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# Psychotherapy for Borderline Personality Disorder: Mentalization Based Therapy and Cognitive Analytic Therapy Compared

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**Abstract**
Mentalization Based Therapy (MBT) and Cognitive Analytic Therapy (CAT) are among a small number of psychotherapy approaches offering specific methods for the treatment of Borderline Personality Disorder (BPD). They share a number of features, notably both

- seek to integrate ideas and methods from psychoanalysis and cognitive psychology, pay attention to early attachment experiences and see harsh and inconsistent care, in combination with biological vulnerability, as playing an important part in the genesis of BPD
- offer treatment based on a developmental understanding of BPD, taking account of recent developments in observational research
- seek to provide therapy appropriate for use in the public service.

These similarities, however, conceal a number of differences in underlying assumptions and emphases and are linked with contrasting therapeutic techniques. In this paper we present a discussion of key features of our models of normal and pathological development and a consideration of the conceptual underpinnings and of how far they are compatible with what is reliably known in the general field of psychology and how far it offers a model accessible to patients and clinician. Where our views diverge significantly, the reader will have some of the evidence on which to make a personal choice.

## Introduction

MBT introduces some concepts from cognitive psychology, notable contingency theory, is allied with developments in attachment theory and associated research of the last few years and discards some psychoanalytic tenets, such as an emphasis on revealing unconscious meaning, and seeks links with neurophysiology. CAT originated in part from the attempt to restate key psychoanalytic object relations ideas in an essentially cognitive language and in the extensive use of repertory grid techniques to investigate psychodynamic therapy. The core concept of the reciprocal role procedure (RRP) represents a translation and modification of object relations theories in which a child's experience is seen as more crucial than hypothesized universal unconscious conflicts. Introducing the work of Vygotsky on the social formation of mind and the key role of

semiotic processes in internalization marked a more distinctive break with both psychoanalysis and cognitive psychology (Leiman, 1992). Subsequent developments were influenced by, and consistent with, observational studies, notably those of Trevarthen (Trevarthen, 2001) whose theory and observations point to the biological underpinnings of human social and psychological development.

In the present paper no attempt is made to offer a comprehensive account of either approach; full descriptions are available in Bateman and Fonagy (2004, 2006) and in Ryle (1997) and Ryle and Kerr (2002) and in numerous papers. The aim is rather to focus on the similarities and differences in the accounts given of the role of early development in BPD and the relation of this to therapeutic change and practice. Each model is presented with comment identifying and discussing some key differences. The different origins and conceptual histories mean that

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no simple translation of the concepts of one model into the language of the other is possible. The aim is to explore how far the differences might be resolved and a more integrated understanding achieved and how far this might improve practice leading to more successful treatment models.

## Models of early development and their relation to BPD

### The mentalizing model of borderline personality

The theory is rooted in Bowlby's attachment theory and its elaboration by developmental psychologists, paying particular attention to the ideas of contingency theory proposed by Gergely and Watson (1999). The development of the self occurs in the affect regulatory context of early relationships and it is assumed that infants require their emotional signals to be accurately or contingently mirrored by an attachment figure. The mirroring must be 'marked' (exaggerated) or, in other words, slightly distorted, if the infant is to understand the caregiver's display to be part of his emotional experience rather than an expression of the caretaker's. The absence or variability of marked contingent mirroring is associated with the later development of disorganized attachment. Infants whose attachment has been observed to be disorganized exhibit behaviours like freezing (dissociation), and self harm and go on to develop oppositional highly controlling behavioural tendencies in middle childhood.

It is assumed, as suggested by Winnicott, that a child who cannot develop a representation of his own experience through mirroring internalizes the image of the caregiver as part of his self representation. This discontinuity within the self has been called the alien self and is considered to be a normal part of development albeit more extensive and liable to fragment the self structure within disorganized attachment relationships. The controlling behaviour of children with a history of disorganized attachment is understood as the persistence of a pattern analogous to projective identification where the experience of incoherence within the self is reduced through externalization. The intense need for the caregiver, characteristic of separation anxiety in middle childhood that is associated with disorganized attachment, reflects the need for the caregiver as a vehicle for externalization of the alien part of the self rather than simply an insecure attachment relationship.

The experience of fragmentation within the self structure is reduced by the concurrent development of 'mentalization', that is to say, the capacity to represent interpersonal experience as well as self experience in mental state terms. Understanding the behaviour of others in terms of their likely thoughts, feelings, wishes and desires is a major developmental achievement which originates in the context of the attachment relationship. Understanding others is achieved through one's own mental states having been adequately understood by caring, non-threatening adults. A secure, child–caregiver relationship that invites playfulness in relation to feelings and thoughts, beliefs and desires establishes the capacity for mentalizing.

