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It would be hard to imagine clinical practice or research that would not be enhanced by familiarity with the incredible precision and utility of SASB as a lens for understanding inter- and intrapersonal behavior. Critchfield and Benjamin have written an essential book articulating SASB's elegant theory and its many past and potential applications. This is a must-read for any clinician or clinical scientist who has ever wanted a more parsimonious yet powerful way of understanding how humans interact and how to use that knowledge to enhance therapeutic processes.

—**Julia Mackaronis, PhD**, Licensed Clinical Psychologist, Praxis Psychotherapy

Critchfield and Benjamin have succinctly captured decades of pioneering work and research demonstrating, with clinical examples and empirical support, how Interpersonal Reconstructive Therapy and SASB can be utilized for case conceptualization and the psychotherapeutic process. This volume is likely to be a classic in the field and a must-read for students and practitioners, as well as offering an elegant system for psychotherapy researchers.

—**Jeffrey J. Magnavita, PhD**, Founder, Glastonbury Psychological Associates, PC; CEO, Strategic Psychotherapeutics, LLC, Glastonbury, CT, United States

In this book, the authors translate half a century of cumulative work on SASB, which is extensively used in psychotherapy research, and present it in a more user-friendly form. Now, students, professors, clinicians, supervisors, and researchers of any level or persuasion can collaborate in broadening and building upon such a solid structural foundation for evolving human relating, AT BEST.

—**Nuno Conceição, PhD**, Faculty of Psychology, University of Lisbon, Lisbon, Portugal; Past President, Society for the Exploration of Psychotherapy Integration

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The SASB is a dimensional assessment system and an interpretative model created by Lorna Smith Benjamin to read personality disorders. It is a “secret lens” which can be used to view and identify behavior patterns. SASB allows its users to analyze the subject’s interpersonal space and view the world from their perspective: a necessary requirement in order to provide the help needed. Critchfield and Benjamin’s book masterfully summarizes SASB theory, explaining its application while connecting it to Interpersonal Reconstructive Therapy (IRT) through the case formulation process. The authors scientifically present ample research material on SASB application to the field of psychopathology and psychotherapy. This is the fully-fledged SASB handbook.

—**Francesco Colacicco**, Psychologist, Psychotherapist, and Director, Istituto Dedalus; Teacher, Centro Studi di Terapia Familiare e Relazionale, Rome, Italy; Member of European Family Therapy Association (EFTA) and Italian Society of Psychology and Relational Psychotherapy (SIPPR)

As a mental health practitioner, educator, scholar, or trainee, if you want to know how to do what you do—in an evidence-based manner that is nonreductionistic—there is no better resource than this powerfully illuminating book. To master the SASB model and method—to see why our clients suffer and how they may heal—there are no better guides than Drs. Ken Critchfield and Lorna Benjamin. Ken and Lorna are not only the brains behind SASB, they are consummate scientists and master therapists, who value craft and rigor in equal measure, a unique gestalt that helps SASB clinicians of all stripes become transformative agents of in-depth change.

—**Craig N. Shealy, PhD**, Executive Director, International Beliefs and Values Institute (IBAVI); Developer of the Beliefs, Events, and Values Inventory (BEVI)

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Structural Analysis of Social Behavior (SASB) is the most fully developed and researched model of human behavior. This volume is the definitive and comprehensive guide for clinicians new to SASB as well as researchers experienced with the system. It is eminently accessible, practical, and carefully organized to be equally useful as a learning and training resource as well as a reference source. It is one of those “core” books that informs when first read, and will keep on serving you at each stage of your career!

—**Adam O. Horvath, EdD**, Professor Emeritus, Simon Fraser University, Vancouver, BC, Canada

For experienced interpersonalists, the interpersonally curious, and everyone in between, Critchfield and Benjamin provide an accessible yet detailed overview of 50 years of theory, research, and clinical application. Because the authors have been gifted scholars, clinicians, and teachers for decades, all readers will leave an encounter with this superbly organized, clinically rich volume with a much more detailed understanding not only of SASB and Interpersonal Reconstructive Therapy (IRT), but also of their own work, even if they don't think of their personal conceptual approach as particularly interpersonal.

—**Timothy W. Smith, PhD**, Distinguished Professor of Psychology, The University of Utah, Salt Lake City, UT, United States

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1 INTRODUCTION TO STRUCTURAL ANALYSIS OF SOCIAL BEHAVIOR

In a science of persons, we state as axiomatic that: 1. behaviour is a function of experience; 2. both experience and behaviour are always in relation to some one or something other than self.

—Laing et al., 1966

Relationships, perhaps more than any other single factor, are at the heart of lived experience, including the “problems of living” captured in part by clinical diagnosis (Stein, 2021).¹ The *Structural Analysis of Social Behavior* (SASB; Benjamin, 1974, 2000) provides an elegant and sophisticated framework for tracking patterns described by patients within and across relationships. Throughout this book, SASB is presented as a tool for instructing mental health clinicians. It applies especially to psychotherapists working with patients who experience interpersonal problems, including the variety of affective, cognitive, and behavioral disturbances that flow from and contribute to those problems. However, the applications of SASB extend far

¹ The clinical material used in this book is adequately disguised to protect patient confidentiality. Patient identity has been maintained.

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Structural Analysis of Social Behavior (SASB): A Primer for Clinical Use, by K. L. Critchfield and L. S. Benjamin

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beyond the clinic. It is of potential use in any setting involving relationships and social interactions. Anyone interested in the workings of human relatedness—from business negotiation to diplomacy, to the courtroom, to the workplace, to parenthood, and so on—will find that SASB facilitates recognition and objective assessment of relationship patterns and provides a path for improving problematic interactions.

A central assumption of this book is that beliefs, expectations, and values learned through loyalty and love guide our interactions and patterns of relating with ourselves and others. Put simply, our early experiences shape what we often think of as personality. Benjamin (2018) used a natural biological perspective rooted in principles of evolution to explain how and why learning that derives from the crucible of important early relationships organizes our nervous system. Specifically, our learning history informs rapid perception and evaluation of safety versus threat cues. It also shapes the relational behaviors and patterns built from those behaviors that we use, adaptively or maladaptively, to seek safety. In line with this developmental perspective, we will emphasize how to use SASB with patients² to identify connections between current symptoms and early and present relational patterns, and to help choose and adopt more adaptive ways of being. The importance of interpersonal patterns, their sources, and their links to symptoms is illustrated next with a brief clinical example.

