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Intensive Psychotherapy of the Adolescent with a Borderline Syndrome

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INTENSIVE PSYCHOTHERAPY OF THE ADOLESCENT WITH A BORDERLINE SYNDROME

The borderline syndrome emerged on the modern psychiatric scene during the early 1950s as a vague, ill-defined entity comprising symptoms that ranged from the neurotic, through the character disorder, to the psychotic. Psychiatrists gave it little attention; for example, the sole article on this subject in any psychiatric textbook to this date was by Schmideberg in 1959.

In the last ten years the concept of the borderline syndrome has been greatly refined by psychoanalytic study, which found that the basic psychopathology existed not in the presenting symptoms but in a specific and stable form of pathological ego structure, a developmental arrest. Rinsley described the clinical manifestations, the psychodynamics, and the intensive treatment of this arrest in adolescents. Grinker, Werble, and Drye classified the clinical manifestations of this pathological ego structure in adults. However, the cause of the developmental arrest remained unknown.

The more recent developmental studies of Mahler on the contribution of the stage of separation-individuation to normal ego development and of Bowlby on the psychopathology of separation at this time of life when applied to the borderline adolescent has led to the theory that the psychodynamic

cause of the developmental arrest was a faulty separation-individuation.

This theory laid bare the underlying psychodynamic structure of the borderline syndrome and so enhanced the understanding of transference and resistance that intensive psychoanalytic psychotherapy became not only possible but the treatment of choice for many of these patients. Properly treated—with a combination of support and analysis—patients can and do work through much painful regressive affect that results in a dramatic attenuation of their disorder.

This chapter briefly outlines borderline syndrome theory and applies it to the diagnosis, psychodynamics, and treatment of the borderline adolescent. It supports the point of view of Rinsley and takes issue with the point of view most recently expressed by Zetzel, that the borderline patient is seldom capable of tolerating the painful affect integral to the emergence of regressive transference reactions. As illustrated in this essay, many, though not all, borderline patients—given the appropriate therapeutic support—can tolerate this painful affect. These issues are dealt with in more detail in other publications.

A Developmental Theory

Since the clinical picture of the borderline adolescent is not what it appears to be, appropriate diagnosis depends on an understanding of the

underlying psychodynamics. The fact that the borderline syndrome is the root of the problem is concealed by the patient's defense mechanisms, which mask his feelings of abandonment, and by his chronological age, which belies the infantile state of his character.

To understand this syndrome it is first necessary to understand not only the theory of the contribution of the symbiotic and separation-individuation stages to normal ego development but more importantly, the developmental consequences that ensue when separation from the symbiotic partner is burdened by an abandonment depression. The theory of the former has been creatively worked out by Mahler and her coworkers in their developmental studies while that of the latter springs from application of the work of Mahler and Bowlby to the borderline adolescent.

Role of Separation-Individuation in Normal Ego Development

The symbiotic relationship can be defined as one in which the functions of both partners are necessary to each. The child's image of himself and that of his mother is of one symbiotic unit. The mother acts as auxiliary ego for the child, performing many functions for him that his own ego will later perform. For example, she sets limits to both external and internal stimuli, and she helps him to perceive reality, tolerate frustration, and control impulses.

At approximately eighteen months, the child, under the impetus of the

biologically predetermined maturation of ego apparatuses—that is, his own individuation—which includes the physical development of learning how to walk, the emotional growth task of separation from the symbiotic relationship begins. The child now undergoes an intrapsychic separation and begins to perceive his own image as being entirely separate and different from the mother's.

This achievement brings with it many dividends for the development and strengthening of the child's ego, as outlined by Rinsley. The child introjects the functions the mother had performed, for example, reality perception, frustration tolerance, impulse control, thereby strengthening his ego structure. The capacity for object constancy, that is, the capacity to evoke the mental image of a person who is absent, develops, and the defense mechanism of object splitting comes to an end. These latter occurrences will enable the child later in life to repair object loss by mourning.

Three forces—(1) the child's individuation process, (2) the mother's encouragement and support (supplies), and (3) the mastery of new ego functions—press the child on his developmental pathway through the stages of separation-individuation to autonomy. A process of communicative matching occurs between mother and child in which the mother responds with approval to the child's individuation cues. The mother, as the catalyst of the individuation process, must be able to read and respond to these cues if

the child is to pass through the stages of separation-individuation to autonomy.

