Michael Svitak
Stefan G. Hofmann

A Process-Based Approach to CBT

Understanding and Changing the Dynamics of Psychological Problems

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About the Authors

Dr. Michael Svitak, born 1969, studied psychology in Regensburg (Germany) and Reading (UK), receiving his doctorate at the University of Salzburg (Austria) in 1998. Since 2004, he has been head psychologist at the Center for Behavioral Medicine at the Schoen Clinic Bad Staffelstein and also a supervisor and trainer for process-based cognitive behavioral therapy.

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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.

a *desire* to change something at some point is formed for the first time ("I should change my drinking habits"). In the *determination phase*, a *resolution* is made: "I will refrain from drinking altogether, even if it is hard." In the action phase, changes are put into practice (*implementation*), and in the following *maintenance phase*, changes are stabilized so that one does not fall back into old patterns. In the *termination phase*, the change is further stabilized and is felt as the new normal. This process is not linear: People may go through it several times and at times revert to an earlier phase. The motivational stage can also differ for different spheres in an overall change process. For example, if I decide to change my health-related behavior after a heart attack, I may be determined in regard to exercising more, but in complete denial with respect to eating habits. In this way the change process may seem inconsistent and contradictory from the outside.

By the time someone seeks psychotherapy, their own previous attempts have usually failed. Repeated failures impair motivation and lead to demoralization (Berking & Kowalsky, 2012). This explains why paradoxically help seekers do not believe they can be helped at the beginning of therapy. "I need help, but everything has failed so far and you won't be able to help me either" is the message many clients are sending in the first hours of therapy.

The motivation process is essential, because it controls, drives, or slows down all adaptation processes. It is therefore closely interwoven with processes at other system levels. In the context of the process-based approach, the motivation process determines the extent to which maladaptive system states can be overcome. To sustainably change from a solidified maladaptive state in a more favorable adaptive state, the motivation process needs to go through the following three stages.

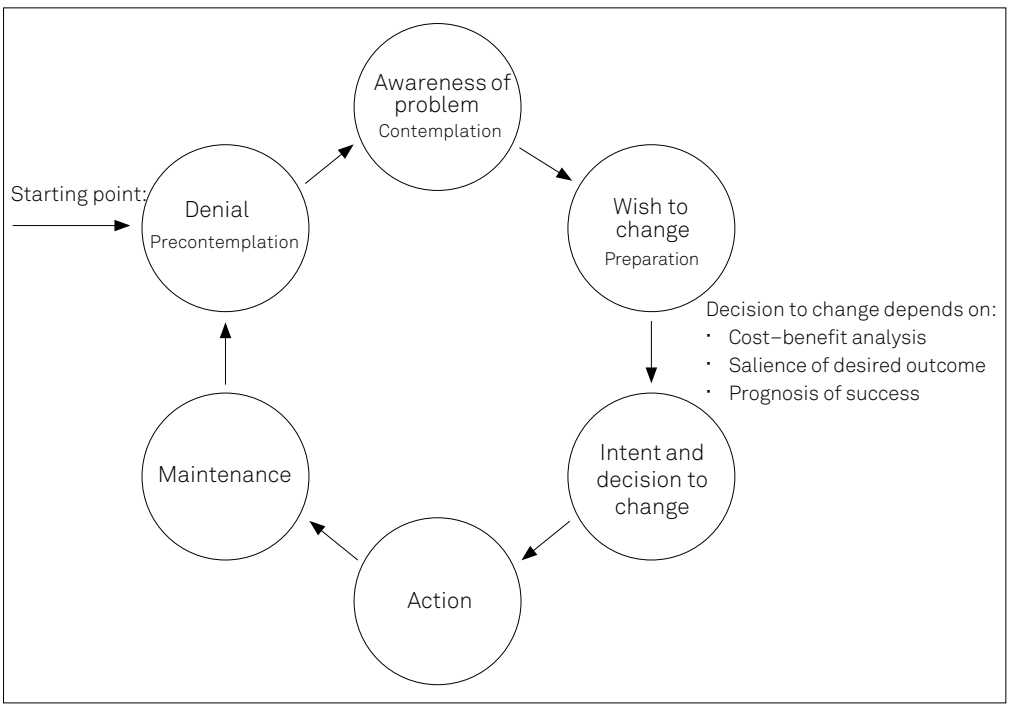

Figure 33. Motivation process based on Prochaska and DiClemente (1983).

