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## ‘Cognitive Behavioral Analysis System of Psychotherapy’: Treatment for chronic depression

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## Abstract

### Background:

Chronic depression is a common disorder in secondary care. Treatment results for this group of depressed patients are often disappointing and the existing treatment protocols are insufficiently tailored to chronic major depressive disorder (MDD). For this reason, an effective psychotherapy will constitute a welcome addition to the range of treatments currently available for chronically depressed patients.

### Goal:

To describe 'Cognitive Behavioral Analysis System of Psychotherapy' (CBASP), the first form of psychotherapy specifically designed for the treatment of chronic depression.

### Method:

This article describes the evidence, rationale and the most important techniques used in CBASP.

### Results:

In the United States, CBASP has proven to be effective in one large trial.

### Conclusion:

As a result of these findings, CBASP is mentioned as an evidence-based treatment option for chronic depression in the Dutch treatment guidelines. However, the findings have not been replicated yet and not much is known about CBASP in the Netherlands. For this reason, a randomized controlled trial has been started in the Netherlands in order to determine the effectiveness of CBASP.

## Introduction

Epidemiological research has shown that roughly 20% of persons with depressive disorders suffer episodes of depression that last for 2 years or longer.<sup>1,2</sup> Within secondary care, the percentage is higher: 25-35% of depressed patients who are treated in secondary care have a chronic form of depression.<sup>3,4</sup> The STAR\*D study found that, in a group of depressed patients in primary and secondary care, 25% were chronic sufferers.<sup>5</sup> Compared to nonchronic forms of depression chronic depression is associated with greater disability, increased health service use, hospitalisation, higher likelihood of suicidal ideation and attempts, and higher burden of disease.<sup>6,7</sup> Moreover, both somatic and psychiatric comorbidity are more common with chronic depression,<sup>8</sup> which is also linked to significant psychosocial impairment.<sup>9,10</sup>

The Netherlands Study of Depression and Anxiety (NESDA) found that chronically depressed patients reported more severe depressive symptoms, were more likely to have a comorbid anxiety disorder (77.7% versus 62.2%) and had more frequently experienced some form of childhood trauma than nonchronically depressed patients.<sup>11</sup> Research using structured clinical interviews to investigate comorbidity between depression and personality disorders found that roughly 50% of chronically depressed patients had comorbid cluster-B or cluster-C personality disorders.<sup>12</sup> About 30% were substance abusers.<sup>13,14</sup>

Chronic depression is often not specifically diagnosed, because chronically depressed patients presenting for treatment tend to report only their current (comorbid) symptoms and psychosocial problems. They are apt to regard their chronic depressive status as *normal* and therefore not worth mentioning or warranting treatment.<sup>15</sup> Consequently, the chronic nature of the patient's depression often does not become apparent until later.<sup>16</sup>

Although research has yet to focus specifically on the effects of interpersonal psychotherapy (IPT) or cognitive behavioral therapy (CGT) on chronic depression, there are indications in the literature that the evidence-based treatment methods for depression, such as pharmacotherapy, CGT and IPT, do not yield such good results with patients who have chronic forms of depression.<sup>17-21</sup> The STAR\*D study, which compared the effect of pharmacotherapy on acute depression with its effect on chronic depression, revealed marked differences in remission rates: 30% in the acute group versus 24% in the chronic group.<sup>5</sup>

Several large studies have found that, in the treatment of chronic depression, the combination of pharmacotherapy and psychotherapy produces better results than either pharmacotherapy or psychotherapy on its own.<sup>22-26</sup> Remission rates for this group were found between 25% to 32% for either psychotherapy or pharmacotherapy on its own, and 43% to 48% for the combination of psychotherapy and pharmacotherapy. The best results were found for 'Cognitive Behavioral Analysis System of Psychotherapy' (CBASP), the first

form of psychotherapy designed specifically for the treatment of chronic depression, in combination with the antidepressant Nefazodone.<sup>25</sup> Since little is known about this relatively new form of psychotherapy, this article considers in turn the evidence concerning, rationale for and principal techniques of CBASP.

