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The Diagnosis and Treatment of Borderline Syndromes of Childhood

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Jules R. Bemporad, Graeme Hanson, and Henry E Smith

Introduction

The possibility of borderline conditions occurring before adolescence is a relatively recent concept in child psychiatry. No such official diagnosis exists for the pediatric population; yet there is a growing body of evidence that a pathological process that is midway between neurosis and psychosis is indeed manifested by child patients. Clinical descriptions of such children have appeared in the literature with growing frequency during the past three to four decades, although, in the older publications, various other diagnostic labels such as “benign psychosis,” “severe neurosis,” or “atypical child” were used. Perhaps the growing interest in borderline conditions in adults has prompted clinicians to search out similar disorders in children and also to view these seriously disturbed children in new ways. Finally, the extensive work on the borderline syndrome in adults may have given authority to the consideration of an analogous syndrome in younger patients.

In this chapter, the authors will attempt to review the literature on borderline children, present criteria for diagnosis (which due to developmentally different levels of maturity, are different from those of

borderline adults), and discuss specific guidelines for treatment. Finally, this chapter should be seen as a preliminary step in a longer and ongoing exploration of this fascinating syndrome of childhood psychopathology.

Review of the Literature

History of the Borderline Concept in Adults

The concept of a disorder that lies diagnostically between the psychoses and the neuroses or, more precisely, of one in which superficially appropriate functioning masks underlying psychosis, can be traced at least as far back as Bleuler's use of the term "latent schizophrenia." Equally as venerable is the debate over the existence of such disorders. Glover attacked the concept in 1932 and his critique may be the first actual appearance of the term "borderline" in the literature. Glover wrote: "I find the terms 'borderline' or 'pre-psychotic,' as generally used, unsatisfactory. If a psychotic mechanism is present at all, it should be given a definite label."

Actually, the term "borderline state" was given status in 1953 by Robert Knight in his description of certain adult patients for whom accurate diagnosis was difficult, although he too argued against its use as a diagnostic label. Borrowing the familiar metaphor of the retreating army, he wrote: "The superficial clinical picture—hysteria, phobia, obsessions, compulsive rituals—

may represent a holding operation in a forward position, while the major portion of the ego has regressed far behind this in varying degrees of disorder."

Knight referred to those authors who had suggested alternative terms, such as the "as if personality" of Helene Deutsch and Hoch and Polatin's "pseudoneurotic schizophrenia." Frosch later described the "psychotic character," and significant contributions and refinements of the borderline concept were presented by Schmideberg, Modell, Zetzel, Grinker, Masterson, and others. In recent years, Kernberg- and Kohut, although differing, have added to the metapsychological understanding and to the treatment of such patients.

In 1975, Gunderson and Singer reviewed the clinical descriptions of adult borderline patients in the literature and suggested six features on which to base the diagnosis: (1) the presence of intense affect; (2) a history of impulsive behavior; (3) superficially appropriate social adaptiveness; (4) brief psychotic episodes; (5) specific patterns on psychological testing; and (6) disturbed interpersonal relationships.

Introduction to the Borderline Concept in Children

When one attempts to apply this concept to children, one faces further complications. Because the organism is in its most rapid period of change and

development, diagnostic criteria are more difficult to establish with children than with adults. There is considerably more controversy even over the use of such terms as “psychosis” and “schizophrenia” as they apply to children. The history of the description of borderline children, nevertheless, roughly parallels that of borderline adults, with similar concepts discussed but with remarkably little dialogue between the two fields. Gradually there has been an attempt to separate out a group of children with disorders distinct from psychosis or neurosis; to define them descriptively, developmentally, and metapsychologically; to characterize their psychological testing and treatment; and to bring some order to the concept of borderline syndrome in childhood.

Early Descriptions

As early as 1942, Bender- proposed criteria for the diagnosis of schizophrenia in children. She felt that it was a form of encephalopathy with behavioral pathology in every area of functioning of the central nervous system: vegetative, motor, perceptual, intellectual, emotional, and social. Shortly afterward, Geleerd published a description of a somewhat different type of child. Not always considered psychotic, “they behave overtly as if they may be suffering from a milder behavior disorder.” Geleerd did consider the disorder to be a psychotic one, “most likely a forerunner of schizophrenia,” but, presented in the mid-forties and early fifties, hers was among the first of

several detailed clinical descriptions of these puzzling children.

The children Geleerd described demonstrated low frustration tolerance and poor impulse control. Pleasant and intelligent when alone with an adult, they became uncontrollably aggressive or withdrawn in a group. They reacted to frustration with an extremely severe form of temper tantrum. Firm handling of their tantrums, which would be the treatment of choice for neurotic children, led these children into paranoia, panic, and loss of contact. Only a loving, soothing attitude of a familiar, affectionate adult could resolve the tantrum. These children were interested in inanimate objects and animals (although they could be cruel to them) more than in humans. By history, they were deviant in all stages of development, and they presented with a variety of "neurotic" symptoms, such as phobias, nightmares, compulsions, tics, and eating, sleeping, and toileting disturbances.

In this and in a later paper, Geleerd related the psychodynamics of the disorder to the infant-mother relationship and felt the child demonstrated interpersonal skills appropriate to a much earlier period in development, namely extreme dependency, difficulty sharing the love object, fantasies of omnipotence, and loss of contact and withdrawal into fantasy when left alone. She stressed the importance of the mother-child relationship as follows:

> In the case of psychotic and borderline children the feeling of loss of the mother is experienced whenever she absents herself for a brief moment or when the child perceives her as not all-loving.

> . . . [p. 285] To the borderline child, losing the mother or being absent from her means being attacked and spells annihilation, [p. 287]

Additionally, during a temper tantrum, the love object became the attacker and the child increasingly lost contact, left alone with his terrifying fantasies. Regarding the tantrum, Geleerd wrote, "The child was overpowered by his fantasies—by his id—and the ego was completely defenseless. The child can only be described as being in a panic. I believe that this helplessness of the ego is pathognomonic for borderline cases." Only by maintaining a fantasy of omnipotence and control over the love object, Geleerd believed, could the child ward off the threat of attack and abandonment in order to function adequately. Geleerd concluded that borderline psychotic children could be distinguished from neurotic children on the basis of an early disturbance in ego development and an inability to function adequately in the absence of the mother or mother-substitute. Much of her discussion anticipates later theories regarding the disturbances of ego and object relations in the etiology of borderline conditions.

Mahler, in an attempt, in 1948, to separate different categories of psychotic children according to the severity of symptoms, age of onset, and period of developmental arrest, described a "more benign" case of childhood psychosis with "neurosis-like defense mechanisms." However, it was not until 1953 that there again appeared in the literature detailed clinical descriptions of children that seem much like those described by Geleerd. In that year,

Annemarie Weil- devoted two separate papers to a discussion of borderline children and, for the first time, compared them to the adult "borderline states" (as described by Greenacre), as well as to adults diagnosed as having early, subclinical, or latent schizophrenia.

A prime feature of the children described by Weil was that they "do not acquire latency characteristics in time." She wrote: "The ego has not reached the consolidation which usually gives the characteristic imprint of reasonableness, attempt at control and integration to children of that age." While not as sick as those commonly called schizophrenic, they differed from neurotic children in their degree of ego disturbance, character pathology, fears, obsessions, and free anxiety, and in their capacity to alternate symptoms within weeks.

The histories of these children revealed disturbances in eating, sleeping, motility, and language, and multiple "neurotic" symptoms. Their play was unproductive. Under- or over-impulsive, they might have become addicted to pretend play or remained listless, concrete, and unimaginative, apparent slaves to reality. There was a general lack of playfulness and a lack of nuance and proportion. Weil wrote: "These children hardly ever hit the middle line. They do react in extremes." Thus they can be oversensitive to others or completely tactless, lacking empathy and discrimination. They may lie excessively or be scrupulously honest. Weil added that in their

communications there was only a thin veiling of symbolic material in contrast to neurotic children who do not so readily reveal conflictual material.

Weil described three general presenting complaints:

1. Problems in social-emotional adaptation are common. Borderline children demonstrate extreme ambivalence and may be very aloof or extremely clinging with family members. She coined the phrase "clinging antagonism" to describe the ambivalent attachment and wrote, "unmitigated outbursts of love and hate in a child well in latency age are characteristic, especially when in close alternation." With nonfamily members, they may be either extremely shy or indiscriminately friendly.

2. Problems of management often occur, with severe temper tantrums.

3. "Neurotic" manifestations, such as fears, obsessions, phobias, or fetishes are found.

