Chapter 10

THE TREATMENT OF PERSONALITY DISORDERS

SUMMARY

Current concepts of personality disorder are confused and frequently unhelpful. Any adequate model must offer a fully biopsychosocial and developmental account of these extreme disorders of self states and function. The CAT multiple self states model of borderline disorder describes increasing levels of damage to the self. Key features of BPD are: (1) a limited repertoire of extreme and 'harsh' RRP's, *(2) a tendency to* partial dissociation *into a characteristic limited number of different self states, (3)* impaired and disrupted capacity for self-reflection. *Narcissistic disorders are described as characterised by two main self states, one described as 'admiring in relation to admired', the other as 'contemptible in relation to contemptuous'. Therapy is difficult because these patients experience neediness as being humiliating and, when faced with their emotional vulnerability, frequently switch to the 'contemptuous' role. All personality-disordered patients are prone to drop out of therapy. It is suggested that some psychoanalytic techniques can inadvertently reinforce dysfunctional procedures, while CBT has no adequate model of how reciprocal role procedures and dissociation may be reinforced. In CAT, a key therapeutic task with such patients is to map out collaboratively, even in rudimentary form, key RRPs and self states as early as possible in order to create a working alliance and generate an overall understanding of the origins and effects of such state switches and subsequent role enactments. A central aim is to help therapists and others not to collude with the extreme RRPs enacted by such patients. These may occur with bewildering and demoralising rapidity and for apparently imperceptible reasons. Such collusions account for most of the difficulty associated with treating such patients and may easily worsen their condition. An ultimate aim of therapy is to enable*

patients to reflect on and ultimately revise their RRPs and their tendencies to dissociated self states. Reformulation with such patients may be assisted by use of the Personality Disorder Questionnaire (PSQ) and of specially-prepared repertory grids. The difficulties in working with patients with these disorders are illustrated by material from two challenging cases.

THE CONCEPT OF PERSONALITY DISORDER

The evolution of the confused, culture-dependent concept of personality disorder is usefully reviewed by Berrios (1993). Current diagnostic procedures such as the DSM IV identify patients as suffering from personality disorders when their personal difficulties are long-lasting, first evident during adolescence and are believed either to be persistent (as in obsessive-compulsive, schizotypal, paranoid and anxious personality disorders) or to show only slow change (as with antisocial, borderline, histrionic, narcissistic and dependent personality disorders). These diagnostic categorisations, modelled on the classification of diseases, depend on the recognition of syndromes—clusters of symptoms and behaviours which occur together—and represent a crude and superficial way of describing the complex variations of human experience and behaviour. Although such diagnostic procedures have served to clarify the epidemiology and course of personality disorders and have distinguished them from psychotic illnesses, they are of limited use in clinical practice in that different diagnoses frequently co-exist in the same individual and in that individuals classified in a given category show wide variations in severity.

None the less, the recognition of personality-disordered patients is of importance to psychotherapists, because they are people who are damaged and damaging and are usually more difficult to help. In psychotherapeutic practice, the most frequently encountered are those with borderline personality disorder (BPD), but cases of narcissistic, histrionic and antisocial disorders (included with BPD in the 'dramatic–erratic' Cluster B of the DSM IV) are also seen, most often in mixed forms. The maintaining of a working alliance is particularly difficult with these patients, owing to the instability and extremity of their shifting states. In forensic practice borderline and sociopathic patients predominate. People with schizotypal, paranoid and obsessive-compulsive personality disorders are less likely to seek therapy and are more difficult to engage. In this chapter only borderline and narcissistic personality disorders will be considered; they are the most commonly encountered and have therefore been more studied. Given the severity of these disorders as they present, at least in health service practice, it is important to bear in mind that they will usually be 'co-morbid' with other categories of disorder, and are therefore rarely seen in pure forms. In many ways it is more helpful to consider such patients as suffering from 'severe personality disorder' (Berelowitz and Tarnopolsky, 1993).

BORDERLINE PERSONALITY DISORDER (BPD)

Patients qualify for the diagnosis of BPD in DSM IV (American Psychiatric Association, 1994) by having at least five of the following nine traits: unstable, intense personal relationships, identity disturbance, affective lability, inappropriate intense anger, frantic efforts to avoid abandonment, impulsivity, suicidal or self-harming behaviour, chronic feelings of emptiness, and transient paranoid thinking or dissociative symptoms. These features are clearly not independent of each other and they may be present to varying degrees, despite which these criteria do serve to identify a seriously disturbed non-psychotic patient group. When systematically screened (e.g. by a structured interview such as SCID (Spitzer et al., 1987)) most borderline patients also meet the criteria of other personality disorders (the number of diagnoses reached providing a rough indication of severity) and virtually all have Axis I ('clinical disorder') diagnoses. Many patients who do not meet full diagnostic criteria (but who do have unstable relationships, identity disturbances and impulsivity) present similar problems to therapists and are best understood in terms of the BPD model.

The causes of BPD

There is uncertain evidence that the prevalence of BPD is rising (Millon, 1993) and that social factors such as poverty, family violence and instability and the lack of traditional structures may contribute to this. There is abundant evidence for an association of the diagnosis of BPD with extremes of childhood deprivation and abuse. Compared to other diagnostic groups BPD patients have experienced more severe deprivation and more severe forms of sexual and physical abuse. However, while the great majority of sufferers have had such early experiences, only a minority of children so exposed go on to develop BPD or other personality disorders. Other associated or predisposing factors include:

1. Gender. BPD is considerably more common in women. In contrast, sociopathic personality disorder (where similar childhood features are found) is much more common in men. These differences may reflect both biological and cultural influences.
2. Neurotransmitter dysfunctions associated with impulsivity and affective instability are found in BPD (Gurvits et al., 2000) but the assumption that these predispose to, rather than reflect, BPD seems uncertainly established.
3. Other biological factors. These may include responses to chronic stress marked by alternations between increased and diminished responsiveness to stress. There is animal evidence that brain structure as well as neuroendocrine function may be damaged by persistent stress (Silk, 2000) and that neural tracts are, to a degree, socially formed (Eisenberg, 1995).

4. Family members of BPD patients show high rates of personality disturbance but not necessarily BPD (Zanarini et al., 1988). Some genetic predisposition to BPD or similar personality features has recently been demonstrated, although the size of the genetic effect is still unclear (Torgersen, 2000). While psychotherapists will be primarily concerned with the effects of early experience on personality, understood in CAT as reflected in the procedural repertoire and its integration, it is important to recognise that biological factors, whether inherited or acquired, may set limits on what can be achieved psychotherapeutically. This supports the use of carefully managed psychopharmacology; while inadequate on its own, this may be of value when used in parallel with therapy. Different drugs may be effective in diminishing the severity of cognitive-perceptual, affective and impulsive symptoms (Soloff, 2000).

