CBASP Basics

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Learning Objectives

1. Describe the basic theory and rationale for Cognitive Behavioral Analysis System of Psychotherapy (CBASP).

2. List the three necessary components of CBASP.

3. Demonstrate how to implement specific strategies utilized in CBASP, including obtaining the developmental history, conducting the situational analysis and interpersonal discrimination exercises.

Basics about CBASP

- Developed by Dr. Jim McCullough at Virginia Commonwealth University, Richmond VA
- Developed for use with chronic depression, expanded to include:
  - Group modality
  - PTSD co-morbidity
  - Addictions (alcohol, nicotine) co-morbidities
- Proven effective in a 12-site national study with 681 chronically depressed outpatients
  - As effective as medication alone (~50% response rate)
  - **When combined with meds ~85% response rate**
  - **Listed as an Empirically Supported Psychotherapy**

Treatment Goals of CBASP

1. Felt emotional safety
2. Ability to engage in formal operations social problem solving
3. Empathic responsivity in social situations (interpersonal mindfulness)

Theoretical foundations of CBASP

- Maturational cognitive-emotional theory of Piaget (1926,1981, Inhelder & Piaget, 1956)
- Social learning theories of Bandura (1977) and Rotter (1954,1966, 1990)
- Operant psychology of B.F. Skinner (1953, 1968)
- Respondent conditioning of I. Pavlov (1929)
- Interpersonal theory of Kiesler (1983, 1996)

Unique Features of CBASP

1. Designed specifically for persistent depression
2. Arrested maturational development is viewed as etiological basis of persistent depression
3. Depression and its modification conceptualized in terms of "person X environment", which educates patient about their interpersonal "stimulus value"
4. Uses disciplined personal involvement of therapist

Unique Features of CBASP (cont)

6. Patient transference issues proactively addressed
7. Situational analysis used to exacerbate the psychopathology of the patient in therapy
8. Use of negative reinforcement to motivate
9. Uses interpersonal discrimination learning
10. Neurobiological impact on fMRI studies

Etiological pathways for chronic depression

1) Dysfunctional development history
   - Cognitive-emotional deficits/preoperational
   - Perceived dysfunctionality
   - Helplessness/hopelessness
2) Stressful event later in life
   - Precipitates episode of unremitting MD
   - Erodes previously acquired normal cognitive-emotional functioning
   - Helplessness/hopelessness

Early-onset Chronic Depression is a Refractory Mood Disorder That Is "Reversible"

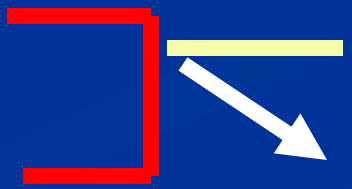
Major Bio-Psycho-Social Variables That Maintain the Disorder

*** Intrapersonal-Interpersonal Emotional Fear (Pavlov)**

**** Pervasive Interpersonal Avoidance (Skinner)**

[Normal] PERSON  **Interpersonal Environment**

(reciprocal interaction)

