Consequences of the breakdown of the potential space of severely disturbed adolescents. How to deal with enactments and developmental lags in psy-chodynamic psychotherapy.

First, I want to present the case example of a 17 year old, female, severely disturbed adolescent. After we knew her better she got the diagnosis borderline personality disorder unstable type on lower border with tendency for psychotic decompensation (DD: dissociative identity disorder, DESNOS).

Before she became our patient she had been treated outpatient and inpatient because of recurrent panic attacks, drug abuse, damaging of self and others, derealization and depersonalisation.

It was to become a very difficult but also very successful treatment. After she had to be discharged 2 month after the beginning of treatment for detoxication she stabilized during the next 6 months after the second admission 6 weeks later. Her symptoms decreased markedly, she started a new life without drugs, attended grammar school to make her university entrance diploma and to go to college.

Up to now she sometimes drops in to report about the aims she has achieved.

I want to report on my first encounter with her because it was of central significance for the further treatment and contact with her. She was in Tiefenbrunn for three days and lived in a single room where I visited her together with a female educator: I met a pale, very unhealthy looking girl with orange coloured dreadlocks and flashy outfit. Her appearance was somewhat shabby but also fancy. She had already done her room up astonishingly well and I asked her how she was feeling on the ward and if she did not feel alone and too far away from everything familiar in this single room. She answered that she was feeling extremely bad and that nobody would care about her. The accompanying educator said reproachful: 'That isn't true, we kept an eye on you several times'. Thereupon J. ran into a state of emergency. She started to hyperventilate, shivered, screamed, moaned and cried for her mama, 'mama I want to go home'. She twisted, threw herself on the bed and remained there like a baby with her legs tucked up.

I sat on a chair in front of her, alarmed and appalled. I did not know how things would develop as I was not acquainted with her yet. I tried to keep quiet and wished to be the mother, holding and consoling her with the words ‚It is not as worse'. However, I remained seated, avoided to be invasive und tried to let her feel that I was with her, probably with sounds like ‚mh' and ‚oh'. Finally I said: 'I see, that you are in a very bad way' and told her that it was important for me to know how she was feeling – to know her perception, her reality. The educator remained silent and irritated.

Gradually, J. calmed down and re-established eye contact. Now I could talk to her about how to avoid her experiencing such unbearable situations of being left alone, about what would be good for her. I made arrangements with her, so that she would be able to stand being in the single room so far away from mother and home without hurting herself or doing things forbidden in Tiefenbrunn as drinking alcohol or abusing drugs. She noticed my worry and care and began to trust me. I became a person meaning it well with her.

In a later conversation I asked her about the picture of the Madonna with the Child at the wall in her room – a piece of embroidery which despite of the subject had nothing friendly but gave a sense of something disconcerting and threatening because of the colours, the design and the dark picture frame. It was a picture her grandmother had embroidered, a woman traumatized by expulsion and violation who had died 2 years ago and of whom J. had been a confidante. She told me that she kept the picture as a memento of her grandmother. I answered that it is important to keep someone in memory who meant it well.
Even later I asked her about a poster of Hannibal Lector in the film 'The silence of the lambs' which hang at the wall above her bed. The poster showed his face with his mouth covered with the mask. I asked why she had hung just this picture above her bed, as it could give one a fright.

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She answered: Not at all, I admire him. He is consequent, he eats human flesh, that's consequent if one eats meat of living beings. I am vegetarian and don't eat any meat. I could not bear it having dead animals inside of me.' I told her that this thought was new for me as I would draw a border between animal and man; only eating familiar pets would be intolerable for me.

With her behaviour, her pictures and accessories (for example the devil cross she wore as necklace) J. confronted with the horror and fear she obviously had experienced without speaking about it. We knew that she had lived in the punk scene and sympathized with goth people and Satanists, but she did not tell us anything about that.
Supposed she had been raped already at age fife or nine – the information was contradictory. Reportedly, her elder brother sold her for some plastic bricks to a friend, later she whored around and split off her body from her feelings. The early abuse was hardly understandable, it remained questionable and seemed to be somewhat unreal. However, it was clear that directly and indirectly her mother and grandmother had exposed her to multiple and cumulative traumata.

