To support patients through termination and the ensuing weeks, therapists write a goodbye letter recording the problems identified and worked on, the progress made, and the areas where further work is needed (for which the reformulation tools may still be useful) and noting or anticipating the patient's disappointments and angers as well as the acknowledgment of change. These letters, read and discussed at the last meeting, are intended to support the internalization of an accurate version of the therapy that neither denies the negative aspects nor avoids the pain of loss by effacing the memory of what was good. Patients are encouraged to write such letters too, as a further exercise in accurate self-evaluation. Not all do so, as the last sessions are an emotionally turbulent time and not writing may be a way of expressing disappointment, but some write moving letters that convey a real appreciation of both the extent and limits of what has been achieved. The weaning period of monthly follow-ups does not deprive patients of the experience of termination and allows its meaning—which often presents reminders of past losses and abandonments—to be considered in the light of the understandings reached during therapy.

Most patients will remain in the care of primary care or psychiatric services that may be able to offer noncollusive support, building on the understandings reached during therapy. Decisions to arrange further periods of active therapy are best postponed until the follow-up period is completed and should be made by someone less involved with the patient than the therapist.

SUB-CLINICAL BPD AND COMORBIDITY

There are many patients with Axis I diagnoses who do not meet the full diagnostic criteria for BPD but who do display the shifts between states and the deficient or discontinuous capacity for self-reflection described in the MSSM. Many of these patients have a dominant self-state manifest in surface compliance combined with emotional resistance and withdrawal accompanied by symptomatic disturbances. Such patients are frequently involved in unsatisfactory noncompliant relationships with medical or psychiatric services, tending to show a relatively poor response to treatment. Psychological intervention for this group needs to detect, describe, and work to revise and integrate their underlying fragmentation of self-states even where this is less severe than in BPD. Screening with the PSQ of patients who show a poor response to basic interventions or who are noncompliant with medical treatment for psychological or somatic disorders could contribute to better care for these numerous patients. As an example, the use of CAT with poorly controlled, insulin-dependent, diabetic patients is described by Ryle, Boa, & Fosbury.(1993) and Fosbury, Bosley, Sonksen, & Judd, (1997).

The term comorbidity implies the simultaneous existence of separate disease states and its extension to describe the very common presence, in cases of BPD, of features of Axis I conditions and of two or more other Axis II diagnoses, is unhelpful. Such a picture is the result of a more extensive range of effects from a common genetic and environmental source and is one indica-

tion of clinical severity but does not usually alter the basic approach to treatment.

NARCISSISTIC PERSONALITY DISORDER

Narcissistic personality disorder (NPD), although rarely encountered in pure form, is perhaps an exception in that, where marked features are present, there are different therapeutic problems and the diagrammatic reformulation has different features. The parents of some patients with NPD have admired and praised them rather than loved them and the resulting reciprocal role pattern is admired and special in relation to admiring. In other cases, the search for praise and recognition has involved sources outside the family and has substituted for the lack of affection within it, and the pattern is one of striving to shine in relation to conditionally admiring and admired others. In either case a grandiose self is formed, sustained by the praise and approval of important others. Real achievement may result, but the lack of loving human acknowledgement remains and the need for admiration may escalate, demanding greater and greater efforts to extract praise, with the need still outstripping the supply. This gap may be filled by fantasies of potential achievement and worth but at some point a state switch may occur to the exposed self, in which the reciprocal role pattern is dismissive and contemptuous in relation to contemptible and weak. In this self-state the preferred role is the dismissive one and others, including those who had offered but have now failed to supply appropriate praise, will be treated with contempt. Applying this reciprocal role pattern to the self is the least desirable place to be; any experience of emotional neediness is dismissed as humiliating weakness.

The absence of warm emotions and the readiness to dismiss others found in NPD patients make them emotionally cold in a way that distinguishes them from BPD. Because of this coldness, they reliably provoke (collusive) dismissive responses from others. If they accept referral for treatment they commonly make an early attempt to recruit special care, expressed through exaggerated gratitude and praise ("I feel so fortunate to have found you . . .") and the denigration of others who have failed them in the past. This is reliably followed by dismissive contempt that all too easily generates a similar (collusive) reaction. Even the diagnostic criteria for NPD are influenced by this countertransference, commonly consisting of a list of clearly undesirable traits and omitting any mention of underlying emotional vulnerability and need. The sequential diagrams in NPD, compared with those in BPD, tend to describe only the two main self-states (the grandiose and the exposed), as described above. An example is given in Figure 3.