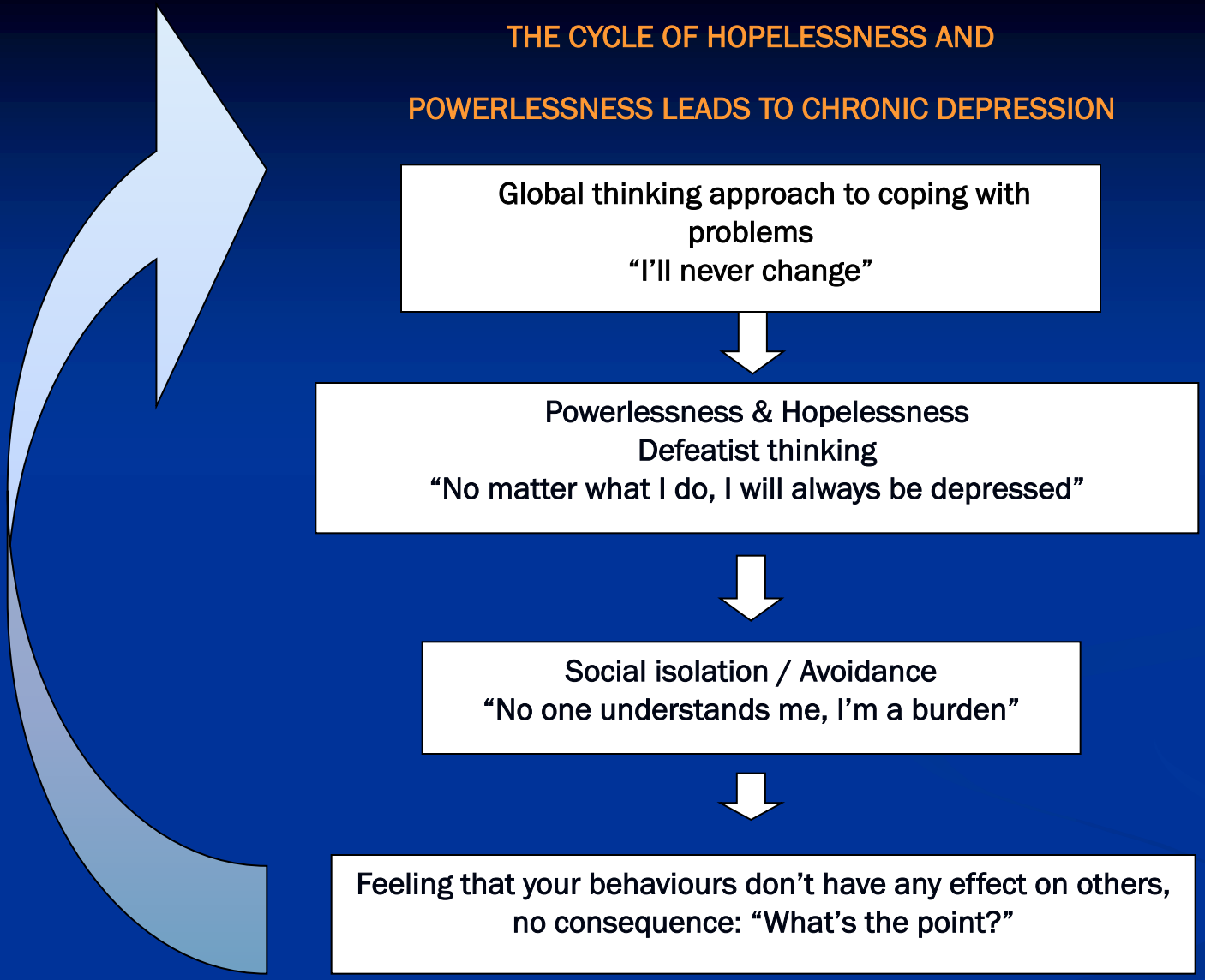
*****[CD] PATIENT**  **ENVIRONMENT (one-way)**

Interpersonal difficulties

- Interpersonal difficulties as an etiological component for chronic depression (Riso, Miyatake & Thase, 2002).
- As a mediator between early childhood adversity and development of chronic depression
- As a destructive process that can contribute to chronicity

THE CYCLE OF HOPELESSNESS AND

POWERLESSNESS LEADS TO CHRONIC DEPRESSION



...and from this we can get the impression that we are losing control over our lives. This is how chronic depression can develop...

