Lorna Smith Benjamin

Brief SASB-Directed Reconstructive Learning Therapy

Handbook of Short-Term Dynamic Psychotherapy

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Brief SASB-Directed Reconstructive Learning Therapy[1]

GUIDING PRINCIPLES

Undergoing the process of psychotherapy is like learning to ski: to the beginner, the task is both attractive and frightening, and one must be strongly motivated to undertake this intimidating activity. In both skiing and psychotherapy, the novice can see that there are many folks who seem to enjoy the endeavor, and that they are willing to spend amazing amounts of money on it. But the process is not for everyone. There are those who have certain handicaps that interfere with development of the needed skills for mastery. On the other hand, there are adaptations and variants to the basic approach which can be implemented by certain creative and highly motivated handicapped persons.

The fundamental principles of learning to ski and of learning in psychotherapy are relatively simple to state, but not so easy to execute: take lessons and practice, because they will help you develop good form, and that will serve you well in the difficult spots. The would-be therapist/ instructor should expect to become quite skilled in what is being taught and know that certification involves an extended, usually painful learning process. Even after therapist learning has reached high levels, expert therapists, like expert skiers, know there always will be times when they fall, and they need not

attempt to deny this vulnerability.

The analogy between psychotherapy and learning to ski is particularly apt when discussing the increasingly popular concept of brief psychotherapy. After killing the third-party goose that was laying golden eggs for years, psychotherapists and patients have been confronted with demands for (often very) brief psychotherapy. Under the learning model, brief psychotherapy can make sense: goals can be set, principles articulated, and a few basic skills imparted; then the person can then go off on his or her own to practice. As with the skier, the psychotherapy student is at some point ready to come back for another series of lessons, to correct recurrent bad habits, or to learn new skills in order to go on to higher levels.

The comparison of psychotherapy to learning a complicated skill like skiing is sharply discordant with the medical model, which dominates current thinking. The medical model holds that mental disorders are diseases transmitted by defective genes, and that they are best treated by chemicals or other physical interventions such as electroshock or surgery. Even though there is a long and venerable tradition in the literature of seeing psychotherapy as a learning process (Marmor & Woods, 1980), clinicians and researchers have been reluctant to make the comparison explicit. Perhaps if psychotherapy were defined as a problem in learning, third-party payments would be withheld, and eventually therapists might be reimbursed as

teachers, a group that is notably underpaid.

Despite the economic and political risks, a view of psychotherapy primarily as a learning experience offers many advantages, not the least of which is provision of a frame of reference within which it is possible to construct testable theories about causes of mental disorders and to develop logically related psychosocial treatment plans. Moreover, the learning frame can relate directly to the definition of mental disorder offered in the official nomenclature of the American Psychiatric Association, the *DSM III-R*. There, mental disorder is defined as a "behavioral or psychological syndrome or pattern that occurs in a person and that is associated with present *distress* (a painful symptom) or *disability* (impairment in one or more important areas of functioning) or with significantly increased risk of suffering, death, pain, disability, or an important loss of freedom" (American Psychiatric Association, 1987, p. xxii).

The view presented in this chapter is that successful psychotherapy, no matter what its theoretical basis, helps the patient to learn about his or her interpersonal and intrapsychic patterns and to develop better alternatives—both more adaptive in the here and now and both associated with less subjective distress. Because it directly addresses the two key aspects of mental disorder, maladaptivity and subjective distress, the learning interpretation of psychotherapy is in fact as relevant to the medical definition

as are the more purely somatic approaches based on a "disease" model. It should be added that the description of psychotherapy primarily as a learning process does not rule out use of medications normally associated with the disease model. Practitioners of psychotherapy can and should refer to qualified professionals for the prescription of drugs, which can provide needed biochemical support in times of crisis or offer relief to individuals with certain limitations. Just as it is widely assumed that genes affect athletic ability, a learning view of psychotherapy also naturally acknowledges major contributions from inherited factors.

Ideally, the psychotherapist who uses a learning model selects from any of the hundreds of available therapy approaches (Goldfried, Greenberg, & Marmar, 1990) to optimize the learning for a given patient at a given stage of psychotherapy. The critical elusive questions for this somewhat self-evident analysis of psychotherapy as a learning experience are these: How does one precisely define patterns that are maladaptive and associated with subjective distress? How does one select an approach that will be optimally effective in changing these patterns at any given moment? and How does one evaluate the effects of the intervention?

At this point the present approach departs noticeably from many others, answering the questions how to define maladaptive interactive and intrapsychic patterns and how to assess the effects of interventions through

the Structural Analysis of Social Behavior, or SASB (Benjamin, 1974, 1984). The key proposition is that each of the mental disorders in the *DSM III-R* is hypothetically associated with specific SASB-codable interpersonal and intrapsychic patterns. This thesis has been explicated for the *DSM III-R* Axis II personality disorders in a forthcoming monograph (Benjamin, in press) wherein the SASB model is used to describe each personality disorder in terms of characteristic interpersonal and intrapsychic patterns. The SASB model also provides hypotheses about specific associated interpersonal learning experiences presumed to contribute to the disorder; the analysis has specific implications for learning experiences needed to change the patterns characteristic of the respective disorders. Comparable SASB-based hypotheses for the Axis I disorders are undergoing informal clinical field trials.

In addition to providing descriptions of characteristic patterns for disorders and their hypothetical interpersonal antecedents, SASB codes of patient responses to a given intervention can provide information about whether the intervention has reinforced old patterns or whether it has moved the patient in the direction of a more adaptive orientation. The use of the SASB model to define patterns and to plan and assess interventions is called SASB-directed Reconstructive Learning (SASB-RCL).

Since learning and dynamic therapy approaches have historically been

placed in opposition (Mischel, 1973; Wachtel, 1973), it is important to clarify how the SASB-RCL approach to psychotherapy can be characterized as dynamic even though it explicitly invokes principles of learning. Gordon Allport defined personality as "the dynamic organization within the individual of those psychophysical systems that determine his unique adjustments to his environment" (1937, p. 48). When he used the word *dynamic*, Allport referred to the person's goals and purposes. The SASB-RCL approach also centers on the concept of goals because interpersonal wishes and fears must carefully be assessed and addressed before therapeutic change can occur. These interpersonal goals may or may not be unconscious, and they are assumed to function just as do more traditional reinforcers such as money, food, or sex. If, for example, a person wishes to have the approval of a withholding and critical parent, then the patient is likely to engage in actions that he or she imagines might generate approval from that parent. Each therapy plan considers possible unconscious interpersonal reinforcers, and standard psychoanalytic procedures such as free association and dream analysis are used to observe the unconscious. Also consistent with the psychoanalytic viewpoint is the belief that insight and understanding facilitate the change process.

The dynamic therapy described here can be brief since the length of the therapy can be determined arbitrarily. It can last until hospital discharge, or for the number of sessions permitted by the patient's HMO, or for a number of

sessions set by any other contingencies. As long as there can be a single session, there can be learning. On the other hand, to ask when the therapy is finished is like asking when has one learned to ski, or to play the piano, or to speak French. The answer is relative to the starting level and to desired goals. If the task of therapy is to start with a patient with personality disorder who has already been unsuccessfully treated with medications, multiple hospitalizations, and various psychotherapies, and to finish with a reconstruction of the personality that includes no more suicide attempts and that permits the person to function consistently well in love and at work, then a long period of learning and practice is required. Two to four years of SASB-RCL therapy meeting at least once a week, with some periods of more frequent contact, would be reasonably brief compared with the normative expectation that this type of disorder could require continual support for decades, perhaps even for a lifetime.

Ideally, SASB-RCL continues until there has been a "reconstruction," meaning the problem patterns are no longer very likely to emerge and new and more adaptive patterns are the ones usually experienced by the individual and observed by the people who know him or her well. For patients with personality disorders, a therapy that implements such a reconstruction within a year is quite brief.

When resources are limited either by patient or therapist contingencies,

then the therapy can be far more brief, provided the goals are reduced to specific targets. An example would be to set a limited goal during hospitalization of helping the patient specifically and concretely understand how his or her perceptions and feelings do make sense, and to understand which specific interpersonal changes can be implemented with further work. Brief inpatient therapies also can focus on a quintessential issue with the hope that subsequent natural processes will help the patient follow the new directions marked by this issue. For example, a young person presenting with schizophreniform disorder could be helped to respond better to medications or to "outgrow" the crisis by a brief inpatient psychotherapy concentrating exclusively on self-definition relative to enmeshed parents. The therapist could support the vital signs of differentiation, for example, by affirming the patient's own choice of lipstick color despite her admirably groomed mother's insistence that another color is better for her. Such validation of the patient's right to discover her own person, if delivered before the schizophrenic life style has evolved, might make the difference between a schizophreniform episode and a lifetime of schizophrenia.

Brevity, then, is relative to the task and to the norms for the task. Brevity is implemented by sharpness of focus, and by consistency in adhering to the selected goals. A brief therapy is defined when the therapy has been effective in reaching its specific goals, and when no time or money has been wasted on maintaining old maladaptive wishes or fears.

HISTORY OF THE DEVELOPMENT OF THE METHOD AND ORIGIN OF THE IDEAS.

The SASB-RCL method consists of two aspects: (1) the interpretation of psychotherapy as a learning experience, and (2) the use of the SASB model to describe patterns, etiology, wishes, fears, treatment interventions, and the effects of interventions. The history of each aspect will be reviewed separately.

Psychotherapy as a Learning Experience

The present version of a learning approach to psychotherapy describes problems, etiologies, interventions, and outcomes in terms of SASB codes. In that effort, there is heavy reliance on the work of many others, starting with Freud (1896/1959), who convincingly argued that childhood experiences have a profound impact on the adult personality. Freud's ideas about the development of mental disorders were given interpersonal emphasis by Henry Stack Sullivan (1953), and, to a lesser but still noticeable extent, by modern object relations theorists (Greenberg & Mitchell, 1983).

