Effective Treatment for Persistent Depression in Patients with Trauma Histories: Cognitive Behavioral Analysis System of Psychotherapy (CBASP)

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Learning Objectives

1. Describe the basic theory of and rationale for CBASP.

2. List the three major treatment strategies of CBASP.

3. Demonstrate & practice implementing specific strategies utilized in CBASP, including obtaining the developmental history, conducting the situational analysis, and interpersonal discrimination exercises, and describing the ethical considerations of disciplined interpersonal involvement.
Basics about CBASP

- Developed by Dr. Jim McCullough at Virginia Commonwealth University, Richmond VA
- Proven effective in a 12-site national study with 681 chronically depressed outpatients
- 16-20 individual outpatient sessions CBASP vs nefazodone vs both (Keller, McCullough, et al. 2000, NEJM, 342, 1462-1470.)

- CBASP as effective as medication alone (~50% response rate)
- When combined with meds ~85% response rate
- Provides additional benefit for patients with early adverse events or trauma history (Nemeroff et al, 2003)
Additional Recent Research Findings

- CBASP associated with clinically significant change in 60% of completers in open case series with N=74 (Swan, et al., 2013)
- Inpatient single-arm study demonstrated significant improvements on HAMD (p=0.000) and BDI (p=0.002) (Brakemeier et al., 2015)
- Depressed pregnant smokers receiving CBASP vs standard treatment had increased abstinence and decreased depressive symptoms 6 mos post treatment (Cinciripini, et al., 2010)
- CBASP vs supportive as adjunct to medication found to be no different from each other & no advantage over meds alone (Koscis et al., 2010)
- CBASP (N=15) vs IPT (N=15) found higher remission rates in CBASP group (Schramm, et al., 2010)
- CBASP more effective than MBCT for treating Chronic Depression (Schramm, et al., 2015)
Theoretical foundations of CBASP

- Operant psychology of B.F. Skinner (1953, 1968)
- Respondent conditioning of I. Pavlov (1929)
- Theory of Mind (TOM) literature
- Neuropsychotherapy of Walter, Schnell
Childhood Trauma Histories in PD
(Swann, et al. 2015)

What proportion of patients present with histories of childhood adversity? (N = 74)

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
Persistent Depression

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)
- learns to “survive” not to thrive (quality of life is low)
- interpersonally detached & withdrawn (H-S)
Role of 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
Etiology of the Early-onset Chronic Depressive Patient

Psychological Insults & Trauma = Interpersonal avoidance

Perceived Disconnection from Environment = Chronic orbit of “sameness”
Chronic Depression

- Interpersonal interactions with therapist
  - Submissive
  - Hostile
- Behavioral deficits
  - Lack of approach or assertive behaviors
  - Minimal perceived functionality
  - Learned 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)

***[Dep] PATIENT ↔ ENVIRONMENT (one-way)
CBASP: Acquisition Learning Model of Psychotherapy

Assumptions:
(1) If the patient learns the tasks of therapy, he/she will overthrow their psychopathology;
(2) Interpersonal fear (Pavlov) and interpersonal avoidance (Skinner) are the core issues that therapy must address. The acquired learning in CBASP addresses these two issues;
(3) Where there is interpersonal avoidance, interpersonal fear is driving the interpersonal avoidance (Bouton, 2007).

CBASP: Is an interpersonal model of psychotherapy based on an interpersonal causal determinant model of behavior.

\[ B = f \left[ \text{Person} \times \text{Environment: Therapist & Others} \right] \]
We have descriptive data on the characteristic interpersonal values and self-efficacy of 102 depressed individuals.
Chronic depression is associated with a lack of interpersonal agency

- Place more importance on avoiding conflict, disapproval, and social humiliation,
- Lack confidence that they can be expressive, assertive, or aggressive, even in situations that require a forceful response, and
- Experience more problems associated with being too socially meek, inhibited, and accommodating (more pronounced for women).
- Patients who reported the lowest levels of interpersonal agency (with respect to values, self-efficacy or problems) also reported the highest levels of depression.
Overall conclusions

• Support the findings outlined by McCullough (2000) that chronically depressed patients have “A submissive style of interacting that makes it difficult for clinicians to avoid assuming a dominant role”

• These patients appear to value submission, lack self-efficacy for self-assertion but not for avoiding conflict and thus report problems with being too inhibited, submissive and exploitable.
Hypotheses I (Basic Study)
Continuous update of predictive models of social partners, enables affective self-regulation through prediction of their affective reactions

Hypotheses II (Clinical Trial CBASP vs Escitalopram)
Update of predictive models of others (TOM) is impaired in chronic depression
Evidence for preoperational processing mode in CD?

**Instruction**

<table>
<thead>
<tr>
<th>perspective</th>
<th>Self</th>
<th>other</th>
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| visuospatial | Change in the number of living beings?  
\(-/0/+\)  
1st Person Perspective (yours) | Change in the number of living beings?  
\(-/0/+\)  
3rd person Perspective (the protagonists’) |
| affective    | Change of affective state  
\(-/0/+\)  
\(-/0/+\)  
1st Person perspective (yours) | Change of affective state  
\(-/0/+\)  
3rd person Perspective (the protagonists’) |

8.5 sec

- 2x2 condition experiment on social cognition.
- Varying participants perspective and focus of cognition while perceiving the cartoon stories.

