MILIEU CONCEPTS FOR SHORT TERM HOSPITAL TREATMENT OF BORDERLINE PATIENTS

Jesse Viner, M.D.

In contrast to the extensive literature on the outpatient treatment of the borderline patient, there exists only a handful of articles which address the complexities of hospital treatment.\textsuperscript{1-5} This paper will focus on aspects of the milieu for short term (less than three months) length of stay hospital treatment.

To begin, it is important to define the patient group referred to as borderline. As Gunderson (1982)\textsuperscript{6} has noted, the results of research give confidence to the conclusion that a borderline syndrome exists as a valid diagnosis, but that questions persist as to the particular criteria that define the syndrome. He asked to what extent the current definitions of borderline personality syndrome define a discrete personality disorder, and to what extent is the syndrome representative of a mid-level personality organization which encompasses a variety of more specific personality disorders, as suggested by Kernberg (1975).\textsuperscript{7} Gunderson concludes that both conceptualizations look for validation primarily in terms of treatment issues and response. For this reason, I have chosen to have borderline refer to the more inclusive concept of borderline personality organization. As almost all authors have noted, this entire patient group, despite differentiating symptom clusters, shares a central aspect of psychopathology: the potential for precipitous, primitive, yet reversible regression. As I have described previously, Viner (1983),\textsuperscript{8} this potential rests on the underlying fragility of a self-organization which lacks irreversible unification. Since borderline patients often enter the hospital in the midst of a regressive crisis, the understanding and management of regression and associated impulsiveness is at the center of any milieu treatment efforts with these patients.

A MILIEU APPROACH TO REGRESSION

Given the centrality of regression, it is important to develop an understanding of this psychic process from which derives an attitude and approach to its manifesta-
tions. Acute regression in borderline patients results from the disruption of the patient's self-organization. It is a symptomatic expression of and a pathological, compensatory attempt at mastery of internal disorganization. As these patients are partially reliant on external objects and the environment for the integrity of their self-organization, assessment of the external and intrapsychic contributors to this breakdown, and their interrelationship, is of critical importance in treatment. Communication of acceptance of the patient as a person vulnerable to regression is critical, but it is no less essential that there be recognition and enforcement of the patient's accountability and responsibility for their behavior and for the consequences that their behavior may bring.

Each milieu needs to define a philosophy within which there is a specific and detailed outlining of the limits of the milieu's willingness or ability to tolerate certain types of regressed or impulsive behavior. Each milieu needs to identify and respect its limitations. Patients are less able to regulate themselves when their caretakers allow them to abuse them.

Case Example

Ms. S, a 24-year-old homosexual woman was admitted to the hospital by her (female) outpatient therapist due to rageful outbursts and suicidal ideation. Once in the hospital, Ms. S began to break furniture after her sessions with her therapist. Consultation with the author as program director clarified the therapist's submission to and withdrawal from the patient's anger and led to an intervention by the program director in which the program's willingness and commitment to treat the patient were reaffirmed; but the patient was made aware of the inability to allow a situation in which the safety of others was compromised and there was willful destruction of hospital property. Her difficulty in managing her anger was acknowledged, the availability of the milieu's resources to cope with these tensions more successfully was offered, and the patient was informed that recurrence would lead to transfer to a state hospital. Ms. S not only did not repeat the behavior, but began to use her psychotherapy more effectively to discuss the origins of her anger.

While the milieu needs to undertake realistic precautions and restrictions to not undermine the borderline patient's capacity to struggle with regressive and impulsive impulses, it is vital to not assume ultimate responsibility for the control of these behaviors. Since these behaviors often are an attack or otherwise directed towards transference figures, it is necessary to develop an understanding and comfort with wishes for omnipotence, and feelings of anger and guilt towards the patient. With patients who insist on regressive behaviors in the milieu, it is vital, after realistic restrictions for the milieu are enforced, that the focus be not on behavioral control, but the dynamic context within which the symptom exists. This may at times require working with, and not being narcissistically injured by, the persistence of a disturbing and dangerous symptom, like self-mutilation. In situations such as these, there needs to be an ongoing assessment of whether the symptom is operating as a core resistance to further progress in treatment. If this (difficult) clinical judgment is made, then there needs to be an insistence on the part of the treatment team that the behavior stop or be significantly modified for continued treatment in the program.

Chronic suicidality and self-mutilation, which potentially threaten life, pose