Borderline Psychopathology and its Treatment

Hospital Management

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Hospital treatment of borderline patients may be indicated during regressions marked by increasingly destructive or self-destructive behavior. In this chapter I shall deal with aspects of the hospital treatment of all borderline patients but shall emphasize those patients already in therapy who require hospitalization during ongoing treatment. I shall stress (1) unresolved developmental issues that emerge in therapy and that require more support than that available to the patient outside the hospital; (2) useful functions hospitalization can perform for both patient and therapist; (3) the therapist's countertransference difficulties and vulnerabilities, which may become more manifest when the patient is hospitalized; (4) hospital staff countertransference difficulties that promote destructive, regressive patient behavior and that may often impede the therapist's work with the patient; and (5) administrative and staff problems within the hospital setting that can facilitate or impede the resolution of issues that led to hospitalization.

Indications for Hospitalization

Hospitalization has to be considered for borderline patients who are experiencing intense panic and emptiness, either because of the emergence of destructive fury in the transference or because of a desperate reaction to relative or total loss of important people or other disappointments in their current lives. Implicit in this desperation is an inability to experience the therapist as someone who constantly exists, who is available and supportive. The fragile, unstable working relationship characteristic of borderline patients readily breaks down under stress. The patient's desperation may include destructive and self-destructive preoccupations and present a serious danger of suicide and other destructive or self-destructive behavior.

Treatment of borderline patients within a hospital setting provides the patient and treatment team, including the patient's therapist, with a series of opportunities to formulate and implement a treatment plan leading to a productive use of hospitalization, rather than one that supports and continues the regressive behavior, with its real dangers. Whether the borderline patient requires and can benefit from

hospitalization depends upon an evaluation of several factors: the patient's basic ego strengths and ego weaknesses, the type or types of precipitating stress, the support systems available to the patient outside the hospital, the patient's relation to his therapist, the intensity of the transference feelings, and the therapist's awareness of his countertransference feelings and responses. Also important are the quality and availability of an appropriate hospital, the patient's and family's willingness to participate in the hospitalization, and the financial resources of the patient and family, including the adequacy of hospitalization insurance.

Because hospitalization may be the first stable situation in a long time for a desperate, disorganized borderline patient, it may also provide the first opportunity for the patient to collaborate in a thorough evaluation. This evaluation should include participation of the family and a careful look at the patient's work with his therapist. Even though the therapist who hospitalizes the patient has attempted to evaluate the needs and usefulness of hospitalization, this outpatient evaluation may of necessity be brief and sketchy because of the chaos of the patient's life and the dangers the patient is facing. On the other hand, patients who decompensate during long-term therapy may have been thoroughly evaluated by their therapist. Hospitalization for this group offers a chance for the therapist to obtain an impartial evaluation of his work with the patient, assistance with the family if indicated, and a safe setting to begin the resolution of transference issues that overwhelm the patient.

Once the decision to hospitalize the patient is made, the choice of hospital is important. When there are several suitable hospitals in which the staff has a dynamic understanding of programs for the borderline patient, considerations include the need for short- or long-term hospitalization, whether the therapist can continue with the patient while the patient is in the hospital, whether the hospital's policy supports this continued psychotherapeutic work, and whether, in cases in which it is indicated, the hospital emphasizes family involvement.

The Hospital Setting: A Good-Enough Mothering and Holding Environment

The borderline patient's developmental vulnerabilities must be addressed in the hospital setting. The regressed suicidal or destructive patient requires a protective environment that fulfills many aspects of Winnicott's (1965) "holding environment" and has a staff with the characteristics of his "good-enough

mothering" concept. The abandoned-child feelings of the enraged, regressed borderline patient are accompanied by distrust, panic, and a feeling of nonsupport and desperation. The transient loss of an evocative memory capacity for important sustaining people contributes significantly to feelings of being "dropped," alone, abandoned, and isolated, and the panic these feelings induce.

When borderline patients require hospitalization, the ward structure must provide holding qualities that offer the needed soothing and security. A sufficient empathic staff response to the patient's rage, despair, and aloneness provides the potential for relationships with new people who can communicate their grasp of the patient's experience with them and be physically present and empathically available often enough. Holding and good-enough mothering imply a genuine flexibility; the child at different ages and with different experiences and stresses needs a varying response from caring parental figures. The highest level of expression of these functions by a hospital staff includes the understanding that the borderline patient is an adult who may be transiently overwhelmed; the adult aspects require nurturance, support, and respect at the same time that the childhood vulnerabilities that have unfolded need an empathic response, which includes, when necessary, a protective response.