Selective Dysfunction of cognition about affective states of others in CD

Schnell et al. 2011
Evidence for preoperational processing mode in CD

Behavior: reaction times

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<tr>
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<th>CD</th>
<th>Cont</th>
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<tbody>
<tr>
<td>3rdPP Aff</td>
<td>4.2 ± 1.3</td>
<td>3.1 ± 1.0</td>
</tr>
<tr>
<td>3rdPP Vis</td>
<td>3.8 ± 1.2</td>
<td>3.5 ± 0.8</td>
</tr>
<tr>
<td>1stPP Aff</td>
<td>4.0 ± 1.1</td>
<td>3.3 ± 0.9</td>
</tr>
<tr>
<td>1stPP Vis</td>
<td>3.7 ± 1.0</td>
<td>3.2 ± 0.8</td>
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Brain function in CD Patients: lower differential activation of social cognition (ToM) network during cognition about affective states of others!

Behavior: In CD Patients response time (RT) is selectively increased for cognition about affective states!

Cont > CD

26 CD (14 fem., M 41.7 ± 7) vs 26 cont (14 fem., M 38.2 ± 2)

Schnell et al. 2011
Overall conclusions

Chronically depressed patients have impaired perceived functionality (can see it in brain)

CBASP increases perceived functionality and there are corresponding changes in brain
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 Personal 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.)
Key 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 “Causal Theory Conclusions” & “transference hypotheses”
• Use of Interpersonal Discrimination Exercises (IDE) based upon this information throughout the therapy
The Interpersonal Circumplex

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
The Interpersonal Circumplex

- Assert (PA)
- Connect + Assert (NO)
- Assert + Separate (BC)
- Separate (DE)
- Separate + Submit (FG)
- Submit (HI)
- Submit + Connect (JK)
- Communal
- Uncommunal
- Agentic
- Unagentic
Persistently Depressed
Situational Analysis: Exacerbation and Resolution of Psychopathology

• Mainstay of CBASP – administered at each session beginning after Significant Other History

• Multi-step, social problem solving procedure that is operationalized in the Coping Survey Questionnaire
COPING SURVEY QUESTIONNAIRE (CSQ) (Situational Analysis)


**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.”
Steps of Elicitation Phase (cont)

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?”

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

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 (cont)

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

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*
Situational Analysis Practice

Break into small groups

Role play situational analysis with one playing the therapist and another playing the patient and one recording information

You can use patient scenarios or one from your real life
DPI: Techniques

1. Interpersonal Discrimination Exercise (IDE)

2. Contingent Personal Responsivity (CPR)
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
Ethics of Disciplined Personal Involvement (DPI)

Difference between **objective** and **subjective** counter transference:

Objective is in the room with the patient (your reactions in the moment with that person in that situation). Subjective is what you bring in with you to the room (your own “baggage”). You must know yourself!

Must ask yourself, am I doing this for *my* benefit or the benefit of the patient.

DPI must always be for a reason to teach the patient something useful.
DPI in the hands of an inexperienced or hostile person can be dangerous and used in unethical ways to do harm to the patient.

This is why Dr. McCullough insists upon therapists doing their own SOH and understanding their own transference hypotheses prior to administering CBASP to patients.
What changes? What leads to improvement?

- Felt emotional safety
- Approach/assertive interpersonal behaviors
- Interpersonal problem solving/Perceived functionality

(Hirschfeld, et al., 2002)?
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
Neuropsychotherapy: conceptual, empirical and neuroethical issues

Henrik Walter · Mathias Berger · Knut Schnell

**Table 1** Neuropsychotherapy as a research field

<table>
<thead>
<tr>
<th>(i)</th>
<th>Identify neural mediators and targets of psychotherapeutic interventions</th>
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<tr>
<td>(ii)</td>
<td>Determine new therapeutic routes using neurotechnology</td>
</tr>
<tr>
<td>(iii)</td>
<td>Design psychotherapeutic interventions on the basis of neuroscientific knowledge</td>
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</table>
CBASP: Group and Co-morbidities

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

1. CBASP is comprised of 3 components: significant other history, situational analysis and disciplined personal involvement
2. CBASP is effective in reducing depressive symptoms in persons with persistent depression and is especially effective in people with childhood trauma histories
3. Each component of CBASP has a theory based rationale and is meant to facilitate the patient’s focused mindful attention in order to utilize exercises in and out of session which help promote perceived functionality and felt emotional safety and change interpersonal "stance"
4. Increased social functioning, namely increased agentic perceived behaviors are associated with improvement & hypothesized to be an effective ingredient of CBASP
CBASP BOOKS


Cognitive Behavioral Analysis System of Psychotherapy (CBASP)

Websites for additional information:

www.CBASP.org

www.CBASPSociety.org

Thank you to the International CBASP Society and Dr. James P. McCullough, Jr.

&

Thank you for your attention!