Phase 3: Developing an Individual Process-Based Complex Network Model

This individual complexity is taken into account in the third phase of therapy. In this phase the therapist and client investigate which interactions between core processes develop a sustaining dynamic in this person. The result is a complex network model based on processes. Its creation is described in more detail in Chapter 10. Figure 38 shows an example of a complex network model of a depressed client. Crucial in this network model are the interactions between the processes, which are shown as arrows of different thickness. For the same diagnosis, different process dimensions (boxes) can create a depressive network, and even when the core processes (boxes) are the same, other interactions (arrows) may be responsible for maintaining the disorder.

In this depressed client, the negative affect (as vulnerability) and the rumination reaction used to avoid negative feelings reinforce each other. For this client, the initial separation from his partner is particularly problematic because it activates an existing attachment disorder and thus generates more negative affect to the already high level of existing negative affect. At the same time, rumination is coupled with withdrawal behavior via self-reinforcing loops. The more the sufferer withdraws, the more he ruminates and vice versa. These two core avoidant processes create a downward spiral and contribute to the maintenance of his depressive state. At this level of analysis of an individualized process model, possible process goals become apparent to interrupt the perpetuating reinforcing spirals. The arrows in Figure 38 indicate the force fields relevant to the disorder. These are also the starting points for effective interventions to slow down the "flywheel" that the arrows create. Process goals in this case are (1) to reduce the intensity of rumination through defusion strategies, (2) to reduce withdrawal behavior through activation techniques, and (3) to decouple thought and action from negative affect. One can see the high individuality of the disorder model, explaining how two individuals with the same categorical diagnosis need not have process-level correspondence.

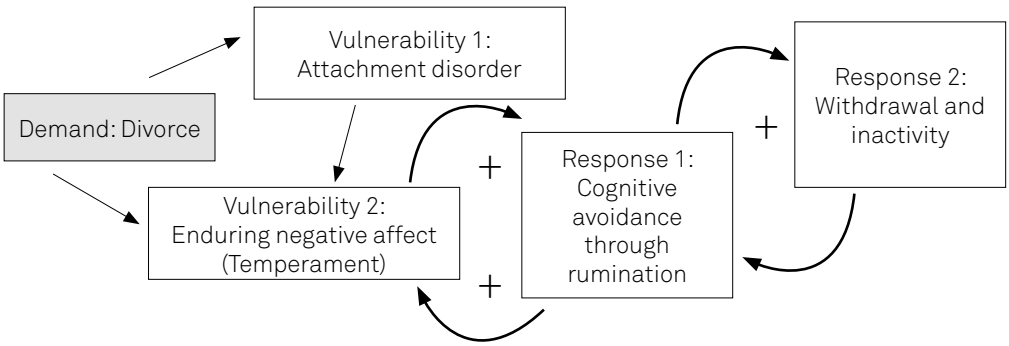

Figure 38. Example of a complex network model of a depressed client.

7.4 Longitudinal Analysis of Symptom Development (Life Chart)

A "Life Chart" (Worksheet 6: Life Chart: Symptom Development Over the Life Span; see Appendix; see also Figure 41) can be used to depict the longitudinal development of the course of certain problems over the life span. This longitudinal visualization helps to adopt a metaperspective and makes other process interrelationships visible in comparison with the survey methods described so far. Clients enter the course of their psychological complaints as a line in a coordinate system on the worksheet. The *x*-axis serves as a time axis, depicting the client's age in years. The *y*-axis maps the perceived intensity of their symptom distress, suffering, or impact the pathology has on their well-being and functioning. As a simple variation, clients can be asked to plot the course of their psychopathology (e.g., depressiveness) over the life span. The upper range of the coordinate system on Worksheet 6 (7–10) indicates high levels of suffering or severe limitations due to psychopathology. The lower range (0–3) indicates that the disorder was present but was experienced as having no or very little distress. This takes into account the dimensional nature and variation across the life span.