The "good-enough mothering" and "holding environment" concepts are often misinterpreted by the staff to mean a position that offers only a constant warm, nurturing response to all patients all the time. Such a staff response may increase the patient's regressive feelings and behavior. This misunderstanding highlights problems of utilizing early child development concepts for adult patients with difficulties that include regressions or fixations to issues related to these early years. Winnicott's concepts, when applied to hospitalized adult borderline patients, must specifically include an empathic awareness and response to adult strengths and self-esteem issues. A misunderstanding of these concepts may be part of a countertransference response that includes an omnipotent wish to rescue the patient. The correct utilization of these concepts helps support the formation of alliances and an observing ego through staff attempts to clarify and share with the patient their assessment of his complex feelings, the fluctuations of these feelings, and the patient's varying capacity to collaborate with the staff to control them over time.

The newly hospitalized borderline patient requires a rapid evaluation on admission that assesses his needs for protection. This initial evaluation investigates the suicidal and destructive dangers, and

reviews the patient's history of dangerous actions in the recent and more distant past. It also includes a beginning understanding of the precipitants that led to hospitalization, as well as an evaluation of the patient's work with his therapist, if he is in therapy. A history of recent losses, whether fantasied or real, including the transient or permanent loss of a therapist, is particularly important, even though some losses may ultimately be understood as fantasied distortions or aspects of projective identification. The staff evaluation makes use of the patient's capacity to give a history, his ability to share fears and fantasies, and the degree to which he can collaborate with the staff to determine a useful hospital treatment plan. Obviously, the early assessment is very tentative, since some borderline patients have a capacity, even when regressed, to present a "false self' picture that minimizes current desperation and dangers. A staff experienced in handling borderline patients will use its empathically based countertransference fantasies and feelings as part of the assessment.

The protective and supportive measures a hospital and its staff formulate and implement, when the patient's needs are assessed correctly, can provide the most supportive holding response to an overwhelmed, regressed borderline patient. A patient may respond with a dramatic decrease in panic when his frightening suicidal feelings are evaluated to be nearly out of control and appropriate measures are instituted. These may range from assignment to a locked ward, frequent staff checks, or the assignment of a special nurse, to the use of antipsychotic medication when there is evidence of disorganization or fragmentation as a manifestation of the patient's anxiety. Again, the frequent collaborative attempts with the patient to reassess his status support the patient as someone who has strengths and the capacity to form working relationships, even though these may be transiently lost.

Once the basic protective needs of the patient are met, a more intensive, thorough evaluation of the patient and family can occur, and a treatment plan developed that includes milieu, family, and individual treatment decisions. This assessment leads to a more definitive treatment plan and helps determine whether short- or long-term hospitalization is indicated.

In the past decade many general hospitals have opened short-term intensive treatment units capable of providing excellent brief therapeutic intervention with borderline patients and their families. Such units sometimes believe they have failed when they cannot discharge a borderline patient as "improved" within weeks. They do not recognize that some borderline patients require long-term

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hospitalization because of long-standing ego weaknesses, overwhelming recent loss, or a family situation that has become increasingly chaotic. Kernberg (1973b) has defined characteristics of patients who require long-term hospitalization; these include low motivation for treatment, severe ego weakness as manifested by lack of anxiety tolerance and impulse control, and poor object relations. In addition, long-term inpatient hospitalization sometimes becomes a necessity because of the lack of alternatives to such hospitalization, such as day or night hospitals or halfway houses.

There are advantages and disadvantages to both short- and long-term units. A short-term hospital presents the expectation to the patient that he can resolve his regressive behavior rapidly. It also discourages new regressive behavior as an attempt to relieve distress, because the patient knows he cannot expect a long stay. Often short-term units discharge or threaten to discharge or transfer to long-term facilities those patients who regress after brief hospitalization. The knowledge of this discharge or transfer policy tends to discourage regressions; the patient may, however, utilize it for a sadomasochistic struggle with the staff or as a way of confirming projections of rage, which are then experienced as angry rejections by the staff. In addition, the patient described by Kernberg as needing long-term hospitalization may feel more misunderstood and abandoned in a setting that expects him to accomplish something beyond his capacity. The policy of discharging patients who regress is especially potentially destructive if it is part of a staff s countertransference, angry, rejecting response to the projective identifications used by the enraged, regressed borderline patient (Hartocollis 1969). When such a policy is an aspect of supportive limit setting that acknowledges realistic expectations and limits, it can be useful for those patients who can benefit from brief hospitalization. These patients may make good use of a short-term unit after discharge through a later readmission that carefully defines workable guidelines, including limits, and patient and staff expectations.