The therapeutic challenge, as in the treatment of BPD, is for therapists to stay off the map and avoid collusive responses. With NPD the involvement of the patient in the creation of the diagram makes it less likely that therapy will be instantly dismissed. The crucial task is to make it possible for the patient to acknowledge and feel emotional neediness in a way that is not humiliating. In achieving this the therapist will have to resist flattery and endure some rough treatment without retaliating. Those patients who are helped to reach their vulnerability and sadness can make real changes.

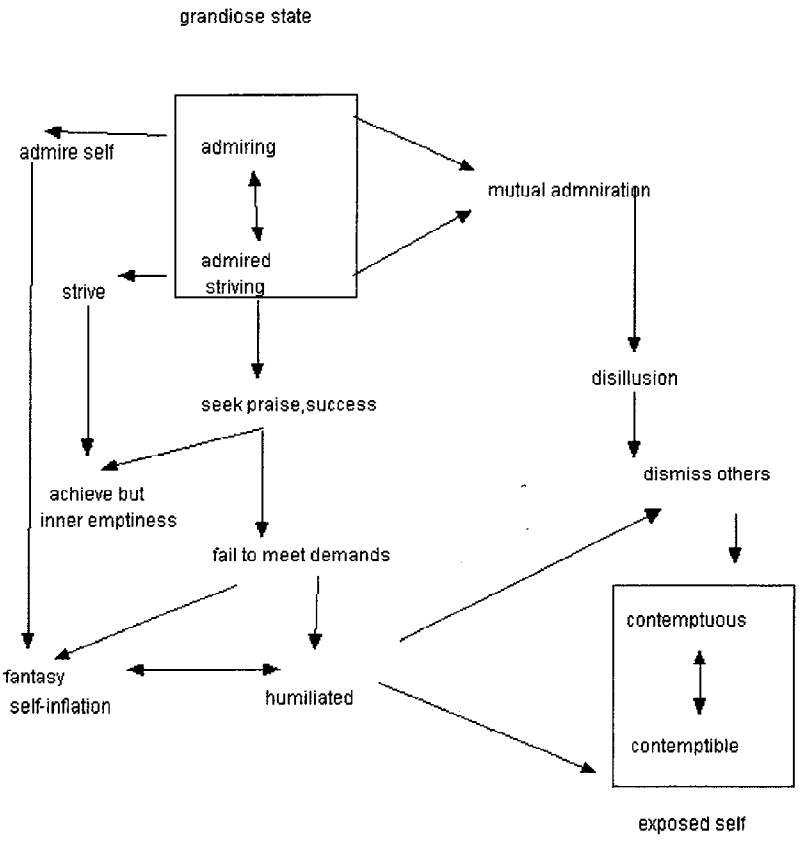

FIGURE 3. Self-State Sequential Diagram: Narcissistic Personality Disorder.

CAT AND THE CLINICAL MANAGEMENT OF BPD IN INSTITUTIONAL SETTINGS

Only a minority of patients with BPD receive psychotherapy, in part because of the shortage of specialist resources, in part because of widespread therapeutic nihilism, and in part because of the difficulty of retaining them in therapy. The majority, however, will have some contact with psychiatric, forensic, or medical services or with social workers. In many settings the recognition of the nature of the problem is less than adequate and treatment often consists of short-term reactions to specific symptoms or behaviors, such as self-harm, substance abuse, depression, or somatization disorders, without any attempt being made to address the whole spectrum of difficulties. In the UK, a recognition that personality disorder is "no longer a diagnosis of exclusion" was finally announced only in 2003 (National Institutes for Mental Health–England, 2003). At present, however, specialist services are uncommon and patients with more disturbed behaviors are commonly regarded as untreatable or uncooperative.

