Cognitive Analytic Therapy
Developments in Theory and Practice

Edited by
Anthony Ryle
UMDS at Guy's Hospital, Munro Clinic, London, UK

Cognitive Analytic Therapy (CAT) is a fast-growing therapy remarkable not only for its integrative approach and power but also for its applicability in the context of brief therapy. Since Anthony Ryle developed the concepts of CAT in the early 1980s there has been an enormous demand for training in this method, from psychologists, psychiatrists, therapists and counsellors, as well as from other health professionals caring for disturbed patients in community settings.

This book reviews the history and essential features of CAT, offers a 'state-of-the-art' detailed description of practice, and continues the conceptual development of the field with discussion of the relationship of the CAT model to cognitive and analytical therapies, and to recent research in early child development. It includes authoritative accounts of the application of CAT to eating disorders, borderline personality disorder, self-harm problems, and to group work. Research into CAT is reviewed and, in the final chapter, Anthony Ryle looks forward to likely developments of research and practice in Cognitive Analytic Therapy.

Trainees and practitioners will find this book a stimulating update on developments of the CAT model and a useful, practical guide to applying CAT in important problem areas.

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Contents

About the Editor

Anthony Ryle, *CAT office, Munro Clinic, Guy's Hospital, London SE1 9RT, UK*

Anthony Ryle qualified in medicine in 1949 and was until 1964 in general practice where his interest in neuroses and therapy began and where his first research was carried out. He was Director of the University Health Service at the University of Sussex and then Consultant Psychotherapist at St Thomas's Hospital, London until his retirement in 1992. He is now Senior Research Fellow and Honorary Consultant Psychotherapist at UMDS at Guy's Hospital, London. Dr Ryle is the author of five previous books and of over 70 papers and chapters in the field of psychotherapy research and theory, and has been involved in the initiation and development of Cognitive Analytic Therapy, research and theory, since the late 1970s.

Contributors

Gillian Butler, ***Departments of Psychology and Psychiatry, Warneford Hospital, Oxford OX3 7JX, UK***

Gillian Butler is a consultant clinical psychologist in the Department of Psychology and University Department of Psychiatry at Warneford Hospital. She is interested in CBT, in particular for complex, longstanding problems. Having done research into the treatment of anxiety states, she is now focusing on worry and social anxiety.

Pauline Cowmeadow, ***York Clinic, Guy's Hospital, St Thomas's Street, London SE1 1NP, UK***

Pauline Cowmeadow is a consultant psychotherapist at Guy's Hospital. She has trained in CAT and in long-term psychotherapy. Her special interests include work with patients in medical settings, and developing psychotherapy within the National Health Service.

Francesca Denman, ***Psychotherapy Department, Casell Hospital, 1 Ham Common, Richmond, Surrey TW10 7JF, UK***

Chess Denman trained at Guy's Hospital and at the Cassell Hospital. She is now Consultant Psychotherapist at Addenbrookes Hospital, Cambridge. Her special interests include audit and research in psychotherapy.

Tim Leighton, ***Clouds House, East Knoyle, Salisbury, Wiltshire, SP3 6BE, UK***

Tim Leighton is director of training and research at Clouds House addiction treatment centre. He now teaches and supervises CAT.

Mikael Leiman, ***Department of Psychology, University of Joensuu, PO Box 111, 80101 Joensuu, Finland***

Mikael Leiman is a psychologist at the University of Jeonsuu. He has played a major part in the theoretical development of CAT and has established a training programme in Finland.

Norma Maple, ***25 Burlington Avenue, Kew, Richmond, Surrey TW9 4DF, UK***

Norma Maple is a CAT therapist and group analyst. She trained at the Institute of Group Analysis and in CAT at Guy's Hospital, where she continues to have a clinical and teaching role.

John Marzillier, ***24 Norham Road, Oxford OX2 6SF, UK***

John Marzillier is a clinical psychologist and psychotherapist in private practice. He is interested in teaching and research into integration of cognitive and psychodynamic therapies, and on ethical dilemmas in the practice of psychotherapy.

Ian Simpson, ***Department of Psychotherapy, St Thomas's Hospital, London SE1 7EH, UK***

Ian Simpson trained at the Institute of Group Analysis and works as a groupwork supervisor in the Department of Psychotherapy at St Thomas's Hospital

Preface

This book offers an account of the evolution and features of Cognitive Analytic Therapy (CAT) and a review of the main developments of the past five years. As regards practice, the core features of the model are firmly established; Chapter 2 summarises my idea of the current 'state of the art' and is as near to manualisation as I would wish to go. Clinical work with three difficult groups of patients is described in Chapter 1, with regard to borderline personality disorder; in Chapter 3, where Pauline Cowmeadow describes work with deliberate self-harmers; and in Chapter 4, where Francesca Denman considers the problems of working with subjects with eating disorders.

Theoretical developments have, up to now, depended largely on my own writing and that of Mikael Leiman, and the latter takes this further in Chapter 6, in which he proposes a key role in human psychology for sign mediation. Despite the fact that most CAT therapists have prior training in other models and in many cases continue to work in them, there has been relatively little discussion of the contradictions and confusions this may engender. For this reason no attempt has been made to impose a uniform voice on the other contributors. For example, in their authoritative review of developments in cognitive therapy, John Marzillier and Gillian Butler describe many convergences with CAT but, to my mind, offer a version of CAT which concedes too much to both psychoanalytic and cognitive theories and which raises many of the issues discussed critically by Leiman. Clearly, further debate is called for here. Other issues are addressed more directly in Tim Leighton's discussion, with me, of CAT's right to call itself analytic, and in Chapter 5 where Norma Maple and Ian Simpson consider the compatibility of CAT and group analysis.