## Evidence

CBASP was originally developed in 1974, before being refined in the course of the 1980s and 1990s. The therapist manual was published in 1995<sup>27</sup> and used in the above-mentioned study.<sup>25</sup> In that study (N=681), the effect of CBASP was compared with that of the antidepressant Nefazodone and that of CBASP and Nefazodone combined. For 12 weeks, patients in the CBASP group and in the combined therapy group received between sixteen and twenty sessions of CBASP (2 sessions a week for 4 to 8 weeks; 1 session per week thereafter). Medication was built up from 100mg to a maximum of 600mg of Nefazodone per day. The results showed that both CBASP and Nefazodone were effective as monotherapies (respective remission rates: 33% and 29%). However, the greatest effect was observed when the two were combined (remission rate: 48%).

During the 4-month continuation phase, patients in the combined therapy group received 6 sessions of CBASP (once a fortnight from week 12 to week 20, then 2 monthly sessions between week 20 and week 28), plus monthly medication consultations. Patients in the CBASP-only group received 6 sessions of CBASP, and patients in the Nefazodone-only group received monthly medication consultations. The results from the continuation phase again showed no difference between CBASP and Nefazodone, while the combination of both was most effective.<sup>28</sup> Moreover, the combination also produced full remission from chronic depression more rapidly than either CBASP or Nefazodone on its own, which did not differ from each other.<sup>29</sup>

The nonresponders in the two acute-phase monotherapy groups took part in the crossover phase. In this phase, those that had previously received Nefazodone on its own were given CBASP on its own, and vice versa. After 12 weeks, the remission rates were 36% in the CBASP group and 27% in the Nefazodone group. A switch from medication to psychotherapy or vice versa appears to be useful for nonresponders to the initial treatment.<sup>30</sup>

Finally, Klein et al.<sup>31</sup> studied the use of CBASP as a maintenance therapy. Comparison was made between a group who received monthly CBASP sessions for a year and a group who underwent monthly assessment but received no CBASP. The assessment involved a consultation with the project coordinator, for which expenses were paid to provide an incentive for ongoing participation. In the CBASP maintenance group, the relapse rate was

2.6%, while that in the assessment group was 20.9%. These findings suggest that CBASP is also an effective maintenance therapy for chronic depression.

In addition to the studies into the efficacy of CBASP referred to above, further analyses with this sample were performed. Klein et al.<sup>32</sup> investigated the influence of the quality of the therapeutic relationship on outcome. They found that a good therapeutic alliance at the start of the treatment (in week 2, after 4 sessions) was a significant predictor of outcome in both the CBASP group and the combined therapy group. Nemeroff et al.<sup>33</sup> used a retrospective analytical technique to examine the influence of childhood trauma on the effect of the treatment. Their analysis showed that chronically depressed patients who had experienced childhood trauma benefitted significantly more from CBASP (on its own or in combination with Nefazodone) than from Nefazodone on its own. For patients who had experienced childhood trauma, the combination of CBASP and Nefazodone was no more effective than CBASP alone. Ninan et al.<sup>34</sup> investigated the effect of treatment on comorbid anxiety disorders. They found that the anxiety symptoms of patients who received Nefazodone on its own or in combination with CBASP improved more quickly than the anxiety symptoms of patients who received CBASP on its own. Manber et al.<sup>29</sup> examined the influence of comorbid anxiety symptoms on depression remission rates and found that having more severe anxiety symptoms was associated with lower remission rates in all 3 therapy groups. Hence, in this study, severe anxiety symptoms inhibited recovery from depression. Comorbid Axis-II disorders (particularly those in cluster C) were not found to inhibit recovery from depression, however. The study of Maddux et al.<sup>35</sup> into the influence of comorbid personality disorders on treatment outcomes revealed that having a comorbid personality disorder did not adversely affect the outcome of treatment with either CBASP, Nefazodone or their combination. Finally, Hirschfeld et al.<sup>36</sup> studied the effect of treatment on psychosocial functioning of chronically depressed patients. Improved psychosocial functioning was most marked in patients who received the combination of CBASP and Nefazodone. However, psychosocial functioning of patients who had achieved remission was still below the population norm.

