**Cognitive-Behavioral Analysis System of Psychotherapy (CBASP)**

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Abstract

This paper offers a general description of chronic depression and the unique characteristics of its psychopathology in adults. The cognitive behavioral analysis system of psychotherapy (CBASP), an empirically supported treatment, developed specifically to address the functional difficulties of chronic depression, offers several ways to produce success cognitively, emotionally, and behaviorally. The aims of the therapy include guiding patients to improve their cognitive and emotional function to mitigate and improve the consequences of their behaviors; learning new skills and coping mechanisms is part of this process. A description of CBASP core goals, techniques (situational analysis, conditioned personal responsivity, interpersonal discrimination exercises, hot spot identification, etc.), and its overall effectiveness are laid out. CBASP has been examined against medications, alone or in combination, and against other psychotherapies in several studies. Reporting on CBASP’s cultural and spiritual applicability wraps up the paper.

*Keywords:* chronic depression, CBASP, efficacy, intervention, maladaptive behaviors

**Cognitive-Behavioral Analysis System of Psychotherapy (CBASP)**

Chronic depression in its various forms is a disabling disorder with a relatively poor response to treatment (McCullough, 2003a). With ineffective treatment, this disorder can result in severe dispositions for the patients living with it (American Psychiatric Association [APA], 2013). The cognitive behavioral analysis system of psychotherapy (CBASP) is an empirically supported therapy, developed specifically to treat chronic depression in adults, with symptoms lasting periods greater than two years. Developed by McCullough (2000), CBASP has shown effects between 0.5% and 1.5% in the United States annually and maybe more effective when combined with medications (Keller et al., 2000).

**Overview of Chronic Depression**

Chronic depression exhibits high rates of relapse and recurrence, considerable functional impairments, and protracted lifetime courses (APA, 2013). In the literature, four subtypes of chronic depression are distinguished: (1) dysthymia, (2) chronic major depression, (3) recurrent major depression with incomplete remission during episodes, and (4) double depression (APA, 2013; Schramm et al., 2011; McCullough, 2003). Dysthymic disorder is defined as a mild condition that persists for at least 2 years (APA, 2013). A major depressive episode, chronic type, refers to a more severe condition that meets full criteria, with symptoms present for a minimum of 2 subsequent years, as described in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders ([DSM-5]; APA, 2013). Patients who no longer meet full criteria for a major depressive episode but continues to experience significant symptoms for a total duration greater than 2 years are referred to as recurrent major depression with incomplete remission during episodes (Schramm et al., 2011; McCullough, 2003). The superimposition of a major depressive episode on antecedent dysthymia is termed as double depression (Schramm et al., 2011; Keller et al., 2000).

**Early Onset**

When children’s energies and behavior are redirected toward survival and not growth, chronic depressive symptomology results in an early onset diagnosis ([≥ 20 years of age]; McCullough, 2003). Research finds that severe environmental conditions frequently disrupt and retard normal cognitive–emotional development and results in an even more substantial human capital loss compared with late-onset (Schramm et al., 2011; McCullough, 2003). The recalled memories of many early-onset patients include injurious themes and motifs that arise from their early developmental history (McCullough, 2000). When they describe their fears concerning family members, lovers, colleagues, friends, as well as therapists, we find similar core themes: “Others will hurt me if given the opportunity” (McCullough, 2003). Such themes, characterizing both early as well as contemporary interpersonal relationships, strongly suggest a development history of maltreatment (McCullough, 2003).

**Late-onset**

On this chronic course, cases of persistent depression (≤ 21 years of age) suggest that previous normal functioning has been compromised due to heightened emotionality that destroys the individual’s typical representational worldview of reality (McCullough, 2003). The unyielding emotional condition leaves the individual with two conclusions: (1) his/her current state is beyond control and things will never improve (hopelessness); and (2) he/she is powerless to modify this negative state of affairs (helplessness) (McCullough, 2003). These conclusions become all-consuming and undermines the patient’s normal structural view of the world and as their cognitive-emotional deterioration process continues, the patient is unable to consider a future without depression (McCullough, 2003). The individual then lives out the theme, “it no longer matters what I do; I’ll always be depressed” (McCullough, 2003).

