Mark Berthold-Losleben
Marianne Liebing-Wilson
John S. Swan

The ABCs of CBASP

A Guide to the Cognitive Behavioral Analysis System of Psychotherapy for Therapists and Supervisors

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About the Authors

Mark Berthold-Losleben, PhD, MD, MA, is a consultant psychiatrist at St. Olavs University Hospital in Trondheim, Norway, and associate professor at the Department of Mental Health of the Norwegian University of Science and Technology (NTNU). He trained with Prof. James McCullough in 2016 in Amsterdam and was supervised by John S. Swan on his way to becoming a therapist, supervisor, and trainer in CBASP. Since 2018 he has been working closely with John S. Swan, Marianne Liebing-Wilson, and Bob MacVicar on making CBASP better known in Norway.

Marianne Liebing-Wilson, RMN, PG DIP CBT, was a senior adult psychotherapist with NHS Tayside and delivered the postgraduate CBT training program at the University of Dundee in Scotland together with John S. Swan. She trained with Prof. McCullough on several occasions on his visits to Scotland, and offered CBASP training to European colleagues with him in Amsterdam. She continues to offer training and supervision in CBASP in the UK and various European countries.

John S. Swan, MSc, BSc, RMN, RGN, PG DIP CBT, was a senior clinical lecturer and course director with the University of Dundee in Scotland. He trained with the originator of CBASP, Prof. James McCullough, in 2006 and was fortunate enough to be supervised by Prof. McCullough for three years after his training. John S. Swan is now retired but continues to offer training and supervision in CBASP upon request.

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Dedication

To my beloved and most significant others in order of their appearance: Katrin, Anouk, Lucia, and Carla.

Mark

To my family who have supported and believed in me, even when I doubted myself.

Marianne

To Dr. Rob Durham, now sadly deceased. A finer friend, colleague, and mentor there never was.

John

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Marianne and John, it has been a real pleasure to work with you. I thank you for this amazing journey and hope this wasn't our last project. To be continued.

I also thank my wife Katrin for her very honest and most valuable feedback, my parents for their support, and my children for how wonderful they are.

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Finally, I want to thank James McCullough who dedicated his life to develop this exciting and important psychotherapy and had a great impact on me and my view of the chronically depressed patient. Thank you, Big Jim, for writing these kind words in your foreword.

Mark Berthold-Losleben

I'd like to thank the late Rob Durham, my mentor and friend who introduced me to CBT. John Swan and Bob (the Bobster) MacVicar who taught me how to teach and who have travelled far and wide with me to spread the word about CBASP.

Thanks go to Mark for being bored during the pandemic and coming up with the idea to write a book – what a blast we had!

And last but not least, Big Jim (McCullough) – thank you for being such a force of nature and a tremendous psychotherapist!

Marianne Liebing-Wilson

Marianne and Mark, we figured out a useful way to spend the pandemic by working on this text. You both made completing the book such a straightforward pleasure.

I offer up a big thank you to my wife Sybille for being so supportive.

Finally, gratitude to Professor James McCullough whose friendship and mentorship made the last 16 years of my career even more enjoyable than it was the 30 plus years before CBASP.

John S. Swan

Contents

1 Introduction

Offering therapy to anyone in distress presents the therapist with numerous challenges and associated tasks. The three core tasks throughout therapy are:

- To establish, foster, and maintain a working alliance that is collaborative and encourages the person seeking help to move toward taking on a participant role in behavioral and emotional change.
- To construct an accurate case formulation of the patient's problems which establishes and clarifies how both current and historical circumstances have influenced the problems in living the patient is experiencing in the here and now.
- To offer an effective treatment strategy specifically targeted to ameliorate those problems in living.

Significant challenges face both the person seeking help and the therapist in meeting these three core tasks. These challenges can be distilled into three core factors:

- The breadth and complexity of the characteristics of the person seeking help.
- The nature and complexity of the diagnosed disorder and concomitant problems in living experienced by that person.
- The fact that most therapists work in situations of significant clinical pressures where there are often limited resources and support (Durham et al., 2000).