CAT developed from a research orientation, and has (too slowly) accumulated a body of research, summarised in Chapter 10. This chapter and the discussion

of audit in Chapter 9, represent a willingness to assess the model and will, it is to be hoped, be a stimulus to an increasing volume of empirical work.

The last five years have seen the establishment of basic training in many places in the UK and abroad, the graduation of the first UKCP-recognised psychotherapists from the advanced training, and the establishment of the Association of Cognitive Analytic Therapists. The work of the contributors to this book rests upon the teachers, supervisors, organisers and therapists who have borne the strains of a rapidly expanding enterprise, and thanks are due to all these people. Particular thanks are due to Mark Dunn and the overworked, under-resourced office staff at the Munro Clinic, to Professor J.P. Watson for maintaining and developing the links between ACAT and the medical school (UMDS) at Guy's hospital (I believe to our mutual advantage) and, finally, to Michael Coombs, Wendy Hudlass and others at John Wiley & Sons, who have always been helpful, straightforward and efficient in their dealings with me.

Anthony Ryle
February 1995

1 Cognitive Analytic Therapy: history and recent developments

Anthony Ryle

Cognitive Analytic Therapy (CAT) is a time-limited, integrated psychotherapy. Its features and development have been described in two previous books (Ryle, 1982, 1990) and in numerous papers, but both the theory and the practice continue to evolve and will, it is to be hoped, continue to do so. This book is therefore an account of work in progress, and is addressed both to new readers and to the increasing number of workers who are involved in the practice of CAT. It is also a reflection of the contributions of many of the latter in practice, theory and research,

This first chapter offers a summary of the evolution of CAT, with, in particular, a review of the main developments of the past five years. In the second chapter an up-to-date description of CAT clinical practice will be presented, in a form which aims to define what CAT is without becoming a therapy cookbook. In the remaining chapters a number of authors will consider clinical and theoretical issues within CAT and related fields.

The pre-history of CAT

The origins of CAT may be traced back to my extensive use of repertory grid techniques (Kelly, 1955) to study the characteristics of psychotherapy patients and to investigate the nature of change brought about by therapy; this work was summarised in Ryle (1975). The experience of applying this cognitive approach to therapies carried out on psychodynamic lines and contact with

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personal construct theory generated a search for a 'common language' for the psychotherapies (Ryle, 1978). At the same time the continuing use of grid techniques to measure change, and the mobilisation of patients' reflective capacities in the course of administering and feeding back grid tests, contributed to the development of new ways of describing core neurotic problems in terms of three patterns, labelled dilemmas, traps and snags (Ryle, 1979). These descriptions, in turn, opened a new way to measure individual change in therapy. It was from these sources that the 'cognitive' concerns and collaborative style of CAT emerged.

Dilemmas, traps and snags are described in the 'Psychotherapy File' (see Appendix 2.1 to Chapter 2). This file is given to patients at the end of the first therapy session, and those descriptions identified by patients as applying are discussed in subsequent meetings. From these discussions and from other evidence a written list of the neurotic processes which therapy will aim to modify is prepared. Neurosis, on this basis, was understood to represent the persistent use of restrictive or damaging strategies; the three identified patterns described three ways in which these strategies had, up to the present time, resisted revision. The next stage in the evolution of CAT was to locate these patterns in a general model of the organisation of intentional action, the Procedural Sequence Model.

Basic theory and practice: the Procedural Sequence Model

The Procedural Sequence Model (PSM), first presented in detail in Ryle (1982), established a theoretical model in which current behavioural and cognitive models could be accommodated, and which served also as a basis for the restatement of a number of psychoanalytic ideas, using a cognitive language. According to this model, intentional acts or the enactment of roles in relationships are maintained by repetitive sequences of mental, behavioural and environmental processes, as follows: (1) perception and (2) appraisal in terms of knowledge, values, other plans and predicted consequences; (3) the (effective or not) enactment; (4) the consequences of the enactment (notably the responses of others) are evaluated; leading to (5) the confirmation or revision of the aim and of the means. While the psychodynamic concern with conflict can be included in this description, notably at stage 2, the main emphasis is on the ways in which procedures are self-reinforcing, and, in the case of problem procedures, particularly resistant to revision. Most procedures, and the higher-order procedures whereby they are activated, operate without conscious thought, but certain aspects of enacted procedures are open to self-reflection.

The therapeutic methods which developed alongside the evolution of this

model were centred on the process of reformulation. During the first three to four weeks of therapy patients are involved in self-monitoring symptoms, unwanted behaviours and mood shifts, and in reading and discussing the Psychotherapy File. This, combined with the therapist's consideration of the patient's history and current situation and of the developing therapy relationship, culminates in the identification and listing of the main Target Problems (TPs) and the underlying dilemmas, traps and snags (Target Problem Procedures, TPPs). This is discussed in detail, modified as necessary and then agreed. It forms the agenda and 'scaffolding' of the therapy. The remaining sessions, usually twelve in number, are devoted to the recognition of these TPPs through diary keeping and other forms of self-monitoring and through the noting of them as they are presented in the narratives brought to therapy and as they are enacted in the therapy relationship. Once recognition is achieved, revision may involve specific behavioural techniques, role play or other techniques, but in most cases the heightened and more accurate self-reflection, coupled with the experience of an explicit, non-collusive relationship with the therapist, allows the development of new procedures.

