**North Carolina Psychiatric Association**

**September 27, 2018**

**IA: Coping Survey Questionnaire (CSQ)**

**IB: Prompts for Situational Analysis (SA)**

**II: Rationale for Discipline Personal Involvement (DPI)**

* **[JP McCullough, Jr., E Schramm & JK Penberthy (2015). *CBASP as a Distinctive Treatment for Persistent Depressive Disorder: Distinctive Features*. London: Routledge Press. Chapter 7.]**

**III: Significant Other History (SOH) Prompts; Transference Hypothesis (TH) Construction Prompts**

**IV. Interpersonal Discrimination Exercise (IDE) Prompts**

**V. Kiesler’s Impact Message Inventory (IMI)**

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**Handout IA**

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

**COPING SURVEY QUESTIONNAIRE (CSQ)**

**Virginia Commonwealth University**

**Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Therapist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Situational Event: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Therapy Session: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Instructions: Select one stress event that you have confronted during the past week and describe it using the format below. Please try to fill out all parts of the questionnaire. Your therapist will assist you in reviewing this situational analysis during your next therapy session.**

**Situational Area: Family\_\_\_\_\_ Work/School\_\_\_\_\_ Social\_\_\_\_**

**1. Describe what happened:**

**2. How did you interpret what happened:**

**3. Describe what you did during the situation:**

**4. Describe how the event came out for you (*Actual Outcome*):**

**5. Describe how you wanted the event to come out for you (*Desired Outcome*):**

**6. RATE: Did you get what you wanted? YES\_\_\_\_\_ NO\_\_\_\_**

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**Handout IB**

**CBASP SA Administration Prompt Guidelines**

**(Using the Coping Survey Questionnaire, *CSQ*)**

**Elicitation Phase**

**Step One:**

**Tell me what happened in the situation. Just who said/did what and then, describe clearly how the situation ended (endpoint).**

**Step Two:**

**Tell me what the situation meant to you. Think back over the event – what sense do you make out of it going from the beginning to the end. Give me one sentence for each interpretation. After one interpretation: “Did it mean anything else to you?”**

**NOTE:** ***A correct patient interpretation is a "description" of some observable behavior in the situational description (Step 1) on the part of the patient or the other person be it a thought, emotion, or behavior.***

***Remember, an “introspection” of a thought or emotion on the part of the patient is a valid interpretation as long as it is "anchored" in the situation (Step 1). Hypothesized thoughts attributed to the other person described in Step 1 are "mind reads" (hence invalid) but an obvious emotional expression of the other person that can be observed is a valid interpretation.***

**Step Three:**

**Think about what you DID in the situation, that is how you behaved. What stands out as you think back on it? What did you do?**

**Step Four:**

**Tell me how the situation came out for you. What was the *Actual*  *Outcome*? Give me one sentence that describes the outcome and that an observer could see.**

**Step Five:**

**Think about the outcome. How would you have liked the situation to have come out for you? We call this the *Desired Outcome*. Say it in one sentence and again, state it in a way that an observer could see. [*Keep the DO “in the patient’s court,”* not *in the Environment.*]**

**Step Six:**

**Now think about the Actual Outcome and the Desired Outcome. Did you get what you wanted here? Did the AO = the DO?**

**Step Seven: Why did you/didn’t you obtain the Desired Outcome?**

**Remediation Phase**

**“Now, let’s go back into the situation and see what you might have changed to get what you wanted. The first thing we’ll look at is the way you interpreted the event.”**

**Step One:**

**a) In your first interpretation, you said……….Is this interpretation grounded in the event? (If so, it is a *relevant interpretation.*)**

**Do you feel that the interpretation is *accurate*? (I mean, do you think the interpretation accurately describes what is happening between you and the other person, or something that is happening in you: feelings, thoughts, etc.);**

**Finally, what does this interpretation contribute toward you getting what you want? (It may or may not; just so it is *relevant* and *accurate.*)**

**In your second interpretation……**

**b) You need an *Action Interpretation* – a thought you could say to yourself that would prompt you to take action, to say what you want or don’t want, etc.**