She showed the following symptoms: fits of crying, anger, hyperventilization, panic and annihilation anxiety, anxiety to become crazy, self-destructive behaviour (hitting the head against the wall, cutting), aggression against others (e.g. biting), alcohol and drug abuse (cannabis, speed, ecstasy, sometimes heroine), hearing of voices, feelings of being threatened, depersonalisation with lacking boundaries between reality and fantasy, disturbed body concept, lacking self-affect-impulse regulation, shifts between extremely threatened and hysteriform conditions.

I come back to the first scene. What had happened? J.'s inner reality differed from the reality perceived by the educator. She felt totally left alone and forgotten. The calling in question of the educator threatened the coherence of her Self and brought her to the edge of a psychotic decompensation or a state of emergency. She was not able to realize that reality can be seen in different ways. The other objective view (the third person) was a catastrophe for her (Britton). The educator was the incarnation of malignant understanding.

In her disorganized state she fell back on primitive regulations of Self and body as hyperventilization, childish behaviour/crying for 'mama', and rocking. In this situation she was not able to transform the symbiosis with mother allowing only one perception of reality into a triad with a dynamic interplay between symbol, symbolized and interpreting subject: 'This is my view, you have another view'. (Other, partly similar explanations can be found by Winnicott and Britton, who connect the ability to take an objective standpoint with spatial metaphors). The following interventions played a role during this first encounter.

1. The offer of safety and basal regulation. I tried neither to take the position of an invasive maternal object, nor to be absent and at the same time to give her some kind of outer interpersonal regulation or support and safety in the containment with my vocalisations. It was a basal non-verbal offer so to speak from body to body and an acknowledgment of her state of being. (A marked mirroring for affect regulation as proposed by Fonagy and Target would have been inappropriate in such a case).

2. Confirmation of reality perception: After she had overcome this condition I confirmed her reality perception and made clear to her that only one, namely her perception was important for me. This intervention had the basal function of acknowledging her psychic existence. 'You are someone having an own perception of reality'. This is a sequence referring to the 'psychic equivalence' defined by Fongay and Target. The inner reality is equivalent to the outer one, a problem characteristic for borderline personality disorders. According to Ogden this inability to differ between inner and outer reality is the result of a breakdown of the psychic dialectical process in the potential space. Ogden proposed in his article 'On potential space' that Winnicott's concept of the potential space might be understood as a state of mind upon a series of dialectical relationships between fantasy and reality, me and not-me, symbol and symbolized. Ogden refers to four different kinds of breakdown: Reality subsumed by fantasy, reality as defence against fantasy, dissociation of reality and fantasy poles and foreclosure of reality. J. responded in this situation with the first mode - reality

subsumed by fantasy - or inner reality is equivalent to outer reality respectively.

In the later conversations the second mode became important - reality as defence against fantasy -, a defence against threatening fantasies and traumatic memories, resulting in superficial adjustment and contact avoidance. She shifted between overwhelming presence, where the past corresponded to the present, and contact avoiding absence, hidden behind the superficial adjustment - between a thinskinned and a thickskinned state.

3. Establishment of treatment conditions, 'development of a cognitive potential space – cognitive mentalisation' as consciousness building intervention: The mutually created scene is discussed afterwards as far as possible to create an additional space for later examination and thinking – of her behaviour and the behaviour of the others leading to her decompensation which comprises traumatic, blindly re-enacted experiences. They should be avoided in everyday life if possible, for that purpose special agreements are necessary.

4. The mentioned interventions are not analytically interpreting ones, but refer to the principle 'answer'. Under consideration of the Ego-psychology and the ideas of Kohut, Kernberg, Blanck and Blanck and their treated borderline-patients the psychoanalytical-interactional psychotherapy was developed in Tiefenbrunn already 30 years ago, it is guided by the prin-ciple 'answer' rather than by the principle 'interpretation'. This method was originally developed by the couple Heigl and Heigl-Evers and was firstly used in the group therapy of early disturbed patients, afterwards also in individual therapy. To answer means that the therapist selectively reports about his own experience and readiness to act which develops in reaction to the patient's behaviour. Thereby he empathizes the difference between Self and object, selectively reveals effects caused by the patient's behaviour and makes him or her clear how his behaviour contributes to dysfunctional interpersonal interactions. In the work with adolescents modifications are necessary which include the developmental perspective, a work as developmental object. I have the impression that there are similarities with the psychodynamic developmental psychotherapy developed among others by Hurry, Fonagy and Target. In this way the answer to the cannibal Hannibal Lector: 'For me there is a border between man and animal' confronted her with her lack of differentiation but she was not penetrated.