In addition to mapping the course of a disorder according to *DSM* categories, it is possible to map other relevant symptomatology or influencing factors using a longitudinal visualization method. Dimensions that can be mapped in this way are: general extent of psychological distress, disorder-related distress, intensity of work-related stress, quality of partnership, intensity of conflicts, degree of physical impairment, distress due to somatic diseases, intensity of financial worries, development of body weight, sleep disturbances, experienced loneliness, PC or internet consumption, problematic alcohol or drug use or extent of social integration. The possibilities to visualize the development and variations of dimensions over the life span are manifold.

The Life Chart is suitable as homework and promotes the development of a metaperspective on one's own problems. Nevertheless, one should set initial reference points together with the client and check whether the person concerned is capable of adopting a metaperspective. Especially the classification of severity requires defining landmarks together. Sometimes patients need objective criteria to assess the severity of a dimension. Severity criteria can include behavioral information like being hospitalized, longer periods of sick leave at work, deteriorating sleep, or neglecting important activities. By identifying indicators of symptom severity, clients become aware of early warning signs of deteriorating mental health. In addition, it is helpful to divide the time axis into manageable phases by adding memorable life events, such as graduation from school, change of occupation, moves, marriage, births, using auxiliary lines on the *x*-axis.

Figure 41 shows an exemplary Life Chart of a client who was very fused with problems in her partnership, so we decided to visualize the intensity of the partnership conflicts (upper line) in addition to the depressiveness over the life span (lower line). It was interesting to note that the partnership was experienced as conflictual from the beginning and that depression developed with a somewhat temporal delay taking a comparable but time-lagged course. This indicated vulnerability factors in the area of relationship/interaction. Thus, it was clear that the depressive development was coupled to the handling of adaptation processes and demands in partnerships.

Box 8. Questions to ask when discussing the Life Chart

- How do you explain these fluctuations over the life span?
- What was different during this period when the symptomatology was less pronounced?
- What factors contributed to the curve rising so sharply, or to a reduction in suffering in this time period?
- What were you doing differently in less distressing (or more distressing) periods?
- What have you noticed? Do you recognize any patterns in the development of your symptoms over your life span?

