CBASP

COGNITIVE BEHAVIORAL ANALYSIS SYSTEM OF PSYCHOTHERAPY (CBASP)

The Techniques and Tools of CBASP

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Stages of CBASP for PDD

Assessment
• Therapist conducts a clinical or diagnostic assessment to determine presence of PDD and other symptoms or diagnoses, with focus on clinical course over time. • Severity of depression is assessed, as is suitability for CBASP. • If patient is deemed suitable for CBASP, the therapist socializes the patient to CBASP and provides the Patient Manual for CBASP (McCullough, Jr. 2003). • Patient is asked to generate a list of significant individuals who played a decisive and influential role in their life and to bring it for the next session. This list should be fairly short with about 3-5 individuals listed. The patient is encouraged only to write down the names and not to think too hard about this exercise.
Initial Sessions
• Therapist reviews patient manual with patient and answers additional questions about CBASP. • Therapist describes the rationale for the SOH and elicits the Significant Other History SOH from the list provided by the patient. Therapist formulates the causal theory conclusions from the SOH with the patient and also develops the transference hypothesis, which may or may not be shared with the patient. • Therapist assesses the interpersonal impact of patient upon the therapist via Impact Message Inventory or similar tool.
Middle Sessions
• Impact message inventory is reviewed by therapist to help inform therapist of the patient's interpersonal "stimulus value" in order to help define therapist interpersonal role with patient and potential interpersonal "hot spots." • Therapist orients the patient to the mainstay of CBASP – the Situational Analysis (SA) of the Coping Survey Questionnaire. • Therapist conducts elicitation phase and remediation phase of the situational analyses during sessions based on past or future events brought by the patient. • Review and remediation of SAs comprises the majority of time and the active treatment stage of therapy can last from 20 sessions and up. • Patients are encouraged to continue with SA until they begin to formulate and achieve realistic and attainable interpersonal goals on their own, thus achieving "perceived functionality."

• It is recommended that patient be able to eventually successfully complete SAs on their own in session, thus demonstrating learning and transfer of learning.
• Therapist also uses the relationship with the patient to help modify patient behavior using discipline personal involvement tools. • Interpersonal discrimination exercises (IDE) are used to help discriminate hurtful or threatening responses from people in the patient's life from the helpful and supportive responses of the therapist and explore the opportunities these insights afford the patient. • Contingent Personal Responsivity (CPR). Contingent interpersonal reactions from the therapist toward the patient are used to target maladaptive behavior of the patient that interferes with the administration of CBASP. The CPR reaction from the therapist makes explicit the consequences of the patient's behavior on the clinician with the goal to modify the problem behavior of the patient.
• Patient acquisition learning is assessed regarding learning how to do the SA and discrimination learning between hurtful others and the therapist.
Termination/Conclusion of Acute Treatment
• The essential goal of CBASP is for patients to learn to self-administer SA correctly. Performance learning to criterion must be achieved in order to terminate treatment. This is assessed via the Patient Performance Rating Form (PPRF). Assessed symptoms and functioning (presumably mediated by above learning) should be significantly improved and ideally patient should be treated to remission prior to termination.
Maintenance
• Continuation of treatment with scheduled "booster sessions" at longer intervals or as needed is recommended to help maintain gains and prevent relapse. This is again solidly based on learning theory and the idea that relapses occur when learning is not maintained and the patient reverts to old patterns of behavior.

CBASP Significant Other History (SOH): Guide for Elicitation

Step 1:

Request a list of five-six Significant Others who have played a major role and had a significant influence upon the direction the patient's life has taken or who has shaped the individual to be who they are. The influences may be either positive or negative.

Step 2:

Go through the list in the order that the individuals were listed. If the list is too lengthy (i.e. greater than 6-7), ask the patient to pick the most influential 5 individuals.

Step 3:

Begin with this question: What was it like growing up or being around this person? Let the patient recall several memories, situations, or stories. Then, go to one of the prompts below and say:

Prompt 1. Tell me how this person has influenced you to be the kind of person you are now.

or

Prompt 2. How has growing up with/around this person influenced the direction your life has taken – What is the direction?

or

Prompt 3. What kind of a person are you as a result of living around this person? How has this person left a "stamp" on you and what is it?

