

BOOK REVIEW

Treating Chronic Depression With Disciplined Personal Involvement: Cognitive Behavioral Analysis System of Psychotherapy (CBASP). By *James P. McCullough Jr., PhD*
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Those of us who treat patients with chronic depression, or who do research on this condition, face a number of paradoxes. Despite growing evidence over the past two decades that many depressed patients have a chronic course of illness, psychotherapy and psychopharmacology research have traditionally focused on acute treatment of depression. There remains a paucity of studies of psychopharmacology treatment of chronic depression, and even fewer studies of psychotherapy or combined psychopharmacology-psychotherapy treatments. Indeed, there have been few psychotherapy approaches that specifically address the needs of depressed individuals who have a chronic rather than an acute course of illness.

In his 2000 book *Treatment for Chronic Depression: Cognitive Behavioral Analysis System of Psychotherapy* (McCullough, 2000), James McCullough, a professor of psychology at the Virginia Commonwealth University, described one psychotherapy approach for chronic depression. CBASP, as it is known, was used for a widely cited medication versus psychotherapy versus combined treatment chronic depression trial (Keller, McCullough, Klein, et al., 2000), a study of 681 patients that demonstrated that combined treatment led to a greater response rate than medication or psychotherapy alone. This large study had a number of limitations: no untreated control group; the selection of nefazodone, a rarely used antidepressant rather than the more commonly used SSRIs; indeed, even the use of CBASP rather than a more conventional cognitive-behavioral or interpersonal approach. Nevertheless the CBASP-nefazodone study set the stage for further investigations, including a new study, REVAMP (research evaluating the value of augmenting medication with psychotherapy), that has attempted to replicate its results and, in addition, to compare CBASP to brief supportive psychotherapy.

Beside its combination of cognitive, behavioral, and interpersonal approaches, McCullough's description of CBASP includes one striking component: "CBASP therapists are encouraged to become personally involved with patients in a disciplined way in order to modify their behavior." McCullough hypothesizes that, "[d]isciplined personal involvement, which involves a willingness on clinicians' part to disclose personal feelings, attitudes, and reactions to patients, facilitates the teaching of empathic behavior" among the chronically depressed (McCullough, 2000, p. 17).

In his current book *Treating Chronic Depression with Disciplined Personal Involvement: Cognitive Behavioral Analysis System of Psychotherapy (CBASP)*, McCullough expands on this concept, which may be discomfiting, even startling, for many traditionally trained psychotherapists, whether from psychodynamic or cognitive-behavioral traditions. His strong belief is that therapeutic neutrality does not apply to the psychotherapy of chronically depressed individuals, and that disciplined personal involvement is an efficacious and perhaps necessary component of their treatment. McCullough states, "when a therapist sees a chronically depressed adult for the first time, he or she meets a patient who thinks, talks, and emotes in a primitive, preoperational manner. The structural cognitive-emotional dilemma precludes normal interaction because the social-interpersonal world has no informing influence on behavior" (McCullough, 2006, p. 45). Often as a result of early trauma and neglect and adverse family environments, such patients are "perceptually disconnected from their interpersonal environment," and as a result, "behavior with others results in consequences that have no informing influence on what the person does or does not do" (McCullough, 2006, p. 58).

CBASP is a learning model, in which the therapist focuses on teaching patients to recognize the consequences of their behavior, "a perceptual skill they do not possess at the outset." Using in-session contingencies to "heal the affective wounds of developmental trauma," the goal is to "teach patients alternative ways to behave with a therapist, who behaves toward them in personal ways," then to help the patient to transfer this relational skill to daily living, and finally to help patients to increasingly share in the responsibility of behavior change (McCullough, 2006, pp.58–59). CBASP techniques include situational analysis, the contingent personal responsibility of therapists, and the repeated use of "interpersonal discrimination exercises."

Disciplined personal involvement (DPI) occurs within this learning context. McCullough claims that "the pedagogy necessary for learning to enact the CBASP therapeutic role is qualitatively different from the training

required to administer any other psychotherapy model” (McCullough, 2006, p. 59). CBASP training requires that clinicians “be themselves” with patients, “which means being able to respond naturally and in a nonneutral manner,” and that they must use such personal responsiveness in a selective and self-disciplined manner. McCullough addresses practical and theoretical objections to this therapeutic approach, which include fears of overinvolvement, and inappropriate behavior, and clinical risks of flooding patients with excessively personal information and content. In case examples, he describes ways in which DPI can be done ethically and judiciously in order to advance treatment.

As a reader, and as a psychiatric clinician, one may find oneself agreeing with McCullough’s clinical sense that it often takes something special to get through to many chronically depressed individuals. In one way or another, there must be a way to interrupt the patient’s despairing monologues, to catch his eye, to communicate with him as one human being to another. Chronically depressed people often live in a “*Groundhog Day*” world, reliving one demoralizing experience after another, filled with a yearning to connect with others but unable to do so. McCullough’s approach often shakes up the consulting room, in which socially jarring disclosures of how the therapist relates to the patient as an individual are woven into the therapeutic conversation. CBASP focuses on the relational aspect of treatment in a way that is often not overtly addressed in cognitive–behavioral therapy training, and that also appears to be at odds with what psychodynamic therapists see as therapeutic neutrality, or what they address through concepts of transference and countertransference.

Ultimately, most readers will finish *Treating Chronic Depression* with many open questions, some specific to McCullough’s approach, others related to this challenging condition itself:

- Is it possible to change the course of this disorder—to prevent progression of acute to chronic depression, and to prevent impairment and debilitation?
- What is the best way to help patients achieve a complete response to treatment? For patients who respond to medication but have residual symptoms, can psychotherapy (or other approaches such as mindfulness, skills training, physical exercise, etc.) lead to more complete recovery?
- Given McCullough’s description of the intrapsychic state of chronic depression, what is the relationship between chronic depression as a mood disorder and other conceptualizations such as the depressive personality disorder?
- How successful is CBASP with DPI in relieving residual impairment, or as a primary treatment for chronic depression? How does it compare in efficacy to cognitive behavioral therapy (CBT), interpersonal psychotherapy (IPT), social skills training, or mindfulness?
- Is ‘disciplined personal involvement’ essential to CBASP outcome? If successful, can DPI be applied to other treatment approaches?
- What proportion of chronically depressed individuals are as interpersonally disconnected as McCullough describes? In my clinical experience, it appears that some chronically depressed individuals return to normal interpersonal functioning after successful medication treatment, and also that many chronically depressed people seem quite well related even when suffering from severe mood symptoms. If that is the case, which patients can be helped by CBASP?

One may finish McCullough’s provocative book rooting for his therapeutic approach, hoping that CBASP plus DPI will be better than other therapy approaches such as CBT, IPT or even supportive psychotherapy (which has increasingly been shown to have a significant degree of efficacy)—or the reverse. One may also hope that CBASP will give an additive effect when applied across many patients, many clinicians, and many settings. But if you’re a betting man, in psychotherapy research it often isn’t a bad idea to put your money on the null hypothesis.

Nevertheless, as McCullough states, one of his purposes in writing this book is to “encourage empirical investigation of the personal involvement techniques” (McCullough, 2006, p. xi). Among other significant contributions, this book appears likely to encourage such studies.

References

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