

# We are IntechOpen, the world's leading publisher of Open Access books Built by scientists, for scientists

6,900

Open access books available

186,000

International authors and editors

200M

Downloads

Our authors are among the

154

Countries delivered to

TOP 1%

most cited scientists

12.2%

Contributors from top 500 universities



WEB OF SCIENCE™

Selection of our books indexed in the Book Citation Index  
in Web of Science™ Core Collection (BKCI)

Interested in publishing with us?  
Contact [book.department@intechopen.com](mailto:book.department@intechopen.com)

Numbers displayed above are based on latest data collected.  
For more information visit [www.intechopen.com](http://www.intechopen.com)



---

# **CBASP with Intensified Significant Other History Exercise for Chronic Major Depression with Antecedent Dysthymic Disorder in Outpatient Treatment: Rationale, Assessment and Effects on the Hypothesized Core Content of the Patient's in-Session Interpersonal Fear in Relation to Symptom Reduction**

---

Dieter Schoepf

Additional information is available at the end of the chapter

<http://dx.doi.org/10.5772/51638>

---

## **1. Introduction**

Major depressive disorder (MDD) with antecedent dysthymic disorder is characterized by the simultaneous occurrence of two unipolar depressions with distinctive symptom severity and course patterns that have different age of onset profiles. The dysthymic disorder usually begins with an insidious onset before the age of 21 with depressive symptoms that are present more days than not over a period of two years or more, sometimes referred to as either "a recurrent veil of sadness and hopelessness" or "a loss of self confidence and self-efficacy". A more severe course of the disorder is reached when worsening of depressive symptoms leads to the onset of either a long lasting single MD-episode or recurrent MD-episodes with or without interepisode recovery, accounting for up to 75% of all cases of chronic MDD (Klein et al, 1996). The overall prevalence of detected dysthymic disorder with and without superimposed MDD is estimated to be approximately 3%, the lifetime prevalence 6% (DSM-IV-TR, 2000). Because many patients do not come to professional psychiatric attention, this likely is an underestimate of the number of cases who have fallen ill. In addition, even after the onset of a MD-episode, many affected patients delay or avoid getting treatment. The multiple negative effects on quality of life and physical health in combination with an increased risk of suicide, as well as the burden that patients are unlikely to remit over time compared to pure

(episodic) MDD, make it important for clinicians (1) to identify the disorder as early as possible, (2) to encourage affected patients to take advantage of treatment as early as possible, and (3) to become familiar with effective pharmacological and disorder specific psychosocial interventions (Schoepf & Neudeck, 2011).

The pathogenesis of chronic MDD with antecedent dysthymic disorder results, to a large degree, from bi-directional interaction between disturbed stress regulation on the one hand and a developmental history that implicates a dysfunctional home life during childhood and the intervening adolescence epoch on the other hand. As a rule, a diagnosis of chronic MDD with antecedent dysthymic disorder is accompanied by a dysfunctional learning environment with- or without early-life adversities, ranging from childhood maltreatment (sexual abuse, physical abuse or emotional abuse) to experiencing neglect to witnessing domestic violence or to having a life-threatening injury (Schoepf et al., 2007; Schoepf & McCullough, 2009; McCullough et al., 2010; Schoepf & Penberthy, 2010; Schoepf & Neudeck, 2011; McCullough, 2012a; Neudeck et al., 2012). From a learning theory perspective a dysfunctional learning environment - in which the child's emotional capacities are recurrently exceeded without providing a (behavioral) solution to stop the condition - may involve survival circuits that detect key conditioned stimuli as a behavioural phenomenon for life. Such classical conditioned stimuli particularly trigger emotional and behavioral species-specific defence reactions, as well as stress associated changes in the inner workings of the body's organs and glands. Increasing evidence suggests that such exposed children may endure long-lasting neural consequences that place them at increased risk for the development of an interpersonal style that is characterized by either moving away from or moving against the other person, and respectively the self (Schoepf et al., 2007; Schoepf & Penberthy, 2010; McCullough et al., 2011; Schoepf & Neudeck, 2011; Neudeck et al., 2012). Anatomically, predefined pathways that connect the limbic system with the neocortex are considerably stronger than those from the neocortex to the limbic system. The asymmetry of these connections as well as mechanisms of sensitization within survival-circuits (escape and avoidance learning) that involve high reactivity of the anterior insular and the amygdale may be the two most important biologically based reasons, why the developmental influences of the disorder remain prevalent in the form of a refractory cognitive-emotional dilemma over time (Schoepf et al., 2007; Schoepf et al., 2008; Schoepf & Neudeck, 2011). In other words, whenever an interpersonal event induces an arousal in the domain in which the origin of the interpersonal fear is established, the individual has no adaptive pro-active behaviour at hand to turn it off at will. In full agreement with these learning-theory and neurobiological based considerations, recent imaging studies demonstrated how chronic environmental stress in child victims of family violence – physical abuse, physical neglect and verbal abuse – primes the brain of the on-growing child for future mental illness by setting its stress system in a permanent state of high alert as well as lead to corticostriatal-limbic gray matter reduction in the intervening adolescent epoch (McCrory et al., 2011). Furthermore, hippocampal and striatal alterations in adults are associated with reported emotional neglect during childhood, suggesting that such neglect may have long-lasting effects on corticostriatal-limbic regions subserving emotion regulation (Edmiston et al., 2011).

Effective treatment of chronic MDD with antecedent dysthymia that aims to achieve complete syndromal remission and, ultimately, long-term, successful outcomes of social functioning is an unsolved problem and remains an outstanding need in psychiatry (McCullough et al., 1996; Kessler et al., 2003; Schoepf et al., 2007; Nelson et al., 2008; Schoepf & Neudeck, 2011). With respect to psychosocial interventions, Cognitive Behavioral Analysis System of Psychotherapy (CBASP) - the only model of psychotherapy specifically developed for chronic MDD - showed divergent short-term effectiveness in the two worldwide most important (NIHM funded) chronic depression studies (Keller et al., 2000; Kocsis et al., 2009). It is important to note that in the earlier Nefazadone/CBASP study - that reported in a cross-over design a short-term overall response rate of 73% for the combined treatment in its Intention-To-Treat (ITT) population (with up to 20 sessions of psychotherapy offered that were demanded with a rate of 80% by the patients) - for the subpopulation of patients with a history of self-reported childhood trauma, CBASP proved to be significantly more effective in the reduction of depressive symptoms than medication alone (Nemeroff et al., 2003). In contrast, the later Research Evaluating the Value of Augmenting Medication with Psychotherapy (REVAMP) study was not able to confirm the results of the earlier study in a different study design (Kocsis et al., 2009). In non- and partial responders of 12-week antidepressant medication CBASP add-on augmentation (again up to 20 sessions of therapy offered but significantly less demanded by the ITT population in comparison to the earlier study) with introducing the technique of "Situational Analysis" (SA) in the third session of therapy was found not to be more effective in the reduction of depressive symptoms in its ITT population than pharmacological augmentation or augmentation with Brief Supportive Psychotherapy (BSP), a type of "non-directive psychotherapy". However, pharmacotherapy with CBASP was associated with greater improvement in problem solving in the population of completers than pharmacotherapy plus BSP, or medication alone (Klein et al., 2011). Further differences between both studies with respect to the patient and the technique variable are:

- The preference for drug treatment was higher in the REVAMP population compared to the CBASP/Nefazadone population. The rate of patients that were prior to study inclusion adequately treated with antidepressant medication was 32% in the REVAMP population. In contrast, 60% of the included patients in the Nefazadone/CBASP population were adequately treated with antidepressant medication.
- The inclusion criterion for the co-occurrence of alcohol abuse varied in both studies. Unlike the CBASP/Nefazadone population, in the REVAMP population alcohol abuse was permitted if an affected patient was embedded in a group of anonymous alcoholics or if a patient was actively treated pharmacologically.
- The number of unemployed patients varied in both studies. Unemployment was higher in the REVAMP population than in the Nefazadone/CBASP population (32 versus 15%).
- The prevalence of chronic MDD with antecedent dysthymic disorder was lower in the REVAMP population than in the Nefazadone/CBASP population (33.1 versus 42.3%).

In the context of these two NIHM funded studies small "dismantling" and "f-MRI system mapping" studies recently begun to look for different mediating mechanisms (McCullough

et al., 2010). Another research line started to focus on the moderator variables that deal with the patient's pre-treatment status and co-morbidity issues, such as alcoholism (Penberthy, 2010). From a CBASP technique variable perspective it is not clear if the early introduction of the technique of SA in the third session of therapy in the REVAMP trial has a positive or a negative effect on in-session acquisition learning and outcome-measures (Schoepf et al., 2011; Schoepf & Neudeck, 2011). A formal public description of the Significant Other History (SOH) procedure with a scheduled time period of one therapy session that was applied in the NIHM studies was recently presented by McCullough and colleagues (McCullough et al., 2011). In Bonn academic CBASP out-patient studies, the technique of SA is usually introduced after the fourth+x session of therapy in the case of chronic MDD with antecedent dysthymic disorder. A prolonged pre-SA phase of treatment in comparison to the NIHM studies implies a prolonged reconstruction process of the emotional learning history in antecedent- consequent way by conducting the SOH procedure as an intensified - more than one session – exposure-based procedure, called I-SOH procedure. The adapted protocol draws a clear distinction between a “pre-SA phase of treatment” that essentially includes the application of the I-SOH procedure, and the following “SA/ IDE phase of treatment”, in which circular (two-way) formal-operational functioning is achieved.

### 1.1. Aim of chapter

This chapter-article provides a comprehensive overview of using CBASP's original one-session scheduled SOH technique in an adapted, intensified and prolonged form for improving treatment in chronic MDD out-patients with antecedent dysthymia.

The first part starts with a recapitulation of key learning theory considerations about the origin of the disorder that follows our previous work published elsewhere (Schoepf & Neudeck; 2011). This starting point provides the foundation for a better comprehension of the rationale to use the techniques of disciplined personal involvement (DPI) early in therapy to shape a sensitive patient-therapist relationship. In the next section I turn to the technique description of the I-SOH procedure, i.e. the I-SOH procedure is described in detail and the underlying learning mechanisms are elucidated. Then the key frontiers in the administration of the I-SOH procedure are outlined. These frontiers include the prerequisites prior to out-patient CBASP psychotherapy (patient variable) as well as the “therapist” variable (Schoepf et al., 2007; Schoepf and Neudeck, 2011, Schoepf et al., 2011, and Neudeck et al., 2012). With respect to CBASP's interpersonal focus, and particularly it's emphasis using the patient-therapist relationship as a therapeutic tool, in the following section the focus is laid on how the hypothesized core content of the patient's interpersonal fear is specifically counter-conditioned in the SA/IDE phase of treatment. In the last section, the assessment for the I-SOH procedure is described in the form of an example and the relevant reference is given, in which the evaluation of the safety-signal impact on the hypothesized core content of the patient's in-session interpersonal fear is described.



