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The Management and Treatment of Personality-Disordered Patients
The Use of Sequential Diagrammatic Reformulation

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The clinical management of patients with personality disorders is seldom satisfactory. It is suggested that the bewilderment provoked and experienced by these patients can be reduced by a careful analysis of their shifting states of mind. The construction of diagrams tracing such shifts is helpful to both patients and clinicians. Illustrative case histories are presented.

Patients with personality disorders of the DSM-III borderline, histrionic, antisocial, and narcissistic varieties (American Psychiatric Association, 1980) are encountered in various settings, including accident and emergency departments after episodes of self-harm, probation departments, addiction treatment units, in forensic settings, and by social workers. In general psychiatry they are not popular. Psychiatrists are happy to treat the relatively common accompanying depression (Perry, 1985; Tarnapolsky & Berelowitz, 1987) but seldom have much to offer for the personality problems, for these patients are often uncooperative and disruptive. Some are referred for psychotherapy, but they are regarded as difficult (Waldinger, 1987). The reason for this unpopularity lies in the nature of the disorder; these patients are prone to express powerful, poorly controlled emotions, and to generate extreme reactions of both concern and rejection in staff, who find the inconsistency of their moods confusing, and who have difficulty in accepting their propensity to harm themselves and undermine attempts to help. These features have been seen by psychoanalysts (e.g. Kernberg, 1975) as reflecting an unstable personality, characterised by opposing or disconnected 'subpersonalities'; this is manifested in a tendency to polarise relations with others between idealised, undifferentiated attachment on the one hand, and bitter, conflicted, or abusive relationships on the other (in which the patient may play either the abusing or the abused role). Self-harm is common. These patients may also manifest a wide range of neurotic symptoms, generalised anxiety and depersonalisation being common. In psychoanalytic terms, they use the primitive defences of splitting and projection.

We have found some success in using 'sequential diagrammatic reformulation' in the cognitive analytic therapy of such patients, in particular the more difficult ones.

Cognitive analytic therapy

Cognitive analytic therapy (CAT; Ryle, 1990) is an integrated, time-limited therapy suitable for use in a public health service. It draws upon a range of psychotherapeutic theories and methods, notably cognitive behavioural approaches and the object relations school of psychoanalysis. As its central feature, it lays particular emphasis on the reformulation of patients' problems; this involves accurate description, at the most general level attainable, of what the patient does to maintain his difficulties, but does not involve the interpretation of unconscious processes. Reformulation is carried out over the first few sessions in collaboration with the patient. A written description of the patient's history is linked with brief descriptions of his current maladaptive strategies (the 'target problem procedures'). The maintenance of intentional acts or roles is seen to be controlled by mental, behavioural, and environmental factors, linked in sequence. Intentional action is organised through a hierarchy of 'procedural sequences' which is normally open to revision by new experiences; neurotic procedures are generally not open to such revision, because of 'traps', 'dilemmas', and 'snags' (Ryle, 1979). Transference is understood in similar terms.

A patient's target problem procedures (TPPs) form the basis of therapy. Patients are asked to monitor and record their current uses of their TPPs in order to help them to recognise and in due course to modify them. Cognitive behavioural treatments are also used. The key role of the therapist in CAT is to help patients to identify their TPPs and to teach them to use them.

Sequential diagrammatic reformulation

Cognitive analytic therapy has proved effective (Brockman *et al*, 1987), and has been applied in a wide range of settings. However, the brief written

descriptions used are not always sufficient for more disturbed patients, and for such patients the additional use of diagrams has proved to be of value. The form of these diagrams was influenced by Horowitz (1979), who described the analysis of transcripts of psychotherapy sessions by identifying different 'states of mind' and by plotting transitions between these states, a method he called 'configurational analysis'. A state of mind (in cognitive and psychoanalytic terms) is described with reference to the typical mood, the defensive organisation, the sense of self, and the sense of other. This retrospective approach was adapted in CAT to reformulate patients' problems after four to five sessions. The agreed sequential diagramatic reformulation (SDR) is then used to guide therapeutic interventions, and as a basis for patients' self-monitoring.

The main source from which a SDR is drawn up is the clinical interview, but patients also contribute through their own self-monitoring, written tasks, and reading. The aim is to identify and characterise the patients' principal mental states, and to work out how transitions occur between them. The end result, characteristically, is a linked set of state descriptions of which one, the 'core state', represents the long-term, unresolved psychic pain of the patient. Patients may be fully or only partially or occasionally aware of this central state; characteristically they avoid it. There is often one dominant 'coping mode', such as desperately pleasing others, which has served as a source of self-esteem since childhood but which is usually accompanied or followed by shallow or unpleasant feelings. Other states may be characterised by unrewarding interpersonal strategies and some may involve somatic, behavioural, or psychological symptoms.

