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## CBASP, the Third Wave and the treatment of chronic depression

### ABSTRACT

First, we present the generation of the so-called third wave of behavioral therapies from its precursors and work out both similar and discriminating features, showing that in contrast to its precursor models the third wave has no theoretical center of gravity and thus also reflects post-modern trends. The second part describes the CBASP approach in which a characteristic feature is added to the third wave the interpersonal concept of mental disorders. The practical therapeutic procedure is described in detail by means of a case study.

**Key words:** third wave, CBASP, chronic depression, interpersonal environment, history of development

### Part One

#### *The First, Second & Third Behavior Therapy Generations*

*BF Skinner and J Wolpe and the First Wave.* As O'DONOHUE (1998) and FRANKS (1964) made clear, first-generation behavior therapy emerged from the psychological learning laboratory. Transferring what was derived in the laboratory to the treatment of aberrant behavior and using learning theory to guide treatment decisions characterized the first-generation wave. There were two main branches in the first wave: (1) the Skinnerian branch (1938, 1968, 1953) emphasized the rate of response of some target behavior and identified the contingencies maintaining the target response. Extinguishing the target through the withdrawal of the maintaining stimuli and reinforcing competing behavior became a major treatment strategy among operant clinicians. The research and clinical practice of JOSEPH WOLPE (1958; O'DONOHUE, 1998; O'DONOHUE & KRASNER, 1995; ULLMANN & KRASNER, 1965) represented the second branch. His landmark text, *Psychotherapy by Reciprocal Inhibition*, published in 1958 described three organismic processes that bring about permanent change: *maturation, lesions in the physiological system, and learning*. Wolpe's research focused on the *learning* process. He'd been influenced by the experimental neurosis literature and studies of PAVLOV (1927/1960)

and MASSERMAN (1943), LIDDELL (1944), MAIER (1949), WATSON AND RAYNOR (1920), as well as the learning theory of CLARK HULL (1943). WOLPE summarized his methodology as follows: "If a response inhibiting anxiety can be made to occur in the presence of anxiety-evoking stimuli, it will weaken the bond between these stimuli and the anxiety" (1973, p. 17). His systematic desensitization technique (WOLPE, 1973), based on this counter-conditioning paradigm, became a prominent treatment for phobias as well as for other anxiety disorders.

The first wave of behavior therapy had four lasting effects on subsequent behavior therapy generations: (1) it transferred the methods of the psychological learning laboratory into the therapy room informing the way the techniques were conceptualized and administered; (2) it focused attention on patient learning encouraging the use of N=1 experimental designs to evaluate the efficacy of psychotherapy (e.g., BARLOW & NOCK, 2009; BARLOW, NOCK, HERSEN, 2008); (3) it also focused exclusively on behavior (first order problems) and on modifying behavioral targets using established learning-based principles; and finally, (4) it, functioning in the absence of an established and reliable diagnostic nomenclature, inadvertently made it acceptable to construct treatment models without being concerned, except in a very cursory way, about patient diagnosis. First wave enthusiasts (e.g., ULLMANN & KRASNER, 1965) could easily assume that normal and non-normal behaviors were simply learning issues (people learned to be normal and learned to behave in ways that deviated from the norm). Reflecting the emphasis on behavior alone, functional analyses of behavior (e.g., BAER, WOLF, & RISLEY, 1968) were instituted among operant researchers to identify the maintaining parameters of behavior which then informed the practitioner what reinforcement strategies needed to be applied to modify the target behaviors.

*A Bandura, A T Beck and the Second Wave.* A second-generation behavior therapist, ALBERT BANDURA (1961, 1969, 1977), widened the breadth of the behavior therapy movement beyond operant and reciprocal inhibition psychology with his social learning theory. Bandura heavily emphasized the role cognition played in human learning. Other clinical researchers followed his lead. Persons such as AARON BECK (1963, 1964; BECK, RUSH, SHAW & EMERY, 1979) proposed the Cognitive Therapy (CT) model that revolutionized the psychotherapy field. "Cognitive" researchers and clinicians then took center stage in the second wave: ARNOLD LAZARUS (1968, 1969) advocated greater multi-modal breadth in the conceptualization of psychotherapy and its tasks; a new focus on clinical experience (GOLDFRIED & DAVISON, 1976), cognitive modification (ELLIS & HARPER, 1975; MAHONEY, 1984), highlighting social-cognitive constructs in the treatment of depressed individuals (ABRAMSON, SELIGMAN, & TEASDALE, 1978; BANDURA, 1969), and the launching of the journal *Cognitive Therapy and Research*, founded by MICHAEL MAHONEY in 1977, reflected the broadening landscape of the second wave. ULLMAN & KRASNER (1965) described the second-generation movement as a "sociopsychological model;" several years later, MAHONEY remarked that the second-wave had "gone cognitive" (1984, p. 9). The empirical emphases of the first wave were not lost in the second as learn-

ing and the evaluation of individual treatment efficacy remained part and parcel of clinical research and practice (McCULLOUGH, 1984a,b; SHAPIRO, 1964, 1966). In addition, the cognitive construct definitely provided the second wave with an organizing center of gravity. Most second generational researchers and practitioners gathered around the “cognitive” campfire (MAHONEY, 1984) giving the movement internal consistency. Again, it must be said that the second wave functioned without an established and reliable diagnostic nomenclature. DSM-III (APA, 1980), the first reliable diagnostic system to appear on the clinical scene, was not published until 1980. Thus, the tradition of a diagnostic-less behavior therapy generation was once again maintained by the second wave.

