

TREATING THE HOSPITALIZED BORDERLINE PATIENT: REWORKING TRAUMA OF TODDLERHOOD

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Frequently borderline patients are found to have suffered specific traumata during the separation-individuation phase. These traumata seem to have been experienced by them as punishment for their attempts at autonomy or for their early masturbatory explorations. Psychoanalytically oriented hospital-based treatment can allow for reexperiencing and resolving these difficulties, as illustrated in a case presentation.

The borderline, living in the gray zone between the schizophrenias, neuroses, and character disorders, exists in a world of action, of present tense and ever-present tension. The very name "borderline" labels that part of the psychologic world which is deficient. The boundary lines between self and others; past, present, and future; human, animal, plant, and inanimate; and, perhaps centrally, between language and action are all undependable. Searles (1986, pp. 43-44) has likened the psychologic world of the borderline to a "syncytium" defined in *Webster's New Collegiate Dictionary*, 1966, as "a multinucleate mass of protoplasm resulting from fusion of cells (as in the plasmodium of a slime mold)." This image evokes for me the affect that I believe is so disorganizing for the borderline, an initial disgust, which soon becomes a dread, as of being engulfed by a gigantic amoeba or sinking inevitably into quicksand.

The refrain, "time unwinds like a falling spool," from Robert Penn Warren's (1976) poem by that name, conveys an image of the chronic urgency plaguing borderline patients. It is as if they are

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falling into zones of danger, losing themselves as they fall. Perhaps I have preconsciously connected the refrain with Freud's (1920) account, in "Beyond the Pleasure Principle," of the healthy toddler mastering the absence of his mother through playing at tossing and retrieving a spool on a string.

The borderline individual's deficiency seems to derive from a lack of conviction of parental holding. These patients want us to feel that their parents were not good enough and often to blame their parents for failing to convey a sense of safety, as if the parents allowed the baby's psyche to drop and unravel like a spool of thread.

If we believe in the badness of these erstwhile young parents and consider them the causative agents of our patients' difficulties, we have joined with the patients' self-perception as victims at the hands of external malevolent forces. At present we do not have the prospective data to confirm or deny this assumption. If we accept the assumption that the parents were evil, we are in jeopardy of reacting defensively when we become transferenceal parents to our patients. With the borderline, this transference identification is instantaneous.

Life for the borderline patients seems an infinite series of "nows," the moments before catastrophe. The nursery song "Rock-a-bye, baby, in the treetops" could be the condition's theme song. The melody gently lulls us with its deep familiarity, but the message says that while a gentle breeze will rock the suspended cradle, without warning, the bough will snap and down will come baby, cradle and all. Perhaps there are as many "borderline-ogenic" parents as there are singers of this timeless lullaby.

This perceptual feeling of raw-nerved uncertainty leaves the borderline feeling chronically on the edge of disaster (Winnicott, 1974). These people feel perpetually resentful of those around them, who seem immune to such distress. They are left consumed by an inarticulable, often largely unconscious yearning for revenge, which they strive to keep out of awareness in a vain effort to trick the environment into sharing its stores of calmness and dependability.

Perhaps universally borderline patients lack a reliable feeling of connection with their own personal histories as history. That is, the childhood events and their affects are not dependably experienced as history but are brought into the current scene, coloring present events so that past and present merge. Thus the current event blurs with a mental replay of the past. Without an ability to cherish

one's past, one cannot build a durable construct of future. The realm of thought involving planning and the detailed rehearsal of possibilities holds little appeal, and the patient lives precariously in the moment.

At Chestnut Lodge, we still find that splitting therapist and administrator functions in a secure hospital setting leads to very gratifying results (Silver, 1989; Stanton and Schwartz, 1954). These are as documented in McGlashan's (1986) follow-up study, which reviewed the subsequent lives of patients hospitalized at Chestnut Lodge between 1950 and 1975. While emphasizing schizophrenia, he found that among the 81 borderline patients (diagnoses made retrospectively using current criteria) 80% had improved moderately or better, and 50% were in the good to fully-recovered range (a far more favorable outcome than reported in other follow-up studies). The much maligned long-term institution did not foster regression but became, instead, a home for the patient, with therapist and administrator assuming parental roles, allowing a reworking of separation-individuation tasks. I hope the following case presentation will illustrate these issues.