McCullough, J.P. Jr., 2000

Early-onset chronic depressive

Preoperational patient who cannot generate empathy:

- pre-logical/pre-causal thinker
- pervasively ego-centric
- employs mono-logic speech (one-way talk)
- perceptually disconnected from the interpersonal environment (ToM: no empathy)
- lives to "survive" not to thrive (quality of life is low)
- interpersonally detached & withdrawn

Chronic Depression

- Interpersonal interactions with therapist
  - Submissive
  - Hostile
- Behavioral deficits
  - Lack of assertive behaviors
  - Minimal perceived functionality
  - Learned helplessness/hopelessness

Implementation of CBASP

1. Diagnosis
2. Significant Other History (SOH)/Causal Theory Conclusion and Transference Hypotheses (TH) Development
3. Situational Analysis (SA) with Coping Survey Questionnaire
4. Disciplined Interpersonal Involvement: Interpersonal Discrimination Exercise (IDE); Contingent Personal Responsivity (CPR)
5. Transfer of learning: Generalization
6. Additional skills training as needed (e.g., Assertiveness Training, Coping with Urges, Problem Solving skills, etc.)
7. Improved outcomes!

Numbers 2, 3, and 4 are required for it to be called CBASP.

CBASP Components

1. Significant Other History (SOH)
2. Coping Survey Questionnaire / Situational Analysis (SA)
3. Disciplined Personal Involvement
   a. Contingent Personal Responsivity (CPR)
   b. Interpersonal Discrimination Exercises (IDE)

Significant Other History / Transference Hypotheses

- List of significant others
- Review of formative influence of these others on the patient (in four realms:)
  - Intimacy
  - Failure
  - Emotive need
  - Expression of negative affect
- Construction of "transference hypotheses"
- Use of CBASP Interpersonal Questionnaire (CIQ)
- Use of Interpersonal Discrimination Exercises (IDE) based upon this information throughout the therapy

Interpersonal Transference Hypotheses

- The patient's ***causal theory conclusions*** are utilized to generate specific ***transference hypotheses*** about how the patient might transfer his/her expectations of, and habitual response patterns to, significant others to the therapy relationship.
- These are used to explore interpersonal ***hot spots*** with the therapist within session in an Interpersonal Discrimination Exercise (IDE)

Significant Other History

- Causal Theory Conclusions:
  - *Because of growing up with a mother who rejected me when I approached her for my emotional needs, I learned that women/people will not help me when I am hurting emotionally.*

- Transference Hypothesis:
  - *If I open up with Dr. Penberthy about my emotional needs, she will reject me.*

Interpersonal Issues

- Keisler's Impact Message Inventory
  - Used to determine the patient's interpersonal "stimulus value" to the therapist
  - Provides guidelines on typical "pulls" and a more productive interpersonal style with which to interact with patient

Situational Analysis: Exacerbation and Resolution of Psychopathology

- Mainstay of CBASP – administered at each session beginning with 3rd session
- Multi-step, social problem solving procedure that is operationalized in the Coping Survey Questionnaire

COPING SURVEY QUESTIONNAIRE (CSQ) (Situational Analysis)

J.P. McCullough, Jr. (2000).

Instructions: **Select one stressful interpersonal event that you have confronted during the past week and describe it using the format below. Please try to fill out all parts of the questionnaire. Your therapist will assist you in reviewing this situational analysis during your next therapy session.**

Step 1. Describe what happened: (Write who said or did what, then describe clearly how the event ended – the final point)

Step 2. How did you interpret what happened:

a. _____

b. _____

c. _____

Step 3. Describe what you did during the situation: (How did you say what you said? What were some of your behaviors, tone of voice, eye contact, etc?)

Step 4. Describe how the event came out for you (Actual Outcome): (What *actually* happened? Describe in such a way that an observer would have seen.

Step 5. Describe how you wanted the event to come out for you (Desired Outcome):

(How would you have *wanted* the event to come out for you? What *goal* would you have wanted to achieve, that is realistic and attainable. Describe it in behavioral terms.

Did you get what you wanted? YES_____ NO_____ Why or why not?

Steps of Elicitation Phase

- Step 1: “Describe what happened, as if you were watching a movie, with a beginning and end.”
- Step 2: “Describe your interpretation of what happened. What did it mean to you?”
- Step 3: “Describe what you did during the situation.”
- Step 4: “Describe how the event came out for you. That is, what was the actual outcome?”
- Step 5: “Describe how you wanted the event to come out for you. That is, what is your desired outcome?”

