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Review Article

Treating the Existential Uncertainty of the Early-Onset Persistent Depressive Disorder Patient

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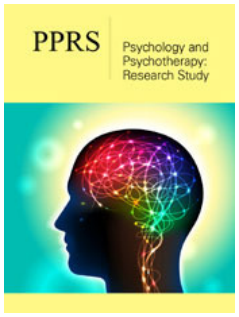

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Abstract

The current lecture will seek to address the theme of The IIIrd Congress of Cognitive Behavioral Psychotherapies, Living with Uncertainty, using the early-onset chronically depressed patient as the example of a person living with uncertainty. The early-onset Persistent Depressed Disorder (PDD) patient presents an appropriate pathological example of one who perpetually lives out a lifestyle of existential uncertainty. The dilemma derives from an etiological developmental history of maltreatment which has inhibited maturational growth in the cognitive and emotional areas; it has left the individual functioning in a preoperational manner [1-9]. These cognitive and emotive limitations make the person a difficult candidate for therapy unless psychotherapists begin treatment cognizant of the patient's maturational problems. CBASP is an interpersonal model of treatment designed specifically to address the idiosyncratic immature problems of the chronic patient. Patients begin therapy dominated by a fear-avoidant lifestyle which has separated them perceptually from any informing input from the interpersonal environment. Their isolation stems from toxic early experiences learned while living with maltreating caregivers.

Several CBASP treatment techniques such as the Significant Other History, the Interpersonal Discrimination Exercise, Situational Analysis, and the therapist's role of Disciplined Personal Involvement will be described to show how they address the uncertainty problems of the patient. Patients who are unable to control their emotions and who are perceptually disconnected from the environment face uncertainty at every turn. Their modal interpersonal styles of rigid detachment, withdrawal, and submission further potentiate felt isolation. These stylistic interpersonal patterns make the patient unable to compete effectively on any level with their peers-in the family, at work, or in social areas. The good news is that these immature individuals may maturate over the process of treatment and achieve formal operational thought as well as learn effective assertive behavior.

Keynote Address

Thank you for inviting me to participate in the IIIrd International Congress of Cognitive Behavioral Psychotherapies. I also feel honored being asked to deliver the Keynote Address which I hope will be interesting to you as well as relevant to the theme of this year's Congress. "Living with Uncertainty" is an appropriate theme for our times as we face the threat of world-wide calamities such as war, poverty, hunger, and a ravenous global movement toward a more despotic mindset when it comes to the governing of peoples. In my eighty-five years I have never lived in a nation whose future I am now fearful of - nor lived in a nation where a significant portion of the population seems determined to move in self-destructive directions. Yes, "Living with Uncertainty" is an appropriate theme for us today.

On a professional level, I have worked for almost one-half century with a patient population who has lived most of their lives with uncertainty. This is the early-onset Persistent Depressive Disorder (PDD) patient who is probably known better to us as the early-onset chronic depressive. Chronic Depression is a condition that lasts continuously for more than two years. In 2019, I published my memoirs in a book entitled, *Swimming Upstream: A Story about Becoming Human* [6]. It was my historical story dealing with my own chronic depression disorder for a number of years. Looking back, I diagnosed myself at 12 years of age as an

early-onset dysthymic individual. I hypothesize that my depression disorder resulted from a toxic developmental history and an unhappy childhood. My book format paralleled Victor Frankl's book (1959), *Man's Search for Meaning* [2]. Frankl has been a hero of mine through the years. Both of us divided our texts in two parts.

