REFLECTIONS ON THE OPEN SETTING

John P. Muller, Ph.D.
Austen Riggs Center, Stockbridge, MA

Some of what follows will be obvious, perhaps even routine, but because of that it may be worth restating. Some of it may also be controversial and thereby provide a position against which discussion can proceed.

In my experience in the development of a new, open, psychiatric hospital in Chicago, in speaking about the open setting to new staff, both therapists and nursing staff who had worked only in closed settings, it seemed most important to convey the idea that what was at stake was developing and transmitting an entire culture. We observed in our initial year as we made the transition from a completely open 30 bed hospital to a 60 bed hospital that included a three bed locked unit, that as soon as we opened the unit, within the first month, the number of critical incidents escalated, as if the patients were handing over to the staff their responsibility for maintaining the boundaries of the treatment and maintaining their physical wellbeing. For me this demonstrated the kind of regressive pull anticipated by Otto Will, M.D., when he reflected back on his experience in first coming from Chestnut Lodge and wondering about the utility of having a small locked unit at the Austen Riggs Center in order to manage patients in severe regression rather than having to transfer them elsewhere.

The second example from my Chicago experience has to do with the enormous power of expectations. At our hospital the free-standing dining room, a large structure with large plate glass windows where both staff and patients took most of their meals, is a place of sane, polite behavior, but within the first month a psychotic young woman threw a large rock through one of

the large plate glass windows. Luckily no one was sitting nearby, no one was physically injured, but the outrage of the entire community was made clear to this patient at several of the twice-weekly hospital-wide community meetings in which she had to explain her behavior, discuss what led up to it, consider what alternatives she might have if she were to experience the same state of mind again, and a mechanism of compensation was worked out for her to repair the damage that she had caused. That was the last such incident in the dining room over the following three years. In fact, there was very little noticeable psychotic behavior in the dining room because the expectations were overwhelmingly clear to everyone who walked into it.

So it seems to me that what is at stake with any discussion of the open setting is the matter of the creation and transmission of a culture. I think, furthermore, that the open setting as a specific culture must be concretized in the structure of the therapeutic community (Main, 1981). This is not to equate open setting with therapeutic community, since therapeutic communities operate in locked units as well (Kernberg, 1984), but I think that the open setting requires the therapeutic community as its proper forum for operating and taking shape. The therapeutic community, in turn, is structured, here at Riggs at any rate, in such a way that it includes three essential components: the community program, individual psychotherapy, and the activities program (Edelson, 1970).

In examining the proper functions for each of these components, it may be useful to consider Freud's reference to the distinction between painting and sculpture (1904, pp. 260-261), that painting adds to the canvas and the sculptor operates by removing. It seems to me that the community program operates by providing an essential social learning through direct instruction and feedback about behavior. Patients require this kind of social learning in order to get on with their lives in a more satisfactory way and the community program is essential in assisting

patients to carry on this type of learning, and in fact much of the learning occurs from the patients themselves — it is not just a matter of staff instructing the patients. Individual psychotherapy, on the other hand, I think essentially promotes a type of unlearning. The patient unconsciously enacts a repetitive pathological pattern in the transference with the individual therapist who alone is empowered by the therapeutic community to interpret such unconscious repetitive behavior in the transference and thereby assist the patient to alter, to unlearn certain ways of thinking, feeling, and perceiving. Of course, in the individual psychotherapy direct learning takes place as well, especially with patients who are less structured. The activities program, in turn, provides a forum for learning and recognition independent of the group dynamics of the community program as well as independent of the transference in the individual psychotherapy so that the patient can engage in a variety of sublimatory activities and also develop skills in specific ways.

I will not dwell on my assumptions, my biases, or premises about human development that make the open setting the ideal form for treatment. These assumptions have to do with the general movement in human development from physical immediacy toward mediated relationships based on the capacity to symbolize (Fonagy, 1991). I also place great weight on the issue of boundaries; how personal, social and even physical boundaries must be symbolically framed for human beings to function well (Schwartz, 1983). Our treatment essentially consists in defining these boundaries symbolically, thereby fostering in the patient the capacity to generalize, across specific, immediately given situations, his or her awareness of boundaries and knowledge of what is proper and improper in certain situations. My third basic premise is that human beings are subjects, not just objects, and that the defining human characteristic is the capacity to refuse, that negation constitutes the specific differential attribute of human beings

(Muller, 1988). If we respect our patients as human subjects we must put in a central place their ongoing capacity to say "no" to us and to our treatment.