## Rationale

McCullough based his rationale on certain pathological characteristics of chronically depressed patients, such as extreme interpersonal fear and avoidance and an external locus of control, which often stem from a developmental history filled with psychological insults and trauma.<sup>16</sup> Chronically depressed patients often have the feeling that they are not able to control or influence outcomes. Therefore, they withdraw more and more and cease to

believe that their condition will never change. In line with Piaget's developmental model,<sup>37</sup> McCullough argues that chronically depressed patients function on a 'preoperational' level; they do not recognize a connection between *what they do* and *the effects of what they do* on others. CBASP addresses this issue and teaches the patient to function on an 'operational' level: the patient is made aware of his or her own role in a interpersonal situation and the ability to influence the outcome of the situation.

In CBASP, beside the regular behavioral, cognitive and interpersonal techniques, specific techniques are used to replace the interpersonal fear of the chronic patient with interpersonal safety, starting within the therapeutic relationship. Subsequently, the relationship with the therapist is used as a tool to help patients to become more aware of their impact on others and to distinguish between adaptive and maladaptive relationships. Finally, the patient learns how to assert him or herself and how to interact in a functional way, creating a more internal locus of control.<sup>16</sup> The techniques used in CBASP are considered below.

The acute phase of treatment consists of 12 weeks, during which 16 to 20 sessions are given. CBASP begins with two 45-minute sessions a week for the first month, in order to build up a good therapeutic relationship. The biweekly sessions can, if necessary, be continued for a further 4 weeks. The session frequency is then reduced to 1 per week. After 12 weeks (16 to 20 sessions), the continuation phase begins; this is followed by the maintenance phase. In these phases, the interval between sessions is extended, first to a fortnight, and then to a month. Patients in the study by Keller et al.<sup>25</sup> received 6 sessions during the continuation phase and 12 monthly sessions during the maintenance phase. However, it has not yet been established whether this is the best therapy schedule for CBASP.

## CBASP techniques

### *Start of the therapy*

To begin with, the emphasis is on finding out what course the patient's depressive symptoms have followed and on characterizing his or her interaction patterns. The course of the patient's depressive symptoms is recorded in the first session using the life chart method. The second session is devoted to interaction patterns, with the therapist establishing the patient's 'significant other history'. This history is compiled by asking the following questions about the patient's significant others: 'How was it growing up around ...?' 'What influence did/does this person have on you?' And, finally: 'What is the stamp that this person has left on you?' In this way, the therapist seeks to identify a consistent theme characterizing the patient's relationships with his/her significant others (4 to 5 persons).

Next, a transference hypothesis is formulated. McCullough<sup>16</sup> distinguishes 4 themes for such hypotheses: intimacy/proximity, the display of emotional needs, making mistakes and the expression of negative feelings. McCullough's themes are based on his clinical experience with chronically depressed patients. Chronically depressed patients often report negative interactions with their significant others, characterized by feelings of rejection. The relationships might have involved abuse, punishment or rejection in response to displays of emotion, mistakes or the expression of negative feelings towards their parents. On the basis of what the patient says, the therapist identifies the most prominent theme in the patient's significant others history. The therapist uses the transference hypothesis to pinpoint interpersonal hotspots, which (will) play a role in therapist-patient contact.

After the second session, the therapist not only makes the patient's current or future perception of the therapist explicit, but also analyzes the feelings that the patient elicits. To this end, the therapist compiles an Impact Message Inventory (IMI).<sup>38</sup> An IMI is a questionnaire concerning the patient that the therapist completes in order to define the patient's attitude towards the therapist. The IMI is divided into 4 domains, which are comparable with Leary's rose:<sup>39</sup> dominant versus submissive and friendly versus hostile. Using the IMI, the therapist can identify the patient's behavior at an early stage in the process and thus avoid falling in with the patient's dysfunctional patterns. The therapist always responds within the friendly domain, while asking him/herself: "What is this patient doing with me (which he/she surely does with other people as well)?" The information gathered using the life chart, the significant other history, the transference hypothesis and the IMI form the background against which the various CBASP techniques (situation analysis, interpersonal discrimination exercise, disciplined personal involvement and social skills training) are used during the course of therapy.