The capacity to understand self and others as being guided by aims and intentions is considered to be a key developmental achievement and the disruption of this is seen to be a major aspect in the psychopathology of BPD. The most important cause of such disruption is psychological trauma early or late in childhood which undermines the capacity to think about mental states or the ability to give narrative accounts of one's past relationships. Even the capacity to identify the mental states associated with specific facial expressions may be impaired. This reduced capacity for mentalizing may be due to four main processes: (1) the vulnerable child's defensive inhibition of the capacity to think about others' thoughts and feelings in the face of the experience of the genuine malevolent intent of others; (2) early excessive stress which distorts the functioning of arousal mechanisms resulting in the inhibition of orbito-frontal cortical activity (the location of mentalizing) at far lower levels of threat than would be normally the case; (3) the fact that any trauma arouses the attachment system, leading to a search for attachment security. Where the attachment relationship is itself traumatizing such arousal is exacerbated because, in seeking proximity to the traumatizing attachment figure, the child may be further traumatized. Such prolonged activation of the attachment system may have specific inhibitory consequences for mentalization; (4) the child, in 'identifying with the aggressor' as a way of gaining illusory control over the abuser may internalize the intent of the aggressor in an alien (dissociated) part of the self. While this might offer temporary relief, the destructive intent of the abuser will in this way come to be experienced from within rather than outside of the self, leading to unbearable self hatred.

The phenomenology of BPD is the consequence of this inhibition of mentalization, and of the re-emergence of modes of experiencing internal reality that antedate the development of mentalization. In addition, there is a constant tendency to re-externalize the self-destructive alien self (projective identification). Individuals with Borderline Personality Disorder are 'normal' mentalizers except in the context of attachment relationships but they tend to misread minds, both their own and those of others, when emotionally aroused.

As a relationship with another moves into the sphere of attachment, the ability to think about the mental state of the other can rapidly disappear. When this happens, pre-mentalistic modes of organizing subjectivity emerge, which have the power to disorganize these relationships and destroy the coherence of self experience which normal mentalization sustains through narrative. As a result, mentalization gives way to (1) psychic equivalence, (normally described by clinicians as concreteness of thought) in which alternative perspectives cannot be considered and there is no experience of 'as if' and everything appears to be 'for real'. This can add drama as well as risk to interpersonal experience and the exaggerated reaction of patients is justified by the seriousness with which they suddenly experience their own and others' thoughts and feelings. (2) pretend mode in which, conversely, thoughts and feelings can come to be almost dissociated to the point of near meaninglessness. In these states patients can discuss experiences without contextualizing them in any kind of physical or material reality. Attempting psychotherapy with patients who are in this mode can lead the therapist to lengthy but inconsequential discussions of internal experience that have no link to genuine experience. (3) Finally, early modes of conceptualizing action in terms of that which is apparent can come to dominate motivation. Within this mode there is a primacy of the physical; experience is only felt to be valid when its consequences are apparent to all. Affection, for example, is only true when accompanied by physical expression.

The most disruptive feature of borderline cognition is the apparently unstoppable tendency to create unacceptable experience within the other through the externalization of the abuser which has been internalized by the traumatized individual as an alien part of the self. This can create a terrified alien self in the other — therapist, friend, parent – who becomes the vehicle for what is emotionally unbearable. Moreover, the need for this other can become overwhelming and an adhesive, addictive pseudo-attachment to this individual may develop. The alternative to such projective identification is to attack or destroy the self by self harm and suicide.

### The CAT theoretical understanding of Borderline Personality Disorder

The CAT model of early development sees attachment security as a necessary but not sufficient condition for normal development. Humans have evolved as social beings and newborn human infants are intensely interested in others (Trevarthen, 2001) and attachment has a function far beyond the provision of safety. Individual psychological development begins in the joint activity of the child, who brings to it personal, temperamental characteristics, and the caretaker, whose personality has been formed in a particular social context. Joint activity with caretakers initially involves mutual imitation, rhythmic activity and expressive communications and leads on to an evolving repertoire of relationship patterns — reciprocal role procedures (RRPs) – and a system of shared signs which constitute a proto-language which is the forerunner of speech. Through the shared exploration of social and physical reality and the conveying of meanings by signs and later by language, the human infant enters culture (Carpendale & Lewis, 2004). Only through this process, sustained by adequately secure emotional attention and support, can the child realize the innate potential of the evolved human brain (Donald, 2001). We are not just influenced by social relations and culture, we are created and maintained by them.

The key concept in CAT is the reciprocal role procedure (RRP). In understanding psychological difficulties the psychoanalytic interpretation of presumed unconscious conflict has been abandoned in favour of the creation and use of a complex, sequential model. The term procedure is used to describe the reiterative processes involved in aim-directed activity and in the understanding of self and others. Descriptions of procedures combine, in sequence, intention or perception, appraisal, plans, action, the consequences of acting and the confirmation or revision of the procedure. They therefore include external and mental phenomena and unite cognitive, affective and behavioural components and communication. Role procedures have the aim of eliciting the reciprocating role from others or from internalized derivatives of others. Low-level detailed role enactments are shaped by high-level patterns. In addition to this hierarchical structure, RRPs are integrated by metaprocedures which mobilize the procedures appropriate for a given aim or context.

The repertoire of reciprocal role procedures is acquired in early relationships, especially those with caretakers but also with siblings and other children. It determines how others are perceived and how subsequent interpersonal roles are enacted. Role procedures have, as their aim, the responses of others; in addition, these same patterns are internalized and determine self management and the accompanying dialogue is also internalized to become the instrument of thought. Conscious thought and self reflection depend upon the semiotic tools, eventually language, acquired through the early years of life. Treating self and others as intentional, precedes the (gradually enlarging) ability to think consciously about intentionality just as dropping toys

from the cot precedes any conscious knowledge of the laws of gravity.