Part One was the personal story and Part Two described our respective therapy models, Logotherapy and CBASP. The early-onset individual like myself, more often than not, comes to treatment as an adult reporting being depressed for years. Onset frequently begins in early adolescence starting with a toxic, maltreating familial environment; the disorder can be a lifetime condition as it rarely remits without adequate treatment. I have also found that the early-onset chronic disorder is seldom cured with treatment. Rather, we teach patients to manage their condition, and this goal can certainly be achieved with gratifying outcomes. In successful cases, living with uncertainty is also reduced as a result of achieving a changed intra- and interpersonal lifestyle. You might think of the chronic depressive condition as being similar to diabetes and high blood pressure. One doesn't cure these diseases, but both may be managed effectively-managed with taught behavioral strategies and medication; however, left untreated, diabetes and high blood pressure, like early-onset chronic depression, pose lethal dangers to the patient.

The Early-Onset PDD Patient

Early developmental abuse and caretaking mismanagement frequently result in children acquiring a persistent avoidant-interpersonal fear of others. At the outset of treatment and to avoid being hurt, "keeping one's distance from others," is the name of their game. Early-onset PDD patients enter treatment reporting a chronic history of feeling alone and lonely, they usually function in an interpersonally detached, withdrawn and submissive manner. The most difficult obstacle therapists face is not well understood. Given the adversities of early childhood abuse and maltreatment, many patients suffer from a maturational train-wreck. What does this mean? It means that they enter adulthood functioning at a Piagetian [9] pre-operational stage of development in the interpersonal, behavioral, and emotional domains. Interestingly, IQ is not affected. I observed early in my work with these persons, that they do not think nor talk like I do. I realized that I am sitting with a chronological adult who functions psychologically on a first-or second-grade level. One consequence of the maturational dilemma is that psychotherapists typically lose patience with them - they are labeled 'treatment resistant' or administered other 'impossible to treat' labels.

Mistakenly overlooking the maturational obstacle, therapists often assume these patients are their cognitive and emotive equals; that is, they are individuals who function at a formal-abstract level similar to themselves. Thus, they overestimate their capabilities at the outset of psychotherapy and attribute a lack of progress to something under the patient's control. Most patients I am talking about are pre-logical and pre-causal thinkers who believe the world is the way it is just because they believe it to be so – so do small children. Abstractive, hypothetico-deductive reasoning is a foreign territory when the patient begins treatment. The good news is that these persons can maturate within a carefully controlled environment of dyadic interpersonal safety, and that they can learn to think abstractly. It's amazing!

There is considerable research evidence that abused and maltreated children may be disabled maturationally in the cognitive-emotive domain as well as in the physical growth sphere. In short, severe abuse may inhibit or derail growth. In training new therapists to treat the early-onset chronic patient, they must be aided to become aware of the maturational limitations of the individual. This is the most difficult lesson to learn in early supervision training. The patient's limitations in the maturational domain is why the Cognitive Behavioral Analysis System of Psychotherapy, or CBASP, is grounded on interpersonal psychological foundations, more specifically, on the interpersonal theory of Kiesler [3]. CBASP therapists are trained to be disciplined teaching comrades to individuals who never had one.

I turn now to explain how the CBASP methodology attempts to take this fearful-avoidant patient and teach them, through acquisition learning trials, to mature and become an effective interpersonal human being. Overthrowing the living with uncertainty impasse is another way of stating the Desired Outcome Goal of CBASP therapy.

The Techniques of CBASP Vis-À-Vis The Uncertainty Of Living

The Significant Other History (SOH) & the Interpersonal Discrimination Exercise (IDE)

This SOH exercise [7,8] is administered primarily as an assessment instrument; it is not designed to remediate the distress of the patient. Patients are told this at the outset of the SOH exercise. At the end of the first session, the patient is asked to bring in a list of 4-5 significant persons in their life. Session two uses this list of significant others in the administration of the Significant Other History (SOH). Significant Others are major players and not just friends or acquaintances. These are the persons who have left their "stamp" on the individual influencing them to be who they are or informing the direction their life has taken. Such persons are usually parents, siblings, relatives, professors or teachers, or religious leaders.