*CBASP and the Third Wave.* Of particular interest to us is the rise of the third wave or Third Generation of Behavior Therapy (KOHLENBERG, BOILING, KANTER & PARKER, 2002; HAYES, 2004; ÖST, 2008). While there are some similarities between the two earlier behavior therapy generations and the third, several features of the third wave qualitatively separate it from its two predecessors. Four of these differentiating features are described below.

(1) When comparing the third wave to the first two generations, the first differentiating feature is seen in the fact that the third wave strongly reflects post-modernistic trends (LYOTARD, 1979/July 1985). This feature is evident in that there is no discernible center of gravity observable in the third wave. With no organizing center or common conceptual thread, the various third generation therapy models don't fit comfortably in any unitary conceptual relationship – the movement can be aptly characterized as a “*you do this and I'll do that*” type of situation. Unlike the first generation that relied upon Skinnerian operant or Hullian reciprocal inhibition concepts or the second that more often than not, gravitated toward the cognitive variable, the third is a collection of non-related conceptual-methodological models each striving to address independent and idiographic issues. In the third wave we move from Acceptance and Commitment Therapy (ACT: HAYES, STROSAHL, & WILSON, 1999), to LINEHAN'S Dialectical Behavior Therapy (DBT: 1993), to YOUNG'S Schema Therapy (YOUNG, KLOSKO & WEISHAAR, 2003), to McCULLOUGH'S Cognitive Behavioral Analysis System of Psychotherapy (CBASP: 2000, 2006), to KOHLENBERG & TSAI'S Functional Analytic Psychotherapy (FAP: 1991. KOHLENBERG & TSAI), to Behavioral Activation Therapy (JACOBSON, MARTELL & DIMIDJIAN, 2001), to Integrative Behavioral Couples Therapy (IBCT: JACOBSON & CHRISTENSEN, 1996), to Mindfulness-Based Cognitive Therapy (SEGAL, WILLIAMS, & TEASDALE, 2001), to Strategic Brief Therapy (HAUKE, 2006a,b; GRAFF-RUDOLPH, & SULZ, 2006) and to Metacognitive Therapy (WELLS, 2000).

This list signifies a array of qualitatively different methodologies; it reflects a multitude of differing theoretical a priori assumptions concerning the etiology and modification of psychological problems; the experiential goals implicated in this list and that focus the strategic attention

of therapists are highly variegated; and finally, different causal determinant models of behavior (BANDURA, 1977) are implicated. Trying to find an integrating common theme or unitary conceptual motif running through these change models is daunting. HAYES (2004) made a notable attempt to provide definitional grounding for the third generation. He wrote:

*"...the third wave of behavioral and cognitive therapy is particularly sensitive to context and functions of psychological phenomena...(the third wave) tends to emphasize contextual and experiential change strategies....These treatments tend to seek the construction of broad, flexible and effective repertoires over an eliminative approach to narrowly defined problems..."* (HAYES, 2004, p. 658).

However, it appears to this writer that what Professor Hayes has really accomplished is to describe the theoretical underpinnings of his own ACT model of psychotherapy (ACT: HAYES, STROSAHL, & WILSON, 1999) rather than providing a general definition of the third generation of behavior therapy. As noted above, universal-general descriptors and post-modernism are incompatible bedfellows.

(2) The second differentiating characteristic of the movement is the fact that the third wave signifies a definite disengagement of psychotherapy from the "cognitive content" focus of Cognitive Therapy (CT: BECK, RUSH, SHAW & EMERY, 1979) or as it is generally known today, Cognitive Behavior Therapy (CBT: ROTH & FONAGY, 2005). This statement is made in spite of HOFMAN & ASMUNDSON'S (2008) comment that the similarities with CBT outweigh the differences. Third generational models emphasize patient language structure more than specific cognitive structure, activated and purposeful behavior is assumed to be the precursor of cognitive and emotive change rather than the other way around, mental imagery and relaxation are emphasized more than belief and attitudinal content, and experiential-approach behavior is frequently touted as a prominent requisite variable for change. Summarily, the ills that afflict humanity and that are targeted for treatment by third wave advocates are no longer narrowly conceived of as *thinking (cognitive) problems* (BECK, 1963, 1964; BECK, ET AL. 1979). Because maladaptive behavior denotes more of a behavioral avoidance problem among third wave adherents, we often see the therapeutic foci moving away from modifying cognitive structure and gravitating towards the wider didactic task of teaching skills to decrease behavioral avoidance and psychological discomfort.

(3) When one examines the causal determinant models of behavior (BANDURA, 1977) implicated in the third wave, two causal determinant models appear operative. The second causal determinant model gives the third wave its differentiating feature when it is compared to the two previous waves. As best as I can determine, the first prominent causal determinant model is the view that behavior change is primarily a function of variables ongoing inside the individual. BANDURA (1977) graphically depicted this model as Behavior =  $f$ (Person), or  $B = f(P)$ . This

means that the therapist focuses solely on the patient who is the primary object of change. In the  $B = f(P)$  paradigm, the therapist teaches the patient something, behaves as a *teacher-midwife* or as a *deliverer* of the newly evoked behavior. Therapy techniques are designed to help patients enact new ways of living. What may be missing here is the often overlooked fact that the patient operates within a dyadic interpersonal environment whereby reciprocal influence is being exerted on both the patient and therapist. Both are operating on each other simultaneously and in the process, changing one another in reciprocal deterministic ways (BANDURA, 1977).