Meanwhile, using an entirely different approach based initially on studies with rats and pigeons, B. F. Skinner and his colleagues (see Keller & Schoenfeld, 1950) effectively identified important learning principles that can be seen to be omnipresent during psychotherapy. The most useful of these

include the concepts of positive and negative reinforcement, punishment, reinforcement schedules, extinction, fading, shaping, stimulus generalization, and discrimination. The idea of connecting the learning literature to psychoanalysis was introduced as early as 1940 by Herbert Mowrer. The application of concepts from the operant conditioning literature to the psychotherapy process is especially effective if the contingencies are described in terms of SASB codes of interpersonal and intrapsychic patterns.

The SASB-RCL learning view of pathology and of therapy assumes that mental disorder represents an *adaptation* to previous interpersonal dilemmas, rather than a "breakdown." From the point of view of the patient, the patterns characteristic of the disorder must have been reinforced at some time, and must continue to make internal sense. The psychotherapist's task is to help the patient learn how his or her apparently maladaptive or subjectively uncomfortable patterns evolved and how they once served adaptive purposes. Then the patient must assess whether the patterns are still adaptive, and if convinced they no longer work, begin the task of learning patterns that are more adaptive in the here and now.

Consider the seemingly maladaptive behavior of a person with self-defeating personality disorder (SDPD). One might ask how negating the self can be seen as adaptive. How can self-defeating behavior sustain itself through reinforcement? In an actual case of self-defeating personality

disorder (SDPD), which will be cited throughout this paper, how can one say that it is adaptive for a woman whose husband has just left her for another woman to invite him to come to her home for brunch and bring the other woman? How can one say it is adaptive for this person to maintain a pattern of dutifully shopping for groceries for her adult sons, each of whom lives in his own apartment, and each of whom mocks, degrades, and refuses her if she requests that he go along with her to the store? How can her patterns at work be adaptive, if she puts in astonishing numbers of extra hours evenings and weekends in order to meet unreasonable deadlines? How can it have been adaptive for her to stay in a work place where she is denied appropriate support staff and where she does not receive adequate compensation either in money or in acknowledgment?

The answer lies in a careful assessment of her early history and present unconscious or preconscious views of herself. By taking the perspective of Sullivan's (1953) participant observer, it is possible to discover that the self-defeating behavior of this woman can be seen as adaptive according to a learned complex of family rules. These are not apparent to the outside observer, but they can be discerned by an empathic interviewer who listens while making the assumption that all interactions make sense from an internal perspective.

This woman with SDPD had been taught that she, the only healthy child

of three, was responsible for the care of her needy and overstressed mother and her two siblings: a sister who was brain damaged, and a brother who suffered from chronic mental illness. This future SDPD patient had been so obviously neglected that she was often invited (and permitted) to take meals and sleep over at a neighbor's home. The demands that she have no needs of her own, that she devote herself to the care of others, were reinforced by a religious orientation that held that the highest moral value is to be humble, to sacrifice oneself for the sake of others, and to show no anger. In light of this background, the woman's tendency to ignore her own feelings and needs, to minister faithfully to her alcoholic husband and his other woman, to cater to her demanding sons, and to try to satisfy her exploitive bosses can be seen as a continuation of striving for the approval of her parents and of God. According to *her understanding* of the rules of good personhood, self-defeating behavior was a maximally adaptive ideal.

The SASB model provides a sharply focused but broadly applicable description of key aspects of intrapsychic and interpersonal patterns in the past and makes the parallels to the present more obvious. Events that seem to have only distant relationships to one another can be connected directly if they can be shown to have the same underlying SASB dimensionality. It will become clear in the next section that the SASB codes for the patient's mother, her siblings, her alcoholic husband, her sons, and her bosses were all the same, even though her specific interactions with these people differed.

Consistency can be seen in her pervasive guilt and in the fact that in each relationship she was compliant as she delivered nurturance and sought affirmation, which rarely was forthcoming—and which made her uncomfortable if it was offered. There also were implicit accusations of others in her recounting of the details of their demands. The self-negating patterns were nothing more or less than repetitions of the way it was in childhood, and they were maintained in adulthood by her supposition of their continuing validity.

The idea that mental illness is an adaptation maintained by reinforcing contingencies is not new. Certainly Freud's notion of thanatos, circular though it may have been, represented acknowledgment that maladaptive patterns must be maintained by some force. Sullivan (as in 1953, pp. 113-122), who reflected carefully on the infant's efforts to avoid anxiety in relation to the "mothering one," invoked principles of interpersonal learning to account for mental disorder. Many other theorists, one of the more notable having been Theodore Millon (1982), have also used the concept of social reinforcers in understanding mental disorders.

Uses of the SASB Model

The SASB model is atheoretical with respect to schools of therapy. In addition to being used to guide the present learning-based view of

psychotherapy, the SASB model can be used to code process and outcome from a variety of therapeutic approaches. It is being used in the European Collaborative Study of Psychotherapy to compare and contrast Gestalt, client-centered, and psychoanalytic psychotherapy (Klaus Grawe, personal communication, 1990). The only requirement for use of the SASB model is that the material to be analyzed must be interactional: something or someone must interact with something or someone else. The interaction need not be explicitly interpersonal. One can use the SASB model to code the patient's relationship with abstractions: his headache, her trust fund, the welfare agency, her psychotherapy, his medications, and so on.

The history of the SASB model has been reviewed elsewhere (Benjamin, 1974, 1984). In brief, the model was based first on Earl Schaefer's (1965) factor-analytic circumplex model of parenting behavior validated in a variety of cultures, and then extended to incorporate the interpersonal circumplex proposed by Timothy Leary and his colleagues (1957). The latter was based on Henry Murray's (1938) description of basic human needs. Although its predecessors were in the form of a single circumplex, the SASB model consists of three surfaces. Among the advantages offered by the three-surface version are its ability to link intrapsychic patterns to interpersonal experience and its capacity to define differentiation. The ability to define friendly differentiation, to articulate the notion of a self that is clearly defined yet maintains attachment (see Berlin & Johnson, 1989)[2] is crucial to the

capacity to define normal behavior as qualitatively different from pathological behavior. A simplified version of the SASB full model, the cluster version, appears in figure 1.

The algorithm for cluster names is simple. Clusters located on the top surface of the model all begin with 1; those on the second, with 2; and those on the third, with 3. The second part of the cluster number ranges from 1 to 8, starting with 1 at twelve o'clock and proceeding clockwise to cluster 8. For example, in figure 1, Cluster 1-4, nurturing and protecting, is on the first surface, and it is the fourth one down from the top.

Consider the SASB cluster codes for the woman with SDPD described above. For research purposes, the SASB coding of a clinical description or narrative is usually done phrase by phrase (Humphrey & Benjamin, 1989; Grawe-Gerber & Benjamin, 1989). In clinical practice, the coding can be more selective, focusing on prototypic statements. The SASB model will be explained by showing how it can be used to describe the prototypic behaviors of the woman with SDPD as she tried to take care of relatives who criticized her for being selfish and stubborn and difficult.

SASB coding begins by designating two interactive *referents*: in this case the patient, X, who is acting upon others (mother, siblings, husband, bosses), Y. Coding proceeds from the point of view of X and starts with consideration

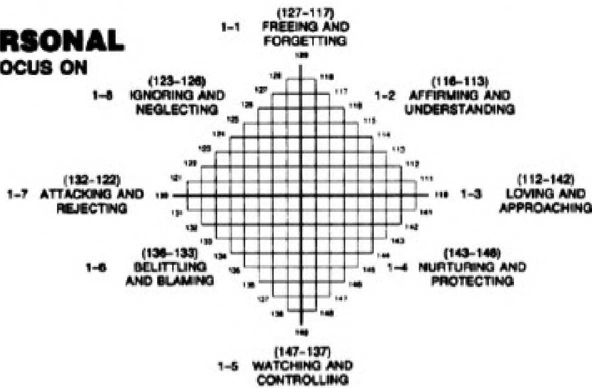
of whether X is (1) focusing on Y, (2) focusing on himself or herself in relation to Y, or (3) directing an action inward upon himself or herself. These three types of focus are represented by the stick figures at the top of figure 2 and by the three diamonds on figure 1 respectively labeled other, self, and introjection. In this example, the patient, X, focuses on her mother (and/or siblings or sons), Y, as she cleans the house, prepares the meals, runs errands, and tries to help in every way possible. The decision that she is focused on others means that the coding of her efforts will be on the top, or transitive, surface of figure 1.

Figure 1

The Cluster version of the SASB Model. The text shows that the illustrative case of SDPD prototypically engaged in behaviors coded at Cluster 1-4, Nurturing and Protecting plus Cluster 2-6, Sulking and Scurrying. Reprinted by permission from Benjamin (1987), copyright 1987 the Guilford Press.