**Step Two:**

**If you had thought of an *Action Interpretation*, how would your behavior have changed?**

**Had you behaved this way, would you have gotten what you wanted - that is, your Desired Outcome?**

**Step Three:**

**What have you learned here?**

**Step Four:**

**Can you think of any other similar situation where what you have learned here can be applied? Tell me about it. (*Transfer of learning/generalization*)**

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**Handout II**

**Rationale for the CBASP  
 Disciplined Personal Involvement Role**

**For over a century, psychotherapists have been universally trained to avoid any personal involvement with patients (McCullough, 2006). The proscription banning therapist personal involvement originated with Sigmund Freud (1963, p. 235) early in the twentieth century. Freud’s opposition to personal involvement was reiterated a half-century later by Carl Rogers (1951, p. 491). A present-day statement strongly advocating the personal involvement proscription was stated by the psychoanalyst Axel Hoffer (2006): “The analyst’s responsibility is to enhance the patient’s capacity for conscious and unconscious conflict elucidation while conflict resolution remains both the prerogative and responsibility of the analysand” (p. 37). Assuming that detached and disengaged psychotherapists can focus their attention on the patient’s problems all the while holding the individual responsible for modifying a state of affairs that was not of their making, particularly among severely abused chronic patients, does not make logical sense. Carrying this logic further, expecting chronically depressed patients to be able to behave in novel ways, *ex nihilo*, is even more unrealistic. Such logic applied to chronic patients poses this question: How can patients be responsible for modifying their behavior when they have never been exposed to a loving and caring environment? It is the assumption of CBASP that patients cannot and will not spontaneously produce alternative novel behavior without learning to do so under salubrious therapeutic circumstances. If one has never experienced positive and facilitative experiences with others, no positive neural or interpersonal potentialities exist for the individual. *In short, persons cannot do what they’ve never learned to do!* CBASP clinicians face the arduous task of programming into the brain positive neural connections that have never been experientially laid in before. This realization led us to rethink the entire therapist role with the chronically depressed patient as well as to review the century-old proscription prohibiting personal involvement in psychotherapy.**

**CBASP’s alternative therapist role for the persistently depressed patient (*DSM-5*, 2013) is labeled, *Disciplined Personal Involvement* (DPI). In extreme instances of maltreatment where patients remain interpersonally detached and withdrawn as well as highly fearful of interpersonal encounter, it’s unlikely that clinicians who themselves remain interpersonally inaccessible and stand behind walls of professional anonymity and non-involvement will be able to facilitate behavior change. CBASP offers the disciplined personal involvement proposal fully aware that the counter-transference proscription has worked well for our psychotherapy profession. It has inhibited therapists from using dyadic treatment to meet their own personal needs (Spotnitz, 1969) – always a destructive undertaking. However, when facing severely maltreated patients, the personal involvement proscription limits practitioners from being themselves and standing with patients as a “participating comrade.” All therapists active today have been trained to remain behind the personal involvement wall and, as much as possible, to remain *a highly restrained but accepting blank slate* (Rogers, 1951). One of the authors tells of his training experiences and how he learned to relate to patients. A patient once remarked that he looked tired. The subsequent comment reflected the traditional role that’s widely taught and practiced today: “We’re not here to talk about me, we’re here to talk about you.” When clinicians are constricted in their reactions to patients, they are unable to respond differentially to what patients do and say. In this example, what’s missing is a very human reaction such as: “You’re right, I’m very tired and thanks for noticing.”**

**Many early-onset chronic patients disclose they have not experienced interpersonal trust before nor experienced feeling safe around another human being. The therapist who becomes the one who is trusted or the one around whom the person feels safe must take these disclosures with the utmost seriousness. Without the precedent experience of interpersonal trust or without having had safe interpersonal relationships, patients are severely and pervasively limited. The challenge CBASP therapists face is accepting the fact such interpersonal events may occur in therapy and that when they do, clinicians must positively respond.Therapists will then urge patients to find one or two relationships on the outside where trust and safety can be achieved.**

