



THE CLINICIAN'S DILEMMA: CORE CONFLICTUAL RELATIONSHIP THEMES IN PERSONALITY DISORDERS

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Psychotherapy as a treatment for mental health disorders has been developing for almost 120 years (Norcross, VandenBos, Freedheim, 2010). This history is a rich one, with many millions of pages of text written about psychotherapy, analysing individual cases (Breuer & Freud, 1895/1955; Watson & Rayner, 1920); collections of cases (Jones, 1936); aggregating multiple sets of studies (Smith & Glass, 1977); and

doing large studies of many thousands of cases (Seligman, 1995). Much of the promise of the Boulder model of clinical psychology training (Raimy, 1950) is to add every trained clinician into the ranks of scientists who can join this discourse and investigation. The 'scientist-practitioner' is a useful rubric for understanding the clinical situation - a client struggling to present their story, and a clinician struggling to make sense of it, using a model of treatment informed by scientific theory and empirical outcomes (Weiner, 2012).

It is tempting to take this further to progress the view that clinicians can and should be taught to be dispassionate scientists performing technical tasks based on empirical procedures documented in manuals. As we know, however, the data from the science of psychotherapy are in, and the results show the necessity and value of therapeutic warmth, engagement and support in this process (Duncan, Miller, Wampold, & Hubble, 2010). The therapeutic alliance is acknowledged as one of the most powerful factors influencing therapeutic success (Martin, Garske, & Davis, 2000). This is now understood as a sophisticated interaction between the clinician and client - with both playing a role (Whipple, Lambert, Vermeersch, Smart, Nielsen, & Hawkins, 2003). The role of the clinician is to provide a sensible explanation to the client with regard to the planned course of treatment and to demonstrate through their behaviour and attitudes that they will support the client on this journey. The role of the client is to be willing and able to work with the clinician on this plan. Our laboratory and those of others around the world are now focusing on this critical relationship between clinician and client. It is evident how complex this critical relationship becomes when severe mental illnesses, and particularly personality disorders, are involved (Lewis & Grenyer 2009).

Research on the science of personality was advanced with the discovery of the Core Conflictual Relationship Theme (CCRT) method. In 1976 Lester Luborsky, one of the great figures in psychotherapy research (Barber, Crits-Christoph, Grenyer, & Diguier, 2010), was carefully reading and re-reading verbatim transcripts of psychotherapy sessions trying to understand the therapeutic alliance when he discovered a pattern within the conversation between clinician and client (Luborsky, 1977). We know that clients come to therapy because they cannot master their problems (Grenyer, 2002). In trying to master them, they tell narratives to both engage the clinician in the task of problem solving, and to invite them to show support and empathy for their suffering. We know that clients who are older with more severe symptoms tell much more negative narratives compared to younger clients (Grenyer & Luborsky, 1998). Close inspection of narratives told by clients allow us to identify three common elements: (i) the wish (W) of the client in relation to the interaction; what they wanted or hoped for from the interaction (such as to get help), (ii) the response of other (RO); the client's understanding of how others responded to their wish, need or intention, (such as the other person rejecting them), and (iii) the response of

self (RS) - how the client responded to the interaction, such as by withdrawing or getting depressed. Thus can the clinician begin to get insight into the relationship between symptoms (the response of self, such as depression or anxiety) and their interpersonal concomitants - the expected, perceived, or actual responses from others. We know that the accounts of relationships given to us by our clients can be distorted (the identification of such cognitive errors was one of Beck's contributions) and the analysis of the RO to RS sequence goes a long way toward assisting joint understanding of the meaning of symptoms. The wish component introduces the motivational component of psychology. Identifying the needs, wishes and goals of the client in itself is an important step in formulation, but goes further to advance our understanding of the psychosocial maturity of the client in relation to the kinds of needs and wishes they present within the context of their development.

When clinicians begin to study these three components across multiple narratives, then a 'signature' CCRT pattern, or several patterns, emerge (Book, 1998). We might alternatively refer to this process as the 'self-fulfilling prophecy' or 'transference' or 'personality style' or 'attachment pattern', in that the client's characteristic attitudes and approach to relationships can be identified. When Freud first discovered this process he called it a 'stereotype plate' in reference to the metaphor of the steel printing press of his time that was capable of printing multiple copies of the same text or image reprinted afresh with each inking (Freud, 1912/1958). Today using more cognitive science language, we might call it a relationship schema (Young, Klosko, & Weishaar, 2003), or the CCRT (Book, 1998).

