An Understanding and Approach to Regression in the Borderline Patient

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THIS PAPER will attempt to synthesize clinical observations and the contributions of investigators in psychoanalysis and developmental psychology to work towards a conceptualization of borderline psychopathology? This understanding will be used to consider a conceptual approach towards treatment. In contrast to the extensive literature on the outpatient treatment of the borderline patient, there exist only a small handful of articles which address the complex issues of hospital treatment. As a result, specific focus on the implications for brief and intermediate length of stay hospital treatment will be discussed.

To begin, it is important to attempt to define the patient group we will call borderline. The work of several investigators notwithstanding, precise definition remains an area of confusion and controversy. Gunderson[1] proposed a set of definitions that are operationally useful to follow. Borderline personality organization is a level of psychic organization and functioning. It represents a stable, albeit volatile and fluctuating, level of psychic organization which is distinguishable from the psychotic and psychoneurotic disorders. Within this level of psychic organization, there are multiple discrete diagnoses of a variety of personality disorders, one of which is the borderline personality disorder as defined in DSM III (1980).[2] Borderline, for this discussion, refers to the more inclusive concept of borderline personality organization.

Why choose this broad definition as most useful? It is because this entire patient group, despite differentiating symptom clusters, shares a central aspect of psychopathology that will provide an organizing conceptual framework. Unlike metapsychological psychostructural diagnostic criteria, such as are proposed by Kernberg[3] this feature is directly clinically observable. All of the patients within this level of psychic organization possess the potential for severe, primitive, precipitous yet reversible regression. More than any other feature, this potential for reversible regression within and outside the

therapeutic situation helps define not only who these patients are, but also what their problem is. How one might understand this and attempt to treat it are the primary questions being addressed.

Regression

What is regression? Arlow and Brenner[4] defined regression as the re-emergence of modes of mental functioning which were characteristic of the psychic activity of the individual during earlier periods of development. Within this definition, there are two different applications of the concept of regression, which it will be helpful to separate. First is the use of regression as a metapsychological concept and second is the concept as used in clinical theory.

Freud[5] identified three types of metapsychological regression within his topographic model of the mind: topographic, temporal, formal. Anna Freud[6] later translated these into the terms of the structural theory. Building upon Anna Freud's distinction between temporal and formal regression, Gedo and Goldberg[7] provide a classification of two types of metapsychological regression. Structural regression, corresponding to Anna Freud's temporal regression, occurs among specific phases of psychological organization that can be separated along a developmental continuum. Phase I is concluded by the acquisition of the capacity to cognitively distinguish the self from object, Phase II by the unification of the self, Phase III by superego formation and Phase IV is concluded and the psychic apparatus fully differentiated by the laying down of a repression barrier. Functional regression, corresponding to formal regression, is regression within the mode of mental functioning. Gedo and Goldberg[7] outline 5 modes which include a hierarchy of the developmental levels of narcissism, anxiety, defenses and the principles of mental functioning. As psychological development proceeds into succeeding phases, individuals are capable of increasingly more mature modes of functioning not previously existent. This discussion will focus on Modes I and II.

The borderline patient can be conceptualized as functioning within Gedo and Goldberg's Phase II of psychic organization. This means they have not yet achieved the irreversible unification of the self. Borderline patients have the capacity to function within both Modes I and II. Mode II seems to aptly correspond to the stable, integrated level of functioning for the borderline patient, while Mode I characterizes the regressions. In Mode II functioning, the psychic danger is separation anxiety, omnipotent illusions are perpetuated through magic, and defenses of projections and introjection prevail. Unification is the aim of this mode and the experience of unification is sought and found within the well functioning self object relationship. Disruptions within this relationship reactive Mode I functioning in which the patient may suffer degrees of loss of differentiation of self from object; the

danger is over stimulation, unconditional omnipotence is in force, discharge of tension is the defensive style and pacification is the aim.