CASE PRESENTATION

Sixteen years ago, four months after I began work at Chestnut Lodge, and while I was still unambivalently thrilled to be there, 20-year-old Margie arrived. A bright but troubled student, she had taken honors courses in high school, and graduated a half year early. But without the structure of a school schedule, she decompensated. A consultant's report from the major teaching hospital where she had spent two stormy years in the locked unit said she had formed no evident alliance with her therapist. He gave the family two choices for her: long-term hospitalization, or a trial of electroconvulsive therapy. The data on admission here minimized her dangerousness.

She is the youngest of five children, the only one accidentally conceived. Her mother had wanted an abortion, but her husband dissuaded her. Father's father, for whom Margie was named, died ten days before her birth; her parents had been sharing a house with him, and he was funding their new business. The patient, reviewing an earlier draft of this presentation, made a revealing slip, saying "I died when my grandfather—er—you know what I mean," thus conveying that she was born into an atmosphere of death, and sensed that, in part, she became her dead grandfather.

At first she was a bouncy and affectionate baby, enjoying additionally the attention of her older siblings and a doting housekeeper. Then, at 18 months, she developed a treatment-resistant rash. Her pediatrician hospitalized her and had her restrained spread-eagle under heat lamps. He forbade her mother's visits, after which Margie would cry inconsolably. After three weeks she came home a changed person: now very clingy, sucking her thumb, and no longer a chatterbox.

When she was seven, a playmate developed leukemia and became bald before she died. Margie then began her life-long habit of hair-pulling to the point of leaving bald patches. The school psychologist recommended treatment, which was not obtained. Her latency years coincided with financial uncertainty. Her parents fought, father and siblings ridiculing mother, whom Margie tried to rescue.

In fourth grade she and a girlfriend apprehensively went to a building site where rumor had it a strange man was loitering. They met up with him. He exposed himself and told the girls to touch his penis. They ran home, swearing not to tell their parents, but the girlfriend did.

From age 14 to 17, despite four sessions per week with a psychoanalyst, she frequently ran away, placing herself in life-threatening situations. Yet she was unable to brave going out of the house with her girlfriends, and hid behind the drapes when they rang the doorbell. She tried caring for the school's laboratory mice. Horrified seeing the mothers eat the newborns, she became a vegetarian. Her dread and yet craving for physical contact propelled her into situations of potential rape or violence. After graduation she repeatedly tried to attend college or to work, each time resulting in escalated suicide attempts by overdose and car wrecks. She began free-fall parachuting, laughingly denying the risk — as oblivious as is a falling spool.

She desired to take in something satisfying, yet dreaded poisoning, and began binging and vomiting; random drug abuse and overdosing with prescribed medication followed. Her doctor tried valiantly to keep her out of "institutions," which he categorically despised. A consultant insisted on hospitalization when Margie was recovering from a nearly fatal drug overdose. She embraced him, said "thank you" and then rushed out of the hospital, clad only in a hospital gown.

Over the next three years she was hospitalized in various places, with ever tighter surveillance. She still managed to cut herself repeatedly with razor blades, watching the skin gradually part,

fascinated as droplets of blood coalesced into a small stream, making a new cut further up her arm, repeating this perhaps fifty times in succession. Once she lightly cut her neck. Her suicide attempts escalated, and she struck out with fists and then weapons when cornered. Increasing numbers and strengths of medication had no effect.

In our first brief meeting, when I had said I would stop by so we could meet and schedule our first hour, I was not aware of her potential for violence. In that encounter I had thought we would hit it off. We sarcastically bantered with down-home directness, what seemed to be the instant rapport of shared ethnicity, which has been shown to correlate with therapeutic errors. The therapist strongly senses a *potential* empathy, and then acts as if it already exists (Basch, 1983).

Among our remarks, she said, "I hated this place until today. I've been waiting all day to see my new doctor. I'd asked for a woman, and I wanted to see if I got one." I said, "Well, now you've seen me. What's next in your day?" Dexter Bullard, Sr., used to remind his medical staff that the roots of the word "sarcasm" are "cutting" and "flesh" and can actually mean this to the regressed patient. When I later glanced at my watch, she said, "Well, I know your time is precious. You don't have to stay." I said, "Isn't your time precious, too?" She said, "Not in this place." We established our schedule of hours; I said I saw our task as working gradually toward mutual understanding over the coming years.