Role of Separation-individuation in the Borderline Syndrome: A Developmental Arrest

This theory, developed by the author, is derived from the study of the borderline adolescent and his mother. The mother of the patient with a borderline syndrome suffers from a borderline syndrome herself. Her pathological needs impel her to withhold support and encouragement of the patient's separation and individuation; rather, she clings to the child to prevent separation, discouraging moves toward individuation by withdrawing her support.

Abandonment Depression

Therefore, between the ages of one and one-half to three years a conflict develops in the child between the developmental push for individuation and autonomy and the withdrawal of the mother's emotional supplies that this growth would entail. The child needs the supplies to grow; if he grows the supplies are withdrawn. Thus arise his feelings of abandonment (depression, rage, fear, passivity, helplessness, emptiness, and void). The depression contains feelings of starvation, of despair and death, of loss of vital supplies often expressed by patients as a loss of oxygen or blood or a body part.

These feelings are intolerable and are handled by the defense mechanisms of ego splitting and denial. Although separated from the mother, the child clings to her to defend himself against the return to awareness of these feelings. The splitting and denial are further reinforced by various defense mechanisms: acting out, clinging, reaction formation, obsessive-compulsive mechanisms, projection, denial, isolation, withdrawal of affect.

The abandonment feelings continue to exert their overwhelming but hidden force through the tenacity and strength of the defense mechanisms used to keep them in check. These defenses, however, block the patient from fully developing through the stage of separation-individuation to autonomy. He suffers from a developmental arrest. He is caught, so to speak, in midstream, en route between two stages of development: He has separated from the symbiotic stage but has not fully progressed through the separation-individuation stage to autonomy.

Narcissistic-Oral Fixation

In order to understand the disastrous consequences of these events for the development of the child's ego structure, we must shift to another framework, namely, Freud's psycho-sexual continuum, which has common meeting points with the one we have been discussing. Freud spoke of two phases, the autoerotic and the narcissistic, that precede the oral phase of

development. Symbiosis is a narcissistic phase, and separation-individuation is ushered in by orality. It is likely that the developmental arrest of the borderline occurs either in the narcissistic or early oral phase. The earlier this arrest occurs the more likely the patient's clinical picture will resemble the psychotic, and the later it occurs the more likely the clinical picture will resemble the neurotic. In either case the developmental arrest produces severe defects in ego functioning. The ego structure remains "narcissistic, orally fixated." Two key characteristics of this ego structure, so important to an understanding of the patient's reactions to separation, are the persistence of object splitting and the failure to develop object constancy.

Prepuberty: A Second Separation-Individuation Phase

The child's defenses enable him to function until prepuberty—approximately ages ten to twelve—when a second marked developmental maturation of the ego occurs. This growth spurt, manifested by a thrust toward activity combined with a turn toward reality, is similar in scope to the maturation of the ego that occurred in the separation-individuation phase. This maturation together with the need to further separate from the mother produces a recapitulation of the separation-individuation phase of development, that is, a second separation-individuation phase.

Precipitating Factors

All adolescents go through a second separation-individuation phase in prepuberty, owing to the maturational spurt of the ego. In some borderline patients this alone precipitates a clinical syndrome; in others this internal event combined with an actual external environmental separation exposes the patient to the experience he has been defending himself against since early childhood—separation from the symbiotic partner to whom he has been clinging. This, in turn, interrupts his defenses against his feelings of abandonment, and they return in full force. The environmental separation precipitates the intrapsychic feelings of abandonment.

These precipitating factors—either the second separation-individuation phase alone or in combination with an actual separation—reinforce the feelings of abandonment and produce a clinical syndrome via the need for an intensification of the defenses.

The clinical manifestations will depend on the patient's unique style of defenses against his feelings of abandonment. Regardless of the type of defense, however, the two diagnostic hallmarks of the borderline syndrome are the abandonment depression and the narcissistic oral fixation.

In order to illustrate how these patients experience and deal with these abandonment feelings, it is most useful to choose a clinical example and follow the lead of Rinsley, who suggested that the adolescent's experience is

similar to that of the infants studied by Bowlby. These infants had to undergo a physical separation from their mother by hospitalization at the very developmental period we are concerned with, namely, during the first two years of life.

Bowlby described these infants as passing through three stages: (1) protest and wish for reunion, (2) despair, and (3) detachment if the mother was not restored. The adolescent is unable to contain the affect associated with the second stage, that of despair.