In another paper in 1953, Weil defined these children's deficits in ego development in terms that anticipate later descriptions of the adult borderline:

> "Their faulty ego development . . . consists in a marked deficiency in the development of object relationship with all its consequences (giving up of omnipotence, of magical thinking, acceptance of the reality principle), in reality testing, in the development of the synthetic function, and in the proper use of age-adequate defenses. Moreover, in many of the children

> this picture is accompanied by an abundance of diffuse or bound anxiety. [p. 272]

She further described their object relations in both papers as imitative and need satisfying. In terms of prognosis, Weil indicated that some proceed to frank psychosis, as Geleerd also found, while others have a better outcome if their symptoms diminish by puberty. Those with a relatively good course may show a rigid obsessional organization and superficial socialization. Weil suspected, as do other writers, that there is a hereditary factor in the etiology of this syndrome.

In 1956, Anna Freud presented a paper on "The Assessment of Borderline Cases," but it was not until 1969 that it was published as part of her collected works. In this paper, she emphasized the necessity of making qualitative, not merely quantitative, distinctions between borderline and neurotic children, focusing on the following differences.

1. Borderline children manifest deeper levels of regression and more massive developmental arrests.

2. They tend to withdraw libido from the object world and attach it to the body of the self. For example, instead of fighting for the right to stay up at night as most children do, they choose to withdraw into bed and sleep, preferring their own company to that of their families.

3. They show an inability to receive comfort from others.

4. They demonstrate a number of ego defects, consisting of (1) unstable ego boundaries and confusions between themselves and others; (2) relative defects in reality testing with difficulty distinguishing fantasy from reality; (3) inadequate synthetic functions; (4) inadequate development of defenses beyond the use of denial, projection, and introjection and little use of repression, reaction formation, and sublimation; (5) primary process thinking; and (6) concretization of thought processes.

Fluctuations in Ego State

Whereas Weil was the first to compare these children to adult borderlines, Ekstein and Wallerstein, in 1954, were the first to call them "borderline children." In "Observations on the Psychology of Borderline and Psychotic Children," they focused on one particular feature, reminiscent of encounters with adult borderline patients, namely, "marked and frequent fluctuation in ego states, visible in the treatment process," which lends a characteristic unpredictability to their behavior. They dramatically described this feature as follows:

> Time and again the child will begin the therapy hour with conversation or play wholly suited to his chronological age, so that the clinical observer may reasonably be led to conjecture the presence of a relatively intact ego, well able to use and to sustain the demands and vicissitudes of classical child therapy and analysis. Yet suddenly and without clearly perceptible stimulus, a dramatic shift may occur: the neurotic defenses crumble precipitously; and the archaic mechanisms of the primary process and the psychotic defenses erupt into view. Then they recede just as rapidly, and

> the neurotic defenses or perhaps more accurately, the pseudoneurotic defenses, reappear, [p. 345]

Ekstein and Wallerstein distinguished the ego of the borderline from that of the neurotic child by its particular vulnerability to regression and compared the ego of the borderline child to "a delicate permeable membrane through which the primary process penetrates with relative ease from within and which external forces puncture easily from without."

They hypothesized three precipitants for such regression: (1) changes in the therapeutic transference; (2) autistically derived changes within the child; and (3) feelings within the child related to "changing introjects." In ways suggestive of the later adult literature on problems in the countertransference and on the difficulty maintaining empathic contact with adult borderline and narcissistic patients, they wrote:

> In reviewing our clinical material we repeatedly found that the ego regression was directly preceded by an inadvertent rebuke or lack of comprehension by the therapist of the child's message, and the return into the secondary process followed directly upon the therapist's retrieving of his error and demonstrating his sympathy and understanding." [p. 350]

Regressions and regressive fantasy occurred in response to some affective threat within the transference and served simultaneously to withdraw from and yet maintain contact with the therapist. They suggested that "every fantasy production carries this double message. It reveals both an

attempt to master conflict and a confession of current inability to do so." The most regressive fantasies were described by the authors as oral in character with the specific themes of separation, abandonment, bodily distortion and disintegration, and cannibalism.

Along with the fluctuation in ego state, each child demonstrated considerable fluctuation in the level of interpersonal relatedness. Thus, the relationship with the therapist at times seemed clearly autistic or symbiotic, at other times more characteristically neurotic. Finally, Ekstein and Wallerstein placed borderline children on a continuum between neurotic and schizophrenic children with respect to the degree of conscious control they could exercise over these fluctuations in ego function. Similar characteristics were observed on psychological testing of borderline children. (See "Performance on Psychological Testing.")

Problems in Psychotherapy

In 1956, Ekstein and Wallerstein continued their discussion of these children with a paper on the psychotherapy of the borderline child. In contrast to the psychotherapy of the neurotic child, in which the therapist can address interpretations to the most advanced level of ego organization, such interpretation precipitates panic, withdrawal, regression, or superficial conformity by the borderline child. Furthermore, unlike the neurotic child, the

borderline child frequently cannot make use of displacement as a defense against hostile and sexual impulses, which then threaten the relationship with the therapist. Thus, with the borderline children, the ability to displace is often a sign of therapeutic progress. Regarding interpretation, therefore, Ekstein and Wallerstein recommended that the therapist *not undo* whatever displacements the child can manage. Rather, he should frame his interventions within the child's own language, primary process fantasy, and level of communication at any given time. They called this "interpretation within the regression" or "within the metaphor." Thereby, in joining the child at his own stage of ego development, the therapist attempts to maintain the relationship while laying the foundation for more mature development through identification.

In "An Attempt to Formulate the Meaning of the Concept Borderline," Rosenfeld and Sprince reviewed the psychoanalytic literature, including Weil, Geleerd, Ekstein, and others, and reported on their own clinical observations. They emphasized that the appreciation of ego deviation alone is insufficient for making the diagnosis and recommended an overall metapsychological assessment, pointing out, among other features, the lack of libidinal phase dominance in both latency and adolescent borderline children and the relative preservation of reality testing as compared to psychotic children.

Rosenfeld and Sprince touched briefly on the problem of interpretation

in the therapy of these children. Whereas interpretation can decrease the acting out and fantasy production of neurotic children, with borderline children, it appears to increase both and to undermine defensive structure. The authors recommended that the therapist begin by facilitating defensive development and avoid content interpretation until later in therapy.

In "Some Thoughts on the Technical Handling of Borderline Children," Rosenfeld and Sprince expanded on these recommendations, emphasizing the danger of mistimed interpretation, which tends to increase anxiety and aggressive behavior. They recommended that in the beginning of treatment the therapist adopt ego-supportive techniques to facilitate displacement and to "arouse in the child the ambition of giving up primitive gratification or direct discharge."

Rosenfeld and Sprince warned of the particular stress these children impose on the therapist, who must for brief periods allow himself to "meet the child's needs for symbiosis." (p.513) Difficult too is the task of finding the balance between the child's need for physical contact and distance. There is also narcissistic hurt in store for the therapist during the periods when he is "unheard," ignored, or "treated as insane." (p. 514) These are dilemmas reminiscent of the therapy of adult borderline patients.

Later Refinements of the Concept

Based on these fundamental contributions, recent authors have elaborated on specific details of the syndrome. In “Borderline States in Children,” Frijling-Schreuder’s major emphases were on the development of language by these children and the quality of their anxiety. The author pointed out that the use of language or of “inner speech,” which she called “thinking in words,” helps the child to convey secondary process, to master impulses, and to tolerate anxiety, especially the anxiety related to the threat of engulfment. The child’s use of language, then, is a major prognostic sign and a feature differentiating borderline from psychotic children.

Whereas Geleerd found these children lacking in signal anxiety and Rosenfeld and Sprince believed they experience signal anxiety itself as a threat leading to fears of destruction and annihilation, Frijling-Schreuder found that their anxiety relates to the fear of becoming someone else and made the useful observation that, in contrast to psychotic children, their anxiety is in fact a measure of relatively advanced ego function, for only the more structured ego can be aware of the threat to its own integrity. This awareness, then, gives rise to their anxiety.

Frijling-Schreuder further pointed out that these children have a tendency to regress into “micro-psychotic” states when stressed. The author warned the therapist, for example, not to push the adolescent into dating, which can be highly threatening. Left to their own devices these children may

in time find mutually dependent partners. The author commented in passing on the perverse traits of these children and emphasized most poignantly their extreme loneliness and isolation. “They feel like toddlers whose mothers are permanently out of the room.” It is this loneliness that, the author believed, leads to their intense need for conformity. In contrast to the patient with childhood psychosis, Frijling-Schreuder found that the borderline child’s improvement may be rapid if he feels understood or, in the case of the young child, if the mother’s handling of him improves.