I gave such a detailed case report because the children and adolescents we are treating in Tiefenbrunnn often show these symptoms. In the treatment of such pa-tients excessive entanglements are created where the therapist gets the role of the abusing person or they remain out of reach or we are involved in dialogues like parrots which are unreal and as if.

I don't want to address the extensive analytical diagnostics, the behaviour diagnostics, screening inventories and so far but to report about the performance and physical diagnostics we did with her: when testing her intelligence (Hawik-R) J. showed high values. Only in arithmetics her results were at the lower border of average performance – nevertheless she had failed a school. We saw an association with deficits in attention regulation (d2) – not with the short-term regulation, but with deficits in sustained attention. This could be explained by findings of the physical diagnostics: She showed deficits in the vestibular system, which made it difficult for her to straighten up, to regulate her balance and to orientate in space. Furthermore, she showed severe deficits in her tactile system like disturbed pain perception, disturbed stimuli discrimination and recognition of shape. This was a matter of dissociative physical processes associated with blockades in the sensory information processing. An aneasthetized person does not feel pain. So she could cut her arms with the Satan's cross in unbearable situations. Sensory psychic connections with the environment are cut off and lead to the clinical observable sensory shutdown-mechanisms. We consider these disorders to be associated with the experienced traumatic violations of her body boundaries and to be a result of her spatial and temporal disorientation. Concerning her motoricity we found especially disturbances of lateralisation and hemispheric dominance, as often seen in early traumatized patients. The right and the left body part are insufficiently connected and coordinated – the lacking coherence of the Self ist also a lacking physical coherence (see also Schore 'Disturbance of the right hemisphere'). I report these

findings as psychoanalytical considerations often leave aside the cognitive and physical ones and thereby ignore that the deficits affect the functions of the whole person. In the treatment of these adolescents it can often be seen that progress is also possible on the psychic level if physical blockades are healed.

Cumulative traumata like neglect, maltreatment and abuse have negative consequences for the physical, emotional and cognitive being. Among others they may lead to severe disturbances of behaviour and affect regulation, changed consciousness and distorted perceptions. These are the results of the breakdown of potential space, a space where playful 'as if', communication and triad are possible. Findings from infant and attachment research as well as from neurobiology are helpful, as they suggest new and more advanced approaches of understanding for treatment besides the psychodynamic models. In the therapeutic work answering and development promoting interventions play a central role which address regulatory activities, decentration or mentalisation, desomatisation and symbolisa-tion of messages made by action.
In the therapy of adolescents acting or acting out has a basically other meaning than in the treatment of adults. I cannot support the notion that acting out corre-sponds to the playing of a child. According to Blos the acting out of adolescents is in the service of memory and development.
From a developmental perspective Josslyn suggests that the singularity of behaviour visible in the acting out pattern is determined by the need of adolescents to learn who they are, to create memory and material for symbolic thinking. The acting of adolescents is followed by thinking. The process of decentration, of self-reflexive observation creates the ability to increasingly develop higher-ranking thought categories. To make two-phase experiences is important for the establishment of the world of symbols. This hermeneutic principle of ex post thinking is of special importance in adolescence as the adolescent writes his life history with his own interpretations of his past. Meaning is given to the own life history afterwards and in comparison with the continued acting. Acting is an important instrument to recognize oneself, in adolescence it is the via regia to the unconscious, but only if one can resort to self-reflexive abilities and if a space for observation exists, requiring that the absence of the object can be tolerated. For the severely disturbed adolescents such a space, a play-, transitional or triadic space firstly has to be created or developed. Just during this period, when they tend to narcissistic stabilisations, adolescents need such spaces where they can make their omnipotence fantasies social. Moreover, the therapist needs inner concepts and images enabling him to fantasize and to think about what may have mutilated them and is hindering their opening up.
I want to throw light on the following aspects:

