Published in final edited form as:

Clin Psychol Sci. 2019 January ; 7(1): 57–59. doi:10.1177/2167702618797104.

Commentary on Hofmann and Hayes: The water looks inviting, but how and when do we jump in?

Bethany A. Teachman

University of Virginia

Abstract

Hofmann and Hayes (this issue) shine a light on our field's lack of progress in reducing the prevalence and burden of mental illness, and suggest that a paradigm shift is needed to make more rapid progress. They argue that empirically-supported processes of change should guide treatment planning, rather than treatment packages. This approach should allow for greater personalization of treatment, more iterative treatment planning, and increase the scalability of our intervention delivery models. In this commentary, I discuss some of the difficult questions that will arise when trying to make the shift from treatment packages to process-based therapy, and highlight some steps that we can take now to facilitate the shift.

Keywords

treatment planning; change processes; dissemination; practice guidelines

Hofmann and Hayes (this issue) challenge the field to look both backward and forward to recognize progress made, but also missed opportunities, in developing and delivering mental health services that can effectively and efficiently reduce the burden of mental illness. They present what is in many ways a simple premise: empirically-supported processes of change should guide treatment planning, rather than treatment packages. While I might quibble with whether or not we really need a new name for this approach (they use the term “process-based therapy”), I agree with the basic argument and believe it can provide a valuable approach to addressing comorbidity, the need to better integrate nomothetic and idiographic approaches, and the limitations of a disorder-based diagnostic approach that fails to ‘carve nature at its joints.’

Moreover, as Hofmann and Hayes note, this is not a new idea and there have been exciting strides made in this direction already. For instance, groundbreaking work over the past 15 years has focused on how to extract the common elements from evidence-based intervention packages that lead to effective mental health outcomes for children (e.g., Chorpita, Daleiden, & Weisz, 2005). Further, Hofmann and Hayes’ hope that, “In the future, it might further be possible to train paraprofessionals in specific therapeutic procedures to target the therapeutic processes that more highly trained professionals identify as the most promising treatment

targets.” (p. 20). This wish for greater dissemination may be less futuristic than they suppose. There is already considerable evidence that non-specialist providers can effectively deliver treatment strategies based on common processes of change (drawn from well-established behavioral, interpersonal, emotional, and cognitive therapy approaches) in low- and middle-income countries. A recent review of 27 trials found a moderate to strong pooled effect size in favor of the active interventions, even when the treatments were mainly delivered by peers or community health workers (Singla et al., 2017). This raises considerable hope for the potential of a process-based therapy approach to have wide reach.

The real question then is less *should* we train the next generation of providers to focus on becoming proficient in targeting key processes of change, and more *how* can we get there? We are swimmers sitting by the edge of the pool - the water looks inviting, but how and when do we jump in? This is a difficult question because so much is not yet known. For instance, what is the final list of change processes that would be recommended, and for which problem areas would these processes be effective, and under what circumstances? And how do we know which combinations of change process strategies should be used for which client, or the optimal way to sequence the strategies? These are not easy questions to address given the data on mechanisms and on personalization of treatments are not nearly as good as we wish (or desperately need them to be; see Teachman, Beadel, & Steinman, 2014). Thus, the fundamental question raised by Paul (1969) still remains unanswered when we shift to a process-based therapy approach: “What treatment, by whom, is most effective for this individual with that specific problem, under which set of circumstances, and how does it come about?” (p. 44).

These many unanswered questions challenge our identity as clinical *scientists* that want a strong base of empirical evidence to guide decision-making. And yet, I would argue that it is time to take the plunge and get wet (at least in the shallow end!). We, as a field, need to do something different given how woefully ineffective we have been at reducing the burden of mental illness in a meaningful way (see Kazdin & Blase, 2011). Moreover, it will be more feasible to answer Paul’s million-dollar question with a process-based approach because the process-based approach is designed to be individualized and starts as a treatment that can be readily dismantled to determine its necessary and sufficient parts, rather than those questions often being addressed decades after traditional treatment packages have been introduced.