Sarah is a married, college-educated, working mother in her mid-30s who lives in a rural community. She was hospitalized and referred to our inpatient clinic for consultation after experiencing multiple psychiatric and somatic complaints, including significant and persistent suicidal ideation. Over the course of a clinical interview, Sarah described strong anxiety and depression directly tied to her attempts to comply with the many demands of her boss at work. Among other things, he demanded that she do the work of several people (including handling his personal finances) but kept her in a position that, at least on paper, required less than the number of hours qualifying for benefits. When she asked her boss for relief in the form of a lessened workload, help from others in the office, better pay, or benefits,

²The term *patient* will be used throughout this book to refer to individuals who seek mental health care from any of the variety of professions that offer assessment, diagnosis, counseling, or psychotherapy. Other terms, such as *client*, are also commonly used and have been offered as an alternative to the medicalized doctor–patient relationship. I (K.L.C.) use these terms interchangeably in my teaching and practice. However, in this book, the choice of *patient* is largely based on a frame offered by my co-author (L.S.B.), who notes that the word can also be heard as a reminder for clinicians to appreciate how often the folks we work with need to be patient with our ongoing attempts to truly hear and be of help to them.

he acknowledged the problems but did nothing. Sarah responded to her boss's unreasonable demands by becoming self-critical and redoubling her efforts to perform. She dutifully pushed on, despite onset of carpal tunnel pain, missed social opportunities, and less time at home with her family, including her two small children. With each failed attempt to get recognition and relief, Sarah became more anxious, depressed, and overwhelmed. Her attempts to work harder were accompanied by increased self-criticism and diminished self-care. Over time, she began to see her situation as hopeless, escalating to the point of significant suicidal ideation.

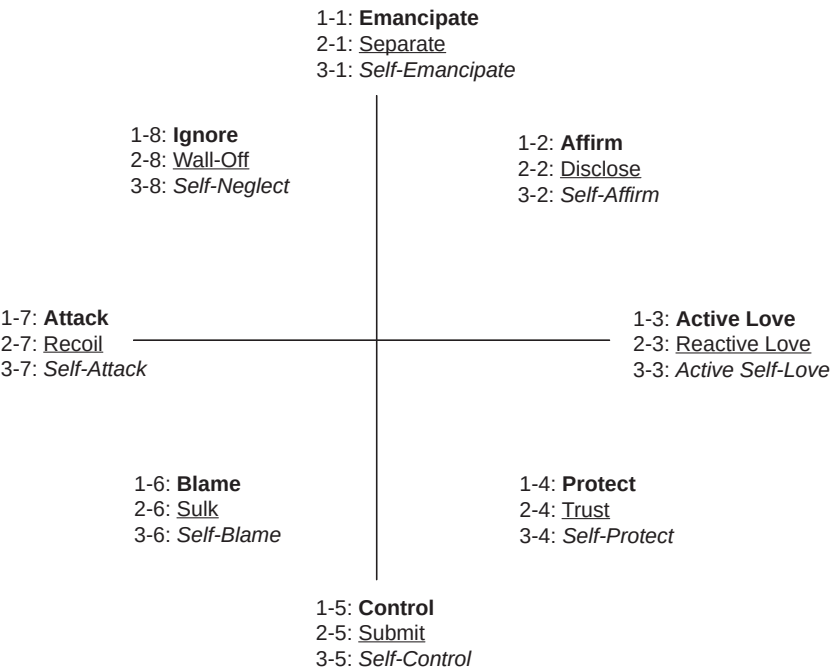
When Sarah was interviewed in the hospital, she described an early history that paralleled the adult experience at work. Her memories of her father included that he was very controlling and made extreme demands of her and her siblings. When any of them deviated from their father's wishes or failed to perform to his standards, he enforced compliance with harsh physical punishment, rejection, and long silences that could last for days. He was otherwise emotionally distant. Unlike her siblings, Sarah succeeded at avoiding punishments by anticipating her father's demands and working hard to comply. It was a strategy that worked for her in that context, and she was able to spend more time with her father, something that she desired very much. Her siblings called her "Daddy's favorite." Although she was only a child, her closeness with her father allowed her to be a mediator between her parents when they eventually divorced.

Sarah's strategy of hard work, self-discipline, and compliance was once essential to gaining her father's favor, avoiding his punishments, and providing service to the family. Applied in the workplace, this same strategy led rapidly to burnout with another controlling but neglectful figure, her boss. Understanding the parallels between past and present turned out to be key in helping her see that she had healthier alternative strategies as an adult in the workplace. This same understanding was key to helping Sarah reduce her suicidality, self-criticism, and sense of failure. It ultimately gave her the ability to work through old feelings, wishes, and fears that were both triggered by, and maintaining parallels in, her adult life.

ON LEARNING SASB AS A CLINICIAN

SASB is a model for describing, organizing, and making predictions about interpersonal behavior. The model, shown in Figure 1.1 and elaborated in more detail in Chapter 2, is organized around two fundamental axes. The horizontal axis captures a range of behavior from the extremes of love to the extremes of hate. The vertical axis ranges from the extremes of enmeshment

FIGURE 1.1. Structural Analysis of Social Behavior (SASB) Simplified Cluster Model (With Two-Digit Codes)



Note. Each position reflects a combination of the primary organizing dimensions of focus (font type), affiliation (horizontal axis), and interdependence (vertical axis). The figure combines two figures: Adapted from *Interpersonal Diagnosis and Treatment of Personality Disorders* (2nd ed., p. 55) by L. S. Benjamin, 1996, Guilford Press. Copyright 1996 by Guilford Press; with numeric codes added from “Use of the SASB Dimensional Model to Develop Treatment Plans for Personality Disorders: I. Narcissism,” by L. S. Benjamin, 1987, *Journal of Personality Disorders*, 1(1), p. 53 (<https://doi.org/10.1521/pedi.1987.1.1.43>). Copyright 1987 by Guilford Press. Adapted with permission.

