CHAPTER 33

Inpatient Hospitalization for Borderline Patients: Process and Dynamics of Change in Long- and Short-Term Treatment

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PROONENTS OF SHORT-TERM inpatient treatment for borderline patients are agreed that it is the treatment of choice and that long-term hospitalization is indicated only when the former has been tried and failed to enable satisfactory social adjustment or, when, from the onset, the regressive potential and destructive behavior of the patient cannot be contained and reversed. The literature describes quite well the advantages, stages, scope, and problems encountered in short-term hospitalization. Some of these contributions are now classics and are recommended highly (e.g., Friedman, 1969; Adler, 1973; Wishnie, 1975). Their essential point is that the borderline’s regressive potential and the corresponding disruptiveness to the inpatient service are so great that only as a last resort should one undertake confinement longer than 10 to 30 days.

Because most of these contributions were written during the pioneering periods, when diagnostic as well as treatment sophistication was evolving, it is worthwhile now to clarify the group of borderline patients to which those writers were referring and whether their caveats are still warranted. A number of classifications, unavailable then, now exist for those patients we usually consider borderline. Following this approach and utilizing first a descriptive frame of reference, the unstable character disorder defined by DSM-III (1980) is the one group that has been most generally delineated in the literature. Subsumed under this category would be Gunderson’s borderline personality disorder (Gunderson and Kolb, 1978), from which a large
part of the DSM-III was derived; Donald Klein's hysteroid dysphoria (1977); and the original description by Grinker, Werbel, and Drye (1968) of the core borderline or their group II. Continuing now from a structural frame of reference, Kernberg's (1975) criteria for a lower order personality organization is another basis for categorization. This would include sufficient evidence for a severe disturbance in general ego functions (i.e., anxiety and impulse control, sublimatory channels, ego boundaries, and a preponderance of primary-process thinking), as well as a disturbance in identity formation and specific ego functions as evidenced by specific primitive defenses organized around splitting, especially denial, projective-introjective and grandiosity mechanisms. Finally, from a genetic-dynamic point of view, there should be evidence that the patient is struggling with what Mahler, Pine, and Bergman (1975) have called the rapprochement crisis, or what Masterson (1972) has termed abandonment depression.

Today, we also need to tease out from this core borderline group current evidence or a history of an affective disorder component (Stone, 1980; Akiskal, 1981); an organic component, such as an attention deficit or dyscontrol syndrome (Andrulonis, 1981); the possibility of a schizotypal (Spitzer, Endicott, & Gibbon, 1979) or primary cognitive-perceptual disorder; as well as a more advanced hysterical personality masquerading in a regressed guise (Singer, 1979). If any of these variants are also present, then the appropriate additional approaches would be considered in the therapeutic equation, be it biological, educational, or psychotherapeutic.

The short-term approach utilizes primarily confrontational techniques that are reality based and address the cyclic interactional maladaptive patterns. Supplementing this reality and ego orientation is an active program to maximize the available resources for successful resocialization. Thus, a concerted attempt is made to strengthen ego props within the interpersonal, career, family, or recreational and religious spheres. Hence, the short-term reality approach can be expected to address only (1) the patient's chronic reactions to disappointment over unattained emotional supplies, that is, impulsive revenge reactions directed toward the self and the object, and (2) the patient's generally disturbed orientation to work and interpersonal relations.

However, disturbances in (1) the sense of self, which includes the basis for feelings of emptiness, loneliness, and fear of being alone; (2) selfobject boundary or differentiation, which prevents any degree of true intimacy or distance; (3) fragmentation or lack of integration of the personality, which creates a perpetually chaotic and hostile persecutory world that can be dealt with only in kind; and (4) the deep, primitive, phantasmagoric fantasies and primary depression that energize all the foregoing can be dealt with only through a long-term approach.