The CAT multiple self states model of BPD

The CAT model of BPD, developed over recent years (Ryle, 1997a, 1997b) builds on basic CAT theory with its emphasis on sequences and reciprocal procedures but adds a structural concept. The multiple self states model (MSSM) is based on the description of three forms of linked damage, as follows:

1. Harsh reciprocal role patterns. Early and extreme patterns, usually derived from relationships with caretakers, of *abusing, neglecting* in relation to *abused, needy* persist in various forms determining self-management and relationships with others. These patterns are at times replaced by symptomatic and avoidant procedures and may be associated with Axis I diagnoses, in particular depression, eating disorders and substance abuse. Not all abused children who develop such reciprocal role procedures (RRPs) become borderline; it seems probable that both the severity of the abuse and a genetic predisposition to dissociation determine the development of BPD. Thus, Zweig-Frank et al. (1994) compared women with BPD and non-BPD disorders and showed that adverse childhood events were equivalent whereas scores on a dissociation measure were significantly higher in the BPD group.
2. Partial dissociation. The coordination, linking and sequencing of reciprocal role procedures is normally carried out automatically by metaprocedures. In BPD these are underdeveloped or disrupted as a result of chaotic parenting and of trauma-induced partial dissociation. As a result, key RRPs are separated to constitute self states which alternate in determining experience and behaviour so that the sense of self and others is discontinuous and access to memory between states may be patchy. Dissociation while experiencing abuse during childhood is commonly reported; this is seen to facilitate subsequent dissociation if further neglect and victimisation were experienced,

perceived or remembered. Such dissociation is not necessarily accompanied by dissociative symptoms. Out of control rage leading to attacks on self or others may occur when such dissociation fails. This may be seen as a primitive reflex or 'defence' of the humiliated, shamed or 'wounded' self (see Kalsched, 1998).

3. Impaired and interrupted self-reflection. The capacity for self-reflection is underdeveloped in BPD due to early neglect and lack of interest from caretakers and what capacity exists is liable to disruption by state switches. Such switches are particularly liable to occur when abuse or neglect is experienced or perceived or when reciprocation to alternative procedures is sought but not elicited, that is to say at the precise moments when self-reflection would be particularly helpful in aiding revision. It has been suggested (Fonagy and Target, 1997) that self-reflective capacity (or 'reflective function') may also be an innate, variable protective factor in the face of such adversity, although we are unaware of any formal genetic evidence for this.

Recognising partial dissociation

When the presence of partially dissociated reciprocal role patterns (self states) is suspected from clinical interviewing or from replies to screening questionnaires the different states must be identified and described. States recur in recognisable form. Switches between them may be triggered by events or by thoughts and images which may or may not be identified by patients; some such switches may be understandable as partially adaptive responses to the context.

Patients will describe their states largely in terms of mood and acts; therapists need to explore the associated role procedures. Borderline patients typically describe a limited number of states; these nearly always include the experience of playing, at different times, both poles of an *abuser–victim* reciprocal role. Abrupt switches may represent (1) role reversal (e.g. the victim turning the tables), (2) response shifts (e.g. switching from *compliance* to *defiance* in response to *control*) or (3) self state switches (e.g. from *caring–cared for* to *bully–angry victim*). The range of states found in borderline patients is not infinite; in a repertory grid study of the partially dissociated states of a series of 20 BPD patients, Golynkina and Ryle (1999) found that 17 patients identified themselves as experiencing ideal states, 14 abuser rage states, 13 victim states, 11 coping states, 8 zombie states and 5 victim rage states. (These states were idiosyncratically named, the above classification being based on the loadings of the states on a range of supplied constructs.)

While the clinical features of partial dissociation are often obvious, some patients may present themselves in emotionally blunted, coping modes, some may be reluctant to describe their dissociative experiences for fear of being seen as mad and, in some, personality features may be overlooked because of the

presence of extreme Axis I disorders such as anorexia nervosa or major depression. In practice, the recognition of borderline states is helped by the routine use of screening questionnaires such as the eight-item Personality Structure Questionnaire (Pollock et al., 2001; Appendix 3) or the end section of the Psychotherapy File (Appendix 2). Discussing replies to these when scores are high and initiating patient self-monitoring of states and state switches will usually (but not always) confirm that clear distinctions between recurrent, recognisable, contrasting states are being reported. This can lead on to the process of characterising these states through further self-monitoring and work in the therapy sessions.

The reformulation and therapy of borderline patients

In everyday life the procedural repertoire of borderline individuals resists revision because the pressures on others to reciprocate (collude with) the various roles are intense and often successful, because others are confused by the patient's shifts and cannot respond in an integrating way and because self-reflection is impaired. The available procedures are all liable to generate further experiences of unmet need and unmanageable feelings. The therapist's task is to overcome these reinforcing patterns by working with the patient to create a narrative account which makes some sense of the patient's story and a diagram indicating the repetitive damaging patterns. These can help the patient learn to recognise and control these patterns and avoid the most damaging states and help the therapist to avoid or correct collusive reciprocations. The explicit aim must be to aid integration through the development of self-reflection ('the eye that becomes an I'), by always working with descriptions that include all aspects of the person.

The collaborative construction of diagrams during the reformulation phase is a powerful experience for patients. Preliminary partial diagrams may be roughly drawn from the first session, especially if therapy-disrupting procedures are suspected; the evolution of the diagrams as more evidence is collected is a positive collaborative map-making exercise which establishes a relationship which is 'off the map', that is to say which provides the patient with a new way of being in relation to another. The following guiding principles have evolved over the years:

1. Where clear evidence for discrete self states exists the dissociated RRPs should be located in separate boxes; a single defining RRP is usually adequate.
2. These boxes are heuristic summaries, not pictures of the inner world. Experiences and actions related to, or generated by, each role will be drawn outside the box as procedural loops which will trace the consequences of enactment. Particular relationships may be located on these loops which will also locate symptoms and unwanted behaviours.

3. As a start, the reported historical childhood pattern(s) will usually be recorded in diagrammatic cores. Other patterns evident in current relationships and in self-management will be added as they are recognised.
4. Either pole of the RRP may be enacted; the procedures generated from both poles, in self-management and in relationships, will be drawn in as they are identified.
5. The childhood-derived *abusive–depriving* to *victim–deprived* roles may be re-enacted and re-experienced in some direct form but they may also be replaced by symptomatic, defensive or avoidant procedures. These will be identified and located on the diagram by symptom monitoring and observation.
6. At some point any of the roles drawn out as procedural loops may lead to the experience of unmanageable feelings, often of rage, or of being overwhelmed by the perception of vulnerability and unmet need. This can be represented as a 'crossroads' or 'flashpoint' on the diagram. This may correspond to the point at which dissociation first occurred during abuse. In most cases this leads to a switch to self states (dissociated RRPs) in which the patient plays a coping, 'soldiering on', emotionally blank or in some cases a hyperactive role. In susceptible people such switches become increasingly easily mobilised by memories or reminders of past abuse and they are liable to be provoked by the experience of therapy. Uncontrolled victim rage may be seen as a partial failure of dissociation; when experienced it is often accompanied by dissociative symptoms such as depersonalisation or perceptual distortions.

In concluding the reformulation of patients with partially dissociated self states, it can be of value to get patients to complete a States Grid. In this the patient rates his or her identifed states against a range of constructs describing the mood, sense of self and other and the degree of access to and control of affects of each state and may also indicate which states are accompanied by physical symptoms and which are associated with impaired memory for other states. Patients can usually describe all their states when in their coping or compliant state, but in more severely dissociated patients the memory of some states may be very limited.

The following case report demonstrates how the use of the States Grid, may be of value.

CASE HISTORY: DEBORAH (Therapist Anna Troger)

Deborah had been treated with CAT four years previously. At that time she had been self-cutting several times each week. She had been involved in a series of relationships with physically abusive men. She returned for treatment on account of very marked mood (state) instability, but she was no

longer self-cutting and was holding down a responsible job. Her present partner was submissive and helpful and she was often impatient and bored with him.