**Disciplined personal involvement means helping patients learn to be human by therapists who permit themselves to be human with patients. The word “discipline” is a critical criterion for the CBASP definition of DPI. DPI is for mature clinicians only, and more time in CBASP training and supervision is invested in this one activity than for other training activities. CBASP clinicians must learn to administer DPI such that their reactions are always delivered with the well-being of the patient clearly in mind. The DPI strategy is presented from an objective counter-transference perspective (Winnicott, 1949); that is, therapists’ reactions involve the verbal articulation of the restricted feelings, attitudes and reactions practitioners have experienced and that have been evoked primarily by the patient’s behavior (e.g., “I can’t say this or the patient will think I’m negatively judging him.”) DPI “objective counter-transference” reactions also include instances when therapists express caring feelings for patients who need to hear it. DPI statements express acceptance, respect, and concern to those individuals who fear being sexually or physically abused by the clinician as well as when therapists want to contrast their negative reactions about abuse vis-à-vis the hurtful behavior of maltreating significant others (e.g., “What you told me your stepfather did to you makes me want to puke!”). In other contexts where DPI is administered, CBASP therapists verbalize their pride and joy over what an emotionally deprived or neglected patient has done (e.g., “I’m delighted about what you’ve just told me you did!”). The overriding goals of DPI are to shape behavior and to compare and contrast the practitioner’s positive behaviors with those of malevolent others. Without making these discriminations explicit, we’ve learned that patients are unlikely to make the discriminations on their own. Patients who realize that the therapist is significantly different as a person compared with others who’ve hurt them respond in positive ways to these new interpersonal experiences.**

**In summary, many chronic patients present for treatment severely damaged genetically, developmentally, cognitive-*emotionally, and behaviorally. CBASP therapists frequently treat preoperational and primitive-functioning adults who, in the beginning, behave like “little boys and girls;” however, these* immature individuals have the capacity to grow and maturate within the dyadic relationship. The DPI therapist role acknowledges this potential and gives therapists permission to be a disciplined and personally involved human being during treatment. The DPI role, when administered appropriately, enables one to behave toward the patient as an interpersonal partner where felt safety, interpersonal trust and problem-solving skills are acquired.**

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**Handout III**

**Significant Other History Procedure (SOH: CBASP Session 2)**

**& Transference Hypothesis Construction**

**Therapist: Last session we went over some history and diagnostic information and today I want to switch gears a bit in order to get to know you a little better. I want you to list no more than 5 people who have, for better or for worst, had a significant impact on your life - we call these persons, *Significant Others*. These persons are the “big players” in your life, the ones who’ve left a “stamp” on you, those who have influenced the direction your life has taken. These are not your casual friends and acquaintances – rather, they have had a significant impact on your life.**

**Patient: Provides the names of 5 Significant Others**

**1. Significant Others are defined as “major players” in one’s life – individuals whose role influences have exerted significantly more impact than (other) friends or acquaintances.**

**2. Significant Others have influenced you to be who you are – these individuals have left a “stamp” or “legacy” on you, determining the interpersonal directions your life has taken.**

**3. These role impacts may be either *positive* or *negative*.**

**4. Restrict your list to no more than 5 individuals.**

***Significant Other History Procedure:***

**The “Significant Others” are reviewed in the order they are listed. Taking the first name on the list, I ask:**

1. **“What was it like growing up around… (*few memories elicited)?***
2. **“How did this person influence you to be the kind of person you are now?” That is, what is the *stamp* he or she left on you?”**

**\*Note: Most patients are able to target at least one quality in themselves that originated from interactions with a Significant Other (e.g., “I learned not to expect anything good from a man/woman;” “I don’t trust any man;” “I learned that if you ask for what you need, you open yourself up to ridicule;” “I don’t ask for anything anymore;” “I learned that I must be perfect in all that I do;” “I can never get angry;” etc.)**