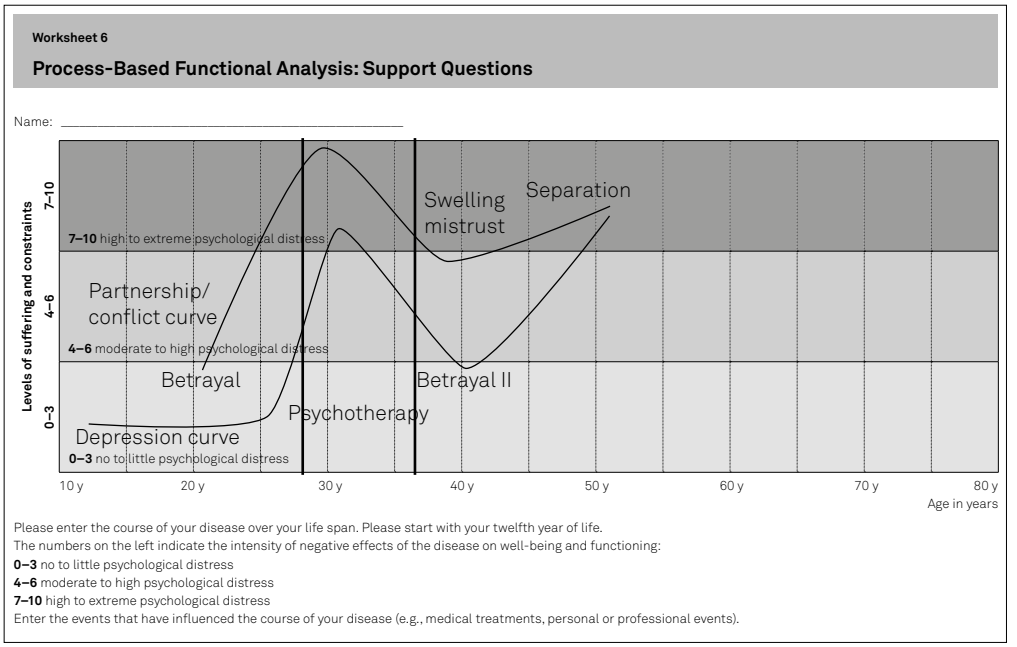

Figure 41. Life Chart of a depressive development against the background of partnership problems. Blank version available in Worksheet 6.

By visualizing the course of her depression and the intensity of perceived conflicts in her partnership, the above-mentioned client at first became aware that although being in a partnership was very important to her, it was also complicated and often stressful, and the quality of her partnership was closely linked to her emotional state. The Life Chart led her to look more closely at possible causal connections and she recognized that unsettling situations in the partnership triggered intense feelings of helplessness and initiated self-perpetuating loops ending in self-deprecation. This dynamic managed to kick off further depressive symptoms every time difficulties arose within the partnership. Her difficulty in dealing with partnership demands (vulnerability) in combination with unfavorable automatic response patterns triggered further symptoms, which together led into full-scale depressive episodes. After deducting this response pattern out of the Life Chart perspective,

cide to work on the body schema disorder (implementation), but she may *not yet recognize a* need for change with respect to adequate food intake (*denial*). In order to be able to determine the current position in the motivation cycle, it is helpful to look at and discuss it together with the client. The first page of Worksheet 15 (Motivation for Change; see Appendix) can be used for this purpose.

Since motivation to change is a central process for therapy, it is recommended to explicitly discuss the factors that are prerequisites for a firm decision for change. Willingness to change is determined by the costs and benefits (valence), the importance (salience) of a change in relation to the status quo, and the assessment of the likelihood of achieving the therapy goal (Berking & Kowalsky, 2012). The second page of Worksheet 15 contains corresponding questions that the clients can clarify for themselves.

For the therapy process, motivation to change is a core process. The success or failure of a therapy is often determined by whether the client can be gently guided from one motivation phase to the next. If this is not the case, it is the therapist's task to make this transparent and to select therapeutic interventions aimed at promoting the motivational process. According to the motivation model of Prochaska and DiClemente (1983), at this point it is often a matter of moving from the state of passive "wanting" (treatment motivation) to an action-oriented "resolution" (change motivation).

There are cases in which clients deny their problems and externalize them exclusively, looking for an ally in the therapist. Or, clients recognize their problems and think that this insight is already enough to change something. These clients do not get beyond the wishing stage. They may have recognized that something is going wrong and ardently wish for a change, such as more self-worth, less anxiety, or less misery, but do not derive from this a purposeful resolution to take certain actions that must precede any change process.

10.3.2 Cost-Benefit Analysis for Change

The client should be able to convince you, the therapist, that (1) they understand that wishing alone will not bring about change, and (2) they can realistically estimate the benefits and costs of change. Further, the client should (3) be able to convince you why the change is so important to them personally (salience), and (4) anticipate that they have the capability to succeed (positive outcome prognosis).

Statements like "It would be nice if I could be more cheerful again" are not convincing. I (M. S.) react to this with provocative interventions by saying: "Oh, cheerfulness is overrated. After all, you are now used to being depressed and hardly know yourself any different. I think you should stick with that concept of depression. Or can you give me a *real* reason to go through the trouble of therapy?" This emphasizes that change does not just happen but requires willingness, overcoming, and perseverance. The resistance built up by such a paradoxical intervention is small compared to the resistance the person must overcome in therapy. It is not uncommon for clients to respond to such a provocation something like, "Yeah, maybe you're right. That's what I always tell myself, and nothing will change anyway." It then makes no sense to ignore this deep negative belief and continue with the interventions that are bound to fail.

