessive preparation; post-event processing; safe conversation topics	Self-focused attention; negative self-image	Threat perception; avoidance cycle; emotional avoidance
Generalized Anxiety Disorder	Avoiding situations involving uncertainty; procrastination	Reassurance-seeking; information-seeking; delegating control	Worry; cognitive suppression; perseverative cognition	Intolerance of uncertainty; perseverative cognition; emotional suppression
Obsessive-Compulsive Disorder	Avoiding triggering stimuli; escaping before compulsion	Compulsive neutralization; excessive reassurance-seeking; checking	Thought suppression; inflated responsibility; danger overestimation	Negative reinforcement cycle; threat perception; avoidance

## **Emotion Regulation and Emotional Avoidance**

When evaluated within the framework of Gross's (1998) emotion regulation model, the vast majority of maladaptive coping strategies observed in anxiety disorders and OCD can be characterized as maladaptive emotion regulation attempts aimed at reducing the experience of negative emotions. A meta-analysis (Aldao et al. 2010) reported a strong correlation between suppression and rumination and the level of psychopathology. Barlow and colleagues (2011) address avoidance responses to emotional experience as a common target across all emotional disorders, placing the direct management of this strategy at the center of treatment.

## Short- and Long-Term Effects of Safety Behaviors

The formulation regarding the maintaining role of safety behaviors was developed by Salkovskis (1991). The long-term negative effects of these behaviors emerge through the following mechanisms:

1. Safety behaviors prevent the disconfirmation of the threat's non-existence.
2. They lead to the development of erroneous attributions to the effect that the threat was averted by means of the safety behavior.
3. In some cases, they directly contribute to symptom production (for example, body monitoring that accelerates the anxiety cycle).

## The Use of the Transdiagnostic Approach in Treatment

### The Unified Protocol

The Unified Protocol (UP), developed by Barlow and colleagues (2011, 2018), is one of the most comprehensive transdiagnostic intervention programs used in the treatment of anxiety disorders, depression, and related emotional disorders (Barlow et al. 2011, 2018; Türk et al. 2026). This protocol aims to overcome the limitations of traditional diagnostic approaches by targeting the common psychological mechanisms underlying different disorders (Sauer-Zavala et al. 2017). The theoretical foundation of the UP rests on an integrated theoretical model that treats dysfunctional forms of emotion regulation – particularly emotional avoidance and neuroticism – as common determinants of various psychopathologies (Barlow et al. 2014; Sauer-Zavala et al. 2017).

A randomized controlled trial conducted by Barlow and colleagues (2017) demonstrated that the UP produces effect sizes comparable to disorder-specific CBT protocols. This finding provides direct empirical support for the clinically equivalent efficacy of transdiagnostic approaches. The comprehensive meta-analysis by Curtiss and colleagues (2021), drawing on data from 54 randomized controlled trials, demonstrated that the UP and its derivative transdiagnostic interventions produce medium-to-large effect sizes ( $d = 0.71-0.95$ ) on primary diagnoses and comorbid symptoms. These effects are particularly pronounced in individuals with high comorbidity rates. These results reflect the increasingly robust empirical foundation of the transdiagnostic framework in clinical practice. In the analysis by Carlucci and colleagues (2021), the UP was reported to be superior to control groups in reducing the severity of anxiety and depression in children, adolescents, and adults. The UP can be administered in individual or group therapy (Farchione et al. 2012, Laposa et al. 2017). It is particularly functional in complex cases involving multiple diagnoses (comorbidity), as it can address problems through a single protocol. The high comorbidity between anxiety and depressive disorders underscores the efficacy of transdiagnostic interventions (Brown et al. 2001, Kessler et al. 2005, Türk et al. 2026). Studies on the cultural adaptation of this protocol have been conducted in Turkey, and the protocol has been reported to produce significant improvements in psychological well-being in Turkish clinical samples (Türk et al. 2026).

### Structure and Implementation Phases of the Unified Protocol

The protocol is a sequential process consisting of eight modules in total – five core and three supplementary – typically administered over 12–18 sessions (Barlow et al. 2018). The modular structure of the protocol offers clinicians the flexibility to adapt to the client's needs and provides a comprehensive treatment option for individuals with multiple diagnoses (Farchione et al. 2012, Bullis et al. 2019). The implementation process includes the following steps:

1. Sustaining Motivation and Setting Goals: Focus is placed on increasing the client's engagement with and motivation for treatment (Barlow et al. 2018).
2. Psychoeducation on the Nature of Emotions: Information is provided about the functions, components (cognitive, physiological, and behavioral), and adaptive functions of emotions (Barlow et al. 2018).

3. **Non-Judgmental Emotional Awareness:** Clients are taught to observe emotions as they arise without judgment. This module aims to develop a mindfulness-based acceptance stance toward emotional responses (Sauer-Zavala et al. 2012).
4. **Enhancing Cognitive Flexibility:** The goal is to identify negative thought patterns and develop more functional alternatives (Beck 2011, Barlow et al. 2018).
5. **Modifying Emotion-Driven Behaviors:** The aim is to modify maladaptive behaviors – such as avoidance or safety behaviors – that emerge under the influence of emotions (Hayes et al. 1996, Barlow et al. 2014).
6. **Increasing Tolerance for Bodily Sensations:** This module aims to develop awareness of and tolerance for the physical sensations accompanying emotions (palpitations, shortness of breath, etc.) and is intended to prevent the misinterpretation of bodily sensations (Reiss et al. 1986, Taylor 1999).
7. **Emotional Exposure:** Controlled exposure exercises are conducted toward situations that trigger intense emotions (Farchione et al. 2012, Craske et al. 2014).
8. **Relapse Prevention Plan:** Strategies are developed to consolidate long-term gains and cope with future challenges (Barlow et al. 2018, Bullis et al. 2019).