The cognitive behavioral analysis system of psychotherapy (CBASP) is a psychological therapy specifically designed to enable therapists to help individuals who experience chronic depression (CD). Please note that we do not make a clear distinction between the terms *chronic depression* and *persistent depressive disorder.* In this book, we prefer the use of chronic depression, as we think it is a more common and probably a better understandable expression also for people not working in healthcare. However, therapy-resistant depression, often used to refer to chronic depression, is – as far as we are concerned – a less diagnostic and more clinical and to date unstandardized term, which we avoid using due to the lack of a broader consensus (see also McIntyre et al., 2014). The CBASP model is predicated on directly addressing the tasks and challenges outlined above (McCullough, 2000, 2001, 2002, 2006; Swan & Hull, 2007). Our clinical experience over many years of attempting to help those with chronic depression led to the realization that the treatment of this disorder calls for a different approach, which is reflected in the literature calling for specific models for treating chronic depression both psychotherapeutically and pharmacologically (de Maat et al., 2007; Fournier et al., 2009; Keller et al., 2000; Keller, 2001; Schramm, Hautzinger et al., 2011; Schramm, Zobel et al., 2011; Swan et al., 2014; Thase et al., 2001). Later in this

chapter, we unpack the principles and procedures within the CBASP to provide a preparatory insight into what follows in subsequent chapters. For now, we want to map out the particular signs, symptoms, and characteristics of chronic depression.

The Nature of Chronic Depression

Chronic depression in DSM-5 is exclusively referred to as persistent depressive disorder (PDD) and is defined as experiencing a depressed mood for most of the day on more days than not for 2 years or longer; the person is never without symptoms for longer than 2 months.

DSM-5 provides a symptom checklist algorithm that includes specifiers such as persistent major depressive (MD) episode, PDD with intermittent MD episode with and without a current episode, and pure dysthymic disorder (APA, 2013). Although DSM-5 may not live up to all of the multifarious distinctions McCoullough presents in his research and various other books about chronic depression, the inclusion of such specifications at all can be attributed to his efforts.

ICD-10 of the The World Health Organisation (WHO) seems to be less sophisticated when it comes to defining chronic depression, and indeed ICD-11 fails to add to ICD 10 in any substantial way. Dysthymic disorder or chronic depressive personality disorder or dysthymia as approximate synonyms are coded under F34 persistent mood [affective] disorders in the ICD-10; different subtypes are not explicitly included. The disorder is considered to be rather mild and does not take into account the severity of the symptoms and different courses of disease we encounter in everyday clinical practice.

Complexity and Characteristics of Chronic Depression

Prevalence and Persistence

Chronic depression is a disorder that develops over years, rarely remits spontaneously, and can last for decades (Al-Harbi, 2012; Klein, 2010). One in five adults with a major depressive disorder goes on to develop a chronic course (Arnow & Constantino, 2003; Kessler et al., 1994; Spijker, 2002; Torpey, 2008), with the lifetime prevalence of chronic depression estimated at 3% to 6% in community and primary-care samples (Murphy & Byrne, 2012; Satyanarayana, 2009; Young et al., 2008). The mean duration of chronic depression episodes ranges from 17 to 30 years. In contrast, nonchronic presentations have a mean duration of 20 weeks (Gilmer et al., 2005; Kocsis et al., 2008). Klein and colleagues (2006) found that individuals with a chronic illness were 14 times more likely to have a chronic presentation 10 years later. In addition to long periods of illness, once affected, people who develop persistent depression tend to have an earlier onset of their mood disorder than

2 Christopher

The alarm goes off shrilly. Again. I had already turned it off 20 minutes ago. It's now 10:30 a.m. The weight sitting on my chest and in the pit of my stomach is still there. It always is these days and has been for as long as I can remember. Why is it I wake up feeling I've been to an all-night party? My head hurts and my body feels as if it is separate from me. The bits of my body I can notice simply ache and hurt like I've been to serious football practice. But I haven't. It's a memory from when I was made to play sports at school mainly because my dad thought it would be good for me. It wasn't.