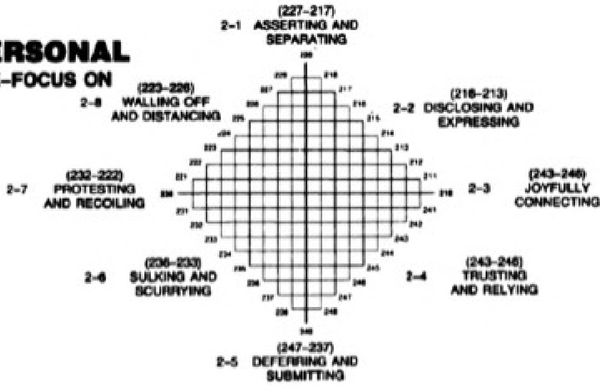
INTERPERSONAL

TRANSITIVE–FOCUS ON OTHER



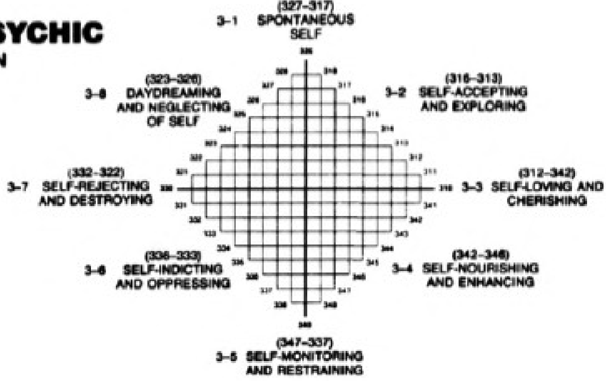
INTERPERSONAL

INTRANSITIVE–FOCUS ON SELF



INTRAPSYCHIC

INTROJECTION

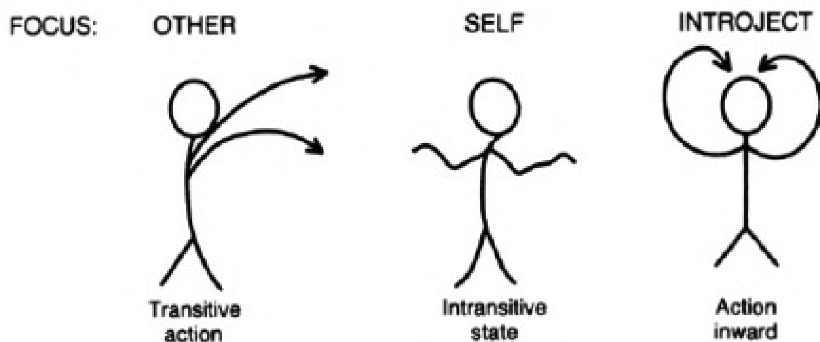


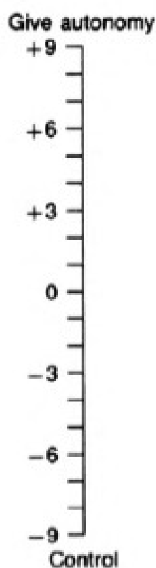
The second coding decision is whether the transaction is friendly or hostile; this is represented on the horizontal axis of the model, shown at the center of figure 2. The patient's efforts to take care of her mother and the others are friendly, say +5 on the horizontal scale.

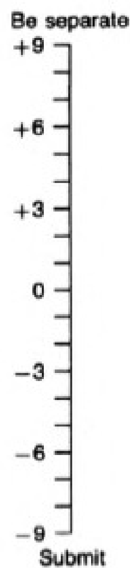
The third coding decision is whether the transaction is interdependent or independent, as represented by the vertical axes of figure 2. The vertical scale runs between different poles depending on which surface of the model describes X's position. In this example, the SDPD who takes care of others, the behaviors are transitive, so figure 2 shows that the interdependence judgments will range from control to give autonomy. The patient's role in the family involves some influencing, say 5 units in the controlling direction on the transitive vertical scale (– 5).

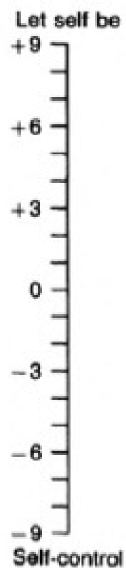
Figure 2

The Three Dimensions of the SASB Model. Therapy content and process expressed in interactional terms can be coded in terms of the three dimensions: focus (the three surfaces of Figure 1), love vs. hate (the horizontal axes of Figure 1), and interdependence (the vertical axes of Figure 1). Viewing all relationships in terms of these dimensions makes parallels among early and current relationships more apparent. Reprinted from Benjamin (1986), by permission of the Guilford Press.









The final SASB classification is determined by the three judgments: focus (surface), affiliation (horizontal axis), and interdependence (vertical

axis). The patient's prototypic set of behaviors has been judged to be transitive (which locates the code on the first surface in figure 1), friendly (+ 4), and moderately controlling (– 5). These judgments create a vector: transitive (+ 4,-5). On figure 1, a vector drawn to 4 units to the right on the horizontal axis and 5 units downward on the vertical scale projects through Cluster 1-4, Nurturing and protecting. In general, the point at which the underlying vector crosses the boundary of the model yields the SASB code. On the full SASB model, which requires the use of each of the nine points in the scales in figure 2, there are 108 possible classifications, while in the simplified version of figure 1, there are only 24 final categories (eight clusters on each of three surfaces). The underlying geometry and the logic for classification is the same for the full model, the cluster version, and the even simpler quadrant version of SASB (see Benjamin, 1984, for a discussion of the three levels of complexity).

The SASB code of the accusations of mother, husband, sons, bosses (X) toward the patient (Y) were transitive, hostile (– 5), and controlling (– 4). A vector representing these judgments is transitive (– 5, – 4), and it crosses the surface's boundaries at Cluster 1-6, belittling and blaming.

Like these two examples, any event, whether it is in the narrative of psychotherapy or in the therapy process itself, can be SASB coded as long as there are two interactive referents (X, Y), and as long as the example is

specific enough that there can be readings of friendliness versus hostility (horizontal), and enmeshment versus independence or differentiation (vertical) dimensions.

Predictive Principles

In addition to offering a generic descriptive frame of reference within which relationships can be compared and contrasted, the SASB model has a number of predictive principles, which facilitate identification of patterns and their interpersonal antecedents. The principles that are most useful in identifying connections between early learning and problematic adult patterns are (1) introjection, (2) opposition, (3) complementarity, and (4) similarity.

Introjection.

The third surface of the SASB model describes Sullivan's concept of introjection by recording intrapsychic events that stem from directing transitive action inward. The stick figure at the right-hand side of the top of figure 2 shows that X is directing an action inward upon him or herself. As the illustrative person with SDPD criticized herself; she (X) directed an action inward upon herself (X). For example, in her first session, this patient stated that she wanted to learn to be more "grown up," and documented the need for improvement with a tale of an afternoon when she avoided saying hello to

her sons at an athletic event because they were accompanied by their father and the "other woman." The SDPD patient berated herself for not being mature enough to nurture her sons in that context. The SASB code for this self-critical attitude is: introject (the patient directs action inward upon herself), unfriendly (– 4), and controlling (– 5). The resulting vector (-4,-5), drawn on the third surface of figure 1, crosses the boundary at Cluster 3-6, self-indicting and oppressing.

SASB introject theory suggests that the patient's self-degradation is a result of internalization of the belittling and blaming (Cluster 1-6) she received from her mother, and later, from her husband, sons, and bosses. The treatment implication is that she will need to develop a different perspective on her relationships with these people or on their internal representations in order to stop her self-degradation.

Opposition.

Opposition, described by points located at 180-degree angles on the model, is another important SASB predictive principle. For example, it can be seen on figure 1 that the opposite of 1-6, belittling and blaming, is 1-2, affirming and understanding. For a long time in therapy, this person with SDPD had difficulty accepting the therapist as affirming and understanding. Instead, there was a strong tendency to assume that the therapist was

secretly judgmental and hostile. On the Berrett-Lennard relationship inventory, measures of the patient's perception of the therapist, the patient marked "?" for the item "I feel appreciated by her (*therapist*)," and penciled in: "Appreciated for what? I think of this as a transitive verb." In short, this person with SDPD was so accustomed to hostile control that it was difficult for her to perceive its opposite: friendly respect for her as a separate, competent person.

The treatment implication is that the transference will likely be negative, and the therapist must be active showing genuine affirmation (1-2, affirming and understanding) to overcome the patient's tendency to see its opposite (1-6, belittling and blaming).

Complementarity.

This illustrative patient with SDPD continually scurried to please demanding others. These behaviors are coded on the intransitive surface shown in the middle of figure 1 because the emphasis was on X and what she was doing or failing to do, rather than on Y. Her intransitive position was tension-laden (– 3 on the horizontal axis), and quite submissive (– 6). The vector (– 3, – 6) drawn on the middle surface of figure 1 crosses the boundary at Cluster 2-6, sulking and scurrying.

Her scurrying to please illustrates *complementarity*, another important

SASB predictive principle. Complementarity is present if a given interpersonal behavior (coded anywhere on either of the top two surfaces of figure 1) is matched by a behavior at the same location on the other interpersonal surface. Scurrying, 2-6, is the complement of blaming, 1-6. For another example, if the therapist provides the desired affirmation (1-2, affirming and understanding), complementarity theory states that the patient is more likely to respond with its complement (2-2, disclosing and expressing). Robert Carson (1969) was an early proponent of the idea that complementarity can be defined among behaviors described by a circumplex model.

It should be noted that no causal direction is implied by descriptions of complementarity. Blaming (1-6) will elicit scurrying (2-6), but it is also true that scurrying (2-6) will elicit blaming (1-6). Affirming (1-2) will elicit disclosure (2-2), and disclosure (2-2) pulls for affirming (1-2).

Similarity.

Similarity, or identification, is manifest when a person acts like an important earlier figure. For example, this SDPD patient dreaded identifying with her oppressors, but in fact she did show similar attitudes when she privately despised (1-6, belittling and blaming) their inconsiderate ways.