In this exchange we illustrated the paradigm of treatment of the borderline condition. The therapist says, "We have time." The patient says, "Oh, yeah?" sensing and reacting to the nonverbal evidence that the therapist does not have time. While the hollow promises are terrifying for her, the connectedness is worse. It is as if "we have time" equals "let's go steady." Time seeming boundaryless suggests merger and physical sexual union. She has since confirmed that her terror that I might abandon her was exceeded by her panic that I might keep her, and while the reader may find the extrapolation to "let's go steady" a bit far-fetched, when Margie read this paper, she marked in the margin, "Right!"

In our first scheduled hour we met alone in the TV room on her unit. She began, "Are you angry?" I wasn't, at the time, as far as I was aware. She was certainly angry and terrified at being left there, in a long-term place, far from home. Perhaps I had so needed to preserve my own unambivalent and thus brittle joy at having found a professional home, that I *had* conveyed anger, hearing her say, "I hate this place." She continued, "You *are* angry. You don't like me.

I don't know *why* you don't like me." I said, "It seems like you see things in extremes." She screamed, "I don't need to be in the hospital. Let me go. I don't want to see you. I don't want to talk to you. I had problems, but they are in the past. Everything is changed." She asked menacingly, "Are you frightened?" "Uh . . . somewhat," I said. "Well, get *out!*" she screamed.

I got up and was moving toward the door, diagonally away from her. I felt defeated over conveying that I was a quitter. If I were a really good therapist, I should have been able to say something instantly calming. She got a plastic knife she had hidden behind the sofa cushions, and jabbed repeatedly at my upraised arm. I called, "We need help in here," while thinking, "what's this *we* stuff?" The psychiatric technicians entered, got her pinned down, and I imagined kicking her as repeatedly in the face as she had pummeled my arm. Instead, I gathered up the contents of my pocketbook, which were strewn around the room.

Her assault shattered my unarticulated notion that my enthusiasm and pleasure at being a Lodge therapist would in itself protect me from danger. My denial of my vulnerability had to be as terrifying to her as I felt her free-fall jumps must have been. My anger toward her was analogous to her anger toward me: We each were occupied by immediate feelings of vengefulness.

Since her arrival there, she had been assaultive and self-destructive previous to her attack on me and had already required cold wet sheet packs. Her administrator, her head nurse, and I concurred in instituting routine cold wet sheet packs for her therapy sessions. ~~After the first week of hospitalization, Margie's self-mutilations and her assaults on others stopped completely.~~ But, had she been able to get away from the hospital, she planned an immediate suicide by throwing herself in front of a moving vehicle. She later told me she had dreaded liking the place, fearing she would then never want to leave.

As Margie and I reviewed the material for this paper, she told me she had hoped for a soft maternal figure, who would soothe her and tell her everything was going to be all right. I was not yet in touch with my identification with my sometimes aggressive and assaultive mother, who had died two months before Margie's arrival. And perhaps my sense of immediate rapport with Margie reflected my wish to resurrect my mother in my new patient. My mother had raged that I was "Little Miss Innocence," not in touch with my provocativeness, and at that point in my analysis, that still was true.

Basch (1983) has commented,

In the case of analyst and analysand, the greater the biological, cultural, and psychological similarity between the two, the more likely it is that, from the very beginning, the analyst's unconscious will be receptive to and understand the significance of his patient's unspoken, disguised, affective communications. Such an experience, only seemingly instantaneous and intuitive, should not be taken as paradigmatic for the empathic process in psychoanalysis. Often as not, such mutuality does not exist and then there is no immediate feeling of affective communion and recognition between analyst and patient. (p. 112)

While in cold wet sheet packs, Margie conveyed information about herself and her family dissociatively, actually reliving recalled situations. She addressed me as if I were her sister, or mother or father, or a classmate or stranger. She hallucinated fish flapping on the floor, as they once had when her fish tank had no lid. Mice crawled in her mouth, as she relived seeing mice eating their newborns. And eyes stared at her from the wall. Once, in a child's voice, she pleaded with me not to make her attend Sunday school that day. In another session, her parents were in coffins, having been murdered by an intruder, and she talked to each of them and they answered angelically.