### *Situational Analysis (SA)*

The main technique used in CBASP is situational analysis (SA). SA puts the patient's behavior under the microscope by focusing on a particular (usually) problematic interactional situation. SA involves the following steps:

- 1) Defining a (problematic) situation (with clear start and end points)
- 2) Defining the patient's thoughts/interpretations in the relevant situation
- 3) Defining the patient's behavior in the situation
- 4) Defining the actual outcome of the situation
- 5) Defining the desired outcome of the situation
- 6) Establishing whether the desired outcome was achieved
- 7) Establishing why the desired outcome was/was not achieved

In this way, an association is made between cause and effect in the context of a recent, real-life interpersonal incident. The patient behaved in a particular way and obtained a particular outcome. Because the outcome will often have been negative (the patient did not achieve the desired outcome), the patient is likely to have found it painful. Such pain acts as a driver of change.<sup>16</sup> SA teaches patients to analyze the consequences of their behavior and to consider alternative thoughts and forms of behavior that could lead to more desirable outcomes.

#### *Interpersonal Discrimination Exercise (IDE).*

One technique that the therapist can use after discussing a situational analysis is the interpersonal discrimination exercise (IDE). Following discussion of the SA, the therapist asks the patient how, for example, his/her father/mother would have responded to the discussion. This exercise recalls the pattern of the patient's interaction with his/her significant others, as defined in the second session. Next, the therapist asks the patient how he or she, the therapist, responded to the situation and goes on to point out that they might have interacted in other ways. Through the IDE, the patient learns to differentiate between the negative responses of significant others and the positive responses of the therapist. The aim of the exercise is to get the patient to generalize the newly discovered alternative interactions to his/her day-to-day contacts. Use of the IDE is illustrated below.

*A patient introduces an SA: he/she had agreed to carry out an assignment at the request of a colleague, when he/she didn't really want to.*

*Th.: How do you feel about having talked this problem through with me?*

*Pt.: Good.*

*Th.: How would your father have responded if you had told him something like that?*

*Pt.: My father? He would have been annoyed and told me to sort it out myself.*

*Th.: How did I respond? How did I appear to you, how did I talk and what did I say?*

*Pt.: You were friendly; you listened and tried to help me.*

*Th.: How did my response differ from your father's?*

*Pt.: You were interested in what I had to say; my father never was.*

*Th.: How did it feel, talking the situation over with me?*

*Pt.: It felt good.*

*Th.: My response was different from your father's. What does that mean for our relationship?*

*Pt.: That I can talk to you about this sort of thing.*

*Th.: And, if you can talk to me like this, maybe you can talk to other people the same way.*

*Pt.: Yes.*

#### *Disciplined Personal Involvement*

A less ideal patient might say, "You are only listening to me because you get paid to." Under such circumstances, the therapist can use a technique called 'disciplined personal involvement'. Disciplined personal involvement implies that a therapist makes his/her personal involvement clear to the patient in a 'disciplined' way, i.e. without crossing any boundaries. The therapist directly expresses the feelings that the patient elicits in him/her, but only insofar as doing so supports the aim of the therapy, namely teaching the patient to understand how his/her behavior influences the way other people respond and to recognize that he/she could learn to elicit different feelings in others. The consequences of the patient's behavior are made explicit, as are the implications of that behavior for the therapy process. The therapist always remains in the friendly domain (see IMI, above). The following illustrates the use of disciplined personal involvement in therapy:

*Th.: You say that I only listen to you because I get paid to. How do you think it feels to be told that?*

*Pt.: I've no idea.*

*Th.: I don't like it. Our talks are important to me; it's nonsense to suggest that I only listen to you because I get paid to.*