So, I lie in bed hurting, unable to think clearly about the day ahead. I don't want to think too much about what the day might hold because I suspect it will be like every other day. Same shit, different day. My stomach turns at the thought of what the day might hold for me. I am not working at the moment. My employers sent me home after 3 or 4 weeks of me being late and leaving early. The message from them was I "just was not up to the job." Little do they know. I've not been up to the job from the start. Always making mistakes and facing complaints from my coworkers, who seemed to find me irritating. I can't think why as I tried to have as little to do with them as possible even when they said they were trying to be helpful. They weren't. I suspect they were *just being nice* and waiting for me to fail or make a mistake so they could have fun with that. The only person who genuinely seemed nice was Amelia. I still can't figure it out, but she seemed to like me, and she never took part in the mind games the others played in the office. Amelia was kind and gentle and had time to listen to me about my worries, even when I was in my *dark days* and couldn't bring myself to talk to anyone. She seemed to understand that my mood would often be quite low and at these times she and I would go for walks or go to the movies. I told her things about myself I don't find easy to share, and she would listen. Never judged, always accepting. Amelia was my first and only real friend, and I guess I came to trust her. Of course, the Universe decided that this goodness for me could not be allowed to persist. Amelia died in a road traffic accident, and it seemed to me that anyone I come to trust simply *leaves*. I feel bad as that thought runs through my mind, but it fits the facts. I couldn't bring myself to go to her funeral and face all those people. I can see now that this was a mistake, and this mistake simply gets added to the ongoing list.

I think to myself that I really should get out of bed and face the day. My psychiatrist, Dr. Phil, like everyone else, has become tired of me and has referred me to a psychotherapist. I'm pretty sure he thinks it's unlikely to make any difference, but he feels it is someone else's turn to put up with me for a while. To be fair, over the years, Dr. Phil has put up with a lot when it comes to me. For the past 9 years or so I think I've been in his hospital ward about

4 Timeline

Maggie: Hi, my name is Mrs. Marlow, but please call me Maggie. What would you like me to call you?

Christopher: People call me Chris – I suppose you can call me that, too.

Maggie: That's great. I am pleased to meet you, Chris. *(silence)*

Christopher: *(What does she want me to say? I'm sure she doesn't mean that she is actually pleased ...)*

Maggie: *(I suppose I need to address the elephant in the room, he noticed me looking at the puddle on the floor.)* I am glad you could make it especially with the weather being as horrible as it is. Did you have any trouble finding the place?

Christopher: I missed my stop and had to walk back two blocks. I guess that's why I'm so wet, I'm sorry for making a mess of your floor.

Maggie: *(So he did notice me staring at the puddle on the floor.)* Yes, I noticed you were soaking wet. But I am not so concerned about my floor – it's only water after all. But maybe you would like to take off your coat, so it has a chance to dry during the time we are talking. You can hang it up over there, if you wish.

Christopher: Okay then, thank you.

(He takes off his coat and hangs it on the coat stand.)

Maggie: So, Chris, you're here today because you were referred to me for therapy by your psychiatrist. He said that you have had problems with depression for years. Can I ask whether you have had therapy for that in the past?

Christopher: Hm, yes sort of, but I can't remember much about it.

Maggie: That's okay, maybe we can have a look at that later on.

Christopher: Yes, sure.

Maggie: Well, would it be helpful for me to tell you a little about how I practice?

Christopher: Ok, if you want ...

Maggie: *(He is very passive and tired of therapy, I need to watch that I don't lose him.)* So, I am trained in treating people who have depression, especially when they have had depression for many years, or the depression keeps coming back. Depression that lasts for a long time or doesn't seem to go away can need a different way of handling it, compared to depression that's just a new and fairly short-lived thing. Would you think that your depression has lasted for some time now?