The abrupt changes in affect, scene, and degree of communication were extraordinarily rapid and unpredictable. During those weeks I learned that she found my words and any movement extremely disconcerting. She taught me how crucial it was for me to simply, quietly, and consistently be there with her. Those early stormy months probably would have been quite different had I been like that from the start.

She then revealed to the nursing staff that she had smuggled in razor blades in the heel of a shoe. The nursing staff located them. I said, "To the part of you that chose to use the plastic knife rather than the razor blade, I say thank you." In the next session, she reported her first dream. She was playing basketball with me with a half-deflated ball. As one or the other of us scored, the psychiatric technicians said "aah" in approval. In the dream she then went to the refrigerator and found four recipes for vegetarian corned beef written on a thank-you card from me.

The four recipes were linked to our four sessions each week. The vegetarian corned beef had actually been given to her by a vegetarian psychiatric technician. The partially deflated ball in the dream seemed breast-like, and was shared back and forth, while we competed. The psychiatric technicians approvingly watched our structured play. We were no longer enacting cannibalistic oral rage. The

basketball going into the hoop I now connect with our providing the other with food for thought, the "ahh" being the sound of agreement or contentment over a good meal.

She began asking to discontinue the routine cold wet sheet packs. I wanted her first to identify the specific moments when she felt trapped by them, that is, when in the sessions she had the impulse to leave. Once she could do this, we worked on relating the impulse to her feelings and thoughts at that moment. We focused on her naming her feelings, an exercise that was apparently new to her, and at first was very difficult. We found that she wished to flee when she experienced me to be passionately in love with her or about to murder her.

She was able, then, to understand both intellectually and emotionally that she had had some hungrily loving or hostile thought or impulse. She would be convinced immediately that it had been *my* feeling she had experienced, so that I then became suddenly menacing, and she would want to fight me off or flee. Often we were able to define her evidence for this realization. Sometimes I could confirm aspects of it, or together we could discover that she was reexperiencing events with family members. Cognitive and emotional boundaries were forming.

With her observing ego more securely functioning, we discontinued routine packs after about five months. The packs, we both agreed, had permitted us each to feel far more secure together, to work much more efficiently than we could otherwise have done. Once packs were stopped, our anxiety in the hours intensified dramatically. She hid from me under her bed, and was mute for days at a time, pulling at her hair. Once she reenacted an early adolescent activity, of strip-tease dancing in front of her mirror.

Occasionally packs were necessary, as when she looked at herself in her mirror and in poignant dissociation said, "That's not Maggie. She's outside the hospital somewhere. I have to get out of here and find her. She is in danger. I don't know who *that* is," (indicating her reflection). She then abruptly began banging her head against the wall. I called for help as I tried to restrain her.

Once in pack, she said she knew there was a man inside her, not in her womb, but in her belly. She said she had to get him out of her or he'd explode out of her and kill her. She thought she would have to cut him out of there. I said she seemed terrified of her own active assertiveness and experienced it as alien to her. I added that over the course of our work together she would become more comfortable with her own active strivings. She relaxed. Now I

wonder, too, if this man might have been an introject of her grandfather after whom she was named, and who had become the dead weight of her chronic depression.

Some months later, when she was far more settled and was developing friendships that still continue, she confessed that for a while she had sequestered a sheet she had fashioned into a noose. She had almost used it to destroy herself four months previously. She no longer had that sheet, but now had ready access to others, and could duplicate it at any time. She asked, "Will you tell the staff?" I said, "They should know about it, but it would mean far more to you if you could confide in them directly." It took her another four months to do so, during which time I experienced a parallel panicky dread, comforted by the knowledge, through regular contact with the nursing staff, that they knew she still required their very close attention.

Margie gradually became more collaborative. She used the sessions to rehearse her participation in unit meetings in which she previously had been mute. Thus the immediate future began to be important. She joined the unit project of raising vegetables, but became panic-stricken when she accidentally broke off a still-green tomato. Desperately, she tried to reattach it, then kept it on her window sill for weeks. I speculated with her that perhaps her panic at breaking the tomato from its stem connected with her experience of being broken off too early from her mother, when she was hospitalized at 18 months. She was intrigued, but commented, "I don't remember that hospitalization, so *why* do you keep thinking it's *important*?"