In the second part typical CBASP-treatment trajectories of my self treated patients are provided without further systematic statistical evaluation as the studies are still running. The trajectories clearly show - without any further necessary explanation - the effect of the I-SOH procedure on the hypothesized core content of the patient's in-session interpersonal fear in relation to symptom reduction. Feasibility and the implications of the I-SOH procedure on the syndromal short term effects as well as the effects over time are summarized and the scientific-related challenges are outlined.

## **2. First part**

### **2.1. The origin of the disorder - key learning theory considerations**

CBASP is a highly disorder-oriented psychotherapy method from the "third generation" of behaviour therapy models that is based on modern learning theory considerations (McCullough et al., 2011; Schoepf & Neudeck, 2011; Neudeck et al., 2012). From a modern learning theory perspective, the origin of chronic MDD with antecedent dysthymic disorder is due to classical conditioned interpersonal fear that often goes hand in hand with traumatically processed experiences of learned helplessness during childhood and the adolescent epoch. The (Pavlovian) fear is perpetuated by several forms of (Skinnerian) avoidance, thus accounting for an uncoupling of the person-environment connection as a contributing cause of depressive symptomatology. Functional brain changes may include that (1) the signal-reinforcer-relationship in relation to the implicit regulation of attentional control is biased towards stimuli that predict uncontrollability and unpredictability, and that (2) the behaviour-reinforcer-relation with respect to the implicit regulation of situational outcome is biased towards an independent of response expectation of some sort of punishment (Schoepf et al., 2007; Schoepf & Neudeck; 2011).

### **2.2. Disciplined personal involvement and the patient-therapist relationship**

In CBASP, the patient-therapist relationship represents a central agent of behaviour change. A unique type of therapist intervention, called disciplined personal involvement (DPI), advocates a non-neutral role for the therapist. The techniques of DPI are based on early concepts of objective counter transference and interpersonal reactions that provide the authorization for using "self disclosures" to shape a sensitive patient-therapist relationship particularly in the early phase of treatment (Schoepf & McCullough, 2009; Schoepf & Neudeck, 2011). The most important precondition for the effective use of the techniques of DPI is that the overt and covert emotional, cognitive, and behavioral responses the patient evokes in the therapist (the patient's stimulus vale) are validly measured by using the Kiesler's Impact Message Inventory after the first session of therapy (Kiesler, 1983). The results of the IMI (Schmidt et al., 1999) provide the necessary information about how the therapist feels like behaving towards the patient that will guide his clinical choices and his plan of treatment. This holds particularly for the use of personal meta-communicative feedback techniques and the way the I-SOH procedure is applied – the latter described in section 2.5. The technique of "Contingent Personal Responsivity" (CPR) is used in instances

where the therapist consequences the behaviour of the patient by disclosing personal responses and feelings produced in the therapist by the behaviour of the patient (McCullough, 2006; Schoepf & McCullough 2009). The positive form of the CPR technique compares the moment-to-moment differences between before and after in case of pro-active in-session behaviour (Schoepf & Neudeck, 2011). As a therapeutic effect, intrapersonal positive reinforcement is induced which allows the patient to experience a new in-session interpersonal reality that increasingly becomes meaningful during the early phase of treatment. For example, in a preceding event a patient denied visual and verbal contact towards the therapist, then in the subsequent event he approached to the therapist and disclosed a fact that he had attributed as a “personal failure”. The patient’s behaviour to consequence is “telling the therapist to have forgotten the homework “. The patient expects that his behaviour of “disclosing the failure” will be met with an interpersonal reaction of “some sort of punishment”. The fact that the therapist reacts with “non-punishment” and that instead the patient is made aware of the positive effects his approaching behaviours have on the therapist by pointing to the contrast between how the therapist felt before (when the patient reacted in a hostile way) and after (when the patient approached) leads to an absence of the negative consequence expected by the patient, and thus to stress reduction. Consequently, it becomes more probable that, in a future situation, the patient talks to the therapist about a failure he has done (Schoepf & Neudeck, 2011). It is important to note that in the original CBASP protocol the imposed IMI data are not shared with the patient (McCullough & McCullough, 2009); the same is valid for the modified I-SOH procedure protocol (Schoepf & McCullough, 2009).

### **2.3. Restructuring helplessness memories in antecedent-consequent way**

Theorists of exposure and cognitive approaches widely agree that effective psychotherapeutic treatment must in some way access or activate past traumatically processed memories, thoughts, and feelings, while providing corrective information that serves to modify the person's unrealistic expectations of harm and danger as well as to reduce excessive negative affectivity (Ehlers & Clark, 2000; Foa et al., 2007). In full agreement with this knowledge the (adapted) I-SOH procedure is primarily designed as an exposure-based technique that first activates the patient’s helplessness memories and then restructures these early memories in antecedent-consequent way. The relation between the patient’s individual developmental history of interactional adversities and his interpersonal functioning in the presence is made explicit by helping the patient to respectively translate the formative influences of his SOs into Causal Theory Conclusions (CTCs). A CTC is a transference prediction that is defined as the interpersonal expectation which is transferred to the interacting partner. From the perspective of the therapist he gains self-reported access to the patient’s interpersonal-emotional history with SOs and therefore is able to identify the individual origins of the patient’s core content of his interpersonal fear as well as how the patient behaved in painful encounters with malevolent SOs. The therapist therefore gains access to the necessary information for formulating the specific Therapy Hypotheses (TH), which will be worked out in the following SA/Interpersonal Discrimination Exercise (IDE)

phase of treatment to assist the patient in achieving two-person circular functioning. The TH represents the hypothesized core content of the patient's interpersonal fear in the form of a predictive-hypothesis that informs the therapist about how the patient is likely to behave interpersonally in "hot spot" in-session events as well as what the patient is likely to expect interpersonally from the therapist. The TH also informs the CBASP therapist how he has to behave in order to address, train and thereby "repair" developmental trauma arising from experiences of felt helplessness with SOs in the SA/IDE phase of treatment (McCullough et al., 2010; Neudeck et al., 2012). It is important to note, that after the I-SOH procedure is finished an in-session zone of felt-safety has usually come into being, but the patient has yet not developed the ability to perceptually discriminate the behaviour of the therapist from the behaviour of his SO's in "hot spot" situations. The zone of felt safety is made explicit in the later SA/IDE phase of treatment through IDE-work, i.e. the patient's behaviour in "hot spot" situations is specifically counter-conditioned with dyadic reciprocity (McCullough et al., 2011). A "hot spot" situation is some behavior/event involving the patient and the therapist that occurs during the therapy session that implicates the TH signaling that an IDE should be administered before the session ends (McCullough & McCullough, 2009). Due to IDE work the therapist demonstrates how the therapist's behaviour in "hot spot" interpersonal situations stands in contrast to the behaviour of SOs, similar to the patients' experiences earlier in his life. Thereby, the deeply personal nature of the therapist-patient relationship "is put into the foreground of therapeutic efficacy". Here we have both: A "moderator variable of in-session acquisition learning" as well as a therapist who creates a situational context where the patient is exposed to avoided emotions and thoughts (Schoepf & McCullough, 2009; Schoepf et al., 2011; Schoepf & Neudeck, 2011; Neudeck et al., 2012).

## 2.4. Major therapeutic goals of the pre-SA-phase of treatment (early phase)

The major therapeutic goals of the pre-SA phase of treatment are:

1. To teach the patient in the first session to self-monitor the intensity of his depression by using the BDI-II and the IDS-SR and to work through the results together at the beginning of every session from a behavioral perspective.
2. To reconstruct the course of the depression from a behavioral perspective in the second session of therapy.
3. To clarify the origins of the patient's interpersonal fear by using the I-SOH procedure (Schoepf et al., 2011; Schoepf & Neudeck, 2011), i.e. an intensified and prolonged form of the original one-session SOH technique described by McCullough and colleagues (McCullough et al., 2011) that is applied in the modified protocol as an exposure-based intervention.
4. To teach the patient to recapture the ability to re-experience repressed emotions by recalling key memories about what it was like being around a SO.
5. To teach the patient to think in an antecedent-consequent way in the interpersonal domain in which the origin of his interpersonal fear was established by supporting him to formulate a core conclusion for every SO about the formative influence the SO



exerted on him, i.e. the interpersonal influence of the SO that is effective in the presence (CTC).

6. To modify dysfunctional and attacking in-session behaviour as well as to induce positive intrapersonal reinforcement of approaching behaviour by using the various forms of the CPR technique.
7. To build-up a sensitive patient-therapist relationship with an attachment bond as well as creating an in-session zone of felt safety.

## 2.5. Technique description of the I-SOH procedure

This section will give the reader an insight into the I-SOH outpatient protocol. In Bonn university, the I-SOH procedure is usually applied in the treatment of chronic MDD patients with antecedent dysthymic disorder, i.e. in the cross-over study “differential responses of CBASP Vs Escitalopram” (clinical trial) and the effectiveness study “CBASP Vs SYSP” (Schramm et al., 2011). A formal technique description of the I-SOH procedure and an elucidation of the underlying learning mechanisms are not presented or discussed in public so far.

Overall view: At a glance, the I-SOH procedure is administered in a highly structured sequence on the flip-chart. The use of the flip-chart helps the therapist to control the risk of inducing excessive and overwhelming negative affectivity (fear, guilt, shame, anger) and it sets the stage for the patient to draw causal connections between the past and the presence. Under a condition of focused attention four tasks are consecutively carried out in order to reveal how SOs affected the patient to behave in his everyday relationships. In the first task the patient is prepared for the I-SOH procedure by the submission of detailed information about the content and the objectives of the procedure. In the second task the patient is focused on the procedure and the flip-chart is introduced. The third task and the fourth task are intended as causal reasoning exercises that build-up on each other. Both exercises emphasize more the processing and the active restructuring of the patient’s thinking in the domain in which the origins of past helplessness memories were established than the thinking process itself. However, the I-SOH procedure can also be seen as an exposure-based intervention. The remembered early memories are usually painful for patients to acknowledge, and the sustained attention to these memories are associated with an increase of negative affect and agitation. Therefore, it is imperative for the therapist to help the patient to reduce his aversive reactions by teaching him effective top-down strategies. The challenge for the therapist is to ensure that each task is always within the patient’s realm of possibility and comprehension.