*Pt.: It was just a casual remark.*

*Th.: But, by saying that kind of thing to me, you push me away. Is that what you want?*

*Pt.: I don't know.*

*Th.: I don't want there to be so much distance between us; that's why I have told you that our talks are important to me. How do you feel about that?*

*Pt.: I find it hard to believe that anyone actually cares about my problems. I'm not used to that.*

*Th.: That's not surprising; it's a new experience having someone who is prepared to listen. And how does it feel to sit down with someone that cares about your problems?*

*Pt.: Weird, but OK.*

*Th.: Good. The distance that I sensed between us a few moments ago isn't there any more. Why is that?*

*Pt.: Because I was honest with you?*

*Th.: Quite possibly. And it feels good.*

Finally, most chronically depressed patients can benefit from social skills training. Some in order to become more assertive, others in order to learn how to control their anger and aggression, see how a situation develops and respond in a less emotionally charged way. The CBASP procedure does not involve detailed discussion of social skills training, the

importance of individualized training is merely highlighted. Role play exercises can be used to practice dealing with the problematic situations identified by situational analysis, such as learning to say 'no', to express opinions, or to ask for help.

## Discussion

CBASP is a relatively new form of psychotherapy, specifically designed to treat chronic depression. In a large-scale US study, CBASP was found to be as effective as medication in the treatment of chronic depression, while the combination of both treatments was clearly superior. As a result of these findings, CBASP is mentioned as an evidence based treatment option for chronic depression in various guidelines, including the Dutch Multidisciplinary Guidelines of Depression.<sup>40</sup>

It is a structured method, which focuses on the patient's problematic interactions with the people around him/her. CBASP integrates techniques from cognitive behavioral therapy, interpersonal psychotherapy and psychodynamic psychotherapy. Consequently, the CBASP model is consistent with various schools of psychotherapy; it is easily applied both by therapists with a background in cognitive behavioral therapy and by those with a psychodynamic background. In addition to techniques familiar from other forms of therapy, CBASP uses new techniques, such as the interpersonal discrimination exercise and disciplined personal involvement, in which the therapist's personal responses to the chronically depressed patient's behavior are examined in order to confront the patient and to address his/her persistent interaction patterns.

The question is whether these additional techniques actually make CBASP more effective than the existing treatment protocols. Knowledge regarding the efficacy of CBASP currently derives from a single study, which has yet to be replicated and did not compare the effect of CBASP with that of other forms of psychotherapy. Moreover, it is not known whether the results obtained in the US are transferrable to the Dutch situation. To examine whether CBASP could be a useful addition to the range of treatments currently available in secondary care in the Netherlands, a randomized controlled trial into the effectiveness of CBASP has been started in 3 specialized mental health care centers in the Netherlands.<sup>41</sup> The inclusion period for the trial ended in December 2008 and the results will be known in the course of 2010.

