

Cognitive analytic therapy for borderline personality disorder

Ian B. Kerr, Dawn Bennett and Carlos Mirapeix

Summary Cognitive analytic therapy (CAT) is a still-evolving integrative and relational model that conceptualises borderline personality disorder as a pervasive and complex dissociative disorder of the self arising largely as a consequence of long-term, developmental psychological trauma in the context of dysfunctional formative relationships and neurobiological vulnerability. Therapy aims initially at the collaborative creation, through a benign and non-collusive relationship, of empathic and validating descriptions and understandings of current difficulties and of their background through written (narrative) and diagrammatic reformulation. These aid self-reflective capacity and integration of the self. They also serve as 'route maps' for the work of therapy and contribute to the therapeutic alliance and to the negotiation of often 'difficult' transference-countertransference enactments. Many of the contributory and perpetuating factors of problems in borderline personality disorder are social and relational and these may be addressed using systemic 'contextual reformulation' in multidisciplinary team-based approaches. Cognitive analytic therapy offers a robust and coherent conceptual framework within which a range of further interventions can be undertaken for various problems and symptomatic behaviours.

In this chapter we describe the conceptual framework and key features of the cognitive analytic therapy (CAT) approach to borderline-type personality disorders (Ryle, 1997, 2004; Ryle & Kerr, 2002; Kerr & Ryle, 2005). We also consider how effective these may be for different patients in different settings and implications of this for further (comparative) research and evaluation. We note some current problems with the concept of borderline personality disorder. These include, in particular, ongoing uncertainty regarding its nosological status, its heterogeneity in terms of both apparent aetiology and clinical presentation, and the range of apparently different 'brand name' models that have addressed it, each with its own emphases and specialist terminology. It will be a major challenge for the future to clarify which approaches do in fact effect lasting change and how they do so, and to elucidate the undoubted considerable commonalities between differing models (Roth & Fonagy, 2004; National Collaborating Centre for Mental Health, 2009).

CAT as a model of development and psychopathology

A still-evolving integrative model of psychological development and therapy, CAT stresses the social and relational formation of the self and its 'psychopathology' (Box 18.1). It was first formulated by Anthony Ryle over a period of several decades, and has been extended both theoretically and clinically by a number of other workers, notably Mikael Leiman in Finland (Ryle & Kerr, 2002; Kerr & Ryle, 2005). Although initially representing an attempt to integrate the valid and effective elements of psychoanalytic object relations theory and the then evolving discipline of cognitive therapy (including, notably, Kelly's personal construct theory), CAT has subsequently been further transformed by consideration of Vygotsky's activity theory (Leiman, 1992; Ryle & Kerr, 2002), notions of a dialogical self deriving from Bakhtin (Leiman, 1992, 2004) and important developments in infant psychology (Stern, 2000; Trevarthen & Aitken, 2001; Reddy, 2008). The latter include findings stressing the actively intersubjective nature of developing infants and their predisposition and need for active, playful collaboration and 'companionship' (Trevarthen & Aitken, 2001). These findings have

Box 18.1 Key features of the cognitive analytic therapy model of development and psychopathology

The model is predicated on a fundamentally relational and social concept of self; this implies that individual psychopathology cannot be considered apart from the sociocultural context in which it arose and within which it is currently located.

In the context of individual genetic and temperamental variation, early socially meaningful experience is internalised as a repertoire of reciprocal roles.

A reciprocal role is a complex of implicit relational memory that includes affect and perception and is characterised by both child-derived and parent/culture-derived poles; a role may be associated with a clear dialogical 'voice'.

Enactment of a reciprocal role always anticipates or attempts to elicit a reciprocal reaction from a historic or current other.

Reciprocal roles and their recurrent procedural enactments determine both subsequent interpersonal interactions and also internal dialogue and self-management.

All mental activity, whether conscious or unconscious, is rooted in and highly determined by our repertoire of reciprocal roles.

Human psychopathology is rooted in and highly determined by a repertoire of maladaptive or unhealthy reciprocal roles.

More severe and complex damage to the self may occur as a result of chronic developmental trauma/deprivation, resulting in dissociation and disruption of the repertoire of reciprocal roles and consequent impairment of self-reflective and executive function. These phenomena are accounted for in the 'multiple self states model' of borderline personality disorder.

important implications for the aims and style of psychotherapy. In CAT, they have influenced the concept of the formation of the (highly social) self and, correspondingly, of its deformation or psychopathology. Cognitive analytic therapy describes early internalised, formative relational experience in terms of a repertoire of 'reciprocal roles', and describes the subsequent habitual coping or responsive (Leiman, 2004) behavioural patterns as 'reciprocal role procedures' (RRPs). These are understood to be partly determined by inherited temperamental variation and the neurobiological consequences of early (e.g. traumatic) experience. Common reciprocal roles range from, for example, 'properly cared for—properly caring for' at one extreme to 'neglected and abused—neglecting and abusing' at the other. Maladaptive reciprocal role procedures are important therapeutic targets.