Nonetheless, many BPD patients receive support in psychiatric outpatients, day hospitals, and therapeutic communities. Some of these offer a wide range of inputs, including the prolonged interaction with other patients that is of particular value to socially isolated people, but it is also the case that, in these settings, BPD patients are liable to provoke rejection and to elicit inappropriate forms of care. The various professionals offering help (e.g., psychiatrists, clinical psychologists, occupational therapists, art therapists, drama therapists, and mental health nurses) may find their contributions undermined because the underlying fragmentation of the patients' personality is insufficiently addressed and is paralleled in the poor integration between different professional groups. Many institutions lack a coherent and unified treatment model that can be shared between the professionals and expressed in terms which make sense to both staff and patients. The way in that Vygotskian understandings might make a contribution here is considered in Kerr (2000).

In CAT-oriented services the treatment plan and detailed therapeutic activities of each patient are based on an individual CAT reformulation, most effectively in diagrammatic form. In addition to providing a basis for individual or group therapy, the diagram can become (a) the basis of a shared language between staff and patient; (b) a common understanding shared by different professionals; (c) a means of minimizing staff collusion with the patients' dysfunctional procedures; and (d) a guide to appropriate interventions. There is some preliminary evidence for the effectiveness of this approach. Dunn and Parry (1997) described its application to BPD in a community mental health center offering inpatient care and consultation to community mental health services. Benefits to staff morale and improved patient management are widely reported and services organized around CAT formulations of patients' problems are now being established and assessed in a number of centers. Work with both generic community workers and specialist services for personality disorders has been initiated and is being researched in Sheffield, England (Dr. I.B. Kerr), a CAT-oriented specialist personality disorder service has been established in Spain (Dr. C. Mirapeix), and a randomized trial assessing the effectiveness of adding CAT to existing services for seriously disturbed adolescents is nearing completion in Melbourne (Dr.A.Chanen).

Training mental health workers to adopt CAT-based methods involves a relatively modest cost. A structured training appropriate to the needs of generic mental health professionals, involving skills and academic training 1 day each week and 9 months of supervised work, was evaluated by the funding body and found to have had a very positive impact on staff knowledge and skills, team work, and client cooperation and satisfaction (Cumbria and Lancashire NHS Workforce Development Confederation,2002).

CONTEXTUAL REFORMULATION

Clinical staff have to face problems around issues of control and support within their work settings. Within particular services, relations between different professions and between clinical workers and administrators can be problematic, and mental health services as a whole are liable to be criticized

and at times abused by the wider society, often being exposed to distorted, sensational media reports. The pressures and demands that are inseparable from work with borderline patients, reflecting abusing and neglecting to abused and neglected reciprocal roles, can be echoed and amplified by these parallel processes in the wider context and it can be helpful to make these explicit in the form of a contextual diagram as described in Kerr (1999) and Ryle and Kerr (2002).

NONCOMPLIANCE WITH TREATMENT

Apart from the more disturbed BPD patients who may reach specialist psychiatric treatment centers there are many patients attending existing medical and psychiatric hospital and primary care facilities who respond poorly to medical and cognitive-behavioral treatments because of dysfunctional reciprocal role procedures affecting self-management and relationships with staff. These patients are commonly regarded as difficult in a way that disregards the fact that many dysfunctional procedures are maintained or reinforced by treatment and management practices. In these contexts, the CAT model offers a clearer understanding and guide to management than do cognitive and behavioral approaches. It offers dynamic insights in the form of accessible concepts and tools and it can extend the scope of liason psychiatry beyond the diagnosis or exclusion of major mental illness.

THE CONTRIBUTION OF RESEARCH TO THE DEVELOPMENT AND EVALUATION OF CAT

CAT, in its less than 20-year history, has yet to be evaluated by the large scale, formal randomized controlled trials that today are considered the gold standard by which a therapy model should be judged. However, there has been a constant output of other, largely small scale research studies, linked to clinical and conceptual activity in a way that has been fruitful. Some randomized controlled trials are now under way.

