# The structure and development of borderline personality disorder: a proposed model

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**Background** The theory of cognitive analytic therapy is extended to offer an understanding of borderline personality disorder (BPD).

**Method** A structural model (the multiple self states model) and a classification of different levels of developmental damage are proposed.

**Results** The model offers an explanation of the phenomenology of BPD.

**Conclusions** The multiple self states model provides insights that will be useful for clinicians involved in the psychotherapy and management of BPD patients.

Most sufferers from borderline personality disorder (BPD) are treated by general psychiatrists and mental health teams often in connection with associated conditions such as depression, deliberate self-harm, substance misuse and eating disorders. The management of these patients is difficult because of their extreme moods and behaviours, and because their general tendency to become over-dependent on, or very angry with, those with whom they are involved is often repeated with clinical staff. Without a way of understanding such behaviour, management can easily become reactive or unduly disciplinarian.

The present paper describes a model of borderline functioning – the *multiple self states model* – which explains many of the features of BPD in terms of the alternating dominance of one or other of a small range of partially dissociated 'self states'. The developmental origins of this structure are discussed, the practical ways of identifying self states are described and illustrated, and the model is compared with some current theories.

## THEORETICAL ISSUES

### Diagnosis of borderline personality disorder

Berelowitz & Tarnopolsky (1993), in a comprehensive review of research, concluded that the diagnosis of BPD based on DSM–III–R (American Psychiatric Association, 1987) was valid but, in view of its multifactorial aetiology, the heterogeneity of its features and the wide differences in severity found in patients so diagnosed, suggested that it might be better regarded as "severe personality dysfunction rather than as a discrete diagnostic entity". Most BPD patients meet the criteria for other DSM axis II cluster B diagnoses (Dolan *et al*, 1995), and patients diagnosed with dissociative identity disorder under DSM–IV (American Psychiatric Association, 1994) frequently meet BPD criteria also. For the clinician, therefore, the categorical diagnosis is of limited value and ways of linking the surface manifestations to underlying processes would be of more use. The aim of the proposed model is to provide such a link.

### Theoretical background of the multiple self states model

The proposed model is derived from cognitive analytical therapy (CAT), a treatment based on an integrative theory drawing on cognitive–behavioural, psychoanalytical and other sources. A recent account of the history and features of CAT and associated research will be found in Ryle (1995). Key concepts contributing to the model of borderline functioning may be summarised as follows:

(a) Behaviour and experience are organised by *procedures* involving repeated sequences of:

  (1) mental processes (perception, appraisal, action planning, prediction);

  (2) behaviour; and

  (3) outcomes and consequences in the light of which

  (4) the procedure may be revised.

(b) Procedures organising relationships involve predicting or seeking to elicit the responses of the other, and are called *reciprocal role procedures*. They determine overall patterns of relating and self-management, are learned early in life and are relatively resistant to revision (Tulving, 1985; Crittenden, 1990).

(c) The procedures acquired in childhood through interaction with parents and other caregivers embody socially derived meanings and values, transmitted through language and other signs (Leiman, 1995).

(d) Procedural learning involves the internalisation of what has first been enacted, experienced and understood with others. Human thought and personality therefore involve internal 'dialogue' between interacting elements and may (but need not) involve internal conflict.

(e) A person may be characterised by describing their *repertoire of reciprocal roles*. The sources of psychological distress and dysfunction may be usefully understood in terms of the repertoire of role procedures causing and maintaining the problems.

### The multiple self states model

Borderline patients are prone to abrupt and discomforting shifts between markedly


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contrasting states, the provocations of which are not always apparent to the patient or to observers. Such switches are often accompanied by alterations in posture, facial expression and tone of voice and, at times, by depersonalisation–derealisation experiences, as described by Putnam (1994). These experiences, and much of the variability described as typical of the borderline patient, are understood in the proposed model to be the effect of switches between partially dissociated self states. Borderline patients have a small number of such self states, each of which can be characterised by its pattern of reciprocal role procedures and accompanying mood, behaviour and symptoms.

