

# Therapeutic Space and Containment in Children with Borderline Disorder (1996)

## Results of an Empirical Study and Implications for Psychoanalytic Treatment

### Characterization of children with borderline development disorder<sup>1</sup>

#### Abstract

Based on the research of the past 25 years<sup>2</sup>, I have carried out an empirical study of borderline disorder in children with a focus on the following questions: what characterizes children with borderline disorder, what did they experience in the first years of their lives, in what kind of family situation do they live, and what form should their treatment take? The data on 190 children were collected by means of a questionnaire survey in which 150 colleagues participated. The results of the study provides detailed knowledge of the social environment of the children, of the genesis, symptomatology and the psychodynamics of the children. (Diepold 1994, 1995) It is a picture constructed by eliciting a subjective evaluation from therapists. Such a subjective picture by therapists is derived from recognized fields of knowledge such as neuroses studies, psychopathology and systematic diagnostics, but also from accumulated therapeutic experience with other or similar patients, styles of therapeutic intervention, and from the therapist's ability to use his own "countertransference" - in the widest sense, that is, his or her own personal attributes in dealing with people.

## 1 Therapists' Description of Borderline Disorder

Parents and grandparents of children with borderline development disorder are usually seriously disturbed: half of the parents and grandparents in my study suffer from personality disorders and somatization, a quarter from addictive illness, 18% from emotional disorders, 14 % are asocial (antisocial), 12 % are psychotic and

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<sup>1</sup>Vortrag als deutsche Delegierte der EFPP (European Federation for Psychoanalytic Psychotherapy in the Public Sector) auf der "Third European Conference on Child and Adolescent Psychoanalytic Psychotherapy" im Oktober 1996 in Stockholm.

<sup>2</sup>Bemporad et al. 1981, Bemporad et al. 1983, Chethik / Fast 1970, Chethik 1979 and 1986, Gualtieri et al. 1987, Holder 1981, Kernberg (1993), Palombo 1983, Petti / Vela 1990, Pine 1974 and 1986

only 0.7 % of the families showed no abnormal symptoms. The children have suffered an appallingly large amount of traumatic experience in the first three years of life: almost 50 % of the children suffered from a severe or chronic illness, 20 % were handicapped, 80 % had traumatic experience in relationships (ill-treatment, death, separations, asocial environment, physical violence or sexual abuse). This diversity of damage through the psychosocial environment, as well as biological impairment, are risk variables for a healthy development. The children's symptoms cover a wide range and include destructive aggression and autoaggression, contact disorder, anxieties, problems in school, depression, micropsychoses and functional disorders. Their psychodynamics is marked by the following characteristics: They suffer from inconsistent development. They have self-esteem disorders. They display rage and destructive behavior. They suffer from fears of destruction and separation. They have limited contacts and connections.

It is significant in psychodynamic terms that the self- and object-representation of children with borderline disorder are split from within. Their overall discrepant development affects the ego with its different functions, the regulation of the libido, the relationship to objects, and the self. Coherent libidinal development is disturbed through destructive aggression. These findings are drawn from the entire group of children examined. Using a cluster analysis, this overall group can be divided into six subgroups. The first three groups, mainly boys, direct their fierce destructive and aggressive impulses towards the outside, but differ in the particular formation of their symptoms and genesis. The last three groups, which is considerably smaller than the first three, contain mostly girls. Their aggressive impulses are more often directed against themselves and they are depressive as well as anxiously clinging. Because impulsive and destructive behavior in schools and family attracts more attention and causes disciplinary problems, these depressive, clinging children are less noticeable in childhood. In adolescence, the need for therapy among the girls becomes more obvious, when problems in self-esteem, eating disorders or suicidal tendencies manifest themselves as symptoms. The therapeutic objective lies in working through the disturbed development to the point where the children can continue to develop at a level commensurate with their age. For this, a change must take place in their deficient ego functions, the special way they relate to objects and their weak sense of identity. Having made these preliminary remarks, I would like to pose the question of how one goes about creating a therapeutic space for children with borderline disorders and how the therapist can serve them as a container for the things they are unable to feel or experience. I will illustrate my ideas with the aid of a case sketch from the treatment of a boy who was 5 years old at the beginning of treatment and who suffered from asthma and endogenous eczema.

