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CLINICAL

LEVELS OF BORDERLINE FUNCTIONING IN CHILDREN: Etiological and Treatment Considerations

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It has been noted frequently in the literature that the term "borderline pathology" denotes a range of disturbances. While borderline patients are characterized by severe object relations problems, there is an extremely wide range of ego functioning in these patients. Stemming from work with borderline children, this paper describes this range of varied functioning and develops inferences, based on clinical material, regarding the etiology of these differences.

Discussion of the borderline syndrome in the adult literature has always appeared to be mired in controversy.[1-8] Initially, there was question of whether the borderline condition described temporary regressed states rather than a syndrome which represented a stable pathological personality organization. Subsequently, for a number of years, there was much debate about the ability to distinguish the so-called lower-order adult borderlines from psychotic patients. Was the quality of regression, the loss of reality testing, the transference psychosis that emerged in the borderline patient separable from the qualities of the typical psychotic patient? In more recent years, there has been increasing interest in clarification at the higher end of the borderline spectrum. Can we adequately distinguish between the relatively "well functioning" borderline patient and the severely neurotic one?

The purpose of this paper is to describe borderline syndrome in children, to see if we can shed some light on these current borderline issues. Using material from a recent study of borderline children at the University of Michigan, this paper will address a number of questions. It will describe the general criteria we used to distinguish these children as "borderline." It will highlight the differences in the two major groups of borderline children we have

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delineated—the more typical borderline youngster and the relatively well-functioning borderline child. In addition, several developmental hypotheses attempting to understand the higher levels of integration and adaptation reached by the more adequate group of children will be discussed. It is this latter group of children particularly that creates the diagnostic ambiguity between borderline, characterological and severely neurotic classifications. For the adult psychotherapist, this highly functioning yet severely disturbed patient group may be of particular interest. It is more likely that these more integrated (presumably) borderline children represent the kind of adult patient now included in the more-disturbed-yet-treatable group.

GENERAL DESCRIPTION OF THE BORDERLINE GROUP

During the middle and late seventies, we studied a group of 15 latency and early adolescent children who were both inpatients and outpatients.* These children presented with a severe form of childhood psychopathology that was clearly not neurotic or psychotic. We concluded that there was a relative stability to the character and pathology of these children, which paralleled aspects of the adult borderline personality organization.** In our work, which has been described in greater detail elsewhere,[2] we highlighted four aspects that characterized the borderline child: *1)* instinctual defects, *2)* ego defects, *3)* object relations defects, and *4)* developmental defects. Since there are differing concepts of borderline, the criteria we used for our population will be briefly reviewed in the context of other borderline literature.

Instinctual Defects

We found that our patients struggled with a predominance of pregenital aggression[5] and that the egos of these children could not give direction to their drives.[8] We felt there were a number of sources for this problem in aggression. Some of these children seemed to be endowed with a "constitutionally determined heightened aggressive drive," as suggested by Kernberg[5] in describing his patient population. Other histories pointed to some of the early mother-child dynamics that Mahler[6] identified: namely, that there were major problems in the separation-individuation subphases of development. It was our impression, however, that the mother-child crises were less focused in the rapprochement subphase, but that the lack of an adequate "holding environment" was evident earlier in the narcissistic (symbiotic) phase during the first year of life. A striking additional finding noted in our population, which gave impetus to heightened problems in pregenital aggression, was physical illness in the first year of life. The various kinds of pain and discomfort seemed to be interpreted by the child as a powerful aggressive attack from without, confirming that reality was painful and devoid of pleasure.

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* All of these children were seen within the Children's Psychiatric Hospital, University of Michigan, for a period of two to four years.

** The diagnostic process consisted of material gathered through parent and collateral interviews (*e.g.*, school, physician), several interviews with the child, and psychological testing. (If inpatient assessment was indicated, ward, school, and therapy notes would be added.) The material would be assembled using the format of the Diagnostic Profile (Hampstead Clinic), and presented to the total staff of the research group in a formal assessment meeting. Patients who met the four criteria we had established became subjects in our research group.