This pattern of partial dissociation is seen to be on the continuum between normal mood instability and state-dependent memory on the one hand, and the profound dissociations between sub-personalities or 'alters' found in dissociated identity disorder on the other (Szostak *et al*, 1994). Levels of dissociation regarded as of clinical importance and as typical of BPD are those where changes are abrupt, evidently unprovoked in many instances, are discomforting to the individual and to those in relation to him or her, and may lead to behaviour which is not appropriate to the context. Some states are accompanied by moods or behaviours which are more extreme than are commonly found in normal or neurotic subjects.

A distinction needs to be made between a state and a self state. In CAT theory a *state* is the subjective experience of playing a particular role. The concept of *role* includes action and expectation and the accompanying memories and affects. Each such role will imply a reciprocating role; for example, the role of 'frightened submissive victim' implies the reciprocating role of 'threatening and abusing'. The description of a *self state* names both poles of the reciprocal pattern and provides a more powerful understanding than that given by state descriptions. The title 'self state' is preferred to 'sub-personality' as the latter term implies a more complete degree of dissociation than is usually present and a more fully developed mode of functioning than is present in many self states.

## Developmental origins of borderline features

The organisation of the procedural system is hierarchical. For the purposes of the present discussion, three levels are described. Level 1 concerns the reciprocal roles organising relationships and self-management. Level 2 consists of higher-order procedures which mobilise the level 1 procedures appropriately and which link them and organise smooth transitions between them. For example, a child at breakfast might effortlessly combine, by means of level 2 functions, three level 1 procedures: (a) silent obedience to an irritable father; (b) nurturant affection for a depressed mother; and (c) cheerful mutuality with a sister. Level 3 is concerned with conscious self-awareness. In summary, level 1 procedures are manifest in the acts and roles performed by the individual, level 2 procedures provide the structure or organising processes of the self, and level 3 procedures are the basis of consciousness and of the sense of self. The developmental origins of BPD will now be considered with reference to damage affecting these three levels.

### *Level 1: Restriction and distortion of the procedural repertoire*

Genetic factors and biological damage may contribute to borderline pathology (van Reekum *et al*, 1993), but the main source of damage is the experience of abusive and neglecting relationships in early life (Perry & Hermans, 1993). Individuals from such backgrounds have difficulty in accepting or in offering care, and often both accept abuse and inflict it on themselves and on others. In addition to learning these damaging patterns directly, the child's internalisation of harsh parental attitudes leads to intrapsychic conflict (the focus of psychoanalytical attention) in which guilt and anxiety are dealt with by repression and symptom formation. Depression, anxiety, somatisation, eating disorders and other axis I pathology, commonly found in association with borderline features, can be seen to be derived from these level 1 problems.

### *Level 2: Disruption of integrating procedures*

Level 2 procedures are concerned with the appropriate mobilisation, sequence and integration of those of level 1. Their development can be impaired by contradictory, incoherent or disrupted parenting. Once developed, they may be disrupted by trauma-induced dissociation. These two factors commonly coexist in the childhood homes of borderline patients. The presence of dissociative *symptoms* is now recognised as a feature of BPD in DSM–IV, and the idea that childhood post-traumatic stress disorder could be an antecedent of BPD receives some support (Gunderson & Sabo, 1993). However, the delineation of the separate self states which result from dissociation and their contribution to the phenomenology of BPD is not part of our current understanding.

### *Level 3: Deficient and disrupted self-reflection*

Consciousness allows attention to be focused on what is new or problematic in the world or in one's own behaviour. Borderline patients, however, seem only partially or sometimes capable of self-reflection. This is understood in the proposed model to result from two factors:

(a) Self-reflection is itself a procedure and, in common with other procedures, originates in interaction with others. Parents whose concern is with appearance, obedience or performance rather than with the child's subjective experience, or who lack interest in, or a vocabulary with which to describe, emotional experience, do not equip the child with a basis for self-reflection. These two factors – *narrow attention* and *deficient emotional vocabulary* – frequently coexist in the parents of borderline subjects.