As the sequence of transitions between all the states is worked out, the persistence of the patient's difficulties becomes explicable, for the arrows inevitably return to the centre, showing how the core state is maintained.

Uses of SDR

SDR is of value to the clinician in that it aids accurate identification of a patient's state shifts and of the clinician's own shifting responses, enabling him to avoid collusion (see case 1 below). The map also indicates where destabilisation of the system is most likely to be effective, and is hence a guide to therapeutic intervention. Such maps could be of use to staff in in-patient or day hospitals, where patient management can often evoke 'coping-mode' conformity or provoke ill-understood acting out (see case 2 below).

For the patient, the SDR provides visible evidence of being understood and is frequently dramatically effective in containing anxiety and in initiating a co-operative attitude (see case 3 below). Patients are encouraged to use their SDRs themselves so that they need not suffer passively and feel out of control. One patient at follow-up interview quoted her therapist as having said "you may be a ship of fools but you can be the captain". She described how the daily charting of her state in this metaphorical role of captain had enabled her to maintain a markedly more stable and nearly alcohol-free existence for the first time for some years.

Case reports

Case 1: Mariette (therapist MM)

Mariette requested psychotherapy at the age of 41 following the end of her relationship with a 33-year-old man. She described uncontrollable moods, outbursts of inappropriate anger and crying, and an increased use of alcohol and cannabis. She had had a number of previous relationships with men, in all of which she became bored after a few months, at which point she would either leave or provoke rejection. She had recently ended her closest relationship yet. When not in relationships she tended to feel bored and empty.

Mariette had emerged from an insecure childhood as capable of and dependent on high achievement. She was currently a successful and ambitious magazine editor. She had had psychotherapy on two previous occasions (for two years and for six months) without feeling any lasting benefit.

She was offered 16 sessions. In the first three she was sometimes aggressive, although on occasions she became vulnerable and then accused the therapist of being insensitive and hurtful. The SDR (Fig. 1) was constructed at session 4 and thereafter she became more open and more able to work in therapy. By the end she could acknowledge that the therapy had provided the experience of being emotionally involved and vulnerable without being damaged. The diagram in this case was helpful as a guide to the therapist in dealing with the shifting aspects that Mariette presented and to the patient in providing a basis for a more coherent sense of self.

Case 2: Jacob (therapist AR)

Jacob, a 26-year-old graduate, had exhibited a schizoid pattern of emotional remoteness and restricted relationships during his adolescence and early adult life. He was assessed while a psychiatric in-patient at another hospital and was seen weekly while the attempt was made to arrange intensive in-patient psychodynamic therapy. For the past two years his schizoid withdrawal had been replaced by an unstable state with features of borderline personality disorder, namely persistent depersonalisation experiences and a mounting sense of futility and despair. Over this period he had had a number of admissions and had made five suicide

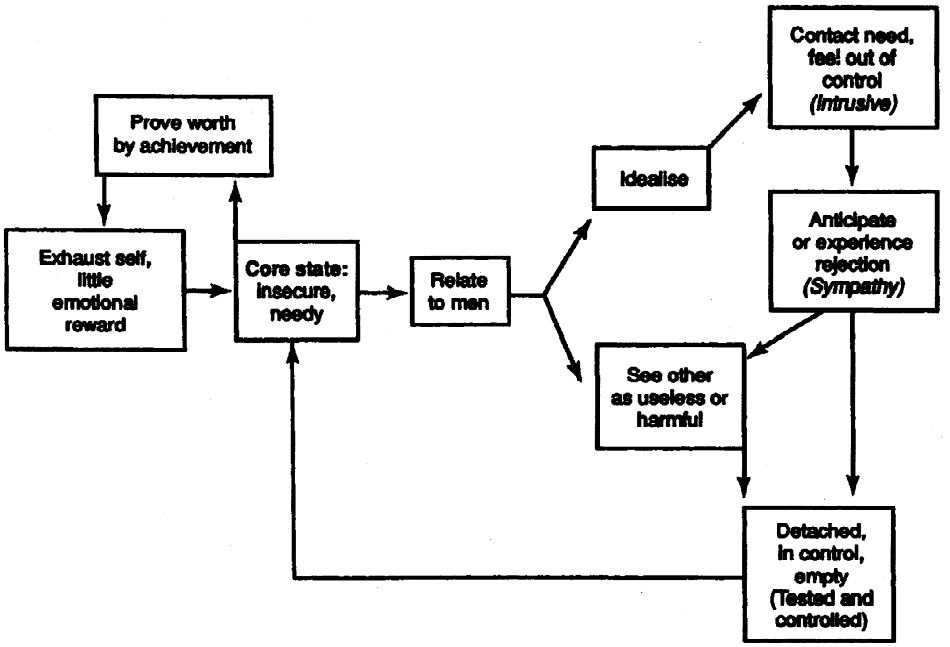

FIG. 1 Sequential diagrammatic reformulation: Mariette (case 1) (counter transference in parentheses).

