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Treatment of adolescent borderline patients in a psychiatric unit

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In this paper we describe the principles of functioning of an adolescent unit and analyzes to what extent borderline patients accept these rules and may profit from psychiatric hospitalization. The borderline personality structure and primitive defence mechanisms are described and discussed in the context of functions of the psychiatric hospital. In the short stay of these patients, some elements of introjection of positive emotional experiences, holding of impulses and acting out tendencies may help borderline patients to acquire some elementary insight, which makes the basis for future long-term outpatient therapy. Coping mechanisms of the staff in dealing with patients' splitting tendencies and projective identificaions are described, as well as other healing factors such as structure of the unit, therapeutic activities and written individual contracts concerning specific behavior of borderline patients.

Key words: borderline personality, adolescent ward

Therapeutic milieu of an adolescent hospital unit

Borderline personality traits in adolescent patients lead to disturbances in social and emotional functioning. Most of these patients should be treated by outpatient psychotherapy, but some of them need hospitalization. It concerns patients, who have insufficient impulse control, resulting in agressive or more often, autoagressie behavior, such as suicidial attempts, self mutilation, drug or alcohol abuse.

In adolescent inpatient units there are also patients who were admitted with other diagnoses, but during their stay there appeared characteristic traits of borderline personality functioning. This often concerns adolescent girls with the diagnosis of bulimia or anorexia. In our article we would like to discuss the functioning of these patients in the adolescent ward, especially emphasizing two subgroups with some differences in the personality structure. We will also deal with the countertransference reactions and ways of coping with them.

In our presentation we would like to discuss several dilemmas posed by the treatment of adolescent borderline patients in the context of basic principles of the adolescent ward functioning. As the basic and most important principle we consider the agreement of all staff members for common, consistent therapeutic goals, realistic share of duties and resposibilities. The ultimate goal of hospitalization in adolescent

psychiatric unit is not only symptomatic improvement, but also to give them help in the solving of adolescent crisis, especially problems of separation and individuation from the family without guilty feelings.

Clear boundaries, good communication, limit setting and most importantly creating the therapeutic atmosphere and allowing to control destructive and autodestructive impulses are important goals of inpatient treatment of adolescents with emotional disturbances. To a great extent such features remind us of the healthy functional family in the adolescent phase of family life cycle.

Let us try to take a look at the problems created by the realization of these principles in relation to borderline personality.

Borderline patients more than others need a clear unit structure which could help them in dealing with destructive or autodestructive impulses. The structure of the hospital ward derives from a therapeutic milieu capable of containing and working through these impulsive behaviors. In such a therapeutic milieu the staff accepts both healthy and sick parts of the patient without too much of anxiety and rejection of symptoms or disfuntional behaviors, which often take place at home or in normal environment. In this meaning the staff accepts the reality of the patient.

Therapeutic environment [1] is something, which holds the patient – in Winncicot's terminology it is a holding environment. Using Kępiński's expression it is a maternal environment [2].It means that the staff plays parental roles toward the patient, adjusted of course to his or her needs and possibilities. In case of borderline patients it is a need of separation and individuation, strengthening of ego boundaries and self identity, and providing means of impulse control. In the unit, nurses play rather a maternal role,while doctors a paternal one. Doctors are difficult to reach and constantly busy. What's more, they are resposonsible for the most important decisions and setting limits, which resemble the socializing process in the family.

Defense mechanisms of borderline personality and their presentation in the hospital ward

It is necessary to discuss basic mechanisms leading to the formation of borderline personality in order to understand their functioning. Projective identification, splitting, primitive idalization and denial are the basic ones.

a) Projective identification

The mechanisms of projective identification are related to the lack of a clear boundary between self and not – self. It works by projecting internal bad revengeful and persecutory objects and the efforts of controlling them in external objects. Often medical institutions and their staff become such objects. Projective identification is therefore experienced in countertransference. Therapists or doctors treating patients with borderline personality very often experience the feeling of helplesness, they have many doubts, feel their own incompetence, doubt the diagnosis, think that their patient may be psychotic (which would simplify the treatment by introducing strong medication), wonder if their achievements were wrong and improper. There exists a different aspect of projective identification, appearing in the situation when the patient

seems to improve. Sometimes the therapist together with the patient may experience the illusion of understanding him.