### **Transdiagnostic Cognitive Behavioral Therapies**

Recent large-scale meta-analyses have demonstrated the advantages of transdiagnostic cognitive behavioral therapies (TD-CBT) compared to traditional methods. The meta-analytic review conducted by Schaeuffele and colleagues (2024) showed that TD-CBT has significantly higher effect sizes than control groups for depression and anxiety ( $g = 0.74$  for depression;  $g = 0.77$  for anxiety). The study emphasized that the efficacy of TD-CBT is comparable to that of disorder-specific CBT. The meta-analysis by Cuijpers and colleagues (2023) concluded that transdiagnostic treatments are effective and offer more practical solutions than disorder-specific interventions in cases of comorbidity.

### **Coping Research Conducted in Türkiye**

In the mental health literature of Türkiye, studies focusing on transdiagnostic variables and intervention programs targeting these variables have been increasing over the past decade. In the area of mindfulness, Özyeşil and colleagues (2011) adapted the Mindful Attention Awareness Scale (MAAS) into Turkish, and Deniz and colleagues (2017) demonstrated that emotional intelligence plays a comprehensive mediating role in the relationship between mindful awareness and psychological well-being. Alkan and colleagues (2025) showed that mindfulness-based interventions (MBIs) have a transdiagnostic effect on depressive symptomatology and can target psychological components common across different diagnostic groups. In the context of cognitive flexibility, Dağ and Gülüm (2013) found that cognitive flexibility acts as a mediator in the relationship between insecure attachment and depression, and between OCD and social anxiety. Kara and Tolan (2023, 2025) demonstrated that cognitive flexibility mediates the relationship between social anxiety via both self-efficacy and fear of negative evaluation, and that increasing this flexibility may reduce the risk of developing social anxiety.

In the context of intolerance of uncertainty, Gerdan and Salcıoğlu (2025) found that experiential avoidance functions as a central transdiagnostic mediator in the relationship between intolerance of uncertainty and maladaptive perfectionism and psychiatric symptoms in a clinical sample; İnözü and colleagues (2021) identified that cognitive flexibility serves as a moderator regulating this relationship.

Regarding transdiagnostic interventions, Erarslan İnceç (2021) empirically demonstrated that the UP – adapted into Turkish – significantly reduced depressive and anxiety symptoms and negative affect, and increased positive affect and well-being, among university students. This study provided the first strong evidence for the applicability of the UP to Turkish culture. In their systematic reviews, Erarslan İnceç (2021) emphasized that transdiagnostic intervention programs offer clinical and economic advantages over

disorder-specific protocols, particularly in cases of comorbidity. Finally, Özdel and Türkçapar (2025) proposed the Three-Dimensional CBT (TriD-CBT) model, which integrates attentional processes, cognitive appraisal, and behavioral components within a transdiagnostic and transtheoretical framework.

## Conclusion

This review examined the maladaptive coping strategies observed in panic disorder, social anxiety disorder, generalized anxiety disorder, and obsessive-compulsive disorder from a transdiagnostic perspective and within the RDoC framework. The evaluation supports the view that these strategies are not merely diagnosis-specific phenomena but constitute different clinical expressions of shared mechanisms. The findings reviewed demonstrate that escape, avoidance behaviors, safety-seeking, compulsive neutralization, cognitive suppression, and perseverative cognition maintain psychopathology across all disorders through negative reinforcement cycles. While these strategies reduce anxiety in the short term, in the long run they prevent the disconfirmation of erroneous beliefs, thereby reinforcing the anxiety cycle. When evaluated in terms of transdiagnostic mechanisms, threat perception biases, intolerance of uncertainty, emotional avoidance, and perseverative cognition play a maintaining role across all four disorders.

The RDoC framework functions in this study not as a clinical classification tool but as a conceptual integration platform. Dimensional constructs such as the Negative Valence Systems and Cognitive Systems contribute to understanding how the mechanisms examined are positioned at neurobiological and behavioral levels. Nevertheless, it should be borne in mind that RDoC was designed to guide the research agenda rather than to replace DSM categories, and that its use in clinical practice remains limited.

Most of the mechanisms examined are based on research conducted primarily in Western cultural contexts. Cross-cultural comparative research would help fill an important gap in clarifying how the functional meaning of safety-seeking, reassurance-seeking, and perseverative cognition is structured across different sociocultural contexts. Furthermore, longitudinal studies are needed to examine whether maladaptive coping strategies emerge at the onset of the disorder or arise with the intensification of symptoms. The existing findings are largely based on cross-sectional studies and are insufficient for explaining causality. The current research suggests that a comprehensive and integrated assessment of maladaptive coping strategies may contribute to clinical formulation. For individuals with multiple comorbid diagnoses, transdiagnostic protocols that directly target perseverative cognition alongside avoidance and safety behaviors may offer clinicians practical advantages.

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