Cognitive analytic therapy adopts a fundamentally relational focus, and stresses the importance of the transformative and mutative psychological internalisation within a developing 'individual' of surrounding social structures and conditions, and of semiotically mediated interpersonal experience. The outcome of this process is an 'individual' who cannot ever be simply individual, but who is socially formed and constituted by developmental interpersonal experience and cultural values and whose very sense of subjective self, relations with others, behaviour and values are socially determined and relative and, for the most, part unconscious. This viewpoint is further supported empirically by observational and experimental studies (Cox & Lightfoot, 1997; Reddy, 2008). An important corollary of the process of internalisation, understood in this Vygotskian sense, is that although it is an individual who experiences and presents with distress and disability, there is in an important sense no such thing as individual psychopathology—only sociopsychopathology (Kerr *et al*, 2007; Kerr, 2009). The implications of this statement, which may sound to most contemporary, post-Cartesian, Western sensibilities largely counterintuitive, will be elaborated below.

A further implication of the model, and of these understandings, is that ultimately therapy may only, or best, be achieved by engaging the ownership, support and participation of a broader community, notwithstanding that specialist understandings and expertise may be required to underpin or support mental health and well-being initiatives overall. But to move towards this, a major paradigm shift is required that our services and our society as a whole will need to address, implement and evaluate (James, 2007; Kerr & Leighton, 2008; Wilkinson & Pickett, 2009). At the least, in routine day-to-day work a coherent model of the socially constituted self can enable better communication and lessen professional stress.

The CAT model of borderline personality disorder

In common with approaches such as psychodynamic therapy, CAT adopts a dimensional approach to the conceptualisation of degrees of damage to and dysfunction of the self. This cuts across current conventional 'shopping

list' diagnostic approaches that describe mental disorders as discrete and separate entities of comparable status. Borderline personality disorder is seen from a CAT perspective as a severe and complex disorder frequently characterised by considerable comorbidity. The self is understood as operating in states ranging from normal multiplicity through to those of overt dissociation (Ryle & Kerr, 2002; Ryle & Fawkes, 2007; Mirapeix, 2008). Lesser degrees of damage to the self are characterised by the presence of mildly dysfunctional or maladaptive reciprocal role procedures (Box 18.1) for coping, located within a more integrated self capable of self-reflection, empathic interactions with others and an advanced capacity for executive function. However, more severe degrees of damage are characterised by failure of integration of structures of the self (notably, its repertoire of reciprocal roles and reciprocal role procedures), and by lack of self-reflective capacity and problems associated with a coherent and continuous sense of identity (Ryle, 1997, 2004; Kerr & Ryle, 2005). Such disorder is also typically characterised by extreme psychological distress that may manifest as stress-related dissociation into different self states. Dissociation is also conceived of as the principle mechanism through which developmentally abusive, traumatic and depriving interpersonal experiences have a deleterious effect on the developing self. The damage is considered to occur in the context of likely neurobiological vulnerability through, for example, possibly impaired impulse control and/or proclivity to dissociation as a defensive mechanism in the face of (psychological) trauma (Ryle & Kerr, 2002).

This conceptualisation addresses and largely accounts for the range of psychopathology encountered in borderline personality disorder, in particular the tendency under pressure to switch suddenly and apparently unpredictably between different self states, with their associated differing reciprocal roles and reciprocal role procedures (Pollock *et al.*, 2001). These switches between self states represent some of the most problematic and challenging enactments encountered in working in any capacity with people with borderline personality disorder, often causing such patients to be seen as 'difficult' or 'hard to help' – at least in the absence of a coherent model accounting for these interactions.

Self states and their identification

The presence of different self states has been empirically demonstrated and validated in several clinically based studies using the Personality Structure Questionnaire (PSQ) and the States Description Procedure (SDP). These instruments were developed from within CAT, but have come to have broader applicability (Bedford *et al.*, 2009).

The PSQ consists of eight pairs of contrasting descriptions of the self, each item scored between 1 (stable) and 5 (changeable). The mean scores of samples of healthy people range from 19.7 to 23.3, whereas those of people with borderline personality disorder range from 30.4 to 31.3 (Pollock *et al.*,

2001). Scores on the PSQ correlated with a number of other measures of identity disturbance and personality fragmentation, establishing the PSQ as a valid, psychometrically sound measure. The broader validity and utility of this measure has been subsequently demonstrated in this and other patient populations (Bedford *et al.*, 2009).

The SDP (Bennett *et al.*, 2005) involves patients in a process of guided introspection, generating detailed and clinically useful understandings of their states and state switches. The first part of the instrument consists of names and descriptions of 10 commonly encountered states, drawn from clinical experience and from Golynkina & Ryle's (1999) study of partially dissociated states in borderline personality disorder. Respondents are invited to identify any states that they experience, to modify the name of the state if they wish, and to select from or add to the listed descriptions. The second part of the SDP is completed for each of the identified states. It consists of detailed enquiries about the frequency, duration, mode and provocation of entry into and exit from the state, and the accompanying emotional and physical symptoms.

Bennett & Ryle (2005) report a series of 12 patients, all of whom had been diagnosed with borderline personality disorder and/or had scored 28 or over on the PSQ. All 10 states on the SDP were recognised by at least half the sample. The most common were the 'victim' and 'bully' states (all participants), the 'zombie' state (11 participants) and the 'high' state (10 participants). The fact that every patient identified with the 'bully' and 'victim' states supports the assumption that experiences of abuse are very frequently a forerunner of borderline personality disorder and demonstrates how patients may identify with both poles of the abusing-abused reciprocal role pattern. The 'victim', 'soldiering on' and 'zombie' states are also similar, in that all are associated with slowness and exhaustion. The 'soldiering on' and 'victim' states are more associated with anxiety and anger than is the 'zombie' state, which is more often associated with dissociative symptoms. The study confirmed that the description of borderline personality disorder in terms of alternating states is meaningful to patients, and the model of the self as made up of distinct, identifiable states was supported, as it had been by Golynkina & Ryle (1999).