Christopher: Yes, I guess I haven't felt right for a while.

Maggie: *(Ok, he is obviously depressed, but I guess this has been going on for a while.)* So, would you say the way you feel at the moment is "fairly depressed"?

7 Kiesler's Theory of Interpersonal Styles

Let's have a look at how Maggie fills out the Interpersonal Message Inventory – Circumplex (IMI-C) on Christopher. The IMI consists of 56 items or questions Maggie scores with 1 – *Not at all*, 2 – *Somewhat*, 3 – *Moderately*, or 4 – *Very much so*.

***

Right, I have left myself a bit of time after today's session, so Chris is fresh in my mind. He really is a quiet young man who doesn't want to get involved with me much. I get it, I'm the therapist and a woman. So, there might be strong associations with people in authority, especially females like his mom. And with people who are older than him.

Anyway, let's see what comes up – there are often some surprises when I go through these questions. Here we go ... So, the first one, about being bossed around, is pretty straightforward – *Not at all* or 1. Next one is asking whether he makes me feel distant from him. Yes, he does, but not in a really full-on way – so that's a *Moderately so* – a 3.

Ok, this is going all right. Some of these statements are a bit trickier though. Some quite straightforward ... Yes, I do feel like an intruder (4 – *Very much so*), and he does make me feel in charge (again 4 – *Very much so*). But how about feeling appreciated by him ... I think he appreciates my input a little – so that would be 2 – *Somewhat*.

Here is question 8 – I always find that one a bit harder, because I have not seen him in that setting. So, it's asking whether I feel part of the group when Chris is around. Let's just imagine we are in a different setting and recall what I know about Chris so far. Would he make a move to introduce me to his mates? Would he include me in an activity? I really can't see that happening. He is way too shy and likes other people to do the introductions ... I will give this a 1 – *Not at all*.

Here is an interesting one: Does he make me feel annoyed (Q 16). I want to say *Not at all*, but that's really not honest, and I have to be honest when filling this in. So, while I want to think that I don't get annoyed with him, I actually do. Especially in moments when he is really submissive and makes me work really hard. I think it is going to have to be 2 – *Somewhat* for this one.

9 Case Formulation in CBASP

In the early phases of any psychological therapy, a core and fundamental task for the practitioner is to assess the patient's presenting clinical problem. This important activity aims to establish the most effective and appropriate intervention. The challenge to the practitioner is knowing which information to gather. The next challenge is to clarify what the patient's problems in living are and then to make a decision on what actions to take – while bearing in mind the necessity of evaluating the impact, in terms of change over time, of these actions or interventions.

In the preceding chapters, we focused on the early phases of CBASP, where the clinician and the patient focus on gathering and clarifying specific categories of information thought to be central to understanding how the past learning biography of the person seeking help influenced the development of their problems in living experienced in the present.

Specifically, these categories of information are:

- Does the patient meet the criteria for chronic depression? Details on this are generated by guiding the patient through the Timeline Exercise (Chapter 4).
- The Significant Other History (SOH) and the derivation of Causal Theory Conclusions (CTCs) or stamps, which then leads to the conceptualization of a Transference Hypothesis (TH) (Chapter 5 and Chapter 6).
- The completion, by the therapist, of the IMI-C, which provides insights into the likely interpersonal style of the patient once engaged in significant interactions within the therapeutic encounters over a course of CBASP (Chapter 7).

As a therapeutic modality with clearly defined principles and procedures, CBASP provides specified ways of describing the patient's presenting problems in living; it frames and communicates the underlying psychological mechanisms that give rise to these problems in living. CBASP therapists are taught how to describe these presenting problems using theory (principles) to develop explanatory inferences about probable causes and maintaining factors of these problems. Finally, they form hypotheses concerning the links between these elements which guide the proposed treatment plan (procedures).

CBASP is a relatively new psychological therapy. Like other established psychological therapies, to date, CBASP has developed with little reference to the practice of case formulation, although we (the authors) consider the development of procedures relating to case formulation to be important in the clinical application of CBASP (Swan et al., 2016).

