

Special article

Group psychotherapy for parents of patients with borderline personality disorder: Basic assumptions and group containing function

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ABSTRACT

Patients with borderline personality disorder (BPD) have great difficulties with interpersonal relations. Their extreme difficulties with interpersonal relations are illustrated in psychic family interaction. Parents become the recipients of conflicts and patients' aggressive behavior, while family stress increases due to suicidal tendencies, self-injuries and substance abuse. The current report presents the introduction of group psychotherapy for parents of young adult patients with BPD, treated in a special unit of personality disorders at Eginition Hospital. The aim is, through the parallel group therapy of patients and their parents, to establish the conditions of continuing therapy for the patients as well as maintaining therapy outcomes and construct a facilitating environment where the family's mental pain, anxieties, anger, shame, guilt and sadness can be contained. Clinical material from the first sessions of a 13-member parent group is presented to illustrate the resistances, the primitive defenses, and the basic assumptions of dependency and fight-flight developing in therapeutic work with parents. Furthermore, the groups' split and hostile transference communications and the therapists' countertransference reactions are discussed. The containing function of the group is described as a therapeutic process of transformation of the primitive anxieties and projective identifications, which is gradually established through the therapists' elaboration of their countertransference reactions and their tolerance to hostility and confusion. Containment facilitates the establishment of a group culture of empathic understanding for parents' unconscious resistances, denial of the illness and negative projections onto their child and the therapists, so that resistances gradually to be curbed and archaic projections to be transformed. Hence, the group is expected to function as a safe space to allow the manifestation and relief of destruction anxieties, and the expression of unuttered and intolerable emotions. Finally, the group as a mother object is expected to be internalized as a model of positive parental care, enhancing the empathic and reflective ability of the parents so that they may repeat the parental role in a process of reparation.

KEYWORDS: Parental group psychotherapy, borderline personality disorder, basic assumptions, group's containing function.

Introduction

Patients with borderline personality disorder (BPD) have great difficulties with interpersonal relations. They are characterized by a lack of integration of the self and of important others, namely identity diffusion and the predominance of primary defense mechanisms: splitting, primitive idealization, projection and

projective identification, denial, omnipotence and devaluation. They also have limited capacity for sublimation and tremendous difficulties with maintaining impulse control. The typical borderline patient usually maintains full control of reality. The main problem consists in an inability to combine positive and negative introjections and identifications. Exacerbation and

pathological fixation of splitting mechanisms are also observed.¹ Possible causes include an idiosyncratically determined lack of tolerance to anxiety and high intensity of aggressive drives usually originating in severe early frustrations. Their extreme difficulties with interpersonal relations are illustrated in psychic family interaction. Parents become the recipients of conflicts and aggressive behavior, while family stress increases due to suicidal tendencies, self-injuries and substance abuse. Thus, patients with BPD bring their family system into therapy in a state of heightened tension.

The model of family transactions includes the projection of unconscious, highly distorted and compact representations among family members. The child with BPD is the object of primitive projective identifications and represents the "bad" part of the family.^{2,3} Borderline pathology induces strong ambivalence in parents. According to the literature, parents, due to their own childhood adversities and serious deficits on the level of identifications, fail to calm the anxieties and satisfy the needs of their children,⁴⁻⁷ whereas strongly resist any efforts of differentiation.^{8,9} Although the children's attempt at differentiation is experienced as a threat by the parents,¹⁰ their history shows that, due to a series of parameters, they were not able to be a stable object for their children in early childhood.¹¹⁻¹³

In this context, the current article presents the introduction of group psychotherapy for parents of young adult patients with BPD, treated in the Special Sector for Personality Disorders, operated at Eginition Hospital, the First Department of Psychiatry, School of Medicine, Athens University.^{14,15} The aim is, through the parallel therapy of patients and their parents, to establish the conditions for commencing and continuing therapy for the patients as well as maintaining therapy outcomes. Group psychotherapy is expected to enable parents to accept and support the changes brought about by therapy in their families. Importantly, parents are expected to reflect more and become more empathic in order to repeat the process of parental care with a view to reparation.¹⁶

The purpose of the current report is to present the objectives and setting of the group, and to illustrate, through session narratives, basic assumptions phenomena, as well as transference and countertransference reactions typically encountered in groups for parents of BPD patients. Furthermore, a discussion of the clinical material as well as therapeutic processes and working through transference and countertransference are provided in order to suggest how the group

can be experienced as a safe and holding environment to enhance parents' tolerance of unbearable emotions and as a model of "containing" parental care.