### 2.5.1. Task one: Preparing

After the reconstruction process of the course of the depression is finished (before the end of the session) the I-SOH procedure is introduced to the patient. The entering wedge is to request the patient to bring into the next session of therapy a list of up to six SOs who shaped the patient to be who he is at present (McCullough & McCullough, 2009;

McCullough et al., 2011). It is explained that a SO is defined as a person, who played a major informing role in the patient's development history and that a SO can be attributed either positive or negative. It is recommended to highlight the following five topics:

1. SOs are not "just friends" or "acquaintances". Instead a SO is defined as a significant person in the life of the patient, with whom the patient grew up, or with whom the patient currently interacts and who exerted either a positive or negative formative influence on the way the patient lives, thinks and feels (parents, siblings, uncles, aunts, grandparents, teachers, etc.).
2. Most patients will list 3-6 SOs who exerted a relevant impact that influenced the direction their life took.
3. In the following sessions the origins of the patient's interpersonal problems are clarified by applying the I-SOH procedure.
4. The results of the I-SOH procedure are a "conditio sine qua non" for the therapist to develop the specific TH. The specific TH represents the hypothesized core content of the patient's interpersonal fear in the form of a predictive-hypothesis that informs the therapist about how the patient is likely to behave interpersonally in "hot spot" situations as well as what the patient is likely to expect interpersonally from the therapist.
5. The detection of the specific TH is necessary for the therapist in order to be prepared for perceiving "hot spot" situations in the subsequent SA/IDE phase of treatment. It is recommended to inform the patient that such "hot spots" are high probability occurring interpersonal events in therapy (McCullough & McCullough, 2009; Schoepf & McCullough, 2009).

At the beginning of the next session it is recommended to address consecutively the following three topics to set the stage for the exposure aspects of the procedure:

1. The I-SOH procedure is of utmost relevance for the therapy, because the therapist has to come to know in detail the origins of the patient's chronic state of depression in order to determine the dominant interpersonal theme domain that describes the negative consequences the patient received from his SOs while interacting with them in that domain (McCullough, 2008).
2. Aversive feelings like fear, pain and sadness as well as shame and guilt may be evoked in the case of a negative SO. The therapist is blind for "hot spot" situations at this time of therapy, such that he can not apply CBASP's specific DPI techniques like the IDE. Instead, the therapist will help the patient to control the evoked arousal by teaching him top-down interventions that will simultaneously prepare the patient for SA work in later therapy (Schoepf & McCullough, 2009; Schoepf et al., 2011; Schoepf & Neudeck, 2011).
3. In the original US-protocol the time instruction for the SOH procedure is one therapy session (second session). It is recommended to explain that this time instruction was taken back by the author of the CBASP in the planning phase of Bonn CBASP-studies, and that according to the modified protocol the emotional reconstruction process of one SO in an antecedent-consequent format usually takes one single up-to one double session of therapy, especially when a positive history of family violence or childhood trauma exists (Schoepf & McCullough 2009; Schoepf et al., 2011; Schoepf & Neudeck, 2011).

After clarifying the content of each topic in its meaning, the therapist goes to the second task.

#### *2.5.1.1. What is learned?*

Early-onset chronically depressed patients with a history of low-to high grade childhood trauma have not enough precedent emotional experiences like the capability to trust another human being or what it is like to be loved and cared for (McCullough, 2012). From a communication perspective, the submission of detailed information about the content and the objectives of the up-coming tasks stands in contrast to the patient's expectation that "one person does not care for the other person". The patient learns that the therapist behaves in a way that stands opposite to the behaviour of his malevolent SOs. Specifically, the therapist establishes a learning environment that is characterized by foreseeable events, openness, trust and care. The door is opened for the development of a sensitive patient-therapist relationship that includes a powerful potential for enhancing and accelerating the up-coming tasks through increased attention and readiness to cooperate. This will shape the patient and produce a relevant impact, or paradigm shift, that also will affect the patient's subsequent interpersonal experiences as well as affect the patient's self-actualization process. From a learning theory perspective, learning of stimuli and behaviour can only occur if there is a discrepancy between the stimulus that is expected (typical behaviour of malevolent SOs) and the one that actually occurs (the therapist's preparing behaviour, Bouton, 2007).

#### *2.5.2. Task two: Focusing*

In the second task the names of the SOs are written on the flip-chart in the order the patient had listed them. Then the list is reviewed together. After the reviewing process is finished, the patient is informed that in the third task both the therapist and the patient go together through the list in the order it was defined by the patient.

##### *2.5.2.1. What is learned?*

In early-onset chronically depressed patients all roads usually lead to the self (McCullough, 2006). By the use of the flip-chart the patient's attention is drawn to the outside. Forgetting is prevented that may occur because of interference as well as because of retrieval failure. In addition, the review process gives the patient time to habituate to a sometimes distinctive evoked arousal. Finally, the patient learns that the procedure slows down the speed of the task.

#### *2.5.3. Task three: Restructuring of closed perceptual systems in antecedent-consequent way*

In the third task the patient's relevant relationships that exerted a formative influence on his life are restructured in antecedent-consequent way. It is recommended that the therapist remains continuously in a friendly and curious position to give birth to causal learning processes and insights the patient experiences during the exercise, but not to do the work for him.

First sub-step: Creation of awareness for key past encounters. The patient is first prompted to describe in storytelling form what it was like growing or being around with his SO. The therapist must be aware, that this prompt is directly addressed to open the patient's perceptual systems that are closely related to his refractory affectivity (fear, anxiety, and psychological pain), i.e. the early-onset chronically depressed patient is confronted with all aspects of his avoided reactions. In particular, earlier memories that are associated with traumatically processed events evoke significant emotional arousal that often seems to be overwhelming from the patient's subjective point of view. The therapist's responsivity is to immediately interrupting the patient's narrative form of reproduction and to teach him to control the induced arousal by (re-)describing a typical encounter from a purely observational descriptive modus (sterns in the example 2.11). Observational-descriptive modus is defined as a report of the key behavioral interactions with extinction of intrusive and destructive behavioral response patterns until the therapist comes to know what happened first, then second, etc. The beginning and the end point of the encounter have to be clearly addressed, not unlike watching an excerpt of a silent movie. As a rule, the therapist writes the reported interactions word by word on the flipchart and clarifies their meaning in behavioural terms. Then the therapist repeats the event. After the intensity of negative emotions is decreased the patient returns to the storytelling form. It is important to note that the therapist should instruct the patient to stay in the alteration between the storytelling form and the observational descriptive form of key encounters to avoid an escalation of negative affect and agitation or in the worst case retraumatization.

Second sub-step: Elicitation of self-referential interpretations and identification of causal relations between the past and the presence. After the first-sub step is finished the patient is prompted to causally think about how the SO's interactional behaviours influenced the course of his life in a way that is still present today or how the SO's interactional behaviours influenced the patient to be the kind of person he is at present. A two-step strategy is applied. First, the patient's self-referential interpretations of his key encounters are elicited; for instance "I felt hurt when my father insulted me", or "I thought I am stupid when I was blamed". Then, the patient is prompted to draw causal relations between his interpretations and his typical interactional responses (behavioral, emotional, cognitive, and physiological) in his everyday relationships, i.e. in antecedent-consequent way. It is recommended to facilitate this causal reasoning task by writing a preparation theorem on the flip-chart, i.e.: "The influence of this SO on me/my everyday relationships is that ...". Now the patient is prompted to add the impacts/effects. The therapist's responsivity is to clarify every reported word in its meaning and to help the patient to restructure his thoughts by organizing the influences according to the patient's personal relevance, as the patient usually thinks in global ways without considering the time and the causality relation.

The exercise ends with a learning summary of the step.

#### 2.5.3.1. *What is learned?*

In this task the patient is exposed at past helplessness memories that contribute to his dysfunctional outcome expectations. When a SO had exerted a negative formative influence

on the patient's life painful reactions (avoided thoughts, avoided emotions, and physiological responses) are evoked. When a SO had exerted a positive formative influence on the patient's life "often forgotten" feelings of affection are evoked. Counter-conditioning according to the principle of reciprocal inhibition takes place by the benevolent reactions of the therapist, who helps the patient to identify and (re-) describe key encounters with his SO from a behavioral observational descriptive focus. Counter-conditioning means that a stimulus-response connection that was established through classical conditioning is unlearned or reconditioned through conditioning with novel stimuli (Schoepf et al., 2007; Schoepf & Neudeck, 2011; Neudeck et al. 2012). According to our clinical experience, an implicit learning process is started at this point during which the therapist becomes safety signal character at the end of the pre-SA phase. The term "safety signal character" implicates that the patient's behaviour has the capacity to terminate the overwhelming character of the aversive feeling that is present. The initiated safety signal learning process is strengthened through associative learning of behavioral effects. The patient's behaviour chain - first report a past stressful event from an observational-descriptive focus, then elicit the cognitive-emotional attributions and finally draw causal relations in antecedent consequent way - is enhanced in the presence of the therapist because it removes or prevents an aversive event (negative reinforcement). Negative enforcement is defined as a specific event in which behaviour is strengthened because it prevents an aversive effect that is a negative reinforcer. In other words, that the therapist reacts with "non-punishment" leads to an absence of the negative consequences expected by the patient, and thus to a further stress reduction. Automatically, there results a felt increase of the potency of the therapist to reduce interpersonal distress during the in-session encounter and a new interpersonal reality of a sensitive therapist-patient relationship comes into being meaningful to the patient.

#### *2.5.4. Task four: Translation of tacit knowledge into explicit causal knowledge*

In the fourth task the patient has to identify and to translate the most relevant causal relation between the SO's behaviour in the past and his transference prediction in the presence that contributes to maintain the disorder. The "so called" Causal Theory Conclusion (CTC) can be formulated either in the form of an (ego-based) transference prediction that becomes prevalent in the patient's everyday relationships or as a conditional rule in the form of an (ego-based) "if then" statement that predicts the patient's prototypical interactional emotional response in relation to the expected up-coming event, i.e. some sort of punishment if a SO had exerted a negative informing influence.

First sub-step: Identification of the compensatory rule that underlies the CTC. The following four questions have to be answered successively by the patient.

