

MANAGEMENT OF THE BORDERLINE PATIENT ON A MEDICAL OR SURGICAL WARD: THE PSYCHIATRIC CONSULTANT'S ROLE

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ABSTRACT

The patient with borderline personality hospitalized on a medical or surgical ward has a disorganizing effect on the house staff, who may regress in response to the patient's impulsivity, dependency, entitlement, and rage. The psychiatric consultant's role in the management of such a patient should consist of a specialized type of consultee-oriented approach in which countertransference¹ hatred and fear, typically generated in the staff by the borderline, are drawn away from the patient and strategically metabolized within the staff-consultant relationship. The consultant should actively promote a *behavioral management practicum*, placed in the medical chart for reference and as a symbol of the psychiatrist's helping presence, which discusses: a) clear communication with the patient and among staff, b) understanding the patient's need for constant personnel, c) dealing with the patient's entitlement without confronting the patient's needed defenses, and d) setting firm limits on the patient's dependency, manipulateness, rage, and self-destructive behaviors. The consultant should work to counteract feelings of helplessness in the staff, to neutralize punitive superego in the staff, and to diminish fearfulness toward the patient.

The patient with borderline personality organization who is housed on a general hospital ward because of a medical or surgical illness may wreak havoc by acting violently, causing friction among house staff, refusing treatment, threatening suicide, or trying to flee the hospital while his medical condition is critical. A psychologically naive house staff may regress to a helpless, frightened, or vengeful position in response to the patient's ingratitude, intractability, impulsivity, manipulateness, dependency, entitlement, and rage.

¹ "Countertransference" here is used to mean all conscious and unconscious feelings toward a patient, rather than in its original, more Freudian sense.

Although the psychiatric consultant may be called to see a florid, acting-out borderline patient only once every year or two, even in a large consultation service [1], the experience is usually a taxing one. Such patients simultaneously demand and reject treatment; they divide, idealize, and scapegoat staff; they complain of incurable anxiety and depression; and they consume vast amounts of staff time and energy.

The Borderline Personality and Primitive Ego Defenses

The term "borderline personality" connotes a severe, stable character disorder, diagnostically falling somewhere between neurosis and psychosis [2, 3]. The pathology of such patients has been linked with a developmental defect occurring early in life, in the pre-oedipal period [4]. Whereas in normal development the child learns to separate from important objects with sadness and anger rather than with despair and rage, the borderline cannot tolerate negative affects associated with separation [5] and continues into adulthood the pre-oedipal child's clinging, as if others were desperately-needed parts of the self rather than separate persons [6]. The boundaries between him and others can become blurred to such an extent that closeness seems to threaten death by fusion and separateness seems to threaten death by emotional starvation.

Just as the borderline's relation to others is either too close or too distant, his sense of self is also fragmented. His sexuality and dependency are confused with his aggression so that needs are felt as rage. He has little sense of ability to master painful feelings or to channel needs or aggression into creative or job areas. He feels so empty and fragile that ambivalence is ill tolerated and impulse control is poor. The borderline has a split representation of himself as simultaneously all-bad and all-powerful; his view of himself is a chaotic mixture of scared, shameful, and grandiose images [3, 7, 8].

Borderline patients sometimes manifest serious flaws in reality testing and can slip into primary-process thinking under stress (losses, drug intoxication, medical illnesses [7, 8]) or in situations where there is too little structure (long-term outpatient psychotherapy, hospitalization in low-demand milieu psychiatric units [9-11]).

While the precise meaning of the diagnosis "borderline" is still undergoing revision, a recent review of the literature [12] identified six features that are commonly mentioned by most authors as characteristic for the diagnosis during an initial interview: 1) the presence of intense affect, usually hostile, 2) a history of impulsive behavior, 3) superficial social adaptiveness, 4) a history of brief psychotic experiences under stress or 5) loose thinking in situations of too little structure, and 6) relationships that vacillate between transient superficiality and intense dependency.