and interdependence to those of extreme separateness, differentiation, and independence. A third distinction tracks the attentional focus of a behavior as being toward others, toward the self (in interaction with others), or intra-psychically (termed *introject*).³ The resulting chart of behavior can be used to clarify and describe relational patterns in ways that make sense of presenting problems and symptoms. For example, Sarah’s relationship with her

³A two-digit numbering system is additionally shown in Figure 1.1 and is used to note structural placement of each behavior on the model. This aspect of the model is described in detail in Chapter 2. It is included here in anticipation that Figure 1.1 will be used as a go-to resource and reference throughout the book.

father, her boss, and herself can be characterized by various positions that include several at the bottom of the model. Her father and boss were controlling (1-5: **Control**) and blaming (1-6: **Blame**), to which Sarah responded with submission (2-5: Submit), forcing herself to comply and criticizing herself for her limitations (3-5: *Self-Control* and 3-6: *Self-Blame*). Several behaviors at the top of the model are also invoked in Sarah's case. The fact that her father and boss's demands were unreasonable and neglected her needs and capacities (1-8: **Ignore**) is mirrored in her willingness to push beyond healthy limits (3-8: *Self-Neglect*). These behaviors occur in Sarah's narrative in recognizable patterns and sequences that make sense of her presenting symptoms. These patterns involve input from others, responses to them, and implications for self-concept and self-treatment.

We expect that most clinicians interested in this book will already have an intuitive understanding of patient patterns and relational themes like Sarah's. It is important to ask what SASB offers over and above a good clinician's experience, training, and intuition. The answer is that SASB's high degree of behavioral specificity can place observations about relational patterns into a precise set of structural relations that extend and offer clarity about their implications. This clarity can, in turn, enhance clinical perception and formulation. Let us consider an example of a problematic behavior in the present. Say that a patient engages in a reckless process of staying out late and drinking, which results in missing important meetings (3-8: *Self-Neglect*), including canceling therapy sessions, and being reluctant to talk about their feelings (2-8: Wall-Off). These behaviors might be understood in light of recent events with a similar interpersonal position, such as (a) a roommate going out with mutual friends and not inviting the patient (1-8: **Ignore**), (b) the patient perceiving her therapist as not appreciating the importance of this (1-8: **Ignore**), while (c) the patient's internalized experience of their mother in childhood is as being depressed, withdrawn, and self-medicating with opiates while the patient was left to fend for themselves (1-8: **Ignore**, 2-8: Wall-Off, and 3-8: *Self-Neglect*). The simple observation that all these clinically salient behaviors "code" into the upper-left portion of Figure 1.1 suggests an avenue for collaborative exploration of how these diverse-seeming experiences may come together and make sense.

Another distinct benefit of SASB for clinicians is enhanced recognition of patterns within the therapy relationship itself. SASB facilitates tracking within the here-and-now process of the therapeutic relationship and guides the clinician to appropriate responsiveness. Examples provided throughout this book are designed to make clear the many practical implications of being able to see recurring patterns through the lens provided by SASB.

Our experience teaching and applying the model over decades suggests that a better articulated sense of their patients' interpersonal patterns offers clinicians a much-improved ability to empathically track the complexity of patients' experience and use that understanding to guide therapeutic action. Accurate empathy is itself associated with better outcomes, particularly in the context of an interpersonal approach to treatment (Crits-Christoph et al., 2010). In addition, a more precise articulation of patterns can help therapists and patients use the resulting awareness to mobilize the will for change. Awareness and agentic choice are key elements of the Interpersonal Reconstructive Therapy (IRT; Benjamin, 2003, 2006, 2018) approach to treatment described in Chapter 5. They have also been proposed as transtheoretical elements involved in all approaches to therapeutic change (Gorlin & Békés, 2021; Williams & Levitt, 2007).

In sum, SASB provides clear language and a structured set of concepts that can help anchor clinical intuition and reduce the likelihood of missing or misunderstanding what is happening in patients' lives or in the here-and-now process of therapeutic interaction. The need to be specific when discussing complex therapeutic principles is a long-standing challenge in mental health. In 1958, Fritz Heider, a pioneering social psychologist, discussed this issue in *The Psychology of Interpersonal Relations*:

. . . though nonscientific language in the hands of a master is unsurpassed for the description of even the most subtle relationships, it lacks the features of a real system . . . the relations between terms are only crudely defined and understood. Though we know the meanings of words like “promise,” “permit,” or “pride” we do not know them in the same way we know the meaning of words like “two” and “four,” or of words like “speed” and “acceleration.” The words referring to interpersonal relations are like islands separated from each other by impassable channels. We do not know how to reach one from the other, we do not know whether they contain a certain number of basic principles of variation, or basic elements, different combinations of which produce the manifold of qualitative differences. (p. 8)

SASB provides a bridge over Heider's “impassable channels” by placing basic principles of interpersonal behavior into a systematic framework that is directly applicable to clinical settings. Some key advantages of the SASB model derive from it being first developed by Benjamin to study primate social behavior in rhesus monkeys while working with her major professor, Harry Harlow (Benjamin, 1961, 1973). Patterns indicative of parent–child attachment, as defined by Bowlby (1969), were of particular relevance. The remainder of this chapter focuses on briefly reviewing the history and

intellectual tradition that has informed interpersonal theory in general and the SASB model in particular. The model is detailed in Chapter 2.