Developments from 1982 to 1989

The next stage of the development of CAT involved the more systematic incorporation of ideas from the object relations theories, notably as presented by Ogden (Ogden, 1983; Ryle, 1985). In this, the idea of *reciprocal role procedures* (RRPs) was emphasised. As in all procedures, the prediction of the outcome of one's acts is an important aspect of the sequence; in *role* procedures these are, above all, the responses of others. Reciprocal role procedures are seen to develop on the basis of early relationships. The infant is seen as learning to respond to or elicit the caretaker's role behaviours, but also as becoming able to enact this other role (for example, to dolls, to others, to the self). Hence each relationship is the basis on which two (reciprocal) roles are learned. The *repertoire of reciprocal roles* so acquired is the basis of relating to others (one role being played, the other elicited) and also of self management, insofar as patterns of relationships with caretakers determine how the self is cared for and controlled. The repertoire of childhood will be open to subsequent elaborations, but an individual's array acquires a certain stability early on, due largely to the way in which others are chosen or induced or seen to offer reciprocations apparently confirming the repertoire.

This model differs from the Kleinian view in that, while innate variations in the power of feelings clearly exist, it is early life experience or trauma and deprivation rather than clashes between innate instinctual forces which are seen to determine the range and quality of an individual's repertoire, and the

degree to which it becomes integrated. The phenomenon of splitting (the presence of contrasted, more-or-less dissociated ways of construing self and the world) is understood in the CAT model to reflect a failure of integration, usually in the face of fairly gross deprivation, trauma or inconsistency, rather than as having a primarily defensive function against innate instinctual forces. The persistence of splitting is understood as being the result of the way in which individuals are able to elicit confirmation from others for each of their separate, split-off 'sub-personalities' or 'self-states'. Splitting both causes and is maintained by the absence of a central self-observing capacity. Projective identification is understood as a form of relating, in which pressure is put upon the other to respond in a way representing the feared or disavowed pole of a dissociated reciprocal role pattern (see Ryle (1994d) for an elaboration of this). Symptoms and defences such as repression and denial are characteristics of particular relationship and self-management procedures, shaped in ways which avoid certain feelings or aims because of their earlier feared or forbidden implications.

On the basis of this model the neurotic individual is understood in terms of the restrictions or distortions evident in his or her procedural repertoire. Some procedures may be characterised by a particular inability to reflect upon, remember, perceive or acknowledge certain situations or wishes. The problems of patients with borderline personality disorder are further compounded by the fact that their range of procedures is divided between a number of more-or-less dissociated self-states; developments in the descriptions of borderline structure are described below.

In line with these theoretical clarifications there were further elaborations in clinical methods. As part of the generally collaborative approach of CAT it had become common practice to show patients the written summaries of their assessment interviews. From this evolved a new component in the reformulation process: at the fourth session therapists summarised their understanding of the patient's situation, usually in the form of a letter, sometimes in the patient's own voice. These rehearse the history and present circumstances, proposing a different emphasis on many aspects of the story, with the aim of acknowledging personal meanings and feelings more directly and of attributing responsibility more equably. They trace how present problematic procedures are either repetitions of early harmful patterns or are (costly) attempted 'solutions' to early situations, now serving to cause difficulty or restriction. Such issues will be explored jointly in the first three sessions and, at the fourth, the therapist will offer a written summary of them for detailed discussion and, if necessary, revision. This account will conclude with a list of the problem procedures identified and will anticipate how these may influence the therapy relationship and the work of therapy. These written descriptions are usually supplemented by *sequential diagrammatic reformulation* (SDR), in which a

flow diagram is constructed tracing how current procedures serve to maintain or reinforce current negative patterns.

The developments summarised above were described in the first book to present CAT as a formal psychotherapy method (Ryle, 1990). During and since that time developments in cognitive psychotherapy, in psychoanalysis and in other integrative approaches have indicated parallel or convergent tendencies. Thus within cognitive therapy interest in personality structure and in the therapy relationship has grown (e.g. Guidano, 1987; Lockwood and Young 1992; and see Chapter 7 in this volume). In psychoanalysis the relevance of observational studies has been increasingly recognised (Stern, 1985; Westen, 1990) and cognitive processes have been more attended to (Westen, 1991). Several authors, while retaining a basically psychoanalytic approach and confining interventions to interpretation, have demonstrated how interventions are normally focused on a small number of core issues, and have shown how these recur both in the patient's narratives and in their way of relating to the therapist (Horowitz and Eels, 1993; Luborsky, Barber and Diguer, 1992). In the integrative field, Wachtel's early (1977) integration of behavioural and psychoanalytic ideas and methods has led to the model of 'Cyclical Psychodynamics' (Gold and Wachtel, 1993) which, in its emphasis on self-maintaining vicious circles, in its attention to both intra- and inter-psychological processes and in its use of a range of therapeutic methods, is close to CAT. Safran's (1990a, b) linking of traditional cognitive and behavioural therapy with interpersonal theory, and his concepts of the interpersonal schema and the cognitive–interpersonal cycle and his emphasis on the use of the therapy relationship to 'disconfirm dysfunctional interpersonal schemas' is also similar in most respects. In the field of group therapy Wessler (1993) describes another CAT (Cognitive Appraisal Therapy) which shares many assumptions and methods with Cognitive Analytic Therapy.

Recent developments

During the past five years the theoretical base of CAT has been further elaborated, with ideas from object relations theories being more fully integrated and linked with those derived from the works of Vygotsky and his followers and from Bakhtin (Ryle, 1991; Leiman, 1992, 1994a). At the same time the exploration of the differences between CAT theory and psychoanalytic ideas continued (Ryle, 1992, 1993, 1994a). These developments were reflected in practice in a clearer and more theory-based approach to reformulation, especially as regards Sequential Diagrammatic Reformulation. These changes were especially influential in the development of understandings of borderline personality disorder. The research which took place during this time, reviewed

in Chapter 10, also contributed to, and was shaped by, these developments. In the rest of this chapter the following topics will be considered: the Procedural Sequence Object Relations Model and the SDR; Vygotsky and Bakhtin; the continuing debate with psychoanalysis; new observational studies of child development and new understandings of borderline personality disorder.