As mentioned earlier, only when the short-term approaches have been in-
dicated and attempted, but failed to encapsulate the psychotic core—the primary depression—or to reconstitute the most adaptive aspect of basic maladaptive interactional patterns should long-term inpatient approaches be considered. Long-term approaches, in contrast, must provide for a full regressive potential, so that the patient can face his abandonment depression (Masterson, 1972), with its serious life-threatening ramifications. This by necessity must include the severe acting-out, disorganizing, and suicidal experiences dreaded by both patient and staff. It goes without saying that both short- and long-term units must have highly skilled staff in a continual process of education, open communication, and self-appraisal to cope with these issues. The early papers' warnings of the pitfalls that could and did occur to the inpatient workers have by now largely been ameliorated. Staff are now better prepared to deal with patients' subversive splitting maneuvers, which cause analogous regressive disorganization within the unit. This paper compares and contrasts the indications and the essential ingredients of both short- and long-term treatment.

CONTRASTING INDICATIONS

Kernberg (1973) recommends a short-term approach for all borderline patients except those who reveal the following characteristics: a low motivation for treatment; severe ego weakness (a lack of anxiety tolerance and impulse control); poor object relations; severe acting-out potential (particularly suicidal and self-destructive behavior); and the tendency toward a negative therapeutic reaction. Wishniew (1975) mentions massive isolation of affect, which cannot be broached in a few short weeks. This is especially true if the detour from avoidance of affect to suicidal behavior is too rapid and treacherous. In a similar vein is Adler's (1973) statement that massive denial of reality under stress is a contraindication to short-term hospitalization.

I have repeatedly seen patients who combine the inordinate regressive potential, negative therapeutic reaction, and suicide potential that force a long-term hospitalization. The contraindications listed previously usually exist together. Furthermore, the conventional psychotherapeutic process, which successfully employs such technical interventions as empathy, exploration, clarification, confrontation, and then interpretation, either fails immediately or results in only a temporary relief. The rapid onset of the hope and well-being generated by the transference fantasy of magical union with the omnipotent therapist and unit turns rapidly into a negative therapeutic reaction. Whether one supports the superego, frees up some id material, or strengthens the reality base or environmental support systems, there is still a relentless imperative toward omnipotence and total need satisfaction in magical unity either with the therapist or, if that fails, through suicide with the
fantasied mother before separation. Death or escape from this world with the fantasied reunion and immortality in the next is a most compelling alternative to restore primary narcissism.

These patients express resistance not only from their primitive superego (as revealed in the need for punishment by demanding the loss of the object), from the ego in the transference, and from secondary gain in the form of an eroticized dependency, but also from an id resistance that refuses to relinquish its primitive needs. These patients not only fear the loss of the object, but are intolerant of psychic pain of being overwhelmed by the drives. This requires that the therapist use parameters and a great deal of patience in this painstaking work.

The patients' manipulativeness, although palpably evident to the primary therapist and therapeutic team, usually is not only totally unavailable for self-observation, but totally repugnant and thus violently denied. Their guilt is too great and primitive at first for them to tolerate this confrontation. They react with revulsion against the confrontation by increasing suicidal behavior—their manipulations are desperate attempts at an allogenic restitution, behind which lurks a primary absolute depression. Their immature personality forces them to deny reality in fantasy and action. Superego-induced masochistic strivings must drive away every potentially nurturing person as retribution for their inexhaustible greed whose origins cover the entire range of psychosexual development. Thus, in compromise fashion, the only fitting punishment is to drive away by their coercions precisely those persons with whom, through their coercions, they desperately seek blissful union. Thus, no therapeutic alliance can be established long enough to become stabilized, and no partnership can be created that provides the empathic union to bridge the psychic pain necessary to work through the depression of loss.