Chethik and Fast focused on those features of ego development and object relations that indicate what they called the child’s “transition out of narcissism.” They placed borderline children between neurotic and psychotic children in terms of the degree of commitment to the “independent reality of the external world” at one extreme and the “narcissistic world of the pleasure ego” at the other.

To Chethik and Fast, narcissistic fantasy serves several purposes for borderline children. First, it is a source of present gratification that wards off pain. Second, it provides a base from which the child can begin to test the external world as a source of pleasure. Third, in therapy it offers a means of expressing fears associated with the child’s further investment in the external world. Therefore, they recommend that the therapist actively participate in and encourage the elaboration of the fantasy in order to delineate and work

through the fears that block the child's further development in his "transition out of narcissism."

In this endeavor, the therapist serves several functions: first, he provides a "complementary object fragment" or transitional object for the borderline child, who has not developed coherent self- or object-representations; second, he acts as a bridge between the child's world of narcissistic fantasy and the external world; and third, he is a stable object on which further self-object differentiation may be practiced.

In 1974, based on an extensive review of the literature and his own clinical experience, Fred Pine differentiated the borderline syndrome into six clinical subtypes. All six manifest severe primary developmental failures in ego function and object ties, as opposed to secondary regressions following developmental conflict. While this distinguishes them from the neuroses, Pine found no sharp distinction between borderline children and some childhood psychoses.

The first subtype is made up of children with *chronic ego deviance.* These children are similar to those described by Weil and by Rosenfeld and Sprince whose ego deficits are " 'silently' present at all times." These children show a simultaneous mixture of varying levels of ego function, drive level, and object relationship. They do not improve with a change in environment.

Whereas the children of this first group show a mixture of ego strengths and deficits, the second group demonstrates *shifting levels of ego organization.* These are the children described by Ekstein and Wallerstein, who, Pine concurs, demonstrate a true ego organization at two different levels, allowing them to make a total shift from one to the other in order to avoid panic.

The third group of children manifest *internal disorganization in response to external disorganization.* These are children from deprived, impulse-ridden homes, who integrate rapidly in a benign hospital environment. Their borderline symptomatology is reactive, although Pine acknowledged the presence of other psychopathology which is not as easily reversed.

The fourth group is closely related to the third and contains children with *incomplete internalization of psychosis.* They manifest psychotic-like phenomena as a result of their attachment to a psychotic love object, usually a parent. Children in the first two categories have a greater internalized ego defect than in the latter two, who in turn manifest a larger reactive component.

Pine described a fifth group of children with what he called *ego limitation.* These are children with severely stunted ego development in all areas, resulting in what some have called an inadequate personality. Pine described two such children and speculated that the clinical picture had been

caused in one case by severe stimulus deprivation and in the other by a combination of intense chronic anxiety and minimal cerebral dysfunction. In both cases the child appeared dull, with below normal intellect and judgment, incapacity for self-care and planning, and limited sense of self.

Pine designated a sixth and final subtype, *schizoid personality in childhood,* a group others have called "isolated personality." These children show constricted affective life, distance in human relationships, and preoccupation with their own fantasy life. Their fantasies serve to ward off panic, permitting them to function, albeit aloofly, in the real world.

Whether or not all six subtypes that Pine has described should be considered "borderline," his is a creative and useful contribution to the diagnostic organization of the complicated group of children who are the subject of this chapter.

As the preceding review of the literature indicates, in the past four decades, investigators working independently have described groups of children with certain shared characteristics, that may represent one or several related syndromes. The symptom clusters and clinical description of these children will be presented in the following section.

Manifest Symptomatology

The borderline child exhibits varying degrees of pathology in all major areas of psychic functioning. No single symptom is pathognomonic, and the entire clinical picture must be considered when entertaining this diagnosis. These children may differ in the severity of their impairments in only certain aspects of the symptom Gestalt. When the total compilation of dysfunction is evaluated, however, a coherent and consistent pattern emerges that may be differentiated from childhood neurosis and psychosis as well as from other established diagnostic entities such as psychopathy or organic syndromes.

Often this overall Gestalt is not apparent at initial clinical contact but may only become manifest after prolonged therapeutic work. Most of the literature on such children, in fact, has been contributed by therapists who observed the symptom picture emerge in the course of psychotherapy. While some borderline children may appear different solely on the basis of observation, others may initially present as neurotic or even normal children and it is only in the course of therapy or in unstructured situations that the full extent of their psychopathology emerges. The symptoms described in the following paragraphs, therefore, may not be observed on a routine or structured interview. Only after the clinician has become familiar with the child and has established a therapeutic relationship can the diagnosis of borderline be made with assurance.

Another important factor in diagnostic assessment is the age or

developmental level of the child. Many of the characteristics that are defined as pathological symptoms in borderline children may be found in the behavior of normal but much younger children. The borderline child thus presents overt behavior, as well as deeper modes of psychologic organization, that are grossly immature; a finding that has led some to explain this disorder as resulting from massive developmental arrests. Before school age (or latency period) much of the borderline child's behavior may appear normal. Therefore, it is impossible to make this diagnosis with certainty before this developmental stage.

Fluctuation of Functioning

One of the most frequently mentioned characteristics of the borderline child is a rapid shifting in levels of psychological functioning, from healthy or neurotic organization to psychotic-like states, with intrusion of bizarre thinking, grossly inappropriate behavior, and overwhelming anxiety. This psychological disintegration occurs with extreme rapidity, often followed by an equally rapid reintegration at a healthier level of functioning. As mentioned previously, Ekstein and Wallerstein believe that this fluctuation in ego states occurs in the context of a significant relationship and that deterioration follows a sense of being rebuked or of not being understood by an important adult. Conversely, the return of a feeling of being understood or approved by the adult lessens the fear of loss and allows the child to once

again function at a healthier level.

Not all authors would agree with this interpretation of the borderline child's fluctuations in behavior although all of those who have worked with such children have remarked on the child's alternation between a reality-oriented mode of relating and an idiosyncratic universe of fantasy. These rapid fluctuations are one of the major differences between these children and their neurotic or psychotic counterparts. Neurotic children may display episodes of extreme anxiety or behavioral dyscontrol, but their thinking remains in a reality context. At the other extreme, schizophrenic children remain in fantasy for very long periods and, in contrast to borderline children, evolve semifixed psychotic delusions that partly ease their anxiety.

Borderline children appear to express great affect in a manner that is neither as well structured as that of neurotics nor as entirely alienated from others as that of schizophrenics. Their "blow-ups" tend to involve others or even provoke others into an emotional engagement. For example, an eleven-year-old borderline boy reacted to the head nurse paying attention to another child by suddenly running around the ward muttering to himself and bumping into the corridor walls. Then, in full view of a ward counselor, he picked up another child's toy and smashed it, forcing the counselor and others to give him attention. When he had been calmed by the staff, he again became rational and able to relate in an adequate fashion.

Nature and Extent of Anxiety

Another key symptom of borderline children concerns the constant presence of varying degrees of anxiety as well as the inability to control the escalation of anxiety. These children do not seem capable of responding to signal anxiety with adequate defenses or activities so that these minimal increments in anxiety due to a conflictual situation rapidly mount to panic and terror. Some borderline children do have a few maneuvers, albeit inadequate ones, to deal with anxiety, such as calling on trusted adults to alter the situation for them or to give reassurance. Others simply escape physically from conflict situations. They will stay away from any object or experience which might arouse their anxiety, for instance by avoiding knives. However, this only adds to their behavioral peculiarity. Many such children, however, decompensate in the face of anxiety-provoking situations and experience states of panic.

There are also indications that the very nature of the anxiety experienced by borderline children differs from the analogous phenomenon in neurotic or normal children. The anxiety of the borderline child is both more global and overwhelming and appears to derive from a different magnitude of threat to the self. The neurotic child may experience anxiety over an urge to disobey some socially or parentally imposed restriction that he is aware may result in punishment or a loss of esteem. In contrast, the

borderline child's anxiety appears to derive from a fear of psychological annihilation, body mutilation, or catastrophic destruction. Rosenfeld and Sprince, for example, reported an eleven-year-old borderline child saying, "You never know what will happen when you sit on that hole—everything may fall out and you'd find yourself being a skeleton with nothing but this bit of skin holding you together." Another child, described by the same authors, was afraid that he would separate from himself, that his mind and body would fall to pieces. It would appear that these fears of destruction are readily aroused in borderline children when they are stressed by frustration, interpersonal difficulties, or other conflicts. However, at more secure and peaceful times such apprehensions appear absent. Also, such fears are not elaborated into the gross distortions of schizophrenic defenses, despite similarities in the nature of the causative anxiety. Frijling-Schreuder spoke to this point, suggesting the borderline child may suffer more anxiety than the blatantly schizophrenic child because he is more aware of the inner threat of psychic disintegration, and is unable to form stable delusions, which, while impairing his relationship to reality, would offer relief from anxiety.