Bandura's description of the interpersonal model is as follows: Behavior =  $f$  (Person x Environment). The CBASP Model of Psychotherapy adds a distinctive interpersonal causal determinant feature to the third wave. CBASP is based on an interpersonal approach to psychopathology and its modification. It conceptualizes the etiology of the patient's psychopathology, describes the maintaining variables as well as their modification from an interpersonal point of view (KIESLER, 1988, 1996; KIESLER & SCHMIDT, 1993). The CBASP therapist is viewed as the primary choreographer of change in the model because he or she, beginning in the first session, deliberately constructs a qualitatively different interpersonal environment for the individual as well as enacts a *disciplined personal involvement role* (McCULLOUGH, 2006) that stands in contrast to the relationships the patient has experienced with hurtful Significant Others. These interpersonal differences are increasingly made explicit to the individual over the course of therapy (McCULLOUGH, 2000, 2006, 2008).

(4) The fourth differentiating feature of the third wave is seen in the diagnostic emphases of two third wave psychotherapy models – both of these treatments emerged from research with specific DSM psychiatric disorders. LINEHAN'S (1993) Dialectical Behavior Therapy was developed originally for DSM-III-R (APA, 1987) Borderline Personality Disorder; McCullough's CBASP was constructed specifically to treat the DSM-III (APA, 1980), DSM III-R (1987) and DSM-IV (1994) chronically depressed patient. It was stated above that in the first two behavior therapy generations, patient diagnostic nomenclature was largely nonexistent, ignored or significantly downplayed. Valid reasons for this omission were noted. It must be said that in general, the third wave, with the exception of DBT and CBASP, continues the behavior therapy tradition of operating without being bound to patient diagnosis.

My general impressions of the first three waves of behavior therapy are summarized as follows. The three generations represent an essential and ongoing "working story" of an assortment of technique-driven methodologies that applied researchers and practitioners have employed to resolve human "problems in living" (SZASZ, 1961/1974). As noted, I feel strongly that we must utilize DSM-IV diagnoses whenever possible to describe the patients we treat. Patient diagnosis will be contributory because it will provide information concerning what works with whom and what doesn't (PAUL, 1967).

We turn now to CBASP Psychotherapy to describe briefly the DSM-IV (APA, 1994) chronically depressed patient and to describe how CBASP is administered to one case. CBASP relies on contemporary learning theory (CLT: BOUTON, 2007) to guide technique administration. Patient in-session acquisition learning is used to measure treatment outcome. In this sense, CBASP, like its first-and second generation behavior therapy cousins, is a contemporary learning theory-based psychotherapy model.

## Part Two

### *CBASP Treatment of a Chronically Depressed Patient: Sandra*

The second part of the paper will describe the treatment of Sandra, a 35-year old Caucasian female who reported an early-onset history (since age 12) of dysthymia with a clinical course that included 5 major depressive episodes – a disorder known as “double depression” (KELLER & SHAPIRO, 1982). Sandra was diagnosed at screening with a major depression stemming from a serious conflict with her second husband. The couple had been married for 12 years. Sandra married at age 17 “to get away from home” and she divorced her physically abusive husband two years later (age 19). She is alcoholic and has been sober for 9 years while participating in Alcoholic Anonymous. The format of this section will describe the CBASP treatment of Sandra and concomitantly present the description and rationale of the techniques administered. Lastly, the outcome of treatment will be illustrated by presenting Sandra’s acquisition learning data that were VHS videotape recorded and then performance-rated by an independent rater, presenting several dependent measures that were obtained during treatment and reporting her diagnostic status at the third month follow-up session. The author continues to see the patient once every three months.

*Symptom intensity, demographic and clinical-course history during Session One:* Sandra obtained a BDI-II (BECK, 1996) score at session one of 54. She grew up in a family and never knew her biological father who died when she was two years old. The mother remarried and her step-father began sexually abusing Sandra (and her older sister) when she was seven. She was forced to have sex with him several times a week and the abuse continued for eight years. She never knew why it stopped. In addition to the abuse, he psychologically insulted her during childhood and adolescence with name calling and other verbal abuse. The step-father was alcoholic as was her mother. The mother appeared to be aware of the abuse which always occurred while she was at work; however, Sandra related that she “never seemed to care.” The mother was a “screamer” who frequently yelled at both daughters. She was emotionally cold and distant and a strict disciplinarian who never praised Sandra for the positive things she did in the home or in school. Her sister would run away from home but never successfully escaped the ongoing parental brutality. At present, her sibling is a heroin addict who earns her money through prostitution. One saving grace for

Sandra was the fact that she was very bright and did well throughout school. Her dysthymia onset began shortly after her first period at age 12. As best as could be determined, two of the earlier episodes of major depression followed severe beatings her sister received when she returned home. Sandra experimented with sex throughout adolescence and used several drugs but alcohol was her "favorite." She told the therapist that she married to "get away from home." The first husband was physically abusive and her third episode occurred when she realized that she'd escaped one horrific environment only to land in another. Episodes four and five occurred during the second marriage. Her current husband was an emotionally distant individual who avoided emotional encounters. Sandra said that intense arguments would follow times when she needed his support; he would usually walk away and withdraw interpersonally. She would then withdraw from him and wouldn't speak to him for several days. The screening interview ended with her reporting that she had seen numerous "counselors" and "therapists" over the years as well as taken "every antidepressant in the book." She also said that nothing had ever helped. The therapist ended the hour by asking Sandra to list the five or six major Significant Others (McCULLOUGH, 2006) in her life who had influenced her to be the person she is today.