Steps of Elicitation Phase (cont)

- Step 6: “Did you get what you wanted in the situation? Yes or No”
- Step 6a: “Why didn’t you get what you wanted here?” or “Why did you get what you wanted?”

Steps of Remediation Phase

- Step 1: Revising irrelevant & inaccurate interpretations
  - May determine that DO is unattainable or unrealistic, and must be immediately revised and made to fit attainable or realistic criteria
  - May need to incorporate "action reads"

Goal: Learn to construct relevant and accurate interpretations and to self-correct errors

Steps of Remediation Phase

- Step 2: Modifying inappropriate behavior
  - Patients learn that their cognitive interpretations are functionally related to how they behave in situations
  - They know what they can do to change behavior and impact mood, etc., this creates strong cognitive dissonance in the patient

Goal: Learn to evaluate situational behavior and self-correct errors; learn behavioral skills

Steps of Remediation Phase

- Step 3: Wrap-up and summary of situational analysis learning
  - Therapist should let the patient summarize and do the work

Goal: Learn to focus on the relevant components of the SA exercise that have lead to DO attainment

Steps of Remediation Phase

- Step 4: Generalization and transfer of learning
  - Patient is asked to pinpoint other similar interpersonal events that are relevant to the SA situation

Goal: Transfer and generalization of learning

****SA can be administered for future events***

Disciplined Personal Involvement (DPI)

- "Disciplined" component → therapists are aware of pt's interpersonal impact on them & use these impacts in a salubrious way

- DPI → demonstrate to pts they're interpersonally connected to the helpful clinician who will not hurt them.

Personal Involvement is done to:

1. modify maladaptive interpersonal behavior

2. heal earlier trauma

DPI: Techniques

1. Interpersonal Discrimination Exercise (IDE)

2. Contingent Personal Responsivity (CPR).

Using the IDE and CPR

- Used in CBASP to address interpersonal learning history deficits
- Improve interpersonal awareness and skills
- Improve interpersonal functioning
- Provide emotional corrective experience

Interpersonal Discrimination Exercise (IDE)

Significant Other's response to patient

Significant Other's emotive-behavioral-cognitive impact on patient

Therapist response to patient in situation

Therapist emo-beh-cog impact on patient

*** Clear discriminations between two interactants**

*** "New" interpersonal possibilities for patient with therapist**

Attentional Focus in Contingent Personal Responsivity (CPR)

Patient's interpersonal impact on therapist

Therapist's interpersonal response to patient (making consequences explicit)

Therapist: "Why are you doing this to me?" & Implications for therapy process

Pinpointing needed alternative behavior

Continual performance feedback for more adaptive behavior (making consequences explicit)

Outcome Goal of IDE Exercises
Accurate Discrimination: S.Os. vs Therapist

This is the Way it WAS:	This Is the Way It Is NOW:
Transference Hypothesis	
Males (SO) Fear/Avoid	Therapist: Safe/Approach
Females (SO) Fear/Avoid	
IDE: Fear/Avoid	Therapist: Safe/Approach
SA: Hopeless/helplessness (Avoid)	Goal-Directed Behavior (Approach)

Mechanisms of Action
What makes CBASP work?

- Learned felt emotional safety
- Interpersonal mindfulness/empathy
- Perceived functionality
- Approach/assertive interpersonal behaviors

CBASP increases perceived functionality and there are corresponding changes in brain as seen in fMRI studies

CBASP: Group and Co-morbidities

- Group therapy
- Co-morbid disorders
  - PTSD
  - Addictive disorders
    - Alcohol use disorder
    - Smoking
  - Personality disorders
  - Children and adolescents
  - Bipolar?