In summary, borderline children share the same non-neurotic form of self-threatening anxiety as schizophrenic children, but only for short periods and in pure form, without psychotic elaborations and defenses.

Thought Content and Processes

From the earliest reports, borderline children have been observed to demonstrate disturbances in the "synthetic functions of the ego" as well as revealing contamination of the "conflict free" spheres of the ego as a result of emotional difficulties. Despite this similarity to psychotic children, the borderline child never seems to lose touch completely with reality or, as stated previously, to create fixed schizophrenic delusions. Borderline children nevertheless show some thought disturbances typical of schizophrenic cognition, although in milder and less extensive forms.

Such children alter otherwise accurate ways of dealing with reality because of their persistent underlying fears of destruction or mutilation. Rosenfeld and Sprince, for example, reported a borderline child who, upon hearing that his school would "break up" for the holidays, envisioned with apprehension the annihilation of the school buildings.

An eleven-year-old borderline boy asked a counselor if another child whom he had befriended would be going home, a possibility that aroused great anxiety. The counselor replied that the decision was "up in the air." The patient seemed suddenly afraid and started looking around the ward, asking "Where?" as if he expected to find the answer literally hanging in midair.

These are illustrations of the process of concretization which, as described by Arieti and others, forms part of the cognitive pathology of

schizophrenia, but is also seen in borderline conditions.

Borderline children also manifest bizarre phobias and obsessions that go beyond the neurotic spectrum. Frijling-Schreuder described a child who would not shake hands with his therapist because he believed she had poison glands on her hands. Pine reported a child who thought people came at night to cut open his stomach. The authors have seen a child who refused to enter any large body of water, including swimming pools, because he was sure there were water demons who would drag him down and drown him. This same child experienced panic during rainstorms and required ear plugs to muffle the sound of thunder. Another child, who suffered from constipation, believed that sharp, "thorny things" would be expelled in his stools and cut his intestines and rectum.

Some of the borderline child's inappropriate fantasies need not relate directly to fears of survival and body integrity. Rosenfeld and Sprince described a nine-year-old boy who at times behaved as if he were a female character from a Dickens novel—to the extent that he requested female clothes and wanted to do housework. Later the same child acted as if he were a "lorry" and invented a "lorry language" with which others had to comply. For example, his food had to be called "petrol." In many cases we have seen, the parents appear to condone or even encourage such unrealistic behavior in the child. One eight-year-old boy was regularly sent to school by his father

dressed in his younger sister's clothes. The mother of a seven-year-old borderline girl actually believed that her daughter was a witch with special malevolent powers and treated her accordingly.

In borderline children thought content in general flows with excessive fluidity from reality to fantasy and back again. A persistent and objective relationship to reality is not maintained for long periods but follows the vicissitudes of the stresses encountered. Over two decades ago, Geleerd aptly described these children as having a short "reality span." Ultimately, fantasied themes of mutilation, survival, and catastrophe intrude into consciousness, accompanied by massive anxiety. Furthermore, these fluctuations between near normal and near psychotic mentation seem chiefly determined by the ups and downs of relationships with others.

Another peculiar aspect of the borderline child's thought content may be his uneven and impractical store of knowledge. These children are frequently quite intelligent but use their intellect in the pursuit of obscure subjects while remaining blatantly ignorant of basic, everyday commonsense facts. One eight-year-old was conversant with the methods by which the ancient Egyptians mummified bodies and was also an expert on dinosaurs (he even knew which were carnivorous and which were herbivorous), but he had no understanding of elementary social interactions. These children appear especially drawn to scientific subjects such as astronomy, the biology of

insects, or the classification of reptiles; however, the authors have known some borderline children with interests in artistic crafts such as making jewelry or photography. It may be that these idiosyncratic interests represent psychic islands of security and regularity in an unpredictable and fearful world, or possibly that these hobbies may be attempts at controlling fears and threats in a symbolic manner. On the other hand, these interests may serve no real defensive purpose and, by excluding a wider range of interests, may represent merely another area of deviant development.

Finally, borderline children often present with a heterogeneous collection of cognitive defects that are picked up on psychological testing. There is no consistent pattern to these deficiencies and different children may have difficulties with focusing attention, learning, reading, perceptual-motor tasks, or abstract concept formation. These deficiencies may indicate the presence of some neurological defect that contributes to the overall clinical picture.

Relationships to Others

It would be surprising if children who manifest the many difficulties just listed did not also exhibit serious problems in relationships. The deficiencies in this area are, indeed, so profound that some clinicians have considered the interpersonal process the foundation of the borderline syndrome on which

the other symptoms are based. Rosenfeld and Sprince postulated that borderline children are caught in a dilemma in which they wish to merge psychologically with a trusted adult but, simultaneously, are terrified by the loss of identity and psychological integrity that would follow from this merger. These authors interpreted the borderline child's symptoms as representing both this desire to merge and his defenses against psychological merger.

Ekstein and Wallerstein described the retreat into fantasy as a means of expressing conflictual material without endangering the relationship with a needed other person and thus also underline the importance of relationships in this condition. Frijling-Schreuder concluded that borderline children are fixated at the symbiotic stage of development, according to Mahler's scheme of psychological maturation. Anna Freud also described these children as exhibiting modes of relating that are appropriate for much younger children, using another person almost exclusively for satisfying everyday needs.

These children do appear to utilize others to fulfill functions that should normally be autonomous or fulfilled by the child himself at his stage of development. They require constant reassurance from others that the environment is safe and that they will be protected. When they feel secure in a relationship, these children may function very well and demonstrate considerable innate talent and intellectual ability. If they sense rejection or

criticism, they react wildly with massive anxiety, destructive rage, or bizarre thinking. It is as if their internal psychic order depends on a modulating external source.

Yet, despite this great need for a stable relationship, the borderline child does not seem to form great attachments to any one person and may rapidly substitute one relationship for another as long as he receives the support and reassurance he needs. The other person is valued for the functions he performs rather than for his offer of intimacy or concern. Rosenfeld and Sprince described a borderline child who became very upset when he learned that his headmaster was leaving, but when questioned about his grief, his primary anxiety was that no one would do all the things that the headmaster had done for him. Other children display a lack of differentiation in their expectations from others and appear to believe that all others will expect them to behave in the same manner and that they are to behave toward others in an identical fashion despite differences in situations or familiarity with other people.

For example, an eight-year-old girl would approach a total stranger on the street and treat him in an inappropriately familiar manner. She would behave as if the stranger were an old friend or a member of her family. This superficial intimacy immediately ceased, however, if the stranger did not react in a warm, gratifying manner. The child would not seem upset but would

simply leave the person and approach a new stranger. This girl's pattern of superficial relatedness demonstrates the borderline child's indiscriminate use of others (who are often interchangeable) to fulfill inner needs.

Anna Freud also commented on a narcissistic investment in others but interpreted the form of relationship as a regression from "object cathexis" to "primitive identification." Rather than considering another person as an individual who may give pain or pleasure but who remains a separate entity, the borderline child, according to Freud, pathologically merges with the other and by assuming characteristics of the other, attempts to share the other's invulnerability and power. In the search for emotional safety, the borderline child will psychologically become one with the other, according to Freud, and, for example, believe that they experience the world in an identical manner. Freud considered this mode of relating as an indication of an arrest at a very early stage of development and as a grossly primitive defensive maneuver. As mentioned previously, Rosenfeld and Sprince, as well as Frijling-Schreuder, described similar phenomena in their observations of borderline children.

The authors have observed children who exhibit an "as if' quality, who mirror the behavior of others, and appear to have no true stable personality of their own. Sometimes this mirroring behavior becomes manifest only in times of stress. For example, one boy who regularly became upset when his mother had to leave the ward after visiting him, behaved like her for some time after

her departure. Other children will show the “merging” type of behavior under similar types of stress. Another boy, for example, became upset by his mother when she visited the ward but felt empty and sad after she left. He became very tense and excitedly walked over to a staff doctor, grabbed his tie, and said “I want your tie.” Then the boy rapidly said he wanted the doctor’s eyes, nose, mouth, and soon until he wanted “all” of him. He wanted to become one with the doctor to undo his sense of anxiety and depression.