Ego Defects

The heightened aggression seemed to have a marked effect on ego development in our child population; this became particularly evident in defense formation. The prominent use of the mechanism of "splitting" was particularly evident, since the children appeared unable to integrate the representations of the bad, aggressive maternal images with positive representations. They could only sustain an image of a good, supportive nurturing object by "splitting" the good from the negative perceptions. Associated with these prominent and primitive defenses were the other more primitive defenses of projection, devaluation, idealization, and denial.[5] In later sections of this paper, we will more fully discuss other aspects of the ego functioning of these children.

Object Relations Defects

As other authors[4, 8] have found, our borderline children related to objects on a need-gratifying basis primarily, and were unable consistently to reach the level of object constancy. Some of our children developed these "need-fulfilling" ties with real people in their environment. However, a significant number of the children withdrew from the perceived pain and lack of gratification in the real world and real attachments, and "peopled" their fantasy life with the omnipotent, protective need-satisfying objects they sought.[3] Their fears of real dependency and closeness to the object also served to promote this extensive fantasy world, and to develop a schizoid-like posture in a number of these children.

Due to the need for the protective, life-sustaining qualities of their objects, these patients erected "self-objects" upon whom they endowed and projected these omnipotent qualities. This was a form of impoverished object relations, since it obscured the real personality traits and character of the objects. It markedly interfered with the ongoing process of constructive identification for these children and limited many dimensions of their personality growth and development.

One of the differences of our findings from those in the general literature[8] was the relative lack of anxiety of object fusion or merger in our child population. This group of patients seemed able to achieve a clarity in terms of physical body integrity, and therefore little anxiety was evident in the area of self-other boundaries. They sought objects and showed marked dependency in their search for safety, in order to deal with their sense of helplessness. But, generally, we found little evidence of anxiety related to the fear of fragmentations or the breakdown of the "cohesive self."

Developmental Defects

It was our general conclusion, in confirmation of other authors, that borderline pathology in childhood represents an inability to progress through early developmental phases and that, through time, certain deficits emerge which are characteristic of that earlier arrest. We found that the children we studied made a partial transition out of the state of narcissism (of the phase of "symbiotic union"[6]). On the one hand, these children were able to achieve effective self-other differentiation, which separated them from the psychotic child. However, due to the heightened problems of early aggression, they failed to achieve the next step in the transition out of narcissism. They were unable to integrate the painful representations and the pleasurable representations of their objects, and correspondingly the "good" and "bad" aspects of the self. This led to the mechanisms of "split-

ting" described by many, and the major problems in development due to the inability to assimilate "good" and "bad" introjects. While the mechanism of "splitting" later had major defensive uses, it emerged out of a failure in early development. Therefore, the distinguishing quality of the borderline children was their partial transition out of narcissism—their achievement of early self-other differentiation on the one hand, and their lack of achievement of their integration of "good" and "bad" aspects of object and self on the other.

CONTRASTING THE BORDERLINE GROUPS

While all our patients evidenced some similar defects (instinctual, object, and ego defects), four of our youngsters clearly functioned on a higher level and were more integrated. These patients, who tended to be represented more in our outpatient group, showed little evidence of impulsivity or rapid oscillation of ego states and often achieved significantly in school and in other areas of their lives. Clinical material from two cases, representing and contrasting children from the two groups—the typical borderline and the "highly functioning" borderline child—will illustrate some of the differences.

Matthew

Matthew represents the typical and more disturbed borderline youngster in our study. Matthew was a ten-year-old youngster hospitalized because of severe withdrawal, but also because of frequent impulsive outbursts that were apparently unprovoked. On the ward, Matthew was quickly nicknamed "Cartoon Boy." Each day he was found totally engrossed in himself in the corner of his room, producing his shows and cartoons. The cartoons were introduced by the appropriate Looney Tunes melody; one heard the sound of the chase, the scuffling, the ultimate victory of his character, and the cartoon was clearly over when the last few fading bars of the introductory melody were repeated. His hero, Popeye, was represented by a little toy animal, who vigorously fought off Bluto, other monsters, or tornadoes with great animation. Where the demands of the day interrupted Matthew's cartooning (for example, when called to lunch), he loudly announced "Intermission" and tentatively and fearfully joined his ward mates in the dining room.

"Cartoon Boy" was also called "baby Matthew" because of his need to be unusually close to adult staff. At times he needed to be in their shadow, almost to touch them. He developed rituals in relation to his safe therapist. He visited the therapy building four times daily, always took the same path to go there, and sat in the same chair in the waiting room. The sameness gave a fixed, reassuring quality to his contact with the therapist.