The SOH experience is the first time in treatment the patient has faced having to look at the impact others have had on their life (e.g., this significant other did this and this is the effect it had on me). The SOH is an interpersonal emotional history procedure, and it is unlike the Mental Status Exam where pertinent facts about one's life are obtained. Two questions are asked as we review each person on the SOH list:

A. what do you recall about your relationship with this significant other? And

B. what is the stamp or major influence you take from this relationship that has led you to be who you are? This will

almost always be the first-time patients will have organized their autobiographical material this way and often often, conclusions about past relationships are unnerving. For example: One male patient reported, "My father used to beat me when I misbehaved and this is the stamp I take from these experiences": I'm afraid of men; or, a female patient reported, "My mother never touched me when I grew up and this is the stamp it left on me": I feel no warmth toward anyone.

Therapists must be highly sensitive while administering these histories and watch for emotional overload. This is particularly true when patients report severe sexual or physical abuse received at the hands of toxic others. The goal of the procedure is to use the obtained stamps and derive a theme placing the dominant theme in one of four domains:

a. Dyadic relationship;

b. Personal disclosure;

c. Making mistakes; and

d. Feeling negative emotions toward the therapist.

Once we select the salient domain we will work with, we construct one Transference Hypothesis (TH) which is a hypothesis statement that expresses the most prominent interpersonal expectancy fear patients bring to treatment: for example, If I make a mistake with McCullough [6], he will reject me and terminate treatment [the Making Mistake TH domain].

The SOH is a collaborative enterprise between the patient and the psychotherapist. It equips the therapist with relevant information that will be used throughout treatment. Whenever the patient's behavior in the session implicates the TH such as occurs in the 'making mistakes domain', the practitioner will administer another technique, the Interpersonal Discrimination Exercise [7]. The mistake might occur when a patient doesn't complete a homework assignment or arrives late for an appointment. The goal of the IDE is to teach patients to discriminate the behavior of their significant others who have hurt them vis-a-vis the behavior of the practitioner who has behaved in an accepting-facilitative manner. Over time, patients become adept at making these interpersonal discriminations and differentiating the person of the therapist from maltreating others. We have found that if these discriminations are not deliberately taught through the IDE, chronic patients will not automatically learn to discriminate the differences between the practitioner and their significant others.

Personal involvement of the therapist in the dyad is highlighted in the IDE and used to modify the harmful expectancies patients bring to treatment. The IDE is an experiential change strategy in the hands of the practitioner. The practitioner becomes a stable and obvious certainty in the patient's life - one whose behavior challenges the interpersonal uncertainties of the patient. What we are doing here is replacing expected uncertainty with explicitly demonstrated certainty over repetitive trials.

Situational Analysis (SA)

Situational Analysis [5,6] is the major technique of CBASP. It is administered in approximately 75% of the sessions. A comrade teaches fellow comrades how to problem-solve by focusing them on one specific situation at a time. Psychopathology by nature denotes behavioral rigidity, so the choice of interpersonal situations is rarely a unique problem. Again, the experience of teaching the 7-step SA will be novel for patients; removing the threat of being hurt from the learning exercise and making it didactically safe enhances the teaching process.

Over time, they learn to obtain more desirable outcomes in exchanges with others, and increasingly assume a greater degree of felt responsibility for the interpersonal outcomes they produce. Through the administration of SA, the 'My life is not my fault,' a universal attitude at treatment outset, is transformed into a realistic assessment of the consequences of my behavior. SA also undercuts the interpersonal isolation which has resulted in the patient's destructive behavior. Patients who learn SA increasingly become perceptually connected to their interpersonal environment and progressively, these fear-avoidant individuals become vulnerable to be shaped through environmental influence. Other people who originally appeared to represent interpersonal uncertainty now become more predictable as patients learn new skills and how to effectively navigate socially. How does SA accomplish these goals?

