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BRIEF CLINICAL REPORT

Evaluation of the impact and acceptability of Cognitive Behavioural Analysis System of Psychotherapy (CBASP) for chronic depression

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Abstract

Background: Cognitive Behavioural Analysis System of Psychotherapy (CBASP) is an evidenced based treatment model for chronically depressed patients.
Aims: The main aim of this service evaluation was to assess the acceptability and clinical impact of CBASP for chronic depression within an Improving Access to Psychological Therapies (IAPT) service.
Method: Routinely collected data were analysed for all patients that received CBASP treatment focussing on the recovery rates of these patients in terms of depression, anxiety and social functioning. Interviews were conducted with patients who had recently been discharged from CBASP therapist within one month of the follow-up date, explore their experiences of therapy.
Results: Outcome data for 27 patients suggested substantial reduction in scoring on measures of depression and anxiety following CBASP treatment. Across all interviews it was clear that patients developed an insight and understanding of how their behaviours affect the outcome of interpersonal situations.
Conclusions: Results from this service evaluation suggest that CBASP is acceptable to service users and has a positive clinical impact in terms of IAPT recovery targets for anxiety, depression and social functioning.

Keywords: anxiety; CBT; depression; Improving Access to Psychological Therapies Programme (IAPT); NICE; service evaluation

Introduction

The Cognitive Behavioural Analysis System of Psychotherapy (CBASP) was developed by James McCullough Junior in the 1980s to treat chronic depression, and it is the only treatment specifically tailored for 'early-onset' (before the age of 21) chronic depression. The average duration of episodes is thought to be 17–30 years. The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* includes, for the first time, a chronic depression classification referred to as 'persistent depressive disorder'. Chronic depression is classified here by the presence of poor appetite or over-eating, insomnia or hypersomnia, fatigue, low self-esteem, poor concentration, difficulty making decisions or feelings of hopelessness for more than two years with less than one month of symptom remission in that period. Depression is a major contributor to the global burden of disease, and costs to the NHS are considerable.

McCullough (2012) described the life of the early onset chronically depressed patient as living in a solitary world of intrapersonal sameness devoid of a future: the present is a replay of a hurtful past where the future bodes only more of the same pain. Not only can episodes of chronic depression persist for decades, but evidence suggests that the mean age of onset is 15 years (McCullough, 2000; Swan *et al.*, 2014). Within the CBASP model, chronic depression is thought to develop due to maltreatment and neglect at an early age, leading to an arrested cognitive and emotional development. These early experiences mean that the person remains stuck at a pre-operational (childlike) level of social/interpersonal development. CBASP specifically addresses this arrested development, asking the patient to consider the impact upon their environments (stimulus value) and to be receptive to the information that the world offers (feedback loop).

Although some of aspects of CBASP therapy are the same as a cognitive behavioural therapy (CBT) framework, a fundamental difference is the departure from the traditional 'one-person psychology' to a 'two-person psychology' tenet. *Disciplined personal involvement* in CBASP invites the therapist to provide direct feedback to the patient regarding the consequences of their interpersonal behaviour on the therapist.

Several studies have shown CBASP to be an effective treatment, by reducing symptomology and symptom burden, reduction in the degree of co-morbidity (see Swan *et al.*, 2014) and significant improvement in 48% of those receiving CBASP alone (Keller *et al.*, 2000). The emerging evidence has led the European Psychiatric Association to recommend tCBASP[1] as first-line treatment for chronic depression, rather than CBT (Jobst *et al.*, 2016).

As far as we are aware, no specific research has been undertaken to assess the impact of CBASP in UK Improving Access to Psychological Therapies (IAPT) services. The IAPT initiative commenced in 2008 and has transformed the treatment and delivery of evidence-based psychological therapies for depression and anxiety disorders in England. Often, IAPT services are commissioned to provide therapy to patients from the age of 16. A review of the caseloads, in which the study was conducted, suggest that approximately 70% of patients could meet the criteria for chronic depression. The absence of evidence for CBASP in this setting was the rationale for introducing CBASP and completing the service evaluation. The aims of the service evaluation were to assess the potential impact and acceptability of CBASP within an IAPT service in Barnsley, South Yorkshire.