A physical or emotional separation so reinforces the abandonment feelings that the patient's defense mechanisms intensify to the point that the clinical condition results. These defenses against the depression, however, interfere with the work of mourning so essential to further ego development.

The clinical picture portrays the repetition in adolescence of an infantile drama—the abandonment depression engrafted to the separation-individuation process which effectively halts further ego development.

Diagnosis

There are as many clinical types as there are defenses. The acting-out adolescent is used in this chapter to illustrate the five clinical characteristics of the syndrome.

1. Presenting symptomatology: acting out. The function of the acting out is to defend the patient against feeling and remembering his abandonment depression. It may begin with mild boredom, or restlessness, or concentration difficulty in school, or hypochrondriasis, or even excessive activity of all kinds (physical and sexual). Finally, more flagrant forms of acting out appear—antisocial behavior, stealing, drinking, marijuana, LSD, Methedrine, heroin, glue sniffing, promiscuity, running away, car accidents, and hippie-like behavior, including long hair, sloppy dress, and unsavory companions.

2. Environmental separation experience. The separation experience itself, though sometimes blatant and obvious, is more often quite hidden. For example, actual separations such as in death or divorce are obvious, but the experience may often be precipitated by such subtle occurrences as an older sibling going away to college, or a grandparent, a governess, or maid becoming ill; or merely by some change in the focus of the symbiotic partner's behavior, such as a mother who becomes involved in an affair, or is herself too depressed to care properly for the child, or one who might have to give most of her attention to a sick sibling. It is important to keep in mind that neither the patient nor the parent has any awareness of the profound significance of the separation experience, so the therapist must ferret this out by himself.

3. Past history (narcissistic orally fixated character structure). The

parents have borderline syndromes themselves and are most often quite unaware of the fact that the patient has failed to negotiate the usual developmental stages. The doctor must pursue the developmental history on his own, looking for signs of prolonged dependency and passivity, developmental defects in ego structure, such as poor frustration tolerance, poor impulse control, and reality perception, which give rise to a host of symptomatic expressions from very early in life. These may range from disciplinary problems at home and in school to difficulties in developing social skills with peers, and include such symptoms as enuresis and obesity. Once an accurate history has been obtained, the clinician must assess the developmental level of the patient's character structure, keeping in mind the enormous discrepancies that can exist between developmental level and chronological age.

4. Parental personalities. The parents themselves have borderline syndromes and have suffered as much from a lack of parenting as do their adolescents. Consequently, the parents, never having been mothered cannot mother, and never having been fathered cannot father. They perceive their children as parents, peers, or objects. They cling to the children to defend themselves against their own feelings of abandonment and cannot respond to the child's unfolding individuality. Thus the child is subjected to scapegoating of the most extreme sort.

The fathers, passive, inadequate men, dominated by and dependent upon their wives, play very minor parental roles. The mothers are controlling women who need and vigorously battle to maintain the symbiotic tie with the child.

5. Pattern of family: communication. These families communicate mostly by acts, not words. Consequently, the adolescent expresses his need for help by an act, a plea for help, that expresses as exactly and poignantly as any words the blind, hopeless, trapped crying out for succor and aid. The final act that brings the patient to treatment usually occurs as the end point of a long series of gradually escalated acts whose goal is somehow to break through the vacuum of unawareness and/or indifference of the parents—to make visible the adolescent's drowning in his own struggle with his feelings. Despite these acts, the intervention often is still not at the behest of the parents but rather some outside figure, such as a friend, a schoolteacher, or even the police or a wise judge.

Let us now turn to a characteristic clinical illustration.

Patient Anne

Fate struck Anne, a sixteen-year-old adopted girl, a particularly cruel blow at the age of ten when the maid who had taken care of her died and her mother became chronically ill with porphyria. The mother and father had a

very distant relationship, the father spending most of his time at work so that the patient was left alone to care for the mother.

Anne, always a behavior problem, was unable to tolerate the feelings of abandonment and responded with heightened acting out behavior both at home and at school. At home she was rebellious, stayed up most of the night, and slept during the day. In school she resented the teachers and dressed inappropriately.