In clinical practice, Hubbuck (2008) reported that, of 32 patients with borderline personality disorder who had completed the SDP, 29 (90.6%) thought that it was 'of value' or of 'considerable value' to their therapy. The SDP helps people with borderline personality disorder to change the way they think about their states of mind. Referring to discussions about their states, Hubbuck reported that 'most of these patients probably finished therapy viewing their states of mind as carriers of highly condensed, highly systemic, and highly important information about their life histories and life plans', able to ask themselves 'What named state of mind am I in at this moment; and what is the reason for it?'. This adds to the likelihood that conscious, positive 'exits' will be sought.

An individual case formulation in terms of partially dissociated states, to which the SPD can contribute, can supplement current formal diagnostic procedures and provide valuable understanding to therapists and others concerned with the treatment and management of borderline personality disorder. More generally, the multiple self-states model and the SPD make it clear that integration must be a central aim in the treatment of borderline personality disorder. It also explains how treatment procedures and clinicians' activities may represent inadvertent collusion with the dysfunctional reciprocal role patterns associated with borderline states, thus undermining that aim.

This conceptualisation of a range of different reciprocal roles and reciprocal role procedures predicts and accounts for the range of comorbid conditions encountered in borderline personality disorder, such as substance misuse, self-harm, anxiety and depression. Given that reciprocal roles associated with self states are characterised by internalised 'inner voices' and beliefs, these may constitute important therapeutic targets. These voices and beliefs may be enacted through coping or responsive reciprocal role procedures in relation to the 'real' outside world, but also, critically, through self-to-self and self-management reciprocal role procedures.

The multiple self-states model, as noted previously by Ryle & Kerr (2002), provides in addition a clinically important understanding of the instability and discontinuities noted, but not explained, in six of the nine features contributing to the diagnosis of borderline personality disorder in DSM-IV (American Psychiatric Association, 1994), namely: unstable intense interpersonal relationships, identity disturbance, impulsivity, affective instability, inappropriate intense anger, and transient paranoid and dissociative symptoms. It has been suggested that 'instability' usually means having fallen below the diagnostic threshold after a considerable length of time (Gunderson, 2003). However, this definition does not address the clinically challenging instabilities due to sudden self-state switches that are evident over short periods and characteristic of these disorders.

It is fundamental to the CAT conceptualisation of borderline personality disorder that widely different, often very extreme reciprocal role enactments may be encountered in work with a patient and that they are likely to elicit corresponding reciprocal role enactments (or reactions) from professionals. These may in turn be mirrored and amplified throughout a healthcare (or other) system. This can have a major effect on the outcome of therapy and of overall clinical management. It is also understood that, as a result of stress-related extreme dissociation, different self states will be encountered, each characterised by essentially very different reciprocal roles and procedures. These reactions may include, for example, 'desperate ideal care-seeking' or 'zombie' states, or enactments of abusive rage towards the self or others. A major interest of workers within the CAT tradition has been the systemic 'knock-on' effect of these enactments (Fig. 18.1) and the ways in

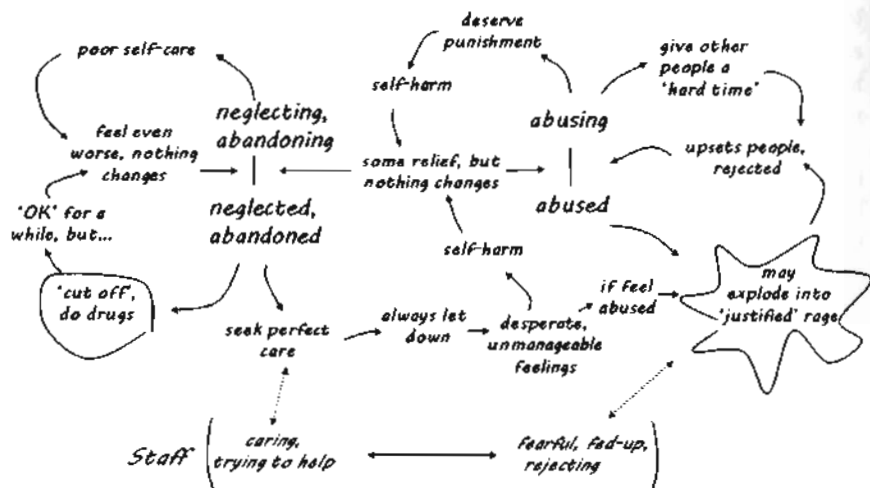


Fig. 18.1 Rudimentary contextual reformulation of a fictional patient with borderline personality disorder, showing basic reciprocal reactions and splitting in the staff team.

which they may provoke stress, disagreements, burnout and splits within services (Kerr, 1999; Ryle & Kerr, 2002). Although these differing role enactments are seen as problematic within CAT, the tools of reformulation and of extended contextual reformulation offer powerful means of both understanding and working with them (Kerr, 1999; Thompson *et al.*, 2008). A further consequence for individual patients of dissociation into differing self states is a resultant difficulty in self-reflection, executive function or what might be called mentalisation (Bateman & Fonagy, 2004) or metacognition (Dimaggio *et al.*, 2006).