These are descriptions of the relationship of the borderline child with one or a small group of sympathetic adults encountered in a therapeutic setting. The borderline child’s reaction to his peers is quite different. They usually do not get along well with other children, who are not as tolerant or as predictable as adults. They bully or torment younger children, by whom they do not feel threatened. At the same time, they are fearful of older children and erroneously expect to be attacked by them. With their own peers, they tend to be withdrawn and jealous of adult attention, although they occasionally fly into rages during which they may attack others or vent their fury on themselves. One consistent finding is that borderline children do not do well in groups with either normal or disturbed children. In such situations they experience chronic anxiety, which they try to relieve either by withdrawing into fantasy or by attempting to monopolize the adult group leader by inappropriate behavior. Classroom teachers frequently report that such children attempt to climb on their laps during class or ask for some other sort

of tangible show of emotional support. Borderline children usually do not grasp the nuances of social behavior and misinterpret group situations causing them embarrassment and anxiety. They are often perceived as odd by their peers, who eventually avoid them or make them the butt of jokes.

The sharp contrast between the borderline child's behavior in a group of peers and his behavior in a one-to-one situation with a benevolent adult may lead to conflicting reports being brought to the attention of the clinician. Similarly, if the clinician is supportive and the interview is highly structured and nonthreatening during diagnostic sessions, the child may evidence little pathology, presenting a markedly different picture than that provided by his history. Later on, during the course of therapy, when free play is introduced or non-supportive interpretations are ventured, the extent of psychopathology may become manifest.

Lack of Control

The final general category of difficulties experienced by borderline children concerns their inability to inhibit impulses, to delay gratification, to control aggressive outbursts, and to suppress frightening fantasies.

During periods of frustration, they may exhibit mounting tension, anxiety, or anger. These experiences syncretically spill over into motor behavior so that they will appear hyperactive and agitated. They may rock

back and forth, start running around aimlessly, or talk in a rambling fashion. They may also work themselves into a rage, becoming verbally and physically abusive, and indiscriminately attack other people or objects or even themselves. During these attacks, they appear wild and out of contact but they usually can be calmed down by a supportive adult.

Another aspect of the borderline child's inability to control his inner states can be observed in the escalation of frightening fantasies accompanied by the increasing anxiety, described previously. If allowed to play freely with dolls or to associate freely verbally, without imposed structure, the content of their productions will often begin to move toward themes of destruction and mutilation. These themes then continue to escalate as the child is apparently helpless to stem the flow of one terrifying thought after another (this is especially observed on projective testing—as will be discussed). Unless the therapist intercedes, the child will soon be overwhelmed by panic and will verbalize grotesque visions of world catastrophes or gory details of bodily injury. This lack of control over thought content again illustrates the borderline child's excessive reliance on external structure to regulate his inner world. This deficit may account for some of the pseudoneurotic forms of defensive symptoms encountered in these children. They may develop obsessions as a way of protecting themselves against some dreaded event. These rituals take on a magical quality and are adhered to desperately, suggesting that they represent a basic means of survival to these children.

Another crippling means of defense consists of phobias that allow the child to avoid those objects that might elicit the chain of terrifying thoughts. Here again, the phobic object does not symbolize rebelliousness or secretly desired transgression of social taboos but is associated with fantasies of annihilation or horrible injury.

Associated Symptoms

In addition to the pathological manifestations listed previously, some borderline children exhibit additional symptoms which are not easily lumped under one overall area of functioning. Among these symptoms may be listed poor social awareness, lack of concern for bodily safety or personal grooming, and an inconsistent ability to adapt to new situations. Others may show "soft" signs on neurological examination, complain of difficulty sleeping, have difficulty concentrating, or have periods of restlessness. While not a specific symptom, many authors have commented on the unevenness of development in these children. This lack of developmental uniformity can be seen in terms of a mixture of ways of relating (genital and pregenital drives), of utilizing defenses (neurotic and primitive), of using intellectual abilities (gaps in knowledge, great disparity on age appropriate tasks), and of general self-management. These children do present a conglomeration of advanced, normal, and grossly delayed behavior, all at the same time, with fluctuations between high and low levels of functioning in almost all areas.

Performance on Psychological Testing

Since borderline conditions of children represent a controversial diagnostic label as well as a fairly recent addition to the unofficial nomenclature, articles dealing with results of psychological testing with these children are quite rare. Appropriate testing of these children, however, would greatly aid in timely diagnosis and would serve as a fruitful area for future delineation of the borderline syndrome. Two reports on testing of borderline children are summarized in order to broaden the description of the clinical syndrome, as well as to add to the clinical evidence that borderline conditions do form a separate diagnostic category of childhood psychopathology.

Engel described the major psychological themes that emerge from responses of borderline children to projective tests. The first issue mentioned is that of *survival.* Engel noted that fears of annihilation appear in a variety of ways on all of the tests. In the stories of these children, incidental aspects of reality are "woven into the fabric of the dread of death." In contrast to schizophrenic children, Engel found that borderline children can transform these morbid ideas into a realistic narrative and are better able to share them with the examiner. The second issue Engel mentioned was the *struggle for reality control.* This aspect is similar to that described by clinicians as fluctuation in ego states. To quote Engel: "What we see in the test material of borderline children is not the complete disruption of reality contact. Nor do

we see the reiteration of concrete, sterile, conventional realities; rather the tests contain illustrations of waxing and waning of reality testing." When terrifying fantasies intrude, the child may say he is just pretending. A ten-year-old boy, for example, did not know whether to interpret a Rorschach card as a monster or a cowboy. He eventually stated that it was really a cowboy and he was just imagining it was a monster. The third finding Engel described concerned the child's attempt to cope with *insurmountable demands.* She found her patients suffer an "ego exhaustion" in their efforts to master frightening forces from without and from within. The child seems to expect no solution to his problems. A fourth manifestation is the selective *distance devices* used by borderline children. In the course of responding to the test material the child will embark on a story that gets out of hand and, by raising frightening material, arouses great anxiety. As mentioned by clinical observers, the child appears to lack the foresight to avoid terrifying material in his productions. Once the child arrives at this anxious point, according to Engel, he utilizes fantastic distortions of time and space in his stories to get back to safer territory. The child distances himself figuratively and concretely to avoid anxiety but at the expense of reality constraints. One borderline boy who was seen in the authors' clinic tried to bite the Rorschach cards and actually pounded them with his fists, apparently in an attempt to control the fantasies that the cards elicited from him.[1] In an analogous manner, Borderline children defend themselves by *pivotal interruptions in testing.*

When absorbed in anxiety-arousing material, the children seek relief by asking for a drink of water, sharpening a pencil, or other maneuvers to interrupt the process. Although all children use some tactics to obtain relief from the demands of testing, especially when confronted by possible failure or other embarrassment, the borderline child attempts to interrupt testing when he is about to lose control and be overwhelmed by anxiety. His motor activity escalates and he appears near to panic, and, most telling, he turns to the examiner for help. If the examiner alters his role to that of therapist and offers reassurance, the child appears relieved and is able to quiet down and return to work. Therefore, by seeking help from an adult, the child transforms the testing situation into a therapy session.

In regard to this last observation, Engel made a number of cogent remarks about the effect of such a child on the examiner. Engel wrote, "From the first moment, such children make much more vigorous use of the testing relationship than do others and cast their intrapsychic struggles upon the testing situations in large and bold signals." The examiner is puzzled and intrigued by such children but most of all he is involved with them more closely than he is with aloof schizophrenic youngsters or self-sufficient neurotic patients. The examiner finds himself intuitively responding to the repeated disintegration suffered by the child as well as to the child's attempt to reintegrate on a reality level. The examiner may be bewildered by the fluctuation between harmless stories and themes of disaster and horror.

Finally, the examiner is caught in the struggle between his duty to obtain an unbiased record and his wish to reassure the child against the mounting anguish of uncontrolled fantasies.

Wolff and Barlow recently administered a number of cognitive, language, and memory tests, and measured the use of emotional constructs in groups of normal, high functioning autistic and "schizoid" children. Wolff and Barlow borrowed the term "schizoid," from the writings of Asperger, who wrote a monograph on disturbed children in 1944-They share Asperger's belief that the condition described is not an illness with an onset and a cause but a consistent, fairly permanent personality pattern. Wolff and Barlow believe that "schizoid" conveys the meaning of Asperger's diagnosis of autistic personality. At the same time, these authors note the similarity of their sample to "borderline" children and cite the same articles mentioned in this chapter in their description of these children. Finally, many of the clinical features they describe are those of borderline children delineated here. It may therefore be assumed that they are referring to borderline children despite the different diagnostic label.

In contrast to Engel's use of projective material, Wolff and Barlow administered mainly structured tests that provided little opportunity for the elaboration of fantasy material. Their results were numerically tabulated so that the three groups could be compared. What is most pertinent is that the

three groups could be differentiated by objective tests, so that the schizoid group appeared to be a distinct sample of disturbed children. In general, the schizoid group scored midway between the normal and autistic groups. For example, they exhibited more scatter than normal children on the subtests of the Wechsler Intelligence Scale for Children but less than the autistic group. Perhaps the most interesting finding was that the schizoid group was more distractible on many measures. Wolff and Barlow believe that this is not the result of an organic attentional defect but rather due to these children being more attuned to their inner world than to the test situations.

