Unconscious Repetition of a Patient's Dynamics on an Inpatient Unit: Treatment Challenges

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This article focuses on the unconscious repetition of a patient's dynamics among a multidisciplinary inpatient treatment team. The patient was diagnosed as having bipolar affective illness and borderline personality traits. The prominent borderline traits displayed by the patient during hypomanic episodes evoked a parallel process of the patient's internal conflicts, rendering the team temporarily divided regarding treatment plans. This divide was resolved by holding dedicated multidisciplinary team meetings in which the patient's projections onto the team were explained and understood. The article highlights some of the therapeutic complexities of and challenges in treating a patient with bipolar illness and borderline traits on an inpatient unit.

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This article presents a clinical case highlighting the unconscious repetition (parallel process) experienced by an inpatient team in treating a patient with bipolar illness and exaggerated borderline personality traits during hypomanic episodes. The focus of the article is on the strong countertransference issues the patient evoked among the multidisciplinary treatment team members while highlighting the dedicated measures taken to remedy these issues.

Both bipolar affective illness and borderline personality disorder are severe and chronic psychiatric disorders with overlapping symptom presentations, and they pose many treatment challenges (1, 2). Recent research in the literature has focused on whether bipolar affective illness is separate and distinct from borderline personality disorder (3–6), with some research positing that the two may be on the same spectrum given their symptom overlap (7, 8). Fiedorowicz and Black (9) noted that as many as 20% of patients with borderline personality disorder have comorbid bipolar disorder and 15% of patients with bipolar disorder have comorbid borderline personality disorder. Garno et al. (10) found that cluster B personality disorders make an independent contribution to lifetime suicide risk for individuals with bipolar disorder. These research findings suggest a trend toward exacerbated severity of and increased complication in treating bipolar affective illness when borderline traits are present.

A literature review, however, has not revealed discussion of how and in what way patients with bipolar disorder and borderline traits pose treatment challenges to the treating team. In particular, no research to date has specifically examined the effect of bipolar patients' heightened borderline traits during hypomanic states on the parallel processing phenomenon in an inpatient unit. *Parallel processing* refers to processes that are at work in the relationship between patient and therapist that may be reflected or enacted in other relationships (e.g., between therapist and supervisor; 11). Several authors have previously described this parallel process in detail as it developed in peer group supervision (12, 13) and in the individual supervisory setting (11, 14, 15). The issue of unconscious repetition by the treating team in managing the care of patients diagnosed as having borderline personality disorder alone has been discussed by Gabbard et al. (16) and Vaslamatzis et al. (17). Moreover, Sachs and Shapiro (18) and Sigman (19) reported on the unconscious repetition of the dynamics of patients with various diagnoses in the case conference setting. These authors noted that it is the shared experience and defensive needs of both patients and staff that contribute to the parallel process in both the case conference and the individual supervisory setting. No research to date has extended these findings by examining this unconscious repetition in a multidisciplinary inpatient treatment team.

The team in this case was multidisciplinary (psychiatrist, psychologist, students of both psychiatry and psychology, nurses, social workers, occupational therapist), met twice a week, and was chaired by a psychologist (MS). Elucidating the team's countertransference manifestations and increased insight, understanding, and empathy may result in better containment and care of patients with severe and chronic psychiatric disorders.

CASE PRESENTATION

Ms. F is a 36-year-old Caucasian woman born in Russia who immigrated to Montreal with her family when she was 6 years

old. Her immediate family includes her parents, who have been divorced for some time, and a sister who is 9 years older. Ms. F also has one daughter who attends college. Her daughter's biological father died prematurely. At the time of his death, Ms. F and he had already separated. Her daughter has mostly been raised by a relative because of Ms. F's frequent and recurrent mood episodes and hospitalizations due to her bipolar illness. On her recent admission, Ms. F was single and had been on welfare for the past 15 years. She had been living with her father or in her own apartment for the past several years. Both of these living situations destabilized her.

PSYCHIATRIC TREATMENT HISTORY

Ms. F met *DSM-IV* diagnostic criteria for bipolar affective disorder with concomitant borderline personality traits (axis II). To date, Ms. F has had eight ward admissions and 16 brief emergency room contacts. The reasons for her frequent emergency room contacts include being impulsive and acting out (i.e., running naked in public, going on spontaneous trips without plans, pulling fire alarms) while in a manic state, alcohol-induced disorganization, and noncompliance with medication (i.e., lithium) prescribed for her bipolar illness. Triggers for these visits were often unstable interpersonal relationships and fears of abandonment by her family.