As she entered her teens, she started to smoke marijuana. At age fourteen she was taken to see a psychiatrist who said she was hopeless and recommended that she be committed to a state hospital. Her parents refused to do this but took her out of the public school system after clashes with teachers and sent her to a private boarding school. After one year there, at age fifteen, she was suspended for violating a number of rules, including visiting a boy in his room. At this time she had sexual intercourse for the first time, soon feared she was pregnant, and had fantasies of running away, taking the baby with her, and working to support it. Fortunately for her this event did not come to pass. After being suspended she returned to the local high school, where she remained for only seven weeks before dropping out. She was taken to see another psychiatrist, started treatment, and again would not talk about herself. The psychiatrist sought more information by means of Amytal interviews, which were also unproductive. Several months before

admission, her behavior got worse; she began leaving the house to take long walks during the middle of the night and dating boys who were taking heroin. Finally her doctor insisted that she be hospitalized. She was sedated and placed in the hospital against her will.

Anne began life with the handicap of having an unwed mother of whom little was known except that she was fifteen years old. Anne early suffered a second reverse when she was adopted at the age of six weeks, presumably because the couple was unable to have a child, owing to the father's sterility, but more probably in order to preserve an already shaky marriage. Surely, this was an ominous beginning for a new life.

According to her adopted mother, she was a difficult baby, crying constantly and banging her head during the first year of life. A Negro maid, Louise, was hired to care for her. The mother said, "The three of us took turns rocking her to sleep. She was a feeding problem. She didn't like anything, she spit everything out unless Louise cooked it for her."

She had difficulties in school beginning in the first grade and disobeyed teachers continually. At five she was told she was adopted and that she was the chosen one for her parents.

Her mother said she had so much difficulty in school that "I would be in school more than she would." The mother tried to discipline her by spanking

her or taking things away, but "Anne would scream so that I couldn't stand it." During the first six years Louise was the only one who could handle her. Louise was overindulgent, did everything for her, and took sides with her against the parents. The mother frequently felt angry at the maid, yet acknowledged her inability to manage the patient without Louise's help. When Anne was eight and one-half the maid left. The patient looked forward to her infrequent visits. Then when Anne was ten, fate stepped in again; suddenly and unexplainably Louise stopped visiting. The die was now cast.

Anne's appearance on admission was striking—shoulder-length black hair, partially covering her eyes, pale white skin, her only makeup blue and white eyeliner, giving her an almost ghost-like appearance She dressed either in blue jeans with a black turtleneck top and black boots or very short miniskirts. She wore one blouse cut out on the sides almost down to the waist without a brassiere. When visited by her parents (as we had not yet learned to prohibit visits), she would demand that they bring in all sorts of unnecessary items for her—five more shirts than she would need—and she was particularly hostile and contemptuous toward her father.

Phase 1: Testing[1]

This phase, which extends from the beginning of treatment to the control of acting out and the establishing of a therapeutic alliance, is

obviously crucial. Why is this first phase so important and what is its significance to the patient?

The adolescent with a borderline syndrome is defending himself against an abandonment depression. Driven by the wish for reunion, he clings to and spends his efforts to keep alive the pathologic symbiotic relationship with his mother. His façade of resistance, though tenaciously clung to, actually masks a feeling of utter hopelessness—his despair and dread of abandonment, which stems from the impasse that has evolved in his relationship with his mother.

Although aware, at some level, that he needs help, he is frightened that if he allows a relationship to develop with the therapist he will risk re-experiencing the abandonment of his earlier relationship. He wants reunion, not consolation of his loss. His first unspoken question then will be: "How do I know you, the therapist, are any different? Prove to me that you have the capacity to understand me. Nobody else ever has. Prove to me you will not abandon me." The aim of the testing process is to answer these questions.

There is no therapeutic alliance as we understand the term. Words at this point are not used to convey or express feeling but to manipulate and test. Behavior is the principal means by which the patient expresses his emotions.

He employs acting out not only as a defense against feeling and

remembering but also as a vehicle for testing. Although basically ineffective and self-destructive, acting out is perhaps not so painful for him as risking trust and placing his all-embracing symbiotic needs in the hands of a person he, as yet, has no reason to trust.

The adolescent patient must then conceal his need for help and engage in an elaborate test that the doctor must successfully pass before the patient will feel enough trust to reveal his painful state. He makes a virtue out of a necessity by extolling the benefits of his acting out while hoping his doctor will have the ability and good sense to see through him. After all, what else can he do? He is grappling with overwhelming primitive conflicts, that is, wishes for fusion and fears of engulfment, on the one hand, and abandonment, on the other.

Let us return to Anne to see how the therapist handled this testing phase of therapy. The principal drama takes place outside the usual psychotherapeutic arena of words in the world of action.