The Procedural Sequence Object Relations Model and developments in Sequential Diagrammatic Reformulation

Reformulation based on the Procedural Sequence Model described individual procedures in terms of the aim, following the processes of thought and action involved through to the consequence and, in the case of neurosis, to non-revision. The aim was to identify general procedural patterns capable of encompassing a wide range of individual activities. Links with other procedures might be indicated, for example, at the stages in the sequence of appraisal, action planning and prediction of consequences, but in general each procedure was addressed as an individual problem. In most cases there would be three or four procedures described in a reformulation, but some of these might be alternative ways of describing the same basic phenomenon; for example, a self-destructive act might be attributed to a dilemma ('as if I must harm myself or harm others') or as a snag ('as if guilty and therefore self-punishing').

The development of the Sequential Diagrammatic Reformulation technique (Beard, Marlowe and Ryle, 1990) allowed the sequential, self-maintaining nature of procedures to be conveyed more explicitly and precisely, and also opened the way to a clearer description of how different procedures might be connected. For example, the fear or expectation of abandonment by others could be shown to generate a dilemma '*either* involved, risking abandonment, *or* avoiding closeness (abandoning the other)'. The former role could in turn generate procedures for controlling emotionally significant others. The latter could lead to compensatory symptomatic procedures such as bulimia, which could substitute for emotional emptiness.

The formal qualities of the SDR were only slowly established. Early sequences of states, acts and consequences were followed by the construction of a central core, from which the various procedures were seen to be generated. This was usually identified in terms of a single role or state, such as 'abused' or 'rejected', being based on reported early experiences and comparable to the 'chronically endured pain' identified by Mann and Goldman (1982). This practice, however, reflected or encouraged the tendency of many therapists to recognise and respond more easily to the deprived and abused aspect of their patients than to the depriving, abusing aspects. To correct this, and to reflect the focus in the emerging Procedural Sequence Object Relations Model

(PSORM) on the reciprocal role patterns derived from early experience, the practice of describing the core in terms of reciprocal roles, in particular Inner Parent–Inner Child (IP–IC) relations (such as 'powerfully rejecting inner parent to submissive and needy inner child') was adopted. Relationship procedures derived from such a core could be seen to reflect the enactment of either the IP or IC role in relation to another (playing the complementary IC or IP role). Self-management patterns could often be seen to be modelled on the same reciprocal roles. There remained, however, three problems with this approach to the SDR. Firstly, it could lead to a too simple equation of reported early experience with the role patterns, ignoring the often partial, polarised or distorted perceptions of the child. Secondly, it could lead to a neglect of other formative relationships. Thirdly, the core reciprocal role pattern could be treated as a representation of the 'inner world' of the patient, rather than as a major determinant of behaviour and the basis on which subsequent experience is patterned. I now consider it best to regard the core repertoire of reciprocal roles as an heuristic device, serving to link and explain a range of phenomena. The construction of the core will draw on a range of data, including the history, current patterns of self-management and of relating to others, the emerging transference and countertransference responses and may involve hypothesising what roles (roles being understood to include action, emotion and communication) might have been replaced by avoidant, defensive or symptomatic procedures. The presumed parent–child origins of many role patterns, which often make sense to the patient, may still be indicated as IP–IC procedures, provided that the considerations above are remembered.

The emphasis on reciprocal role patterns encompasses the concepts described in psychoanalysis in terms of identification, introjection and projection, internal objects and part objects. A particular role is not granted the quasi-autonomous status of an internal object, but such roles may be modelled on historical figures or may appear as idealised characters in dreams or fantasy. Such figures, however, need to be thought of in relation to their reciprocating roles; St George implies the dragon and the dragon implies St George. Roles which were historically untenable, through prohibitions or associated unmanageable affects, may be 'projected' (that is, induced in the other) or they may be replaced by symptomatic or avoidant procedures, or by defensive procedures in which there is restricted access to memory, feeling or wish. All such procedures, once established, will be stable due to the fact that the confirming reciprocations of the enacted role can usually be elicited from others, leaving the core repertoire unchanged. Compared with the PSM, the PSORM offers, in this way, a more general understanding of the stability of personality.

Taking account of these theoretical developments, it will be clear that the

present reformulation process, described in detail in the next chapter, is a complex procedure, requiring both conceptual clarity and accurate empathy from the therapist. The complete diagrammatic and written reformulation combines the two modes of conveying knowledge and influence described by Bruner (Bruner, 1986; Ryle, 1994b). Thus the letter is an example of the 'narrative' mode whereby experience may be endowed with different meanings, while the TP and TPP descriptions and the SDR represent the 'paradigmatic' mode, offering descriptions the accuracy of which has been, and will be, tested against experience. The completion of the reformulation and the patient's participation in this task will have initiated the work of therapy and the reformulation itself will be in active use through the rest of therapy. How this may contribute to change will now be considered in the light of the ideas of Vygotsky and Bakhtin.

Vygotsky, Bakhtin and the debate with Psychoanalysis

An early influence on the development of CAT was a paper describing Bruner's development of Vygotskian ideas (Wood, Bruner and Ross, 1976). This introduced the notion of the 'scaffolding' role of the teacher in providing, but progressively handing over, the tools or concepts necessary for the ordering and execution of a task. The direct introduction of Vygotskian ideas followed my meeting with Mikael Leiman in 1983, at which he recognised similarities between the PSM and the use made of reformulation in CAT and Vygotsky's (1962, 1978) emphasis on mediation in higher mental processes and Leonjew's (referred to in Leiman, 1994b) circular and hierarchical model of higher mental functions. A comparison of 'activity theory' (derived from Vygotsky and his school) and object relations theories as presented in the PSM was presented in Ryle (1991). In this paper it was suggested that activity theory and object relations theory were complementary in many ways. The understanding of higher learning through joint activity with a more experienced other, offered by activity theory, was extended to therapy, as being at least partly analogous; it was suggested that the best approach was for the therapist (teacher) to involve the patient (pupil) in tasks for which appropriate concepts are provided and for which responsibility is progressively handed over. This understanding is in marked contrast to the idea that change requires the induction of regression.