**Transference Hypothesis Construction**

**(Constructed Following Session 2)**

**PURPOSE: Transference Hypothesis generation seeks to pinpoint the prominent trauma domain that results in anxiety/fear/pain for the patient. The Hypothesis content is utilized throughout treatment through the implementation of the Interpersonal Discrimination Exercise *(IDE).* The major goals of the IDE are to *create dyadic safety for the patient* and to modify the refractory trauma emotions by teaching patients to discriminate emotionally between the relationship with the psychotherapist and relationships with malevolent Significant Others (who’ve hurt the individual). The underlying rationale for targeting a transference hypothesis is based on a transfer of learning assumption: patients will transfer to the person of the therapist the interpersonal expectancies (both positive and negative) acquired from earlier learning with important persons in their life.**

**There are four modal therapist-patient experiences in psychotherapy that are used as potential target domains for transference hypothesis construction. These are the following:**

* ***relational intimacy* between patient and therapist**
* **patient *disclosure* of highly private material-content**
* **patient *mistakes* in the dyadic relationship during the process of treatment**
* ***feeling or expressing negative emotions* either toward the therapist or in the presence of the clinician.**

**Several steps must be taken before the clinician can administer the IDE. They are described below.**

**A. Obtain the Transference Hypothesis (TH) content material during Session Two:**

**1. The Significant Other History (SOH) is administered in Session Two.**

**2. Causal Theory Conclusions (potential trauma domains) are extracted from the SOH post Session 2.**

**3. One Transference Hypothesis is constructed from one source: the dominant *theme* derived from the Causal Theory Conclusions.**

**B. *Transference Domains:* Decide which of the Four Transference Hypothesis Domains should be targeted to address the trauma most salient to the behavior 🡪 consequence domain: *“if this event occurs…then that consequence will likely follow.”* As noted above, these situations are high probability occurring interpersonal events in therapy, called *“hot spots”* in CBASP treatment.**

1. **If I get close to Dr. Smith (*intimacy/closeness event*), then ….. (the anticipated interpersonal expectancy/consequence based on the hypothesized transfer of learning assumption).**
2. **If I disclose personal matters or needs to Dr. Smith, then, Dr. Smith will ….. (anticipated interpersonal expectancy/consequence).**
3. **If I make a mistake while working with Dr. Smith, then….. (anticipated interpersonal expectancy/consequence).**
4. **If I experience negative feelings toward or while with Dr. Smith, then ….. (anticipated interpersonal expectancy/consequence).**

**C. *Construct one Transference Hypothesis post Session 2:***

1. **Review the “stamp/legacy” conclusions derived from the five-six Significant Others. Then, try to identify the *dominant trauma theme* *domain* that describes the negative consequences the patient received from the maltreating Significant Others while interacting with them in that domain**
2. **Construct only one *Transference Hypothesis* that expresses this most prominent thematic interpersonal trauma domain and the interpersonal expectances associated with it.**
3. **Therapists should also remember that the Transference Hypothesis may represent *tacit knowledge* – that is, the patient may not be aware of these functional expectancies.**

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**Handout IV**

**CBASP IDE Administration Prompt Guidelines**

**The CBASP Interpersonal Discrimination Exercise (IDE) step-procedure based on the Transference Hypothesis:**

**Step One:**

**The IDE can be administered whenever a patient and therapist transverse or enter a “hot spot” arena (i.e., talk about material or participate in an in-session event that is covered by the Transference Hypothesis).**

**Step Two:**

**Therapist administers IDE by asking several questions of the patient:**

**a] How did your mother, father, sibling, etc., react to you when you said or did the *content* implicated in the Transference Hypothesis (get close, disclose, make a mistake, or express negative affect?).**

**b] How have I just reacted to you in this similar Transference area?**

**c] What are the *differences* between their reactions and mine? What is different about *what* you experienced then, and *what* you have just experienced here, with me?**

**d] What are the interpersonal implications *for you* if I respond differently to you in this situation?**

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**Handout V**

**Form for Female or Male Patients: IMI**

**\*Impact Message Inventory (Octant Form)**

**This inventory contains words, phrases, and statements which therapists use to describe how they are emotionally engaged or impacted when interacting with patients.**