1. What was the SO's interactional behaviour that stands in relation to your typical behaviour in everyday encounters?
2. Identify your most relevant emotional interpretation by going through the key encounters with the corresponding interpretations.



3. What is the underlying compensatory rule in behavioral terms that protects you from the effects the SO's interactional behaviour had on you? Example 2.11: Avoiding closeness to my father protected me not to get hurt.
4. Proof the rule by going through all key events written on the flipchart from a prosecutor perspective.

Second sub-step: Creation of awareness for the up-coming event when acting against the compensatory rule. Again the patient has to answer successively four questions.

1. Judge from a prosecutor perspective to what up-coming event (behavioral consequence of the SO) your most relevant interactional emotional response was related in the past?
2. Proof the up-coming event (behavioral consequence of the SO) by your drawn causal relations in the second sub-step of the last task and test alternative events you may have forgotten to mention.
3. Explain what the up-coming event (behavioral consequence of your SO) was when acting against the compensatory rule? Example 2.11: Overt punishment, i.e. being criticized, being yelled at.
4. Proof the identified up-coming event (behavioral consequence of the SO) and your emotional response by going through all key events written on the flipchart from a juror perspective.

Third sub-step: Development of the CTC. Three questions have to be answered successively.

1. What do you feel is the most relevant emotional impact that the SO exerted on you that is most relevant in your everyday relationships?
2. Formulate the corresponding CTC with the help of the underlying compensatory rule and the identified up-coming event when acting against the compensatory rule. The CTC should built-up on the legacy you feel the SO has left on you. It can be formulated either in the form of an (ego-based) transference prediction that makes-up how you emotionally experience the world or as a conditional rule in the form of a "if then" statement that predicts your prototypical emotional response in relation to the expected up-coming event (behavioral consequence). Example 2.11: I am afraid of authoritarian dominant men (CTC as a conditional prediction), or if I come closer to an authoritarian man then I freeze (CTC as a "if then" statement). To note, from a learning theory perspective the "if then" statement is a conditioned response with predictive strength that is self reinforcing.
3. Proof the CTC by going through all key events written on the flipchart.

The exercise ends with a learning summary of the step.

#### *2.5.4.1. What is learned?*

The fourth task can be described as a top-down guided re-evaluation process of the results of the previous task. The therapist helps the patient to translate the most relevant formative influence of his SO into a transference prediction that was established while living together with the SO, i.e. a CTC. With respect to exposure aspects, the patient becomes exposed at tacit knowledge about what behaviour predicts at what time a negative reinforcer or the

absence of a positive reinforcer when a SO had exerted a negative formative influence on the patient's life, as well as what behaviour predicts at what time a positive reinforcer or the absence of a negative reinforcer when a SO had exerted a positive formative influence on the patient's life. Concerning associative learning of behavioral effects the early-onset chronically depressed patient - sometimes for the first time of his life - becomes aware (feels) that the key encounters with his SO are taken seriously by the therapist. In addition, the therapist does not attack the patient's difficulties in causal reasoning. Instead, the therapist cooperatively helps the patient to work-out the most meaningful relation between his previous learning experiences and his interpersonal transference prediction. The therapist thus contributes to meaningfully inform the patient. A second fact is important to note: The behaviour of the patient to explore and verbally designate a CTC respectively terminates the overwhelming character of the aversive feelings that usually increase and decrease several times during the fourth task. The termination of the uncomfortable emotional state respectively represents a different (or opposite) outcome compared to the patient's independent of response expectation of being punished in some way. The patient therefore experiences in the presence of the therapist that cooperating in logically thinking is an effective strategy of affect regulation that has the capacity to stop the induced aversive cognitions and feelings as well as to become less afraid of or threatened by traumatic processed helplessness memories and reminders of failure events themselves, helping the patient to integrate trauma memories and reminders into his self-image. This new element of reaction amplifies the conditional relationship between positive efficacy beliefs and positive outcome expectations. Furthermore, the patient's perceptive and interpretative performance is sensitized by means of attention-focused interventions under aspects of awareness. In sum, the patient's door is opened to bring into the subsequent SA/IDE treatment phase stressful everyday encounters all of which play in the interpersonal domain in which the origin of the interpersonal fear was established.

## **2.6. Key frontiers in the administration of the I-SOH procedure**

### *2.6.1. Patient variable*

CBASP psychotherapy includes much exposure aspects in its cutting edge techniques of behaviour change (Schoepf et al, 2011; Schoepf & Neudeck, 2011; Neudeck et al., 2012). According to our clinical experience, the following six prerequisites should be fulfilled prior to out-patient CBASP therapy in the sub-group of patients who suffer of chronic MDD with antecedent dysthymic disorder:

1. The patient should be sufficiently self-motivated to learn to effectively interact with his environment. A good indirect clinical clue is when a patient comes in a reliable way to the preceding diagnostic dates.
2. Simple relationships between behaviour and its effect with respect to adaptive behaviour should be understood by the patient. A good clinical clue is how a patient responds to contingent personal responsivity in case of a proactive behaviour - like asking the clinician clarifying questions during the diagnostic phase.

3. The patient should be able to respond to contingent personal responsivity in case of pro-active behaviour with affects that can be clearly defined and specified in simple discrimination exercises.
4. If necessary, the patient should be adjusted to a stable antidepressant medication before CBASP psychotherapy starts.
5. Both somatic and mental co-morbidity should be sufficiently treated before CBASP psychotherapy starts. Do not start CBASP if a different mental disorder is leading or a somatic disorder is untreated.
6. Criteria for termination of outpatient treatment in case of a severe increase of world-weariness/or acute suicidal behaviour as well as a severe "breaking-through" MD-episode that needs antidepressant medication should be defined and clarified.

If the prerequisites are not fulfilled a multi-step psychotherapy approach that integrates McCullough's model, has proven to be successful in a small regular ward at Bonn University equipped with a specialized outpatient department (Schoepf & Neudeck, 2011).

### 2.6.2. *Therapist variable*

According to Winnicott "objective" counter transference is the constricted feelings, attitudes, and reactions of a therapist induced by a patient (Winnicott, 1949). Within CBASP, Winnicott's concept constitutes the most important basic assumption, establishing how, with the help of DPI, the patient's resistance that is caused by reactions of negative transference is dealt with and the integration of traumatic learning experiences into his or her self-image is achieved. This implies according to McCullough that the CBASP therapist:

1. Applies objective counter-transference as a vehicle of in-session change.
2. Is able to be oneself with the patient in the therapy, i.e. that the patient encounters an authentic therapist who is neither afraid to be himself nor to walk with the patient as a "comrade" (McCullough, 2012).
3. Salubriously uses personal responsivity.
4. Arranges contingencies so that the patient can learn.
5. Makes moment-to moment decisions with respect to CBASP treatment goals.
6. Self-monitors the patient's moment-to-moment verbal- and nonverbal messages.
7. Is focused in supervision on his non-reflected verbal- and nonverbal messages that interfere with CBASP treatment goals.

As a rule (and as described in 2.2), optimal use of DPI techniques requires that the therapist has learned to alternate between the dominant and submissive octants of the Kiesler circle as the in-session occasion requires. The therapist has also to remain on the friendly side of the interpersonal circle so as to avoid reinforcing the negative interpersonal transference expectancies early-onset patients often act out during treatment (McCullough & McCullough, 2009).

## 2.7. Identification of the dominant interpersonal-emotional theme domain and formulation of the TH

After the I-SOH procedure is finished the CBASP patient's manual for patients is distributed and the patient is prepared for the SA/IDE phase of treatment that starts in the subsequent session. In the period until the beginning of the first therapy session of the SA/IDE phase of treatment the TH is formulated in the absence of the patient, especially in early-onset chronically depressed patients with a history of family violence or childhood trauma (McCullough, 2006: page 130; McCullough, 2012b). For this purpose, the dominant interpersonal-emotional theme domain is defined by the therapist. The interpersonal-emotional theme reflects the early learning history of the patient and is derived from the CTCs. CBASP assumes four transference areas of interaction in early-onset chronically depressed patients that, from the perspective of developmental psychology, play an important role in the patient's relationship with significant others. His theoretical considerations concerning the transference hypothesis refer to the concept of "tacit knowledge" (Polanyi, 1966) and the idea of "reasoning based on implicit causal theories" (Nisbett and Wilson, 1977). Specifically, McCullough (2006) describes working with the construct of transference as an exercise in "focused attention." The TH differs from Freud's concept of transference since it can be actively acted out in session with the therapist and then processed within the IDE. From a learning theory perspective the transference hypothesis includes the hypothesized core content of the patient's in-session interpersonal fear that most likely reflects the patient's expectancy of the therapist's reactions toward the individual (McCullough et al., 2010). The four transference areas of interpersonal dysfunction in that "hot spots" occur are:

1. In-session moments of intimacy (either felt by the patient or the therapist) that evoke in the patient (Pavlovian) fear of being physically or emotionally abused (intimacy area).
2. In-session events in which the patient discloses emotional needs toward the therapist that evoke in the patient (Pavlovian) fear of being ridiculed or censored (disclosure of need area).
3. In-session events during which the patient makes mistakes towards the therapist (i.e. not doing his or her homework or being unable to solve problems presented during therapy sessions) that evoke in the patient (Pavlovian) fear of severe physical or emotional punishment (mistake and failure area).
4. In-session events in which the patient expresses negative affects towards the therapist that evoke in the patient (Pavlovian) fear of punishment (expression of negative affect area).

The TH then becomes central in the IDE because it defines the starting point of IDE or interpersonal "hot spot". Through the controlled use of the IDE in "hot spot" situations it becomes possible for the patient during the course of the treatment, to clearly distinguish the therapeutic relationship from the relationships the patient experienced with his SOs (Schoepf & Neudeck, 2011).

## 2.8. Therapeutic goals of the SA/IDE phase of treatment

The SA/IDE phase of treatment starts with introducing the SA. The major therapeutic goals of this phase are:

1. To focus the patient on the situational consequences of behaviour and to demonstrate him continuously that what he does matters through SA work.
2. To strengthen functional interpersonal behaviour contingently.
3. To counter-condition fear reactions those occur during the practising of realistic and goal-oriented behaviour in the elicitation phase of SA work.
4. To shape action-related interpretations and missing behavioral aspects in the remediation phase of SA work.
5. To help the patient to process how the present patient-therapist relationship differs from his past relationships with his SOs due to the various forms of the IDE - that are employed in relation to the progress of therapy (Schoepf & McCullough, 2009; Schoepf & Neudeck, 2011; Neudeck et al., 2012).