I have also seen patients whose negative therapeutic reactions derived from negative introjects that were so well entrenched they overpowered extant positive internalizations. Thus, no sufficient inner good object existed to sustain the person as he worked through the conflicts that had to be faced; there was only the external safety of a protective hospital setting for extended periods. Gradual internalization of a good mother—safe infant interactional unit to counterbalance and replace the bad through techniques of empathy, containment, confrontation, and clarification requires individual therapy on a daily or at least every other day basis. The good mother experience cannot be retained or retrieved without this availability of staff and therapist. In accordance with Piaget's cognitive developmental schema (Piaget and Inhelder, 1958), borderline patients function at the sensorimotor level, which precludes perceptual object permanence. Recall of the memory of the good mother at this level can occur only when there is perceptual recognition of the external counterpart. Following object relations theory, the patients func-

tion at the level of pretestibial object constancy, or there is a fixation at an early stage of separation-individuation, implying a failure or fusion of the drives with a preponderance of aggression over libido and thereby a split world of self and object. Thus, out of sight is out of mind or gone, and the patient is then subject to a world of diabolical enemies. Hoffer described the object at this stage as still perceived as part of the body's "milieu interne," and Hartmann named it the stage of the need-satisfying object (see discussion in A. Freud, 1952).

In other borderline patients, there may be sufficient internalization of positive human experiences and only some suicide potential, but a limitation exists in the availability of adaptive, autonomous, and defensive mechanisms. Then, serious sociopathic-like, self-destructive, impulsive behavior (i.e., abuse of drugs or alcohol and sexual promiscuity) may be the only coping patterns available for those patients to deal with their primitive strivings. In this case, the limitation on their ego resources mandates long-term hospitalization. Occasionally, lack of outer resources, such as family, residential living, or day care, also prevents rapid discharge and forces long-term hospitalization.

Mention must be made again of motivation in borderline patients as an indicator for short-term hospitalization. Unlike more neurotic patients, for whom the primary indicators of successful treatment are for their motivation for personality change and then symptom relief (Sifneos, 1972; Malan, 1976), borderline patients live by different criteria. Manipulation of the external world is their principal coping mechanism. It provides them with safety by the omnipotent possession and control of the idealized object. There is no hope, let alone awareness, of possible change from within. They perceive only inner emptiness (see Singer, 1977a, b, 1981). Thus, borderline patients can symptomatically rapidly improve and become motivated to leave the hospital if a person appears in their external world who would be lost to them if they appeared too ill or incapacitated. This is true, at times, even for borderline patients with severe depression and suicide potential.

There is also the borderline patient in outpatient therapy who is deeply immersed in the transference and has an established therapeutic alliance—when a disruptive environmental circumstance sets in motion a regression, which can be resolved now only by long-term hospitalization. A common example occurs when the family, having become sufficiently threatened by the patient's progressive movement away from dependency, suddenly initiates removal of the patient from treatment. I have also seen the emergence of a sudden, unexpected severe regressive pocket or equally unexpected counter-transference difficulty disrupt the established symbiotic-like transference, creating a delusional one and mandating long-term hospitalization to work through the reactivation of this deeper and potentially dangerous material.

A most dangerous situation is the sudden, surprise perception of loss of the
object in the borderline patient who has severe fragmentation or dissociation of the personality. The usual functioning may have been adaptive, provided the ego unit in control of affect and behavior has been supported by a positive external relationship. But under the disruptive impact of this severe external oral frustration, a split-off ego state gains control of the personality and, in desperation, a sudden impulsive suicide attempt occurs in this altered state. Mending the caesa to prevent another attempted suicide may require long-term hospitalization. This split-off, irreconcilable ego unit must be mobilized to enter into the primitive split transference. This sets the stage for their partial integration through the binding power of the eventual positive internalizations. Only then is the patient safer from the danger of suicide. This is especially true if the borderline structure is complicated by the addition of major affective, addictive, or organic components.