Step 4:

The goal of this step is to have the patient formulate one *Causal Theory Conclusion* for each Significant Other. The *Conclusion* should represent the "stamp" or "legacy" that the patient feels the Significant Other has been left on him or her that influenced the patient to be who he or she is now. This will take the form of a causal statement such as, "Because my father treated me with contempt and anger and was physically abusive, I learned that men will hurt me." or "Growing up with a mother who told me she never wanted me and ignored my needs, I learned that others are not there for me."

Note: *This is a Piagetian mismatching exercise meaning that the therapist asks the preoperational patient to think and function on an abstract level here – that is, take a step back and think about the influence the Significant Other (SO) has had on the patient.*

CBASP Transference Hypothesis Construction

PURPOSE: Transference Hypothesis generation seeks to pinpoint the prominent trauma domain that results in anxiety/fear/pain for the patient. The Hypothesis content is utilized throughout treatment through the implementation of the Interpersonal Discrimination Exercise *(IDE)*. The goal of the IDE is to modify the refractory trauma emotions by teaching patients to discriminate emotionally between the relationship with the psychotherapist and relationships with malevolent Significant Others who've hurt the individual. The underlying rationale for targeting a transference hypothesis is based on a transfer of learning assumption: patients will transfer to the person of the therapist the interpersonal expectancies (both positive and negative) acquired from earlier learning with important persons in their life.

There are four modal therapist-patient experiences in psychotherapy that are used as potential target domains for transference hypothesis construction. These are the following:

- relational *intimacy* between patient and therapist
- patient **disclosure** of highly private material-content
- patient **mistakes** in the dyadic relationship during the process of treatment
- **feeling or expressing negative emotions** either toward the therapist or in the presence of the clinician.

Examples:

Intimacy: *"If I get emotionally close to Dr. Penberthy then she will hurt me."*

Disclosure of Need: *"If I disclose personal matters or needs to Dr. Penberthy, then she will use it against me and humiliate me."*

Making Mistakes: *"If I make a mistake while working with Dr. Penberthy, then she will berate and reject me."*

Expression of Negative Affect: *"If I experience negative feelings toward or while with Dr. Penberthy, then she will punish me or abandon me."*

CAVEAT: *Therapists are encouraged to formulate only ONE Transference Hypothesis. The major reason is to insure that thorough coverage of the one trauma domain is achieved over the therapy process. If more than one hypothesis is constructed, our experience has been that coverage becomes compromised or else, very little work in Situational Analysis is completed as patients and therapists remain excessively focused on the interpersonal involvement arena.*

Cognitive Behavioral Analysis System of Psychotherapy
Case Formulation Worksheet

Patient:
Presenting or Key Problems of Living:
(Brief description with an order in terms of priority or importance/impact)

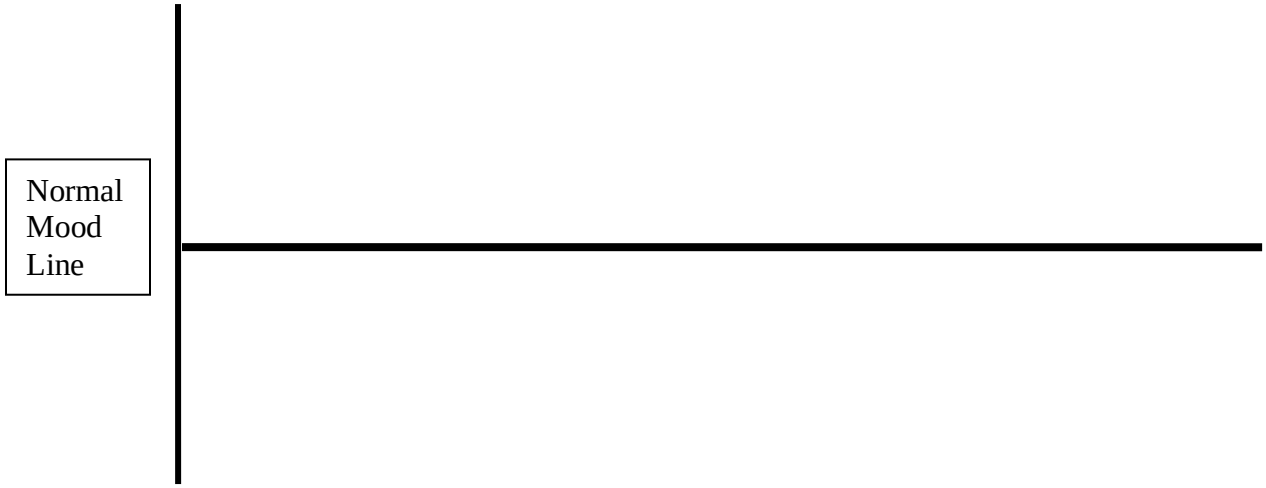
1.