The content of Anne's initial interviews was more or less as follows. She did not want to be there. There was nothing really wrong. Why should she follow the stupid rules? People do not live by rules. She denied depression, but said, "No, it is just a feeling of vagueness, numbness, emptiness. I'm not really unhappy; it is just that I don't care. All I really want is out." She

wondered why she did not feel more depressed in a horrible situation like this. She hoped something would happen so that she could get out of the hospital.

Anne's initial acting out consisted of her exhibitionistic appearance in wearing miniskirts, her negativistic, sarcastic, flip attitude toward the therapist, writing provocative letters to her friends about hospitalization, procrastination in school, phone calls to friends to make provocative statements, and failure to keep her room clean. Efforts to limit the acting out were begun by forbidding miniskirts, monitoring her letters, limiting the phone calls, and expecting her to be at school on time and to keep her room clean.

The anger that had previously been dissipated in this defiant behavior now began to come out more directly. For example, "I'm not picking up this room. You can tell the doctor that if I am in occupational therapy and she wants an interview, I'm going to refuse to come down. If she comes near me I'll throw something at her face." In short, she is saying the doctor is unreasonable, she does not understand her, and she is "square."

At this point the patient was totally unaware of the relationship between her acting-out behavior and her emotional state. For example, she did not realize that after an upsetting visit or phone call from her parents, she

would resume acting out by staying up late and dressing inappropriately.

The first breakthrough in her awareness of the relationship of feeling to behavior occurred about ten weeks later, when the doctor forgot to leave an order giving the patient permission for a visitor. The patient was furious but rather than verbalize it she acted it out, refusing to go to bed on time, wearing eye makeup and perfume and a shirt borrowed from one of the male patients. She remained in the next interview only five minutes and said: "This interview is a waste of time. You forgot what was important. You demand things of me, but forgot what was important to me." And she stormed out.

In the next interview, it was pointed out to her that she expressed her anger at the doctor in the same destructive manner that she had with her parents. In addition, it was suggested that verbalization might be more constructive. Still angry, she denied any connection: "People are trying to change me. When I get out nothing will change, I will still be the same."

After many interviews dealing with the relationship of feelings to behavior, the patient began to control her behavior. She now dressed appropriately and participated well in school. Her acting-out defense thoroughly controlled, the feelings of depression and abandonment against which it had been a defense rose to the surface.

Phase 2: Working through the Abandonment Depression[2]

Passage of the patient from Phase 1: Testing, to Phase 2: Working through, is signaled clinically by control of the major part of the acting out, a consequent deepening of the depression, and spontaneous recall (this time with more appropriate affect and detailed memory) of the history of the separation and abandonment.

The patient has now fulfilled the conditions necessary for the working through of the mourning process and other emotional conflicts in the interviews, that is, (1) the patient is now aware of the relationship between feeling and behavior; (2) she has begun to check the impulses to act out, which allows feeling to rise into consciousness and which also impels her to remember her past.

At the same time that conflicts are brought to the interview for discussion rather than acted out, words are used to express feeling rather than to manipulate the situation. Finally, with the conclusion of the testing process, the patient, assured of the therapist's competence and trustworthiness, allows a therapeutic alliance to develop, which makes the first dent in the patient's feeling of despair and hopelessness.

The patient enters into a transference, which later will have to be resolved. Nevertheless, this relationship breeds confidence and allows the patient to work through the rage and depression associated with separation

from the mother.

This change in the patient's clinical condition warrants a parallel change in both the therapeutic focus and approach. The focus shifts from the environmental milieu and behavior to expression of the patient's feelings in the interview, with consequent recognition and working through of the conflicts. The goal of therapy in Phase 2 is to work through the rage and depression at the abandonment, which lays the groundwork for the repair of ego defects through new introjections and once again starts the patient on her development through the stages of separation-individuation.

Therapeutic technique shifts from controlling acting out to working through in the interview, that is, from limit setting to interpretation. With the deepening of her depression the patient institutes a secondary line of defense, such as withdrawal, evasion, and denial, which must be interpreted by the therapist, thus bringing the patient back to accepting and working through the depression. At the same time, the therapist supports and encourages verbalization as a superior alternative to acting out for relieving the depression and for eventual resolution of the conflict.