## **2 Countertransference**

Often at the beginning of treatment, you are confronted with an unclear relationship situation and are put under immediate pressure - the school demands fast therapeutic results, otherwise the child will have to leave school, parents living separately or at constant variance present you with their own, opposing views of the problem and slander one another. Sometimes they idealize you: "You were recommended to us!" I hear about previous, failed treatments, let myself become alarmed by the violence and number of the symptoms, and vacillate between alter-

native extremes. On the one hand, I do not want to accept the case because the illness appears to be too severe and I am afraid of becoming too involved. However, on the other hand, I tend to want to begin treatment immediately, because visions of grandeur awaken in me that I am the right therapist for this child and can do better than the parents, teacher and previous therapists. You may be surprised that before I have said anything at all about the treatment, I am already talking about the problems of countertransference. But whoever has treated borderline patients will not wonder at this. One's own emotions and impulses very quickly take on a violence and intensity that is quite difficult to overcome, something that I have not only experienced myself, but know from supervision and discussions with colleagues. The projective processes and externalizations of the children result in emotions which increase in intensity to the point where they can hardly be controlled. The intensity of countertransference seems to be an indication of the severity of the illness. In any case, a mild, unpronounced, positive transference, regarded by Freud as favorable at the beginning of a psychoanalytical cure, is not to be expected with these children. (S. Freud 1914, p. 131) Sometimes we therapists are asked to do the seemingly impossible - on the one hand to give the child the stability and limits that he does not have himself, and on the other, to follow him into his chaotic and dangerous inner world and to accept its psychic reality. This produces fear and confusion. Because children with borderline development disorder can sense the emotional state of the person with whom they are dealing, they are quick to detect these uncertainties and confusions, which can result in difficult transference-countertransference developments. I would be unable to endure these extreme emotional situations without long experience of myself in analysis and self-encounter groups, a space of stable and reliable relationships where I can recognize and work through my own sadistic and masochistic impulses, depressiveness, delusions of grandeur and fears. Moreover, despite years of professional experience, I need supervision - especially with borderline patients - in order to discover my own entanglements and to achieve some emotional distance. I consider this an important act of self-preservation (Sachsse S. 54).

### 3 Beginning Treatment

The initial phase of treatment for the child is characterized by fears, hectic behavior or chaos, depending on the manifestation of the illness.

The treatment of 6-year-old Peter, who suffered from asthma and endogenous eczema, began chaotically. Peter's father came to the first therapy appointment, instead of Peter, in order to tell me that the therapy could not take place because his wife, together with Peter, had left him. At the health resort to which they had gone for the summer holidays, because of Peter's severe eczema and asthma, she had met and fallen in love with another man and had decided to stay with him. I bore the father's desperation with him and offered to speak with him again about it the following week. My bewilderment was great when Peter was brought to this session without any explanation to me as to what had happened in the week since our last appointment. Only much later did I learn that the father had brought his wife and Peter

home by physical force, and then cut the telephone wires so that his wife could not telephone her lover.

Here, at the very beginning of treatment, I was presented with a desolate marital situation. The family was split in the truest sense of the word. Peter entered therapy severely ill physically and suffering. He had white bandages on his arms and legs, so that only his face, with large, sad eyes, and his hands, could be seen. He spoke in gasps about his fears. "I was in the sanitarium and then my Papa came. My Granny is sick and there is a lot of blood. There are so many Poles where we live, and there was a flood. And I am always so afraid, I always have to watch out all night, otherwise burglars will break in." His fear apparently increased after the beginning of therapy. Then in the third session he said, "I have to talk to you about something - we want to arrange that I don't have to come to you anymore - and that is namely because I'm so afraid. I don't like to be in my bedroom anymore, there could be ghosts under the bed. And I can't sleep all night, because I have to make sure no burglars get in." Because I felt that the treatment structure agreed upon was in danger, (Kernberg 1993, p. 29 onwards) I answered, "That must be terrible for you, that you are so terribly afraid. But that is why you're here. Together we want to make your fear smaller, and we do that by understanding them better. That's why it's important that you keep coming here." He continued to come, and this was a period of turbulent, violent acting out. He would be unexpectedly furious with me, for example, when I could not repair a car fast enough. He said, "Then I'll come and kill you, but with my ax." His impulsiveness threatened the framework, in that sand flew out of the sandbox, a building block would hit me or the room was an indescribable mess by the end of the hour.