2.

3.

4.

Clinical Course Profile:



From information developed from the timeline you should sketch out the clinical course profile that best captures the course of the patient's experience of depression. Start at the left with age of onset and write estimations of duration for each phase of the pattern derived. You can annotate dates or other important information. You can also note onset and events (remission, relapse, etc.) below:

Age of Onset:	Trigger/timing of Event 1	Trigger/timing of Event 2	Trigger/timing of Event 3	Trigger/timing of Event 4

Significant Other History:

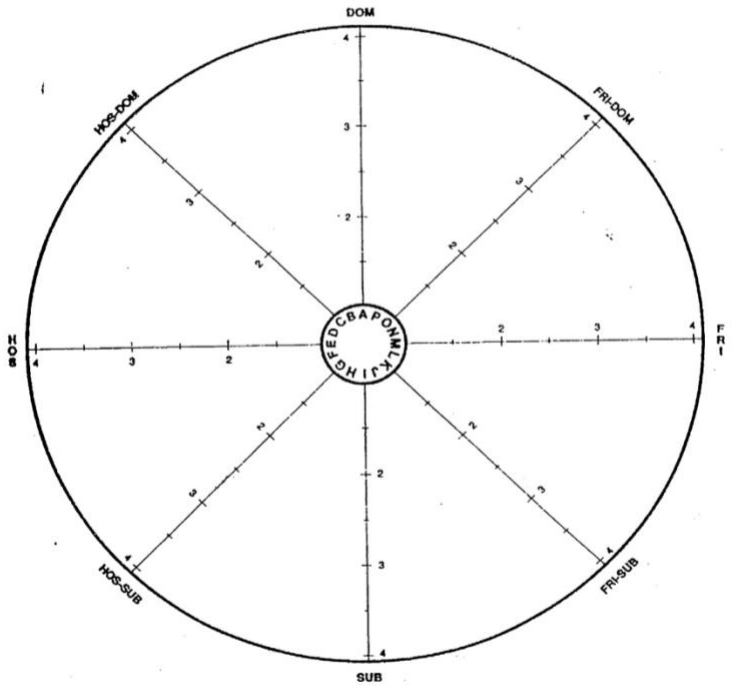
Significant Other	Causal Theory Conclusion (Stamp)

Transference Hypothesis:

Domain	Transference Hypothesis
Intimacy	
Making mistakes	
Expressing negative affect	
Expressing needs	

Ideally, try to construct one transference hypothesis (TH) as it may apply to the relationship between the therapist and the patient. Clinical experience suggests this is often difficult. Therefore, it is legitimate to have more than one TH but endeavor to target the primary one.

Impact Message Inventory: The therapist completes the IMI based on interpersonal reactions to the patient and graphs the scores on the circumplex to help inform the relationship with the patient.



Patient's actual Stimulus Value (peaks on IMI)	Description of actual problematic behavior in the interpersonal environment	Potential Interpersonal response/consequence with the therapist	Potential Interpersonal response/consequence outside therapy

Treatment Plan:

- Assessment (including timeline, significant other history, transference hypothesis and impact message inventory)
- Introduction to Situational Analysis
- Situational analysis of distressing interpersonal events – one slice of time each session
- Optional – skills training (what is the one thing to add to your repertoire?)

Summary: This is written to the patient and is a summary of the patient's background, assessment outcomes, and treatment plan, as well as possible difficulties, related to his or her stimulus value and current behavioral repertoire.