I had felt empathically connected with her as she described trying to reunite tomato and plant, recalling the time when I accidentally knocked my favorite figurine from its scone. Her hand had broken off; I had seen that it would look almost as good as new when it was reglued, but then had cried hysterically, through the sobs, "It's not broken. It's not broken." My parents were clearly shaken, and had tried to reglue my sense of reality testing by repeatedly telling me that it was, in fact, broken.

As I silently reminisced, she recalled her mother telling her in a family session that she had wanted to abort her and had then felt responsible for her daughter's illness. As Margie studied the tomato for signs of ripening, she recalled awakening from a drug-induced coma to find her parents standing by her bed. She said, "For the first time, I'm thinking of how that was *for them*. It's amazing. It never occurred to me before! It must have been awful for them,

seeing their daughter who wanted to kill herself and almost did." Again, she wondered about telling them, again we waited for her to sense she could trust them. These focused acts of trust demonstrated her increasing comfort with her own empathy.

Next, she tested whether I could tolerate rivalry. She told me about her favorite male psychiatric technician, who had been part of the team containing her in packs, and who was her preferred staff escort when she began going to the dining room. She asked him detailed questions on the timeless theme "What do men want?": how they regard women, how they interpret certain comments or gestures from their dates. She let me know that he and I were in brisk competition concerning who was more useful to her.

Meanwhile, she often responded to my remarks linking one area of discussion with another, by saying "You're *weird*," or, "People don't think like that outside the hospital. If I think like you, I won't be able to get along with them." Much later she often said, "I'm worried. I'm starting to think like you. You've gotten into my head. I'm not sure it's right." She then would report some neat piece of self-analysis.

I underwent emergency surgery with complications (Silver, 1982, 1986, 1990). My patients were told, since maintaining analytic anonymity seemed impossible. They were even encouraged to continue with their interim therapists. Margie stayed with me, sending me a Natalie Shange book, *For Colored Girls Who Have Considered Suicide/When the Rainbow Is Enuf*. My dread on leaving the hospital was analogous to hers on being admitted to Chestnut Lodge. As the title seemed to command, I did consider suicide, deciding instead to read the book, which turned out to be a perfect gift. When I returned, she hugged me, told me she knew I would be fine, and wrapped me in a white crocheted shawl. She had asked the rehabilitation liaison to teach her to crochet so she could make this get-well gift, which seemed to me the closest she could come to reciprocating the cold wet sheet packs. She resumed her work as if I would live forever, and I felt immortal, but only during the sessions, on which I then deeply relied. She had shown me her worst, and I hadn't quit. Now I was showing her my worst, and she, too, stayed around.

She took courses at the local community college, did extremely well in some, and showed major talent in sculpting, where she found metaphors for her hatred and sensation of being shattered. Again she had gained her introduction to sculpting in the rehabilitation program. But more often than not, she withdrew from

courses, immobilized by apprehension. She got a job, and after marked shyness and seclusiveness, she became a highly successful salesperson. Next, she very gradually moved out of the hospital, to become a day patient, after two years as an inpatient. She continued as an out-patient for another three years, then became a private patient of mine, still meeting with me at the Lodge. She began complaining that the work wasn't progressing, that she experienced me too much as a friend, and felt disappointed after the sessions, feeling she had been chatting rather than working. I suggested she might find using the couch helpful with that, and after some hesitation she did so, and it helped. I should add that at no time in her work with me did she receive psychotropic medication.

At work, she met a shy, scholarly man. They dated tentatively and then romantically and then became engaged and married. Gradually she decreased the frequency of our sessions, and there were increasingly long interruptions as they travelled, first to various cities in the United States, and then on an ambitious and enviable three-month backpacking tour of Eastern Europe, which they organized and conducted independently. Upon her return, we stopped meeting. They recently opened their own art-supply store, and are planning a family.

I'd like to add here that Margie's recovery is not an unusual story. Two fellow patients whose histories are in many ways analogous and similar in severity, and who became her friends during their hospitalizations, have both gone on to careers. The two other patients of mine who weathered the storm of my chronic anxiety when I was sick have also married.