**Rationale for Use of CBASP**

The uniqueness of CBASP as a therapy cannot be understood in isolation from consideration of the idiosyncratic psychopathology of chronic depression, when attempting to transform habitual and treatment-resistant patterns of behavior (Swan 2013, 2014; APA, 2006). The chronic patient is difficult to work with, but the efforts are highly rewarding when one begins on the level where patients are currently functioning cognitively, emotionally, and behaviorally. With this in mind, CBASP has been designed to treat specifically these “difficult-to-treat” pathological characteristics of the chronically depressed patient (McCullough, 2003). Examined against medications, alone or in combination and against other psychotherapies, in an increasing number of trials, as the only specific and clinically promising psychological intervention for chronic depression, CBASP focuses on the patient’s dysfunctions and reshapes interpersonal behavior from the preoperational stage to the operational stage (McCullough, 2000, 2006. 2010).

CBASP is an empirically supported therapy that provides aid for a large proportion of patients with chronic depression and is associated with a clinically significant change in 60% of completers (Swan, et al., 2014; McCullough, 2003a). Central to CBASP is to teach patients to become connected with the deleterious and their depressogenic consequences (McCullough, 2003). Its main therapy target is learning to recognize the consequences of one’s behavior on other persons, to develop social problem-solving skills (McCullough, 2003). In CBASP, patients are perceptually connected/re-connected with the interpersonal consequences of their behavior (McCullough, 2006).

To do this, treatment techniques and strategies address derailed affective and motivational regulation by using the therapist-patient interaction such that the therapist role becomes the major vehicle of change through felt security (Sibcy & Knight, 2017; McCullough, 2003a). When implementing CBASP tools, clinicians choreograph a collaborative focus on resolving current problems of living using behavioral analytic procedures (McCullough, 2003a). The therapists deliberately manage transference issues (learned interpersonal expectancies) within the therapeutic relationship (McCullough, 2003a). The way CBASP therapists manage and modify these transference issues and the way they understand and manage their own reactions to the patient’s learned expectancies, make CBASP a unique model when compared to other treatments for depressive disorders (McCullough, 2003).

**Treatment Targets of CBASP**

CBASP follows a highly structured manual approach based on an interpersonal contemporary learning acquisition model (McCullough, 2003a). Once the perception of a functional connection between behavior and consequences is learned, the patient is taught the behavioral skills necessary to bring about more empathically responsive, appropriate interactions in their specific interpersonal setting (Swan 2013, 2014; McCullough, 2001). According to McCullough, such patients do not suffer simply from having excessively pessimistic thoughts but rather from an arrest in their cognitive development that leaves them unable to critically assess and correct their pessimistic assumptions about life. The treatment modifications include directly challenging patients’ unfounded pessimistic assumptions, helping them to make causal connections between more mature thinking and better outcomes, reworking patient’s negative patterns of interaction with family and friends. This process begins with the first session which focuses on the diagnostic interview (McCullough, 2001).

**CBASP Techniques and Strategies**

McCullough, using the Piagetian model of emotional-cognitive development, presents his conceptualization of chronic depression as the product of arrested maturational development, the outcome of emotional deprivation during development that undermines an individual’s sense of efficacy in dealing with the environment. The following techniques and strategies were offered to reduce and eventually eradicate the aforementioned symptomology.

**Significant Other History (SOH)**

During the second session, the clinician administers the Significant Other History

procedure (McCullough, 2000) and, from the obtained information, constructs one or

more transference hypotheses concerning the patient’s postulated interpersonal expectancies. The Significant Other History (SOH) has four main goals designed to provide interpersonal-emotional material originating from relationships the patient has had with approximately five Significant Others (SOs). When administering the SOH, memories concerning each SO are evoked (McCullough et al., 2001). The patient’s SOs are the noteworthy players who have left positive or negative “stamps” on the individual, shaping how the patient behaves and determining what he or she expects in interpersonal relationships (McCullough et al., 2001).