Medical and surgical house staff unfamiliar with such a personality structure may react with anger and fear when they encounter provocative behavior,

desperate hunger, inchoate rage, untreatable fear, inconsolable depression, unfillable emptiness, and what (to them) appears to be raw sexuality—all in the same patient at the same time.

Most important from the consultant's point of view are the primitive defenses of the borderline [7, 8], highly visible during a medical or surgical hospitalization:

1. *Splitting* refers to an active process of keeping separate from each other perceptions and feelings of opposite quality. Staff members are categorized as "all good" and "all bad" because the patient cannot tolerate the anxiety-producing idea that his caretakers can be both good and bad at the same time.
 - a. *Primitive idealization* is the patient's tendency to view some staff as totally "good" in order to protect himself from "bad" staff members and painful experiences.
 - b. *Projective identification* is a tendency to perceive some staff members as negatively as the patient's felt self. This gets translated into behavior based on the following kind of "logic": "I'm bad and you take care of me. That means you're rotten and dangerous as I am or otherwise you wouldn't have any dealings with me."
2. *Primitive denial* operates as an alternating expungement from consciousness of first one and then another perception of opposite quality, or a wish so powerful that it obliterates crucial aspects of reality contradicting it. For instance, fear may cause the patient to deny a serious medical illness and flee the hospital, where it could be treated.
3. *Omnipotence and devaluation* represent the patient's shift between the need to establish a relationship with a magically powerful staff and a conviction of omnipotence in the self which makes all others impotent by comparison. When the omnipotent caretakers are unable to protect the borderline from all badness, the staff becomes impotent and hateful.

While the long-term psychotherapy of the borderline patient may involve therapeutic undoing of these archaic defenses, it is dangerous for a consultant to confront such defenses willy-nilly in such a brief encounter as a hospitalization for physical illness. It is crucial, however, to be aware of their presence. For example, awareness of borderline splitting will prepare the consultant to deal with the division of the house staff into "good ones" and "bad ones." Recognition of the patient's primitive idealization of a doctor may help the consultant prepare for the furious devaluation which is likely to follow.

Hate in the Countertransference

As Bibring pointed out, when good relationships cannot be established between doctor and patient, it is not always because the doctor does not

understand the patient; it may be that the doctor does not understand his own reaction to the patient [13]. In one borderline patient, the several "types" of dependent or hostile or ungrateful patients who engender conflict can become manifest all in the same day, confronting the staff with all countertransference pitfalls.

Winnicott pushed psychiatry a quantum leap forward by daring to name what a therapist may feel toward a patient—*hate* [14]. While the psychotherapist expects to hate the patient sometimes, the house staff on a medical or surgical ward may not be prepared for the depth of feelings which the borderline can provoke. Maltzberger and Buie's recent extension of the concept of countertransference hatred argues that the more the therapist's murderous feelings towards the patient are *conscious*, the less likely is the patient to come to harm [15]. They describe how the therapist's defenses—such as repression, turning against the self, reaction formation, projection, distortion, and denial of hatred—increase the danger of patient suicide. The caretaker, who hopes to "heal all, to know all, and to love all," when confronted by a hateful patient, may feel malice (loathing, hatred) and aversion (desire to flee) [15]. Likewise the house staff may be guilty about malicious or aversive feelings and avoid the patient or force him to flee instead.

Milieu Phenomena and Staff Disagreement

Since Stanton and Schwartz's original description of the phenomenon of hidden staff disagreement, its relationship to acting-out behavior by patients in the mental hospital has been recognized [16]. Burnham's work extended the concept of the patient-as-victim of conflict to include patient-as-cause, as well [17]. In view of the intensity of highly-staffed milieu-oriented mental wards, it is not surprising that borderline patients often respond better in less stimulating, highly structured environments [10-12].