BRIEF INPATIENT TREATMENT: GOALS AND PROCESS

The literature on brief inpatient treatment lists one major caveat and four points regarding goals. On entrance into an inpatient unit, the promise of regaining “paradise lost” is activated. One sees, therefore, a rapid mobilization of a primitive oral transference to the caretaking milieu, which, in dialectic fashion, may activate in the staff a corresponding split countertransference. Based on splitting and projective mechanisms in the patient more than in the staff’s psyche, there is a sequestering of the staff so that some staff members experience concordant and others complementary counteridentifications with positive and negative aspects of the patient’s inner world of self and objects (Racker, 1953). The potential for this melodrama to be repeatedly played out may be related to latent conflicts within the staff, which are organized on higher levels but can still resonate sufficiently to join forces in the acting out of the patient.

The patient’s typical history of frustration of need either from deprivation (i.e., a lack of being heard or felt to exist as a real person) or from marked inconsistency (i.e., overindulgence followed by neglect and punitiveness) has created massive disjunctive forces within the basic fabric of the personality so that there is a lifestyle of chaos and confusion over who the patient is and what is real internally and externally. Hopelessness exists regarding realistic satisfaction of needs. Thus, the solution comes out of despair—to live moment to moment, essentially by the pleasure principle, under the sway of primary-process thinking.

The staff must provide for the first time the essential experience of consistency, containment, and empathy as the scenario unfolds. The script calls for firm but nonpunitive limit setting so that the patient can begin self-obser-

vation and internalize trial action in thinking, not impulse discharge, as the only possible method of tension regulation.

The oft-stated feelings of entitlement betray the fantasy that all the patient’s wishes will be gratified. This must be effectively confronted and attenuated if the patient is to function safely outside a hospital. Adler (1975) and Wishnie (1975) both describe essentially the same three-step process that must be traversed so that the underlying dreaded psychic pain of abandonment depression can emerge and then be faced. The first step is the rapid appearance of the magical expectation of nirvana or total gratification. This is followed by disappointment, disillusionment, and despair, when the patient continually raises the ante until expectations reach the point of nonfulfillment. The self-fulfilling prophecy can then be realized, that is, “I am unlovable and the world is empty and treacherously barren.” Finally, there is the vengeful acting out toward the unit and the self in a state of panic. All these phases are well-known examples of the repetition compulsion (id resistance) or, in adaptational terms, a test of the environment to prove it will not be different and they won’t have to chance trusting a person separate from and not dominated by them.

Borderlines universally believe that not their words, but only their actions will be heard—provided, however, their actions are outrageous enough to evoke guilt or social disgrace in the depriving, treacherous other. Genuine caring does not exist, but gratification can be achieved, albeit by coercion. Family studies of adolescent borderline patients have found that their parents, to a significant degree, were truly impervious (Zinner and Shapiro, 1974; Singer, 1975). Facing the abandonment depression is at the heart of the treatment. The acting out is a resistance against facing this psychic pain, which is unconsciously viewed as annihilation by the most fiendish means.

The treatment process is repetitive, but certainly not dull. The staff must rapidly establish the diagnosis and then institute reasonable goals and expectations within clearly defined guidelines. Regular as well as impromptu (Crabtree & Horowitz, 1974) staff meetings are mandatory to maintain consistency within the milieu staff to avoid splitting. The skill and strength of the psychiatric supervisor is essential in confronting and integrating the beleaguered staff. Promptly, the patient tests the resolve of the staff structure and goals. Confrontations occur and recur. Discipline must be consistent across the three dimensions of the transactional sequence, policy making, policing and punishing (Singer, 1975). The patient begins to realize that the staff actually does maintain limits while retaining empathic contact, without the expected withdrawal or overresponsiveness. The transition points from confrontation to empathy are smooth and gradual so that dissociation is not encouraged (Lichtenberg, 1982).

If the patient can acknowledge the genuineness of this human attempt to help, the treatment deepens, and this creates anxiety. With the removal of the
acting-out defense (entitlement followed by disappointment and revenge), which confirmed their fear of rejection, the patient begins to lose previously validated defensive protective omnipotence and self-absorption and becomes aware of deeper dependency cravings without control. Then fears of total engulfment and treachery emerge.