DISCUSSION

When I had asked Margie what in her treatment seemed most important to her, she said, "You taught me that it is all right to hate, and that it will not hurt the other person or myself." This connects with the borderline's urgency. It was her hateful feelings that knocked her into panic, like a dropped spool of thread. She had come to dread her own hatred, and reacted to it by projecting it into the other person.

Work with Margie taught me to be extremely respectful of the terror of a borderline or psychotic patient who is in a new situation. She almost killed herself in each of two attempts to go away to college. After innumerable hospitalizations, she was turning

this murderousness on others as well. She lacked a sense of personal identity but was unable to complain about this, since she did not at that time have a self that could articulate "I feel . . ." That is, when she was hateful, she automatically chose to lose her self rather than to acknowledge this hatred. I was initially unaware of the intensity of her panic. She experienced my lack of relatedness probably with inarticulate despair.

Often over the years we reviewed our first encounters. By mid-treatment, she could say, "That must have been awful for you. How could you stand working with me after that?" I was able to tell her about my fantasy of kicking her in the face when the technicians had pinned her down. She had said, with obvious surprise and gleeful horror, "Doctors aren't supposed to think like that. What about the Hippocratic oath?" We had then worked at differentiating thought and action, and she became progressively more comfortable owning her own hateful and vengeful fantasies. She had developed dependable boundaries. She could imagine being me, imagine being herself in the past, and, further, could imagine me as a person with memories of past events. She could acknowledge that her past selves still existed in the memory of her new self, which was then able to make plans.

Her illness, with its loss of effective boundaries and loss of ability to categorize, left her in a state of chronic active terror. Impulsive action alternated with immobilization. She suffered profound sensitivity to abandonment because of her heightened need for predictability. She first needed to know that she was safe, and then gradually enlarged the circle of safety. This circle could only widen once her mind itself became a safe place, peopled with relatively safe introjects. Her reality gradually became more real. Her images of her parents became fully human ones, not a jumble of disconnected vignettes of demands, intrusiveness, abandonment, narcissistic aloofness, manipulation, or assaultiveness. The images came to include previously forgotten or massively depreciated acts of nurturing and dependability. I needed a similarly cohesive integration of parental introjects, both to avoid contributing to reenactments and to permit and foster her integration, without my vengefully or enviously disrupting it.

Her history raises the question of the role of specific traumata in the etiology of the borderline condition. The borderline patient is classically described as not mastering the rapprochement or separation-individuation phase (Mahler, Pine, and Bergman, 1975). My patient underwent a profound trauma at the height of the

rapprochement phase, and could well have experienced that hospitalization, her confinement, and her mother's not visiting as irrefutable evidence that she was being punished for her efforts at individuation, and perhaps for masturbation. The works of John Bowlby (1969, 1973, 1988), Mary Ainsworth (1982), and others studying attachment behavior are of enormous importance here. Robertson's 1952 film, "A Two-year-old Goes to Hospital" documents the trauma I am describing, with its phases of Protest, Despair, and Detachment.*

The event of that early hospitalization occurred in a matrix of family anxiety and depression, less than two years after the death of the family patriarch, which had occurred just days before Margie's ambivalently desired birth. It seems to me to have confirmed her preverbal sense of having a tenuous place in the family. This sense of extrusion was perhaps rekindled as she attempted to go away to college.

Additionally, she may have experienced the hospitalization when she was 18 months old—and having been tied spread-eagle under heat lamps, deprived of seeing her mother—as a punishment for the joyful exhibitionism of toddlerhood. Perhaps the rash itself, which apparently itched severely, may have left her feeling that masturbation is dangerous. It seems evident that she struggled with intense and primitive feelings of shame and dread of punishment. She later tried to master these feelings through reenactment, as she was drawn to seek out the exhibitionist man in fourth grade, and again in compulsively running away, hitchhiking in early adolescence, or dancing seductively in front of her mirror.

Also, I am left wondering about the interplay of traumatic events in the lives of the patient and the therapist, and the roles these play in the patient's ultimate recovery. My mother had died shortly before Margie's arrival. I believe I reacted deeply to similarities in verbal style and physical appearance between the two of them, and unconsciously adopted her as a mother-substitute. Later when I was dangerously ill, and for me time was unwinding like a falling spool, Margie stayed with me, although unconsciously expressing her ambivalence in the title of the book she gave me, which seemed to command me to consider suicide, much as her mother had considered aborting her. Perhaps she projected her sick self into me and worked successfully to heal it.