Although a long-term hospital may tend to prolong hospitalization unnecessarily for some patients, it can present a safe, supportive structure for the appropriate patient to do important work on issues of vulnerability or the precipitating stresses that led to hospitalization. For some patients it provides the required safety for the beginning resolution of the life-and-death issues that have emerged in the transference in psychotherapy. Long-term hospitalization also allows milieu aspects to be utilized more creatively than is possible in short-term settings. For example, a variety of therapy groups can flourish when the patient population is relatively stable, in contrast to the disorganizing effect of rapid group

member turnover in brief hospitalization.

As Bion (1961) and Kernberg (1973a) have indicated, open-ended groups that offer little task structure tend to be regressive experiences for the participants. These regressive phenomena occur in both hospitalized borderline patients and normal populations in situations in which group tasks are left vague or undefined. This knowledge can be used in planning group experiences for a hospitalized borderline patient. A program of specific task groups, as in community and ward meetings and occupational therapy, and less structured experiences, such as those of psychotherapy groups, can be defined to fulfill the needs of each patient. It may be that a hospital staff that is sufficiently firm and supportive can "contain" the regressive features of an unstructured ward group. In such a setting the patient program may benefit from the mobilization of negative transference affects that gravitate to the surface and are subject to group transference interpretations (Boris 1973). These negative feelings then may not need to be acted on to sabotage other parts of the program.

Limit setting, as we have seen, is an important aspect of the borderline patient's treatment. When limit setting is too firm and is employed too rapidly and readily in a treatment program, the unfolding of the patient's psychopathology, both in action and in words, may be seriously impeded. Among the results of such an approach may be lost opportunities to understand the patient's fears, since they may not be permitted to emerge. On the other hand, when limit setting is so lax that patients can act out issues to a degree that frightens them, their increasing individual chaos can spread to the entire ward structure and involve other patients and staff. A major aspect of successful limit setting depends upon whether it is utilized as part of a caring, concerned, protective, and collaborative intervention with a patient or as a rejecting response and manifestation of countertransference hate.

Therapist-Patient Issues in Hospital Treatment

If the therapist decides that hospitalization is indicated, a setting that allows him to continue regular appointments with his patient is crucial. The "abandoned child" theme, which emerges with intense rage and panic, remains among the major issues to be resolved. A hospital that encourages the therapist to continue with his patient during the hospitalization can offer the supportive structure in which this rage can be safely experienced and analyzed. For many borderline patients, hospitalization

itself seems to threaten the loss of or abandonment by their therapist. The therapist's willingness to continue with the patient, in spite of the patient's conviction that he will be abandoned because of the dangerous, provocative behavior that necessitated hospitalization, also presents an opportunity for a new kind of experience.

A major aspect of the patient's hospital evaluation consists of the clarification of the patient's therapy, including the transference-countertransference issues. Under optimal circumstances the hospital unit can function as a consultant for the therapist and can clarify treatment issues to facilitate continuing work. The therapist who hospitalizes a regressed borderline patient may feel devalued, defensive, guilty, or ashamed as he relates to the hospital staff. In part these feelings are his countertransference responses to the patient's intense fury, devaluation, and projection of worthlessness, which the therapist may experience as a part of himself through projective identification. Earlier there may have been a reactivation in the therapist of primitive omnipotent and grandiose feelings, followed by shame for his supposed failure with the patient. When these countertransference feelings are coupled with the hospital staffs own omnipotent and grandiose responses, which include devaluation of the therapist and a wish to rescue the patient from him, the therapist and patient are placed in a situation that can accentuate the defensive splitting borderline patients tend to act out with any hospital staff. The experienced staff always keeps in mind its own propensity for certain countertransference responses to therapist and patient as it evaluates and treats the patient.

An important task for the hospital staff is the development of a safe environment in which the patient can experience and put into words his overwhelming feelings with his therapist. The borderline patient's readiness to use splitting as a defense can easily keep these feelings, especially anger, outside of the therapist's domain. The traditional use of separate therapists and administrators in many hospitals, both of whom are on the hospital staff, tends to support the splitting process in borderline patients. The patient may be angry at the administrator for decisions that limit his activities or privileges, and idealize the therapist as the caring person who would not allow such things to happen if he had the power. When the therapist is a member of the hospital staff, it is sometimes possible for him to be both administrator and therapist. If the therapist cannot assume both roles, he can, in collaboration with the administrator, ally himself with administrative decisions—assuming that he is consulted and agrees with them. He can present to the patient his agreement with the administrator, especially when the

patient attempts to avoid his anger with the therapist by devaluing the administrator for some management decision.