A major aim of CAT is to enable a containing and collaborative understanding and insight into patients' dissociative states and switches. This helps them to reduce and contain intense and unmanageable emotional states that might otherwise lead to desperate coping behaviours (procedures) such as substance misuse or self-harm. It is implicit in the approach that patients may need active supportive assistance to deal with problems associated with these coping behaviours. However, CAT practitioners would not concur with the view asserted by, for example, practitioners of dialectical behaviour therapy, that these behaviours in themselves should always be addressed and contained first, without reference to their underlying recent or historic causes. It has been argued from a CAT perspective (Kerr & Ryle, 2005) that to do so may be an unwitting collusion with underlying historic reciprocal roles and that focus on behaviours such as self-harm or substance misuse can actually reinforce and represent a 're-run' of historic experiences such as being emotionally neglected, conditionally loved or not listened to.

CAT as treatment for borderline personality disorder

Cognitive analytic therapy has been employed for the most part as an individual therapy offered on a time-limited basis (Box 18.2). A time limit and 'ending well' are of fundamental importance in CAT. A typical initial contract would be for 24 weekly sessions. However, CAT is increasingly used as a common language to inform more intensive and/or team-based approaches (Sheard *et al.*, 2000; Ryle & Kerr, 2002). One interest within CAT has been the use of shared contextual reformulation, either implicitly or explicitly, within treating teams. This use has been explored in a variety of settings, including intensive treatment programmes, therapeutic

Box 18.2 Key features of the cognitive analytic model of therapy for borderline personality disorder

Proactive and collaborative ('doing with') style, stressing the active participation of the patient/client.

Aims at non-judgemental description of, and insight into origins and nature of, psychopathology conceived as procedural enactments of reciprocal roles and associated dialogical voices, and of a tendency under stress to dissociate into different self states.

Aims to offer a new form of non-collusive relationship with a benign, thoughtful other that the patient/client can internalise in the form of new reciprocal roles and that enables the exploration of new perceptions of self and new ways of interacting with others; this is conceived of in terms of recognition and revision of maladaptive reciprocal role procedures.

Therapy is aided by the early collaborative construction of written and diagrammatic reformulations (conceived of as psychological tools) by the end of the initial phase of therapy. These serve as 'route maps' for therapy and also as explicit narrative and validating testimonies.

Therapy subsequently focuses on revision of maladaptive reciprocal role procedures and associated perceptions, affects and voices as they are evident in internal self-to-self dialogue and self-management, through enactments in the outside world, and also as manifest in the therapy relationship (as transference and countertransference).

Further techniques may facilitate this ranging from challenging of dialogical voices to behavioural experiments, mindfulness exercises, 'empty chair' work or active processing of traumatic memories.

The focus from the beginning is on a time limit (whether in individual therapy or CAT-informed approaches in other settings); 'ending well' is seen as an important part of therapy (experience of new reciprocal roles), and as a means of addressing issues surrounding loss and of avoiding protracted and collusive relationships.

Social rehabilitation is an important although often neglected aspect of therapy.

communities and day hospital services. The cognitive analytic approach is also increasingly used to inform broader consultancy work that does not necessarily involve individual therapy as such.

The therapeutic style of CAT is consistent with more recent findings on the nature of normal human growth and development, as mentioned above, and with emerging evidence on the features of successful psychotherapies. That is to say, it is proactive, collaborative, it stresses an active therapeutic alliance, and is clear and coherent to both professionals and patients. These characteristics are stressed in treatment guidelines such as that for borderline personality disorder published by the National Institute for Health and Clinical Excellence in England (National Collaborating Centre for Mental Health, 2009). Cognitive analytic therapy focuses on the internalised social and relational origins of a patient's difficulties and problems (in terms of their repertoire of reciprocal roles and reciprocal role procedures) and offers a means of addressing these both in general and as they are enacted within the therapeutic relationship. Thus, a major focus in therapy is work on what might be called transference and countertransference, although these are thought of and described rather more specifically in terms of named reciprocal role enactments. This work is aided by the use of summary reformulation letters and maps. These are conceived of in the language of Vygotsky as psychological tools. Joint construction of these can be seen as a form of narrative therapy (Dimaggio *et al.*, 2005, 2006) or of testimony and also as an exercise in validation as stressed in dialectical behaviour therapy (Linehan, 1993). They also effectively serve as jointly agreed 'route maps' for the subsequent course of therapy.

Therapy in CAT focuses initially, therefore, on the collaborative exploration and making sense of the patient's formative interpersonal and social experiences in terms of reciprocal roles, the coping patterns (reciprocal role procedures) emanating from them and, importantly, their consequences. The latter usually reinforce initial formative experiences in 'vicious cycles'. Many of these procedures and self states may be identified from the psychotherapy file (discussed in 'Use of adjuvant paperwork' below). Therapy focuses on helping patients to reflect and 'try things differently' in the context of a more benign and facilitating relationship. Ideally, the patient will internalise this relationship as an important aspect of therapy, although this is rarely in itself enough to effect significant change. However, the relationship might also constitute collusion with the patient, in a 'needy victim-sympathetic carer' reciprocal role, to the neglect of other, more difficult reciprocal role enactments. It is important to be aware of such collusion in professional work – especially since it may unwittingly perpetuate or exacerbate the difficulties with which the patient presents (see the case study of Anna below).