This brief exposition has reviewed how to use the SASB model to

describe interpersonal and intrapsychic patterns and how to understand connections between early learning and problematic patterns in adulthood by using the predictive principles. The illustrative case has demonstrated that a few SASB codes can describe the structure of interpersonal and intrapsychic space for a person with personality disorder. Starting in childhood in relation to parents and siblings, this woman's early patterns extended in adulthood to her relationship with her husband, her sons, and her bosses. In all these relationships, she was aptly described by a prototypic position of hustling (2-6, sulking and scurrying) to take care of others (1-4, nurturing and protecting). Because her caregiving (1-4) was inextricably mixed with appeasement (2-6), her final prototypic code is recorded as: [1-4 4-2-6], and is called complex. It is a complex code because this person did not at times nurture and at times comply; rather, she always combined the two positions. Her acts of nurturance were always accompanied by resentful compliance with the assumed demand that she nurture. Her nurturance was locked into a context of exploitation and abuse.

SELECTION OF PATIENTS

SASB-RCL therapy is appropriate only if the patient and therapist both speak the same language—normally English in the United States.

The model is collaborative, and patient and therapist must be able to

agree that the therapy has the goal of building personal strength. The acceptance of a learning model and a willingness to focus on and work with the self are required. In cases where the therapy is court ordered or if other kinds of noncollaborative coercion are involved, the therapist's first task is to provide experiences that encourage trust and collaboration and that can stimulate the desire to build personal strength. These preliminary and vital tasks do not comprise the therapy itself. Paradoxically, in cases of unwilling clients, once collaboration appears so that therapy can begin, major constructive changes already will have been made!

Persons who cannot, after a reasonable trial period, enter the collaborative mode to enhance their personal strength also cannot be successfully treated by SASB-RCL. Examples of such inappropriate cases are people who cling to the "wrong patient syndrome"—those who cannot resist blaming and complaining about others and who are utterly unwilling to work on enhancing their own strength. Persons who abuse alcohol and other drugs frequently have the wrong patient syndrome. Referral to Alcoholics Anonymous or Narcotics Anonymous, where powerful and enlightened group process can take place, can sometimes prepare such people for SASB-RCL.

Requests for therapy that violate the therapist's personal norms rule out the necessary collaboration. For example, I once declared myself unsuitable to work with a highly successful and altogether engaging person

whose therapy plan was to receive help with time management. His presenting problem was that he was unable to keep both his mistress and his wife and family happy, because they all demanded that he spend considerable time with them, and his professional commitments also were substantial. He insisted that he needed help to maintain all relationships while remaining fully committed to his career.

Normal developmental crises are also inappropriate for SASB-RCL psychotherapy. The college student worried about normal career and relationship decisions should not have his or her lessons in living contaminated by professional input. Similarly, normal existential dilemmas are not appropriately solved in SASB-RCL psychotherapy. An example would be when a person wonders whether to take a new job that offers more money but involves unwanted changes in life style. SASB-RCL psychotherapy cannot help a person make such value choices. In brief, SASB-RCL helps people learn about their maladaptive interpersonal and intrapsychic patterns, and then helps them develop better patterns. Ideally, this learning in psychotherapy clears the way so that the individual has appropriate insight and skills for making his or her own developmental and existential decisions.

Of course, therapy should not be used to manipulate someone without his or her knowledge and consent. One example would be “treatment'' geared to "cure" a college student of homosexuality when the person is content with

the adaptation. Another would be to engage in attempts to convince a person that he has an incurable, genetically based psychological illness, so that he must accept that his mind is diseased, give up his "inappropriate" attempts to receive an education and find a profession, and come home to receive "proper" care and attention as a mentally handicapped person.

It is possible to use outpatient SASB-RCL psychotherapy with difficult cases that involve chronic threats of suicide or homicide or abuse of drugs and alcohol. However, it is not appropriate to continue with the therapy if these destructive behaviors are not sharply curtailed after an initial trial period of about three months. In other words, the SASB-RCL therapist can agree to try to help a properly motivated person overcome these difficult patterns, but since the patterns are often dangerous and interfere with learning in a major way, there must be unequivocal behavioral evidence that the approach is going to be effective in order for a person to continue in treatment. Similarly, SASB-RCL psychotherapy can be used with persons vulnerable to psychotic thought processes, but only if they show an ability to contain auditory hallucinations most of the time by the use of neuroleptics or by their own will as it is strengthened in therapy.

Certain other disabilities make individuals ineligible for a learning psychotherapy—for example, those with organic brain damage that interferes significantly with their ability to learn about patterns and their consequences.

Nor could persons benefit who utterly lack attachment to other human beings. Some of these individuals might be prepared for SASB-RCL therapy by the creation of unconventional learning experiences designed to address the major deficiency. For example, young antisocial personalities might benefit from a carefully structured wilderness camping experience designed to teach them rudiments of trust and trustworthiness.

GOALS OF TREATMENT

After hearing the patient's view of the problem and its desired solution, the therapist explains that SASB-RCL therapy will offer a "chance to learn what your patterns are, where they came from, what they were for, and whether they are worth continuing."

If interested in this task, patients are invited to take the Intrex (SASB) questionnaires. These give the patient an opportunity to rate himself or herself and important others, such as spouse and parents, in terms of the SASB model. The long-form Intrex questionnaires (used in this case) include an item to represent each point on the full SASB model, while the short-form Intrex questionnaires provide a single item for each cluster in figure 1. Raters can assign a number from 0 to 100 to each item, and they are asked to think of ratings of 50 or more as indicating "true." For both versions, the computer program INTERP provides feedback to the patient in terms of the perceived

patterns for each relationship. The algorithm suggests whether the patient is maintaining a pattern of complementarity with an oppressive earlier figure, identifying with him or her, or neither. For example, after rating herself in relation to her husband, her mother, and her father, the SDPD patient described above was shown the output from INTERP. The key ratings related to the self-defeating pattern are shown in figures 3 and 4, which respectively present her introject at worst and her reactions to her husband at worst.

A glance at the introject pattern presented in the left-hand side of figure 3 shows that this person with SDPD was very self-attacking at worst. The long lines of plus signs on the left-hand side indicate strong endorsement of self-destructive items. The pattern coefficients, explained in Benjamin (1984), can range from –1.00 to +1.00 and indicate the degree to which the rater's endorsements of the items conform to the theoretically underlying dimensionality. A positive attack pattern coefficient (ATK) indicates a hostile orientation, while a negative ATK coefficient suggests friendliness. A positive control pattern coefficient (CON) marks enmeshment, while a negative CON suggests differentiation. Positive conflict pattern coefficient (CFL) suggests conflict about enmeshment versus differentiation (vertical axis), while negative CFL shows conflict about love versus hate (horizontal axis). The self-attack in figure 3 is summarized by an ATK pattern coefficient of .895.

The right-hand side of figure 3 suggests that the patient's self-attacking

attitudes were associated with her experiences with her husband and her mother. This woman's husband provided the interpersonal antecedents of blaming (1-6), attack (1-7), and neglect (1-8), which, according to SASB introject theory, antedate self-blame (3-6), self-attack (3-7), and selfneglect (3-8). The figure also suggests that the self-restraint (3-5) and self-belittling (3-6) were enhanced by mother's control (1-5) and blaming (1-6).

Figure 4 shows that this woman recoiled from her husband at worst (pattern coefficient = .833) with an especially strong tendency to scurry (2-6) in complementary relation to his blaming (1-6). The right-hand side of figure 4 also suggests that her tendency to scurry while under the control of others has its early beginnings in her relationship with her mother because the complementary relationship with mother suggests that the patient was loving (2-3), trusting (2-4), deferential (2-5), and scurrying (2-6) as mother was warm (1-3), nurturant (1-4), controlling (1-5), and belittling (1-6).

In the early stages of therapy, output like that in figure 3 can demonstrate to the patient that there are "reasons" for poor self-concept, although it by no means conveys the meaning of the introjective process in all of its complexity. Output like that of figure 4 can help the patient understand his or her interpersonal patterns and their antecedents. Usually, with some explanation from the therapist, a patient can understand the output from INTERP and feel reassured to see that the patterns do make sense. As therapy

progresses, the goals can be deepened as the patient's understanding increases. For example, after trust in the therapeutic relationship is well established, the possible erotic elements of the self-defeating patterns can be discussed in terms of simple associative learning. Such understanding can help the patient stay in a new relationship with a kinder partner, and try to "reprogram" herself, even though he is not at first as interesting sexually as the abusive partner.

Figure 3

Output from INTERP for the Introject Ratings of SDPD at the Beginning of Therapy. The Attack, control and conflict pattern coefficients are explained briefly in the text, and in detail in Benjamin (1984). This part of the output from program INTERP shows that the patient was very harsh on herself at worst, and that this self-criticism was encouraged by the criticism she received from her husband and from her mother.