(b) A second factor is the *disruption* of self-reflection caused by state shifts. Borderline subjects may be sensitively aware of the feelings of others and themselves when they are in certain states, but such awareness is discontinuous and is liable to interruption by state shifts, often at the precise moment when it could be of value in reviewing and revising problematic procedures.

## PRACTICAL APPLICATIONS OF THE THEORY

### Identifying and characterising states

In order to recognise the existence of separate states it is necessary to hold the concept of them in mind. While one may be alerted by the presence of borderline symptoms and by the usual accompanying history of childhood abuse or severe deprivation, once dissociated self states are suspected, detailed evidence needs to be sought from a number of sources, as follows.

### *Patients' self-reports*

Some patients are aware of their shifting states and may volunteer this fact and be able to describe in some detail some of their states. Others may recognise descriptions of states and state shifts given in screening questions, such as those reproduced in the

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appendix (part of the 'Psychotherapy File' given to patients receiving CAT). Responses to these, while not offering a reliable discrimination between borderline and non-borderline subjects, serve to introduce the idea of states. On this basis, patients may be asked to describe their different states carefully, from memory and through self-monitoring as they occur. Most borderline patients can do this, but some may have difficulty in recalling some states. In more dissociated cases it may be necessary for the patient to record the details while in the state. In some states, cooperation with the task may be lacking.

#### *Direct observation and enquiry*

In the course of history-taking, particular attention needs to be paid to any acount of sharply contrasting states or relationships. In addition, shifts occurring during interviewing, often provoked by the anxiety experienced or anger mobilised by the interview, and either directly expressed or evident from changes in expression, posture or voice tone, can be noted and discussed. Subjectively, the interviewer may become aware of these through an uneasy sense of disjunction or confusion. At a more subtle level, familiar to psychotherapists, patients may evoke strong (countertransference) reactions in the interviewer. Whether these represent identification with some aspect of the patient or a reciprocating response to overt or covert behaviour, they can contribute to the recognition and description of the patient's states.

#### *Reconstructions of early experience*

While major amnesia for childhood may occur, most borderline patients have recollections of some of the abusive or depriving experiences of their childhood. Such memories often lack detail or affect. Where an abuse history is obtained, it is usually the case that the pattern of that relationship still dominates one state, with a main reciprocal role pattern along the lines of 'abusive in relation to victim'. Other details of the childhood family experiences and role of the patient may suggest the form and early origins for other idiosyncratic patterns.

#### *Joint clarification and description*

As data are collected from the above sources, the clinician and patient can together gather and label a list of apparently regularly appearing and distinct states and will have begun to characterise these. As a final step the states can be rated against a range of descriptions. This ensures that a systematic comparison is made in terms of the important variables which include, as well as mood and behaviour, descriptions of the degree of control of and access to emotion, and descriptions of the sense of self and others. These ratings of the different states can be processed as a repertory grid to give an accessible display of their similarities and differences, a process which demonstrates that patients can clearly discriminate between their states (see Ryle & Marlowe, 1995), but for most clinical purposes this is not necessary.

## Describing self states

When the state list is assembled, it is helpful to identify the reciprocals of the roles associated with each state, in order to characterise the self states. In many instances, for example in the *abusing–victim* self state mentioned above, the roles at both poles will have been identified in the state descriptions. However, patients may not subjectively identify with every role; thus Pollock (1996) has shown that abused women who had attacked their abusers were not able to see themselves as victims. Other individuals may not be able to describe themselves as providing care. Even where only one pole of the reciprocal role procedure is identified as a state by the patient, the nature of the other pole (which is attributed to others) should be identified.