The primitive defenses of the patient with borderline personality can stimulate staff disagreement. In order to cope with deep feelings of self-loathing, he may see the staff as loathsome; otherwise why would they take care of him (*projective identification*)? Or he may see staff as magically all good, to keep all the badness in the world away (*primitive idealization*). In order to make sense of a world in which people are both good and bad, such a patient may choose some people on the staff to be "all good" and some as "all bad" (*splitting*). This "explains" for the patient "why" he feels the way he does: he is caught between good and bad forces *outside* him.

When the patient views the staff through his defense of splitting, he may eventually get them to behave as if it were so. The patient will tell an "all good" staff member what terrible things an "all bad" staff member has done or said or thought, and then swear the "good" one to secrecy. As less and less communication takes place and as the patient gets worse and escalates demands, the "good" staff and "bad" staff begin to disagree about the care of

the patient, since the borderline may be "good" with "good" staff, and conversely. The remedy for this depends first on re-establishing open staff communication, even if it is hostile, to enable staff to get a well-rounded view of the patient.

Adler [18] discussed firm, non-punitive limit setting as crucial for inpatient treatment of the borderline, because "the patient has to learn that he cannot destroy the object or be destroyed by it, no matter how much he may wish this or fear it." It is a natural human instinct to confront such patients angrily. Adler and Buie offer a useful set of restrictions and precautions for in-milieu management [19]:

1. acknowledge the real stresses in the patient's situation,
2. avoid breaking down needed defenses,
3. avoid overstimulation of the patient's wish for closeness,
4. avoid overstimulation of the patient's rage, and
5. avoid confrontation of narcissistic entitlement.

This last dictum is as important as it is difficult to follow. Borderline patients exude an offensive sense of deservedness, which is always tempting for an overworked staff to confront angrily and suddenly. The point is, often the borderline has only this sense of entitlement to keep his personality together during the multiple stresses of hospitalization. Entitlement is to him what hope and faith are to some normal persons. Preserving it requires a deliberate effort by an un-split staff.

Setting limits, avoidance of confrontation, and averting over-stimulation of desire for closeness and of rage are difficult to arrange on the instrumental and fast-paced medical or surgical ward. Prevention of staff splitting is especially difficult because of the dense hierarchical structure. If the patient chooses the nurses to be "all bad" and the doctors to be "all good," the nurses may displace anger to the doctors but be unable to express it because of role-induced sanctions, and the doctors may see the nurses as merely incompetent and unable to comprehend their plans, ideas, and feelings about the borderline. Such situations are fertile ground for a splitting patient and require concerted effort toward open communication within the staff.

The Ward Consultation

In general, the earlier in the borderline patient's hospitalization the consultant is called, the more overt is the reason for the consultation and the more effective the intervention. Late in the hospitalization, however, the consultant may be urgently called in to see the patient for very vague reasons and arrive to find the medical or surgical ward in a shambles, the patient in restraints, and the staff in bitter conflict. Usually nobody is either willing or able to say what has been going on. The patient and staff are seeking

immediate relief, punishment of offending others, a convenient scapegoat, vindication, magic, and solace—all covertly. The stronger the house staff's conflicted feelings about the patient, the less the consultant is likely to hear them honestly acknowledged. The staff mainly wants the patient transferred somewhere—anywhere—else.

Generally, the most helpful approach to such a consultation is the familiar consultee-oriented model of mental health consultation [20], which involves thinking of the patient and staff as a single entity and dealing as much as possible with the strong, healthy part. The entity consists of two parts. One part, the borderline patient, has problems with object relations, pathologic behaviors exacerbated under stress, and several self-defeating and infuriating defenses, especially splitting. To prevent his being split, the consultant should try to deal mainly with the healthy part, the staff. Since the staff is often closely linked in an unwilling, hateful, and guilty alliance with the patient, and its collective self-esteem is already damaged by encounters with the patient, the consultant should not damage it further by interpreting the staff's pathology without caution and support.