A year later Leiman (1992) extended this integrative endeavour in a paper critically examining the limitations of Vygotsky's definition of the sign. In a consideration of Winnicott's concept of the transitional object on the one hand, and of the writings of Bakhtin on the other, he pointed out how these disparate sources converge in locating, as initially *between* people, the signs

(transitional objects, words, all cultural artifacts) which, when internalised,. are the basis of the individual psyche. The earliest developmental stages, understood as joint action sequences, were further considered in Leiman (1994a).

The contribution of a theory of sign mediation to the understanding of early development is considered by Leiman in Chapter 6. This approach is an important contribution, emphasising the cultural, that is the specifically human, elements in human personality. In highlighting the role of dialogue in human thought and personality (see Holquist, 1990) these ideas can largely replace the pseudo-biological elements of psychoanalytic theory, and correct what Leiman identified as a 'cognitivist' bias in the PSM and PSORM. Our aims and our intentions, as much as the other characteristics of our procedural repertoire, are learned in interaction with others and mediated by the language and concepts of the culture we are raised in. We do not, usually, validate our acts like scientists but we can reflect upon them using our more or less adequate symbolic mediating tools, notably language. From which it follows that the extension of the capacity for self-reflection is an appropriate aim of therapy (Leiman, 1994b).

It is of interest to consider an early discussion of psychoanalysis from this viewpoint. Despite its polemical style, the critique of the philosophical assumptions underlying psychoanalysis, written in the twenties by Voloshinov (a colleague of, or pseudonym for, Bakhtin) (Voloshinov, 1987) raises many issues which are still of relevance. Voloshinov argues that Freud, while attempting and claiming a scientific psychology, was in fact trapped in the assumptions of subjective psychology, projecting into the unconscious many of the same qualities as are characteristic of the conscious. The polarisation of the conscious and unconscious, their 'mutual incomprehension and hostility' and their 'endeavour to deceive each other' suggest to Voloshinov a relation between 'two ideas, two ideological trends, two antagonistic persons', rather than opposing, essentially different, psychical forces.

However, in the object relations school of psychoanalysis, the unconscious has been increasingly described in terms compatible with Voloshinov's conflicting ideas and antagonistic persons; one could argue that, in this respect, Freud's projection of the qualities of the conscious into the unconscious turned out to have been appropriate. The dynamic unconscious can be understood as the suppressed partner in an inner relationship, of whom we are not directly aware but whose existence is declared by unbidden thoughts and omissions and, more importantly, by evidently motivated acts and in the determining of our relationships with self and others. It is no less shaped by our experiences than are those aspects we can reflect upon, and is equally formed through culturally transmitted 'signs'.

The fascination exerted by the 'discovery' of the unconscious, and with the

decoding of obscure messages from it, has dominated psychoanalysis, and neither other forms of unconsciousness nor the source and form of consciousness have been attended to with the same enthusiasm. The polarisation of conscious and unconscious has obscured the common origins and shared features of the two systems. In my view, the mythic elements of psychoanalytic theory, whether expressed as the clash of dark forces or named after heroes like Oedipus, are reflections of how culture has shaped both the conscious and unconscious mind. Myths are powerful because they distil the experience of centuries. But they refer to the content, not the structure, of mind, or demonstrate how the mind's functioning is shaped both by its biological properties and by the way experience is reordered through signs which in turn determine further activity and the shaping of further experience.

The practical implications of these differences in outlook are manifest in CAT in the central role accorded to *descriptive reformulation*. Procedural descriptions do not distinguish between procedures or parts of procedures which are open to introspection and those which are not. The description of a procedure may be derived from the patient's introspection, that is to say upon the aspects of inner dialogue which he or she can report, but must also take account of a range of other observations. We enact procedures all the time without reflection and without recall of the circumstances under which they were formed. The two poles of a dilemma, the evident source of a snag, or the assumptions generating a trap, may or may not be in awareness. But whether awareness is partial or complete, and whether the formative events or situations are recalled or buried in amnesia, the shape of the procedure may still be discerned. Once this has been achieved, consciousness can intervene to block or modify the procedure.

If the classical preoccupation with conflict and defence is set aside, or retained as only one of many ways in which we may be barred from introspection, the therapeutic task becomes more general; it is to identify all those ways in which an individual's repertoire of procedures is restricted or distorted, and all those ways in which conscious awareness of these restrictions may be limited but capable of extension. Therapeutic change involves, inseparably, new *experiences*, new *behaviours* and new *understandings*, but it is through new understandings, especially new capacities for self-understanding, that the patient becomes capable of independent and continuing change. In a paper considering the place of consciousness in psychotherapy (Ryle, 1994c) I suggested the following possible sources of procedural restriction and limited capacity for self-reflection, all of which, once identified with the patient, are open to correction:

1. Restricted experience Narrow family role definitions, or culturally inappropriate ones, or family beliefs about the world (for example as

excessively dangerous) may leave an individual with a small repertoire which, as always, may be maintained by the extraction of evident confirmation from the world.

2. Restricted self-reflection Conscious self-reflection will be learned from the kind of reflection offered by others. Parents concerned with appearance, achievement or obedience may have children who display, perform or obey but who may have no awareness or concepts with which to consider their own subjective experience and who in consequence may be open to abuse and unable to seek corrective or compensatory experiences.