BRIEF REVIEW OF HISTORY: INTERPERSONAL THEORY LEADING TO DEVELOPMENT OF SASB

Harry Stack Sullivan has been widely recognized as the father of interpersonal psychiatry. Sullivan wrote in 1940, “The field of psychiatry is the field of interpersonal relations—a personality can never be isolated from the complex of interpersonal relations in which the person lives and has his being” (p. 10). Going against dominant theories of the time, Sullivan viewed psychopathology, including schizophrenia, in terms of characteristic patterns of relating with others. He saw the origins and motivation to maintain those patterns as being a function of early experiences with caregivers (and other important people) through a process of social learning:

But, I shall insist that, however like some average people I may be in many respects, I am nonetheless the product of a unique course of acculturation. . . . From infancy each of us is trained to think in this way. If one was fortunately born, the parents have been fairly consistent in their expressed appraisals, and one has elaborated a dependable self. However absurdly it may be related to one’s manifest behavior, one is relatively secure in dealing with others. If one’s parents have been less reassuring or if experience subsequent to childhood has demonstrated the serious deficiency of a once-trusted illusion as to one’s personality, the case is quite otherwise. “I did not think you were that kind of a person” comes to be a very painful remark the deeper implications of which do not engage one’s attention. One becomes as realistically as possible a member of the group made up of the right kind of people and acts as rightly as possible in those restricted interpersonal contexts in which one still has freedom to participate. (Sullivan, 1939, pp. 932–933)

Sullivan’s work both influenced and was influenced by emerging themes about the nature and structure of the self in the 1930s. G. H. Mead’s approach to social psychology, as well as neo-Freudian and early object-relations modifications to psychoanalysis, emphasized the role of other people in relation to a concept of the self, including how primary survival needs—to belong and to relate—shape us (J. R. Greenberg & Mitchell, 1983). At that time, the main clinical implication of a social view of the self was that personality and pathology are both intimately connected to past and present experiences with others. Sullivan (1938) described psychopathology as having “a developmental history which is in turn completely understandable in terms of the functional adequacy of the person in the

series of interpersonal situations through which he has had to live” (p. 79). Like Sullivan, we view psychopathology as reflecting ongoing attempts to implement patterns of relating with the self and others in settings where they are no longer adaptive. However, like Heider, Sullivan (1953) noted the need for a reliable science of observing and describing relationships:

. . . the fabulous difficulty of teaching psychiatry, as I have seen it over the years, is that it is quite easy to learn certain things—that is, to get so you can talk about them—but it is extremely difficult to get any two people to mean just the same thing when they talk about what they have supposedly learned. (p. 3)

Measurement: Capturing Interpersonal Patterns, Personality, and Processes of Self

Working separately but at about the same time as Sullivan, Murray (1938) generated the list of human needs shown in Table 1.1. Later, Freedman and colleagues (1951) placed a subset into a circular order that provides a measurement framework. Initially, Murray organized needs in two broad categories: those related to basic physical survival (*vicerogenic* or primary needs) and those related to psychological functioning (*psychogenic* or secondary needs). Consistent with the expectation of Sullivan and others, many of the psychological needs involved other people.

Structure of the Interpersonal Domain: Inventing the Wheel

In Murray’s (1938) initial presentation of the list, human relational needs were grouped according to themes of status (achievement and recognition, defense of status, and avoidance of humiliation), power (assertion of power, reactions to power through submission, separation, or opposition), aggression (giving, receiving, and avoiding it), affiliation (seeking, giving, exchanging, or withholding it), and knowing (the need to know and be known; see Table 1.2).

Freedman et al. (1951) and Leary (1957) combined these basic themes with clinical observations to form a two-dimensional, circular structure referred to as the *interpersonal circle* (IPC). As can be seen in Figure 1.2, the IPC involves two dimensions; the first (horizontal) ranges from hate to love, while the second (vertical) ranges from dominate to submit. In pioneering work, the structure was used to map clinical concepts and diagnoses relative to their respective interpersonal tendencies (Leary, 1957). Others refined the IPC further (e.g., Kiesler, 1983; Lorr et al., 1965; Plutchik & Conte, 1997; Wiggins, 1979; Wiggins et al., 1988). From initial charting, the interpersonal domain showed systematic and useful connections to clinical work.

TABLE 1.1. Murray's List of Needs

	Secondary (psychogenic) needs		
	Primary (vicerogenic) needs	Inanimate	Human
Air	Harmavoidance	Acquisition	Dominance
Water	Noxavoidance	Conservance	Deference
Food	Heatavoidance	Order	Similance
Sex	Coldavoidance	Retention	Autonomy
Lactation	Sentience	Construction	Contrariance
Urination	Passivity		Aggression
Defecation			Abasement
			Blameavoidance
			Superiority
			Achievement
			Recognition
			Exhibition
			Inviolacy
			Infavoidance
			Defendance
			Counteraction
			Affiliation
			Rejection
			Nurturance
			Succorance
			Play
			Cognizance
			Exposition

Note. Data from Murray (1938).

TABLE 1.2. Murray's People-Oriented Needs, Organized by Theme

Status	Power	Aggression	Affiliation	Knowing
Gaining	Dominance	Aggression	Affiliation	Cognizance
Superiority	Deference	Abasement	Rejection	Exposition
Achievement	Similance	Blame avoidance	Nurturance	
Recognition	Autonomy		Succorance	
Exhibition	Contrarience		Play	
Protecting				
Inviolacy				
Infavoidance				
Defendance				
Counteraction				

Note. Data from Murray (1938).

FIGURE 1.2. Interpersonal Circle for (A) Observed Behaviors and (B) Using Trait Terms