In terms of Matthew's history, his mother described a nightmare-like first year of development for the child. Matthew cried constantly during the day. Often his distress reached screaming intensity without any evident source of irritation or frustration. His parents finally found that the only way to soothe him was to drive endlessly in the family car. Even when he slept, Matthew was obviously fussy and troubled. Throughout that first year, he was tense and stiff when held in his mother's arms. He arched his back away from her, and she found herself unable to calm him. She also had trouble with feeding. As the year progressed, Matthew refused to chew and would not take liquids other than milk and cocoa.

His mother described Matthew at age 4 as an "albatross around her neck." She could not limit him. At the supermarket he ran throughout the store pulling items off the shelves and jumping and climbing over counters. Mother was unable to visit anyone when accompanied by Matthew because he was restless and needed constant supervision. At times, Matthew yelled and screamed in a very infantile way; tantrums, produced by very minor frustrations, were an everyday affair. With Matthew present, his mother found it very difficult to share her attention. He seemed jealous and interfered with her when she was on the telephone. Matthew refused to do anything for himself—he refused to try to unbutton his jacket and waited for his mother to take off his hat and coat. Matthew's mother also noted some of his occasional efforts to restrain himself. He doubled up his fists and made squeezing noises as if to keep himself from breaking things.

Tom

Tom, an 11-year-old whom we saw as an outpatient, represents a youngster from our highly-functioning group. He also evidenced early and long-standing difficulties. Tom's early life was

dominated by pain. He underwent constant pyloric spasms during the first 18 months of his life, and all medication seemed ineffective. His chronic pain was evident—he grimaced, was often doubled up, and cried constantly, particularly in relation to feedings. He fought feedings and vomited a good deal, suffered diarrhea, and gained little weight during that period.

All milestones seemed delayed or not traversed at all, especially those in object development. Tom's mother recalls no early smiling, no growing mother-child dialogue within the first year, no stranger anxiety, and poor molding behavior. Often in pain, Tom held onto his mother tenaciously, clutching her and digging his fingers into anything he could grasp on her person. Under the dominance of pain, he had little tolerance for toys. During the first 18 months, he played little with them, except to throw them or bite into them. There was no unfolding of gross motor development that we typically see: crawling, standing, walking. Tom developed his own unique means of propulsion. Again under the aegis of pain, he dug his heels into the household carpeting while lying on his back, and he pushed himself backward with intense momentum throughout the house. On many occasions, he crashed into furniture.

It was apparent to all members of the family that the pain abated when Tom was about 18 months old. But his parents questioned whether Tom ever recovered from the experience. Essentially, from that point on, Tom was described as a "stoic" youngster. He was easy to handle, never made demands on anyone in the family, and evidenced few needs. But it was felt that he had developed a "shell-like" buffer between himself and the world.

Tom enjoyed reading and made a healthy dent in the extensive family library. Father had spent some time with all of the children, explaining the natural phenomena they experience, in terms of his extensive scientific background. Tom was evidently quite bright, scored superior in IQ on achievement tests, yet the same theme of nonengagement was evident in class. He completed no or very few class assignments, never spoke or volunteered in class, and seemed to drift off mentally during the school day. At times he would also wander back home from recess without comment or explanation to the teacher. He did not arouse anger in the teaching staff; rather, he stimulated rescue fantasies, for though he seemed lost, he was felt to be shy and appealing and teachers longed to make contact with him.

From this early descriptive material and history, both youngsters evidenced early painful feeding histories and major problems with ability to be soothed and gratified by primary objects within the first year of their lives. After a full diagnostic workup using the criteria outlined earlier, we felt that both Matthew and Tom were borderline children. These early first-year deprivations confirmed for them that the real world was a painful or unsafe place. Both youngsters appeared to utilize severe forms of withdrawal to handle this frightening reality. By age ten, Matthew built his extensive "cartoon world." His fantasy life was filled with aggressive monsters and tornadoes. Matthew attempted to handle his fears by identifying with a superstrong, omnipotent Popeye. Tom withdrew into his compliant, buffer-like shell. He "split off" safe and limited areas, and avoided the dangerous world outside.