Objectives and setting of the parents' group

Parents' groups meet for 3 years. Sessions occur every fortnight on the same day and hour and last 90 minutes. The group is coordinated by two therapists. The objectives of the group are as follows:

1. To create a space offering the appropriate mental stimuli for sensitization, understanding and acceptance of the mental disease.
2. To construct a facilitating environment where the family's mental pain, anxieties, fears and sadness can be contained.
3. To create an atmosphere of trust where direct and honest verbal communication will allow the expression of painful feelings such as anger, shame or guilt, and offer relief from these painful emotions. At the same time, the sharing of common experiences is expected to reduce the feelings of loneliness, demoralization and stigma while enhancing empathic listening and bonding between the members.
4. To reinforce the motivation of parents for individual therapy.

Before parents join the group, the two parental therapists meet separately with each parental couple in order to evaluate the family, investigate the parents' request for help, try to secure their commitment to therapy and establish the therapy contract.

In parent-group therapy sessions, the method of free discussion is used without the therapists introducing a fixed topic from the start. Careful listening and observation by therapists are part of their effort to understand latent content without overlooking the explicit aspects of the explanations provided by the parents. The main concern of the group is identified and structured in a framework of cognitive, emotional and psychological elements. These elements must mobilize members by offering relief and giving meaning to the incomprehensibility of the disease and the behavior of their children. Parents are encouraged to be involved in the discussion, enquire, make hypotheses and attempt to explain. The interventions are of a supporting, pedagogical, social and psychotherapeutic nature. The understanding of their children's difficulties proceeds through clarification and mirroring. Interpretation comes later on to illuminate their own difficulty to contain the anxieties of their children.

Basic assumptions, transference and countertransference reactions

When the family of a borderline patient comes to the Clinic for help, the family is already deep in crisis and there is a great extent of regression. The parent's participation in group therapy creates expectations of relief from the mental pain caused by their children's disorder but exacerbates narcissistic injuries, since the request for help officially confirms their failure to perform the parental role.¹⁶

At this point, pieces of clinical material from the first sessions of a 13-member parent group are presented. Two female analytic therapists led the group. The particular material was deemed appropriate to illustrate the resistances, the primitive defenses and the basic assumption group phenomena developing in therapy work with parents.

At the initial stage of therapy, the group condition further consolidates regression. The feelings of guilt, shame, fear and anger overwhelm parents unavoidably, affecting their transference reactions. During the first session, overexcitement is obvious among them. They speak non-stop providing minute details of their children's symptoms: self-injuries, virulent attacks against family members, substance abuse, episodes of anorexia and binge eating. The group is terribly upset. The difficult and incomprehensible behavior of their children causes confusion, powerful feelings of despair and violent anger, overwhelming and blocking their thinking. They assail the therapists with questions, rudely interrupting each other. They urgently seek information about the disorder, its causes and outcomes and ask repeatedly for immediate practical advice on how to deal with the difficult, unpredictable and aggressive behavior of their children.

In the first session, after a short silence, Mrs. S. takes the floor and says: "I'm Mrs. S., Z.'s mother and I'm very relieved that this therapy group is starting"-her soft eyes filled with tears. "Z. took pills again yesterday, thankfully not too many. We went to the hospital and they pumped her stomach. This happened yesterday and today this group started. I was lucky at least in that, talk to people who understand and tell me how to deal with my child. But I find it very difficult to understand what is happening to her. Please, help me. Will you tell me why she's doing this?" ...she asks, indignantly looking at the therapists... "All the time that my daughter is cutting herself or trying to kill herself, I alone without any help try to support her. I have had no help from her father since we divorced. The psychiatrist who treated

her before avoids me and doesn't answer my calls. I don't know what else to do anymore. My whole life is spent trying to help her and save her life. But that's not enough either. We're lucky the unit accepted Z. here for treatment. Only you can save us. Every expert I asked said this unit here is the only one suitable to deal with Z's problems". Then Mr. K., H.' father, interrupting her, asks the therapists: "Please, tell us, do these children ever get better? Tell us, whose fault is it? Is all this hereditary? Is it the genes? We've given her everything. We've sacrificed our lives for this child. Have we given her too much love, is that it? But why does our daughter hate us so much? She has been aggressive with her mother since she was a child, but now it's vomiting and it's suicide attempts. Can you help her? Because we are desperate. You are our last hope. If you can't help our child, our family will be destroyed".