Reviewing these interpersonal-emotional stamps leads to the construction of a Transference Hypothesis ([TH] McCullough, 2000; 2006). The TH, developed in collaboration with the patient, is a predictive hypothesis about how the patient is likely to behave interpersonally in treatment and what the patient is likely to expect interpersonally from the therapist (McCullough, 2006). The TH will be implicated whenever the dyad encounters the interpersonal “hot spot” targeted by the Transference Hypothesis (McCullough, 2006). The TH also functions to inform the clinician how he or she must behave to counter-condition the malevolent behavior of the hurtful SOs (McCullough, 2006). These functional statements generate one or more Causal Theory Conclusions about each significant other. The Causal Theory Conclusions are derived and implemented in session two (McCullough, 2006).

**Situational Analysis**

Situation Analysis (AS) is a significant contrivance to the working phase of each session as it exposes the patient's behavioral deficits (Jehle & McCullough, 2003). Beginning in the third session SA gathers data using the Coping Survey Questionnaire (CSQ) and Therapist Prompts for Administering Situational Analysis (PASA) to obtain information (McCullough, 2000). During the process, the patient is given an overview and rationale of the technique, which unfolds in two phases: the illicitation phase followed by the remediation phase (McCullough, 2000, 2001).

The exercise requires the patient to (1) behaviorally describe one interpersonal event providing specific situational description (2) to construct situational behaviors and interpretations of the event, (3) to describe one’s behavior in the situation, (4) pinpoint an actual situational outcome (consequence) and (5) to state how he or she would have liked the situation to turn out (desired outcome) (Jehle & McCullough, 2002). Then (6) the patient is asked if he or she obtained the desired outcome, and (7) is to ask, why?; “why did you not get the desired outcome?” (Jehle & McCullough, 2002). This is the “transition step” between the elicitation and remediation phases. The essential purpose of SA is to teach patients that they are responsible for the outcomes they report (perceived functionality) and that their interpretations and behaviors contribute specifically to the consequences (Jehle & McCullough, 2002). With this the patient can now grow and develop into the individual they desire themselves to be. To track the process the patient completes at least one CSQ each week (McCullough, 2000).

**Disciplined Personal Involved**

Disciplined personal involvement (DPI) differentiates CBASP from other psychotherapies (McCullough, 2006). This technique begins with the Impact Message Inventory assessment administered by the therapist (McCullough, 2001, 2006) The results from the Impact Message Inventory may reveal the patient’s submissive behaviors and allows the therapist to implement the disciplined personal involved technique to modify those behaviors addressed (Kiesler & Schmidt, 1993). A secondary source of behavioral deficit information comes from observing the in-session behavior of patients (Kiesler & Schmidt, 1993). The results of the primary and secondary sources of data allow for the implementation of DPI. Here the patient encounters the therapist’s direct and systematic replications of acomplementary behavior (McCullough, 2001). By walking with the patient in disciplined personal involvement it decreases the frequency that the patient disengaging when experiencing stress (McCullough, 2001).

The transference hypothesis, developed using the SA, is revisited by the therapist and the patient to create a causal theory using information collected from the significant other history’s four main themes: intimacy/closeness, emotional needs/problems, making mistakes/failure, and negative emotions (McCullough, 2000). With the generation of the client’s causal inferences leading to the transference hypothesis, the therapist can assist the patient in focusing their attention on these differences; helping the patient see their hypothesis are not confirmed (McCullough, 2000). This intervention avoids the pitfalls of doing the work of therapy for patients (McCullough, 2001; McCullough, 2006).

**Interpersonal Discrimination Exercise (IDE)**

Preoperational patients habitually reconstruct therapists into hurtful significant others

from their past (McCullough, 2006). This propensity inhibits behavior modification because, given the learning history of most patients, clinicians are expected to proffer rejection, punishment, abandonment, and/or actual physical/sexual abuse (McCullough, 2006). Viewing the therapists in these unrealistic ways creates hotspots and decreases motivation to change (McCullough, 2006). Left untreated, these perceptual alterations of reality often subvert successful treatment (McCullough, 2006). The Interpersonal Discrimination Exercise (IDE) is designed to correct these interpersonal misinterpretations by the therapist highlighting said hot spots (McCullough, 2006).