Deborah completed the States Grid, the elements being five states which she labelled blank, hopeless, speedy, victim and angry. The grid was analysed in two parts, using 'Flexigrid' (Tschudi, 1990), one based on constructs concerning self-descriptions and the other based on descriptions of self-to-other and other-to-self relationships. Figures 10.1 and 10.2 map out the location of the elements in these two analyses, by plotting the states and the constructs (written in the margins for clarity) in terms of their loadings on the first two principal components derived from the analysis. Closeness on this map implies conceptual similarity and vice versa.

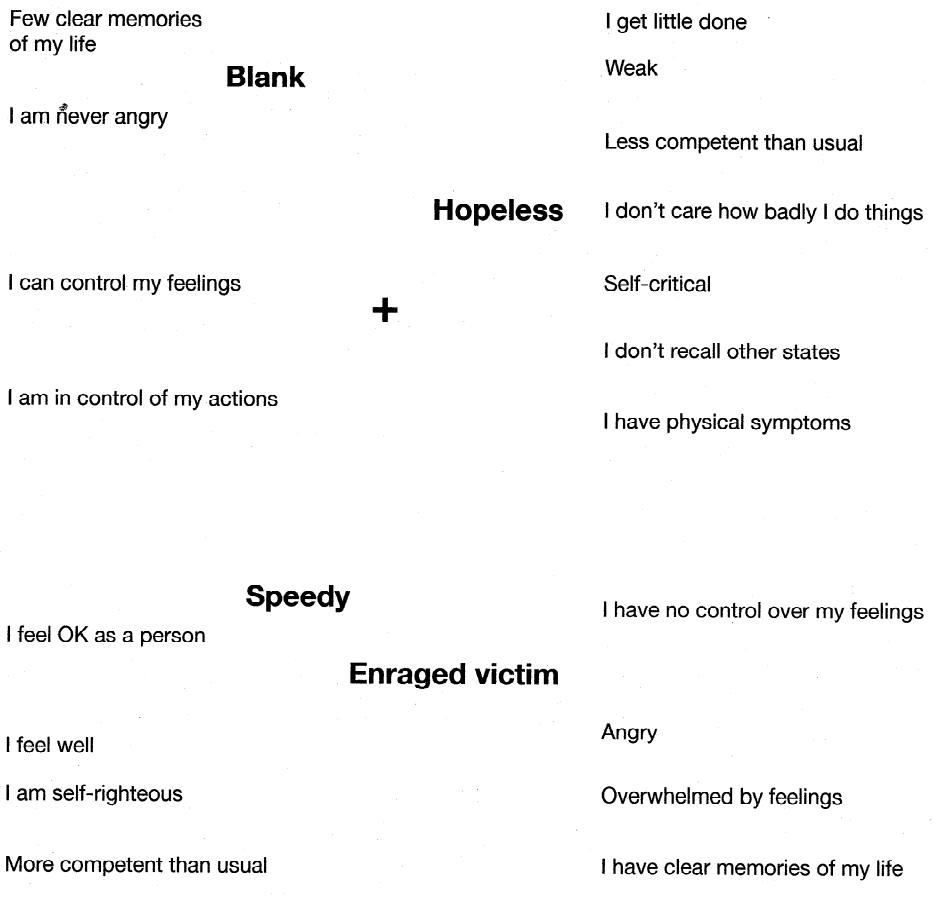

Figure 10.1 Deborah—grid of self descriptions

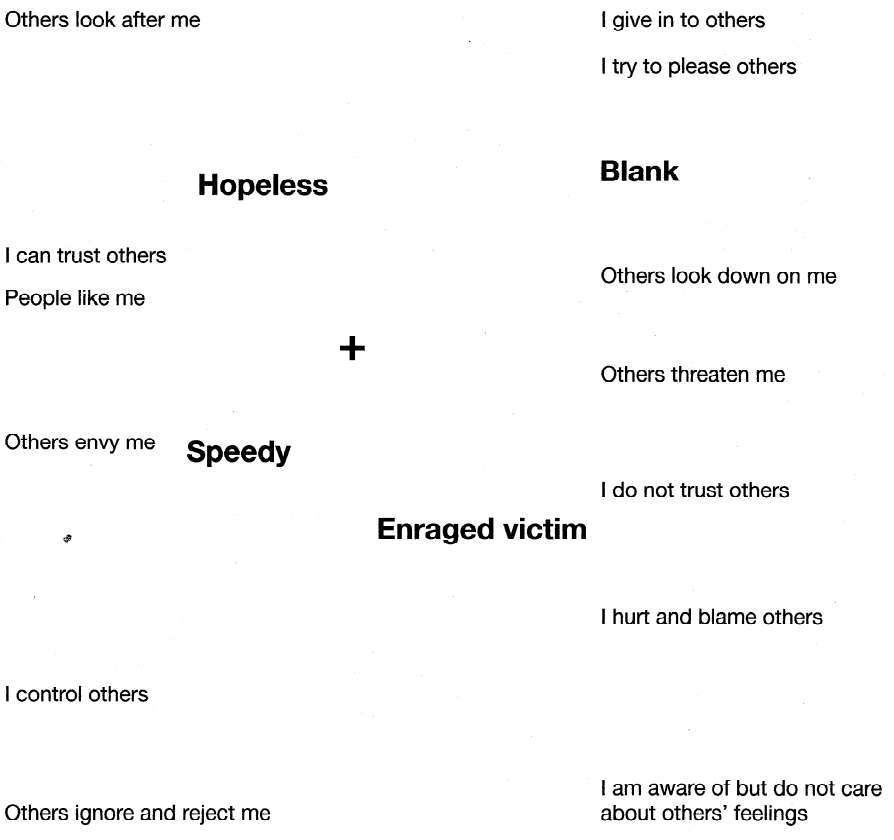

Figure 10.2 Deborah—grid of self–other relationships

Results

The self-descriptions grid

The abused and angry states are identically located; in the map they are re-described as 'enraged victim'. Deborah commented that any hint of feeling abused now leads to immediate anger. Located in the lower right quadrant, this combined state is described as angry, overwhelmed by feelings and with clear memories of the past. It is contrasted with the blank state in the upper left; this is associated with having few clear memories and with never being angry. On the upper right the hopeless state is described as sad, weak and indifferent to doing things badly, accompanied by physical symptoms and as lacking memory of other states. This state is contrasted with the speedy state in the lower left in which she is more competent than usual, self-righteous, feels well and okay as a person and is in control.

The grid of relationships

The angry and abused states are identical as on the first grid and are labelled enraged victim. In this state she sees herself as threatened and disliked and as indifferent to, and blaming and hurting of, others. In the contrasting hopeless state she can trust, depend on and be looked after by others. In the blank state she gives in to and tries to please others, whereas in the speedy state she controls others and feels they envy her.

The implications of this picture are as follows: to be cared for she has to be hopeless, incompetent, sad and have physical symptoms. Other patterns of relationships involve being either submissive, mutually destructive or very positive about herself but controlling of, and envied by, others.

It is evident that each state carries with it costly implications; therapy must seek to maintain a less fractured sense of self. With integration, the extreme, contrasting qualities of the different states may be mitigated so that both personal strength and mutuality with others may become possible.

The course of therapy

The course of therapy with borderline patients is never smooth. Reformulation and the active shared use of the diagram offer a basis for maintaining or repairing the therapy relationship and for the establishment of an observing eye. But the safety established through the creation and use of reformulation tools is often followed by increasing access to painful memories and by enactments of negative or avoidant procedures in relation to the therapist. Surviving and containing these is personally demanding, as the case reports earlier and at the end of this chapter demonstrate, but it is greatly helped by the reformulation. Patients should never be pressed to enter or extend these severely disturbing feeling states and should be given explicit control of the pace of therapy. Termination involving a weaning pattern of follow-up sessions at increasing intervals is usually helpful and will often involve planning some form of further support.