RRPs describe patterns similar to those proposed in Object Relations theories, but their description does not depend upon interpretation. They are understood to be built up from early post-natal experiences through the infant's constant search for engagement through imitation, co-operation and communication with caretakers. This view is consistent with studies of early development by Trevarthen (2001) and with the patterns identified in Attachment Theory. Research using the dyad grid (Ryle & Lunghi, 1970), in which subjects rate self-to-other and other-to-self attitudes and behaviours in respect of emotionally significant others, showed that individuals repeat a small number of reciprocal role patterns. These can also be suggested by standard repertory grid testing with individuals as elements as when, for example, dependency and submission are highly correlated. The behavioural implications of such measures are clear and predicted desirable changes in them have been shown to accompany successful therapy (Ryle, 1980; Brockman et al., 1987). With experience, clinicians usually can deduce the main RRPs from the patients' accounts and from the early transference-countertransference interactions.

The internalization of relationship patterns is seen to involve more than representation or mirroring, theory being influenced here by the work of Vygotsky and Bakhtin, which in turn give full acknowledgement to the unique biologically based human ability to make and use symbols. Experience of the world, of others and of self is imbued with meaning through expressiveness, proto-language and finally language, and hence knowledge is inescapably linked to socially derived meanings and involves signs which become the tools of conscious thought.

Individuals may identify with and enact either pole of a RRP and such enactments may be in relation to others or to the self. In normal development a repertoire of reciprocal patterns of care–dependency, control–submission, demand–striving and so on is internalized and serves to maintain the self in the social world. Deficiencies of care, excesses of control and demand, critical and conditional acceptance applied to relationships and to self management lie behind many common psychological problems. They are derived from caretaker–child interactions to which both deviant parental attitudes and extremes of child temperament may contribute, in which major inconsistencies and traumatic events such as separation may play a part and in which the meanings communicated may be sparse, misleading and contradictory. The repertoire of RRPs acquired in early life is usually stable, due to being formed early and unreflected on and because enactment of a role

elicits reinforcing reciprocations from others, and this stability applies to normal and to dysfunctional procedures.

The concept of the procedure in CAT theory, therefore, unites the affects, cognitions, communications and actions involved in relationships and dialogue; studying only one of these can be misleading. So too is the traditional study of the individual in isolation; individual humans exist only in relation to external others and to internalized derivatives of others. In normal subjects a relatively extensive range of reciprocal role procedures is manifest in satisfactory and flexible patterns of relationship and self care; transitions between these patterns are more or less appropriate and smooth, and modifications and elaborations on the basis of further experiences are possible. Common psychological disorders can be attributed to the narrow range or dysfunctional nature of the person's role procedures; these commonly represent the defensive alternatives to feared or forbidden affects and behaviours.

These restrictions are found in BPD, where emotional neglect, threat and violence have instituted destructive patterns and a range of avoidant or defensive role procedures, but additional problems arise due to structural dissociation between parts of the procedural system. Borderline Personality Disorder (BPD) is characterized by the narrow and predominantly negative range of RRPs, the repertoire including patterns of abuse and neglect in relation to deprived victimhood in virtually all cases. While BPD patients commonly inflict abuse on, or accept abuse from, both self and others, they may also enact avoidant, compliant and idealizing roles. Furthermore, traumatic experiences result in a stable pathological dissociation, establishing a small range of self states which operate at different times, with switches between states being often abrupt and unprovoked. Evidence for this dissociative picture is provided by a repertory grid study (Golynkina & Ryle, 1999) and the use of the States Description Procedure (Bennett, Pollock, & Ryle, 2005). The Multiple Self States Model (MSSM) of BPD (Ryle, 1997) proposes three developmental and structural elements:

1.  The internalization of harsh reciprocal role patterns, typically of the general pattern of neglectful abuser in relation to deprived victim, and of restricted defensive alternatives. Individuals can play either role of a RRP at different times, both in relation to others and in self management, and borderline subjects experience both being abused and are abusive to others and to themselves.

2.  In response to emotionally unmanageable experiences, genetically vulnerable subjects

develop patterns of dissociation which, with repetition, lead to the establishment of a range of dissociated, alternative self states. Each of these is characterized by its particular reciprocal role pattern. The shifts between self states are often abrupt and confusing to self and others. They may appear to be unprovoked but usually follow perceived repetitions of threats of abuse or abandonment or the failure to elicit the expected reciprocation to the role procedure being enacted. Remembering or talking about past abuse can also provoke state switches.

3. These state switches interrupt conscious self reflection (already diminished due to the early indifference of caretakers) at the precise moments when it might allow re-evaluation of the perceived threat and consideration of alternative actions. The sense of stability of normal personality depends on eliciting the expected responses from others; the same is true for each self state, the reciprocal role patterns in these are often extreme and narrowly defined and pressures on others to reciprocate are correspondingly powerful. Projective identification and other transference phenomena are understood as particular examples of such role induction. This process is not a defensive one and may be found in respect of idealizing as well as destructive role procedures.

## Some questions and further discussion of MBT

It is unsurprising that the conceptual view of development of Borderline Personality Disorder put forward within the model of MBT has led to some questions. Some of the points raised will be discussed here.