Three essential characteristics of children with borderline development disorders are displayed in this initial therapy situation and which can therefore be considered general: fears that apparently become panic in certain situations, rage and destruction, and an inconsistent development. In Peter's case the latter is characterized by the fact that he has developed to the level of a six-year-old, but that he regresses to the level of a toddler at the slightest hurt or frustration. From this the following requirements are necessary for the introduction of treatment of children with borderline development disorder, for the physical space of the treatment, as well as for the pact:

1. *The physical space:* The therapy session should always take place at the same time whenever possible. A frequency of two hours per week has proved effective. More frequent sessions are more likely to trigger a tendency to regression, and sessions of only once a week make it difficult to develop a viable relationship. Greater frequency is advantageous with highly deprived children, in order to build up any viable relationship at all. The regularity of sessions should be interrupted as seldom as possible, as this puts a strain on the child by producing emotions he is unable to work through.

Children with borderline development disorder need a sparsely furnished therapy room, in which specially designed materials stimulate him to act out inner fan-

tasies, not a Disneyland that increases his inner hectic confusion. There should be no dangerous objects in the room because of impulsive outbursts.

2. *The pact*: A clear agreement with the parents and child are necessary in order to limit acting out. This means explaining to the child in language commensurate with his level of development, when the session begins and ends, that it lasts 50 minutes, no more and no less, that toys are not to be destroyed on purpose, that we are not going to hurt each other, and that the playroom is to be tidied up at the end of the session. If a desk is in the therapy room, it should be clearly indicated as an off-limits zone. The therapist's obligation regarding confidential communications must be explained. In this connection, the child should be told that here he can speak about anything. I find it difficult with each new therapy to make clear to the child the purpose of the therapy, especially if he himself does not suffer from his behavior, but rather others who must endure his destructiveness and impulsiveness. Formulating an objective for the therapy together with the child has proved useful because it is good to be able to go back to this objective later. The history of a therapy, which can be reviewed together, has elements that promote development.

I make a point of keeping exactly to the agreed pact. For example, I never exceed the time of the session, even when the child urgently desires to do so and I understand this desire. I make sure the room is returned to order and do not accept any compromises. The child need not absolutely help to clean up the room, but if I must do it myself and there is not enough time left in the session, I tell him I will have to end the next session earlier in order to leave time to clean up before the session is over. I keep to the agreed framework with therapeutic authority, thereby offering the child a highly structured and reliable environment in which his impulsive, inappropriate and destructive behavior has a place with limits and that affords him what Winnicott calls a "holding environment". It is vitally important to avoid interpretation as this will be received by the child as an invitation for further acting out and strengthens regression. For example, I say to Peter with regard to the building block that he has thrown at me, "Peter, we promised each other at the beginning that we would not hurt each other. I don't want you to throw blocks at me." Under no circumstances should one attempt to interpret his anger as a reaction to the fact that he does not wish the session to end yet. The abilities of the child's ideal self and its regulative functions grow through fostering the internalization of limit-setting and directive functions.

The first phase of treatment therefore concentrates on reducing the child's fear, on creating a therapeutic bond with the child, the parents or caretakers, and perhaps even with the school - a bond appropriate to the given level of functioning, and which works against the intensive regressive needs (Chethic / Fast). The function of therapy is to set boundaries and to give support.

#### **4 Working Through**

What happens when in the course of the therapy, a child stages his main relationship conflicts in transference? This again can best be illustrated by a scene from the beginning phase of Peter's treatment:

Over many sessions I had to pretend to be a horse in a make-believe game. As a horse I would be shut in a stable, received nothing to eat

and had to sit in the dark. During one session he cut off my legs and hands and watched how the blood flowed. I did not get a bandage. Instead, he said, "That's supposed to bleed. It should bleed until all the blood has run out." In another session I had to pretend that I was hungry. He fed me and then continued to stuff oats into me long after I was full. My stomach was swollen so big that it filled the whole room, then it stuck out into the corridor, then it reached to Kassel, Switzerland, then France, America, Africa and Russia. And he continued, "I am God, who knows everything and does everything and I live forever, but you are already long dead." As God he let his power have free range, and I was the plaything of his power. He sent me, for example, into the clouds and then suddenly let me fall down to earth, where I hit so hard that I broke my back. My body had to bleed from many wounds, and he watched my pain, how I suffered, slowly bled to death and died. A short while later he brought me back to life. This game sequence was gone through repeatedly and for me bordered on the limits of endurance - I caught myself sometimes looking at my watch to see if the session was nearly over.

