Michael Svitak
Stefan G. Hofmann

A Process-Based Approach to CBT

Understanding and Changing the Dynamics of Psychological Problems

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Foreword

Why a Process-Based Approach Is the Next Logical Step in CBT

A process-based vision is not new to cognitive behavioral therapy (CBT), but our field has been through so many years of narrowing, caused in part by our own success, that today it can feel as though it is entering the field orthogonally rather than as a historical foundation. An evidence-based approach to psychological intervention began with the task of applying well established principles to the problems of an individual, but it was not long before the central task came to be to diagnose a problem based on signs and symptoms, to categorize these under a specific mental disorder label, and to apply a manualized set of interventions aimed at reducing those signs and symptoms. CBT was spectacularly successful in that task, and that approach helped CBT prosper world-wide. But a sense of stagnation has now arrived, due in part to the galling fact that our effect sizes are not increasing (Hayes, Hofmann, & Ciarrochi, 2023). We need a new way forward.

A process-based approach returns our field to the difficult but exciting task of modeling the complex interplay of affect, cognition, attention, sense of self, motivation, and overt behavior, along with processes in the sociocultural and biophysiological domains, in order to understand why problems arise and persist and how to resolve client problems and promote greater prosperity. Instead of the fruitless pursuit of latent mental diseases, our field is moving towards a new vision in which it is the task of the CBT clinician, and all evidence-based clinicians, to answer this question: "What core biopsychosocial processes should be targeted with this client given this goal in this situation, and how can they most efficiently and effectively be changed?" (Hofmann & Hayes, 2019, p. 38).

The book you have in your hands takes a sober look at the situation and draws on the now large body of basic and applied knowledge regarding process of change, from basic science to third-wave methods in CBT, and applies it to the radically "transdiagnostic" task of answering the key "what," "why," and "how" questions that have always been part of our professional and scientific journey. Why did this problem develop in the first place? What are the goals of the client and what is needed to initiate change? How will change become self-amplifying or be maintained?

This well-written book is not a cookbook of methods, nor it is theoretical tome. It is a practical process-based road map that describes in a step-by-step fashion how to take a process-based approach to CBT, and how to so deeply understand the dynamic of your clients' psychological problems that they can be changed in a systematic fashion that is both strategically sensible and empirically sound.

While traditional evidence-based therapy often employs a nomothetic approach, aiming to generalize from a sample population to individual cases, a process-based approach is idionomic in nature, focusing on the unique characteristics of individual clients but then generalizing them as warranted to nomothetic principles, provided always that the clarity of the individual is thereby increased or at least not compromised. A client is never

treated as an "error term" in this approach, nor in this volume. Each unique person is still unique, and a process-based approach sets as its goal that the person will be seen even more clearly and heard even more thoroughly by the analytic steps taken.

That is not mere rhetoric. You will sense as you use the methods this book contains that they bring you as a provider closer to the idiosyncratic details that often get overlooked when we focus on latent disease entities. You will better understand your clients and the options you have to create progress will be more illuminated.

A process-based approach moves practitioners away from a static, linear, pauci-variate model of psychopathology to one that is dynamic and network-based. A process-based approach accommodates complex models of causality, such as feedback loops and dynamic systems, which capture the nonlinear and multicausal nature of psychological phenomena. This approach enhances our understanding of why treatment works when it does and sets the stage for more targeted, kernelized, individualized therapeutic strategies.

This process-based approach recognizes and enriches the strengths of CBT. Svitak and Hofmann are not saying "let's discard our CBT methods." Instead, they are saying "let's understand why our interventions work, for whom, and under what circumstances."

Pursuing a process-based approach is akin to training to be a master chef who knows not just the recipe but also the intricate interactions between ingredients – the subtleties that transform a dish from good to great. It seeks not to replace CBT but to evolve it, to move from a focus on what we should do in therapy, to how and why we should do it, in a way that is attuned to the individual complexities of each client. It is an invitation to be more nuanced, more flexible, and, ultimately, more effective in our practice.

This well-written book lays out the problems of traditional diagnosis and its excessive focus on a nomothetic search for latent diseases, and instead proposes a more idiographic, complex dynamic network approach to psychological difficulties. This shift is not an abstract academic matter – it is an urgent call to action and attention by researcher and practitioners alike. The subpar remission rates in intention-to-treat samples highlight a daunting truth: We are only partially effective in our therapeutic endeavors.