Firstly, the theory of mentalizing takes a complex attachment view considering disorganized and other dysfunctional interaction patterns to undermine the child's developing capacity to naturally/spontaneously conceptualize behaviour in mental state terms. This is considered as too narrow a focus and there is some merit in this argument. However the role of disorganized attachment as an indicator of later psychiatric disturbance is reasonably well recognized (Lyons-Ruth & Jacobovitz, 1999). Problems in attachment undermine the felicitous development of higher level social cognition. Mentalizing theory is particularly concerned that disorganization of attachment system has two primary consequences (1) disorganization of self system which normally develops as a mirroring process and (2) an easily triggered attachment system. So, new findings from attachment research are considered

important because they may indicate different vulnerabilities to mentalizing and therefore allow further elaboration of the theory and understanding of treatment of BPD and other personality disorders. Two different attachment patterns in borderline patients have been identified which may be important for treatment. Borderline patients show higher than normal levels of anxiety but manage their difficulties through either avoidance or approach of others. This provides some support for our earlier suggestion about the use of different techniques for borderline patients demonstrating different patterns of attachment behaviour (Bateman & Fonagy, 2006).

The concept of mirroring offers an attractive metaphor but has been used within different contexts to mean different things (e.g. by Lacan, Winnicott). It can imply an over simple account of an interaction which involves the active participation of the infant as well as the parent. There is little doubt that this is a highly complex process and MBT has simply tried to give more developmental specificity and operational definitions to 'mirroring' using evidence from mother/infant research. It remains clear though that this is just the beginning of that process and, over the years, more evidence will become available to identify those elements of 'mirroring' that are important and necessary if a child is not to be left vulnerable to later psychopathology. Intersubjective intuitions, signs and other phenomena need further specificity and detail if they are to help us understand those aspects of mother–infant interaction which are crucial for future coherent mental development.

Second, the problem with the concept of contingent and marked mirroring is that it appears to offer a one-sided and reductive account of the maternal–infant interaction. Differentiation via 'marking' is based in experimental findings from mother–infant interaction. The mentalizing perspective is a dynamic developmental view where the respective capacities of child and parent, and therefore the nature of their contribution to interactions, change as the child matures. While the mentalizing approach considers that contingent mirroring may be the key contribution of the parent in the first year of life, this gives way to more complex interaction centering on language, playfulness and other developmental processes later on as long as there is a relative absence of threatening or frightening harsh interactions. In normal development, at each stage, the parent acts optimally within the constraints of the child's capacity to respond appropriately. Thus contingent mirroring is more difficult with infants whose temperament is harder to manage but it appears to be also harder for parents with a history of maltreatment, abuse and borderline symptoms (Crandell, Patrick, & Hobson, 2003).

Third, the concept of the internalization and particularly the suggestion of internalization of abusive caretakers as the 'alien self', may become confused with the internalization of the father as the superego in classical psychoanalysis or the internalization of the split objects of Kleinian theory. The difficulty probably lies in the clash of conceptualizations because classical psychoanalysis and its structural model is a representational frame of reference whereas mentalizing is concerned with the construction of a self process not a representational structure (i.e. James' 'I' not 'me'). What we are attempting to depict with the concept of the alien self is the episodic separation of a sense of ownership or identity with one's own actions or experiences – something that is actually done by 'me' but does not feel as if 'I' did it which is a common experience for borderline patients. The self is manifest through a process not a mental structure with a location so we are concerned with how the brain acts and functions as a mind rather than the regions or object relations that are activated.

Fourth, the emphasis in mentalizing is less on the nature and origins of roles and enactment of object relationships than on the dysfunctional use of these (e.g. their rapidly accelerating tempo of intimacy in relationships, the unthinking nature of some of the interpersonal patterns, the massive distortions of others' mental states, etc.). This view of internalization has its origins in object relations theory and whilst the relationship may be internalized within a secure attachment we are suggesting that this process is distorted in disorganized attachment. To translate our formulation into the language of psychoanalytic therapy (which we do not normally do as implied earlier), in the MBT model of BPD it is not aspects of the caregiver or roles which become represented or internalized within the other but the understanding the caregiver has of the mind of the child. When this is incongruent or not clearly differentiated, full internalization of roles cannot take place and there is inadequate development of the processing and internalizing ability that develops developmentally via repetitive contrasting of mental states of self and other.

From a mentalizing perspective, role enactments, whatever their origins, lack specificity to BPD and they are likely to occur in 'normal' individuals (although perhaps to a lesser extent) as well as in many different conditions and are therefore not considered core to the difficulty. From a mentalizing perspective the problem lies in the capacity to process roles and experiences when they are activated within specific contexts. Individuals with a more robust capacity to mentalize are able to manage their minds when confronted with an interaction that stimulates a powerful emotional response that may itself, in turn, stimulate an equally powerful response from another.