NARCISSISTIC PERSONALITY DISORDER (NPD)

Narcissistic features are commonly found in association with borderline structures, as in the case of Deborah, and the same methods of mapping self states are applicable. 'Purer' examples of NPD show a predominant preoccupation with issues of surface, appearance, success and status; their search is not for care and love so much as for admiration. The preferred reciprocal role relationship for a person with NPD is to feel admired by an admirable other. Where this is unachievable, the concern is with the relative status of self and other and

hence with occupying the more powerful contemptuous role in the reciprocal role pattern of *contemptuous* in relation to *contemptible*. Because emotional neediness is closely identified with the contemptible role, therapy, as an admission of need, is hard to seek or persist with. Extreme sensitivity to criticism and envy are common features. Therapists treating NPD patients may be briefly idealised but will soon have to survive indirect or blatant dismissiveness from the patient who is intolerant of perceived criticism of any sort. The key task is to make it tolerable for the patient to be sad and vulnerable. These main features of NPD are summarised in the 'split egg' diagram (Figure 10.3). Narcissistic patients will identify themselves in terms of the admired state as far as possible, often achieving highly, especially in areas where performance is visible and rewarded. Failing to achieve adequate recognition leaves them in the other self state, in which they will seek to preserve a good opinion of themselves by looking down on others. In mapping such states it is best to illustrate the different roles using the patient's own descriptions as far as possible, but descriptions should always be as general as possible. Because the descriptions offered by the sequential diagram are unflattering it is particularly important to work collaboratively and non-judgementally with narcissistic patients and to

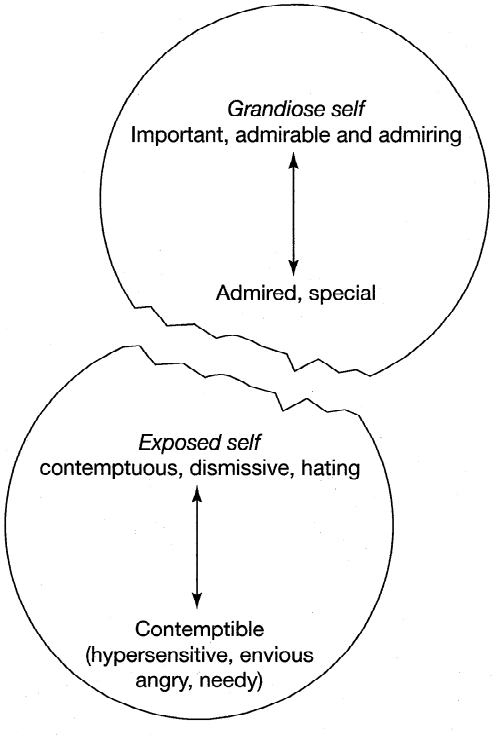

Figure 10.3 Narcissistic personality disorder: the two common self states

acknowledge both their real achievements and their real but feared vulnerability. And because therapists can easily fall from grace and be transformed from admirable helpers to contemptible fools deserving revenge, it is wise to get the patient's signed acknowledgement that they accept the final letter and diagram.

The sources of NPD are often traced to an early childhood in which the requirement was to be pretty or clever and to perform in order to be a good advertisement for the parent, while being deprived of real, consistent care or concern. In other cases, emotional deprivation in the family may be more overt but the child discovers an alternative source of acknowledgement and praise by shining at school, in sport or in some other sphere. The preoccupation with surfaces and with being admired can lead to real achievement, particularly in careers where merit is clearly recognised or performance is the point, and in such cases consultation usually follows some setback or a shortfall in the supply of praise. In less talented narcissists there may be an earlier consultation because loneliness and emotional coldness leave a sense of inner emptiness. Whereas BPD patients evoke a range of powerful and mixed feelings in their therapists those with NPD are more prone to generate irritation, coldness and rejection, responses which reflect their mobilising the contemptuous and critical roles in themselves and in their clinicians.

The textbook descriptions of NPD are also liable to reflect this reinforcing countertransference, emphasising the negative characteristics of envy and coldness and ignoring the underlying neediness which, even when it is well concealed, must be recognised by therapists.

Patients weaning themselves from the need for admiration and acknowledging their neediness must be supported (and can be genuinely admired) through a period of vulnerability and deep sadness; the first tears of a patient with NPD are signals of hope. If sadness is not reached, little changes and the end result may be renewed efforts to extract admiration from the world or the turning of the tables by dismissing the useless therapist.

Owing to the extreme vulnerability of these patients, giving up protective role enactments can be experienced as highly threatening, especially if a therapist is experienced as being more knowledgeable than they are. This can provoke enactment of dismissive or contemptuous roles and in extreme cases can lead to a patient dropping out of therapy, even when conducted as carefully as described above. Rarely, but seriously, such roles may be enacted as litigation towards a therapist who is perceived to have failed or damaged them.

CASE HISTORY: OLIVIA (Therapist Anna Troger)

Olivia, a 28-year-old secretary, was referred for CAT following an admission after an overdose. She met diagnostic criteria for both borderline and narcissistic personality disorders. While superficially lively and attractive she described a feeling of there being a void inside her. In the first half of therapy she was

frequently dismissive of the therapist and declared that none of the items in the Psychotherapy File applied to her. In her work and social life she described a desperate wish to please and a related pattern of passive resistance and sabotage. In the early sessions she completed none of the agreed homework tasks, for fear they would be wrong. Her diagram is reproduced in Figure 10.4.

By mid-therapy Olivia could accept the part of her diagram spelling out the *critical dismissive demand* in relation to *irrational guilt and striving* pattern and she became less desperately competitive. She could also acknowledge that the *preoccupied with surface appearances and unprotective* in relation to *empty* self state was typical of her family. It was only in the last three sessions, when the therapist could say clearly how she had felt dismissed and could recognise that she had found it hard to acknowledge the reality of the void, that Olivia could acknowledge a dilemma generated by these two cores, summarised as *either* envy those 'above' *or* dismiss those 'below'. At follow-up, when she reported considerable improvement, she spoke of how difficult and painful it had been to acknowledge the accuracy of this description, in particular of her own dismissiveness. It was only in the last few sessions that she realised that it was true and had been true of her relationship with her therapist; she saw this as the turning point in her therapy.