The attempt to ally with staff rather than the patient is destined to encounter several resistances at the outset. First, the patient will be eager to engage the consultant in order to find out whether he is "all good" or "all bad." Second, the staff, needing the patient as a scapegoat for its sense of failure with him, wants the consultant to take over the care of the patient completely. Third, neither the staff nor the patient has the patience and energy to understand what is going on: they are in pain and want relief *now*, preferably by removal of the patient from the ward.

The consultant's job is similar in many ways to the treatment of the borderline patient in individual psychotherapy and similar to inpatient psychiatric management; what is different is that the psychiatrist is mainly working with the staff. His work proceeds along the following idealized steps.

IDEAL PROCEDURES

The alliance—The alliance with the staff depends to a large extent upon previous experience with the consultant, staff's view of psychiatry, how long it takes the consultant to answer the consultation request, and how much sense the advice makes. The consultant's alliance with the patient is dramatically less important in terms of outcome than that with the staff. Ideally, the patient should be seen only briefly if there are enough data from corollary sources to make the diagnosis. The patient can be told that the consultant will work mainly with staff and that he will be seen briefly and infrequently. Aside from a brief history of the immediate stress and precipitant for the consultation request, no alliance with the patient should be sought.

Visiting the patient should be reserved for the specific purpose of the

consultant's alliance with the staff. He should go see the patient only 1) when a magical gesture of "taking over" is needed to comfort a desperate staff, 2) when staff members are feeling the consultant does not know how much they are suffering, and 3) when the staff needs a specific model or example for carrying out the consultant's recommendations, for example, limit setting.

The consultant's note—The note in the medical record, by its tone, its helpful information, and its description of a patient the staff can immediately recognize as its own, can help cement the alliance. Formal but not condescending, it should briefly outline the precipitant, the history, the mental status examination, previous psychiatric history, and previous behavior in medical situations. It should be explicit about medications and suicide potential. And it should include attitudinal recommendations for the care of the patient on the ward. For example:

Psychiatric consultation is sought for this 21-year-old white single woman who is well known to Medical Team B because of multiple hospitalizations for complications of regional enteritis. Consultation is sought for "evaluation and management of ward behavior prob." (She has been spitting in her hyperalimentation line.)

Present illness. Patient is admitted for her 12th hospitalization because of fever, malnutrition complicated by alcoholism. While she abuses barbiturates and amphetamines, she refuses to take prescribed medications for her enteritis. She is usually quite hostile in hospital and causes staff discord.

Psychiatric history. Patient is well known to psychiatry for several hospitalizations for suicidal gestures—overdoses and wrist-slashing, usually—and multiple trials of outpatient individual and group psychotherapy. She is usually maintained on diazepam 10 mg po qid prn anxiety and flurazepam 60 mg po hs prn insomnia, but when she develops stress-related psychotic episodes, she is treated with haloperidol 5-10 mg bid and hs, up to a maximum of 50 mg per day.

Developmental and social history. (See old chart.) Lives with psychotic mother, unemployed. Remarkable lack of affirmative experiences in growing up, truancy, arrests, no friends, homosexual promiscuity and occasional heterosexual prostitution.

Mental status. Examination today shows an emaciated blond woman with acne and tatoos of both arms. She is hostile and demanding. She is fully oriented and cognitive functioning such as memory and fund of knowledge are intact. Judgment and attention appear poor. Her speech is normal and she appears to have no formal thought disorder at this time. She is anxious and depressed but denies any immediate suicidal plan.

Impression. This patient has an illness of character which psychiatrists call "borderline personality." This means that she is somewhere between neurotic and psychotic diagnostically and personally she has very pathological relationships with people.

Recommendations.

1. Suicide precautions.
2. Continue diazepam and flurazepam as above.
3. Refer to behavior management protocol below.
4. Will follow with you.
5. Doubt it will become necessary, but if so, call me and restrain her for violence or self-destructive behavior.

