working with clients with borderline personality disorder in the lower North Island of New Zealand. It is a service-wide intervention with a long-term perspective, providing stabilisation and containment for both patient and staff. It is encapsulated in a management plan – a behavioural intervention to minimise reinforcement of hazardous behaviours and promote self-responsibility.

The plan defines the treatment system (e.g. psychiatric team, family, police, accident and emergency department staff), contains an acceptance of risk and explains the dangers of risk-averse responses from the service (Maltsberger, 1994). This breaks the cycle of assuming responsibility for the client and replaying a traumatising parent–child dynamic, with subsequent regression, increased risk and institutionalisation. We found that this is achieved through the process of writing and implementing the plan and it enables patients to move towards autonomous functioning. It must be agreed to by all involved and regular review meetings provide a forum for staff to own and manage their differences. Each plan should be an individualised document written by the case manager in consultation with the client; however, we have designed a template for ease of use. This work grew from the ideas of Krawitz & Watson (1999) around the use of brief admissions as a successful part of long-term management, and the observation that the majority of work by out-of-hours services involved these 'revolving door' patients. As yet, our approach has been validated only by empirical evidence. A paper is currently in preparation.

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Cognitive analytic therapy

The review by Marks (2003) of our book *Introducing Cognitive Analytic Therapy: Principles and Practice* (Ryle & Kerr, 2002) is both rude and misleading. His reminiscences about a visit to Leningrad in 1966 have nothing to do with the book and we certainly do not see 'Pavlovian therapy' (with which we are entirely unfamiliar) as 'part of cognitive analytic therapy (CAT)'. His objection to the fact that our explicitly integrative model draws on a wide range of sources tells us more about the limitations of his own conceptual framework than about CAT. These limitations are also evident in his inability to understand or unwillingness to mention the key features of CAT, which he seriously misrepresents. These include: (a) focus on 'reciprocal role procedures', which are formed though the internalisation of socially meaningful, intersubjective experience and subsequently determine both interpersonal behaviours and self-management; and (b) the practical emphasis on the joint creation of descriptions of these, which serve to enlarge patients' capacity for self-reflection and change and therapists' ability to provide reparative, non-collusive relationships.

The reviewer's bias is epitomised in his discussion of one of the case histories in the book (pp. 138–144). While asserting that this 'patient with obsessive–compulsive rituals' would have been better served by nine sessions of behavioural therapy or by one session plus computer-aided therapy, he fails to record that the patient was presented precisely to illustrate the limitations of cognitive–behavioural approaches and does not mention that she had previously dropped out of an anxiety-management group and of cognitive–behavioural treatment. Of this she had noted that the more her symptoms were worked on, the 'more grimly' she hung onto them. This was not a report of the treatment of obsessive–compulsive rituals, it was a summary of the psychotherapy of a person, an unhappy woman with a history of many years of panic, phobias, obsessive–compulsive behaviours and irritable bowel syndrome. The case was chosen, in part, to demonstrate how focus on presenting symptoms can actually be counterproductive and paradoxically collude with the enactment of underlying reciprocal role procedures in a patient who had come to be regarded as 'difficult' and 'resistant'. This patient's list of 'target problem procedures', as worked out with her, included a pervasive need to control both her feelings and other people's behaviours. As is usual in CAT, this formulation, and her therapy, focused on intra- and interpersonal attitudes, assumptions and behaviours (procedures) and paid little direct attention to her symptoms. Therapy included, importantly, work on reciprocal enactments with the therapist. Assessment at termination and follow-up showed major improvements in her life, and psychometric testing demonstrated reductions in symptoms at termination with further reductions at 6-month follow-up.

We think it unfortunate that so obviously partisan a reviewer was selected to discuss a book outside his area of expertise and sympathy and that it was considered appropriate to publish so tendentious a review of the work of colleagues.

Marks, I. (2003) Book Review: *Introducing Cognitive Analytic Therapy* (A. Ryle & I. B. Kerr). *British Journal of Psychiatry*, **182**, 179–180.

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Cinders, you shall go to the ball

Goodwin has described bipolar disorder as the Cinderella of psychiatry, largely on the basis of his study showing the relative paucity of research studies in bipolar disorder compared with schizophrenia (Goodwin, 2000). This study has been reinforced by Clement *et al* (2003), who similarly concluded that bipolar disorder is underrepresented compared with schizophrenia and that this disparity is not declining over time. The importance of this discrepancy is demonstrated by the finding that bipolar disorder causes a greater global burden of disease than schizophrenia (Murray & Lopez, 1997) and by the huge financial impact of bipolar disorder on society (Das Gupta & Guest, 2002)

Clement and colleagues appear to lay the responsibility for the relative lack of bipolar research on a national shortage of specialist clinical services and on the lack of interest of researchers. However, clinical services such as our own in the Northern Deanery are flourishing and we suggest that historical difficulties in obtaining public

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