Next, an examination of regression as a concept in clinical theory is in order. Freud's concept of clinical regression was inextricably intertwined with the concepts of fixation and the repetition compulsion. Regression served two purposes: (a) as a mechanism of defense and (b) to restore psychic equilibrium by an attempt to master unresolved trauma. In the former the ego seeks security and gratification by returning to a previous form of satisfaction or successful anode of operation when threatened with a new conflict not yet mastered. In the latter, then is a compulsive return to a fundamentally different intrapsychic experience. Regression is to a trauma, an attempt to resolve a conflict that was not solved in the past. Balint[8] attempts to expand the concept of regression beyond the repetition compulsion. He writes that regression aims at establishing an object relationship similar in structure to the primary relationship and that this is determined not by the repetition compulsion but by the expression of a developmental need, a quest for what Balint calls "the new beginning." This is similar to Winnicott's[9]view.

These clinical concepts of regression have had enormous implications for the therapeutic approach to regressed behavior in patients. Alexander[10] to whom Balint acknowledges similarities with his own work, demonstrated how regression within the transference can follow both types described by Freud. As a defense it functions as a resistance. As an attempt to master it runs parallel with therapeutic efforts.

How does one resolve this controversy as it applies towards the approach to acute regression in the borderline patient? First, it must be understood that this controversy fails to recognize the distinction between functional and structural regression. The controversy meaningfully applies only to the complex questions involved in the treatment of structuralized regressions and attempts to change an individual's phase of psychic organization such as in a psychoanalysis. Acute regressions in the borderline are functional regressions. Gedo and Goldberg[7] write that acute regressions from a more or less stable adaptive state are functional regressions and usually involve only a resort to functioning within a more archaic mode without a retreat of the entire psychic organization to a previous phase of development. Therefore, the question for the therapeutics of functional regressions is not whether regression should be encouraged or promoted. There is no therapeutic potential in encouraging a functional regression. The question is rather, what is the meaning of functional regression in the borderline and how can patients be restored to the highest mode of functioning of which they are capable.

Valenstein[11] writes that these primitive affect states occurring during periods of marked regression appear to be consequent to the propensity of such individuals to relive in later life what they cannot remember, namely the aura of their early experience, especially the sense of the self and its relationship to the self-object. Kohut's[12] concept of the self-object has increased our understanding of how in developmental and normal adult functioning another person can at times serve the functions of psychic structure rather than serving only as object for drive gratification. In people whose narcissistic structures have not fully developed, there persists a deficit; parts of psychic structure are lacking so that others are called upon to perform the psychic functions of that structure. To apply the concept of the self-object towards a clinical theory of regression, it can be stated that regressive behaviors may serve an additional aim beyond defense from conflict, attempt to master, and quest for a new beginning. Regressions in patients with structural deficits are attempts to supply or substitute for missing psychic structure and function.

There is a group of non psychotic disorders in which there is no irreversible establishment of self (Tolpin[13]). This seems to apply to the borderline psychopathology and provides a useful explanation for this patient group's vulnerability and potential for precipitous regression. This follows Kohut's (1971) description of the borderline person as having no cohesive self and therefore living in constant danger of severe regression when archaic transferences emerge. According to Paul Tolpin,[14] the cohesiveness of the self is maintained in the borderline patient but it is a specious and fragile integration because it is sustained through complex defenses rather than underlying psychic structure. Adler[15] adds that the establishment but relative inability to sustain self object transference is a primary feature of this patient group.

There seems to be a correspondence with Kohut's (1971) concept of self-object and Edgcumbe's and Burgner's[16] concept of the need satisfying relationship as a stage in the psychological development of object relations. At the need satisfying level of development, the object (self-object) exists only at moments of need and the relationship is to the function, not the object. According to Edgcumbe and Burgner,[16] borderline psychopathology occurs within a stage of transition between the need satisfying relationship and object constancy. There is a characteristic attachment to a specific-object while continuing to function in a need satisfying mode. Regression occurs when this specific attachment is threatened and is an attempt to bind the object more firmly. The object provides needed functions, the loss of which threatens the individual with disintegration anxiety. The threat to the attachment stimulates disintegration anxiety as it threatens to expose the psychic deficit. Acute functional regressions, as seen in the borderline, are attempts to stem the tide of disintegration.