## 2.9. Achieving in-session two-way circular functioning in the SA/IDE phase of treatment

The core content of the patient's interpersonal fear is counter-conditioned in the SA/IDE phase of treatment due to IDE work. The technique of IDE was formerly described by our group as a bottom-up technique that is assumed to be the major CBASP technique of (explicit) in-session acquisition learning (Schoepf et al. 2007; Schoepf & McCullough, 2009; Schoepf et al., 2011; Schoepf & Neudeck, 2011). In general, bottom-up techniques like the IDE are designed to lead the patient from the concrete therapeutic situation to interpersonal situations which resemble the therapeutic situation (Neudeck et al., 2012).

Table 1 represents the learning context and the different phases of the IDE (adapted from Schoepf et al., 2011; Schoepf & Neudeck, 2011).

The starting point of an IDE is defined by the presence of an in-session "hot-spot" event/moment. The core content of the patient's interpersonal fear is activated any time the dyad encounters an in-session relationship issue signaling that a relational "hot spot" is encountered (McCullough et al., 2010). Three different forms of the IDE are applied in Bonn out-patients:

1. In the cognitive form of the IDE the principle of counter-conditioning cognitive evoked (Pavlovian) fear is limited to the negative phase. The mechanism of sensitization is started in the positive phase and is increased in the healing phase (adapted from Neudeck et al., 2010; Schoepf & Neudeck, 2011; Neudeck et al., 2012).
2. In the emotional form of the IDE the principle of counter conditioning of re-experienced (Pavlovian) fear predominates within all IDE phases (Schoepf et al., 2011; Schoepf & Neudeck, 2011). A strong feeling of "safety" within the therapy dyad results that usually elevates the probability of generalizing outside of therapy to the patient's other relationships (adapted from Schoepf & Neudeck, 2011).



<p><b>Learning context</b></p> <p>The therapist directs the focus of attention to the just happened “hot spot” in-session event/moment and writes the patient’s „hot spot” behaviour on the flip-chart. Then the three phases of the IDE are consecutively carried out.</p> <p><b>Negative phase</b></p> <p>The patient is gently asked to recall a typical past social interaction with one or two of his maltreating “Significant Other’s” in a similar situation. In the cognitive form the patient has to describe the behavioral consequences on himself caused by the behaviour of his significant other. In particular bad thoughts are evoked through tacit knowledge. In the emotional form the patient is additionally gently asked to re-experience the associated hurtful (refractory) emotions in the presence of the therapist. In particular negative feelings like fear, pain and sadness are evoked. Counter-conditioning according to the principle of reciprocal inhibition takes place by the benevolent therapist’s reaction (Schoepf et al., 2007; Schoepf et al., 2011; Schoepf &amp; Neudeck, 2011).</p> <p><b>Positive phase</b></p> <p>After the intensity of negative thoughts and emotions is decreased the patient is gently asked to describe his perception of the therapist’s reactions. Furthermore, he has to characterize the feelings that have been evoked by the current incident with the therapist. He is then asked to compare the therapist’s behaviour to the recalled behaviour (and the corresponding emotion in the emotional form of IDE) of his significant others in a similar situation. The felt distress of the patient usually decreases at this moment of the exercise.</p> <p><b>Healing phase</b></p> <p>Sensitive to the timing and the magnitude of the felt decrease of distress in the healing phase of the IDE, the patient is encouraged by the therapist to identify the contrast between the therapist’s behaviour and the significant other’s’ behaviour. “Automatically” there results a felt increase of the potency of the therapist to specifically reduce interpersonal distress during the experienced “hot spot” situation and a new interpersonal reality of the therapist-patient relationship comes into being meaningful to the patient.</p>
--

**Table 1.** Learning context, negative phase, positive phase and healing phase of the IDE (adapted from Schoepf & Neudeck, 2011).

3. In the double counter conditioning form of the IDE interpersonal fear is first counter-conditioned with the goal of modifying strikingly maladaptive behavioral patterns. Then the cognitive or the emotional form of the IDE is coupled contrasting the reactive behaviour of the therapist against the maladaptive behaviour of one or two SOs (adapted from Schoepf et al., 2011; Schoepf & Neudeck, 2011).

2.9.1. *The three options to use the various forms of the IDE*

The IDE is used in it various forms to address, train, and thereby “repair” developmental trauma memories and associated symptoms arising from negative experiences with abusive

SOs. It is recommended to use the three various forms of the IDE in relation to the progress of therapy throughout the SA/IDE phase of treatment, table 2 (Schoepf et al., 2011; Schoepf & Neudeck, 2011; table 2).

<p><b>First option</b> – when a patient shows early benefit in SA work</p> <p>When patients show sufficient symptom reduction in the pre-SA phase of treatment and fast benefit of SA-work during the SA/IDE phase of treatment the cognitive form of IDE has approved itself to specifically reduce interpersonal distress by helping the patient to cognitively discriminate the therapist’s interactional behaviour in “hot spot” in-session events from the interactional behaviour of hurtful SOs in similar past encounters (McCullough et al., 2011).</p>
<p><b>Second option</b> – when a patient shows delayed benefit in SA work</p> <p>When patients show sufficient symptom reduction in the pre-SA phase of treatment and delayed benefit of SA work during the SA/IDE phase of treatment the emotional form of IDE has approved itself to modify closed perceptual trauma domains that perpetuate the cognitive-emotional dilemma of the patient (Schoepf et al., 2011; Schoepf &amp; Neudeck, 2011).</p>
<p><b>Third option</b> – when a patient does not show benefit in SA work</p> <p>When patients show little symptom reduction in the pre-SA phase of treatment and do not benefit from SA work during the SA/IDE phase of treatment a modified form of the IDE (double-counter conditioning) to modify strikingly maladaptive in-session behavior has approved itself to be successful (Schoepf et al., 2011). An example of the modified form of IDE is published elsewhere (Schoepf et al. 2011; Schoepf &amp; Neudeck 2011).</p>

**Table 2.** Early benefit, delayed benefit and no benefit in CBASP psychotherapy as orientation for the use of the three various forms of the IDE in the SA/IDE phase of treatment.

**2.10. Evaluation of the safety-signal impact**

The goal of measuring if interpersonal safety is achieved in the domain in which the origin of the patient’s interpersonal fear is established is accomplished with the use of the Personal Questionnaire (PQ). The PQ represents a patient-self-report methodology comprised of paired comparisons using three cards that are each compared to one another (McCullough, 2006). The three cards contain the same content of the TH used in the various forms of IDE work, but formulated with (1) a baseline illness-level indicating no perceived change observed between the therapist and malevolent SOs, (2) an improvement-level indicating some perceived change observed between the therapist and malevolent SOs, and a (3) recovery level indicating clear perceived change observed between the therapist and malevolent SOs. The scoring of specific increases in expected in-session emotional safety with respect to CBASP’s TH construct are done by the patient himself and blind to the therapist before the beginning of every session and in the absence of the therapist. The

patient is instructed not to tell the therapist the scoring results. The therapist obtains after 32-35 therapy sessions a feedback about the scoring of the results. The safety signal impact of the therapist on the hypothesized core content of the patient's in-session interpersonal fear is highest at a scoring of 1 and lowest at a scoring of 4. The procedure is clearly outlined by McCullough (McCullough, 2006, pp 163-167). The self-report questionnaire represents a cost-effective option to systematically, reliably, and validly evaluate the safety signal impact of the therapist on the patient because it is inexpensive in terms of professional time needed for administration, and does not require special training for administration.

## 2.11. Assessment of the I-SOH procedure up-to the TH

<b>TASK 1: Preparing, see text</b>
<b>TASK 2: Focussing, see text (flip-chart)</b>
<u>List of SOs reported by the P:</u> Father, mother, first girl friend, later girl friend, and his travelling companion.
<b>TASK 3: Reconstruction of closed perceptual systems in antecedent-consequent way (flip-chart). To note, the third and the fourth tasks are carried out successively for all SO's.</b>
<b>Example of first listed SO</b>
<u>Father</u> (exerted a negative formative influence with high impact)
<b>First sub-step: Creation of awareness for key past encounters</b> *: T teaches P to respectively describe one typical key interpersonal encounter in behavioral terms (using the flip-chart)
<u>Report of the patient.</u> My father was frequently absent. His manner was quick-tempered, i.e. he often yelled and demanded obedience without notice <sup>1*</sup> . He punished verbally if someone did not follow his rules <sup>2*</sup> . In addition he always reacted angrily if someone disclosed an emotional need. He himself had great difficulties in showing any of his feelings. He reacted extremely angry if I had a different opinion <sup>3*</sup> . On the other hand he helped his friends and he was proud of his son. Confidence on each other is his highest inner worth until today. Another attitude of him is, that you have to work harder then the rest to be respected. He sent me to an off-shore oil platform after school <sup>4*</sup> .
<b>Second sub-step: Elicitation of self-referential interpretations and identification of key causal relations between the past and the presence</b> <b>Eliciting self-referential interpretations (flip-chart)</b>
I (always) felt defeated when he yelled at me ( <sup>1*</sup> ). I (always) thought that I am a looser ( <sup>2*</sup> ). I (always) froze when I saw the anger in his face before he yelled at me ( <sup>3*</sup> ). I (always) felt so lonely ( <sup>4*</sup> ).