SA, as noted earlier, is a 7-step problem-solving formula. Step One requires the individual to describe one situational interaction or 'slice of time.' The event must have a starting point in time, include a brief series of interpersonal exchanges, and then close with a stated behavioral endpoint. The endpoint becomes the Actual Outcome or consequence for the interaction. SA teaches unfocused and disorganized thinkers to attend to a specific point in time. Step Two requests the individual to construct 2-3 interpretations concerning the meaning of the interaction; therapists ask: "What did the event mean to you?" We want the patient's attention focused on the event-at-hand so general beliefs or assumptions are not acceptable. For example, what did your behavior in the situation imply, and what sense did you make of the other person's behavior?

Step Three asks the individual to describe their behavior or what they did during the interaction: "How did you behave in the situation?" Therapists might even request that the person act out their behavior and demonstrate what they did and how they talked. Step Four is the Actual Outcome (AO) or endpoint of the situation which has already been identified in Step One. The AO is the all-important CONSEQUENCE that we want perceptually connected to the cognitive and behavioral components previously identified in Steps Two and Three. We are trying to demonstrate to patients that how they think and behave, directly affects the Actual Outcome of interactions. In the early stages of treatment, the AOs are usually quite unpleasant to recall.

Step Five denotes a motivational strategy in SA. Patients are asked to propose a desirable alternative to a problematic AO or

situational consequence. Therapists ask, "How would you have liked the AO to have come out?" Chronic patients have never considered that reality could be anything other than what happens. This is a difficult request for many and in the early going, patients frequently need help to formulate their Desired Outcomes (DO). We want them to construct a DO in one behavioral sentence - something the therapist could have seen or heard. One patient constructed a DO this way: "I would ask my wife to listen to what I want to tell her." This patient reported his Actual Outcome to be one where he stomped out of the room and slammed the door.

The Sixth Step is a question that is asked the patient after the AO and DO have been formulated: "Did you get what you wanted here?" New patients infrequently achieve their situational DOs, so their replies are, "No!" The Seventh Step is another question that asks: "Why didn't you get your DO?" The answers are fairly predictable: "Nothing ever works out for me." "I always fail. "No one cares about me." "I'm just a loser." Therapists gently say to this defeated individual who has inadvertently just constructed a negative reinforcement event "Let's go through your SA once again and look at what you put into the event and see how we might fix your inputs so you can achieve your DO." Learning to fix mismanaged situations is something that patients have seldom previously experienced; and relief from the discomfort of failure when the AO ≠ the DO is often replaced with a reinforcing experience of success. Negative reinforcement occurs in such moments. Remediating outcomes where the AO ≠ the DO is carried out in the following manner.

First, we examine the interpretations (Step Two) which frequently are off-task (e.g., "No one likes me" which may be revised to read, "I'm not asking for what I want."). Another interpretation might be, "Here is another event where I fail," which when revised might state, "She didn't hear that I needed her to listen to me?". When the interpretations are grounded in the event and not global, we then inquire about how the patient behaved (Step Three). Stomping out of the room and slamming the door will never achieve a DO but asking what I want from the other person might. The focus is on obtaining the patient's DO and not on manipulating the behavior of the other interactant. We have very little control of others - most of our control comes from how we think and behave. If the patient's DO is to be listened to, then he must make his wishes known; if he does, then he achieves his DO. After SA is completed, assertive behavior role practice is frequently undertaken. Learned goal-directed thinking and behavior in interactions coupled with assertive behavior frequently result in obtaining Desired Outcomes. Ironically, it becomes increasingly difficult for persons to remain depressed when they are obtaining DOs.

Situational Analysis, without talking about depression, teaches patients to behave in ways that checkmate the fear-avoidant lifestyle. Dyadic safety imparts the courage to learn effective interpersonal strategies. Generalization training stemming from SA has encouraged individuals to practice with others what they learned with the psychotherapist. An uncertain existence has become more predictable. The last CBASP strategy to be described makes the CBASP therapist role a unique one in our field. The strategy is called, Disciplined Personal Involvement [7].