*Session Two: The Significant Other History (SOH).* The session began with Sandra listing five Significant Others (SOs) and JPM (author) writing down the list on a flip chart. We went through her list in the order she gave them (step-father, mother, sister, first-husband, second husband). The SOH exercise is an emotional history attempting to obtain emotional information for each SO. JPM asked Sandra two questions about each SO: (1) "What was it like growing up or being around this SO?" When it became obvious that the affect associated with her memories for the SO had been activated, JPM asked the patient the second question: (2) "What is one *stamp* or *mark* this SO left on you that influenced you to be the kind of person you are today?" Five SO "stamps/marks" were elicited. From this list of influences, JPM then looked for a common expectancy theme/thread that might be played out by Sandra in their relationship. Hypothesizing an interpersonal expectancy from the five thematic influences, a Transference Hypothesis (TH) was constructed. The TH would be used proactively in subsequent sessions in an Interpersonal Discrimination Exercise (IDE) to help Sandra discriminate JPM from hurtful SOs. An abbreviated description of her SO list and the "stamps/marks" are shown below:

a. *Step-father*: "He made me have sex for years." "I never had any privacy." "I never felt safe in my home." "He invaded every corner of my life." *STAMP*: I'm afraid of every man I meet.

b. *Mother*: "She never helped me or cared what happened to me." "She was always screaming at me." "Most of the time she was drunk when she was home." "She didn't care what my father did to me." *STAMP*: I cannot trust anyone to help me when I need it.

c. *Sister*: "She was brutalized by my father." "I wanted to help her but there was nothing I could do." "She and I talk about once-a-month, and I love her." *STAMP*: There is no hope in this life for people who need help.

d. *First Husband*: "He was a brutal man like my father." "We'd argue and he'd hit and hurt me." *STAMP*: Another man, I don't trust any man. They'll just hurt me.

e. *Second Husband*: "He's okay and he doesn't beat me." "He just will not help me out when I need it." *STAMP*: I cannot expect anything good from a man.

The expectancy Sandra is likely to transfer to the dyadic relationship particularly with JPM being male cannot be particularly positive. The TH expectancy JPM constructed at the end of the second session was as follows:

*If I have a relationship with JPM, then he will hurt me in some way – I can expect nothing good to come out of this relationship.*

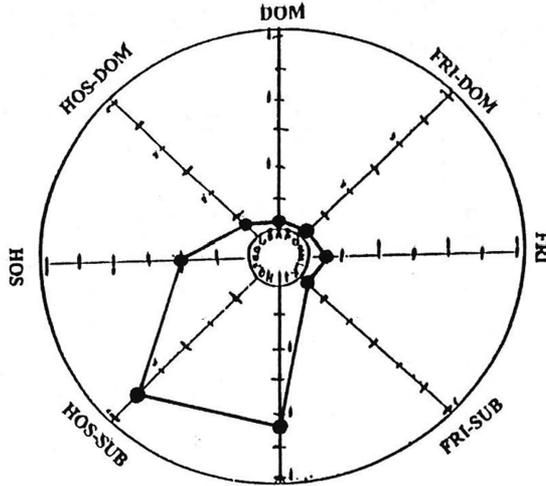
From a contemporary learning theory framework (BOUTON, 2007), the TH assumes that Sandra will view JPM as a Pavlovian conditional stimulus (S:CS: i.e. a male) (BOUTON, 2007) who elicits an emotional unconditional reinforcement (S\*:UCS) reaction of felt pain/fear. The TH will also enable JPM to teach emotional discrimination between himself and previous toxic SOs. The first goal of the Interpersonal Discrimination Exercise (IDE) is to unhook the S:CS (therapist) → S\*:UCS (felt pain/fear) connection and to replace it with felt in-session interpersonal safety (S\*:UCS). The IDE will be administered in future sessions when interpersonal events, or *hot spots*, arise suggesting that Sandra and JPM shared an in-session moment where pain/fear were absent. This occurrence will be made explicit in the IDE exercises.

Before the second session ended, Sandra was given the *Patient's Manual for CBASP* (McCULLOUGH, 2003) and asked to read the short text prior to the next meeting. She was told that if she had any questions after reading the *Manual*, JPM would try to answer the questions during session three.

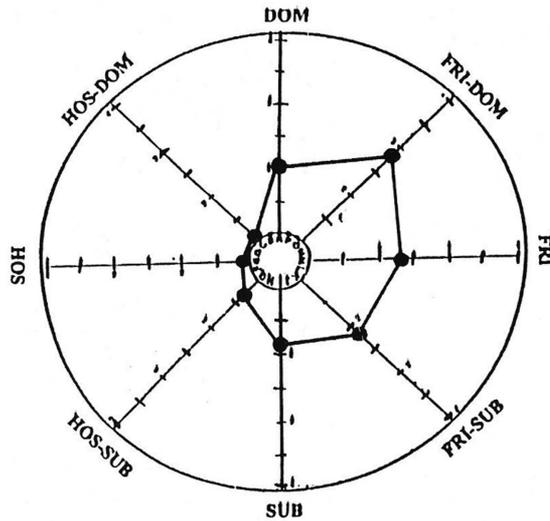
*Patient characteristics.* In spending two sessions with Sandra, JPM observed several intrapersonal and interpersonal characteristics that are frequently associated with early-onset chronically depressed patients (McCULLOUGH, 2000, 2006). Her interpersonal style was the first area of concern. JPM completed an Impact Message Inventory (IMI: KIELSER & SCHMIDT, 1993) on her following session 2. The post-session 2 IMI data are illustrated in Figure 1. Her peak scores fell on the Hostile-Submissive (H-S) and the Submissive (S) octants denoting a significantly detached and withdrawn interpersonal style coupled with extreme interpersonal passivity, respectively. Her IMI profile is a modal one for chronic patients suggest-

