

## **BORDERLINE CHILDREN AND YOUNG ADULTS: FACING THE CHILD'S NEEDS IN THE CASSEL HOSPITAL THERAPEUTIC COMMUNITY.**

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### **SUMMARY:**

The present document describes the current views and approaches on Borderline Personality Disorders, (BPD), in children and adolescents. The author stresses the lack of empirically supported research on the subject, very scarce in the adult population, and practically non-existent in the adolescent and child group. Much more research is needed on the subject to reach conclusive evidence.

Among the different approaches valued when treating BPD non-adult patients, the contribution of the Therapeutic Communities (TCs) is emphasized, highlighting the work done at the Family Unit of the *Cassel Hospital Therapeutic Community*, in London, England, and raising the issue of how the budget crisis of the National Health service is going to affect the quality of attention given to BPD children.

### **RESUMEN:**

En el presente artículo la autora resume la aproximación que se realiza en la Comunidad Terapéutica del Cassel Hospital de Londres en la evaluación y tratamiento

**de niños y adolescentes que se presentan con sus familias frecuentemente en situaciones de graves crisis.**

**La intensa y prolongada actividad desarrollada actualmente se encuentra actualmente amenazada por las drásticas restricciones presupuestarias por las que atraviesa el Servicio Nacional de Salud Británico que hace peligrar actividades como las que se describen que no cuentan con demostraciones “basadas en las pruebas” de su eficacia.**

#### 1. CURRENT VIEWS ON BORDERLINE PERSONALITY DISORDERS IN CHILDREN AND YOUNG PEOPLE.

The “Borderline Personality Disorder”,(BPD), is a complex psychiatric disorder characterized by unstable personal relationships, intense anger, feelings of emptiness, and fears of abandonment, that result in impaired functioning. It is a term full of diagnostic ambiguity. The concept remains unsatisfactory, as it describes, above all, symptoms, not traits. Its validity is thus, not high, because although it has been similarly described in many countries, the biological findings remain doubtful and scarce, in spite of some reliable neurophysiological results. These findings, mostly concern the adult population, and if anything, the term remains yet more confusing and mired with controversy, when applied to children and young adults (Bleiberg, 2000).

Currently, the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR)* allows BPD to be diagnosed in adolescents when maladaptive traits have been present for at least 1 year, are persistent and all-encompassing, and are not likely to be limited to a developmental stage or an episode of an Axis I disorder (APA, 2000; Becker et al., 2002). In other words, it is possible to diagnose borderline personality disorder in children and teens, but only if the symptoms have been present, continuously, for over a year. The manual also underlines that evidence of conduct disorder, with onset before the age of fifteen, (characterized by aggressive behaviour towards

people and animals, destruction of property, deceitfulness or theft, and serious violation of rules), is common in the history of adults diagnosed with BPD (APA, 2007).

We must keep in mind that any diagnosis of BPD should be done with extra care when speaking of adolescents and, especially children, as the personality of both age groups is still at a developmental stage. It follows that, the older the child, the more certain the diagnosis. As Bleiberg points out (Bleiberg 2000), problematic behaviour, or difficulty with emotional regulation in children, could be labelled as borderline, but it is in adolescence when the onset of the full range of borderline symptomatology is triggered, and becomes more evident. Adolescents with BPD have disturbed thinking patterns and always seem to be in crisis. They can be rational and calm one moment, and then explode into inappropriate anger in response to some perceived rejection or criticism, the next. The disorder occurs in all races, is prevalent in females (female-to-male ratios as high as 4:1), and typically present by late adolescence (Finley-Belgrad E., Davies J., 2005). The unstable relationships become prominent and transient idealization and clingy overdependence alternate with rage and devaluation, and feelings of abandonment and betrayal. In girls, promiscuity and self-mutilation are common behaviours, while the boys are commonly aggressive. The use of drugs, alcohol, or food binges are strategies used to block feelings of discontrol, fragmentation and loneliness, brought on usually by their difficulty to relate appropriately to others. Suicidal and parasuicidal behaviours come forth, as a way to release tension and restore the capacity to feel alive, escape anxiety and depression, punish disappointing or abandoning partners or manoeuvre to evoke guilt or involvement in others (APA, 2007).