Abandonment Feelings

"After Louise left I started getting really lonely." Doctor: "What did you think about her leaving?" Patient: "I don't know but I felt more acute

loneliness. She used to stay with me. I didn't realize she was good for me until long after she had gone. Mother told me she didn't know where she was. I had the feeling that maybe something happened. I felt nostalgic, something that was part of me was taken away." Here Anne literally reports her feeling that the separation involved a loss of part of herself.

Doctor: "Was that about the time you began to have trouble in school?" Patient: "Yes, I started getting called down. I didn't do well in the first part of the seventh grade. In the summer I really got close to Jan and Bill. We used to stay over at one another's house. Jan and I were always freer, we had less of a front with each other than I had with other people. I really was terribly lonesome."

"Mother started getting sicker then. I'd come home to a different friend's house each night, and father stayed in New York City." Anne then reported her acting out as a defense against the depression. "I think I would have talked to anyone. I didn't know what I felt. I mainly acted. I did whatever I wanted to. I don't think I have ever talked to anyone really deeply. I wasn't aware of feeling lonely, but I thought I really needed somebody. I wasn't aware of feeling lonely until one or two years ago."

Rage at Mother

As the patient slid further into a trough of her depression she worked

through her feelings of being abandoned by her mother-surrogate Louise and then confronted the basic conflict over separation-individuation with the mother. At this point she began to near the bottom of her depression where lay feelings of homicidal rage at the mother and suicidal depression. “I never remember a mother-daughter relationship, maybe just a bit when I was young. I ended up hating her. I wish I didn’t. Talking to her makes me pissed off at the world. Sometimes I could pound her into the ground. Then she’d get sick, and I’d feel bad, and I’d take her to the hospital. A couple of times she would come up to slap me, and I’d push her away. I felt I could kill her a couple of times. I wound up feeling sorry for her.”

Rage and Acting-Out Behavior

“I don’t think she ever knew what it would be like to love without convenience.” Anne then suddenly recognized the relationship between her behavior and her anger. “It is funny, I thought I was doing all those things because I wanted to do them.

“I spent a lot of time with Bill. I’d be upset and he would come to my house, and then when he left I would be upset again. We would watch television or go to a movie. I’d also go to Jan’s house. But when I was thirteen or so, Bill and I broke up, and Jan moved away. Things were still groovy in a way, but we were more separated.

"Then I started to smoke pot and go out with Danny. When Jan and I got together we used to look back to when everything was okay—two years before when I wasn't smoking pot. My parents didn't hassle me as much about Bill, and I stayed away from them as much as I could. I had stuff to look forward to, such as being with Bill or going to Jan's.

"I think that there is a kind of loss that goes with smoking pot. I was kind of happy but I knew that it couldn't go on, but I didn't want things to change so radically. I had to have someone to hang on to. I figured I could focus all my attention on Bill and Jan. I was out of school, nothing to do, just waiting and waiting. My mother expected me to be rotten no matter what happened."

Expressing Depression Patient Improves

With the expression of the rage and hopelessness the patient began to improve. In an interview a few days later the patient said, "I don't know why, but I feel more comfortable now, calmer, waiting for something to happen. Up to now I have had no hope. I have thought things would go on just like before. But now things do seem to be getting better, perhaps not completely changing. In fact, I am coming back to when I was comfortable, and I kinda expect things to keep getting better."

Joint Interviews

After the patient had passed the bottom of the depression, namely, homicidal rage and suicidal depression, and when the parents had become aware of their conflicts in the parental role and had to some extent begun to learn a more appropriate parental role, it was necessary for parents and patient to be brought together.

These joint interviews had a specific and limited purpose: They did not attempt to do family therapy as such but (1) to expose the family myth; (2) to restore more appropriate patterns of emotional communication in the family, the patient doing now what she was unable to do originally, namely, expressing her rage verbally and working it through with the psychotherapist, thereby relieving the pressure behind the acting out and discovering a new mechanism for dealing with family conflict; and (3) to find more constructive and newer ways of dealing with family conflicts on the part of both patient and parents. This initial confrontation always arouses great anxiety, which immediately leads to regression on the part of both patient and parents. However, after successful confrontation and catharsis of the underlying emotions, the family is freed to seek better patterns of adjustment. This crucial operation finally brings a strong ray of hope to the patient.

Phase 3: Separation[3]

As the adolescent enters the separation phase he develops great anxiety,

since the impending separation from the therapist revives all the old feelings of being abandoned, which then come to dominate the issue of separation. The patient responds to this anxiety as of old by regressing and acting out to impel the therapist to keep him in the comfortable, dependent position and not require him to deal with the anxiety he feels about the move to autonomy, that is, to being on his own.