**IMPACT MESSAGE INVENTORY: FORM IIA OCTANT VERSION**  
 Donald J. Klesler & James A. Schmidt (1991)

Patient Sandra  
 Therapist JPM  
 Session Post-Session 2



Patient Sandra  
 Therapist JPM  
 Session Post-Session 28



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Figure 1. JPM's Impact Message Inventory ratings on Sandra's post-session 2 (Hos-Sub & Sub peak scores) and post-session 28 (Fri-Dom & Dom nadir scores).

ing that Sandra looked to JPM for answers and help that she couldn't generate for herself (S); ironically, even though she came to treatment asking for help, she wasn't going to risk becoming involved in a therapy relationship to obtain it (H-S). This is the frequent challenge CBASP therapists confront at treatment outset. The second concern was the way Sandra talked about herself, her problems, and her outlook for therapy. *Pre-logical thinking* characterized her description of what was wrong in her life and summarized her thoughts about never being able to "fix" anything; she talked in a *global way* about the problems she faced, and she couldn't focus on any one thing that was wrong ("Everything is wrong." "It's always been this way since I was born." "I'm a loser and always will be." "Trying to do anything is a waste of time." etc.); her verbal style was *egocentric* and *monologic* meaning that JPM was in the room but had the distinct impression that Sandra was talking to herself – she was not making eye contact with JPM nor using language in ways that made him feel that she really wanted him to understand her. Several times he remarked that he thought he understood why she felt so hopeless. Her automatic reply each time was something like this: "When you get to know me better, you'll hate me like everyone else." Sandra was *perceptually disengaged* from her environment (i.e. JPM) and her verbalizations suggested an individual who orbited in a solitary psychological cocoon fueled by a primitive belief that the way she experienced the world was the way things had to be – period! The strong interpersonal impact Sandra had on JPM was that it left him feeling alone and by himself (this is the usual interpersonal impact of the Hostile-Submissive patient during the early sessions). Her intrapersonal style represents the prototypical *preoperational-type* chronic patient. Sandra, even though in actuality she was an adult, behaved psychosocially like a small child (McCullough, 2000, 2006).

CBASP attacks the interpersonal isolation of the patient in two ways: (1) her disengagement from or her Skinnerian avoidance of the interpersonal environment will be addressed by repeated demonstrations, using Situational Analysis (SA), that her behavior has unavoidable consequences on others and JPM. Once the person-by-environment connection is perceptually achieved, the helplessness of the patient is usually modified. Sandra will then become more open to learning how to produce the interpersonal consequences she desires; (2) the second way CBASP tried to modify Sandra's interpersonal isolation was through the *disciplined personal involvement role* of the therapist (McCULLOUGH, 2006). As noted above, disciplined personal involvement will be initiated to assist Sandra to achieve a clear discrimination between the person of the therapist and maltreating Significant Others. When the perceptual discrimination between JPM and her SOs is achieved, opportunities for growth and new learning arise. As long as Sandra maintains her avoidant lifestyle in the sessions, new learning is inhibited and the old Pavlovian fear maintaining the interpersonal avoidance is maintained.

The third concern was Sandra's passivity as reflected in her extreme Submission score on the IMI. Submission pulls for dominance from others (KIESLER, 1996, 1988; KIESLER & SCHMIDT, 1993). In Sandra's case, her passivity has resulted in a lifetime of abuse and emotional neglect. If therapy is to be successful, the S interpersonal impact must be modified and the patient must learn to take care of herself.

### Situational Analysis (SA)

*Session Three.* SA is a Skinnerian contingency exercise consisting of two goals: one goal is to teach the patient to recognize the consequences of his or her behavior – a perceptual set labeled *perceived functionality*; the second goal is to teach the patient to be able to self-administer SA with no assistance from the therapist.

Situational analysis involves 5 steps enabling one to focus on a single problem situation and to learn how the interpretations they made and the behaviors they enacted lead to an identifiable situational outcome. The outcome is labeled an *Actual Outcome* (AO). Sandra will learn to answer correctly each of five questions.

The five SA questions are as follows:

- (1) *What happened in the situation?* This step requires one to pinpoint a *slice of time* involving an interaction that has a beginning point, an endpoint, and a story in between. Sandra will be asked to delineate what she did, what the other person did, and so on. The endpoint must be stated in behavioral terms.
- (2) The second question is: *What did the situation mean to you or, how did you interpret the situation?* Sandra will learn to focus on the slice of time and to describe correctly the interactive events occurring between herself and the other person. This is what is meant in CBASP by the word *interpretation*.
- (3) The next question is: *What did you do in the situation or, how did you behave?* Here we will concentrate on Sandra's behavior and on what she actually said, did and nonverbally, how she talked, gestured, etc.
- (4) The fourth question returns attention to the endpoint by asking: *How did the situation come out for you or, what was the actual outcome?* Sandra will learn to provide a one-sentence behavioral response that mirrors the endpoint in Step 1. Over time, the patient also learns that the AO is the consequence of her situational behavior. The last or fifth question is often a challenge for chronic patients who rarely think of possibilities beyond what happens to them.