In brief inpatient therapy, however, as soon as the patient can tolerate the beginnings of depression without resisting in behavioral acting out, discharge to a day program with outpatient treatment is planned. The further process of facing primitive depression is left for outpatient work.

In summary, the goal is for borderlines to face their wish to return to the state of primary narcissism, to begin the process of tolerating psychic pain, delaying gratification, initiating a therapeutic alliance and to begin to use words not action as a tension regulator and means of communication. These new ego skills are initiated through functional ego identifications with the primary and milieu therapists in the context of a basically facilitative human interactional experience. In the best sense of the term, this is a corrective emotional and intellectual experience, which is grafted onto and strengthens the defensive structures that have encapsulated the psychotic core. Then, as an outpatient, the borderline can begin to consolidate truly human ties, including trust and the expectation of a reasonable degree of gratification, without exploitation or the need to manipulate.

When reconstitution of the premorbid personality does not occur in the brief hospitalization experience, precluding an outpatient approach, then long-term inpatient treatment is indicated. As mentioned, the failure to tolerate psychic pain or to stabilize the adaptive mechanisms and autonomous functioning, as well as the severity of the negative therapeutic reaction—all contribute to this dilemma.

LONG-TERM INPATIENT TREATMENT: GOALS AND PROCESS

Rather than fulfilling the dreaded warnings from the past that the regressive potential is accelerated as a result of the implicit promise of long-term hospitalization—that their inordinate infantile longings would be gratified—the properly trained staff and organized unit structure can provide perhaps the only opportunity for a gradually progressive regression to the point of fixation and eventual resolution of the problem. Inasmuch as the precipitating event is usually an actual or imagined loss of the external representative for the maternal need-satisfying part-object, the unit and staff become the substitute for this ultimately desirable but totally unattainable person. The process of establishing the contact, maintaining, and deepening it offers the hope of working through the primitive anxieties that will eventually lead to greater and sustained intimacy in their real object relationships. Traversing this course entails transforming a multitude of maladaptive patterns of coping, defense, thinking, and feeling so that a more stabilized personality emerges. Structural change is attempted, and if this greater integration and differentiation can be sufficiently achieved, there will be in evidence a toleration for greater intimacy and separateness.

Since their major coping patterns are alloplastic, repeatedly disrupting their life, the continual, unique capability to monitor their behavioral patterns and interactional sequences within this microcosm of the real world becomes the major asset, not liability, of long-term inpatient treatment. Sadovoy, Silver, and Book (1979) have felicitously termed this technique “therapeutic encirclement,” that is, ensuring a continuous control of the acting out and preventing a reversion to old patterns. Perhaps it is only in this setting that the therapeutic focus can be maintained at a tolerable pace, fostering the regressive and progressive process. Individual therapy is its center, providing the deepest and richest access to the primitive fantasies, while the interactional therapies within the milieu reveal the derivatives of these same fantasies played out by the patient in action patterns with the staff and other patients. The casting and narratives within the milieu provide the clearest expression of the patients’ role-induction maneuvers, projection systems, and character distortions, which sabotage all relationships.

Appropriate disclosure and sharing of information between all the staff is essential, especially with borderline patients, whose major defense is splitting and externalization. This rich cross-fertilization enhances the effectiveness of all the approaches by providing firsthand evidence unavailable to any one approach alone. Since the most far-reaching interpretation is the one that is most immediate and “at the point of urgency,” the on-the-spot interventions available only on the therapeutic milieu are without rival for their value in effecting insight and change in these acting-out disorders.

Two other crucial therapeutic tasks in long-term inpatient work include providing a “container” for the mass of chaotic, fragmented, and undifferentiated feelings, thoughts, and actions (Bion, 1963) and a “holding environment” to establish and sustain the threadlike relationship with the external representative of the good internalized maternal image (Winnicott, 1962).