With immediacy from the therapist, the client is asked to describe an event or memory when something similar happened with a significant other, and processes with the client how the therapist’s reaction was different than the significant other’s reaction (McCullough, 2006). When patients can understand and discuss these new interpersonal realities, the IDE exercise achieves the desired effect (McCullough, 2006). CBASP therapists want patients to recognize that they are participating in a new interpersonal reality, so the IDE exercise is repeated throughout treatment to maximize patient’s self-efficacy (McCullough, 2006).

**Behavioral Skill Training/Rehearsal (BST/R) & Conditioned Personal Responsivity (CPR)**

Behavioral Skill Training/Rehearsal (BST/R) is a type of assertion training and

Practice (McCullough, 2003a). With this training and rehearsal process, the patient learns to inhibit reflexive hostile reactions and, instead of reacting impulsively, to wait to see how the situation unfolds and then to react with less effect (McCullough, 2003a). BST/R practice takes many forms, and with various training, techniques to help patients learn to govern their out-of-control emotional outbursts in and outside of the therapy sessions (McCullough, 2003a). The Conditioned Personal Responsivity(CPR), 4-step technique, may be used here to present the problem in a contingent/consequating manner. While this is a standard CBASP technique, strategies of this training are always tailored to a patient’s particular needs to help them manage the interpersonal challenges encountered daily (McCullough, 2003a)

**Felt Safety**

Through a “circularity” loop the patient keeps a wall of interpersonal fear and establishes a zone of felt safety (Sibcy & Knight, 2017; McCullough, et al., 2011). By breaking through the wall intra-personal functioning can be counter-conditioned with dyadic reciprocity for the patient to experience a sense of safety (McCullough, et al., 2010). The chronically depressed patient must learn to experience felt safety with the clinician as a way to deactivate the system of attachment behaviors (Sibcy & Knight, 2017).Successfully establishing interpersonal safety prepares the way for the patient to master the next step, which is, learning to function interpersonally and to generate empathy, which are important steps to acquire before patients can break out of their refractory wira-personal isolation (McCullough, 2011).

**Empirical Support for CBASP**

CBASP has fulfilled the criteri for empirically supported treatments outlined by Chambless and Hollon (1998), thus it is described as efficacious (Negt et al., 2016; McCullough, 2011). CBASP is held by at least two randomized controlled trials (RCT) of sufficient size and quality, which demonstrated superiority to waiting list control conditions, or treatment‐as‐usual (TAU), or equal effects to empirically established treatments. Additional evidence supports CBASP and its method in a single case series (Negt et al., 2016; McCullough, 2011).

**CBASP Compared to Other Psychotherapies**

A robust randomized national study in 12 sites with 681 chronically depressed outpatients found that the system was as effective as pharmacotherapy (Keller et al., 2000). Combining it with drug therapy was more effective than either treatment on its own (Keller et al., 2000). This was the first conclusive evidence that combination therapy is more effective than using either pharmacotherapy or psychotherapy alone in treating chronic depression (Arnow & Constantino, 2003). Keller et al., 2000). CBASP was also demonstrated to have prophylactic effects for up to one year with a survival rate approximating 89% (Klein, et al., 2004).

When compared to other psychotherapies CBASP consistently shows superiority when treating early-onset chronic depression however, the primary outcomes are not significant and suggest that chronically depressed patients may need extended treatment courses (Schramm et al., 2011). A study comparing CBASP and Interpersonal Psychotherapy (IPT) found significantly higher remission rates in the CBASP (57.1%) as compared to the IPT (20%) group, however, when looking at the intent-to-treat (ITT) analyses of covariance (ANCOVA) revealed that there was no significant difference in using the posttreatment Hamilton Rating Scale for Depression (HRSD) scores between the CBASP and the IPT condition, but in self-rated Beck Depression Inventory (BDI) scores (Schramm et al., 2011). The study showed participants’ self-reported depression symptoms decreased in the CBASP group (pre-treatment *M* = 25.43, post-treatment *M* = 10.79) compared to the IPT group (pre-treatment *M* = 28.47, post-treatment *M* = 21.27) (*p* = 0.47, Cohen’s *d* = .87) (Schramm et al., 2011).

