North Carolina Psychiatric Association
September 27, 2018

CBASP Workshop

Rationale, Techniques and Goals of the CBASP System

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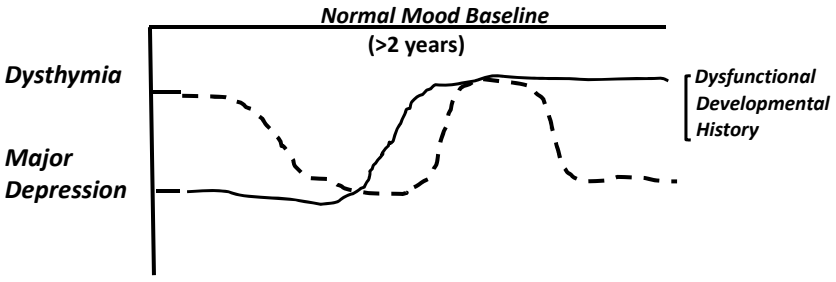
***DSM-5* Persistent Depressive Disorder (PDD)**
Psychopathology

Graphing the Clinical Course



JP McCullough, et al. (2016). Introducing a clinical-course graphing scale for DSM-5 Mood Disorders. *American J of Psychotherapy, 70*, 383-391.

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***DSM-5* Persistent Depressive Disorder**
Psychopathology

Jordan B. Peterson : *12 Rules For Life: An Antidote To Chaos (12 disk set).* Brilliant insights, but "flawed" when it comes to psychopathology assumptions.

***Not everyone can take responsibility for his/her life!**

<u>An assumption you may not be aware of</u>: Early trauma & abuse may produce a cognitive-emotional maturational retardation & train-wreck (adults who function like 4-7 year old children; has nothing to do with IQ).

- **René Spitz: marasmus children [non-responsive]**
- **Jean Piaget: paroxysms [cognitive disorganization]**
- **JP McCullough, Jr.: cognitive-emotive retardation [adult primitive thinking: *preoperational functioning*]**

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***DSM-5* Persistent Depressive Disorder**
Psychopathology

<u>Early-onset Persistent Depressive Disorder</u>

<u>Etiology</u>: Traditional Abuse Constructs

- **Rape**
- **Physical Abuse/Bullying**
- **Parental Abandonment**
- **Sexual Abuse**
- **Emotional Deprivation**
- **Physical Deprivation**

<u>Etiology</u>: Psychological Insults

- **Frequent Negative Comments**
- **Predictive Negative Comments**
- **Emotional Abandonment/Threat of**
- **Accusatory Negative Comments**

→ **Maturational Retardation**

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***DSM-5* Persistent Depressive Disorder**
Psychopathology

Maturational Retardation → **Adult Preoperational Functioning**

(Jean Piaget (1924): *Development of The Child*)

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Dysfunctional Early-onset Histories (Developmental Disruptions)

- **Schramm, et al. (*2011*). *J Affective Disorders***

Patient 1: **Twenty-one year-old female reporting extreme sexual abuse and physically beaten from the age of 5-11 years by a stepfather. She reported that he screamed at her and threw her favorite stuffed animals in the trash can. She can recall him saying to her: "I will be your first sexual partner as soon as you turn 12." The mother never protected the patient from the stepfather.**

Patient 2: **Female (23 years) with severe-to-extreme emotional neglect and abuse coupled with physical and sexual abuse. The mother often took her in a car while she made love to other male friends.**

Patient 3: **Female (34 years) with a history of severe-to-extreme physical and emotional abuse as well as neglect. Patient worked hard on the farm as a young child and was often physically beaten by her father. She described her life in terms of being one in which she had never experienced a "decent" human being.**

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Developmental Disruption (*J Affective Disorders)*

Patient 4: **Female (27 years) who reported severe-to-extreme sexual and emotional abuse and neglect. She began treatment with a significant body odor that was addressed successfully early in treatment. Her mother made it clear that she never wanted her, and she ignored and ridiculed the patient throughout the time she remained at home. The patient also reported a history where her biological father sexually abused her.**

Patient 5: **Male (58 years old). The patient rated moderate emotional and physical abuse. His father was the only loving and stable person he could recall in his life, and the father died when the patient was seven years old. The mother never played with him and no one in the family was allowed to speak about the father or the reason for his death. The patient refused to go to school at age 8 and was subsequently put in a boarding school. He related he was often beaten by his boarding school teacher. He recalled wanting to die at age 11.**

Patient 6: **Male (23years old), moderate-range emotional abuse. Father died while patient was a child and left the family in a "chaotic state." Father was French, mother was Polish and they never adapted to living in Germany. Patient evinced antisocial behavior as a child (e.g., stealing, etc.).**

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Conclusion

All of the above patients were once young children. When developing children are overwhelmed by the dangers of an abusive or neglectful home life, normal growth is thwarted because one's energies and behavior are directed towards surviving the 'hell of the family' and not growth (Drotar & Sturm, 1991; Money, 1992; Money, Annecillo, & Hutchinson, 1985; Vander Molen, 2010). McCullough (2000, 2006) writes that among many adult early-onset patients, maturational stunting of growth or said another way, a failure to mature cognitively and emotionally is often painfully evident in the way the patients talk and behave. Reviewing the ten abbreviated abuse histories makes it easier to understand why early-onset chronically depressed individuals present with a pervasive interpersonal fear of others. As stated above, these fears conjoined with a generalized interpersonal avoidance pattern maintain the preoperational, intra-personal functioning of the chronically depressed adult.