Fifth, although the capacity to mentalize has been emphasized in MBT as a core concept and is seen to be facilitated by secure attachment which involves the resonance of caretakers to the child's arousal and non-verbal expression through marked, contingent displays which constitute a basis for the child's internalization of the image of the other which is 'symbolically bound' to the initial state of arousal, the account lacks clear discussion about the origins of symbolization. Mentalizing theory is based on a constructivist developmental approach and does not see mind as emerging *de novo* in a Cartesian fashion and the lack of elaboration about symbol formation may suggest a need for further development in the theory. Certainly the construction of mind in the child's social context (particularly but not exclusively the family) is highlighted in MBT throughout but is narrow in the sense of being particularly concerned with the social construction of social cognition (mentalization) rather than symbolization as a whole. MBT is thus specifically concerned about symbolization of the symbolic system. In general terms when psychoanalysts talk of symbolization they actually tend to talk about meta-representations (or symbols of symbols) and in MBT the same applies to our approach to mindfulness. MBT is mindful of minds not mindful of everything that is happening to the person).

Sixth it has been suggested that 'psychic equivalence' and dissociation from feeling are regressions to earlier modes of function when mentalization is inadequate. Mentalization theory does not specifically see them as 'regressions'. The emphasis (unlike psychoanalysis) is on actual early capacities rather than as they are imagined by adult analysts to exist in imaginary children's minds. We agree with scepticism about regression because it generally referred to adults behaving in ways that appeared childish to an adult observer. We are attempting to identify mental processes that are actual and not overridden but masked by later developments (Fischer, Kenny, & Pipp, 1990). They are therefore revealed when mentalizing is lost.

## Implications of the theories for practice

### *MBT – The nature of therapeutic change and practical methods*

Whatever the mechanisms of therapeutic change might be (creation of a coherent narrative, modification of distorted cognitions, emotional experience of a secure base, the giving of insight, or simply the

rekindling of hope), traditional psychotherapeutic approaches depend for their effectiveness on the capacity of the individual to consider their experience of their own mental state alongside its re-presentation by the psychotherapist. The appreciation of the difference between one's own experience of one's mind and that presented by another person is a key element of interventions in MBT. The integration of one's current experience of mind with the alternative view presented by the psychotherapist must be at the foundation of a change process and the capacity to understand behaviour in terms of the associated mental states in self and other, that is mentalizing, is essential for the achievement of this integration. Hence the aim of MBT is to increase mentalizing without engendering too many harmful effects. What we hope of another with whom we interact in therapy is not that he or she will go through some gyrations which we have already planned in detail, but that he or she will make some contributions to moving forward the joint and co-operative enterprise in which we are both, more or less explicitly, engaged.

The therapists ability to stimulate a mentalizing process as a core aspect of interacting with others and thinking about oneself inevitably will act in part through a process of identification in which the therapists ability to use his mind and to demonstrate delight in changing his mind when presented with alternative views and better understanding will be internalized by the patient who becomes better able to reappraise him or herself and his understanding of others. But in addition, the continual re-working of perspectives and understanding of oneself and others in the context of stimulation of the attachment system and within different contexts is key to a change process as is the necessity to work within current rather than past experience. The therapist's task is to maintain mentalizing and/or to re-instate it in both him or herself and his patient whilst simultaneously ensuring that emotional states are active and meaningful. Excess emotional arousal will reduce mentalizing and potentially lead to action, whilst inadequate emphasis on the relationship will allow avoidance of emotional states and a narrowing of contexts within the patient can function interpersonally and socially. The addition of group therapy to individual sessions increases dramatically the contexts in which this process can take place and so MBT is practiced in both individual and group modes.

Borderline patients are uniquely vulnerable to psychotherapeutic interventions so the mentalizing therapist must not only develop mentalizing techniques but avoid non-mentalizing interventions. To this end a careful assessment of mentalizing and its vicissitudes is made at the outset of treatment. Detailed evaluation of mentalizing vulnerabilities takes place within the first few sessions. Patterns of mentalizing failure and success are identified explicitly with the patient and incorporated into a written formulation, which represents the therapist's understanding of the patient's problems in developmental and mentalizing terms. In the light of the teleological understanding encountered in the majority of borderline patients, this formulation is given to the patient in writing (the physical world) and continually re-worked with the patient as he questions it, challenges the therapists view, or simply corrects factual inaccuracies. This is an example of explicit mentalizing work in which the representation of the patient as held in the mind of the therapist is presented to the patient who in turn re-presents his view of him or herself to the therapist who can then demonstrate his own ability to re-appraise his understanding of the patient. The important issue here is stimulation of the inter-actional mentalizing process and not the accuracy of the formulation. In MBT, interventions serve the function of re-instating or stimulating further the process of mentalizing in different emotional states and a variety of contexts. Insight and accuracy are not the primary objectives.

Interventions are organized according to the patient's level of mentalizing capacity as assessed by the therapist at any given time. Capacities vary considerably within sessions and over time and so the mentalizing therapist has constantly to monitor the state of mind of the patient and to give interventions according to this evaluation, following a principle that the more fragile the mentalizing ability, the simpler the intervention has to be. The clinician should monitor several parameters in relation to the quality of mentalization including the level of emotional arousal, the intensity of attachment, and the need to avoid a perceived threat, for example from the therapist who is experienced as hostile or unable to understand. In accordance with our focus on the detail of attachment patterns, a detached attachment pattern requires more therapeutic work to be done within the patient–therapist relationship using mentalizing transference interactions whilst the enmeshed pattern needs careful titrating of the emotional state and the intensity of the relationship and commonly greater use of validating and empathic techniques.