Method

A mixed methods approach was used for this evaluation. Quantitative evaluation of therapy outcomes was undertaken using a pre- and post-design, in addition to thematic analysis of patient experience interviews.

Data on therapy outcomes are routinely collected at every session using the Patient Health Questionnaire-9 (PHQ-9), Generalised Anxiety Disorder-7 (GAD-7), and the Work and Social Adjustment Scale (WSAS). The WSAS is designed to measure functional impairment attributable to an identified problem.

Reliable improvement was calculated using the reliable change index (Jacobson and Truax, 1991). Patients were considered to have made reliable improvement if their scores had improved at post-treatment by at least 6 points on the PHQ-9 or by at least 4 points on the GAD-7.

The sample included all patients who had received CBASP within the service, and the criteria for offering CBASP was two years of dysthymia/major depression without remission. The sample of 27 consisted of 16 females and 11 males. At the commencement of treatment, the average age was 39. Four CBASP trained therapists treated the 27 participants with up to 20 sessions using

[1]For further information about CBASP, visit https://www.cbaspsociety.org

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Table 1. Rates of reliable improvement and recovery

	PHQ-9 (*n*=27)	GAD-7 (*n*=27)
Rates of reliable change		
Reliable improvement	93% (*n*=25)	89% (24)
Stasis	8% (2)	11% (3)
Reliable deterioration	0%	0%
Rates of recovery		
Reached recovery	81% (22)	77% (21)
No recovery	19% (5)	23% (6)
Attained reliable improvement and recovery status		
Reliable and clinically significant improvement	81% (22)	73% (20)
Reliable change but did not attain recovery	11% (3)	15% (4)
No reliable change but attained recovery	0%	4% (1)
No reliable change and no recovery	8% (2)	8% (2)

PHQ-9, Patient Health Questionnaire – 9 items; GAD-7: General Anxiety Disorder – 7 items.

McCullough's treatment manual. All four therapists are accredited with the British Association of Cognitive and Behavioural Psychotherapists (BABCP).

For the qualitative review, patients who had recently been discharged from CBASP therapist within one month of the follow-up date, were chosen to be interviewed regarding their experiences of therapy. A limit of one month post-therapy was chosen to aid recollection. Five patients fulfilling the above criteria were identified and three patients gave consent to be interviewed using a semi-structured interview exploring treatment experience, acceptability and satisfaction. Interviews were conducted by a psychology assistant independent of the treatment team and transcribed *in vivo* before thematic analysis was completed with lead therapist in accordance with the method outlined by Braun and Clarke (2006).

Results

Data on 27 patients were included in the evaluation receiving an average of 15 sessions each. There were significant improvements in all scale scores following therapy of between 58.8 and 64.8%, with the largest improvement in PHQ-9 mean scores [18.33 (*SD* 4.7) to 6.46 (5.44): t=8.62; p<0.001] than GAD scores [14.78 (4.6) to 5.85 (4.6): t=7.13; p<0.001] and WSAS scores [26.22 (6.2) to 10.81 (5.8): t=9.43; p<0.001]. Social functioning improved following intervention with a near 60% reduction in the WSAS score.

In terms of depression scores, 93% of patients achieved a reliable improvement (as defined by Jacobson and Truax, 1991) in their scores after therapeutic intervention, 81% patients attained a score which was indicative of recovery and all patients who attained recovery also made a reliable improvement in their scores over the course of the therapy (Table 1). Similar rates were demonstrated on the measure of anxiety which showed 88% of patients' scores reliably improved after therapy and 77% attained a score indicative of recovery. The majority of patients who attained recovery had also made reliable improvement over the course of therapy. A small minority (n=1) attained recovery but had not changed to the degree which is indicative of a reliable change (Table 1).

Overall, the results suggest that 81% of patients achieved recovery in relation to their depression and 77% achieved recovery in terms of their anxiety symptoms, compared with standardised IAPT 'caseness' and recovery targets[2] of 50% (Table 1).

[2]In IAPT context recovery is measured in terms of 'caseness'. A client has moved to recovery if they were defined as a clinical case at the start of their treatment and not as a clinical case at the end of their treatment.

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Thematic analysis

The themes generated from the patient experience interviews were broadly organised under five main headings: Expectations of therapy; Overall experience; Aspects of therapy, which could have been done differently or were not as helpful; Helpful aspects of therapy; and Outcomes.