He is afraid he will be unable to cope with his own feelings, parents, and life situation. In addition, he fears that he will yield to the temptation to regress and be drawn back into the old bind of dependency with his parents.

Separation as an Abandonment

Anne talked about experiencing the impending separation from the therapist as

abandonment, and at last perceived that she was handling this fear by acting out in an effort to get the therapist to hold her back as her mother always had.

The therapist reinterpreted her fears with a discussion of the difference between separation and abandonment and reassured the patient that she would not have to move away from the security of her relationship with her therapist any faster than she was able. Anne then began to work through her

fears of being abandoned, in the setting of the impending separation from the therapist.

She recalled the day Louise left, at age ten, and her feeling that people could only get so close. Much as she loved and needed Louise, she could not hold on to her. She then remembered her loneliness and anger at her mother for not fulfilling her needs when Louise left. Patient: "When Louise left, mother was pretty cold to me. She would be sick and sleep a lot. I would get home from school and go to my room. There was nothing to come home to. My mother wasn't even around to say 'Hello.' She really wasn't a mother at all. As far as I was concerned she was a grownup living a world apart from me."

As the patient returned to her fear of doing things on her own, the therapist reassured her about her capacity to handle things herself, and of the therapist's support until she was on her own—pointing out that the patient's life had been characterized by either overindulgence or abandonment and that there was a middle course until she was able to be independent.

Final Improvement

She summarized her treatment: "I have gone through three stages here: First, it was really hard and everything was drag. Second, then I went back to being a little kid, running to you and mama. Third, now it is okay, I am growing up at last, I hope it will be more like a happy medium between the

dependency I hated and the freedom I feared, like you have talked about for a long time now." After this interview, which was in the middle of June, the patient gave no evidence of any regressive tugs, nor any acting out, nor any depression.

A Libidinal Refueling Station

Our early unsuccessful experiences in attempting to send these patients either home or to a boarding school after discharge have slowly led us to understand that the hospital treatment, effective as it is, is only a beginning for the following reason: The patient has not resolved his separation anxiety, which continues to frustrate any effort at a close heterosexual relationship because of fears of engulfment or abandonment.

The manifold problems associated with the oral fixation, particularly the demand for an exclusive dependent relationship, have not been fully worked through. Discharge from the hospital, that is, from the caretaking apparatus, over and above its abandonment significance, leaves the patient open to severe oral frustration with consequent rage and depression due to his continued emotional need for supplies in order to build ego structure.

In addition, although the patient is somewhat freed from the old environmental conflict with the mother, he now engages in an intensive intrapsychic battle between his push for individuation and the anxiety and

guilt that spring from his introjected maternal image. Beyond this, the patient's discharge from the hospital again raises the mother's wish for reunion, which she implements to pressure the patient to regress and return to the old symbiotic union. The patient, for his part, suffering severe depression and guilt, is severely tempted to regress and rejoin the mother.

The issue which dominates all others, however, is the patient's continued need for emotional supplies and for relief from anxiety and guilt in order to continue on his developmental way to autonomy. To meet these issues we are now in the process of setting up another caretaking facility—a halfway house—which can be used as a libidinal refueling station until the patient is emotionally ready to go off on his own. Our patients will be able to put the halfway house to a use similar to that of the normal toddler who returns to the mother for libidinal refueling as an aid in his journey. In addition, to minimize some of the separation anxiety, we have arranged to have the patient continue with his inpatient therapist for a second outpatient year.

In the meantime, we have been placing our patients with relatives or at boarding schools. Freed from the regressive pull of constant contact with their parents and supported by a continuing relationship with their therapists, the patients are far better able to cope with their intensive intrapsychic conflicts. The vicissitudes of this therapeutic struggle are

described in other publications.

Although the borderline adolescent's problem is severe, and therefore his therapeutic requirements high, there is no reason for discouragement. If we have understood and properly treated the patient's pathology, we will have made it possible for him once again to harness the enormous power of his own inherent growth potential to his own ego development.

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Notes

1 Rinsley50-53-56 termed this phrase “the resistance phase of residential treatment.”

2 This phase corresponds with Rinsley’s “definitive” or introject phase.

3 Rinsley’s phase of “resolution” (de-symbiotization).