The hospital staff that excludes the outside or staff therapist from collaborative work with treatment planning may foster a continuation of pathological splitting and lose an opportunity to help the patient develop the capacity to love and hate the same person, an obviously important step in emotional growth. It also tends to perpetuate the unit's devaluation of the therapist and his work with the patient and further intensifies another aspect of the splitting process: The patient views the therapist as weak and worthless and idealizes the hospital or hospital administrator as the omnipotent, rescuing parent. The borderline patient's defensive use of splitting is supported whether the therapist is idealized or devalued; the hospital is then less able to help the patient and his therapist continue the work of reconciling murderous fury toward a therapist who is felt as an abandoning as well as a beloved, caring, holding parent.

Of course the hospital administration can only work collaboratively with a therapist if its assessment of the therapist's work is largely positive. Often the process of evaluation helps the therapist clarify issues for himself. Sometimes the staff can formulate issues that help the therapist think through countertransference difficulties that were interfering with therapy. Such countertransference issues that can be clarified through staff consultation usually are not deeply rooted psychopathological problems in the therapist but, rather, transient, overwhelming countertransference feelings that emerge in the heat of the treatment of regressed borderline patients. The hospital setting that protects the patient and takes the pressure off the survival issues in therapy often automatically allows the therapist to get his own perspective on countertransference issues. Sometimes a supportive, tactful consultation by an appropriate staff member helps complete the outside therapist's understanding of his work with his patient and helps him resume a useful therapeutic stance that focuses on the issues formulated.

How does the hospital staff proceed when it feels that there are serious, perhaps unresolvable difficulties in the therapist's work with his patient? The staff's obligation to the therapist and patient includes a careful assessment of its own possible devaluing countertransference responses to the therapist as part of the already defined splitting processes. When the staff feels increasingly certain that pathological countertransference difficulties exist that cannot be modified through consultation, it must

carefully review the data obtained from patient and family and the therapist's work as presented in conferences and consultations that are tactful and supportive of him. The staff may, after this review, feel that countertransference difficulties or empathic failures based on limitations in the therapist's personality have led to an unresolvable impasse. This impasse, which may itself threaten the life of the patient, often is the major manifestation of countertransference hate that remains unmodified and largely unconscious. At such times the staff has little choice but to help the patient and therapist end their work. Goals then include (1) protecting the patient while helping him understand that there is an impasse and that he need not see this impasse in terms of his own badness or failure, and (2) helping the therapist maintain his selfesteem in the termination process while also helping him learn from that process. Ideally both patient and therapist should be supported to learn as much as possible, maintain their self-esteem, and say good-bye appropriately.

Staff Countertransference Issues within the Hospital Milieu

The borderline patient presents special challenges to any hospital staff. His use of primitive defenses—projection, projective identification, and splitting—becomes especially manifest during the regression that leads to hospitalization, and may quickly involve the hospital staff (Main 1957). Some staff members may become recipients of aspects of the patient's projected positive, previously internalized self and object representations, while negative self and object representations are projected onto other staff members. This description is not meant in a literal sense but, rather, as a way of conceptualizing the intense, confusing affects and fantasies in the patient and staff. Often these projections coincide with similar but repressed affects, fantasies, and self and object representations in specific staff members. These staff members may have achieved much higher levels of integration and maturity; however, primitive aspects that were repressed can readily become reactivated in work with borderline patients, most of whom intuitively choose a staff member to project aspects of themselves that reverberate with similar but repressed aspects in that staff member. When these projected aspects are projective identifications, the patient's need then to control the staff member, and the latter's countertransference need to control the patient, compound the chaos of the splitting phenomena. The disagreements, fury, and often totally opposite views and fantasies staff members have about a specific borderline patient are manifestations of the splitting and projective identification process.

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The implications of projective identification and splitting are profound. Staff members who are the recipients of cruel, punishing parts of the patient will tend to react to the patient in a cruel, sadistic, and punishing manner. Staff members who have received loving, idealized projected parts of the patient will tend to respond to him with a protective, parental love. Obviously a clash can occur between these two groups of staff members. These mechanisms also help to explain why different staff members may see the same patient in very different ways.