It seems to me, therefore, that an open setting provides the best forum for treatment in order to undermine the patient's compliance as the most subversive aspect of their pathology that they have brought over many years to various other forms of treatment. Patients in our setting are required to actively plan their treatment. That is to say, we do treatment with, not to, our patients Furthermore, patients are held responsible for their actions and their speech in an open setting. Essentially, the patient is responsible for maintaining his or her own treatment, that is for keeping to the essential conditions that make treatment here possible. These essential conditions must be specified through a short list of behaviors that constitute such severe transgressions of boundaries that they have immediate consequences regarding administrative review and discharge, and this short list usually has to do with issues of physical safety; it is also useful to have, in addition to that, a longer list of problematic actions that are serious enough to warrant review and whose continuance places the patient's treatment in jeopardy.

Now even though patients will agree to collaborate with these limits of treatment in an open setting they will proceed, sometimes systematically, to attack the treatment. They test to find the limits, to bump against them, to see if there is a frame that will hold, to see if there is a seriousness about the symbolic order, the symbolic binding that we claim supports us in our work and in our social relations. For many patients fighting against the frame is the treatment, that's what constitutes the treatment. We provide an arena for the fight, for patients to develop certain skills as fighters and for patients to see if we are fighters too, if we care enough for our culture that we will fight in certain ways to defend our culture from attack.

One of the most important aspects of an open setting is its capacity to expose what I take to be one of the basic human motives, namely the struggle for recognition, especially in the face of coercion. Patients will transgress, will then insist on a coercive response, and often they will in fact get staff to make coercive responses, and then engage in a power struggle for recognition with the staff even at the cost of their treatment (Cooperman, 1979). But the open setting aims at being a culture in which boundaries are mainly symbolic and not physical, so that transgressions occur in a realm of symbolization, not so much in a realm of physical destruction. Transgressions then bring with them a kind of symbolic dimension, they bring with them a baggage from the past and a set of implications about the future. Transgressions must be interpreted. The symbolic dimension is inseparable from the act.

Now for the open setting to work, to have depth, to provide over time the patient with a kind of ballast, a kind of substance that gives solidity to the self and its actions, all behavior in the open setting is taken as communication. Except for the very short list of actions, behavior is not taken as directly consequential, behavior is taken as something else. All behavior in the open setting exists in the form of what some philosophers have called the hermeneutical as, behavior as representative of something else, behavior as essentially symbolic, as referential, as pointing to, as aimed at an addressee, an other, the community as other. Behavior in an open setting is part of a text that must be read aloud. But behavior in itself is mute, helpless and needs us to interpret its meaning which is complex, in a communal context, and so we all must give voice to its interpretation which will remain ambiguous and never fully articulated. No one of us has the encompassing perspective to say what a piece of behavior completely means. Everyone in the open setting occupies a specific place in the structure that provides an opportunity to speak from that place in a way that is distinctive.

Now because behavior is mute, communicative, and to be interpreted, it seems to me there is no behavior that goes on in the open setting that is private. All behavior of staff and patients is public, interpretable by anyone in the community, always communicative. To claim that there is private behavior in a communal context is like insisting that there is such a thing as a private language, which I think is a contradiction. Nothing in the open setting, therefore, means that our hands are tied in interpreting or communicating about behavior. The decision to interpret a piece of behavior, to flag it, to call people's attention to it or not, is always ours to make, but this decision itself is interpretable and bears weight in the open setting. Cutting or substance abuse, for example, in an open setting is never a private act, is always addressed to the community, and to decide not to share knowledge of such behavior with the community is itself an interpretable act.