<p><b>Identification of key causal relations between the past and the presence (flip-chart)</b></p> <p><b>Preparation theorem: The impact of my father on me/my everyday relationships is that....</b></p>
<p>I do not disclose what I feel (1*).</p> <p>I do not express my own opinion (2*).</p> <p>I am convinced that something bad will happen if I do not follow the rules of authorities (3*).</p> <p>I avoid conflicts by running away (3*).</p> <p>I submit myself authorities (4*).</p>
<p><b>TASK 4: Translation of tacit knowledge into explicit causal knowledge (flip-chart)</b></p>
<p><u>First sub-step (underlying compensatory rule):</u> Avoiding closeness to my father protected me to get hurt.</p> <p><u>Second sub-step (up-coming event when acting against the rule):</u> Overt punishment.</p> <p><u>Third sub-step (CTC):</u> I am afraid of authoritarian dominant men - <u>if I come closer to a authoritarian man then I freeze -</u></p>
<p><b>CTCs of other listed SOs, i.e. after the patient has formulated one CTC for each SO</b></p>
<p><u>Mother</u> (exerted a negative formative influence with high impact) I am afraid of dominant-hostile women, i.e. if I come closer to women then I will be punished irrationally.</p> <p><u>First girlfriend</u> (exerted a negative formative influence with <u>traumatically processed impact</u>) I am afraid of attractive hysterical women, i.e. if I come closer to attractive women I will become existentially hurt.</p> <p><u>Second girl-friend</u> (exerted a positive formative influence with low impact) If I keep distance then I can trust a woman in some way.</p> <p><u>Travelling companion</u> (exerted a positive formative influence with low impact) If I interact with a calm and composed non-authoritarian man who has no prejudice against my background I feel happy.</p>
<p><b>Determination of the dominant interpersonal theme domain - ascertained in the absence of the patient</b></p>
<p>The patient does not know how to relate emotionally with humans. He can not trust in relations (intimacy area)</p>
<p><b>Transference hypothesis, i.e. the associated in-session transference prediction related to the therapist for IDE work</b></p>
<p>If I (patient) come emotionally close to Dr. Schoepf, I am sure that he will point on my deficits and something hurtful will happen that is lying out of my control and that will make me feel lonely (here formulated as a baseline illness sentence).</p>

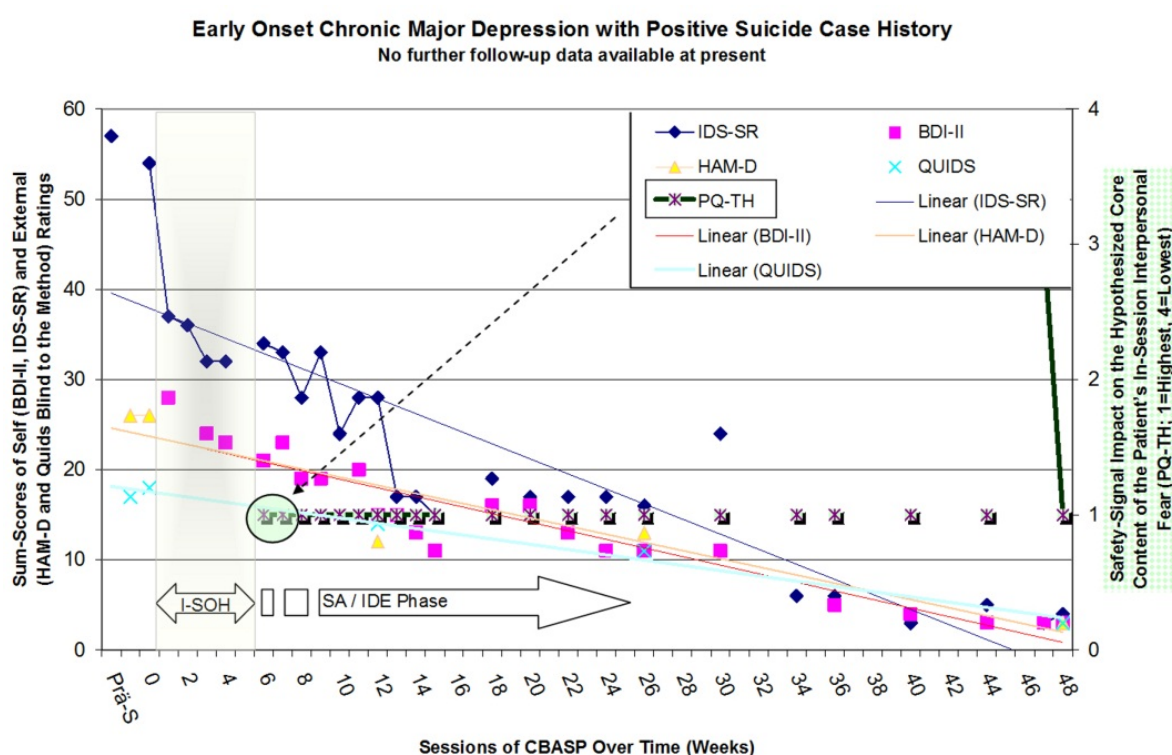
Table 3.

### 3. Third part

#### 3.1. Treatment trajectories of early-onset chronically depressed outpatients

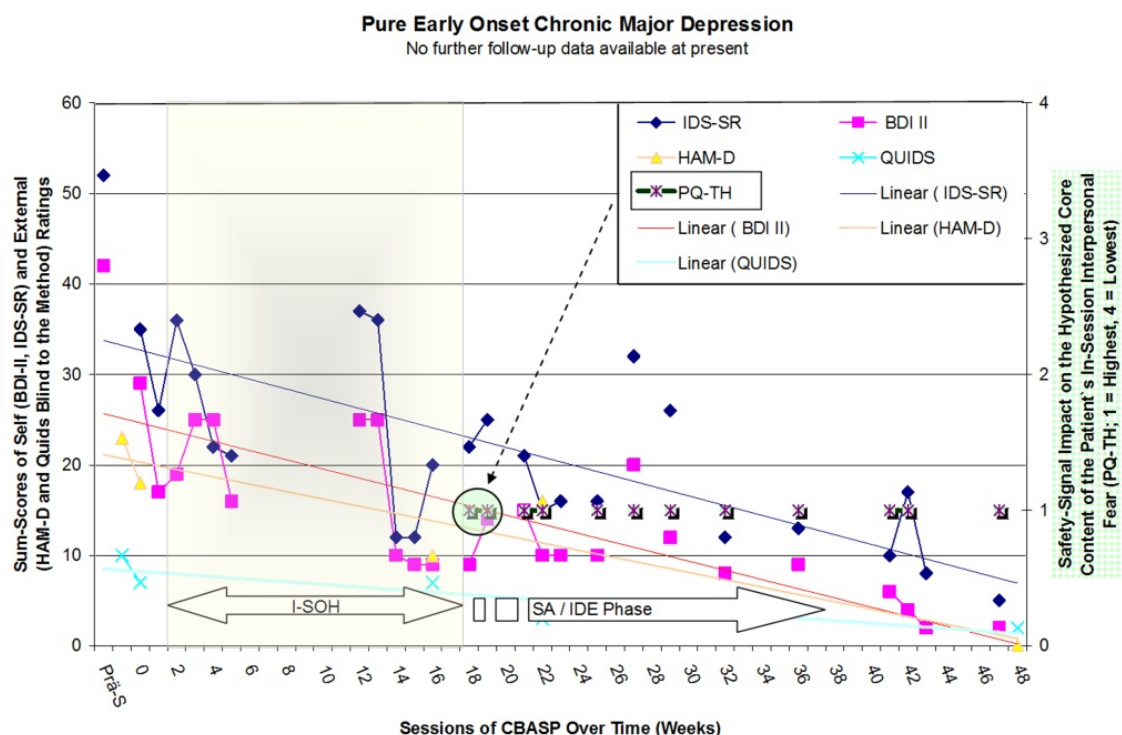
Typical treatment trajectories over 32 sessions in 48 weeks (figures 1-5) of 5 younger to middle age adult chronic MDD outpatients with antecedent dysthymic disorder that were treated according to the modified protocol are represented without further systematic statistical evaluation as the studies are still running.

The SCID I and II were used for diagnosis. Early life trauma and live events were assessed by using the Childhood Trauma Questionnaire and the Early Trauma Inventory. The external ratings (HAMD or MADRAS as primary-outcome measures) were done blind to the therapy method; the PQ ratings were done blind to the therapist. All therapy sessions were videotaped. Concerning feasibility, all patients completed the treatment. The adapted I-SOH procedure protocol proved to be feasible and there were no major difficulties with side effects of potential symptom aggravations, affective overflow or potential retraumatization.

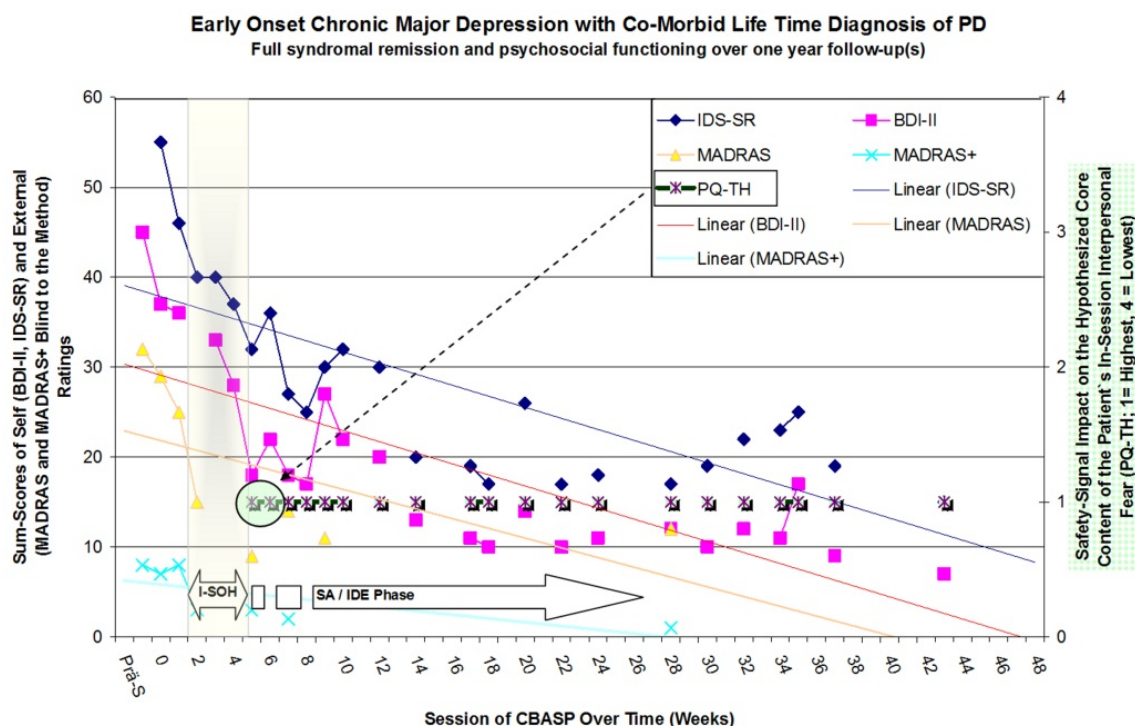


**Figure 1.** Female patient under 30 years. X-axis: Prä-S = pre-screening. 0 = just before start of treatment. 1<sup>st</sup> Y axis (left): Full syndromal remission according to self-ratings at week 36 (BDI-II  $\leq$  10). 2<sup>nd</sup> Y axis (right): The highest possible safety-signal impact of the therapist on the hypothesized core content of the patient's in-session interpersonal fear at the start of the SA/IDE phase of treatment (week 6, arrow) maintained until the end of treatment.