Her seventh admission followed a suicide attempt with an overdose of acetaminophen that resulted in elevated liver enzymes due to acetaminophen intoxication. She was found in a hotel with a bill showing that she had purchased five bottles of acetaminophen. Ms. F said that all the "bad things" had led her to attempt suicide, including feeling rejected by her family. She had written a suicide letter to her daughter. Ms. F's father stated that she did call him before her suicide attempt but lied to him about her whereabouts, reflecting the seriousness of the attempt. Ms. F's most recent (eighth) hospitalization occurred two weeks after being discharged from her previous admission. She reported feeling depressed and again endorsed passive suicidal thoughts without any plans, saying she did not want to live anymore but was "too scared to do anything" to end her life at this time.

COURSE OF TREATMENT

A difference from Ms. F's previous admissions was that most oral medications, in particular lithium and other mood stabilizers, were discontinued because of her serious suicide attempt by overdose and her current passive suicidal ideations. These medications were replaced by an injectable antipsychotic (paliperidone) in conjunction with quetiapine to help manage her symptoms. In addition, to treat her resistant and recurrent episodes of major depression, she underwent a series of 10 electroconvulsive therapy (ECT) sessions.

DM, a psychology intern, had been assigned to provide psychotherapy to Ms. F. Throughout the course of Ms. F's hospitalization, DM worked closely with the psychiatrist, psychiatry resident, psychologist (MS), social worker, occupational therapist, and nurses to provide a multidisciplinary treatment approach to treatment.

DM's first impression was that Ms. F was extremely sad and hopeless, felt empty, and had very low self-esteem, which met the diagnostic criteria for a major depressive episode. She displayed extremely concrete and inflexible thinking patterns and was fixated on two particular stressors in her life, her future living arrangements after discharge and her wish for employment. DM's goal was to identify the triggers and maladaptive coping and thinking styles that exacerbated Ms. F's depression. Specifically, she tried to ease Ms. F out of her fixated, inflexible, and unrealistic expectations regarding her future. This was extremely challenging because Ms. F was so preoccupied with her own worries and anxieties that she refused to hear what she did not want to hear. When DM suggested that they make a plan together to take the steps needed to help her realize these goals, Ms. F would ignore the suggestion, often get irritable and angry, and repeatedly tell DM that her "life suck[ed] . . . but once I get an apartment, then a job, then I'll be depressed no more."

With the combination of ECT and medications, in addition to weekly therapy and several crisis management sessions, Ms. F's depression slowly lifted and her mood returned to a neutral state. With the improvement in her mood, DM decided to allow Ms. F a weekend pass out of the hospital before discharge so that she could stay with her mother and see how she functioned outside of the ward. This decision respected Ms. F's insistent wish at the time to live with her mother and was communicated to the patient's family during a team meeting. However, this decision was also the first instance of team splitting because Ms. F's social worker was opposed to this idea, whereas DM and other members of the team felt that it might be a feasible plan given that the patient's mood was stable and her mother had also agreed. This was an early example of the patient's ambivalence being unconsciously repeated by members of the treating team.

Despite the fact that Ms. F had insisted on staying with her mother, she came back to the ward a day later reporting that she "felt depressed and lonely." DM explored the feelings and thoughts Ms. F experienced while she was out on her pass. Ms. F displayed no insight and laid the blame on her mother for being too demanding and critical of her, making her feel as though she needed to submit to her mother's every wish. Subsequently, other housing options (i.e., group homes) were explored with Ms. F's social worker. Despite having categorically refused and sabotaged her previous placements, Ms. F agreed for the time being, telling DM that she could "always go back again to [her] mother's place if something goes wrong" despite her most recent negative experience of staying at her mother's. When confronted with the question of how she thought it would be different this time, Ms. F responded with an angry and hostile outburst and accused DM of being "just an intern, with your whole life in front of you, and too young to understand" and "not caring about [her] well-being at all."

At this point, Ms. F became very erratic in her daily behaviors on the ward. She was confused and frequently sought medication, requiring close observation in a high-care closed unit following the recommendation of the nursing staff. When told on one of these occasions that she could not have any more anxiolytics, Ms. F burst into a tearful fit, accusing the psychiatrist and nurses of withholding medication because they "hated" her and threatening that she was "going to die." DM worked with the psychiatry resident to educate Ms. F about the combination of medications that she had already been prescribed, but the patient was fixated on the need for more.