Many countertrasference feelings are related to anxieties about the life of a patient and may reflect of his fears about the future, recovery, relations with others. The specific trait of treating borderline patients in hospital units is the massive experiencing of projective identification by the staff. Patients put various conflicting aspects of the self, into different staff members which results in an iconsistent image of a given patient in the eyes of different staff members. It may lead to conflicts among staff, which is the reflection of projective identification and splitting which takes place in the patient [3].

b) Denial

Denial is a defense mechanism often observed in the patients with borderline personality diagnosis. We can distinguish two kinds of denials. The first one is more archaic and is related to the splitting mechanisms and it is the denial proper. The example of such splitting denial is a lie. It is known, that adolescent patients often lie, in matters concerning eating behavior, bringing sharp and dangerous objects, breaking the rules or stealing. They are stubborn in their lying, they keep their version in spite of clear evidence, which may give the impression that they falsify the reality in a delusional like way. These lies are based on an archaic form of denial – they have the memory of the performed act, but are not able to integrate an intelectual remebering process with the emotion. Simplifying, the mechanism of such a lie is following: „I remember that I did it, but it is improbable that I could do it, so, perhaps I did not do it". The denial of death is also an archaic denial, patient may feel immortal, uncosciously they feel omnipotent, and perceive death on the level of childish game of dying during which they lie down and then stand up in order to live again. They perform suicidal attempts without the fear of real death. The second kind of denial, the negation, is more mature and is related to the mechanisms of repression. Patients using such obvious negations deny the existence of problems. They deny their appearance, their somatic experiences, their illness, their position in the unit and the rule of staff or problems with relations with important objects (for example with mothers). They also deny some of their behaviors like stealing or lying (which they use in many aspects of their lives not necessarily related to their illness). It seems, that denial plays the role of mechanism defending the ego of the patients from sadistic and omnipotent superego. On one hand patients show perfectionist, compulsive behaviors, they are scrupulous and exact, but on the other hand they steal and lie, try to overcome the established rules. This phenomenon is exactly described by Kernberg, who states: „in these traits are included both the defense and direct expression of impulse, therefore archaic instinct gets through the defence" [4, 5]. Stealing resembles the behavior of a small child who takes the toy from other child, not having the feeling of ownership (because children do not have the feeling of identity). By denying their „true self" in the social relations they defend against guilt feelings, and against their own punitive superego, which they place in others (for example they may ask for punishment). But in order to make such denial possible, the patient must at first deny his own instinctual and somatic impulses. The

denial may be strong enough to allow the patient to function adequately in spite of symptoms. They are able to be strong enough to perform their work during many hours of the day, or suffer strong discomforts. The perfectionist „false self" of these patients partially defends them against the demanding and sadistic superego.

c) Splitting

Splitting is an archaic defense mechanismin in which internal or external objects are splitted onto all good or all bad ones, without communication with each other and without the ability to use memory of each other. In the adolescent unit splitting results in creation of subgroups. A more or less cohesive group of patients begins to fall apart, if there are too many borderline patiens at the same time. The group falls apart into small subgroups, which are conflicted with each other, fight or devaluate themselves. In consequence, communication becomes highly distorted. This kind of group mirrors split and distort objectual representations of patients. It results in temporal difficulties in group work including therapeutic community meetings – some of the patients discontinue coming to therpeutic community meetings or group therapy, some are late, others leave the room during a psychotherapy session.

During such time, a special role is played by secrets and mysteries, which hold together each subgroup of patients. Secrets cannot be discussed openly, so very rarely they are the topic of group work. Those secrets are usually highly emotionally charged. Most often such as traumatic events from the past, in which the subject – borderline patient is tormented by sadistic, bad objects. Secrets enhance group pseudocohesion, its' temporal solidarity and help create new unit norms.These norms are usually in conflict with each other, or with regular ward norms and principles. In such a situation therpists begin to feel impotent, weak and unimportant. Yet such experience is an effort on the patienets' side to gain access to the splitted psychic contents and may be prone to the therapeutic group process. It may be intertesting, that revealing of the secret can be the revealing of very different or contradictive contents for every group member. In the atmosphere of a holding therapeutic milieu, the meaning of a group secret diminishes, and patients begin to bring their own psychic contents or traumas to therapy.