However, from their early histories, it appeared evident that these youngsters had very different ego capacities to handle this perceived powerful aggressive assault. Matthew showed an extensive history of tantrums, erratic behavior, and a driven restlessness throughout his life. He was often overwhelmed by stimuli. Primitive efforts for control of impulses—like doubling up his fist at age four to control wishes to tear up his home—were ineffectual and represented poorly developed superego building blocks. He sought and clung to outside objects to manage him, to function as an auxiliary ego, and to provide a sense of safety.

Tom appeared to deal with his unsafe and attacking world very differently. His ego seemed able to erect a powerful defensive system, at a much earlier age. There was a quality of massive "coping" when, at 18 months, he withdrew from the painful world. Tom appeared to erect an extensive character defense to ward off "pain" from objects and the world. He was not overwhelmed by

anxiety; he seemed able to use signal-anxiety and to master his internal aggressive impulses throughout his childhood. (Only later, in the course of the regressive pull of therapy, did we encounter his primitive, pregenital aggression.) The schizoid-like character defense, however, prompted many problems, since it cut him off from objects and severely limited his experiences. There was also early evidence in Tom's history of his ability to use his intellect and sublimatory potential.

In the early process of therapy, Matthew and Tom presented their pathology in very different ways:

After Matthew had been successful in controlling his cartoon world (giving up a major defense of withdrawal into fantasy), much more direct aggression appeared. The appearance of impulsive and chaotic material was much more evident. In this post-cartoon period, Matthew often broke up the therapist's office. On the ward, he seemed to direct his physical attacks toward younger girls, attempting at times to scratch and choke them. Following these open attacks, he would engage in intense self-abuse, such as throwing himself against the wall or asking to have his fingers cut off to keep him from scratching.

His theme in therapy was that his "madness" was coming out. The madness came in the form of dreams which filled the entire night and which he then had to relate fully in his therapy sessions. At first, in his dreams, little girls got hurt. They tripped, damaged their knees, and had to go to the hospital for an operation. There was, however, a special rock near the hospital which became a rock monster; it rolled into the hospital and bashed and battered the little girls until they were all dead.

As this material poured forth, Matthew's anxiety mounted. He became more overtly agitated, and random aggressive and self-abusive behavior became a greater part of his total day. After a while, in his fantasies, the little girls changed into one specific little girl—Matthew's sister Katie, whom he described as having long blonde hair. In his continuous dreams, Matthew tricked his sister into entering a rocket alone. His mother, sensing danger, tried in vain to stop him. The rocket flew into space, crashed into meteorites, broke apart, and Katie was killed. For long periods of time, as she rode into space, the wild flight made her scream and yell. There were variations in the dream. At times, Matthew was able to trick his mother into entering the rocket to take the fatal trip. In his sessions, he vigorously played out the rocket trip, smashing the rocket against the wall, mimicking the screams, and at some points stabbing Katie and Mother after the rocket had crashed.

Tom also struggled with his aggressive impulses:

After a number of months in treatment, Tom slowly explained his withdrawal to his home and grounds, and his aversion to the world outside. Ann Arbor was a city of pollution, he believed, and he couldn't stand the streets and shops. There was nothing good to buy in the stores. He also worried that muggers were out to kidnap him for ransom, since he came from a wealthy family. While he knew it wasn't true, he nevertheless felt that one could be assassinated on any corner in the city. (He lived this fear out by not venturing into the city.) Maybe there was even a major murder plot going on, and sometimes he thought his mother was an important member of this evil group. Was I, the therapist, recently hired as part of this conspiracy, and could I be there to brainwash him so that he wouldn't be as vigilant as he needed to be?

Tom's parents had been divorced in recent years, and the father now lived in Sun Valley, Colorado. In reality, contact was very infrequent, and Tom's father never sent birthday gifts, acknowledged holidays or called. Tom, however, felt that his father was a "unique genius," that there was an exceedingly strong bond between the two because they "thought exactly alike." Tom longed for his father; he believed there would eventually be a total reunion, and he would leave the "prison" of Ann Arbor. This wish was in marked contrast to the real world in which he was disregarded by the father. He felt, on the other hand, that his mother was totally worthless—she was weak, empty, and pathetic. He never had anything to say to her. He described a dream in which his mother came up to say goodnight to him during a party with guests downstairs. He noted a blood stain on her white blouse, and he realized he held a knife. Tom totalized this concept of his mother, and his daily plan was to avoid all contact with her.