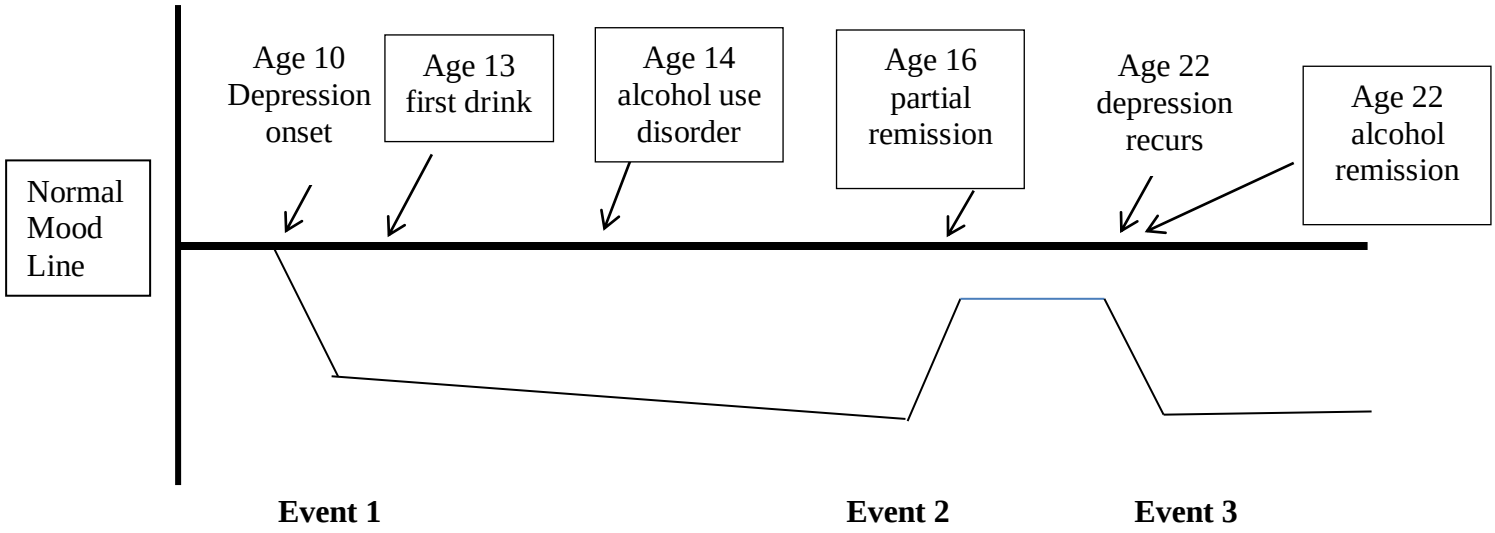
CBASP Formulation Example

Patient: Allison D.

Presenting or Key Problems of Living:

1. Depressed affect, low mood, avoidant, lethargy
2. Estranged from family and loved ones
3. Unemployed

Clinical Course Profile with Timeline Onset/Remission/Relapse:



Clinical course of depressive symptoms as well as symptoms of co-occurring disorders are charted on the timeline. Substance use data is captured in the boxes above to distinguish it from depressive symptoms. Start at the left with age of onset and underpin with estimations of duration for each phase of the pattern derived. You can annotate dates or other important information that best serves your purpose. You can also note below:

Age of Onset of diagnosed disorder:	**Trigger/timing of Event 1: Onset of disorder**	**Trigger/timing of Event 2: Remission of disorder**	**Trigger/timing of Event 3: Relapse of disorder**
Depression: 10 years old	Death of mother	Patient moved in with grandparents	Death of grandparents
Alcohol use disorder: 14 years old	Father introduces alcohol	Grandparents placed father in treatment for alcoholism	Patient leaves grandparents home

Significant Other History:

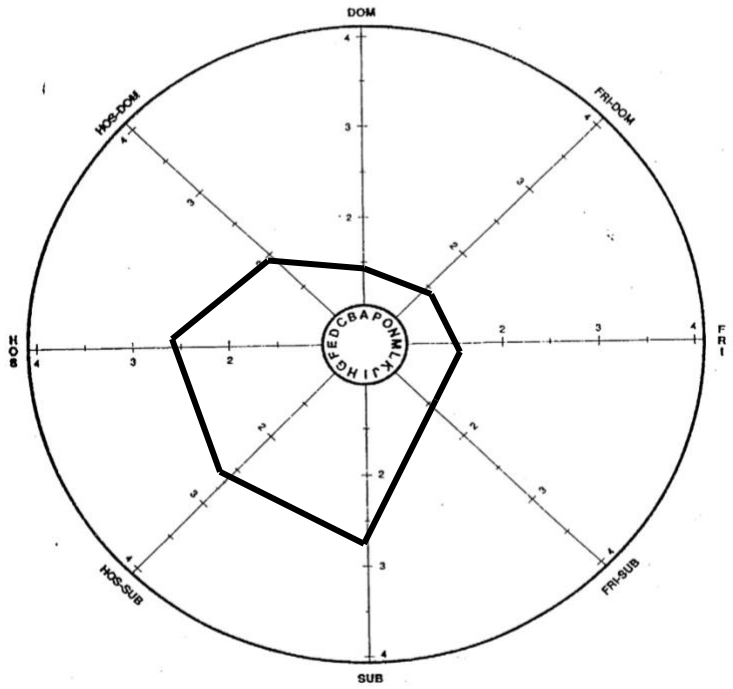
Significant Other	Causal Theory Conclusion (Stamp)
Mother	"Positive relationships don't last."
Father	"Men are dangerous and confusing, I can't trust them."
Grandparents	"Good people can only do so much, and they don't last."
Friend	"Getting close to people only leads to disappointment and pain."

Transference Hypothesis:

Ideally, try to construct one transference hypothesis (TH) as it may apply to the relationship between the therapist and the patient.

Domain	Transference Hypothesis
Intimacy	"If I get close to Dr. Penberthy, she will leave me or hurt me."
Making mistakes	
Expressing negative affect	
Expressing needs	

Impact Message Inventory:



The therapist completes the IMI based on interpersonal reactions to the patient and graphs the scores on the circumplex to help inform the relationship with the patient.

Patient's actual Stimulus Value (peaks on IMI)	**Description of actual problematic behavior in the interpersonal environment**	**Potential Interpersonal response/consequence with the therapist**	**Potential Interpersonal response/consequence outside therapy**
Hostile	- Avoiding people or being short with people, not looking them in the eye	→ Therapist feels distant from Allison and pulled to be hostile in return	→ people respond in a hostile way and stay away from Allison or ignore her
Hostile-submissive	- Expressing strong negative feelings and hopelessness to others repeatedly	→ Therapist wants to help, but finds Allison hard to approach, so wants to take charge of the session	→ people cannot get close to Allison and tell her what they think she should do or get fed up and withdraw from her
Submissive	- Going along with what other people suggest. Allison does not voice her needs or preferences	→ Therapist takes control when Allison can't make up her mind about what to do or talk about	→ others don't see what Allison wants, assume she is happy to do go along

CBASP Situational Analysis

Elicitation Phase

Step One:

Tell me what happened in the situation. Just who said/did what and then describe clearly how the situation ended (endpoint). Remember to give a beginning, middle and end.

Step Two:

Tell me what the situation meant to you or how you "read it." Think back over the event – what sense do you make out of it going from the beginning to the end. Give me one sentence for each interpretation. After one interpretation: "Did it mean anything else to you?"

Step Three:

Think about what you DID in the situation - how you behaved. What stands out as you think back on it? What did you do? How did you look and act?

Step Four:

Tell me how the situation came out for you. What was the *Actual Outcome*? Give me one sentence that describes the outcome and that an observer could see.

Step Five:

Think about the outcome. How would you have liked the situation to have come out for you? We call this the *Desired Outcome*. Say it in one sentence and again, state it in a way that an observer could see [*Keep the DO "in the patient's court,"* not *in the Environment*]. This needs to be something that you can do – needs to be realistic and attainable.

Step Six:

Now think about the Actual Outcome and the Desired Outcome. Did you get what you wanted here? Did the AO = the DO? YES or NO

Step Seven: Why did you/didn't you obtain the Desired Outcome?

Remediation Phase

If you have determined that the DO is not realistic (the patient cannot produce it) or not attainable (the environment cannot produce it), then the DO will need to be revised.

This can be done by asking the patient if they think that the DO is realistically achievable and working with them in a motivational interviewing, collaborative style, to help them ascertain that it may not be if it is deemed something that they cannot produce or that the environment cannot produce. Try to let them come to this determination – they may struggle, but it will mean more if they determine that the goal they have is not feasible and they work to modify it with you.