The splitting mechanisms in borderline patients create two different groups on the axis of resistance versus acting out.The acting out group is active, expansive and ready for confrontation and direct conflict. In this group patients prevail with diagnoses of bulimia, behavior disorders, drug abuse.Tension in such groups is reduced by acting out. Typical behaviour of such patients are sexualization of relations, mutual support in antitherapeutic activities, like attempts to break ward rules, such as bringing alcohol or drugs.This group of borderline patients is also ready for confrontation with the staff memebrs and to attack them (for example in the form of various accusations). In the other group, which we call the resistance subgroup, patients prevail with the diagnosis of anorexia or obsessive compulsive disorders, which present on the surface a correct and superficially well socialized picture based on the creation of false self. The same processes,which in the previuos group were externalized, mostly through acting out behaviors, here are internalized and expressed through escape from reality

and attempts to stop personal growth. Relations in this group rely mostly on control, devaluation, often on sadistic attack on its' members. The staff is either idealized or devaluated. That group is focused on waiting through the hospitalization, adaptation and preserving their symptoms. Patients presenting such a form of resistance often say: "time in the hospital has stopped", "days pass, but nothing changes". Their stay in hospital may in fact be a trial to stop maturation and an escape from reality. They present a very disturbed experience of time, because they see time as something that can be stopped.

d) Primitive idealization

One of the borderline traits is primitive idealization. In the psychiatric unit it is expressed by admiration of the unit and its' staff, fantasies of its' unlimited therapeutic possibilities, expectations of a fast magic cure. During confrontation with reality such idealization breaks down and is replaced by devaluation of the unit, criticism of the staff or therapeutic methods. It is sometimes expressed verbally, and sometimes by acting out behaviors like refusal to attend therapeutic activities or breaking the rules, formation of subgroups and so on. In such situations constant projection of bad objects onto other subgroups, staff, the therapeutic group, or the therapeutic community can be observed. That mechanism provides internal consolidation of the subgroup and its' internal security, but it becomes the basis of acting out. These acting out behaviors are aimed at the norms and regulations – it may be noisiness during sleep time, drinking alcohol, using drugs, stealing in the unit or outside, self mutilation, excessive eating and vomiting and many others. Breaking the regulations is carefully hidden, which creates secondary subgroup secrets.

In strongly integrated subgroups the content of the secret may be distant from reality, creating the system of norms and beliefs similar to delusions. Like in some of the delusions it is hidden and it is not prone to verification. Resistance and the feeling of emptiness can be observed during group therapy sessions together with the existence of some strange, internally integrated object, competing with therapy, so present norms seem relative and unimportant.

Therapy of a borderline patient in the adolescent hospital unit

a) The norms of the ward, regulations, problem of punishment

In context of the above described various forms of breaking rules, there we can see a problem, specially important in adolescent units, in which besides therapy the education has its' important place. In every reality and every society the phenomenon of punishment has to exist. Lack of punishment, performed for example by parents is the expression of their indifferency and helplesness. The therapeutic community cannot be indifferent or helpless where facing some behaviors like physical agression or stealing. The problem is not to punish or not to punish, but how to punish. Many psychiatric patients associate the punishment with a furious parent, hitting with a pole or a rope. Such punishment is a traumatic event. In a psychiatric unit the punishment takes a covert form (for instance painful injections). Such a form of punishment is also

noxious, because it is based on the confusion of meanings. But punishment executed in the atmosphere of deliberation, calmness or even sadness because of its necessity, previously discussed on the therapeutic community meeting may become a therapeutic event, or even it may be the turning point in the therapy. The punishment in the adolescent ward has to be in agreement with the patients' rights: so it cannot be isolation, physical restriction or any other form of physical abuse. The staff can execute punishment for example in the form of withdrawing priviledges such as permission of leaving the ward for some days, enforcing apologizing, or extra duty such as cleaning of the recreation room, or in the form specifically adjusted to the characteristic of a given patient. The ultimate form of punishment is compulsory dismissal from the hospital, sometimes with the offer of re-admittance two or three weeks later.