Respondents expected 'coping strategies and exploration of depression' were 'sceptical at first but got better over time' and 'better than expected'. They found 'early phase of therapy distressing' but 'therapeutic relationship positive'. Therapist input on content was helpful in terms of 'recognising impact of actions on interpersonal outcomes'. Respondents would have liked more sessions and found it 'difficult to implement outcomes from situational analysis' and 'would have liked more guidance and reassurance'. Outcomes of CBASP were all positive: 'I am able to deal with people and situations more effectively', 'others have noticed a positive difference in me', 'more mature outlook', 'more able to cope' and 'improved mood and positivity'.

Discussion

In this service a small sample CBASP intervention reduced depression and anxiety symptoms and improved functioning. The majority of participants achieved recovery targets for depression and anxiety and reliable improvements in depression and anxiety. The recovery and improvements findings of 80% overall compare favourably with the 50% recovery target set by the IAPT service, and demonstrates that the CBASP intervention provided for this group of patients compares well with findings from previous research studies investigating the efficacy of CBASP in terms of moving patients to recovery.

Patient feedback on their experience of CBASP were generally positive. Although initially patients reported some scepticism about what therapy might entail, by the end of therapy all participants reported achieving insight and transition from pre-operational to operational thinking. For chronically depressed patients, understanding how they interpersonally affect other people is an essential aspect of therapy. Across all interviews the therapeutic relationship was held in high regard, which is extremely positive as the importance of a disciplined therapeutic relationship cannot be overstated within the CBASP model of therapy. The interviewees' responses indicate a shift in their willingness to express their feelings to others.

Due to the paucity of CBASP research conducted in primary care settings, it is difficult to compare these results with other studies. However, Swan *et al.* (2014) provided CBASP to a cohort of secondary and primary care patients. They concluded that CBASP is an acceptable therapy for a large proportion of patients with chronic depression and was associated with clinically significant change in 60% of completers, compared with 80% in this evaluation.

Some limitations of CBASP were noted by those interviewed. Initially, patients' reports suggest uncertainty and scepticism about what therapy might entail. Interviewees would have preferred a greater number of therapy sessions to address residual problems. It is possible that this reflects the complexity of the patient group needs or perhaps that the therapist should pay specific attention to endings. The interviewees highlighted a lack of guidance and reassurance during their therapy linked to a particular phase in therapy known as *situational analysis.* Negotiating this moment in therapy requires experiential judgement by the therapist to determine the appropriate timing, so this phase needs more careful preparation.

This was a small-scale evaluation of CBASP in an IAPT service and will therefore be vulnerable to biased findings and it is not possible to make definitive conclusions about transferability or generalisability to other similar services or settings. The cases were selected by the therapists and not all improvement can be attributed to the intervention. It is not possible to measure effectiveness in a small, uncontrolled study. Only three patients were interviewed from a convenience sample of five, so it is difficult to draw reliable conclusions regarding how representative they were of total sample and overall acceptability, although the responses were

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detailed, and relevant themes were identified suggesting acceptability and areas for future evaluation.

In terms of efficacy and acceptability, this evaluation provides promising results for providing CBASP to patients experiencing chronic/persistent depression and CBASP is currently being considered by NICE as the first-line treatment[3]. Although mean age of the sample was 39 years, IAPT services can provide early intervention to young people, thereby altering the course of what can be, for some individuals, a lifelong debilitating experience. Further research and a controlled trial in an IAPT setting is required to evaluate effectiveness of CBASP intervention.

Data availability statement. The data that support the findings of this study are available on request from the corresponding author, J.L.

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Author contributions. **Jonathan Linstead:** Conceptualization (equal), Formal analysis (equal), Methodology (equal), Project administration (equal), Writing – original draft (equal), Writing – review & editing (equal); **Michael Doyle:** Formal analysis (equal), Supervision (equal), Writing – original draft (equal), Writing – review & editing (equal).

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Conflict of interest. There are no conflicts of interest.

Ethical standards. The NHS Trust R&D department confirmed that ethical approval was not required as this was a service evaluation using anonymous routinely collected data. The authors have abided by the Ethical Principles of Psychologists and Code of Conduct as set out by the BABCP and BPS.

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