Once it is established that the DO is not realistic or attainable, work with the patient to establish one that is. This can be done by asking "what do you think is a realistic goal in this situation, but not the AO?" or "What might be a first step towards what you want?"

When a realistic, attainable goal is set, then you can proceed to remediation. You may wish to briefly review the situation again, especially if the elicitation phase has been long and complicated. Use the patient's words and terminology and check with the patient that you have it right. When this is completed, proceed with …

"Now, let's go back into the situation and see what you might have changed to get what you wanted. The first thing we'll look at is the way you interpreted the event."

Step One:

a) In your first interpretation, you said…….Is this interpretation grounded in the event? That is, is it based on the present event or is it based on the past or future? (it is a *relevant interpretation*);

   Do you feel that the interpretation is an accurate description of the interaction? (I mean, do you think the interpretation accurately describes what is happening between you and the other person, or something that is happening in you: feelings, thoughts, etc.);

   Finally, what does this interpretation contribute toward you getting what you want? How does it help you achieve your desired outcome? (it may or may not; just so it is *relevant* and *accurate*)

   In your second interpretation…… (go through each interpretation, which may follow the timeline of the situation)

Go through each interpretation, revising and eliminating portions of them until you have statements that are relevant, accurate, grounded and help facilitate achievement of a realistic and attainable goal.

If necessary you may need to add interpretations:

b) "You need an *Action Interpretation* – a thought you could say to yourself that would prompt you to take action, to say what you want or don't want, etc., what could that be?"

Step Two:

a) "If you had thought of an *Action Interpretation*, how would your behavior have changed?"

"Had you behaved this way, would you have gotten what you wanted - that is, your Desired Outcome?" – focus on solidifying learning

Step Three:

a) "What have you learned here?" – focus on solidifying learning

Step Four:

a) "Can you think of any other similar situation where what you have learned here can be applied? Tell me about it." – focus on generalization of learning

COPING SURVEY QUESTIONNAIRE (CSQ)

Patient: _____

Therapist: _____

Date of Situational Event: _____

Date of Therapy Session: _____

Instructions: Select one stress 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.

Situational Area: Family_____ Work/School_____ Social_____

1. Describe what happened:

2. How did you interpret what happened:

   a.

   b.

   c.

3. Describe what you did during the situation:

4. Describe how the event came out for you (Actual Outcome):

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

6. RATE: Did you get what you wanted? YES_____ NO_____

7. Why?

COPING SURVEY QUESTIONNAIRE (CSQ)

Patient: _____

Therapist: _____

Date of Situational Event: _____

Date of Therapy Session: _____

Instructions: Select one stress 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.

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1. Describe what happened:

2. How did you interpret what happened:

   a.

   b.

   c.

3. Describe what you did during the situation:

4. Describe how the event came out for you (Actual Outcome):

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

6. RATE: Did you get what you wanted? YES_____ NO_____

7. Why?

EXAMPLE COPING SURVEY QUESTIONNAIRE (CSQ)

Patient: Mary

Therapist: Dr. Smith

Date of Situational Event: June 23, 2005

Date of Therapy Session: June 26, 2005

Instructions: Select one stress 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.

Situational Area: Family_____ Work/School_____ Social__X__

1. Describe what happened:

I went to the office picnic but nobody was speaking to me and I felt embarrassed. I wanted to talk with a man who works in the cubicle next to me, but he walked past me when I started to walk toward him. I went to the bar instead and got a drink. I ended up drinking 5 beers and getting a buzz.

2. How did you interpret what happened:

a. The man doesn't like me (*mind read:* inaccurate, irrelevant)

b. I never get what I want (to talk to the man): (*irrelevant:* not situationally anchored)

**** (*Add Action Interpretation*) Got to ask for what I want!**

3. Describe what you did during the situation:

Did not try to speak with the man, went to the bar and drank instead.

**** (*Add assertive behavior*) I want to go to the man and say hello.**

4. Describe how the event came out for you (*Actual Outcome*):

I drank 5 beers and got a buzz.

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

I wanted to talk with the man at the party.