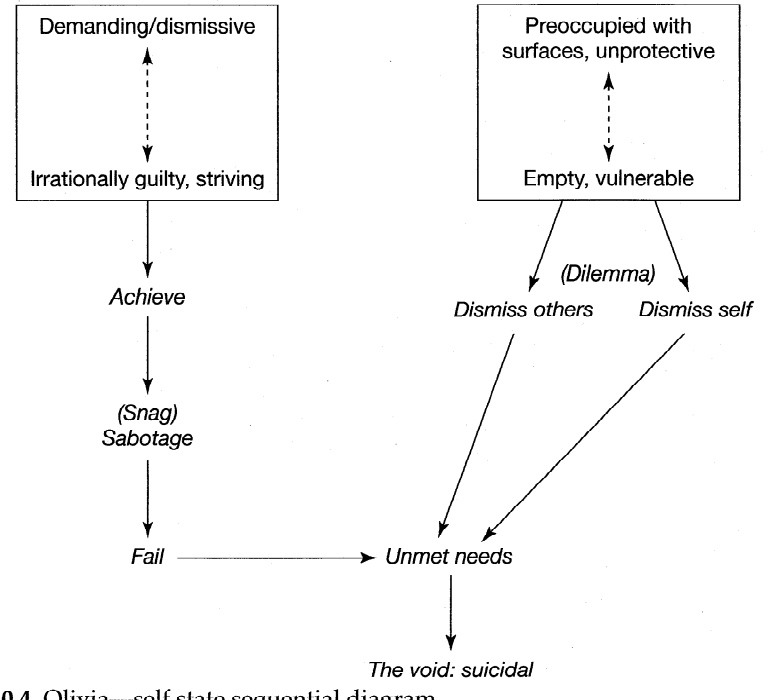

Figure 10.4 Olivia—self state sequential diagram

A fuller account of a therapy will now be offered, demonstrating in more detail how, while diagrammatic reformulation enables therapists to stay in relation to patients showing extreme states and marked state shifts, the process can be extremely demanding of both technical skills and human sensitivity and resilience. Our attention was drawn to this account by the therapist's supervisor. We are very grateful to the therapist Kate Freshwater (a clinical psychologist) for her permission to publish this moving and in many ways intimate account of her work, and to the patient 'Sam' (whose story has been altered in detail), both for the courage and intelligence he displayed in the work of therapy and for his being willing for his story to be told, in order, he said 'to contribute to the education of health care workers regarding the impact of abuse'.

CASE HISTORY: SAM (Therapist Kate Freshwater)

Sam was a 45-year-old man with a mixed Axis II Cluster B diagnosis, who had been in the mental health system since his early twenties and had also spent time in prison for grievous bodily harm. He was attending a day centre full-time and had been supported by a psychiatric nurse for many years; two years previously he had revealed a history of severe sexual abuse to the nurse. He was receiving both antidepressant and anti-psychotic medication. His early childhood had been marked by severe psychological and physical abuse from his stepfather, who had also beaten up his siblings and his mother. He began stealing when aged 11 and subsequently spent four years in an approved school where he was regularly beaten and buggered by older boys until he began to fight back. His mother died in his early twenties, a death he linked to his stepfather's repeated violence and neglect. He had worked intermittently during his twenties at unskilled jobs and was married with a son and a daughter but it was 12 years since he had been in employment.

During his assessment sessions Sam spoke calmly and, to quote the therapist 'frequently made remarks about women which he believed to be charming but left me feeling uncomfortable'. Early sessions ran over time and the therapist felt passive and powerless, struggling to retain control over the process; she felt further muddled by Sam's presentation of himself as having four separate personalities. These were characterised as follows:

1. 71; this was Sam's number in the approved school; he described 71 as gentle, scared, loving, numb and severely depressed.
2. Heartless Sam; described as having emerged when in the approved school and as being fearless and indifferent to pain; he would quickly divide up the world into the abused and the abusers. He would get involved in, but might have little recall of, violent episodes. He was rejected by the other personalities as being too much like his abusive stepfather.

3. Benjamin Sam was a sad, beaten up, spaced out child.
4. Friend of Benjamin. He was described as protective of Benjamin Sam; he was rebellious and had offended as a boy in order to be sent away from home. He would try to calm down Heartless Sam.

The first diagram consisted of four circles standing for these four 'personalities', listing their main attributes. Two intermediate diagrams traced the sequences between and procedures generated by these as they were identified. The final diagram (Figure 10.5) was constructed around two cores, one derived from his painful relationship with his victimised mother, the other based on his many experiences of being abused at home and at school.

Sam sought help for his inability to control his violence and for being emotionally numb and scared of closeness and he wanted his four selves to be on better terms with each other. When offered therapy he said that 'three of us are terrified', having experienced the 'mind games' of psychiatrists. He saw the therapist as a 'sculptress' setting out to work on him as a lump of clay, adding that they would need the water of emotion to achieve change. This metaphor, from the client, gave an opportunity to negotiate the work together and develop the alliance. It could have left the therapist feeling controlling, seductive or

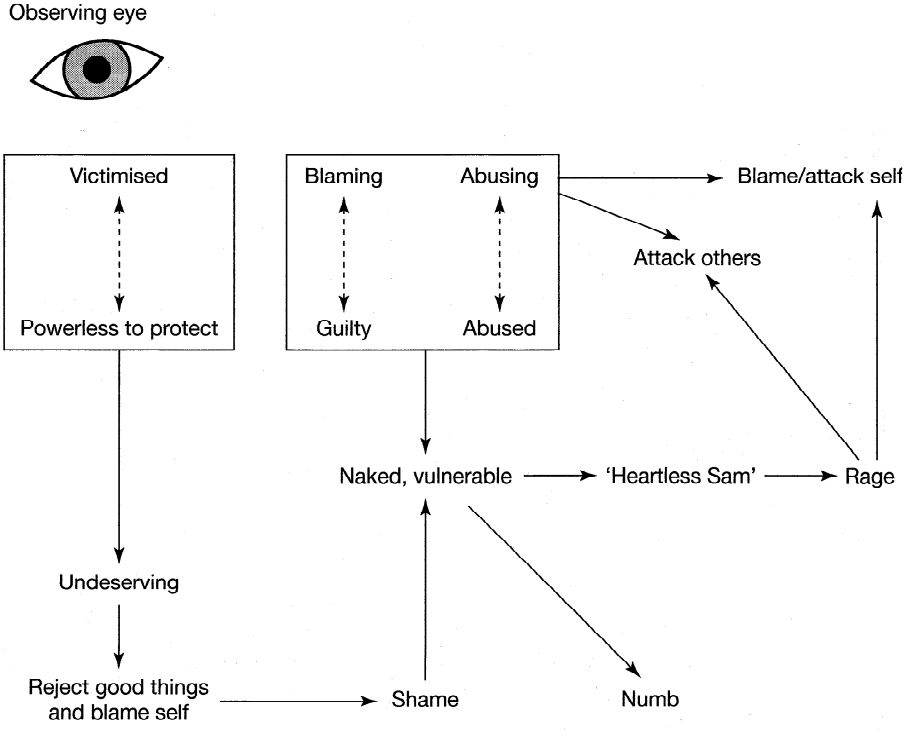

Figure 10.5 Sam—final self state sequential diagram

intimidating but was used to develop a more cooperative style of working as the client accepted the concept of working together to 'mould the clay'.

The therapist considered the possible diagnosis of dissociated identity disorder but the absence of amnesia for any one personality, his ability to switch at will between them and the fact that many features and questionnaire scores were constant across states argued against this. (The presence of both partial dissociation and multiplicity in more severe borderline patients is described by Pollock et al., 2001.) Having listed the main features of each state ('self') as a first step, successive diagrams were constructed over the first 11 sessions. Sam's identity as a case of 'multiple personality disorder' provided an important framework of meaning to him and the therapy involved gentle negotiation over the language used; such as always using 'self states' to describe Sam's different personalities. During this time Sam suffered a bereavement (the death of a loved niece) after which he was involved in picking a fight with seven men. He explained this as being angry at Heartless Sam for having no feelings about the death and as expressing this in anger with others but he could follow the therapist's suggestion that by starting a 'no-win' fight he was also punishing himself.

