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Moving from protocols to idionomic processes of change: process-based therapy as the future of psychosis psychotherapy

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ABSTRACT

Background: The role of psychotherapy in treatment for psychotic disorders is established as a core component of standard care in international guidelines. Recent reviews of outcome trials have, however, indicated these interventions have smaller-than-anticipated effect sizes and wide variation in outcomes across persons. This is in part because psychotherapy protocols tend to rely on nomothetic outcome evidence and latent disease models that undercut the diversity of human well-being and suffering.

Methods: In this commentary, we outline the application of the process-based therapy (PBT) framework in psychotherapy for psychosis.

Results: We present an argument that the emerging PBT framework offers a novel solution to the limitations imposed by protocols for syndromes by embracing individual complexity and enabling a more precise, personalized application of evidence-based interventions for psychotic disorders. We also present brief case studies to illustrate how applying the PBT approach can enhance person-centered treatment of psychosis.

Discussion: Using the PBT framework, we advocate for a change in how researchers and clinicians think about, research, and provide psychotherapy for psychosis.

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The latent disease framework, which posits that conditions like schizophrenia exist as discrete and unitary entities, has dominated psychosis research for decades but now faces growing skepticism (Dazzan, 2022). This is, in part, due to increasing evidence for heterogeneity within the construct of schizophrenia and the psychosis spectrum broadly. Intensively collected time series data has shown that individuals diagnosed with schizophrenia, as well as other psychotic disorders, display person-specific patterns in daily life that depart considerably from inferences made at the group level. This is true of dynamics among symptoms (van der Tuin et al., 2021), aspects of social functioning (Steenhuis et al., 2023), and response to treatment (Thonon et al., 2020).

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It is perhaps unsurprising then that frontline psychotherapy protocols designed for specific syndromes, like cognitive-behavioral therapy for psychosis (CBTp), have yielded only small-to-medium effect sizes (Solmi et al., 2023). Clinicians, as a result, often face what Levine et al. (1992) called the therapist's dilemma: providing individualized psychotherapy while drawing on a dizzying number of treatment protocols built from group-level evidence.

A current movement in clinical psychology research is underway, calling for a shift from diagnoses to understanding and treating individualized processes of change. This presents an opportune time to re-evaluate our reliance on traditional protocol-for-syndrome approaches to psychotherapy, which are organized around homogenized, reified diagnostic categories and which rely on evidence from group-level outcome trials that overlook person-specific processes. Calls for the personalization of psychosis psychotherapy are not new (Newman-Taylor & Bentall, 2024). However, we argue that the process-based therapy movement (PBT; Hofmann & Hayes, 2019) provides a compelling biopsychosocial framework to achieve this goal and has much to offer psychotic spectrum disorders.

PBT does not purport to be another psychotherapy protocol but a model of models (Hofmann & Hayes, 2024) in which formulation, assessment, and evidence-based techniques are organized. PBT is guided by a foundational question of "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. 2).

Rooted in evolutionary science and network theory, PBT challenges mainstream views of psychopathology that adopt a "top-down" matching process between a diagnostic category and enumerated symptoms, and matching that diagnosis to a specific treatment protocol. Instead, PBT views human maladaptation as a network of interacting processes that arise from context-inappropriate disruptions in variation (e.g. incorporating new ways of responding), selection (e.g. identifying which of these new ways work best), and retention (e.g. retaining new habits) across six dimensions (affective, cognitive, attentional, self, motivational, behavioral) and along three levels (biophysiological, psychological, sociocultural). Together known as the extended evolutionary meta-model (EEMM; Hayes et al., 2020), this organizational scheme can personalize treatment by creating individualized "maps" or networks that highlight many processes that may benefit from intervention. This stands in stark contrast to diagnosis-based approaches, where a person with multiple diagnoses might receive an equal number of separate, uncoordinated treatment protocols.

As an organizational framework, PBT is agnostic to theoretical orientation. Instead, PBT formulations focus on underlying processes to explain the client's struggles (replacing a categorical diagnosis) and enable clinicians to develop treatment plans that draw on treatment kernels from different treatment approaches to best target the identified core processes. Hence, PBT offers a coherent framework for a person-centered, tailored approach.

We present two fictitious adult clinical cases to illustrate the application of this approach, beginning with brief descriptions of the individual clients, the development of a PBT-informed case conceptualization, and treatment planning. Accompanying figures are available in the online supplement. Despite presumably attracting the same DSM-5 diagnosis of schizophrenia (e.g. auditory verbal hallucinations (AVH), negative symptoms

of avolition and asociality), we demonstrate how the PBT approach ultimately informs personalized targets for treatment based on the individual's salient processes of change rather than a diagnosis.