The behavior management practicum—While the following protocol appears too long and detailed, it not only gives the staff a sense that the consultant understands the magnitude of their problems but also that he has some solutions. Moreover, it saves the consultant's time in the future. Other than a successful suicide attempt, there is scarcely a behavior that the borderline can manifest in hospital that is not touched on by the practicum. It remains in the patient's medical chart as a tangible symbol of the consultant's presence on the case. After it has been read by the staff, most of the consultant's work becomes sorting the daily problems posed by the patient into the following four categories and effecting the recommendations.

Behavior Management Protocol. The successful ward management of a patient like Ms. B _____ revolves around four factors. They are:

1. *Communication.* Ms. B. _____ needs to be told simply and truthfully what is being done to and for her. She may try to split up the staff, playing off one member against another, telling different versions of a story to different staff members.

Recommendation: Have brief daily staff conferences to plan her treatment and to reach a consensus about what is to be told to her.

2. *Constant Personnel.* She gets panicky when she cannot identify staff members working with her. Ideally, one person should make all decisions and negotiate them with her. Since this is not possible in the real world, just bearing in mind that she feels scared at each change of shift can help.

Recommendation: At the beginning of each shift a staff member should familiarize himself with Ms. B. _____'s treatment plan and then introduce himself to her, ask how things are, and tell how long he will be on duty.

3. *Entitlement.* Ms. B. _____ has, along with her self-loathing, a paradoxical and repugnant sense of innate deservedness. While this is difficult for staff to stand, it is important to remember that this entitlement is about all she has to hold herself together when she's scared of her physical illness.

Recommendation: Always be alert for the signs of this entitlement, be aware of your own anger over it, but do not confront Ms. B. _____ with it or imply that she does not deserve the

impossible and contradictory things she asks for. Rather, say over and over that you understand what she is asking but, because you feel she *deserves* the best possible care, you are going to continue to pursue the course dictated by your experience and judgment.

4. *Firm Limits.* Ms. B _____ makes a lot of demands, usually for conflicting things, and is quick to rage when her demands are not met. This may make you feel trapped and helpless, as if you were at fault for not being able to do everything. She may blackmail you by threatening suicide if she does not get her way.

Recommendation: Do not try to argue with Ms. B _____, but quietly and firmly, over and over again, set limits on her problem behavior, demandingness, and rage. If she threatens self-destructive behavior, assure her that physical restraint will ensue if she tries to carry it out. (This does not mean that she should not be allowed to demand and complain, but it does mean that you need tolerate not more than twice as much as you would from an average patient.)

Work with the staff—On the day the note is written there is a second part of the alliance with the staff that needs to be tended—getting to know how members of the staff working most closely with the patient feel about him. This entails getting around and talking a few minutes with each one, ostensibly to gather data about the patient, but actually to find out about the interaction.

The initial encounter with the staff provides a place to start working with staff countertransference. Each time there is a hint of negative reference to the patient, the consultant can recognize it by saying something like, "Yes, these patients *are* manipulative," or "Everybody finds this kind of patient hell to deal with," or "This is the worst patient I've seen all year." This legitimizes expression of hostility and brings it to the consultant rather than to the patient.

Ongoing work with the staff consists of identifying and interpreting to them the patient's pathologic defenses. For instance, when there has been splitting of staff, the consultant is the go-between for comparing stories, identifying the splitting process, and reminding staff that brief, daily conferences are necessary to prevent it. When projective identification occurs, this is explained and reminders are given to set firm limits on the patient's rage. When a staff member becomes the "all bad" one, this can be identified for his education, guilt diminution, and support, with firm limits again suggested.

Work with countertransference hatred—Hatred toward the patient has two components [15], malice and aversion, both of which should be brought out into the open by the consultant's voicing openly what staff may be afraid to speak: "Yes, he makes everybody hate him *and* also he makes all of us want

to stay away from him," or "Yes he drives me away too, because I just *hate* him!"