As network thinking is initially explored by the authors it becomes evident that it matters how we conceptualize and analyze client problems, and their predisposing, contextual, sustaining, and protective or positive factors. The authors detail a system of understanding and tracking the major known processes of change, and how they might be impacted by the core processes of psychotherapy.

English readers might be surprised to find that a forward looking and very well-known German psychotherapist, Klaus Grawe (1995), long ago laid out a vision of a scientifically based psychotherapy that focused on relevant processes of change rather than on diagnoses and therapeutic procedures. Details of his theory have not been well validated but his work makes it easier to understand how a process-oriented approach can indeed provide an umbrella for the systematic application of evidence-based methods that modify the processes establish and maintain a pathological network. It also explains why the German psychological community has been particularly welcoming to a process-based approach and is assuming a leadership role worldwide in this area.

A strength of this volume is the detailed way that these core ideas are linked to phases of process-based psychotherapy, from recognizing processes and exploring their determinates, to creating a process-oriented functional analysis and repeatedly assessing client progress. This is a practical volume that has already gone through the hard test of application in systems of care. When the dynamics of a case are clear, a rational kernel-based

intervention plan can be uniquely constructed and targeted toward client needs, and an iterative virtuous cycle of monitored steps towards goal attainment can ensue.

In the latter parts of the book, the focus on practical application, assessment tools, and real-life examples offers a seamless bridge from theory to practice. Therapists are not just offered abstract concepts but actionable steps, forms, measures, and strategies to bring the process-based approach to life within the therapy room and system of care.

We have to acknowledge that while meta-analyses already show that taking a more personalized approach produces small but significant therapeutic gains (Nye et al., 2023), a lot remains to be done empirically. But this approach is more a model of how to apply existing knowledge than a radically new set of proposals disconnected from our existing research base and therapy traditions. You can still be you in a process-based approach and the methods that matter can still be used. What is different is your ability to do so is guided by process-based evidence that has been there all along, unseen because of our excessive latent disease focus.

Each era of psychotherapy brings with it new insights, tools, and challenges. The shift towards a process-based approach, as articulated by Svitak and Hofmann, is not just the next phase of this journey but shows every sign of being a transformative leap. It holds the promise of deeper understanding, more effective interventions, and the potential to touch and transform countless lives.

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Preface

If you can add up, that is often enough to deal with most basic requirements in everyday life. If the requirements become more complex, the concept of adding up becomes limited. Then it's helpful when you learn to multiply and divide to understand and deal with more complex demands. Suddenly, previously complicated tasks seem easy. The incomprehensible takes on a logic that helps you to keep track of more complex tasks and to find solutions.

From this point of view, we psychotherapists have become very good at adding up, but we reach our limits with the high degree of complexity we are confronted with in treating our clients, especially when mental disorders do not only occur once but recur or manifest themselves in combination with other disorders. The remission rate in intention-to-treat samples is usually below 50 % (Cuijpers et al., 2010; Spijker et al., 2013). (Intention-to-treat means that the data of all clients who were previously intended to be treated are also evaluated afterwards. This ensures that the data of clients who do not benefit from a treatment and drop out are also evaluated.) We could blame the 50 % failure rate on our clients, but perhaps our current models of mental disorders limit the effects of psychotherapy because we cannot grasp the complexity with our existing models. Perhaps our models of psychological suffering do not adequately represent the complexity and dynamics of mental problems, or perhaps we are focusing on the wrong aspects. Where do we find the complexity and dynamics of mental disorders if they are not sufficiently to be found in the current causal models of disorders? This book is all about focusing on the level of relevant processes, instead of looking at symptoms and syndromes that are often merely a result of these underlying processes. This helps us understand the dynamic interactions of multidimensional processes clients are suffering from in more depth and opens up perspectives for change that are concealed on a symptom level.

From the Symptom Level to the Process Level

Normally, cognitive, emotional, behavioral, motivational, and interactional processes work well together so a person can cope with ongoing demands. In a healthy state, we are as unaware of these coordinated background processes of the mental adaptation apparatus as we are of the work of our PC's operating system. We only become aware of them when the initiated psychological processes aren't successful and either lead into processing loops that generate more and more information or result in processes working against each other. We perceive these underlying adaptation processes gone rogue as a kind of psychological strain, draining psychological energy until we fear the mental system goes haywire or collapses. When clients are asked what percentage of their mental energy is being absorbed by unsuccessful inner processing attempts to solve their problems, many respond: "Over 90 %. And it feels like it's getting more all the time."