In this period of treatment, both children struggled with underlying aggression. As Tom dealt with his aggressive impulses, we noted evidence of typical borderline defenses. Tom "split" his introjects into "all-good" images (father)

and "all-bad" images (mother). The splitting led to the process of idealization and devaluation, which had not only affected his object attachments but spread to the world as well. Thus, Ann Arbor, along with his mother, contained the totalized denigrated, polluted, evil world. Tom used denial extensively; his father's real rejection and disinterest had no relevance for him in his need to worship and revere his father. Tom also made extensive use of projection. He expelled all that was bad within him onto the muggers, kidnappers, and murderers who populated Ann Arbor. His hostile, aggressive impulses were separated from himself and infected his surrounding world. Only in a dream did he own an element of his aggression, when he held a knife that apparently bloodied his mother's blouse. While there was some paranoid-like thinking, for the most part Tom's reality testing remained intact. The murder and kidnapping plots were primarily fantasies and unreal. While Tom struggled with his internal aggression, he experienced little anxiety, his defenses remained intact, and there was a minimum of regression.

When Matthew faced similar aggressive impulses toward mother and sister (in the rocket fantasies), his ego functioning deteriorated. He regressed markedly into severe acting out of these feelings, and there was a loss of impulse control. His anxiety became overwhelming and, during this period, primary process thinking dominated his consciousness. Magically, he feared his thoughts were actually hurting his mother and sister, and he desperately wanted the therapist to control these thoughts. We saw, in Matthew, a much more extensive (though temporary) breakdown of reality testing, wherein he was unable to distinguish between internal thoughts and the external consequences. During this period, Matthew experienced flooding of primitive thoughts, cognitive disorganization, and concretistic thinking that was not evident in Tom. As treatment progressed, the quality of interventions for the two youngsters differed markedly. Vignettes from these cases will illustrate the differing courses of the psychotherapies.

The following material describes a productive period for Matthew, when he brought to therapy some of his concerns about working in school:

> Matthew was often overwhelmed in school. When frightened he tore at his books and cried, but then returned to struggle with his assignments. For example, when Matthew began learning about Paris in social studies class, he became very frightened. When he grasped that France was separated from America by a large body of water, he was assailed by "getting lost" worries. It was as if learning about distant Paris reverberated with his own feelings of estrangement. In his sessions, the therapist highlighted and specified Matthew's anxiety. To Matthew, reading about Paris made him feel "lost" from everyone he knew. But he discovered a new approach to his problem. He associated all of the foreign (dreaded) landmarks with familiar landmarks within the United States. The Champs Elysees was similar to a broad street in Detroit, the Arc de Triomphe was similar to the Washington Square arch in New York, and the Eiffel Tower reminded him of the electrical transmitters he saw near his home. The effect of these associations was to invest the foreign places with a kinship to more familiar places, and his separation anxiety seemed to abate.

This very cumbersome system provided a view of the extraordinary amount of energy necessary for this child to cope with object loss; it was nonetheless a more effective pattern than his earlier method of attaching himself to his protecting teacher. By continuing to use this process of familiarizing associations, Matthew was presently able to move farther way from his need for direct, immediate "refueling" objects:

> As Matthew extended himself further, the need to anticipate potential upsets became singularly im-

portant. Matthew developed an "early warning system" so that he could be "on guard." When school was over, for example, he attempted to anticipate his summer fears. When camp began, he worried about insect bites and poisoning, or his "getting lost" worry might return. Before travel vacations with his parents, he prepared himself for car accident thoughts, noise of the subway, reactions to tall buildings, and so forth. A heavy burden of homework or a harsh comment from a cottage staff member would also put him "on guard."

In work with the more typical group of borderline children, the therapist was most effective when he functioned as an auxiliary ego and helped these youngsters develop and strengthen coping skills. The therapist helped Matthew develop an obsessional system, which served as a more adequate defensive structure. Since Matthew (and many other children in this group) had major problems in signal anxiety, the "early warning system" work provided him with greater capacity for anxiety tolerance and reality frustration as he left his isolated world and invested in reality.