**You are to respond to this Inventory by indicating how accurately each of the items** **describes your reactions to the patient under consideration. Respond to each item in terms of how precisely it describes the feelings this patient arouses in you, the behaviors you want to direct toward him or her when in their presence, and/or the descriptions of the patient that come to mind when you’re with him/her. Indicate how each item describes your reactions using the following scale: 1-Not at all, 2-Somewhat, 3-Moderately so, 4-Very much so.**

**First, imagine you are in the patient’s presence, interacting with him or her. Focus on the immediate reactions you would be experiencing. Then read each of the items and fill in the number on the separate answer sheet which best describes how you would be feeling and/or would want to behave if you were, at this moment, in the patient’s presence. Mentally insert the patient’s name in the blank space which appears in each question.**

**Example: “When I am with this patient, \_\_\_\_\_\_\_\_\_\_ (assume patient’s first name or appropriate pronoun) makes me feel appreciated by \_\_\_\_\_\_\_\_\_\_ (assume patient’s first name or appropriate pronoun).” There are no right or wrong answers since different therapists will react differently to the same patient.**

**At the top of each page is a statement which is to precede each of the items on that page. Read that statement with each item; it will aid you in imagining the presence of the patient described.**

**Be sure to make all your marks on the separate answer sheet.**

**\*Kiesler, DJ & Schmidt, JA (1993). The Impact Message Inventory. Form II Octant Scale Version. Palo Alto, CA: Mind Garden.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Adapted from The Impact Message Inventory which was developed by Donald J. Kiesler, Jack C. Anchin, Michael J. Perkins, Bernard M. Chirico, Edgar M. Kyle, and Edward J. Federman of Virginia Commonwealth University, Richmond, Virginia.**