3. Disjointed self-reflection This may result from inconsistent, contradictory parenting, which is often accompanied by disjointed or misleading accounts. This may make integration of the different reciprocal role procedures impossible.

4. Errors of attribution Errors due to the child's false deductions about causality and responsibility can lead to guilt and to avoidant or symptomatic procedures. Irrational guilt for imaginary consequences of what was wished for, often reinforced by adult suggestions that desires are in themselves bad, can lead to guilt. The guilt of victims is similarly based on the belief that what happened must have been deserved.

5. Unmanageable experiences These can overwhelm the capacity to feel, think or act and may become unthinkable. Examples include childhood abuse and bereavement, and abnormal grief reactions or post-traumatic stress disorder in adults. Other people often reinforce the tendency to put the experience out of mind and procedures are evolved for avoiding thoughts or actions likely to lead to remembering.

6. Silencing This is an example of the above in which the perpetrator of abuse also threatens dire punishments if the event is ever mentioned.

7. Defensive anxiety reduction Anxiety reduction in the face of critical or threatening voices from actual parents or from the internalised voices of parents can be alleviated through the forgetting of desire or of the possibility of pursuing it. This represents the classic ego defences.

These different forms of restriction, derived from both trauma and deprivation, frequently coexist, and all need to be considered. Whatever their origins, procedures tend to be self-perpetuating, and the therapist's task is to identify, describe and not reciprocate the damaging procedures.

While some problems are maintained by powerful intrapsychic forces which appear self-perpetuating, all procedures originate in interpersonal experiences, and the specific, targeted interpersonal activity of therapy can provide the basis of a changed inner dialogue.

It is for this reason that the CAT therapist is primarily concerned with *accurate description* and *non-collusion* rather than with interpretation. Interpretation can be experienced as omniscient, feeding fantasies of magical care, or as critical and intrusive, repeating patterns which can be subsumed under persecuting or abusive reciprocal role procedures. Description, on the other hand, can be discussed and modified in a direct, equal conversation; any hypothetical elements can be clearly identified as such. Persistent interpretation can induce a regressed state which further emphasises the power of the analyst and which can exclude from the work of therapy the patient's own capacity (Ryle, 1992, 1993). Whether or when such regression may be necessary or helpful, and how far the phenomena produced in the analysand are derivatives of human development rather than products of the analytic relationship, are open questions. But in CAT and other forms of brief therapy the aim is to avoid regression and to mobilise the patient's capacity for self-reflection. In this respect, experience shows that the zone of proximal development (to use Vygotsky's phrase) is extensive, even in patients who are seriously damaged.

It is perhaps worth noting that an absence of any detailed consideration of the origins of consciousness in culture and language is also characteristic of cognitive psychology. Thus Stinson and Palmer (1991), in the context of a stimulating discussion of parallel processing models, attribute consciousness to 'innate neurological influences' and of processes which 'unfold during development'. I believe that the important attempts by writers such as Horowitz and his colleagues (Horowitz, 1988, 1991) and Westen (1991) to integrate psychoanalytic and cognitive understandings would be more fruitful if these ideas were incorporated. The extension of self-awareness and self-control and self-possibility are central goals of psychotherapy. Theories which polarise conscious and unconscious mental processes and neglect the former, theories which seek to explain culture in terms of psychology rather than psychology in terms of culture, theories which fail to note the difference between biological evolution and cultural development, and theories which model the mind in terms of affectless rationality can distort the act of therapy. The historical tendency to greater human complexity and the possibility of greater freedom through consciousness is a model for the task of therapy.

Observational studies of early development and their relevance to CAT

It was always my aim to base CAT on a developmental theory which was compatible with what was reliably known from observational studies.

However, the main emphasis up to now has been on the differentiation of the theory from the object relations theories from which it was derived. This involved the rejection of aspects of those theories (notably those emphasising innate intrapsychic conflict, those equating the phenomena of regression and psychosis with early development and those proposing untenable developmental timetables) and the introduction of alternative understandings derived from the work of Vygotsky and Bakhtin, summarised above and developed in the chapter in this book by Leiman.

While these developments were taking place, the work of Stern (1985) announced a new convergence between developmental psychologists and analysts and was evidence of what has become a massive explosion of new research in the field of early development. To assimilate the full impact of this on the theory and practice of CAT will require serious attention over the next few years; in the meantime two bodies of work with clear implications for CAT will be discussed briefly.

Despite Leiman's reservations about the 'biologism' of attachment theory (Leiman, 1994a), the theory has generated an impressive volume of research on psychological phenomena. Bowlby's (1969) concept of the intergenerational transmission of 'working models of relationships' is close to what, in CAT, would be described as the creation of the individual's repertoire of reciprocal roles, implicit in which is the assumption that, as these are formed in interaction with parents, they will inevitably reflect the parents' own repertoires.

In a recent paper, Fonagy et al. (1994) review and add to research stemming from Bowlby and initiated by his colleague Ainsworth concerning this process of intergenerational transmission. Much of this work depended on the development of two research tools, the Strange Situations technique and the Adult Attachment Interview. The former, applied to infants aged 12–18 months, involves watching the child's response to a brief separation from, and reuniting with, the parent. This yields a reliable classification of children into four main attachment styles, namely securely attached, avoidant, angry/passive and disorganised. The latter, on the basis of interviewing, described early attachment experiences as generating four groups, namely the autonomous, the dismissive–detached, the preoccupied–entangled and those who have failed to mourn the loss of an important attachment figure.

Using these methods Fonagy and his colleagues demonstrated that parental attachment styles, assessed during pregnancy, were highly predictive of the attachment styles of their subsequently born children, assessed at 12 and 18 months, the association being stronger for mothers than for fathers. The child's attachment style was specific to the parent concerned, indicating that 'working models' were separately transmitted, an observation which can be seen to justify the common CAT practice in reformulation of identifying separately the reciprocal role patterns derived from each parent.