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***DSM-5* Persistent Depressive Disorder**
Psychopathology

Most early-onset chronic adult patients do NOT think or emote the way you do. He or she functions on a level that mimics a very young child: I've described it as a "preoperational adult" whose cognitive-emotive maturational level in the interpersonal arena remains under-developed. These patients' functioning does not reflect a defective IQ (McCullough, 2000, 2006).

Early-onset Chronic Preoperational Functioning Characteristics

- **Pre-logical functioning (we "overestimate" their logical capacity)**
- **Reality is the way it is because "I believe it" – absence of formal/abstractive operational reality testing**
- **Monologue speech (they don't talk with us or with others, they talk at us: Bi-directional speech/empathy is absent)**
- **Ego-centric (all roads leads to the patient) – you don't exist for the patient (in any informing way that could change behavior)**
- **"Global thinker" when it comes to problems (always, everyone, forever, never, nothing, etc.)**

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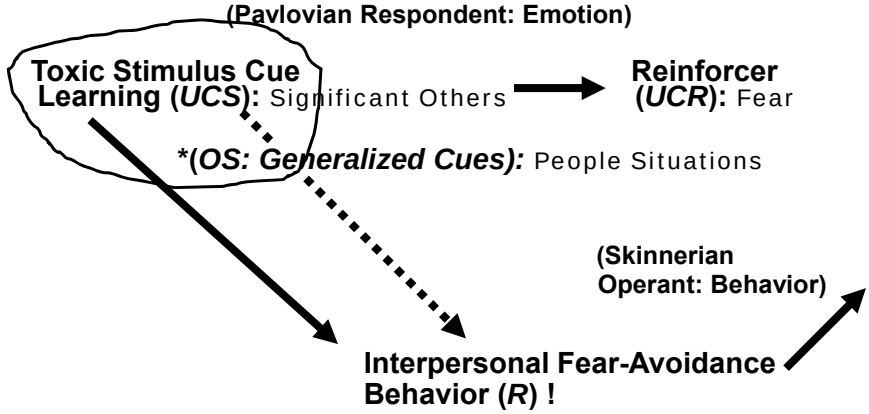
Emotional-Fear Behavioral Dilemma of Preoperational Patient



(Mark E. Bouton, 2007. *Learning and Behavior: A Contemporary Synthesis*)

*OS: Occasion Setters

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What's The Patient Afraid Of?

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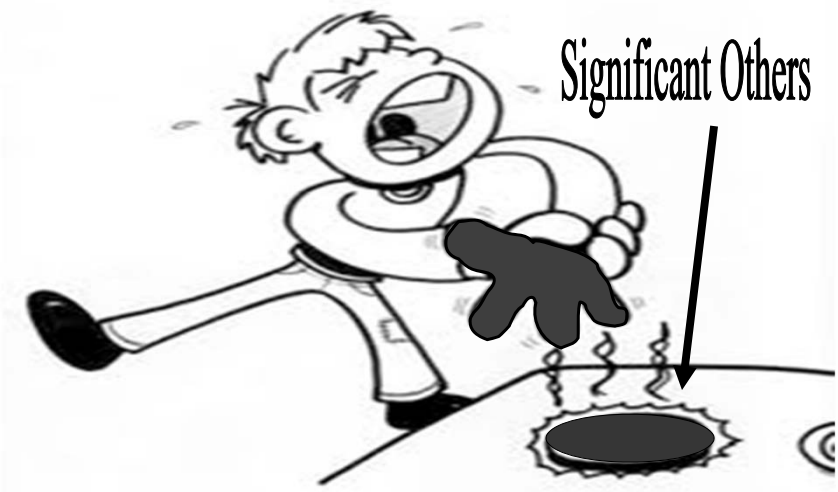
Early Developmental Experiences with Significant Others Produce Pervasive Interpersonal Avoidance!



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INTERPERSONAL POSSIBILITIES AT OUTSET!

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PREOPERATIONAL ADULT PATIENT (AGES 4, 5, 6 YEARS OF AGE)

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Two Types of Chronic Patients & Therapist Strategy

* **The Actively Abused Patient (physically, verbally and/or non-verbally) requires the Therapist to "slow down," "hold back," "tread lightly," and to be aware of the pace of the patient while doing CBASP Work [TH: "If I have a relationship with Dr. Klein, then he will hurt/reject me."]**

* **The Emotionally Deprived or Physically Deprived Patient requires the Therapist to "be more forthcoming," to be more active and to extend oneself more toward the patient while making sure one is walking with the patient. [TH: "If I have a relationship with Dr. Schramm, then whatever I do will not matter to her/she will not care."]**

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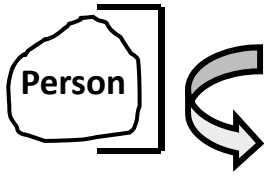
CBASP Goal: Teach the Patient a Pervasive Interpersonal *"Approach"* Style of Living [Goal of CBASP Treatment]

From this (P):



Therapist (one-person functioning)

To this (P x E):

Patient ⟷ **Therapist (two-person functioning)**

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How Is This Achieved in CBASP?