*I am grateful to C. Sanders for her comments regarding the centrality of attachment theory to the psychotherapy of the borderline condition.

Daniel Stern's (1985) classic work *The Interpersonal World of the Infant* includes a description of a nine-month-old baby at play whose mother joins in the play in perfect attunement, synchronizing her sounds and her movements exactly with the rhythm of her baby's spontaneous efforts. He then asks,

Can you attune with anger that is directed at you? Certainly you can experience the level of intensity and quality of feeling that is occurring in the other and that may be elicited in yourself. But it can then no longer be said that you are "sharing in" or "participating in" the other's anger; you are involved in your own. The entangling contingency of threat and harm places a barrier between the two separate experiences such that the notion of communion is no longer applicable. (p. 160)

Betty Joseph (1982), discussing a group of patients addicted to near-death experiences, says,

My impression is that these patients as infants, because of their pathology, have not just turned away from frustrations or jealousies or envies into a withdrawn state, nor have they been able to rage and yell at their objects. I think they have withdrawn into a secret world of violence, where part of the self has been turned against another part, parts of the body being identified with parts of the offending object, and that this violence has been highly sexualized, masturbatory in nature, and often physically expressed. . . . This deeply masochistic state, then, has a hold on the patient, that is much stronger than the pull towards human relationships. (p. 455)

For Margie, the barrier of threat and harm was first contained by the cold wet sheet pack, and once the contingency of danger was removed, actual sharing and participating in the feelings could begin. ~~This patient had not been able to differentiate action and language. To say something angry was to strike out. To think of striking out then brought forth a need to flee retaliation.~~

When Margie and I began our work together, our first boundary was a barrier of mutually generated anger. Cold wet sheet packs provided a dependable physical boundary. Gradually, we substituted increasingly successful attunement. With such attunement, she relied less addictively on projection and projective identification. Her relationship with me and with others then became real, mutually validating, and mutually valued. She is proceeding with her adult life, hoping soon to mother her own infants. Perhaps she soon will sing "Rock-a-bye baby" to her own son or daughter.

The concept of time and the varieties of ways of coping with its passage are perhaps the central issue in all varieties of mental

health and illness. For the healthy, shielded with the distractions of collaborations and daily tasks and schedules, there is a calm sense of sufficiency. When we say to a patient, "We have time," we believe it, and comfort ourselves that the statement is largely probably statistically true. For the depressive and anxious neurotics, the limitations of time form a problem impeding efficiency. But for the borderline, the resultant anxiety cripples and fragments cognition. With the psychotic, anxiety reaches such a pitch that denial is necessary, and the individual becomes immortal or re-incarnated, responsible not for his own fate but that of the entire universe.

These diagnostic states are states of current tension, not statements of fixity as are the Linnean categories of genus and species. The boundary with the psychoses is also diffuse. Usually the borderline individual is involved enough in current social living not to rely on imagination to provide gratification. But if the environment is sufficiently frustrating, the borderline retreats to hallucination, sometimes escalating this process, promoting a fully developed hallucination or a finely worked delusional system. The chronic borderline patient will often suffer hallucination in all sensory areas.

Even when the borderline is in contact with others, this experience is often highly distorted. He or she is clearly out of touch with reality, if reality includes a consensus of the affect tone of the other individuals involved. If confronted with the contradiction, the borderline will work diligently to convert the level of tension in others to that of his or her own, thus apparently winning the battle of whose reality is the real one.

If the others happen to be the patient's psychotherapist or hospital treatment team, the patient has both won and lost. The patient has "won" in proving that there really was a war going on all along, but has lost in usually being the first or only casualty. Yet again, the bough has broken and the sense of dread is confirmed as appropriate. The outcome depends on the ability of the professional team to process their countertransference reactions (Fromm-Reichmann, 1950; Searles, 1979, 1986). This in turn rests crucially on their having come to grips with their own borderline disorder, its roots, and its present condition. They must acknowledge the extent to which they share a worldview with their patient of righteous indignation, yearning for revenge and a wish to find an enemy to blame for their own raw-nerved jumpiness.

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