**1 – Not at all 3 – Moderately so**

**2 – Somewhat 4 – Very much so**

**WHEN I AM WITH THIS PERSON, \_\_\_\_\_\_\_\_ MAKES ME FEEL …..**

**1. bossed around. 10. complimented.**

**2. distant from \_\_\_\_\_. 11. as if \_\_\_‘s the class clown.**

**3. important. 12. uneasy.**

**4. entertained. 13. dominant.**

**5. like an intruder. 14. welcome with \_\_\_\_\_**

**6. in charge. 15. as important to \_\_\_\_ as**

**others in the group**

**7. appreciated by. 16. annoyed.**

**8. part of the group when**

**\_\_\_\_\_’s around. 17. taken charge of.**

**9. forced to shoulder all the**

**responsibility.**

**1 – Not at all 3 – Moderately so**

**2 – Somewhat 4 – Very much so**

**WHEN I AM WITH THIS PERSON, \_\_\_\_\_\_\_\_ MAKES ME FEEL …..**

**18. I want to tell \_\_\_\_\_ to 26. I could tell \_\_\_\_\_ anything**

**give someone else a and he/she would agree.**

**chance to make a decision.**

**19. I want \_\_\_\_ to disagree 27. I should tell \_\_\_ he’s/she’s**

**with me sometimes. often quite inconsiderate.**

**20. I could lean on \_\_\_ for 28. I should tell \_\_\_ not to be**

**support. so nervous around me.**

**21. I’m going to intrude. 29. I could ask \_\_\_ to do**

**anything.**

**22. I should tell \_\_\_ to 30. I want to get away from**

**stand up for him/ \_\_\_\_\_.**

**herself.**

**23. I can ask \_\_\_ to carry 31. I should do something to**

**his/her share of the load. put \_\_\_ at ease.**

**24. I could relax and \_\_\_’d 32. I want to point out \_\_\_’s**

**take charge. good qualities to him/her.**

**25. I want to stay away from \_\_\_.**

**1 – Not at all 3 – Moderately so**

**2 – Somewhat 4 – Very much so**

**WHEN I AM WITH THIS PERSON, IT APPEARS TO ME THAT …..**

**33. \_\_\_ wants to be the 45. \_\_\_ thinks he/she is**

**center of attention. inadequate.**

**34. \_\_\_ doesn’t want to get 46. \_\_\_ thinks I have most of**

**involved with me. the answers.**

**35. \_\_\_ is most comfortable 47. \_\_\_ enjoys being with**

**withdrawing into the back- people.**

**ground when an issue arises.**

**36. \_\_\_ wants me to put him/ 48.\_\_\_ weighs situations in**

**her on a pedestal. terms of what he/she can**

**get out of them.**

**37. \_\_\_’d rather be alone. 49. \_\_\_’d rather be left alone.**

**38. \_\_\_ thinks he/she can’t 50. \_\_\_ sees me as superior.**

**do anything for him/herself.**

**39. \_\_\_’s time is mine if I need it. 51. \_\_\_ wants to be with others.**

**40. \_\_\_ thinks it’s every 52. \_\_\_’s carrying a grudge.**

**person for him/herself.**

**41. \_\_\_ thinks he/she will 53. \_\_\_’s nervous around me.**

**be ridiculed if he/she**

**asserts him/herself with others 54. whatever I did would**

**be okay with \_\_\_.**

**42. \_\_\_ would accept what- 55. \_\_\_ trusts me.**

**ever I said.**

**43. \_\_\_ wants to be the 56. \_\_\_ thinks other people**

**charming one. find her/him interesting,**

**amusing, fascinating, and**

**44. \_\_\_ thinks he’s/she’s witty.**

**always in control of things**

**IMPACT MESSAGE INVENTORY**

**OCTANT SCALE VERSION: SCORING SHEET – 56 items**

**Person1 \_\_\_\_\_\_\_\_\_\_\_\_ Person2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1. D: DOMINANT 5. S: SUBMISSIVE**