A further aim in work with individuals who have extreme damage to the self is the clear depiction of the various self states that they experience, of

what provokes their switches and of the consequences of coping procedures (reciprocal role procedures) emanating from them. This offers a coherent overview of often very confusing and distressing subjective states that is frequently very containing for the patient and, through its collaborative construction, strengthens the therapeutic alliance. Although with less unwell patients this mapping is normally attempted only after several sessions, paradoxically with very disturbed patients it is often helpful to attempt even a rudimentary version as quickly as possible – perhaps in the first meeting. In CAT both the written narrative reformulation and the diagram (or map) imply also the need to articulate ‘exits’ or ‘aims’ to help the patient move on and attempt things differently. Later phases of therapy offer an opportunity to process and ‘work through’ often painful formative experience and, possibly, major losses. Aims might include, for example, not repeating familiar coping reciprocal role procedures, or noting and challenging a critical inner voice.

Any more practical or behavioural work in CAT is always undertaken in the context of a shared reformulation, i.e. an understanding and appreciation of the interpersonal origins and nature of dysfunctional coping strategies (reciprocal role procedures) and their consequences. In our experience, not only may more relational therapeutic approaches be engaged in alongside more behavioural interventions – in practice, they may be necessary to enable such interventions, notwithstanding the need at times for emergency interventions for difficult behaviours such as self-harm, perhaps with brief hospital admission. These considerations would also apply to complementary approaches sometimes used within a CAT framework, such as creative therapies or ‘empty chair’ work attempting to access and process difficult memories (see the case study below). At times, interventions such as somatosensory approaches (Ogden *et al.*, 2006) or a more active cognitive-behavioural desensitisation may be necessary, and the help of colleagues might be sought to undertake them. Some patients might receive eye movement desensitisation and reprocessing (EMDR) nested within a traditional CAT therapy (see Ryle & Kerr, 2002).

In common with most, particularly Western-based, therapies focusing on the individual (with the possible partial exception of some therapeutic community approaches (Kennard, 1999; National Collaborating Centre for Mental Health, 2009), the challenge of social reintegration and rehabilitation is frequently not addressed in CAT, although for many (see the case study below) this is a massive and debilitating problem.

Later phases of therapy and ending

Beyond the reformulation phase, work on maintaining a focus on recognising and revising maladaptive reciprocal role procedures (through clearly stated aims and exits) continues, aided by the tools of reformulation. Other important work, such as working through or grieving for previous

losses or traumatic events, may also be undertaken (sometimes using complementary techniques). Existential issues relating to the meaning and purpose of life might be acknowledged, although focus will also be maintained on current life experience, for example in the family, at work or, importantly, within therapy. All of these will be respected and validated, but also recurrently challenged (non-judgementally) through the use of the previously jointly agreed reformulations. The latter also help to defuse the intensity and perceived personalisation of transference or countertransference enactments.

For good theoretical and clinical reasons, as already mentioned, all CAT-based approaches maintain firm focus on time limitation and ending well (Box 18.2). This maintains impetus, activity and, arguably, hope within therapy. It also minimises the temptation to drift into interminable, potentially collusive, relationships that may generate both dependency and demoralisation in the patient and, possibly, also in the therapist. Reciprocal roles enacted in such relationships include the 'superior empowered therapist-hopeless needy patient' or, more insidious, the mutually narcissistic 'special, admired, indispensable therapist-special, needy, admiring patient'. Ending well is seen as a therapeutic aim in itself, and is characterised ideally by enactment of new or modified reciprocal roles and reciprocal role procedures. These would include roles characterised by open dialogue and sharing of powerful and possibly angry or distressed feelings about ending and loss – as opposed to having to resort to more familiar historic defensive, avoidant or symptomatic reciprocal role procedures such as 'soldiering on', 'placating' or 'illness behaviours'. By this stage, it is hoped that, to some extent, a new, benign reciprocal role based on the experience of therapy will have been internalised. It should be stressed that time limitation and focus on ending well in CAT are not a response to economic pressure or the restricted delivery of an intervention that should ideally be much longer – notwithstanding the fact that an important part of Ryle's initial aim was to offer a good-enough therapy to as many patients as possible in a public health service.

Having said all this, it is recognised that individuals presenting with borderline personality disorders frequently remain fragile and vulnerable and may merit multidisciplinary and longer packages than less disturbed or damaged individuals with simpler conditions (for example, depressive disorders). More extended follow-up and support (ideally psychologically informed) may be required, including social rehabilitation and 'remoralisation', both of which are, in our experience, frequently underemphasised and underdeployed in these contexts. Reformulation frequently reveals particular formative (and current) sociocultural contexts that are beyond the remit or power of mental health professionals to address or modify. Nonetheless, sociocultural micromapping may be important in identifying and acknowledging the impact of such influences and how they might affect attempts to offer therapy or social assistance.

This process has obvious parallels and overlaps with the 'social-power mapping' (the structuring of who or what holds the power in an individual's social environment) described by Hagan & Smail (1997). However, the CAT approach offers a clearer and more effective means of conceptualising and dealing with the risk of collusion either directly with a patient or with a professional care group by means of techniques such as contextual ('systemic') reformulation or mapping (Fig. 18.1) (Ryle & Kerr, 2002). Indeed, cognitive analytic principles are being increasingly used to inform systemic consultancy work, both clinical and organisational. We have argued that sociocultural micromapping is always applicable, even if not very obviously, with every 'individual' treated or cared for by mental health services (Kerr, 1999; Ryle & Kerr, 2002). An important consequence of these considerations has been the recognised need to develop more complex models of treatment for borderline personality disorder. These could be based on CAT, but they could equally make use of other paradigms, such as Livesely's eclectic approach (Mirapeix *et al.*, 2006). In CAT-based models, efforts at rehabilitation would be particularly emphasised, given their theoretical and practical importance and their striking absence in, for example, the North American literature.