MY INTROJECT OR HOW I SEE MYSELF AT WORST

```
                                      3-1 SCORE = 50
                                      SPONTANEOUS
                                      SELF

         3-8 SCORE = 80                                3-2 SCORE = 0
         DAYDREAMING &                                 SELF-ACCEPTING
         SELF-NEGLECTING      +                        AND EXPLORING
                                +          +
                                  +        +
                                    +      +
                                      +    +
      3-7 SCORE = 90                    +  +             3-3 SCORE = 0
      SELF-REJECTING   + + + + + + + + +  @              SELF-LOVING AND
      AND DESTROYING                    +  +  O           CHERISHING
                                      +    +    O
                                    +      +
                                  +        +
                                +          +
         3-6 SCORE = 90       +            +           3-4 SCORE = 30
         SELF-INDICTING                    +           SELF-NOURISHING
         AND OPPRESSING                    +            AND ENHANCING
                                           +

                                     3-5 SCORE = 90
                                     SELF-MONITORING
                                      & RESTRAINING
```

+ SHOWS THE ITEM WAS MARKED TRUE; O THAT IT WAS FALSE

THE MAXIMUM CORRELATION WAS = .895 WITH PATTERN PROFILE 2
WHICH MEANS THIS RELATIONSHIP IS BEST DESCRIBED AS
SUICIDAL

ATTACK PATTERN = .895 (PROFILE 2)
CONTROL PATTERN = -.432 (PROFILE 8)
CONFLICT PATTERN = .235 (PROFILE 9)

```
ASPECTS OF SELF CONCEPT LISTED IN THE LEFT COLUMN MAY BE
RELATED TO SOCIAL EXPERIENCE LISTED IN THE RIGHT COLUMN

MY INTROJECT OR HOW I SEE MYSELF AT WORST


SPONTANEOUS SELF
            MAY HAVE BEEN INCREASED BY:
            MY SIGNIFICANT OTHER AT BEST (HE OR SHE IS RATED)
                           WHEN HE OR SHE WAS:
                           FREEING AND FORGETTING
            STATISTICS: R = -.928 (6DF); DIFFERENCE IN Z SCORES = .278

SELF-INDICTING AND OPPRESSING
SELF-REJECTING AND DESTROYING
DAYDREAMING & SELF-NEGLECTING
            MAY HAVE BEEN INCREASED BY:
            MY SIGNIFICANT OTHER AT WORST (HE OR SHE IS RATED)
                           WHEN HE OR SHE WAS:
                           BELITTLING AND BLAMING
                           ATTACKING AND REJECTING
                           IGNORING AND NEGLECTING
            STATISTICS: R = .750 (6DF); DIFFERENCE IN Z SCORES = .874

SELF-MONITORING & RESTRAINING
SELF-INDICTING AND OPPRESSING
            MAY HAVE BEEN INCREASED BY:
            MY MOTHER WHEN I WAS AGE 5-10 (SHE IS RATED)
                           WHEN HE OR SHE WAS:
                           WATCHING AND CONTROLLING
                           BELITTLING AND BLAMING
            STATISTICS: R = -.036 (6DF); DIFFERENCE IN Z SCORES = 1.997
```

THEORY OF CHANGE

Mental illness is conceived as an adaptation to social contingencies presented in childhood and recapitulated in adulthood, superimposed upon temperamental factors. The theory of change is that the patient must learn to recognize his or her patterns and understand their payoffs (insight), decide whether to give them up, and learn new ones. The answer to the question

How does awareness lead to change? is as elusive for this approach as for any other. For the present, the answer rests simply on the observation that when people are aware of what they are doing and why, they have more—but not necessarily complete—choice and control over whether to continue.

A therapist using an SASB-based reconstructive learning therapy consistently attempts to understand important events from the perspective of the patient, in terms that are object relational (that is, allow definition of referents X and Y), and that are concrete and specific enough to use figure 2 to code degrees of love and hate (horizontal dimension), and degrees of enmeshment and differentiation (vertical dimension). The therapist's assumption is that social or intrapsychic stimuli and responses are adaptive from the perspective of the patient and that they follow ordinary principles of learning. Specific experiences shape specific symptoms, and mental processes replay original object relations. Diagnosis is in terms of SASB codes of present patterns, and the etiological assumption is that present patterns represent (1) continuation of earlier positions (sustained complementarity) or (2) identification with (similarity to) important early figures.

Figure 4

Output from INTERP for the Ratings of SDPD with Her Husband. The output shows that she was very deferential to his attack, and that this was reminiscent of her position with her mother. Showing patients such output at the beginning of therapy can help them understand their interactive patterns and their origins, and assist in setting interpersonal goals.

AS I SEE MYSELF IN RELATION TO MY SIGNIFICANT OTHER AT WORST (I AM RATED) WHEN IN AN INTRANSITIVE STATE

2-1 SCORE = 30
ASSERTING AND
SEPARATING

2-8 SCORE = 40
WALLING OFF
DISTANCING

2-2 SCORE = 20
DISCLOSING AND
EXPRESSING

2-7 SCORE = 40
PROTESTING AND
RECOILING

```
  O     O
    O   O
      O O O
O O O O @ O O O
      + O O
    +   O   O
  +     O
+       O
```

2-3 SCORE = 30
JOYFULLY
CONNECTING

2-6 SCORE = 50
SULKING AND
SCURRYING

2-4 SCORE = 30
TRUSTING AND
RELYING

2-5 SCORE = 40
DEFERRING AND
SUBMITTING

+ SHOWS THE ITEM WAS MARKED TRUE; O THAT IT WAS FALSE

THE MAXIMUM CORRELATION WAS = .833 WITH PATTERN PROFILE 4
WHICH MEANS THIS RELATIONSHIP IS BEST DESCRIBED AS
HOSTILE INTRANSITIVE STATE OR REACTION

HATEFUL RECOIL PATTERN = .833 (PROFILE 4)
SUBMIT PATTERN = .445 (PROFILE 6)
CONFLICT PATTERN = .167 (PROFILE 18)

```
INTRANSITIVE STATES OF THE RATER LISTED ON THE LEFT INCREASE LIKELIHOOD OF
THE TRANSITIVE ACTIONS OF THE PERSON RATED ON THE RIGHT—AND VICE VERSA

AS I SEE MYSELF IN RELATION TO MY SIGNIFICANT OTHER AT WORST (I AM RATED)
SULKING AND SCURRYING

          MY STATES WERE MATCHED BY:
          MY SIGNIFICANT OTHER AT WORST (HE OR SHE IS RATED)
                      BELITTLING AND BLAMING
          STATISTICS: R = .794 (6DF); DIFFERENCE IN Z SCORES = .740

                    ****************

INTRANSITIVE STATES OF THE RATER LISTED ON THE LEFT INCREASE LIKELIHOOD OF
THE TRANSITIVE ACTIONS OF THE PERSON RATED ON THE RIGHT—AND VICE VERSA

AS I SEE MYSELF IN RELATION TO MY MOTHER WHEN I WAS AGE 5-10 (I AM RATED)
JOYFULLY        CONNECTING
TRUSTING AND    RELYING
DEFERRING AND   SUBMITTING
SULKING AND     SCURRYING

          MY STATES WERE MATCHED BY:
          MY MOTHER WHEN I WAS AGE 5-10 (SHE IS RATED)
                   LOVING AND       APPROACHING
                   NURTURING AND    PROTECTING
                   WATCHING AND     CONTROLLING
                   BELITTLING AND BLAMING
          STATISTICS: R = .851 (6DF); DIFFERENCE IN Z SCORES = .550

                    ****************
```

The goal of SASB-RCL therapy is to develop contextually appropriate interpersonal flexibility within a baseline of friendliness (Clusters 2, 3, and 4), and differentiation (Clusters 1 and 2). In the case of the woman with SDPD, the friendliness was in place, but she needed to learn about differentiation, including how to become angry if appropriate. For this person, the goal of differentiation was explained in simple language: she was told she needed psychologically to separate herself more from the views of those inconsiderate other people.

Interventions in therapy are successful if they block maladaptive patterns or if they enhance new, better patterns. The general approach is to choose interventions that will optimize the chances that the patient will understand, reconsider, and decide to give up old interpersonal and intrapsychic patterns in favor of learning new patterns more appropriate to the here and now.

The most elusive phase of psychotherapy is arriving at the *decision* to give up the old patterns. This vital act of will is facilitated when the patient comes to understand how the patterns are maintained by wishes or fears about his or her relationship with beloved others or their internalized representations. New learning can follow if and only if there is a decision that it is no longer worth it to be directed by the old wishes and fears. This decision need not be conscious, but awareness usually helps. The woman with SDPD, for example, was moved to give up her self-sacrificing ways in relation to her husband, mother, and bosses as she came to realize how angry she was at their outrageous expectations and as she accepted that she never would receive their approval. She did, however, remain in the self-sacrificing mode in relation to her handicapped siblings because she wanted to do so out of an internally directed moral sense of herself.

Occasionally, confrontation of that key underlying organizing wish can occur in a single session. For example, a woman who had suffered a two-year-

long intractable depression, which had been unreliably responsive to medication and psychotherapy, sought brief consultation. She was divorced from an apparently self-centered, controlling, and abusive man, and was now in a wonderful new relationship; but she remained depressed, unable to enjoy it. The consultation ended with the interviewer's comment that the patient should bring her ex-husband in for marital therapy. The interviewer observed that maybe he had given up his drug abuse, and maybe he had learned to be more concerned about others; the patient definitely shouldn't miss the chance to recapture this wonderful relationship. The patient left the session thoughtfully, and a few months later called back just to say she felt much better and “empowered." Although she actually had called her ex-husband to see if he would come to such a session, and he had agreed, her subsequent reflection upon this unrealistic wish to recapture her original marital fantasy had freed her to go on and develop the new relationship.

Usually the reconstructive process occurs in about six stages. (1) A collaborative relationship develops between patient and therapist. (2) The patient learns to identify his or her interactive patterns, and where they came from. (3) Unconscious wishes and fears are faced, and directly or indirectly, the patient decides whether it is worth continuing to try to fulfill the wishes and honor the fears. (4) Stages of grief follow the decision to give up the old ways. These resemble the bereavement process described by Kiibler-Ross (1969). (5) Panic and chaos follow implementation of the decision to

reorganize. Patients say, in effect, "If I am not this, then I don't exist." Being in a massively new and unstructured state typically is terrifying. (6) A new self emerges. At this point, the therapist becomes a midwife, and enjoys the rebirthing process, while remaining on standby to help guard against regression.

TECHNIQUES

Techniques in SASB-RCL therapy must facilitate constructive learning. They are selected and evaluated in terms of whether they block destructive patterns and/or build constructive new ones. Since therapy is a complicated learning process, many different techniques are appropriate at different times.