In the reformulation letter and the developing diagrams the therapist accepted Sam's account of the different selves as a basis for describing self states but continually emphasised that she saw them as aspects of a single person, stressing that the integration of the states would be an important aim of the therapy. Sam was predominantly controlling in the sessions, but after a second bereavement—the suicide of a half-brother—and an initial reaction of self-blame (saying the deaths were punishments for his talking about the abuse) he had an intense experience of grief. At this time he was able to place at the centre of his diagram the description 'nakedness' (a description relating to his abuse experiences) which continued to be important through the rest of the therapy, and from this time he began to stop and think more before reacting with violence. During the next few sessions he showed greater swings in his moods. The therapist described this phase as follows:

...he seemed to swing between feelings of grief and vulnerability, feelings of intense guilt and anger at the 'system' for abusing and failing him, and wanting to take control and protect me from his more traumatic experiences. He came to one session looking dishevelled, saying 'the deaths are catching up on me' and describing how he had been uncharacteristically quiet at the Day Centre. At other times he attacked 'the mental health system' (and myself) for wasting time in working with abusers; although he could now acknowledge his own physical abusiveness, he regarded sexual abusers as despicable animals whom he wished to destroy. He described how he had 'arranged' for a reported pervert to be beaten up. ... I initially felt powerless and outwitted, for this was hardly the safe way of venting his anger which we had been discussing, but I was helped by supervision to avoid my induced self-blame and sense of failure and to challenge Sam to think through the consequences of such vigilante behaviour. We completed

the final diagram at session 11 [see Figure 10.5], adding his sense of having been unable to protect his mother and how this had contributed to his self-blame and to his sense of not deserving anything good, and linking his dismissal of past careworkers with his search for perfect care and its inevitable disappointment. Following this we began to name 'exits'—alternative behaviours—and he recalled his childhood image of a bird which, while he was being abused, would fly away with the pain. This bird image became a fifth 'personality', able to show some compassion towards Heartless Sam. Picturing his granddaughter was suggested as a way to remind him of his own vulnerability and powerlessness as a child.

By this midpoint of therapy Sam was speaking more openly to his wife and his GP, to whom he had shown his reformulation letter, and he was more in touch with the day centre staff. The release at this time of the Department of Health's Consultation Paper 'Managing dangerous people with severe personality disorder', which he read, made him angry with 'the system' and evoked the statement that he would never have come to therapy had this been policy, for fear of being detained. This was used by the therapist to clarify confidentiality, to remind Sam that her concerns about violence had already been shared with Sam's GP in a letter of which he had a copy, and to point out that this concern about his violence was now balanced by the way he was already using therapy to find ways of controlling his abusiveness.

At session 18, Sam read out a letter to his dead stepfather, in which he detailed the abuse of his mother and the terror shared by all the children. The letter concluded:

We carry your name but that is all you ever gave us. Not one ounce of love or affection. Just pain, pain and more pain... You cannot hurt us anymore because a heart attack took you to the devil's door. We will all call upon you there to tell you to your face what an evil cunt you were. Bye bye for now you bastard.

This session continued as follows:

Therapist: You've said you'll meet him at the gates of hell. You've said why he deserves to be there but why do you?

Sam: Well for what happened to us—for being abused—Innocence and everything is taken off you. You no longer have a childhood, they take all that.

Therapist: But why should that be punished rather than comforted?

Sam: It's just the way we think, Kate, just the way we think... It seems to follow naturally that we'll go there.

Therapist: But you know how many people there are who have been sexually and physically abused. Do they all deserve to go to Hell?

Sam: Well, I would say no to that.

Therapist: So why do you?

Sam: Well it just seems to follow... They've taken the goodness off us... it's as if we're evil in our way. I'll give you an example: I can see a plane crash on TV or kids starving and it doesn't touch me—things that should mean something. But to us it don't mean a thing...

Therapist: Isn't that because from a very early age you learnt to cut off from painful feelings because they were so overwhelming...

Sam: Oh yeah, so now it's automatic.

Therapist: Are you saying that because you can do that then it makes you bad?

Sam: Yeah, I'd go along with that, yeah.

Therapist: Well I don't think that makes you evil; It's how you learned to survive as a kid and it still happens. But I don't think it makes you bad.

Sam: Well we do. (pause)

Therapist: But I can see where you are coming from. (pointing to the diagram) Abusing, attacking yourself. (pause). Thinking about—In the letter to your stepfather, I was struck by where you wrote how he never gave you any affection

Sam: He didn't. Not once. Never like I used to do with my son—like ruffle your hair. You know what I mean. ... We were always on guard... always afraid we'd start something and then my mother would step in and then she'd finish up getting a whack. If we could avoid his company we did. It was as simple as that.

Therapist: So he didn't show any care and it feels as though you can't show yourself any either—can't be patient with yourself or love yourself.

Sam: I'd agree with that. I think it's beautiful to love yourself and all that. If you love yourself I imagine it means that others might love you too, eventually. But it just doesn't seem to apply to us. I can see what we're missing out on.

Therapist: Mmm.

Sam: There are odd times, a few seconds, when I get like a euphoric state. Just for a few seconds but they're lovely when I get them. But I don't get them every week, maybe every three months. And I don't know what triggers that ...

Therapist: Do you remember the last time?

Sam: Oh, it was a few months ago. I can't explain it. It's as if something sweeps through me. It's almost dreamlike, but I'm wide awake and I want to hang on but it goes. It's almost as if ... as if I'm brand new. (pause). I don't read the papers or watch TV, you know, because I get tripped back with all the stories of abuse that are coming to light now, all the churches and approved schools. There's a lot more to come through your hands. You know what I mean.

Therapist: Your euphoric state, when you feel brand new... It makes me think about you feeling tainted and marked so much by the abuse, so full of shame and evil ... (pause). How do you think I see you?

Sam: (pause) Well, like I said. Tainted. And things like that.

Therapist: Is that really what you believe?

Sam: Yeah. That's how I feel everybody who knows about our abuse thinks. That's the reason why we didn't discuss it. I wouldn't have discussed it with my mother, it would have broken her heart.

Therapist: What does it mean that you are tainted; what does it mean that I think of you?

Sam: Well, we can never be good or anything. Because of what happened to us. They stole everything of decency off us.

Therapist: So how do I feel about being with you?

Sam: Well ... the same way... you know... you're just doing your job and through your eyes you see us as tainted. Like we're a couple of classes lower—I don't mean class systems, I just mean lower; like castes. We're right at the bottom. They steal off you your soul. That's why we have no emotion. Soulless. Shell-like.

Therapist: That is not how I see you. People did things to you that were so horrendous that your whole life is affected. But in terms of you as a person, I don't see you as any the less for that, I don't feel that at all. I actually feel that you have shown enormous strength and courage to have got through as you have.

Sam: (jokingly) Without doing serious jail?

Therapist: Just the fact that you have lived. The bits I do not sit comfortably with, as you know, are when you hurt yourself or hurt other people. I want to work with you about getting more control over them. But as I said, I do not see you as less of a person. In fact I see you as having enormous courage. There's a lot about you that I respect.

Sam: Is that right? (pause) I'll try to take that on board. I took on board thinking about the baby... I can see the baby and the baby can't stop anybody raping the baby.