Hospital Treatment

What are the implications of this view for the conceptualization of brief and intermediate length of hospital treatment of the borderline patient? Borderline patients most often enter acute regressions, and the hospital, when there is a disruption in a self object relationship. This occurs within social and therapeutic relationships, as well as within the hospital itself. The goal of hospitalization is to repair this disruption and enable such patients to organize and unify themselves through the renewed use of a self/object relationship. Besides providing a setting where this may occur, the role of the hospital serves to facilitate and reinforce the patient's integration around one or several self objects. Techniques such as assigning one worker per shift to the patient or rigid adherence to a policy of certain issues being discussed only with the therapist achieve their effectiveness primarily on this organizing basis, not because they interfere with defensive splitting. Daily visits with specific appointment times also help such patients organize themselves around the visit by their therapist. The principle of facilitating the patient's organization around self-objects has multiple applications for specific techniques. Adler[17] has written on the function of the hospital in repairing disruptions in the patient therapist relationship for the borderline patient in outpatient psychotherapy. This is one very important example of the role of the hospital in repairing the disrupted self-object bonds for the patient. When the disruption occurs in extratherapeutic relationships, the hospital most make active efforts to include these significant others in the treatment plan. An additional implication is that the establishment of extratherapeutic self-object relationships should not be interpreted as a defensive displacement from the transference but should frequently be encouraged as it provides stability on a broader basis. It should also be explored because it demonstrates and is a manifestation of the patient's core psychopathology. Particularly for the more schizoid borderline patient, this self-object relationship may not exist with another person but only with inanimate objects or a specific talent or capacity, such as artistic creativity, which provides these same functions of tension and self-esteem regulation. In any case, the borderline patient cannot be discharged until there is a reestablishment of a self-object relationship that will sustain them beyond discharge. Because therapists so often become the central self-object relationship, no borderline patient should be treated by a therapist who is unable to continue with the patient after discharge.

Another important role of the hospital is as an institutional self-object. Reider[18] described a group of patients who formed idealized transferences to clinics and hospitals which helped them regulate and sustain self-esteem and functioning. This is an example of how the hospital itself can serve as a self-object and perform psychic functions either in actuality or in conscious and unconscious fantasy within the patient. These transferences exist simultaneously with similar transferences organized around the

therapist or other self-objects. The institutional transference is best understood not as displacement but as a further manifestation of the patient's specific psychic deficit.

For those patients who have been hospitalized but were also involved in intensive outpatient psychotherapy, the institutional self object transference often assumes the character and function of the transitional object. As described by Winnicott,[19] the transitional object of infancy is provided by the environment but the illusion cast upon it by the child allows the child to experience it as neither me nor not me. It must never change unless changed by the infant who, while abrogating a measure of omnipotence, assumes rights over the object. It must soothe, give warmth and survive loving and hating. Borderline patients often describe their attitude about the hospital in these terms. Rage reactions and regressions may occur when the hospital is unable or unwilling to function within this characterization. This may help to explain why these patients may at times be unable to allow the hospital to comfort them but rather must either reject and hate it or be rejected and hated by it.

For Winnicott, the transitional object is not internalized or forgotten but loses meaning as development ensues. Marion Tolpin[20] agrees that the transitional object is not internalized but adds that it serves as a transitional mental structure through which the infant is able to gradually internalize the tension regulating functions of the infant mother relationship. It is this author's belief that for the borderline patient, the hospital serves this very same function of facilitating the processes of internalization which are occurring in the patient-therapist relationship. When the therapist frustrates, disappoints, or is not available in a minor way, the borderline patient often evokes the fantasy of hospitalization and is able to use this fantasy to comfort himself. At times of major disruption and regression, the hospital itself must actually provide these self soothing functions. Gradually, as therapeutic progress occurs and the borderline patient internalizes tension regulating functions in psychotherapy, actual regressions to the hospital are replaced by the associated fantasy and then this fantasy becomes increasingly less meaningful. The patient is more able to comfort himself without the use of the transitional mental structure.