Trauma History
(Swann, et al. 2015)

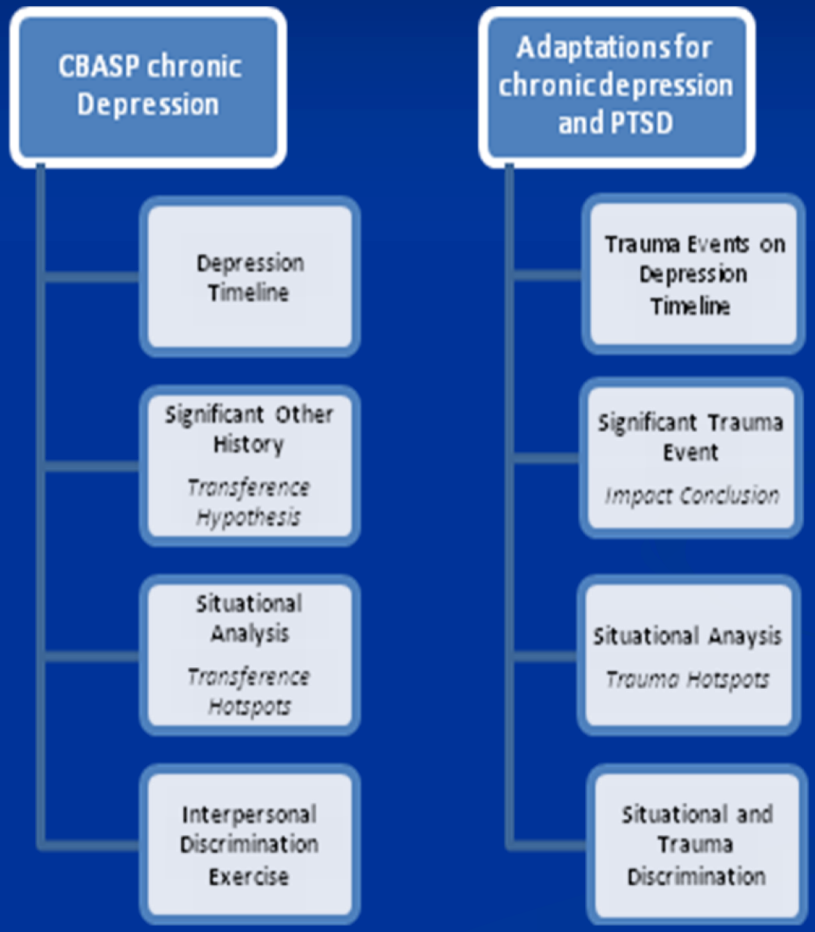
What proportion of patients present with histories of childhood adversity?

- ***47.3% Significant Emotional Abuse***
- ***31.1% Significant Physical Abuse***
- ***20.3% Significant Sexual Abuse***
- ***47.3% Significant Emotional Neglect***
- ***24.3% Significant Physical Neglect***

CBASP for MDD/PTSD

- A significant proportion of veterans diagnosed with PTSD also carry a diagnosis of depression (Campbell, et al., 2007).
- There are substantial symptom overlaps between these diagnoses (American Psychiatric Association, 2000).
- This population has a high treatment refractory rate for both antidepressant medication and psychosocial interventions (Santiago, et al., 2006).

CBASP: Adaptations for Co-morbid PTSD



Interpersonal Discrimination Exercise (IDE)

- Identified "hot spot" from Situational Analysis
  Identify transference domain related to SO
  Closeness, Mistakes, Neediness, Negative affects

- Recall: What did they do in similar situation? What did they say? How did they look?

- Compare: What did I do? How did I look? What did I say?

- New Learning: What did you learn? What does this mean in future situations?

Significant Trauma Event

- Significant Trauma Event (STE)
- Description and *Impact Conclusion* based on trauma event.

Thematic domains:

Safety, Trust, Power/Control, Closeness, Self-Esteem

- Situational Analysis – Trauma hotspots
- DPI- focus is on one of 3 sources:

1. Interpersonal (Transference Hypothesis)
2. Trauma Events (Impact Conclusion)
3. Interpersonal and Trauma Events (most relevant focus)