From a process-based perspective, mental disorders are the result of these multidimensional adaptation processes gone wrong, so that a formerly healthy state transforms into a system state experienced as stressful (Hayes et al., 2015). So, while we are used to focusing on the level of symptoms, the dynamics and complexity of the regulation process is found at a level "below" the symptoms: at the level of processes, where processes interact with each other to react to demands to the adaptation apparatus. The visible symptom level is merely the result of interacting processes.

Process-based approaches (Borsboom et al., 2011; Hayes et al., 2015; Hayes & Andrews, 2020; Hayes & Hofmann, 2018a, 2018b, 2020; McNally, 2016; Robinaugh et al., 2016) have the potential to add promising new dimensions to our understanding of the complexity and dynamics of mental disorders. They view psychopathology as dynamic networks in which interacting processes are responsible for maintaining pathological system states (Hofmann et al., 2016).

In the first part of the book, we present the most important theoretical foundations of the process-based approach and explain what a process-based view means for our conception of mental disorders and their treatment. In the second part of the book, we describe the practical application – step by step through the phases of a therapy. We hope this approach will inspire your work with clients as it did us. After we spent some time considering the implication of a more process-based approach, we began to look at mental disorders more through a process lens. This helped us to look beyond the content of the disorder and identify the relevant underlying process patterns. This has broadened our understanding of mental disorders and revealed opportunities for change that would have remained hidden through a diagnosis-oriented perspective.

Part I

Theoretical Foundations

1
Limitations of Diagnosis-Oriented Psychotherapy

1.1 Inadequate Conceptualization of Mental Disorders

Why bother with mental processes? Is it not enough to know the diagnosis and select the right evidence-based therapy? It works in somatic medicine, does it not? With the establishment of psychotherapy in health care, paradigms of somatic medicine have been applied to conceptualize mental problems. According to the latent disease concept of somatic medicine, it should be possible to identify diseases based on symptoms that differ in etiology, course, and responsiveness to treatments. This model promises to greatly simplify therapy and allow therapists to provide effective treatment even without an individualized understanding of the individual processes involved. Similar to the approach in somatic medicine, a prescribed treatment is derived from the diagnosis. This is almost standardized for all clients. The goal of this approach is that treatments can be offered in a disorder-specific, manualized, evidence-based, and guideline-driven manner. The associated hope is to treat according to a prescribed set of measures for each definable mental illness, thereby simplifying and improving treatment (Hofmann et al., 2016). As a result of this development, the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013) now lists approximately 350 disorders for which more than 270 treatment manuals exist, and their efficacy is more or less well supported by outcome studies (Hofmann & Hayes, 2018). In many studies, the effectiveness and superiority of cognitive behavioral therapy (CBT) approaches over other methods could thus be demonstrated (Heidenreich & Michalak, 2013).

In the textbook or in the guidelines, this makes psychotherapy sound simple, almost like a cookbook. Depression can be determined by asking about nine symptoms using a checklist. If at least five of the nine symptoms are reported, the client can receive the diagnosis. But does this represent the psychotherapeutic reality? Are mental disorders so easy to categorize? Does it really make sense to define an arbitrary combination of five of the nine possible symptoms as depression? Why aren't psychotherapies more effective if the psychotherapists treating them only have to reach for the right manual? The psychotherapeutic reality is actually more complex, dynamic, and individualized than the *DSM* and *ICD* (*International Statistical Classification of Diseases and Related Health Problems* of the World Health Organization, WHO) classification systems and the guidelines derived from them suggest (Deacon, 2013; Hayes, Hofmann, & Ciarrochi, 2020; Hofmann et al., 2016; McNally, 2016; Nelson et al., 2017). Neglecting this complexity and dynamic leads to limiting treatment outcomes on a practical level, which alienates psy-

chotherapists and clients alike. Moreover, ignoring complexity and dynamics on a theoretical level hinders the advancement of psychotherapy because existing model conceptions that are disconnected from reality treads on the spot, instead of creating more refined models (Hofmann & Hayes, 2018; McHugh et al., 2009).