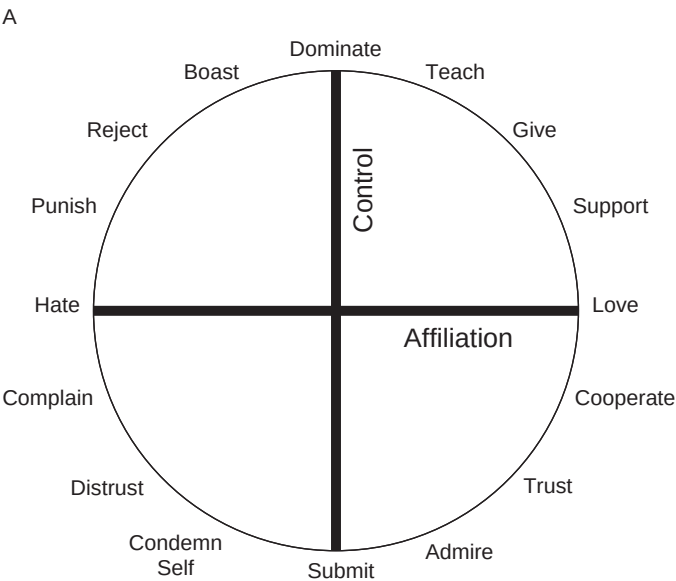
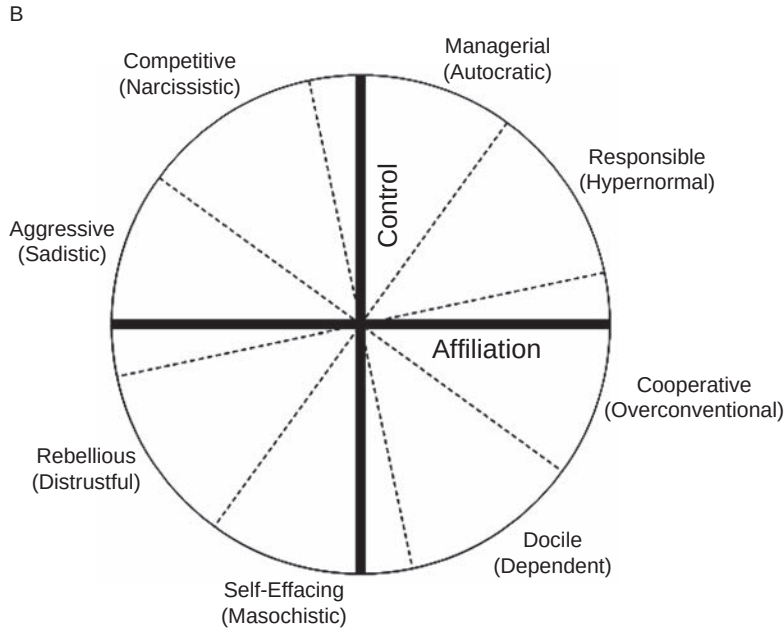


FIGURE 1.2. Interpersonal Circle for (A) Observed Behaviors and (B) Using Trait Terms (*Continued*)



Note. Panel A (observed behaviors) has been simplified from the original to emphasize illustrative verbs for each model position, and labels for the underlying dimension have been added. Adapted from “The Interpersonal Dimension of Personality,” by M. B. Freedman, T. F. Leary, A. G. Ossorio, and H. S. Goffey, 1951, *Journal of Personality*, 20(2), p. 151 (<https://doi.org/10.1111/j.1467-6494.1951.tb01518.x>). Copyright 1951 by John Wiley and Sons. Adapted with permission. Panel B (trait terms) has been simplified from the original to show general category labels in adaptive and maladaptive forms (with the latter in parentheses), plus the addition of labels for the underlying dimensions. Adapted from *Interpersonal Diagnosis of Personality: A Functional Theory and Methodology for Personality Evaluation* (p. 65), by T. Leary, 1957, Ronald Press. Copyright 1957 by Timothy Leary and reprinted in 2004 by Wipf and Stock Publishers (<https://www.wipfandstock.com>). Adapted with permission.

Structure Revisited: Solving the Problem of Autonomy

Leary (1957) predicted that additional developments would follow: “We cannot doubt that more complex formal systems will eventually add new spatial dimensions to the organization of personality” (p. 64). SASB builds on the IPC with an additional distinction requiring reorganization of the conceptual space. The distinction hinges on recognition that expressions of autonomy, separateness, and other forms of agency are missing, especially those that are nonhostile and neither dominate nor submit to others (i.e., to either dominate or submit denotes a lack of separateness from the other person or persons).

As a specific example, like many humanist and existentialist writers, poet Rainer Maria Rilke recoiled from a view of the world in which human relationships allow only for varying degrees of domination or submission. He once wrote in a letter to a friend, “I beg all those who love me to love my solitude too” (Leppmann, 1984, p. 237). The IPC does not provide a clear language for the condition described by Rilke’s request: to be allowed distance in a context of warm relatedness that does not involve significant control or submission by anyone else involved. The same can be said for clinically relevant goals that invoke humanistic and existential themes, such as developing a well-differentiated, healthy sense of self through the letting go of old wishes, fears, relationships, hurts, identities, and so on. These involve a very different stance than simply becoming more or less dominating or submissive in relation to others or to the self.

Insights About Autonomy From Parent-Child Interaction Research

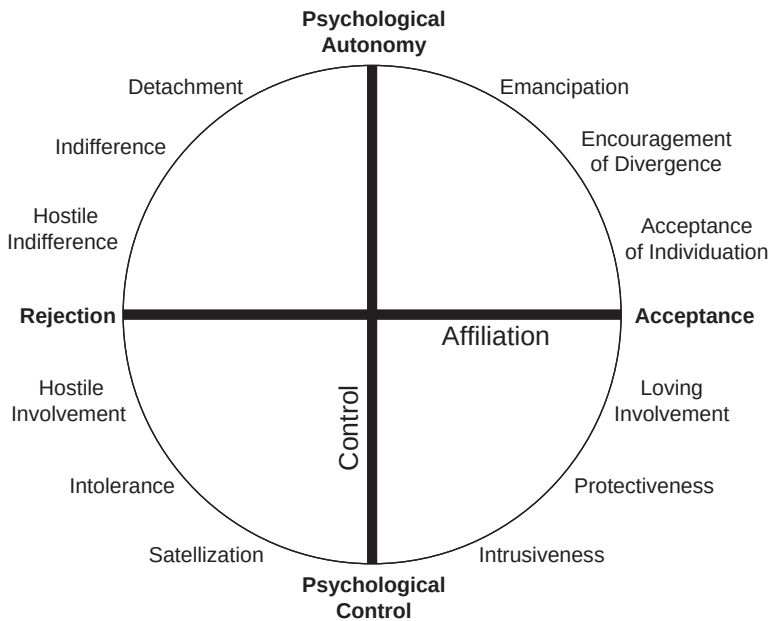
A structural model of behavior that more clearly embraced the issue of autonomy was developed at about the same time as the IPC, but in a different area of psychology. Schaefer (1959, 1965) developed a circular model of parental behavior shown in Figure 1.3. Like the IPC, Schaefer’s model had a horizontal dimension ranging from loving, affiliative parenting to aggressive, disaffiliative parenting. Also similar was a vertical dimension describing degrees of control or domination.