In a further important study, mothers were rated (a) on the degree of early deprivation they had experienced, and (b) on their capacity for self-reflection. Ten out of ten deprived mothers rated high on self-reflection had securely attached children, compared with only one out of seventeen similarly deprived mothers who were low on self-reflection. The capacity for self-reflection is understood to operate by allowing the mother to acknowledge and reflect upon the child's experience and mental state. A child endowed with the capacity for self-reflection is, in turn, less at the mercy of abuse or neglect. Abuse, however, is likely to be committed by an unreflective parent who is unlikely, therefore, to engender self-reflection in the child. This effect may be heightened, according to Higgitt and Fonagy (1993), by the child's defensive inhibition of the capacity to reflect upon the mental states of (hostile) caretakers; these authors see this as a major source of borderline states.

The second source which I would like to refer to is the powerfully argued book by Hobson (1993) in which the phenomena of autism are considered in the light of recent studies of normal development. Hobson argues that the organic defect underlying autism causes an impairment of the active interest in persons and relatedness which characterises normal children from birth onwards. He emphasises that the normal infant, from the beginning, is interested in persons as persons, not in bodies that later are seen to have minds. Thought and feeling develop in the perceptually anchored, intersubjective exchanges of the pre-verbal child, and only within this affectively driven connection can the child learn the difference between persons and things, between self and others and between real and pretend or reality and image. These discriminations are made prior to language and prepare the path for it. Lacking this intensity of connection, the autistic child acquires incomplete understanding of these differentiations and only a partial command of language.

Hobson is clear that symbolic functioning can only arise in the context of an interpersonal relationship in which both engage with an object or event in the world. But, despite his acknowledgement of Vygotsky's contributions, despite his rejection of cognitivist views of the 'child as scientist', and despite his specific recognition of the autistic incapacity for abstract thought, he seems to pay little attention to the role of the adult in providing the signs (contexts, objects, communications) which, internalised, become the tools of mediated thought. This recognition would in no way undermine his central argument for the inseparability of thought, affect and relationship, nor his basic thesis about autism.

These two contributions, both incidentally by psychoanalysts working on observational data, do not contradict the broadly conceived developmental account on which CAT is based, but both add considerable fine grain to that account, and both highlight the importance of the individual's intersubjectively

acquired 'theory of mind'. While Hobson illuminates the way in which this is acquired by contrasting normal and autistic development, Fonagy demonstrates how such a 'theory' may be underdeveloped through the lack of reflection from caretakers and, he argues, from defensive inhibition in the face of hostility. The nature of the damage is clearly different in the two cases, but the arguments of both fully justify the emphasis placed on learning in the context of a relationship which is part of all therapies but which is given a central place (with a Vygotskian concern for mediating tools) in the practice of CAT.

Borderline personality disorder

The diagnostic features of borderline personality disorder (BPD), as summarised in the DSM-III(R) (American Psychiatric Association, 1989), include a pervasive instability of mood and self-image, self-harm and self-neglect, destructive and unstable relationship patterns, identity diffusion and impulsivity. There are frequently associated Axis 1 disorders, notably depression, alcoholism and eating disorders, and the condition is not reliably distinct from other Axis 2 diagnoses (histrionic and narcissistic personality in particular). Berelowitz and Tarnopolsky (1993), in reviewing recent research, conclude that the diagnosis, while reliably identifying a group of seriously disturbed patients, might be better regarded as 'severe personality dysfunction'.

While instability figures large in the diagnostic criteria, for example as 'stable lability' (Higgitt and Fonagy, 1993) or as 'identity diffusion' in the DSM-III(R), and while psychoanalytic ideas of structure (notably splitting) have contributed to these understandings, a useful understanding of the structures generating this unstable picture has been wanting. It is here that the CAT-derived model of multiple self states has a contribution to make.

The multiple self states model of borderline personality organisation

In the course of reformulating the problems of borderline patients receiving CAT, it became increasingly evident that it was both possible and necessary to identify and describe the various 'sub-personalities' or 'self states', the alternations of which determine the patient's confusing experiences and actions. Once these were identified, the disconcerting 'state switches' could be recognised and their provocations monitored (Marlowe, 1994). Each self state can be described in terms of mood, access to and control of emotion, and the reciprocal role repertoire generating self-management and relationship procedures. These descriptions are similar to those employed by M.J. Horowitz (1979) in his analysis of therapy transcripts in terms of 'states of

mind'. The model so constructed is in line with the suggestion made by L.M. Horowitz (1994) that the DSM term 'identity diffusion' should be replaced by 'identity confusion', implying shifts between 'contrasting, even contradictory, identities'. The model has similarities with accounts of multiple personality disorder (MPD) (Ross and Gahan, 1988) but in the case of BPD most states have never been clearly identified, let alone named, by patients or by clinicians; moreover the degree of dissociation between states is seldom as absolute in BPD as in MPD.

The Self States Sequential Diagram

In order to emphasise the need to identify separate self states, I suggest that the sequential diagrams of borderline structure patients should be called 'Self States Sequential Diagrams' (SSSD). These should be constructed for diagnosed borderline patients, for those who, in the course of early sessions or assessment interviews, give clear evidence of state switches and in those who give many positive responses to the screening questions at the end of the 'Psychotherapy File'. The construction of the SSSD requires a detailed attention to the history and current relationship patterns of the patient and an alertness to state switches occurring during or between sessions, including those less dramatic ones sensed largely through countertransference changes. In addition, patients must be recruited to the task of describing their states in detail and of noting shifts between them. This task culminates in the patient systematically rating all the self states against descriptions relating to mood, access to feeling self and others, using provided descriptions with individual additions. These ratings may be processed as a repertory grid (Ryle and Marlowe, 1995). This provides an indication of how well discriminated the different states are (some may be paired or clustered) and comparison with the SSSD can ensure that the latter contains all the self states. It is quite possible to construct an SSSD without the grid analysis, provided the need to identify all states with distinct reciprocal role patterns is borne in mind; the 'broken egg' diagrams introduced into CAT several years ago (see Chapter 2), which described a split into two states, became somewhat conventionalised and led to some equally discriminable states being left out of the diagrams. It is important to identify all states, as only a full account of reciprocal role patterns can permit the prediction and recognition of transference–counter-transference changes.