The translation of their confusion into words, living in their chaotic life experiences, is best done by the highly trained and skilled psychoanalytically oriented therapist. Articulation of their behavior, as well as their thoughts, feelings, and bodily reactions, must be complemented by the therapist’s awareness of his or her own emotional experiences and responses to the patient made accessible by empathic, intuitive, and introspective means.

Since splitting, coupled with projective-introjective mechanisms (Grotstein, 1981), is centrally operative, the therapist must utilize his or her own in-
spective abilities while simultaneously attempting, not always successfully, to empathize with the patient's subjective experience. However, the crucial point is that the two are usually disjunctive at the moments of strain and insight into what is actually being enacted. The patient is inducing in the therapist a role, and thereby an experience, on a sphere dissociated from their own centrally experienced state. This explains an aspect of the borderline's agony of feeling one thing and being accused of doing another. These two independently operative states and experiences must be skilfully integrated to reveal the interactional and intersubjective experience that is being compulsively directed. Many times, this integration can occur only after the fact. The therapist and staff have already acted out the counteridentifications projected and induced onto them; only then can they replay them and subsequently alter their behavior and confront the patient with their feelings regarding his or her behavior.

Only through this transsubjective interactional experience (Pontalis, 1981) can one approximate an explanation of what is transpiring in the borderline patient. This experience provides, according to Green (1975), the first verbal statement of the borderline's heretofore nonverbalized experience and allows an initial retention in memory of a mnemonic trace. A primary-process experience is thereby transformed into secondary process; simultaneously the cathexis charge is raised and bound. The pleasure principle is changed to a reality base by the switching of impulsive to trial action in the cognitive plane of logic and ordered casuality. This binding of the drives or tension regulation begins to replace tension discharge by impulsive action or fantasy. Linking the body self with the psychic self gives words eligibility for psychic elaboration. However, in order for the borderline patient to travel this course, protective companions are absolutely necessary.

These companions must provide what Winnicott (1962) called the "holding environment" for the borderline patient eventually to face the indescribable horrors along his journey toward union with the "good mother before separation" (Mahler et al., 1975). The following interactional characteristics of the "holding environment" apply to the milieu team as well as the individual therapist: (1) consistency, (2) reliability, (3) availability, (4) devotion or dedication, (5) incorruptibility, (6) coesthetic empathy, (7) the provision of hope and patience—not despair—in the patients' eventual improvement, (8) a respect for their autonomy, (9) the experience of toleration for borderline rage and survival in both therapist and patient, and (10) the demonstration that the therapist is not created by the patient's hostile projections but, rather, is separate, real, and loving.

These qualities provide the basic groundwork of treatment. Borderline patients must experience this continual, consistent, and reliable presence, protection, and nurturance from the caretakers in spite of the patients' kaleidoscopic changes in attitude and behavior, which are inconsistent, unreliable and unfaithful toward the staff. Borderline patients must also sense that the staff empathizes at an emotional, or "gut," level, not just intellectually—that the staff feels with the patient. Further, the staff must, at the same time, respect the patients' delicate ego boundaries and not impinge so much that a panic reaction results. Laing (1960) said, "Let them be." One must also be incorruptible. Their needs are so great that borderline patients are vulnerable to any caring person's own needs. In his discussions on countertransference, Winnicott (1958) warned therapists, "Behave yourself." Perhaps for the first time, the borderline is able to create, in a realistically appropriate manner, an inner world of need satisfaction in which infantile omnipotence is achieved, even if only momentarily, in a human context of caring without excesses in satisfaction or frustration.

Finally, perhaps the most difficult yet most crucial requirement for traversing the bad object stage is that the staff survive borderline patients' rage. If they can experience your steadfast commitment to them in spite of their wickedness, oral envy, greed, and rage, they can begin to believe they are lovable despite their hate and perhaps can eventually be loved by the good mother. Be mindful, though, that even positive experiences, which should be retained, can instead be destroyed and consumed by wave after wave of mistrust and the delayed misperceptions of mistrust. The staff and individual therapist must not despair, but reaffirm each other's hope in future improvement. If the internalized good, idealized maternal imago can be saved and not destroyed and turned into the bad object, then the patients' protective barriers can gradually be lowered. They can then take the chance of developing basic trust through a unifying experience with the good mother.