For Schaefer, the conceptual opposite of parental control was to grant autonomy. Like the IPC, the Schaefer model has had a long history in research. For example, the same essential dimensions underlie the Parental Bonding Instrument (PBI; Parker et al., 1979). The PBI has been widely used in clinical and epidemiological research to link early experiences with parents to anxiety and depressive disorders, delinquency, drug and alcohol abuse, personality disorders, and schizophrenic relapse (Parker, 1990). As such, the model is clearly useful for understanding clinical phenomena. Items measuring the opposite pole of parental control are clear examples of an autonomy-granting stance and include “let me decide things for myself” and “gave me as much freedom as I wanted.”

What Is the Opposite of Control? Integration of Models to Produce SASB

The IPC and Schaefer models each capture something about control that is not directly covered in the other. A parent may permit a child to go their own way rather than controlling them (Schaefer model), but a parent may

FIGURE 1.3. Schaefer's Circle



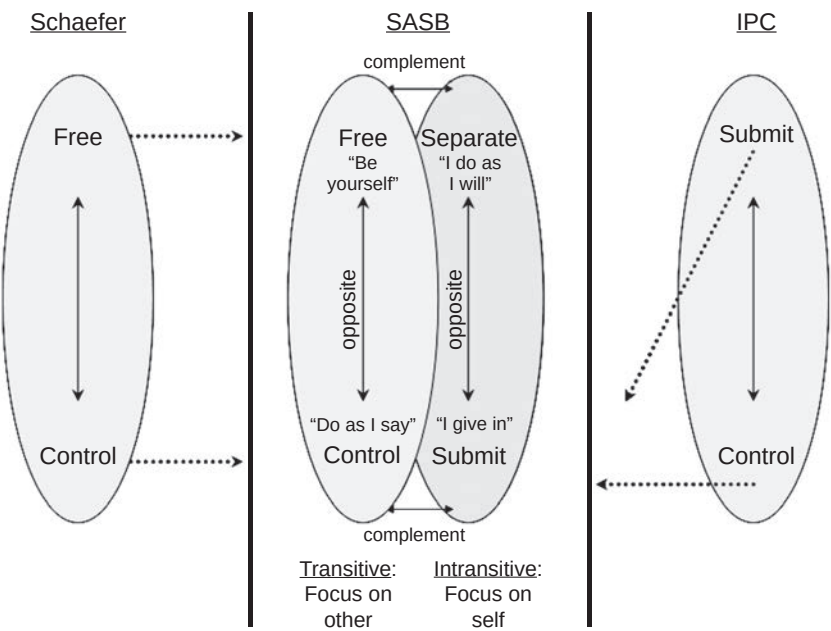
Note. The figure omits from the original a proposed third dimension for lax versus firm control and adds labels to identify the underlying dimensions. Adapted from "A Configurational Analysis of Children's Reports of Parent Behavior," by E. S. Schaefer, 1965, *Journal of Consulting Psychology*, 29(6), p. 557 (<https://doi.org/10.1037/h0022702>). Copyright 1965 by the American Psychological Association.

also submit and comply with a child's insistent demands (IPC model). SASB incorporates the constructs of both models, as shown in Figure 1.4.

The reorganized structure involves two parallel planes defined by their interpersonal focus. One plane consists of behaviors that are primarily about something that happens to the other person (prototypically parentlike, involving transitive actions). The other plane includes behavior concerned with what is happening with the self in relation to others (prototypically childlike, involving intransitive states). The resulting structure creates complementary pairings of behavior that share the same combination of underlying dimensions (referred to as *affiliation* and *interdependence*) but differ by focus.

The model includes positions for important themes from the clinical literature. At extreme poles of the model, these positions include sexuality, aggression, power, and separateness. The ability to track each of these behavioral positions in ways that were anchored in an assessment of underlying constructs that existed separate from language was necessary to apply to primate

FIGURE 1.4. Control, Submission, and Freedom in the Schaefer, Structural Analysis of Social Behavior (SASB), and Interpersonal Circle Models



Note. Dotted lines indicate the location of conceptual parallels integrated into the SASB model.

nonverbal behavior in the context of Harlow’s laboratory. Benjamin (1973, 1974, 1979) later developed the model for analysis of clinical processes, including narrative descriptions involving a wide range of developmental contexts. As will be described in more detail in Chapter 2, the extensions of the model explicitly incorporate self-treatment into its framework with a plane of behavior termed *introject*. This surface reflects Sullivan’s (1940) sense of introjection as reflecting the behavior of others taken in and applied to the self. For example, as can be seen in Figure 1.1, each position focused on others (e.g., 1-2: **Affirm**, 1-5: **Control**, and 1-8: **Ignore**) has a parallel behavior involving self-treatment (e.g., 3-2: *Self-Affirm*, 3-5: *Self-Control*, and 3-8: *Self-Neglect*).

When used in clinical practice, SASB provides a language that can be used to focus, summarize, and reflect a patient’s relational narrative in lay terms. An accurate model can correctly shape clinical perception and language, providing seamless connection with everyday language to enhance clinical discernment and allow clinicians to provide accurate empathy.

TABLE 1.3. Contrasts Between Use of SASB and IPC When Coding Autonomy

Source	Referent	Rated item	IPC description	SASB description
MMPI item	Rater to family	1. <u>I have been quite independent and free from family rule.</u>	Dominance	2-1: <u>Separate</u>
Therapy transcript	Mother to speaker	2. I think it <u>makes her retract, withdraw from me</u> when I am dependent on her.	Hostile dominance	2-8: <u>Wall-Off</u>
Therapy transcript	Speaker to mother	3. . . especially my mother, tried to push me a little which I resented and probably <u>went out of my way to do the opposite.</u>	Dominance	2-1: <u>Separate</u>
TAT card response	Child to mother	4. I think <u>she'll run away</u> , but it isn't from the school—because she hates her mother who is unkind and doesn't show her any love. My own experience tells me <u>she runs away.</u>	Hostile submission	2-8: <u>Wall-Off</u>

Note. Coded segments are underlined in rated items. IPC codes and illustrative clinical material are from Freedman et al. (1951). SASB descriptors are from the model shown in Figure 1.1. IPC = interpersonal circle; MMPI = Minnesota Multiphasic Personality Inventory; SASB = Structural Analysis of Social Behavior; TAT = Thematic Apperception Test.