The primary focus for the therapist has to be on the current state of mind of the patient and we therefore place considerable emphasis on understanding the patient's perspective within a validating context and interventions are structured accordingly. Observing and reflection – two aspects of validation – are common to every therapy and are an essential aspect to MBT, but we are not suggesting a simple confirmation of the patient's experience and

contingent response as being understandable in a specific context although this must be the first part of any intervention. The patient's experience is rooted in the reality of psychic equivalence in which alternative perspectives are not possible and so immediate challenge by the therapist is likely to be futile. The focus is on exploration and on elaborating a multi-faceted representation based on current experience particularly with the therapist. So, validation of patient experience moves gradually towards exploration in the current therapeutic relationship but first the therapist must demonstrate his/her understanding of the patient's experience as real and justified. Only once that is established can alternative perspectives be placed into the dialogue. Even then, in keeping with the 'not-knowing' or 'inquisitive' stance of the therapist, this process is understood as impressionistic and the therapist contribution is considered as having no more or less validity than that of the patient — together they should arrive at an understanding but it is likely to be the therapist who teases out an alternative perspective. Once an alternative perspective about an interaction is identified, the therapist must monitor not only his/her own reaction but that of the patient. The joint reaction then becomes the focus of the session and so the process moves on. It is especially important to note again that the aim of this is not to increase insight and understanding, for example about the contribution of the past to the present, but is to repair a current break in the self structure and to facilitate mentalizing within the context of an emotional interaction. The process of therapy becomes more important than the content.

The focus of the therapeutic work is within the current relationship with the therapist as manifested and contributed to by both patient and therapist. Links are continually made across modalities, i.e. from group to individual, from outside life to the relationship in therapy, from understanding in therapy to life outside and finally, commonly stated from the therapist's perspective but jointly worked, a hypothesis about unconscious motivations.

### Aims and limits of therapy

It follows from the MBT theoretical perspective that the overall aims of MBT are to

- Promote mentalizing about oneself
- Promote mentalizing about others
- Promote mentalizing of relationships

If this is to have a chance of success, therapy has to be organized around (a) structure; (b) development of a therapeutic alliance and adequate repair of ruptures;

(c) a focus on interpersonal and social domain; and (d) exploration of patient–therapist relationship. But there is a lot that can go wrong in therapy with borderline patients. Borderline patients are uniquely vulnerable to therapist interventions and can easily be thrown in to pretend mode in which they take on the perspective of the therapist and use it as part of themselves or alternatively are thrown in to confusion as their mentalizing capacities collapse. A specific formulation too early in therapy runs the risk of inducing pretend mode in vulnerable borderline patients and we would suggest therapists need to be alert to such problems which can be difficult to identify. MBT tries to formulate a process rather than actual relationship patterns in an attempt to reduce the risk of inducing pretend mode.

Some therapy techniques should therefore be avoided in MBT. First, we suggest that therapists avoid allowing excessive free association, a technique possibly more useful for neurotic patients. Second, we do not encourage active fantasy about the therapist. The use of fantasy and free association is not a major aspect of MBT because the development of insight is not a primary aim of MBT. Working with fantasy is a technique used in insight-orientated therapy as a way of understanding unconscious thinking. MBT is more concerned with pre-conscious and conscious aspects of mental function within the interpersonal domain. Fantasy itself is too distant from reality and we do not therefore encourage elaboration of the patient's fantasies about the therapist because it is likely to be iatrogenic and to invoke pretend mode rather than increase elaborated representations linked to reality. Alternatively, fantasy experienced in psychic equivalence mode becomes reality and is experienced as real, losing its 'as if' quality. Third, recognizing that patients operate in psychic equivalence mode also implies that their understanding is characterized by a conviction of being right and that makes entering into Socratic debates mostly unhelpful. Fourth, patients commonly assume that they know what the therapist is thinking. This is to be accepted initially or a clear statement by the therapist of not being aware of such thoughts followed by exploration of how the patient has come to his conclusions with some authentic self exploration about whether such thoughts had been present at a different time or in a different form. Problems for the therapist will arise if he claims primacy for introspection, i.e. saying that he knows his own mind better than the patient. This will lead to fruitless debate. Finally, in contrast to many therapies which actively withhold self disclosure, we suggest that tactful disclosure about what you are feeling is essential.

In addition, MBT has concerns that too much identification of patterns, for example in schema focused therapy (Young, Klosko, & Weishaar, 2003) might reduce the development of the patient's ability to seek his own understanding and that relationship patterns tend to multiply and in psychometric terms have sensitivity without specificity (i.e. that they absolutely are there but are not exclusive to the group). Central to us is the mental resources that are available to deal with recurrent patterns of behaviour and relationships rather than identification of the patterns themselves. This emphasis is non-trivial clinically. Mentalizing therapists do not get involved in discussing the structure or nature of the relationship that the patient brings but focus more on the patient's capacity to think about the relationship. For example the MBT therapist addresses the rigidity of schematic representations or roles rather than the roles or schemas themselves; the MBT therapist tries to enhance and facilitate flexibility and generate alternative perspectives. We suspect that this process may be one effective component of a number of psychotherapeutic approaches – while ostensibly focusing more on teasing out the actual roles, it is the action of teasing out rather than the understanding that the patient arrives at as a consequence of the work that is crucial.