A larger research program was not possible for a number of reasons. First, rapid growth in the numbers of applicants for training meant that those who qualified were quickly involved in training and supervision. Second, training was established in a number of sites, none of which had a secure academic base. Third, the establishment of an organizational structure (the Association of Cognitive Analytic Therapists) and of instituting recognized validation procedures absorbed much (initially unpaid) time and energy from the clinical workers who constituted the founding members. This situation has only changed in the last few years as a critical mass of trained profesionals has become available, among them an increasing proportion with clinical psychology training and research experience. Fourth, as the professional and political pressures to perform large scale studies has grown over the past decade or two, funds for research have become increasingly scarce.

Earlier involvement in large scale, randomized controlled trials , even had it been possible, might well have been stultifying. Leaving aside the ethical dificulties and uncertain clinical significance of randomised controlled trials (Eliott, 2002; Parry, 2000) it would have required halting development so

as to define a standard input involving either manualization, which would undermine the technical flexibility of the model, or the creation and validation of instruments for analyzing therapy sessions, a process that has only recently been accomplished (see below). It would also have involved confining the research to defined patient groups—and the research literature suggests that groups selected to test efficacy tend to show little resemblance to actual clinical populations—and might have delayed the extension of CAT to different clinical groups and different service contexts.

The more piecemeal approach followed has generated different forms of data of variable quality and requires judicious appraisal but the work involved played an integral part in the extension and development of the model. Support for this aspect of research can be derived from the great 19th century physiologist Claude Bernard, who wrote: ". . . . we usually give the name of discovery to recognition of a new fact: but I think that the idea connected with the discovered fact is what really constitutes the discovery" (Bernard, 1957). The ideas of CAT actually benifitted from research even before any facts were discovered because collaborative reformulation, intended to contribute to the gathering of facts, had such an evident impact on the therapeutic process that it was adopted as a therapeutic practice without, it must be said, any formal validation. Confidence in the model was increased by the demonstrations of change in ratings of dysfunctional procedures and in selected grid measures in two small studies that showed the specific changes aimed for were being achieved (Ryle,1979b, 1980). Building on these, a small, randomized controlled trial compared the emerging CAT methods with Mann's brief dynamic model (Brockman, Poynton, & Ryle, & Watson, 1987). Both nomothetic and ideographic measures were used, the latter showing significantly greater change in the CAT group.

The design and scale of these early studies are such that they cannot be said to offer firm evidence of the effectiveness of CAT. However, they did play a part in the clarification of its methods and they supported the subjective impressions of practitioners. Such influences lack rigor but are, of course, the common reality during the development of new models.

STUDIES OF CAT WITH MORE DISTURBED PATIENTS

The application of CAT to more disturbed patients was described in a number of case histories and naturalistic studies. Those reporting measured outcomes, in which some or all of the patients were cases of BPD, include an evaluation of CAT group therapy (Duignan & Mitzman, 1994; Mitzman & Duignan, 1993), a study of a large outpatient sample in Greece (Garyfallos et al., 1998), and studies of adult survivors of child sexual abuse (Pollock, 1996, 2001; Clarke & Llewelyn, 1994). A series of cases meeting formal criteria for BPD patients who received up to 24 sessions of CAT, in most cases from trainees, was reported by Ryle and Golynkina (2000). Of 37 patients recruited, three were referred out for treatment of substance abuse, one was admitted for inpatient treatment and two moved away before treatment was completed. Of the remaining 31 patients, four dropped out and 27 completed therapy. Half the sample was receiving and continued to take medication. On the basis of clinical and psychometric measures 6 months

post-therapy, half the sample (classified as improved) no longer met diagnostic criteria for BPD. Two-thirds of the patients were successfully followed up 18 months after therapy; it was found that further positive changes in mean psychometric scores had occurred in both improved and unimproved groups. The pretherapy characteristics of the improved and unimproved groups were compared; the unimproved group had a poorer occupational history, higher rates of self-cutting and alcohol abuse, and higher ratings of the severity of their DSM IV borderline traits but psychometric test scores, demographic features, impulsivity, current medication, and a history of violence or substance abuse other than alcohol were similar in the two groups.

