

Characteristics of the Optimal Cognitive Behavioral Analysis System of Psychotherapy (CBASP) Therapist Role

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Introduction

I developed the Cognitive Behavioral Analysis System of Psychotherapy (CBASP) [1-5] to specifically treat Persistent Depressive Disorder (PDD) [6]. CBASP is an interpersonal model of psychotherapy, and it has achieved empirically validated status in the United States, Germany, United Kingdom, Finland, Switzerland, and Netherlands. After personally treating over 400 PDD patients, participating as Principal Investigator in four national randomized clinical trials enlisting 2200 PDD outpatients, and training/supervising hundreds of professionals to administer CBASP, I wanted to write a non-research study article [7] discussing the optimal therapist role characteristics of CBASP professionals. The paper is written from the perspective of the originator of CBASP.

Becoming a CBASP psychotherapist is not a simple undertaking. The reasons are two-fold:

- (1) Many early-onset PDD patients present unique and difficult challenges to practitioners such as maturational retardation in the cognitive-emotive-behavioral interpersonal arena; and secondly,
- (2) Learning to administer (to criterion) the techniques of CBASP is a difficult acquisition learning task.

Entrenched cognitive-emotive-behavioral patterns characterize the PDD early-onset adult patient. The long-standing disorder mandates that a unique therapist role, Disciplined Personal Involvement (DPI) [2,4], be administered. DPI seeks to "humanize" this primitive-functioning adult- patient using a clinical role that is novel and different from many other therapist role models available today. It is unusual to think that adult persons who dress and look like adults function cognitive-emotive-behaviorally in the interpersonal sphere much like 5-7 year-old children. Therapists who treat these preoperational patients [8] and do not take their pre-causal/pre-logical thinking into account often find that their ministrations result in no change. CBASP training teaches clinicians to understand the etiology of the disorder and how early toxic maltreatment during the developmental years results in a maturational stunting of growth. Training also shows practitioners how to meet these individuals on their level of functioning and how using DPI will promote maturational growth. Summarily, CBASP therapists help these adult-children mature and, in the process, the patients learn to manage their own chronic depression.

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Optimal CBASP Therapist Role Characteristics

Four optimal characteristics describe the best CBASP practitioners.

- (1) They can enact a DPI clinical role in an effective manner;
- (2) These clinicians are able to implement an acquisition-learning approach to therapeutic administration;
- (3) This cohort adheres to the standards of CBASP technique administration; finally,
- (4) They possess facilitative interpersonal skills. Each characteristic will be briefly described below.

Effective DPI Role Administration

DPI is based upon the Kieslerian concept of interpersonal interaction [9,10]. From the moment the patient steps into the office, there is a reciprocal relationship ongoing in the therapeutic dyad. The clinician begins treatment operating from an empathic position, a formal operational (abstractive) skill the patient does not have at the outset but will achieve by the termination of treatment. The best clinicians ably interpret the impact-effects that patients have upon them and use this information to diagnose the interpersonal functioning level of the patient. Then, they utilize these data to teach patients to behave with them and others in more adaptive ways.

Able to Implement an Acquisition-Learning Approach to Patient Treatment

CBASP is an operationalized model of psychotherapy and the two major operationalized goals are felt dyadic safety [patient learns to discriminate the therapist from maltreating significant others] and perceived functionality [patients learn to recognize the interpersonal effects of their behavior]. These goals are achieved during the dyadic process and determine the quality of treatment effectiveness. The basic assumption of the model is the following: If the patient learns to criterion what treatment teaches, the chronic disorder will be effectively brought under control. Optimal CBASP practitioners approach their cases as learning endeavors and define their clinical role as “teachers.”

The best CBASP practitioners adhere to the standards of CBASP technique administration

Several techniques are implemented in treatment and include the Significant Other History (SOH: An interpersonal-emotional history with significant others); Transference Hypothesis Construction (TH: A one-sentence hypothesis [if this happens in the dyad, then that will be the interpersonal outcome for me, the patient] denoting the core fear expectancy derived from the patient’s abuse history; the Interpersonal Discrimination Exercise (IDE: A technique designed to teach patients to discriminate their clinicians from maltreating significant others who have harmed the individual); and Situational Analysis (SA: The major change strategy in CBASP that perceptually connects the patient with their interpersonal world). SA is a five-step exercise that patients must learn to criterion and that moves the individual toward the second goal of the model, perceived functionality: perceived functionality denotes learning that behavior has consequences and indicates that the patient can recognize those consequences. All the above techniques are delivered within an interpersonal-interactive dyad of safety which teaches patients to relate to the DPI therapist as a comrade who cares for the person.

The best CBASP therapists draw from a repertoire of facilitative skills that potentiate patient change. These practitioners can

- a) Be themselves with patients in honest ways (personal authenticity).
- b) Be comfortable working with a chronic condition that is not quickly modifiable.
- c) Be facilitative teachers without being slavish to a protocol.

d) ‘Control’ the session by teaching interactive verbal control without resorting to dominating tactics.

e) Treat two types of PDD individuals [one, physically and sexually abused patients; and two, patients who have come from emotionally and physically deprived settings].

f) Tolerate ‘silent periods’ and their own anxiety without reducing it by verbal means.

g) Effectively manage ‘anger’.

h) Avoid preaching, exhorting, or telling.

i) Track the ‘interpersonal impacts’ patients have on them moment-to-moment.

Conclusion

In conclusion, we must listen to the best CBASP therapists and learn from them. The unique difficulties of this patient and the challenges one faces in administering this specific model of psychotherapy make successful outcomes significant achievements for those fortunate patients who work with practitioners who have taken the time to be the best they can be.

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