These enhancements can be seen in Table 1.3, which shows differing results when SASB and IPC are applied to examples of clinical material provided by Freedman and colleagues (1951) in their initial presentation of the IPC. The examples were selected to highlight the way each model addresses differentiated interpersonal behavior. In each instance, the SASB-based description can be seen to land closer to the qualitative material being described. More than this, the distinctions have profound implications for therapeutic decision-making. Clinicians might be set down very different paths if, as in the first three examples of Table 1.3, expressions of separateness (including simple disagreement) are mistaken for the exertion of power over another person. The final example invokes parent–child relationships. A child who responds to a parent by shouting an angry “no” or by avoiding and fleeing (i.e., separating or walling off) is not engaging in the same pattern as a child who complies fearfully or resentfully (i.e., sulking or submitting).

Returning to the example of Sarah, the response she learned with her father and then carried forward to her adult workplace was one of submitting to the demands of others. If key distinctions between enmeshed and differentiated behavior are not made clear, Sarah may think the only options she has are to continue submitting or to flip the script and somehow find a way to oversee her boss. However, for Sarah, a more effective approach would be to learn to assert herself and explore “empowered” interpersonal territory that she has less familiarity with per history, which involves being self-possessed and able to be separate enough from those who make inappropriate demands of her that she can decide for herself what solutions best fit the situation. Subsequent chapters of this book will unpack such distinctions further to guide readers through the process of “coding” behavior using SASB to characterize clinical material accurately and precisely, to develop clinical case formulations, to monitor treatment processes and outcomes, and to guide therapist behavior. For now, the goal is just to get acquainted with SASB’s underlying structure and concepts and obtain a sense of how they relate to clinical work.

COGNITIVE AND AFFECTIVE PARALLELS TO SOCIAL BEHAVIOR

SASB’s structural elements build on a rich scholarly tradition in interpersonal measurement. Benjamin’s theory extends beyond this domain, however, to include consideration of the cognitive and affective precedents of interpersonal behavior. As will be described in detail in Chapter 2, these domains have a parallel structure based on cognitive and affective appraisals of focus, affiliation, and interdependence. Benjamin (2018) argued that due to natural biology, cognition, affect, and behavior have evolved in tandem such that they can be measured and tracked using parallel conceptual models. For example, the cognitive and affective parallels of 1-6: **Blame** would be cognitions involving condemnation and feelings characterizable as scorn. These models are extensions of the SASB model reviewed earlier and efforts to operationalize and test them using questionnaire and observational coding methods are underway (described in Chapter 2).

Interactive Context

As an observational coding system, SASB has potential to be applied micro-analytically to track relational behavior moment by moment. This includes the sequential patterning of behavior between two people, including their inputs and responses to each other over time. In other words, SASB can be used to

track what happens in a relationship, including the therapy relationship, in real time. The interactive context of two or more people influencing each other in sequence is often key to understanding clinically relevant patterns, and this is at the core of a SASB-based understanding of patient patterns as well as the interactive flow of therapy sessions. For example, one patient may recoil and withdraw from others (2-7: Recoil) but only in response to perceived control (1-5: **Control**). A different patient may respond in the same way but only recoils in response to perceived abandonment (1-8: **Ignore**). The interactive, *input-response* nature of this information could be used differentially, for example, to help understand, predict, and defuse marital conflicts or to detect and address signs of a rupture in the therapeutic alliance. Additional contextual factors can also prove important for understanding when or why characteristic patterns will be enacted (e.g., only in relation to people outside the family, or with a certain gender, age, or role). As will be illustrated in examples throughout this book, a SASB-based definition of personality is usually thought of in contextualized terms that involve a process of interacting with others.

Interactive context can be captured not only through behavioral observation and narrative description but also with the SASB-based Intrex questionnaires (Benjamin, 2000), as will be explained in subsequent chapters. Intrex instruction sets can be tailored to capture specific state-by-trait-by-situation ratings. For example, the Intrex standard series asks patients how they and a significant other relate to one another (both partners are rated) when their relationship is at its best and again for when it is at its worst. The issue of how to handle the interface between moment-by-moment observation in sessions, repeating patterns acted out and described by patients, and specific states or circumstances that produce one pattern or another will be repeating themes in the examples used in this book.

SASB's History and Track Record in Clinical Research

The SASB model has now had more than 50 years of application in research and clinical practice. A 2006 summary cited a wide range of representative topics researched using SASB's interpersonal lens (Benjamin, Rothweiler, & Critchfield, 2006). The list has grown considerably since then. In addition to interpersonal and psychodynamic approaches, the list of topics using SASB in published research includes diverse theoretical orientations, including cognitive behavior therapy (Critchfield et al., 2007; Hara et al., 2022; Karpiak & Benjamin, 2004), patient-centered (Wong & Pos, 2014), and emotion-focused (L. S. Greenberg & Malcolm, 2002) approaches, as well as application to a range of integrative methods (e.g., Bennett & Parry, 1998;

Critchfield et al., 2017). Across the various orientations, SASB has been directed toward questions of case conceptualization (Bennett & Parry, 1998; Critchfield et al., 2015), the impact of specific interventions (Ahmed et al., 2012; Vittengl et al., 2004), in-session processes of relating (e.g., alliance, rupture and repair processes, resistance episodes; Eubanks et al., 2019), the role of therapist and patient interpersonal histories to in-session relating (Hilliard et al., 2000), analysis of session content (e.g., dreams; Frick & Halevy, 2002), therapeutic change in relationships (Bedics et al., 2005), self-concepts (Bodlund & Armelius, 1994; Forsén Mantilla, Clinton, & Birgegård, 2019; Forsén Mantilla, Norring, & Birgegård, 2019; Jeanneau & Armelius, 2000), and more. Multiple modalities of treatment have also been explored, including application to individual, couple (Knobloch-Fedders, Caska-Wallace, et al., 2017), group (Canate, 2012; Dobner-Pereira, 2021; Tasca et al., 2011), and family (Stern et al., 2023; Woehrle et al., 2023) settings across a spectrum of diagnostic labels and severities.