The presence of comorbid disorders to BPD can complicate both diagnosis and treatment. These disorders, which include mood disorders, substance-related disorders, eating disorders (notably bulimia), post-traumatic stress disorder, other anxiety disorders, dissociative identity disorder, and attention-deficit/hyperactivity disorders, are commonly suffered by borderline children and teens. Depression is particularly common in patients with BPD (APA, 2004). Other personality disorders have also been documented as comorbid with BPD. A study of 138 adolescents and 117 adults with BPD showed a significant occurrence of schizotypal and

passive-aggressive personality disorders in the adolescent group, and antisocial personality disorder in the adult group. The researchers suggested that BPD may represent a more diffuse range of psychopathology in adolescents than in adults, because adults had comorbidity only with another Cluster B disorder, whereas adolescent comorbidity encompassed aspects of Clusters A and C (Becker D., Grillo C., Edell W., McGlashan T., 2000).

In terms of the diagnosis, it is unclear how helpful diagnosing a child or teen with BPD would be. Borderline pathology in children refers to a syndrome characterized by a combination of disruptive behavioral problems, mood and anxiety symptoms, and cognitive symptoms. Follow-up studies of these children show that they have a tendency to develop a wide range of personality disorders, not just BPD. Although borderline pathology in childhood is not necessarily a precursor to BPD in later adolescence and adulthood, evidence suggests that both have strikingly similar risk factors, which may indicate a common aetiology. These risk factors include: family environments characterized by trauma, neglect, and/or separation; exposure to sexual and physical abuse; and serious parental psychopathology, such as antisocial personality disorder and substance abuse, (Finley-Belgrad E., Davies J., 2005).

There is some evidence that BPD diagnosed in adolescence is consistent in adulthood. It is possible that the diagnosis, if applicable, would be helpful in creating a more effective treatment plan for the child or teen, but the need of more evidence based studies is a key for these treatment plans to be successful (Netherton, S.D., Holmes, D., Walker, C.E. 1999).

## 2. TREATMENT OF BORDERLINE CHILDREN AND TEENS

The treatment studies on children and adolescents with BPD are virtually nonexistent, and very scarce in the adult population. Although treatments effective in adults would be expected to be efficacious, research demonstrates that this efficacy is needed, (APA, 2004). Overall, treatment planning should address BPD, as well as any existing comorbid disorders, and must be flexible to respond to the changing characteristics of the child and adolescent in their

development. The child, youth, and family need to realize that the treatment will take an extended amount of time.

In essence, the same treatment is applied to children and teens, than to adults, though taking more cautionary measures. Multidimensional programmes combining pharmacological treatment with psychotherapy conform the primary treatment of BPD. Though, when considering biological treatment for selected symptoms, one must again realize that data is lacking on their use with children and adolescents, and be aware of the US Food and Drug Administration's (FDA's) raised concern on suicidality in children and adolescents treated with antidepressants (FDA, 2005). The most commonly used medications are as follows: The affective symptoms are initially treated with a selective serotonin reuptake inhibitor (SSRI). The mood stabilizers (lithium, valproate, and carbamazepine) remain a second-line or augmentation treatment. The impulsive behaviours are also treated with SSRIs. Valproate, carbamazepine, and atypical neuroleptics are also administered, despite limited data (Schulz, 2004). As for the cognitive-perceptual symptoms: low-dose neuroleptics are the treatment of choice. The biological treatment must be considered very carefully, as many times the secondary effects can prove to be equally, or more disruptive, to the young patient than the actual borderline symptoms.

Along with pharmacological treatment, extensive therapy is required to attain and maintain lasting improvement in their personality, interpersonal problems, and overall functioning. The long-term dialectical behaviour therapy (DBT) appears to be one of the most effective. DBT is a type of cognitive behavioural therapy that focuses on coping skills, so patients learn to better control their emotions and behaviours. This may be complemented with symptomatic psychopharmacology to address affective instability, impulsivity, psychotic-like symptoms, and self-destructive behaviour. Psychoanalytic/psychodynamic therapies have also proven effective (APA, 2001). Within these, therapeutic communities (TCs), have demonstrated to be a valid option for the treatment of borderline children and young adults, as the communities provide the general, intensive and long term treatment that is so beneficial to the patients suffering from these disorders (Campling & Dixon Lodge,

1999a, 1999b; Campling & Haigh, 1999). One of these therapeutic communities is the Cassel Hospital. This hospital in London, England, is a unique therapeutic community in that it provides therapy based on psychodynamic concepts, but combining them with psychosocial principles. In the next section I will proceed to describe the way in which severe borderline children and adolescents are treated within the Family unit and Children Centre of this Hospital.