**1. \_\_\_ 6. \_\_\_**

**17. \_\_\_ 13. \_\_\_**

**18. \_\_\_ 19. \_\_\_**

**33. \_\_\_ 22. \_\_\_**

**36. \_\_\_ 32. \_\_\_**

**44. \_\_\_ 46. \_\_\_**

**48. \_\_\_ 50. \_\_\_**

**TOTAL - \_\_\_ TOTAL - \_\_\_**

**MEAN - \_\_\_ MEAN - \_\_\_**

**2. HD: HOSTILE-DOMINANT 6. FS: FRIENDLY-SUBMISSIVE**

**12. \_\_\_ 3. \_\_\_**

**16. \_\_\_ 26. \_\_\_**

**25. \_\_\_ 29. \_\_\_**

**27. \_\_\_ 39. \_\_\_**

**30. \_\_\_ 42. \_\_\_**

**40. \_\_\_ 54. \_\_\_**

**52. \_\_\_ 55. \_\_\_**

**TOTAL - \_\_\_ TOTAL - \_\_\_**

**MEAN - \_\_\_ MEAN - \_\_\_**

**3. H: HOSTILE 7. F: FRIENDLY**

**2. \_\_\_ 7. \_\_\_**

**5. \_\_\_ 8. \_\_\_**

**9. \_\_\_ 10. \_\_\_**

**21. \_\_\_ 14. \_\_\_**

**34. \_\_\_ 15. \_\_\_**

**37. \_\_\_ 20. \_\_\_**

**49. \_\_\_ 23. \_\_\_**

**TOTAL - \_\_\_ TOTAL - \_\_\_**

**MEAN - \_\_\_ MEAN - \_\_\_**

**4. HS: HOSTILE-SUBMISSIVE 8. FD: FRIENDLY DOMINANT**

**28. \_\_\_ 4. \_\_\_**

**31. \_\_\_ 11. \_\_\_**

**35. \_\_\_ 24. \_\_\_**

**38. \_\_\_ 43. \_\_\_**

**41. \_\_\_ 47. \_\_\_**

**45. \_\_\_ 51. \_\_\_**

**53. \_\_\_ 56. \_\_\_**

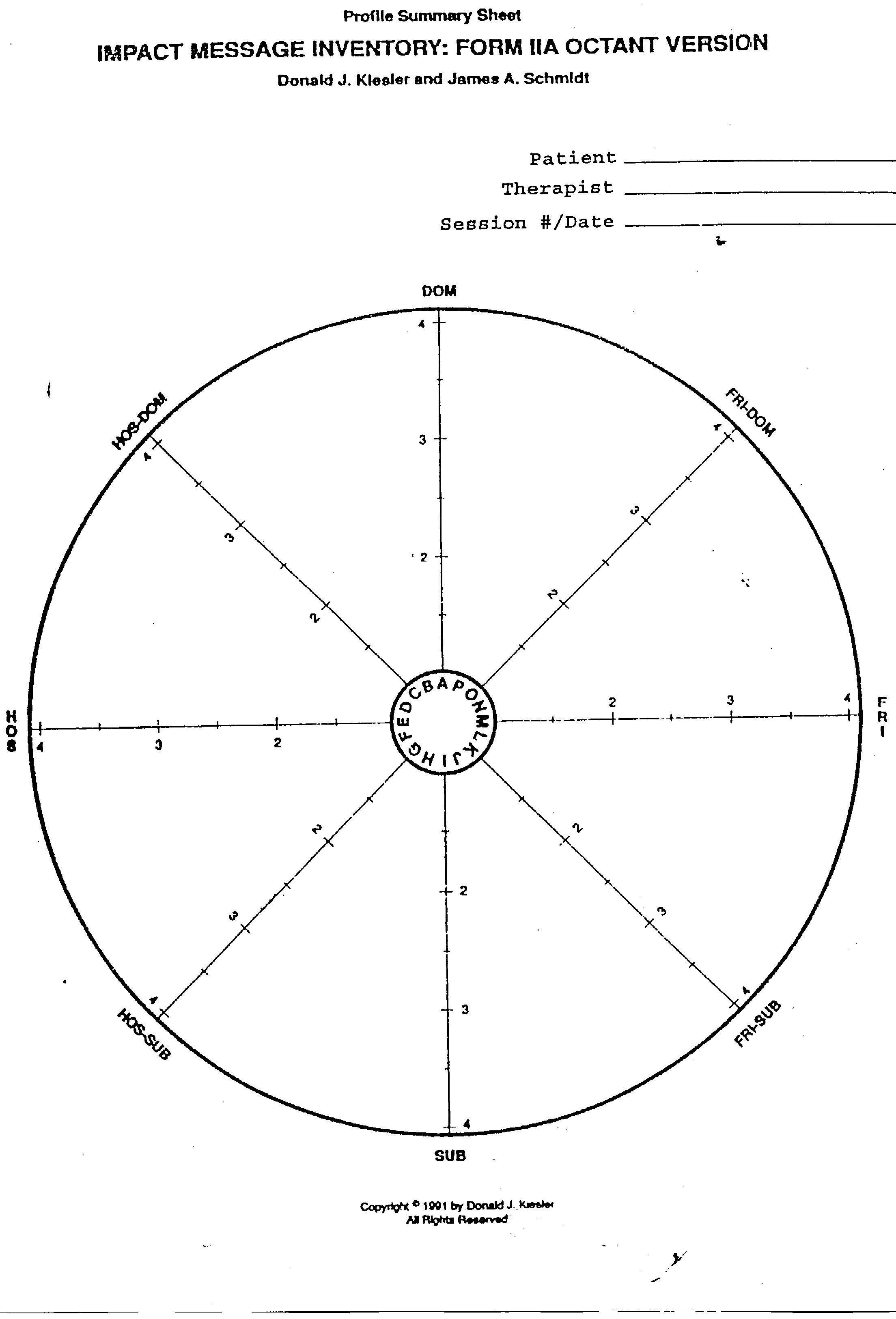
**TOTAL - \_\_\_ TOTAL - \_\_\_**

**MEAN - \_\_\_ MEAN - \_\_\_**

**IMPACT MESSAGE INVENTORY: FORM 11A OCTANT VERSION**

**Donald J. Kiesler and James A. Schmidt**

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