In defining himself as God and me as nothing, Peter had externalized a non-integrated part of his self. In transferring this to me, he used me as an external substitute for his inner condition. In me he could look at this unbearable aspect of himself, live it through and combat it. Only much later, when it had become acceptable, could he integrate this part into his self. Peter would go to some effort during these exciting fantasy games to keep his therapeutic split ego. He would say, for example, "I'm going to shoot you dead!...but not really." But sometimes he would lose this ability, so that I worried that he would be unable to find his way back to reality. I would then say, for example, "The session is over soon and then our game is finished. Then you are Peter again and I am Mrs. Diepold". I find it difficult in phases of such regressive make-believe games, to identify casually with the self aspects of the child and then to swing around to an observant distance, because the regression level to which one must follow is deep. My dialogue with Peter in the beginning was influenced by the nearness to the primary process of his inner objects. Hence the relationship between us sometimes took place in outer space, a typical meeting place for children with borderline disorders. Later we played against one another as two different football teams; he was always the winner and I was always the loser. In this way he kept enough distance between us, as otherwise the danger of merging would have been too great.

If it becomes a decisive therapeutic objective to understand the child and to follow him into his regressive fantasies, then this can be done only if the therapist's own inner strength is sufficient to be able to accept, endure and limit this acting out and destructiveness. Over the years, it has become important to me to carefully observe my own inner situation and to ask myself whether I am strong enough. In doubtful situations I would rather end the session early than run the risk of becoming inadvertently entangled in a transference-countertransference situation that could ultimately lead to a transference psychosis. I indicate clearly that I am

leaving the fantasy level and announce this decision without arousing feelings of guilt in the child. I say, "Our game was dangerous and exciting and has tired me out so much that I cannot go on, so we'll end the session now, even though we would still have had 10 more minutes."

The first structural changes are often apparent in dealing with separations.

During the last session before the Easter holiday, Peter was excited and said, "What I'd like to do most right now is kill you." This aggression differed from many aggressive fantasy games in which he had committed murder, because this time his murder fantasy is not acted out, but expressed as a wish. "What I'd like to do most..." He meant me directly as a recognized object divided from himself, and he experienced his anger aimed directly at me. I suggested, "Can it be that your anger has something to do with the Easter holiday that is starting soon, because we won't see each other for three weeks?" He replied, "Yes, that's right, because I'm not finished being angry about the last holiday, at Christmas ."

After about a year of therapy, this kind of interpretive intervention was possible with Peter - one that identified his affects and classified his actual failures in our relationship. After another two years the therapy came to an end after structural changes had occurred. He was able to use the therapeutic relationship to make up deficiencies in his development. This was due first of all to the fact that, if you were to judge the severity of the disorder, it would fall in the "upper border" area; second, to the fact that he was able to come to terms with parts of his archaic, primary-process inner world - which sometimes bore psychotic qualities - by means of the interaction with me, and that finally, he was able to use my supportive and mirroring function for development.

## **5 Therapeutic Work in the social environment of the child**

As a rule, the psychodynamics of the parents are similar to that of the child. This also proved to be the case with Peter. As a therapist working with parents, one is the object of both their idealization and belittlement, and one runs some danger of reacting with a latent, accusatory attitude towards them as the perpetrators of their child's illness. If this happens, the chance of therapeutic work with the parents is lost. Here too, the aim is to put a check on acting out and aggression, but also to give empathetic understanding to their situation as parents of a severely ill child. The work can take a positive turn if the parents re-experience their own situation as children, and in this way, enter more into their child's feelings. In addition, it helps if they identify with the empathetic interest of the therapist.