### 3. BORDERLINE CHILDREN AND TEENS AT THE CASSEL HOSPITAL

In the root of the work at the Cassel Hospital, lies the philosophy and main goal of the Therapeutic Community: to focus on the quality of relationships and communication between people, on the way they naturally set about dealing with one another, as the essential working material of treatment. It comes down to the individual within the group being able to see the fellow human being in the other person, whether patient or colleague, and to create environments where anyone can learn to see one another in this way (Kennard D., 1998). The hospital's day to day revolves around these three key ingredients, cited by Maxwell Jones (Jones, M., 1982), and that are common structures to other existing TCs: the community meetings, the staff review meetings, and an overall *culture of enquiry* that promotes a “living and learning experience”. These structures are a necessary tool that enables the discussion of relevant incidents; and in turn, this discussion allows further insight into the reasons of individual and collective behaviours. It is a way of testing distorted perceptions against common consensus, and has been vital in all borderline patients as a way to confront the polarized reality they live in.

The Cassel Hospital consists of a recently merged Adult and Young Person's Unit, and a Family Unit. As a whole, it provides a specialist inpatient psychotherapeutic treatment for adults, young persons and families within a therapeutic community context. It also provides

an assessment and consultation service, and a specialist outreach service that acts as a bridge between the residential treatment and the complete rehabilitation of the patient into his community. Of special interest to this paper is the services provided by the Family Unit, (and within it the Children Centre), as it exemplifies the value of the TC ideas when treating young persons and children, who show incipient, if not already manifested symptoms of BPD.

### 1.1. The Family Unit and Children Centre

The Cassel Hospital has a distinct structure from that of other TCs, combining individual psychotherapy with psychosocial nursing taking place within the community of up to 50 patients. As Hinshelwood explains, (Hinshelwood, 2002), this dual track approach keeps the individual work separate from the community, but it also allows more specific psychoanalytic thinking about the community itself, as a tool of therapy. The psychosocial practice plays a key role in the day to day life of the hospital. The nurse works alongside the patient rather than for him/her. In doing so, the potential for a particular intimate relationship is developed, reminiscent of those with important others in childhood, usually within the nucleus of close relations (Santos, A., Hinshelwood R.D., 1998). This acquires special relevance when working alongside a family in the hospital unit. The nurses' work will evoke strong reactions in both the parents and child, and the transference and countertransference emerge strongly, as important material for later use, both in the individual psychotherapy sessions of each member, and in the family sessions.

The families that come to the Cassel are families going through severe and extreme difficulties. Most of the referrals are done through court, involve varying degrees of abuse and neglect in the history, and require intensive specialist input from both therapists and nursing staff. Prevalent diagnoses are different forms of personality disorders, BPD being the one most frequently manifested (or incipient) in the child or adolescent. The common comorbid disorders mentioned before, associated to BPD are also present: depression, eating disorders, substance abuse, etc... The parents have undergone traumatic childhoods, many times having been themselves victims of the abuse and neglect, that they are now inflicting upon their children. On the other hand, children still going through a very traumatic experience

commonly present conduct disorders, and as they reach adolescence there is an increase in self-harming behaviour and suicidality, and the emerging borderline symptomatology becomes evident.

The aim at the Cassel is to treat and assess the family as a whole, but keeping in mind the child's well-being and best interests. The importance of the parent-child attachment, in Bowlby's sense (Bowlby, 1988), is considered throughout all the treatment and assessment of the family dynamics. Whenever possible, rehabilitation and reconstruction of a healthy family life will be attempted, when not, therapy will be structured around the management of the difficult feelings that the final separation and loss will evoke in each member of the family, most especially in the child.

Central to the work with these families is the notion of the *ordinary work of the day*, around which both psychotherapy and nursing work is focused (Kennedy R., 1986). The term *work of the day* makes reference to those events that are significant to the individual and his/her family, which have precipitated some kind of thought process and/or action: unsolved problems, major worries, overwhelming experiences, undigested thoughts, forbidden or unsolved thoughts... In other words, what has been rejected and suppressed and set in motion by the unconscious. This is what provides material for thought and provides a basic frame for living, enabling us to discover the underlying emotions through the ordinary daily events. In the patients that we are talking about, the things that they do are charged with emotion and conflict, and they will emerge in the day to day activity. Between individual and family sessions parents are expected to take an active role in the community, attending the daily community meetings, the parent meetings with other families in the community, (and where the struggles that relate to parenting are discussed) and overall, work alongside the nurse in the difficult process of rehabilitation.

The children, on their part, also undertake normal day to day tasks. In their case they are expected to attend school and engage with activities more adequate to their age. Depending on their circumstances they will continue to part-time attend the mainstream school outside the community. Otherwise, they will attend, full time, the school and nursery that the Children

Centre provides. This school offers an educational environment, individual, and small group teaching, to all school age children from the family unit and to some adolescents from the Adult and Young Persons Unit.