Reflecting upon this important and moving session, the therapist was aware of having been hurt by Sam's saying she was 'just doing her job' and questioned whether this has mobilised her forceful insistence on disclosing her positive feelings and naming his abusive aspects. In supervision she was encouraged not to over-analyse or rubbish what had been achieved by her intervention. At the following session a sadder Sam described how he had been 'talking to Benjamin Sam' about the past and when his wife had noticed his sadness he had been able to give her an account of his experiences for the first time. The therapist wrote:

The pervading feeling of the session was of sadness and Sam went on to describe his shame and fear regarding what he had experienced at the hands of the abusers. He told me that he had been fearful of telling me this at previous sessions and that these events represented his deepest fear that the abusers had left their badness inside him, thus representing the permanence of the damage of his abuse. These images struck me as very powerful with regard to Sam's struggle to fully recognise his own more abusive parts as

the ultimate terror was that the abusers who had tortured him sexually were inside him. Thus I became more attuned to his difficulty in discussing the either abused or abusive dilemma and to the need to distinguish his physical abuse of others from his experience of sexual torture.

Towards the end of this session the therapist noted Sam's difficulty in recalling the emotional tone of the previous week as he continued to blame himself and was unable to remember the therapist's disclosure of her positive feelings towards him:

Therapist: I did wonder if you would want to shut down and if it would be hard to take in. I said that I respected you but also that there were parts of you I do not like, as when you were abusive. It seems the urge to block out good things is very strong. And as we have a two-week break now you may need to distance yourself from me.

Sam: You've noticed that?

Therapist: Yes. As with past breaks. Perhaps this time you could think what you've done with what I said about my positive feelings.

Sam: (As they walked towards the door) Can I ask you a question? Why do you never wear skirts? I don't mean to embarrass you ...

In commenting on this, the therapist wrote:

Sam may have felt helpless in the face of my comments on his need to distance himself and so perhaps needed to reassert his power by switching to an exposing position. I wondered if he recognised the intimacy and exposing power of what he had said .... I was able to revisit this issue at our next meeting (session 20), at which he spoke about his fears regarding the end of therapy, and again in session 21, when he described how an acquaintance had been arrested for molesting a woman he describes as 'jail bait'.

Therapist: Thinking about how you describe her as using sex as a power thing and then about how for you as a child sexual issues were merged with being used and abused ... and being humiliated ... I want to come back to your comment about my not wearing skirts. At first in our relationship you had to be very much in control, not letting me get too close but I feel as we have gone on that has changed, you've let me get closer.

Sam: Oh yeah, there's trust.

Therapist: Well I wondered when you asked me about skirts whether you'd thought I'd felt unable to wear them with you in case I felt vulnerable ...

Sam: It wasn't like that. It wasn't meant in any depth. I just wondered, that was all. You know ... you've got nice bits to go with a skirt. Are you with me? I relate women who wear trousers as a power thing as well. Some like to wear the trousers, to be in charge. But I thought no, she doesn't come over as that type ...

The therapist commented on this:

I was able to talk about the skirt issue and use the diagram to link it with my early need to protect myself from his controlling and dominating behaviour in contrast to the greater trust that had developed. His embarrassed comment about 'nice bits to go with a skirt' felt very different to the arrogant 'charm' of the early sessions. In the rest of the session he acknowledged that there are more 'shades of grey' when it comes to considering sexual power and he was able to speak of the increasing physical intimacy with his wife which had developed during therapy.

The therapy ended with an exchange of 'goodbye letters', read out at the last session. In hers, the therapist reviewed in detail the work done in challenging Sam's sense of being tainted and in resisting his self-attack and finding some ways of being comforted. Various ways of controlling switches into destructive states were rehearsed, namely walking away, counting, reminding himself that it was the present time and not 30 years ago, describing to himself where he was as a way of staying in the present and explaining to others when their behaviour or talk was upsetting him and asking them to stop. The change in the relations between his different 'selves' was noted. In particular in the greater tolerance for Heartless Sam, based on an understanding of how he had been a way of surviving, and noting how Sam, in this state, was far more mellow, with more 'shades of grey', a change clearly experienced in the therapy relationship. To conclude, the therapist's letter spelled out Sam's difficulty of being vulnerable and of allowing good things, reminding him how he had blocked off her affirmations of respect and concluding:

It may have been really hard to hear the positive messages in this letter, as it often was in our sessions, but I hope you will re-read it often and continue to explore ways of soothing your more painful feelings and reducing your attacks on yourself and others.'

Sam's letter, addressed to Dearest Kate, read as follows:

We wonder what to write. I suppose you wondered about us too. Well let us inform you that you have helped us a great deal, i.e. our trigger factors, our mood swings and teaching us about self-harm, which was all news to us. You have also told us that we are not tainted like we all think but that will take time to adjust to, if we can ... We are pleased that you began to understand us. You are the first. Maybe there will be more. It all comes down to trust and you know that doesn't come easy to us ... yet.

The highest compliment we can pay you is to say we trust you, even Heartless Sam. Knowledge without understanding is just knowledge. Understanding without knowledge is just understanding. Put both together, that equals wisdom. Therefore we all bow to your wisdom. Thanks from us all.

The therapist commented on Sam's letter as follows:

His remarks about my 'wisdom' concerned me as possibly idealising me and potentially rubbishing help from others. I discussed this with him gently, being mindful of the need not to minimise his experience of having something with me he had not had before.

In reviewing the whole therapy she reflected as follows:

When I first began working with Sam I felt fearful, intimidated and powerless and doubted whether I had the therapeutic skill to help him. Towards the end, I felt a fondness towards him and a sense of privilege that he had been able to expose his long-concealed vulnerabilities... . As he said goodbye I remained acutely aware of his long-term psychological damage ... but I also felt a sense of hope that he left therapy with new experiences and a desire to explore himself further.

The collaborative and open nature of CAT were central to his ability to trust me and the diagram helped him to look at all his parts rather than remain trapped in one or other 'personality'. The evolving diagram was essential in helping me acknowledge the 'powerfully controlling to exposed and powerless' reciprocal role pattern and so to resist Sam's domination. It also helped me control my tendency to be appeasing in the face of his attacks or protective of him by not naming his abusiveness. And it protected me from feeling self-idealising and grandiose in relation to other staff who did not share my understandings. The diagram also provided me with a link to the comments of my supervisor, reminding me of the range of positions which Sam or I might occupy.

Conclusion

It is to be hoped that the combination of the summarised account, the actual dialogue between the therapist and this eloquent patient and the therapist's sensitive reflections on her work can convey something of the therapeutic process in which the role of theory and of supervision in supporting the therapist's human presence can be seen.

The psychoanalytic concepts of transference and countertransference have been incorporated in CAT theory, located, along with the concept of projective identification, as examples of the more general phenomena of reciprocal role induction through empathic identification and elicited reciprocation. But in CAT these processes are not so much interpreted to the patient as they are incorporated in the explicit shared framework. This allows the creation and maintenance of a carefully defined and circumscribed but genuine human relationship. By working jointly at reformulation and by recognising and avoiding potentially collusive responses, the therapist, in this case, had established the right to offer the direct human affirmation given in session 18 which is likely to have been the critical moment in this therapy.

THE TREATMENT OF BPD: RESEARCH EVIDENCE

Research evidence for the effectiveness of different models of therapy in BPD is scanty, although less negative than is sometimes alleged. Thus Perry et al. (1999) reviewed 15 outcome studies, 6 of which were controlled, of different interventions and concluded that, on average, the treatments were responsible for a sevenfold increase in the rate of recovery. A recent controlled study of the impact of a partial hospitalisation programme combining a range of interventions including psychodynamic individual and group therapy showed significantly better outcome in severe cases of BPD compared to those receiving routine hospital treatment (Bateman and Fonagy, 1999b).