Use of adjuvant paperwork

Various paper-based tools are routinely employed in CAT. In addition to the SDP, PSQ and contextual reformulation, patients routinely fill in a questionnaire called a psychotherapy file. A purpose of the file is to identify dysfunctional reciprocal roles and reciprocal role procedures (described by Ryle in terms of traps, snags and dilemmas; Ryle & Kerr, 2002). They might also complete a broad assessment measure such as the Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM; Evans *et al.*, 2002) (including its distinct risk subscale). Such instruments are of considerable benefit not only as a measure of initial distress and disability and of outcome, but also heuristically, in discussion and psychoeducation with the patient. In research, an instrument derived from CAT to measure psychotherapeutic competence, the Competence in Cognitive Analytic Therapy (CCAT; Bennett & Parry, 2004), may be used to evaluate treatment integrity and fidelity. The CCAT has demonstrated and confirmed the importance of adherence to the model in achieving positive outcomes. It has been also used more generally in evaluating other treatment approaches.

Evidence base for CAT in borderline personality disorder

Cognitive analytic therapy conforms almost entirely to generic features of effective therapies for borderline personality disorder (Roth & Fonagy, 2004; National Collaborating Centre for Mental Health, 2009). Therefore,

a key research question for the future is the extent to which CAT overlaps with other approaches and/or complements and extends them. Much of the formal evidence for the effectiveness of CAT has been naturalistic (Ryle & Golyukina, 2000; Ryle & Kerr, 2002) although a large randomised controlled trial demonstrating its efficacy has more recently been reported (Chanen *et al.*, 2008, 2009a,b). Two further comparative trials of CAT for borderline personality disorder have recently been completed and should be published in the near future (personal communications: S. Clarke, 2012; G. Parry, 2012).

Given the important role of a range of professionals, from psychiatrists to social workers, in patient care, a pilot project has been run offering intensive training in CAT skills to mental health social workers and community psychiatric nurses (Thompson *et al.*, 2008). This largely successful pilot demonstrates the feasibility of a whole-team approach to thinking about treatment.

Therapy in practice

The following fictionalised case vignette illustrates some of the points that we have discussed. It involves a whole-team approach to care, highlighting contextual and social factors, both formative and current, along with the challenges implicit to our ways of working.

Case vignette: Anna

Anna was a young woman in her mid-20s with a long history of difficulties of a borderline personality disorder type complicated by anorexia nervosa. She had had multiple hospital admissions for emergency treatment of anorexia and for incidents of serious self-harm (including overdoses and cutting). At one point, she had spent several months in a residential therapeutic community but was discharged home to local services after self-harming following the suicide of her best friend Susan (also a community resident) and interpersonal difficulties with a member of staff. A despairing local psychiatrist and the community mental health team referred her for assessment for psychotherapy. She lived alone in modest flat funded by her parents in a small town in a socioeconomically deprived area. She felt very isolated and rarely went out, partly because of social anxiety.

Anna's family background was characterised by an atmosphere of tension between her parents. Her father (an accountant and an aggressive man dependent on alcohol) was preoccupied with material wealth and 'succeeding' in life. Her mother tried to keep the peace and not offend or upset her husband. Anna's father had forced her to attend a distant school with a good academic reputation. She hated school and sometimes claimed sickness to avoid going. She 'couldn't' tell anyone about this. Her younger sister Mary was less pressured and somehow more 'thick-skinned', but has also had problems with anxiety.

At presentation, Anna stated that she saw no future for herself and no point in living and that only a small part of her wished to think about any further attempts at treatment. Part of her would rather join her dead friend Susan, whom she envied. She appeared very wary and rather hostile towards her therapist. She refused to contact the local eating disorder service, saying that the staff there did not listen to her or take her seriously and that she did not trust them. However, she agreed to see a community psychiatric nurse intermittently and attend a (different) psychiatrist for occasional review.

In the absence of a more specialist intensive treatment service locally she was offered, and agreed to, an initially time-limited (24 sessions with subsequent review) course of CAT. She remained worryingly underweight although she continued to feel overweight and to believe that this would be disgusting to everybody, including her therapist. There was serious concern about her cognitive ability (concentration and memory) to make use of therapy. During the initial months of CAT, she remained mostly very gloomy and hopeless about change or about any future. She attended regularly, apart from two periods when she was re-admitted to hospital following episodes of self-harm. One of these occurred while the therapist was away and the community psychiatric nurse was off ill with no replacement.

During the course of CAT, Anna was supported by regular contact with her mother, from whom she received some (mostly practical) support. She had worried about contact with her father, whom she rarely saw. She clearly had strong feelings about him, but was very reluctant to talk about him. She was, however, able to engage with the work of reformulation, which she described as illuminating and helpful. This appeared to firm up the therapeutic alliance considerably and to provide an agreed joint understanding that could be referred to. During this early period, the therapist received repeated calls from colleagues (e.g. Anna's psychiatrist) about 'dealing' with her and whether therapy was 'working'.