For the practitioner, the question also arises to what extent it is useful to know the more than 270 treatment manuals for the more than 350 *DSM-5* categories if in individual cases it is unclear which comorbid disorder should be treated in which order with which therapy components. Especially in the outclient setting, the flood of disorder-specific approaches can overwhelm therapists and lead to the unsystematic application of different therapy components (Harvey et al., 2009). As a solution many therapists resort to a one size fits all approach, in which one treatment method is applied to all clients. Instead of using the evidence-based procedure designed for a specific disorder, a preferred method of treatment is used (Harvey et al., 2009). This is reflected in statements such as "I normally work according to acceptance and commitment therapy (ACT), which seems to suit me" or "I work eclectically, based on my personal opinion."

The limitations of the current heterogeneous and overlapping diagnostic groups derived from the assessment of subjective client data have also been recognized by the American National Institute for Mental Health (NIMH). It initiated a comprehensive, multidisciplinary project over ten years ago to identify diagnostic groups based on measurable biological and behavioral process dimensions. Known as the Research Domain Criteria (RDoC) initiative, this project aims to diagnose mental disorders using clinical neuroscience methods rather than subjective symptom descriptions. This will involve, for example, electrophysiological and imaging techniques that map neurological structures or functions, genetic analyses, and standardized tests to study learning processes under laboratory conditions. As a result, mental disorders should be traced to core biological and behavioral dimensions (Insel et al., 2010). The dimensional nature would solve the problem of cut-off boundaries and better map the fluid transitions between mental health and mental illness. The hope is that valid structural or functional disease entities can be found at this biological level of analysis to replace the current categories. Although the project does not yet have direct consequences for changes to the existing *DSM* categories, it demonstrates that a paradigm shift should occur and that future models of mental disorders must be conceptualized dimensionally at a process level rather than categorically at a symptom level (Hofmann & Hayes, 2018) so that further development of concepts of mental disorders and their treatments is not hindered (Hayes, Hofmann, & Ciarrochi, 2020).

1.2 Complexity and Dynamics of Mental Disorders

In my practical work (M. S.), in the context of a psychosomatic clinic, singular disorders, as presented in most textbooks, are not only the exception, but virtually nonexistent. The results of the National Comorbidity Survey (Kessler et al., 1994), in which more than 65,000 persons were examined, showed that almost 80 % of the diagnoses were already comorbid disorders; in the case of severe mental illnesses, three or more other disorders were present in 89 % of the cases. The complexity and possible combinations of symp-

toms in two to three disorders are so great that the supposed simplification provided by a diagnosis-oriented approach is lost. The currently dominant disorder-specific approaches are therefore only suitable for a few exceptional cases.

The results of comorbidity studies also support the low discriminant validity of diagnostic categories (Brown & Barlow, 1992) and that individual disorder components interact with each other at a transdiagnostic level (Harvey et al., 2009). Furthermore, what we see phenotypically at the symptom or diagnostic level has no clear correspondence at the process level. On the one hand, the same processes can be responsible for the development and maintenance of different mental disorders (Fisher et al., 2018; Harvey et al., 2009): A rumination process can maintain a depression, a generalized anxiety disorder, or a somatoform disorder. On the other hand, very many different processes can result in the same diagnostic category (Harvey et al., 2009): The core process behind depression can be a negative self-schema, but it can also be difficulties regulating negative affect, behavioral deficits, or relationship difficulties. The possible combinations of multidimensional, transdiagnostic processes are enormous. This possibility for variation explains, first, the great interindividuality of mental disorders and, second, the great variation in mental health complaints across the life span (Harvey et al., 2009). The assumption that common core processes are responsible for the development and maintenance of different disorders also explains why recorded comorbid mental disorders improve in treatment studies, even if they are not specifically treated (Borkovec et al., 1995; Brown & Barlow, 1992; see also Harvey et al., 2009).

These findings indicate that isolated illnesses as classified in the *DSM* or *ICD* are rare, and thus attention should be focused on core transdiagnostic processes of psychopathology and psychotherapy (Hayes, Hofmann, & Ciarrochi, 2020; Hofmann & Hayes, 2018).