attempts. He was an anxious, deeply unhappy young man. Self-monitoring made it clear that his depersonalisation experiences followed the emergence of feelings of being misunderstood, accompanied briefly by considerable anger. On rare occasions the anger was vehemently expressed to the doctors and nurses looking after him, but he was usually either reserved and compliant or inert and passively resistant.

Jacob was born a year after an elder sibling who had been described as furious and uncontrolled from birth, and who had become schizophrenic at the age of 16. Jacob, by contrast, was quiet, docile, and close to his mother. He was successful at school. From his earliest years, however, he had a sense of feeling different and cut off, and he compensated for this with an elaborate fantasy life; from adolescence onwards this included homosexual fantasies of being cared for. He developed an interest in, and considerable talent for, imaginative writing. He had enjoyed his years at university but, on starting work, found the demands placed upon him increasingly meaningless and confusing; it was at this point that his despair and depersonalisation experiences began.

Jacob was seen before the development of SDR, and the diagram (Fig. 2) is a version made later by the therapist. The verbal reformulation, worked out with Jacob, identified two dilemmas: firstly that, for him, the choices seemed to be to live either in the fantasy world of care and understanding or in the painful and unmanageable real world; secondly, within the real world, the choice was seen as being either totally compliant (his historical survival mode, which he experienced as increasingly intolerable) or furious and mad (like his sibling), a role so unacceptable that he became depersonalised or suicidal. The ordinary expectations placed on him in his role as an in-patient felt to him like one more set of demands for compliance. Sadly, before his admission to a therapeutic unit could be arranged, he succeeded in killing himself.

Case 3: Pearl (therapist HB)

Pearl, aged 18, was referred to a community mental health centre by workers in a hostel where she was living. She had recently left home, against her parents' wishes. She came from a non-European Muslim background, the family having arrived in England a few years previously.

The referral followed a brief admission to a psychiatric unit from which she had discharged herself. The admission had been arranged from a casualty department where she had presented in an amnesic and almost mute state following a disturbed outburst at the hostel. Her recent behaviour had included verbal abuse, excessive drinking bouts, a preoccupation with knives, and taking an overdose of medication prescribed for a physical condition. She denied any awareness of these incidents, stating that they had occurred "in her sleep". At her initial assessment interview, Pearl reported a history of deprivation and

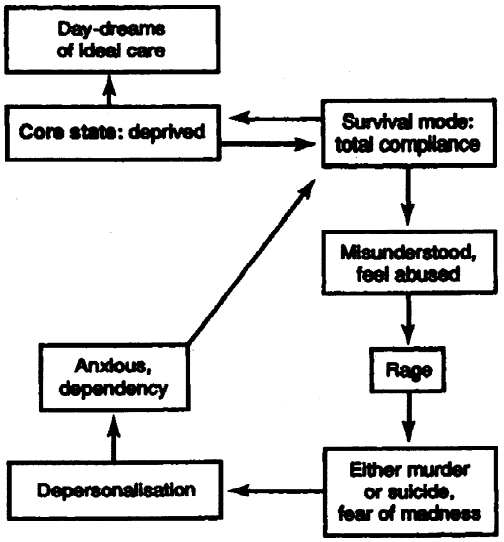

FIG. 2 Sequential diagrammatic reformulation: Jacob (case 2).

severe abuse, but in doing so claimed that she was "very happy", and she denied any connection between her past experiences and her current disturbed behaviour. She was deeply ambivalent about seeking help. She was considered to meet the criteria for a diagnosis of borderline personality disorder.

Pearl was brought up initially away from her family by a couple who returned her to her natural parents when she was five. From that age until she was 14 she was sexually abused by a neighbour. It later emerged that Pearl had submitted to this continual abuse to protect her younger sister, the man saying he would otherwise do the same to her. She perceived her upbringing as having been punishing, strict, emotionally depriving, and said that she had been desperately lonely. She saw herself as a 'stranger' in the family, and felt she was treated differently. She was beaten by her parents and frequently accused of being the source of the family's ill fortunes. She gave a history of frequent overdoses and self-cutting, none of which had been severe enough to induce intervention by the family or external agencies. She had not received any previous psychological or psychiatric help. In the first two sessions Pearl described disturbing life events vividly while expressing contradictory attitudes and feelings towards them, often within a sentence or two of each other. During these sessions her state switched between excited overactivity, anger, self-hate, and distress. She feared that she might lose control and go "crazy", and she expressed strong suicidal ideas.