MBT was introduced within a partial hospital programme but has been developed as an out-patient model and is now being diversified as training for mental health teams. Treatment has been offered in all contexts for 18 months which is longer than CAT, on the basis that establishing a robust mentalizing process cannot be done in the short term although this remains an empirical question. There is now some evidence that not all treatments increase mentalizing and indeed we have only limited data to show that MBT itself increases mentalizing. But behavioural and supportive psychotherapy was less successful than transference focused psychotherapy in this regard in a recent randomized controlled trial. One of our original hypotheses was that a change in mentalizing ability would allow patients to manage increasingly complex social and interpersonal situations and we have some evidence that social and interpersonal improvements do occur and that they continue over a 5–7 year follow-up, but we do not know if the same would apply with shorter treatment. Overall, therapists should be modest both in their aims and in their claims. Whilst MBT can demonstrate reasonable outcomes and the effect sizes found in the original study have been replicated in an independent cohort study, social and interpersonal function of patients remains somewhat impaired even after 18 months treatment.

## CAT – The nature of therapeutic change and practical methods

Different therapeutic inputs can produce similar changes and the similar inputs can produce different effects and, as Frank (1973) argued, effective therapies share common features in that they are emotionally arousing, restore hope and extend the patient's sense of mastery. These non-specific effects are understood in CAT to reflect the hierarchical structure of procedures whereby change at the 'tactical' level can modify 'strategic' procedures and vice versa, and whereby the sequential processes involved in reiterative procedural enactments may be changed at a number of points, namely by new experiences, by a revised appraisal of experience, by clarifying the links between experience, intentions and the consequent action, by increasing the skillfulness of action, by increasing the accuracy with which consequences are appraised and by influencing such consequences. In addition, in treating BPD a specific model of the fractured self structure is essential if therapists are to avoid confusion and collusion and support integration. CAT addresses high level self processes and therapeutic work aiming to influence symptoms or individual problem behaviours will only be delivered within that wider context.

Psychotherapy resembles the child's early learning of relationship procedures, involving joint activity and the creation, use and internalization of mediating tools. These tools consist of the descriptive reformulation of the patient's dysfunctional procedures and poorly integrated structure. This equips patients with the means of accurate self observation and guides the therapist in maintaining a real but non-collusive relationship. Successful therapy results in the internalization of the RRPs experienced in the therapy experience, the addition of a new 'voice' to the patient's inner dialogue and the integration of the patient's fragmented procedural system.

### Practical methods

CAT involves patients in explicitly cooperative work in the development of psychological tools combining, from the first session, the conventional enquiring stance of psychodynamic therapies with the discussion of provisional descriptions of the procedural patterns manifest in the history, current relationships and the developing transference. This is supplemented by involving patients in various paper-and-pencil procedures, as follows:

1.  homework tasks such as symptom monitoring and focused diary keeping designed to locate symptoms in the associated RRPs;

2. reading the Psychotherapy File, which describes three main patterns whereby dysfunctional procedures are self reinforcing and offers examples of each;

3. Screening questionnaires, notably the 8-item Personality Structure Questionnaire (PSQ) (Pollock et al., 2001) which contrasts descriptions of unusual stability with those of unusual variability and discontinuity;

4. The use of the States Description Procedure (Bennett et al., 2005) which involves patients in guided introspection yielding descriptions of the patient's dissociated states.

Exploratory interviewing supplemented by these tools allows therapists to draft a reformulation letter, usually in four to six sessions, offering an outline account of how negative early experiences had shaped current role procedures which now either repeat early damaging patterns or which represent dysfunctional defensive alternatives. After detailed discussion with the patient a reformulation letter is written, offering the outline of a meaningful life story which can transform the borderline patient's often chaotic account. This questions some of the conclusions drawn from the past, clarifying the patient's responsibility both by challenging irrational guilt and by acknowledging what harm has been done. Patients experience the reading of the final revised letter as profoundly moving. To this narrative reconstruction the therapist adds a Self States Sequential Diagram (SSSD), a paradigmatic model (Bruner, 1990) of the processes currently maintaining the patient's problems. These, tested out against further experience, serve to understand ongoing relationships and to anticipate how dysfunctional RRPs are likely to affect the therapy relationship. The construction of the SSSD is aided by the fact that variations in the underlying patterns are not infinite: important RRPs are concerned with core dimensions (care-dependency, control-submission, abuse-victimization) and the features of common borderline self states have been demonstrated in research studies (Bennett & Ryle, 2005; Golynkina & Ryle, 1999). The diagrams describe the different states and trace switches between them; they can also demonstrate the common patterns and mutual influence of interpersonal and self management reciprocal role procedures. It should be noted that whereas a state is the subjective and behavioural manifestation of a given role and can be recognized by the patient, RRPs are more theoretical concepts and are less likely to be identified without help. In the course of therapy the majority of the RRPs described in the diagram will be manifest in reports of the ongoing life and in the therapy relationship; the availability of the diagram alerts therapists to

recognize these and to anticipate the range of countertransference feelings likely to be mobilized.