Children with borderline disorders generally have problems at school. Cooperation with the teacher presents us with the difficult problem of confidentiality with regard to the patient. On the other hand such a cooperation affords a chance to influence a social area very important to the child, and to solicit understanding for the child's often bizarre behavior. The destructive, non-conforming and un-concentrated borderline patient stimulates just as violent emotional reactions in

the teachers as in ourselves as we know from therapy. For this reason they need emotional reassurance, because their aggressive or excluding feelings are often intolerable to their pedagogic superego and they suffer from guilt. I relieve them of their guilt, inform them of the psychodynamics of the disorder and reinforce their teaching function.

In a number of classic studies on borderline disorders in children, but especially in the most recent American literature, authors describe the need for medication in the treatment of borderline spectrum children located at the "lower border". (Petti, 1983) We, as psychoanalysts, usually regard pharmacotherapy with reservations. This may have something to do with our having too little technical knowledge in this regard. In the case of severe, neurocognitive and motor disorders combined with psychic regression, I regard cooperation with a child or adolescent psychiatrist, who sees the cooperation as an informal support for psychodynamic therapy, to be indispensable. Finally, we must consider when the child's acting out becomes so forceful that it endangers the child himself or others, and the parents are unable to give him sufficient support and structure. Nevertheless, the regressive atmosphere in a clinic can result in still intact ego functions being relinquished. The pros and cons of such a measure should therefore be weighed very carefully.

## 6 Conclusion

Borderline patients entangle their therapist in an intensive relationship web. When they behave in an angry, destructive or hyperactive manner, they are externalizing their traumatic experiences. This releases powerful countertransference feelings and makes therapeutic treatment difficult. The majority of traumatized children attempt, through violent acting out, to overstep the boundaries of the therapy pact and of the therapist. Especially in the initial phase of the treatment, the therapeutic space is threatened by the uncontrolled movement and hectic behavior of the child. The primary task in this case is to ensure the integrity of the space. An unequivocal and definite stop must be put to anything that runs counter to the agreement. This requires clarity and resolution. Granting concessions or compromising in this regard only serves to relieve our own fears, but deprives the child of the firm guidelines that he urgently needs. It encourages acting out, thereby allowing fears to take hold. This limit-setting function lays down rules and is more "fatherly". The ultimate objective, however, is to follow the child into his threatening and symbiotically colored fantasies, to take on empathetically the destruction and dangers found there, and so to offer the child a motherly support and mirrored relationship. It seems to me that the limit-setting, fatherly function and the supportive motherly function are equally important in different situations.

At the beginning of the analysis, the traumatic identity is presented via transference. Violence becomes real and is expressed through a lack of relationships, through destructive aggression and mental rigidity. The actual traumatic content is not symbolized and is not accessible to feeling. As an analyst, one is overwhelmed with primary process material. One usually lacks experience for this and the ability to empathize is overstrained. For a relationship in this context, Bion uses the metaphor of a container that gets filled up with the patient's experiences and affects which cannot find anywhere else to go at present. A container can hold ev-

everything, it lets itself be used, and nothing deposited there for "safe-keeping" - to "keep one safe" - gets lost.

Difficulties can however arise if this deposit does not rest quietly in the analyst, but develops repercussions. Analysts are not simply lifeless, like a container, but feeling people who become moved by the suffering of a traumatized child. Things that the child cannot yet feel develop their affective impact in the analyst. The prerequisite answer to this is, of course, not to succumb to the danger of rigidity or overexcitement induced by the patient. Overexcitement, in particular, carries the danger of countertransference. But this is just what makes this work so strenuous. Analysts, though able to conceive through their own feelings what suffering a child is enduring, must still not be seduced into trying to make amends for his pain. Clearly this is impossible and an attempt to do so would precipitate a spiral of needs and a regressive escalation in the child.

This is all very difficult to endure, because there is a limit to how much an analyst can fall back on his or her professionalism. The cure lies in one's own humane feelings. However, in the analysis of children there is a decisive power that reinforces this work, and that is the creativity of children. For their particular conflict situation, they find exactly the right game to help them, in interacting with the analyst, to speed up the analysis of their trauma. The task of the psychoanalyst is to be alert and sensitive to this aid, to try to understand what the child is showing them in symbolic play, and to follow the back-and-forth performance of roles (Herzog 1994). The objective is not accurate interpretations, but to make therapeutic use of the "stage" on which the child is the director, and progress is determined by his inner development. In this way, the therapy room can become a "room for imagination" between trauma and reality.

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