Disciplined Personal Involvement (DPI)

I know of no other therapy model that recommends Disciplined Personal Involvement (DPI) as an essential strategy for the therapist role. In 1996, I wrote a book entitled, Treating Chronic Depression with Disciplined Personal Involvement; CBASP [7]. I wrote the text to support my CBASP therapists who had participated in a large 12-site randomized clinical trial. CBASP was being administered to several hundred chronically depressed outpatients. The occasion arose when a small number of CBASP therapists were accused of malpractice by several of their faculty colleagues. The reason was because of their advocacy and practice of DPI in the national study. Early in the twentieth century Sigmund Freud made patient personal involvement verboten; his views were reiterated by Carl Rogers in the early 1950s.

The line separating the patient's space and the psychotherapist's space were made clear, and the separation boundary became inviolate in training and practice. The tradition has been universally accepted by our professions for over a century. I might be a "warm blank slate," but I'd better not step across the personal involvement barrier-line. I made it crystal clear in my 1996 text [7] that I was focusing only on the chronic patient when advocating DPI and only because of the idiosyncratic developmental history of the chronic patient. I concluded largely from my own personal history of chronic depression [6] and from my own work with chronic patients that just talking about relationship apart from actually experiencing comradeship had severe didactic limitations. My final conclusion which resulted in my formulation of Disciplined Personal Involvement was that people learn best to actualize interpersonal relationship by experiencing actual interpersonal relationships first-hand. How does CBASP define DPI?

Our profession of psychology has flirted with the notion of DPI in Bandura's [1] reciprocal interaction construct and in Kiesler's [4] metacommunication formulations. I felt that neither author had gone far enough. Another step-in therapy practice must be taken if we are to teach human beings how to relate to other human beings. DPI denotes that next step. I realized that in order to practice DPI, I must give myself permission to be myself with patients but to do it in a disciplined manner with the patient's wellbeing foremost in my mind. Being myself also suggests that I do not relinquish my boundaries in relationship, nor do I have to behave in ways I don't want to - that's part of being myself. Remaining sensitive to the patient's needs demands that I decide how to stand with the patient in their distress without imposing myself on them or distancing myself from them. At times I must hold back while at other times I must move toward. I can express frustration, hostility, joy, encouragement, confusion, answer their personal questions about my life, take pride in what they do, express my ignorance at not knowing what to do, as well as ask help from them when I need it.

In short, I can be myself in a tangible way but always in a clinically disciplined manner. Brutalized and abused patients demand that I hold back, walk softly, and not impose myself in their space. Others who have been deprived of genuine human encounter and who have grown up around non-responsive caretakers require that I take the initiative and move toward while not waiting for them to ask for anything. I already know that they expect nothing will be coming from me. These interpersonal strategies which are so prevalent at the outset of therapy, often undergo revision as patients experience greater dyadic safety over time.

I have written about the optimal behavior of CBASP therapists delineating how I think DPI therapists ought to behave [5]. In all my years of practice and training, I have never heard of one complaint where a CBASP psychotherapist has abused the privileges of Disciplined Personal Involvement. I come to the close of this lecture hoping that you have learned some things about CBASP that you might not have known before. Again, I feel honored to have been asked to address this august Congress which includes so many distinguished cognitive-behavioral colleagues past and present-beginning with Professor Aaron Beck, Dr. Judith Beck, and the subsequent cognitive-behavioral practitioners and researchers who have led and enriched our field for so many years. In multiple ways, CBASP is clearly indebted to these individuals.

In these days of uncertainty, my hope for you is that you may find certainty in spite of our external circumstances; certainty that arises from secure attachments with people we love and who love us. Finally, I am proud to have been a long-time participant in our collegial profession which has taken its healing powers to many who desperately needed it. Best wishes to all of us in the future, and I hope we continue to obtain our Desired Outcomes!

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