Homogeneity and Heterogeneity of Borderline Conditions

In concluding this section on manifest symptoms, it is worthwhile to consider whether borderline syndromes in childhood actually form a separate clinical group. Certainly, children so diagnosed show marked differences in superficial symptomatology; some may be overtly aggressive and others shy and withdrawn, while still others may present with conspicuous phobias and obsessions. Pine has, in fact, lumped together a variety of subgroups of children with different etiology, course, and response to treatment under the rubric borderline which, he believes, does *not* really define a separate clinical entity but rather a descriptive comment on other diagnoses. Until we have more data on the etiology and course of borderline children, it will be difficult to decide whether they do form a valid clinical group. On the basis of manifest

symptoms, however, these children do appear to share a constellation of specific and fundamental areas of psychopathology that sets them apart from other disturbed individuals. These areas have been described above and are listed in Table 11-1. It is this Gestalt rather than any single symptom that is characteristic. The first step in the delineation of any pathologic syndrome is a purely clinical description of symptoms. We are still at this initial state of knowledge in regard to borderline conditions of childhood but it is hoped that this attempt will lead to further definition, understanding, and, ultimately, appropriate treatment for these children.

Etiology, Clinical Course, and Prognosis

There is currently very little certain knowledge regarding the cause of borderline syndromes in childhood, the direction these disorders take throughout development, or the eventual outcome of such children in adult life. The literature on borderline children consists almost entirely of scattered single, or small series of case reports, with a paucity of any overall large and systematic study of this syndrome. Furthermore, these case reports present minimal clinical data on history or outcome, stressing instead diagnostic documentation or metapsychological interpretations of the symptoms. An additional limitation is the lack of extensive neuropsychological testing which might better define possible organic impairments in borderline children. Therefore, our knowledge of borderline children is based primarily on

subjective and anecdotal material that variously presents data on antecedent factors and eventual outcome. Yet despite this diversity of reporting from different orientations, the clinical descriptions of borderline children are remarkably similar.

One systematic study on possible etiological factors is a recent report by Bradley that examines early separation experiences of borderline children. Bradley found more frequent separations from mother figures or caretakers during the first five years of life in borderline children than in neurotic, psychotic, or delinquent children. Though a definite step in the right direction, this study is hampered by significant problems. One is that the children were diagnosed by criteria devised by Gunderson and Singer that were intended to describe adult and not child patients. Another difficulty is that the nature and extent of the separations were not specified.

On the basis of a review of the literature and of clinical experience, the authors have formulated a few speculations regarding the causes of this syndrome. These will be presented here with the knowledge that validation awaits more vigorous and extensive investigations. The authors have found evidence of mild to moderate organic impairment in borderline children as compared to either their siblings or children with other forms of psychopathology. This organicity may manifest itself in “soft” neurological signs, disorders of impulse control, or cognitive deficits. These defects are

identified on neuropsychological testing but are often missed in a routine physical examination.

Often these children are remembered as difficult infants with poor homeostatic patterning. They were irregular in sleeping, eating, or elimination. As toddlers, some are described as excessively clinging, others as hyperactive, and still others as aloof and withdrawn. All are reported as "different" and as presenting management problems for various reasons.

I) Fluctuation of functioning

A) Rapid decompensation secondary to objectively minimal emotional stress with rapid reintegration after reassurance from environmental figures

B) Brief shifts from neurotic to psychotic ideation

C) Recurrent intrusions of bizarre preoccupations and fantasies

D) Extreme dependence of level of functioning on environmental support

II) Nature and extent of anxiety

A) Inability to contain anxiety with rapid escalation of anxiety to panic unless helped by environmental figures

B) Inability to utilize signal anxiety

C) Basis of anxiety residing in fears of destruction, mutilation, and emotional annihilation

D) Greater suffering from anxiety due to inadequacy of neurotic defenses and lack of psychotic reconstitutive symptoms

III) Thought content and processes

A) Inadequate "synthetic ego functions" with some gross distortions and concretizations but without stable delusions, hallucinations, or prolonged or profound loss of reality contact

B) Excessive fluidity of thought between fantasy and reality with inability to control potentially frightening avenues of association

C) Short "reality span" with recurrent but transient intrusion of grotesque and bizarre fantasy themes

D) Concern with survival manifested by poorly developed defenses (obsessions, phobias, extreme dependency, merging) to ward off possibility of catastrophic destruction

E) Proficiency in obscure areas of knowledge with lack of awareness of practical, everyday matters

F) Heterogeneous cognitive defects

IV) Relationships to others

A) Immature attachments to need-fulfilling adults (merging, primitive identification, dependency)

B) Excessive reliance on others to maintain inner security, function well with trusted adult

C) Poor relationship with peers, inability to utilize intellectual talents in group situations

V) Lack of control

A) Inability to delay gratification or tolerate frustration

B) Syncretic expression of anxiety and tension by action and aggression

C) Inability to contain inner life so that anxiety leads to action

VI) Associated symptoms

A) Social awkwardness, lack of adaptiveness

B) Neurological "soft" signs

C) General unevenness in development

Toward middle childhood, problems with peers become apparent as greater socialization is expected. Other difficulties are lack of social and

practical judgment, poor coordination, excessive aggression and rage attacks, incipient anxiety attacks with associated phobias and sleep disorders, and precocious intellectual interests.

While the evidence for constitutional factors is still inconclusive, there is little doubt that borderline children come from chaotic and unstable homes. The mothers of these children were found to be disturbed in varying degrees. Most frequently, the mothers exhibit symptoms of the adult borderline syndrome. They are unstable, easily frustrated, quick to anger, unable to sustain an empathic relationship, and likely to distort essential aspects of interpersonal relationships. Many of the mothers of borderline children exhibited poor judgment and lacked common sense in childrearing. Often they would excessively stimulate their children sexually or have the child participate in the acting out of the mother's fantasies. For example, one nine-year-old boy was regularly taken into bed by his mother, where they would play at biting each other. Another mother regularly exposed her breasts to her son in a seductive manner. The mother of an eighteen-year-old patient, who has progressed rather well, still tries to bathe him and dress him despite his mature physical development.

The fathers of these children also manifested instability in emotional control and relationships. Violent scenes and physical fights were common among the parents. Some of the children were "kidnapped" back and forth by

combative parents who used the children as pawns in their battles. We also found significant but inconsistent abuse and neglect of the child, depending on parental moods. One child was repeatedly smashed into the wall because her mother believed the child was a witch. Another child, as an infant, was given LSD by his father. Yet another child was routinely beaten by a paranoid, acting out father. The most characteristic quality of childrearing was lack of consistency of care. Many of the parents were quite successful in their professional or adult social lives but were unable to care adequately for their children because of personal psychopathology. Those families who could afford it often turned the care of the children over to a succession of baby sitters or nursemaids. Others utilized older siblings in caretaker roles.

The status of borderline children after they reach adulthood is unknown. Some- report that they become “odd” adults. Others consider them pre-schizophrenic. We have followed some children to adolescence and found a heterogeneous outcome. One child, who is now fifteen years old, had progressed well in a special boarding school until he learned his family was moving out of state. Upon hearing this news, he became very anxious, started stealing, initiated sex play with a younger girl, and eventually exhibited psychotic behavior. Another formerly borderline child, now eighteen years old, attends a regular school, excels in electronics, but is socially shy and withdrawn. Another eighteen-year-old former patient is doing well and leads a fairly normal life. However, he tends to lack certain social graces and

remains ignorant of social amenities. Those children with the best outcome had minimal organic impairment, took part in prolonged intensive individual psychotherapy, and experienced considerable improvement in their home environment. The authors have found that the greatest impediment to a favorable long-term outcome has been a continued chaotic family situation which all too often rapidly nullifies improvement laboriously obtained in therapy.

Treatment of Borderline Children

It is difficult to make general statements regarding the treatment of borderline children. Since these children present with a wide range of symptoms as well as deviations in their overall development, a broad range of therapeutic approaches is usually indicated. As Rosenfeld and Sprince pointed out, the particular combination of strengths and weaknesses, of innate vulnerability, and of environmental interferences create a most unusual set of characteristics for each of these children. The usual and expectable accomplishments in maturation are not readily and reliably found in these children. The strengths and capacities that are present are too easily subject to interference and regression. As Anna Freud emphasized in her paper on the "Assessment of Borderline Children," it is important to assess the *total* personality development of the child before initiating treatment and not to limit the focus to the presenting symptoms alone.