1. The disturbed regulations in the area of the Self, the affects, the impulses, the attention and the body in connection with working models of a ‚Self being with a not- or disregulating or threatening other'.
2. Disturbances of sensorimotor integration and executive functions.
3. The speechless and embodied messages in conjunction with disturbances of memory and building of representations which are linked to lacking right-left hemispheric connections.
4. The disturbances in differentiating between reality and fantasy, self and object, past and present, which inhibit learning from experience and knowledge and lead to sensory shutdowns.
5. Work as developmental object in psychoanalytical interactional psychotherapy.

ad 1:
A large part of the multiple symptoms of these children and adolescents is associated with the threatened or disturbed Self-coherence and the lack of regulatory abilities. Instead of experiencing a Self,being with a regulating other' they experience a Self, being with a dis- or not-regulating or threatening other'. They could not experience the early caregiver as neuropsychobiological regulator within a mutually tuned intersubjective matrix. Instead they were exposed to their neglecting, abusing or invasive gestures, confronting them with unbearable and uncontained states of tension and pain. They responded with primitive reaction patterns like flight/fight/freezing and dissociation, described for example by Fraiberg. Their loss of Self-coherence might be associated with different levels of functioning, with shifting between different developmental levels, disorganised conditions or superficial adjustment (false self). An intrapsychic space with successful dialectics of reality and fantasy allowing self-observation can be developed only insufficiently.

Also as a result of inadequate verbal abilities and temporal and spatial parameters for representation building we see disturbed provisional or pathological

regulations like disturbances of Self-, affect- impulse-regulation, attention disorders and so on. In the case of supported regulations – a provisional attachment to the early caregiver (reality as a defence against fantasy) - they seem able to regulate themselves in the presence of the caregiver. In fact this is a form of coping where the potential menace of the caregiver is controlled by mimicry behaviour. The regulation remains dependent of and supported by outer objects. If the object is absent the regulation from the outside is lost and actions are started to avoid the state of emptiness (the empty space), of insecurity, which would confront with non-existence.

We observe regulation disorders on the physical level, in the regulation of stress. They manifest themselves for example in motor restlessness, attention disorders affecting the cognitive and affective development. Provisional regulations or pathological self-regulations are the result as rocking, seesawing, licking, urge to move, self-hurting, tearing out hair and eyelashes, picking, hyperventilization and so on. During adolescence damaging of the Self and others, drugs, alcohol and pills get regulating functions.

Ad 2:
Adolescents with cumulative traumatizations are not able to communicate in a way that we are informed about their actual state and their past experiences. When they talk about their experiences they fall back on subsequent, cognitively shaped knowl-edge, that often does not correspond to the real behaviour and give them an unau-thentic appearance. We recognize their original experiences in their actions and interactions. What they are talking about is sometimes totally disconnected. As they are not able to see themselves from the perspective of another person they do not attach importance to their behaviour – it remains unreflective and speechless. The problematic of children and adolescents with early unfavourable development conditions happens in the Here and Now. If asked about problems they answer for example 'I don't know' and show at the same time a frightened facial play and a posture as if they expect hiding. Implicitly they express something they cannot grasp or they get into interactions which cannot be verbalized and connected with earlier experiences although they are familiar. There is no consideration of the past, no time dimension of past, presence and future. The absent cannot be thought or played. The past exists in the presence und presence is past within the collapsed or empty potential space. Fonagy et al. developed the concept of mentalisation disturbance in these disorders and Piaget, Sterba and others have examined this problem from different perspectives. Piaget used the concept of decentration: according to him it is necessary not only to be in the world with the own experiences but also to have these experiences, to recognize and observe them. If this decentration is not successful, the process of representation building is disturbed. These adolescents do not have the ability of self-reflexivity associated with the early experience of a sensitive mirroring caregiver. This experienced fault of recognizing oneself in the other person is associated with disturbances in memory formation, the lacking ability to resort to internalized object representations and correspondingly developed representational abilities. During the structural organisation which depends on development neither symbolic-evocative representations nor pre-symbolic representational abilities and visuo-affective interactive representations like facial impressions of an adequately regulating mother can be developed, so that the adolescent cannot resort on reparative functions of the evocative memory. The memory comprises declarative and procedural parts, with other words explicit and implicit contents. While children with secure attachment can use their implicit knowledge as potential evocable reservoir for relationship regulation the early traumatized ones have great lacks due to mentalisation disturbances and traumatic and not recallable memories. Early traumatic experiences are re-enacted and not recognized. As they depend on outer triggers, special stresses, it can happen that these disorganized conditions cannot be created in the Here and Now of the therapeutic relationship and therefore cannot be dealt with, especially if the therapeutic relationship is determined by flat adjustment and flat therapeutic mirroring, or so to say if the space of communication remain empty (Britton?).
J. shifted between overwhelming scenarios making the therapist to the traumatizing, mad driving person and absence hidden behind a superficial adjustment. In these moments she was emotionally out of reach but a fluent speaker. If the absent cannot be thought the disturbed interaction is created in the presence, in the entangled am-bivalent mode or relationship is avoided. In the moments without entanglement their behaviours are reflected to these adolescents: You behave like someone who was raped or Your body speaks another language or The things around you give impor-tant information. However, if the therapeutic space between therapist and adoles-cent has