So, how do we ‘get in the pool’ in an ethical and scientific way given the unknowns? Clearly, the answer to this question will require a book, rather than a brief commentary, but a few initial steps that seem helpful include:

1. Clinical Practice Guidelines, such as those developed by the National Institute for Health and Care Excellence (NICE) in the United Kingdom and recently by the American Psychological Association, provide treatment recommendations based on a systematic review of the efficacy data. New guidelines need to move away from being DSM disorder- based for the guideline topics and package-based for the treatment recommendations. Instead, more systematic reviews and associated recommendations are needed on processes of change to clarify both what is known, and also the large scope of what is not known. This can help

prioritize the domains where more research is most needed. Notably, I would define processes of change broadly, including both specific mechanisms (like inhibitory learning during exposure therapy) and non-specific factors (like therapeutic alliance, for which we still need more experimental data but have considerable correlational data), and even processes tied to other aspects of treatment delivery, such as outside-of-session practice and application of treatment material (with homework being a common treatment strategy to achieve this change process).

2. Obtaining thorough and open informed consent with clients so that clients are aware of the limits of what is known about the planned approach is key. Further, this openness needs to be paired with careful progress monitoring of both change in the process of interest and change in the therapeutic outcomes (expected to follow from those change processes). By viewing treatment planning as a dynamic process that happens iteratively based on client-level data, it becomes clearer how to view therapy planning in phases (Woody, Detweiler-Bedell, Teachman, & O'Hearn, 2002), rather than as a one-time decision based on which treatment package was selected.
3. Providers need access to good, free, easily digestible (minimal jargon) resources to facilitate training in the strategies to achieve empirically-supported processes of change. The field currently has too many barriers to providers accessing the resources needed to build their toolbox and keep it up to date (e.g., resources are expensive, often time-consuming to digest, dispersed so hard to locate, and lack cultural adaptation, etc.). A clearinghouse of simple resources (videos, handouts, etc.) to help providers learn and apply process-based therapy could help dissemination and implementation greatly.
4. We need to learn from the successes in global mental health. The impressive effects when scaling interventions with non-specialist providers in low- and middle-income countries can teach us a lot about how to increase adoption of process-based therapy. We have a bad habit of thinking that progress moves only from disseminating Western treatment approaches to other places, but there is much we can learn from non-Western mental health success stories.
5. Greater investments are needed in research on personalizing treatments (beyond work on biomarkers; e.g., DeRubeis et al., 2014) to learn how to match treatments to a given individual and context, and in idiographic network models (e.g., Borsboom & Cramer, 2013) to identify the key change processes for a given person that can start a domino effect for that person and efficiently lead to other changes.

Much remains unknown about how to shift from a treatment package to a process-based therapy approach and what impact this shift will have, but the time has come to 'jump in the water.' For the sake of our clients and their families, we cannot sit on the sidelines any longer.

Acknowledgments

The authors are thankful for the feedback provided by members of the PACT lab at the University of Virginia. This research was supported by NIMH R01MH113752 grant to B. Teachman.

References

- Borsboom D, & Cramer AO (2013). Network analysis: an integrative approach to the structure of psychopathology. *Annual Review of Clinical Psychology*, 9, 91–121.
- Chorpita B, Daleiden E, & Weisz J (2005). Identifying and selecting the common elements of evidence based interventions: A distillation and matching model. *Mental Health Services Research*, 7, 5–20. [PubMed: 15832690]
- DeRubeis RJ, Cohen ZD, Forand NR, Fournier JC, Gelfand LA, & Lorenzo-Luaces L (2014). The Personalized Advantage Index: Translating research on prediction into individualized treatment recommendations. A demonstration. *PloS One*, 9(1), e83875. [PubMed: 24416178]
- Kazdin AE, & Blase SL (2011). Rebooting psychotherapy research and practice to reduce the burden of mental illness. *Perspectives on Psychological Science*, 6(1), 21–37. [PubMed: 26162113]
- Paul GL (1969). Behavior modification research: design and tactics In Franks CM (Ed.), *Behavior therapy: Appraisal and status* (pp. 29–62). New York: McGraw-Hill.
- Singla DR, Kohrt BA, Murray LK, Anand A, Chorpita BF, & Patel V (2017). Psychological treatments for the world: Lessons from low-and middle-income countries. *Annual Review of Clinical Psychology*, 13, 149–181.
- Teachman BA, Beadel JR, & Steinman SA (2014). Mechanisms of change in CBT treatment In Emmelkamp PMG and Ehrling T (Eds.), *The Wiley Handbook of Anxiety Disorders*, 824–839. Wiley Blackwell.
- Woody S, Detweiler-Bedell J, Teachman BA, & O'Hearn T (2002). *Treatment planning in psychotherapy: Taking the guesswork out of clinical care*. New York: Guilford Press.