This first contact with parents was experienced by a couple of female therapists as the agonizing groping of the shipwrecked for his/her rescuer. The group expresses powerful infantile oral needs, demanding immediate gratification and pressing hard on therapists. The basic assumptions of dependency prevail through the idealization of the Unit and also the therapists, as the representatives of the institution. During these first sessions, the therapists experienced their idealization as a form of blackmail to act concurrently as omnipotent mother figures, meeting these greedily expressed needs and as paradigmatic representatives of the idealized institution. They were not allowed to fail because their failure threatened to undermine the reputation of the entire institution. They were terrified of disappointing these greedy "infant parents" -yet knowing that disappointment is inevitable- because dissatisfying their oral sadism threatened to trigger their hostility which was being appeased through idealization. As Ganzarain¹⁷ points out "the dependency basic assumptions idealize the therapist as a source of everlasting omnipotent nurturance... The dependency basic assumptions form a cluster of defenses against guilt induced by greed... Greed and hostility were split and projected as a defense against guilt". Obviously, the child with BPD is the object of projected parental greed and demanding hostility: "We've given her everything. We've sacrificed our lives for this child... But why does our daughter hate us so much?". Therapists speculated that parental denied guilt, expressed through idealization, was possibly triggered after parents were greedily taking over the role of the client in this group, claiming help through their children's difficulties. Moreover, therapists wondered whether this characterizes their pat-

tern of parental bonding, conceiving their children as transitional objects and inanimate extensions of themselves or as need-gratifying objects, which is repeatedly described in previous works.¹⁸⁻²⁰

When in a subsequent session the same agonizing questions on who's to blame for their children's illness are repeated, some members of the group were more willing to accept and express feelings of guilt. In particular, Mrs. B. said: "Why do we keep asking whose fault it is? It's our fault. We blew it."

This comment triggered great tension in the group. A prolonged silence ensued until Mr. K. spoke: "I don't know what you believe but I, for my part, think that people are born, people don't become. What is happening to our children is hereditary, I said it before. Do you really believe what the lady is saying?" he asks addressing the therapists. And he goes on: "Do you believe it's our fault? Because, if you believe that, we have no reason for being here. We came here to get help for what we're going through, not to listen to this lady saying it's our fault. What is this, a court passing judgment on what we did or didn't do? You don't understand what we're going through. It's easy to talk when you're not involved. Do you think you can cure H. here? I'm telling you, you're in the dark. And I ask you (addressing the therapists again), what would you do when H. turns into a wild beast at home and hurls ashtrays, heavy crystal ashtrays, nearly killing myself and her mother? How do you keep calm when you have the devil in disguise in front of you? How can you take it easy? Would you take it easy or beat the hell out of her? I don't even know what kept me. I only gave her a couple of smacks on her thighs, just to stop her from beating her mother. I'm telling you this to make you understand what we're going through at home. Can you do something about this situation? Can you rid us of the devil who's got into her? Can you explain to us why she's doing these things? We've given her everything. She never missed anything. What about us, we've known poverty and hunger and had no assistance or understanding from our parents. My father used to hang me from a tree head down and beat the hell out of me when I did some mischief. I admit it, I was wild, but if I dared do what she's doing to us, he would have killed me."

The group is obviously seized by powerful feelings of anger and hatred and their attacks against the therapists are merciless. Paranoid-schizoid phenomena prevail and the group is in a state of fight-flight. Psychotic anxieties arise, as feelings of guilt threaten to invade

the group's psychic life. Primary defense mechanisms are mobilized to stall thinking, and subsequent feelings of shame and guilt threaten members with narcissistic collapse. Splitting phenomena predominate. Through primary projective identifications, dichotomized "good" and "bad" sides of the self and the object are projected onto the therapists, the members and the group as a whole.²¹ From "saviors", therapists are turned to "punishing judges". The group is turned into a "merciless court" threatening to pass cruel penalties and "hang the members-parents from the tree heads down" for what they did or failed to do. The omnipotent therapists are turned into inadequate parents who do not understand, do not help and abuse. From the object of cherished love, the child becomes an object of archaic projections and is made into a terrifying persecutory figure threatening to eliminate and destroy. The child becomes "the devil in disguise". The therapists are under tremendous pressure from the attacks and the attempts to dissolve the group. They feel the need to remain steady, holding back the anxiety of members and setting clear limits in order to preserve the setting, maintain their therapeutic role and salvage the possibility of thinking and hope.