Together, Anna and her therapist explored formative reciprocal roles in Anna's life (Fig. 18.2) and created a self states diagram (Fig. 18.3). The following extracts are from the therapist's reformulation letter, written after the first eight sessions of CAT.

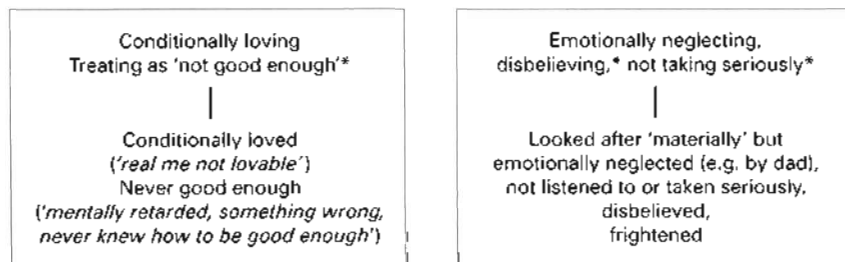


Fig. 18.2 Formative reciprocal roles for Anna; *internalised dialogical voices.



Fig. 18.3 Extended multiple self-states diagram for Anna showing different self states and maladaptive procedures; *internalised dialogical voices.

Dear Anna,

This is a letter attempting to summarise some of the key issues which seem to have emerged in the course of our initial work together and to try to think about how they are affecting your life at present as well as to think about what might historically lie behind them, as we have been doing. I hope that this will ultimately help you to move on to a more rewarding future. We have already attempted to sketch some of this in a diagrammatic form, which I think by your account seemed quite useful, although I think it seemed also quite disturbing and upsetting in some ways as well. This will only be my version of what we have been talking about and is very much open to your feedback or modification. [...]

In looking back over some of the things I have jotted down over the past few months I am very struck by the importance for you of not having other people's versions of events or their expectations imposed upon you, which does seem to have been your experience very frequently throughout your life, both in childhood and more recently. In fact, looking back at our very first meeting, one of the first things you said to me was that you felt that you had not really ever been listened to. In looking back over some of my notes, I am also struck by just how painfully difficult life must seem to you day to day and this was also reinforced by looking through your psychotherapy file again, where you highlighted some very extreme and difficult states. [...]

As well as the unbearable feelings, I have been very struck by how hard day-to-day life must be with little to do and few real social contacts, your difficulties with sleep and the terrible dreams which you sometimes describe, and just generally with the panicky feelings which seem to accompany you most of the time. We have talked about various ways you have coped with

these unbearable feelings over the years by doing controlled overdoses, laxative misuse and other forms of self-harm, such as cutting, although this seems to have become more difficult for you recently. It did seem very striking both from our chats and the diagram we did that the consequences of these ways of coping unfortunately on the whole still leave you, even if numbed out for a while, ultimately on your own, unappreciated and often pressurised and rejected by people again. All of which, of course, in a vicious cycle seems to reinforce your original experiences and keep them going. These cycles do seem to have acquired quite a life of their own. [...]

I would like to emphasise, however, how impressed I have been at you sticking with the work we have been able to do, even if it has been interrupted by your trips to the ward occasionally or our other difficulties in getting together (sometimes mine). If the small part of you which is holding on can continue to keep thinking together with me about these issues, reflecting on them and considering jointly ways of addressing and challenging them, then it is perfectly possible that you will be able to move on to a more fulfilling and meaningful life – although the path I am sure will not be easy or straightforward. [...]

With best wishes

In subsequent sessions, key issues (important reciprocal role procedures) were highlighted and articulated, along with therapeutic aims.

Key issues/target problem procedures (TPPs)

TPP1: Because of your experience of being frequently criticised, pressurised and only ever conditionally loved, you have finished up assuming that there is something wrong with you (e.g. missing some chromosome!) and have finished up frequently enacting these criticising roles towards yourself. This leads you to never feeling good about yourself and never trying to do good things for yourself – which reinforces your original experiences.

Aim: To try to watch out for that self-criticising and self-pressurising ‘voice’ and identify it as we have been doing and to try to consider whether you really accept its validity.

TPP2: Because of your experiences of never feeling properly listened to or respected, you finish up feeling abandoned and alone and often full of desperate feelings which you have coped with in various ways, including self-harm and dietary restriction – as well as sometimes, perhaps, behaviour towards other people that they may have experienced as apparently ‘difficult’. This all tends to lead you to be again rejected and misunderstood and leaves you still unappreciated and with your emotional needs unmet, so reinforcing your original experiences.

Aim: To try to bear in mind when you are feeling desperate how it is that these feelings have come about and the consequences of your traditional ways of coping and try to consider alternatives such as communicating calmly to trusted people (as we have begun perhaps to do in therapy) how you are feeling and what your needs are.