A Baseline of Empathy

The baseline therapist position in SASB-RCL includes the Rogerian positions of empathic understanding, positive regard, and personal congruence. These are well represented by the SASB, Cluster 2, and the corresponding Intrex short-form items: Therapist 1-2, affirming and understanding—"X likes Y and tries to see Y's point of view even if they disagree." The patient complement is 2-2, disclosing and expressing—"X warmly and openly states his innermost thoughts and feelings to Y."

Internalization of the therapy experience is 3-2, self-accepting and exploring —"understanding his or her own faults as well as strong points, X lets him or herself feel good about him or herself 'as is.'"

However, the positive regard is not unconditional, because the therapist does not affirm destructive patterns. The therapist at times takes a powerful position to block reenactment of pathological patterns and to facilitate the development of new ones. This is SASB coded as: 1-4, nurturing and protecting—"With much kindness, X comforts, protects and teaches Y."

Observing the Unconscious

In the middle stages of therapy, the understanding of connections with the past and the uncovering of wishes and fears are priority experiences. These are facilitated by classical analytic techniques such as free association, dream analysis, tracking the stream of consciousness, and so on. The Gestalt derivatives of analysis, such as two-chair techniques, and discussions of "adult" and "child" are also helpful in pattern recognition.

SASB codes of these materials facilitate the identification of connections (see Benjamin, 1986). The therapist does not use SASB language in the session, but the sharp delineation by SASB of the underlying dimensionality of the patterns aids the therapist in choosing metaphors that are usually quite accurate.

In a sense, the SASB formulations of patterns and connections among relationships serve as *clarifications* or *interpretations* in the classical analytic sense. However, unlike the analytic interpretations, the clarifications and interpretations in SASB-RCL therapy are always interpersonal or SASB codable intrapsychic and they are based on patient recollections of very specific interpersonal experiences. If, for example, patient and therapist agree that there is probably is a pattern resembling the classical Oedipus complex, the patient must be dreaming, fantasizing about, or actually recalling clearly romantic contact with a parent. The therapist and the patient can agree that such contact was likely even though no clear memories remain. In this case, both see the oedipal hypothesis as a provisional hypothesis until further evidence emerges. No "interpretation" is maintained without patient collaboration.

It should be noted that many analytic techniques for uncovering were developed under the guidance of the cathartic model. The classical view is that these techniques serve to get out unconscious material, and that in itself is thought to be curative. An extended discussion of the differences between the SASB-RCL model and the cathartic model as applied to the expression of anger appears in Benjamin (1989). There, examples are given to show that encouraging the expression of anger can, in many instances, enhance maladaptive patterns, and in so doing can be iatrogenic. The SASB-RCL approach holds that it is important, when encouraging the expression of

buried affect, to be sure that the experience is in the service of changing maladaptive patterns or building constructive new ones.

The Observing Ego

Intense and consistent focus on patient learning about key patterns is the constant objective for the SASB-RCL therapist. The maintenance of relevance makes the therapy briefer. Each intervention is evaluated in terms of whether it enables personal strength by working on problem patterns or enhancing new and better ones. Hypnosis, the use of sodium pentathol, and other methods for gathering unconscious information without active collaboration from the patient's observing ego are usually not invoked in SASB-RCL therapy. Such techniques are vulnerable to encouraging the patient's dependent wishes to merge with an all-powerful magical therapist, and this move toward enmeshment is antithetical to the goals of a learning model.

Helping Patients Observe Themselves

One particularly useful technique for breaking logjams in individual therapy is to hold a single family conference and record it. The goal of this conference is to elicit family perceptions of, wishes for, and fears of one another, and there is an attempt to facilitate understanding and

communication. Unfortunately, family members usually approach such conferences with the agenda that others should "shape up," and they are not pleased with any other result, particularly one that might validate the perspective of those others. In fact, a single family conference is unlikely to successfully work out longstanding differences between the patient and others. However, the tape recording of the single conference can be used in subsequent individual sessions to help with pattern recognition. Typically, the resulting tape provides a frightening but potent stimulus for any family members who are in individual therapy. As the patient and therapist listen to the tape together, the bare bones of the interaction patterns are starkly apparent. As the patient listens to himself or herself in the family milieu, the patient's own objective third-party observing ego may be moved toward change, because as the patterns become clear, it is easier to give up fantasies about what can happen.

If an actual family conference cannot be arranged, an alternative is to concentrate on developing an observing ego just prior to a family visit. Taking the mental set of watching for patterns and reflecting on them during the visit, rather than being drawn into useless repetitions of old habits, can give the patient an effective new sense of differentiation. The woman with SDPD was able to use this approach to come to understand that no matter how self-sacrificing her nurturant acts of good will might be, her mother would never approve of her.

SASB Coding of Concepts

All patient-therapist exchanges in SASB-RCL must be SASB codable. This means that at a minimum they must be object relational and quite concrete. Codable material is elicited by liberal use of the question: "Would you please give me an example of that?" repeated until the basic material is at the level of "He said . . . and I said. . .." Greater specificity enhances clarity and there is evidence that therapies with more uncodable exchanges have poorer outcomes (Mueller, 1985).

Negative Transference

Negative transference offers a wonderful opportunity for new learning. Since the patient and therapist are engaged in a collaborative process, negative feelings must be recognized and discussed as soon as they arise in SASB-RCL therapy. The reasons are: (1) that little learning can occur in an atmosphere of tension and suspicion, and (2) in all likelihood, the negative transference invokes key problematic interactional patterns. Discussion of negative transference assures that the therapist and patient are focusing on basic issues.

Countertransference

Since awareness facilitates choice, and since choice enhances the

likelihood that participants will remain at their task, the therapist must be aware of his or her own countertransference feelings and perceptions. If the therapist's special sensitivities can enhance the patient's needed learning, they are not a problem. If, for example, the patient struggles with issues that the therapist has mastered, the therapist may have unusual compassion, which could help rather than hurt the process. However, it is more likely that distortions, overdetermined interest, and so on will interfere, and so they must be known and avoided. The therapist is responsible to identify these vulnerabilities, and either master them or not attempt to work with people who touch on them. A ski instructor who can't handle moguls, for example, would be foolish to give a mogul lesson.

In SASB-RCL the therapy relationship itself can have a central or a peripheral role in the treatment. The personal relationship between the therapist and patient is totally confined to the office and it does not involve physical contact; but within those limits, the relationship can be a major medium for learning. For example, the patient may learn that even though he or she engages in monumentally provocative behavior, the familiar consequences of attack, or seduction or rejection, and so on, do not follow. Such new personal experiences can be vital to the formation of new patterns. But they are not required, for learning can occur in many different ways. Some skiiers can learn a great deal by simply watching videotapes, while others need a strong supportive personal relationship with the instructor.

The “White Heat of Relevance"

"Confrontation" and "pointing out" are not characteristic of SASB-RCL therapy because of the high risk that they will be experienced by the patient as 1-6, *belittling and blaming.* Nonetheless, to make therapy brief and effective, every intervention must be meaningful in the sense that it enhances collaboration, patient awareness of patterns, patient will to change, or patient learning of adaptive patterns. By making nearly every statement SASB codable interpersonal or intrapsychic, SASB-RCL therapy usually develops a "white heat of relevance." Sessions are intense and draining on both therapist and patient. A therapist would no more be able to maintain concentration in SASB-RCL for eight sessions in a row than an Olympic skier could safely make championship runs all day long without resting.

CASE EXAMPLE

The woman with SDPD previously discussed was treated for nine months behind a one-way mirror, viewed by senior psychiatric residents as part of a seminar. The criteria for patients selected for that seminar were that the chief complaint had lated for at least ten years and that there had been least two previous failed therapies.

Space limitations preclude full explication of the treatment of this woman with SDPD. Two key and frequently very difficult junctures of her

therapy have been selected for illustration: (1) avoiding the draw to enable the negative transference, and turning it instead to self-discovery; and (2) addressing the underlying goals that drove the maladaptive patterns.

Using Negative Transference Interpretation

Maintaining the collaborative relationship is vital, and the therapist must actively block transference distortions in a collaborative, nonjudgmental way. Careful use of humor is one means to discuss negative transference. The following exchange occurred about five months into the therapy, and found the patient in a depressed condition, castigating herself for not being tougher, and commenting bitterly on her destiny as an "adult" who had to cope with an abusive husband, a negligent lawyer, demanding sons, and exploitative bosses. She had just decided she would be unable to take a planned vacation because she had so much to do. (Unfortunately, the quality of the audiotape was very poor, and so there are gaps in the transcript indicated by [unclear].)

> Therapist: When you think about feeling bad about yourself, what are your thoughts? What do you feel badly about?
>
> Patient: I guess like I hate myself for not managing it better, you know, being a little bit stronger emotionally, tougher.
>
> Therapist: Managing it, being what?
>
> Patient: Well, [unclear] moving through life . . . being tougher . . . I mean like a lot of energy just goes into trucking on, you know, getting up in the morning

[unclear] and there's not enough energy to be able to [unclear].

Therapist: Yeah, so you're not taking care of yourself and you're feeling that [unclear].

Patient: Well, I mean I'm smoking [unclear], I feel pretty out of control in the sense that I know I could have more control, do it.

Therapist: So the solution is you should be stronger and tougher, get yourself together.

Patient: Uh-huh. Pull myself by the bootstraps . . .

Therapist: By the bootstraps, you say?

Patient: Yeah. This is called adult life . . . and if you can't enjoy it, it's your own fault.

Therapist: OK. We've reviewed the problems and your solution.

Patient: Yes.

Therapist: Let's see—I guess I could bring a whip next time.

Patient: I already have one.

Therapist: I noticed.