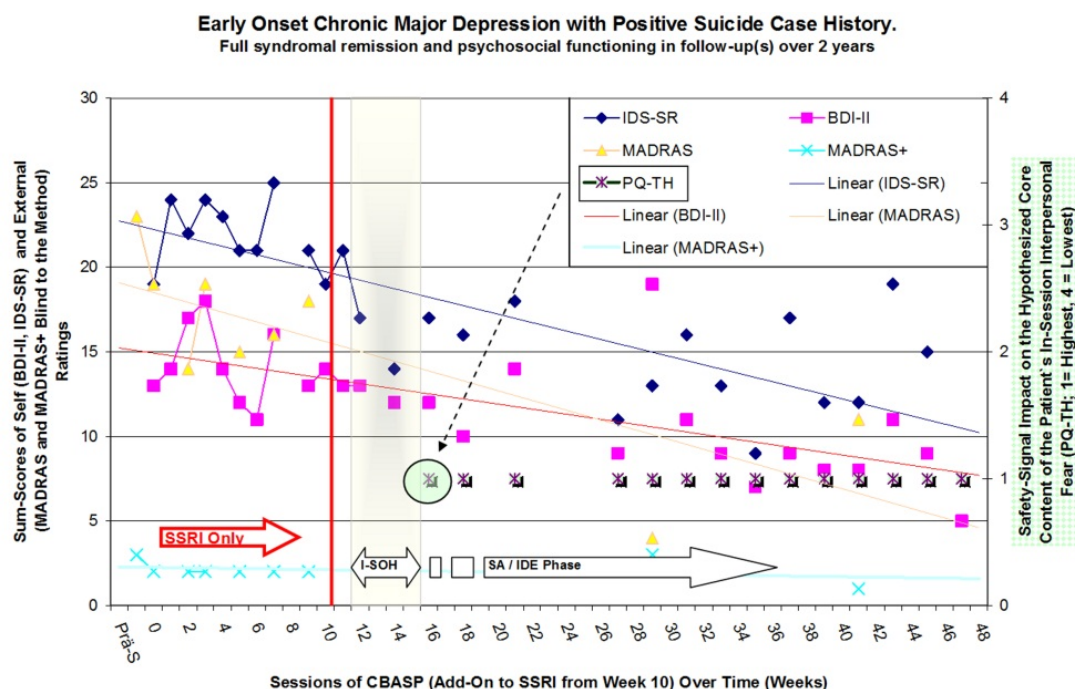




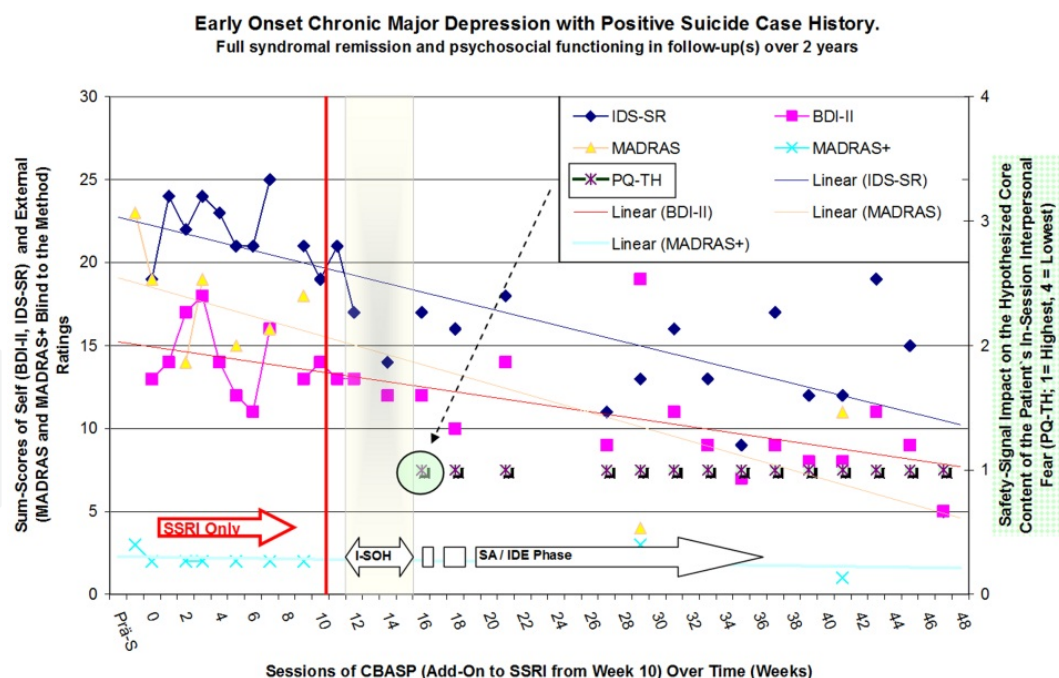
**Figure 2.** Female patient in middle age under 50 years. The pre-SA phase of treatment was interrupted with no ones fault between the fifth until the 12<sup>th</sup> week. Full syndromal remission is reached at week 13 (BDI-II  $\leq$  10). The highest possible safety-signal impact of the therapist is reached at the start of the SA/IDE phase of treatment (week 17, arrow) and maintained until the end of treatment. Axis labels as in figure 1.



**Figure 3.** Female patient under 40 years. The highest possible safety-signal impact of the therapist is reached at week 6 (arrow) and maintained until the end of treatment. Full syndromal remission at week 17 (BDI-II  $\leq$  10). PD = Panic Disorder..



**Figure 4.** Male patient with age under 50 years. Start with SSRI treatment alone. CBASP added after week 8 because of non-response (Reduction MADRAS sum score < 20%). Red vertical line signifies the start of CBASP. The highest safety-signal impact of the therapist is reached at week 16 (arrow) and maintained until the end of treatment. Full syndromal remission at week 18 (BDI-II  $\leq$  10).



**Figure 5.** Female patient with age under 40 years. Start with SSRI treatment alone. CBASP added after week 8 because of non-response (Reduction MADRAS sum score < 20%). Red vertical line signifies the start of CBASP. The time period of the I-SOH procedure is short. Correspondingly, the safety-signal impact of the therapist is low (arrow) at the beginning of the SA/IDE phase. The highest safety-signal impact of the therapist is reached at week 35 on a stable niveau. Full syndromal remission is achieved at week 14 (BDI-II  $\leq$  10).

The treatment trajectories clearly show - without any further necessary explanation - a positive short-term effect of the I-SOH procedure on the hypothesized core content of the patient's in-session interpersonal fear in relation to symptom reduction. In addition, over the period of the treatment a state of full syndromal remission was achieved in all patients. In addition, the treatment trajectories demonstrate that under out-patient study conditions the adapted study protocol works best with a dosage of up-to 35 sessions. The first three figures represent treatment trajectories of CBASP only treated patients which were highly motivated for the method. Figures four and five represent trajectories of CBASP add-on treatment to non-response to previous 8-week SSRI treatment. The SSRI medication was further prescribed and controlled during the course of therapy. Both patients had no preference for one of the two methods but were highly motivated to be included into the study.

### 3.2. Challenges and future directions

Around 3.7 million children are assessed for childhood maltreatment each year alone in the United States. Converging data support adverse effects of early life stress on morphologic development of corticostriatal-limbic structures (Edmiston EE, et al., 2011). Clinically, there is ample evidence that a persisting state of depressed emotion and interpersonal anxiety in chronic MDD with antecedent dysthymic disorder cannot be shaken easily by any kind of antidepressant medication or biophysical intervention; neither in a dozen of disorder specific therapy sessions that are embedded in a conceptually framework that has just started to point in public to the exposure aspects of its major techniques of change (Neudeck et al., 2012) nor by simply changing the situational thoughts and/or problem solving capabilities (Schoepf et al., 2007; Kocsis et al., 2009; Schoepf & Neudeck, 2011; Schoepf et al.; 2011; McCullough, 2012).

Animals and human beings view the world causally; exactly the same early-onset chronically depressed patients. However, the patient's bottoms-up and top-down driven processes largely operate in the absence of cognitive awareness as stimulus learning of stressful encounters with their SO's in the past dominates over social adaptive outcome-effect learning in the presence. Based on my clinical experiences and the treatment effects of my self treated patients that are represented in this chapter article in the form of simple treatment trajectories without further statistical evaluation, I assume that the successful mastering of the I-SOH procedure in the presented exposure based form - that primarily focuses on activating and restructuring past helplessness memories with SOs in the early phase of treatment - represents a key stepping stone in CBASP out-patient treatment that turns the page from the patient's idiosyncratic functioning at the beginning of therapy to circular formal-operational functioning and long term success in the later therapy process. McCullough would say: The I-SOH procedure in the presented form thrusts the therapist into the core perceptual-emotional arena involving the patient and his SOs. I have to add, that at the end of the pre-SA phase of treatment, the technique loosens these emotional connections, replacing them with a salubrious new connection to the therapist. Additionally, every SA patient brought to therapy in the second treatment phase played in the dominant

interpersonal theme domain, in which recurrent experiences of helplessness were earlier made. This is motivation to change and approaching behaviour from the patient's side and challenges the therapist.

Behaviour therapists often express that working with exposure is quite rewarding, as fear inhibitory learning allows the therapist and the patient a more flexible adjustment of fear related associations in changing environments, exposure is intellectually and behaviourally stimulating, and exposure has the potential to facilitate lasting change in the patient. However, in the treatment of chronic MDD with antecedent dysthymic disorder potential challenges may come about severe side effects of potential symptom aggravations, potential retraumatization and affective overflow that may be caused by techniques like the I-SOH procedure that confront the patients with their helplessness memories that are sometimes traumatically processed. Indeed, helplessness memories and associated core-beliefs are often quite painful for patients to acknowledge, and sustained attention to closed perceptual systems in session is usually associated with an increase of negative affect and agitation. Not only then, it is important for the therapist to be able to be oneself with the patient in the therapy, i.e. that the patient encounters an authentic therapist who is neither afraid to be himself nor to walk with the patient as a "comrade" (McCullough, 2012). It is also imperative, that the patient learns from the beginning of therapy to effectively use specific interventions of CBASP's functionality teaching and skills teaching dimension to deal with these inevitable and for the progress of therapy necessary symptom aggravations. Because fear inhibitory learning is not attained fully after one session, the patient may experience a temporary increase in symptoms in between sessions. Therapists should anticipate this and should meet special agreements in the form of additional short sessions.