If anything, these children tend to be undertreated, or treated with an approach that is either too narrow or is carried out under the pressure of immediate exigencies and emergencies. Because these children are often capable of high-level functioning, the severity and chronicity of their personality difficulties, their vulnerability to decompensation, the serious interferences with their development, and their lack of successful mastery of developmental stages is underestimated. Usually, individual psychotherapy alone is not sufficient to address their multiple needs.

Therapeutic aspects will be discussed under two broad categories: (1) the important aspects of individual treatment; and (2) general approaches that should be considered when arriving at a treatment plan for the child.

A treatment plan should usually include interventions in the child's educational and social environment as well as individual therapy. It is important that there be one responsible person to coordinate and oversee the implementation of the treatment plan in all of its components. Usually, the individual therapist undertakes this role. The parents of these children are often incapable of the organization and follow-through necessary to ensure adequate coordination of the various aspects of the treatment plan.

Not infrequently, a special day program or placement in a residential treatment program is indicated. These modalities will be discussed in a

separate section, as will be the use of medication.

Individual Psychotherapy

For borderline children, individual psychotherapy can be extremely helpful in working out their multiple, unresolved internal conflicts and in strengthening their adaptive defenses. In working with the child in individual therapy, it is important to keep clearly in mind the severity of the child's difficulties. One must be prepared for the sudden and unpredictable shifts in functioning to very primitive levels, and the equally sudden recovery. One must be on guard *not* to encourage the child to elaborate fantasy play, which will elicit so much anxiety that the child only deteriorates further. Most of these children, when confronted with fantasies impinging on the most vulnerable areas in their mental life, have difficulty maintaining distance from the material, even when it is brought up in a displaced form such as in doll play. Reality testing is weak, and transient lapses in the relationship to reality are frequent. Often, when the child is encouraged to express fantasies freely, the child becomes more and more stimulated and eventually the ability to deal adequately with the anxiety and excitement breaks down. For example, an eleven-year-old boy in a day program was transferred to a new male therapist. The boy came to the treatment an hour early and quite appropriately began to make a tower out of plastic blocks. The therapist encouraged the boy's fantasies while he was making the tower. The play

began to shift and in rapid succession the boy introduced increasingly primitive themes, his excitement mounting until it was out of control. After a few minutes of building the tower, he introduced a male and female doll, whom he had, in sequence, kissing, having intercourse, and then merging together. He said the female was pregnant, then that the male doll was being penetrated anally and was pregnant. He then quite impulsively grabbed a pencil and pretended to stick it in his own anus, pushed the dolls together, and "glued" them together with clay, saying they were now one creature. During all of this play, he was increasingly agitated, and at one point grabbed at the therapist's penis and then ran out of the room, ending the session. He was clearly unable to maintain distance or use successful displacement and repression that is typical of latency children.

One must sensitively gauge when the child has the ability to utilize anxiety to stimulate adequate defensive maneuvers or when anxiety results in a disintegrating structural regression, as in the preceding case. For this reason, the therapist must be more active in directing the play, and intervening when the child is becoming overly stimulated; the therapist must set limits on the expression of aggressive, sadistic, and blatantly sexual material. The therapist may have to intervene physically to protect the child from harming himself, or the therapist. Frequently with these children, one treads a very narrow line between a sensitive and careful uncovering of the most vital concerns on the one hand, and a strengthening of repressive,

obsessive-compulsive maneuvers on the other.

As previously mentioned, Ekstein and Wallerstein emphasized the fluctuating nature of the ego organization of these children. They also emphasized the fragility of the therapeutic alliance with the child and how even subtle breakdowns in the empathic communication with the child can result in a regressive retreat to psychotic functioning. Again, these are disruptions of a transient nature but they are painful to the child and perplexing to the therapist.

Another difficulty in the individual treatment of the borderline child stems from the nature of the interpersonal relationships characteristic of these children. Many of these children do not experience close relationships as safe. In fact, closeness is frequently very threatening, although at the same time greatly desired. As the therapeutic relationship progresses, the child may become frightened of the developing closeness and will retreat, frequently becoming provocative or attacking the therapist in some manner.

For the borderline child who uses more schizoid mechanisms, a retreat to compulsive “out in space” fantasy play may result from the growing closeness to the therapist. The child will allow the therapist little or no inclusion in the play; the child becomes aloof, distant, and uncommunicative. For instance, a ten-year-old boy, after a few sessions with his therapist, in

which he had been gradually more interested in and warmer toward the therapist, played out, week after week, the same theme—an endless battle in outer space consisting mainly of attacks and counterattacks by spaceships with no human or "humanoid" protagonists, and, most strikingly, little emphasis on who was good and who was bad. The therapist tried frequently to join the child in the play with little result. After several months, people rather than machines appeared and the therapist was gradually included in the play. This change coincided with reports from home that the boy was beginning to make friends for the first time and was beginning to assert himself in a positive way.

One must constantly be on the alert to strengthen reality testing whenever possible. Using an approach of gently but consistently reminding the child that it is "just pretend" or "just play" when playing out some important theme in displacement can help the child resist the disintegrative pull of his fantasies. At the same time, however, the therapist must communicate to the child that his problems are important and serious and that the therapist is not treating them lightly. Frequently, the experience of these children is that their deep concerns are not acknowledged and that they as individuals have not been taken seriously by their parents. To communicate that one understands the child without simultaneously encouraging the regressive wish to merge requires considerable sensitivity and skill on the part of the therapist.

One of the major difficulties in dealing with these children is the range of feelings the child evokes in the therapist. These children, compared with others, either healthier or with more pathology, almost universally provoke the therapist, as well as others, to experience frustration, confusion, and often helplessness. These children are the cause of some of the most heated disagreements among staff members, and not uncommonly rather desperate recommendations for alternative therapeutic approaches are proposed with increasing frequency when the child fails to respond to the more usual modes of intervention. The therapist is frequently seduced into thinking the child is more able to employ age-appropriate mechanisms on a consistent basis than is the case, and so becomes frustrated. Also, these children, because of their tendency to primary identification and immediate intimacy, fool the therapist into thinking there is a more genuine relationship than is actually possible. In addition, these children can quickly, and in a raw and undefended manner, raise very primitive issues that can be threatening to the therapist. Following the shifting levels in organization of these children can be both trying and confusing for the therapist. The problems of dealing with borderline children are magnified for persons who are not psychologically sophisticated or trained in these areas and account for the very strained relationships such children have with family members, teachers, neighbors, and peers.

Work with Families

There has been a striking paucity of information in the literature on the families of borderline children. In the authors' experience, the parents of these children frequently exhibit considerable pathology. Extensive contact with the family, especially in the early phases of treatment, has been found to be essential for several reasons. Frequently, the parents feel overwhelmed, frustrated, hopeless, and angry with the child who has been creating difficulties both at home and in the community. The relationship between the parent and child is on a downhill course, caught in a vicious cycle of mutual disappointments, frustrations, and hostility. Active intervention with the parents is needed to interrupt this cycle and to offer hope of improvement.

The situation is, of course, complicated since many of these parents have serious character difficulties and the child's problems partially reflect the destructive influences of parental pathology. In regard to this, it is important to assess to what extent the child's pathological state is reactive to an interfering or destructively stimulating environment (for example, where the parent is either abusing the child outright, is alternately sadistically critical and seductive, or does not help the child to adequately assess and test reality).

The authors have often found the families of borderline children very difficult to engage in therapeutic work on their own behalf, and more often than not, the therapeutic team spends much clinical energy in maintaining an alliance with the parents in order to give them directions, advice, or even

admonitions about their handling of their child. It is necessary to maintain the cooperation of the parents to make plans for their child. Many parents use mechanisms of projection, denial, and impulsive action to deal with their conflicts, and resist insight into their relationship with their child. A direct, matter-of-fact, advice-giving approach seems to work best. It is often necessary to give them simple, clear tasks and goals to effect changes in their relationships to their child. This can help minimize the often unmanageable negative transference that may arise in the parents of these children.