The process of reformulation commonly makes patients intensely and actively involved but before long dysfunctional procedures, commonly idealizing, passively resisting, destructive or emotionally distancing, are likely to be manifest. The active use of these understandings and tools to challenge every manifestation of disintegration or of dysfunctional procedures generates emotionally intense interchanges and can initiate change after a very short time, but phases of inertia may still occur. Supervision of the therapy of BPD is important and supervisors are helped by the diagrams to identify the influence of unrecognized countertransference collusion in such cases. As termination approaches, powerful feelings derived from past losses will surface; linking these with the reformulation and avoiding denial and idealization offer the patient a possibility of experiencing a manageable loss. Patient and therapist exchange 'goodbye letters' seeking to record realistically what has been achieved and follow-up meetings at one, two, three and six months are arranged. During or preferably at the end of this time, further needs will be assessed. Not all cases need this (Ryle & Golynkina, 2000) but in many cases group therapy or CMHC support, informed by the therapy experience and reformulation tools, maintain the changes achieved.

### The aims and limits of therapy

Stable change in borderline patients can be achieved and, given the suicide risk, is a basic aim. But the objective must be realistic. Untreated borderline subjects often learn to maintain emotional distance from others so as to avoid mobilizing their more dangerous procedures and therapy may at times do little more than encourage voluntary control of this sort. In other cases, however, learning to modify or replace the dysfunctional procedures which have elicited negative reactions from others can open the way to the more effective use of support and treatment and to more satisfying modes of relating to others and hence to continuing change. Such changes can be achieved in a 24-session CAT intervention with follow-up meetings at 1, 2, 3 and 6 months. This relatively brief intervention can be effective because the early establishment of a collaborative working relationship and the early creation and use of writing and diagrams mean that every report or manifestation of dysfunctional procedures in daily life or the transference can be identified and challenged and alternatives explored. Therapists, and, importantly, staff groups in CMHC or Day Hospital settings (see Kerr et al.

in this issue) being contained by the clear conceptual frame, are better able to avoid inadvertent collusions and despite the borderline patient's shifting transferences can offer a genuine, human and explicitly non-collusive relationship.

## The way ahead

It is evident that there are major incompatibilities between the concepts used in MBT and CAT to describe the role of early development and of therapeutic change. We have not resolved these differences and they are unlikely to be resolved by force of argument, if only because theory does not only exist to guide practice, it has other less rational but important purposes, serving to embody values, to define schools and to offer a specific identity to therapists. The reader must decide how far MBT and CAT can draw support from the available evidence. Comparing practices, however, is a more realistic aim. Despite the fact that the principles underlying therapy with MBT are similar to those guiding CAT, the differences in practice are extensive and it is here that empirical studies could offer important clarifications. The following are among the potentially researchable issues:

1. The duration and intensity of therapy; what is a minimum sufficient therapy? CAT originated as individual therapy within a predetermined time limit while MBT was developed in the context of a prolonged and intensive partial hospitalization programme. The economic advantages of brief therapy are clear and its potential is considerable. Hence for patients not considered very high risk and not detained under the mental health act MBT is now offered on an out-patient basis. This 'variant' is the subject of a randomized controlled trial. But greater severity, comorbidity and deprived social circumstances of the patient may all indicate a need for more prolonged or intensive interventions. A comparison of the two models could involve a RCT design either within a service hospitable to both models or following the randomization methods described by Gieson-bloo et al. (2006) in their multi-centre comparison of schema-focused and transference-focused therapies. Rather than trying to identify the needs of patients at an initial assessment, it would seem sensible to offer a staged programme given that briefer and cheaper interventions will prove adequate for some and will at worst provide preparation for more costly interventions. Patients could be randomly allocated to MBT or CAT strands through successive stages, moving to the next stage if not adequately helped. These stages could consist of outpatient psychotherapy, care in CMHC settings by staff supervised in the model, the addition to this of individual or group psychotherapy and therapeutic community or partial hospitalization programmes. Outcome measures could focus on drop-out rates, the proportion treated satisfactorily in each phase, the overall cost of the intervention, and the global assessment of function which takes into account the social functioning of the patient.

2. Teaching and supervising non-therapy trained staff. Both MBT and CAT have developed models of such training and these are of considerable importance given that, although personality disorder is 'no longer a diagnosis of exclusion' (DoH, 2003), most patients will be in the care of staff with little or no special training. The acceptability and effectiveness of the two approaches to training and supervision could be usefully compared by qualitative research.

3. What are the specific effects of specific aspects of the models? It is likely that many aspects are common to the two models, such as the positive impact of trust in the therapist, while other features are only present in one model, for example written and diagrammatic reformulation in CAT or combining individual and group therapies in MBT. An assessment of the impact of both the common and the different interventions could best be made through the use of hermeneutic single-case efficacy (Elliot, 2002) or Single Case Experimental Design studies (Turpin, 2001) applied to a series of patients. The latter method is illustrated by Kellet's study of the CAT treatment of a case of Dissociated Identity Disorder (Kellett, 2005). A study of CAT in group format with borderline subjects is currently under way. This relatively inexpensive research could identify which aspects of each model are always, sometimes or never associated with change (positive or negative). This approach has the added advantage that other models with broadly similar aims could be similarly investigated. Such research is more likely to influence practice than are RCT designs and we recommend more research into the process of therapy than has been suggested over recent years. This would allow identification of the effective ingredients of both therapies and perhaps lead to a therapy more efficacious than either CAT or MBT.

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