Discussion

The first issue emerging from the clinical material is the ambivalent attitude of parents towards parallel therapy,¹⁶ despite their desperate call for help, and their regression to primitive defenses. The fact that they accept or seek therapy for their children and for themselves does not necessarily mean that they are willing to confront their own deficits. Nor that they are willing to modify their defenses or the model of family communication and function. Therefore, one of the basic tasks of a parental therapist is to investigate the unconscious meaning of these primitive mechanisms. Unconsciously, the child with BPD is assigned the role of scapegoat to ensure family cohesion. Although this is a pathological family function, parents are bent on its preservation. The changes to this pathological family balance pursued by therapy inspire fears of family breakdown in parents. Concurrently, the parents' resistance is often expressed as denial of the disorder. To deny the disorder is to deny the painful narcissistic blow caused by it. Moreover, the terror of retaliation from the setting, generated in parents at the beginning of therapy, leaves no room for mature guilt which will in time be transformed to care.

The second fundamental issue emerging from the reported clinical material is double identification

which is activated during the performing of the parental role.^{4,16} This is the kind of identification whereby adults, on the one hand identify with their own parents in order to perform the parental duty, and on the other, with their own childhood in order to communicate with their children, understand their needs and respond to them. Unresolved conflicts with their own parents and childhood traumas are revived during parental care and unavoidably affect parental function. Deficits and old traumas may have seriously disturbed the normal internalization of parenthood and may prevent the identification of parents with their children at distinct developmental stages of their lives.²² In particular, as the reported clinical material indicates, the borderline pathology of the child and the onset of parent group therapy mobilize dynamics of deep regression in parents. The group setting creates the conditions for a revival of the parental family where parents-members become children in regard to two therapists-parents. Experiences from their original family come alive again and powerful contradictory feelings vis-à-vis parents and siblings are stirred. In the context of multiple transference and group phenomena, conflicting object relations and representations of the self and the object are activated. Intrapsychic conflicts are externalized through projective identifications. "Bad" aspects of the self and the object are projected onto the therapists, the members, the borderline child and the fellow parent.

According to Bion's concept of "container-contained";²³ therapists' capacity to contain the projected primitive emotions, fantasies and thoughts - inherent in "basic assumptions"- and the hostile or split transference communications is of paramount importance for the salvation of the group, and the evolution of thinking and meaning processes.²⁴ However, therapists' capacity to tolerate primitive attacks relies on their fortitude to contain their countertransference or other emotional reactions induced by members' projective identifications. Therapists' strength to withstand members' hostile and ambivalent communications, instead of acting out the projected aggressiveness, can be primarily based on their inner emotional and cognitive reserves and, importantly, on their mutual support and understanding of the projected material. Very often this means that therapists are called upon to endure feelings of inadequacy, frustration, failure and guilt and to bear that sometimes they cannot think about and make meaning of the group interactions. Therapists' containing capability enables them, working through their countertransference and emotional experiences

in the group, to unravel the significance of the confusing and hostile projections and to trace the underlying early psychotic-like anxieties. The containing function becomes then a transformative process: therapists decode and reconstruct the confusing, unacceptable and intolerable thoughts and emotions, and communicate them back to parents, through verbal and non-verbal interactions, in a form that can be acceptable, meaningful and tolerable.²⁴ This process is expected to reduce parents' anger, desperation and helplessness and to reinforce the tolerance of feelings of guilt and frustration.

Conclusion

Containment facilitates the establishment of a group culture of empathic understanding for parents' unconscious resistances, denial of the illness and negative projections onto the borderline child, so that resistance gradually to be curbed and archaic projections are transformed. Only then will the group be experienced as an adequate mother object whose containing function will provide that safe, holding and facilitating environment that will endure the attacks, metabolize and return them in a digested form free of toxicity. Hence, the group is meant to function as a safe space to allow the manifestation and relief of destruction anxieties, the expression of unuttered, painful and intolerable emotions, and to host the pain of living with the borderline patient. Finally, the group as a mother object is expected to be internalized as a model of positive parental care, enhancing the empathic and reflective ability of the parents so that they may repeat the parental role in a process of reparation.