Why do we consider this development to be important?

Maggie: Indeed, it would, Chris! So, would you be ok with taking this sheet with you and for our next session noting down a stressful situation?

Christopher: I can give it a go, I suppose ...

Maggie: That would be great for you to give it a try despite your doubts. I respect that. Let's arrange another date for next week, then.

Christopher: Yeah, ok.

***

Guidelines for Situational Analysis

1. There are very few stipulations in CBASP therapy, but one cardinal stipulation is that the patient complete the in-between session task of bringing a written, completed CSQ to each session. Preferably do not accept CSQs presented from the patient's memory or no presentation of CSQs at all. If necessary, problem-solve the nonpresentation of CSQs. Provide whatever input is required to ensure the probability of future compliance with the weekly completion of a CSQ. One can always do an SA on why no CSQ is being offered! Much can be learned if the patient and the therapist do this.
2. When you begin an SA, try to ensure completing it within one session. In the beginning, when teaching the steps and phases of SA, it is probably best to increase the time available within the session. But once the patient has practiced a few times with your help and support, it becomes possible to do SA within the "golden hour" of therapy.
3. Once completion of the CSQ and subsequent SA sessions has become the default activity for sessions, spend the entire first session walking the patient through what is known as the Elicitation Phase, which includes the completion of the CSQ as provided below. Use a recent event from the patient's experience.
4. Take your time and actively coach the person on the steps and rules/criteria for each step.

Steps of Situational Analysis

Phase 1: Elicitation

1. Situational description
2. Situational reads or interpretations
3. Situational behavior
4. Actual Outcome (AO)
5. Desired Outcome (DO)
6. Comparison of AO and DO

6a. Reason why DO does not match AO (if the case)

Phase 2: Remediation

1a. Examining reads or interpretations
1b. Generating action reads
2. Impact on situational behavior
3. Summary of learning
4. Generalization of learning

18 The Good CBASP Therapist

Patients may feel uncomfortable having to change behaviors or talk about alternatives, but they should never feel unsafe with the therapist.

(McCullough et al., 2015, p. 58)

When Maggie walked home from Helen's office, she found herself recalling the conversation with her supervisor. The last session with Chris was 2 weeks ago, and the therapy with him was complete. She had not heard from him since and did not expect to hear from him soon. Not that she thought he may never need help in the future, he most likely would; but he seemed to be quite stable over that last couple of weeks, so she thought this might last for a reasonable period. Especially if he realized some of his ambitious, but still realistic plans. If he did, he would continue to choose change before stagnation. She thought that if Chris maintained the current level of self-reflection about his interpersonal functioning, he would continue to learn new interpersonal behaviors on the way and expand his interpersonal repertoire.

So, all in all, she thought it went well with Chris. Much better than expected. That was a familiar experience for Maggie after a completed course of CBASP therapy: Much better than expected. That's what she had told Helen half an hour ago. Her supervisor's response had hit her like a two-by-four:

> Better than expected means the discrepancy between your expectation of the patient after the first sessions and the Actual Outcome of therapy is large. Next week, I want you to answer this question: Do you really expect so little of your patients or are you such an efficient and fantastic CBASP therapist? Or both? Before you think about it, I ask you to read the latest paper on the characteristics of the optimal CBAPS therapist role, published in *Frontiers in Psychiatry* by McCullough himself. (McCullough, 2021)

Two days later, Maggie found time to download the article. It was a Sunday afternoon, and she sat on the balcony of her apartment with a nice cup of coffee.

According to McCullough, the best CBASP therapists he had observed tended to show characteristics that are very valuable to learn from. Some of them represent the transition from theory to practice: Effective CBASP therapists enact Disciplined Personal Involvement (DPI) in their clinical role, and they adhere to CBASP protocol. Maggie had thought that CBASP is highly structured and manualized for a reason. The other two desired general categories are more goal-directed: The outcome of the patient is associated with the