Therefore in an open setting confidentiality is not about behavior but about speech. The open setting must provide a protected, private space for speech, speech between patients, among staff, in the administration, over the telephone- - intimate, legal, pastoral, amical speech. Here the typical issue is whether or not to tell what one has heard regarding dangerous intentions or past actions. Clinical judgment enters into the decision to treat an action reported only to the therapist as addressed primarily to the therapist in the transference. A useful norm about whether or not to tell is provided by Plakun (1992) who distinguishes between a short list of behaviors that threaten the continuance of the treatment and a variety of other masochistic acts. In the latter case, a more grievous assault will be inflicted on the treatment and on the therapeutic community if the therapist reports the behavior prematurely because of anxiety or repressed retaliatory anger. This interface between therapist and other staff members is most vulnerable to the effects of projections, identifications, and consequent splitting of staff into good and bad objects.

Because the symbolic boundaries that hold humans emerge only in a culture, from a community of speakers, who articulate standards both in their speech as well as in action, these symbolic boundaries are effective only because they are shared. Therefore they require a community structured so that mutual recognition provides the operative role definitions rather than operating through power. The therapeutic community is one that aims for rational, sane, articulable procedures, a utopian community that is never accomplished but whose continual failures must be interpreted through communal reflection through an ongoing kind of conversation that looks at the various, interesting ways in which none of us lives up to the ideal of the rational, sane community. We expect failures to take place and they provide the material for us to interpret together.

A major source of such failure lies in the patient's aggressive attack on the treatment. I have found it useful to think triadically about this, to distinguish the patient, the treatment, and the staff. This provides some distance between patients and staff so that, for example, when staff feel personally attacked it is helpful to see that the patient is attacking the treatment, not the individual persons who are usually for many patients quite irrelevant and simply happen to be occupying the place of the treatment provider at the time. By keeping this triadic structure in mind I think staff are enabled to respond by defending the treatment against the patient's attack, defending the culture, the therapeutic community, and by so doing make clear that they are not attacking the patient in a retaliatory manner. In this perspective open setting clearly does not mean laissez-faire. Our caring, our commitment is to the patient's treatment, to the patient's possibilities for change.

Staff defends the treatment because staff, I believe, is responsible for preserving the patient's possibilities for change, the inchoative, not yet articulated, but definite avenues for

change whose helpless, mute existence requires protection in the culture that holds all of us. We must try, therefore, to signify the patient's future but not to control it.

In general I conceive of the treatment course as a broad movement toward embracing loss and symbolizing absence, the not yet, the invisible, the potential present, and the potentially and expectable absent. Not every patient can do this. Patients are responsible for deciding to stay within our culture and its boundaries, but we are responsible for defending its boundaries against assault, for defining firm limits, for clear speech and action at these limits. An open setting usually provides its most interesting work at the limits which we try to stretch maximally to give patients plenty of room to wander and transgress and thereby create interpretable events.

REFERENCES

Cooperman, M. (1979). A possible development in psychoanalytic psychotherapy and some caveats. NAPPH Journal: 10, No. 4, 16-21.

Edelson, M. (1970). The Practice of Sociotherapy: A Case Study. New Haven: Yale University Press.

Fonagy, P. (1991). Thinking about thinking: Some clinical and theoretical considerations in the treatment of a borderline patient. International Journal of Psycho-Analysis, 72: 639-656.

Freud, S. (1904). On Psychotherapy. Standard Edition, 7. Tr. J. Strachey. London, Hogarth Press, 1953. Pp. 257- 268.

Kernberg, 0. (1984). The therapeutic community model of hospital treatment for severe pathology. In: Severe Personality Disorders: Psychotherapeutic Strategies. New Haven: Yale University Press. Pp. 330-342.

Main, T; (1981). The concept of the therapeutic community: Variations and vicissitudes. In: The Ailment and Other Psychoanalytic Essays. Ed. J. Johns. London: Free Association Books, 1989. Pp. 123-141.

Muller, J. (1988). Negation in "The Purloined Letter": Hegel, Poe, and Lacan. In: The Purloined Poe: Lacan, Derrida, and Psychoanalytic Reading. Ed. J. Muller and W. Richardson. Baltimore: The Johns Hopkins University Press. Pp. 343-368.

Plakun, E. (1994). Principles in the psychotherapy of self-destructive borderline patients. The Journal of Psychotherapy Practice and Research, 3:138-148.

Schwartz, D. (1983). The open hospital and the concepts of limits. In: Psychosocial Intervention in Schizophrenia: An International View. Ed. H. Stierlin, L. Wynne, M. Wirsching. Berlin: Spring Verlag. Pp. 83-92.