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Successful Discrimination [SOs vs. Therapist]

This is the way It WAS THEN with Significant Others	This is the way it IS NOW with My Therapist:
Fearful	Safe
Unsafe	Helpful
Unchanging	Hopeful
Hopeless	Empowering
Helpless	Interpersonal Approach!
Interpersonal Avoidance!	

Felt Interpersonal Safety Achieved! (Goal I of CBASP)

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DSM-5 **Persistent Depressive Disorder**
Psychopathology

Two Major Goals of Cognitive Behavioral Analysis System of Psychotherapy (CBASP):

I) Creation of Dyadic Safety between Clinician & Patient

II) Perceptual Connection between patient's behavior and consequences (perceived functionality)

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AVAILABLE CBASP BOOKS

1) McCullough, Jr., J.P. (2000).*Treatment for Chronic Depression: CBASP*. New York: Guilford Press.

2) McCullough, Jr., J.P. (2006). *Treating Chronic Depression with Disciplined Personal Involvement: CBASP*. New York: Springer.

3) McCullough, Jr., J.P., Schramm, E. & Penberthy, JK (*2015*). *CBASP as a Distinctive Treatment for Persistent Depressive Disorder: Distinctive Feature Series.* London: Routledge Press.

<www.cbasp.org>

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CBASP WORKSHOP

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Psychological modifications [through CBASP Therapy] may occur in later adult life in the interpersonal arena through (1) the influence of a 'new' attachment figure [Goal I: Disciplined Personal Involvement] combined with (2) the development of formal operational (abstractive) thought [Goal II: Situational Analysis Exercises].

Katherine L. Schaefer-Berg (2004)
Chicago, Illinois

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Situational Analysis (SA): ***Handouts IA & IB***

<u>Rationale & Procedure</u>:

1. **SA teaches patients to recognize the consequences of their behavior [Actual Outcomes or AOs in SA]; this skill is labeled "perceived functionality." It means realizing that *what I do makes a difference!* Goal II of CBASP**
2. **SA teaches patients to focus on situational events - where problems can be solved (and ceasing to think globally)**
3. **SA teaches patients to focus on situational goals: Desired Outcomes (DOs) and recognize the *thinking* and *behavioral strategies* required to achieve the goals.**
4. ***Review Handouts IA & IB***

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Disciplined Personal Involvement (DPI): *Handout II*

Goal: (proactive counter-transference role)

1. Discrimination goals for the patient are the following:

- **a. Recognize Significant Others' responses to patient**
- **b. Recognize Significant Others' emotive-behavioral-cognitive effects on patient**
- **c. Recognize Therapist's responses to patient and the Therapist's emotional-behavioral-cognitive effects on patient**
- **d. Learning to discriminate the Therapist's behavior from that of one's Significant Others; then, generalize the learning**

2. Shaping in "dyadic-interpersonal Felt Safety

3. Review *Handout II*

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Disciplined Personal Involvement Techniques

1. Significant Other History (SOH): *Handout III*

a. Interpersonal-Emotional History designed to make the specific interpersonal effects of Significant Others on the patient *explicit knowledge*.

b. These effects have never been previously and overtly organized in this manner, hence have remained *tacit knowledge* for the patient.

c. Review Procedure for SOH: Handout III

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2.Domains in Transference Hypothesis (TH) Construction: *Handout III*

a. dyadic relationship domain

b. disclosing personal information domain

c. making mistakes domain

d. expressing/feeling negative affect toward therapist domain

3. **Review Procedure for Transference Hypothesis Construct*ion: Handout III***

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4. Interpersonal Discrimination Exercise: *Handout IV*

IDE Exercise designed to enable patients to interpersonally discriminate their Therapist from their maltreating Significant Others. This is CBASP Goal I which is *Felt Dyadic Safety.*

a. Procedure for Administering the Interpersonal Discrimination Exercise (IDE): *Review Handout IV*

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CHECK OUT!

CBASP Website

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CBASP Workshop Training

Brief review of "What I have learned "

- **Structuring the CBASP Sessions**
- **Definition of Discipline Personal Involvement (DPI)**
- **Two Sources Used to Define the CBASP Therapist Role: (1) Significant Other History [SOH]: Transference Hypothesis; (2) Kiesler Impact Message Inventory [IMI]**
- **Major CBASP Techniques: (1) Situational Analysis [SA]; (2) Interpersonal Discrimination Exercise [IDE] Handout V**
- **CBASP Treatment Goals: (1) Dyadic Safety; (2) Perceived Functionality (connecting the patient perceptually to the social environment)**

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