## References

1. Judd, L.L., Akiskal, H.S., Maser, J.D., et.al. (1998). A prospective 12-year study of subsyndromal and syndromal depressive symptoms in unipolar major depressive disorders. *Archives of General Psychiatry*, 55, 694-700.
2. Spijker, J., Bijl, R.V., de Graaf, R., et.al. (2004). [Depression: longer-lasting episode not an automatic indication for referral]. *Nederlands Tijdschrift voor Geneeskunde*, 148, 247-248.
3. Rush, A.J., Laux, G., Giles, D.E., et.al. (1995). Clinical characteristics of outpatients with chronic major depression. *Journal of Affective Disorders*, 34, 25-32.
4. First, M.B., Donovan, S., & Frances, A. (1996). Nosology of chronic mood disorders. *Psychiatric Clinics of North America*, 19, 29-39.
5. Gilmer WS, Gollan JK, Wisniewski SR, et al. (2008). Does the duration of index episode affect the treatment outcome of major depressive disorder? A STAR\*D report. *J Clin Psychiatry*, 69, 1246-1256
6. Spijker, J., de, Graaf, R., Bijl, R.V., et.al. (2002). Duration of major depressive episodes in the general population: results from The Netherlands Mental Health Survey and Incidence Study (NEMESIS). *British Journal of Psychiatry*, 181, 208-213.
7. Klein, D.N., Schwartz, J.E., Rose, S., et.al. (2000). Five-year course and outcome of dysthymic disorder: A prospective, naturalistic follow-up study. *American Journal of Psychiatry*, 157, 931-939.
8. Keller, M.B. (1994). [Long-term treatment of depression]. *Fortschritte der Neurologie-Psychiatrie*, 62, 32-38.
9. Klein, D.N. & Santiago, N.J. (2003). Dysthymia and chronic depression: introduction, classification, risk factors, and course. *Journal of Clinical Psychology*, 59, 807-816.
10. Enns, M.W. & Cox, B.J. (2005). Psychosocial and clinical predictors of symptom persistence vs remission in major depressive disorder. *Canadian Journal of Psychiatry*, 50, 769-777
11. Wiersma, J.E., Hovens J.G.F.M., van Oppen, P., et.al. (2009). The Importance of Childhood Trauma and Childhood Life events for Chronicity of Depression. *Journal of Clinical Psychiatry* 70(7), 983-989.
12. McCullough, J.P., Kornstein, S.G., Belyea-Caldwell, S., et.al. (1996). Differential diagnosis of chronic depressive disorders. *Psychiatric Clinics of North America*, 19, 55-71.
13. Weissman, M.M., Leaf, P.J., Bruce, M.L., et.al. (1988). The epidemiology of dysthymia in five communities: rates, risks, comorbidity, and treatment. *American Journal of Psychiatry*, 145, 815-819.
14. Keller, M.B., Harrison, W., Fawcett, J.A., et.al. (1995). Treatment of chronic depression with sertraline or imipramine: preliminary blinded response rates and high rates of undertreatment in the community. *Psychopharmacological Bulletin*, 31, 205-212.