Instead, clarifying the components of the required motivation through a cost-benefit analysis helps the client build up the goal-oriented motivation that is needed to overcome a pathological network state and establish a new coping network. Worksheet 16 (Cost-Bene-

Table 7. Cost-benefit analysis for treatment

	Advantages/benefits	Disadvantages/costs
Previous handling of the challenges	• What desired effect is achieved by the current handling? • What negative effects are currently being prevented? • What other benefits does the status quo have?	• What does this also prevent? What will I miss out on as a result? • What are the downsides of the status quo in the long run? • What are the side effects of currently dealing with my problems?
Dealing with the challenges through therapy	• What benefits are hoped for? • What would be the overall impact of a change? • What is worth fully engaging in therapy for?	• What disadvantages do I fear? • What problems does this create? • What am I afraid might happen if I pull through and change? • What do I have to do to deal with then?

Case Study 3.6. Julia, a client with PTSD and depression

Julia was initially in the "wishing" phase in which she hoped her unpleasant memories, permanent arousal and avoidance would just disappear. The resolution to confront herself actively with her unpleasant internal and external states had not yet matured. When discussing realistic goals, she became aware of the costs holding her back: "I can never tell my father what happened" or "I can't bear the memories. I will just go crazy and end up in a psychiatric ward." Discussing and analyzing the motivational phases of change, Julia was able to localize herself in the "wishing" stage, so we first dealt with the development of a "resolution to change" before beginning actual interventions targeting PTSD symptoms. For this, she intensively examined the costs, benefits, and importance of achieving her global goals (cost-benefit analysis).

fit Analysis for Treatment in the Appendix) can be used for this purpose. The questions help elicit (see also Table 7) significant benefits for the client, but also the costs of changing. In this way, the client can examine whether the motivation to change is sufficient to tolerate the expected negative consequences (costs) and thus to be able to achieve their long-term goal. Such a cost-benefit analysis can help to strengthen the decision-making process with regard to the desired change through treatment (therapy) and thus generate motivation to change (see Case Study 3.6).

10.3.3 Determining the Type and Duration of Motivation Required for Change

To illustrate the importance of developing the right kind of motivation to the kind of change process I am engaged with, we will look at everyday challenges. It makes a big difference if I am motivating myself for a one-time action or if I have to make a resolution for a change I have to keep up for many years. For example, I might be carrying around the idea of ex-

Worksheet 1 (page 1/7)

Guide to a Process-Based Anamnesis

1. Spontaneously reported symptomatology

What brings you to therapy?
What are you suffering from?

2. External triggering events

Which external events/stressors/problems have triggered your problems?
Which ones weigh particularly heavily on you?

See p. 213 for instructions on how to obtain the full-sized worksheets as printable PDFs.

Notes on Supplementary Materials

The following materials for your book can be downloaded free of charge once you register on the Hogrefe website:

Appendix: Tools and Resources

Worksheets 1–18

Worksheet 1: Guide to a Process-Based Anamnesis
Worksheet 2: Hypothesis Sheet on Relevant Core Processes
Worksheet 3: Checklist: Vulnerability Mechanisms
Worksheet 4: Checklist: Problematic Response Mechanisms
Worksheet 5: Process-Based Functional Analysis: Support Questions
Worksheet 6: Process-Based Functional Analysis: Support Questions
Worksheet 7: Questions for Relatives About the Development of the Disease
Worksheet 8: Process-Based Assessment of Psychopathology
Worksheet 9: Emotional Stress Test: 3-Hour Monitor (5-Minute Intervals)
Worksheet 10: Emotion-Monitor Over the Course of a Day
Worksheet 11: Monitoring Emotions on a Daily Basis
Worksheet 12: 24/7 Monitor
Worksheet 13: Process-Based Diathesis Model
Worksheet 14: Evaluating Adaptivity Through the Extended Evolutionary Metamodel
Worksheet 15: Motivation: Building up Motivation to Actively Change
Worksheet 16: Cost-Benefit Analysis for Treatment
Worksheet 17: Evidence-Based Treatment Strategies (based on Kazantzis et al., 2018)
Worksheet 18: Standard Psychotherapeutic Procedures for Targeted Interventions

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