By the third session the therapist felt confused and exhausted. At this point she suggested that they look at these different parts of Pearl. Pearl, with apparent ease, proceeded to introduce the therapist to "crazy", "angry", "smart", and "happy" Pearl, each description being accompanied by observable changes in her body posture and vocal tone. "Crazy" and "angry" Pearl were characterised by feelings of isolation, distrust, omnipotence, and fear, and by destructive acts, seen as the result of powerful parts of herself which assumed control against her will. "Smart" Pearl was characterised by conformity, placation, and careful control. "Happy" Pearl had no past, was overactive, playful, exuberant, trusting, and caring; this was Pearl's preferred state and was referred to by her in the first person. The therapist remarked to Pearl that she had also seen a "sad" Pearl, who was then acknowledged briefly as being hurt, lonely, in need of help, and wanting happiness. She stated that "angry" and "crazy" Pearl were furious that

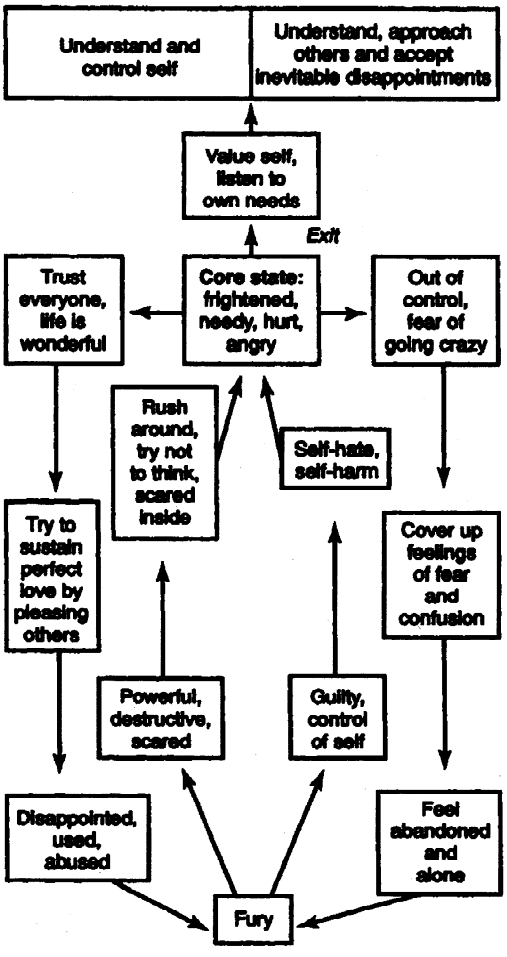

FIG. 3 Sequential diagrammatic reformulation: Pearl (case 3).

their presence had been revealed but that "happy" Pearl was very pleased. The possibility of these different parts becoming more familiar with each other, in order to help her feel more in control of her life, was proposed.

At the next session, the attempt was made to bring all of Pearl's parts into the room together, linking them to her core state of deprivation and suffering. Pearl connected some of her current feelings to her past abuse, and the rest of the session became an abreactive release of some of the pain she had held onto for so long. She not not keep her next appointment but responded to a letter. During this time a worker from the hostel reported concern about Pearl's self-destructive behaviour, for which she was at risk of being asked to leave.

In the ensuing session, the therapist worked with Pearl at the task of identifying the sequence of transitions between Pearl's states, and at the sixth session the SDR was finalised (Fig. 3). Pearl had worked with the therapist at the task of describing her states and state transitions, and by the time the reformulation task was completed at the sixth session, she reported that she felt that she had already changed. She took up the 'exit' suggested in the SDR, namely approaching others, and using her written reformulation and SDR to explain to her peer group and to the hostel staff her recent behaviour and her needs. Her improved self-esteem and behaviour were confirmed by the hostel staff.

Conclusion

Ross & Gahan (1988), in reviewing the treatment of patients with multiple personality disorder, reported that successful treatment required the explicit goal of personality integration and the use of diagrammatic reformulation. Our own work with less dissociated personality disorders suggests a more extensive use of this approach. The aim of psychotherapy or of day hospital or in-patient care of patients with disordered personalities is to aid their self-control and integration. Those in contact with these patients must be able to resist the strong pressures to collude with their pathological processes if this aim is to be achieved. We believe that a jointly produced SDR can make an important contribution to management and therapy, and can assist patients in their own self-understanding and control.

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