collapsed and if the inner reality corresponds to the outer it is important to take into consideration that the therapist has changed into an abusing object. Every reference to the past evokes outrage or a new catastrophe.

Ad 3:
The dissociation in the behaviour, acting, memory and speech and the disturbed representation building lead to blurring boundaries between fantasy and reality, presence and past, Self and object. Because of the lacking mentalisation the Self cannot be experienced as disconnected from the other person. Such children, adolescents and adults are exposed to an essential paradoxon, a "paradoxon referring to the person, that means – is this me or the other one – referring to acting – have I done it or the other one – to the time – is it now or then – and to emotions" (Russel 1993). They as well as the therapist are exposed to confusions which remain unsolvable as long as they cannot be sorted during direct interaction. The distorted perceptions cannot be corrected, for example: but reality was different, after all you were aggressive. There is no work during the scene – only afterwards when observing the mutually created scene: I did something and you did something. Distorted perceptions lead to activations of always the same or similar threatened/threatening scenes. Confronted with annihilation anxiety fronto limbic circuits are activated and continuously create scenarios in compulsive repetitions. These fixations hinder learning by experience and learning by knowledge. Learning is only possible under conditions of a secure readiness which have to be created first.

In the treatment of such adolescents the problems do not occur only concerning the relationship but also concerning the general set-up. The threatened/threatening pat-ters of unpredictability, of arbitrary abuse continue in the set-up if secure and reliable conditions are not established. The set-up determines the ecology of the therapeutic space (Treuniet). Spatial and temporal organisation of the day gets the function of containment, security, reliability and development. Work with these adolescents is only possible if the originally traumatic and unpredictable object experience is contradicted by another developmental object answering immediately, sensitively, empathetically recognizing the concerns of the adolescent. The therapist pays attention to his emotional and physical response to non-verbal messages, for example implicit relationship knowledge (inner working models [Bolwby]). The therapist perceives actions, scenes, behaviours as well as frozen physical messages. The developmental functions of the therapist are the following:

- Containing (therapist as container)
- Helping with sorting and anticipating the own behaviour and that of the other (adoption of perspective)
- Picking up physical reactions, selective verbalisation of feelings
- Reflecting and translating actions, setting boundaries
- Creating the experience of the third party
- Assumption of psychobiological regulatory functions of the self object (for example arousal, amplifying, breaking, recovering).
- Mentalisation by IMM (Interpersonal Interpretation mechanisms).
- Social feedback-behaviour: Reflecting the realistic version and marking with brinks.

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(Traduction à paraître)

Se casser la tête pour ne pas souffrir (psychiquement): adolescence et polyphonie des processus psychiques.

Fils d'une mère malade de cancer qui découvre sa maladie pendant la grossesse (et qui ne se soigne pas afin de ne pas perdre son enfant, ce qui la conduit assez vite à la mort), M se présente pendant une longue phase de sa cure (un psychodrame psychanalytique individuel) comme un adolescent dont le processus de subjectivation est en train de se mettre en place d'une manière classique autour de la problématique œdipienne.

Toutefois, à un moment donné le compagnon de la femme à qui il est confié menace de les quitter et M se sent le seul coupable. L'angoisse de perte donne lieu à une longue période d'impasse dans laquelle la pensée laisse la place aux agirs (conduites à risque avec des accidents graves, absences) et aux somatisations. Comment comprendre ce changement? Le matériel œdipien n'était qu'une défense qui visait à cacher les failles narcissiques sous-jacentes?