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Ειδικό άρθρο

Ομαδική ψυχοθεραπεία για τους γονείς των ασθενών με οριακή διαταραχή προσωπικότητας: Οι βασικές υποθέσεις και η περιέχουσα λειτουργία της ομάδας

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ΠΕΡΙΛΗΨΗ

Οι ασθενείς με οριακή διαταραχή προσωπικότητας (ΟΔΠ) εμφανίζουν εξαιρετικές δυσκολίες στις διαπροσωπικές τους σχέσεις. Η δυσκολία στις διαπροσωπικές σχέσεις των ασθενών με ΟΔΠ απεικονίζεται στο πλαίσιο της ενδοοικογενειακής ψυχοσυναλλαγής. Οι γονείς γίνονται οι αποδέκτες των συγκρούσεων και της επιθετικής συμπεριφοράς του ασθενούς, ενώ το stress της οικογένειας είναι αυξημένο εξαιτίας της αυτοκτονικότητας, των αυτοτραυματισμών, της χρήσης ουσιών. Το παρόν άρθρο παρουσιάζει την υιοθέτηση ομαδικής ψυχοθεραπείας για τους γονείς νεαρών ενηλίκων ασθενών με ΟΔΠ, οι οποίοι παρακολουθούν το θεραπευτικό πρόγραμμα το οποίο παρέχεται στο Αιγινήτειο Νοσοκομείο από την Ειδική Μονάδα Διαταραχών Προσωπικότητας. Διαμέσου της παράλληλης θεραπείας παιδιών και γονέων, επιδιώκεται η εξασφάλιση των προϋποθέσεων συνέχειας της θεραπείας των ασθενών, η διατήρηση των θεραπευτικών αποτελεσμάτων και η οικοδόμηση ενός διευκολυντικού περιβάλλοντος, όπου ο ψυχικός πόνος, οι ανησυχίες, ο θυμός, η ντροπή, η ενοχή και η θλίψη της οικογένειας να μπορούν να περιεχθούν. Παρουσιάζεται το κλινικό υλικό από τις πρώτες συνεδρίες μιας ομάδας γονέων με 13 μέλη για να απεικονίσει τις αντιστάσεις, τις πρωτόγονες άμυνες και τις «βασικές υποθέσεις» εξάρτησης και μάχης-φυγής, οι οποίες αναπτύσσονται στη θεραπευτική εργασία με τους γονείς. Επιπλέον, αναλύονται οι διχοτομημένες και εχθρικές μεταβιβάσεις της ομάδας όπως και οι αντιμεταβιβαστικές αντιδράσεις των θεραπευτών. Η περιέχουσα λειτουργία της ομάδας περιγράφεται ως μια θεραπευτική διαδικασία μετασχηματισμού του πρωτόγονου άγχους και των προβλητικών ταυτίσεων, η οποία εγκαθίσταται σταδιακά μέσω της επεξεργασίας στην οποία προβαίνουν οι θεραπευτές σχετικά με τις αντιμεταβιβαστικές τους αντιδράσεις, αλλά και με την ανεκτικότητα τους στην εχθρότητα και τη σύγχυση. Η περιέχουσα λειτουργία διευκολύνει την καθιέρωση μιας κουλτούρας ενσυναισθητικής κατανόησης στην ομάδα για τις ασυνείδητες αντιστάσεις των γονέων, την άρνηση της ασθένειας και τις αρνητικές προβολές στο παιδί τους και στους θεραπευτές, έτσι ώστε οι αντιστάσεις να περιοριστούν σταδιακά και οι αρχαϊκές προβολές να μετασχηματιστούν. Κατά αυτόν τον τρόπο, η ομάδα αναμένεται να λειτουργήσει ως ένας ασφαλής χώρος που επιτρέπει την εκδήλωση και ανακούφιση του καταστροφικού άγχους όπως και την έκφραση ανείπωτων και ανυπόφορων συναισθημάτων. Τέλος, η ομάδα ως μητρικό αντικείμενο αναμένεται να εσωτερικευθεί ως πρότυπο θετικής γονικής φροντίδας, ενισχύοντας την ενσυναισθητική και αναστοχαστική ικανότητα των γονέων, ώστε να επαναλάβουν επανορθωτικά τον γονικό ρόλο.

ΛΕΞΕΙΣ ΕΥΡΕΤΗΡΙΟΥ: Γονεϊκή ομαδική ψυχοθεραπεία, οριακή διαταραχή προσωπικότητας, βασικές υποθέσεις, περιέχουσα λειτουργία της ομάδας.