Most countertransference difficulties I have studied involved the therapist's and staff's dissociated complicity in promising total gratification. This difficulty is compounded by a second split involving therapists' unawareness of building reactive countertransference rage and death wishes, which were being subtly acted out against the patient on a second unconscious plane. The patient's exquisite sensitivity or empathic awareness of hostility activates homicidal and suicidal panic reactions as the patient desperately attempts to cope with the perceived treachery of the therapist and staff. The carrot was inadvertently dangled and then withdrawn, placing the borderline seemingly in the same dilemma as Tantalus—tortured for eternity!

A number of patterns of interaction have been described that emerge in all long-term treatment units. These must be confronted, clarified, and worked through before the borderline patient is ready to attempt trusting (see Book, Sadovoy, & Silver, 1978; Sadovoy, Silver, & Book, 1979). These maladaptive allopastic patterns are external expressions of the borderline's intrapsychic world dominated by their attempts to control the oral and anal aggression of the negative introject or sadistic idealized object to which they are subservient. There is a failure of fusion of the drives and integration of the good and
bad idealized objects because of either a failure in maternal empathy (Kohut, 1971), her emotional unavailability (Mahler et al., 1975), or a disappointment in the expectation of gratification (Benedict, 1938). Thus, the resultant slavish relationship to the sadistic superego forerunners must be relinquished. This can be accomplished only by gradual clarifications and interpretations of either their misperceptions or their establishing the set to be disappointed, hurt, abandoned and abused. Every intervention replacing the negative with a positive provides a positive internalization. This gradually builds up sufficient libidinal units of self and object to bind the now-reduced negative, establishing integration or synthesis and thus building ego strength.

Some of the patterns can be enumerated as: (1) patients’ always expecting too much and coming up empty handed; (2) a constant refrain that “nothing is happening,” that is, they are always disappointed; (3) stretching the rules until the patients’ must be constrained or confined (The day of reckoning always arrives); (4) always creating the crucial dilemma — how much gratification versus frustration must the staff provide that can be tolerated by the patient — either way, patients are prevented from facing the real test of trusting another person without the power of coercion over them or they over the staff; (5) championing the cause of the underdog or coming to the rescue against all other patients’ injustices — borderlines are the perpetual reformers against all authority figures perceived as evil; (6) they divide and conquer the unit by recreating in the milieu their internal war of the worlds, made up of grandiose part-self and part-objects, and playing out their grand destructive design externally — they are masters at inciting riots.

All or some of these patterns and others are a desperate attempt to confirm the borderlines’ expectation that there is no good object, only a diabolical one masquerading as good to perpetuate the deception until their guard is lowered and they are then at the mercy of some fiendish plot. Gradually, through growing insight into this fantasy and their own self-perpetuating role in their plight, borderline patients can tolerate increasing doses of closeness without their omnipotent control or possession by ruthless coercion. This would allow for the internalization of real dependency in a situation of trust (i.e., basic trust). However, this process does not occur smoothly. Rather than challenge this diabolical internalized object, they make a pact with it. They are familiar with relating to real objects only on the model that coercion, manipulation, or perverse identification, in the form of a manic-like defense, can allow them to survive and avoid the ultimate rendezvous with death or what Little (1958, 1966) called an “orgasm of pain.”

Their defense then is to treat all possible good relationships with contempt and devaluation and deny all reality contingencies that indicate opportunities in that direction. They are safe and in potential control only in a bad relationship. At the extreme, if the borderline patient cannot control and triumph over the sadistic ego ideal by coercion or self-sacrifice, the only method left is suicide (Kernberg, 1975).