The construction of the SSSD is described in Chapter 2 and research related to it and to the self states model is summarised in Chapter 10. The studies reported lend some empirical support to the model and suggest that diagrams can be constructed by patient–therapist pairs which are accurately reflective of early therapy events and stories and which are predictive of later therapy events and feelings.

The nature of borderline self states

All borderline patients have one, usually dominant, state which reflects the remembered interactions of childhood. Some procedures generated from this state may be derived from the originally child role, accepting abuse or neglect; others may represent the enactment of the original adult role (abusing and neglecting) towards others and/or the self. A second common state is the split-off idealising or the admiring–admired grandiose pattern described in the 'broken egg' diagrams. Other common patterns are: emotional blankness in relation to others seen as out of reach, hurtful and sometimes also vulnerable; out of control rage in relation to others seen as humiliating or abusive; submission to the critical demands of self or others expressed in placation, perfectionism or manic activity. These are not complete descriptions, and it should be remembered that either pole of the pattern may be enacted, elicited or replaced by symptomatic procedures. In every case it is essential to go through the process with the patient of identifying and characterising each state, for this process, apart from ensuring accuracy and comprehensiveness, plays a large part in building the working alliance and in establishing or equipping a capacity for self-observation in the patient.

The causes of borderline personality disorder

Abuse, both physical and sexual, and neglect, figure in the early histories of most borderline patients. Beyond that, the relative importance of

1. being deprived of the reflections of self-reflective caretakers
2. a defensive inhibition of thinking about the mental states of others, and
3. the disruption of self-reflection due to constant state switches

is hard to assess. In CAT the role of inadequate reflection from others in childhood in limiting the capacity for conscious self-reflection has been recognised, but the main emphasis has been on the disruption of self-awareness and the absence of an ongoing process of self-monitoring, whereby the results of ones own acts could be recognised and responsibility accurately perceived. While fully endorsing the emphasis on self-reflection and on the capacity to think about the mental states of others (capacities which probably grow from the same experiences), incapacity in these respects is not, in my experience, typical of all the states in borderline patients. Some, indeed, have an uncanny awareness of others mental states, including those of their therapists. This

capacity, however, serves them but little as long as they are prone to state switches, often into states characterised by powerful one-dimensional reciprocal role patterns in which the other is essentially, and forcefully, required to do no more than reciprocate.

The different explanations are, of course, compatible with each other and may vary in importance between cases. But the experience of time-limited work centred on integration through the use of reformulation shows that in many patients surprisingly rapid extensions of self- and other-awareness and of integration can be achieved. These changes seem more understandable as the result of the new higher-order capacities for self-observation than as the result of the resolution of defensive inhibition.

Cognitive Analytic Therapy with borderlines

In a condition widely acknowledged to be difficult to treat and having a relatively poor short-term prognosis, any successful brief intervention demands some attention. Case histories describing such reasonably effective interventions have been published (Ryle, 1990; Ryle, Spencer and Yawetz, 1992; Ryle and Beard, 1993; Ryle and Low, 1993; Dunn, 1994) and will not be repeated here. As a result of clinical experience of this nature and of a small pilot study, an ongoing research programme accumulating and following up cases of BPD was started in 1992. In this, normal CAT practice is varied, patients being offered up to 24 sessions (the final number being agreed at around session 12) and medication needs being assessed and treated by psychiatrists outside the project. Therapists are mostly trainees selected for experience and ability, and supervision is provided in groups of three for one-and-a-half hours weekly, which is a better ratio than is usually possible. Patients are recruited on the basis of standard diagnostic procedures and all sessions are audiotaped.

Some early findings from this project are reported in Chapter 10, but it is too early to be able to offer hard data concerning the overall outcome of the interventions, or linking process measures with outcome. The experience of the pilot study and the early cases in this series is, however, encouraging; it seems that dropout rates are relatively low and that at the three-month follow-up about half of the patients no longer meet DSM-III(R) criteria for BPD.

The central feature of CAT in these cases is the joint creation and use of the SSSD and the avoidance of, or recovery from, collusive involvement with the patient, the explicit aim being the achievement of integration through self-awareness. The work of such therapies is very intense and demanding on both patient and therapist, but the containment offered by the reformulation makes it possible to endure the difficult times and make constructive use of whatever aspect of the patient presents.

Most authorities still recommend long-term work in borderline patients. Gunderson and Sabo (1993), for example, in reviewing the available treatments, suggest that psychoanalytic psychotherapy requires at least three sessions per week for a minimum of four years. More practicable interventions are also being reported, however, Linehan (Shearin and Linehan, 1993) describes a two-year behavioural intervention combining individual and group therapy and demonstrating a thorough and sensitive awareness of countertransference problems. Stevenson and Meares (1992) report a series of severe borderline patients treated by intensively supervised trainees in twice-weekly therapy based on a self psychology model. Therapy lasted for one year and all patients derived some help, with 30% no longer meeting borderline diagnostic criteria at the post-therapy assessment one year after treatment. The place of CAT in services treating borderline patients will, it is to be hoped, be evaluated in relation to approaches such as these.

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