In a group modality of CBASP consisting of two individual and eight group sessions revealed clear advantages over TAU (Morris, 2002). One factor might be that a group setting facilitates interpersonal learning, which is an important part of CBASP (Morris, 2002). Even though CBASP was adapted to the general format of mindfulness-based cognitive therapy (MBCT) (8 group sessions of 2.5 h) in this study, it showed greater benefits (Myers, 2001). Compared to the REVAMP trial (12 sessions) (Kocsis et al. 2009), the positive results observed among the other CBASP studies (Keller et al. 2000; Schramm et al. 2011a, 2015; Wiersma et al. 2014) were accompanied by higher dosages of the intervention (16–25 sessions). Respectively, the dosage or duration of treatment might be a crucial factor in CBASP (Klein et al., 2004).

Confirmed in a noncontrolled study, high dosages of CBASP proved to be efficacious in an inpatient setting resulting in high response and remission rates (Brakemeier et al. 2015). This study was a non-controlled trial of CBASP with participants with treatment-resistant CD (*N* = 70) after inpatient hospitalization. According to the study’s analysis, 75% of participants experience symptom reduction by at least 50% on the HAMD. With 40% of participants were in remission, their results on the HAMD were less than or equal to 10 (Cohen’s *d* = 2.5). At the scheduled follow-up, at the six months mark and again at one-year, the participants’ responses indicated that 75% of treatment participants sustain deterioration of symptoms achieved during the active treatment (Brakemeier et al. 2015).

Wiersma and colleagues (2014) conducted a robust study comparing the efficacy of CBASP to cognitive-behavioral therapy, interpersonal psychotherapy, psychoanalytic supportive therapy, and supportive/structured therapy, calling these treatments to care as usual (CAU). During a year, participants (*N* = 139) with CD show improvement moving from the severe depression range to mild depression range after 52 weeks of the CBASP at approximately 23 (45-minutes) individual sessions. However, the other psychotherapies, also seeing a shift from the severe depression range baseline, more effectiveness reduced participant symptomology into the moderate range. It is important to note there were no significant differences between the CBASP and CAU groups in participants’ response or remission.

Here again, the results obtained by Wiersma et al. indicated clear advantages of CBASP over other evidence‐based treatments particularly in the longer run (Wiersma et al. 2014). This study followed the results of Cuijpers et al., which demonstrated that approximately 18 treatment sessions are required to achieve favorable results in chronically depressed patients (Cuijpers et al. 2010a).

**Conclusion**

In summary, the CD has debilitating effects and an estimated lifetime prevalence from 3% to 6%. To treat this disorder, CBASP highly structured psychotherapy was created specifically to integrate behavioral, cognitive, and interpersonal strategies to help the patient recognize the consequences of their behavior. Other goals of CBASP include the transferal of social problem-solving strategies to daily living, the interpersonal healing of earlier trauma, and generating authentic empathy. CBASP is adaptable to most-all multicultural settings and groups. Additionally, CBASP is well integrated with clients of varying religious or spiritual (S/R) beliefs. CBASP presents evidence of closure and healing to different relationship levels by using the spiritual intervention of mindfulness and other techniques (McCullough, 1999; Worthington & Sandage, 2001). CBASP’s entire conceptual framework can be seamlessly integrated with the Christian worldview, however, it is interpreted around the world, through using several of the Bibliotherapy interventions (scripture reading, forgiveness, and prayer). Evidence suggests incorporating the work of CBASP when working with S/R patients is as equally effective (Sperry, 2007). Overall, the CBASP treatment model applies to a wide array of clinical problems and is an important achievement in psychotherapy.

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