15. Arnow, B.A. & Constantino, M.J. (2003). Effectiveness of psychotherapy and combination treatment for chronic depression. *Journal of Clinical Psychology*, 59, 893-905.
16. McCullough, J.P. (2000). *Treatment for Chronic Depression. Cognitive Behavioral Analysis System of Psychotherapy*. New York: The Guilford Press.
17. Blom, M.B.J. & Jonker, K. (2005). Chronisch maar niet hopeloos. Een overzicht van de psychotherapeutische mogelijkheden bij chronische depressie en dysthymie. *Maandblad voor de Geestelijke Volksgezondheid*, 60, 995-1007.
18. Blom, M.B.J., Spinhoven, P., Hoffman, T.O., et.al. (2007). Severity and duration of depression, not personality factors, predict short term outcome in the treatment of major depression. *Journal of Affective Disorders*, 104, 119-126
19. Riso, L.P. & Newman, C.F. (2003). Cognitive therapy for chronic depression. *Journal of Clinical Psychology*, 59, 817-831.
20. Markowitz, J.C. (2003). Interpersonal psychotherapy for chronic depression. *Journal of Clinical Psychology*, 59, 847-858.
21. Kocsis, J.H. (2003). Pharmacotherapy for chronic depression. *Journal of Clinical Psychology*, 59, 885-892.
22. De Maat, S.M., Dekker, J., Schoevers, R.A., et.al. (2007). Relative efficacy of psychotherapy and combined therapy in the treatment of depression: a meta-analysis. *European Psychiatry*, 22, 1-8.
23. Hollon, S.D., Shelton, R.C., Wisniewski, S., et.al. (2006). Presenting characteristics of depressed outpatients as a function of recurrence: preliminary findings from the STAR\*D clinical trial. *Journal of Psychiatric Research*, 40, 59-69.
24. Pampallona, S., Bollini, P., Tibaldi, G., et.al. (2004). Combined pharmacotherapy and psychological treatment for depression: a systematic review. *Archives of General Psychiatry*, 61, 714-719.
25. Keller, M.B., McCullough, J.P., Klein, D.N., et.al. (2000). A comparison of nefazodone, the cognitive behavioral-analysis system of psychotherapy, and their combination for the treatment of chronic depression. *New England Journal of Medicine*, 342, 1462-1470.
26. Thase, M.E., Greenhouse, J.B., Frank, E., et.al. (1997). Treatment of major depression with psychotherapy or psychotherapy-pharmacotherapy combinations. *Archives of General Psychiatry*, 54, 1009-1015.
27. McCullough J.P. (1995). *Therapist manual for Cognitive Behavioral Analysis System of Psychotherapy*. Richmond: Virginia Commonwealth University
28. Arnow B.A. (2005). Cognitive Behavioral Analysis System of Psychotherapy for Chronic Depression. *Cognitive and Behavioral practice*, 12, 6-16.
29. Manber, R., Kraemer, H.C., Arnow, B.A., et.al. (2008). Faster remission of chronic depression with combined psychotherapy and medication than with each therapy alone. *Journal of Consulting and Clinical Psychology*, 76, 459-467.
30. Schatzberg, A.F., Rush, A.J., Arnow, B.A., et.al. (2005, May). Chronic depression: medication (nefazodone) or psychotherapy (CBASP) is effective when the other is not. *Archives of General Psychiatry*, 62, 513-520.
31. Klein, D.N., Santiago, N.J., Vivian, D., et.al. (2004). Cognitive-behavioral analysis system of psychotherapy as a maintenance treatment for chronic depression. *Journal of Consulting and Clinical Psychology*, 72, 681-688.
32. Klein, D.N., Schwartz, J.E., Santiago, N.J., et.al. (2003). Therapeutic alliance in depression treatment: controlling for prior change and patient characteristics. *Journal of Consulting and Clinical Psychology*, 71, 997-1006.
33. Nemeroff, C.B., Heim, C.M., Thase, M.E., et.al. (2003). Differential responses to psychotherapy versus pharmacotherapy in patients with chronic forms of major depression and childhood trauma. *Proceedings of National Academy of Sciences U.S.A*, 100, 14293-14296.
34. Ninan, P.T., Rush, A.J., Crits-Christoph, P., et.al. (2002). Symptomatic and syndromal anxiety in chronic forms of major depression: effect of nefazodone, cognitive behavioral analysis system of psychotherapy, and their combination. *Journal of Clinical Psychiatry*, 63, 434-441.
35. Maddux, R.E., Riso, L.P., Klein, D.N., et.al. (2009). Select comorbid personality disorders and the treatment of chronic depression with nefazodone, targeted psychotherapy, or their combination. *Journal of Affective Disorders*, 117, 174-179.
36. Hirschfeld, R.M., Dunner, D.L., Keitner, G., et.al. (2002). Does psychosocial functioning improve independent of depressive symptoms? A comparison of nefazodone, psychotherapy, and their combination. *Biological Psychiatry*, 51, 123-133.
37. Piaget, J. (1962). The stages of the intellectual development of the child. *Bulletin of Menninger Clinic*, 26, 120-128.
38. Kiesler, D.J. (1996). From communications to interpersonal theory: a personal odyssey. *Journal of Personality Assessment*, 66, 267-282.
39. Leary, T. (1955). The theory and measurement methodology of interpersonal communication. *Psychiatry*, 18, 147-161. *Landelijke Stuurgroep Multidisciplinaire Richtlijnontwikkeling in de GGZ [2005]. Richtlijn voor de diagnostiek en behandeling van volwassen cliënten met een depressie 2005. Websites: www.ggzrichtlijnen.nl; www.cbo.nl. (2005).*
40. Wiersma, J.E., van Schaik, D.J., van, Oppen, P., et.al. (2008). Treatment of chronically depressed patients: a multisite randomized controlled trial testing the effectiveness of 'Cognitive Behavioral Analysis System of Psychotherapy' (CBASP) for chronic depressions versus usual secondary care. *BioMedCentral Psychiatry*, 8, 18.