b) The role of written words

Words are very important in psychotherapy – they carry the meaning of what is going on between the patient and therapist, the patient and the rest of the unit. But, at the same time words are only pronounced, which make them prone to manipulation, (consious and unconsiuos) or distortions. It is aspecially true in case of borderline patients, who have a tendency to change and manipulate reality. To the borderline patients words have a special meaning – they cannot be freely changed, interpreted or distorted. Sometimes it is usefull to write down the words, then words gain more power and are not prone to manipulations, misinterpretation or falsification by memory. Words gain more power when they are signed personally (in spite of the fact, that such a signature has no real legal value).

Most of the patients start their treatment with signing the contract with a set of regulations.This contract begins with words of greetings, followed by a description of norms and principles. Consequences of unwanted behavior are explicitly stated – the patient is warned about eventual penalites for breaking ward regulations – such as withdrawing privileges, or even compulsory discharge as in the case of alcohol and narcotics use.

Diagnostic heterogenity of the ward makes it difficult to treat all the groups of patiens in the same way. There is no doubt that borderline patients need more structure than schizophrenic, or a different structure than eating disorders patients. For them, special, individual contracts are reached. Very often, this contract concerns specific behaviors such autoagressive acts. During art therapy one of the borderline patient had expressed, that written contract was the most important part of the treatment program, which helped her tohold autodestructive impulses. This special, individual contract is usually signed by the patient himself, the staff representative, sometimes by the patient's family, which makes it even more important for all concerned, especially the patient himself.

As it was already stated, it is very difficult to keep consistent regulations of the unit, with many diagnostic subgroups, which need different structure and limits. This is also complicated by the problem that such a unit functions in fragments of many theoretical models. Fragments of medical, systemic and recently psychoanalytical models complicate further our problems with consistent ward structure.

c) Meeting of the staff

One of the main defense mechanism of borderline patients – projective identification poses many problems within the adolescent unit. The specifity of the treatment of borderline patients lies in the massive experience on the part of the staff of the projective identifications.

These patients project different, fragmented aspects of their self onto the staff. In effect their image is inconsistent and sometimes totally different among the staff memebrs. Part of the staff sees good aspects of the patient and the other part – bad aspects of the same patient. One may have an impression that sometimes we speak about a totally different patient.

These problems of being a target of patients' projective identifications are complicated by the fact that nursing staff, who is most often at risk of these identifications is rather medically trained and probably has less psychological insight which sometimes causes many conflicts among the staff subgroups. Therefore very often our nurses and educators vote for discharge of difficult patients in order to make place for those "really ill", with whom they feel at ease and consistent with the role model.

In therapeutic work with borderline patients, the staff has to enter into the patient's reality and then leave it without damage for themselves. Sometimes it is very difficult, even for the most experienced therapists. It is then, very important for the therapist to be well settled in reality and also that this reality is attractive enough.

Primitive defences of borderline patients sometimes provoke easier identification with the patient, than with the staff, so in our opinion staff meetings play a crucial role in an adolescent unit, where borderline patients are treated. As the maingoal of these meetings we consider mutual support and control if some of us has not been lost in his role. They also provide us with a full picture of what's going on in the unit and with understanding and control of complicated dynamics of the treatment processes. Some processes which begin for example during group therapy, are then continued during other forms for example music therapy or therapeutic community meeting, or are acted out during recreational time in the unit, or outside, during visiting e.g. a museum, group excursions to the park and so on.

Family therapy

Family therapy, which is a stable part of our adolescent unit is also very important in the treatment of borderline patients. While therapeutic community and group therapies help the patient on his individual level and in his relations with others, family therapy helps them to deal with their adolescence crisis, mainly with problem of separation.

Beside having a borderline personality structure, patients however remain young boys and girls, for whom separation from their families is even more difficult, than in case of normal or less disturbed adolescents. Family therapy addresses this issue, which in the circular way influences the individual processes as well. Continuation of family therapy after the discharge from the hospital gives the possibility of deeper changes in the family functioning, including such changes which could help the patient to gain better control of disfunctional behaviors.

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