The process of recognising states is made easier by the fact that the range of self states encountered is not infinite. In addition to abuser–victim patterns, commonly encountered self states, described in terms of their dominant reciprocal role patterns, as enacted in relation to self or others, are the following:

(a) Idealisation. Perfect care in relation to safely, unconflictedly cared for.

(b) Emotionally blunted overactivity in relation to critical, unavailable or rejecting others.

(c) Zombie. Emotionally blank in relation to threatening or absent other.

(d) Loss of control, rage in relation to threatening or humiliating other.

The work done in identifying self states has a number of functions. For the patient, it serves to introduce an unfamiliar way of thinking about the self and about relationships which links early experience, current understandings, behaviour and problems. For the clinician, it offers a way of understanding the possible meanings of the treatment relationship, and serves to limit or repair occasions when this may reinforce damaging procedures. Through jointly working in this way, the patient experiences a mode of relating (cooperative, respecting), which is not part of his or her repertoire. Finally, once self states are reliably recognised, the factors leading to shifts into negative states can be monitored. By locating acts and experiences on a map (sequential diagram) of self states, the patient acquires a new capacity for self-reflection and integration.

## Identifying and describing self states: a clinical example

> Janet, a 37-year-old woman, currently involved in part-time professional training, sought therapy on account of long-standing unhappiness and intense anxiety about the course, where she had a feeling of being picked on and unvalued. In completing the Psychotherapy File she ticked the ++ column for all the screening items on unstable states [see Appendix] and described herself as exhausted by her alternations between intensely experienced moods.

The identification of Janet's self states was largely accomplished over the first two sessions. Three main patterns were apparent, namely:

(a) *Idealised caretaker – perfectly cared for and possessive*;

(b) *abusive–victim*;

(c) *critical control–compliant or witholding*.

The sources from which these were identified are indicated by their letters in the account which follows.

The eldest child of six, reared on a farm, she had been her heavily drinking father's favourite and had been sexually abused by him throughout childhood (b). She described her mother as depressed and exhausted. She herself was a strong woman who, as an adult, had no time for men, being involved in friendships with women which either became intense, possessive and sexual, or came to nothing (a). In one such relatively long-term relationship when she was aged 29 she was physically violent towards her partner (b). At this time she became alcoholic (b) and sought counselling. In her professional life she described herself as capable of being "very strong" (a) but at the same time was extremely sensitive to criticism and feared being found wanting (c). This fear was evident in her largely irrational feelings about her present training (c), generating both compliance and resentful passive


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resistance, which did indeed provoke some criticism. It had been manifest in cancellations and revisions of the arrangements for her therapy (c). In a previous therapy she had formed a powerful, idealising, erotic transference, and elements of this were sensed by her female therapist in the first sessions of the current therapy (a).

On the basis of further consideration and of early repetitions of many of the patterns in the therapy relationship, a self-state sequential diagram, illustrating the self-reinforcing nature of the three self states, was completed and used thereafter by the patient and therapist to monitor both in-session and daily events.

By being aware of these roles and of the pressure to be drawn into reciprocating in the patient's terms, the therapist was able to maintain an effective working alliance. It is part of CAT practice for patient and therapist to exchange 'goodbye letters' at the end of therapy, as a way of reflecting on the process. Janet, in hers, written at the end of her 16-session therapy, included the following:

> Seeing my blind spots down in the diagram was really helpful; I could no longer ignore the reality of where I was at. I felt shame in seeing it, but this was also strangely freeing. Maybe after all I could come out of the dark prison . . .

## DISCUSSION

### Borderline phenomenology and the multiple self states model

The nine traits on which the DSM–IV diagnosis of BPD rests are understood in the model as described below. Those exhibited by the patient Janet are asterisked.

(a) *Frantic efforts to avoid abandonment* reflect intense, possessive forms of attachment derived from unmet needs and idealising, overdependent attachments.*

(b) *Unstable intense interpersonal relationships alternating between idealisation and devaluation* reflect switches between idealising and abusing–victim self states.*

(c) *Identity disturbance* is the result of shifting between self states and of the accompanying lack of continuing self-awareness.