(5) Question 5 functions as a motivational variable using negative reinforcement to increase felt discomfort when the negative AO is compared to a more desirable outcome. The question is asked: *How would you have liked the endpoint of the situation to have come out for you or, what is your Desired Outcome (DO)?* The DO must be stated in behavioral terminology that could have been seen or heard. Patients are assiduously shown that non-attainment of the DO stems from their failure to make the right responses in the situation – a usually unpleasant experience of failure and despair.

During Phase II (i.e. remediation phase) of SA, the period during which Sandra will be shown how “to correct” her cognitive and behavioral errors, Sandra will hopefully experience a decrease in felt discomfort and a growing sense of empowerment. The SA task is in effect a “mismatching exercise” (COWAN, 1978; GORDON, 1988; MCCULLOUGH, 2000) where primitive, pre-operational thinkers are asked to perform a task that requires formal operational thought. Over time, Sandra will become quite adept at the task.

*An example of Sandra's early SA homework performance:*

Step 1 (*situational description*): I had another argument with my husband. Had been having several bad days at the office and wanted him to listen to my difficulties. He'll never turn the television off. I should leave him. He will not talk to me. He's just another man who will never come through for me. Well, that's it. I'm a failure and a loser and I'll never get anything right. I'll never learn to do this SA stuff.

Step 2 (*interpretations*):

- a] Nothing ever works out for me. I hate myself.
- b] You must really be bored listening to all this.
- c] I never get anything right.

Step 3 (*patient's behavior*): I told Vick I wanted to talk and he just said “Okay” and kept looking at the stupid television. Finally, after just looking at him like he was crazy, I got up and left the room. He never even knew I was gone.

Step 4 (*actual outcome*): I failed again.

Step 5: (*desired outcome*): I would like to find another man.

*SA Performance Summary:* The preoperational features of Sandra's behavior is evident in this early SA performance. Sandra's global thinking, her inability to focus on the real problem that exists with Vick (he isn't listening to what she says), her self-blame that distracts her from concentrating on getting what she wants in this situation (she wants Vick to listen to her), her illog-

ical thinking about the problem-at-hand (“I would like to find another man.”) and her inability to pinpoint a behavioral consequence/endpoint in the situation (“I’m a loser and I’ll never get anything right.”), all taken together, mean that she cannot resolve any problem. Several things will have to be added to this chaotic SA if Sandra learns to solve her problem with Vick: (1) she must learn to focus on what she wants (DO); (2) she must learn to fix attention on what is actually going on between herself and Vick (interpretations); (3) she must learn how to ask specifically for what she wants; and, (4) she must learn to observe if she successfully achieves her DO (i.e., learn to compare the AO with her DO).

A very late example of Sandra’s verbatim SA performance is detailed below:

Step 1 (*situational description*): My boss asked me to work late on Tuesday night. I told him I couldn’t because Vick and I had planned to go out for an early supper. He said that he really needed my help. I again told him that I was sorry, that I wished I could help him out but tonight I had other plans.

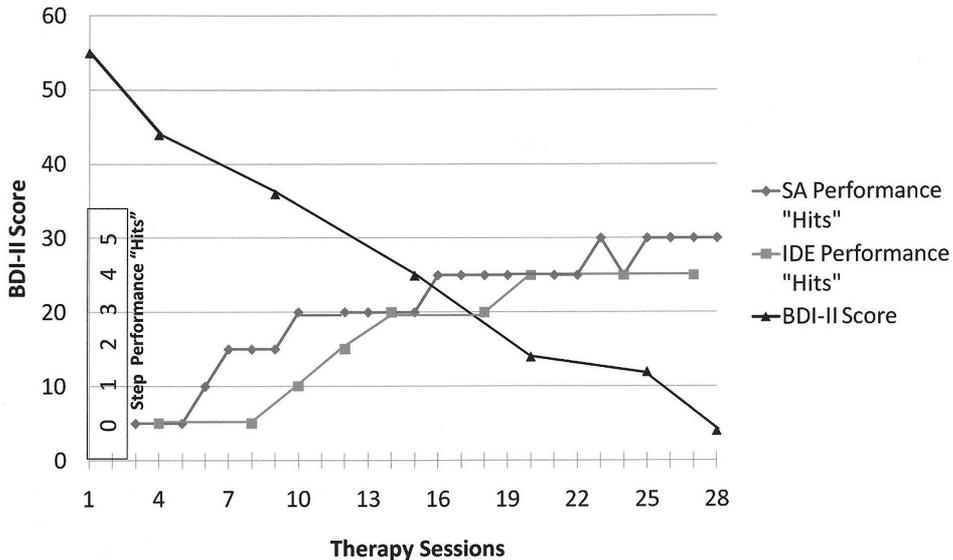
Step 2 (*interpretations*): a) I told my boss that I could not work late.  
b) He insisted that I work late.  
c) I refused and said that I was sorry.