Here, the therapist marked the fact that the patient was engaged in extensive self-blame (3-6), and with warm humor suggested an outrageous form of therapist blame (1-6), the hypothetical antecedent to introjected self-blame. This immediate result was that the patient reflected on her tendency to self-flagellate. This was followed by examination of her worry that her new

lover would become critical of her because he "notices everything":

> Therapist: And you're worried about that?
>
> Patient: I'm worried that that's a very nice thing that's happening.
>
> Therapist: Uh-huh.
>
> Patient: But you know, with everything else, I'm not sure that I can handle it.
>
> Therapist: What does that mean?
>
> Patient: Well, maybe it means that I'm not sure I'll let myself enjoy it.
>
> Therapist: Yeah. Can you say more about that?
>
> Patient: No. But I don't understand myself [unclear].
>
> Therapist: You recognize that you might undermine yourself.
>
> Patient: Uh-huh.
>
> Therapist: And you might take away from yourself the thing you really need the most . . .

The conversation continued in this vein; the patient was able to stay for a long time in this new relationship, which presented her with unfamiliar attentiveness, kindness, and consideration.

Addressing the Underlying Goal

In a different session, the patient reflected on her reaction to the

suggestion that she think about the therapy and how she felt about it.

Patient: . . . but I still feel puzzled about what it is I think I want, and you had said last time that I should think about that. And I took that to mean, you know, you need to decide who you want to be, what's your mind-set and emotional-set, what needs to be what you want to do. I have thought about that and I realize that perhaps one of the reasons I've had a problem is that, and I've—that I guess I really do want my life to go, to be in a certain way [unclear]. That may be overly romanticized . . . that I still value it very much. . . . But time and again it does conflict with, with other goals or things in the real world . . . [My husband] used to say I was just a pussycat, and it used to make me really mad because I . . . care very much about the notion of people loving one another, taking care of one another, you know. Life isn't all roses, and people need each other.

Therapist: Let me be sure I'm hearing what I think I'm hearing.

Patient: OK.

Therapist: We're talking about, I asked you how you felt about what we're doing, you said "I know I need to do something, I don't know what. You asked me to think about it." Now I think I hear you saying you're really quite content with what you are and with your ideas, but you're afraid they won't do in the real world. Is that what you're saying?

Patient: Yes. That they will set me up [unclear] with failing to achieve them, or realize them.

Therapist: So you have very high standards but the world can't live up to them. So you're doomed to failure whenever you interact with the world. Is that an accurate statement?

Patient: I guess. I guess that's the way I feel also.

Therapist: So, to the extent then, that . . .

> Patient: So you can't, yes, you can't force other people . . . to live your way or adopt your standards. You look for people who share things [unclear].

> Therapist: Well, so what that means, then, is if in therapy you are to change at all, what we need to do is degrade you, or lower you to a level of the rest of the world.

> Patient: Yeah, I guess what I worry about is that I've been sort of stubborn and, and maybe afraid to change, too. I haven't thought about, you know, about changing my ideas. . . . I have clung to them over the years, and not wanted to change the way I am.

There followed an exchange during which the patient recalled that her husband mocked her for her high ideals, and the therapist elicited the transference feeling that she was also being mocked in the above exchange. Following the therapist's inquiry about why she still wore her wedding ring, she became very tearful about the loss of her marital relationship. That led to a discussion of her fear of being hurt in her new relationship. The therapist suggested that her injuries in marriage were related to early learning.

> Patient: Yes, I suspect that a lot of what the behaviors that I have now that have been nurtured over the years in this marriage are old relics that, you know, were convenient in the environment of marriage, [unclear] that would not be convenient if I'm ever to, you know . . .

> Therapist: So what we're talking about is in your family of origin you had some patterns which you took to the marriage and which you don't want to take with you from here on. Now if we work on that, would that be a degrading agenda?

> Patient: No.

Therapist: OK. All right, then we're agreed. We'll work on that.

Patient: I'll need lots of help to see it, because I don't trust myself to be objective.

Therapist: No?

Patient: I feel really confused.

This crucial session confronted the idea that the patient's moral goals might be driving the self-defeating behaviors that were maintaining her pain. She was able to understand that early patterns had been repeated in her marriage, and that she was vulnerable to repeating them again in her next relationship. She was confused about whether she would need to diminish her moral standards in order to achieve a more comfortable interpersonal adjustment.

Ultimately, in therapy she resolved the conflict by accepting and legitimizing her anger at exploitation, valuing her own contributions, and giving up the noncontingent self-negating nurturance of her husband, her sons, her mother, and her bosses. But she retained her sense of moral obligation to take care of her handicapped siblings, and later on made good on that promise. In short, this kind woman learned to expect and receive decent treatment in her everyday exchanges, while retaining her moral standards to give to others. The change amounted to learning that she herself was worth decent treatment and that she should not suffer exploitation, while at the same time she still could identify contexts in which self-sacrifice was

indeed appropriate.

APPLYING SASB TO SPECIFIC POPULATIONS

The general SASB-RCL approach of identifying key patterns, their roots, and their goals, then facilitating goal change and fostering the learning of new patterns, applies to all populations meeting the inclusion/exclusion criteria. For the different populations, different therapist techniques are chosen during each session depending on the nature of the problematic interpersonal and intrapsychic patterns and on the developmental stage of the therapy.

In the monograph identifying prototypic SASB-coded patterns for each of the *DSM III-R* Axis II personality disorders (Benjamin, in press), there is a discussion of typical transference problems as well as of a list of new patterns recommended for the respective disorders. One consequence of this pattern analysis is that therapists have a guide for determining which technique is good for which person at which phase of therapy. To illustrate briefly, while persons with SDPD have difficulty accepting therapist affirmation (1-2, affirming and understanding), persons with narcissistic personality disorder demand it, even when they are engaged in destructive transference reactions. These differences in patient expectations suggest that in cases of SDPD, the therapist needs to maintain the position of benign affirmation more often in order to introduce a new experience and to inspire more self-affirmation. By

contrast, in the cases of narcissistic personality disorder, gentle but firm confrontations need to be offered more often (in a supportive way, of course) if there is to be constructive change.

EMPIRICAL SUPPORT

The SASB questionnaires and coding system have been used to describe process and outcome from a number of different theoretical perspectives (Henry, Schacht, & Strupp, 1986; Quintana & Meara, 1990; Grawe, personal communication, 1990). SASB-RCL itself has been formally studied in only three cases, all treated in the one-way mirror, year-long therapy context described above. All three cases met the criteria of a ten-year-long problem and failed previous therapies. All three showed major improvement according to SCL-90 (Derogatis, 1977), MCMI (Million, 1982), and Intrex (Benjamin, 1984) ratings. Selected data from the person with SDPD discussed above appear in figures 5 through 7.

Figure 5 presents changes in SCL-90 ratings for the person with SDPD. It shows she began therapy with quite high scores for obsessive compulsive symptoms, depression, and psychoticism, and all of these exhibited dramatic decreases over the nine-month treatment period.

Figure 5

Changes in SCL-90 Scores. These self ratings of traditional psychiatric symptoms suggested marked improvement during therapy (Derogatis, 1977).

Changes in SCL-90 Scores Self Defeating Personality (SDPD)

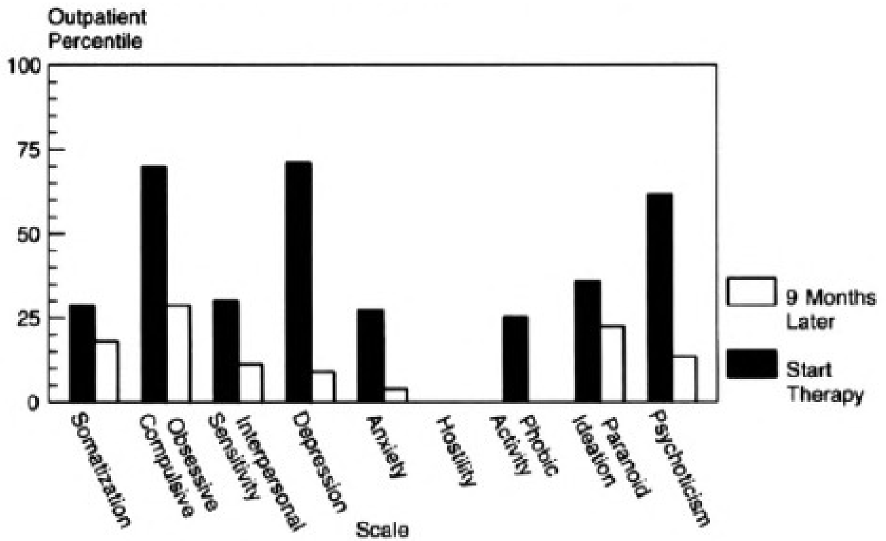


Figure 6 presents the changes in the MCMI during the same period of time. The MCMI measures are in terms of base rate (BR), which compares scores to known cases and sets 75 percent as a cut point that optimizes the ratio of valid positives to false positives. The upper part of the figure, which depicts the MCMI scales theoretically measuring Axis II personality disorder, shows that this person started therapy with positive classifications (BR > 75) for narcissistic and obsessive compulsive personality disorder. The scores for histrionic and for antisocial personality disorders were close to the boundary

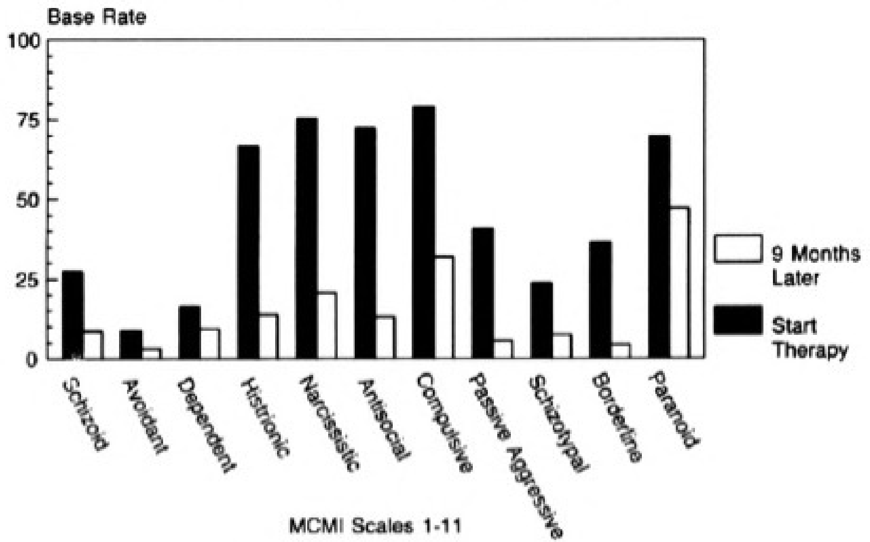
for diagnosis. By the end of therapy, all scales for Axis II were comfortably below the critical mark of 75.