The treatment process with Tom took a very different form. Tom enjoyed his fantasy life and, after a significant period of work, he shared his world in a series called the "Henry stories:"

The Henry stories slowly provided a greater avenue into Tom's internal world. A pleasure world appeared that centered on Sun Valley, an area he and his family had visited for many summers. Henry entered into a huge mine shaft and came out, after a long struggle, into a beautiful valley. He lived there in peace in a small house and endlessly watched the wild life, the vegetation, and the light around him. Stories included wandering through the woods, touching the deer he had befriended, and walking in the company of two dogs he had known. His stories, at first, had no beginning, middle, or end. They were captured still-life scenes that he recounted in detail. His rebirth fantasy through the long mine shaft led to a pleasure world of pastoral peace and beauty. There was a strong sense of a total, endless world of pleasure, a Garden of Eden where no pain ever entered.

The threat to Tom seemed to be the state of being in need, for with the tension of need an object was necessary. The Henry stories often led us to view the Nepal Man, a special character in the stories: Henry passed this old man who sat endlessly in a religious trance. Because of his inactivity, he could survive on the juice of one orange every other week. At times when the Nepal Man was going to move his hand to reach out, he would squeeze it in a particular way with the other hand, stop the motion, and create a temporary paralysis. Similarly, Henry passed an old woman who sat trying to thread a needle. Though she was shaking from age, she never stopped and she evidenced no frustration or need for help.

When Henry finally turned to people, the objects were typically empty. Henry wandered into an old warehouse that was filled with rusty cans and parts of old tools. He picked them up, one by one, and examined them. Finally, he came to a room with a bed in it. When he lifted up the cover, he was confronted by a skeleton in the middle of the bed. Sir Henry went back into time to the era of King Arthur's knights. He mounted his steed and rode out. Facing him on the highway was the figure of the Black Knight. He was still, and Henry attacked with his lance. The knight clattered to the ground and when Henry lifted the iron mask, there was nothing but blackness inside. On another occasion Henry rode down in his kayak on the Colorado River. Vultures circled overhead. He was frightened and moved to a cave for safety. No one lived there and he could only faintly make out the writing of some dead civilization on the stone walls.

Interpretations and reconstructions were possible with this material. Tom was uncomfortable with his isolation. The therapist discussed with Tom his wish (like the Nepal Man) to set up a "need-free existence" which minimized his involvement with others. The therapist reconstructed the roots for him—early feeding experiences (states of need) produced exploding pain when he was little, and he now expected the same pain or emptiness to engulf him if he emerged from his barriers. Generally we found in our work that the "highly-functioning" group of borderline youngsters had some significant capacity for intense insight-oriented psychotherapy and they could at times deal meaningfully and effectively with unconscious

material. There were restrictions, however, on their capacity to tolerate transference-based work.

In summary, Matthew and Tom illustrate similarities and differences we have found in our two major groups of borderline children. Both groups tended to have significant object relations problems, show significant problems in their instinctual drives (dealing with aggression), and illustrate the primitive defenses of splitting, idealization, devaluation, and projection. However, there are major differences in many other components of ego functioning which allowed the "higher-ordered" group to function on a very different level.

In general, the better functioning group had less tendency for regression and much better anxiety tolerance. They were able to develop stable impulsive-defense configurations. Secondary process thinking was more highly developed in the well-functioning group. They had a capacity for verbalization, extensive speech, imaginative thinking, and metaphor rather than action. There was evidence of some successful sublimation. Creative and synthetic functions were achieved by these youngsters outside of the object relations realm. Their capacities in ego functioning and affect tolerance sharply distinguished these two groups, and these differences were expressed in their general functioning as well as their treatment capability.

DISCUSSION

How can we explain the differences between these two groups of children? How does the "well-functioning" group achieve the level of integration and structuralization that becomes evident in their development? At this point, we can provide some inferences based on clinical experience with these two groups of patients. While we can initially speculate that Tom (like the other "highly-functioning" children) is perhaps better endowed than Matthew—namely, that basic primary ego functions such as perception and memory may be of better quality—it is clear that important sources of motivation were required for him to utilize these basic ego ingredients.

In our general theory of normal development, the development of the child's complex ego functions, capacities, and abilities depends significantly on the nature of object tie. The child masters basic tasks, slowly becoming civilized and accepting of reality because of his attachment to the object. The object serves as the primary and critical catalyst for integrative development. For example, while the young child is endowed with some capacity for language, this function develops through the affective context of the mother-child relationship. During the first year there is an affective grounding expressed through the mother-child dialogue. Words and phrases develop to please the object and to be able to communicate the child's specific needs and wishes to the object in the search for gratification.