Day or Residential Treatment

The decision to recommend a therapeutic residential or day program depends on a number of factors, most significantly an assessment of the child's home environment and the degree of disturbance in the family relationships, especially the parent-child relationship. Often a day program is the treatment of choice if the relationship between parent and child has not become overly hostile and destructive. The combination of impulsivity, easy deterioration into anger, and difficulty on the part of others in understanding these children usually leads to a breakdown in the relationship with those who could, in the context of the relationship, help the children master their developmental tasks. These children often alienate those in their environment and establish relationships that are not helpful to growth. The parents' personality difficulties, particularly those that prevent them from separating

themselves psychologically from the child, are frequently a part of the child's problem. For these reasons, a most effective intervention with many of these children is to separate them totally or partially from the home and to provide a different environment that can address the various aspects of the child's difficulties. The very fact of the separation forces the child and the family to confront their relationship, particularly its destructively symbiotic aspects, as when parent and child do not have a clear sense of their individual separateness from each other. This difficulty in establishing a sense of separateness has many important clinical ramifications. For the child it can mean the development of merging fantasies as well as fears of these fantasies and the use of projective identification. For the parents, there is often a reactivation of their unresolved conflicts with their own parents, resulting in difficulty in distinguishing their experience in the past from their child's experience in the present. For these parents, it is not merely that their child's struggle *reminds* them of their difficulties as children; it *revives* these conflicts all too vividly. Their response may give validity to the child's terrifying fantasies and beliefs. This is alarming for the child, who needs, if anything, some reassurance and security that his most frightening wishes will not come true. An interruption in this destructive parent-child situation may be very useful and can be accomplished by temporarily separating the child from the parent.

One of the chief advantages of a therapeutic milieu program is that it

permits a consistent and integrated approach to those aspects of the child's life that are so often pathologically disturbed—peers, school, building self-esteem, and so forth. Especially important is the close relationship between the educational and social/interpersonal components, allowing mutual feedback, illuminating the way the intrapsychic conflicts, character deficits, and cognitive and central nervous system dysfunctions mutually affect each other. For instance, the awareness by the special education teacher that the child has specific deficits in keeping in mind a sequence of instructions can help the people dealing with the child in his social environment to give directions in a simple step by step approach. One can help the child become aware of this difficulty and how it affects his social interactions and help him devise ways to deal with it. Likewise, the child-care professionals who have a deeper understanding of the child's fears and coping mechanisms can help teachers, parents, and others to understand the behavior of the child and to gain the perspective and distance that are so essential in dealing with these children.

This close coordination and feedback applies to the treatment of all children, but with borderline children it is of even more importance because their behavior is often so difficult and threatening, because they shift so rapidly from state to state, and because the countertransference feelings become so intense that people working with them need support to maintain their objectivity.

The borderline child's problems with impulse control and his tendency to take immediate action, rather than to employ fantasy or displacement when threatened, often lead to sudden and serious threats to others or to himself. At these times, the child requires direct physical controls. Often, removing the child to a safe, secure space where there is little stimulation is necessary. Going to the "seclusion" room is a most useful intervention, especially if used sensitively and with an understanding of the child's vulnerability at the time. As mentioned earlier, Geleerd observed that while most children, when in the midst of a temper tantrum, will settle down if securely and firmly confronted by an adult, some children further lose control and experience panic if such an approach is used. She found that these children needed a much warmer, supportive approach with affectionate holding to help them come out of the temper tantrum. While the authors' have found this a useful observation in handling some borderline children, others become even more panic-stricken when approached physically during a temper tantrum. It is as if during their outbursts their ego boundaries are even less well defined and the closeness of another person seriously threatens their integrity. They need distance, safety, and security in order to reintegrate. They respond well to being quickly removed to the seclusion room with as little physical handling as possible. Once there, verbal and/or visual contact is maintained with the counselor, but at some distance. This helps the child maintain contact with the outside world, but at a sufficiently safe distance to

permit him to recover his more mature defenses. In the therapeutic milieu, a variety of methods may be employed to help the child develop better impulse control and to increase his ability to delay gratification. A reliable and consistent system of limits and rewards administered with objectivity is most important. Perhaps the most powerful therapeutic tool is the identification with a beloved counselor who has been intimately involved with the child's everyday activities. The authors' have seen children, after treatment in an inpatient program, institute for themselves limits that had previously been set by their counselor, for instance, taking a "time out" in a chair or going to the quiet room on their own.

School as a Therapeutic Milieu

As has already been mentioned, the borderline child's cognitive development is frequently delayed or impaired. This may take the form of a classic specific learning disorder or a more subtle impairment in learning functions. He may have a learning disability that has not been diagnosed because his social and behavioral difficulties are so pronounced that subtle underlying perceptual-motor or cognitive deficits are overlooked. A complete psychometric and cognitive assessment is imperative in elucidating the nature of the child's learning difficulty. Often a specific individualized program needs to be devised to meet the child's educational needs.

The school situation confronts the child with expectations and requirements that the borderline child is frequently unable to reach at first. The problems with impulse control, difficulty in delaying gratification, and the relative ease of disintegration make the classroom an especially problematic area for the borderline child. Since many of these children have not adequately internalized controls and since their social conscience still depends on the presence of an adult, these children have special difficulties being members of a group and taking their places in a more or less democratic social setting. They frequently demand the exclusive attention of the teacher and, when that is not available, behave in such a way as to force the teacher to attend to them. The more withdrawn borderline child, when not given the constant and exclusive attention of an adult, will retreat to a schizoid reverie.

Another major factor that affects the borderline child's adjustment to school is his inability to develop and elaborate satisfactory sublimatory channels. School and the process of learning provide for the healthy child a rich variety of sublimations, which, when successful, are very gratifying to the child and promote a strong investment in learning. The capacity for successful sublimations is limited for many borderline children and, when present, is subject to great fluctuations under the pressures of internal conflicts, the breakdown of age-appropriate defenses, and frequent regressions. For instance, in the child's view, the teacher too readily becomes the parent who is viewed with marked ambivalence, and struggles ensue that are based on

conflicts originating well outside the classroom setting. Therefore, the learning situation may be experienced as unsuccessful and ungratifying. In addition, many borderline children have a very fragile regulatory system for self-esteem and when confronted with academic challenges at school feel overwhelmed and incapable. They tend to give up in despair, become self-denigrating, and are especially sensitive to criticism and failure. For example, a child of nine with a superior intelligence had a remarkably inconsistent report card from school with the frequent comment that when he cannot solve problems immediately, he gives up in despair, tears up his papers, sulks, refuses to do any more work, and calls himself stupid and dumb.

Generally, the children who are not learning up to their capacity and who are management problems in a regular class do function much better in a small classroom that permits considerable individual attention, with tutoring addressed to their specific limitations. The small class allows the child an opportunity for more guidance and reassurance from an adult. Also, since many of these children are easily overstimulated and have difficulty screening out distractions, the smaller, structured setting is useful. Often, by the time these children come to professional attention, they have already fallen considerably behind in scholastic achievement. This deficit contributes further to their low self-esteem. The child's teacher often needs consultation and support since, as has already been mentioned, these children present special emotional challenges to the people working with them.

Medication

In general, the use of drugs with children is complicated, unpredictable, and still rather poorly understood. However, there are some situations in which medication can be quite useful in treating the borderline child. If, as a significant part of the clinical picture, there is evidence of attentional disorder and hyperactivity (often including specific learning disorder and evidence of central nervous system dysfunction) dextroamphetamine or methylphenidate may be given a trial.

The management of anxiety is a major problem with all borderline children, and, on occasion, antianxiety medication may be useful. The minor tranquillizers so often used with adults are of limited value with children. Some children with crippling anxiety do respond to some of the major tranquillizers. The authors have found Thioridazine, chlorpromazine, Trifluoperazine, and haloperidol especially useful. Generally, anything that will help increase his sense of mastery is very important to a borderline child, and if medication can help him decrease or tolerate severe anxiety and control his bodily functions it should become a part of the overall treatment plan.

Side effects, although limited and usually not serious, can be distressing to borderline children and their families, who often have rather extreme and magical fantasies about drugs and their effect on the body. One father of a ten-

year-old boy who had agreed to the authors' trying Thioridazine for a period of time to help the boy's extreme anxiety and subsequent wild behavior, gradually became quite paranoid about the use of the drug for his son and, without telling the authors, stopped giving the medication to the boy. This father also became much more suspicious and guarded with the staff at this time. Another borderline boy, who was eight years old, showed marked attentional disorder and hyperactivity and was given methylphenidate. He experienced a decrease in appetite, especially at noontime, and, instead of sitting at the lunch table with other children as he had done previously, isolated himself, sucking his thumb and looking extremely perplexed. It gradually became clear that the loss of appetite, although not pronounced, was confusing and frightening to this child who was overly reactive to most external and internal sensations. It is important, then, to be especially alert to the fantasies, misinterpretations, and magical beliefs of both the child and the parent when administering medication to borderline children.

In summary, the treatment of the borderline child is complex and of long duration. Individual psychotherapy is most important, but only one of many factors in the total therapeutic constellation, which touches almost every aspect of the child's life. Furthermore, the authors have found that therapy often has to be continued until the child has progressed into early adolescence in order to ensure the consolidation of therapeutic gains.

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Notes

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