(d) *Impulsivity*, while possibly reflecting biological predisposition, is also derived (1) from the narrowly defined role repertoire of some precarious self states and the intensely felt need to elicit reciprocation, and (2) from the nature of self states derived from deprivation and abuse and characterised by extremes of need or rage.*

(e) *Suicidal and self-mulitating behaviours* may express the enactment on the self of early abusing–victim (sometimes sexualised) role procedures, or may represent efforts to exercise control in situations of powerlessness or to escape from emotionally null states.

(f) *Affective instability* reflects state shifts and poor control of emotion in some states.*

(g) *Chronic feelings of emptyness* reflect unresolved early deprivation and its continuation due to damaging and ineffective interpersonal procedures.*

(h) *Inappropriate, intense anger* is a feature of self states derived from early abuse, reflecting either role reversal or the revengeful rage of the originally powerless victim.*

(i) *Transient stress-related paranoid ideas* derive from early experiences of powerlessness in the face of abuse and blame, and can be mobilised by actual or perceived repetitions.* *Dissociative symptoms* may accompany state shifts.

### The multiple self states model in relation to other theories

The understanding of BPD offered here shares with psychoanalysis the attempt to provide a developmental and structural account, but differs in that much greater weight is placed upon the impact of early environment, and in that structure is described in terms of dissociation rather than of intrapsychic conflict and defence. Dissociation occurs initially in response to *unmanageable external threat*, and recurs in response to reminders, memories or repetitions of the threat. Dissociation is persistent because, at the point when procedural revision might occur, state switches intervene and feared memories remain unassimilated and inadequate procedures remain unrevised. Repression, on the other hand, is seen to represent the effects of *internal conflict*, and psychoanalytic notions of splitting and projection are similarly attributed to largely intrapsychic forces. These assumptions, and the continuing neglect of trauma and actual experience which followed Freud's rejection of the 'seduction hypothesis', have had an unfortunate influence on the models of BPD derived from psychoanalysis.

These differences are not trivial in their practical implications. Interpreting dissociative experiences in terms of conflict and defence may be seen by the patient as blaming, intrusive and omnipotent, and may be an equivalent to the attributions of early abusers, or may be subsumed under one of the patient's existing negative procedures. This can lead to very long and ineffective therapies, as has been argued in detailed studies of Kleinian case histories (Ryle, 1992; 1993). Higgitt & Fonagy (1992) reviewing the psychoanalytical treatment of BPD, stated: "explorations of the patient's past, and interpretations using childhood experience as an explanation of current behaviour, are unlikely to do more than divert attention from the pathological nature of the patient's current behaviour". Here too is evidence of an attitude which repeats the disregard for personal experience shown by the parents of many borderline subjects. In CAT the detailed acknowledgement of the patient's real experience is regarded as both humanly necessary and, in its re-creation of a life narrative, as an essential part of the process of integration.

The CAT approach is closer to some recent cognitive–behavioural models. Linehan's 'dialectical behaviour therapy' (Linehan, 1992) is, in practice, an integrative approach, incorporating understandings of transference and countertransference and combining a humanist respect for the patient's experience with a detailed programme of individual and group behaviour therapy. Her detailed 'chain analysis' of the factors preceding, accompanying and following problem behaviours resembles the CAT procedural sequence analysis. The model lacks, however, any account of inter- and intrapersonal processes comparable to the reciprocal role model, and intervention remains focused on low-level, molecular behaviours. Perris (1994) is critical of this latter aspect of Linehan's work, and describes an attachment theory-derived approach aimed at restructuring underlying high-level schemas and at promoting integration; this model is therefore closest to the one proposed here but, in common with Linehan, it lacks any description of dissociated states and does not share the use of reformulatory tools in the therapy.