1.3 Somatic or Latent Disease Model

Transferring the diagnosis-oriented approach of somatic medicine to mental illness only makes sense if the individual symptoms are produced – independently of one another – by an underlying disease entity (see left side of Figure 1). For example, a lung tumor produces the symptoms of cough, chest pain, and breathing difficulties. If the disease disappears, the symptoms caused by the disease disappear. This model, which assumes existing disease entities, has been applied to mental illness, although the individual symptoms are usually not independent of each other ("axiom of local independence") and symptoms can persist even if the disease disappears (Hofmann et al., 2016).

The right side of Figure 1, on the other hand, depicts a disease model based on a network understanding: Here, the individual symptoms of disorders interact highly with each other and contribute to overlapping diagnostic categories. The mental disorder *is* the network of interacting symptoms and processes (e.g., rumination process, avoidance behavior, emotional states). The symptoms and the interactions between these processes *are* already the pathology to be treated and do not indicate an underlying disease, as assumed in the "latent disease" model of somatic medicine (left side of Figure 1) (Hofmann et al., 2016). According to the network model, mental disorders can be viewed as a dynamic network or complex system. The elements of this *psychopathological system* are interact-

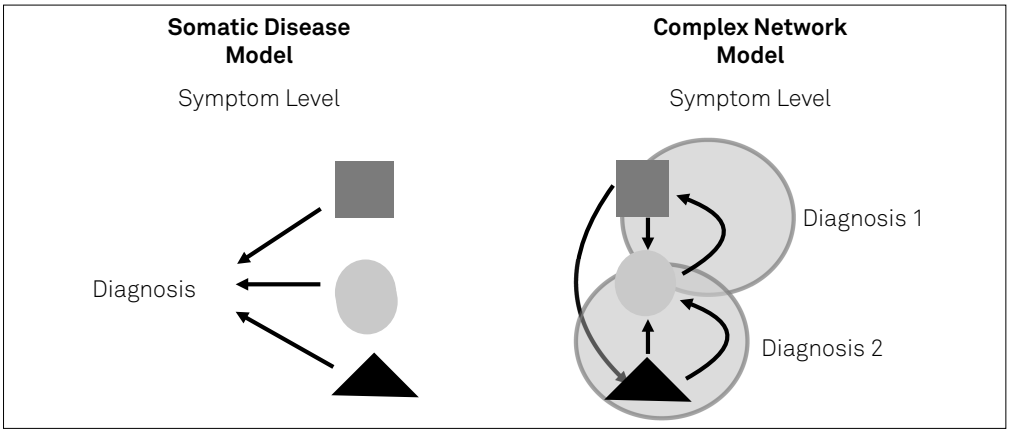

Figure 1. Somatic disease model (left) vs. complex network understanding (right). The symbols in the middle represent different symptoms.

ing processes at the cognitive, emotional, somatic, and behavioral levels. Because of these multidimensional interactions, the psychopathological system, similar to other complex systems (e.g., the weather), cannot be described with linear or causal models. It is dynamic and nonlinear and thus requires a different approach.

1.4 Applying Linear Thinking to Complex Systems

In everyday life, a relatively linear and causal way of thinking is usually sufficient. I am out of coffee, so I have to buy coffee. If I am hungry, I eat something. If I have a psychological problem, I think about solutions. And that's where it starts to get complex. Thinking can contribute to the solution. But the thoughts can also branch out and reinforce the problem or even create new problems. The pondering can make you feel helpless, and the helplessness can trigger a chain of other feelings, such as inferiority and guilt. As a result of my ruminating, behaviors or relationships may change. The psyche consists of numerous subsystems that are highly interconnected. Such complex systems cannot be represented with linear cause–effect notions. They behave dynamically and nonlinearly.

Understanding complex systems such as mental disorders requires a systemic perspective (McKey, 2019; Meadows, 2008). A system can be described simplistically using three components: It consists of (1) elements (what is seen), (2) connections or relationships among these elements, and (3) a function or purpose of the system. The latter can be seen in the effects (see Figure 2).

The system "soccer game" for example has the elements player, ball, goal, and field. The relationships are the actions in the game that occur between the elements and the applied rules affecting the game. The purpose or function is to get the ball into the opponent's goal and at the same time prevent the ball from entering your own goal while adhering to the rules. What is the most important thing if you want to define or understand the system behind a soccer game? If you change the elements (players), it is still a soccer game. However, if you change the relationship patterns, for example, by having oppos-