The entitlement of the patient is particularly hard for the staff to bear. Their first impulse is to be generous toward the patient: after all, giving is a comfortable role. But after a while the demands become intolerable and cause hatred. This hatred may be denied until a breaking point is reached in which entitlement is confronted suddenly and devastatingly. In the consultation note, however, the consultant has called the patient's entitlement "repugnant" and has laid groundwork for bringing out the staff's anger. If staff recognizes it early and identifies feelings toward it, the consultant can speak early to the necessity for setting firm limits on it but not challenging the patient's "right" to feel deserving. That is, it is important to avoid a confrontation in which the patient is told that the care is not *deserved* but a gift, and an unwilling gift at that. Entitlement is the borderline patient's religion and must not be confronted blasphemously.

Supervising the staff in firm, non-punitive limit setting hinges upon the consultant's ability to help them work through countertransference hatred over the entitlement, to diminish guilt-inducing, unrealistically high expectations, and to promote an identification with the consultant-as-therapist. At first, the staff will say the task of setting limits is an impossible one. The consultant concedes that it is very difficult and goes on to ask the staff to share with him its malicious and aversive hatred about the patient's entitlement. Then, he points out 1) the impossibility of meeting the patient's demands, 2) the fact that it is not the staff's job to cure the patient of his psychiatric problems but only to see him through a medical hospitalization, and 3) the fact that the staff feels guilty about not being able to satisfy and cure the patient. Finally he goes with them to the patient, models for them a limit-setting interaction, and discusses it with them afterward.

The more the consultant is visible and working with the staff, and the more trust the staff has in him, the more—not less—the staff will give indications of dissatisfaction with him. They will say that the recommendations are not clear, not possible to follow, not applicable to the situation, and so on. And if they really trust the consultant, they may tell him that, besides, *they* have to do the work, not *he*. Rather than retorting that it is *their* job to take care of the patient, the consultant can acknowledge that his role *is* less important and demanding than theirs. Staff dissatisfaction with the consultant may surface in a remark that the patient is complaining of how little time the consultant has for him, or somebody else (family, other staff) is complaining of something else. This should alert him to look for staff anger toward himself, explain (but not justify) his actions, and be more supportive with staff.

Education of the staff—The process of taking care of the borderline patient is an education in itself, but the process can become more enjoyable for the staff if they feel they are learning something useful. After the alliance is secure,

after the staff understands the practicum, and after there has been some work with countertransference hatred, it may be appropriate for the consultant to assume a more didactic function, pointing out some of the theoretical reasons behind the practicum, some of the theory of the borderline's archaic defenses. (In doing so, the consultant should promote the idea that the staff's job is to observe, not cure, the dynamics of the borderline patient. He should be alert to the danger of creating a staff of amateur analysts who will go about accusing the patient—and each other—of malevolent unconscious motives.) Spotting the patient's "defense of the day" and other such games helps sublimate the anger of the staff, buttresses intellectual defenses against the despair of dealing with a hopeless patient, promotes therapist role-identity, reinforces cohesion among staff, and lays the foundation for the sense of humor required for effective dealings with such pathetic patients. In many ways humor is the mother of empathy.

Termination of hospitalization—Termination requires considerable preparation by the consultant. He should ensure a disposition adequate for the medical and psychologic needs of the patient. He should also warn the staff about termination. From such experiences as the distress of the patient on the day off of a favorite staff member or other evidence of the ambivalent love-hate the patient bears for his caretakers, the staff can infer that termination will be difficult. It is well, nonetheless, to warn the staff that not only will the patient intensify pathologic behavior, demands, and rage, but that he may try to extend his stay and simultaneously try to leave prematurely. For instance, he may secretly infect his dressings or intravenous lines with saliva or feces to run a temperature while at the same time trying to leave the hospital against medical advice. Firm limits and contingency plans for sabotage and premature leaving should be discussed. The staff should be more vigilant in observing the patient at this time and more visible and available.

Finally, after the patient has left, it is well for the consultant to return to the ward just once more. With a brief review of their successes and failures with the patient and by sharing with the staff some of his own feelings during their joint endeavor, the consultant not only terminates with the staff but prepares the way for further work if the patient should "bounce" back into the hospital or soon be followed by the arrival of another borderline patient.

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