Step 3 (*patient’s behavior*): I asserted myself in a direct way and without being ugly. Just told my boss that I had already made other plans. I said what I wanted to in a few words.

Step 4 (*actual outcome*): I told my boss I had other plans.

Step 5 (*desired outcome*): I wanted to tell my boss that I had other plans. I got what I wanted here (i.e. the AO = the DO).

*SA Performance Summary.* Sandra is now focused solely on the problem-at-hand. She’s no longer distracted by self-blame; rather, she was clear about her desired outcome and she enacted the assertive skills to obtain it. The preoperational features of Sandra’s earlier behavior have been replaced by a formal operational interpersonal style that’s direct, effective and successful. No one has to guess anymore what she wants. Finally, she’s aware of the consequences of her behavior as seen in her statement that the situational outcome resulted because of the way she managed the situation. Sandra has achieved a *perceived functionality* style of living by being able to recognize the consequences of her behavior. Her avoidant lifestyle (i.e. hostile-submissive & submission impacts) has been modified by increased interpersonal approach behavior (i.e. dominant & friendly-dominant impacts).



**Figure 2. Sandra’s BDI-II scores “averaged” every fifth session: her SA step performance “hits” using the PPRF; and her IDE step performance “hits” using the IDE-RF. Both were rated by the clinical rater.**

The patient’s SA performance was rated using the Patient Performance Rating Form (PPRF: MANBER, ARNOW, BLASEY, ET AL. 2003; McCULLOUGH, 2000, 2006). The PPRF was rated by the clinical rater after the sessions ended. Sandra’s acquisition performance on the SA five-step task is shown in Figure 2. Obtaining a correct “hit” denotes that the patient was able to self-administer the SA step without assistance from JPM.

**The Interpersonal Discrimination Exercise (IDE)**

*Session Five:* Sandra began treatment “appropriately” fearful of JPM. The first IDE was administered in the fifth session following a difficult SA in which both Sandra and JPM worked hard to repair several responses that led to her failure to achieve the DO. Instead of being hurt or rejected by JPM, he and Sandra worked together to “fix” the cognitive and behavioral problems. This shared dyadic moment signaled that a *hot spot* had occurred and JPM administered the first IDE. The exercise is based on the Transference Hypothesis (i.e. *If I have a relationship with JPM, then he will hurt me in some way – I can expect nothing good to come out of this relationship.*). The primary goal of the IDE is to assist Sandra to discriminate the behavior of JPM from that of maltreating Significant Others.

Sandra was asked four questions during the IDE:

- (1) *How would your step- father have reacted had you had the difficulties with him that you have just gone through with me?* She will also be asked the same question involving her mother and first husband. Holding the situational context stable and eliciting memories about the reactions of hurtful Significant Others (SOs) sets the stage for the emotional discrimination to be made between the SOs and JPM.
- (2) The second question inquired about JPM's reaction to her: *How did JPM react to you as you went through the difficulties with him in this SA?* Sandra had difficulty describing JPM's reactions during the early IDEs. She was not paying attention to his reactions and certainly not comparing the therapist's responses to those of the SOs.
- (3) The third question required a discrimination to be made in a compare and contrast manner: *What were the differences between JPM's reactions and those of your step-father, mother and ex-husband?*
- (4) The final question builds on the discrimination just made: *What are the emotional and behavior possibilities available now that were not available to you with your SOs?* Over time, Sandra will be able to make the discrimination between JPM and her SOs in a clearer way.

Viewed over time, Sandra's initial discriminations in the IDE will be that there are "general" differences between JPM and her SOs. Then, her discriminations will become more specific and then, more believable as JPM's non-hurtful behavior is repeatedly enacted over time.

This is the way the fifth session IDE developed when JPM asked how three Significant Others would have reacted to her in a situation (like the SA) where she was having difficulty:

Question 1 (*focus is on the SOs reaction to Sandra*): "My FATHER would have just laughed at me. Then he would have started calling me 'stupid' or using more insulting language. If my mother had been at work, he would have hurt me physically."

"My MOTHER would have been too drunk to have reacted. The best she would have done is just look at me like I was dumb and then start laughing. It would have been awful. I learned early not to let her know anything about any problems I was having."

My EX-HUSBAND thought I was dumb and he would have laughed at me. He liked to talk about how stupid I was and never missed the opportunity to let me know that I was unable to learn anything.

Question 2 (*focus is on JPM's behavior toward Sandra*): "I don't know – don't have any idea."

JPM: "Think about how I reacted to you during the SA. What did I do?"

Sandra: "You weren't ugly to me. You didn't yell or tell me I was stupid."

JPM: "You're right. But, what did I do? How did I react to your difficulties?"

Sandra: "You tried to help me fix the problem. I still can't believe that you won't hurt me. I just can't believe it."

Question 3 (*compare and contrast SOs behavior with that of JPM*): Sandra was able to say that she had been hurt in the past whenever she tried to solve her problems around her SOs but JPM had not hurt her. She had difficulty focusing on the positive behaviors of JPM.

Question 4 (*emotional and behavioral possibilities available now with JPM*): The patient was unable to think of any and continued to focus on the fact that she had not been hurt. The first IDE ended here.

*IDE Performance Summary (Session 5)*. The best discrimination Sandra could make was that JPM had not hurt her. She begins the acquisition learning task in the IDE recognizing that hurt and felt discomfort were not present in the session; however, it must be noted that Sandra does not believe that the therapeutic relationship will be qualitatively different from previous ones.