### Clinical implications of the CAT model

The defining features of therapy based on the approach proposed here are those common to all CAT, involving the joint elaboration of high-level descriptive tools through which

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therapists avoid collusive reinforcement of problem procedures and patients acquire precise, relevant tools for self-reflection. Where dissociation is a major feature, as in BPD, this process is more complex, but the work involved is also a source of active integration. Change involves firstly reformulation, then recognition, and finally integration and revision.

### *Application to psychotherapy*

The application of CAT to the psychotherapeutic treatment of BPD has been described in case studies (e.g. Ryle & Beard, 1993) and has been researched systematically for the past five years. Process studies based on audiotapes of a series of therapies are being carried out, and the approach is now well enough defined for the criteria of its satisfactory delivery to be established; this is a necessary stage in the development of new therapy techniques. On this basis a randomised controlled trial would now be feasible, if the practitioners of another defined intervention were to show interest. The results of the current study will be published in the near future; in the meantime it can be reported that, of the first 33 patients with BPD recruited to the study, three were found unsuitable and referred out, one moved away, and three dropped out before completing. Twenty-four of the 26 completers have attended for post-therapy assessment, of whom only seven were considered to need further treatment. Follow-up for 1–4 years suggests that improvement is maintained.

### *Other applications of the model*

As noted at the start of this paper, most borderline patients do not get referred for psychotherapy, and the question of how far this model and associated methods might be applicable in other settings is an important one. It cannot, at this stage, be answered on the basis of experience or research, but only on the basis of the following argument.

The stability of both normal and borderline personality is maintained, at least in part, by the person's ability to extract confirmation from others through eliciting reciprocations to their usual roles. The pressures exerted by borderlines on others are intense because of the precarious and narrowly defined role repertoires of their self states. This being so, it can be argued that a great deal of 'supportive therapy' for BPD is bound to be either ineffective or actively harmful, because, without adequate understanding, collusion is bound to occur. Any intervention which attends to only one self state implicitly maintains dissociation, and any relationship which represents a reciprocation of a negative role procedure of the patient will reinforce pathology. The multiple self states model could offer clinicians in out-patient, day hospital and mental health centre settings a more precise, accessible and clinically relevant understanding of personality disorder than do most current descriptions and categorisations. The process of jointly arriving at self state descriptions is no more difficult to learn than many clinical procedures, and has a positive effect on the treatment relationship. Clinicians responsible for the management of borderline patients might discover that this normally refractory and frustrating patient group can be better understood and managed with the help of the model and methods described here. Clearly this assertion needs to be tested out in practice.

## APPENDIX

**Screening questionnaire from the Psychotherapy File**

Some people find it difficult to keep control over their behaviour and experience because things feel very difficult and different at times. Indicate which, if any of the following apply to you.

(a) How I feel about myself and others can be unstable; I can switch from one state of mind to a completely different one.

(b) Some states may be accompanied by intense, extreme and uncontrollable emotions.

(c) Others by emotional blankness, feeling unreal or muddled.

(d) Some states are accompanied by feeling intensely guilty or angry with myself, wanting to hurt myself.

(e) Or by feeling that others can't be trusted, are going to let me down or hurt me.

(f) Or by being unreasonably angry or hurtful to others.

(g) Sometimes the only way to cope with some confusing feelings is to blank them off and feel emotionally distant from others.

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### CLINICAL IMPLICATIONS

- The model makes many borderline symptoms and behaviours more comprehensible.
- Brief psychotherapy of borderline patients based on the model can produce clinically significant change.
- The detailed description of patients' self states promotes integration and enhances self-reflection.

### LIMITATIONS

- At this stage the model represents a new conceptual framework rather than a testable theory.
- Research into the psychotherapy of borderline patients based on the current model has not so far included a controlled trial.
- The suggestion that the non-psychotherapeutic management of borderline patients could benefit from the use of the model remains untested.


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