6. RATE: Did you get what you wanted? YES_____ NO__X_

7. Why? I don't know. I guess I just never get want I want.

EXAMPLE CBASP COPING SURVEY QUESTIONNAIRE

Step 1. Describe what happened:

Leila had asked me two days ago to fix the lawn mower. Today she told me to put it in the shop, and I explained that I had already fixed the mower on Tuesday. I also told her that I had fixed the tank on the toilet. Her comment was that she had seen the toilet repair and that "it wasn't done right." It needed adjusting. I looked at her and said "you fix the toilet the way you want it*." She asked me if she was being too critical and I said, "yes," and walked away (ENDPOINT).*

Step 2. What did the situation mean to you? (How did you <u>read</u> the event?)

a) I told Leila about the lawn mower repair (relevant, accurate).

b) I also told her of the toilet repair (relevant, accurate).

c) Her comment about the "toilet needing adjusting" really angered me and I wanted a drink (relevant, accurate).

****<u>Add an Action Interpretation</u>:** ***Got to tell Leila she hurt my feelings.***

Step 3. Describe what you did in the situation:

Told her what I had done. Then, I told her to adjust the toilet herself and that she was being too critical and walked away.

****<u>Add assertive behavior</u>:** ***Leila, you just hurt my feelings by saying what you did.***

Step 4. Describe how the event came out for you (What was the *Actual Outcome*?)

I told her to adjust the toilet and that she was being too critical, and I was craving alcohol.

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

I wanted a simple "thanks" from her *(NO; take DO out of the Environment and place it in the patient's court)*

****<u>Revise DO</u>:** ***You hurt my feelings by what you just said.***

Step 6. Did you get what you wanted here? Yes _____ NO __X___

Step 7: Why? I don't know.

Administering *Future* Situational Analyses (SA)

Step One: **Formulate a "behavioral" Desired Outcome (something the patient can do: *realistic* DO)**

Step Two: **Elicit the "interpretations/reads" that must be in place to achieve the DO (may need one *Action Read* that can be repeated to oneself)**

Step Three: **Elicit the "behaviors" that must be present to achieve the DO (may have to do some *role playing*)**

Other Concerns:

(1) Don't worry about an Actual Outcome (future event)

(2) Keep the SA simple – not complicated

(3) Review the Future SA at the beginning of the next session

Disciplined Personal Involvement (DPI)

Two Ways Disciplined Personal Involvement Is Used in CBASP

(1) to demonstrate to the patient that his behavior has consequences

(2) to heal refractory trauma emotionality by teaching patients to discriminate between the person of the psychotherapist and malevolent Significant Others.

CBASP's basic motif is to connect the patient perceptually to his/her environment. *Perceived functionality,* a primary goal of treatment, denotes that the patient is able to identify and finally utilize the consequences of his/her behavior in facilitative ways (i.e., consistently obtain his/her Desired Outcomes). Both usages of disciplined personal involvement are firmly grounded on the Person x Environment causal determinant model of behavior: B = f(P x E). The interactional relationship is as Albert Bandura (1977) essentially defines it: a "reciprocal interactive relationship" where the E is changed by P and P is modified by E in an ongoing reciprocal process. We have modified Bandura's optimal reciprocal interactional view in order to treat our primitive patient population of chronic depressives. We are using the P x E behavioral equation in a unilateral way: meaning that the therapist is functioning unilaterally in the early stages of treatment as he or she functions as an E for the patient (and is not being personally changed by the interaction) and the patient is playing the role of the P in the equation.

Ethics of Disciplined Personal Involvement

The "disciplined" component of personal involvement here is realized in that the therapist is aware of the objective impacts (*objective countertransference*: Winnocott, 1949) the patient (P) is evoking in him/her and is NOT reacting the way most people react to the patient in the external social milieu. Instead, he/she is choreographing his/her reactions in a consequation manner to teach patients that they are interpersonally <u>connected</u> with the therapist in an ineluctable way – this procedure communicates over time that "you and I are interpersonally connected and that everything you do affects me and vice versa." As therapy progresses and as the patient achieves increasing degrees of *perceived functionality*, the nature of the relationship in the dyad undergoes a significant change and the relationship approximates the reciprocal two-way type of mature interpersonal relationship Bandura (1977) described.

1. Contingent Personal Responsivity (CPR)

The first way disciplined personal involvement is used in CBASP is in instances where the therapist consequates the behavior of the patient by disclosing personal reactions and feelings produced by the behavior of the patient. Several things happen in this exercise:

(1) the personal reaction must be publicly pinpointed ("I'm getting pessimistic about our work just listening to you tell me that you are wasting your time here.");
(2) the behavior that pulled the reaction must be identified (i.e., "Your continual attempts to persuade me that nothing will help you.");
(3) the patient must be shown explicitly that the effect on the therapist derives from the P x E connection ("Did you realize that what you just did affects how I feel now, what I think, and my reactions toward you right now?)