A naturalistic study of 24-session outpatient CAT for BPD has been reported by Ryle and Golynkina (2000); it showed that half the sample no longer met BPD diagnostic criteria six months after therapy ended and that mean scores for the whole sample on a number of questionnaires showed further improvement at 18 months (although one-third were lost to follow-up at that point). Poor response to treatment was associated with greater initial severity. Publications reporting the use of CAT in BPD include the following: Dunn (1994); Marlowe and Ryle (1995); Ryle and Beard (1993); Ryle (1997a, 1997b). Pollock (1997) describes the treatment of an offender with BPD and the same author (Pollock, 1996) described the value of reformulation in allowing women with histories of abuse who had attacked their partners to accept both their victim and abuser roles. Pollock and Belshaw (1998) describe the use of CAT in violent offenders with mixed personality disorders where CAT reformulation offers a means of understanding the offender's relation to his or her victim and provides a guide to treatment and management. Pollock (2001) has edited a book on the role of CAT and the MSSM in survivors of child sexual abuse. Although no formal randomised controlled trial of CAT for adult personality disorder has yet been reported, one is currently under way at Guy's Hospital (despite not receiving funding from health service research sources, even following a successful pilot study). Meantime, the fact that increasing numbers of experienced clinicians are finding that the CAT model is a powerful one suggests that, in a comprehensive outpatient service, CAT would represent a powerful and economical first intervention for a currently poorly provided for group of patients. It can also contribute to clinical management in many settings (see Chapters 9 and 11). It could be lengthened for more disturbed patients and it could be linked with other interventions such as CAT-based CBT aimed at revising identified but persistent problematic procedures. In therapeutic communities or group therapy CAT can offer a concise, accessible way of identifying the ongoing procedures (Kerr, 2000).

THE RELATION OF CAT TO CURRENT MODELS OF BPD

The most influential psychoanalytic models (e.g. Kernberg, 1975) focus on concepts like internal object relations, weakness of the ego and so-called primitive defences and offer a developmental and structural understanding. Few workers nowadays recommend 'pure' psychoanalytic approaches to treatment or, if they do, reserve them for patients who have graduated from lengthy supportive therapy, often recommending intense and prolonged treatment. Kernberg has proposed the model of transference focused psychotherapy (Clarkin et al., 1999), which involves imposing a firm structure and the determining of priorities with a central emphasis on interpreting transference.

Most of the approaches based on cognitive-behavioural theories focus on core beliefs and behavioural strategies which are seen as under- or over-developed. Treatment on this basis is clearly discussed in Davidson (2000) and can be of value for particular aspects of BPD. However, no therapeutic use is made of problems in the therapy relationship and little help is provided to the therapist struggling to establish a relationship with these patients whose key problems are precisely to do with mistrust and interpersonal destructiveness. Where they are effective in containing this destructiveness it is through the imposition of controls (in a way not unlike Kernberg's approach) which, in many cases, echo the authoritarian attitudes of the patient's parents and which therefore risk reinforcing restrictive forces within the self. This approach is exemplified, despite its humanitarian orientation, by Linehan's dialectical behaviour therapy (Linehan et al., 1991, 1993; Koerner and Linehan, 2000) which involves an intense behavioural programme combining individual and group interventions. Small-scale controlled studies show that, in those accepted for and accepting the treatment, it reduces self-harming behaviours but has relatively little impact on the wider personality problems. Beck and Freeman (1990) extended basic cognitive therapy techniques to treat personality-disordered patients by describing both manifest problems and inferred underlying schemas. These latter are articulated in the form of basic themes and beliefs concerning the self and others. The only structural understanding offered is the description of dichotomous thinking.

Most recent commentators agree that any approach to the treatment of BPD must involve a flexible combination of therapeutic methods, and some convergences between hitherto opposed schools of thought are apparent. Stone (2000) proposes a pragmatic approach summarised as ABCD = E, indicating roles for Analytically oriented, Behavioural, Cognitive and pharmacological (Drug) interventions in an Eclectic programme. He accepts that at the present time little firm research evidence exists on which to base decisions in this field.

Livesley (2000) is concerned to develop an integrated rather than an eclectic approach and in his review gives a very accurate account of CAT. He sees BPD as a disorder of the self associated with, and mutually reinforcing of, affective instability and cognitive organisation and is opposed to using 'an array of

interventions combined in a piecemeal fashion'; the aim must be 'to promote integration and the development of a more cohesive self-system'. Livesley sees the similarity of the effects of different interventions as pointing to the need to maximise the non-specific or generic elements of treatments; he summarises these as the development of a therapeutic bond and a collaborative relationship linked by the technical aspects of the treatment contract. These views are entirely convergent with CAT, in which the technical procedures serve precisely to foster an emotionally important relationship contained within a collaboratively achieved framework of understanding.

The difference between CAT and Livesley's understandings and those of both psychoanalytic and cognitive-behavioural workers stems from the different theoretical underpinnings. CAT emphasises in particular a full recognition of the dialogic nature of human personality. Psychoanalytic object relations theory offers an important recognition of the fact that relationships with others are internalised to form personality structures, but the preoccupation, in much of the literature, with innate forces, fantasies and defence and its formation of the therapy relationship as an unequal interpretive one constrain or distort the uses made of this understanding. In CAT's (Vygotskian and Bakhtinian) object relations theory the 'permeable' self is seen to have been formed in, and to be maintained through, interactions with others; the internalised relationship dialogue from the past is constantly expressed in, and may be maintained or modified by, current relationships. Much of the stability of BPD reflects the inadvertent collusion with negative procedures elicited by borderline patients from others, including clinicians. The concepts of the zone of proximal personality development (ZPPD) and the idea of the scaffolding role of the therapist are further distinguishing features of CAT. Cognitive models aim to generate a benign teacher–pupil relationship but fail, in our view, to take adequate account of, or to use with adequate complexity, the potential power of the therapy relationship. In CAT, the understanding of sign mediation and internalisation derived from Vygotsky's ideas emphasises how growth and change occur within the dyad and reflect the wider social context.

Persuasive or authoritarian (Magistral) behavioural or psychoanalytic therapists fail to provide a mutual, collaborative relationship within which new meanings of the self and other can be created and the active participation of the patient in psychological change can be promoted. CAT aims to incoporate the strengths of the two traditions in which as much attention is paid to the therapy relationship as is the case in psychoanalytic interventions and in which the cognitive-behavioural practice of accurately describing assumptions and sequences is extended to describe high level self processes. The understanding and descriptive analysis of the main features of BPD (namely the instability of mood, behaviour, sense of self and relationships with others) which the MSSM provides is absent from cognitive and behavioural models. These various distinguishing aspects of CAT theory determine a range of practical activities, notably in the joint creation and use of reformulatory tools, and these tech-

niques in turn serve, we believe, to support therapists in the provision of a focused, powerful and human experience which can allow significant change in a limited time.

FURTHER READING

Ryle (1997a) presents a full account of the CAT approach to the treatment of borderline personality disorder. Golynkina and Ryle (1999) provide some empirical support for the multiple self states model. Pollock et al. (2001), in describing the Personality Structure Questionnaire, also address the relationship between multiplicity and dissociation. Davidson (2000) summarises the principles and methods of cognitive therapy for personality disorders. Magnavita (1997) offers an account of a short-term dynamic approach which incorporates some cognitive methods and Giovacchini (1993) gives an overview of more conventional psychoanalytic ideas. Livesley (2001), in a review volume, draws on recent developments to propose principles underlying any practical approach to treating personality-disordered patients which are close to CAT practice.