A client, Mark, recently told me about his concerns about attending therapy, and that he didn't feel it was helping. These conversations were preceded with many sessions discussing his difficulties maintaining interest at work as he didn't feel appreciated, and his disengagement from his wife and daughters who were busy attending dance classes most evenings. When I had previously asked about his earlier experiences, he related a narrative about when he once came home from school and his family were all celebrating the graduation of his older brother who had got straight 'A's' in class. As well as being preoccupied with the brother's success, the father had remarked that with this success he felt completely fulfilled as a father. This made my client feel even more like there was no space for him in his father's heart or life. From a CCRT perspective, we could understand that his wish (W) to feel important for others was repetitively experienced as rejection by others (RO) - his father, boss, wife - and this fuelled his depression (RS) and avoidant personality disorder. We could also understand in the therapy that he expected me to also reject him, and he had accordingly begun to withdraw from therapy and our relationship. It was only by working through this core pattern, by understanding and learning to recognise it in multiple parts of his life, that he could begin to question and change his usual pattern of the

expected RO or rejection, which would lead him to instigate interpersonal withdrawal, and thereby confirm his expectation of rejection from others. Thus could we both understand the dilemma of him getting close to me, yet without that closeness he would remain unhelped.

Attending to narratives, as a scientist collects data, allows us to aggregate our understanding of what has gone wrong in the client's life through the multiple relationship conflicts affecting the ability to productively love and work. The hallmark of those with good mental health is the ability to satisfy their wishes through mutually enhancing and rewarding interpersonal relationships contributing to generativity and meaning.

Personality disorders are unfortunately common in mental health. In recognition of this, a large team of us from Wollongong, Sydney and Melbourne have been undertaking a major project for NSW Health to raise awareness and improve treatments, called the Project Air Strategy for Personality Disorders (www.projectairstrategy.org). Estimates suggest that 31.4% of patients with common Axis I disorders (such as anxiety and depression) also have a personality disorder (Zimmerman, Rothschild, & Chelminski, 2005). The presence of personality disorder complicates the clinical picture, and this is where tools such as the CCRT can assist the clinician both in the session and in supervision. Thus, in supervision I discussed my relationship with Mark and found, through an analysis of the RO component, that I too was withdrawing from him because of out of awareness feelings that he was rejecting me. Analysing the RO allowed us to find my counter-transference was mirroring his transference. Thus we were able to prevent a repetition of the CCRT in the therapy relationship.

We have recently been studying in more detail the challenges clinicians face in working with borderline personality disorder (BPD). With my colleague Marianne Bourke, the technology of the CCRT has shown that it is not the symptoms of BPD, such as self-harm and affect dysregulation that worries therapists most (Bourke & Grenyer, 2010). Rather, it is the characteristic RO the therapist experiences from the client. What makes maintaining therapeutic consistency and composure a key challenge is the client's interpersonal hostility, criticism, rejection and withdrawal towards the clinician. Remarkably, neuroimaging and social cooperation research with BPD has reinforced how client's social deficits in understanding the RO - or other's minds - predicts and explains the therapist's dilemma (King-Casas, Sharp, Lomax-Bream, Lohrenz, Fonagy, & Montague, 2008). Indeed, one approach to BPD, mentalisation based therapy (Bateman & Fonagy, 2009), has been devised to specifically target the client's incapacity to understand others, otherwise known as reflective functioning. Other findings with Phoebe Carter in our laboratory have shown how BPD clients' poverty of speech in describing their internal world magnifies the difficulties therapists face in making progress (Carter & Grenyer, 2012).

In relation to the treatment of personality disorders, therefore, it is clear that attending to the therapeutic relationship is a key challenge and the CCRT provides a key tool to help the clinician and supervisor. In fact, our recently developed clinical guidelines for personality disorders are based on a relationship model (Project Air Strategy, 2011). The model emphasises three relationships as the key to treatment: the relationship between the client and themselves (which sadly is often full of toxic attacks on self-esteem), the client and the clinician (as described above), and the client and the health service (which unfortunately can be equally rejecting (Department of Health, 2003)). Here we see the clinicians' dilemma in working with personality disorders - the need to get interpersonally close, which in turn stirs up the core conflicts in the client, which then spill into the therapeutic relationship inside and outside the room. The good news, however, is that by maintaining composure and thoughtfulness, good work can be done and the long term prognosis for people with personality disorders is turning out to be quite positive (Zanarini, Frankenburg, Reich, & Fitzmaurice, 2012).

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