INVESTIGATING THE PHENOMENOLOGY OF BPD

The development of the MSSM of BPD was supported by a repertory grid study in which 20 patients with BPD who had completed the reformulation process in therapy were given a repertory grid in which their identified states were the elements (Golynkina & Ryle, 1999). This showed that there were a relatively small number of typical partially dissociated states, as listed above. This work confirmed the ability of BPD patients, at least while in some states, to give an account of and to learn to recognize their personal range of states. An individual case example of the use of the states grid is given in Ryle and Kerr (2002). This showed how, for this patient, to be cared for by others required her to be hopeless, incompetent, and symptomatic. In other states she was either hurting and blaming of others or confident, energetic, and controlling of, and envied by others. There was no state in which she could give and receive care and be an energetic and effective person.

STUDIES OF PROCESS

In establishing the effectiveness of a psychotherapy model, the demonstration of how specific inputs contribute to the particular changes predicted by the theory may be of greater importance than are studies based on comparisons of scores on general pre- and post-therapy measures. The specific aspect of CAT that is considered to contribute most to therapeutic change is the constuction and use of the reformulation tools, notably sequential diagrams. Bennett and Parry (1998) compared the diagram created collaboratively by a therapist and a borderline patient with analyses of transcripts of the early sessions, using two well-established research instruments. The diagram was shown to identify all the main themes indicated by the two analyses. Bennett subsequently replicated this finding on three further cases. The conduct of postreformulation sessions, involving the use of the diagram, was further investigated by Bennett, who developed an "ideal model" of practice based on a task analysis of good outcome cases. This work focused on how threats to the therapeutic alliance (representing manifestations of dysfunctional role procedures in the therapy relationship) were resolved (Bennett, 1998). From this she generated "an empirically refined model of reciprocal role procedure enactment resolution" summarized in Ryle and Kerr (2002). A preliminary method of rating therapist interventions

for use in supervision was described in Ryle (1997a) from which Bennett developed the Therapist Intervention Coding (TIC), which could be used in supervision or in a quantified form by observors analyzing transcripts of therapy sessions for research purposes. Comparisons of TIC ratings in good and poor outcome cases showed significantly higher rates of recognition of, and appropriate response to, problem procedures in good outcome cases. Experienced therapists scored better than inexperienced ones and trainees' scores increased during the course of supervised work. This work is described in Bennett and Parry (2003). The same authors have developed a measure of competence in general and CAT-specific skills (Bennett & Parry, in press). Bennett's meticulous studies have generated an exceptionally well-established methodology for measuring key elements in the CAT treatment of BPD and have confirmed the importance of specific aspects of CAT practice.

RANDOMIZED CONTROLLED TRIALS

No randomized controlled trials of CAT for BPD of the scale that is now considered essential have been published. A randomized study in which CAT is added to existing responses is nearing completion (Chanen, 2003). Other studies of particular patient groups are planned or under way but it may be the case that interest in researching the treatment of BPD may shift to the more complicated but more relevant task of evaluating complex treatment facilities.

THE NEED FOR INSTITUTIONALLY BASED RESEARCH AND FOR A FOCUS ON COSTS

The naturalistic outcome study reported above and much clinical experience shows that 24 sessions of CAT therapy can free some less severely disturbed borderline patients from negative interpersonal cycles, leaving them able to cope with little or no further treatment or to be more able to make use of whatever forms of management and support are available. Many patients will need more elaborate and prolonged help. Long-term individual therapy has not been shown to be an effective mode and is too expensive for general use, so many of these patients will receive day hospital or therapeutic community care. Interpersonal difficulties and destructiveness are central characteristics of BPD patients and it is not surprising that their clinical management in such settings is problematic and that many interventions end with little benefit. Borderline patients are not helped by disciplinary regimes, tending to adopt a conformist, submissive, and often passive-aggressive role. They are not helped by unrealistic offers of care and they are not helped if management is inconsistent between staff members and through time. However, they will act in ways likely to provoke all these reactions. I have argued that the shared use of a CAT diagram as a basis for care planning and as a basis on which staff can learn to respond to rather than to react to patients' shifting role procedure offers the best chance of providing patients with a noncollusive, reparative experience. Research aiming to demonstrate such effects is bound to be complex. There is also a need to de-