Dans cette intervention je vais interroger la place du corps et des agirs lorsque la fonction représentative est en souffrance, ainsi que les effets de ces « passages par l'acte et par le corps » sur la relation de transfert et contretransfert, à partir d'un vertex théorique processuel (Ogden, Roussillon) permettant de penser le psychisme de chacun de nous comme une pluralité de registres qui s'alternent et se superposent.

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Symposium 19

Place du corps dans les traitements à l'adolescence

Président : Antoine Masson

Le soin psychiatrique aux adolescents, présentant des pathologies psychotiques, est tributaire des modalités d'engagement du corps des soignants. L'objet de la communication sera de discuter, à l'appui d'éléments cliniques relatifs à une investigation en psychodynamique du travail, en quoi le « prendre soin » relève d'un travail spécifique à partir des éprouvés du corps du soignant suscités par la rencontre avec la souffrance des adolescents. Le soin relève en effet de processus d'affectation du corps qui conditionnent et orientent les modalités du traitement thérapeutique.

La conception du soin psychiatrique dans l'institution étudiée est centrée sur la «mise en mouvement» des adolescents, et l'élargissement de leurs registres de fonctionnement et d'investissement, mais elle mobilise aussi une transformation de soi chez les soignants. Parmi les différentes dimensions du travail psychique des soignants, la possibilité de ressentir, face aux adolescents, de l'angoisse se présente comme un premier mouvement d'élaboration des impressions diffuses ressenties par le corps. Mais de cet éprouvé, il s'agit d'être en mesure d'en faire quelque chose, car cet affect à l'état brut tend spontanément à discriminer et à exclure l'autre, soit l'adolescent qui fait vivre cette sensation désagréable. Ce vécu angoissant occupe pourtant une place centrale dans l'expérience de chaque soignant et engage l'ensemble de l'économie psychique. La présentation envisagée cherchera à préciser les conditions individuelles et collectives qui organisent le soin aux adolescents psychotiques et ses enjeux psychiques pour les soignants.

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Les scarifications de l'adolescent(e)

Ce comportement fait très souvent l'objet d'interprétations réductrices qui vont, soit, dans le sens d'une perversité narcissique sadique soit dans le sens d'un aménagement psychique d'évitement réussi du suicide. Il nous semble pourtant que ce fait clinique mérite plutôt plusieurs lectures. La première sera du côté développemental ou de l'opération adolescente dans son rapport au sexué. La deuxième sera selon un axe transférentiel du passage-à-l'acte à l'acting-out et la troisième sera à l'intérieur de la dynamique psychique qui se déploie dans le transfert, en particulier la revisitation de l'Oedipe.

La pulsion de mort s'inscrit dans le parchemin cutané différemment selon les registres structuraux inconscients. Les scarifications névrotiques invitent à une lecture dans un se faire voir ou un cacher qui appelle un dévoilement. Le clivage du moi-peau semble à l'œuvre dans l'exhibition et le versant perverti de désaveu de l'orgasme, cette équivalence peut alors produire une dépendance (scarifications compulsives). Le terme d'automutilation convient peut-être à l'aspécifique de la pulsion (de mort) dans la psychose. Il s'agit pour l'adolescent d'installer un sinthome de lien social par l'inscription d'une source à la pulsion.

Après avoir esquissé le statut des scarifications dans ces structures déjà formées, nous aborderons le fait clinique des scarifications « traumatiques » de l'adolescent. L'opération adolescente ramène une intrusion du Réel, un traumatisme infantile. Nous pouvons entendre le traumatisme, dans une conception stricte, comme une rencontre avec le Réel – ici - de la mort ou, dans une conception plus large, « un événement est considéré comme traumatique s'il donne lieu à une réorganisation psychique d'ordre symptomatique »(Mac Dougall). Ce psychotraumatisme exige un « scriptal », un support à l'inscription – à entendre comme « le corps fait trait pour le signifiant», c'est-à-dire évitement du symptôme. Dès lors, il y a lieu de viser à installer un transfert langagier en proposant un objet à la pulsion et au mieux la naissance d'un discours hystérique.

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