CPR Goals:

- teach the P x E connection to the patient)
- modify behaviors that are hurtful and which limit the progress of psychotherapy
- transfer the newly acquired interpersonal skills to relationships on the outside.

Most patients, early- and late-onset patients, will benefit from this type of exercise. The therapist functions as *AN ENVIRONMENTAL CONSEQUENCE* for inappropriate in-session patient behavior.

2. Interpersonal Discrimination Exercise (IDE)

The IDE is a Pavlovian emotional retraining exercise. Said another way, it modifies refractory emotions associated with earlier trauma experiences. As noted earlier in the Patient section, Pavlovian fear drives Skinnerian interpersonal avoidance patterns. As long as the patient continues to avoid others, his/her emotions do not change. The perceptual disconnection existing between patient and others (*described by McCullough, 2000, pp. 270-274; 2006, pp. 124-129*) maintained through avoidance perpetuates the dysphoric mood state and the emotions remain refractory to change. To overthrow the avoidance, the IDE directs the attention of the patient to the specific traumatic domains where malevolent Significant Others have hurt them and then assists the patient to discriminate the interpersonal behavior the therapist has just acted out with them while maintaining his/her focus on the same historical event. The interpersonal situational event occurring in the dyad must mirror the earlier trauma situation. For example, where intimacy is experienced between the practitioner and the patient, the salubrious consequences are then compared and contrasted to earlier memories of intimacy with Significant Others where the patient had been hurt. In this way, the patient is reconnected to a situation of "safety" in the present, and now emotional change can occur with the individual experiencing novel feelings of safety.

Basic Assumption of the IDE: *No emotional change is possible until the patient reconnects himself/herself to the original trauma event context and learns to feel emotional reactions other than fear, anxiety or pain. This is the emotion goal of IDE work in CBASP Therapy.*

The exercise, as noted above, is used to HEAL EARLY INTERPERSONAL TRAUMA EMOTIONALITY. In the IDE, the patient's behavior in one interpersonal trauma domain is targeted as well as the reactions of maltreating Significant Other's. In the targeted trauma domain, the Significant Other's responses have usually had pernicious effects and traumatized the patient in serious ways. Then, the therapist *discriminates* himself/herself from the negative significant others by focusing the patient's attention on the differences between the clinician's behaviors in the trauma domain compared explicitly to those of the traumatizing Significant Others.

IDE Goals:

- patient experiences novel ("safety") emotions in the context of the trauma or psychological insults domains that previously led to hurtful consequences and avoidance behavior
- awaken the patient to a new awareness of interpersonal behavioral possibilities with the therapist
- identify facilitative individuals on the outside who will respond in a similar, salubrious fashion
- patient learns to self-administer the IDE without assistance from the clinician.

In summary, *disciplined personal involvement* is used by the therapist to modify patient behavior by the disclosure of personal reactions and feelings the patient has pulled from the therapist (CPR), with the therapists functioning in an interpersonal Skinnerian- consequation role and secondly, through IDE administration with the Pavlovian goal being to modify earlier emotional trauma that resulted in avoidance behavior and replace it with safety feelings that can then be transferred to the external social arena.

CBASP IDE Administration Prompt Guidelines

The CBASP Interpersonal Discrimination Exercise (IDE) step-procedure based on the Transference Hypothesis:

Step One:

The IDE can be administered whenever a patient and therapist transverse or enter a "hot spot" arena (i.e., talk about material or participate in an in-session event that is covered by the Transference Hypothesis).

Step Two:

Therapist administers IDE by asking several questions of the patient:

a] How did your mother, father, sibling, etc., react to you when you said or did the *content* implicated in the Transference Hypothesis (get close, disclose, make a mistake, or express negative affect?).

b] How have I just reacted to you in this similar Transference area?

c] What are the *differences* between their reactions and mine? What is different about *what* you experienced then, and *what* you have just experienced here, with me?

d] What are the interpersonal implications *for you* if I respond differently to you in this situation?