termine the least expensive but adequate levels of care for different patients. Some need prolonged support, perhaps combined with intermittent therapy, and some require the intensive treatment and containment provided by therapeutic communities. But the cost of the latter is very high and the proportion of patients retained in treatment, even after careful selection, is low. For example, Bateman and Fonagy (2001) demonstrated good outcome in a randomised controlled trial in which severe cases of BPD received multiple inputs in a partial hospitalization program, but the dropout rate was 28% and the cost per treatment £14,000. The Cassel Hospital, treating less severe cases, had a drop out rate of 36% and a cost of £37,000 per treatment (Chiesa, Bateman, Wilberg, & Friis, 2002). Research into the effectiveness, scope and limits of less expensive interventions and into the criteria by which the pathways followed by patients who end up receiving intensive treatments are determined, must not be neglected.

CONCLUSION

This article should be viewed as a report of work in progress, rather than as a presentation of an established treatment for BPD. Although CAT started as a model of individual therapy, it has extended its scope to a wide diagnostic spectrum. From its initial integration of two theoretical traditions, the many contributions of which are recorded in earlier publications and will be apparent to the reader, CAT has gone on to attempt a more ambitious integration of ideas and methods from a wider field. It is a model that seeks to offer a nonreductive account of our patients. Given the extensive damage to the self in borderline patients, I believe that this wider focus is appropriate, but the balance achieved between rigorous proof and clinical experience and relevance is not likely to please everyone. However, it does please many people. In the 20 years since I first put CAT forward as a formal model, nearly 500 clinical workers in the UK have been or are being trained in it. Trainings on an equivalent scale are established in Greece and Finland and on a small scale in several other countries. Although this may not be acceptable as evidence for the effectiveness of CAT, it does suggest that the model is here to stay.

APPENDIX A. PERSONALITY STRUCTURE QUESTIONNAIRE (PSQ)*

The aim of this questionnaire is to obtain an account of certain aspects of your personality. People vary greatly in all sorts of ways; the aim of this form is to find out how far you feel yourself to be constant and "all of a piece" or variable and made up of a number of distinct "sub-personalities" or liable to experience yourself as shifting between two or more quite distinct and sharply differentiated states of mind.

Most of us experience ourselves as somewhere between these contrasted ways. A state of mind is recognized by a typical mood, a particular sense of oneself and of others, and by how far one is in touch with, and in control of, feelings. Such states are definite, recognizable ways of being; one is either clearly in a given state or one is not. They often affect one quite suddenly; they may be of brief duration or last for days. Sometimes, but not always, changes of state happen because of a change in circumstances or an event of some kind.

Please indicate which description applies to you most closely by shading the appropriate number. Please complete ALL questions. Shade *only one number* per question.

THANK YOU FOR YOUR HELP. ALL INFORMATION WILL BE TREATED AS PRIVATE AND CONFIDENTIAL.

	Very True	True	±	True	Very True	
1. My sense of myself is always the same.	(1)	(2)	(3)	(4)	(5)	How I act or feel is constantly changing.
2. The various people in my life see me in much the same way.	(1)	(2)	(3)	(4)	(5)	The various people in my life have different views of me as if I were not the same person.
3. I have a stable and unchanging sense of myself.	(1)	(2)	(3)	(4)	(5)	I am so different at times that I wonder who I really am.
4. I have no sense of opposed sides to my nature.	(1)	(2)	(3)	(4)	(5)	I feel I am split between two (or more) ways of being, sharply differentiated from each other.
5. My mood and sense of self seldom change suddenly.	(1)	(2)	(3)	(4)	(5)	My mood can change abruptly in ways which make me feel unreal or out of control.
6. My mood changes are always understandable.	(1)	(2)	(3)	(4)	(5)	I am often confused by my mood changes which seem either unprovoked or quite out of scale with what provoked them.
7. I never lose control.	(1)	(2)	(3)	(4)	(5)	I get into states in which I lose control and do harm to myself and/or others.
8. I never regret what I have said or done.	(1)	(2)	(3)	(4)	(5)	I get into states in which I do and say things which I later deeply regret.

*The PSQ in in the copyrighted public domain.

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