The lower part of figure 6 includes Millon's clinical scales. None of these was above the 75 mark at the start or at the end of therapy. It is not clear whether the apparent increases in clinical scores (anxiety, hypomania, alcohol abuse, and psychotic depression) should be interpreted. The patient's experience of some anxiety and her use of evening cocktails were discussed in interviews, but neither was defined as a problem.

Figure 6

Changes in MCMI Scores. At the beginning of therapy, the woman with SDPD scored above the critical base rate of 75, and qualified for the labels narcissistic and compulsive personality disorders. After nine months, she was well below this range. In clinical scales, she did not exceed the critical rate either at the beginning of therapy or at nine months (Millon, 1982).

Changes in MCMI Personality Disorder Scales Self Defeating Personality (SDPD)



Changes in MCMI Clinical Scales Self Defeating Personality (SDPD)

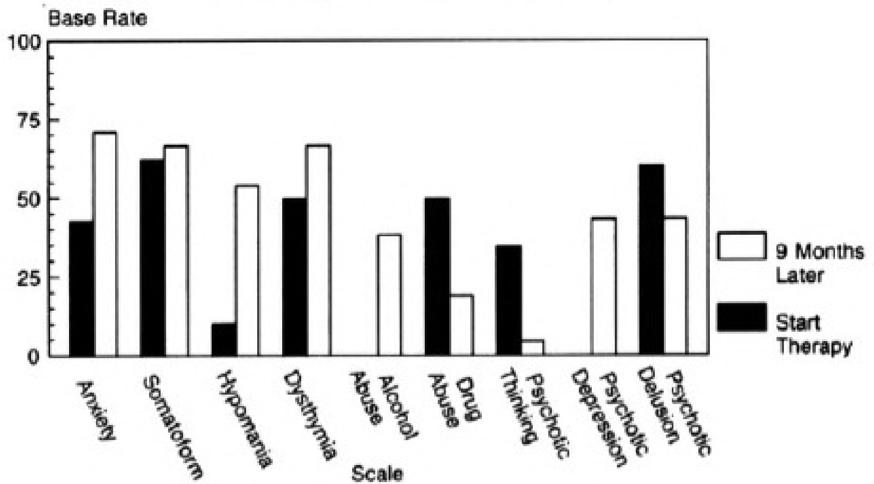


Figure 7 shows the SASB attack and control pattern coefficients for this person's major relationships as she experienced them at the beginning of therapy and at nine months.

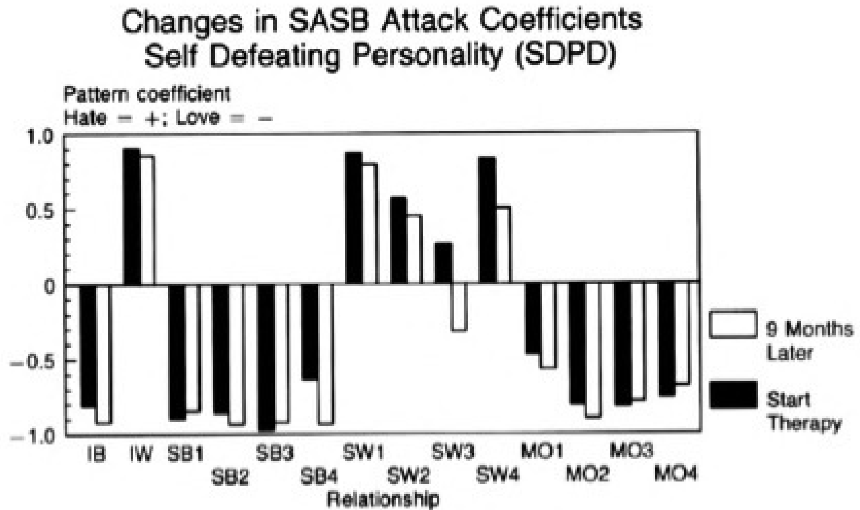
Inspection of the figure shows that the patient's pattern of liking herself a lot at best and attacking herself a lot at worst did not change much from the beginning to nine months of therapy. Although there was no formal measure, her worst moments were less frequent later on in therapy. The only really noticeable changes in the attack patterns themselves were in some aspects of her relationship with her husband: over the nine months of treatment, she became somewhat friendlier. Divorce proceedings were fully under way by the nine-month point in therapy.

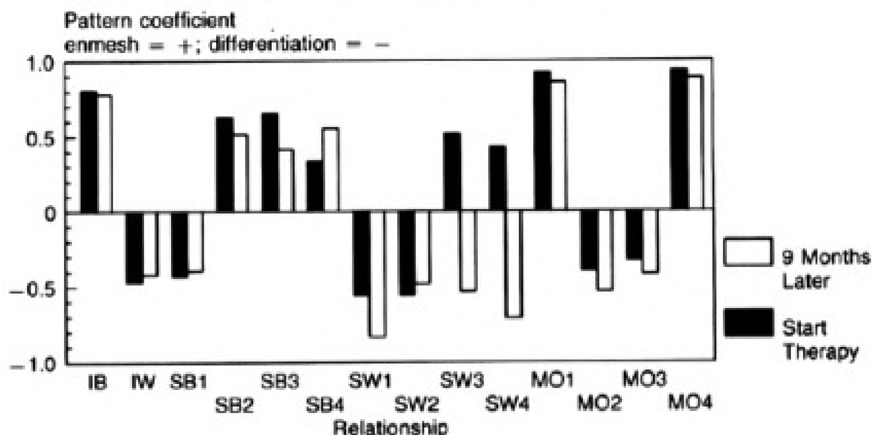
Lack of friendliness was never a key issue. Rather, the problem at the outset was the patient's expression of love in self-defeating ways. Accordingly, the bottom part of figure 7 shows that the major interpersonal change was from clear enmeshment with her husband to differentiation from him. The control pattern changes for her relationship with her husband at worst shifted from clear interdependence to clear separation for both types of focus (SW3, SW4).

Figure 7

Changes in SASB Attack and Control Pattern Coefficients. 1 = introject; B = best state; W = worst state; S = spouse; M = mother. Ratings: 1 = other's (spouse's or mother's) transitive focus on the

rater; 2 = other's intransitive reaction to the rater; 3 = rater's transitive focus on other; 4 = rater's intransitive reaction to other. At the beginning of therapy, this woman perceived and showed hostility only toward herself (IW), and in her relationship with her husband at worst (SW). There were no marked remarkable changes in her baseline of friendliness during the nine months of therapy. However, she did show a major change from enmeshment to differentiation in ratings of herself with her husband at worst (SW3,SW4) (Benjamin, 1984).





A third SASB parameter, the conflict coefficient, suggested a shift from an attachment conflict to an intimacy-distance conflict in her perception of her husband and in her memory of her mother. Her self-descriptions did not change, but her views of these other key persons did: she came to see them as conflicted over whether they wanted to be close or distant to her, rather than over whether they loved or hated her.

Her ratings of her new relationship with a kind, attentive man were very positive. Theoretically, the internalization of that good new relationship should help her soften the harshness of her introject at worst. The SASB-RCL view is that much interpersonal learning goes on outside of the therapy session, and it is important to identify and facilitate relationships that

enhance the goals of therapy.

The patient became more assertive at work, insisting on receiving suitable support services and an appropriate raise. She worked less often on evenings and weekends and instead allocated more discretionary time to activities of her own choosing.

The patient viewed herself as much improved at the end of the seminar, but she asked to continue her work in the therapist's private practice. She did this for another half a year, but unfortunately there are no final ratings available. She asked not to make them, and since assertiveness was a part of the therapy goal, the matter was dropped without comment. At termination she was quite comfortable and, according to her own conversational report five years later, maintained her new adjustments reasonably well.

One might ask: Did she get better or not? Did her patterns change or not? But this is like asking: did she learn to ski or not? It is clear that there was definite improvement. It is also apparent that more learning is needed. SASB-RCL therapy makes no claim to "cure" or to implement "complete change." There is, however, the opportunity to make significant changes that will improve a person's relationship with himself or herself and important others. Without question, this patient broke her rigid devotion to self-defeating patterns and became more skillful in asserting herself on behalf of

her own rights and interests.

The current research plans are to obtain funding to validate the SASB diagnoses of the personality disorders, and following that, it is hoped that there can be a project to study the effectiveness of the SASB-RCL approach in a broader way. Other than the three aforementioned cases, the validation of the SASB-RCL approach now rests only on testimonials of patients and therapy trainees.

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Notes

[1] Thanks are expressed to friends and associates who made helpful comments on an earlier draft of this paper: Hans H. Strupp, Paul Crits-Christoph, Jacques Barber, and the patient identified as SDPD.

[2] The use of the SASB model to define differentiation and attachment is discussed at length in Benjamin (in press).