To enable the patient to reach a unity experience with the individual therapist and to trust the milieu staff requires a great deal of skill, respect, and communication among the therapeutic team. Again, the patient’s anxiety is at the level of ultimate panic over helplessness — annihilation or phenomenological death. “Falling forever” or “being blown apart into a million pieces” are commonly heard expressions. These are not just metaphorical, as in nerves, but are viewed concretely — fantasy is reality. As they approach surrender, borderline patients must react with a number of flight or flight reactions. These range from marked withdrawal to homicidal-suicidal panic reactions. Every relinquishment of a hard-won defensive pattern eventually brings on a renewed panic that the sadistic idealized maternal imago has been resurrected. A monstrous trick has again been perpetrated on the patient, leading to diabolical death through the promise of love and care.

The therapeutic team must accept whatever linkages to the patient’s symbiotic experience the patient will allow (Sadovoy et al., 1979). Patients usually will provide clues through music, eye contact, hand holding, or empathic sharing. Their ordeal and travail reminds one of the heroic stories and myths from ancient literature — Odysseus fighting monsters and witches, which have barred him for 20 years from returning to the land of his birth. This is the same rendezvous with death that the borderline must endure before union with the good mother. Unlike the neurotic, who from fear of unconscious conflict takes flight by repression, or from fear of real world events that would remind him of this conflict, takes flight by withdrawal either through inhibition or restriction of activity, the borderline employs flight mechanisms that are much more primitive and destructive, involving severe acting out against self and object with loss of reality orientation. Furthermore, the neurotic’s lowered self-esteem, feelings of being cheated, of inferiority and injustice are magnified tenfold by the oral and anal sadistic colorings of borderline pathology.

An understanding and constant self-reminder of borderlines’ basic primitive anxieties can provide the empathic leverage to tolerate the frustration engendered by their sabotage mechanisms. Their basic fears are annihilation of the self and loss of the object, castration or loss of the object’s love, as in a more fully integrated and individuated personality, are inaccessible. At different moments within the treatment, one can best conceptualize these primitive anxieties as originating in the depressive and paranoid positions (M. Klein, 1932, 1952). Whether they fear that their aggression projected onto the object and redirected against the self will devour them out of mobilized oral envy and greed (paranoid position), or that their oral envy will mobilize such intense murderous rage that the garrisons protecting the internalized good
mother are jeopardized and thus they will destroy their only connections to any potential love and security (depressive position), their world is fraught with absolute danger and helplessness. Finally, one must remember that the eventual wish for oneness with the good mother also holds the danger of annihilation since the still fragile individuated self will give itself up for want of the unity experience.

CONCLUSION

At first, primarily from a theoretical and heuristic point of view, brief inpatient treatment drew the most interest and was considered the only viable form of hospitalization for this group of devious, crisis-provoking, disruptive patients. Today, it remains the treatment of choice for a wide range of borderline patients with moderately severe regressive episodes. The indications, goals, process, and methodology of treatment are well delineated and elaborated. This favored position may be even truer today because of increasing costs and negative bias, and the disinclination of governmental and third-party carriers to provide financial support for a longer term enterprise.

However, the observer has effected what he has observed. Long-term hospitalization, which implies a period of confinement over six months and preferably between one to two years or more, has become, in skilled hands, the most efficacious treatment for many severe borderline disorders. Through the combination of the three modalities of “therapeutic encirclement,” providing a cognitive “container,” and an emotional holding environment, borderline patients have a chance to alter their basic primitive structure. Integration of the split self and object world and greater self-object differentiation can be attempted through constant surveillance, confrontation, containment, empathy, and clarification. Access to the myriad split-off, fragmented, part-self and part-object projections and associated phantasmagoric fantasy life can best be observed, labeled, integrated, and worked through when the patient’s entire life is under close, continuous scrutiny by a highly skilled staff. This therapeutic team continually rehashes the borderline patient’s action patterns, thoughts, and feelings under the overriding guidance and wisdom of the psychiatric supervisor and in mutual cooperation with the individual dynamic therapist.

REFERENCES