Later in therapy in session 23, Sandra and JPM were working on a SA in which she'd asserted herself to her sister who wanted to borrow money. Sandra told the older sister that she would not make any more loans until her sister paid her in full for the previous ones. The IDE was administered in that same session. Sandra self-administered the 4-step IDE and answered the questions for herself.

Question 1 (*focus is on the SOs reaction to Sandra in an assertive situation*): "I could have never asserted myself to anyone before I began this therapy. I never said "No" to my step-father, and I rarely talked to my mother and certainly never talked back to her. My ex-husband would have hit me had I said "No" to him. Vick never asks me to do anything.

Question 2 (*focus is on JPM's behavior toward Sandra when she asserted*): "What I get from you is that you are pleased when I stand up for myself. You like it! You had a big smile on your face the whole time I went through my SA."

Question 3 (*compare and contrast discrimination*): "There's no comparison between you and them. I could do nothing around them and around you, I can be myself and say what I want and don't want. That's okay with you. Thank God!"

Question 4 (*emotional and behavioral possibilities available now with JPM*): "My life is no longer a dead-end street. I have a future not only with you but with others. Do you know that my boss told me the other day that I was the most improved employee in the department. I'm speaking up in departmental meetings and my colleagues like what I have to say. I'm no longer a helpless wimp."

*IDE Performance Summary (23rd session)*. Sandra now appears to be able to trust JPM. The expected hurt and felt discomfort in the relationship with JPM has not materialized and he's become a "safety signal" (S:CS). From a Pavlovian perspective, the safety she experiences with JPM is a tangible reinforcing stimulus (S\*:UCS) that's resulted in a decrease in Skinnerian interpersonal avoidance and led to a concomitant increase in growth, empowerment and approach behavior. Additional good news is seen in the fact that Sandra is beginning to transfer what she's learned in therapy to interpersonal encounters on the outside (e.g. her boss and work colleagues).

The patient's IDE performance was rated using the Interpersonal Discrimination Exercise-Rating Form (IDE-RF: McCULLOUGH, May 2008). The IDE-RF was rated by the clinical rater after the sessions ended. Her successful acquisition performance on the four-step IDE task is shown in Figure 2. Obtaining a correct "hit" on the IDE task denotes that the patient was able to self-administer the discrimination step without assistance or prompting.

### End of Therapy Assessment

Sandra's post-session 28 IMI data are shown in Figure 1. She had decreased both her Hostile-Submission (H-S) and Submission (S) impact scores to negligible levels. Her *nadir scores* (KIESLER, 1988, 1996) on the first IMI completed by JPM following session 2 (i.e., nadir scores denote the octants opposite the peak octants; namely, the Friendly-Dominant [F-D] and Dominant [D] octants) increased in strength at the twenty-eighth session. Sandra was now frequently bragging on herself and her accomplishments in the session (F-D) and enacting her new assertive skills (D) with JPM. She was no longer impacting JPM from the hostile side of the circle (avoidance type of impacts); rather, her friendly octant scores had increased signaling greater in-session approach behaviors.

Her BDI-II score at the beginning of session 28 was 7 indicating no depression. The BDI-II scores averaged every fifth session are shown in Figure 2. At the 3-month follow-up session, JPM rediagnosed the patient for double depression using the DSM-IV (APA, 1994) major

depression and dysthymia checklists. Sandra did not meet criteria for major depression. In addition, she only met criteria for one dysthymia symptom (insomnia) at the 3-months follow-up period. She decided to continue to meet every three months for the next year. At that time, another decision would be made concerning scheduling future therapy sessions.

### Summary of the Case

The CBASP model is based on two assumptions: (1) the interpersonal Skinnerian avoidant lifestyle of the early-onset patient is maintained and fueled by Pavlovian fears of being hurt by others. The felt discomfort around people, more often than not, stems from a developmental history where actual trauma and psychological insults (McCULLOUGH, 2008) have been experienced at the hands of maltreating Significant Others. Protecting oneself by avoiding others exacts an exorbitant psychological price from the patient. (2) The second assumption is derived from observing interpersonally avoidant patients function in the therapy session and watching the environment (including the therapist) have no informing effect on the patient's behavior. The patient is perceptually disconnected from the interpersonal world of people; hence, normal growth and development have been precluded. These adult patients behave in a primitive and childlike manner that is blatantly age-inappropriate. McCULLOUGH (2000, 2006) describes this cognitive-emotive lifestyle as *preoperational functioning* (PIAGET, 1926/23). Such was the case with Sandra when treatment began. Learning that her behavior had specific interpersonal consequences, learning that she was able to attain her desired outcomes, over time, appeared to result in a perceived connection to her interpersonal world (SA performance: See Figure 2). The modification of her avoidant lifestyle began first with JPM and then with others. This interpersonal achievement enabled Sandra to replace her interpersonal avoidance with a generalized interpersonal approach strategy (IDE performance: see Figure 2).

The presentation of Sandra's case in an N=1 design format reflects a first wave emphasis as treatment was conceptualized herein as a learning experiment. The acquisition learning design (McCullough, 2006, 2008) illustrates both what was learned as well as examines the hypothesized effects the learning has had on therapy outcome. Finally, the case illustrated the utility of using a DSM-IV diagnosis by describing the type of patient being treated and the type of treatment being administered for a specific type disorder.

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