Progress

Anna continued to attend therapy, with apparently increasing commitment and less wariness and hostility. Continued collaborative use of diagrams in therapy appeared to assist in containing 'unbearable feelings' and to reflect on her habitual patterns of feeling, thinking and coping. She seemed more willing and able to discuss feelings in relation to her therapist. Towards the end of the initial contract, she finally agreed to discuss her feelings about her father and to address him using an empty chair approach. Through this, she expressed powerful, unresolved and angry feelings about the effects of his behaviour on her and her wish that he could be able to appreciate this. This appears to be an important moment which seems to considerably 'loosen up' her thoughts and feelings overall. Despite this progress, patterns (reciprocal role procedures) of restricted eating and misuse of laxatives and medications remained major problems, with little apparent change. However, the frequency of self-harm episodes reduced considerably. Anna complained of always being tired, finding concentration difficult and experiencing frequent palpitations. However, she stated that she was now keen to remain in therapy and a further 24-session course was agreed. She reluctantly agreed to consider seeing a member of the local eating disorder team to address nutritional concerns. She agreed that reduction of various psychotropic and other medications was also a long-term aim but was reluctant to countenance this at the time. With Anna's enthusiastic permission, her diagram was shared usefully with other team members, to enable understanding and communication. During one admission, she requested that a copy be sent for this purpose to the ward. However, Anna remained socially isolated and lonely and felt stigmatised by family and others. She recurrently talked of wishing to be 'out of it all' and appeared still at considerable risk of serious self-harm.

Background problems

In terms of case conceptualisation, Anna's problems appeared to be due to a mix of factors: temperamental vulnerability (a possible tendency to obsessional perfectionism and dissociation); dysfunctional, intense (nuclear) family dynamics (criticising, conditional love, not listening to or taking seriously); and cultural influences (a competitive school environment, cultural preoccupation with dieting and appearance). These were apparently exacerbated and perpetuated contextually by the 'doing to', authoritarian approach of many mental health services, which apparently colluded with her historic reciprocal roles. No collective meaningful attempt at social therapy or rehabilitation was possible in these circumstances.

Reflections on treatment outcome

Overall, the cognitive-analytic approach appears to have been successful in collaboratively and empathically engaging Anna in therapy and in generating insight and understandings of her difficulties and their origins.

In turn, this improved the integrity of her self, partly through the joint creation of the collaborative tools of reformulation. The improvement was reflected in significant reductions in her PSQ and CORE-OM scores. However, some issues remained problematic and refractory, including her long-standing patterns of dietary restriction, occasional (although greatly reduced) self-harm because of intense, unmanageable feelings, and difficult and disturbing memories and emotions surrounding her experiences of her father. These may require further active processing, perhaps using the empty chair method that has already been of help. Major contextual issues relating to the absence of social support and active rehabilitation and the absence for Anna of a sense of common social purpose, identity and meaning remain obstacles to further therapeutic improvement. However, these appear to be beyond the reach or remit of psychotherapy services within the National Health Service (whatever its working model) as presently constituted.

Future perspectives

There is good evidence that CAT is an effective, conceptually coherent and robust approach to the treatment of borderline personality disorder in individual and group therapy, as well as an effective common language to inform and improve collective team and/or systemic function. Further extended formal studies are required to determine its comparative effectiveness for a range of patients and types of problem – as is the case for all therapeutic models in the field. Large controlled studies must be complemented by much more comparative and ‘dismantling’ research, especially of a qualitative nature (e.g. the hermeneutic single-case efficacy design (HSCED) described by Elliott, 2001), that moves beyond the simplistic pre- and post-treatment group-mean type of controlled trial currently employed as the benchmark of clinical research – and recognised to be seriously limited in this respect (Elliott, 2001; Roth & Fonagy, 2004). Practitioners of CAT have been active in these areas with, for example: the randomised controlled trial reported by Chanen *et al* (2008) in Australia; an extended multiple case series being undertaken by Ryle and his team in the UK (Kellett *et al*, 2011); and a naturalistic study of a multicomponent CAT-based programme in Spain (Mirapeix *et al*, 2006). The partly CAT-based technique of dialogical sequence analysis (Leiman, 2004) is a further powerful tool for conceptualising and exploring research into the process of change in borderline personality disorder. It will also be important to evaluate effectiveness in terms of cost and resources (Bartak *et al*, 2007; Arnevik *et al*, 2009). It appears that many patients with less severe disorder can be treated on an individual, short-term basis (as in the case of Anna above). However, those with more severe disorder may require more intensive, longer-term multidisciplinary programmes, in line with the emerging consensus (National Collaborating Centre for Mental Health, 2009).

The sociocultural dimension of borderline personality disorder remains poorly conceptualised and studied, despite the demonstrable partial effectiveness of many relational approaches (Roth & Fonagy, 2004; National Collaborating Centre for Mental Health, 2009). We see this as an urgent challenge for the future. We are currently studying the possible importance of internalised social conditions and values from a CAT-informed perspective, through assessment of what we have described as a patient's sense of 'subjective communality' (Kerr, 2009) and through approaches involving the active participation of a broader community. This we see as complementing but extending the demonstrable significance of phenomena such as social capital (Whitley & Mackenzie, 2005). It is clear that socioeconomic and political interventions will ultimately be necessary to improve all aspects of mental health, but especially borderline personality disorder. This is implied and argued by authors such as Wilkinson & Pickett (2009), James (2007) and Marmot (Marmot & Wilkinson, 2006). Clearly, these initiatives are beyond the immediate scope or remit of mental health professionals, but we argue that our models need to reflect these realities and that, along with colleagues in sociology and medical epidemiology, we have a duty and responsibility to articulate and publicise them. A CAT-based perspective can offer a helpful framework within which to discuss and articulate these issues and on which to base effective treatments, be they one-to-one therapy or multidisciplinary team-based interventions.

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