The school is staffed with a teacher and a psychosocial nurse that work alongside the pupils. Many of the symptomatology of the BPD children and teens becomes more evident during these school hours: The sudden acute anxiety, when presented with an exercise that lies within their resource; their inadequate defence mechanisms, such as denial, and projective identification, which is many times followed by acute rage reactions and destruction of objects, and on occasion, attacks on people; The general behaviour is erratic, at one time they are coping and at the next they are disintegrating; The poor impulse control, that is either insufficient or excessive, and the impairment in the ego and object relations, makes it difficult for them to relate to themselves and to others (Kernberg,1991;Lubbe, 2000).

The school setting gives each child a separate space from that of the family, in which he/she can feel in control, but at the same time taken care of. The teacher and nurse set the scene for the borderline child to change, to be able to form trusting relationships, feel safe and secure, build their self-esteem and self confidence, and develop social skills that will allow them to live comfortably with others. BPD children require regular and repeated experiences to help reframe their view of themselves and the world around, and repair their distorted perceptions. In the school, and in the community, the staff need to be prepared to deal with the same issues, the same extreme levels of resistance and insecurity, and the fight/flight reactions from the children on a daily basis. What was achieved the day before, will need to be faced several times, before any real change is effected (Lole, A., 2003).

Schooling and a life in the community prove an essential part in the creation of a safe, nurturing and *holding* environment (Winnicott, 1964). Family rehabilitation is a difficult and arduous process. The parents are not yet able to provide the containment for the healthy development of the child, but are in fact, a source of the opposite feelings of insecurity and inconsistency. In this delicate situation, the Children Centre and the Community offer the

environment in which the child can feel slowly tolerated and cared for, able to learn anew how to respond to adults who set appropriate and thoughtful boundaries (Pooley J., 2003).

As Flynn points out (Flynn D., 2004), when working with borderline children, the dual approach of psychosocial nursing, allowing the child to experience a normal developing relationship, and the psychotherapy, which follows the unfolding transference, are a key for the modification of behaviour. They remedy the deficits the child has suffered in his early attachments, and allow, in the growth of the transference relationship with the therapist, the emergence of a central figure in the inner life of the young patient, and with it a capacity to deal with internal conflict.

Adolescents take a more active role in the life and daily responsibilities that living in a TC requires, as the hospital tries to balance both the necessity of a nurturing environment, and the need for a greater independence that a healthy person, nearing adulthood would need (Flynn, D., 2003). Thus, they will take part in the Community Meetings and discuss along with other patients and staff the daily occurrences and problems that have arisen, both on a personal, and on a communal level. Behaviours such as, self-harm, suicidal attempts, drug use, usual in the borderline patients, will be brought up, and confronted. The borderline teen has then to face the consequences of his/her actions on other members of the community, and in doing so, analyze the reasoning that was behind the acting out. The common consensus, combined with the individual therapy, helps integrate a more consistent sense of self, so necessary in BPD patients. It is the starting point to repairing their broken relationships with carers, families and peers, and the first step in the construction of a consistent inner world that will enable them to relate adequately with the outside world.

Engaging with patients suffering from BPD is always a very difficult and taxing process, more so, when treating children and teens within a severe dysfunctional family setting. It is in this situation when the value of the Cassel Hospital becomes evident. The hospital provides the long intensive global attention that these children and families need, if they have any hope of rehabilitation, offering the holding, containing environment so necessary when working with these highly disturbed patients.

#### 4. CHANGES :THE FUTURE OF THE TREATMENT OF CHILDREN AND TEENS IN THE TC'S

On the 24<sup>th</sup> of November 2005 the Lords of Appeal overturned a previous childcare case law in England, effectively reinstating the distinction between the medical psychiatric assessment and the treatment of a child (Kent County council vs. G & others , 2005). They upheld that the purpose of the section 38 (6) of the Children Act 1989 was to grant an assessment of the child under an interim care order and, that the power of the court to order local authorities to fund the treatment of the child did not fall within the remit of that section. This, has far reaching consequences for the Cassel Hospital, as the psychosocial treatment does not fall within the provisions of the National Health Service (NHS). The Therapeutic Community has always functioned through public funding, and this appeal, plus the current economical crisis of the NHS, makes the future of the Cassel Hospital uncertain. More so, it leaves the real possibility that once the assessment of the child's need is completed, access to treatment will then not be granted. The Cassel is one of the few specialist centres that deals with the complex psychosocial problems of neglect and abuse, but if not funded, its work cannot continue. This raises the very worrying issue of how then to attend to the welfare of the minor, and break the cycle of deprivation and abuse, that will otherwise be transmitted through the next generations in England (Jones, B., 2006).

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