Although CBASP, as a "difficult to learn" treatment package that can only be acquired through intensive training, showed significant effects for treating refractory outpatients with chronic MDD in one of the two large NIHM funded studies, especially in its combination with medication (Keller et al., 2000) and developmental trauma (Nemeroff et al., 2003), rarely research is conducted concerning the role exposure aspects play in patient change. Thus, a much-needed direction for future research is to dismantle specific CBASP interventions and to evaluate their efficacy in reducing depressive symptoms, improving functioning, and improving quality of life. Such process research has to involve a time-series analysis of standardized assessments completed at the beginning and the end of each therapy session, and across the course of multiple sessions. In addition, by the research on the neural mechanisms of chronic depression and the impact of CBASP on behavioural and neural functioning (Schnell et al., 2010), more is learned about the fundamental processes of learning and memory that take place during administering CBASP intervention strategies (Walter et al., 2009).

### 3.3. General conclusion

In this chapter, I have given an overview of an important excerpt of my clinical work under study conditions that I have carried out in the last six years. The I-SOH procedure and the



modified protocol have been discussed with Jim McCullough, Kim Penberthy and Henrik Walter since 2006 and later Knut Schnell. The fifth colleague of this core working group is Peter Neudeck who joined the Bonn CBASP Centre of Competence 2009. Peter is an excellent exposure therapist whom I supervise in CBASP until today as I have been supervised by Jim McCullough once (2007-2008). All of us strongly emphasize the aspects of modern learning theory in CBASP as CBASP therapists and all of us feel the need to further dismantle CBASP's interventions for better treatment. Hopefully, this chapter has persuasively articulated a constructive use of the modified out-patient protocol for chronic MDD patients with antecedent dysthymic disorder. It is again my concern to bring into consciousness that disciplined personal involvement CBASP techniques that are both reliable and valid can only be learned through intensive training. This is the reason why, to this day, even McCullough himself conducts training for selected learning therapists, using video-supervised case studies. As CBASP-providers, CBASP-supervisors and CBASP-therapists, these therapists are responsible for the distribution and quality control of CBASP in their respective countries (Schoepf & Neudeck, 2011). Further information is available at [www.cbasp.org](http://www.cbasp.org). Like the last year, when I wrote the 2011 CBASP overview chapter, I found myself again fueled by hope that this articulation can be of assistance to other psychiatrists and psychotherapists, as well to other mental health practitioners who are interested in working with chronically depressed patients in a constructive way to help their patients to get out of their prison of negative thoughts and outcome expectations, as well as to change their destructive interpersonal behaviors.

## Author details

Dieter Schoepf

*Bonn University, Department of Psychiatry and Psychotherapy,  
CBASP-Centre of Competence, Germany*

## Acknowledgement

I am grateful for the collaboration of James P McCullough JR, Commonwealth University of Virginia; Jennifer Kim Penberthy, University of Virginia Health System; Wolfgang Maier, Department of Psychiatry, University of Bonn; Henrik Walter, now Department of Psychiatry, University of Berlin; Knut Schnell, now Department of Psychiatry, University of Heidelberg; and Elisabeth Schramm, Department of Psychiatry, University of Freiburg. I also thank CBASP-network and the whole Bonn CBASP-1 and CBASP-2 study team for their pro-active work, as well as the whole team of my inpatient department.

## 4. References

- American Psychiatric Association: Diagnostic and statistical manual of mental disorders, 4<sup>th</sup> edition, text revision (2000). Washington DC, American Psychiatric Association.
- Bandura A (1969). Principles of behaviour modification. New York; Holt, Rineheart & Winston.



- Bouton ME (2007). Learning and behaviour: A contemporary synthesis. Sunderland; Mass: Sinauer Associates, Inc.
- McCrory EJ, et al. (2011). Heightened neural reactivity to threat in child victims of family violence. *Current Biology*; 21 (33): doi: 10.1016.
- Edmiston EE, et al. (2011). Corticostriatal-limbic gray matter morphology in adolescents with self-reported exposure to childhood maltreatment. *Arch Pediatr Adolesc Med*; 165(12):1069-1077.
- Ehlers, A & Clark, DM (2000). A cognitive model of persistent Posttraumatic Stress Disorder. *Behaviour Research and Therapy*, 38, 319-345.
- Foa EB, et al., (2007). Prolonged exposure therapy for PTSD: Emotional processing of traumatic experiences. New York: Oxford University Press.
- Keller MB, McCullough JP, et al. (2000) A comparison of nefazadone, the cognitive behavioural analysis system of psychotherapy, and their combination for treatment of chronic depression. *New England Journal of Medicine*; 342: 1462-1470.
- Klein DN et al. (2011). Social problem solving and depressive symptoms over time: a randomized clinical trial of Cognitive-Behavioral Analysis System of Psychotherapy, Brief Supportive Psychotherapy, and Pharmacotherapy. *Journal of Consulting and Clinical Psychology*; 79 (3): 342-352.
- Klein DN, Kocsis JH, et al. (1996). Symptomatology in dysthymic and major depressive disorder. *Psychiatr Clin North Am*; 19 (1): 41-53.
- Kocsis JH, Gelenberg AJ, et al. (2009). REVAMP Investigators: Cognitive behavioural analysis system of psychotherapy and brief supportive psychotherapy for augmentation of antidepressant nonresponse in chronic depression: the REVAMP Trial. *Arch Gen Psychiatry*; 66:1178-1188.
- McCullough JP (2012a). The way early-onset chronically depressed patients are treated today makes me sad. *Open Journal of Psychiatry*; 2: 9-11.
- McCullough JP (2012b). Answer of McCullough to official request of E. Schramm after supervisor meeting in CBASP Vs SYSP. Freiburg, Germany.
- McCullough JP et al. (2011). The significant other history: An interpersonal-emotional history procedure used with the early-onset chronically depressed patient. *Am J Psychotherapy*; 65(3):225-48. .
- McCullough JP et al. (2010). A method for conducting intensive psychological studies with early-onset chronically depressed patients. *American Journal of Psychotherapy*; 64: 317-337.
- McCullough JP, McCullough RF (2009). CBASP intensive training workbook. A 2-day-CBASP-professional workshop. The author of the CBASP present at the second day. University Bonn, CBASP Centre of Competence, September 19th and 20th.
- McCullough JP (2008). Personal discussion between workshop leader (McCullough) and co-leaders (Penberthy and Schoepf) during one work intensive training week. Richmond, USA.
- McCullough JP (2007). What are we trying to teach our early-onset chronically depressed patients? Contemporary learning therapy and CBASP psychotherapy for chronic depression (book in preparation). Los Angeles; Psychiatry Grand Rounds, June 26.

- McCullough JP (2006). Treating chronic depression with disciplined personal involvement: CBASP. New York; Springer.
- Nemeroff CB, Heim CM, et al. (2003). Differential responses to psychotherapy versus pharmacotherapy in patients with chronic forms of major depression and childhood trauma. *Proc Natl Acad Sci USA*; 100(24):14293-6. Erratum in *Proc Natl Acad Sci U S A*. 2005 Nov 8; 102(45):16530.
- Neudeck P, Walter H, Schoepf D (2012). Exposure aspects of the interpersonal discrimination exercise (IDE) and the situational analysis (SA) in Cognitive Behavioral Analysis System of Psychotherapy (CBASP). In: *Exposure Therapy - Rethinking the Model - Refining the Method* (ed. by Peter Neudeck & Hans-Ulrich Wittchen). Springer International (pp. 153-166). 233 Spring Street, New York, NY 10013, U.S.A.
- Nisbett, Richard, & Wilson, Timothy (1997). Telling more than we can know: verbal reports on mental processes. *Psychological Review*, 84: 231-259.
- Penberthy JK (2010). CBASP and the chronically depressed alcoholic. WCBCT, Boston, June 3; Symposium 33: KCB 101.
- Polany Mi (1966). *The tacit dimension*. Doubleday; Garden City, NY.
- Schmidt, JA et al., (1999). Psychometric and circumplex properties of the Octant Scale Impact Message Inventory (IMI-C): A structural evaluation. *Journal of Counselling Psychology*, 46, 325–334.
- Schnell K, Schoepf D, et al. (2010). Insights into the „Helpless Brain“– an fMRI-Model of perceived functionality in chronic depression. WCBCT, Boston, June 3; Symposium 33: KCB 101.
- Schoepf D, Neudeck P (2011). Cognitive Behavioral Analysis System of Psychotherapy (CBASP): a disorder-oriented, theory-driven psychotherapy method from the "third generation" of behaviour therapy models, designed for the treatment of chronic depression. In: Uehara T (Ed.) *Psychiatric Disorders - Worldwide Advances* (pp. 87-120). ISBN: 978-953-307-833-5.
- Schoepf D, Neudeck P, Walter H (2011). Learning theory aspects of the Interpersonal Discrimination Exercise (IDE) and Clinical Applications. International CBASP-Network Conference, Lübeck, August 25 - 27.
- Schoepf D, Penberthy JK (2010). Cognitive Behavioural Analysis System of Psychotherapy (CBASP): new applications and neurobiological mechanisms. WCBCT, Boston, June 3; Symposium 33: KCB 101.
- Schoepf D, McCullough JR (2009). CBASP's cutting edges to change the behaviour of the chronically depressed patient. Paper presented at the professional 2-day workshop with the author of the CBASP present at the second day, University Bonn, September 19th and 20th.
- Schoepf D, Schnell K, Walter H (2008). Das Cognitive Behavioral Analysis System of Psychotherapy (CBASP): Theoretische Basis und Therapiestrategien. DGPPN Kongress, P-012-: Depression, II, Track: Depression/Affektive Erkrankungen
- Schoepf D, Konradt B, Walter H (2007). Specific psychotherapy of chronic depression with the Cognitive Behavioral Analysis System of Psychotherapy. *Nervenheilkunde* 26: 790-802.

- Schramm et al. (2011). Comparative efficacy of the Cognitive Behavioral Analysis System of Psychotherapy versus Supportive Psychotherapy for early onset chronic depression: design and rationale of a multisite randomized controlled trial. *BMC Psychiatry*, 11:134.
- Walter H, Berger M, Schnell K (2009) Neuropsychotherapy. Conceptual, Empirical and Neuroethical Issues. *European Archives of Psychiatry and Clinical Neuroscience* 259, Suppl. 2, 173-182.
- Winnicott DW (1949). Hate in the counter transference. *International Journal of Psychoanalysis*; 30: 69-75.