A rupture in the therapeutic relationship began soon after this. Ms. F accused DM of having placed her in the closed unit as punishment and kept asking DM what she had done wrong. Even after DM repeatedly explained to her that it was not a punishment but rather a precautionary measure recommended by her team to ensure her safety, Ms. F still believed that speaking with DM had caused her to be placed in a closed unit. At this point, Ms. F was hypomanic, extremely angry, and blamed the team, especially DM, for "overanalyzing" her and making her worse. She began to show prominent splitting behaviors, seeking out other members of the team while avoiding DM, choosing who she thought would most likely give in to her demands. At one point, Ms. F even consulted a psychiatrist on another team to clarify a question regarding her medication because she believed that her treating psychiatrist was ignoring her. Ms. F was successful in projecting different parts of herself and her wishes onto different members of the team. During team meetings, this was reflected by members of the team themselves becoming advocates for the patient's different desires and wishes, preventing a unified treatment plan.

Moreover, Ms. F became extremely changeable, impulsive, and impatient in terms of what she wanted. She changed to such an extent that her behaviors and wishes in the morning were drastically different, often in the opposite direction, by the afternoon. An important example of this was when, at a patients' meeting with staff on the ward, she reported her inability that morning to hand out résumés and recognized in a realistic manner that she was not ready to do so given her current condition. However, half an hour later, at the multidisciplinary team meeting, she seemed to have forgotten those previous thoughts. Instead, she resumed her insistence on her need to work and not stop her job search because she "needed to have hope and do something with [her] life." Similarly, Ms. F displayed impulsive and changeable behaviors regarding her living arrangements, agreeing to a group home one day and deciding to live on her own the next day. These changeable behaviors in turn influenced the changes in treatment plan by her psychiatrist, social worker, and DM. Ideas and plans were discussed but then traded in favor of another treatment plan. The members of the treatment team often felt pulled into numerous different directions in managing the patient, paralleling the patient's own indecisiveness. This parallel projective process onto the treating team was recognized and fully discussed at several of the team's biweekly meetings.

During this period, however, the process of projective counteridentification (20) was quite strong in DM with respect to Ms. F; specifically, DM felt alienated and ignored by Ms. F's psychiatric resident and social worker. She felt that she had done something wrong in her treatment of Ms. F. In fact, DM's feeling of having done something wrong was echoed by Ms. F in another patient's group meeting when Ms. F said, "Even though the team is helping me out so much, I feel that I'm not . . . that I'm disappointing them and can't do it." Moreover, DM also felt Ms. F's feelings of being ignored by her psychiatrist when DM felt as though the psychiatry resident was purposefully avoiding her on several occasions when she wanted to consult him on treatment matters concerning Ms. F. This projective counteridentification was so strong that for several days DM felt quite unsure of her therapeutic competence.

These issues were discussed in detail with MS, her supervisor, so that DM could understand clearly the parallel process that was unfolding. The importance of the team speaking as one voice was continuously reinforced at team meetings. With a united approach, the team was able to provide Ms. F with structure, which was crucial in helping to contain and anchor her. Weekly treatment plans were discussed and then implemented by all members of the team, supporting Ms. F by being her auxiliary ego to help model self-regulatory processes. Ms. F benefited well from this structured plan, which consisted of weekly tasks of attending activities on the ward and planned job explorations (i.e., preparing résumés and handing them out) to help her take realistic steps in terms of her future goals.

TREATMENT OUTCOME

Functioning within this structure, Ms. F's splitting behaviors decreased, and she became open again to meeting with DM. Ms. F became calmer, more level headed, and less impulsive and was able to distract herself from her anxiety and fixation on certain ideas. As she returned to a neutral mood, the borderline traits described earlier became less dominant. Approximately six months after this admission, Ms. F was discharged. Her depressed mood had improved, and her passive suicidal ideations were also reduced. Having refused a day hospital program after her discharge, Ms. F instead pursued independent housing and for a time attended weekly transition groups on the ward.

CONCLUSION

This article describes the treatment challenges faced by an inpatient interdisciplinary team in the management of a patient diagnosed as having bipolar illness with borderline personality traits. The team observed the fluctuations in mood of Ms. F's bipolar disorder and noted the exacerbation of her borderline traits during the hypomanic phases.

Concomitantly, the parallel process of unconscious projections onto the treating team members were experienced and subsequently explained and understood, which led to more coherent treatment of the patient. The case illustrates the need for team members to understand their own countertransference feelings emanating from both the patient's projections and their own dynamics so that a clear, unified treatment plan to manage a patient can be implemented.

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