All borderline children evidence major problems in object attachment and typically fail to develop "object constancy." Motivation for growth and development in relations with others is often minimal. Tom's object images are empty. The skeleton figure on the bed provides no warmth. When unmasked, the Black Knight on the horse is empty inside. The language Tom does find on his travels comes from a dead civilization and he is unable to make out the faint lettering on the cold rocks. Clearly, for Tom and many of the children in our study, their objects were significantly

ungratifying and did not serve as a primary source or motivation in development.

For the "well-integrated" borderline youngsters, the impetus for organization and integration of their world seemed to stem from their driven wishes for survival and the avoidance of pain and terror, rather than from object attachment. Tom, for example, in his efforts to minimize pain stemming from early feeding experiences, worked tenaciously throughout his early years to develop a "needless" (need-free) state. In his history, in contrast to Matthew, Tom had the capacity to erect a "stoic equilibrium," a shell-like buffer from the objects and the world that he saw as producing exploding pain. He appeared to develop an early capacity to control his impulses and needs in a highly directed manner. In treatment, he described this "needless" state in the person of the Nepal Man, the epitome of the self-contained man, who Henry often sees in his trance. He survives on the juice of an orange every other week, and has a way of paralyzing his own arm in mid-motion as the hand reaches out for any help. Tom symbolically warded off the early powerful feeding situation by containing the hunger needs. The trembling old woman, a similar self-contained figure, arduously struggles to thread a needle but never turns to others for help. These images were both ego ideals and self-representations for Tom, describing the adaptation he created that minimized the pain of the real world. However, these images, highly developed and elaborated, emerged from his extensive reading and library. They were part of a major quest to monitor and master his needs, and he developed and utilized many ego functions in his drive for this equilibrium. In general, in our well-functioning group, the motivation to master the perceived fears of the real world appeared successfully to stimulate the development of many adaptive capacities.

A parallel and additional source of motivation for the better endowed children in our study emerged from their need to erect and develop a pleasurable world. A significant number of our population developed "Garden of Eden" fantasies, worlds of endless pleasure. These worlds had all of the features of the early, omnipotent, undemanding, symbiotic environment, akin to the period of primary narcissism. In the construction of these worlds, complex ego functions and much learning seemed to occur. Yet the function of this primary creativity was maintained in the service of omnipotence. It differed from the function of fantasy in normal children, whose fantasy life is anchored in reality, serves as trial action, and leads to doing. (While Tom had achieved a major store of knowledge, he had little investment in performing in school.) Such atypical motivations (dealing with the projected painful world, building the fantasized pleasure world) seemed to provide the impetus for adaptation and integration in part of our borderline population.

It is our conclusion that part of the controversy related to understanding and treating "borderline" patients in general stems from many authors generalizing from a specific type or level of borderline patient. We have described a range of borderline pathology in children who, while they have the essential features of this pathology, have markedly different ego capacities and achievements. These differences substantially alter the treatability and prognosis for a significant part of the borderline population.

REFERENCES

1. ABEND, S., PORDER, M. AND WILLICK, M. 1983. Borderline Patients: Psychoanalytic Perspec-

tives. International Universities Press, New York.
2. CHETHIK, M. 1980. The Borderline Child. *In* Basic Handbook of Child Psychiatry, J. Noshpitz, ed. Basic Books, New York.
3. CHETHIK, M. AND FAST, I. 1970. A function of fantasy in the borderline child. Amer. J. Orthopsychiat. 40:756–765.
4. FRIJLING-SHREUDER, E. 1970. Borderline states in children. Psychoanal. Study Child. 24:307–327.
5. KERNBERG, O. 1975. Borderline Conditions and Pathological Narcissism. Aronson, New York.
6. MAHLER, M., PINE, F. AND BERGMAN, A. 1975. The Psychological Birth of the Human Infant. Basic Books, New York.
7. MASTERSON, J. 1976. Psychotherapy of the Adult Borderline Patient. Brunner/Mazel, New York.
8. ROSENFELD, S. AND SPRINCE, M. 1963. An attempt to formulate the meaning of the concept "borderline". Psychoanal. Stud. Child 18:603–635.

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