Benjamin has long advocated for an interpersonal approach to diagnosis and case conceptualization (Benjamin, 1993, 2018; Benjamin, Wamboldt, & Critchfield, 2006; McLemore & Benjamin, 1979). Accordingly, Benjamin and others have applied SASB to topics of differential diagnosis (Panizo Jansana, 2020; T. L. Smith et al., 2003), category definition (Benjamin, 1993, 2018), and relational context for all major diagnostic groups, including mood disorders (Knobloch-Fedders, Critchfield, & Staab, 2017), psychosis (Armelius & Granberg, 2000; Harder, 2006), posttraumatic stress disorder (Knobloch-Fedders, Caska-Wallace, et al., 2017), substance use disorders (Florsheim & Moore, 2008; MacDonald et al., 2007), eating disorders (Monell et al., 2020), anxiety disorders (Erickson & Pincus, 2005), adolescent and adult suicidality (Harvell-Bowman et al., 2022; Ness et al., 2018), and personality disorder (Ruiz et al., 1999).

SASB's uses have also extended beyond psychopathology and its treatment to include issues in normative development (Beveridge & Berg, 2007), parenting (Bowman, 2018; Skowron et al., 2011), dating (Eastwick et al., 2010), spirituality (Stucker-Rozovsky, 2022; Vespa et al., 2018), teaching of psychology (Paddock et al., 2001), intergenerational patterns of relating (Critchfield & Benjamin, 2008, 2010; Cushing, 2003; Woehrle et al., 2023), medical health problems (T. W. Smith, Baron, Deits-Lebehn, et al., 2020; T. W. Smith, Baron, & Grove, 2014; Vespa et al., 2018, 2021), sleep (Gunn et al., 2017), behavioral genetics (McGonigle et al., 1993), and sports performance (Conroy, 2003; B. E. Smith, 2018). The range of applications and uses of the SASB model over 50 years speaks to the transtheoretical relevance of the interpersonal domain. As a descriptive system, SASB clearly provides valuable information across topics of key interest in human affairs.

ORGANIZATION OF THIS BOOK

This book is intended to support clinical use and application of SASB. As such, each section focuses on a different topic of relevance to clinicians. Chapters 1 through 3 comprise Part I and will give readers a basic understanding of SASB theory and application needed for more sophisticated uses of the model. Following the historical overview provided in this chapter, Chapter 2 presents several versions of the SASB model with examples of their varied clinical uses. Chapter 3 provides instructions for how to gather questionnaire and observational data to be interpreted through SASB's lens.

Part II is composed of two chapters that address how SASB can be integrated and applied within existing clinical models. Chapter 4 focuses on transtheoretical use, while Chapter 5 provides an overview of IRT (Benjamin, 2003, 2006, 2018). IRT is the clinical method that Benjamin derived from observations made with the SASB lens. Our initial case discussion of Sarah suggests key components of the IRT perspective, which understands current interpersonal patterns in light of prior learning in close attachment relationships that continue to govern behavior via the internalized *family in the head*. IRT represents an integrative approach to treatment that incorporates elements of cognitive behavior, dynamic, and humanistic therapies. Use of techniques from each of these perspectives is guided by a comprehensive conceptual framework guided by a SASB-based case formulation. Subsequent chapters use clinical material from IRT sessions to illustrate principles of conceptualization and intervention.

Part III focuses on observing, assessing, and formulating patient patterns. SASB is used to develop and apply case formulation via the questionnaire-based method (Chapter 6), followed by the interview-based method (Chapter 7). The conceptualization method in part tracks evidence of the role that internalized relationships play when patterned repetitions are observed in interpersonal behavior across developmental context (e.g., acting like an important other person; expecting others to behave the same as others once did; treating oneself as other did). This includes patterns that can be enacted in the therapy relationship itself. In these chapters, repeating interpersonal patterns with the self and others are the primary lens through which (a) personality is understood and (b) symptoms and problems “make sense” and form the basis for therapeutic decision-making.

In Part IV, Chapters 8 through 10 turn attention to treatment processes guided by IRT principles, with each topic cued to a SASB-based understanding of patient problems, the therapist's choice of intervention and in-session manner of delivery, and therapeutic outcomes. We provide diverse case examples from patients referred to the IRT clinic due to high levels of diagnostic

complexity, severity, and nonresponse to prior treatment attempts. Clinicians will gain an understanding of SASB-based methods to organize that complexity and enhance patient motivation for change. Names and details are changed to protect confidentiality, but the SASB-based descriptions are true to the original cases. The therapy perspective includes the idea noted earlier in the case of Sarah, that psychopathology often reflects misdirected attempts to adapt to new circumstances by using old interpersonal strategies and views.

As described in Chapter 5 and illustrated with additional case examples, maladaptive patterns (with the self and others) often resist change because they are linked to attachment with important others. In IRT, a key hypothesis is that the persistence of problem patterns represents continued attempts to receive real or imagined love, acceptance, security, or restitution from key attachment figures or their internalized representations. Behaviors enacted out of this motivation are termed *gifts of love* (Benjamin, 1993). A gift of love is suggested in the case of Sarah, described earlier. Sarah stated in her clinical interview, “I tried to get Dad to love me by doing all that he said,” and went on to link this to her desire to keep working to the point of extreme burnout and serious contemplation of suicide. The IRT approach uses SASB not only to increase the accuracy of case conceptualization but also to use awareness to help patients like Sarah to give up the gift of love motivation and choose more adaptive ways of being. The associated change process can be difficult and entail substantial grief as a person comes to terms with problematic aspects of the internalized attachment. In Sarah’s case, it would mean giving up the assignment she had accepted to get her father’s love and affirmation by doing the impossible in relation to her boss. Strategies for detecting, working with, and therapeutically responding to similar attachment-linked patterns, as well as summaries of evidence for that approach, will be provided in these final chapters focused on treatment processes and outcomes (Chapters 8–10).

In summary, it is our hope that readers finish this book feeling comfortable with a new clinical tool, SASB, that they can use to enhance specificity, empathy, and efficacy in their work across theoretical orientations and clinical settings. Readers will learn how to use SASB and IRT methods to help even the “stuck” and “complex” patients with whom they work to access motivation and internal permission to change, even when it means letting go of wishes to finally be loved and accepted by an internalized family in the head.