People who usually function at a high level of integration can feel and act in regressive ways in group settings, especially when there is a lack of structure or a breakdown in the group task. This observation is consistent with the experience of staff members in the hospital setting, who tend to act empathically on projections they receive from patients. Because patients can project different parts onto different staff members, an internal drama within the patient can become a battleground for the staff. Staff members can begin to act toward one another as if each one of them had the only correct view of the patient and as if the part the patient projected onto the other staff members were the only true part of those staff members.

A brief vignette illustrates aspects of these complex mechanisms of patient-staff interaction. At a staff meeting a series of angry outbursts occurred among nurses, social workers, and occupational therapists about who would be responsible for supervising cleaning up after a family night (which involved dinner and a discussion group for patients, their families, and staff members). Repeated accusations and recriminations centered around the feelings of each discipline that the others really did not care about them and did not really understand the burden of work they had, especially on the day that family night occurred. Interpretations of the personal problems of staff members began to appear. The heated discussion ultimately led to a detailed account about the specifics of clean-up.

It then became apparent that although the patients had agreed to assume responsibility for the preparation of food, serving, and clean-up, they tended to disappear during the day and after the meeting, leaving much of the actual preparation and clean-up to the staff. Instead of supervising, staff members were cooking and scrubbing pots. It became clearer that the staff members were fighting with one another while forgetting the origin of their problems, that is, their difficulties in working with the patients. The patients were not expressing any direct anger about their reluctance to fulfill their agreed-

upon participation in family night and their simultaneous wish to be cared for and fed by the staff. In its meeting the staff was oblivious to this reality. Instead they showed massive anger toward one another for not caring or doing enough for one another.

Another aspect of the staff s countertransference difficulties with borderline patients involves a process in which the patient is labeled as “manipulative.” Manipulation for many borderline patients is largely unconscious and characterological, has important adaptive elements, and helps keep some of them from feeling and being totally alone. When the patient, however, is seen predominantly as a conscious, deliberate manipulator in the negative sense, the staff feels entitled to make unrealistic demands, punish the patient, and even threaten him with discharge (Hartocollis 1972). An observer who is not part of this ward process is often impressed with the almost total lack of empathy for the patient’s pain or distress. It is as if the patient had succeeded in convincing the staff that only his negative aspects exist; at such times the staff may find it impossible to see any other part.

As stated, borderline patients use manipulation in their relations with people. Their primitive narcissism, which is part of their entitlement to survive, and the neediness associated with it, as well as the voracious oral quality of their hunger and rage, are often accompanied by a manipulative attitude when this neediness is most manifest. To miss the patient’s pain, desperation, and distress, however, is to allow the splitting and projective identifications to become the staff*s only view of the patient. This image of the patient as manipulator is also evidence of the patient’s success in getting himself punished and devalued, a process that may involve projections of his primitive, archaic superego. Often the patient is seen by the staff as manipulative when he is most suicidal and desperate. At these times staff countertransference hate is potentially lethal (Maltsberger and Buie 1974).

A hospital staff working with borderline patients has the responsibility to itself and its patients to be alert to the described countertransference danger signals. There is no simple prescription or solution for them. Obviously, the quality of the professional staff, in particular, their achievement of higher levels of ego functioning and a solid capacity for object relations without ready utilization of primitive projective defenses, is important. In spite of the maturity of the staff, however, regressive group phenomena, especially in work with borderline patients, are inevitable (Hartocollis 1972).

The structure of the hospital unit becomes important in the resolution of these regressive staff responses. Regular staff meetings at which patient and patient-staff issues are open to scrutiny in a nonthreatening environment are particularly useful. Staff members who know each other well are less likely to respond regressively to a borderline patient's projections, that is, staff members' reality-testing capacities are enhanced when they have prolonged contact with other staff members in settings where they can learn clearly the reliable, consistent responses and personality characteristics of their co-workers.

A hospital administrative hierarchy that values the varying contributions of different disciplines and workers and clearly defines staff responsibilities and skills aids in minimizing projections. Such an administration also understands the importance of establishing sufficient task-oriented groups for both patient and staff needs to protect against a staff regressive pull (Garza-Guerrero 1975). The ability of the hospital or unit director to maintain equanimity in the face of the regressive propensities of staff and patients may be a crucial ingredient in successful hospital treatment. The administrator who respects staff and patients, who can tolerate their anger without retaliating and yet be firm when necessary, and who can delegate power unambivalently can provide the mature "holding environment" and a model for identification for the staff that facilitates a similar experience for the patients.