# Milieu Concepts For Short Term Hospital Treatment Of Borderline Patients

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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.[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)[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).[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),[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 manifestations. 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 special problems in hospital treatment. Often the staff and physician feel obligated to continuously and indefinitely monitor the patient (1:1 observation). In my experience this most often leads to a stalemate or deterioration in the treatment process as the focus shifts towards behavioral control as the implicit goal of treatment. It often becomes a burden to both patient and staff and becomes a vehicle for sado-masochistic struggles and acting out of affects by patient and staff. A more effective course is to acknowledge with the patient that staff cannot fully protect the patient, and that meaningful treatment may involve serious suicidal risk, accidentally or intentionally. The patient, sometimes with the family, the physician, and the hospital, need to agree on pursuing meaningful treatment in the face of these risks. If it is decided, this decision should be documented in the chart. The patient is then taken off prescribed 1:1 staffing and allowed to participate fully in the milieu. The patient and staff then have as a plan that they will share a responsibility for helping the patient identify and experience affect states and their relationship to self-mutilation and suicidality, and adjust staff contact according to their ability to be successful in this task. It is acknowledged that both the patient and staff may make mistakes, perhaps serious, even lethal ones, but that this risk is necessary to create the conditions which allow the patient an opportunity to work on the identification and management of profound affect states.

***Case Example***

Ms. B was a 29 year-old woman admitted for suicidal ideation and self-mutilation by cutting and burning herself following tile announcement by her therapist that he was leaving the city in two months. Ms. B. had a history of serious suicide attempts in the past. She was admitted and placed on 1:1 with a treatment plan of focusing on her feelings about the termination and starting with a new therapist. Ms. B. continued suicidal and engaged in head banging and cutting herself, requiring restraints at several points. Staff felt provoked by the behaviors and unable to maintain an empathic or supportive response. The author intervened and suggested a change to the approach as above. This required additional support for the physician and a willingness to share medicological responsibility, and working with the staff to relieve them of feelings of guilt and helping them tolerate and work with the anxieties inherent in the alternative plan. Most importantly, it required repeated explanantion and clarification with the patient, as well as a discussion of her feelings of being abandoned and unprotected. The plan was introduced gradually over a period of a week. Following its introduction, the patient's self-mutilation and suicidality gradually subsided. Episodes of self-mutilation were less intense and were now the focus of psychotherapeutic inquiry. The physician and staff felt the patient made significant gains in working through her separation reaction such that she was able to be discharged and successfully transferred to another therapist.

**Creating The Conditions For Attachment**

The milieu must be constructed in such a way as to support the integrity of the patient's self-organization and to minimize the vulnerability of the patient to regression. Thus the milieu attempts to create the conditions of security necessary for therapeutic attachment. Three aspects of the milieu which can contribute to a condition of security include:

1. The levels of frustration and stimulation.
2. The degree of structure and maintenance of task functioning.
3. The quality of the object relationships.

Frustration and regression are concepts linked together since Freud's[9] early writings. It must be remembered that stimulation of regressive needs can be overwhelming for the borderline patient and lead to intense overstimulation and subsequent disappointment, frustration, and rage attacks. Borderline patients need to he realistically supported while also challenged to take responsibility for their lives and develop their internal capacities to function autonomously, while recognizing and working with the knowledge that this level is fragile in the face of certain internal and external stresses.

An important developmental need of the borderline patient is a stable and secure relationship which provides tension regulating functions and protects against the dangers of separation and over-stimulation. Patients will fail to attach to individuals, treatment milieu, or systems that do not address these needs and do not respect these particular vulnerabilities. Beginning on the day of admission, the issue of discharge and the anxieties around separation must be attended to and discussed in-depth.

The inpatient milieu is often hesitant, if not outright frightened and conflicted, about engaging the newly admitted borderline patient in an appropriately nurturing and supportive manner. This ambivalence can itself often create the feared complications of intensification of hostile dependency. Many borderline patients respond positively to the appropriately nurturing milieu and use it to stabilize themselves. This is especially true when the hospitalization was precipitated by a situational crisis.

Patients who respond to the support of hospitalization with intensification of profound dependency needs and rageful reactions to frustration, disappointment, and narcissistic injury are often involved in intense, sometimes chronic, transference regressions, including psychotic transferences. For these patients, the appropriately nurturing milieu is over stimulating. They often require, as Friedman suggests, therapeutic transfer to an understimulating environment like a state hospital.

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, plans, and limit setting. The milieu program, while allowing for unstructured time "to be" with themselves and other patients informally, should be organized with a variety of task oriented structured groups (e.g. goals, discharge, tension reduction groups, etc.) which address the patient's difficulties making an adequate adjustment to reality stressors. It is vitally important that there is a discrete maintenance of specific task functioning among treatment personnel of various disciplines. This helps the patient, who is functioning in a need satisfying, function related, manner and whose boundaries are unstable. It also helps stabilize the staff as a work group against the regressive processes activated by borderline patients.

The quality of the therapeutic object relationships will exert a major influence on the patient's potential for regression. These patients require relationships which provide needed support without overstimulation, along with a level of structure, boundaries, and expectations which meet the patient's actual needs while continuing to also respect their vulnerabilities, limitations, and capacities. The therapeutic attitude should accept, but not encourage regression, while providing support for appropriate autonomous functioning, not pseudo-independence. Tile patient may stimulate and provoke the staff, through projection identifications, to participate in relationships which are experienced as either magically and mutually satisfying, or exploitive, controlling and depriving. Because of this, it is essential that staff develop a maturity about their own feelings regarding omnipotence, dependency, and aggression. Staff can help each other with these difficult tasks by developing a basic knowledge and trust in the people you work with and participating in an atmosphere which allows frank discussion of how patients may involve us in their intrapsychic process due to their perceptions of our character

traits. Weekly meetings which allow for discussion of staff's experience in relation to their work tasks can be helpful towards the goal of developing staff.