Client A: "Robert"

Background

Robert is a Black cisgender male in his early 40s who began experiencing psychotic symptoms shortly after his 19th birthday. During his clinical interview, he reports longstanding distressing AVH, including multiple derogatory voices commenting on his behavior (e.g. *"You're going to mess this up again"; "Disappointment"*). Collateral information from Robert's case worker also indicates longstanding difficulties with social withdrawal and motivation to engage in goal-directed activities. Although Robert resides in a group home, he often stays in his room and struggles with daily hygiene and communal chores.

As Robert discusses his AVH, the clinician observes signs of discomfort and distraction (e.g. shifting in seat, glances around room). Robert reports feeling *"wound up"* and *"tense"* when the voices occur, with jaw pain from prolonged clenching, and remains on edge between episodes, anticipating their return (*"I'm always waiting for when I'm going to feel like this, when they'll start talking again"*). Glances from others at his group home remind him of encounters in previous involuntary hospitalizations, which puts him *"on edge"* and narrows his attention to the voices and accompanying dread. To avoid feeling this way whenever possible, Robert states he tries to *"avoid anyone at all costs"* and feels apathetic towards activities involving interaction or visibility to others.

Case conceptualization

Network maps are used in PBT to detail the interconnected ways in which events and processes are linked for a given client. Although reviewing the network theory underpinning PBT is beyond this commentary's scope (see Hoffman et al., 2021, pp. 13-25), network maps depict nodes (circles or squares) representing events or dimensions of a person's life, with edges or links (arrows) indicating relationships among nodes. Edges may be single- or double-headed and may vary in size or weight to indicate the direction and strength of the relationship. They may form relatively simple unidirectional or mediational relationships, and/or depict complex self-reinforcing networks called subnetworks. Networks offer several advantages over diagnostic categories. Edge strength is context-dependent rather than fixed, capturing how symptoms vary across situations (e.g. voices triggering withdrawal when alone but not with a trusted person) rather than reflecting static labels. Bidirectional connections also reveal self-reinforcing loops that are not captured by simple cause-and-effect chains, while highly connected nodes (or hubs) identify processes where easing one can loosen several problems at once, showing the clinician where to start.

To co-develop a conceptual network map, the clinician first organizes Robert's presenting concerns along the EEMM dimensions, recognizing that some dimensions may emerge later and be revised iteratively as the conceptualization matures. For Robert,

affective, attentional, biophysiological, cognitive, and motivational dimensions or levels are involved. To facilitate comparison with the second vignette, nodes representing auditory hallucinations and negative symptoms are first drawn (Figure S1(A)), although clinicians could organize these or other symptoms within the EEMM framework (e.g. asociality as a dimension of behavioral avoidance) or begin with other target(s) identified through functional analysis.

The clinician may next turn to clarifying the underlying processes that maintain Robert's symptoms. An arrow is drawn to hypothesize the affective and biophysiological domains associated with Robert's AVH (Figure S1(B)). This experience has the affective consequence of feeling anxious or tense, and, in turn, this arousal likely influences further AVH. Robert's jaw clenches whenever he experiences heightened tension, forming a similar self-reinforcing relationship that thwarts relaxation. Another arrow is drawn to illustrate the consequence of Robert's acute anxiety on his generally diminished motivation to attend to daily tasks.

The clinician next examines the role of attentional and cognitive dimensions in Robert's network (Figure S1(C)). Given that Robert reports a persistent state of hypervigilance in response to distressing experiences associated with AVH, particularly the unpleasant tension he feels, two bidirectional arrows indicate that hypervigilance influences and is maintained by AVH and anxiety. However, Robert's attentional bias also seems fueled by appraisals of certain social stimuli as threatening, reminiscent of prior traumatic encounters with his involuntary hospitalization. This orientation toward threat not only bolsters guardedness but also decreases his desire for social interactions (asociality).

Lastly, the clinician maps a motivational node focused on avoiding fear as exerting a broad influence on other parts of Robert's network (Figure S1(D)). Unidirectional arrows linking this node to avolition, and especially asociality, illustrate that Robert's efforts to avoid fear come at the cost of withdrawing from social contact and engaging in daily prosocial activities. Similarly, his avoidance motivation is hypothesized to maintain a state of alertness and negative appraisals by preventing disconfirmation of expected threats, especially in social situations.

Treatment planning

The clinician and Robert conduct a functional analysis of his completed network map and use shared decision-making to identify which processes are most central, impairing, and feasible to address, as well as which are most aligned with his treatment goals. This leads to a conversation in which they identify which treatment *kernels* (i.e. specific change processes) are best suited to facilitating change by increasing Robert's variation, selection, and retention of adaptive behavior, given his context. As observed in Figure S2, multiple kernels are possible. For example, the self-reinforcing link between AVH and feeling tense suggests that prioritizing kernels linked to affect that calm the nervous system, such as Progressive Muscle Relaxation or Body Scan practices (CBT), could help perturb this process. Elsewhere, targeting beliefs about potential threats from others through cognitive restructuring (CBT) may be prioritized, given that Robert's tendency to appraise social stimuli as threatening narrows attention, which, in turn,

fuels the reinforcing loop between AVH and anxiety. To align with the evolutionary framework of change in the PBT model, the chosen intervention should help Robert develop new responses (variation; e.g. reappraising dysfunctional beliefs), learn which strategies support positive trajectories (selection, e.g. noticing the effects of adaptive beliefs), and build healthy habits (retention; e.g. planning to practice cognitive strategies in daily life).