The concepts of the good enough mother and holding environment have often been used to describe the optimal, posture of the therapist and hospital milieu for the borderline patient. The basis for this recommendation has been that this leads to internalization of the holding functions. For brief hospitalizations, the aim of providing a holding environment is attachment, not internalization. The holding environment allows the patient to securely attach and form a self/object relationship to the milieu. The patient cannot attach and form a sustaining self object transference to a person or milieu that is in disequilibrium. Avoiding such disruptions requires an awareness of the factors which can

produce disequilibrium in individuals and the milieu. Disruptions stem from sources capable of inducing regression: (1) the balance of frustration vs. gratification, (2) the degree of structure and maintenance of task functioning, and (3) the quality of the object relationship.

Frustration and regression are concepts linked together since Freud's early writings. In deficit disorders the transference is comprised of legitimate developmental needs and not primarily drive needs (Tolpin).[13] Demands for drive gratification result from the frustration of developmental needs. Assessment of the specific developmental needs of a patient must be made and provided in reality as a legitimate treatment intervention. Particularly with the borderline it must be remembered that stimulation of regressive needs can be overwhelming for the patient and lead to intense overstimulation and subsequent disappointment, frustration and rage attacks. Borderline patients need to be realistically supported while also challenged to develop their internal capacities to function autonomously. The most important developmental need of the borderline patient is a stable and secure self-object relationship which provides tension regulating functions and protects against the dangers of separation and overstimulation. Patients will fail to attach to treatment milieu or systems that do not respect those particular vulnerabilities. Requirements include but are not limited to therapists who can continue with the patient following discharge and the provision for a stable and predictable staffing pattern, especially for primary workers with the patient. The equilibrium of the milieu must be protected from a multitude of severely disturbing patients or the disruptive effects of large numbers of simultaneous admissions and discharges. Beginning on the day of admission, the issue of discharge and the anxieties around separation must be attended to and discussed in depth.

Environments in which there is a lack of structure promote regression. The borderline patient's vulnerabilities and lack of ego development become exposed when the milieu or specific treatment relationships lack structure and role definition. Treatment plans need to be collaboratively formulated among staff with the patient and must include specific indications for hospitalization, treatment goals, tasks, plans and expectations, limits of the milieu and rational, predictable consequences for violations of these limits. It is vitally important that there is a discrete maintenance of specific task functioning among treatment personnel of various disciplines. This not only helps the patient, who functions on a need satisfying, function related manner, but also helps stabilize the staff as a work group against the regressive processes activated by borderline patients. While providing needed structuring functions, this approach also helps to give patients a sense that their problems and the solutions to them are real, that the staff, therapist, and the patient are not helpless, and that they can change if they choose to do so. The structure provides the opportunity for the hospitalization to be experienced as a success and an accomplishment, thereby building a foundation of hope.

The quality of the therapeutic object relationship exerts a major influence on the patient's potential for regression. These patients require relationships which provide just that much real support, availability, presence, consistency, structure, flexibility, etc. which meets the patient's actual needs while continuing to also respect their vulnerabilities, limitations and capacities.

Kernberg[21] has described the regressive processes in organizations which are influenced by the quality of the object relationships among its members. His dealings have enormous implications for the psychiatric hospital milieu and treatment of the borderline patient. Regression within the milieu will stimulate regression in the patient and vice versa. Effective leadership is necessary at all levels of the treatment team but especially at the level of clinical administrator to stabilize the milieu against regressive processes. The functional leader is defined as one who is accountable and responsible for his constituency, exercising only as much authority as is necessary for the task and is appropriate for his role. It is essential that the clinical administrator demonstrates and provides a model of this type of leadership in his relationships with staff. He also needs to create a structure within which specific roles and tasks are defined with appropriate support for autonomous functioning within the structure. The clinical administrator is responsible for establishing himself or herself as a model committed to staff cooperation and mutual respect, understanding of individual and group regressive processes, quality of care, ethical integrity, and a genuine and appropriate concern for the institution, and the people that work and are treated within it.

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