More often than not, the most important object relationship is to the individual psychotherapist. The goal of creating conditions of security in the milieu is often in the service of fostering attachment to the psychotherapist. In most cases, this is not enough as the potential of a relationship to the therapist is often a serious threat to the patient. The relationship threatens to expose the patient's deficits and his need of the object, thereby creating a humiliation for the patient. In addition, the mobilization of longings for the therapist usually stimulates the potential for rage over deprivation and disappointment with associate primitive anxieties, guilts, and defenses. The milieu needs to reinforce the efforts of the individual psychotherapy by mobilizing and supporting the patient's capacity for hope, trust, and the ego functions necessary for psyhotherapeutic work.

**Treatment Planning**

The treatment plan has three stages: first is the pretreatment contract, followed by the initial treatment plan as performed by staff, and finally by the formal treatment plan.

Sederer and Thorbeck (1983)[10] have outlined the usefulness of a preadmission contract for borderline patients. As many hospitals may not have the opportunity to arrange for this prior to admission, I have revised the concept to that of a pretreatment contract, recognizing that admission may have already occurred. They note that it is useful in defusing primitive idealization which might subsequently lead to disappointment and regression that could disrupt the treatment. They encourage a discussion with the patient regarding the goals for hospitalization, the length of stay, and the philosophy and policies of the milieu. This discussion mobilizes the potential for a therapeutic alliance with the patient.

Hospital goals in most cases should be focal, modest, in the here and now, and should be limited to the indications for hospitalization. The indications for hospitalization should be clearly and explicitly identified for the patient and staff. Koenigberg[11] has recently described these for short and longer term hospitalizations. As Gordon and Beresin (1983)[12] have noted, the establishment of a goal of internal change for the patient has implications for the milieu's approach to regression and acting out. The more a milieu seeks to achieve goals associated with internal changes, the greater the likelihood of regression and therefore the necessity for flexibility regarding acting out. If the milieu is encouraging the patient to become immersed in their internal world, it must be prepared to respond both supportively and psychotherapeutically when the patient predictably has brief periods of being overwhelmed. There needs to be a vigilance towards attempts to change the goals once they have been achieved. Failure to achieve the goals should include an honest assessment of the limitations of the milieu's ability to help the patient.

Because borderline patients often enter the hospital in the midst of an acute regression, the first few hours and days can be critical in determining the potentials for the success or failure of the treatment efforts. The first goal of the initial plan is to help the patient develop an attachment to the treatment team which will interrupt and not stimulate further regression. This allows the patient to begin to utilize the staff to work on the problems that required hospitalization. A beginning focus on the specific indications for the hospitalization often provides a useful starting point.

Other aspects of the initial treatment plan to be performed by staff include:

- Immediate, in-depth, collaborative assessment with the patients of their need for protection from self-destructive impulses or for protection from aggressive outbursts.
- Immediate and in-depth orientation to the unit and as to what is going to happen.
- Assessment of the patient's ability and willingness to collaborate and accept responsibility within his own treatment.
- Assessment of the patient's actual level of coping and social skills functioning; self-care, task completion, cognitive functioning and interpersonal relations so as to define an appropriately supportive environment.
- Assessment of the patterns of interaction with staff and patients that are being established.
- Early identification of issues that might disrupt treatment so that they may be addressed collaboratively by staff, therapist, patient, and family.

The formal treatment plan is the result of an in-depth diagnostic process among the staff and the individual therapist, utilizing an understanding of the patient from a variety of frames of reference including, but not limited to, medical, intra- psychic, behavioral, family, and milieu perspectives. The emphasis of the formal treatment plan will be determined by the specific indications for and goals of the hospitalization. However, there should be an assessment and consideration of treatment possibilities in each of the areas of a biopsychosocial perspective.

It is essential that the role of the milieu be defined in the formal treatment plan. As discussed previously, the milieu has an important role in the assessment of the patient. The attention by the milieu to regression, realistic autonomy, limits and consequences, and the patient's involvement and responsibility offers the patient a form of containment in an attempt to create the conditions which will stabilize the patient, create conditions of security, and allow the pursuit of additional specific treatment goals. Where these goals include psychotherapeutic interactions, the mi- lieu can serve additional roles of supporting the psychotherapy and/or supportive psychotherapy proper. Supporting the psychotherapy might include providing observations, encouraging trust in the therapist, hopefulness about therapy, and by providing support for the capacities required for psychotherapy such as reality testing, verbalization of affects, self-observation, etc. Supportive psychotherapy by the milieu might include an active involvement by the staff, usually in task oriented groups, in exploring and changing the patient's coping and problem solving skills, tension reduction exercises, social skills training, etc.

In summary, this paper has attempted to outline a milieu approach to short term hospital treatment of the borderline patient. Due to the incompleteness of the self-organization, these patients are especially reliant on the external object and environment for psychic stability. This incompleteness creates a vulnerability to precipitous, but reversible regression and impulsivity. An understanding and approach to regression has been discussed. Treatment planning has been conceptualized as a three-stage process of pretreatment contract, initial treatment plan by staff, and the formal treatment plan.

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