Client B: “Sally”

Background

Sally is a white cisgender female in her early 30s with a recent onset of psychotic symptoms while completing her postgraduate studies. Now on medical leave, Sally’s temporary exit from university was precipitated by a sharp decline in her academic performance, class attendance, and withdrawal from friends and study groups.

Like Robert, Sally endorses prevalent AVH, but the content of her voices is more degrading (“*You’re disgusting*”, “*You’re such a failure*”), and accompanied by other auditory experiences, such as hearing her peers laugh. Sally becomes visibly distressed as she discusses this, breathing rapidly and shallowly. The clinician finds out that these experiences evoke intense humiliation and perceived inferiority with multiple consequences. Sally acknowledges that shame reduces her desire to socialize, stating, “*I just want to disappear . . . I don’t want to be around anyone, they’re all judging me*”, and admits that these feelings can also lead her to lash out at others, disrupting meaningful relationships. The clinician learns that Sally unquestioningly accepts the voices, indicating “*They’re right, I’m pathetic*”, and that viewing herself as defective has immobilized her from completing daily tasks and schoolwork.

Case conceptualization

Developing Sally’s network map follows a similar approach to Robert’s case (see Figure S3, panels (A–D)). The clinical interview clearly articulated a strong link between Sally’s experience of the AVH and ensuing shame, which itself appears to play a central role in multiple self-reinforcing loops. One such subnetwork involves the activation of shame through humiliating voice content, leading Sally to engage in self-attacking in an attempt to control or respond to these perceived threats. In turn, further self-criticism worsens the intensity and emotional impact of the voices. Viewing herself as undeserving or incapable also appears to fuel avolition by diminishing Sally’s motivation to pursue her academic goals. Another subnetwork features the indirect and direct ways Sally’s shame contributes to her asociality: indirectly, by heightening her criticism of others as a strategy to reclaim a sense of agency or control; and directly, by avoiding others due to fear of rejection from her perceived inferiority. Finally, a biophysiological domain plays an important role, forming a mutually reinforcing threat cycle whereby rapid breathing accompanying derogatory voices is interpreted as a personal failure, intensifying self-criticism and, in turn, increasing the frequency and distressing content of the voice.

Treatment planning

Despite containing similar symptoms as reflected in Robert's network map, functional analysis of Sally's map uniquely highlights the harmful power that shame plays in maintaining her psychotic symptoms. Rather than utilizing a treatment approach like Robert's, Sally's map suggests she may benefit most from prioritizing treatment kernels featuring de-shaming interventions (Figure S4), such as Compassion Focused Therapy (Gilbert, 2009), which cultivate self-compassionate responding and enhance emotion regulation. By selecting this approach and prioritizing the perturbation of shame-driven ways of responding to herself, her voices, and others, Sally is presented with opportunities to increase the variation of her self-relating, experiment with alternative responses characterized by compassion, and build new repertoires that gradually replace shame-based patterns of responding with more adaptive ones.

Future directions

Given the nascent stage of research on PBT generally, we believe there are rich opportunities for future work applying PBT to psychosis populations. The network diagrams presented in this paper represent what might be termed "perceived causal networks" because they reflect the client's own understanding of what influences what. While clinically valuable, these perceptions may not always align with actual causal relationships. Ecological momentary assessment (EMA) research, which involves data collection on mobile devices at multiple time points each day, offers a way to move beyond perceived networks toward empirically derived ones. Future EMA studies of persons experiencing psychosis could assess the practicality and usefulness of clinicians presenting clients with network maps based on their own intensively collected data, the effectiveness of personalizing treatment plans based on these conceptualizations, and whether this approach to conceptualization enhances recovery-oriented interactions that utilize shared decision-making principles. Further opportunities could involve tracking intervention progress using EMA methods and immediately tailoring treatment to be responsive to client changes.

Conclusion

The PBT movement offers unprecedented focus on the idiosyncratic complexity of each individual, for both case conceptualization and treatment planning. This approach is likely to make a significant contribution to better understanding the heterogeneity in psychotic spectrum disorders, and potentially lead to better treatment outcomes through tailored and responsive treatment planning. We hope that through presenting this theoretical rationale, this paper propels the application and study of PBT in this underserved population.

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